Somerset Domestic Abuse Needs Assessment 2017

Produced by Somerset Public Health, Somerset County Council

On behalf of the Safer Somerset Partnership

Contents

1 Introduction

Domestic abuse is an international issue that also affects many men, women and children within Somerset. It can create health, social and economic inequalities and also sadly can lead to death. It's therefore an issue that's vitally important for all sectors of society, and so this needs assessment has been created in order to help illustrate the scale of domestic abuse and what can be done to help not only raise awareness but also to ensure victims and perpetrators can access the support that they require.

2 Executive summary

Domestic abuse is an issue that affects Somerset and which leads to many inequalities for women, men and children within the county.

According to data analysis approximately 57,000 adult residents (aged 16-59) have ever been a victim of domestic abuse in Somerset, with 17,300 residents being a victim of domestic abuse within the past year (July 2015 – June 2016). Partner abuse was the most prevalent type of abuse experienced by victims, with family based abuse being less common but still suffered by over a third of domestic abuse victim.

In 2017 the Somerset Domestic Abuse Board will commit to a set of standards to reflect the commitment of both statutory and specialist organisations to tackle domestic abuse. There is also a commitment to learning the lessons from local and national domestic homicide reviews to help improve the response to those affected by domestic abuse in Somerset.

Key Findings

This needs assessment has highlighted several ways that the co-ordinated community response to domestic abuse can be progressed further and help achieve the strategic aims, including:

Monitor data, quality and access issues – including:

- Monitoring how long people are being abused before they seek help. Effective intervention at an earlier stage will reduce the harm and inequalities that domestic abuse causes.

- Monitoring the effectiveness of action to support perpetrators of domestic abuse who recognise their harmful behaviour and want help to stop

Make sure evidence based action takes place, including:

- Making sure specialist support services are enabled to be part of networks and partnerships with statutory, voluntary and private sector organisations so that effective multi-agency working can take place to help support those who need it

- Make sure there is an increase in the uptake of specialist training so that the signs of domestic abuse are widely recognized and can be referred as required to local specialist support

Consider other steps, including:

- Considering developing closer-working with schools to ensure every child receives education on healthy relationships including domestic abuse.

- Considering supporting victims/survivors whose families have been affected by multiple issues of mental health, substance misuse and domestic abuse, in a gender responsive way to recognize that the needs of men and women are different.

3 Recommendations

Recommendations in this document do not take account of what is already happening within the county or what is already in place. Therefore many of the recommendations may only serve to reaffirm existing action, plans and practice. The current structure of domestic abuse support amongst specialist services, partner agencies and others should be considered in conjunction with the recommendations of this needs assessment when developing strategy. The only exceptions are where there are formal multi-agency agreements. Appendix Two identifies where each recommendation maybe monitored.

The recommendations are split into three groups and defined by the first word or phrase:

- Monitor – data surveillance, availability and quality issues
- Make sure – steps which should be taken based upon guidance and evidence provided
- Consider – steps which appear to be beneficial but where data is inconclusive as to their effectiveness.

A fourth group are any recommendations which are taken directly from national guidance will be listed by the organisation (for example “SafeLives”).

1. Monitor domestic abuse incidents reported to the police and prosecutions of Somerset perpetrators. If reported crimes or successful prosecutions (both in number and as a proportion of all prosecutions) do not increase then it will be important to understand why this is not happening.
2. Make sure that local support for perpetrators is easily accessible for people who recognise their own abusive behaviour and want help to stop.
3. Considerer incorporating Women's Aid’s LASTS (Listen, ask & act, specialist support, tools, sustained independence and freedom) model into future strategies and local practice amongst all agencies – not just specialist domestic abuse support.
4. Make sure specialist support services for victims and survivors of domestic abuse link with other support agencies and third-sector groups in the county,

possibly with joint protocols, so that multi-agency support for specific issues can be effectively delivered to those who need it.

5. Make sure all or the appropriate staff in criminal justice, health and other appropriate settings are trained to recognise the signs of domestic abuse and how to respond when victims present to them (whether or not a disclosure is made) and that there is a clear pathway in place to support staff making referrals where appropriate.
6. Monitor the length of time people have been experiencing abuse before successfully receiving the help they need. If this is not reducing then understand why this is the case and consider if more can be done to identify victims and perpetrators early.
7. Make sure that there is joint working between domestic abuse specialist services and other agencies involved in children's safeguarding (for example Police, Children's Social Care, Youth Offending Team, Targeted Youth Support, Leaving Care, drug and alcohol services and mental health services) so that early identification and interventions can be made to prevent the very serious and life-long effects of domestic abuse from becoming any more severe.
8. Make sure professionals who interact with children at home (for example health visitors), at school (for example school nurses and teachers) and other settings (for example GPs) are trained to identify signs of domestic abuse in children and respond appropriately.
9. Make sure domestic abuse, mental health and substance misuse specialist services work together to identify as early as possible and then support complex individuals who face multiple issues ('Hidden Harm'), to identify children and families at risk as a result of this and to work together to safeguard the children and reduce the risks to everyone involved including perpetrators of domestic abuse.
10. Make sure all contacts to treat substance misuse, domestic abuse or mental health focus on the needs of all family members particularly the children; but without pathologising all children (assuming they will be negatively affected) and without pre-conceptions. [1]
11. Monitor outcomes for perpetrators, witnesses and victims assessing specialist domestic abuse support services as part of routine performance management, including monitoring where clients drop out of a service.
12. Make sure that all staff from specialist domestic abuse, mental health and substance misuse services receive awareness, screening and referral (level 1) training as a matter of course. Multi-agency training looking at case management, information sharing, actions and roles (level 2) training should also be received by all staff but should be delivered with staff from different agencies attending training together to share expertise. [2]
13. Consider gender responsive approaches when supporting victims whose families have been affected by multiple issues of mental health, substance misuse and domestic abuse.

14. Make sure mental health and substance misuse agencies consider how to incorporate a greater understanding of the impact of trauma on the clients' presentation and treatment engagement. [3]
15. Make sure that staff are aware of options to help them assist victims in finding solutions to leaving their abusive relationship, that don't further endanger the pet(s) or risk the victim losing their pet(s).
16. Make sure that local groups, communities, housing providers, homelessness prevention services and businesses have access to information and tools to support them in preventing, identifying and reporting (possibly including referring) cases of domestic abuse.
17. Consider engaging employers within Somerset and signposting to the *16 days of action* campaign material.
18. Monitor prevalence and levels of need for substance misusing clients around domestic abuse and for domestic abuse clients around substance misuse in collaboration with substance misuse commissioners.
19. Make sure that both domestic abuse and drug and alcohol service staff are trained to identify all of the needs of their clients around both of these issues and to work together to ensure that the vulnerable people receive all the support that they need. This also should include determining if domestic abuse victims who misuse drugs and alcohol encounter barriers to access specialist support – e.g. refused access to refuge or safehouse accommodation. Where barriers can and do exist, an options appraisal should occur to help shape appropriate service provision.
20. Monitor the prevalence of different experiences (perpetration, witnessing and being a victim) of domestic abuse recorded amongst people accessing substance misuse services once the improved data collection is in place post April 2017: so that the local situation can be understood more clearly. This will also allow commissioners of services to identify areas of good practice, improvements and closer working between providers.
21. Make sure that the reasons why fewer people than expected appear to be accessing domestic abuse services from mental health services are understood and take any necessary steps to rectify any issues in the pathways.
22. Make sure that the wider workforce is able to identify the signs of financial difficulties, particularly amongst women and mothers who may be more at risk, and to signpost individuals to support.
23. Consider domestic abuse services commencing offering financial management support as part of their work or as a referral as a prevention and harm reduction strategy working with medium risk and younger victims.
24. Make sure that domestic abuse services are routinely and effectively screening all clients (victims and perpetrators) for financial issues.[4]
25. PHE: healthcare professionals should support homeless individuals and families by supporting access to domestic and sexual violence and abuse

services, harm reduction and exiting services for women involved in prostitution.[5]

26. Make sure that the homelessness prevention teams within the district councils are aware of the domestic abuse support and pathways to help residents in need.
27. Where people are presenting as homelessness, the council makes sure the DASH RIC is completed where the presentation is related to abuse in the household.
28. Signposting to third-sector organisations that can help build social networks may be useful. Having visible information and signposting online so that it can be accessed by people who do not come into contact with services as well as promoting the helpline locally should be considered.
29. Consider working with schools to work towards every child receiving educational programmes focusing on healthy relationships, and challenging gender inequality, sexual stereotyping, and domestic abuse, should be integrated with work on anti-bullying and conflict resolution as a mandatory part of the Personal, Health and Social Education (PHSE) curriculum What works
30. Make sure the Somerset Public Health team shares information about relevant campaigns with the Somerset Domestic Abuse Board so they can feature in relevant communications planning.
31. Make sure that partnership and multi-agency working is a key part of any commissioning processes and the Somerset wide strategy to tackling domestic abuse.
32. Ensure that the NICE guidance and gaps for domestic abuse is incorporated into Public Social Partnerships (PSP) and future commissioning plans.
33. Make sure health visitor staff are trained in identifying the signs of domestic abuse and how to assess and refer individuals and families.
34. Make sure that all services dealing with vulnerable clients who may be at risk of domestic abuse are aware of the full range of support available within the county and that clear easy to follow pathways exist between all services.
35. Make sure national and local learning from domestic homicide reviews (DHRs) is acknowledged and introduced in Somerset.
36. Monitor domestic abuse flagged crimes within Somerset to identify local trends and respond to them. Avon & Somerset Constabulary will need to perform this analysis or make anonymised data available to the Somerset Domestic Abuse Board.
37. Monitor trends to make sure that when prosecutions are brought to court victims and witnesses are coming forward and are supported to do so.
38. Monitor the number of MARAC cases and the recent increase in rates. If this continues it will be important to understand why this is happening (for example it may be a result of better detection and interventions rates or improved pathways and not necessarily an increased prevalence of high risk victims)

39. Make sure that MARACs are responsive to repeat victims and take steps to understand why the proportion of repeat cases is currently lower than expected in Somerset.
40. Make sure partner agencies are engaged in identifying victims and making appropriate referrals to services at the earliest opportunity.
41. Monitor the reasons why perpetrators assessed for the programme are not offered a place onto the courses.
42. Monitor how many Somerset residents or people accessing Somerset services are being referred to refuge placements across the country if possible.
43. Consider developing a systematic training programme for staff for all partner agencies and particularly within specialist services to understand the particular cultural and communication needs of individuals from particular groups. This is particularly important so that staff have the tools to deliver effective support for people who are at risk of multiple or overlapping inequality.
44. Safe Lives: Services should proactively seek out victims from diverse backgrounds and early identification of victims and families from diverse backgrounds needs specific approaches. [6]
45. Make sure the strategy for tackling domestic abuse acknowledges the very clear gender inequality and, in terms of scale, focuses on reducing, ending and preventing domestic abuse affecting females.
46. Make sure that males have a safe environment to make disclosures and receive support when they need to while recognising that this need is much less common than for women.
47. Make sure specialist domestic abuse services support and link with midwifery services to implement the NICE guidance as fully as possible.
48. Contact and reunification plans for looked after children should take ongoing domestic violence in birth families into account and respect children's views. Work with adolescents, particularly those who are looked after and leaving care, should address their peer relationships.[7]
49. Specialist domestic abuse and substance misuse services for young people should work collaboratively with youth justice to make sure that these complex young people have access to holistic support around all issues. It is important that where young people and children are identified as drinking alcohol that potential issues of domestic abuse are also explored.
50. Make sure services are aware of the high levels of domestic abuse experienced by young people, young people's attitudes and the specific and different types of abuse that they experience which are often digital and changing. All agencies dealing with young people should be able to identify signs of abuse and be able to take action with the support of a clear pathway and process.

51. Services and staff supporting and in contact with older people have access to training around domestic abuse affecting older people and in identifying the signs.
52. Domestic abuse service staff receive training to help understand the specific needs of LGBTQ+ clients and that services are inclusive and accessible and adaptable to the needs of this group.
53. LGA/ADASS: Support to address domestic abuse should be offered if abuse is causing a carer's physical or mental health to deteriorate or preventing or hindering them from caring for another adult. [8]
54. Monitor the locations where victims referred to the specialist service were living at the time of their last domestic abuse incident to identify geographic areas which might benefit from targeted intervention. This data could be triangulated with the police domestic abuse flagged crimes data which was recommended to be used in the same way earlier in this report.
55. Home Office: It will be important to ensure good local links between agencies working with people with disabilities and domestic violence services to promote disclosures and referrals. The Disability Discrimination Act 1995 obliges service providers to ensure that people with disabilities can use their services. [9]
56. PHE: Domestic abuse service providers should be trained to recognise and respond to needs related to impairment and to develop a deeper under-standing of the impact of abuse on disabled people's lives.
57. Make sure staff in domestic abuse services are trained to identify signs of CSE and take appropriate action.

4 Aim

This document aims to understand the needs of victims, witnesses and perpetrators of domestic abuse and related offences and the levels of domestic abuse that might need to be addressed.

Ultimately the intention is to provide evidence-based recommendations to support the future commissioning of specialist domestic abuse services and the wider approach to tackling domestic abuse in Somerset.

5 Purpose

The needs assessment will be used to develop Somerset's next domestic abuse strategy.

Home Office guidance says that service users, service providers and the local community should have their needs considered in the decision-making process, through the development of a needs assessment. This document aims to fulfil this purpose. Wider stakeholders such as the police are critical to this process therefore the Somerset Domestic Abuse Board (SDAB) will have oversight of the needs assessment to ensure that this is the case. [10]

6 Scope

The main focus of the report is any form of domestic abuse affecting victims and perpetrators aged 16 and over and witnesses including children. Locally abuse within relationships between children under the age of 16 is also recognised and considered. The following specific domestic abuse related offences will all be considered individually:

- Sexual abuse
- Female genital mutilation (FGM)
- Adolescent to parent violence and abuse (APVA)
- Forced marriage
- Modern slavery
- Honour based violence (HBV)

7 Method

The national and local policy context and guidance will be considered first and the impacts and key risk factors will be discussed.

National prevalence estimates will be considered and applied to Somerset's population to understand the scale of the problem. This data will be supported by local service data from a number of sources. Prevalence and effects on individual groups which may be more vulnerable or face disproportionate rates of domestic abuse will be looked at. These groups will be identified using national evidence based guidance and local equalities directives.

The assessment will look at the evidence base where this has been synthesised or examined and the results have been published (usually specifically as guidance for commissioning in local areas) by:

- the Home Office, Public Health England (PHE), National Institute of Health and Care Excellence (NICE) and other governmental departments
- national charities especially SafeLives which is dedicated to ending domestic abuse and National Society for the Protection of Children (NSPCC) in relation to children witnessing domestic abuse.
- Two local authorities (Devon County Council and South Gloucestershire Council) within the South West who have appraised research within their own domestic abuse needs assessments that have been made publically available.

The needs assessment has not committed to examining the research base through systematic or narrative reviews or by any other method.

8 Definition of domestic abuse

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

Any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to: psychological, physical, sexual, financial and emotional.

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

Coercive behaviour is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim. This definition, which is not a legal definition, includes so called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group. [11]

9 Policy context

9.1 National

Evidence shows that females disproportionately experience repeat incidents of domestic abuse, sexual abuse and all forms of sexual violence and other forms of violence and abuse. All governments have a responsibility to progress the elimination of such gender-based violence under international directives upheld by the United Nations (UN). [12]

Domestic abuse can affect anyone. The UK government considers it to be unacceptable and tackling it to be a priority. In 2009 the outgoing Labour government released its *Together We Can End Violence Against Women and Girls: a Strategy* which introduced a requirement for local authorities to develop a local Violence Against Women and Girls strategy.[13] This was retained as a priority under the Coalition Government in its 2010 release a *Call to End Violence Against Women and Girls* (VAWG) which aimed to:

- **Prevent** such violence from happening by challenging the attitudes and behaviours which foster it and intervening early where possible to prevent it;
- **Provide** adequate levels of support where violence does occur
- work in **partnership** to obtain the best outcome for victims and their families;
- and take action to **reduce the risk** to women and girls who are victims of these crimes and ensure that perpetrators are brought to justice[14]

In March 2016 the strategy was refreshed by the current Conservative government for the years 2016-2019 emphasising that national and local government, local partners and agencies and every community must work together: to prevent women and girls from becoming victims in the first place and make sure those who have experienced abuse receive the support they need to recover. The UK Government want to see a reduction in the levels of all forms of violence against women and girls but at the same time to see a corresponding increase in reporting, police referrals, prosecutions and convictions.[15]

® Monitor domestic abuse incidents reported to the police and prosecutions of Somerset perpetrators. If reported crimes or successful prosecutions (both in number and as a proportion of all prosecutions) do not increase then it will be important to understand why this is not happening.

In 2014, the Annual Report of the Chief Medical Officer focused on Women's Health, and a chapter of the report was dedicated to gender-based violence against women. The report included recommendations that policy work should include initiatives that challenge gender stereotypes, involve men and boys, and address the needs of vulnerable groups. Moreover it was recommended that the National Institute of Health and Care Excellence (NICE) guidelines PH50, 2014 were implemented in local areas and used to commission services, ensuring the inclusion of marginalised groups.[16]

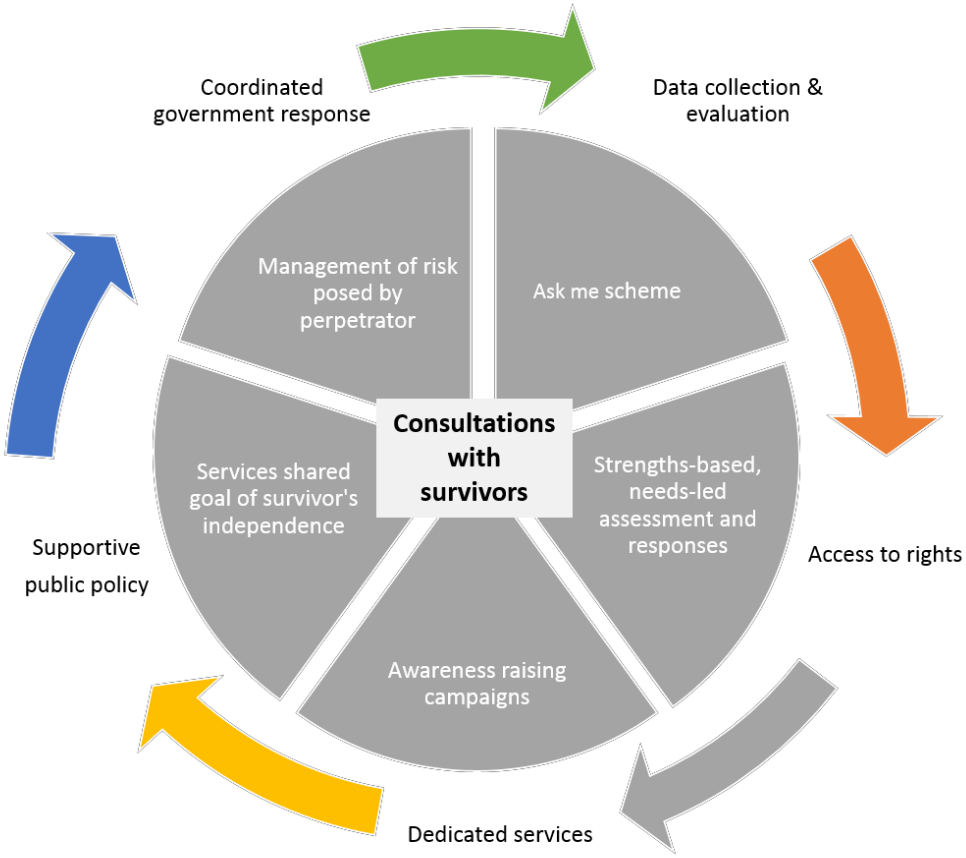
Government policy states that it is important to work with perpetrators of domestic abuse. Perpetrator programmes can help perpetrators to end their abusive behaviour and to address the impacts that their actions can have on their children. This is particularly important for men, most of whom will maintain contact with their family and move onto new relationships potentially creating new victims.[17]

® Make sure that local support for perpetrators is easily accessible for people who recognise their own abusive behaviour and want help to stop.

Another way that this effect can potentially be mitigated is the '*domestic violence disclosure scheme'* otherwise known as 'Clare's Law' which the government introduced from March 2014.[18] This gives an individual (the 'right to ask') or an agency that believes an individual is at risk (the 'right to know') the right to ask the police to check if a new or existing partner has a violent past. If records show that an individual may be at risk of domestic abuse from a partner, the police will consider disclosing the information. A disclosure can be made if it is legal, proportionate and necessary to do so. [19]

Women's Aid (England) and Welsh Women's Aid have worked in partnership to develop a new, cross sector model response to domestic abuse: Change that Lasts. Their LASTS model is described as follows: [20]

- **L**isten – always listen to survivors and place their needs at the centre
- **A**sk & Act – ask the right questions safely & act appropriately
- **S**pecialist support – know when and how to refer to your local specialist service
- **T**ools – provide clear procedures, roles, information and training across agencies
- **S**ustained independence and freedom – [services] work together for an independent future for survivors



Source: Women's Aid (England) and Welsh Women's Aid

® Consider incorporating Women's Aid's LASTS (Listen, ask & act, specialist support, tools, sustained independence and freedom) model into future strategies and local practice amongst all agencies – not just specialist domestic abuse support.

9.2 Local

In Somerset the Interpersonal Violence Strategy was a collaboration of the Safer Somerset Partnership. In 2016 a new Somerset Domestic Abuse Board was formed to ensure that all relevant agencies are involved in the strategic oversight of the response locally and that organisations work together to tackle the issue. The Somerset strategy comprises four key themes in line with the national directives:[21]

1. Effective and Resilient System for Supporting Victims of Domestic Abuse
2. Break the Cycle of Victimisation and Offending with Effective Prevention Activity
3. Working in Partnership for Best Results

10 Impact of domestic abuse

10.1 On the individual

The human cost of Violence Against Women and Girls (VAWG) is high. Experiences of abuse have serious psychological, emotional and physical consequences and may contribute to multiple disadvantage or a chaotic lifestyle that might involve combinations of substance misuse, homelessness, offending behaviour, gang involvement, prostitution and mental health problems.[22]

Victims of domestic abuse have a higher rate of drug and/or alcohol misuse (whether it starts before or after the abuse): at least 20% of high-risk victims of abuse report using drugs and/or alcohol. Furthermore 40% of high-risk victims of abuse report mental health difficulties. 16% of victims report that they have considered or attempted suicide as a result of the abuse, and 13% report self-harming. Domestic abuse has significant psychological consequences for victims, including anxiety, depression, suicidal behaviour, low self-esteem, inability to trust others, flashbacks, sleep disturbances and emotional detachment. Domestic abuse victims are at risk of post-traumatic stress disorder (PTSD) – in one study as many as two-thirds of victims of abuse (64%) developed PTSD. Between 30% and 60% of psychiatric in-patients had experienced severe domestic abuse. [23]

® Specialist support services for victims and survivors of domestic abuse should link with other support agencies and third-sector groups in the county, possibly with joint protocols, so that multi-agency support for specific issues can be effectively delivered to those who need it.

In the year before they got effective help four in five high-risk victims (78%) and two-thirds of medium-risk victims (62%) reported the abuse to the police. Nearly a quarter of high-risk victims (23%) and one in ten medium-risk victims went to an accident and emergency (A&E) department because of injuries. In the most extreme cases, victims reported that they attended A&E up to 15 times.[24] One in five high-risk victims reported attending A&E as a result of injuries in the year before getting effective help.[25]

As well as short term injuries, victims of abuse suffer long-term physical health consequences. Health conditions associated with abuse include: asthma, bladder and kidney infections, cardiovascular disease, fibromyalgia, chronic pain syndromes, central nervous system disorders, gastrointestinal disorders, migraines/headaches. Domestic abuse often leaves victims with reproductive consequences too, including gynaecological disorders, sexually transmitted infections, pre-term (when a baby is born too early) and pregnancy difficulties. [26] SafeLives say that all services should make identifying make identifying domestic abuse part of their everyday practice. [27]

- ® Make sure all or appropriate staff in criminal justice, health and other appropriate settings are trained to recognise the signs of domestic abuse and how to respond when victims present to them (whether or not a disclosure is made) and that there is a clear pathway in place to support staff making referrals where appropriate.

SafeLives say that the success of local domestic abuse strategies should be judged on whether they have cut the duration of domestic abuse. [28]

- ® Monitor the length of time people have been experiencing abuse before successfully receiving the help they need. If this is not reducing then understand why this is the case and consider if more can be done to identify victims and perpetrators early.

10.2 On children (witnessing domestic abuse) and families

The impact of hearing or witnessing '*domestic violence'* can be very traumatic for a child and result in emotional or psychological abuse. [29] Children exposed to '*domestic violence'* are more likely to have behavioural and emotional problems. [30] Witnessing '*domestic violence'* can have significant short and long term effects on children's development, resulting, for example, in eating and sleeping disorders, and emotional and behavioural problems. Long-term effects can include poor educational attainment, anti-social behaviour, youth offending, high levels of teenage pregnancy, and alcohol and drug misuse. As children become adults, they are more prone to becoming victims or perpetrators themselves. Mothers living with '*domestic violence'* are often unable to protect their children from the direct and indirect effects of abuse, despite their best efforts. [31]

Domestic abuse perpetrated by a parent is a significant indicator of dangerous parenting by that parent. It's essential that any intervention to support children living in a domestically abusive household also provides effective and specialist support to the non-abusive parent.

- ® Make sure that there is joint working between domestic abuse specialist services and other agencies involved in children's safeguarding (for example Police, Children's Social Care, Youth Offending Team, Targeted Youth Support, Leaving Care, drug and alcohol services and mental health services) so that early identification and interventions can be made to prevent the very serious and life-long effects of domestic abuse from becoming any more severe.

Other effects on children can include emotional withdrawal, aggression or bullying, tantrums, vandalism, problem at school (truancy, speech and learning difficulties), attention seeking, nightmares, insomnia, bed-wetting, anxiety, depression, fear of abandonment, drug or alcohol misuse, eating disorders, constant colds, headaches, mouth ulcers, asthma and eczema.[32]

- ® Make sure professionals who interact with children at home (for example health visitors), at school (for example school nurses and teachers) and other settings (for example GPs) are trained to identify signs of domestic abuse in children and respond appropriately.

There is a major overlap between direct harm to children and domestic abuse - 62% of children exposed to domestic abuse in a recent study were also directly harmed.[33] A serious case review (SCR) takes place after a child dies or is seriously injured and abuse or neglect is thought to be involved - domestic abuse is a factor in half of them.[34] A third of children witnessing domestic abuse also directly experienced another form of abuse. [35] It is thought that at least 18% of children in domestic abuse households are injured as a result of the abuse. [36] People with a history of extensive childhood sexual and physical abuse are 15 times more likely to have three or more mental health conditions, 15 times more likely to commit suicide and 12 times more likely to be admitted to an inpatient unit.[37]

New SafeLives data shows that 85% of victims sought help from professionals on average five times in the year before they got effective help to stop the abuse. Regardless of whether the contact was about the abuse, each contact represents a chance to help the victim disclose the abuse and get help – a chance that was missed, leaving the family to live with abuse for longer. In recent years, an increasing number of victims and families have been identified by other agencies such as health and children's social services. But still too many families are only getting help when the abuse reaches crisis point and the police are called – and not every family gets the right help then. [38]

Four in five of the families where a child is exposed to domestic abuse are known to at least one public agency. But too often agencies do not link up what they know about risks to each individual in a family, so other children or adults at risk of domestic abuse are not identified. Children's services must actively link the risks between mother and child in cases of domestic abuse. And agencies focussed on adults – whether the victim or on the perpetrator – must make sure that they consider the risks to any children in the family. [39]

The impact of domestic abuse on the victim and on children even after they have achieved safety is severe and long-lasting. Families live with domestic abuse for too long before getting effective help: on average it is around two and a half years for high-risk abuse and three years for medium-risk. Given that many children living with domestic abuse are very young, the impact on them is severe. At the point when a victim gets help, the abuse is likely to be escalating in either frequency and/or severity. [40]

However it is important to note that domestic abuse can and does continue to happen even after parents have split up. In half of cases the domestic abuse continues following a parental break up and can happen during contact visits. [41]

Children, parents and families affected by the trio of domestic abuse, substance misuse and mental health

In order to safeguard and promote the welfare of children, parents must provide basic care, safety, emotional warmth, appropriate stimulation, guidance and

boundaries and stability. Mental illness, learning disability, substance misuse and domestic abuse can affect parents' capacity to address adequately these issues. A single disorder can negatively affect parents' capacity to meet their children's needs but the co-existence of these types of problems has a much greater impact on parenting capacity. [42]

Parental alcohol misuse is strongly correlated with family conflict and with domestic abuse. This poses a risk to children of immediate significant harm and of longer-term negative consequences. Alcohol plays a part in between 25% and 33% of known cases of child abuse. [43]

An internal Somerset County Council draft report considered Hidden Harm, defined as the actual and potential effects of parental substance misuse (drugs and alcohol), domestic abuse and mental health issues on dependent children. The aim when considering Hidden Harm is to 'intervene early with vulnerable children and young people in order to improve lifetime health and wellbeing, prevent mental illness and reduce costs incurred by ill health, unemployment and crime. It is anticipated that early intervention will bring benefits to the individual during childhood and into adulthood but also improve his or her capacity to parent'. [44]

Treatment of substance misuse, domestic abuse and mental health involves a range of stakeholders and service providers at any one time. In complex cases the involvement in assessments of practitioners from different specialist services will result in a better understanding of how parental problems impact on family functioning and parenting capacity. Robust professional links, joint protocols and procedures between children's and adults' services will help to ensure collaboration during assessments and service provision. [45] The significant impact of the trio of domestic abuse, substance misuse and mental health on the health and wellbeing of children and families is well evidenced; and the need for effective joint working is crucial.

- ® Make sure domestic abuse, mental health and substance misuse specialist services work together to identify as early as possible and then support complex individuals who face multiple issues ('Hidden Harm'), to identify children and families at risk as a result of this and to work together to safeguard the children and reduce the risks to everyone involved including perpetrators of domestic abuse.

It is essential that professionals who work with a specific one of these client groups consider the needs of all family members, particularly the children. At the same time it is important that professionals do not 'pathologise' all children who live in families where a parent suffers from mental illness, has problems with alcohol and drugs or is in a violent relationship. [46] A significant proportion of these children do not show any long-term behavioural or emotional disturbance.[47]

® Make sure all contacts to treat substance misuse, domestic abuse or mental health focus on the needs of all family members particularly the children; but without pathologising all children (assuming they will be negatively affected) and without pre-conceptions. [48]

The Training Exchange were commissioned Somerset County Council between November 2015 and September 2016 to produce a report on *Improving outcomes for children and parents affected by the trio of substance misuse, domestic abuse and mental health*. The main focus was of the project was the interface between the three specialist services to reinforce a 'Think Family' approach to responding to parental issues; improving communication between the 3 specialist areas; ensuring that they are working well together; and developing an outline joint working protocol.[49]

Research identified wider benefits to shared training: these included breaking down formal agency barriers, trust building, increased routine screening between the services, formal service linkage agreements, cross referral, development of effective working partnerships. [50]

As a result of this a joint protocol has been agreed in Somerset titled *Working Together to respond to parents and children affected by the trio of domestic abuse, mental health and substance misuse*. This is underpinned by the 'expectation that commissioned services in these 3 specialist areas will adopt this joint approach to meet the needs of this client group'. The shared vision is to:[51]

- Promote a shared understanding of the links between domestic abuse, mental health and substance misuse.
- Support staff working in domestic abuse, mental health and substance misuse services to understand the issues outside their own area of expertise and work in partnership.
- Promote co-ordinated and collaborative approaches and clear pathways through services for clients and families affected by domestic abuse, mental health and substance misuse.
- Promote collaborative approaches to risk assessment and management.
- Address inequalities in access to services.
- Improve health and social outcomes for clients and families affected by domestic abuse, mental health and substance misuse.

The domestic abuse, stalking and 'honour'-based violence (DASH) risk assessment is used for assessment by domestic abuse services across the country. It contains questions around mental health and drug and alcohol misuse, but they have limitations as they are open to misinterpretation, are not specific and are exclusive of certain conditions for the victim. [52]

- Question 5: Are you feeling depressed or having suicidal thoughts?
- Question 21: Has [name of abuser(s)] had problems in the past year with drugs (prescription or other), alcohol or mental health leading to problems in leading a normal life? If yes, please specify which and give relevant details if known.

The protocol standardises the assessment of domestic abuse, mental health issues and substance misuse issues across the services so that where a disclosure is made to any service about one of these issues, the staff at that service will use the appropriate tools (shown in the table below) before deciding on the most appropriate course of action. [53]

Issue	Tool or Response
Alcohol misuse:	Alcohol use and disorder identification tool (AUDIT) is used.
Domestic abuse	DASH risk indicator checklist.
Drug misuse:	The 30 day substance use profile or Somerset Young People's Screening and/or Assessment Tools.
Mental Health	Warwick -Edinburgh Mental Well-being scale (WEMWBS) (as a starting point)

The Somerset protocol also acknowledges that for person centred care there needs to be an element of care co-ordination and in all cases one agency and a named worker who will act as the care co-ordinator for the client and that this will be decided in conjunction with the client. [54]

Limited outcome data for perpetrators, victims or families should be recorded. Measuring the impact on families is vital. Approaches to outcome measurement include using key performance indicators to identify where clients complete or drop out of a service; and the adoption of validated outcome tools to measure effectiveness. [55]

® Monitor outcomes for perpetrators, witnesses and victims assessing specialist domestic abuse support services as part of routine performance management, including monitoring where clients drop out of a service.

One limitation in terms of data collection is that the specialist mental health service provider, Somerset Partnership NHS Foundation Trust, does not record parental status on the front screen of the client record. The 'Triangle of Care' (a three way partnership between staff, carer and patients)[56] is embedded in practice but this limitation means that parental status is not reportable. [57]

International evidence suggests that training to enhance the capacity for co-ordination, aligned to local clinical screening tools, assessment and referral processes is important.

® Make sure that all staff from specialist domestic abuse, mental health and substance misuse services receive awareness, screening and referral (level 1) training as a matter of course. Multi-agency training looking at case management, information sharing, actions and roles (level 2) training should also be received by all staff but should be delivered with staff from different agencies attending training together to share expertise. [58]

International research suggests that as the evolution of substance misuse and mental illness, differs for men and women, and the development of gender specific programmes may cater more efficiently for the needs of women. This includes greater emphasis on trauma and violence, women's family and intimate relationships, and attention to children in the context of women's treatment. [59]

Specifically using trauma-informed care which is described by Australian charity The Blue Knot Foundation as:

a strengths-based framework grounded in an understanding of and responsiveness to the impact of trauma, that emphasises physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment.[60]

- ® Consider gender responsive approaches when supporting victims whose families have been affected by multiple issues of mental health, substance misuse and domestic abuse.

- ® Make sure mental health and substance misuse agencies consider how to incorporate a greater understanding of the impact of trauma on the clients' presentation and treatment engagement.[61]

10.2.1 Animal abuse

Animal abuse is the intentional harm of an animal. It includes, but is not limited to, wilful neglect, inflicting injury, pain or distress, or malicious killing of animals. Where serious animal abuse has occurred in a household there may be an increased likelihood that some other form of family violence is also occurring. Acts of animal abuse may in some circumstances be used to coerce, control and intimidate women and children to remain in, or be silent about, their abusive situation. The threat or actual abuse of a pet can prevent women leaving situations of domestic abuse. [62] The perception that a loved pet will be left uncared for if a victim needs to get support remains a barrier for domestic abuse services.[63]

There were 64 (18%) specialist service outreach clients in Somerset who reported animal abuse by the perpetrator of their domestic abuse between April and December 2014.[64]

- ® Make sure that staff are aware of options to help them assist victims in finding solutions to leaving their abusive relationship, that don't further endanger the pet(s) or risk the victim losing their pet(s).

Outreach services tend to work with medium risk clients in the community and often within people's own homes. Outreach services can often be very effective in working with groups of people that might otherwise struggle to access support from services such as those living in rural or isolated communities.

10.3 On communities

There are wider societal costs of domestic abuse including those relating to criminal justice, healthcare, other services and time off having to be taken by survivors from paid employment and caring responsibilities.[65]

The Nottingham Crime and Drug Partnership has considered the impact of domestic abuse on local communities and suggested that domestic abuse on women, children and young people is likely to impact a local community in a number of ways including:

- Housing e.g. possible increase in the number of rent arrears, vacant properties, pressure on local housing authorities for re-housing
- Homelessness e.g. possible increase in the number of homelessness applications, heighten number of rough sleepers and people seeking emergency accommodation
- Poor mental & physical health may contribute to a community's poor health status
- Education e.g. underachievement, absenteeism
- Safety of women and children e.g. at work, at school, in public & at contact centres
- Neighbourhoods e.g. sights and sounds, resident turnover, poverty, breaking up of extended family and/or community groups
- Anti-social behaviour e.g. children and young people loitering around vacant properties, substance misuse, crime, decreased safety & stability of an area
- Local businesses and employment e.g. unemployment, high job turnover, absenteeism, anti-social behaviour such as vandalism and theft, decreased tendency to employ local people
- Increased pressure on local agencies for support such as Housing Authorities, the Police, Women's Aid, Health Services and the Voluntary Sector.[66]

® Make sure that local groups, communities, housing providers, homelessness prevention services and businesses have access to information and tools to support them in preventing, identifying and reporting (possibly including referring) cases of domestic abuse.

10.4 On business and the workplace

The 16 Days of Action Against Domestic Violence campaign by the Corporate Alliance in 2016 was supported by Public Health England. It aimed to support businesses to tackle domestic abuse and violence by providing a step-by-step toolkit. It has calculated that the annual cost of '*domestic violence'* to business is £2 billion. The campaign literature suggests that 58% of abused women will miss at least three days of work a month and 56% arrive late for work at least five times. At the extreme end 33% of all domestic homicides happen on workplace grounds. [67]

® Consider engaging employers within Somerset and signposting to the *16 days of action* campaign material.

Following an award of funding by the Avon and Somerset Police Crime Commissioner, in autumn 2016, Women's Aid (England) were commissioned by Somerset County Council to deliver a series of training days for organisations to understand more about how domestic abuse affects their employees, and how to help and support them. This also included guidance on developing appropriate HR policies and procedures and implementing them effectively. Over 60 people from across Avon and Somerset attended these training sessions.[68]

11 Risk factors and their effects

Services may miss victims who remain in a relationship with their abuser or those who do not have children living with them. Although friends and family may be the first to know about abuse, they may not know how to get help. And if they do use local or national websites or helplines to seek support, these may not be linked to local systems of support, so they might not get the right response. [69]

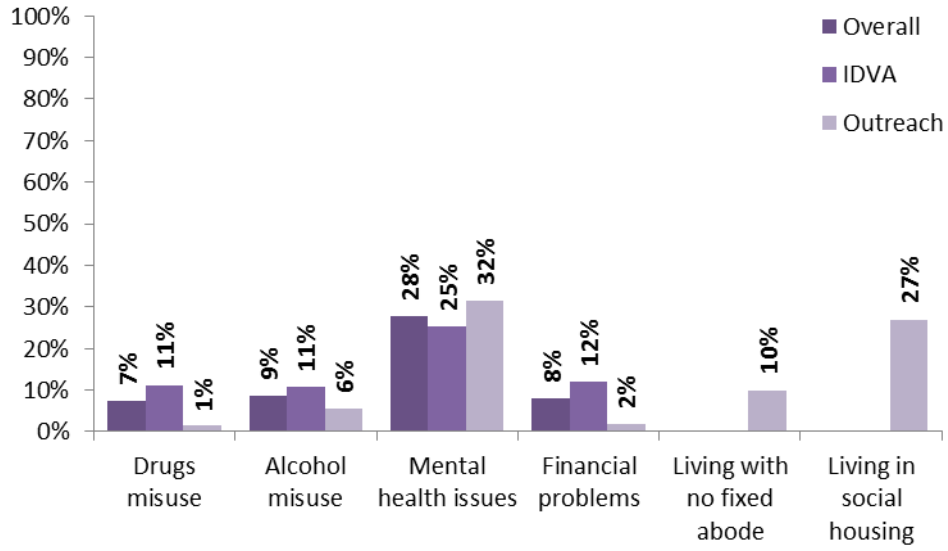
A child protection plan is put together by a local authority if a child protection conference decides that a child is suffering, or is likely to suffer, significant harm. In Somerset there were 522 children subject to a child protection plan at the end of March 2015 at a rate that was significantly higher than the England average.

In January 2015 the proportion of children on a child protection plan in Somerset who were affected by domestic abuse, substance misuse and mental health issues was 18%.[70]

Wherever appropriate, specialist domestic abuse services in Somerset are involved in the Child protection process

In 2014/15 the specialist domestic abuse service was split into outreach (including refuge) for medium risk clients and Independent Domestic Violence Advisors (IDVAs) for high risk clients. The table below shows the proportion of clients who accessed support from the domestic abuse service in Somerset in 2014/15 with risk factors. The most common risk factor was mental health issues for both high risk clients in the IDVA service and medium risk clients receiving outreach support.

The proportion of specialist domestic abuse service clients in Somerset with additional risk factors by service in 2014/15.



Source: Somerset County Council

11.1 Substance (drug and alcohol) misuse

Specialist drug and alcohol support services in Somerset are provided by the Somerset Drug and Alcohol Service (SDAS). SDAS currently considers people's drinking habits based on levels of risk. Research – based around slightly older terminology – indicates there are strong links between intimate-partner abuse and both 'drinking in the event' and 'problem drinking'. [71]

The Crime Survey for England and Wales (CSEW) for the 2014/15 financial year found a lower proportion (17%) of perpetrators had been under the influence of alcohol. However there were relatively high responses that were 'don't know' or don't want to answer' so the true figure may have been higher. The CSEW found that 10% of victims had been under the influence of alcohol last time they suffered abuse.[72] Previous research has found that around a third of domestic abuse victims said their attacker had been drinking. [73]

Drug misuse tends to be less of an immediate factor than alcohol misuse but has been found to be more common where misuse is chronic with 8% of victims reporting their perpetrator was under the influence of drugs.[74] This is supported by the 2014/15 CSEW which found that 10% of victims reported the perpetrator had been under the influence of drugs. Just 1% of victims reported that they themselves were under the influence of drugs. Again there is a caveat due to the number of responses where the respondent answered 'don't know' or don't want to answer' therefore figures given may be under represent the issue. [75]

® Monitor prevalence and levels of need for substance misusing clients around domestic abuse and for domestic abuse clients around substance misuse in collaboration with substance misuse commissioners.

A report for the mayor of London in 2005 found that almost two-thirds of women involved with domestic violence agencies who also reported having a substance misuse issue, said that they had started using substances following their experience of domestic violence. [76] Devon County Council's review of the evidence found that there was no or little evidence to suggest any causal link between drug misuse and domestic violence. However, victims may start using drugs or increase their use as a coping mechanism while women who are open about their substance use may find themselves excluded from refuge accommodation.[77]

® Make sure that both domestic abuse and drug and alcohol service staff are trained to identify all of the needs of their clients around both of these issues and to work together to ensure that the vulnerable people receive all the support that they need. This also should include determining if domestic abuse victims who misuse drugs and alcohol encounter barriers to access specialist support – e.g. refused access to refuge or safehouse accommodation. Where barriers can and do exist, an options appraisal should occur to help shape appropriate service provision.

The combined issues of domestic violence, mental ill-health and substance misuse have been identified as significant indicators of risk of harm to children and there is a need to ensure that agencies working with each of these issues is aware of the risks, is able to ask clients of their service about the other issues and works closely with

services specialising in the other fields. To this end a joint protocol has been developed in Somerset between: Somerset Drug and Alcohol Service (SDAS), Somerset Integrated Domestic Abuse Service (SIDAS) and Somerset Partnership NHS Foundation Trust as mentioned in the earlier section on the trio of domestic abuse, substance misuse and mental health. [78]

SDAS ask new clients coming into treatment if they have 'ever been affected by domestic abuse' – although clients may have been a victim, witness or perpetrator or any combination of these. Depending on the response this may lead the professional to complete a domestic abuse, stalking and 'honour'-based violence (DASH) risk assessment with the client. The question uses the phrase 'ever' which means the experience(s) could have occurred at any age. Overall in 2015/16 the proportion of women (aged 18 and over) who had ever experienced domestic abuse was 48% where this was recorded and the proportion for men was 18%.[79]

The CSEW demonstrates that women (26.3%) are more likely than men (13.6%) to experience Domestic Abuse within the past year (2015/16).[80] It would suggest that women who are receiving treatment for substance misuse are around 80% more likely to experience domestic abuse than the general population and the men are around a 30% more likely than men in the general population.

From April 2017 SDAS will be expanding the initial assessment to capture the more nuanced information about the experience of domestic abuse and the perspective(s) of the client. The questions that will be asked are listed below. These questions will be accompanied by a more detailed risk assessment of domestic abuse issues. This information should be considered by commissioners once available.[81]

1) Are you a perpetrator, victim or witness of domestic abuse? (multiple answers will be accepted)
2) Is the domestic abuse currently ongoing or was it in the past?
3) Are any children in the household involved or witnessing the domestic abuse?

® Monitor the prevalence of different experiences (perpetration, witnessing and being a victim) of domestic abuse recorded amongst people accessing substance misuse services once the improved data collection is in place post April 2017: so that the local situation can be understood more clearly. This will also allow commissioners of services to identify areas of good practice, improvements and closer working between providers.

The number of individual clients who had contact with SDAS in 2016/17 and who reported that they had ever experienced domestic abuse was 478 representing 17% of all those in contact with service: of these 406 clients accessed structured treatment (16% of the total in structured treatment).

This is a decrease on the previous year when there were 537 (20%) people in contact with SIDAS who had ever experienced domestic abuse and 420 of these who were in structured treatment (19.3%).

People accessing support from the Somerset Drug and Alcohol Services (SDAS) who said they had ever been affected by domestic abuse, 2016/17

2016/17		New starts	Total supported
Episodes	In contact	307	575
	In treatment	203	448
Individuals	In contact	269	478
	In treatment	188	406

There were 6 (2%) Somerset Integrated Domestic abuse Service (SIDAS) referrals in quarter 2 (June-September 2016) 2016/17 where the client reported having an issue with alcohol misuse and 9 (3%) with drug misuse. However in both cases this information was not provided in around 60% of cases so the true numbers could be higher. Between April and December 2014 the number of outreach and Independent Domestic Abuse Advisors (IDVA) clients who reported having an issue with drug misuse was 66 (7%) and it was 78 (9%) for alcohol misuse. The proportion of high risk IDVA clients with a drug (11%) or alcohol misuse problem (11%) was higher than for medium risk outreach clients (drug: 1%, alcohol 7%).[82]

11.2 Mental health

If someone has a mental health diagnosis the abusive partner may use it to undermine the victim's independence and control them even further. Women's Aid suggest that women with mental health diagnosis may find it harder to report domestic abuse than other women and are likely to face stigma due to their diagnosis. This can have a knock on effect accessing services as staff may not believe them, may only see them with their partner, may accept the partner's account and feel sympathy for the partner who is being abusive.[83]

More than one in three people with mental illness have experienced domestic abuse in the past year and one in twenty experienced sexual violence in the past year. People with mental illness are also almost four times more likely to experience violence in the past year than the general population.[84]

The mental health of a mother suffering domestic abuse is the most significant determinant of her child's resilience.[85] Women with anxiety disorder are over four times more likely to experience domestic abuse. Women with depressive disorder are over two times more likely than women without a mental illness to experience domestic abuse. Men with post-traumatic stress disorder are over seven times more likely to experience domestic abuse. [86]

In quarter 2 2016/17 there were 20 (2%) cases where the client reported having an issue with mental health. However this information was not provided in around 20% of cases so the true numbers could be higher. Between April and December 2014 the number of outreach and IDVA clients who reported having a mental health issue was 251 (28%) and 30 (3%) specifically identified self-harm as an issue. The proportion of outreach clients (32%) with mental health issues was actually higher than the proportion of high risk IDVA clients (25%).[87]

At the end of June 2016 there were 8,785 adults in contact with specialist mental health services in Somerset. [88] In 2015/16 a total of 2,798 young people (under the

age of 18) accessed community mental health services and 2,624 of these young people accessed the Child and Adolescent Mental Health Services (CAMHS).[89]

Given that one in three people with a mental health issue are expected to have suffered from domestic abuse in the past year: it would be expected that around 3,000-4,000 of these people might need support from domestic abuse services each year. However despite the potential underreporting the numbers of referrals to domestic abuse services was much lower. This may be because not everyone referred to Somerset Partnership had a diagnosable condition or did not meet the threshold for services.

® Make sure that the reasons why fewer people than expected appear to be accessing domestic abuse services from mental health services are understood and take any necessary steps to rectify any issues in the pathways.

11.3 Low income

Women in households with an income of less than £10,000 have been found to be three and a half times more at risk than those in households with an income of over £20,000. [90]

A report produced by Women's Aid for the Trades Union Congress (TUC) found that some survivors of domestic abuse had no money or were given an allowance by the abusers. It found that 67% of survivors in paid work at the time of the abuse agreed that their partner had monitored their work activities. Impacts of financial abuse included going without (71% of survey respondents went without essentials, 41% had to use the children's birthday money or savings to buy essentials); 61% were in debt and 37% had a bad credit rating; 77% said their mental health had been affected. [91] There is a suggestion that financial abuse and emotional abuse often preceding other forms of abuse and that it may be possible to identify these early and intervene to prevent the abuse escalating. Financial abuse is a barrier to leaving the abuser – some women had no money of their own. 52% of women survey respondents still living with their abuser said they could not afford to leave. [92]

® Make sure that the wider workforce is able to identify the signs of financial difficulties, particularly amongst women and mothers who may be more at risk, and to signpost individuals to support.

® Consider domestic abuse services commencing offering financial management support as part of their work or as a referral as a prevention and harm reduction strategy working with medium risk and younger victims.

The report identified that financial abuse continues after separation, often concerning difficulties getting child maintenance arrangements in place; legal disputes including court summonses; and disentangling joint assets. Some abusers take women's wages or benefits or get their (the victim's) benefits put in their own (the abuser's) name. There were particular problems for non-UK nationals claiming benefit. Of those victims who responded to their survey:

- 36% had asked no-one for help with the financial abuse

- 35% had told family
- 26% told friends
- 25% had asked a domestic violence service

The Government has said that, in cases of financial abuse, they can consider splitting Universal Credit between partners. But almost 85% of survey respondents agreed or strongly agreed with the statement that split payments would make the abuse worse when their partner found out.[93]

In Somerset between April and December 2014 the number of outreach and IDVA clients who reported having financial issues was 65 (8%). The proportion of high risk IDVA clients with financial issues however was much higher (12%) than for medium risk outreach clients (2%).[94]

This might suggest that high risk clients are more at risk of financial issues or that financial issues are associated with an increased risk of domestic abuse. Alternatively it may be that medium risk clients were not being engaged as effectively as they could be.

11.4 Homelessness

There is evidence that domestic abuse and homelessness can be linked.

® PHE: healthcare professionals should support homeless individuals and families by supporting access to domestic and sexual violence and abuse services, harm reduction and exiting services for women involved in prostitution.[95]

The homelessness charity, St Mungo's, has found that half of its female clients have experienced domestic violence and a third have said that this contributed to their homelessness. [96]

There were 443 households accepted as statutory homeless in 2014/15 at a rate that was significantly lower than the England average. However, family homelessness (defined as people accepted as statutorily homeless and in priority need (vulnerable) who had dependent children or were pregnant) was significantly higher than for England with 237 families meeting this criteria in 2014/15. [97]

® Make sure that the homelessness prevention teams within the district councils are aware of the domestic abuse support and pathways to help residents in need.

® Where people are presenting as homelessness, the Council makes sure the DASH RIC is completed where the presentation is related to abusive behaviour in the household.

The number of outreach clients between April and December 2014 living with no fixed abode was 35 representing 10% or one in ten of all outreach clients. A further 96 (27%) clients were tenants in social housing and whose accommodation status may be less secure. [98]

11.5 Social isolation

Services may miss victims who remain in a relationship with their abuser or those who do not have children living with them. [99] Refuge have said that abused women can become increasingly dependent on the abuser and it can be very hard to make sense of what is really happening. Over time the women's self-esteem may be worn down and she may start to believe her abuser's insults. She may blame herself for the abuse, deny that it is taking place or ignore it hoping that her partner will change.[100]

® Signposting to third-sector organisations that can help build social networks may be useful. Having visible information and signposting online so that it can be accessed by people who do not come into contact with services as well as promoting the Somerset helpline locally should be considered.

11.6 Intergenerational norms

There is evidence that women living in single-adult households (22.6%) are more likely to experience domestic abuse within the past year than women living in households with children and more than one adult (6.3%).[101]

In 2013 CAADA (now SafeLives) found that 61% of children in Independent Domestic Violence Advisory services in 2013 had been themselves subject to abuse.[102] Child maltreatment and domestic abuse between adults frequently co-exist. Since the 1970s, numerous studies have consistently found that between 65-77% of households where women are subject to domestic violence, children are also physically maltreated.[103]

The Early Intervention Foundation (EIF) argue that there is an overwhelming argument for a preventative approach. They have found witnessing domestic violence and abuse between parents irrespective of whether it results in direct physical harm to the child can have similar long-term consequences for a child to physical abuse that is targeted at the child. Children who have experienced domestic violence and abuse in the home display increased fear, inhibition, depression, as well as high levels of aggression and antisocial behaviour, which can persist into adolescence and adulthood. There is evidence to suggest that these children have later difficulty forming adolescent and adult relationships as a result of an increased propensity for violence, antisocial behaviour and a lack of trust. The overall costs to the public purse of domestic abuse are substantial without consideration of the wider long-term impact on mental health and intergenerational effects on child development.[104]

Women's Aid suggest that the "cycle of violence" otherwise known as the "intergenerational theory" is often referred to when considering the effects of domestic abuse on children; however research findings are inconsistent, and there is no automatic cause and effect relationship. They suggest that not every child who is a victim or witness to domestic abuse will grow up to be either an abuser or victim later in life. Instead they argue that Educational programmes focusing on healthy relationships, and challenging gender inequality, sexual stereotyping, and domestic abuse, should be integrated with work on anti-bullying and conflict resolution as a

mandatory part of the Personal, Health and Social Education (PHSE) curriculum in all schools.[105]

® Consider working with schools to work towards every child receiving educational programmes focusing on healthy relationships, and challenging gender inequality, sexual stereotyping, and domestic abuse, should be integrated with work on anti-bullying and conflict resolution as a mandatory part of the Personal, Health and Social Education (PHSE) curriculum What works

12 What works

The Government strategy for Violence Against Women and Girls (VAWG) states that this is a complex issue that needs sensitive handling by a range of health and social care professionals. The cost, in both human and economic terms, is so significant that even marginally effective interventions are cost effective.[106]

The cost to individuals cannot be measured but the costs of violence and abuse to the economy can be calculated and are considerable. Sylvia Walby's (2009) report estimates that providing public services to victims of domestic violence and the lost economic output of women affected costs the UK £15.8 billion annually. The cost to health, housing and social services, criminal justice and civil legal services is estimated at £3.9 billion.[107] More recently the Early Intervention Foundation (2016) estimates that the 'cost of picking up the pieces from damaging social problems affecting children, young people and families' in England and Wales is around £17 billion a year or £287 per person: £5.2 billion is associated with cases of domestic abuse.[108]

The *Violence Against Women and Girls Ready Reckoner* tool produced by the Home Office in 2010 suggests that domestic violence and sexual violence cost Somerset £55 million and this does not include human and emotional costs which are valued at £174 million. [109]

12.1 Primary prevention and intervention

Primary prevention interventions aim to prevent domestic abuse before it has even occurred by limiting exposure to risk factors and building resilience of individuals, families and communities. These interventions can be universal or target high-risk groups of people.[110]

The National Institute of Health and Care Excellence (NICE) have said that they were not able to find sufficient evidence to suggest any specific primary prevention programmes, commenting that most research in that area has been school based and that this is outside their remit.[111]

Public Health England (PHE) state' that preventing domestic abuse often focuses on changing the attitudes and norms that encourage abuse, on empowering those who may experience domestic abuse and on promoting non-abusive behaviour. Domestic abuse prevention often uses awareness campaigns, education, skills building, community mobilisation and participatory group education efforts. Evidence supports

the value of these various strategies for preventing more broad domestic abuse and shows significant reductions in both disclosures and violent crime incidents. [112]

® Make sure the Somerset Public Health team shares information about relevant national campaigns with the Somerset Domestic Abuse Board so they can feature in relevant communications planning.

PHE say that school-based education should focus on changing attitudes and norms that support domestic abuse and that teach children and young people about healthy relationships and consent. School-based education has led to significant reductions in perpetrating and experiencing domestic abuse.[113] A review for the World Health Organisation (WHO), by the London School of Hygiene and Tropical Medicine, found that schools-based programmes were the only effective prevention approaches targeting children through to young adulthood.[114]

12.2 Secondary prevention

The Domestic Abuse Stalking and Honour Based Violence (DASH) Risk Identification Checklist (RIC) was created in 2009 as a result of joint work between the National Police Chief Council (formerly ACPO) and Safe Lives (formerly CAADA) working with leading specialist academics. Its purpose was to create a tool that could be used by the Police and other agencies that would help identify victims, and create a culture of "ask", rather than relying on a victim to disclose without prompting. It (if staff are properly trained) also provides a consistent approach to risk assessment and identification of victims of domestic abuse across all multi-agency partners).

Secondary prevention is focused on the identification of domestic abuse and preventing further abuse from taking place or escalating. There is an emphasis on delivering early-interventions that are often very cost-effective and can significantly reduce the human and financial costs that can occur if the abuse becomes entrenched or escalates. [115] This encompasses awareness, training, early identification, improving access to services, risk assessment, multi-agency working, breaking the cycle of abuse (pattern changing and perpetrator work) and victim support services.

The NICE guidance PH50 *Domestic Violence and Abuse: multi-agency working* was published in February 2014. The guidance is clear that multi-agency partnership working is the most effective way to approach the issue both operationally and strategically.[116]

® Make sure that partnership and multi-agency working is a key part of any commissioning processes and the Somerset wide strategy to tackling domestic abuse.

NICE make a range of specific recommendations for commissioners and services.[117]

- ® Ensure that the NICE guidance and gaps for domestic abuse is incorporated into Public Social Partnerships (PSP) and future commissioning plans.

Programmes in GP surgeries and advice agencies have shown that it is possible to significantly increase identification. And these programmes may also reach a group of victims and families who are different to – and in some cases, more vulnerable than – those identified by other routes. [118]

In 2014/15 a project was launched to create a network of "champions" within GP surgeries who could help support their practices to effectively identify and support victims of domestic abuse. Through the securing of funding by Somerset County Council and the Police Crime Commissioner a co-ordinator was employed by Knightstone Housing as part of the Somerset Integrated Domestic Abuse Service in order to develop this network. Initially the key area of focus was within the Mendip and West Somerset areas of the county because of the proportionately lower level of referrals.

As a result of the success of this project, in 2015 it achieved a national "Community Impact" award by the National Housing Federation within the 'Health and Wellbeing' category.

For perpetrators of domestic abuse anger management is not recommended and could actually be dangerous.[119]

A review by South Gloucestershire Council found some promising evidence that visits by community health workers or nurses to households may be effective in reducing the future risk of abuse although this was not conclusive.[120]

- ® Make sure health visitor staff are trained in identifying the signs of domestic abuse and how to assess and refer individuals and families.

South Gloucestershire Council found that one study provided reliable evidence that for children suffering from post-traumatic shock disorder following exposure to domestic abuse, there is evidence that cognitive behaviour therapy (CBT) can help. [121]

13 Interventions and services in Somerset

13.1 Primary prevention

The Somerset Youth Offending Team currently delivers 'Healthy Relationships' group work within schools (including Pupil Referral Units) across the county. Additionally, it's understood that there are a variety of interventions delivered within schools across the county. However, the breadth and scope of each is unknown.

Perpetrator programmes are discussed in secondary prevention as they have been identified as a result of coming forward following an incident or experience of perpetrating domestic abuse. However there is also a primary preventative effect for any future relationships they may have if the relationship with the victim ceases.

13.2 **Secondary prevention**

Somerset County Council invests in a service to support victims of domestic abuse, their families, as well as help perpetrators who recognise they need help to change their pattern of behaviour.

The Somerset Integrated Domestic Abuse Service (SIDAS) is Somerset's main specialist service to provide support to men, women and children who are affected by domestic abuse. The SIDAS was commissioned from April 2016 and provides outreach support, refuge (female only) and safehouse (male and female) accommodation and programmes of support to men and women including for those who want to change their abuse behaviour in intimate relationships.[122]

The specialist services comprise of:

- Independent Domestic Violence Advisors (IDVA) for high risk adult clients
- Domestic Abuse Co-ordinators (DAC) for medium risk adult clients
- Young People's Violence Advisors (YPVA) for high risk young people (aged 13-19)
- Family Intervention Workers (FIW) to help children aged 3 to 15 years recover from the trauma and impact of domestic abuse they have experienced by working with their family.
- A series of pattern changing courses to help break the cycle of victimisation for adult victims.
- 'Lifeline' programme for supporting perpetrators who wish to break the cycle of offending.
- A domestic abuse helpline for professionals, victims and perpetrators as well as concerned others (such as family members, friends or neighbours of both victims and perpetrators).
- Refuge and safehouse accommodation

The Health and Schools Champion project is co-ordinated by SIDAS. The aim of this was to develop and support a network of domestic abuse/sexual violence champions in the two settings of schools/colleges (state, academies and independents) and primary health settings. The purpose of this was to raise awareness of the health and wellbeing impacts that domestic abuse and sexual violence have. During 2015/16, schools were prioritized and the following were visited and training and support provided to improve their awareness and response to domestic abuse: 32 schools were visited and 11 champions were identified. [123]

The SIDAS service has been targeted with increasing the proportion of referrals received from health and other sources. The intention is to identify at risk individuals and deliver early interventions to prevent issues from developing, as opposed to waiting for a domestic abuse incident to be reported to the police before victims can be referred to support. This is currently being achieved for all parts of the service with the exception of the high risk client groups referred to the IDVAs. [124]

Funding from Somerset County Council and the Police Crime Commissioner is being used for a support worker at Musgrove Park Hospital and another support worker with the South West Ambulance Service Trust (SWAST). These posts are designed to raise awareness about domestic abuse amongst hospital staff and paramedics as well as improving identification of victims and providing a new pathway for victims to be referred for support. Five females who have been experiencing domestic abuse have been identified and supported between in the first six months of 2016/2017. [125]

The service is also contractually required to achieve the Respect Safe Minimum Practice Standards accreditation for its voluntary perpetrator programme. This is a national accreditation standard awarded by the national domestic abuse charity 'Respect', that ensures a quality, safe service is being delivered.

My Change is a programme funded by the Police and Crime Commissioner's office designed as a training programme to help professionals support their clients who are 'lower risk' perpetrators of domestic abuse. Five staff have been trained and there is planning for a further 7 members of staff to be trained. The staff being trained are from SIDAS, Taunton Deane Borough Council, the One Teams and getset children's services. [126]

The Lighthouse unit at Avon and Somerset Constabulary provides victim support and an enhanced service to vulnerable, intimidated or persistently targeted victims of crime and anti-social behaviour, and victims of serious crime.[127]

Somerset Partnership NHS Foundation Trust delivers Health Visiting, School Nursing, Somerset-wide Integrated Sexual Health (SWISH) and urgent care services across the county. Somerset Partnership has a domestic abuse policy which aims to ensure staff identify and assess victims of domestic abuse and either directly support the victim or refer them to specialist domestic abuse services where appropriate. [128]

Health Visitors will routinely screen families for risks and signs of domestic abuse and will offer support for less severe cases. School nurses will not routinely screen children but must be aware of the signs, symptoms and risk of domestic abuse. They can offer support and listening time to children during term time. Both school nurse and health visitors have a clear pathway to receive support if unsure how to manage the contact and to escalate more severe cases. They will communicate with Children's Social Care whenever a domestic abuse disclosure is made.

Similarly SWISH staff will routinely question patients for domestic abuse at their first visit and provide information and advice and refer to services where appropriate. Emergency Nurse Practitioners at Minor Injury Units will follow the same process but will only screen patients where a patient raises something of concern for the clinician but does not make a disclosure. [129]

RSPCA Pet Retreat Scheme arranges foster care or adoption for the pets of domestic violence victims and operates in Somerset. The scheme also signposts human victims to support for humans affected by domestic abuse. The Dog's Trust Freedom Project and Paws for Kids schemes also covers some areas but the whole of England is not yet covered by the charities.[130]

The Bristol, Gloucestershire, Somerset and Wiltshire Community Rehabilitation Company (BGSW CRC) provides services aimed at rehabilitating medium to low risk offenders given community sentences by the Courts. The National Probation Service manages high-risk offenders. The Building Better Relationships programme (formally the Integrated Domestic Abuse Programme, IDAP) is a nationally accredited group-work programme run by community probation services in Somerset. It is designed to reduce re-offending by adult male perpetrators of Intimate Partner Violence and aims to reduce the harm and likelihood of reoffending for men who are violent or aggressive within a domestic setting. [131]

The Somerset and Avon Rape & Sexual Abuse Support (SARSAS) is a specialist support service for people in Bath and North East Somerset, Bristol, North Somerset, Somerset and South Gloucestershire who have experienced any form of sexual violence, at any point in their lives. This local specialist charity delivers a range of services including:

- Local support centres with skilled, knowledgeable, supported workers able to provide accessible high quality face to face support using evidence based models of practice within a trauma informed empowerment framework.
- Helpline and e-support services for all survivors to use for enquiry, anonymous ad hoc or ongoing support, safe disclosure, up to date information and crisis interventions.
- Awareness raising within the general public of services available, active sexual consent and attitudinal challenges contributing to a cultural shift of encouraging survivors to speak out and for others to support and stand alongside them.

The Bridge is a Sexual Assault Referral Centre (SARC). They offer medical care, emotional and psychological support, and practical help to anyone who has been raped or sexually assaulted.[132]

The Child and Adolescent Mental Health Service (CAMHS) Transformation Plan, led by Somerset CCG, identified a gap in support for young people who fall below CAMHS threshold. The emotional and mental health of children and young people is a priority concern for Somerset and childhood experience of abuse is a major predictor of mental health issues. Targeted consultation among stakeholders showed huge backing for a new service to support young victims of sexual abuse and trauma: as a result of this the Public Health team at Somerset County Council have led a commissioning process and a new support service for children and young people (aged 5 to 18) who have been a victim of sexual abuse and trauma will shortly be operating in Somerset. The overall vision for the service is to:

- Significantly reduce the negative impact child sexual abuse has on the lives of children and families living in Somerset
- Address problems before they become too serious and entrenched
- Innovate and build capacity to support children
- Work proactively with other stakeholders

- Ensure children and young people get the support they need to recover their childhoods and rebuild their lives [133]

® Make sure that all services dealing with vulnerable clients who may be at risk of domestic abuse are aware of the full range of support available within the county and that clear easy to follow pathways exist between all services.

14 Domestic Homicide Reviews (DHRs)

Since the drafting of this report the Home Office's *Domestic homicide reviews: key findings from research*, has been updated (December 2016). The content of the updated report has not been considered here. It should, however, be taken into account when considering responses to domestic homicide offence and prevention. This new report is available online at https://www.gov.uk/government/publications/domestic-homicide-review-lessons-learned.

When someone has been killed as a result of domestic violence (domestic homicide) a review should be carried out. In Somerset this is the responsibility of the Safer Somerset Partnership.[134] Professionals need to understand what happened in each homicide and to identify what needs to change to reduce the risk of future tragedies. [135] It is a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by a person to whom he was related or with whom he was or had been in an intimate personal relationship, or a member of the same household as himself,. It is held with a view to identifying the lessons to be learnt from the death.[136]

14.1 Definition

The definition of a Domestic Homicide Reviews (DHR) as per the Safer Somerset Partnership (Avon and Somerset) wide DHR protocol is as follows:[137]

1.1. DEFINITION AND PURPOSE FOR A DOMESTIC HOMICIDE REVIEW

The Definition of a Domestic Homicide Review is: (Para 12-13 – HO Guidance, 2013)

Domestic Homicide Review means a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:

a) A person to whom he was related or with whom he was or had been in an intimate personal relationship. It should be noted that an 'intimate personal relationship' includes relationships between adults who are or have been intimate partners or family members, regardless of gender or sexuality.

Or

b) A member of the same household as himself. This is defined in section 5(4) of the Domestic Violence Crime ad Victims Act (2004) as:

1) A person is to be regarded as a 'member' of a particular household, even if he does not live in that household, if he visits it so often and for such periods of time that it is reasonable to regard him as a member of it.

2) Where a victim (V) lived in different households at different times, 'the same household as V' refers to the household in which V was living at the time of the act that caused V's death.

1.1.1 A Domestic Homicide Review is held with a view to identifying the lessons to be learnt from the death.

1.1.2 So called 'Honour'-Based Violence, 'honour crimes' and 'honour killings' embrace a variety of crimes of violence (mainly but not exclusively against women), including, assault, imprisonment and murder, where the person is being punished by their family or community. They are being punished for actually, or allegedly, undermining what the family or community believes to be the correct code of behaviour. In transgressing against the code of behaviour, the person shows that they have not been properly controlled to conform by their family and this is to the 'shame' or 'dishonour' of the family.

1.1.3 Enquiries into abuse / neglect occurring in an institutional setting will not be classified under the DHR definition as 'household'.

1.1.4 DHRs can and should be considered in the circumstances of a suicide, where the death meets the criteria listed above.

14.2 Learning

Nationally, in both 2013 and 2016 the Home Office have produced reports identifying key themes arising from DHRs and what local areas should consider as a result. The national charity 'Standing Together' has also produced (2016) a report identifying key learning points from the reviews they have undertaken for multiple Community Safety Partnerships.

Locally, in 2015-16, the Community Safety Partnerships within Avon and Somerset received support from the Police Crime Commissioner to commission an independent review of the completed DHRs in the area, to identify common themes with the aim of also identifying how as an area we could work together to tackle domestic abuse. [138]

Additionally, in 2017 the Somerset County Council on behalf of the Safer Somerset Partnership completed a review of Somerset's DHRs in order to identify common themes.

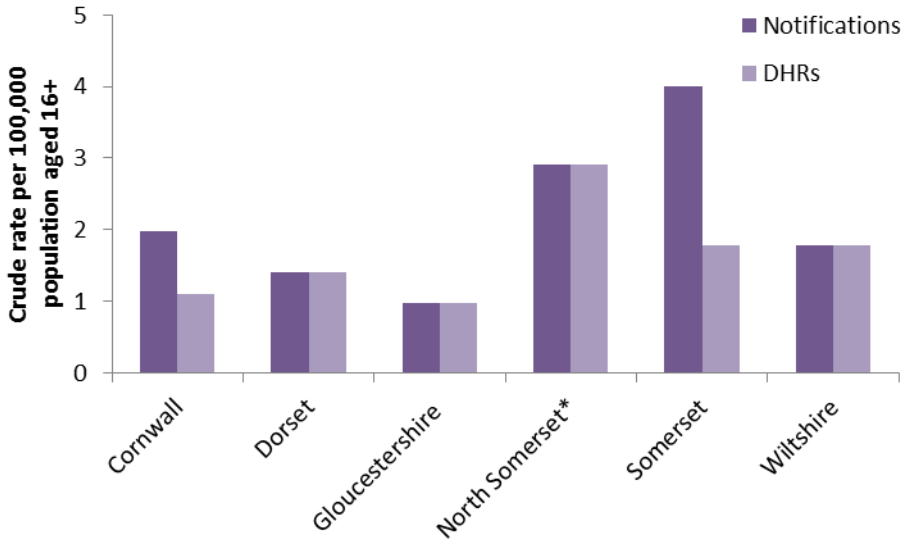
® Make sure national and local learning from domestic homicide reviews (DHRs) is acknowledged and introduced in Somerset.

The South West Domestic Abuse Network Survey of Domestic Homicide Reviews at December 2016 found that there have been 18 notifications of deaths in Somerset: 8

of these have met the criteria for a domestic homicide review while two are currently pending a decision.[139]

Compared with other areas in the South West that have responded to the survey Somerset appears to have a higher rate of notifications. However a smaller proportion of notifications have passed the criteria for a DHR than elsewhere. In Somerset 44% of notifications proceeded to a DHR although that figure could rise to 56% if the two pending meet the criteria. Cornwall (56%) was the only other area not to complete a DHR for all of their notifications. [140]

Death notifications and Domestic Homicide Reviews by upper tier local authority area, crude rate per 100,000 population aged 16 and over. [141]



Areas that did not respond to the survey or that had fewer than five DHRs have been excluded.
*includes suicides

15 Prevalence of domestic abuse – the scale of the problem

This sections aims to identify useful sources of data to understand the levels of domestic abuse that are perpetrated and experienced in Somerset. However, it is important to remember when considering data from sources – such as service providers and offences recorded by the police service – that most cases of domestic abuse are not reported. In fact many victims and survivors will not tell anyone about what has happened to them. Previous findings from the 2007/08 Crime Survey for England and Wales have found that only 11% of female victims of sexual assault have told the police and 40% of women had not told anyone. The prevalence figures in this section are therefore likely to be a quite considerable under-estimate. [142]

15.1 Somerset's Population

The Office for National Statistics (ONS) mid-year 2015 population estimates indicate that there are 545,000 people living in Somerset. There are around:

- 96,000 children under the age of fifteen

- 232,000 adult women and 217,400 adult men aged between 16 and 59
- 164,000 older people aged 60 and over

Around 51% of the Somerset population is female. [143]

15.2 Mortality

In 2013/14 there were 85 women murdered by their partner or ex-partner in England and Wales. This accounted for just under half (46%) of all murders of women aged 16 or over. In comparison, 7% of men murdered were killed by their partner or ex-partner. This means 1.6 women a week – or 7 a month – are killed by a current or ex-partner in England and Wales. It is estimated many more take their own lives as a result of domestic abuse: every day almost 30 women across Britain attempt suicide as a result of experiencing domestic abuse and every week three women take their own lives. [144]

15.3 Crime Survey for England Wales (CSEW)

All data in this section is taken from the Crime Survey for England and Wales (CSEW) year ending June 2016.[145] Somerset modelled estimates use Office for National Statistics mid-year 2015 population estimates as the denominator.[146]

Domestic abuse remains a 'hidden' issue in England. It is generally accepted that these issues are under-reported both to the police as crimes and in face-to-face interviews. It is impossible to get a full and true understanding of the levels of domestic abuse and the prevalence of different types of abuse. The best source of information is the CSEW. This includes a self-completion module allowing respondents anonymity and has been shown to increase the prevalence levels reported.

The proportion of people aged 16-59 reporting having been being a victim of domestic abuse in the past year (July 2015 – June 2016) has been between 6.1% and 7.0% in each year since 2009, although there has been a downward trend since 2012. In 2015/16 the proportion of respondents who said that they had been a victim of domestic abuse in their adult life (since the age of 16) was 20.0% and the proportion who had been a victim in the past year was 6.1%.

Applying these figures to Somerset's population suggests that around:

- 57,000 adult residents (aged 16-59) have ever been a victim of domestic abuse
- 17,300 residents were a victim of domestic abuse within the past year (July 2015 – June 2016)

The levels of domestic abuse committed by partners and by families are both reported. It is further broken down into four categories. A number of people who report being victims of domestic abuse will have experienced more than one of these categories and this should be considered when looking at the figures below. Unfortunately the cross-over is not reported but the categories are as follows:

- Partner abuse – non-sexual

- Family abuse carried out by a family member other than a partner (father/mother, step-father/mother or other relative) – non sexual
- Sexual assault
- Stalking

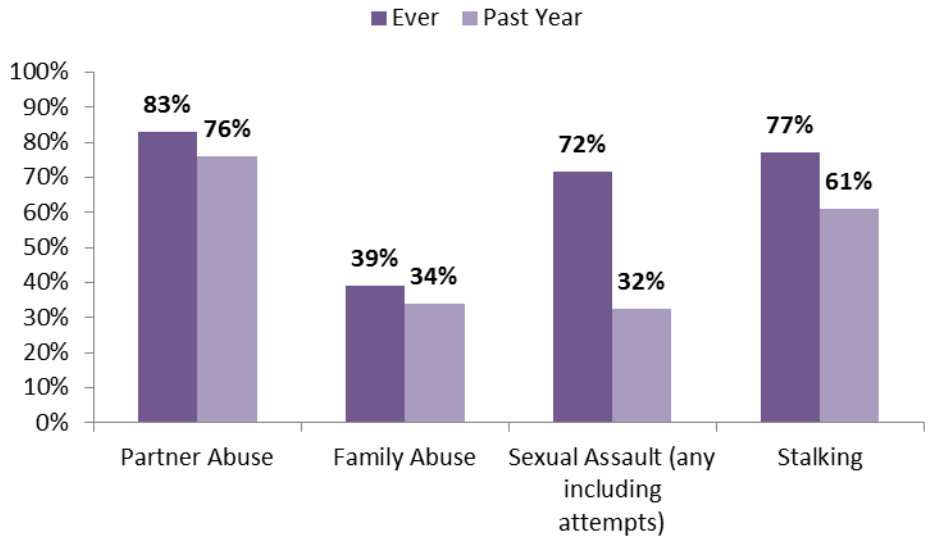
The figure below shows that partner abuse was the most prevalent type of abuse experienced by victims in both the past year (76%) and for those who had ever been a victim (83%).

Family based abuse was less common although it was still suffered by over a third of domestic abuse victims in the past-year (34%) and all-time victims (39%).

Three fifths of people who had ever experienced domestic abuse had experienced sexual assault (including attempts) but only around a third of victims in the past year had suffered a sexual assault (including attempts).

Stalking was also very common with 77% of all time victims having been stalked and 61% of those in the past year. Stalking was most likely to be committed by someone that was not a partner or family member but was more than twice as commonly committed by partners as it was by family members.

The types of abuse reported by past-year (July 2015 – June 2016) and all-time (since the age of 16) victims of domestic abuse.



Source: Crime Survey for England and Wales

The table below breaks down how likely someone reporting partner abuse is likely to experience different types of abuse and violence.

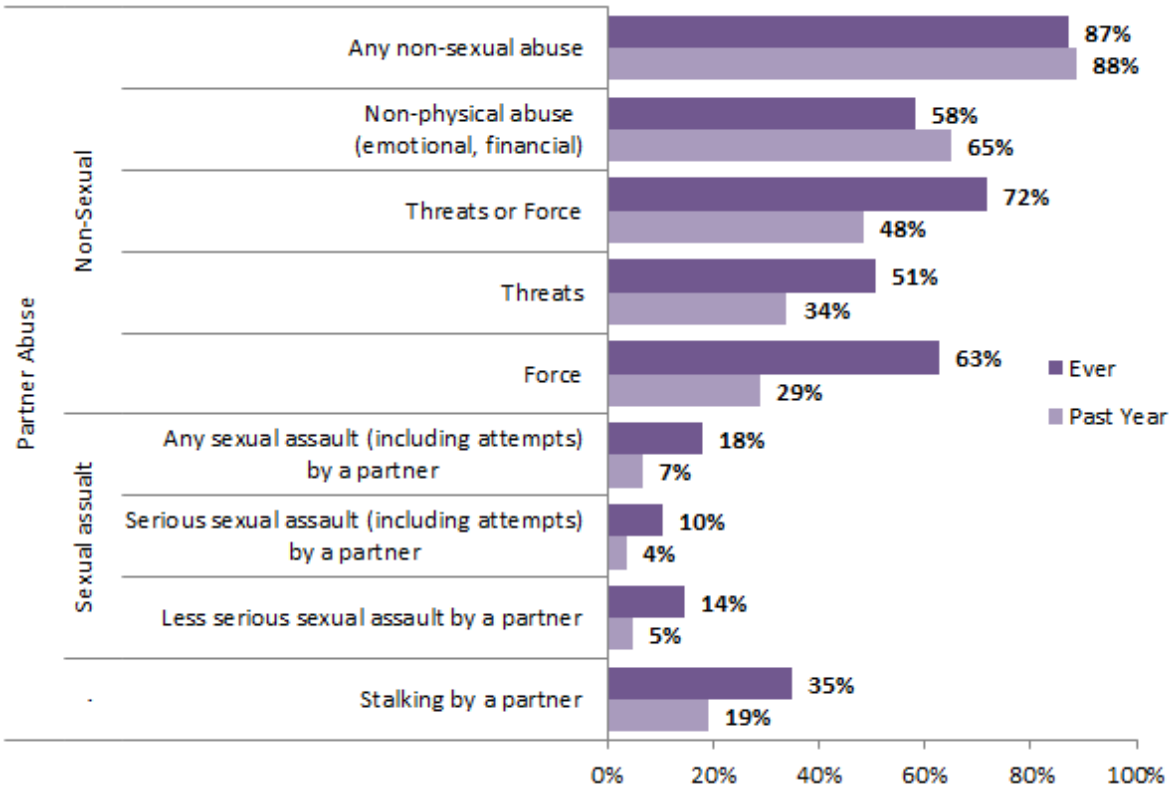
The majority (ever: 87%, past-year: 88%) of partner abuse victims had experienced some form of non-sexual abuse. Less than one in five (18%) had ever experience sexual assault by a partner and less than one in five (7%) had done so in the past year. In addition over a third (35%) of people experiencing partner abuse had been

stalked by a partner in their adult life and one in five (19%) had been stalked by a partner in the past year.

Non-sexual abuse was most likely to be non-physical abuse (emotional or financial) in the past year. Physical force was the most common for those who had ever been a victim but least common for those who were a victim within the past-year. This might suggest that force is experienced by more people but less regularly.

The proportion of all-time partner abuse victims who had also been subjected to a serious sexual assault (including attempts) by a partner was 18% and the proportion of past year victims was 7%: over half of these victims (ever: 10%, past-year: 4%) had been subjected to a serious sexual assault or attempt by a partner.

Specific abuse experienced by victims of partner inflicted abuse.



Source: Crime Survey for England and Wales

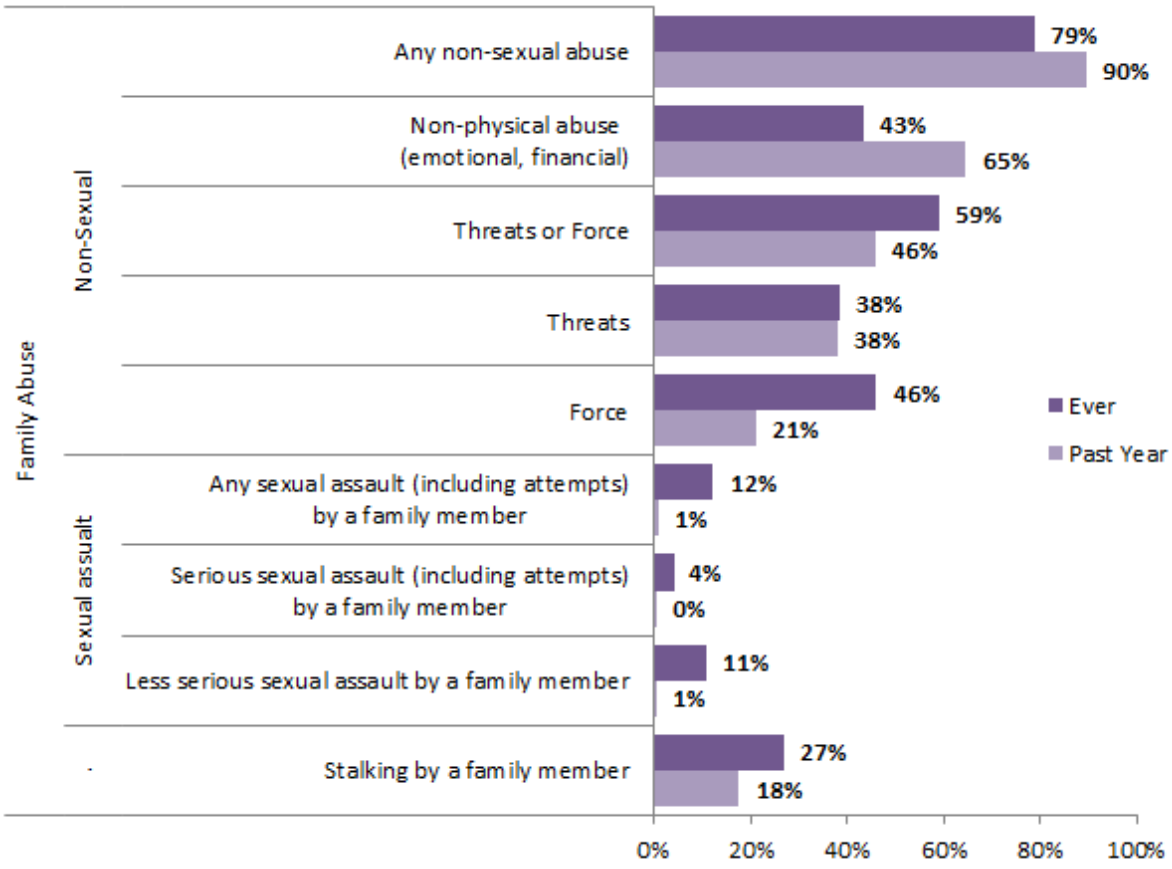
Similarly most (ever: 79%, past-year: 90%) victims of family based abuse reported non-sexual abuse.

The graph below breaks down how likely someone reporting partner abuse is likely to experience different types of abuse and violence. As with partner abuse non-sexual family abuse was most likely to be non-physical abuse (emotional or financial) in the past year and physical force was the most common for those who had ever been a victim.

Similarly to victims of partner abuse most victims of family based abuse (ever: 79%, past-year: 90%) had experienced some form of non-sexual abuse. Just over one in ten (12%) had ever experienced sexual assault by a family member and just 1% had so in the past year. However they were much less likely to experience a serious sexual assault or attempt from a family member than victims of partner abuse to from their partners.

In addition over a quarter (27%) of people who experienced family abuse in their adult life had been stalked by a family member and one in five (18%) had been stalked by a family member in the past year.

Specific abuse experienced by victims of family based abuse.



Source: Crime Survey for England and Wales

The chart below gives estimates for the number of Somerset residents that might be expected to be experiencing (past-year) or to have ever experienced domestic abuse in their adult life. These estimates are modelled on the Crime Survey for England and Wales (CSEW) and the Office for National Statistics (ONS) mid-year 2015 population estimates.

The number of people in Somerset who have ever been a victim of domestic abuse (since the age of 16) and who have been a victim in the past-year (July 2015 – June 2016) modelled on the Crime Survey for England and Wales (CSEW).

Any domestic abuse (partner or family non-physical abuse, threats, force, sexual assault or stalking)	**57,000**	Any partner abuse (non-physical abuse, threats, force, sexual assault or stalking)	**47,430**	Partner abuse - non-sexual	**41,390**	11,660	Non-physical abuse (emotional, financial)	**27,530**	8,570
							Threats or force	**33,990**	6,360
							Threats	**24,070**	4,470
							Force	**29,670**	3,780
			13,180	Any sexual assault (including attempts) by a partner	**8,460**	880	Serious sexual assault (including attempts) by a partner	**4,950**	500
							Less serious sexual assault by a partner	**6,870**	640
				Stalking by a partner	**16,450**	2,500			
		Any family abuse (non-physical abuse, threats, force, sexual assault or stalking)	**21,970**	Family abuse - non-sexual	**17,360**	5,310	Non-physical abuse (emotional, financial)	**9,530**	3,830
							Threats or force	**12,950**	2,710
							Threats	**8,430**	2,260
							Force	**10,140**	1,260
	17,280		5,930	Any sexual assault (including attempts) by a family member	**2,700**	60	Serious sexual assault (including attempts) by a family member	**900**	30
							Less serious sexual assault by a family member	**2,390**	30
				Stalking by a family member	**5,890**	1,040			
		Any sexual assault (including attempts)	**33,590**	Less serious sexual assault	**31,470**	4,900			
				Serious sexual assault including attempts	**9,300**	1,230			
				Serious sexual assault excluding attempts	**7,580**	760			
			5,600	- Rape including attempts	**8,040**	820			
				- Rape excluding attempts	**6,440**	540			
				- Assault by penetration including attempts	**6,230**	880			
				- Assault by penetration excluding attempts	**4,690**	420			
		Stalking	**44,030**						
			10,510						

Ever experienced
Experienced in the Past-Year

Note: Modelled estimates rounded to the nearest 10.
Source: Crime Survey for England and Wales

15.4 Recorded crime

15.4.1 Domestic abuse

The Home Office has been collecting information from the police, since April 2015, on whether recorded offences are related to domestic abuse. Crimes are "flagged" as being domestic-abuse-related by the police if the offence meets the government definition of domestic abuse. In the year to June 2016 the percentage of offences flagged in England and Wales was 11%. The offence types with the highest proportion of tagged crimes were violence against the person (32%) and sexual offences (12%).[147]

® Monitor domestic abuse flagged crimes within Somerset to identify local trends and respond to them. Avon & Somerset Constabulary will need to perform this analysis or make anonymised data available to the Somerset Domestic Abuse Board.

Applied to the 38,300 reported crimes in Somerset over the same period this would be the equivalent of 4,200 domestic abuse offences locally. [148]

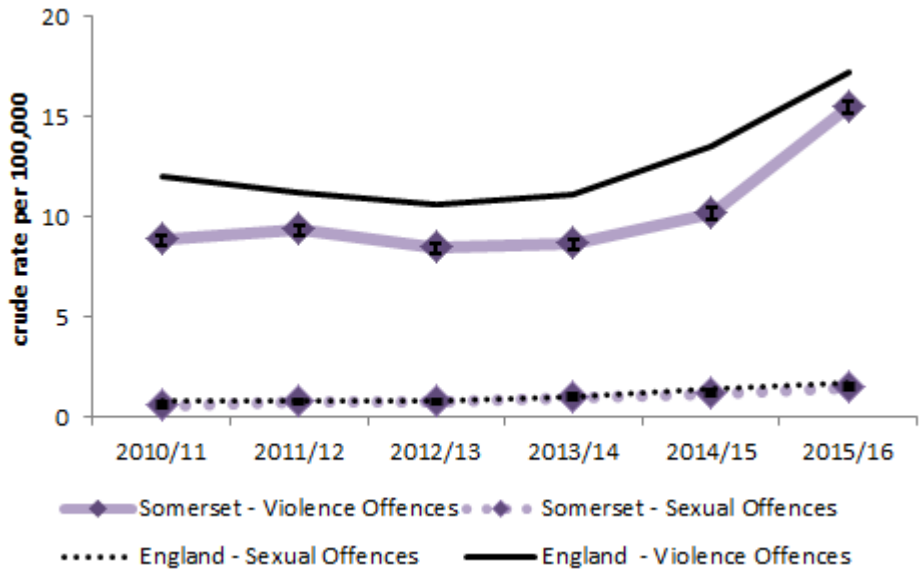
Applying this to the number of violent offences (8,386) and sexual offences (808) reported by Public Health England for 2015/16 it would suggests that 2,680 violence offences and 100 sexual offences will have been a result of domestic abuse incidents. [149]

The rate of domestic abuse incidents recorded by the police for people aged 16 and over in the Avon & Somerset Constabulary Police Force Area was 17.3 per 1,000 during 2014/15. This was significantly lower than the England average. [150] The force area includes Bristol, North Somerset, South Gloucester and Somerset. Therefore in reality the true picture would likely show a certain amount of variation in the rates between the different upper tier local authority areas.

15.4.2 Violence and sexual offences

There were 808 sexual offences and 8,386 violent offences recorded by the police for Somerset in 2015/16 at a rate that was significantly lower than the England average. There have been significant increases in the rate of violent crime recorded within Somerset over the past two years. However, at this stage it is believed that this is largely a result of process improvements rather than being a result of significantly higher levels of violent crime. Furthermore many of the violence offences will be unrelated to domestic abuse.[151]

The crude rate of Violence and Sexual Offences in Somerset.[152]



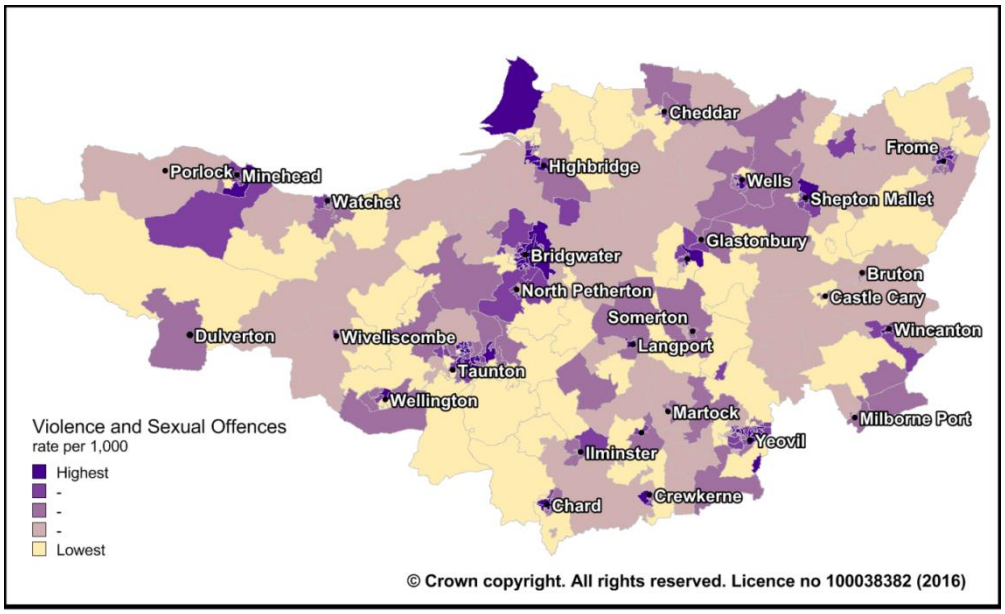
Source: Public Health England

Data from the website https://data.police.uk/ has offences based on small neighbourhood areas known as lower layer super output areas or LSOAs. At the time of the 2011 Census each LSOA represented around 1,500 people on average. However the dataset combines sexual offences and violence offences into a single category.

There were 8,640 violent and sexual offences recorded by Avon & Somerset Constabulary in Somerset in 2015/16 as reported by https://data.police.uk. However, it is likely that only between 12% and 32% of these crimes will be related to domestic abuse based on national Home Office data.[153] The map below shows the variation in the rate of these offences by neighbourhood. This shows that rates of reported sexual and violent crimes are higher in urban areas. The rates are likely to be more a

reflection of the violence offences as they are much more common than sexual offences.

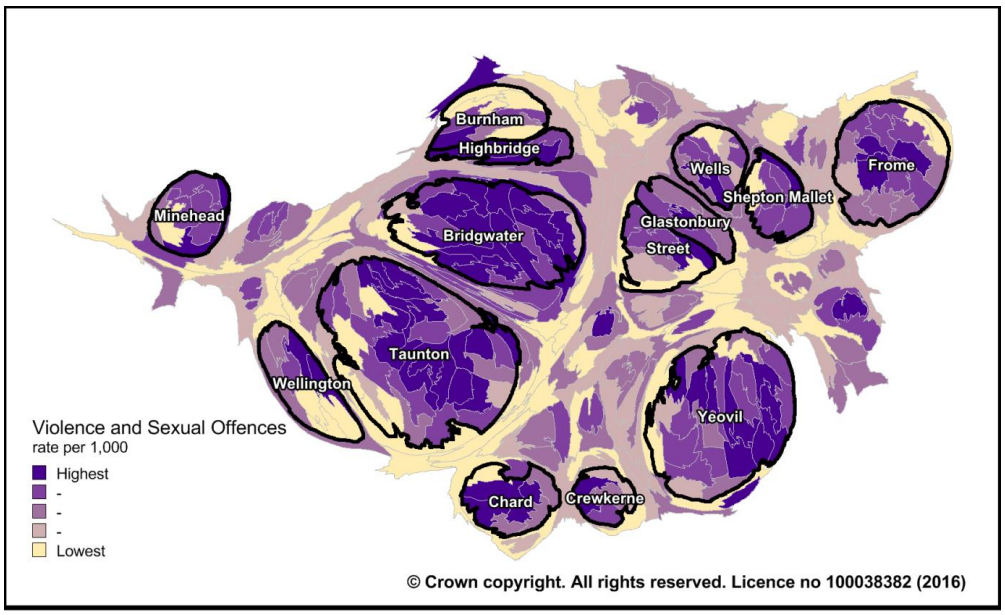
The crude rate of Violence and Sexual Offences by Somerset Neighbourhood (LSOA), 2015/16.[154]



Source: Office for National Statistics, data.police.uk

The second map below shows exactly the same information but the boundaries have been adjusted to represent the number of people living in each neighbourhood. The benefit of this map, known as a cartogram, is that it gives an accurate impression of how many people are affected in each area. Therefore rural and very sparsely populated areas (such as those in West Somerset) are much smaller and urban highly populated areas (such as Taunton, Bridgwater and Yeovil) are much larger.

The crude rate of Violence and Sexual Offences by Somerset Neighbourhood (LSOA) with boundaries adjusted to represent population size, 2015/16. [155]



Source: Office for National Statistics, data.police.uk

15.5 Domestic Violence Protection Notices (DVPNs) and Orders (DVPO)

Domestic Violence Protection Orders (DVPO) were implemented across England and Wales in 2014. A Domestic Violence Protection Notice (DVPN) can be applied in the immediate aftermath of a domestic violence incident and is valid for 48 hours. If appropriate, the police can then apply within the 48 hour window for a DVPO which can ban a perpetrator from returning to a residence and contact with the victim for up to 28 days. This allows time for the victim to consider their options and get the support they need. [156]

Both DVPN's and DVPO's are used in Somerset by Avon and Somerset Constabulary as part of their approach to tackling domestic abuse

15.6 Crown Prosecution Service (CPS)

As discussed earlier the UK Government want to see a reduction in the levels of all forms of violence against women and girls but at the same time to see a corresponding increase in reporting, police referrals, prosecutions and convictions.[157]

There were 281 defendants and 350 victims at the Yeovil specialist domestic violence court and 364 defendants and 138 victims at the Taunton court. The Government have said that they want to increase the successful rate of prosecutions. In Yeovil there were 48 successful prosecutions at a rate of 69% and in Taunton there were 256 at a rate of 70%.[158]

It is important that a high proportion of people who are required to attend court, as either a victim or witness, do actually attend. If the percentage that does not attend is high it may indicate that there are barriers to people coming forward with evidence or that victims/witnesses feel there are inadequate safeguards in place to protect them.

In Yeovil 85% of victims and 88% of witnesses required to attend did so while in Taunton 58% of victims and 76% of witnesses attended. [159]

® Monitor trends to make sure that when prosecutions brought to court victims and witnesses are coming forward and are supported to do so.

15.7 Multi-Agency Risk Assessment Conferences (MARACs)

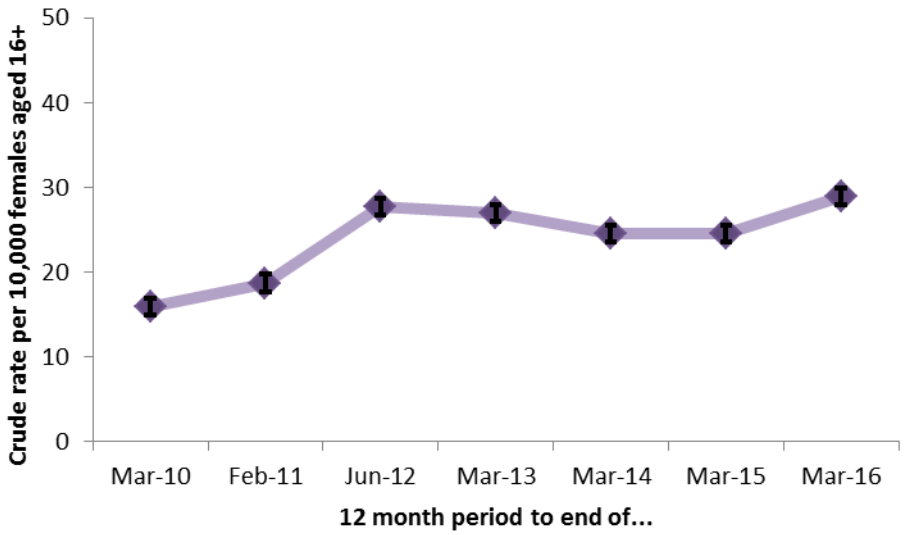
A Multi-Agency Risk Assessment Conference (MARAC) is a regular local meeting to discuss how to help victims at high risk of murder or serious harm. A domestic abuse specialist, police, children's social services, health and other relevant agencies all sit around the same table. They talk about the victim, the family and perpetrator, and share information. The meeting is confidential. Together, the meeting writes an action plan for each victim. They work best when everyone involved understands their roles and the right processes to follow. These meetings are called MARACs, but they are also referred to as a multi-agency risk assessment conference.[160]

The role of MARAC coordinators and administrators is to help to establish communication between all parties, give information to partner agencies about the MARAC process, where appropriate, work with the chair to identify agency gaps and establish links with these agencies to enable them to take part in the MARAC.[161]

Across the Avon and Somerset Constabulary area a review of the functionality and principles is currently being undertaken. In Somerset during 2015/16 there were 671 MARAC cases discussed in Somerset. The rate of MARAC referrals has been fairly steady in Somerset since the 2011/12 financial year, although there has been a statistically significant increase between 2014/15 and 2015/16.[162]

® Monitor the number of MARAC cases and the recent increase in rates. If this continues it will be important to understand why this is happening (for example it may be a result of better detection and interventions rates or improved pathways and not necessarily an increased prevalence of high risk victims)

Multi-Agency Risk Assessment Conference (MARAC) cases in Somerset. [163]



Note: March 2011 and March 2012 data was not available.
Source: Somerset County Council

The proportion of MARAC referrals from the police was 66% with a third coming from partner agencies who may be in a better place to identify victims at an earlier stage.[164]

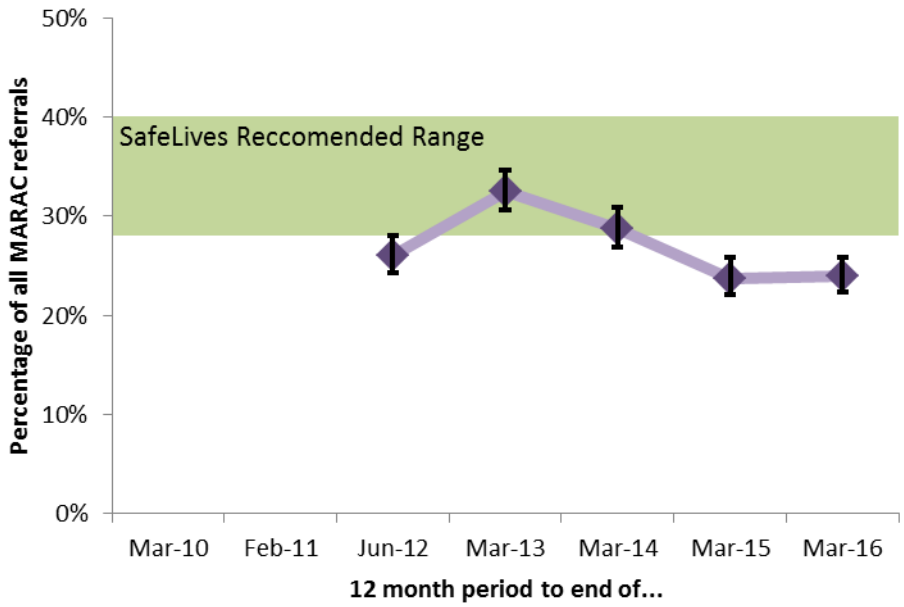
75% of all domestic abuse happens to victims who experience it repeatedly. It has the highest rate of repeat victimisation of any crime. 26% of victims have been victimised three or more times.[165]

A repeat MARAC case is one which has been previously referred to a MARAC and at some point in the 12 months from the date of the last referral a further incident is identified. [166] The proportion of MARACs that were repeat cases was 24% in 2015/16. This proportion has been significantly lower in the past two years than it had been in 2012/13 and 2014/15. [167]

The latest 24% figure is below the SafeLives recommended range of 28%-40%.[168] This recommended range is to ensure that services are easily accessible to clients who have a further incident soon after the initial incident, while still striving to ensure that the fewest possible number actually need intensive support from services again.

® Make sure that MARACs are responsive to repeat victims and take steps to understand why the proportion of repeat cases is currently lower than expected in Somerset.

Multi-Agency Risk Assessment Conference (MARAC) referrals in Somerset that were repeat cases. [169]



Note: Data only available from June 2012
Source: Somerset County Council

15.8 Somerset Integrated Domestic Abuse Service (SIDAS)

All data in this section has been provided by Somerset County Council unless stated otherwise.

A new Somerset Integrated Domestic Abuse Service (SIDAS) was commissioned from April 2015. The recording processes were still being developed throughout 2015/16 and therefore detailed data are limited to the six month period between April 2016 and September 2016 or in some cases the nine month period to the end of December 2016.

Throughout the report data is provided based on the information recorded for clients engaging with the SIDAS. In many cases the levels of completeness will seem low. Most notably no reliable data are available for the 2015/16 financial year because it was when the new service was implemented. Additionally due to the highly sensitive nature of domestic abuse many clients prefer not to share personal information.

The previous configuration of specialist domestic abuse services operated until the end of March 2015 and comprised of three separate services:

- Outreach – including refuge
- IDVA/pattern changing
- Make the Change – perpetrator

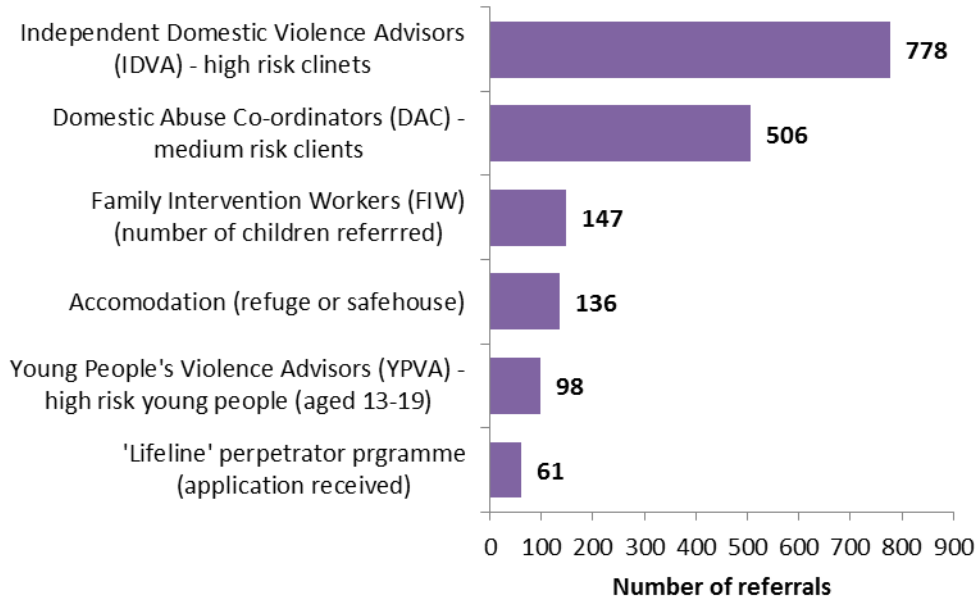
Data from the 2014/15 financial years have been provided where available as a reference.

15.8.1 Referrals

There have been 1,726 referrals to the SIDAS between April and December 2016. Some individuals will have been referred on more than one occasion so this should not be considered a true reflection of the number of people accessing the service. The types of referrals received are shown in the table below.

SIDAS is an integrated service and it is expected that a client's risk and needs will change over time and that they will move between different parts of the service as required. In the nine month period there were 171 internal transfers between different parts of the service. These internal transfers are included in the table here as well.

The number of referrals to specific SIDAS service areas in the period between April and December 2016.

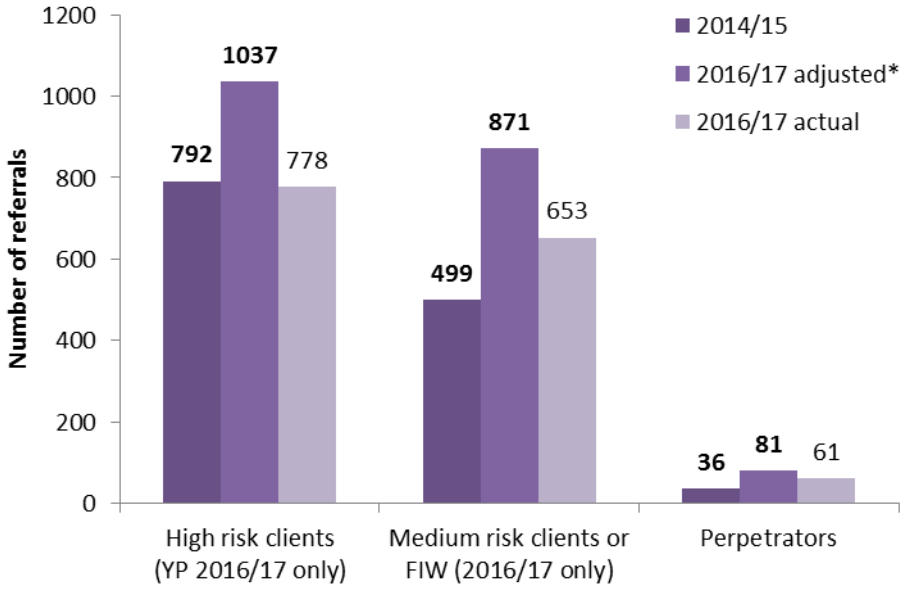


Source: Somerset County Council

During 2014/15 there were 1,327 referrals to specialist domestic abuse services in Somerset. Referral data is not available for any of 2015/16 but there were 949 individual clients in contact with SIDAS throughout the year.

In the first nine months of 2016/17 the numbers of referrals received seem to suggest a considerable increase on the 2014/15 financial year. This may be in part due to the new young people's violence advisor (YPVA) function for high risk clients aged 13-19 and the new family intervention worker (FIW) function for children and their families. It may also reflect improved identification of victims and cases and more effective pathways to support.

The number of referrals to specific SIDAS service in 2016/17 and the previous specialist domestic abuse service configuration in 2014/15 by client grouping.



Source: Somerset County Council

Figures do not include referrals to refuge and safehouse accommodation.

*2016/17 figures are only available for nine months and so have been adjusted here to estimate a full year's number of referrals by a simple multiple of 4/3.

15.8.2 Referral sources

Two fifths (41.5%) of all referrals to SIDAS, between April and December 2016, came from the police, 15.4% came from a local authority (county or district) and public health commissioned services (excluding SIDAS) and 6.1% were from the health sector.

The table below shows that the largest specific referral source is the Lighthouse unit which provides victim support and an enhanced service to vulnerable, intimated or persistently targeted victims of crime and anti-social behaviour, and victims of serious crime. One in ten referrals were internal SIDAS transfers.

The proportion of SIDAS referrals by referring agency, April to December 2016.

Referring agency	Proportion
Police - Lighthouse (victim support)	34.7%
Self-Referral	14.8%
SIDAS (internal)	10.3%
Children's Social Care	6.9%
Police - Safeguarding Co-ordination Unit	6.7%
MARAC to MARAC	6.5%
Mental Health Services	3.6%

Other Domestic Abuse Services	2.8%
Housing	2.4%
Adult Social Care	2.2%
getset - children's services	1.7%
Health - Hospital IDVA	1.1%
Others	6.3%

Source: Somerset County Council

® Make sure partner agencies are engaged in identifying victims and making appropriate referrals to services at the earliest opportunity.

15.8.3 Helpline

There were 2,144 calls made to the domestic abuse helpline in the first nine months of 2016/17. The majority (66%) of these calls were made by professionals while 19% were female victims, 3% were male victims, 1% was relatives, friends, neighbours or general members of the public and less than 1% were perpetrators.

7% were marked as 'other', 1% of calls were terminated before connecting and 1% were not known.

15.8.4 Perpetrator programme

Fewer than five male perpetrators completed the Lifeline Level 1 course between April and December 2016 and fewer than five completed the Lifeline Level 2 course. Numbers may be low because courses are new and take time to complete and Lifeline Level 2 enrolment is reliant on completion of the Lifeline Level 1. However 35 applications to the Lifeline programmes have been assessed during this period.

In 2014/15 there were 36 assessments for the 'Make the Change' programme for perpetrators and 16 were subsequently offered a place on the course. Nine clients were carried over from the previous financial year and continued to be supported and 16 completed the course.

There is a clearly a demand from some perpetrators to access support to change their abusive behaviour. However given the low number of perpetrators currently completing the courses the support does not appear to be as accessible or effective as it could be.

® Monitor the reasons why perpetrators assessed for the programme are not offered a place onto the courses.

15.8.5 Refuge and safehouse accommodation

The refuge and safehouses are often used to accommodate people from elsewhere in the country. The numbers of referrals to this type of accommodation are therefore likely to represent demand from elsewhere in the country more than prevalence of domestic abuse in Somerset. Indeed Somerset victims are likely to be accommodated outside of the county or within a different Local Authority area of Somerset. For many survivors fleeing domestic abuse, their immediate safety from harm will be dependent on access to a safe, secret space outside of the local

authority where they are usually resident. Local refuges need to be linked into a national network of provision, as well as being repositories of local knowledge and expertise. Limiting access to refuge based on locality compromises the ability of this national network to function effectively and provide support to all those who need it.

® Monitor how many Somerset residents or people accessing Somerset services are being referred to refuge placements across the country if possible.

The charity 'Mankind Initiative' has identified a national gap in refuge accommodation for men with just 20 dedicated and 58 gender neutral spaces across England despite there being 500,000 male victims; although not all would necessarily require refuge accommodation.[170]

During 2015/16 there was an approximate 60% reduction in the number of referrals received for Refuge/Safehouse services in Somerset, (about 100 in 2015/16 compared to 266 referrals during 2014/15).[171] Around three quarters of victims originated from within the South West. Data is not readily available to determine the number of Somerset victims in refuge/ safehouse accommodation outside of the county.

In the first half of 2016/17 there have been 136 refuge and safehouse referrals to SIDAS. Around 70% of referrals have been from outside of Somerset. The number of referrals where a decision has been made is currently 123 and of these 41 (33%) have been approved. The high levels of referral not being approved are the result of a number of factors including:

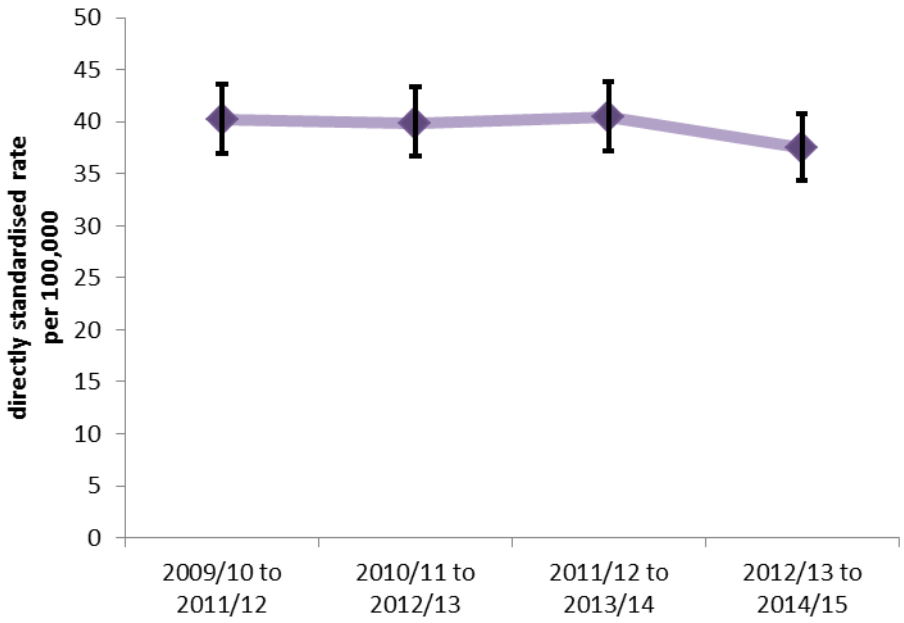
- Somerset not being an appropriate location due to being too close to the victim's perpetrator
- Not currently affected by domestic abuse although often people had been assessed as high risk using a domestic abuse, stalking and 'honour'-based violence assessment (DASH).
- Incomplete referrals
- Unsuitable client mix in available accommodation

A survey of 52 local authorities in England, Scotland and Wales was conducted by Somerset County Council in 2015. It found that demand for Somerset's refuge facilities was found to be lower than in many other areas. Most surveyed authorities tended to place people in refuge within their own region, often in neighbouring local authorities, rather than further away. However, there was a demand for victims to be able to move on a national basis to seek safety.

15.9 Hospital admissions

Public Health England have reported that there were 560 hospital admissions of Somerset residents related to violence between April 2012 and March 2015 at a rate of 37.5 per 100,000 per year and this was significantly lower than the England average. The rate in Somerset has not had any statistically significant variation in the past four years.[172]

Hospital admissions for violence in Somerset directly standardised rate per 100,000.



Source: Public Health England

Local analysis looking at all people registered with a Somerset GP shows that there were 15,715 hospital admissions of 12,200 patients for any injury, accident, assault or event of undetermined intent and was not related to a traffic accident between April 2015 and March 2016. 8,591of these admissions were of 6,545 individual females. However, there is no way of knowing what proportion is domestic abuse related. This also assumes that all road traffic accidents are not domestic abuse related and that may not be the case

16 Prevalence amongst people with protected characteristics and at risk groups

This section examines the different experiences of domestic abuse in different groups and communities at the population level.

Violence and abuse can happen to people of all ages, sexualities and all cultural, social and ethnic backgrounds, which is why it is imperative for services to meet the diverse needs of victims and survivors. At any stage of life it causes varying degrees of harm, vulnerability and disadvantage in a number of overlapping ways. This includes impacts on physical and mental health, damage to self-esteem and confidence, isolation, homelessness, and reduced economic prospects. [173] Particular groups of victims may be less visible to services or be given less priority. These include young people, victims from black and minority ethnic (BME) backgrounds, male victims and Lesbian, Gay, Bisexual, Trans, Queer/Questioning and Others (LGBTQ+) victims.

Victims risk is assessed using the DASH RIC and where they are found to be at high risk of murder or serious harm the victim will receive IDVA support and the case will

be considered at a MARAC meeting.[174] Each year the situation of 50,000 high-risk victims and 70,000 children are discussed at MARAC meetings across England and Wales:

- More than 90% of these victims are female and 5-10% are male
- 15% have a BME background
- 4% are disabled
- 1% are lesbian, gay, bisexual or trans (LGBT). [175]

On an individual basis it is important as well to consider how overlapping inequalities may impact on an individual to create multiple risks. It is not enough simply to consider gender inequality for females who are also from other minority groups (for example LGBTQ+, BME communities). [176]

® Consider developing a systematic training programme for staff for all partner agencies and particularly within specialist services to understand the particular cultural and communication needs of individuals from particular groups. This is particularly important so that staff have the tools to deliver effective support for people who are at risk of multiple or overlapping inequality.

The Equality Act 2010 covers nine protected characteristics, which cannot be used as a reason to treat people unfairly. The protected characteristics are:

- age
- disability
- gender reassignment
- marriage and civil partnership
- pregnancy and maternity
- race
- religion or belief
- sex
- sexual orientation

Carers are protected through association with disability but it is not one of the nine protected characteristics.[177] However, Somerset County Council has additionally identified carers along with rurality, low income and military status as issues locally that have a real impact on people's ability to access services.[178]

Perpetrators may often target victims from vulnerable groups, even if they don't belong to those groups themselves. BME women with insecure immigration status and no recourse to public funds, for example, can be vulnerable to perpetrators who know they fear engagement with statutory services and lack information about their rights. People living with disabilities or older women may also experience abuse from those outside of the family network – for example the perpetrator could be a carer or personal assistant.[179]

® SafeLives: Services should proactively seek out victims from diverse backgrounds and early identification of victims and families from diverse backgrounds needs specific approaches. [180]

16.1 Sex and gender

The Home Office says that abuse should also be understood as a cause and consequence of gender inequality, and as a result, impacts disproportionately on women and girls. [181] The Crime Survey for England and Wales (CSEW) demonstrates that women (7.7%) are more likely as men (4.4%) to experience Domestic Abuse within the past year. The survey also found that men (2.0%) and women (2.2%) were roughly equally likely to have experienced family abuse. However, women (6.2%) were much more likely to have experienced abuse from a partner than men (3.0%) were. Women (3.2%) were over four and a half times more likely to have experienced sexual assault than men (0.7%) and were more likely (4.6%) to experience stalking than men (2.7%).[182]

Applying these prevalence figures to Somerset's population would suggest 11,100 females and 6,200 males aged 16-59 have been victims of domestic abuse in the past year. [183]

® Make sure the strategy for tackling domestic abuse acknowledges the very clear gender inequality and, in terms of scale, focuses on reducing, ending and preventing domestic abuse affecting females.

Although the scale of females affected by domestic abuse is much greater than for males, both women and men can experience violence and abuse and at any age; as a child, adult or older person. Every case should be taken seriously and each individual given access to the specialised gendered support they need. [184] NICE guidance states that:

> Women and men can experience this type [domestic abuse] of violence in heterosexual and same-sex relationships. The prevalence of physical assaults from a partner or adult family member is higher among heterosexual women than among men. Moreover, heterosexual women experience more repeated physical violence, more severe violence, much more sexual violence, more coercive control, more injuries and more fear of their partner.[185]

It is less likely that women will perpetrate domestic abuse and violence against a male partner but where this does happen, it is likely to be less severe and less repetitive. The physical and emotional effects are also significantly higher for women than they are for males.[186]

® Make sure that males have a safe environment to make disclosures and receive support when they need to while recognising that this need is much less common than for women.

SIDAS records clients' gender identities and 94% of clients engaging with SIDAS in the first half of 2016/17 have been female. The number of males engaging with the

service was 30 over this period compared with 494 females. This is in line with the proportion (94%) of people engaging with the previous service in 2014/15.[187]

In 2015/16 the proportion of victims and witnesses at the domestic abuse court in Yeovil who were female was 68% compared with 8% of defendants. Similarly at the Taunton court 70% of victims and witnesses were female but only 5% of defendants were women. This reinforces the fact that women are more at risk of domestic abuse and men are more likely to be perpetrators. [188]

In 2015/16 around 4% of MARAC cases in Somerset were for male victims. [189]

16.2 Pregnant women

A number of studies suggest there can be an increased incidence of domestic abuse and violence during or shortly following pregnancy. Over a third of domestic violence starts or gets worse when a woman is pregnant. [190] Domestic violence has been identified as a key cause of miscarriage or still birth and of maternal death during childbirth.[191] Domestic abuse can:

- make it harder for pregnant women to receive antenatal care
- impact on the development of the foetus and future development of the child
- increase the risk of premature birth
- increase the risk of low birth weight

NICE clinical guidance [CG110] *Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors* considers pregnant women who experience Domestic Abuse. It says that local antenatal services should have a local protocol developed jointly with social care providers, the police and third-sector agencies by a healthcare professional with expertise in the care of women experiencing domestic abuse.[192]

The protocol should include:

- clear referral pathways that set out the information and care that should be offered to women
- the latest government guidance on responding to domestic abuse
- sources of support for women (including addresses and telephone numbers) such as social services, the police, support groups and women's refuges
- safety information for women
- plans for follow-up care, such as additional appointments or referral to a domestic abuse support worker
- obtaining a telephone number that is agreed with the woman and on which it is safe to contact her
- contact details of other people who should be told that the woman is experiencing domestic abuse, including her GP.

The guidance goes further, including specific recommendation for the commissioners of ante-natal and midwifery services. It includes allowing flexibility around appointments, training of staff, ensuring all organisations involved in providing domestic abuse support services recognise the need to provide coordinated care and support for service users during pregnancy, offering the women information in a

safe way (for example a credit card-sized information card) and considering offering a referral to domestic abuse services. [193]

® Make sure specialist domestic abuse services support and link with midwifery services to implement the NICE guidance as fully as possible.

In Somerset, health visiting and school nursing services are delivered by Somerset Partnership NHS Foundation Trust while midwifery servers are provided by the acute trusts, for Somerset residents this is mostly at Yeovil District Hospital and Musgrove Park Hospital in Taunton; although some areas in eastern Mendip are serviced more by Royal United Hospitals Bath and some area in North Sedgemoor may be serviced by Western General Hospital.

There is a process for midwifery colleagues to flag up concerns with Somerset Partnership NHS Foundation Trust where there is domestic abuse in pregnancy. If a Health Visitor receives a notification of a domestic abuse incident from the police then they are required to liaise with the community midwife and identify the most appropriate professional to follow up the incident. If a school nurse receives a notification of a domestic abuse incident from the police for a school-age victim or perpetrator who is pregnant then communication is required with Maternity Services as well as the GP, health visitor and the child's school.[194]

In the first half of 2016/17 there were 26 (5%) SIDAS cases where the client was pregnant. In 2014/15 there were 61 clients who were pregnant representing 5% of the caseload. [195]

16.3 **Age**

Under 16 Age Group

Domestic abuse, whether or not it involves violence, is a significant child protection issue, and is seen as one of the main causes of risk to the safety of children. The NSPCC has estimated that 6% of children in the UK are exposed to severe domestic abuse between adults in their homes at some point in childhood.[196] As many as one in five are estimated to have been exposed to some form of domestic abuse.[197]

Two thirds (64%) of high and medium risk victims have children and they have two children each on average. A quarter (25%) of children in high-risk domestic abuse households are very young; under the age of three. On average, high-risk abuse has been going on for 2.6 years. This means that some of these children have been living with abuse for most of their life. 62% of children living in domestic abuse households are directly harmed by the perpetrator of the abuse. This is in addition to the harm caused by witnessing the abuse of others.[198]

There are 60,040 families resident in Somerset that claim child benefit.[199] The proportion of families for whom Children's Social Care have identified Domestic Abuse as an issue is less than 1% and relates to 589 individual families. [200]

Somerset police recorded 4,474 incidents of domestic violence in which a child was present during 2012/13. A total of 4,925 individual children (aged 0 to 17) experienced at least one domestic violence incident in this way. The figures suggest

that domestic violence affects around 5% of Somerset's child population. The highest concentrations of incidents were in parts of Taunton, Yeovil and Bridgwater.[201] This coincides with the some of the highest areas of d deprivation in the county based upon the Indices of Multiple Deprivation (2015).[202]

In the first half of 2016/17 there were 388 (45%) SIDAS cases where the client had children. Data captured in quarter 2 alone showed that there were 761 children affected, 82 were considered 'at risk' of harm and 6 were children in care. In 2014/15 the proportion of clients who had children was 63% with approximately 2,500 children potentially affected. The drop in the percentage of clients is more likely to be related to service design and recording processes (for example the number of duplicate cases) than a real change in the client base.[203]

Parallel to this there were 815 children who had lived in a household of a MARAC case during 2015/16. There is likely to be a large amount of double counting between children of clients in specialist domestic abuse service and children in MARAC households. Of the 671 cases discussed in the year six involved direct harming of children aged under 18.[204]

The Somerset Early Help Assessment is a shared tool which can be used by all agencies in Somerset who are delivering early help in a co-ordinated way, so that they understand and respond to the needs of children/young people. The assessment captures all of a child/young person's and family's needs at the earliest opportunity.[205] In 2016 there were 283 Somerset Early Help Assessments completed where domestic abuse was identified as an issue.[206]

16.3.1.1 Children in Care & Leaving Care

A report by co-ordinated action against domestic abuse (CAADA now SafeLives) found that half of children who were or had been exposed to domestic abuse were known to social care. However 80% were known to at least one public agency including children social care (54%), the police (30%), other voluntary services (15%), other statutory services (12%), educational welfare (12%), CAMHS (9%), CAFCASS (5%), youth offending teams (2%), speech and language services (2%), family intervention projects (1%) and youth services (1%). The report suggests that outcomes for children across all 'key measures' improve following support from specialist children's services and that cessation of domestic abuse seems to correlate with a cessation of direct harm to children.[207]

Domestic violence characterises the history of a substantial proportion of looked after children. School-age children may develop conduct disorders and difficulties with their peers and find it hard to concentrate.[208]

- ® Contact and reunification plans for looked after children should take ongoing domestic violence in birth families into account and respect children's views. Work with adolescents, particularly those who are looked after and leaving care, should address their peer relationships.[209]

Somerset has lower rates of children in care than the England average and the rates of children leaving care locally were similar to the England average. Somerset had

490 looked after children at the end of 2014/15 and 295 young people left care during the year.[210]

There were 6 (2%) clients engaging with SIDAS between June and September 2016 with children in care. There were 115 (6.9%) referrals from children's social care between April and December 2016.[211]

The Pathways to Independence (p2i) needs analysis found 519 care leavers had been in contact with the Leaving Care team over the two year period. In addition there were 55 children in care currently in national curriculum year 11 who would potentially become care leavers in the near future. Around 2% of care leavers were assessed as being at risk of domestic violence and 2% at risk of childhood sexual exploitation. [212]

16.3.1.2 Children with a disability

Disabled children are over three times more likely to be abused or neglected than non-disabled children.[213] There may be difficulty for the child in understanding what is happening to them and even where they do in effectively communicating this to the people and services that can help them. Professionals may also have difficulty in isolating signs of abuse and neglect from the effect of the child's impairment. Professionals working in child protection might not have the specialised skills to accurately assess or understand a disabled child's needs, or to communicate with them properly.[214]

There is no definitive single source of data about disability amongst children and young people. However at the 2011 census 1,148 children were reported to have their day-to-day activities limited 'a lot' due to a disability or long-term condition; a further 2,086 were limited 'a little'.[215]

16.3.1.3 Children in low income families

In 2013 there were 14,700 children under the age of 20 living in low income Somerset families. This represented 13.4% of the all children and was significantly lower than the England average.[216] In 2014 the proportion of Somerset children in low-income families has fallen to 11.3%.[217]

The Index of Multiple Deprivation (2015) has a supplementary index looking at what proportion of the children aged 0 to 15 in each neighbourhood throughout England experience income deprivation. This is known as the Income Deprivation Affecting Children Index (IDACI). The Somerset percentage is 14.8% and suggests there are 14,200 0-15 year olds who experience income deprivation. The England value based upon ONS mid-year 2015 population estimates is 20.0% %.[218]

Research also suggests that families with low incomes are more likely to feel 'chronically stressed' and those living in poorer areas have higher stress levels. [219]

Between April and December 2014 the number of outreach and IDVA clients who reported having financial problems was 72 (8%) although it is not known how many of these clients had any children or how many children they might have had in total. [220]

16.3.1.4 Children Not in Education Training or Employment (NEET)

Domestic abuse can lead to problems at school, such as truancy, for affected children .[221]

An average of 730 young people aged 16-18 were not in education, training or employment (NEET) during 2015 at a rate of 4.0% that was similar to the England average.[222] There is not currently any data but it is planned that the new SIDAS will record data around young people who are NEET. [223]

The proportion of school days missed through authorised and unauthorised absence was similar in Somerset to the England average. A total of 500,789 school days were missed in 2014/15, at a rate of 4.4%.[224]

16.3.1.5 Youth offending

In a study of young offending cases where the young person was also misusing alcohol, 78% had a history of parental alcohol abuse or domestic abuse within the family.[225]

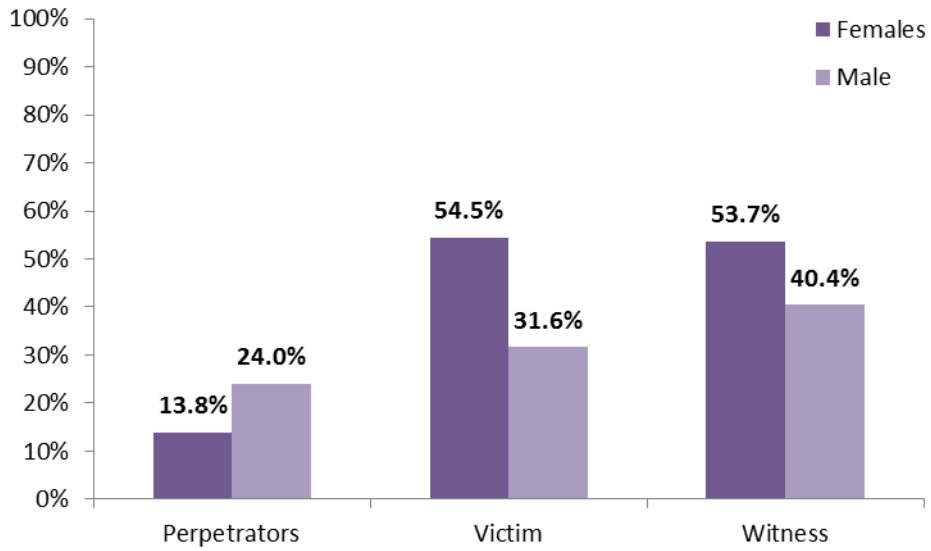
® Specialist domestic abuse and substance misuse services for young people should work collaboratively with youth justice to make sure that these complex young people have access to holistic support around all issues. It is important that where young people and children are identified as drinking alcohol that potential issues of domestic abuse are also explored.

The incidence of crime committed by young people has fallen over the past five years. In 2014 the number of 10-17 year olds in Somerset who were first time entrants to the youth justice system was 226 and in 2013/14 there had been 423 young people supervised by the Youth Offending Team. In both cases the rates were similar to the England average.[226]

A pilot undertaken by Somerset County Council's Youth Offending Team (YOT) and Targeted Youth Support (TYS) service to screen young people accessing their services for domestic abuse was undertaken between July and August 2014. The screening process asked if the client had ever experienced domestic abuse or violence as a witness, perpetrator or victim. It was not ascertained if the abuse was current. Overall 61% of participants reported being either a perpetrator, victim or witness to domestic abuse or violence. It is likely that some domestic abuse will remain 'hidden' and that true levels of domestic abuse will be higher than reported. The pilot found that males were more likely to be perpetrators and that females were more likely to have witnessed domestic abuse or violence or to have been a victim. 31% of young people who reported acting as a perpetrator had also been a victim.[227]

The link between young people being victims of domestic abuse increasing the risk that the young person will go onto to become a perpetrator or a victim of domestic abuse is clearly established. [228]

The proportion of Youth Offending Team (YOT) and Targeted Youth Support (TYS) service clients who reported having experienced domestic abuse or violence, July and August 2014. [229]



16.3.2 Young people

Young people can experience domestic abuse in their own relationships and girls are more likely than boys to report experiencing abuse in their relationships. It doesn't matter what age they are, young adolescents are just as likely to experience abuse as older teenagers. One in five teenagers has been physically abused by their partner.[230]

Home Office guidance to local authorities has highlighted that teenagers experience high levels of relationship abuse and may be more vulnerable to certain methods of abuse. Sixteen to nineteen year olds across England and Wales report higher levels of partner abuse in the last year than any other age group. Domestic abuse can be particularly hidden as teenagers can be more accepting of this type of behaviour. There are particular concerns around the use of technology to target young people such as: [231]

- Gifts of expensive smart phones which can be used in exchange for gang membership, sexual favours and abuse
- Cyber bullying
- Online grooming
- Digital stalking
- Naming of rape victims online
- Social location services whereby perpetrators can keep track of where victims are
- Use of Blackberry messenger (this can now be applied to many other web based programs and mobile apps that work in a similar way) to target vulnerable young people

- Sexting – the “exchange of sexual messages or images” and “creating, sharing and forwarding sexually suggestive nude or nearly nude images” through mobile phones and the internet

However it is also important to recognise that technology and the internet also offer unique ways of accessing and providing support and information. [232]

® Make sure services are aware of the high levels of domestic abuse experienced by young people, young people’s attitudes and the specific and different types of abuse that they experience which are often digital and changing. All agencies dealing with young people should be able to identify signs of abuse and be able to take action with the support of a clear pathway and process.

In the first half of 2016/17 there were 47 (9%) SIDAS clients aged 16-20 years old who engaged with the service following a referral or who were already in contact from the previous period. These figures may be affected by double counting across quarter 1 and quarter 2. [233]

In 2015/16 around 1% of MARAC cases in Somerset were for 16 or 17 year old victims. [234]

16.3.3 Older people

Nationally SafeLives have said that although there is no accepted prevalence figure for domestic abuse amongst older people they believe that around 120,000 individuals aged 65 and over have experienced at least one type of abuse (psychological, physical, sexual or financial). The evidence they used appears to have focused on abuse within the past year. This would represent around 1.2% of the 65+ population. Applied to Somerset that would be approximately 1,580 people. [235]

SafeLives suggest that people aged 61 and over are more likely to experience abuse from an adult family member or current partner and this ties in with being more likely to live with the perpetrator. Older people are less likely to attempt to leave in the year before seeking help and on average the abuse will have been ongoing for a longer period of time. Older people experiencing domestic abuse are also more likely to have a disability which could make them more vulnerable.[236]

A local report commissioned in 2012 discussed the impact of domestic abuse on older people. It commented that research literature is sparse and this is not helped by the fact that older people do not form a homogenous group. Domestic abuse affecting people can often be overlooked as it is often consider a ‘sub-set’ of abuse against older people and therefore particular experiences of older people and the particular difficulties they face can be ignored. Despite this, the impact of domestic abuse in later life is significant and it is apparent that domestic abuse does not stop at age 60.[237]

® Services and staff supporting and in contact with older people have access to training around domestic abuse affecting older people and in identifying the signs.

The report also made a number of recommendations that have led to improvements locally. Somerset County Council has made domestic abuse training mandatory for all adult social care staff and in 2015/16 ran two training days specifically on older people affected by domestic abuse. Domestic abuse resources have gone and continue to go out to settings where older people are known to visit in order to increase awareness and all domestic abuse material is designed to be age-neutral. [238]

The report had recommended changes to the existing service to increase the visibility of older survivors within domestic abuse forums.[239]

A longer-term study is required in order to explore multi-agency practice and service provision models on a longitudinal basis alongside in-depth survivors and perpetrators accounts of service provision and this has not yet taken place. [240]

In the first half of 2016/17 there were 25 (5%) SIDAS cases closed where the client was aged 61 or over. [241]

16.4 **Lesbian, Gay, Bisexual, Trans, Queer/Questioning and Others (LGBTQ+)**

The LGBT acronym has is now more commonly expanded to LGBTQ+ so that it is more inclusive and is considerate of how individual people might themselves identify.

It has been found that domestic and sexual abuse are actually more common amongst same-sex couples than amongst heterosexual couples.[242] LGBTQ+ people can experience specific forms of abuse that may also act as barriers to seeking help, such as threats to reveal sexuality to family or colleagues. The perpetrators of the abuse may be current or ex-partners (these may be either a same-sex partner or, particularly for women, a former heterosexual male partner or family members). [243]

LGBTQ+ people require the same services as the rest of the community, but it is important to consider that there may be differences in how they choose to access them. In some cases they may also have had negative experiences when accessing services. For example, there is a common experience of heterosexism (the assumption that everyone is heterosexual) and homo/bi/transphobia (discrimination on the basis of sexual orientation and gender identity). [244]

® Domestic abuse service staff should receive training to help understand the specific needs of LGBTQ+ clients and that services are inclusive and accessible and adaptable to the needs of this group.

There were fewer than five people who engaged with SIDAS in the second quarter of 2016/17 who identified as LGBTQ+. However 57% of cases did not have sexual orientation recorded or the client preferred not to say. In 2014/15 there were 20 (2%) clients who identified as having an LGBTQ+ sexual orientation, which again may be an underrepresentation as 33% did not have a sexual orientation recorded or preferred not to say. [245]

In 2015/16 around 2% of MARAC cases in Somerset were for LGBTQ+ victims. [246] In 2015 the ONS report that 1.7% of the UK population identify as specifically Lesbian, Gay or Bisexual.[247]

The South Gloucestershire Council's *Domestic violence and abuse needs assessment* published in 2016 found that research suggests lifetime prevalence of domestic abuse for men in same-sex relationships is at least as high as it is for females. Furthermore this is associated with depression, anxiety, being human immunodeficiency virus (HIV) positive and harmful behaviours such as substance misuse and unprotected sex amongst this cohort.[248]

16.5 Ethnicity, race, nationality and language.

The additional cultural barriers and strong taboos exist which act as an obstacle to leaving an abusive partner for many black and minority ethnic (BME) groups, are particularly strong within the Gypsy Roma Traveller community. These barriers often include loss of community, fear of racism, isolation, concerns about possible accommodation alternatives, and expectations that marriage is for life.[249]

The majority of Somerset residents have a White (98.0%) ethnicity and the majority are specifically White English, Welsh, Scottish, Northern Irish and/or British (94.6%). There are still approximately 11,000 Somerset residents from a BME background and these people may face additional barriers to recognising and reporting domestic abuse as well as to accessing services. These barriers may be further entrenched where English is not the first language.[250]

Furthermore 94% of Somerset residents were born in the UK, 3.1% from European Union (EU) countries and 2.9% from countries outside of the EU. There were 410 Somerset residents who could not speak English and an estimated 2,382 who cannot speak English well.[251] The number of outreach and IDVA clients who reported needing a translator in this period was 5 (1%) which may mean that language barriers are not very common but do exist and must be catered for.

SafeLives in the MARAC quality assurance role nationally recommend that 11% of referrals should be from BME victims/survivors. Given the much smaller representation of BME communities in Somerset compared with the England, average local targets are focused on achieving a minimum of 6%.[252] Services may miss victims who remain in a relationship with their abuser, a higher proportion of whom may be BME. [253]

The proportion of SIDAS clients identifying as White British was 63% however ethnicity was not provided in 31% of cases. Clients had the following ethnicities: 9 an 'other white' ethnicity, 6 an Eastern European ethnicity, 7 an Asian ethnicity. All other ethnicities listed were given by fewer than five people these included Portuguese, 'Black, African, Caribbean', 'dual heritage' and gypsy/traveller. [254]

Similarly between April and December 2014 78% of clients were white British or white Irish and a further 8% were 'other white' background. 10 clients had a black, African or Caribbean ethnicity, 8 an Asian ethnicity and 6 clients had a dual heritage. [255]

In 2015/16 around 2% of MARAC cases in Somerset were for BME groups. [256]

There were 733 Gypsy or Irish Travellers estimated to be living in Somerset at the 2011 Census, representing around 0.1% of the population.[257] Friends, Families and Travellers is a registered charity that aims to end racism and discrimination against Gypsies and Travellers. They report that domestic violence is seen as normal for many in these communities. Leaving their marriage to escape domestic violence can mean they are forced to leave their 'whole culture'. Specialist or tailored domestic violence support is needed and service providers should have cultural awareness training. Work with men, perpetrators and families is needed to stop the violence.[258]

Ethnicity for victims and witnesses is largely unrecorded by the domestic abuse courts. However, 82% of defendants in at the Yeovil court and 77% at the Taunton court were white British. This is an under representation of the White British population but the disparity may be accounted for by the defendants without an ethnicity recorded. [259]

Ethnicity of defendants at the domestic abuse courts in Somerset, 2015/16. [260]

Ethnicity	Taunton Court	Yeovil Court
White British	85%	82%
White other	4%	6%
Non-white or mixed	1%	5%
Not Recorded	10%	7%

16.6 Religion or belief

There may be certain barriers to services for people from different religious background or those who hold particular beliefs. At the time of the 2011 census 64.0% of Somerset residents said they were Christian, 26.6% had no religion, 8.0% did not state their religious status and fewer than 1% indicated any other specific religion.[261]

In quarter 2 the majority of SIDAS clients did not have a religion or belief status recorded (76%). Of those who did have a religion or belief most either had no belief or were Christian while fewer than 5 identified as Muslim. There was a similar picture between April and December 2014 when255 (28%) clients said they had no religion or belief, 102 (11%) were Christian and 472 did not have a religion or belief recorded. Other religions were reported for fewer than five clients each these were Buddhist, Jewish, Muslim and 'other'. [262]

16.7 Marriage, Civil Partnerships and relationships

Domestic violence is higher amongst those who have separated, followed by those who are divorced or single. [263]

At the 2011 census of those who were married or in a civil partnership 218,377 (51.4%) lived together, 4,256 lived alone and 7,823 (1.8%) had separated. 29,271 (6.9%) residents were divorced, 30,343 (7.1%) were widowers, 52,004 (12.3%) were cohabitating couples and 82,437 (19.4%) were single people who had never married or been in a civil partnership. [264]

A third of SIDAS cases in the first half of 2016/17 have involved clients where the relationship status has not be ascertained. The majority of those had either been in a relationship (32%) or were separated from an ex-intimate partner (31%) however there was a small number of people who reported being single (5%).[265]

In 2014/15 data was collected based on a victim's relationship to the perpetrator of domestic abuse as opposed to their marital status: 150 (17%) were married or in a civil partnership, 220 (24%) a current intimate partner and 434 (48%) an ex-intimate partner. Additionally 27 (3%) were family members with the perpetrators. The remainder were marked as other, as multiple perpetrators or not recorded. [266]

16.8 Unpaid carers

A report for the Local Government Association (LGA) & Association of Directors of Adult Social Services (ADASS) found that carers may cause harm, through abuse or neglect of the person they care for, they may be caused harm by the person they care for, or they may be important observers and reporters of harm by others.

Some people with care and support needs are intentionally abusive to their carer. However, others may not have capacity to choose not to be abusive; their disability may cause abusive behaviour, as in some cases involving people with dementia. The carer may feel unable to leave or seek help for themselves due to fear of leaving the person they care for with the perpetrator, or fear of being unable to care for them on their own. [267]

® LGA/ADASS: Support to address domestic abuse should be offered if abuse is causing a carer's physical or mental health to deteriorate or preventing or hindering them from caring for another adult. [268]

In the 2011 Census 58,300 people (11% of the population) in Somerset said they provide unpaid care to family members, friends, neighbours or others because of long-term physical or mental ill health or disability, or problems related to old age. This represents an increase of about 8,000 in the past decade. However, this is thought to be an under-estimate. Around 3,300 of the unpaid carers identified in the Census were younger than 25. More than a thousand are estimated to be children under the age of 16.[269]

16.9 Rurality

In 2013/14 the rate of violence and sexual crimes reported was 3.7 per 1,000 population in rural areas in Somerset and 6.8 per 1,000 in semi-rural areas compared with 13.5 in urban areas. This would suggest that people living in rural areas of Somerset are much less likely to experience domestic abuse. However it could be that they are more isolated and actually less likely to report domestic abuse that does take place. It could also be that victims in urban areas are more likely to be targeted repeatedly. It may also be linked to areas of high deprivations which are typically urban, it can also be noted that rural areas rates increased between 2012/13 and 2013/14 while urban rates fell. [270]

® Monitor the locations where victims referred to the specialist service were living at the time of their last domestic abuse incident to identify geographic areas which might benefit from targeted intervention. This data could be triangulated with the police domestic abuse flagged crimes data which was recommended to be used in the same way earlier in this report.

16.10 Military status

There is no evidence to suggest that domestic abuse is any more prevalent within the Armed Forces, however the following points could place additional pressure on families: Research has indicated that people between the ages of 20 and 40 are at highest risk of experiencing domestic abuse – this age range is strongly represented in the Armed Forces. Regular assignments and geographic separation can isolate victims by cutting them off from their family and support systems. Regular assignments can make it difficult for a spouse to maintain a career, resulting in them being more economically dependent on the serving partner. Regular deployments and reunions create unique stresses on Armed Forces families. [271]

In the 2011 Census 3,171 Somerset residents said they worked for the armed forces. There are no definitive data on the numbers of dependants of serving armed forces personnel living in a particular area. It was estimated that for Somerset in 2012 there were between 3,300 and 3,900 family members of service personnel, including 1,700 to 2,200 children. The January 2013 School Census recorded 1,157pupils attending LA-funded and academy schools from a service family. There will be a number of children in addition to this who attend non-state funded schools.[272]

16.11 People with a learning difficulty

People with a learning disability are more likely to be a victim of domestic abuse in the last year than the general population: with 12.8% of women and 6.1% of men with learning difficulties experiencing domestic abuse compared with 6.5% of women and 6.1% of men respectively. They are also more likely to be a victim of stalking (6.5%) than people without a learning disability (3.7%).[273]

People with an intellectual disability were 1.6 times more likely to experience violence in the past year.[274] It is estimated that there are 1,250 cases of sexual assault against adults with a learning disability in England and Wales every year. This is very likely to be an under estimate because of the difficulties some people with a learning disability can have with communication in addition to the normal underreporting of domestic abuse and related issues.[275]

In the period between April and December 2014 there were 43 (5%) SIDAS clients with physical or mobility impairments, 15 (2%) with sensory (hearing, visual and speech) impairments, 23 (3%) with learning difficulties and 32 (4%) with non-visible conditions (such as epilepsy or diabetes). [276]

16.12 People with a disability

All information in this section has come from the Public Health England (PHE) report *Disability and domestic abuse: Risk, impacts and response* from November 2015 unless stated otherwise. [277]

Disabled people make up a significant minority within England: one in five of the population are disabled. Disabled people experience disproportionately higher rates of domestic abuse. They also experience domestic abuse for longer periods of time, and more severe and frequent abuse than non-disabled people. They may also experience domestic abuse in wider contexts and by greater numbers of significant others, including intimate partners, family members, personal care assistants and health care professionals. Disabled people also encounter differing dynamics of domestic abuse, which may include more severe coercion, control or abuse from carers.

In England, disabled people experience twice the rate of sexual assault, domestic abuse and stalking than non-disabled people. Disabled people are significantly more likely to:

- be threatened with violence
- be physically abused
- be sexually assaulted by intimate partners or strangers
- experience physical, sexual, emotional and financial domestic abuse than people without disabilities

Disabled people are often in particularly vulnerable circumstances that may reduce their ability to defend themselves or to recognise, report and escape abuse.

Having an impairment can create social isolation Physical and environmental inaccessibility, stigma and discrimination can also exclude and isolate them. Their reliance on care increases vulnerability to the controlling behaviour of others and can exacerbate difficulties in leaving an abusive situation.

® Home Office: It will be important to ensure good local links between agencies working with people with disabilities and domestic violence services to promote disclosures and referrals. The Disability Discrimination Act 1995 obliges service providers to ensure that people with disabilities can use their services. [278]

Not only do disabled people experience higher rates of domestic abuse, they also experience more barriers to accessing support, such as health and social care services and domestic abuse services. Disabled people are excluded from society by various barriers: social and cultural discrimination; negative attitudes; limited social support; inaccessible transportation, public buildings, information formats, products and built environments; inflexible organisational policies, procedures and practices; lack of services; and problems with service delivery and a lack of involvement.

There are clear links between poverty and domestic abuse for disabled people and, as a group, they experience greater exclusion from employment and education.

Therefore increasing economic empowerment opportunities for disabled people may have a preventative effect.

- PHE: Domestic abuse service providers should be trained to recognise and respond to needs related to impairment and to develop a deeper understanding of the impact of abuse on disabled people's lives.

MARAC referrals define disability as 'a limiting long term illness, health problem or disability which limits a person's day-to-day activities. A person is stated to be disabled and will be protected under the 2010 Equality Act if they have: 'a physical or mental impairment which has a substantial and long-term adverse [negative] effect on their ability to carry out normal day-to-day activities''.[279] In 2015/16 around 1% of MARAC cases in Somerset were for victims with a disability. [280]

16.13 Prisoners

There are no prisons in Somerset but Somerset residents do go to prison elsewhere. Evidence suggests that as many as 60%-80% of women in prisons have experienced domestic and/or sexual abuse.[281] Ministry of Justice statistics show that there were 3,862 female prisoners in England and Wales as at 30 June 2016. This represents around 0.01% of the female population.

If Somerset mirrors this national pattern then this would indicate that around 40 women would be in prison at any one time and that between 22 and 29 of them could be expected to have experienced domestic abuse in their lifetime.[282]

17 Specific domestic abuse related crimes

17.1 Sexual abuse

Nearly half a million adults are sexually assaulted in England each year and nearly one hundred thousand are raped. The proportion of rape victims who are female is 88% and approximately 90% of all victims know their perpetrator.[283] Like domestic abuse this is an underreported crime. Devon County Council have reported that 97% of callers to Rape Crisis know their rapist but fewer than 7% had reported the assault to the police.[284]

Nationally around 20% of women and 3% of men experience sexual assault as an adult. Around 21% of girls and 11% of boys experience some form of childhood sexual abuse. However, it is believed that just 15% of cases are reported to police. 28% of females who experience the most serious forms of assault tell no one and 31% of children reach adulthood without having disclosed their experience.[285]

The rate of sexual offences recorded in Somerset reported by Public Health England (PHE) for 2015/16, was 1.5 per 1,000 in Somerset and this was significantly lower than the England average although this could be partly due to Somerset having an older population and/or being having generally low level of deprivation relative to the rest of the country. ..[286]

Previous analysis on the Somerset Intelligence website shows that annually there are estimated 4,250 sexual offences occurring in Somerset based on national prevalence estimates. By comparison, the total number of reported offences in the year 2012/13 was 399 which would represent only around one in ten of all estimated offences being recorded/reported.[287]

The estimated total number of rape offences (including attempts) of females annually in Somerset is 460. In 2012/13 a total of 125 rape offences were reported, equating to around a third of the total number of estimated offences. [288] Each adult rape is estimated to cost over £96,000 in its emotional and physical impact on the victims, lost economic output due to convalescence, treatment costs to health services and costs incurred in the criminal justice system.[289]

17.1.1 Crime Survey for England and Wales (CSEW)

As shown earlier the Crime Survey for England and Wales (CSEW) gives national rates of adults (aged 16-59) who are domestically abused and sexually assaulted. Around 12% (Women: 19.9%, Men 3.6%) respondents report having ever been sexually assaulted and 2% (Women: 3.2%, Men 0.7%) report having been sexually assaulted in the past year. [290]

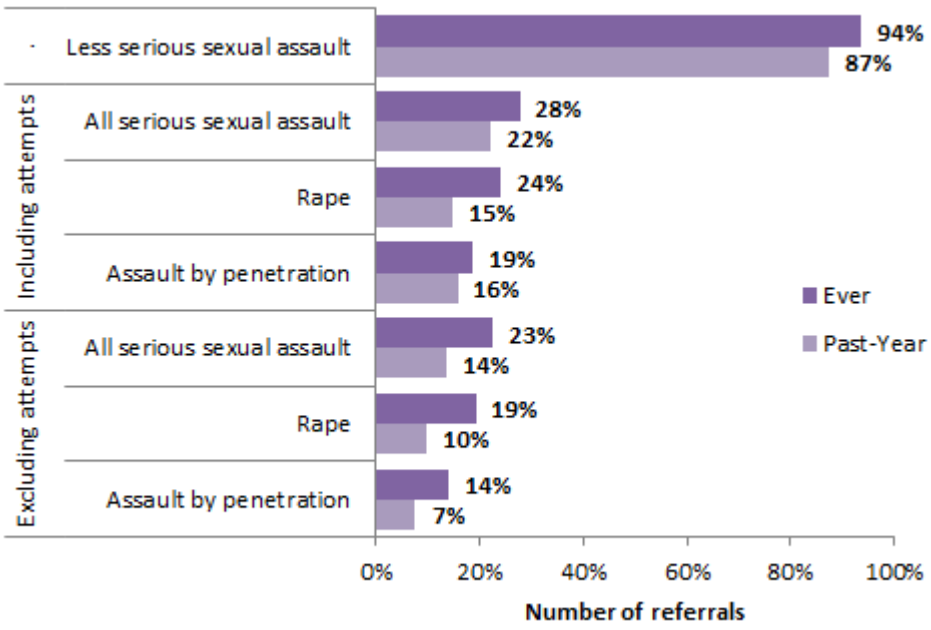
Applying these estimates to Somerset's Office for National Statistics (ONS) mid-year 2015 population estimates suggests that are:

- 33,600 adults aged 16-59 who have been sexually assaulted in their lifetime
    - Women = 28,700*
    - Men = 5,000*
- 5,600 adults aged 16-59 who have been sexually assaulted in the past-year
    - Women = 4,700*
    - Men = 1,000*

*Numbers will not sum to total due to rounding

Almost everyone (ever: 94%, past-year: 87%) who had experienced a sexual assault had been subjected to a "less serious sexual assault". Roughly a quarter of victims of sexual assault have experienced a serious sexual assault. This shows that some people experience a less serious sexual assault in addition to a sever sexual assault. This may suggest that there is often a pattern of less severe assault leading up to, concurrent with and/or following more serious assaults taking place. If true this may present opportunities for identification and early intervention.

Specific abuse experienced by victims of sexual assault or attempted sexual assault.



The table below gives estimates for the number of adult (aged 16-59) Somerset residents that might be expected to be experiencing (in the past-year) or to have ever experienced different types of sexual assault in their adult life (since the age of 16).

The estimated number of people in Somerset who have ever been a victim of a sexual assault and who have been a victim in the past year modelled on the Crime Survey for England and Wales (CSEW).

Indicator	Ever	Past-Year
Less serious sexual assault	31,470	4,900
Serious sexual assault including attempts	9,300	1,230
Serious sexual assault excluding attempts	7,580	760
- Rape including attempts	8,040	820
- Rape excluding attempts	6,440	540
- Assault by penetration including attempts	6,230	880
- Assault by penetration excluding attempts	4,690	420

17.1.2 'The Bridge': sexual assault referral centre (SARC)

The Sexual Assault Referral Centre (SARC) for South Gloucestershire, Bristol, Bath and North East Somerset, North Somerset and Somerset, called 'The Bridge', is jointly commissioned and funded by Avon and Somerset Constabulary, and NHS England. The service is delivered by University Hospitals Bristol NHS Foundation Trust. It provides: [291]

- Forensic Medical Examination including the option of taking samples that can aid police investigations or be stored to allow the victim time to consider if they want to report the incident later on.
- Referrals to sexual health clinics, GPs and Independent Sexual Violence Advisors (ISVAs).
- Access to specialist counselling clinics.

The SARC is receiving ever greater numbers of people coming forward, with an increase from 490 people in 2013/14 to 935 in 2014/15 and 968 in 2015/16. This has been attributed to changing attitudes to gender based violence and increased media awareness. [292]

73% of victims knew the perpetrator while 18% were assaulted by a stranger and 9% of victims did not disclose this detail. Around 38% of victims choosing to undergo a forensic medical examination were referred by the police. This suggests that many people are coming forward early and awareness of the service in the community is being increased.[293]

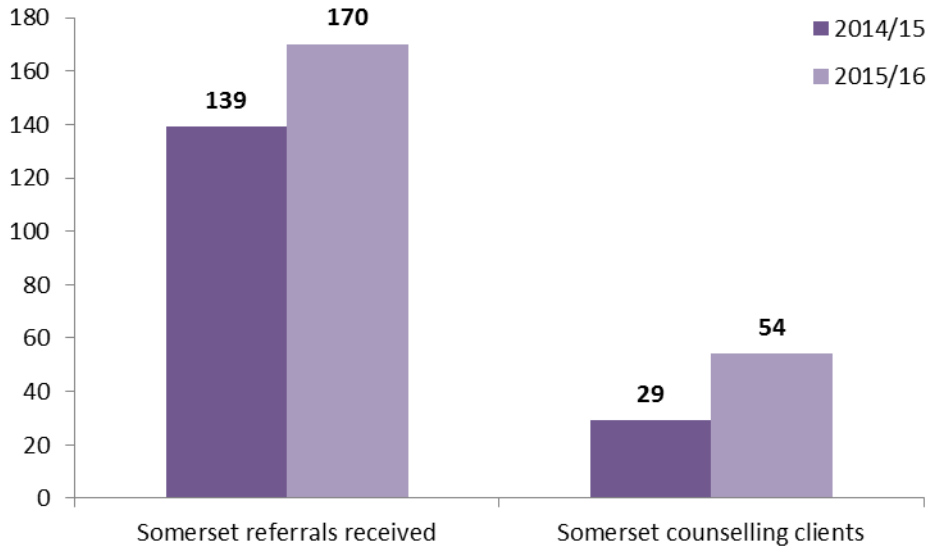
Safe Link provides the Independent Sexual Violence Advisors (ISVA) service covering BANES, Bristol, North Somerset, Somerset and South Gloucestershire. It offers sexual assault follow up and empowerment for any victim of rape, sexual assault or abuse. The service received 200 referrals for Somerset residents during 2015/16.[294]

17.1.3 Somerset and Avon Rape & Sexual Abuse Support (SARSAS)

The Somerset and Avon Rape & Sexual Abuse Support (SARSAS) is a specialist support service for people in Bath and North East Somerset, Bristol, North Somerset, Somerset or South Gloucestershire, who have experienced any form of sexual violence, at any point in their lives.

The chart below shows that the number of Somerset referrals received by SARSAS and the number of Somerset clients receiving counselling have both increased between 2014/15 and 2015/16.

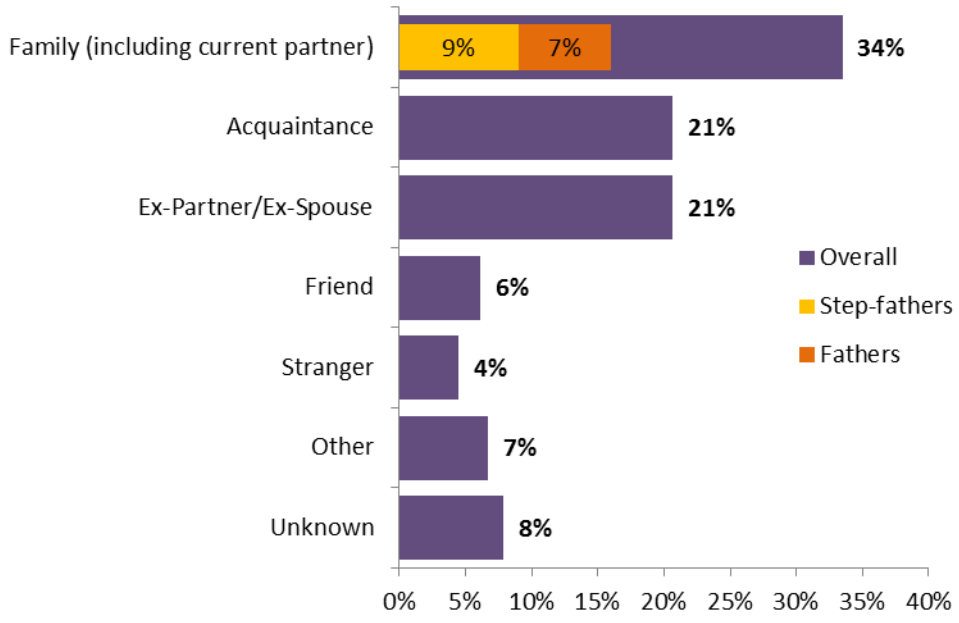
The numbers of Somerset residents with a referral to SARSAS or receiving counselling from the service 2014/15 and 2015/16.



It is important to note that location of clients, particularly at referral, can often not be obtained and so this is likely to be an under-estimate of actual service demand from Somerset residents. There were 63 SARSAS referrals in 2014/15 and 114 in 2015/16 where the person's residence was unknown.

The most common relationship the victim had with the perpetrator was a family member and the most common family members were step-fathers (9%) and fathers (7%). In all cases where sex was obtained the perpetrators were male although 7% were for 'other family members'.

The proportion of victim's based on their relationship to the perpetrator for those victims receiving support from SARSAS in Somerset in 2015/16.



The most common primary referral reasons for SARSAS in Somerset during 2015/16 were child sexual abuse (37%) and historic rape or sexual violence (36%) followed by rape that had taken place within the last year (14%).

17.1.4 Children and young people's (aged 5 to 18) sexual abuse and trauma service

As discussed earlier, in the Interventions and services in Somerset - Secondary prevention section, this service will begin operating later in 2017.

17.2 Childhood sexual exploitation (CSE)

17.2.1 CSE definition

The National Working Group for Sexually Exploited Children and Young People introduced the following definition in 2008: [295]

> The sexual exploitation of children and young people under the age of 18 involves exploitative situations, contexts and relationships where young people (or a third person or persons) receive 'something' (e.g. food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money) as a result of performing, and/ or others performing on them, sexual activities. Child sexual exploitation can occur through the use of technology without the child's immediate recognition, for example the persuasion to post sexual images on the internet/mobile phones with no immediate payment or gain. In all cases, those exploiting the child/young person have power over them by virtue of their age, gender, intellect, physical strength and/or economic or other resources. [296]

The Somerset Safeguarding Children's Board defines child sexual exploitation as follows:

> Child sexual exploitation is a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can also occur through the use of technology.[297]

17.2.2 CSE identification

The National Society for the Protection and Care of Children (NSPCC) say that "the *prevalence of CSE is notoriously difficult to estimate*". Indeed, it is often described as a 'hidden issue'; official records will not capture the majority of incidents, as many remain undisclosed and unreported. It is likely that prevalence figures are significant underestimates. [298]

Research into CSE shows that there is not one type of abuser: perpetrators of CSE can be male or female, come from any ethnic background and be any age. They may have a low social and/or economic status or they could be a wealthy individual in a considerable position of authority. Exploitation can also involve opportunistic or organised networks of perpetrators who may profit financially from trafficking children / young people between different locations to engage in sexual activity often with multiple men.[299]

The fact that young people are engaged in what they view as consensual sexual activity does not mean that they are not being exploited.

- Victims of sexual exploitation may be coerced into sexual activity with the perpetrators or they may feel unable to say no.
- Some young people may not recognise they are being sexually exploited, instead believing they are behaving as they wish.
- 16 and 17 year olds are often viewed as being more in control of their own choices and so are seen as less vulnerable to exploitation but this may not be the case.
- Sexual activity between young people of the same age is often perceived as being consensual but exploitation may still be occurring

Victims of CSE rarely see themselves as victims or recognise that they are being abused. They are unlikely to report abuse to the police. A key challenge therefore is to ensure that all police officers and staff, staff from partner agencies, and the public recognise the signs of abuse and know what action to take. [300]

The Somerset Safeguarding Children's Board have a standardised screening tool and standardised risk assessment tool for CSE available on their website for use locally. Avon and Somerset Constabulary have developed a campaign strategy to raise awareness of Child Sexual Exploitation. The first part of this strategy targets information at practitioner groups and has been developed using victim's voices to inform its key messages. The campaign call to action is: [301]

– Ask. Ask me again. Keep asking…
– CSE is happening

More details and the posters as well as the screening and assessment tools are available from the Somerset Safeguarding Children's Board webpage on CSE: http://sscb.safeguardingsomerset.org.uk/working-with-children/cse-protocols/

17.2.3 CSE risk factors

Domestic abuse has been linked with child sexual abuse. [302]

® Make sure staff in domestic abuse services are trained to identify signs of CSE and take appropriate action.

17.2.4 CSE prevalence

31% of young women aged 18-24 report having experienced sexual abuse in childhood. [303] In 2012-13 in England and Wales there were 22,654 cases of sexual offences against children under the age of 18 reported to the police and four out of five cases involved female victims. [304]

Child Sexual Exploitation (CSE) is not a "crime type" so in November 2012 a CSE Force Crime Tag was introduced which, in addition to providing safeguarding and investigation benefits, allows the monitoring of crimes that fall within the national definition of CSE. Recorded CSE tagged crimes in Somerset increased to 76 in the year to August 2015, compared to 50 in the previous 12 months. The rise is similar to the increase (+53%) in the number of recorded CSE tagged crimes across the Avon & Somerset force as a whole. The likelihood is that officers, police staff and partner agencies are getting better at recognising the warning signs that a child might be at risk of, or being, sexually exploited and have an improved understanding of the action to take. Therefore this probably does not suggest an increase in amount of CSE taking place.[305]

17.3 Female genital mutilation (FGM)

Female genital mutilation (FGM) comprises all procedures involving the partial or total removal of the external female genitalia or any other injury to the female genital organs for non-medical reasons. FGM is considered a grave violation of the rights of girls and women. [306] The World Health Organisation estimates that three million girls undergo some form of the procedure every year in Africa alone. It is practised in 28 countries in Africa and some in the Middle East and Asia. FGM is also found in the UK amongst members of migrant communities. It is estimated that approximately 60,000 girls aged 0-14 were born in England and Wales to mothers who had undergone FGM. [307]

Usually it is a girl's parents or her extended family who are responsible for arranging FGM. Some of the reasons given for the continued practice of FGM include; protecting family honour, preserving tradition, ensuring a woman's chastity, cleanliness and as a preparation for marriage. [308] FGM is often seen as an act of love rather than cruelty. However, it causes significant harm and constitutes physical and emotional abuse. FGM is considered to be child abuse in the UK and is a violation of the child's right to life, their bodily integrity as well as of their right to health. [309]

FGM leads to severe short and long term physical and psychological consequences, and survivors may have not have spoken about their experience for many years.[310] The Devon County Council needs assessment found that 'FGM is often only discovered when survivors are pregnant or once they reach adolescence and is a particular concern for unaccompanied asylum-seeking children' and that 'Fear of disclosing FGM can create additional health inequalities as it reduces women's ability to access healthcare services such as cervical screening sexual healthcare and maternity services'. 311

In the UK, it is estimated that 170,000 women and girls are living with FGM and 60,000 girls under the age of 15 are at risk.[312] In the South-West (excluding Bristol) the estimated prevalence of possible cases of maternities to women who have undergone FGM is 0.15%.[313] This is the equivalent of 9 maternities in Somerset each year. [314] Looking at the country of birth of the mother and father and using prevalence data from their countries of origin, it is possible that around 10 babies born in Somerset each year might be at risk of FGM in their lifetime.[315]

The number of FGM cases reported to NHS Digital by hospitals, mental health providers and GP practices for Somerset residents in 2015/16 was suppressed due to small numbers (that is less than 5).[316]

17.4 Adolescent to parent violence and abuse (APVA)

Adolescent to parent violence and abuse (APVA) is not specifically flagged on police or health and social care databases and so it is difficult to count the number of reported cases on a national level. Research has shown that APVA is predominantly a son-mother phenomenon although it may be affected by bias relating to gender and social norms.

The national charity Family Lives runs a helpline which receives substantial numbers of phone calls from parents experiencing violence from their children. In 2008 a survey revealed that 7 per cent of 30,000 calls to the helpline were about physical aggression from children to their parents, mostly from adolescents aged 13-15 years and usually targeted at mothers. In 2010 it was reported that between June 2008 and June 2010, the helpline received 22,537 phone calls from parents reporting aggression from their children, 7,000 of which involved physical aggression.[317]

As part of the Somerset County Council domestic abuse training programme, a course was held in 2014 specifically on “adolescent to parent abuse”. This was attended by 23 delegates from a range of agencies.

17.5 Forced marriage

A forced marriage is where one or both people do not (or in cases of people with learning disabilities, cannot) consent to the marriage and pressure or abuse is used. It is an appalling and indefensible practice and is recognised in the UK as a form of violence against women and men, domestic/child abuse and a serious abuse of human rights.[318]

The pressure put on people to marry against their will can be physical (including threats, actual physical violence and sexual violence) or emotional and psychological (for example, when someone is made to feel like they’re bringing shame on their family). Financial abuse (taking your wages or not giving you any money) can also be a factor.[319]

The Forced Marriage Unit (FMU) is a joint Foreign and Commonwealth Office and Home Office unit was which set up in January 2005 to lead on the Government’s forced marriage policy, outreach and casework. The Forced Marriage Unit gave advice and support to in 1,220 cases in 2015. However, this will include both support within the UK and support for British nationals overseas. 27% of cases where advice

was given involved a child under the age of 18. Only 35 (3%) cases were based in the South-West of England. Additionally 141 cases involved someone with a disability.[320] There is a concern that forced marriage of people with learning difficulties might be widespread amongst communities that practice arranged marriage.[321]

82% of cases dealt with by the Force Marriage Unit involved female victims.[322]

17.6 Modern slavery

There is no typical victim of slavery; victims can be men, women and children of all ages. It is normally more prevalent amongst the most vulnerable, minority or socially excluded groups. It can include victims that have been brought from overseas as well as vulnerable people in the UK. These people may be being forced to work illegally against their will in many different sectors, including brothels, cannabis farms, nail bars and agriculture. [323]

Signs of slavery are often hidden, making it even harder to recognise victims around us but there are some common signs to be aware of such as: [324]

- **Poor physical appearance:** Victims may show signs of physical or psychological abuse, look malnourished or unkempt, or appear withdrawn and neglected. They may have untreated injuries.
- **Isolation:** Victims may rarely be allowed to travel on their own, seem under the control or influence of others, rarely interact with or appear unfamiliar with their neighbourhood or where they work.
- **Poor living conditions:** Victims may be living in dirty, cramped or overcrowded accommodation, or living and working at the same address.
- **Few or no belongings:** Victims may have no identification documents, have few personal possessions and always wear the same clothes day in day out.
- **Restricted freedom of movement:** Victims may have little opportunity to move freely and may have had their travel documents (such as passports) retained.
- **Unusual travel times:** They may be dropped off or collected for work on a regular basis either very early or late at night.
- **Reluctance to seek help:** Victims may avoid eye contact, appear frightened or hesitant to talk to strangers and fear law enforcers for many reasons, such as not knowing who to trust or where to get help, fear of deportation, fear of violence to them or their family. They may be accompanied by someone else who speaks for them.
- **Grooming:** Children may not always demonstrate outward signs of distress and may have a "bond" with those exploiting them and have been groomed to not disclose their abuse. However, they are likely to be very scared and traumatised.

There were 1,746 cases of slavery reported in the UK in 2013. However, numbers are likely to be much higher due to the hidden nature of slavery. [325] Somerset County Council represents local partners on the Avon and Somerset Anti-Slavery Partnership. The Partnership aims to:

a) Raise awareness of the issue amongst frontline staff across all sectors.

b) Train people to spot the signs of trafficking and modern slavery and know where to go for help.
c) Increase local intelligence (Avon and Somerset Force Area).
d) Encourage collaborative working locally and information sharing between agencies.
e) Prevent exploitation, either wittingly or unwittingly, by members of the public, businesses, vulnerable adults or other groups through awareness raising and provision of training.

The National Referral Mechanism (NRM) is a framework for identifying victims of human trafficking or modern slavery and ensuring they receive the appropriate support.

The NRM is also the mechanism through which the Modern Slavery Human Trafficking Unit (MSHTU) collects data about victims. This information contributes to building a clearer picture about the scope of human trafficking and modern slavery in the UK.

The NRM was introduced in 2009 to meet the UK's obligations under the Council of European Convention on Action against Trafficking in Human Beings. At the core of every country's NRM is the process of locating and identifying "potential victims of trafficking".

From 31 July 2015 the NRM was extended to all victims of modern slavery in England and Wales following the implementation of the Modern Slavery Act 2015.[326]

17.7 Honour based violence (HBV)

There is no specific offence of "honour based crime". It is an umbrella term to encompass various offences covered by existing legislation. Honour based violence (HBV) can be described as a collection of practices, which are used to control behaviour within families or other social groups to protect perceived cultural and religious beliefs and/or honour. Such violence can occur when perpetrators perceive that a relative has shamed the family and/or community by breaking their honour code.[327]

It is a violation of human rights and may be a form of domestic and/or sexual violence. There is no, and cannot be, honour or justification for abusing the human rights of others. The Crown Prosecution Service, Association of Chief Police Officers (ACPO) and support groups have a common definition of HBV: 'Honour based violence is a crime or incident which has or may have been committed to protect or defend the honour of the family and/or community'.[328]

In 2015, Her Majesty's Inspectorate of Constabulary (HMIC) carried out an inspection of the police response to HBV. Inspectors found that the police are not sufficiently prepared to protect effectively the victims of HBV. They found pockets of good practice, but a lot that needed to improve. Forces needed to improve engagement with community groups that support the interests of victims. This is in order to understand better the complexities cases of HBV can pose, which will give victims and those affected the confidence to come forward.[329]

The numbers of victims accessing SIDAS services at risk of HBV in Somerset is generally very low. HBV was recorded in fewer than 5 cases in quarter 2 2016/17. In 2014/15 there were fewer than 5 high risk clients at risk of HBV in the whole year.

Appendix 1 - Abbreviations

Abbreviations have been kept to a minimum. In each section the abbreviation will be given in brackets next to the full name and then the abbreviation will be used in the rest of that section only.

Some abbreviations are more common than the full name (NICE, SNPCC) these are given in full only once and then the abbreviation is used throughout the rest of the report.

The following exceptions exist:

- The United Kingdom of Great Britain and Northern Ireland is only ever referred to as the UK.
- The National Health Service is only ever referred to as NHS.
- General Practitioners are only ever referred to as GPs.

Table of abbreviations and acronyms

Abb.	Description
ACPO	Association of Chief Police Officers
adass	Association of Directors of Adult Social Services
APVA	Adolescent to parent violence and abuse
BME	Black and minority ethnic
CAMHS	Child and Adolescent Mental Health Services
CBT	Cognitive behaviour therapy
CCG	Clinical Commissioning Group
CSEW	Crime Survey for England and Wales
DAC	Domestic Abuse Co-ordinators
DASH	Domestic abuse, stalking and ‘honour’-based violence assessment
DHR	Domestic Homicide Reviews
DVPN	Domestic Violence Protection Notice
DVPO	Domestic violence Protection Orders
EIF	Early Intervention Foundation
EU	European Union
FGM	Female genital mutilation
FIW	Family Intervention Workers
GPs	General Practitioners
HBV	Honour based violence
HIV	H*uman immunodeficiency virus*
HMIC	Her Majesty’s Inspectorate of Constabulary
IDACI	Income Deprivation Affecting Children Index
IDVA	Independent Domestic Abuse Advisor
IESD	Innovation, Excellence and Strategic Development Fund
IRIS	Identification and Referral to Improve Safety
ISVA	Independent Sexual Violence Advisors
LGA	Local Government Association
LGBT	Lesbian, gay, bisexual or trans

Abb.	Description
LGBTQ+	Lesbian, gay, bisexual, trans, queer/questioning and others
LSOA	Lower layer super output areas
MARAC	Multi-Agency Risk Assessment Conference
NCDV	National Centre for Domestic Violence
NEET	Not in education, training or employment
NICE	National Institute of Health and Care Excellence
NHS	National Health Service
NSPCC	National Society for the Protection of Children
ONS	Office for National Statistics
p2i	Pathways to Independence
PCSO	Police Community Support Officers
PHE	Public Health England
PHSE	Personal, Health and Social Education
PTSD	Post-traumatic stress disorder
RSPCA	Royal Society for the Protection and Care of Animals
SARC	Sexual Assault Referral Centre
SARSAS	Somerset and Avon Rape & Sexual Abuse Support
SCR	Serious case review
SDAB	Somerset Domestic Abuse Board
SIDAS	Somerset Integrated Domestic abuse Service
SWAST	South West Ambulance Service Trust
SWISH	Somerset-wide Integrated Sexual Health
TUC	Trades Union Congress
TYS	Targeted Youth Support
UK	United Kingdom of Great Britain and Northern Ireland
UN	United Nations
VAWG	Violence Against Women and Girls
WHO	World Health Organisation
YOT	Youth Offending Team
YPVA	Young People's Violence Advisors

Appendix 2 – Domestic Abuse Needs Assessment 2017 – Recommendations Monitoring

Recommendation (DA Needs Assessment)	How to Monitor
1. Monitor domestic abuse incidents reported to the police and prosecutions of Somerset perpetrators. If reported crimes or successful prosecutions (both in number and as a proportion of all prosecutions) do not increase then it will be important to understand why this is not happening.	DA Board Scorecard
2. Make sure that local support for perpetrators is easily accessible for people who recognise their own abusive behaviour and want help to stop.	SCC SIDAS Contract Monitoring
3. Considerer incorporating Women's Aid's LASTS (Listen, ask & act, specialist support, tools, sustained independence and freedom) model into future strategies and local practice amongst all agencies – not just specialist domestic abuse support.	DA Board
4. Make sure specialist support services for victims and survivors of domestic abuse link with other support agencies and third-sector groups in the county, possibly with joint protocols, so that multi-agency support for specific issues can be effectively delivered to those who need it.	SCC SIDAS Contract Monitoring
5. Make sure all or the appropriate staff in criminal justice, health and other appropriate settings are trained to recognise the signs of domestic abuse and how to respond when victims present to them (whether or not a disclosure is made) and that there is a clear pathway in place to support staff making referrals where appropriate.	DA Board
6. Monitor the length of time people have been experiencing abuse before successfully receiving the help they need. If this is not reducing then understand why this is the case and consider if more can be done to identify victims and perpetrators early.	SCC SIDAS Contract Monitoring
7. Make sure that there is joint working between domestic abuse specialist services and other agencies involved in children's safeguarding (for example Police, Children's Social Care, Youth Offending Team, Targeted Youth Support, Leaving Care, drug and alcohol services and mental health services) so that early identification and interventions can be made to prevent the very serious and life-long effects of domestic abuse from becoming any more severe.	SCC SIDAS Contract Monitoring
8. Make sure professionals who interact with children at home (for example health visitors), at school (for example school nurses and teachers) and other settings (for example GPs) are trained to identify signs of domestic abuse in children and respond appropriately.	DA Board

9. Make sure domestic abuse, mental health and substance misuse specialist services work together to identify as early as possible and then support complex individuals who face multiple issues ('Hidden Harm'), to identify children and families at risk as a result of this and to work together to safeguard the children and reduce the risks to everyone involved including perpetrators of domestic abuse.	SCC Public Health [reporting to DA Board?]
10. Make sure all contacts to treat substance misuse, domestic abuse or mental health focus on the needs of all family members particularly the children; but without pathologising all children (assuming they will be negatively affected) and without pre-conceptions. [i]	SCC Public Health [reporting to DA Board?]
11. Monitor outcomes for perpetrators, witnesses and victims assessing specialist domestic abuse support services as part of routine performance management, including monitoring where clients drop out of a service.	SCC SIDAS Contract Monitoring
12. Make sure that all staff from specialist domestic abuse, mental health and substance misuse services receive awareness, screening and referral (level 1) training as a matter of course. Multi-agency training looking at case management, information sharing, actions and roles (level 2) training should also be received by all staff but should be delivered with staff from different agencies attending training together to share expertise. [ii]	SCC Public Health [reporting to DA Board?]
13. Consider gender responsive approaches when supporting victims whose families have been affected by multiple issues of mental health, substance misuse and domestic abuse.	SCC Public Health [reporting to DA Board?]
14. Make sure mental health and substance misuse agencies consider how to incorporate a greater understanding of the impact of trauma on the clients' presentation and treatment engagement. [iii]	SCC Public Health [reporting to DA Board?]
15. Make sure that staff are aware of options to help them assist victims in finding solutions to leaving their abusive relationship, that don't further endanger the pet(s) or risk the victim losing their pet(s).	
16. Make sure that local groups, communities, housing providers, homelessness prevention services and businesses have access to information and tools to support them in preventing, identifying and reporting (possibly including referring) cases of domestic abuse.	DA Board
17. Consider engaging employers within Somerset and signposting to the *16 days of action* campaign material.	DA Board
18. Monitor prevalence and levels of need for substance misusing clients around domestic abuse and for domestic abuse clients around substance misuse in collaboration with substance misuse commissioners.	SCC Public Health [reporting to DA Board?]

19. Make sure that both domestic abuse and drug and alcohol service staff are trained to identify all of the needs of their clients around both of these issues and to work together to ensure that the vulnerable people receive all the support that they need. This also should include determining if domestic abuse victims who misuse drugs and alcohol encounter barriers to access specialist support – e.g. refused access to refuge or safehouse accommodation. Where barriers can and do exist, an options appraisal should occur to help shape appropriate service provision.	SCC Public Health [reporting to DA Board?]
20. Monitor the prevalence of different experiences (perpetration, witnessing and being a victim) of domestic abuse recorded amongst people accessing substance misuse services once the improved data collection is in place post April 2017: so that the local situation can be understood more clearly. This will also allow commissioners of services to identify areas of good practice, improvements and closer working between providers.	SCC Public Health [reporting to DA Board?]
21. Make sure that the reasons why fewer people than expected appear to be accessing domestic abuse services from mental health services are understood and take any necessary steps to rectify any issues in the pathways.	SCC Public Health [reporting to DA Board?]
22. Make sure that the wider workforce is able to identify the signs of financial difficulties, particularly amongst women and mothers who may be more at risk, and to signpost individuals to support.	DA Board
23. Consider domestic abuse services commencing offering financial management support as part of their work or as a referral as a prevention and harm reduction strategy working with medium risk and younger victims.	SCC SIDAS Contract Monitoring
24. Make sure that domestic abuse services are routinely and effectively screening all clients (victims and perpetrators) for financial issues.[iv]	SCC SIDAS Contract Monitoring
25. PHE: healthcare professionals should support homeless individuals and families by supporting access to domestic and sexual violence and abuse services, harm reduction and exiting services for women involved in prostitution.[v]	DA Board
26. Make sure that the homelessness prevention teams within the district councils are aware of the domestic abuse support and pathways to help residents in need.	DA Board
27. Where people are presenting as homelessness, the council makes sure the DASH RIC is completed where the presentation is related to abuse in the household.	DA Board
28. Signposting to third-sector organisations that can help build social networks may be useful. Having visible information and signposting online so that it can be accessed by people who do not come into contact with services as well as promoting the helpline locally should be considered.	SCC SIDAS Contract Monitoring

29. Consider working with schools to work towards every child receiving educational programmes focusing on healthy relationships, and challenging gender inequality, sexual stereotyping, and domestic abuse, should be integrated with work on anti-bullying and conflict resolution as a mandatory part of the Personal, Health and Social Education (PHSE) curriculum What works	DA Board
30. Make sure the Somerset Public Health team shares information about relevant campaigns with the Somerset Domestic Abuse Board so they can feature in relevant communications planning.	SCC Public Health [reporting to DA Board?]
31. Make sure that partnership and multi-agency working is a key part of any commissioning processes and the Somerset wide strategy to tackling domestic abuse.	DA Board
32. Ensure that the NICE guidance and gaps for domestic abuse is incorporated into Public Social Partnerships (PSP) and future commissioning plans.	DA Board
33. Make sure health visitor staff are trained in identifying the signs of domestic abuse and how to assess and refer individuals and families.	SCC Public Health [reporting to DA Board?]
34. Make sure that all services dealing with vulnerable clients who may be at risk of domestic abuse are aware of the full range of support available within the county and that clear easy to follow pathways exist between all services.	DA Board
35. Make sure national and local learning from domestic homicide reviews (DHRs) is acknowledged and introduced in Somerset.	DA Board
36. Monitor domestic abuse flagged crimes within Somerset to identify local trends and respond to them. Avon & Somerset Constabulary will need to perform this analysis or make anonymised data available to the Somerset Domestic Abuse Board.	A&S Police reporting to DA Board
37. Monitor trends to make sure that when prosecutions are brought to court victims and witnesses are coming forward and are supported to do so.	DA Board Scorecard
38. Monitor the number of MARAC cases and the recent increase in rates. If this continues it will be important to understand why this is happening (for example it may be a result of better detection and interventions rates or improved pathways and not necessarily an increased prevalence of high risk victims)	DA Board Scorecard
39. Make sure that MARACs are responsive to repeat victims and take steps to understand why the proportion of repeat cases is currently lower than expected in Somerset.	DA Board Scorecard
40. Make sure partner agencies are engaged in identifying victims and making appropriate referrals to services at the earliest opportunity.	DA Board Scorecard
41. Monitor the reasons why perpetrators assessed for the programme are not offered a place onto the courses.	SCC SIDAS Contract Monitoring
42. Monitor how many Somerset residents or people accessing Somerset services are being referred to refuge placements across the country if possible.	SCC SIDAS Contract Monitoring

43. Consider developing a systematic training programme for staff for all partner agencies and particularly within specialist services to understand the particular cultural and communication needs of individuals from particular groups. This is particularly important so that staff have the tools to deliver effective support for people who are at risk of multiple or overlapping inequality.	SCC Public Health [reporting to DA Board?]
44. SafeLives: Services should proactively seek out victims from diverse backgrounds and early identification of victims and families from diverse backgrounds needs specific approaches. [vi]	SCC SIDAS Contract Monitoring
45. Make sure the strategy for tackling domestic abuse acknowledges the very clear gender inequality and, in terms of scale, focuses on reducing, ending and preventing domestic abuse affecting females.	DA Board
46. Make sure that males have a safe environment to make disclosures and receive support when they need to while recognising that this need is much less common than for women.	DA Board
47. Make sure specialist domestic abuse services support and link with midwifery services to implement the NICE guidance as fully as possible.	SCC SIDAS Contract Monitoring
48. Contact and reunification plans for looked after children should take ongoing domestic violence in birth families into account and respect children's views. Work with adolescents, particularly those who are looked after and leaving care, should address their peer relationships.[vii]	DA Board
49. Specialist domestic abuse and substance misuse services for young people should work collaboratively with youth justice to make sure that these complex young people have access to holistic support around all issues. It is important that where young people and children are identified as drinking alcohol that potential issues of domestic abuse are also explored.	SCC SIDAS Contract Monitoring and Public Health
50. Make sure services are aware of the high levels of domestic abuse experienced by young people, young people's attitudes and the specific and different types of abuse that they experience which are often digital and changing. All agencies dealing with young people should be able to identify signs of abuse and be able to take action with the support of a clear pathway and process.	DA Board
51. Services and staff supporting and in contact with older people have access to training around domestic abuse affecting older people and in identifying the signs.	DA Board
52. Domestic abuse service staff receive training to help understand the specific needs of LGBTQ+ clients and that services are inclusive and accessible and adaptable to the needs of this group.	DA Board
53. LGA/ADASS: Support to address domestic abuse should be offered if abuse is causing a carer's physical or mental health to deteriorate or preventing or hindering them from caring for another adult. [viii]	SCC SIDAS Contract Monitoring

54. Monitor the locations where victims referred to the specialist service were living at the time of their last domestic abuse incident to identify geographic areas which might benefit from targeted intervention. This data could be triangulated with the police domestic abuse flagged crimes data which was recommended to be used in the same way earlier in this report.	DA Board
55. Home Office: It will be important to ensure good local links between agencies working with people with disabilities and domestic violence services to promote disclosures and referrals. The Disability Discrimination Act 1995 obliges service providers to ensure that people with disabilities can use their services. [ix]	SCC SIDAS Contract Monitoring
56. PHE: Domestic abuse service providers should be trained to recognise and respond to needs related to impairment and to develop a deeper under-standing of the impact of abuse on disabled people's lives.	SCC SIDAS Contract Monitoring
57. Make sure staff in domestic abuse services are trained to identify signs of CSE and take appropriate action.	SCC SIDAS Contract Monitoring

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