

Preventing Domestic Violence and Abuse: Common Themes Lessons Learned from West Midlands' DHRs

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Executive Summary

1.0 Introduction

Tackling domestic violence is a core issue for the current government, as laid out in the *Call To End Violence Against Women and Girls* paper (Home Office, 2010) and the accompanying (updated) Action Plan published earlier this year. The Action Plan acknowledges that progress is being made in reducing rates of domestic violence (figures from the latest Crime Survey for England and Wales¹ (2011/12) show that levels of domestic abuse have fallen since the 2004/5 survey, when the question set was first introduced); however rates for domestic homicide remain reasonably static. In 2010-2011 twenty-one (21) men and ninety-four (94) women were killed by a current or former partner or lover, and the rate for female victims of domestic homicide has sat consistently around the 100 per year mark for the past decade. In addition, the 2010-2011 data show that over half (54%) of female homicide victims over the age of 16 are killed by an ex/partner or lover.

With this in mind, Domestic Homicide Reviews were introduced in April 2011 with the aim of allowing and encouraging local areas to work together following a domestic homicide in order to focus on: future prevention, provision of relevant services, partnership and interagency working, justice outcomes, and risk reduction. DHRs were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). Responsibility for undertaking domestic homicide reviews lies with the Community Safety Partnership (CSP) within the victim's area of residence. The act states:

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, or
- (b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death.

¹ <http://www.crimesurvey.co.uk/>

The recently revised guidance issued in June 2013 has stipulated that where this definition of a domestic homicide is met, then a DHR must be undertaken. No additional resources were made available to CSPs to meet this new statutory requirement. One hundred and thirty-two (132) DHRs were carried out between their introduction in April 2011 and October 2012, providing much scope for learning and improving on best practice both within local areas and nationally.

Review panels make a thorough assessment of all relevant information surrounding a domestic homicide, and include a wide range of insights from a variety of sources (social services, councils, police, other community-based organisations, friends and family of victim etc.). Each report then identifies lessons to be learned, nationally and locally, and provides specific and achievable recommendations for improving practice as swiftly and efficiently as possible. As such, each individual review provides a wealth of information pertinent to service, practice improvement and policy change surrounding the area of domestic homicide, and domestic abuse more generally.

In 2013 the Home Office released a document identifying common themes across the fifty-four completed reports that had been received nationally, and identified key lessons learned across reviews (Home Office, 2013b). Although useful, the *'Domestic Homicide Reviews: Common themes identified as lessons learned'* report (Home Office, 2013b) is a brief document that does not address the more complex and nuanced issues that domestic homicides raise. The HMIC (2014) notes the value of DHRs, but maintains that there are barriers to DHRs being effective, including: the time lag between the incident and the completion of the review; the responsibility for implementing recommendations being at too tactical a level within organisations; the focus of the review being felt to be more an exercise in the apportionment of blame than one of learning lessons; and the difficulty in accessing learning from reviews relating to other forces.

In February of 2014, the National Institute for Clinical Excellence (NICE) issued guidance on domestic violence, focusing on ways in which health services, social care, and organisations that work with them can respond effectively to domestic violence. This guidance is aimed at identifying, preventing and reducing domestic violence, and they suggest that a multi-agency partnership approach is the best and most effective way of responding to domestic violence, at both the operational and strategic level. Training and organisational support are also key focal points of the guidance.

Noting the lessons emanating from the Home Office (2013b) report, the seven Community Safety Partnerships (CSPs) across the West Midlands Police Force Area (WMPFA) believed there to be tangible benefits of understanding where the nationally identified themes are present across the WMPFA, and where a potential alteration of policy and practice across the region could improve response to domestic violence. As such, this report was commissioned by the seven CSPs across the WMPFA, and has been funded by the Police & Crime Commissioner. It is the aim of this report to build on the findings of the Home Office report (2013b), the NICE Report (2014) and the HMIC recommendations (HMIC, 2014) and tailor recommendations for the WMPFA with regards to strategies for tackling domestic violence, and specifically for addressing issues that may lead to domestic violence homicide.

2.0 Methodology

This research provides a collation of the key learnings from thirteen (13) DHRs completed or underway across the West Midlands area. These include DHRs that have been finalized and published, but some areas within the West Midlands were able to share DHRs that were near completion, but had not had final sign off from the Home Office. As such, we have anonymised the DHRs and assigned them random numbers (from 1-13), to ensure that key details are kept confidential. It should be noted that there are thirty-five (35) DHRs finished or being undertaken currently in the West Midlands area, so there is much scope for these findings to be expanded upon in the future.

Each of the DHR reports that we reviewed had a specific set of circumstances that needed to be considered. Our aim when reviewing the documents was to find common issues that arose out of the reports, and to try to draw conclusions about best practice in relation to existing literature around the key areas that emerged. As such, we have looked at the individual DHRs to understand the key issues that led to a homicide, but we have tried to situate these within a wider context so that a more general and far-reaching set of recommendations can be made.

In-depth qualitative interviews were also conducted with eight key stakeholders from the West Midlands area. The stakeholders were identified in relation to their knowledge of DHRs and domestic violence, and included those who work in the police services, health services, spanning both statutory and third sector. Interviews

were conducted via telephone and recorded, and transcribed verbatim. The interviews have been anonymized to maintain the confidentiality of participants.

The findings from the West Midlands DHRS are integrated with learnings from DHRs in other parts of the country and interviews with key stakeholders, and the report identifies emergent themes across the relevant areas (service, practice, policy); and makes a number of recommendations at the local and national level. The report also provides the West Midlands with an action plan over the short, medium and long term. This action plan will inform the ongoing implementation of both DHR and wider responses to domestic abuse with the best available evidence.

The research team has worked closely with West Midlands CSPs throughout the project to facilitate ongoing consultation and regular input into the direction and nature of the review. The next section will outline key themes that have emerged from the analysis of DHRs and where relevant, data from the interviews will be included to explore key issues.

3.0 Key Findings from the DHRs and Stakeholders Interviews

A number of key themes emerged from an analysis of the 13 DHRs. We have grouped them into six thematic areas: Process & Policy, Tools, Caring Issues, Health Issues, Services, and Systemic Issues. The thematic areas are then further broken down into subcategories. The below table shows which themes occurred in the thirteen DHRs analysed:

Theme	DHR1	DHR2	DHR3	DHR4	DHR5	DHR6	DHR7	DHR8	DHR9	DHR10	DHR11	DHR12	DHR13
Process & Policy													
Use of MARACs		✓		✓	✓		✓						✓
Lack of proactive response / holistic responsibility		✓	✓	✓	✓		✓					✓	✓
Fear of having children removed may prevent full disclosure				✓		✓							
More robust response from police		✓	✓	✓	✓		✓	✓			✓		✓
Disclosure of abuse of previous partner				✓	✓		✓	✓					
Domestic abuse of extended family				✓			✓						
Not following care/safety plan							✓		✓	✓			
Tools													
Diversity of assessment tools	✓				✓								✓
Failure to administer DASH when police called to a domestic incident		✓						✓					✓
Caring Issues													
Managing care / managing carers			✓						✓	✓		✓	
Failure to involve families	✓			✓					✓	✓			
Lack of transition in care									✓	✓			
Health Issues													
Issues related to GPs	✓	✓	✓	✓	✓		✓				✓		✓
Management of prescriptions / noncompliance	✓		✓				✓		✓	✓			
Failure to ask new mothers about domestic violence		✓		✓		✓	✓						
Services													
Complex needs of perpetrators	✓	✓	✓	✓	✓		✓		✓	✓	✓		✓
Failure to engage with services offered		✓	✓				✓				✓		✓
Lack of provision of perpetrator programmes		✓		✓									
Systemic Issues													
Problems with partnership working / communication	✓	✓	✓	✓	✓		✓		✓	✓	✓		✓
Staffing issues / lack of facilities		✓		✓	✓		✓			✓			
Equality issues					✓	✓		✓					✓

3.1 Process & Policy

Use of MARACS

Locally, inter-agency domestic violence risk management will now commonly involve a multi-agency risk assessment conference (MARAC) (Robinson, 2004). These bring together professionals from all relevant agencies, both statutory and voluntary, to share information about victims assessed as high risk (by the risk identification tool developed by the charity Co-ordinated Action Against Domestic Abuse (CAADA) and the Domestic Abuse, Stalking and Honour Based Violence (DASH)). A recent evaluation of the use of these tools found that they helped to make risk identification part of the routine work of Cafcass officers and focused attention on key risks (Debbonaire, 2008). MARACs help key agencies such as social services, police and victim services to share information, identify high risk victims, and plan safety strategies to protect victims and children (Robinson, 2004). At the heart of the MARAC is "the working assumption that no single agency or individual can see the complete picture of the life of a victim, but all may have insights that are crucial to their safety" (HMIC, 2014:90).

A review of MARACs in 2011 found that information sharing, appropriate agency representation and the role of the IDVA in representing and engaging the victim in the process are vital to their effectiveness, and pointed out the need to establish robust information sharing protocols (Steel, Blakeborough & Nicholas, 2011). In most MARACs the police take a lead role in coordination and planning (HMIC, 2014). However, the HMIC (2014:16) notes that in some forces, a quota is placed on the number of cases assessed as high risk "based on the number of cases a MARAC, or a specialist unit, can manage, rather than on the actual level of risk to the victim" and states that this needs to stop.

Despite their obvious utility, this review found that MARACs are sometimes not carried out in the West Midlands area, even when they would probably have been extremely helpful. This is in-keeping with national findings (Home Office, 2013b; HMIC, 2014). As well, criteria for MARACs also need to be better understood, as this was not always made clear in each case. When they do occur, MARACs also need to be managed carefully and in accordance with guidelines.

Issues related to MARAC were highlighted in a number of interviews with stakeholders from different areas. Even when cases were identified as high-risk, there were cases where there was no clear action to manage the

risk (the safeguarding plan was ineffective), and many cases were repeatedly referred to MARAC. However, there was also a note of caution about using MARACs as “a panacea”. Indeed, given the frequency with which many MARAC cases are repeated, thinking about a longer-term strategy to working with high-risk, particularly vulnerable, or high-level need clients may have merit.

Lack of proactive response / holistic responsibility

Related to information sharing and the MARAC process, a number of DHRs highlight a lack of joined up thinking within and between agencies, and reluctance from any individual agency to take responsibility for coordinating a holistic response to a situation where someone is identified as being at risk of/experiencing domestic abuse. Taking a proactive response is important, not just for promoting interagency working, but to help those involved in domestic abuse to better understand and engage with the services available to them.

The lack of a holistic approach was something that was mentioned in a number of interviews as a key issue, although many participants suggested there was a good sense of communication between agencies, a lack of joined up and proactive approaches was a problem. Several recommendations have been made around this area in previous reports, as this is also something which has been highlighted at a national level (Home Office 2013b; HMIC, 2014).

Fear of having children removed may prevent full disclosure from victims

In some cases reviews highlight the fact that victims may feel reluctant to disclose abuse in the home for fear of having their children taken into care. This may serve to reinforce the abuser's power and control within the family, and runs the risk of social care re-victimising those who are experiencing domestic violence. This concern needs to be addressed.

More robust response from police

Several findings from across the DHRs were in-keeping with some of the criticisms levelled at the police force by the HMIC (2014 – discussed in the introduction). A number of DHRs stress the need for a more robust response from the police in response to domestic violence. There were a number of ‘missed opportunities’ in several DHRs, where proactive police interventions may well have made a difference.

One of the interview participants highlights constant changes to policy as a key issue that prevents police from responding appropriately to certain situations. Finding ways of communicating changes to the police, particularly those that are essential to the protection of victims, is key. Specific and personalized training is an important element of ensuring this happens. Likewise, ensuring that appropriate supervision and management procedures are in place would be useful for making sure police are able to respond to situations appropriately.

Disclosure of domestic abuse of previous partner

In five cases the victim's partner had previously been violent towards a former partner. Previous violence towards a partner is clearly a risk factor for perpetuating future violence (Campbell, 2008).

Clare's Law, known as the domestic abuse/violence disclosure scheme [DVDS], is aimed at giving members of the public a formal mechanism to make enquires about an individual who they are in a relationship with or who is in a relationship with someone they know where there is a concern that the individual may be abusive towards their partner (Greater Manchester Police, 2014). If police checks show that the individual has a record of abusive offences, or there is other information to indicate the person they are in a relationship with is at risk, the police are able to share this information with the person(s) best placed to protect the potential victim. Originally piloted in by Police Forces in Greater Manchester, Gwent, Nottinghamshire and Wiltshire in 2012, the scheme was adopted nationally in March 2014 and forms an integral part of the Government's *Call To End Violence Against Women And Girls' Action Plan 2014*. The scheme has been welcomed by West Midlands Police² and relevant leaflets and website information have been produced³. It is suggested that this information is widely disseminated, and that invested stakeholders make sure there is awareness of this new law amongst those living in their areas/boroughs.

It should be noted, however, that there is a risk that victims could be subjected to more victim-blaming and the threat to remove their children may be greater if this information is not shared with a good understanding of coercive control and commitment to empowering victims.

² See West Midlands MAPPA Annual Report, 2012-2013, available at: <http://www.swmprobation.gov.uk/wp-content/uploads/2013/12/West-Midlands-MAPPA-Annual-Report-2012-13-FINAL.pdf>

³ See: <http://www.west-midlands.police.uk/advice-centre/help-and-advice/domestic-abuse/domestic-violence-disclosure-scheme/index.aspx>

Domestic abuse of extended family

In two cases the perpetrator had a history of violence towards his family growing up, prior to his relationship with the victim(s). This is also recognised as a predictor of future domestic abuse (Stuart & Campbell, 1989) and should be borne in mind when considering overall risk.

Not following care/safety plan guidance

In three DHRs potential risks were highlighted (often on several occasions, and by different agencies), but were not robustly followed up on. It is essential that, where they exist, Safety Plans are followed, and that attention is paid to care plans.

3.2 Tools

Diversity of Assessment Tools

Several DHRs mention the problematic nature of using a variety of assessment tools to assess risk (both within and across various agencies), which means it is difficult to understand the holistic risk presented by an individual or to monitor and understand fluctuations in risks they might present in a consistent manner. In some cases, providing training around these areas may be of benefit.

In addition, there is also a general reliance across all DHRs (especially in the case of mental health problems) on assessment tools instead of tailored, individual assessments and bespoke risk management. Kroenke, Strine, Spitzer, Williams, Berry, & Mokdad (2009) note that because mental health may be only one of a number of health indicators assessed in a clinical setting, brief measures, rather than an independent structured psychiatric interview, may be essential to reduce respondent burden. They note that the PHQ⁴ "is a useful depression measure" (p.163), however it should be borne in mind that it is **not** a risk assessment in terms of likelihood of carrying out acts of violence (either to the self or others).

Borum (1996) notes that despite a long history of interest in, and criticism of, the ability of mental health professionals to assess and predict violence, there have been few efforts to develop or evaluate interventions to improve decision making in this area. It is not within the scope of this review to provide a detailed critique of current mental health provision in the UK, but it is worth noting that Borum's (1996:945) recommendations

⁴ The Patient Health Questionnaire (PHQ) is a multiple-choice self-report inventory that is used as a screening and diagnostic tool for mental health disorders of depression, anxiety, alcohol, eating, and somatoform

for improving the clinical practice of risk assessment: (a) to improve assessment technology, (b) to develop clinical practice guidelines, and (c) to develop training programs and curricula, mirror many of the recommendations made in DHRs where a perpetrator has sought help from either their GP or other mental health professionals for emergent or ongoing mental health problems.

Failure to administer DASH when police called to domestic incident

In a number of cases a DASH was not carried out by attending officers who were called to a domestic incident, either because of misinterpretation of guidance or because the attending officers did not regard the situation as sufficiently high risk. This ties-in with the concerns raised by HMIC (2014) in their review of police response to domestic violence.

3.3 Caring Issues

Managing Care/Managing Carers

In two cases the victim was the primary carer for the perpetrator, and in one additional case, although not formally appointed, the victim was acting as a *de facto* carer for the perpetrator in the face of his disintegrating physical and mental health. In a fourth case the perpetrator was a carer for the victim. All four cases suggest that understanding the pressures that carers face, and how caring situations may facilitate abuse should be considered more carefully.

ADASS (2011b:10) mentions the need to empower carers to speak up, confident in the fact that professionals are "really listening, responding and learning from what they have to say" which may entail some shifts in organisational cultures and procedures. This is a challenge for adult social care services, but also Statutory Directors of Adult Social Services (who in their leadership role for safeguarding adults have a key role to play), local Health and Well-being Partnerships, and Safeguarding Adults Partnerships (who need to develop robust policies and procedures that support carers).

Faulkner & Sweeney (2011) point out that the risk of abuse (including violence) increases in cases where a carer feels isolated and is not getting any practical and/or emotional support from their family, friends, professionals or paid care givers. There is an acknowledgement that risk factors also tend to be greater where the carer is a partner or close relative (Livingston, Manela, & Katona, 1996), and where the carer is trying to

support a relative involved in serious substance misuse (ADASS, 2011b:12). ADASS (2011b) notes that timely and careful assessment of carers is critical, and that local safeguarding work needs to embrace the potential need for support for both carers and those being cared for.

Risk factors for carers hurting those in their care include: having unmet or unrecognised needs of their own; having had to unwillingly change their own lifestyle; feeling emotionally or socially isolated and/or undervalued by the person they are caring for and/or social services; and having other responsibilities such as a job or a family (Faulkner & Sweeney, 2011; Choi & Mayer, 2000; Oxfordshire Safeguarding Adults, 2010; McCreadie, 2002). Careful risk assessment, consistency and competence in safeguarding functions, and in working with carers are therefore all essential for those working alongside carers (Skills for Care, 2011). Several DHRs mention 'the rule of optimism' with regards to the affect it can have on professional perceptions and recognition of risk of harm, abuse, or violence in relation to child safeguarding and intimate partner violence. This also applies in the case of carers. It is clear that in several cases reviewed here the 'rule of optimism' was applied when it came to caring situations.

Failure of various professionals to involve families of victims/perpetrators

A number of DHRs drew attention to the fact that the families, friends, and carers of both victims and perpetrators who were engaged with various agencies often felt excluded from treatment/support programmes and therefore felt powerless and disenfranchised. This was particularly (although not exclusively) the case with health professionals. We suggest that the ability of family to engage with GPs is a key issue, and we suggest looking at the national programme, '*Time to Change*⁵', which includes a pilot training scheme for GP surgeries to improve healthcare professional's knowledge, attitudes, and practices in relation to mental health and highlights the need to support patients **and** their families.

Lack of transition in care

In several cases where there was a transition between individuals and/or agencies involved with both victims and/or perpetrators, there was no formal handover of cases and therefore information and institutional knowledge was often lost. There are also several examples where social workers were not fully briefed on cases they were taking over.

⁵ <https://www.time-to-change.org.uk/news/gps-learn-users-primary-care-mental-health-problems>

3.4 Health Issues

Issues related to General Practitioners

For many perpetrators and victims GPs are the only group consistently and actively engaged with, and are therefore uniquely placed to help. They are often the key point of contact, seen as a trusted figure, and the first port of call when issues related to domestic abuse emerge (mental health problems, alcohol and drug misuse, depression etc.) Despite this GPs are often poorly prepared to deal with issues related to domestic abuse, and do not communicate effectively either within practices or with other agencies.

The World Health Organisation [WHO] (2008) observes that integrating mental health services into primary care is the most viable way of ensuring people get the mental health care they need. They note that as certain skills and competencies are required to effectively assess, diagnose, treat, support, and refer people with mental health problems, it is essential that primary care workers are adequately prepared and supported, and that "to be fully effective and efficient, primary care for mental health must be coordinated with a network of services at different levels of care" (WHO, 2008:1). This report notes that in several areas across the region GPs are often **not** well coordinated with other services. Many have not been trained or provided with clear referral pathways to respond to domestic violence, and this can lead to domestic abuse situations not being handled appropriately. GPs are also often uniquely positioned to deal with mental health issues. Compared to Home Treatment Teams (which in two cases reviewed here were seen as invasive and unsympathetic⁶) GPs are seen as approachable and knowledgeable. It is vitally important they capitalise on this to deliver effective mental health interventions to at risk individuals.

Both the DHR reports and other research (Hester *et al.*, 2006) suggests that perpetrators often have contact with their GPs, and awareness from GPs as to how to engage with patients around perpetrating domestic abuse is key to ensuring they can get appropriate assistance. Related to the lack of understanding of domestic abuse, there are a number of cases where GPs make inappropriate referrals, especially to anger management or counselling programmes (when a patient has made a disclosure of perpetuating domestic abuse). Greater understanding and clearer domestic abuse protocols would help with this. There is an issue about availability of services in different areas, and the impact that this might have on GPs being able to direct a patient into an appropriate programme; this was particularly true for perpetrators. However, Hester *et al.* (2006) make it

⁶ This phenomenon is not unique to this report. Davies *et al.* (2009) also found experiencing mental health services as intrusive and controlling was an important reason given for going out of contact.

clear that engaging perpetrators and getting them involved in appropriate services that aim to challenge violent behaviours is critical.

Management of Prescriptions and Non-compliance with Medication

A number of DHRs critique the way prescriptions are issued and managed. In the majority of homicides involving mental health problems on the part of the perpetrator, non-compliance with prescription medicine was highlighted as a high risk indicator. However, there is often no clear protocol for monitoring medication compliance for people who are considered to require sustained (long-term) treatment with antipsychotic medication.

Compliance is defined as "the extent to which a person's behaviour coincides with medical or health advice" (Haynes, 1979:2). In their review of compliance with schizophrenia medication, Fenton, Blyler & Heinssen (1997:637) observed that "available social support, substance abuse comorbidity, and the quality of the therapeutic alliance each affect adherence and offer potential points of intervention to improve the likelihood of collaboration". In their review of 23 studies of compliance with medication for various mental health problems, Thompson & McCabe (2012) also highlight the central importance of the clinician-patient alliance and communication.

Fischer *et al.* (1999) note that negative beliefs about medication may lead to failure to seek medical help and a lack of compliance with any medication recommended (Fischer *et al.*, 1999). It has been proposed that greater account should be taken of patients' views in negotiating the treatment approach. In this regard, the term 'concordance', which implies a two-way negotiation between doctor and patient, is more appropriate than 'compliance' (Mullen, 1997). While noting that time constraints pose a challenge to clinicians in developing bonds with patients, Thompson and McCabe (2012) stress the importance of more effective collaboration on practical aspects of treatment. Training clinicians to discuss treatment specifics, including patient concerns about treatment, may improve their ability to perceive this agreement (Phillips, Leventhal, & Leventhal, 2011), and improve patient's beliefs about and attitudes towards treatment.

In addition, there are also problems raised around the issue of repeat prescribing, and relatedly, there appears to be a tendency to prescribe drugs without involving patients fully in treatment decisions. Often when medications don't work (or the patient perceives them not to be working) the drug is simply changed or the

amount altered. This can often lead to patients feeling disillusioned with their treatment process and may be one of the contributing causes of non-compliance. Peveler, George, Kinmonth, Campbell, & Thompson, (1999) state that non-adherence is a serious problem in the treatment of depression by general practitioners. In a randomised control study they found that counselling about drug treatment ('compliance therapy') significantly improved adherence, whereas treatment leaflets had no significant effect on adherence. This highlights the importance of health care professionals engaging fully with patients about the importance and purpose of medication.

Failure to ask new mothers about domestic abuse in the home (health visitors)

Asking new mothers about domestic violence in the home is considered best practice (HMIC, 2014), however, health visitors did not do this in at least two of the DHRs – doing so might have highlighted the risk in the victim's situation.

3.5 Services

Complex Needs of Perpetrators

In 9/13 cases the perpetrator had recorded mental health issues, and 7/13 had multiple factors and/or dual diagnosis – mental health issues drug use, and/or alcoholism. A wealth of studies have revealed the significant link between the problematic use of alcohol and drugs and perpetrating domestic violence (Straus & Gelles, 1990; Brown et al., 1998; Hutchinson, 2003; Mirrlees-Black, 1999), and much of the literature on drug use and domestic violence suggests that perpetrators who use drugs and alcohol together are more likely to be dangerous than single drug users (McCormick & Smith, 1995; Denison *et al.*, 1997; Schafer & Fals-Stewart, 1997; Mayor of London, 2005). While this does not necessarily demonstrate causality, it is clear that services could be regarded as 'missing a trick' if they continue to look at these issues in isolation.

Humphreys, Regan, *et al.* (2005) state that there are very few perpetrator programmes which address substance use in any systematic way, and, likewise, there is a scarcity of drug or alcohol services which explore the issues of domestic violence for perpetrators, leading them to conclude that "in the process of referral and help-seeking, one or the other issue becomes lost" (p.1304). In a recent Home Office (Mayor of London, 2005) report, only a minority of perpetrators had experience of both domestic violence and substance use agencies, tending instead to "go down one route (substance use) or the other (domestic violence) with the opportunity

to work effectively with both problems being missed" (p.12). The report notes that this is "particularly problematic" considering that the issues are so often interlinked (p.12).

Service providers interviewed by Humphreys, Regan *et al.* (2005) had no problem in acknowledging that service provision was inappropriately separated, a finding which was mirrored by stakeholders that we interviewed in the process of writing this review. Despite a willingness to work together, a range of reasons were given for the barriers to inter-agency working or the inability of agencies to address the dual issues. In relation to such barriers, Humphreys, Regan, *et al.* (2005:1311) note "undoubtedly, urging hard-pressed front line workers to engage in more extensive inter-agency working to meet the needs of their service users is a further 'old chestnut' which is depressingly familiar and does little to make a real difference to entrenched patterns and relationships between workers and organizations". They note the problems of resourcing men, women and children with complex needs, the lack of training and knowledge across substance misuse and domestic violence, and fragmentation at the government level, stating "an holistic approach is not assisted by the policy and dominant funding for each sector being separated. Drugs issues are based within the Home Office, due to the links with the crime and disorder agenda; alcohol issues are the responsibility of the Department of Health, emphasizing the connection with health and the medical model... while the voluntary sector and probation services fund programmes for perpetrators" (Humphreys, Regan, *et al.*, 2005:1314). As well as calling for greater voluntary inter-agency and inter-disciplinary co-operation, they also uphold that there is a useful opportunity for the creation of more external injunctions to co-operate (provided by legislation or administrative guidelines) which would enforce linkages between organizations such as those seen in the area of child protection and some areas of community care.

Given this association, it is clear that drug and alcohol services are well placed to address the perpetration of domestic violence by their clients. In 7/13 cases the perpetrators had diagnosed mental health problems and were heavy users of alcohol and/or drugs. This highlights the need to recognise substance misuse and mental health problems as a cluster of issues.

Brandon, Bailey & Belderson (2010) first introduced the concept of the 'toxic trio' of adult behaviour. The term has been used to describe the issues of domestic violence, mental ill- health and substance misuse which have been identified as common features of families where harm to women and children has occurred - particularly used to identify at risk children and has been highlighted in SCRs within the West Midlands

region⁷. It is worth noting that the term is not universally supported due to the implication that individuals who experience one or more of the issues are “toxic” themselves (Holly & Horvath, 2012) - it is of utmost importance not to further stigmatise or stereotype vulnerable adults with complex needs. However, there is clearly utility in applying some of the lessons learned from safeguarding children to thinking about risk in domestic situations more generally.

Failure to engage with services offered

Clearly a more effective response needs to be formulated when at risk individuals fail to engage with a variety of services that have been offered to them. There seems to be a particular reluctance of patients to engage with drug and/or alcohol services (the importance of which is key considering the role drug and alcohol misuse can be seen to play in domestic homicide cases).

Lack of provision of perpetrator programmes

Risk assessment often focuses on the victim’s behaviour and ability to make choices, which effectively makes the victim responsible for the perpetrator’s behaviour and often ignores all other risks of harm (Hoyle, 2008). These other risks include having to uproot children or risk losing them, and effectively punishes the victim if they take a different view to professionals about the management of risks.

Radford and Gill (2006:379) assert that “risk assessment that fails to deal with the perpetrator's responsibility for the violence can support victim blaming and the categorisation of women into ‘deserving’ and ‘non-deserving’ victims”. Victims have often been burdened with some of the blame for domestic violence, as police officers have typically dealt increasingly unsympathetically with those who would not support attempts to arrest and charge perpetrators (Hoyle, 1998).

Hoyle (2007:335) notes that "in the UK, the risk management techniques are directed firmly at helping victims to reduce their risk of victimisation. The responsibility is clearly to be shared between victims and criminal justice. The perpetrators are not encouraged to be accountable for their behaviour; they are assumed to be determined by their characters and environments toward offending. They do not take into account the potential for change, a potential many victims embrace. Risk assessment and management models should not be so deterministic, but should allow for the fact that perpetrators also have agency". She argues that risk

⁷ See, e.g., Coventry's 'Learning From Serious Case Reviews' document, dated May 2013

management programmes should include opportunities for perpetrators to voluntarily attend domestic violence perpetrator programmes, and that risk assessment therefore should also incorporate an assessment for the possibility of change (Maruna, 2001).

Despite this, there were very few perpetrators across the DHRs who were advised to attend perpetrator programmes, even when they disclosed their concerns about past abuse or the threat of possible future abuse. When referrals were given, they were rarely followed up on by the agency to which the perpetrator had made the disclosure.

The HMIC (2014) notes that research is fairly mixed about the effectiveness of perpetrator programmes (Hamberger & Hastings, 1993), and that there is a lack of evidence, particularly in the UK. A recent systematic review within Europe found only 12 studies that attempted to evaluate a perpetrator programme, and of those 12, none was of sufficient quality to determine whether any of the programmes had a positive (or negative) effect (Akoensi, Koehler, Lösel, & Humphreys, 2013). A larger body of research exists in North America, but there still exists uncertainty about what works best, for whom, and under what circumstances (e.g., Babcock *et al.*, 2004; Davis & Taylor, 1999; Feder *et al.*, 2008). However, recent work by Gondolf (2012:198) concludes that a conclusion that can be drawn from the research is that perpetrator programmes must "be held accountable for their work, derive feedback to develop and improve, and test out innovations and new developments", and that "a coordinated community response helps batterer program[mes], and intervention more broadly, to be more effective". Critics of perpetrator programme evaluations point out that abusers who participate in intervention programmes may simply become more skilful at concealing their renewed abuse from detection, and thus, evaluation results will reflect more positive change than truly occurs. Moreover, critics suggest that the reported programme effects only pertain to men who complete the programmes, and that 'programme drop-out' is a significant problem for programmes that serve court-mandated abusers. Indeed, it appears that 22–42% of abusers in US and Canadian programmes fail to complete their assigned programme (Rooney & Hanson, 2001; Saunders & Parker, 1989; DeMaris, 1989; Gondolf, 2002; Pirog-Good & Stets, 1986). Many studies also look at a narrow range of outcomes (for example, the continuation of abuse), and do not consider what the victim actually wants to happen as a result of the intervention (Westmarland & Kelly, 2012). Nevertheless, Rothman, Butchart & Cerdá (2003:3) note "these criticisms notwithstanding, it is possible to conclude on the basis of existing evaluations that batterer

intervention programmes offer some hope for behaviour change among intimate partner violence offenders... though they are not a panacea".

HMIC (2014) raises the concern that, in some cases, "ill-thought through programmes are being developed on an *ad hoc* basis by forces, and are not based on evidence of what works" (p.108), and notes the need for programmes to be trialled "both safely, and in a way that will provide a valuable addition to the evidence base" (p.109). It is clear that perpetrator programmes need to be carefully developed on the basis of existing best practice, and then systematically evaluated - with lessons learned being shared between all relevant agencies.

3.6 Systemic Issues

Problems with Partnership working/ Lack of effective communication

This was identified as a key factor in ten DHRs. The lack of communication both within and between agencies severely inhibits adequate and accurate analyses of risk, and means that proactive action to safeguard potential victims or treat/support potential perpetrators is often not taken. There is also a lack of information sharing within individual agencies.

There was an awareness amongst stakeholders that partnership working was a key issue. One participant shared their experience of trying to develop better communication and partnership working practices, but recognized that getting this process right was not straightforward, pointing out the difficulties of the IT challenges, as well as situations where teams became "swamped" with information they were unable to act on effectively.

Staffing Issues / Lack of facilities

Many DHRs identified systemic issues that occurred leading up to the homicides around lack of access to staff and/or facilities. Access to facilities is often also limited because of insufficient resources – this was particularly true for mental health services.

Equality Issues

It is clear that a number of agencies involved with clients at risk of being involved in domestic violence need a more robust policy for providing an interpreting service. In cases where language was an issue, interpreters were only used on rare occasions when both the victim and the perpetrator (neither of whom were able to speak English fluently) were in contact with various agencies – the agencies concerned often relied on the couple's child or a family friend, which made full and open disclosure problematic. All agencies in this case had access to 'Language Line', an easy telephone access system for interpreting services, but none used it. The report recommends that agencies ensure there is a "robust policy for providing interpreting services excluding the use of family members or friends except in extreme emergencies" (p.99), noting "the language problem prevented [the whole family] having access to the appropriate services to meet their needs" (p.107)

In the UK there is little variation in the prevalence of domestic violence by ethnicity (Walby & Allen, 2004), but studies have found that minority victims are less likely to report the violence or seek help from other sources (Parmar *et al.*, 2005). In a U.S. based study, Eng (1995) found that Asian immigrant women had difficulty acknowledging domestic abuse as they felt ashamed, having been socialised to believe that marital failure is always the fault of the wife. Hoyle (2007) makes the additional point that ethnic minority and/or immigrant women might lack sufficient resources to leave violent relationships, and therefore over time might be more likely to experience greater levels of domestic abuse. This is based on an understanding of dependency theory, which argues that "low opportunities and multiple constraints stemming from women's positions in the socio-economic structure affect women's control over their lives, making them dependent on their male partners, and raising the probability of experiencing violence" (Rodríguez Menés & Safranoff, 2012:586). Hoyle (2007:333) argues therefore that "risk assessment tools must be sensitive to differences between victims, not just gender differences but other cultural and structural differences, as strategies of risk management differently impact gendered, stratified and racialized groups". A number of DHRs notes possible cultural issues related to the reporting of domestic violence. As such it is important that access to police services should be promoted to newly arrived communities, as well public campaigns to encourage new entrants to communities to disclose concerns around domestic violence. Local safeguarding teams should work closely with voluntary and community sector organisations to promote the reporting of domestic abuse.

Relatedly, in DHR 5 the police were also concerned that the victim's acceptance into the UK was based on a financial threshold (husband's earnings) without consideration of a risk assessment of her safety in respect of

potential domestic abuse, especially given the history and antecedents of her husband (whose domestic abuse against previous wife was known to police). The report states that the UK Government needs to review the criteria and threshold for allowing foreign nationals to enter the UK without a consideration of a risk assessment of both applicant and sponsors with regards to domestic violence and sexual abuse.

4.0 Stakeholder Findings

There were two issues raised in the interviews with stakeholders that were not explicitly covered in the DHRs. Firstly, discussions around the process of conducting DHRs, and secondly (and relatedly), funding for domestic violence at local and national levels. In general, participants felt that the process of conducting DHRs had brought an attention and focus to domestic violence, and having a statutory obligation to review homicide cases had brought greater lessons learnt in general. The DHRs have also had an impact on service delivery and training around key issues for some groups.

However, despite the general acknowledgement that the DHRs were helpful in identifying areas where efforts could be concentrated, and playing a role in creating positive changes in response to the lessons outlined in the reports, there was a feeling that the process of conducting the DHRs was not only time consuming, but also created a drain on finite resources. This links into funding for domestic violence provision more generally and for the DHRs specifically. Ensuring that there is adequate funding to carry out the intensive demands of a DHR is essential to ensuring that teams have the capacity to deliver a robust report. There was little doubt that the impact of the DHRs was substantial, and in general there was a sense from all participants that the process of reviewing helped focus and cement strategies for tackling domestic violence, but that there was a need to provide greater funding to ensure that the DHRs were effective in highlighting key issues, and that other services did not suffer at the expense of the review process.

Sustainable funding was highlighted as a key issue for many of the stakeholders we spoke with, particularly statutory and third sector stakeholders. While many felt that the DHRs had put DV back on the local agenda, there was still a sense of insecurity when thinking ahead to funding posts, and a sense of frustration that these posts were not permanent, but rather had to be continuously created and funded, creating a revolving door of writing funding applications for staff that already have heavy workloads. Even in areas where funding was

relatively secure in the short term, there was an awareness that the posts could go at any time. In certain areas previous agencies/domestic violence services had closed down with the advent of the austerity measures. This meant that previous best practice and lessons learnt have disappeared – sustaining services and ensuring that necessary DV posts are made permanent is critical to ensuring that quality services can be provided.

5.0 Key Learning from National DHRs

We explored a number of DHRs across England that have been published and are available online. Twenty-seven (27) areas emerged as having either full reports published and available, or provided information about ongoing DHRs (key thematic issues etc), and reports from these areas were examined. Some common themes have emerged that are relevant to our findings here. Out of the twenty-seven (27) published DHRs, some of the common themes that emerge are similar to issues raised in our analysis.

GP services and A&E emerge as key areas where both victims and perpetrators present. Ensuring the A&E staff and GPs are aware of local services, and can direct either victims or perpetrators to appropriate services are critical. Again, GPs are uniquely placed to help both victims and perpetrators access services that are relevant – often counselling and anger management services are advised for perpetrators, but specialist perpetrator programmes that tackle violent behaviour are needed.

Alcohol and mental health is another key area of concern, and is relevant for both victims and perpetrators. Again, inappropriate referrals, referrals not being taken forward, and a lack of communication between agencies is a key issue, and something that needs to be considered at a national level. Keeping relatives informed and involved was another key area that came out across different DHR areas. Threats of violence and/or murder made by the perpetrator were realized in many of these cases. Incidents of violence, including physical violence, were often precursors to murder, and many of the perpetrators in the DHRs had been cautioned or arrested for domestic violence by the police. Further, there is confusion in some areas as to when a DASH assessment is appropriate, and how to categorize risk appropriately.

One of the key differences that we could see from areas that had multiple DHR reports available, was that some areas have a clear issue with one particular service in terms of being able to safeguard victims of domestic violence. One reason for focusing on each individual DHR and the outcomes from specific cases in the West Midlands was that there was no one clear service that had failings, nor was there a clear element or strand that had not tried to reasonably fulfil their obligation. While it is clear that there is work to be done improving West Midlands' response to domestic abuse in line with the key thematic issues that this report has raised, it is also important to point out that the West Midlands stand out in relation to many of the other areas we investigated, particularly in their police response to domestic violence. Many areas had major failings with regards to police involvement, and specialist domestic violence services in particular. In the West Midlands there is a demonstrated commitment to partnership working across different areas, and while there are clear recommendations that can be made to improve responses, it is important to point out that in relation to other areas, and failure of services in other areas to engage appropriately with victims of domestic violence, the West Midlands have made clear attempts at engaging with guidance from the government, and are making steps in the right direction.

6.0 Discussion

There are a range of conclusions that can be drawn from this research. While each of the 13 DHRs we investigated had its own individual profile, and a number of failings specific to each situation emerged, there is no one overarching issue that needs to be addressed by the West Midlands. In a sense this makes it more difficult to provide targeted recommendations, because there are a range of issues that need to be addressed at different levels, to ensure that victims are safeguarded appropriately. Each of the thematic areas that we have highlighted suggests that different areas, and different service providers, need to think through their own service delivery to ensure that adequate provisions are in place.

We have tried, as far as possible, to make general recommendations based on the outcomes from individual DHRs. However, given that we were only able to explore 13 DHRs in detail means that some of our findings are limited. We would suggest that a larger study that explores DHR outcomes in detail would provide a more nuanced picture. A national-level study would be welcomed.

The recommendations we have made below are, we believe, the most pertinent in terms of the analysis. Some of the recommendations are about making changes to local services – and some are wider recommendations

that would apply to national level issues. We are aware that the West Midlands can only do so much – and indeed we would suggest that the government has a central role to play in ensuring that some of the key issues that emerge here, particularly around service provision and funding, are addressed. Indeed, it will be very difficult for any area in the UK to make the fundamental changes necessary to tackling domestic homicide without a shift from the government in terms of prioritizing domestic violence.

One area that the authors did not cover, as it was outside the remit of the DHR reports, was the issue around prevention. While there is competing evidence about the efficacy of prevention programmes (NICE, 2014:50), which makes it difficult to determine to what extent prevention programmes should be prioritized (particularly those that have not been subjected to an evaluation), and which prevention programmes are most effective. This is an area that requires further investigation. Equally, other areas of support including advocacy, carer interventions, and different pathways for interventions require further research to understand their efficacy, but these may be areas that the West Midlands may want to investigate further.

7.0 Recommendations

Based on the findings from the analysis of the DHRs and the interview data, we have been able to draw together a range of recommendations at both the local and the national level. We are aware that some of the recommendations we make, particularly at the national level, are perhaps unlikely to be taken forward, as they constitute a distinctly separate path from the policies made by the current government. However, we would like to draw attention to the 2014 Action Plan: *A Call to End Violence against Women and Girls*, where the government clearly states that it hopes to achieve "nothing less than the elimination of violence against women and girls". If the government plans to make good on this promise, then more funding has to be made available to tackle these issues, particularly to domestic violence and health services. The Home Office (2013) 'Lessons Learnt' document is too brief to fully address the complex findings that have emerged from DHR reports across the country. A more in-depth analysis of these findings is necessary to ensure that the time and resources spent on conducting DHRs is not lost and that the lessons learned take in and analyse findings from a national perspective. We would suggest that the Home Office make this a priority, and provide greater detail about how to develop lessons learnt into real change.

7.1 Recommendations Local

Improving Health Services

- National Guidance from the Royal College of General Practitioners identifies a range of recommendations with regards to the role of GPs and GP management in understanding and responding to domestic violence. It is not clear that this is being followed through at a local level. We recommend that this guidance is instituted in GP practices, and that more face-to-face training for GPs about how to respond to DV are rolled out. The Home Office has highlighted an e-learning training course, but given the importance of GPs to almost every case, and their engagement with both victims and perpetrators, it is suggested that more specific training is delivered to GPs and their role as a critical point of contact is made clear. The IRIS (Identification & Referral to Improve Safety) model may be a first point of call for GPs wishing to commission and engage with domestic violence prevention (c.f. Howell and Johnson, 2011).
- The Home Office suggests that training for Health Visitors around domestic violence is due to be rolled out in 2015. Again, given the importance of child protection issues, and the failure of health visitors to enquire about domestic violence in two cases where appropriate questions may have helped, we would also suggest that at the local level, Health Visitors are given guidance about how to address issues around domestic violence – specific training would also be appropriate around these issues. It would appear that this kind of training is already happening in areas of the West Midlands - the tool kit will look at how best practice can be adopted across the area.
- Addiction services and mental health services should develop an assessment tool to identify potential perpetrators of domestic violence⁸, and have access to information about how to refer clients to appropriate services. Commissioners and providers of services in the West Midlands should look at ways in which they can integrate the guidance on dual diagnosis (Department of Health, 2002) with the models of care framework to create a single policy document that also addresses referral to mental and addiction services from primary care.
- The WHO (2008) suggests that integrating mental health services into primary care is the most viable way of ensuring people get the mental health care they need, something which is supported by recent NHS documentation. The report writers recommend looking at the national programme, *'Time to*

⁸ Such as that developed by AVA: <http://www.avaproject.org.uk/media/124125/ava%20toolkit%20section%201.pdf>

*Change*⁹, which includes a pilot training scheme for GP surgeries to improve healthcare professional's knowledge, attitudes, and practices in relation to mental health and highlights the need to support patients **and** their families.

Engaging Carers

- With regards to ensuring carers are properly supported at a local level, progression of the national competence framework for safeguarding adults (Bournemouth University, 2010) is something all local partnerships should consider adopting, and ensuring carers are offered frequent assessments is key. Equally, joint training and local awareness work with GPs are also needed to develop stronger referral pathways that are seen as person-centred and proportionate to risks presented, rather than as simply process driven.

Assessment Tools

- MARAC – there are questions about the usefulness of MARAC in terms of its ability to assess risk appropriately. In some cases there is a clear sense that the judgements used to assess criteria for MARAC are subjective, and that there is a discrepancy across different areas about when a MARAC referral is appropriate. MARAC seems to work best when there are high levels of engagement from relevant partners. However, the discrepancies across different areas suggest that in general, a greater level of coordination is often needed. We would suggest reviewing MARAC procedures in each local area, and make sure they are fit for purpose. Ensuring that clear strategies are in place and can be actioned once a high-risk domestic violence situation has been alerted is also critical.
- It may be useful to consider the introduction of longer-term interventions for repeat MARAC cases, or in instances where specific risks are identified.
- In line with the HMIC (2014) recommendations, we would also recommend the development of a tactical toolkit to assist staff called to domestic abuse incidents (particularly on the appropriate use of the DASH). This can build on/be adapted from the existing toolkits already in existence in other police forces, and referenced in this report.

⁹ <https://www.time-to-change.org.uk/news/gps-learn-users-primary-care-mental-health-problems>

Sharing Information

- Developing coordinated and joined-up approaches to engaging perpetrators in relevant programmes is an important element to tackling domestic violence. While the safety of victims is essential, there needs to be an awareness that perpetrators need specific services that target their violent behaviour, and that recognize the complex needs that perpetrators often have (e.g. mental health problems and substance abuse) when developing services. There also needs to be recognition that without a full awareness of a perpetrator's offending history it can be difficult for other services to respond appropriately to a high risk situation.
- Clare's Law has been welcomed by West Midlands Police and relevant leaflets and website information have been produced. It is suggested that this information is widely disseminated, and that invested stakeholders make sure there is awareness of this new law amongst those living in their areas/boroughs.

Funding for Services

- Mapping and assessing domestic violence provisions in each of the areas, and ensuring that key posts necessary to ensuring domestic violence can be tackled is essential to ensuring quality provision (NICE, 2014). Providing adequate and sustained funding to domestic violence coordinators, and ensuring that all domestic violence posts are filled, is a critical component to ensuring that someone has an overview of domestic violence across the different areas. Investment into IDVA services to high risk victims must be a priority.

Equalities Issues

- Access to police services should be promoted to newly arrived communities, as well as public campaigns to encourage new entrants to communities to disclose concerns around domestic violence. Local safeguarding teams should work closely with voluntary and community sector organisations to promote the reporting of domestic abuse across different communities.

Child Protection Issues

- A number of child protection issues emerged across the DHRs, particularly around policies, procedures, training and supervision. Training around domestic violence across different sectors for any agency

that deal with children or young people is essential, particularly around recognizing indicators of domestic violence.

- Agencies that work with children or young people, particularly vulnerable young people, should have clear policies, procedures and training, around these issues, and that these are locally relevant and specifically tailored to meet local needs.
- Implementing clear information sharing protocols across different agencies, and where child protection procedures are being undertaken, making sure that a sensitive approach to dealing with a parent who has been a victim of domestic violence (and indeed, may still be in a violent relationship), is adopted.

Preventing Domestic Violence

- It was clear that there were a number of different services, pilots, and interventions being run in different areas within the West Midlands. It was not clear to what extent information about these interventions were systematically shared, or to what extent these services were being evaluated. As this is a key area where further research is required, we would suggest a more systematic approach to both evaluating and sharing findings about prevention interventions across the West Midlands. Examples include MASH, the Mental Health Triage Pilot in Birmingham, and NHS pilots in A&E.

7.2 Recommendations – National

Health Services

- While the National Guidance from the Royal College of General Practitioners (RCGP) identifies a range of recommendations with regards to the role of GPs and GP management in understanding and responding to domestic violence, as stated above, it mostly focuses on how GPs should engage with and respond to *victims*. In particular, the Resource: Process for responding to domestic abuse only provides details how to respond to disclosures made by victims. This is obviously of tantamount importance, but specific guidance for perpetrators would also be helpful here, and may help get perpetrators into appropriate programmes.
- It is clear that having a more engaged GP service, where patients are able to see a dedicated GP with whom they can build trust and rapport would be of the utmost importance in terms of victims being able to disclose domestic violence. The funding cuts made to NHS provisions have left GP services on

the 'brink of extinction' (Campbell, 2014). Providing adequate provisions, and ensuring that patients are able to easily make appointments with a doctor of their choice (particularly when there is a language issue) is fundamental in ensuring that victims of DV, and indeed perpetrators, can receive help from someone they trust and who has an awareness of the particular issues that patient faces. This is certainly true of patients with complex needs.

- There is currently no mandatory requirement for GPs or practice staff to undertake training around domestic violence. We would suggest that the RCGP make this a mandatory requirement.
- Arrangements need to be made whereby NHS England and local public health structures work together to commission services and ensure that all contracts with providers stipulate effective joint working and clear pathways to meet the needs of people with co-existing mental health and substance misuse problems.

Improved Understanding of Risk Factors

- Current definitions of domestic violence make no distinction between intimate partner violence and familial violence. However, the risk-factors that may prompt someone to perpetrate violence in an intimate relationship may differ to someone perpetrating violence against a family member. Equally risk-factors for victims will likely differ as well. Developing a specific risk assessment for intimate partner violence and another for familial violence may help to flag potentially violent situations that would otherwise have gone unnoticed. This is particularly true for vulnerable/disabled/elderly people who have carers.

Funding for Services

- Funding for domestic violence provision is woefully under-resourced. Towers and Walby (2012) have made clear that the recent cuts to women's service provision in the UK are leading to increased levels of violence for women and girls. While the government has suggested that they are making violence against women and girls a key issue (Home Office, 2011) they have failed to provide adequate funding resources to ensure that services are in place to protect victims. Indeed, £5.6 million in cuts was made to domestic violence refuges and other women's services across England between 2009/10 and 2012/13 (Bennhold, 2012). It is clear that if the government wants to tackle DV, providing funding to a wide range of agencies that deal with violence against women (including third sector and statutory agencies, as well as the NHS, the police, and the CPS) is essential for ensuring that there are adequate

and appropriate provisions in place to not only prevent, but also to manage domestic abuse. This also includes funding provisions for perpetrator programmes. Whilst the authors recognize that local authorities are meant to be able to allocate funding at a local level, we would argue that dedicated funding should be made available, and that this should be nationally ring-fenced, to ensure that domestic violence is a clear priority on a national agenda.

Developing a Coherent and Sustained Approach to Tackling DV

- Despite many examples of best practice, there still often exists a lack of clarity about existing programmes and policies, and the constantly changing landscape can make it difficult even for the most dedicated of individuals to keep up with what the current expectations are in relation to domestic abuse. While there is a need to reconsider best practice in different areas, and to improve services by making changes, there is an overwhelming amount of information that professionals are expected to manage. The Home Office needs to look at ways this information can be packaged and disseminated appropriately, in a way that practitioners can understand and implement quickly and efficiently.
- The UKBA have had involvement with a number of the DHRs; they need to ensure that their guidelines about referrals are understood and followed by staff to safeguard potential victims of DV.