Healthy and safe communities

Incidents of domestic abuse and violence

The 2013 Government definition of domestic violence is ‘any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, psychological/emotional; physical; sexual; and/or financial abuse.

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

Stalking is also acknowledged as a form of domestic violence. It is repeated harassment causing fear, alarm or distress. It can include threatening phone calls, texts, letters, damaging property and spying on or following the victim.

Domestic Violence (DV) remains highly prevalent in the borough. It is a priority strand for the borough’s health and wellbeing strategy, the Local Safeguarding Children’s Board, the Adult Safeguarding Board, the Community Safety Partnership and the Children’s Trust.

Domestic violence in Barking and Dagenham

In 2013/14 there was a total of 1,991 DV crimes reported to the police. Although this was a 25.4% increase on the previous year, Barking and Dagenham continues to have the highest DV reported incident rate in London. (Figure 6.4)

Figure 6.4: 2013/14 Domestic Violence Offences per 1,000 population

Source: Barking and Dagenham Police data
Nationally in 2012/13 DV accounted for 20% of all violent crime. In Barking and Dagenham 41% of violence with injury offences were related to DV between June 2013 and May 2014. In 2013/14, IDSVA services reported 14% of DV cases for which a result was recorded resulted in an unsuccessful prosecution. This rate is a reduction from 2011 recorded at 39%. Historically, around 40% of victims did not attend court for cases of DV, which reduced the number of prosecutions. During early 2014, Victim Support introduced a court worker to support victims of DV at court and the non-attendance rate reduced to 3%.

Low referrals from health services and the need for staff training

Currently, there are low levels of referrals from health services. During 2013/14, GP referrals made up 0.65% followed by 2.11% from Health Visitors and 6.01% from Midwives of all referrals to the IDVAS service. The cause of an injury due to domestic violence is not routinely coded. Often a domestic violence incident is recorded as an assault and the location is coded but this is insufficient to tell whether a case is domestic violence.

The domestic violence screening tool used by Multi-Agency Safeguarding Hub (MASH) in Children’s Services went live on 1 April 2013. There is now a young person’s Independent Domestic Sexual Violence Advocacy (IDSVA) Service and a Children and Families IDVAS posts in place as part of the IDSVA contract for 11-18 year olds. The children and Families IDSVA is co-located in the MASH hub and they continue to review the cases where domestic violence is relevant.

The domestic violence screening tool is used to assist in the identification of risk to the child / victim and the level of intervention required. The tool is used in conjunction with the social workers’ own risk determination and is most useful when the risks are borderline tiers 2 and 3. This could also explain an increase in child protection cases referred to Children’s Services.

Service provision

The DV services in the borough work together to help deliver a coordinated community response model which:
- Increases survivor safety.
- Holds perpetrators accountable for their behaviour.
- Challenges the social tolerance of domestic violence.
All services responding to DV contribute to the delivery of the Domestic and Sexual Violence Strategy and Health and Wellbeing Strategy locally.

Service responsiveness

In 2013/14 the borough’s IDSVA service received 297 referrals for victims of DV from Black, Minority Ethnic and Refugee (BMER) communities and 276 referrals for White British victims. The Multi Agency Risk Assessment Conference (MARAC) in 2013/14 had
Appendix 4, Incidents of domestic abuse and violence section of JSNA

no cases of honour based violence. In the past, 3 cases of female genital mutilation have come to notice in the borough (1 case suspected, 1 case investigated and was from a neighbouring borough), but no cases were raised to MARAC in 2013/14. As these types of domestic violence and sexual abuse are hidden problems it is difficult to estimate the prevalence of the problems locally. Partnership services are reviewing case management systems and appropriate flags to identify victims or at risk individuals and help provide more robust data in the future.

Demographic expectations

Individuals from Black Minority and Ethnic backgrounds appear to be reporting broadly proportionally with the ethnicity profile of the borough (Asian - 15.39% of the residents, 17.37% of reports and Black: 19.85% of residents, 17.53% of reports), which suggests reporting levels are consistent across the borough’s ethnic groups. With the knowledge that one in four women and one in six men will experience Domestic Violence, we are able to estimate 24,000 females and 15,000 males, living in Barking & Dagenham will experience domestic abuse at some stage during their lifetime.

Presence of alcohol

In 2012/13 Barking and Dagenham had a rate of 10.53 per 1,000 population for alcohol related crimes. Although this is an increase from the previous year it is still below both the regional and national averages (9.02 and 5.74 respectively). Barking and Dagenham is ranked as the 9th highest in London for alcohol related crime per 1,000 population in 2012/13.

Research nationally of convicted offenders has shown that alcohol is a common feature in as many as 62% of domestic violence offences. 18% of recorded domestic violent crimes in Barking and Dagenham involve an offender who was under the influence of alcohol. However, there is no national evidence to show that alcohol use directly causes DV. The reasons why DV happens are complex and varied. The presence of alcohol must be viewed with caution and viewed against the social factors and the underlying beliefs of violence against women, sexism, and gender entitlement that underpin DV.

Economic impact

The hidden costs to agencies in Barking and Dagenham in responding to DV (its immediate and the long term impact) could be £19 million a year[1]. This figure includes the costs of visits to GPs and A&E, treatment for injuries, use of ambulances, prescriptions, and referrals to services for treatment, mental health and rehabilitation. Research has also shown that the average high risk DV case costs an estimated £20,000 per year to the public purse, costing the health service £5,000 per victim.

Appendix 4, Incidents of domestic abuse and violence section of JSNA

Gaps in knowledge and delivery

In Barking and Dagenham there is a Domestic and Sexual Violence Strategy 2012 – 2015 and delivery plan which has been developed jointly with partnership services. In Barking and Dagenham the priority objectives and outcomes of the Strategy are:

Figure 6.5:

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<tr>
<th>Priority objectives</th>
<th>Outcomes: by 2015 we aim to have achieved the following</th>
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<tbody>
<tr>
<td><strong>PREVENT domestic and sexual violence from happening in the first place</strong></td>
<td>• A suitably trained universal services workforce, able to appropriately recognise, refer and support survivors to safely exit all forms of domestic and sexual violence</td>
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<td>• Health services (maternity, sexual health, GPs) to increase the early identification of women and girls who have experienced or are at risk of experiencing FGM by 10% year on year.</td>
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<td>• A reduction of 2% of repeat domestic violence incidents reported to the MARAC</td>
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<td><strong>PROVIDE SUPPORT to victims where violence does occur</strong></td>
<td>• All victims attending court are offered active advocacy support at Court</td>
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<td>• The development of a joint Health and Social Care Commissioning Framework to ensure that victims have regional access to specialist domestic and sexual violence services.</td>
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<td>• Schools and colleges to ensure that staff is aware of how violence may affect young people’s behaviour and what action they should take if they suspect that it is.</td>
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<td>• Provision of specialist service to victims using specialist risk assessment screening tool.</td>
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<td><strong>REDUCE THE RISK and BRING PERPETRATORS TO JUSTICE</strong></td>
<td>• An increase in the sanction detection rate of domestic and sexual violence incidents.</td>
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<td>• A reduction in the number of ‘ineffective’ domestic and sexual violence cases through the courts[1]</td>
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<td>• Explore provision of an adequate non-court ordered perpetrator programme.</td>
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<td>• Robust monitoring of the Integrated Domestic Abuse Programme (IDAP) and its outcomes.</td>
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<td><strong>WORK IN PARTNERSHIP locally to achieve the best outcomes for victims</strong></td>
<td>• An increase in the partnership’s local understanding of the prevalence of the different strands of domestic and sexual violence through improved data recording and monitoring.</td>
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<td>• Contribute to the development and implementation of an operational plan for responding to the impact of criminal gangs and serious youth violence on women and girls.</td>
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<td>• Work in partnership with the Metropolitan Police and London Ambulance service to overcome data recording restrictions in regard to FGM so that future data analysis can be conducted.</td>
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<td>• Improve Crown Prosecution Service (CPS) of statistics on DV to enable analysis on outcomes of DV cases that do and do not progress to court and reasons behind the outcomes.</td>
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<td>• Housing review action against secure sole tenants where perpetration of DV has occurred.</td>
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</table>

[1] Ineffective trial: on the trial date the expected progress is not made due to action or inaction by one or more of the prosecution, the defence or the court and a further listing for trial is required.

Recommendations for commissioners

All Partnership recording systems to have alerts for domestic and sexual violence (including female genital mutilation, honour based violence, forced marriage and no recourse to public funds).
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Improvement in the interrogation of existing systems is required to identify at risk individuals and families so that preventative and support services can be put in place for these individuals.

Ensure resources are available to implement the local delivery plan for the 2012-2015 Domestic and Sexual Violence Strategy and to allow for the continuation of key services and ensure they are approachable, accessible and supportive, including maintaining the health commissioned domestic and sexual violence services. The development of a joint Health and Social Care Commissioning framework will help to ensure victims have regional access to inclusive domestic and sexual violence services.

Consideration should also be given to:

- Developing specialist provision for individuals who experience violence against women and girls issues, including female genital mutilation, honour based violence and forced marriages.
- Provision of dedicated domestic violence and sexual violence support to health services (GPs, practice nurses, health visitors, school nurses and their patients).

This would improve:

- Identification and recording of DV concerns.
- Disclosures and injuries would generate more referrals to DV services.
- Improve safeguarding response by GPs to children and adults experiencing DV.
- Specialist domestic violence input into troubled families programme.