



Insights

into domestic abuse

1



A place of greater safety

www.caada.org.uk/commissioning

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Foreword

CAADA Insights 1: a place of greater safety is the first in a series of annual policy reports from the national domestic abuse charity Co-ordinated Action Against Domestic Abuse (CAADA). Using evidence gathered directly from victims, the series aims to save lives and public money by making recommendations for improving the response to domestic abuse across the UK. We believe that it is vital to keep the experience of victims at the heart of service delivery and this report represents a step forward in achieving this.

This year's report is aimed at commissioners and policy makers with strategic responsibility for funding domestic abuse services. Our evidence comes from 2,500 victim cases, collected by 14 specialist domestic abuse services which used CAADA Insights in the year to March 2012. Using this dataset – the largest of its kind in the UK today – together with information from focus groups with survivors, we demonstrate the best ways to invest local resources to keep victims and their children safe. By making recommendations to address domestic abuse, the report also aims to increase the effectiveness of other essential public services such as the police, health, and child and adult social care.

Over the next six months CAADA will provide a suite of tools for commissioners to support their work. Accompanying practice briefings for service managers and other professionals will also be available, to enable all stakeholders to make a stronger business case for continued funding in their area. If you would like to receive this information, please visit www.caada.org.uk/commissioning and leave your contact details via our online form, or alternatively email commissioning@caada.org.uk today.

Diana Barran MBE
Chief Executive, CAADA

What is CAADA Insights?

CAADA Insights is an outcomes measurement service designed specifically for the domestic abuse sector. The service evidences the outcomes that domestic abuse services have on victim safety, enabling services and commissioners to make a stronger case for funding and service improvement.

Insights works through a simple system of data collection. CAADA provides frontline practitioners with practical tools for collecting service user information, and the data is analysed by our research and evaluation team. Outcomes are presented back to services and commissioners through regular reports. Service level data is also aggregated and anonymised to form the CAADA Insights National Dataset, which we use to influence national policy and practice.

Although this year's report focuses on the outcomes of services for high risk victims, Insights is used by other services such as outreach and refuge. As a result, future reports are likely to focus on the wider domestic abuse sector. For more information please email insights@caada.org.uk today.

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Introduction

*To protect identities names have been changed.

“As the years went on the abuse continued to become worse. I wasn’t allowed to speak to my children during the evening. He regularly used to turn off the electricity in the evening to prevent any of us from relaxing. Beatings were a regular occurrence for all of us. He even killed two of our family pets.” – Melanie, victim of domestic abuse¹*

Domestic abuse is an intractable and widespread problem. Two women per week are killed by their current or ex-partner² and CAADA estimates that there are 100,000 victims at high risk of serious harm or murder.³ It costs the tax payer an estimated £3.9bn per year, with high risk domestic abuse making up nearly £2.4bn of this.⁴

Domestic abuse has adverse impacts on the health and wellbeing of victims,⁵ and is closely associated with child abuse and neglect,⁶ as well as a range of other social issues including homelessness⁷ and substance abuse.⁸ It has always been challenging for commissioners to address, affecting many different local policy agendas and requiring the cooperation of multiple agencies to resolve it. In addition, the public sector is now operating in the harshest financial climate for a decade: local areas must deal with competing demands for funding in the face of unprecedented spending cuts. Many families are also coping with unemployment, mounting debts and housing difficulties. Too often, it is victims who bear the brunt of this double hardship.

This report provides practical advice for commissioners and policy makers. Using data gathered directly from victims as evidence, the report recommends cost effective ways of keeping victims and their children safe. CAADA’s aim is that every family can live safely and free from abuse in their home. In the following pages we set out how to achieve this.

Our evidenced recommendations:

1. Mainstream funding for existing services which support victims at high risk of serious harm or murder. This model supports at least 43,000 adult victims each year.⁹
2. Locate additional IDVA services in A&E and maternity units to create a platform of extra provision. This would start to address the abuse experienced by 10,000 extra high risk

victims who are currently hidden from the criminal justice system and who receive no support today.¹⁰

3. Implement specialist domestic abuse services for children and young people to secure the health and wellbeing of the estimated 130,000 children and young people living with high risk domestic abuse today.¹¹

Policy context: support services for high risk victims of domestic abuse

Over the last seven years, services for victims of domestic abuse have been transformed. At the heart of this change is a national model which prioritises victims at high risk of serious harm or murder. The model depends upon specialist support from trained advisors called Independent Domestic Violence Advisors (IDVAs). IDVAs are independent and provide emotional and practical support. They engage with adult victims from the point of crisis and mobilise the resources of up to 15 local agencies to keep each victim and her children safe. The effective coordination of other public services now happens through the work of Multi-Agency Risk Assessment Conferences (MARACs), meetings chaired by the police, where statutory and voluntary sector partners work together to share information on the highest risk cases, and a coordinated safety plan to protect each victim is developed. Because multi-agency support is not successful without a close relationship with a victim, the work of IDVAs and MARACs are inextricably linked, with an IDVA representing the voice of each victim at the local MARAC. Through the work of 260 MARACs and an estimated 500 IDVAs, over the last 12 months more than 43,000 adults living with 57,000 children were supported by this model.⁹ For more information on how IDVAs/MARACs work, see p.18.

**CAADA
Insight:
the scale
of high risk
domestic
abuse**



at risk of serious harm or murder



victims experience cessation of abuse
after receiving support from an IDVA



children living with high
risk domestic abuse



average length of
abusive relationship



estimated gross amount saved by adopting
all of CAADA's recommendations

**CAADA
Insight: how
high risk
domestic
abuse affects
lives**



experience jealous and controlling behaviour



experience physical abuse



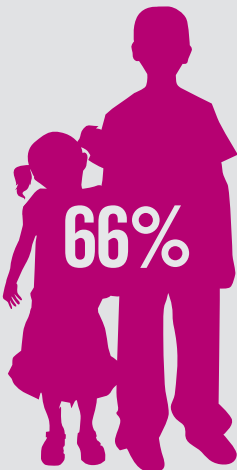
have financial issues



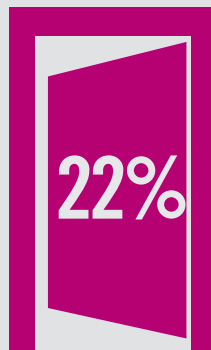
have mental health issues



experience stalking and harrasment



have children



experience sexual abuse



misuse drugs and alcohol

Recommendation 1

Mainstream funding for existing high risk services

“My initial contact with the IDVA was earth-shattering, she asked very specific questions in exactly the right areas and I couldn’t believe how much she understood my situation.”
– Jane*, victim of domestic abuse

Evidence: how domestic abuse affects victims’ lives

CAADA’s dataset of more than 2,500 victim cases highlights the extreme levels of abuse that tens of thousands of victims are experiencing in the UK today. The majority of victims are women¹² aged 21 to 40¹³ with young children:¹⁴ on average these victims live with abuse for five years before finding effective help.¹⁵ Three quarters of victims experience multiple types of abuse and 70% experience at least one form of severe abuse such as strangulation, rape or threats to kill.¹⁶ More than half of the victims in our dataset reached the threshold for their case to be heard at MARAC.¹⁷ High risk domestic abuse is underpinned by coercive control, and this is evidenced by the 79% of victims who experienced jealous and controlling behaviour.¹⁸

Our data confirms that where high risk domestic abuse is present in a household, it is rarely the only issue experienced by the family. Children will be experiencing degrees of abuse and neglect,¹⁹ and substance misuse, mental ill health, anti-social behaviour and other difficulties may also exist.²⁰

Evidence: how IDVAs and MARACs support victims to safety

“I needed my IDVA to literally negotiate with all these people on my behalf...grab them by the scruff of the neck and make them understand the situation, which she did.” – Sue*, victim of domestic abuse

“Because IDVAs are independent, they play a valuable role in gaining a full picture of the abuse. I often tell victims that if they disclose offences to me then I have to officially record them and positive action will be taken. Often this results in the victim not telling police the whole story and we are therefore unable to correctly assess the risks.” – PC Jo Griffiths, Hampshire Police

Policy context: the Violence Against Women and Girls agenda, domestic violence homicide reviews and stalking

As part of its Call to End Violence Against Women and Girls Strategy, the government has part funded 144 IDVA and 54 MARAC coordinator posts with £3.3M of funding per year until 2015.²¹ But whilst this provides clear direction, these posts are far from secure: national coverage of MARACs has now been achieved, but local authority grant cuts have depleted overall IDVA numbers and there are now only an estimated 500 IDVAs in post.²² At least 650 are needed to support all high risk victims in the UK.²³ Domestic violence homicide reviews were also established in April 2011 on a statutory basis.²⁴ These create an expectation for local areas to undertake a multi-agency review following a homicide. The aim is to establish whether local changes should be made, including for example, whether sufficient priority and resources are allocated to meeting the needs of local victims. In 2012, a new offence of stalking was introduced.²⁵ Commissioners will need to address all of these priorities in their strategies for domestic abuse; having effective high risk services helps to achieve this.

Our research shows that the IDVA and MARAC approach is an effective means of addressing high risk domestic abuse and thereby saving lives. The majority of adult victims in our dataset reported improved safety and wellbeing outcomes after receiving support, including a cessation of abuse, feeling safer and an improved quality of life. IDVAs assessed that 74% of the victims in our dataset experienced a reduction in their risk levels at case closure,²⁶ and 63% reported a total cessation of abuse at case closure.²⁷ The safety of victims is significantly improved through good action planning at MARACs: the more intensive the support from multi-agency partners, the better the outcomes, as the diagram on the next page reveals.²⁸

In 2011 CAADA worked with 15 local MARACs to analyse the outcomes of 350 cases. The research showed that in the 12 months after the MARAC, 45% of victims experienced no further police call outs, 20% of victims had fewer reported incidents and 14% reported an increase.²⁹ MARACs also enable the identification of perpetrators and child victims of abuse, further supporting the work of other agencies such as children's safeguarding and probation.

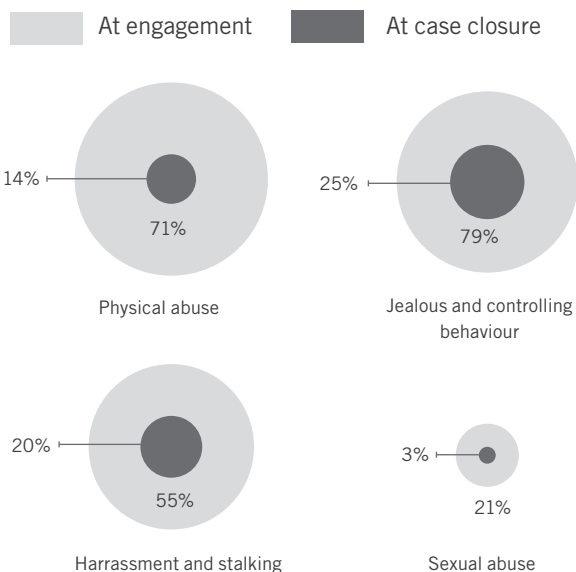
i Evidence: how this recommendation will save public money

In 2010 CAADA published *Saving Lives, Saving Money: MARACs and high risk domestic abuse*, a report which estimated the potential savings that could be realised if the MARAC/IDVA model was properly implemented, with the right number of services all managing a full case load.³⁰

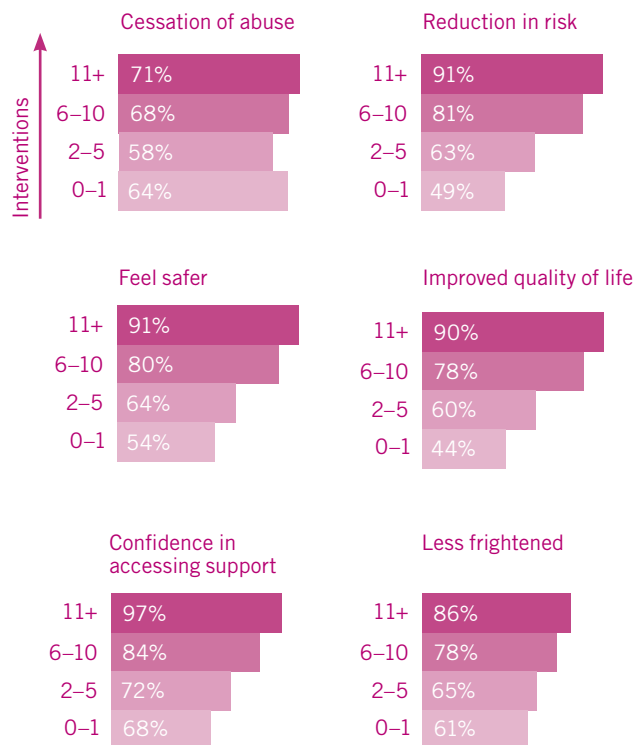
Enormous steps have been made with the implementation of the model, with more than 43,000 adults and 57,000 associated children supported last year. But the reality is that there are not enough IDVAs to effectively support the MARACs which exist. To achieve optimal social and financial impact, there needs to be sufficient provision in every area, with a recommended 4 IDVAs and 1 MARAC coordinator for every 100,000 of the adult female population.²³ Services should also be operating to maximum capacity and quality assured to a good and safe standard. At present, many local areas are desperately under resourced and are not able to offer this level of support.³¹

Despite the fact that the model is under resourced, a substantial return on investment is still realised with the current level of provision. We estimate that existing high risk services cost £70M to run and for every £1 spent, £2.90 is saved.³² Around £44M of this funding is mainstreamed already (the cost of public agencies attending MARACs),³³ but a further £26M should be mainstreamed by commissioners over the longer term to support the roles of the IDVA and MARAC coordinator.³⁴

Levels of abuse reported by service users



Intensive support leads to better service user outcomes

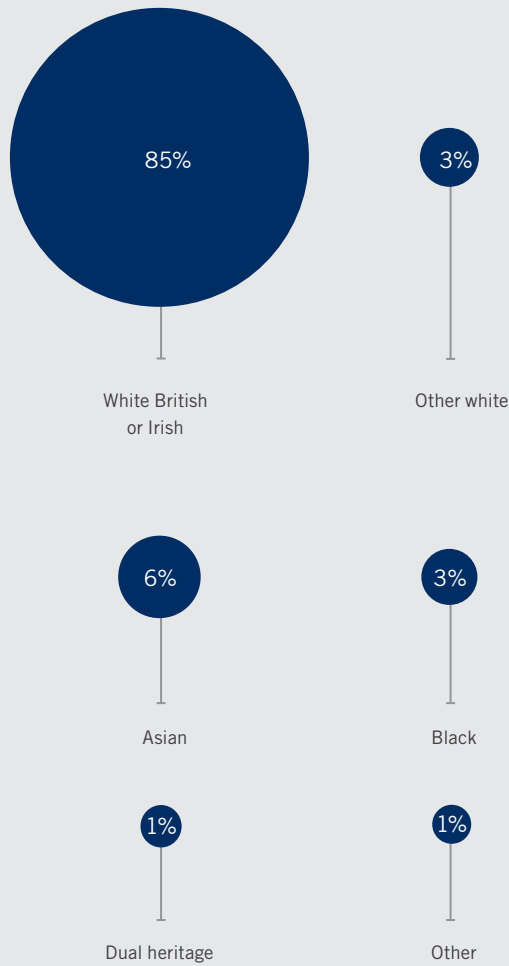


How to do it:

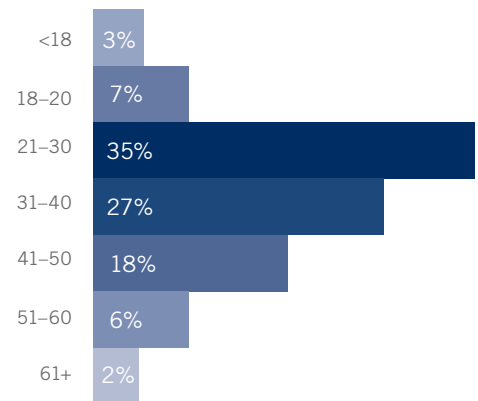
1. Prioritise domestic abuse in your local Joint Strategic Needs Assessments, Joint Health and Wellbeing Strategy and the Community Safety Strategy. The strategies should address the additional needs of victims and their families, in particular substance use and mental health issues. Ensure strategic accountability to partnership boards.
2. Mainstream funding for 4 IDVAs and 1 MARAC coordinator for every 100,000 of the adult female population. Formalise shared responsibility through a pooled budget between the Local Authority (including Public Health), Clinical Commissioning Groups and Police and Crime Commissioners. Commit to funding this budget for at least 3 years.
3. Create a clear care pathway across all agencies underpinned by shared outcomes. Ensure that pathways for groups with specific vulnerabilities, e.g. teenagers or pregnant women, are clearly identified.
4. Embed outcome measurement and quality assurance in the commissioning framework and throughout the care pathway to track performance from the point of identification through to case closure. Assess whether the agreed outcomes for victims in your area are being achieved.

Demographic data at intake

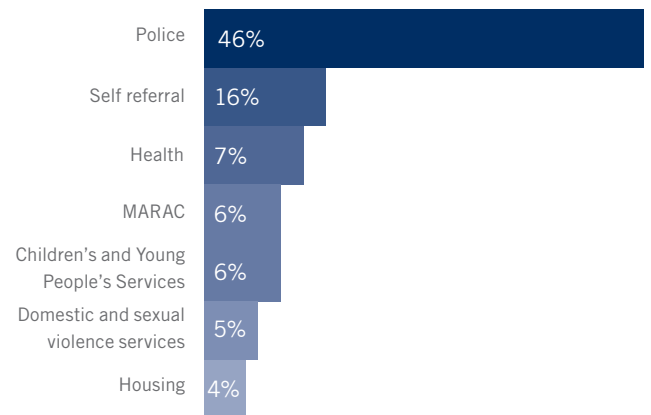
Ethnicity of service users:



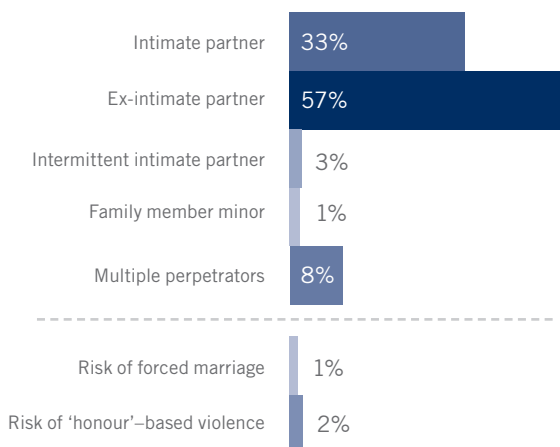
Age of service users:



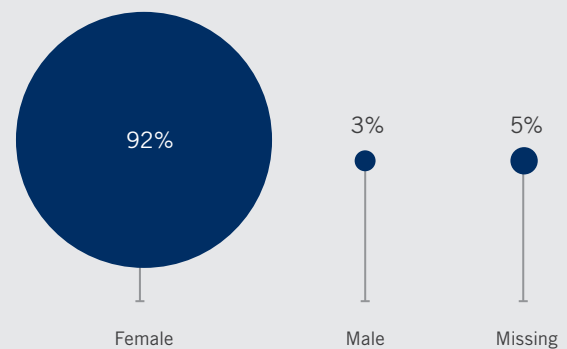
Referral routes:



Relationship to perpetrator and associated risks:



Gender of service users:



Recommendation 2

Locate additional IDVA services in A&E and maternity units

“If someone else asks you about abuse, like at a hospital or something, it might make you think about it, and if they tell you where the support is it might make you think about leaving the relationship.” – Janet, victim of domestic abuse*

Evidence: the identification of victims

Our data tells us that on average, it takes 5 years for a high risk victim of domestic abuse to find effective help.³⁵ Different referral routes to IDVA/MARAC services influence early identification and the profile of victims who are supported.³⁶ Nearly half of the victims in our dataset were identified through the criminal justice system.³⁷

Victims who were referred through health agencies were more likely to reflect vulnerable, hard-to-reach groups. These include pregnant victims,³⁸ those still living with the perpetrator,³⁹ the young,⁴⁰ those with mental health and substance use issues,⁴¹ and victims from black and minority ethnic communities.⁴²

Early evidence also suggests that victims who are identified through health agencies also experience a shorter length of abuse than victims who are identified by the criminal justice system or who self refer.⁴³ In particular, pregnant victims were most likely to access IDVA support through a health professional's referral, and they did so at a much earlier stage of the abusive relationship than clients who were not pregnant.⁴⁴

Evidence: locating IDVA services in A&E and maternity units can improve early identification

“I left when I was 17 weeks pregnant, because you know you're not just putting yourself in danger but your baby too... you have to stay healthy and safe for them.” – Sarah, victim of domestic abuse*

150 additional IDVAs are required to achieve national coverage; our recommendation is that the most effective places to locate these extra posts are A&E and maternity units. These services provide a safe location to disclose domestic abuse to a trusted health professional at an earlier stage in an abusive relationship. We estimate that 10,000 high risk victims of domestic abuse who are unable to access help through the criminal justice system could be supported each year through an improved health care pathway.¹⁰

Co-location of IDVA services in hospitals also provides easier access to on-site services which benefit these vulnerable victims, for example drug and alcohol, mental health and safeguarding nurse teams. In this way victims are offered a complete package of immediate support.

Evidence: how this recommendation will save public money

Even if funding for every current IDVA post (c.500 in total) was mainstreamed, the current number of IDVAs still falls well below the amount required to support all high risk victims in England, Wales and Northern Ireland. We estimate that there are currently 3 IDVAs per 100,000 of the adult female population: our recommended ratio is 4:100,000.⁴⁵

Co-locating 150 extra IDVAs in A&E and maternity units will create a platform of sustainable national provision from which further cost savings could be realised. These services should not replace IDVA services in the community, rather they should complement and reinforce them, allowing the model's overall potential to be more fully realised.

An extra £6M spent on the additional 150 IDVAs in A&E units would return an estimated £60M in savings.⁴⁶ If this was added to the cost savings achieved by the current level of provision, then we estimate that local public agencies would spend £1 to save £3.40.

How to do it:

1. Identify victims who are not accessing help via the criminal justice system by locating an IDVA service in an A&E or maternity department in your local hospital.
2. Develop care pathways for the referral of victims to appropriate safety and recovery services; ensure that substance use, mental health and safeguarding teams are linked in.
3. Train health professionals on identification and referral processes.
4. Ensure domestic abuse is a named priority on your local Health and Wellbeing Board strategy.

Policy context: domestic abuse and health

As shadow Health and Wellbeing Boards emerge to support joined up commissioning of social care and health, so national health policy makers have advocated a more joined up approach with local domestic abuse services. In 2011 the Department of Health produced guidelines for commissioners of health services on violence against women and girls and a specific taskforce to take work forward.⁴⁷ The Royal College of General Practitioners has made domestic abuse a strategic priority and produced guidelines for GP practices in association with CAADA and IRIS.⁴⁸ The National Institute of Clinical Excellence is also producing guidelines for domestic abuse and these will be published in February 2014.⁴⁹



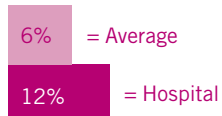
Hospital IDVAs are able to access immediate support for victims from psychiatric liaison and substance misuse specialists

Profile of service users identified by hospital IDVA services

Mental health issues:



Substance misuse:



Alcohol misuse:



BME:



Disability:



A&E dept, maternity unit and hospital IDVA service numbers in the UK



major accident and emergency departments in the UK



maternity units in the UK



Only 20 IDVA services currently based in hospitals

Service case study: Bristol Royal Infirmary IDVA service

NHS Bristol Public Health Directorate has taken an innovative approach to supporting local victims by providing direct funding for two IDVAs located in the Bristol Royal Infirmary (BRI), the city's main hospital run by United Bristol Healthcare Trust. The service operates seven days a week and is based in the emergency department; referrals are also taken from other departments across the Trust. The co-located IDVAs train clinicians, so that all frontline health practitioners feel confident about 'asking the question' and referring patients. Initial data shows that the IDVA team is supporting a large proportion of high risk victims with complex needs, many of whom are slipping through the net of other agencies, for example the police or social services.

The IDVA's experience

Punita Morris, IDVA Service Manager:

"The success of our service shows that victims feel safe disclosing abuse to a health professional in a hospital. 80% of the victims we support have mental health issues,⁵⁰ and many service users present at A&E with drug overdoses and self-harm, as well as physical injuries. We work closely with the drug and alcohol specialist nurses and the psychiatric team within the Trust to ensure clients are offered a complete package of support. Our referrals can often increase at the weekend, and that's why it is important to run a service seven days a week.

Clinicians are often reluctant to ask questions because domestic abuse is so difficult to address and they are unsure of the next steps to take. Because clinicians can safely and quickly refer patients, our service helps them to be confident about identifying victims, sending a positive and validating message that abuse is wrong. Our service fulfills an unmet need and therefore results in more victims being supported in the long run."

The Clinician's experience

Dr Richard Jeavons MBChB MRCS FCEM, Consultant in Emergency Medicine, Bristol Royal Infirmary:

"Our emergency department is so much better off with the IDVA service. Previously there was no on-site service that we could easily access. The IDVA team's willingness to see patients at their earliest convenience prevents patients from returning to a clinic at a later date because they are still experiencing abuse."

The Commissioner's experience

Jackie Beavington, Associate Director of Public Health for NHS Bristol:

"I strongly recommend that commissioners consider locating IDVAs or domestic violence advisors within a hospital setting, particularly A&E. It's important that the service is mainstreamed and ideally that IDVAs are employed by the hospital, as this gives more credibility within the medical community and increased access to files.

The BRI IDVA service doesn't replace other domestic abuse services available within the community; it complements them. A health service response to domestic abuse was the missing piece of the jigsaw in Bristol, and this is something we wanted to address. We originally ran a pilot service in the BRI for one year; using Insights we were able to evidence the outcomes of the service which led to longer term funding. Early indications show that the service has reduced re-presentations to A&E. We are now planning to roll out another IDVA service pilot in the A&E department of a neighbouring Trust hospital."

Recommendation 3:

Fund specialist support for children and young people

"I have had lots of problems with my behaviour and attendance at school, and dad says I am a psycho because I am getting help from the CAMHS (Child and Adolescent Mental Health Service). I only need that help because of what he put us through at home." – Jake, young victim of domestic abuse*

Evidence: child victims living with domestic abuse

66% of the victims in our dataset had children living in or visiting the home where domestic abuse was taking place.⁵¹ Most of these children are under 5 and have been living with abuse for the majority of their lives.⁵² On average, it took victims with children one year longer to access support than those without children.⁵³ Children who live with domestic abuse are at increased risk of behavioural problems and emotional trauma, as well as mental health difficulties in adult life.⁵⁴

In addition to domestic abuse, many families in our dataset experienced multiple other adversities which place children at further risk, such as parental mental ill health and substance misuse.⁵⁵ 35% of the families in our national dataset were involved with children's safeguarding at the point of engaging with the IDVA service.⁵⁶ A 2009/10 review of serious case reviews showed that 63% of families experienced domestic abuse, 42% experienced substance misuse and 58% experienced mental health problems.⁵⁷

CAADA estimates that there are 130,000 children and young people living in households where high risk abuse is taking place.¹¹ Whilst these children might not be in an abusive relationship themselves, they are still victims of domestic abuse and receive little support today. Data collected from 32 children and young people accessing children's support projects at four IDVA services demonstrates the positive outcomes that these services achieve:¹⁹

- 44% of children frequently felt worried before they received support; this figure dropped to 16% at case closure.
- 28% of children frequently felt unhappy before they received support; this figure dropped to 19% at case closure.

Policy context: statutory measures to safeguard children

The Children Act 1989 gives local areas a statutory responsibility to safeguard children who are in need, including a duty to investigate if a child is suffering, or likely to suffer, 'significant harm'.⁵⁸ At the time of publication, Ofsted was consulting on proposals for a multi-agency inspection programme for the protection of children, including the inspection of MARACs and partner agencies. The unannounced inspections will focus on the effectiveness of agencies working together in partnership to protect children who may be at risk of harm.⁵⁹

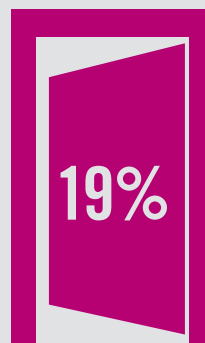
How to do it:

1. Put referral pathways in place to services which assist the recovery of child victims of domestic abuse, for example, AVA's Community Groups Project for mother and child victims of abuse.⁶⁰
 2. Ensure that close and effective joint working exists between services that safeguard children and MARACs.
 3. Make sure your Local Safeguarding Children Board monitors the cohort of children whose mothers' cases are addressed at MARAC, as part of its responsibility to ensure that children are effectively safeguarded.
 4. Train all domestic abuse, substance use and mental health practitioners on the lifetime impact on children of living with parents who are experiencing these problems.
- 34% of children found it difficult to control their emotions before they received support; this figure dropped to 13% at case closure.

CAADA Insight: how high risk domestic abuse affects teenagers



experience physical abuse



experience sexual abuse



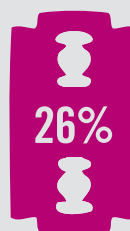
are pregnant



have financial issues



experience severe
physical abuse



self harm



experience jealous and
controlling behaviour

i Evidence: severe domestic abuse in teenage relationships

"I tried getting out of the relationship but I couldn't get rid of him. He would threaten to kill me if I said I was leaving. At the time, it didn't occur to me that I was experiencing domestic abuse. I just thought I was in a relationship from hell." – Claire, teenager victim of domestic abuse*

CAADA's data shows that teenage victims of domestic abuse are particularly vulnerable. Of the 73 teenage victims we received data on in the 12 months to April 2012, 67% were assessed as being in high risk relationships and 22% were pregnant. 67% of these young people had experienced at least one severe abuse incident, for example threats to kill, stalking, rape, serious sexual assault, broken bones or strangulation. Nearly a third (32%) had attended A&E because of injuries, compared to 21% of adults. 21% were suicidal, 26% had self harmed and 23% were experiencing financial problems,⁶¹ which research shows acts as a barrier to leaving the abusive relationship.⁶²

Information on the referral routes taken by these younger victims demonstrates that they were more likely to be identified by

the police, children's safeguarding and health agencies and only 4% would self refer to a specialist domestic abuse service. CAADA estimates that there are 3,500 young people who are at high risk of serious domestic abuse in the UK today.⁶³

Policy context: extending the definition of domestic violence to include under 18s

Until recently teenage victims were not recognised in the government's definition of domestic violence; most of the IDVA services that CAADA collected data from provided an 'above and beyond' service for victims who were under the age of 18. However, from March 2013 the definition will change and anyone over the age of 16 who experiences abuse will be entitled to receive support.⁶⁴ Local commissioners should resource this provision to ensure that they meet their statutory obligation to safeguard children in their area.

Evidence: how support for children and teenagers will save public money

“Looking back, the thing that really upsets me is how the abuse impacted upon the children. As soon as my son came home from school he’d check on me and say, “Are you OK? Has he started on you today?”. My daughter spent most of her teenage years in her bedroom, hiding from what was going on.” – Karen, victim of domestic abuse*

The moral argument here is clear: domestic abuse has a lifetime impact on children. The potential inter-generational costs of witnessing or experiencing abuse as a child or young person, although not yet quantified, are likely to be huge, both in terms of the costs to public agencies, and the emotional costs borne by children themselves.

How to do it:

1. Provide dedicated IDVA support to teenage victims. Ensure that the young people’s IDVA service includes expertise to address issues such as gangs, sexual exploitation and ‘honour’-based violence.
2. Develop a care pathway for referring teenagers to MARAC and the young people’s IDVA service so all multi-agency professionals can confidently support these young victims. Ensure the care pathway has clearly identified points of safeguarding referral or input.
3. Train those already working with young people to equip them with the basic knowledge to identify and refer teenage victims to the young people’s IDVA service and MARAC in their area.

Victim case study:

Maria,* 18 years old, teenage survivor of domestic and sexual abuse

“I was 13 when I met my ex-boyfriend, T.* When we started going out together, I knew he had anger management problems but he was very persuasive and I didn’t really feel like it was something I could get out of easily. Quite quickly he became emotionally abusive, calling me ugly, fat, stupid. Because it was my first relationship, I thought this behaviour was completely normal.

He began hitting me. I would try and hide things from my mum, who was worried – if I had bruising I would tell her that it was because we had been play fighting. I think my mum knew what was going on but I couldn’t tell her the whole truth because I didn’t want her to worry. He was a strong person. On one occasion he held a knife to my throat, another time he broke my wrist and another time he strangled me until I passed out. That was really scary because I thought I was going to die.

Soon after the physical abuse started, T began raping me. He told me that if I ever told anyone what was going on, he would sexually abuse my two young nieces. I was terrified that he would do to them what he was doing to me, so I didn’t say anything and the abuse went on.

Whilst this was going on my life started to fall apart. I stopped going to school and started feeling really anxious and sick all the time. I took an overdose on two different occasions. I told a teacher that T was abusing me and she took it really seriously. She said she had to let the authorities know, she couldn’t keep it a secret because she felt I was really at risk and she was so worried about me. In a way I felt relieved when I told her.

The police took it very seriously and they took me to see a rape and sexual assault doctor who provided the evidence needed for them to prosecute. But whilst this was going on T continued to harass me by standing outside my front door and laughing at me and my mum. His family tried to intimidate us as well. It was a really frightening time and I felt like there wasn’t anywhere I could go to escape. He even went on Facebook and posted a description of all the things he did to me.

I received some help from WORTH services, an IDVA service based in a local hospital, but because of my age it was difficult to get all of the help I needed. I found this really upsetting as by this stage I had developed Post Traumatic Stress Disorder and I really needed help. The police arranged for me to have injunctions to stop T coming near the house but he kept breaking them all the time.

Finally when I was 17 the court case came around, and T was found guilty of several counts of rape as well as assault. Although I think he should have got life for what he put me through (after all he has ruined my life) I was really pleased as I felt there was some justice.

I’m 18 now and I still get nightmares all the time. My mum has had to stop work to look after me. We have moved home to be away from his family. I’m getting better help now that I’m 18, including a therapist who specialises in supporting victims of sexual abuse.

I wanted to tell my story to encourage other teenage girls to get help. It can be really difficult to speak to someone about domestic or sexual abuse, especially if someone is threatening to kill you or hurt your family. But there are kind people out there and you will be believed.”

References:

Download the accompanying appendix to this report, 'Appendix 1: Insights National Dataset 2011–12' at: www.caada.org.uk/policy/research-and-evaluation.html

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3. No hard data is available on the number of people who experience domestic abuse annually. Data is available from the British Crime Survey (BCS) which includes reported and unreported incidents. In 2010 CAADA used a number of proxies to estimate the number of high risk victims in the UK. These include the Home Office Research Study 276 by Walby, S. (2004) which analysed the detail of the self completion questionnaire of the BCS 2001. 3.3% of women had suffered from all three forms of abuse (domestic violence, sexual assault, and stalking), since age 16, which we used as a proxy for high risk victims suffering a pattern of abuse. The same data showed that between 15 and 23% of victims reporting domestic abuse since age 16 had suffered abuse in the year prior to the survey, similar to the Safety in Numbers research finding that 19% of high risk cases were less than a year old. CAADA assumed around 20% of the victims suffered this pattern of abuse in the last year, corresponding to about 110,000 women and 10,000 men each year in England and Wales. Both calculations are thought to be a conservative estimate of the number of high risk victims. Using the same calculation, our updated estimate of the number of high risk victims is 100,000.
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10. An extra 10,500 victims per annum could be supported by 150 additional IDVAs supporting the CAADA recommended case load of 60 to 80 service users per annum.
11. No hard data is available on the number of children who are living with high risk domestic abuse. Using CAADA's estimate of 100,000 victims living with high risk domestic abuse as a baseline measurement, we have applied Insights data (see appendix Table 5, pages 6–7) relating to the percentage of high risk victims with children (66%) and the average number of children which each victim has (2). This results in a total estimated figure of 132,000.
12. See CAADA Insights 1: a place of greater safety: Appendix 1, National Dataset, Table 4, page 6.
13. See appendix, Table 4, page 6.
14. See appendix, Table 5, page 8.
15. See appendix, Table 9, page 12.
16. See appendix, Table 10, page 14.
17. See appendix, Table 8, page 12.
18. See appendix, Table 10, page 14.
19. Data from children and young people accessing specialist domestic abuse services for children in the year to April 2012. The information was recorded using a pilot Insights outcome measurement tool for children and young people.
20. See appendix, Table 6, page 9.
21. Home Office (2011) 'Call to End Violence Against Women and Girls: Action Plan'. London: Home Office.
22. Estimated number of IDVAs is based on CAADA's contact database, which is updated regularly.
23. CAADA's experience of training, implementing and working with IDVAs and MARACs since 2005 has resulted in our capacity recommendation of 4 IDVAs and 1 MARAC Coordinator per 100,000 of the adult female population; this equates to 650 IDVAs across England, Wales and Northern Ireland.
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25. Home Office (2012) 'New offences of stalking announced' [online]. Available at: <http://www.homeoffice.gov.uk/media-centre/news/Stalking> [Accessed October 2012].
26. See appendix, Table 13, page 18.
27. See appendix, Table 12, page 17.
28. See appendix, page 22.
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31. Towers, J. and Walby, S. (2012) 'Measuring the Impact of Cuts in Public Expenditure on the Provision of Services to Prevent Violence against Women and Girls'. London: Trust for London and Northern Rock Foundation.

32. The total estimated cost of current capacity is £70M comprising of 500 IDVAs at £25,000 each plus on costs and training = £19m; 240 FTE Coordinators at £20,000 including on costs = £7m; 260 MARACs (some fortnightly) x £11,900 per meeting = £44m. The £44m MARAC costs include police plus 10 additional agencies for 4 days of time per MARAC meeting to prepare for the meeting, attend and follow up with actions. At current IDVA capacity, we estimate that about 60% of all referred MARAC victims are meaningfully engaged with an IDVA. We estimate that 56% of these victims become 'safe' following support: this is based upon Insights data highlighted in the appendix which indicates that 74% of victims achieved a significant or moderate reduction in their risk, as recorded by their IDVA, and that there was medium or long term sustainability in 76% of these cases, as recorded by their IDVA (see reference 21), thereby resulting in 56% 'success'. We estimate a conservative cost saving per year per 'saved' victim of £14,200. This is based on a weighted average of public agency costs related to healthcare, the police, other criminal justice support, housing and children's services. This analysis does not count the benefit of reduced physical and emotional harm to victims of domestic abuse. These harms are considerable so the benefits reported are likely to be underestimated.
33. £44m is already mainstreamed through the attendance of agency representatives at MARACs.
34. £26M is the cost of mainstreaming existing IDVA capacity of 500 IDVAs at £19M plus the cost of Coordinators at £7m.
35. See appendix, Table 9, page 12.
36. See appendix, page 5.
37. See appendix, Table 3, page 5.
38. See appendix, page 9.
39. See appendix, page 11.
40. See appendix, page 5.
41. See appendix, page 10.
42. See appendix, page 7.
43. See appendix, page 5.
44. See appendix, page 9.
45. There are currently 500 IDVAs for 16.2m adult females, this equates to around 3 IDVAs per 100,000 of the adult female population.
46. 150 IDVAs x £25,000 plus on costs and training = £5.7m. CAADA recommends an average engaged case load of between 60 and 80 victims per IDVA per year; for the purpose of this calculation we have taken a conservative estimate of 50 engaged victims per IDVA per year. We assume that 56% of these engaged victims become safe after support (as explained in endnote 28), with a public agency saving of £14,200 per victim, this equates to a total cost saving of £60m. These additional IDVAs would support existing MARAC referrals as well as generate new referrals which can be absorbed into existing MARAC capacity without the MARAC incurring any extra costs.
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51. See appendix, Table 5, page 8.
52. See appendix, Table 5, page 8.
53. See appendix, page 8.
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How IDVAs and MARACs work

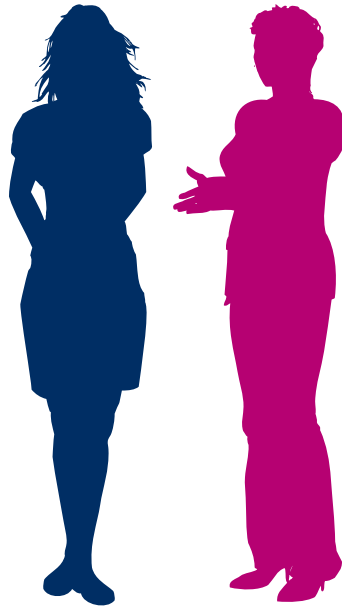
IDVAs and MARACs support vulnerable families to live safely in their own home



The action plan is implemented & agencies support the victim to live safely in her home



A victim experiences domestic abuse and other vulnerabilities



The IDVA's close relationship with the victim enables her to coordinate the action plan



A frontline professional risk assesses the victim & refers her to an IDVA & MARAC



The IDVA establishes a relationship of trust with the victim & provides immediate practical support

Agencies attend the MARAC to share information & create an action plan
The victim is represented by the IDVA



About CAADA:

Co-ordinated Action Against Domestic Abuse (CAADA) is a national charity supporting a strong multi-agency response to domestic abuse. Our work focuses on saving lives and saving public money. CAADA provides practical help to support professionals and organisations working with domestic abuse victims. The aim is to protect the highest risk victims and their children – those at risk of murder or serious harm.

CAADA's goal over the next five years is to transform the UK's response to domestic abuse, to make sure victims are identified as early as possible. We want to work in partnership with commissioners, policy makers and the domestic abuse sector to:

- **Halve the number of victims experiencing high risk domestic abuse from 100,000 to 50,000.**
- **Halve the average time it takes victims to seek help from 5 years to 2.5 years**

N.B. In recognition of the severity of the abuse which many individuals experience, throughout this report we refer to people who experience domestic abuse as victims. Although the majority of the victims in our dataset are female, CAADA recognises that domestic abuse is also experienced by men. Female IDVAs are referred to throughout this report but we recognise that there are a number of male IDVAs practising in the UK today.

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Gateshead; and WORTH Services. We would like to thank the following MARACs for participating in our MARAC outcomes project: Arun & Chichester; Blackpool; Bristol; Hammersmith & Fulham; Kensington & Chelsea; Lambeth; Lewisham; North Worcestershire; Rhondda Cynon Taff; Southampton; South Worcestershire; Sutton; Wandsworth; Westminster; and Worthing and Adur. We would like to thank IDVA staff at WORTH services and Bristol Royal Infirmary for their assistance in compiling this booklet, as well as the brave women and children who supported our work by relaying their personal experiences.

Disclaimer:

The content of this publication is provided for general information only. All statements made in this publication are made in good faith on the basis of CAADA's past experience and (where applicable) the assumptions referred to. Although it is CAADA's belief that the MARAC/IDVA approach furthers CAADA's objective of saving lives and saving public money, CAADA will not accept any liability (to the fullest extent permitted at law) for any errors or omissions in the statements and information contained in this publication or for any claim, loss, damage, or inconvenience arising as a consequence of any use of or reliance on any such statement or information.

About this CAADA report:

This report is aimed at local commissioners with strategic responsibility for funding health, policing and crime, children's and adults' safeguarding and troubled families services. Using evidence from over 2500 domestic abuse victim cases, the report demonstrates the best ways to invest limited local funding to keep victims and their children safe.

Recommendations:

1. To save both lives and money, mainstream funding for existing IDVAs and MARACs

How to do it:

1. Prioritise domestic abuse in your local Joint Strategic Needs Assessments, Joint Health and Wellbeing Strategy and the Community Safety Strategy. The strategies should address the additional needs of victims and their families, in particular substance use and mental health issues. Ensure strategic accountability to partnership boards.
2. Mainstream funding for 4 IDVAs and 1 MARAC coordinator for every 100,000 of the adult female population. Formalise shared responsibility through a pooled budget between the Local Authority (including Public Health), Clinical Commissioning Groups and Police and Crime Commissioners. Commit to funding this budget for at least 3 years.
3. Create a clear care pathway across all agencies underpinned by shared outcomes. Ensure that pathways for groups with specific vulnerabilities, e.g. teenagers or pregnant women, are clearly identified.
4. Embed outcome measurement and quality assurance in the commissioning framework and throughout the care pathway to track performance from the point of identification through to case closure. Assess whether the agreed outcomes for victims in your area are being achieved.

2. To improve early identification and reach victims who are hidden from the criminal justice system, locate additional IDVA services in A&E and maternity departments

How to do it:

1. Identify victims who are not accessing help via the criminal justice system by locating an IDVA service in an A&E or maternity department in your local hospital.
2. Develop care pathways for the referral of victims to appropriate safety and recovery services; ensure that substance use, mental health and safeguarding teams are linked in.
3. Train health professionals on identification and referral processes.
4. Ensure domestic abuse is a named priority on your local Health and Wellbeing Board strategy.

3. To improve support for children and young people experiencing domestic abuse, fund specialist services for children and young people

How to support children:

1. Put referral pathways in place to services which assist the recovery of child victims of domestic abuse, for example, AVA's Community Groups Project for mother and child victims of abuse.⁶⁰
2. Ensure that close and effective joint working exists between services that safeguard children and MARACs.
3. Make sure your Local Safeguarding Children Board monitors the cohort of children whose mothers' cases are addressed at MARAC, as part of its responsibility to ensure that children are effectively safeguarded.
4. Train all domestic abuse, substance use and mental health practitioners on the lifetime impact on children of living with parents who are experiencing these problems.

How to support teenagers:

1. Provide dedicated IDVA support to teenage victims who are experiencing intimate partner abuse. Ensure that the young people's IDVA service includes expertise to address issues such as gangs, sexual exploitation and 'honour'-based violence.
2. Develop a care pathway for referring teenagers to MARAC and the young people's IDVA service so all multi-agency professionals can confidently support these young victims. Ensure the care pathway has clearly identified points of safeguarding referral or input.
3. Train those already working with young people to equip them with the basic knowledge to identify and refer teenage victims to the young people's IDVA service and MARAC in their area.



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