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

Dr Lucy Neville and Dr Erin Sanders-McDonagh

With Vivian Latinwo-Olajide, George Lewis, and Hayley Tustin

July 2014

Acknowledgements

About the authors

Dr Lucy Neville is a lecturer in Criminology and Dr Erin Sanders-McDonagh is a lecturer in Sociology. They are based in the Department of Criminology & Sociology, School of Law, Middlesex University.

1.0 Introduction

1.1 Domestic Homicide Reviews

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 Wales[1] (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/

It should be noted therefore that DHRs cover a much wider remit than intimate partner violence as they occur after any domestic homicide, including cases involving relatives or other household members - as well as those involving partners or ex-partners. 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 March 2011 and October 2012, providing much scope for learning and improving on best practice both within local areas and nationally.

Once a decision has been taken to carry out a DHR 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). The over-arching themes they identified were:

Awareness raising and communication: The report identified "gaps in understanding what constitutes domestic violence and abuse" (Home Office, 2013b:3) and expressed concern that early warning signs might be being missed due to an assumption that only physical violence constitutes domestic violence. There was particular concern that power and control elements of domestic violence were not being recognised. The report urged local stakeholders to review internal training to make sure that all forms of domestic violence and abuse were covered, and to publicise to the general public the fact that help and support is available even if abuse has not been physical.

Awareness and training for healthcare professionals: The report stressed the need for improved training and awareness on domestic violence and abuse for GPs and healthcare professionals, noting that GPs often did not follow up on disclosures of abuse, or did not know what to do on these occasions. It advised that local stakeholders should make GPs aware of the guidance published by the RCPG, IRIS, and CAADA (RCPG *et al.,* 2013) in responding to domestic violence, and also noted that midwives should undertake routine enquiry by asking all pregnant women whether they are at risk of, or are suffering/have suffered from, domestic violence.

Risk assessment: The report stressed the importance of a consistent approach to risk identification, assessment, and management for all professionals, including the operation of the DASH risk assessment tool by police and the CAADA DASH for multi-agency partners. It noted that there were several examples of cases where risk assessments did not take account of prior known incidents which meant "the the true picture of the escalation of abuse was not presented" (Home Office, 2013b:5), and additional cases where the level of risk was not reviewed despite an increase in the severity of abuse/violence suffered by the victim. The report suggested that service providers review their risk assessment and management approach to ensure that it is robust, and ensure that staff have appropriate training.

Information sharing and multi-agency working: The report acknowledged that information sharing about the risk of domestic violence between agencies was often inadequate and/or lacking. It noted that referrals between agencies, or to the MARAC, were sometimes not made when it would have been appropriate to do so, and that there were also inconsistencies in how agencies refer to MARAC. The report asked that local stakeholders review information sharing protocols and consider options for multi-agency information sharing, and ensure that appropriate agencies are attending MARACs.

Complex needs: The report stressed the fact that, in a number of cases, the victim and/or the perpetrator had complex needs such as alcohol abuse, substance misuse, and mental illness, as well as involvement in domestic abuse. It noted that agencies, generally working in silos, were often focussed on addressing **one** of these other needs, and missed the opportunity to identify the domestic abuse. The report recommended that drug and alcohol

services should review, amend, and make robust use of their risk assessment frameworks, which involve assessment of risk in relation to violence and abuse, as well as promoting the AVA *Complicated Matters* (AVA, 2013) toolkit and training with local practitioners.

Perpetrators and bail: The report highlighted inadequate information sharing between agencies in some cases where a perpetrator was released on bail or from prison, particularly in relation to breach of bail - as this can be critical in protecting victims and managing suspects. It also stated that a lack of suitable accommodation for individuals leaving prison had led to a number of cases where the perpetrator returned, or attempted to return, to the victim's home. The report urged police and prison staff to be aware of the marker on OFFLOC[2] to identify prisoners who have been assessed as presenting a risk of involvement in domestic violence, and to ensure that bail conditions are shared with all agencies present at MARACs.

Awareness of the safeguarding needs of children: The report also discovered that there were a small number of situations where opportunities were missed to refer cases to Children's Services. It reminded local stakeholders that PCCs should hold chief constables to account for the exercise of duties in relation to the safeguarding of children and the promotion of child welfare.

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, and many partners/forces felt there were limited insights provided by the report (HMIC, 2014). The HMIC (2014) goes on to note 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. It observes that "there is a real appetite from all partners for a more open and facilitated approach to support local partners to learn from all DHRs, including those that do not relate specifically to their own or to neighbouring forces"

---

[2] Offence location

(HMIC, 2014:110). In addition, the authors state that "police and crime commissioners should track how and when recommendations from domestic homicide reviews are implemented" (HMIC, 2014:24), and place emphasis on the importance of partnership working throughout the DHR process and when seeking to implement recommendations.

The HMIC (2014) also notes that there is an argument for more of a focus in the DHRs to be on offenders (e.g. whether the offender is a serial perpetrator, whether they have convictions for other offences, and whether they suffer from mental health problems) and what can be learnt from that. As such, this is a key focus of this report.

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 in response could identify domestic violence victims and reduce their vulnerability. As such, this report was commissioned by the seven CPGs 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) 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.

1.2 Domestic Violence and Abuse

Mears (2003:130) states that "domestic violence itself is often used to refer not only to violence among intimate partners but also to child abuse and elder abuse"; a view which is reflected in the updated Home Office definition of what constitutes domestic violence and abuse : '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' (Home Office, 2013a). In all thirteen (13) DHRs reviewed for this report, the victims were female. Eight were the partner or ex-partner of the perpetrator, and three were the mothers (and carers) of the

perpetrator. One victim was receiving care from her perpetrator (due to physical frailty), and one was an extended family member of the perpetrator (sister-in-law).

Domestic abuse causes both serious harm, and constitutes a considerable proportion of overall crime. It costs society an estimated 15.7 billion pounds a year (ONS, 2013). Police forces interviewed told the HMIC that crime relating to domestic abuse constitutes some eight percent of all recorded crime in their areas, and one third of their recorded assaults and injury (HMIC, 2014). As such, 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.

In 2013 the Home Secretary commissioned HMIC to conduct an inspection on the police response to domestic violence. The ensuing report (HMIC, 2014) concluded that "the overall police response to victims of domestic abuse is not good enough... [and sometimes] victims are put at unnecessary risk" (p.6). It stated that while domestic abuse might be a "priority on paper" it was unfortunately not a priority "in practice" and remained a "poor relation" to acquisitive crime and serious organised crime (p.6). In particular it critiqued: the lack of visible leadership and poor supervision from senior officers; weaknesses in some core policing activity, especially the collection of evidence by officers at the scene of domestic abuse incidents; and a lack of skills and knowledge around domestic abuse and how to engage with victims. It also acknowledged that there was often "little kudos attached to being a domestic abuse specialist in the police service" and that a lot of good work done in this area by frontline staff goes "unrecognised" (p.7).

Tackling domestic violence is not solely the domain of the criminal justice system. The Coalition Government's vision (Department of Health, 2010) for adult social care identifies seven key principles for building up a modern system of social care. They are: prevention, personalisation, partnership, plurality, protection, productivity and people. The principle of "protection" is defined as follows: "there are sensible safeguards against risk of abuse or neglect. Risk is no longer an excuse to limit people's freedom" (Department of Health, 2010:8).

The Department of Health argues that a modern social care system needs to balance freedom and choice with risk and protection. The ability to do this involves building on local

practice, experience, and empowerment; and ensuring that adult safeguarding in general is connected to wider community strategies in areas such as children's safeguarding and domestic violence (Humphries, 2011:6). It means engaging with people as individuals, communities, carers, users, practitioners, staff, or volunteers to improve recognition and respond sensitively and effectively to situations of potential or actual domestic abuse.

Local progress is more likely to be achieved within an increasingly personalised, community-based approach: "risk management and protection/safeguarding should be addressed in a balanced way across all sections of the community, avoiding an approach that views people in receipt of social care funding as most at risk" (Sector Consortium, 2011:5).

In March 2011, in response to the *'No Secrets'* review on protecting vulnerable adults, the Department of Health issued best practice guidance for NHS senior managers and their boards, commissioners, and practitioners. This suite of guidance highlights: the commitment to patient choice, control and accountability, including support and protection for those in the most vulnerable situations; safeguarding adults is a core responsibility of the delivery of effective healthcare; safeguarding is integral to patient care; health services have a duty to ensure the safety of all patients (but must provide additional means for patients who are less able to protect themselves from harm or abuse); prevention from harm and abuse can be promoted through the provision of high quality care; effective responses to allegations of harm and abuse (and that are in line with organisational, clinical and multi-agency procedures) are expected and essential; and that learning should be used to improve service to patients.

1.3 Responding to Domestic Violence

In February of 2014, the National Institute for Clinical Excellence (NICE) issues 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.

Within the guidance 17 evidence-based recommendations are made around a number of key areas.

Service Provision

Strategic Partnerships should plan services based on needs assessments undertaken as part of a wide joint strategic assessment exercise. Mapping local services across different areas that engage with or deliver domestic violence services should be included, and the needs assessment and mapping exercise should feed into both commissioning and referral pathways. As well, senior officers from a wide range of services should participate in the local partnerships, alongside frontline staff, service providers, and health and social care professionals.

Raising Awareness and Training

Raising awareness about domestic violence, and ensuring that details about where to get help are displayed in suitable spaces (and in a range of different languages) is important. There should be age-appropriate referral pathways into specialist violence and abuse agencies, and frontline and supervisory staff should have training around managing disclosures and suspected cases of domestic violence. This training should extend to cover issues around diversity and equalities, to make sure that particular groups who may find it difficult to disclose do not face further barriers to getting help. Safe spaces should be created to ensure that discussions and disclosures can be done in an environment where the person feels safe, and ensure that people who may be experiencing abuse can be seen on their own.

The following staff trained in: antenatal, postnatal, reproductive care, sexual health, alcohol or drug misuse, mental health, children's services, and vulnerable adult's services should be trained in responding to domestic violence, and should ask service users if they are experiencing or have experienced domestic violence. This is recognized as good practice, even when there is no indication of violence or abuse.

Furthermore, specific training to provide 'a universal response' should be given to all health and social care professionals, around the best ways of responding to domestic violence. Specialist response training should be given to staff with more detailed understandings of

domestic violence. GPs and GP practices are highlighted as key areas where training and education is needed, as well as organisations that are responsible for training health and social care professionals.

Commissioning

An integrated commissioning strategy is recommended, with a focus on meeting the health and social care needs of victims, as well as children and young people who are affected by domestic violence. Furthermore, addressing the perpetrators behavioural and health needs is also highlighted. Commissioning strategies should be based on the mapping exercise, and should involve a collaborative approach (both in terms of funding and delivering services), with evidence-based commissioning principles at the heart of the process.

Information Sharing

Information sharing and adopting clear protocols both within and between agencies is highlighted as a key issue. The Caldicott guardian principles are highlighted here, and standards around confidentiality and information sharing in relation to risk must be considered.

Support

Providing tailored support to meet the needs of those who experience domestic violence is critical. Safety must be prioritised, and referral pathways to specialist services should be made clear. There should be a regular assessment of needs, both immediately and for the longer term. If someone has alcohol, drug misuse, or mental health problems, they should also be referred to specialist support services around their particular issue. Advocacy and support services should also be available in different languages, and should be offered in places where people may disclose domestic violence.

Interventions

Mental health support is specifically highlighted as a key area for health and social care workers to consider. Appropriate and specific interventions should be offered, ongoing risk assessments should take place, and collaborative safety planning should be a priority. Any

interventions or treatment programmes should be evidence-based treatments, and meet national guidelines.

Similarly, perpetrators should be engaged in evidenced-based interventions. Robust evaluations of current programmes is required, and tailored interventions for perpetrators in accordance with national standards should be commissioned. Increasing the safety of victims and children should be the primary aim, and linking perpetrator programmes to specialist services may help increase the safety of victims and children.

Children and Young People

Information sharing, training, and clear referral pathways are all highlighted as important ways to support and safeguard children and young people who have be experiencing, or are being affected by domestic violence. Staff who engage with young people should have a good level of awareness about services, policies, and procedures for dealing with disclosures or suspected cases of domestic violence, and the emotional, social and physical harms should be dealt with, in addition to their safety requirements. Services provided to children and young people should be coordinated, and support should be age-appropriate and should continue over a long enough period to achieve results. Advocacy, therapy, or other support sessions that strengthen the relationship between children and their non-abusive parent are key.

The issues raised in the NICE report clearly highlight a range of areas that local authorities need to consider when planning and developing their own domestic violence responses.

1.4 Risk and Domestic Violence

Risk assessment processes in domestic violence cases are not only focused on responding effectively at the scene, but also on the medium and long-term risks to the victim's safety. By putting into place a risk management plan, the hope is that serious or fatal injury to the victim will be avoided (Richards, 2004). The main purpose of such a risk assessment, and its subsequent management, is to improve the protection and interventions for

individuals/families who are experiencing domestic violence and to target those interventions on those cases that need them most because they present the highest risk.

Identification of risk and safeguarding concerns in family law disputes is significantly improved by the consistent use of a risk identification tool (Harne, 2009). Hoyle (2007:335) refers to the "confusing plethora" of risk assessment tools, which she believes indicates, "much doubt remains as to the most reliable indicators of repeat victimisation" in domestic violence cases. While there have been several positive moves to unify and consolidate methods of risk assessment across stakeholders involved in preventing domestic violence (see below for further discussion), it became clear throughout the process of compiling this report that more could be done in this area; this has been committed to within the HMIC report.

In 2005 the Association of Chief Police Officers (ACPO) of England and Wales produced guidance on Identifying, Assessing and Managing Risk in the Context of Policing Domestic Violence to accompany the ACPO Guidance on Investigating Domestic Violence[3]. It specifies the core aims of identifying, assessing and managing risk in the context of policing domestic violence as: "to reduce the likelihood of future harm" and "to facilitate the effective use of police powers" (ACPO, 2004:2). It lists the objectives of risk assessment and management as: preventing homicides and serious injuries, preventing and reducing repeat victimisation, and increasing reporting of domestic violence to the police.

Campbell (2008) has identified multiple risk factors for domestic violence, which are well-documented throughout the literature. Arguably, the most robust and straightforward risk factor is previous physical assault by the perpetrator (Walby & Myhill, 2001). Others include: previous police call-outs to attend a domestic situation, separation, threats to kill, presence of children or step children, breach of civil orders or criminal sanctions, drug or alcohol abuse by the perpetrator, the perpetrator's obsessive jealousy, and conflict over child contact (Brookman & Maguire, 2003, drawing heavily on Campbell, 2008). Debbonaire (2011) highlights the fact that "contrary to popular belief, separation increases the risk of further violence in about half of all domestic violence cases in the short- to medium-term".

---

[3] Updated in 2008

In 2002, the UK Metropolitan Police Service conducted research into risk factors and domestic homicide (Richards, 2003a). They identified six 'high risk' factors, under the acronym SPECSS: separation (victims trying to leave relationships or disputes over child contact); pregnancy/new birth; escalation (repeat and escalating violence); cultural issues/sensitivity (women might be killed for behaviour or perceived behaviour considered to be immoral in some communities, community barriers and barriers to reporting); stalking; and sexual assault. In addition to the six SPECSS high-risk factors, officers from the Metropolitan Police and other forces who have adopted this tool are advised to consider and ask questions at the scene based on a 'supplementary list' about other risks, which have emerged from the work of various other studies on domestic violence. These are: child abuse, (Moffitt & Caspi, 1998); past physical assault of intimate partner (Sonkin, 1987); past use of weapons and/or credible threats of death (Sonkin *et al*., 1985); extreme minimisation or denial of spousal assault history; past assault of strangers, acquaintances, family, and/or police (Stuart & Campbell, 1989); animal abuse; recent employment problems (Campbell, 1986); recent substance abuse/dependence (Stuart & Campbell, 1989); issues of control/unpredictability (Campbell, 1986; Wilson & Daly, 1993); recent suicidal or homicidal ideation/intent (Menzies *et al*., 1985); background of violence/criminal career (Fagan *et al*., 1983); and violation of contact and non-contact orders (Richards, 2003b).

In 2009 the DASH Model was designed as a multi-agency tool to be used by all professionals who work with victims of domestic abuse and their children, stalking and harassment, and honour based violence. It was built on the existing good practice of the evidence-based SPECSS+ Risk Identification, Assessment and Management Model (see above) and includes various risk factors (including SPECSS factors).

However, Debbonaire (2011) notes that many risk assessment tools used by agencies involved in domestic abuse and violence do not contain all of these indicators, or contain indicators which are "difficult or impossible to document objectively", such as "cultural sensitivities" (designed to signify heightened risk through isolation, attitudes, and barriers to help seeking), which is open to misunderstanding and stereotyped or racist interpretation (Hoyle, 2008; Humphreys, Thiara, *et al*., 2005).

Despite this, it is apparent that the rigorous, consistent use of an evidence-based tool can and does inform responses to domestic violence (Harne, 2009; Debbonaire, 2008). DASH can help to identify those cases which require particular attention, and help to highlight both situations and perpetrator behaviours which are likely to exacerbate risk (Harne, 2009).

However, in order to assess risk effectively, and use risk assessments to their fullest potential, the HMIC (2014) points out that "the police need to have the right tools, resources, training and partnerships in place" (p.8). Currently, the police as a whole are hampered by outdated IT and poor force information systems (HMIC, 2014:9). The HMIC (2014) maintains that the current approach to training (which is largely reliant on e-learning) is failing to give officers sufficient insight into how to handle domestic abuse, noting in addition that "training alone will not fix this... Robust supervision should reinforce the attitudes and behaviours expected of officers" (p.53).

The HMIC (2014) report states that quality of service that victims received at the time of the initial response (to a domestic abuse incident) was largely dependent on the empathy and understanding of the individual officer attending, adding "the service that some of the most vulnerable victims in our communities receive should not be a lottery" (p.11). The authors note a lack of clarity around what 'positive action'[4] constitutes when responding to a domestic abuse incident, and express concern that this means perpetrators are not being arrested when the attending officer has grounds to do so. They also highlight that both the extent to, and the manner in which, DASH is used varies significantly, and "too often the completion of the DASH form is seen as a compliance exercise rather than one that is necessary to protect a victim" (p.13). Some officers complete the DASH from memory, or from 'cutting and pasting' from previous forms. The report warns against this, pointing out that "officers who approach risk assessment with a 'cut and paste mentality' risk making poor decisions" (p.69). The report also raises serious concerns about the extent to which the police follow the procedures and practices documented in the *Guidance on Investigating Domestic Abuse* (ACPO, 2008). A result of this is that victims who have not been correctly identified as high risk are in danger of not being offered appropriate safeguarding services. The authors praise certain forces, such as Durham and Cambridgeshire, for providing a

---

[4] This term originates from the ACPO Guidance on Investigating Domestic Abuse, 2008

tactical toolkit to assist staff called to domestic abuse incidents[5]. To improve the assessment and management of risk, the HMIC (2014) recommends: secondments and attachments to work in specialist areas pertaining to domestic abuse; additional training; and use of independent domestic violence advisers in police stations to help build the capability and expertise of officers.

On a final point, the HMIC (2014) points out that forces are not "deploying one of their most valuable assets, neighbourhood policing teams, in the fight against domestic abuse" (p.16). There is a need to use broader resources to target and manage the perpetrator population. Neighbourhood officers and PCSOs should know which victims are at greater risk in their area; which domestic abuse offenders are the most dangerous; where there are 'hotspots' for repeat victimisation; and should also be made aware of prolific domestic abuse perpetrators (HMIC, 2014:88).

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 anonymized 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

---

[5] For an example of such a toolkit see HMIC, 2014, p.63

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 has been commissioned by the seven Community Safety Partnerships (CSPs) across the West Midlands Police Force Area (WMPFA), and has been funded by the Police & Crime Commissioner. 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   Presentation and Analysis of Emergent Themes from DHRs and 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 responisbility		✓	✓	✓	✓		✓					✓	✓
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	✓				✓								✓
Failre to administer DASH when police called to a domestic incident		✓						✓					✓
Caring Issues													
Managing care / managing carers			✓						✓	✓		✓	
Failre to involve families	✓			✓					✓	✓			
Lack of transition in care									✓	✓			
Health Issues													
Issues related to GPs	✓	✓	✓	✓	✓		✓				✓		✓
Management of prescriptions / noncompliance	✓		✓				✓		✓	✓			
Failre 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

3.1.1 Use of MARACs

Locally, inter-agency domestic violence risk management will now commonly involve a multi-agency risk assessment conference (MARACS) (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 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).

CAADA believes that MARACs are "the single most important advance in protecting adult victims and their children since the introduction of refuge provision in the 1970s" and that they represent the most effective use of public resources (CAADA, 2010). However, there is currently no legislation protecting the role of the MARAC. CAADA (2010) states that this is necessary in order to "ensure sustainable local funding that will deliver the high quality services so necessary" (p.94) and cites research that shows that "any financial commitment to the MARAC process could result in savings to the public purse of up to six times that investment" (pp.93-94).

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). In DHR 4 as the victim was only classified as 'medium risk' no MARAC was triggered – a more holistic approach taken by the multiple agencies she had engaged with might have changed this assessment. In DHR 5 the victim's risk assessments were conducted in isolation of each other by differing agencies (p.43). The report notes that "a free flow of information was desperately required" (p. 44), and that a referral to MARAC would have made this possible but did not happen. In DHR 13 the report notes that the case warranted a MARAC meeting

(p.20) but no agency sought to refer the family to the MARAC panel, "therefore missing the opportunity to share all of the information known about [the perpetrator, the victim, and their child] which in this case would have been extremely useful" (p.20). The report states that there is a "misconception about the ownership of the MARAC process" and that it is not the "sole responsibility of the police to initiate MARAC procedures" as is often assumed (p.20). Greater clarity is needed for all agencies around the MARAC process.

Criteria for MARACs also need to be better understood. In DHR 2 a lack of information sharing restricted any agency carrying out a full risk assessment of all the information available and therefore no one made a complete risk reduction plan for either the victim or her baby (e.g. the information the victim gave to the IDVA was not shared with any other agency). However, the IDVA stated that they had attempted to refer cases not meeting the criteria for a MARAC where they have concerns on previous occasions but have been rejected by the local MARAC coordinator (p.25).

When they do occur, MARACs also need to be managed carefully and in accordance with guidelines. In another case a MARAC did occur, but the meeting was not effective at identifying risks to the victim from the perpetrator, or in establishing a safety plan for her. It is key that all agencies work together to ensure that MARACs are effective and productive.

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. Problems with repeat MARACS with no positive outcome were also highlighted by key stakeholders during participant interviews.

However, there was also a note of caution about using MARACs as "a panacea". A participant pointed out that MARACs only work if the at risk person is willing to engage, and that in situations where this is not the case, the intensity of the process can be distressing or off-putting.

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.

3.1.2 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. DHR 7 highlights the need for victims to receive a co-ordinated package of support from agencies, and emphasises the importance of inter-agency communication in enabling this to happen. In several cases there was insufficient communication between agencies who were working with the victim, and agencies who were working with the perpetrator - with no one taking responsibility for the overall pattern of risk that was emmerging. DHR 2 concludes "here was a man [the perpetrator] who had become increasingly angry and violent to others, to property and to himself. However, the rule of optimism was applied and the case was closed as he failed to engage rather than result in any escalation or the taking of any proactive action" (p.33).

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. DHR 4 notes, with regards to multi-agency working/decision making, "if the professionals are unclear about their roles and authority, the service users, who are vulnerable, will find it difficult to navigate through the services and in particular to understand the aims of the different professional interventions" (p.50)

DHR 4 also recommends that mechanisms be established to break down boundaries and promote collaborative working across the divide between adult focussed and children focused services where there are concerns of domestic violence involving adult victims and children (p.11)

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).

3.1.3 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 concern needs to be addressed. DHR 4 states that the victim's social worker "interpreted the behaviour of the victim as uncooperative and reluctant because she presented as vague and ambivalent about her relationship with the perpetrator" (p.45). The perpetrator often reported the victim as being a bad mother and tried to have their children removed from her care. At one point the victim's social worker said that "child protective action might be taken if she [the victim] did not protect the children... [by stating this] the social worker was confirming to the victim what the perpetrator had said". The report concludes that this approach "was not sensitive to the victim's situation and served to reinforce the oppression by the perpetrator" (p.45). A letter sent out in connection with the case by a social work assistant used similar wording. The report quotes Humpreys *et al.* (2011): "Such letters, even when they include information about agencies which might be helpful, reinforce women's worst fears about social work intervention in relation to their children and may therefore close down help seeking and reinforce the abuser's power and control within the family".

The collators of DHR 6 held a focus group with Eastern European women following the death of a victim from a similar demographic and noted that many women were reluctant to talk about family problems such as domestic violence for fear of their children being taken into care.

3.1.4 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. One DHR notes that the perpetrator had a history of violence towards intimate partners stretching back over twelve years, but had only ever had to face comparatively

minor consequences for his actions. In DHR 4 there were no prosecutions and therefore no convictions of the perpetrator despite him having a history of violence against his intimate partners. However, the review notes that the "pattern of reported incidents demonstrated escalating repeat offender behaviour which, when passed on from one victim to another, had become serial offender behaviour as well. The substance misuse offences should have alerted the police to the increasing risks" (p.38)

In DHR 5 the victim's husband was neither arrested nor interviewed following the victim initially reporting he had raped and assaulted her. The report notes that not arresting the husband was a missed opportunity for the police to prevent further offences being committed against the victim, and posits that had this happened it may have given the victim confidence that the allegation had been taken seriously and therefore more choices would have been apparent to her.

There is also a suggestion that the police should follow up situations which imply risk to an unknown victim more thoroughly, In DHR 11 the perpetrator claimed to the police that his 'girlfriend' was poisoning him - her identity was never established (it is likely she is the victim). The report notes that police "lacked any curiosity about her identity and any potential risk posed to her" (p.5), especially as the perpetrator had made a similar claim one month previously at a different police station. The report notes "whilst there was generally good liaison between the police and the GP, there was little effort to identify the girlfriend" (p.26).

One of the interview participants highlights constant changes to policy as a key issue that prevents police from responding appropriately to certain situations, noting that this overload of information makes it very difficult to prioritise what needs to be done and make swift, practical changes.

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 is essential for making sure police are able to respond to situations appropriately.

3.1.5 Disclosure of domestic abuse of previous partner

In five cases (5/13) 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). In DHR 4 the victim's family felt information regarding the perpetrator's previous domestic abuse should have been disclosed to the victim so she could make a more informed decision about her relationship with him (p.18). In DHR 5 the father of the victim stated that he thought there should be facilities to be able to check the histories of intended partners. (Note, while her abusive husband was not the perpetrator in this case, the report notes that "vulnerable women under the circumstances the victim found herself in are more susceptible to [future] domestic violence and sexual violence" (p.31)).

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 Police[6] and relevant leaflets and website information have been produced[7].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

---

[6] 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

[7] See: http://www.west-midlands.police.uk/advice-centre/help-and-advice/domestic-abuse/domestic-violence-disclosure-scheme/index.aspx

not shared with a good understanding of coercive control and commitment to empowering victims.

3.1.6 Domestic abuse of extended family

In two cases (2/13) 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 bourn in mind when considering overall risk.

3.1.7 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

3.2.1 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. DHR 5 indentifies the need for "a common understanding of the results measured by risk assessment processes" (p.44). DHR 13 highlights that there was no method for bringing together the numerous risk assessments conducted into the perpetrator and his mental health. Because various agencies used differing risk assessment tools and models there "were no opportunities to view the holistic risk he posed to [the victim and his child] or indeed to himself" (p.18). The report notes that the MHT IMR calls for a nationally agreed risk assessment framework to be used across all mental health agencies, as opposed to the numerous individual tools that are used presently.

In some cases, providing training around these areas may be of benefit. Stakeholders indentified the utility of developing protocols around domestic violence, and then sharing

these with other agencies/CSPs etc. to promote best practice and create a unified, effective response.

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/counselling. 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 Patient Health Questionnaire [PHQ] "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). DHR 1 refers to the reliance on questionnaires for depression (e.g. PHQ, CORE) and notes these are not designed to be risk management tools, and that a more tailored approach may have highlighted the risk the offender posed both to himself and 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 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.

3.2.2 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 serious concerns raised by HMIC (2014) in their review of police response to domestic violence. For example, in DHR 2 a risk assessment of the victim was not carried out (contrary to current

policy) as the officer who should have carried it out misinterpreted the guidance. Had the victim been asked the detailed questions contained within the DASH risk assessment more information about the history of the domestic abuse may have been revealed, and a full assessment of risk leading to interventions may have taken place (p.20). In DHR 13 the police were called by the child in the household because the perpetrator was attempting suicide. Both the victim (his wife) and their child fled the family home in fear of their lives. The police made a referral to the Child Protection Team but failed to complete a DASH risk assessment form, apparently because they did not feel there was immediate risk to the victim and did not recognise the situation as one which involved the potential for domestic violence - instead they viewed it as a mental health issue.

In DHR 8 the initial contact with the victim via an emergency telephone call should have been responded to as an incident of domestic abuse. If it had been defined as such this would have led to allocating the response to a police officer to follow up the same day (and a DASH to be carried out), and it is possible the victim would have then disclosed more information about the abuse incident (p.11). The report notes that "all incidents of domestic abuse have to be treated with proper significance from the outset; the escalation of violence can be very fast" (p.48)

3.3 Caring Issues

3.3.1 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.

There is currently no single agreed definition of what is meant by the term 'carer'. However, within this review we have used the definition contained within 'Commissioning for Carers' (Fox, 2009:4): "*A carer spends a significant proportion of their time providing unpaid*

support to a family member, partner or friend who is ill, frail, disabled or has mental health or substance misuse problems."

The risk of deterioration in carers' health and well-being as a consequence of their caring responsibilities is well documented (see, e.g., Carers UK, 2004), and there is growing awareness of the risk of violence occurring between carers and those they care for. ADASS's (2011a:9) Safeguarding Advice Note recognises: "Carers have a range of roles regarding safeguarding: as partners and informants; **themselves as vulnerable to harm and abuse; as abusers.**" They highlight some key 'crunch' points that might make violence more likely, including: stress, tiredness, lack of support, and lack of information.

ADASS (2011b) notes that sometimes professionals may place undue confidence in the capacity of family members to act as carers effectively and safely. This is coming to be known as "the rule of optimism"[8], and should be borne in mind, and guarded against, as it is for children's safeguarding. Galpin & Morrison (2011) note the need for carers to be recognised, listened to and respected by skilled and competent staff when concerns arise. As caring situations can often be both sensitive and complex, Galpin & Morrison stress that it is vital that "appropriate levels of skills and protocols for staff should be achieved, so they have the ability to recognise and respond to...more subtle and complicated scenarios" (p.48). ADASS affirms this, stating "we expect Safeguarding Adults Boards to… ensure their policies, procedures and practice recognise the need to support carers and work with carers who are experiencing or causing harm or abuse" (ADASS, 2011a:9).

Carers are often well placed to see and say something about concerns they may have around the potential of those they are caring for to become violent (or of concerns they have around their own ability to cope with their caring role). However, some of the carers involved in this review did not unequivocally state their concerns. It is therefore important that there is a good level of understanding around potential barriers to reporting concerns, so that stakeholders can then work to overcome them and ensure staff have the right skills and approach to do so. ADASS (2011b:8-9) identifies three key barriers to carers sharing concerns, including several that are of great relevance to this review:

---

[8] The concept of the "rule of optimism" comes from children's safeguarding. See: C4EO, Safeguarding Briefing No. 3 November 2009; Munro Review of Child Protection (2010), Department for Education

1) **Issues relating to understanding and awareness** - being unclear about rights and standards; being unclear about what 'abuse' means; worry that organisational/staff attitudes to concerns would be defensive rather than responsive.

2) **Issues relating to communication** - uncertainty of who to go to with concerns; lack of trusted source of advice/support; general communication difficulties, including language and literacy barriers; respect or deference to people in 'authority' roles; unsatisfactory earlier experiences around sharing concerns, such as staff not listening or understanding, no change happening, or issues around confidentiality.

3) **Issues relating to the consequences of saying something** - protecting the feelings of the person they are concerned for; worries about the impact on the care of the person supported; guilt or fear over personal comebacks (if they are the carer) or not being seen as grateful for care received (if they are receiving care); fear of social services involvement and unwanted care alternatives.

These identified barriers have much in common with the those discussed in the findings of the *'No Secrets'* (2009) Safeguarding Adults consultation review carried out by the Department of Health, the Home Office, and the CJS, which states that carers' knowledge as 'expert partners' can be helpful in scoping and managing risks in a proportionate, enabling and sustainable way. It warns that where carers are not involved or treated as partners who are listened to, the chances of unrecognised or unreported risks of abuse, including violence, may well increase.

A report from the Commission for Social Care Inspection (2008:9) highlighted the fact that "… councils, care providers and regulators all have crucial roles to play in ensuring that the essential elements of prevention and early intervention are in place, namely: people being informed of the right to be free from abuse; and supported to exercise these rights; including having access to advocacy." It points out that a 'joined up' local approach to advocacy would be helpful, and notes that access to individual advocacy for people using care services or carers entitled to an assessment of needs is often difficult to obtain.

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.

ADASS (2011b:12) recognises the sorts of institutional behaviours that may place carers at risk of harm include: not listening to carers and/or being dismissive; failure to recognise or respond to carers who seek to share their concerns or needs with a professional; making wrong assumptions about their situation and coping capacity when making decisions about assessment, care, and support; excessive emphasis on the requirements of 'confidentiality' within mental health (notwithstanding guidance on this issue, see McDonald, 2009) that may place carers at serious risk of harm; and poor management systems, weak care monitoring, and lack of supervision and leadership.

There are also indications that some older carers, and those from ethnic minority groups, find difficulty with, or are intimidated by, organisational behaviours (Department of Health *et al.*, 2009:98-99). ADASS (2011b:11) warn that such carers may "feel that it is 'OK not being OK'".

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. This may have arisen from: generalised assumptions about 'carers'; uncritical efforts to see the best; concerns about consequences of intervention; minimising concerns; not seeing emerging patterns; or not ensuring a consistent focus on the person at risk.

The proposed framework for transparency in social care outcomes (Department of Health, 2010) offered five outcomes that are relevant to this paper. They are: everyone enjoys physical safety and feels secure; carers can balance their caring roles and maintain their desired quality of life; social care users and carers are satisfied with their experience of social care and support services; carers feel they are respected as equal partners throughout the carer process; providing effective safeguarding services.

Local progression of the national competence framework for safeguarding adults (Bournemouth University, 2010) is something all local partnerships should consider adopting. Equally, joint training and local awareness work with General Practice 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.

None of the carers in these cases were offered a carer's assessment, and often their needs were not considered when decisions were made concerning those they were caring for. For example, in DHR9 a decision was made to leave the perpetrator in the victim's care, following an emergency appointment with mental health professionals with regards to his deteriorating mental state. This based on both the perpetrator and victim's wishes, however "no consideration had been given as to whether the victim was able to cope with him when he was unwell, and the opportunity to explore her concerns about his mental state had been missed" (p.15). Likewise, in DHR 10 the review notes that "the victim should have been given the opportunity to be part of a risk assessment and there is guidance under

Care Programme Approach (CPA) that makes it clear that carers' welfare, their caring capacity, and their safety should be considered" (p.13).

In DHR 12 the review records that more could have been done to engage with the victim's informal carers (including the perpetrator) "to ensure that their needs were taken fully into account and to signpost them to other sources of support, information, and advice. Each of them should have been offered an assessment of their needs in their own right, giving an opportunity for them to speak individually to a member of the assessment staff if they wished" (p.7). The report notes that carers are often placed under stress as a result of managing caring responsibilities alongside other demands in their lives. The fact that "they are family members should not result in their own needs as carers being overlooked" (p.7).

3.3.2 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. In DHR 1 the perpetrator's wife (and the victim in the case) had previously attended surgery with the perpetrator. However, she was asked to leave room when he started talking about having 'dark thoughts'. Subsequently she found it harder to approach the GP with her concerns about the perpetrator's deteriorating mental health. This situation also meant the GPs were reliant entirely on information given by perpetrator when assessing his needs and risk. The couple's children also felt concerned about "what they perceived as the inaction of the GPs" (p.26). The report thus raises the 'ability of family to engage with GPs' as a key issue. The report writers recommend looking at the national programme, '*Time to 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.

In DHR 9 the victim's perception was that her "confidence had been broken by a health professional when she discussed her concerns about her son's mental health on a previous

---

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

occasion" (p.13). The health professional had then gone on to share what she discussed with perpetrator (her son), leaving the victim feeling "let down" (p.12 (full report)). Engagement with victim, as the mother and sole carer of a patient suffering severe mental health problems, was thus judged to be "inconsistent and inadequate" (p.15), and the review identified the need to "engage with... relatives/friends/significant others in a more positive and meaningful way" (p.26).

In DHR 10 the report notes that there was an assumption from various agencies that the victim could cope with caring for the perpetrator (her son), and that views of other family members who were less close to the whole issue were not considered when making this assessment. Hence "there was an over reliance on the information being supplied by the victim, when her capacity to make such decisions had not been assessed" (p.16). The wider family could not understand why they had not been kept informed about perpetrator's mental state

It is not only the health services which are highlighted as not providing sufficient support to family networks, or taking their concerns seriously. In DHR 4 the victim's mother expressed concern to a social worker that the victim was intimidated by the perpetrator at a Child Protection Conference held for their child (harassing her as she was leaving and arriving etc.) The response was reportedly that "if the victim was fearful she must report this herself to the professionals" (p.17-18).

3.3.3 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. In DHR 9 when the CPN/Care coordinator for the perpetrator retired "there was a lack of a transitional process to introduce the new Care Co-ordinator" (p.16). Likewise in DHR 10 when the perpetrator moved from HTT to EIS the report notes a "missed opportunity to hold a formal 'handover' meeting" (p.15) or a multi-agency decision to be made about the perpetrator and the victim's future care needs. There are also several examples where social workers were not fully briefed on cases they were taking over.

3.4 Health Issues

3.4.1 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, despite the multiple difficulties this may present, 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. Stakeholders interviewed also observed that engaging with GPs around domestic abuse issues through existing structures posed challenges.

In five cases it was noted that GPs had either not had training in DV, there was no identified lead for DV, or no formal pathway for responding to disclosure (and in many cases all three conditions were met). This often led to risks posed either by or to patients not being dealt with as effectively as they might have been. In DHR 13 the perpetrator's GP was aware that the perpetrator had concerns that he might harm his family, and was also aware of his mental health issues.   However, the review notes that "it appears that the GP considered these issues around [the perpetrator's] mental ill-health and did not consider the wider issues of the risk to his family" (p.19). In DHR 5 when the victim disclosed domestic abuse her GP told her to contact the police, and did not pursue it further himself. The review

concludes that it would appear the victim was let down by agencies and professionals she disclosed to, which may have contributed to her making the choices she did, as she may have perceived that she only had limited options. It and goes on to note that GPs should never assume that someone else will take care of domestic abuse issues, as they may be the woman's first and only contact. It quotes from *'Responding to Domestic Violence'* (Department of Health, 2005:35) saying "the health service alone cannot meet all the needs of those experiencing domestic abuse but it is uniquely placed to ensure that they access services which can help change their situation". In DHR 11 the victim's GP did not have domestic abuse policies in place, staff were not aware of protocols with other agencies, and there was no questioning of the victim when she reported having personal problems that she could not talk about; hence "no further information was gleaned as to the source and nature of the [personal] problems and issues" (p.19).

In four cases the poor standards of record keeping by GPs was noted. DHR 3 suggests that practices "receive training on record keeping and consider implementing templates to assist in consultations for those patients with mental health needs in order to ensure effective record keeping is in place and that the patient receives appropriate care" (p.18). This is particularly important because patients are often seen by a range of GPs within a practice, instead of steady contact with one GP who is then able to build a personal relationship with them and have an overview of their health problems. In DHR 1 the perpetrator saw three different GPs with regards to his deteriorating mental health, and poor record keeping meant there was little communication between them with regards to his case. In DHR 2 the perpetrator was seen by ten different GPs at the same practice over the three year period, and five different GPs saw him regarding his mental health. Again, there is little evidence of review/communication or follow up between them, and no GP ascertained who else might be at risk from the perpetrator.

GPs are often uniquely positioned to deal with mental health issues. Compared to Home Treatment Teams (which were seen in two of the reviews where clients had contact with them as invasive and unsympathetic[10]) GPs are seen as approachable and knowledgeable. It

---

[10] 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.

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). In DHR 2 GPs were unaware that it was no longer appropriate practice to refer perpetrators of domestic abuse for anger management programmes (as these programmes do not address the underlying issues and may in fact heighten the risk of harm to victims). 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 clear that engaging perpetrators and getting them involved in appropriate services that aim to challenge violent behaviours is critical.

3.4.2 Management of Prescriptions and non-compliance with medication

A number of DHRs critique the way prescriptions are issued and managed. In four of the 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.

Responsibility for compliance is therefore generally considered to lie with GPs. In DHR 7 the perpetrator voluntarily stopped taking medication several months prior to the homicide and the prescribing GP failed to notice or respond to this situation. The report notes that the perpetrator's behaviour towards the victim deteriorated significantly from this point, and that while it cannot be proved the two issues are linked, systems within GP practices need to be sufficiently robust to identify and address such situations with patients enduring long term conditions. A similar situation arose in DHR9 - blood tests demonstrated sub-therapeutic levels of drugs even though the perpetrator said he was taking them; however, "it was accepted he had re-started his medication because he said that he had – there was no robust monitoring put in place for this" (p.14). In DHR10 the victim (the offender's mother) suggested she be allowed to supervise the administering of the perpetrator's medication, which was agreed. However this was only days after the perpetrator claimed the victim was putting poison in his food, and is thus identified as an extremely unwise move on behalf of mental health services. Subsequent to this a CPN left a supply of medication with the perpetrator. It is not known how much medication was left with him, and the review suggests this was "another unwise move" (p.10). The report notes "there was clearly the absence of a robust medication plan in place" (p.10-11), and states that "it is essential that everyone involved in the care of the service user understands who prescribes the medicine, where it is obtained from, the instructions for administering it, and what other medicines are being proscribed at the same time" (p.14).

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.

As a side note, it should be borne in mind that delusions of poisoning are relatively common in patients diagnosed with schizophrenic disorders (see Masson, 1985; Tateyama *et al.,* 1998). It is perhaps inadvisable to allow the carers of such people, who are also often close family members, to be in charge of administering their medication without ensuring careful monitoring and support. In two cases here there is evidence that the perpetrator believed the victim was "poisoning" them, and DHR10 highlights this as a possible exacerbating factor in the lead up to the offence.

In addition, there are also problems raised around the issue of repeat prescribing. DHR 3 makes mention of issues relating to repeat prescribing and recommends that GP practices "review prescribing protocol in respect of antidepressant prescribing to include requirements for periodic medication review to ensure that the patient receives effective treatment" (p.18). Often when medications don't work (or the patient perceives them not to be working) the drug is simply changed or the amount altered. In DHR1 the perpetrator was prescribed 3 different antidepressants over a 12 week period in attempt to find one that suited him and "arguably never achieved a therapeutic dose" (p.30-1). 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.

3.4.3 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 either DHR 2 or DHR 4 – doing so might have highlighted the risk in the victim's situation. Likewise, a third DHR notes a "lack of professional curiosity" from the health visitor even though the perpetrator (the victim's

partner and father of her child) was "rude, angry and confrontational" when she tried to set up the primary visit.

3.5 Services

3.5.1 Complex Needs of Perpetrators

In 9/13 cases the perpetrator had recorded mental health issues. As well, 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.

There is increasing awareness of the benefits of integrated services for people with co-occuring mental health problems and substance misuse issues (McGovern, Lambert-Harris, Gotham, Claus, & Xie, 2014). Mueser, McHugo, & Bond (1998) conclude that comprehensive dual-disorders programmes that tackle both mental illness and substance misuse are able not only to better attract and retain patients in services but also to help patients attain reduction of problematic substance use over time. While the needs of dual diagnosis service users are often complex, and in most cases cannot be met by individual services, the NHS recognises the importance of collaborative working between mental

health and substance misuse services and in ensuring that "service users are not shunted from one service to another"[11].   However, looking at the process of treating people with a dual diagnosis in a large English city, Kelly & Humphrey (2013:314) noted a number of barriers to the NHS better engaging with integrated treatment programmes, namely: organizational complexity; arrangements for governance and accountability; competing priorities; financial constraints; high staff turnover; and complex information and IT systems. Abou-Saleh (2004:352) also observed "serious implementation barriers related to service organisation, staffing levels, training and - most importantly - the difficulties of engaging people with severe mental illness and comorbid substance misuse in treatment".   A survey of the training and support needs of staff working with patients with dual diagnosis showed that mental health service workers lacked the knowledge and skills for assessment and treatment of substance misuse and were insufficiently aware of the available resources and how to access substance misuse services (Maslin *et al.*, 2001). Abou-Saleh (2004) concludes that commissioners and providers of services 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.

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 - it is particularly used to identify at risk children and has been highlighted in SCRs within the West Midlands region[12]. 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.

---

[11] See: http://www.lancashirecare.nhs.uk/Services/Children-Families/Dual-Diagnosis.php
[12] See, e.g.,
http://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=5&ved=0CE8QFjAE&url=http%3A%2F%2Fwww.coventrylscb.org.uk%2Ffiles%2FEvents%2Fmay_13%2FLearning_from_Serious_Case_Reviews.doc&ei=1IJvU-X5H4eX1AW-q4CQAQ&usg=AFQjCNESkXPtPuBsnnG0LSAacWW_Ad5ucA&sig2=JT3csXVLQkLO-PILnSqssQ

Mirroring our findings, the Metropolitan Police, in a review of domestic violence homicides in 2008-9, found that all six of the perpetrators who killed family members (mother or father) were either suffering from mental health problems and/or were under the influence of drugs and/or alcohol.

DHR 4 notes that "the presence of a cluster of problems including substance misuse, mental health concerns, and violent behaviour, in relation to the perpetrator, was not picked up and his circumstances were never assessed adequately at any point by the agencies" (p.37). All agencies need to be more sensitive to the risk posed by this particular combination of factors

If people are going to be offered dual diagnosis integrated services, joint commissioning of mental health and drug and alcohol services "needs to become the norm" (UKDPC, 2012:3). 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. Local leadership is vital to ensure people requiring support from more than one service get coordinated and consistent responses and appropriate priority from a range of agencies.

3.5.2 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 was evidence within the reviews of 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). In DHR 2 the perpetrator failed to fully engage with drug and alcohol services, but despite this his GP continued to refer him to such specialist services. His failure to engage did "not seem to raise any concerns or cause any escalation to an alternative approach" (p.5). It is clear from some DHRs that not all health staff are aware of the Trust policy for managing patients who persistently fail to keep (mental health) appointments, which emphasises the need to risk assess to differentiate patients who can safely opt out from those who may pose a risk to themselves and others – in these cases non-engagement needs to be robustly followed up. DHR 3 notes that "such

services can only be offered, not imposed" (p.18), but a more robust approach to ensuring engagement needs to be taken.

Daniels, Crum, Ramaswamy & Freudenberg (2011:50) point out that interventions that address only single health problems may fail to engage clients (particularly younger men), "who seldom see health or substance abuse as a priority need" - again highlighting the importance of joint working to create unified programmes that engage with complex and interlinked needs.

3.5.3 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 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.

In stakeholder interviews, there was a significant difference in opinion with interviewees about the value of perpetrator programmes, which may reflect local approaches/attitudes. One participant, for example, highlighted a clear need to extend perpetrator programmes, as funding had been significantly cut, and this was a clear priority for them. Another noted the need to "recognise serial and repeat offenders and tackle them effectively, now" but pointed out "there are no key, well-researched offender management tactics for policing, there are some treatment programmes but, again, very limited".

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".

As well as issues surrounding effectiveness, 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), in-keeping with the conclusions drawn by Gondolf (2012), 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

3.6.1 Problems with Partnership working/ Lack of effective communication

This was identified as a key factor in ten DHRs, and DHR 2 notes that the failure to share information is a recurring theme in reviews of both domestic homicide and child protection cases that have been carried out nationally (p.7). 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. DHR 9 notes that "recording systems and working practices" are often "inadequate" and that this can "result... in information not being shared with the multi-disciplinary team" (p.16). DHR 13 concludes that "agencies appeared to act in silos without the benefit of collation, analysis and dissemination of information and intelligence about

[families]" and notes that people who live together and/or share an intimate relationship are often "seen and dealt with as individuals" (p.25) rather than an interconnected group.

A deficit in open communication is recorded at almost every level. In DHR 2 there was a lack of effective and swift communication between the two areas involved (an area in the West Midlands and an area in the south of England) after the victim moved between areas. The review notes there is no national policy for the police service regarding notification of victims of domestic abuse who move to another police area, other than when the victim is subject to a MARAC.

In DHR 2 mental health services dealt with each of perpetrator's incidents in isolation and tried to treat each of the symptoms separately (e.g. providing information on drug misuse programmes). None of the services treating the perpetrator had the full picture of what had happened as they did not share or seek any additional information. None were therefore able to fully assess the risk he posed to his wife and baby. Similarly, in DHR 13 the perpetrator was well known to variety of services but consistently there was "no consideration of either adult or child safeguarding" in respect of the victim (his wife) and his child (p.11).

In DHR 4 the social worker coordinating the ICPC (Initial Child Protection Conference) did not invite GPs, housing, or the police. They could not provide a reason for why this happened (p.30); "it is unclear... why the joint decision...concluded that the matter could be pursued as a single agency Section 47 enquiry" (p.43). Police were therefore "left out of the loop" (p.43) and could not share info about the perpetrator's criminal and violent background so conference members could better understand risk. Contact between the police and MHS is often seen as key - DHR 9 notes that the relationship between the police and the MHS could be "strengthened by enhancing police records on people known to have mental health conditions who are in contact with the police" (p.16).

There is also a lack of information sharing within individual agencies, such as a lack of communication within the police regarding risks which should determine the setting of bail conditions.

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.

3.6.2 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. For example, in DHR 2 a multi-agency screening process for incidents of domestic abuse where children are resident did not occur due to a backlog of reports, and in DHR 4 there were lots of delays at various points in the victim's risk being dealt with (delays in formal meetings, in reports, in getting information to relevant parties including the victim) with "workload pressures" often noted as cause (p.26; p.28; p.44). Such pressures also often resulted in a lack of access to appropriately trained staff. For example, in DHR 4 when the victim's mother contacted Children's Social Care to report threatening behaviour from the perpetrator, the allocated social worker was unavailable and the duty officer had not known what to do. In DHR 10 no approved mental health professional [AMHP] was available when attempting to acquire the perpetrator a bed at a secure hospital (the two on duty were engaged elsewhere – new service (post review) requires 12 on duty in peak hours) and so "the opportunity was missed for him to be admitted to hospital for treatment" (p.12). In another DHR a referral had been made to a domestic abuse organisation asking for help safeguarding the victim, but this had not been actioned at the time of her death. The review attributes this to a lack of senior management available to advise and support staff at the organisation due to redundancies and the deletion of posts. The report notes that this case and the volume of new referrals to the organisation concerned gives ample evidence that it is needed, so sufficient funding to ensure an appropriate level of trained, supervised staff is key.

Access to facilities is often also limited because of insufficient resources. In DHR 10 attempts were made to admit the perpetrator to hospital under the Mental Health Act 1983. However, initially no beds available, and following on from this "the escalation process when there are difficulties finding available beds was not followed, which frustrated

his admission to hospital" (p.15). At various points the victim (his mother and carer) is described as "desperate" to have son admitted (p.12). The report notes that had the perpetrator "been recognised earlier as a patient requiring admission, the attack would not have occurred and therefore the death of the victim was preventable" (p.18). In DHR 5 the victim was not interviewed at SARC (following an alleged rape and assault by her husband) as is best practice, as there weren't sufficient facilities at the SARC due to the volume of other victims present.

3.6.3 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. For example, DHR 5 records that one time when the victim complained of rape and violence by her husband, her GP used a friend of the victim as an interpreter. The victim "felt uncomfortable talking about these issues with the interpreter present" (p.21). The report notes the victim often found herself having to explain to male GPs and male POs intimate and sensitive details about being raped by her husband without interpreter present despite her limited English, and that "no consideration given to her needs in this regard" (p.42). In DHR 13 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)

The recruitment and use of such interpreters is also key. In DHR 6, Eastern European women interviewed in a focus group after the homicide of the victim stated that they did not want interpreters when meeting GPs, police etc. when talking about domestic violence as they were worried they would know interpreter who might reveal information to their

local community. This suggests interpreters should be drawn from outside the community (e.g. native English speakers who have other language skills as opposed to vice versa).

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). Hoykle (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. In three DHRs the victims were (relatively) newly arrived to the UK from parts of Asia and the Middle East. The advice the victim in DHR5 received from her family with regards to the domestic abuse she experienced was to "stick it out" as she already had one failed marriage behind her. On a later date the victim was "reassured" by her GP about her domestic problems, "another poor response" (p.35). The report postulates that perhaps "there was an issue of cultural acceptance of this dilemma within families" although acknowledges one can't know this (p.36). DHR 13 also notes that domestic violence may be seen as an acceptable part of the culture of the victim's country of origin, that domestic violence is seldom reported there, and that the police offer very little assistance to women who complain about domestic abuse. Women therefore tend to hide the truth from others rather than complain and bring shame upon their family (p.47). DHR 8 notes the victim possibly has a "cultural heritage of greater deference" (p.15) and that "her culture and

socialisation is highly likely to have made her less likely to elaborate information or to be assertive in challenging the way the call [to police] was being handled" (p.16). In her country of origin "volunteering information can be seen to be too bold and inappropriate" (p.17) and "the disclosure of domestic abuse is even more difficult when the victim has more limited means of expressing problems and a cultural disposition to self criticism" (p.46).

In DHR 6 the victim was Eastern European. The perpetrator himself commented that "it was more usual in [his country of origin] to deal with such problems [marital difficulties] within the family" (p.13). The DHR panel carried out a focus group with Easter European residents following the homicide, as well as conducting a review of the literature, and concluded that this is an issue, citing 'Domestic Violence in [a European Country] July 2002' as saying "the {Eastern European Country}'s legal system regularly fails to protect women from violence by their partners in intimate relationships... Cases of domestic violence are seldom prosecuted". It adds: "Perceptions of, and expectations from, women in [this] society have significant implications for victims of domestic violence as conservative tradition hinders women from recognising, reporting, and seeking help when they experience abuse"[13]

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 originations 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.

---

[13] Dziewanowska, M., Khomuk, V., & Krawczyk, L. (2013). *Airing the dirty laundry: Exploring the challenges of domestic violence in Poland*. Humanity in Action.

In DHR 13 the victim disclosed to the UK Border Agency (UKBA) that the perpetrator had hurt her and her son and that he was not normal. The UKBA failed to implement their own clear guidelines about referrals to other agencies when such information came to their attention. The UKBA needs to ensure these guidelines are understood and followed by all staff.

In her interview, Participant 1 highlights equalities and cultural issues as a key issue in terms of effectively engaging with families who come from diverse cultural backgrounds, stating that it is "difficult just to talk about equalities when the whole problem is so huge, equalities is just one small element of that... [but we have had] difficulties with translation services, with people not understanding the culture; [and] how women were perceived in that culture".

4.0   Issues raised in stakeholder interviews

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.

4.1 Importance of the DHRs

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. One participant noted that DHR findings had driven specific training and had had a positive impact on the importance given to domestic violence by a range of agencies, and facilitated a more joined up response.

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 incredibly time consuming, but also created a drain on finite resources. Many of the participants suggested that more strategic thinking from the Home Office on how these would be managed at a local level would have been useful – and that a lack of resources more generally around DV had an impact on how services were delivered.

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. As such, there was added concern that they 'get them right', but also an awareness, and sometimes real concern, that money that could be put towards supporting women was being put towards the DHR process. This raises questions about how funding for domestic violence is allocated at both a local and a national level, and the onus that is put on teams with an already limited capacity to carry the DHRs out.

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.

4.2 Funding

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. Areas that were included in the analysis include:

- Doncaster (2 published DHRs)
- Essex (3 published DHRs)
- Durham (1 published DHR)
- Guildford (1 published DHR)
- Hackney (1 published DHR)
- Kent (3 published DHRs)
- Kirklees (1 published DHR)
- Newham (1 published DHR)
- Norfolk (1 published DHR)
- Peterborough (1 published DHR)
- Rochdale (1 published DHR)
- Sheffield (3 published DHRs)
- South Oxfordshire (1 published DHR)
- Southwark (1 published DHR)
- Southampton (1 published DHR)
- Southend-on-Sea (1 published DHR)
- Staffordshire (Overview slides)
- Stockport (1 published DHR)
- West Berkshire (2 published DHRs)

- Wycombe (1 published DHR)

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 other 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 - such as the use of DASH, proportionate checks, offender management, as discussed in the analysis above - 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, such as those outlined in the HMIC report, and are making steps in the right direction. Further recommendations for improvement, including in the area of police response, will be laid out below.

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 being 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, not just in relation to domestic violence provision, but to health services in particular. The Home Office (2013) 'Lessons Learnt' document is an inadequate response to 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.

6.1 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, that more specific training is delivered to GP 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 violence[14], 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

---

[14] Such as that developed by AVA:
http://www.avaproject.org.uk/media/124125/ava%20toolkit%20section%201.pdf

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 Change*[15]', 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

---

[15] https://www.time-to-change.org.uk/news/gps-learn-users-primary-care-mental-health-problems

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.

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 originations 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.

6.2 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.

Bibliography

Abou-Saleh, M. T. (2004). Dual diagnosis: Management within a psychosocial context. *Advances in Psychiatric Treatment, 10(5),* 352-360.

ACPO (2004). *Guidance on investigating domestic violence*. Centrex, London: National Centre for Policing Excellence.

ACPO (2005). *Guidance on identifying, assessing and managing risk in the context of policing domestic violence*. London: Association of Chief Police Officers.

ACPO (2008). *Guidance on investigating domestic abuse*. London: NPIA

ADASS (2011a). *Advice Note: Safeguarding Adults*. Available at: http://www.adass.org.uk/uploadedFiles/adass_content/policy_networks/safeguarding_adults/key_documents/LGA%20ADASS_SafeguardingAdviceAndGuidanceToDASS_Mar13.pdf

ADASS (2011b). *Carers and safeguarding adults: Working together to improve outcomes*. Available at: http://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=4&ved=0CEwQFjAD&url=http%3A%2F%2Fwww.jitscotland.org.uk%2Fdownloads%2F1321289085-carers-and-safeguarding-document-june-2011-5730[1].pdf&ei=O39qU5b9NY6PyASlyoKIDA&usg=AFQjCNGfKHNFNR4puovGbc-Hc68RViGjtw&sig2=NAVk_ALciqA2kJqrCmaYpw)

Akoensi, T. D., Koehler, J. A., Lösel, F., & Humphreys, D. K. (2013). Domestic Violence Perpetrator Programs in Europe, Part II A Systematic Review of the State of Evidence. *International Journal of Offender Therapy and Comparative Criminology, 57(10),* 1206-1225.

AVA (2013). *Complicated Matters: Stella Project Toolkit and e-learning*. Available at: http://www.avaproject.org.uk/our-resources/good-practice-guidance--toolkits/complicated-matters-stella-project-toolkit-and-e-learning-%282013%29.aspx

Babcock, J. C., Green, C. E., & Robie, C. (2004). Does batterers' treatment work? A meta-analytic review of domestic violence treatment. *Clinical Psychology Review, 23,* 1023-1053.

Brandon, M., Bailey, S., & Belderson, P. (2010). *Building on the learning from serious case reviews: A two-year analysis of child protection database notifications 2007-2009.* Available at: http://dera.ioe.ac.uk

Borum, R. (1996). Improving the clinical practice of violence risk assessment: Technology, guidelines, and training. *American Psychologist, 51(9),* 945.

Bournemouth University Centre for Post-Qualifying Social Work (2010). *Towards a National Competency Framework for Safeguarding Adults*. Bournemouth: Bournemouth University.

Brookman, F., & Maguire, M. (2003). *Reducing homicide: A review of the possibilities*. Home Office Online Report 01/03. London: Home Office.

Brown, T., Werk, A., Caplan, T., Shields, N., & Seraganian, P. (1998). The incidence and characteristics of violent men in substance abuse treatment. *Addictive Behaviours, 23*, 573–86

Campbell, J. C. (1986). Assessing the risk of homicide for battered women. *Advances in Nursing Science, 8(4),* 36–51.

Campbell, J.C. (ed.) (2007). *Assessing Dangerousness: Violence by Batterers and Child Abusers*. New York: Springer

Carers UK (2004). *In Poor Health: The impact of caring on health*. London: Carers UK

Choi, N. G., & Mayer, J. (2000). Elder abuse, neglect, and exploitation: Risk factors and prevention strategies. *Journal of Gerontological Social Work, 33(2),* 5-25.

Churchill, R., Khaira, M., Gretton, V., Chilvers, C., Dewey, M., Duggan, C., & Lee, A. (2000). Treating depression in general practice: Factors affecting patients treatment preferences. *British Journal of General Practice, 50(460)*, 905-906.

Commission for Social Care Inspection (2008). *Safeguarding Adults: A study of the effectiveness of arrangements to safeguard adults from abuse*. London: CSCI.

Co-ordinated Action Against Domestic Abuse (2010). *Saving Lives, Saving Money: Maracs and high risk domestic abuse*. Bristol: CAADA. Available at: http://bit.ly/cmk0Nn

Daniels, J., Crum, M., Ramaswamy, M., & Freudenberg, N. (2011). Creating REAL MEN: Description of an intervention to reduce drug use, HIV risk, and rearrest among young men returning to urban communities from jail. *Health Promotion Practice, 12(1),* 44-54.

Davis, R. C., & Taylor, B. G. (1999). Does batterer treatment reduce violence? A synthesis of the literature. *Women & Criminal Justice, 10,* 69-93.

Davies, R., Shocolinsky-Dwyer, R., Mowat, J., Evans, J., Heslop, P., Onyett, S. & Soteriou, T. (2009). *Effective involvement in mental health services: The role of assertive outreach and the voluntary sector*. Bristol: Mind. Available at: http://www.bristolmind.org.uk/files/docs/research/assertive-outreach-summary.pdf

Debbonaire, T. (2008). *Evaluation of the use of a risk identification tool in Cafcass, Relate and Respect projects*. London: Cafcass/Relate/Respect

Debbonaire, T. (2011). Research: assessing risk in domestic violence cases. *Children, Research, Workforce.* Available at: http://www.communitycare.co.uk/2011/09/30/research-assessing-risk-in-domestic-violence-cases/#.U2zerFdcKSo

Denison, M., Paredes, A., & Booth, J. (1997). Alcohol and cocaine interactions and aggressive behaviours. In M. Galanter (ed.), *Recent Developments in Alcoholism, Volume 13, Alcohol and Violence*. New York: Plenum

Department of Health (2002). *Mental Health Policy and Implementation Guide – Dual Diagnosis Good Practice Guide*. London: Department of Health

Department of Health (2005). Responding to domestic abuse: A handbook for professionals. London: Department of Health.

Department of Health (2010). *A Vision for Adult Social Care: Capable Communities and Active Citizens* (Gateway ref: 14847). London: Department of Health

Department of Health (2010). *Transparency in Outcomes: A Framework for Adult Social Care* (Gateway Ref: 14865). London: Department of Health.

Department of Health/Home Office/CJS (2009). *Safeguarding Adults consultation on the review of the "No Secrets" Guidance*, [Gateway Ref Guidance, 10624] and Safeguarding *Adults , Report on the consultation on the review of "No Secrets"*[Gateway Ref:12247]. London: Home Office.

Drake, R. E., Mercer-McFadden, C., Mueser, K. T., McHugo, G. J., & Bond, G. R. (1998). Review of integrated mental health and substance abuse treatment for patients with dual disorders. *Schizophrenia Bulletin, 24(4),* 589-608.

Eng, P. (1995). Domestic violence in Asian/Pacific island communities. In D. L. Adams (Ed.), *Health issues for women of colour* (pp. 78–88). Thousand Oaks, CA: Sage.

Fagan, J., Stewart, D. K., & Hansen, K. V. (1983). Violent men or violent husbands: Background factors and situational correlates of severity and location of violence. In D. Finkelhor, M. Straus, G. Hotaling, & R. J. Gelles (Eds.), *The Dark Side of Families* (pp. 49–68). Beverly Hills, CA: Sage.

Faulkner, A. & Sweeney, A. (2011). *Prevention in adult safeguarding: A review of the literature*. *Adult Services Report 41*. London: SCIE.

Feder, L., Wilson, D. B., & Austin, S. (2008). Court-mandated interventions for individuals convicted of domestic violence. *Campbell Systematic Reviews, 12*, 1-46.

Fenton, W. S., Blyler, C. R., & Heinssen, R. K. (1997). Determinants of medication compliance in schizophrenia: Empirical and clinical findings. *Schizophrenia Bulletin, 23(4)*, 637-651.

Fischer, W., Goerg, D., Zbinden, E., *et al.* (1999). Determining factors and the effects of attitudes towards psychotropic medication. In W. Guimon, W. Fischer & N. Sartorius (Eds.), *The Image of Madness: The Public Facing Mental Illness and Psychiatric* (pp. 162-186). Basel: Karger.

Fox, A. (2009). *Commissioning for Carers and Commissioning for Carers: An Action Guide for Decision Makers*. The Association of Directors of Adult Social Services, The NHS Confederation, The Local Government Association, The Improvement and Development Agency, The Princess Royal Trust for Carers, Crossroads Care, Carers UK and the National Black Carers and Carers Workers Network, with Department of Health support. Available at: www.idea.gov.uk/idk/core/page.do?pageId=6001526

Galpin, D. & Morrison, L. (2011). *National Competence Framework for Safeguarding Adults*. Bournemouth: Bournemouth University, Learn to Care, Skills for Care, SCIE.

Gondolf, E. W. (2012). *The future of batterer programs: Reassessing evidence-based practice*. Boston, MA: Northeastern University Press .

Greater Manchester Police (2014). *Clare's Law: The domestic abuse disclosure scheme.* Manchester: GMP. Available at:
http://www.gmp.police.uk/content/WebAttachments/88A190F67550078780257A71002E5DC8/$File/claire%27s%20law%20other%20people%20booklet.pdf

Hamberger, K. L., & Hastings, J. E. (1993). Court-mandated treatment of men who assault their partner: Issues, controversies, outcomes. In N. Z. Hilton (Ed.), *Legal responses to wife assault: Current trends and evaluation* (pp. 188-229). London, England: Sage

Harne, L. (2009). *Domestic violence and safeguarding children: the use of systematic risk identification and assessment in private law proceedings by family court advisors*: *A pilot study*. Bristol: University of Bristol and Cafcass.

Haynes, R.B. (1976). A critical review of the "determinants" of patient compliance with therapeutic regimens. In D.L. Sacket & R.B. Haynes (Eds.), *Compliance With Therapeutic Regimens* (pp. 26-39). Baltimore, MD: Johns Hopkins University Press.

Hester, M., Westmarland, N., Gangoli, G., Wilkinson, M., O'Kelly, C., Kent, A. & Diamond, A. (2006). *Domestic Violence Perpetrators: Identifying Needs to Inform Early Intervention*. Bristol: Northern Rock & Home Office.

HM Government (2014). *A Call to End Violence Against Women and Girls: Action Plan 2014.* Available at:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/287758/VAWG_Action_Plan.pdf

HMIC (2014). *Everyone's business: Improving the police response to domestic abuse*. Available at: http://www.hmic.gov.uk/wp-content/uploads/2014/04/improving-the-police-response-to-domestic-abuse.pdf

Holly, J. & Horvath, M.A.H. (2012). A question of commitment – improving practitioner responses to domestic and sexual violence, problematic substance use and mental ill-health. *Advances in Dual Diagnosis, 5(2*), 59 - 67

Home Office (2010). *Call To End Violence Against Women and Girls.* London: Home Office. Available at: https://www.gov.uk/government/publications/call-to-end-violence-against-women-and-girls

Home Office (2013a). *Guidance: Domestic Violence and Abuse*. London: Home Office. Available at: https://www.gov.uk/domestic-violence-and-abuse

Home Office (2013b). *Domestic Homicide Reviews: Common themes identified as lessons to be learned*. London: Home Office. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/259547/Domestic _homicide_review_-_lessons_learned.pdf

Hoyle, C. (1998). *Negotiating domestic violence: Police, criminal justice and victims*. Oxford: Oxford University Press.

Hoyle, C. (2008). Will she be safe? A critical analysis of risk assessment in domestic violence cases. *Children and Youth Services Review, 30(3)*, 323 – 337.

Humphreys, C., Regan, L., River, D., & Thiara, R.K. (2005). Domestic violence and substance use: Tackling complexity. *British Journal of Social Work, 35(8),* 1303 - 1320

Humphreys, C., Thiara, R. K., Regan, L., Lovett, J., Kennedy, L., & Gibson, A. (2005). *Prevention not prediction? A preliminary evaluation of the Metropolitan Police Domestic Violence Risk Assessment Model (SPECSS)*. Final Report. Warwick, Centre for the Study of Safety and Wellbeing: University of Warwick and Child and Woman Abuse Studies Unit, London Metropolitan University.

Humphries, C., Mullender, A., Lowe, P., Hague, G., Abrahams, H., & Hester, M. (2011). Domestic violence and child abuse: Developing sensitive policies and guidance. *Child Abuse Review, 10(3),* 183-197.

Humphries, R. (2011). Adult Safeguarding: Early messages from peer reviews. *The Journal of Adult Protection, 13(2),* 89-99.

Hutchinson, I. (2003). Substance use and abused women's utilization of the police. *Journal of Family Violence,18(2)*, 93–106

Kelly, M., & Humphrey, C. (2013). Implementation of the care programme approach across health and social services for dual diagnosis clients. *Journal of Intellectual Disabilities, 17(4),* 314-328.

Kroenke, K., Strine, T. W., Spitzer, R. L., Williams, J. B., Berry, J. T., & Mokdad, A. H. (2009). The PHQ-8 as a measure of current depression in the general population. *Journal of Affective Disorders, 114(1),* 163-173.

Livingston, G., Manela, M., & Katona, C. (1996). Depression and other psychiatric morbidity in carers of elderly people living at home. *BMJ, 312(7024),* 153-156.

Maruna, S. (2001). *Making good: How ex-convicts reform and rebuild their lives.* American Psychological Association.

Maslin, J., Graham, H. L., Cawley, M., *et al.* (2001) Combined severe mental health and substance use problems. What are the training and support needs of staff working with this client group? *Journal of Mental Health, 10,* 131–140.

Mawson, D. (1985). Delusions of poisoning. *Medicine, Science and the Law, 25(4),* 279-287.

Mayor of London (2005). *Domestic violence and substance use: Overlapping issues in separate services?* London: Home Office (available at: http://legacy.london.gov.uk/mayor/strategies/dom_violence/docs/dom_vi_sub.pdf)

McCormick, R. & Smith, M. (1995). Aggression and hostility in substance abusers: The relationship to abuse patterns, coping style and relapse triggers. *Addictive Behaviours, 20*, 555–62.

McCreadie, C. (2002). A review of research outcomes in elder abuse. *The Journal of Adult Protection, 4*(2), 3-8.

McDonald, B. (2009). *Information Sharing and Mental Health: Guidance to Support Information Sharing by Mental Health Services* (Gateway ref: 11920). London: Department of Health.

McGovern, M. P., Lambert-Harris, C., Gotham, H. J., Claus, R. E., & Xie, H. (2014). Dual diagnosis capability in mental health and addiction treatment services: An assessment of programs across multiple state systems. *Administration and Policy in Mental Health and Mental Health Services Research, 41(2),* 205-214.

Mears, D.P. (2003). Research and interventions to reduce domestic violence revictimisation. *Trauma, Violence, and Abuse, 4(2),* 127-147.

Menzies, R. J., Webster, C. D., & Sepejak, D. S. (1985). The dimensions of dangerousness: Evaluating the accuracy of psychometric predictions of violence amongst forensic patients. *Law and Human Behaviour, 9,* 49–70.

Mirrlees-Black, C. (1999). *Domestic Violence: Findings from a New British Crime Survey Self-Completion Questionnaire*. London: HMSO

Moffitt, T. E., & Caspi, A. (1998). Annotation: Implications of violence between intimate partners for child psychologists and psychiatrists. *Journal of Child Psychology and Psychiatry, 39(2),* 137–144.

MPS (2009). *The MPS Report of Domestic Violence Homicide Reviews for Financial Year 2008/09.* London: Metropolitan Police Service. Available at: http://www.ccrm.org.uk/images/docs/7.12a_mps_dv%20hom%20review.pdf

Mullen, P. D. (1997). Compliance becomes concordance. *British Medical Journal, 314*, 691 -692

NICE. (2014). Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively. *National Institute for Clinical Excellence.* Available at: http://www.nice.org.uk/nicemedia/live/14384/66668/66668.pdf

Office for National Statistics (2013). *Focus on violent crime and sexual offences 2012/2013*. Available at: http://www.ons.gov.uk/ons/dcp171776_352362.pdf

Oxfordshire Safeguarding Adults (2010). *Safe from Harm – Risk Factors*. Available at: http://www.safefromharm.org.uk/wps/wcm/connect/occ/Safe+From+Harm/Professionals/What+is+adult+abuse/SFH+-+Prof+-+T+-+risk+factors

Parmar, A., Sampson, A., & Diamond, A. (2005). *Tackling domestic violence: Providing advocacy and support to survivors from Black and other minority ethnic communities.* London: Home Office.

Peveler, R., George, C., Kinmonth, A. L., Campbell, M., & Thompson, C. (1999). Effect of antidepressant drug counselling and information leaflets on adherence to drug treatment in primary care: Randomised controlled trial. *British Medical Journal, 319(7210),* 612

Phillips, L.A., Leventhal, E.A., & Leventhal, H. (2011).   Factors Associated with the Accuracy of Physicians' Predictions of Patient Adherence*. Patient Education and Counselling, 85*, 461–467

RCPG, IRIS & CAADA (2013). *Responding to abuse in domestic violence*. Available at: http://www.rcgp.org.uk/clinical-and-research/clinical-resources/~/media/Files/CIRC/Domestic%20Violence/RCGP-Responding%20to%20abuse%20in%20domestic%20violence-January-2013.ashx

Richards, L. (2003a). *Findings from the multi-agency domestic violence murder reviews in London*. London: Metropolitan Police Service.

Richards, L. (2003b). *MPS domestic violence risk assessment model*. London: Metropolitan Police Service.

Robinson, A. (2004). *Domestic violence Maracs (Multi-Agency risk Assessment Conferences) for very high-risk victims in Cardiff, Wales: A process and outcome evaluation*. Cardiff: Cardiff University

Rodríguez Menés, J., & Safranoff, A. (2012). Violence against women in intimate relations: A contrast of five theories. *European Journal of Criminology*, *9(6),* 584-602

Rothman, E.F., Butchart, A. & Cerdá, M. (2003). *Intervening with Perpetrators of Intimate Partner Violence: A Global Perspective*. Geneva, Switzerland: WHO. Available at: http://www.who.int/violence_injury_prevention/resources/publications/en/intervening_full.pdf

Schafer, J. & Fals-Stewart, W. (1997). Spousal violence and cognitive functioning among men recovering from multiple substance abuse. *Addictive Behaviours, 22,* 127–30.

Sector Consortium (2011). *Think Local, Act Personal: A sector-wide commitment to moving forward with personalisation and community based support, putting people first*. Available at: http://www.thinklocalactpersonal.org.uk/_library/resources/personalisation/tlap/think_local_act_personal_5_4_11.pdf

Skills for Care (2011). *Carers Matter – Everybody's Business: A guide to supporting carers through staff learning and development*. Available at: http://www.skillsforcare.org.uk/Document-library/Skills/Carers/Partone.pdf [parts two and three available, just change document title accordingly]

Sonkin, D. J. (1987). The assessment of court-mandated male batterers. In D. J. Sonkin (Ed.), *Domestic violence on trial: Psychological and legal dimensions of family violence* (pp. 174–196). New York: Springer.

Sonkin, D. J., Martin, D., & Walker, L. E. (1985). *The male batterer: A treatment approach*. New York: Springer.

Stanley, N. & Humphreys, C. (2006). Multi-agency and multi-disciplinary work: Barriers and opportunities. In . C. Humphreys, & N. Stanley (Eds.), *Domestic violence and child protection: Directions for good practice.* London: Jessica Kingsley Publishers.

Steel, N., Blakeborough, L., & Nicholas, S. (2011). *Supporting high-risk victims of domestic violence: A review of Multi-Agency Risk Assessment Conferences (MARACS), Research Report 55*. London: Home Office. Available at:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/116537/horr55-report.pdf

Straus, M. & Gelles, R. (1990). *Physical Violence in American Families.* New Brunswick: Transaction Publishers

Stuart, E. P., & Campbell, J. C. (1989). Assessment of patterns of dangerousness with battered women. *Issues in Mental Health Nursing, 10*, 245–260.

Tateyama, M., Asai, M., Hashimoto, M., Bartels, M., & Kasper, S. (1998). Transcultural study of schizophrenic delusions. *Psychopathology, 31(2),* 59-68.

Thompson, L., & McCabe, R. (2012). The effect of clinician-patient alliance and communication on treatment adherence in mental health care: A systematic review. *BMC Psychiatry, 12(1),* 87-99.

UKDPC (2012). *Dual diagnosis: A challenge for the reformed NHS and for Public Health England*. Available at: http://www.ukdpc.org.uk/wp-content/uploads/dual-diagnosis-a-challenge-for-the-reformed-nhs-and-for-public-health-englan.pdf

Walby, S., & Allen, J. (2004). *Domestic violence, sexual assault and stalking: Findings from the British crime survey.* London: Home Office.

Walby, S., & Myhill, A. (2001). Assessing and managing risk. In J. Taylor-Browne (Ed.), *What works in reducing domestic violence? A comprehensive guide for professionals*. London: Whiting Birch.

Westmarland, N. & Kelly, L. (2012). Why extending measures of 'success' in domestic violence perpetrator programmes matters for social work. *British Journal of Social Work, 43(6),* 1092-1110.

Wilson, M., & Daly, M. (1993). Spousal homicide risk and estrangement. *Violence and Victims, 8,* 3–16.

World Health Organization, World Organization of National Colleges, Academies, & Academic Associations of General Practitioners/Family Physicians (2008). *Integrating mental health into primary care: a global perspective*. World Health Organization.