

**Domestic abuse and change
resistant drinkers: preventing and
reducing the harm**

**Learning lessons from
Domestic Homicide Reviews**

**Part of Alcohol Concern's
Blue Light Project**

In partnership with AVA's Stella Project

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ABOUT THE PARTNER AGENCIES

Alcohol Concern is the national charity on alcohol misuse. Founded in 1984 it has campaigned for responsible drinking, appropriate legislation and robust treatment across the alcohol agenda. In particular, it ran the Embrace project, which focused on alcohol and domestic abuse and developed the Blue Light project, which has worked to improve the response to change resistant drinkers.

Against Violence and Abuse (AVA) is a national charity working to end violence against women and girls. The Stella Project was founded in 2003 as the first initiative in the country to address the overlapping issues of domestic violence and substance use. Today, the Stella Project is a research, training and consultancy resource aimed at improving responses to domestic and sexual violence, substance use, mental health and homelessness.

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1. Introduction

...the apparent excessive alcohol consumption...on the parts of both Adult A and Adult B on a number of separate occasions appears to have had a significant bearing upon the prevalence of domestic abuse and domestic violence. ¹

The relationship between alcohol and violence is well researched, although less so in the more complex context of domestic abuse. ² Whilst there is evidence that alcohol use by perpetrators, and to a lesser extent by victims, increases the frequency of violence and the seriousness of the outcomes ³, this does not mean that alcohol use causes domestic abuse. ⁴ It is neither an excuse nor an explanation.

Both Alcohol Concern's Embrace Project and AVA's Stella Project have previously produced guidance on how to address domestic abuse and alcohol use. ⁵ This guidance builds on the existing literature and uses the learning from reviewing domestic homicide review (DHR) reports to further our understanding of how to deal with cases of alcohol related domestic abuse, particularly more complex cases that involve change resistant drinkers.

The aim of this guidance is to create a baseline of good practice for those supporting clients that have been understood to be change resistant drinkers and who are perpetrating or experiencing domestic violence.



2. The background

This guidance builds on three recent developments:

+ The introduction of domestic homicide reviews

Since 2011, local authorities have had to undertake a Domestic Homicide Review (DHR) after a homicide in which someone aged 16 or over has died as a result of violence, abuse or neglect from someone to whom they are related, have been in an intimate personal relationship with or are a member of the same household. These reviews aim to identify lessons to be learnt from the death.⁶

These reviews reveal both the role of problem drinking and the challenge of managing it in the context of domestic violence. They offer a level of detail that was previously unavailable, so that we can now see what has happened in tragedy after tragedy and perceive patterns that can guide future interventions. This information has been the bedrock of this project and we quote the DHRs extensively throughout.

+ Alcohol Concern's Blue Light project

This guide is also rooted in Alcohol Concern's Blue Light project. The perception exists that if a problem drinker does not want to change, nothing can be done. This is not true. The Blue Light project is Alcohol Concern's national initiative to develop alternative approaches and care pathways for change resistant drinkers who place a burden on public services. It has shown that there are positive strategies that can be used with this client group.

The project developed:

- Tools for understanding why clients may not engage
- Risk assessment tools which are appropriate for drinkers
- Harm reduction techniques workers can use
- Advice on crucial nutritional approaches which can reduce alcohol related harm
- Questions to help non-clinicians identify potential serious health problems and deliver enhanced personalised education
- Management frameworks
- Guidance on legal frameworks

The Blue Light manual, which sets out all these tools, is available at: www.alcoholconcern.org.uk/wp-content/uploads/2015/01/Alcohol-Concern-Blue-Light-Project-Manual.pdf

+ The Stella Project's **Complicated Matters** resources

The Stella project is the country's leading initiative addressing domestic violence, substance use and mental ill health. As a part of a three year project looking specifically at the needs of domestic violence survivors who are affected by substance use and/or mental ill-health, the Stella Project produced a toolkit and e-learning programme for supporting survivors who experience these interconnected issues.

The toolkit is available at: <http://avaproject.org.uk/wp-content/uploads/2016/03/Complicated-Matters-A-toolkit-addressing-domestic-and-sexual-violence-substance-use-and-mental-ill-health.pdf>.

There is also a free elearning available at: <http://elearning.avaproject.org.uk/>

3. Linking to current national priorities

The main focus of this guidance is preventing and reducing risk related to domestic abuse. However, many of the cases highlighted in the domestic homicide reviews suggest that the identification of problem drinkers involved in domestic violence also offers an opportunity to intervene with individuals who may be at the intersection of multiple patterns of problematic behaviour. This is a group with heavy and complex service use, who pose a challenge to many agencies. ⁷

- Targeting these needs will be a way into working with a very challenging set of clients.

The Care Act (2015) brought in a swathe of new statutory responsibilities for those deemed as 'in need of care and support.' Under the act someone who 'misuses substances or alcohol to the extent that it affects their ability to manage day-to-day living' is recognised as potentially being in need of safeguarding.

The Act makes clear that if someone is in need of care and support and is experiencing abuse and neglect then the local authority would have a duty to investigate. Abuse and neglect includes:

- Physical Abuse
- Psychological and Emotional Abuse
- Coercion and Control
- Neglect and Acts of Omission
- Sexual Abuse
- Financial Abuse
- Discriminatory Abuse
- Organisational Abuse
- Domestic Violence
- Self-neglect
- Modern Slavery ⁸

Within the Act, domestic violence has been added as a new category, putting it on a statutory footing for the first time. In the context of change resistant drinkers who experience domestic violence, statutory agencies have a clear duty to safeguard and ensure that people are properly supported and non-statutory agencies have new tools to seek help and support for this group. The Local Government Association has produced helpful guidance on Adult Safeguarding and Domestic Abuse. ⁹

Targeting this group will also meet key health, social care and crime reduction priorities. *Public Health England's report Alcohol Care in England's Hospitals* from 2014 ¹⁰ has a detailed list of the Public Health Outcomes Framework indicators which can be affected by work with problem drinkers. These are equally applicable here. Relevant indicators include:

- 1.11: Domestic abuse
- 1.12: Violent crime
- 2.18: Alcohol related admissions to hospital
- 4.6: Mortality from liver disease

Domains in the NHS Outcomes Framework will also be affected, e.g.:

- Domain 1. Preventing people from dying prematurely. ¹¹

This client group sits at the intersection of the health and community safety agendas. Commissioning services will build links between these areas. It will also help to:

- reduce crime and anti-social behaviour;
- develop local crisis care concordats;
- protect vulnerable adults; and
- reduce call outs to the emergency services.

4. Project partners

The full list of the local authority areas contributing to the project is as follows:

| | | | |
|---------------------|---------------|------------------------------|---------------|
| BIRMINGHAM | EAST CHESHIRE | NORFOLK | TOWER HAMLETS |
| BURY | HARINGEY | NORTH TYNESIDE | WARWICKSHIRE |
| CAMDEN | HAVANT | NOTTINGHAM & NOTTINGHAMSHIRE | WESTMINSTER |
| COVENTRY | HOUNSLOW | OLDHAM | WIGAN |
| DEVON | KINGSTON | SANDWELL | |
| DURHAM & DARLINGTON | KENT & MEDWAY | SOUTH TYNESIDE | |
| EAST SUFFOLK | MERTON | STOCKPORT | |



5. Methodological issues

5.1 Definitions

Change resistant drinkers

Based on the Blue Light project, change resistant drinkers refers to people who:

- have an enduring pattern of problem drinking;
- demonstrate a pattern of not engaging with or benefiting from alcohol treatment, despite being referred on more than two occasions; and
- repeatedly use a range of services, at significant cost to the public purse.

N.B. The term does not necessarily suggest that the person is choosing not to engage with services. He/she may be unable to access and benefit from alcohol treatment for a range of reasons. This group includes some of the most vulnerable and risky members of the community.

Domestic abuse

The cross-government definition uses the term 'domestic violence' and defines it as: Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse:

- Psychological
- Physical
- Sexual
- Financial
- Emotional ¹²

The Embrace Project comments that: Whatever form it takes, domestic violence is rarely a one-off incident. More usually it's a pattern of abusive and controlling behavior through which the abuser seeks power over the victim. ¹³

5.2 Methodology

In October 2014, Alcohol Concern and AVA wrote to all the local authorities in England asking whether they wanted to financially support, and be part of, a project to develop responses to change resistant drinkers in the context of domestic abuse. Twenty-eight authorities contributed and participated. This positive response was both an example of localism in action - local bodies joining together to solve national problems - and a message about the importance of this issue to local partners.

The first stage of this project was research into the incidence and role of alcohol misuse, and particularly change resistant drinkers, in DHRs. The findings are set out in section 6.

Developmental workshops were run in every participating area. Each of these considered an individual DHR that contained change resistant drinkers and discussed how this aspect of the tragedy could have been better addressed. The Blue Light project manual provided a framework. These workshops engaged around 600 people working in domestic violence, substance misuse, health, criminal justice and housing settings and included a session with domestic homicide review chairs.

The guidance was then developed through a process of peer review. A draft version of the guidance was sent out to all the participants and funders as well as some national stakeholders for comment.

The final guidance document was then turned into a one-day training course that has been run twice in each partner area.

5.3 The DHR report sample

As the first stage, the project team undertook research into the role of alcohol in a sample of publicly available DHR reports. Accessed via a Google search for “domestic homicide review”, the initial sample of DHRs was considered to be acceptably random: DHRs were not initially selected because of the presence or absence of alcohol related harm.

From the original sample, only full reports were included in the analysis. Other reports were excluded for being too heavily redacted to be workable, involving perpetrators under 18 or being dated prior to 2011 when DHRs were made a legal requirement after a domestic violence homicide. This left a total of 39 reports, which are listed in appendix 1. The exact number of DHRs undertaken nationally is not known, but the researchers believe this sample represented 20-30% of the total.

Alcohol is mentioned as a negative issue in 27 (69%) of the 39 reports, and these reports comprised the final chosen sample to be analysed in detail. It is crucial to note at this point that the data presented is only representative of this deliberately selected sample. Furthermore, due to the paucity of research into DHRs more generally, it is not possible to make comparisons between this sample and domestic violence homicides that do not specifically involve a perpetrator and/or victim that is a change resistant drinker.

It is also important to note that the original sample of 39 reports, and thus the final 27 reports, all involved heterosexual couples except for two child-parent homicides. The authors are aware that this is a gap, but can only highlight this as a need for further research. At present, the core guidance is seen as being applicable to all perpetrators and victims, regardless of their sexual orientation.

5.4 DHRs as a source of data

DHRs were introduced to ensure that agencies undertook a process of reviewing their actions relating to the perpetrator and/or victim of a domestic violence homicide. The aim is to enable agencies to change their practices so that the risk of a similar homicide occurring in future is reduced as far as possible. As such, DHRs mainly review individual agency management reports, but can also include information gathered through interviews with the victim’s family and friends as well as the perpetrator.¹⁴

All the data collected is reviewed by a DHR panel, comprising senior managers of the agencies involved, plus representatives from any other relevant organisations and is overseen by an independent chair. The information analysed in this project, therefore, does not come from the original source but has been filtered through the DHR process. Indeed, a key finding of this project has been the varying levels of understanding of domestic abuse and alcohol misuse – and specifically the complex interaction between the two – that DHR panel members hold.

- Thus a recommendation from this project is the need for people involved in DHRs to receive training on alcohol-related domestic abuse.

A particular concern to be addressed is the frequency with which victims of domestic abuse who use alcohol problematically are viewed negatively because of their alcohol use. For example, victims may be seen as causing the abuse that is perpetrated against them due to their own seemingly antisocial behaviour, including their use of violence to defend themselves. Similarly, in the small number of cases where a domestic abuse victim ends up being the perpetrator of the homicide, it is important that the homicide perpetrator’s original victimhood is recognised and remains central throughout the DHR process.

6. The findings

6.1 Acknowledging the role of alcohol in domestic homicide

Alcohol misuse was a central element in (the) domestic abuse but was never effectively tackled. ¹⁵

Alcohol use is a common theme among the initial sample of 39 DHR reports examined, with 27 (69%) featuring varying levels of alcohol related harm. Not all cases involve one or both of the partners having an ongoing alcohol *problem*, however alcohol misuse is commonplace within the sample:

- In 22 reports (56% of the 39) the perpetrator of the homicide is identified as experiencing problems with alcohol.
- In 15 reports (38%) the victim is identified as experiencing problems with alcohol with a possible problem identified in two further reports.
- In 15 reports (38%) both the victim and perpetrator are identified as experiencing problems with alcohol. Every case in which the victim has an alcohol problem, the perpetrator also has a problem.

This data is not a surprise. British Crime Survey data shows that in 2011, 38% of domestic violence incidents involved alcohol. ¹⁶ Similarly, the North Somerset DHR refers to a study of 336 convicted domestic abuse offenders that found 48% of offenders were alcohol dependent (Gilchrist et al, 2003)¹⁷, although it is not clear from the report how alcohol dependence was measured.

It is clear that in eight of the homicides, the victim, perpetrator or both were intoxicated at the time of the homicide. It is highly likely that there were more cases of intoxication, however this information is not included in all of the DHR reports as information on how alcohol contributed to the actual homicide is limited. A number of technical factors contribute to this:

- the homicide was not discovered for some time; or
- the perpetrator was not arrested until a later date.

Both hinder an understanding of the immediate circumstances. Perhaps more crucially, following Home Office guidance, many DHR chairs have focused the reviews on how services managed the involved individuals in the lead up to the homicide and not on the circumstances of the killing itself.

- While little would be gained by understanding the mechanism of the death, information on how the interaction of two (or more) people led to the homicide could be useful in developing risk assessment and safety planning. This issue was discussed in the workshops and the consensus was generally surprise that this did not already happen and a recognition that such a focus would be useful.

6.2 Non-engagement with alcohol services

This report differs from previous guidance on domestic abuse and alcohol misuse in emphasising the role of change resistant drinkers. A clear pattern of an alcohol problem being identified, a referral being made, but the person not taking up the offer emerges from the reports reviewed:

- On 8th September 2010 Elizabeth made contact with (an alcohol service)...She was offered an initial assessment appointment...which she did not attend. ¹⁸
- Their abuse of alcohol was a significant risk factor, yet there is no evidence that it was being tackled. No other agency tried to engage Male A with addressing his misuse of alcohol. ¹⁹
- Adult A was referred to a local substance misuse initiative however she failed to attend and also failed to return to see her GP in a month as advised at the time of referral. ²⁰

- MP entered a phase of disruptive behaviour: not attending appointments with his probation officer or at the alcohol or drug services; and attending at the A&E in an inebriated and “high” state. ²¹
- Female 1 received treatment for her conditions with varying degrees of success. Male 1 never effectively engaged with services and consequently his dependency on alcohol over-shadowed all else in his life. ²²
- A number of services were available to assist the couple to address their alcohol dependency and their abusive relationship. However, neither party were motivated to access these services or engage with them in a meaningful way. ²³

The DHR review found that:

- In only 8 of the 22 DHRs (36%) where the perpetrator had a problem with alcohol was a referral made to a specialist alcohol service.
- Of the 15 cases where the victim drank problematically, in ten (67%) a referral to a specialist alcohol service was made.

In each case a referral was made on one or two occasions.

The more crucial question in relation to identifying change resistant drinkers is whether the client had difficulty in maintaining engagement with specialist alcohol services. Again, this project found a distinct pattern:

- In six of the eight cases (75%) where the perpetrator was referred to specialist alcohol services the perpetrator had a pattern of non-engagement.
- In eight of the ten (80%) relevant cases the victim had a pattern of non-engagement with specialist services.

This pattern is not surprising. At any one time the vast majority of problem drinkers are not engaged in services or even a process of change. Public Health England has suggested that at any one time 75% of dependent drinkers are not engaged with services. ²⁴

What the DHR reports highlight, however, is a lack of general understanding of how perpetrating or experiencing domestic abuse may be a factor in someone being a change resistant drinker, i.e. struggling to engage with or benefit from an alcohol treatment service.

The Blue Light project guidance on change resistant drinkers ²⁵ discusses a large number of factors that might act as a barrier to people engaging with alcohol services. A number of these factors may be particularly pertinent in cases involving domestic abuse e.g.:

- Peers or family members are subverting efforts to change - perpetrators may simply not allow the victim to attend alcohol treatment.
- Lack of belief in the ability to change - this again could be directly undermined by a perpetrator.
- Victims may also be living with anxiety or depression, which may affect their ability to engage with services. ²⁷

Being a perpetrator may also contribute to someone’s resistance to change. For example, a perpetrator may:

- be reluctant to address alcohol consumption as it is used as an excuse for abusive behaviour;
- practice-based evidence suggests some perpetrators may experience negative feelings about themselves as a result of their abusive behaviour. Alcohol may be used as a mean to cope with these feelings.

Thus it is critical that alcohol services screen for domestic abuse and vice versa. Neither issue can be wholly addressed unless the accompanying abuse or alcohol misuse is taken into consideration. Furthermore, in cases where both domestic abuse and alcohol misuse are present, professionals should be alert to how this might affect their ability to engage with services and should seek out strategies to actively pursue engagement with both the victim and perpetrator. As the Wiltshire DHR says: *If a violent client consistently fails to engage, agencies should always explore any possible alternative action that may be necessary to manage the risk rather than closing the case.* ²⁶

To address alcohol’s role in domestic abuse, commissioners and providers need to allow for more flexibility in services, particularly to overcome the challenge of encouraging and enabling change resistant drinkers

into support and treatment. A clear example of the lack of flexibility in existing services was highlighted in the County Durham DHR:

On the 7th February 2005, Adult A attended her GP and reported that she was still drinking 'over one bottle of vodka a night', was still suffering with depression and had 'issues of DV and husband having an affair'(sic). A further referral was made to the substance misuse service and it was also noted that she specifically wished for the support of a female counsellor and to be seen at home when the children were not present. However despite these requests she did not attend the misuse service and was discharged on the 31st March 2005. The overview notes that the seeking of services and disclosures made by Adult A were made in what appears to be a 'cry for support'. In this case the failure to engage further by Adult A was at the core of the closure without any additional follow up to her by any of the agencies. (p.22)

If a client requests a female worker and to be seen at home, it is of course highly unlikely that she will attend an appointment at the service with a worker who may or may not be a woman. In such cases, screening effectively for domestic abuse at referral and initial assessment as well as being able to meet such requests may potentially go some way to engaging a particularly hard to reach group of problem drinkers.

6.3 The complex relationship between alcohol misuse and domestic abuse

The primary lesson... is the need for professionals to recognise when they are faced with a complex problem involving domestic violence and alcohol dependency and plan accordingly; both of these elements were missing in this case.²⁷

Many of the DHRs highlight the role of alcohol:

- Adult B...had difficulties with excessive use of alcohol which frequently resulted in violent incidents.²⁸
- Male A was arrested and admitted he had fallen downstairs and could not recall saying he had been pushed. He confirmed the volume of alcohol they had consumed and recalled the argument saying that Female A attacked him and he may have punched her.²⁹
- Risk was thought to be greatest when the offender was failing to cope with emotional problems and whilst under the influence of alcohol.³⁰

These examples and the statistics in section 6.1 demonstrate the existence of a relationship between alcohol and domestic abuse. It is by no means a simple relationship, as there is not a direct causal link.³¹ For example:

- Victims may be using alcohol as a means of coping with the abuse. One DHR comments that: "...women exposed to Domestic Abuse suffer a loss of confidence, depression, feelings of degradation, problems with sleep and increased isolation, and use medication and alcohol more frequently."³²
- The DHRs also confirm other evidence that victims are more likely to use violence to defend themselves, or in retaliation, when they have been drinking. This will make it hard for agencies to discern who is the perpetrator and who is the victim.

Alongside the DHRs, other evidence exists that alcohol use can increase the severity and frequency of abuse by a perpetrator. Gilchrist et al.Home Office Findings, researching the characteristics of domestic violence offenders, found that 73% of perpetrators had been drinking at the time of the assault. North American studies have also found increased rates of violence after the perpetrator has been drinking. Finally, a number of studies have found that the perpetrators' use of alcohol, particularly heavy drinking, was likely to result in more serious injury to their partners than if they had been sober. In a recent study by Hester of domestic violence incidents reported to Northumbria police, it was found that men's violence was far more severe than women's and that perpetration of abuse usually included alcohol, particularly among men.³³

6.4 Working with couples that drink

A number of the DHRs identified couples where both partners used alcohol.

- The relationship appears to have been volatile, and the use of alcohol was a feature. ³⁴
- The relationship between Christopher and Elizabeth had always been affected by alcohol and violence. ³⁵
- On 19 May 2010, Surrey Police received a call from Adult A stating that Adult B had hit him following an argument about the cat and the amount of alcohol they had consumed that day. The police attended their home address and found both Adult A and Adult B heavily drunk. ³⁶
- The relationship between MS and AF1 was at times volatile and violent with alcohol misuse acting as an aggravating factor in disputes and other offences. ³⁷
- Alcohol misuse appears to be a strong characteristic of Adult A & B's life... concerns of excessive alcohol consumption by both of them were frequently highlighted... There are frequent references to the excessive consumption of alcohol and when incidents appear to be triggered following consumption by one or both adults. ³⁸
- Both FL and KT were known to be chronic misusers of alcohol. ³⁹
- X and Y are said to have had frequent arguments which occurred particularly when the couple had been drinking. ⁴⁰
- When officers arrived, Mr A stated he wanted Mary out and she was refusing to leave. Both Mary and Mr A were under the influence of alcohol. ⁴¹
- Male 1's drinking escalated and Female 1 increasingly resorted to alcohol to provide a sanctuary from his abusive behaviour. ⁴²

Alcohol misuse by both parties increases the level of risk and may mean agencies focus on the alcohol and do not recognise that the victim is drinking to cope with the abuse. In particular, alcohol use by both people in a relationship can increase the likelihood of professionals being faced with cases of so-called bidirectional violence: both parties using violence. ⁴³

In such situations, it can be difficult to discern between the victim and the perpetrator. Research has found that in most cases of bidirectional violence, there often remains a power imbalance. There is still a perpetrator as well as a victim using violence, or a primary and secondary perpetrator. ⁴⁴

Good practice recommends that, wherever possible, practitioners determine who is the primary aggressor in order to make appropriate referrals. ⁴⁵ Where alcohol is involved, this is more problematic.

- Hester (2006), for example, has investigated domestic violence perpetration and noted that with drinking couples the police are more likely to arrest both parties and view them as dual perpetrators, even when only one person was recorded as actually being abusive. ⁴⁶
- Hester also found evidence that in cases of alcohol-related domestic abuse – which included the cases with the most repeat incidents and the most chaotic behaviour – officers rarely did more than remove the perpetrator for a short time. Only occasionally were perpetrators referred to alcohol services. This may be indicative of a similar attitude highlighted in this project, whereby the police particularly viewed the violence as almost to be expected when dealing with couples that drink, as well as something they might feel unable to intervene in effectively.
- It makes it hard for professionals to grasp the dynamics of the situation and properly risk assess. Without appropriate identification and assessment the perpetrator of domestic violence may end up as the victim of the homicide.

Addressing the normalisation of violence within drinking couples is critical in reducing the risk of harm to all involved and should be included in any training on alcohol-related domestic abuse.

6.5 Gender

Domestic abuse is a gendered problem. The Crime Survey of England and Wales has repeatedly demonstrated that more women than men are victimised in this way. In some data the number of women and men experiencing domestic abuse can appear to be similar; however, the reality is very different. Women, for example, make up 89% of the victims that report four or more incidents and are more likely to have injuries that require medical attention than men.⁴⁷

Similarly, domestic homicides are gendered, with the majority of victims being women.⁴⁸ Around 120 women and 30 men are killed annually as a result of domestic violence – that is around 50 per cent of all murders of women and 8 per cent of all murders of men.⁴⁹

Ingala Smith (2015) breaks this down further. Using data on homicides of partners / ex-partners from the Office of National Statistics (ONS) from 2011 to 2014 it was found that:

- 249 women and 57 men were killed in partner / ex-partner homicides.
- Of the men, 21 were killed by other men and 14 were killed by a lover's spouse / love rival.
- Of the 249 women, 247 were killed by men, one by a woman and one unknown: none of the female victims of partner/ex-partner homicide were killed by the spouse of their lover or an emotional rival.⁵⁰

Thus, over three years 22 women killed men who were intimate partners or ex-partners.

The DHR review found that a slightly higher than expected proportion of the killings were committed by a woman:

- of the 27 cases involving problematic alcohol use, around two-thirds were women killed by men and one-third men killed by women.

It is difficult to make direct comparisons between the ONS and DHR data because recording methods for what constitutes a domestic violence homicide varies between the two. However, in the majority of cases of female to male killings (six out of nine) within the DHRs, the woman had been a long-term victim of domestic violence.⁵¹

It is, however, noteworthy that in all the cases of female to male killings in the reviews, alcohol was involved for both parties. Due to the small sample used in this project, as well as the fact that there is no comparative data for domestic homicides committed by women that do not involve alcohol, it is impossible to draw any definitive conclusions about this finding at this stage. Rather, further research into the role of alcohol in women's use of fatal violence is clearly needed.

6.6 Risk assessment

A key finding of this project is that alcohol-related domestic abuse, particularly in cases where both the perpetrator and victim are change resistant drinkers, can create a context in which fatal violence is more likely, and yet appears to be particularly difficult to prevent.

In order to tackle alcohol-related domestic abuse it is vital that professionals have a clear understanding about the interaction between both issues, how it may increase the risk of harm, and finally how to identify and manage the risk.

- The view from the workshops, however, was that risk assessment systems do not adequately reflect the importance of alcohol.

The key tool is *The Domestic Abuse Stalking Honour Based Violence Risk Identification Checklist (DASH)* (see appendix 3). This is a risk-screening tool used by the police and other agencies to identify the risk to a victim of domestic abuse. It has the following question about alcohol:-

21. Has (the perpetrator) had problems in the past year with drugs (prescription or other), alcohol or mental health leading to problems in leading a normal life?

Workshop participants commonly felt that this question does not do justice to the potential significance of alcohol problems in domestic abuse. Similarly, the DHR reports suggest that failure to take medication, even psychoactive medication, is not an equivalent risk factor to the presence of alcohol.

Domestic violence situations are then graded via the DASH tool as:

- Standard – Current evidence does not indicate likelihood of causing serious harm.
- Medium – There are identifiable indicators of risk of serious harm. The offender has the potential to cause serious harm but is unlikely to do so unless there is a change in circumstances, for example, failure to take medication, loss of accommodation, relationship breakdown, and drug or alcohol misuse.
- High – There are identifiable indicators of risk of serious harm. The potential event could happen at any time and the impact would be serious.^{52 53}

In Kent DHR FL/2011 a heavily drinking couple with extensive histories of violence were graded as “medium risk” by local services. Concern was commonly expressed in the workshops that situations graded as medium risk seemed to be those where the more serious violence ended up occurring. This could be because the high-risk cases are better managed but it does raise the question of whether alcohol should be specifically included in the higher level of risk category.

This was not the only concern expressed about the state of risk assessment. It was suggested that:

- Too many risk *assessment* systems are actually no more than risk *screening* processes. Risk screening is a simple, perhaps tick box, process involving the worker and the client at a particular point in time. These processes, e.g. the DASH tool, are very necessary to provide an immediate picture of the risk, but should be distinguished from risk assessment. Risk assessment is a longer term and more inquisitive process that builds up a picture of the risk using a range of information and is developed over, perhaps, three to four weeks. The level of risk posed by many problem drinkers requires both risk screening and risk assessment.
- In risk screening, questions about alcohol use should be more sophisticated. The case below highlights the danger of confused messages: The assessment noted, “*Female A stated problem with alcohol misuse in 2009 drinking daily, stayed with sister – not drunk since*”. The DHR Panel was unsure whether “not drunk since” referred to abstinence or tolerance. In either event it was misleading given that Female A acknowledged on many occasions that “they had been out drinking” and...noted she was drunk on more than one occasion.

The social instability associated with drinking also means that apparently simple questions such as “are you currently in a relationship?” or “where do you live?”, are less likely to have clear cut answers. For example, in Rochdale male 1 the couple were divorced 30 years before the homicide but a relationship continued because of their children and then grandchildren. Yet if asked “are you in a relationship?”, the ex-wife may have said no, and the risk would have been obscured.⁵⁵

6.7 What is an ‘alcohol problem’?

Concern was expressed in the developmental workshops that many professionals believe that the term alcohol problem denotes the traditional image of the alcoholic. Such a belief will hinder identification and referral. People drinking at home with their partners of an evening may not fit the stereotype of the isolated, chaotic and dependent drinker.

The DHRs demonstrate the pervasive nature of that image of the problem drinker on the part of both clients and workers:

- *Christopher stated that he was not an alcoholic as he never drank before midday.*⁵⁶
- *The...report noted that ‘Mr A did not declare any dependency on alcohol but described “binge type” drinking; he also stated he was “clean” referring to being drug free’. However, it is noted that Mr A was at this time subject to an alcohol treatment requirement as part of his probation order.*⁵⁷
- *The Alcohol Liaison Team made an assessment: MP admitted to drinking 2 litres of cider a day, which he did not consider problematic although his behaviour became uncontrollable when he was drinking and caused relationship problems.*⁵⁸

It is vital in the context of domestic abuse that inappropriate understandings of what is an alcohol problem do not impede intervention. If workers are only looking for people who match a particular stereotype the risk associated with other patterns of problematic alcohol use will be undervalued. The key question for workers is not “Is this person an alcoholic or have an alcohol problem?” Instead the focus should be, “Is this person’s drinking causing a problem in the context of his or her life?”

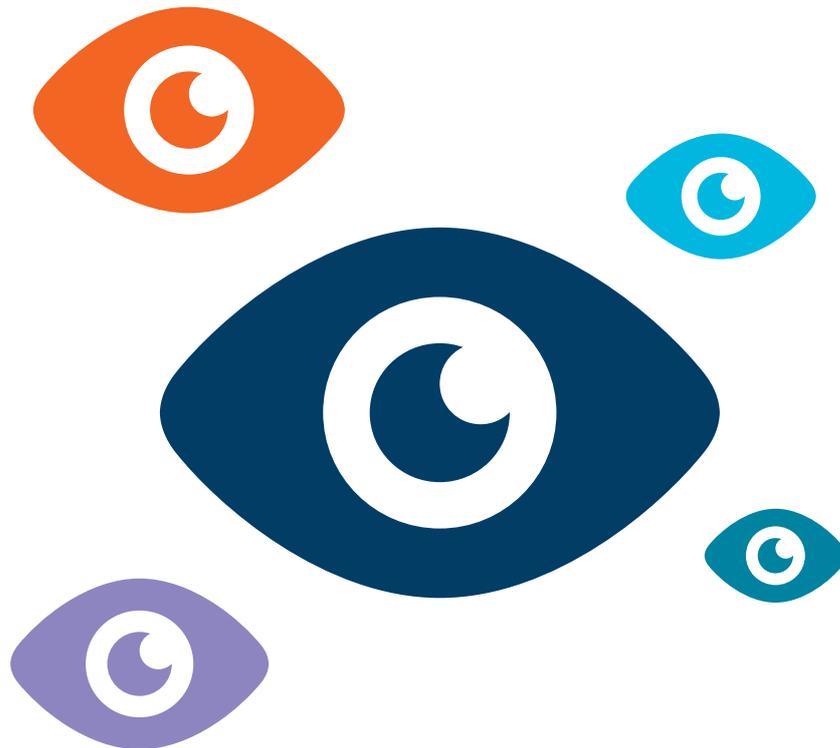
If it is, action needs to be taken. Guidance on current definitions can be found on the [Alcohol Learning Centre website](#).⁵⁹

6.8 Addressing trauma and alcohol use

The use of alcohol and other drugs is widely understood to be a means of coping with traumatic life experiences.⁶⁰ The research did not systematically analyse this data for evidence of childhood trauma. However, it was noted in several cases that, following trauma, individuals started drinking heavily from as young as 13 years old. During the workshops frontline workers highlighted their awareness of the traumatic life experiences of many individuals that they supported.⁶¹

Domestic abuse is highly traumatic, and is a leading cause of depression and anxiety among women.⁶² Domestic violence is not simply about physical assaults but also a pattern of control and degradation which, over time, result in complex trauma, anxiety and depression.⁶³

- Many of the people in the DHRs, both perpetrators and victims, have lived lives characterised by trauma. This needs to be considered by services that aim to work with a change resistant drinker. If the alcohol is being used to manage distressing thoughts and feelings, for example, other coping strategies will be required.⁶⁴

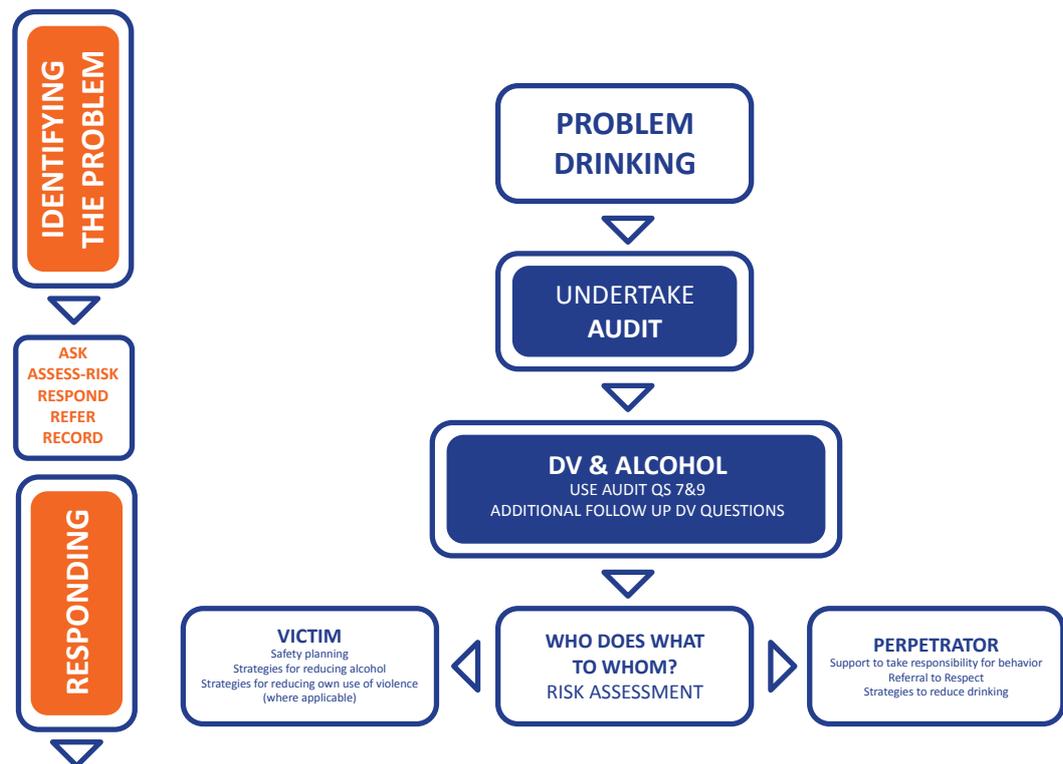


THE GUIDANCE

7. Introduction

The aim of this guidance is to create a baseline of good practice for those supporting clients that are understood to be change resistant drinkers and who are perpetrating or experiencing domestic violence.

A model for identifying the problem and responding to it is below



This model assumes the starting point is the identification of an individual's problematic alcohol use. However, in cases where a person's experience of perpetrating domestic abuse or being a victim is identified first, it is recommended that a full assessment is completed including using the AUDIT and then the above model should be followed.

In order to support professionals to implement this model, the following sections provide guidance about:

- identifying if someone is using alcohol problematically;
- identifying if someone is perpetrating or experiencing domestic violence;
- how to engage both perpetrators and victims that are change resistant drinkers;
- reducing the risk of harm where possible in cases where both issues are present; and
- what specialist and non-specialist agencies can do to improve their practice.

8. Assessment, identification and brief advice: alcohol

8.1 Alcohol screening - the AUDIT tool

The workshops around the country suggested many professionals are uncertain how to screen for problematic alcohol use, and very few domestic abuse workers are using a specific tool but rather tend to generically ask if someone has a drug or alcohol problem.

This is a clear gap, and one that is easily addressed as the starting point for assessing a person's use of alcohol is the AUDIT tool. This is advocated by NICE as the "gold standard" in alcohol screening.⁶⁵ It is a simple tool that can be readily used by any professional, including those working in domestic abuse services. The tool is included in appendix 2.

DHRs specifically reference this tool:

- *When excessive alcohol intake is identified or suspected an assessment of alcohol dependence using a recommended tool e.g. AUDIT-C, should be undertaken and an appropriate referral made to specialist alcohol services dependent on the results.*⁶⁶
- *The use of a self - assessment tool for patients attending the A&E in order to...raise awareness of excessive alcohol use...is seen as a positive step.*⁶⁷

Importantly the AUDIT tool can be used to start a conversation about domestic abuse, specifically in relation to being a perpetrator. Three questions can facilitate this:

- How often during the last year have you had a feeling of guilt or remorse after drinking?
- Have you or somebody else been injured as a result of your drinking?
- Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?

These can be enhanced by linking to the questions in section 9.

Local authorities may be able to provide free training on using the AUDIT tool. Alternatively, substance misuse and domestic violence agencies could arrange a training exchange that includes how to administer the AUDIT.

However, simply screening, may not be enough. The DHRs highlighted widespread minimisation by both victims and perpetrators of their alcohol problems, experiences of violence and/or perpetration of abuse. For example:

- *Elizabeth gave misleading information such as having no alcohol and drugs problems.*⁶⁸
- *He also minimised the level of his alcohol consumption.*⁶⁹

The DHRs emphasise the need for workers to be curious about many aspects of their clients' lives, including the impact of alcohol.

- *...GP2...in response to a question concerning Adult A's excessive use of alcohol stated "if a patient doesn't tell you about a problem again you would presume it has gone away". It is essential to ensure that practitioners deal with facts as opposed to presumption and it is rare that problems such as alcoholism simply go away without some identification of how or indeed why. The simple matter is if a question isn't asked an answer is unlikely to be forthcoming and again is an example of how curious professionals need to be at all times.*⁷⁰
- *Adult B minimised alcohol use during assessment and it would appear that he was not open about his level of use. Alcohol was therefore not identified as a priority supervision objective. The offences all contain reference to the impact of alcohol on violent incidents. It is, therefore, surprising that this was not addressed and there was not more curiosity.*⁷¹

Where someone reports drinking a relatively low level of alcohol, workers may need to ask supplementary questions which attempt to substantiate initial reports of the amount consumed e.g. by asking about:

- the amount drunk in the last few days;
- the type of drink consumed;
- where the alcohol is bought and how frequently;
- the situations in which it is drunk.

By simply asking a single initial question about alcohol, especially a closed question that allows a simple “no”, the worker is not giving the client time to begin to feel comfortable with talking about the drinking and to open up.

Given the frequency with which alcohol features in domestic violence, workers particularly need to be curious and facilitate clients opening up about their drinking. Equally, professionals should use the example questions in section 9.1 to enable victims and perpetrators to talk their experiences being abused/abusive.

8.2 Brief Advice

...(the) alcohol counselling and support agency... provided training on alcohol identification and brief advice to specialist domestic abuse workers. ⁷²

Following the use of the AUDIT tool, NICE advocates the use of Brief Advice, i.e. people should be given feedback about their AUDIT score and brief advice about their drinking. ⁷³ This can be:

- A sentence or two of feedback about his/her drinking based on the AUDIT score and the person’s circumstances;
- A sentence or two of feedback plus an information leaflet;
- Five minutes of advice based on the FRAMES structure (see below).

This approach is primarily aimed at pre-dependent drinkers (8-19 AUDIT score). The majority of these at risk drinkers can benefit from simple, brief advice delivered by professionals without a specialism in alcohol misuse.

This is not wishful thinking. The World Health Organisation and the Department of Health have both acknowledged that over 50, peer reviewed, academic studies demonstrate that Identification and Brief Advice (IBA) is both effective and cost-effective in reducing the risks associated with drinking. On average 1 in 8 drinkers who receive this type of support from a healthcare professional will reduce their drinking to within the lower risk guidelines. ^{74 75 76} This may be an underestimate of the benefits. Some drinkers will make reductions but not to within lower risk levels. On average, following intervention, individuals reduced their drinking by 15%.⁷⁷ A recent study has demonstrated that even a sentence or two of feedback based on the AUDIT score can be beneficial. ⁷⁸

Identification using AUDIT, followed by brief advice is effective. It is also quick and easy to do. Ensuring that all professionals are using these tools as part of their daily work will improve the lives of thousands of people, reduce costs to society and ultimately ease the burden on the workers who deliver the IBA.

FRAMES is an evidence-based structure for the delivery of brief advice. It suggests that along with basic information about alcohol, the client could be given brief advice covering:

Feedback: Structured and personalised Feedback on risk and harm. “The score shows that your drinking might be putting you at risk of harm.” “Drinking at this level puts you at increased risk of accidents and health problems.”

Responsibility: Emphasis on the client’s personal Responsibility for change. “Only you can decide if you want to make some changes.” “What do you think you might like to change about your drinking?”

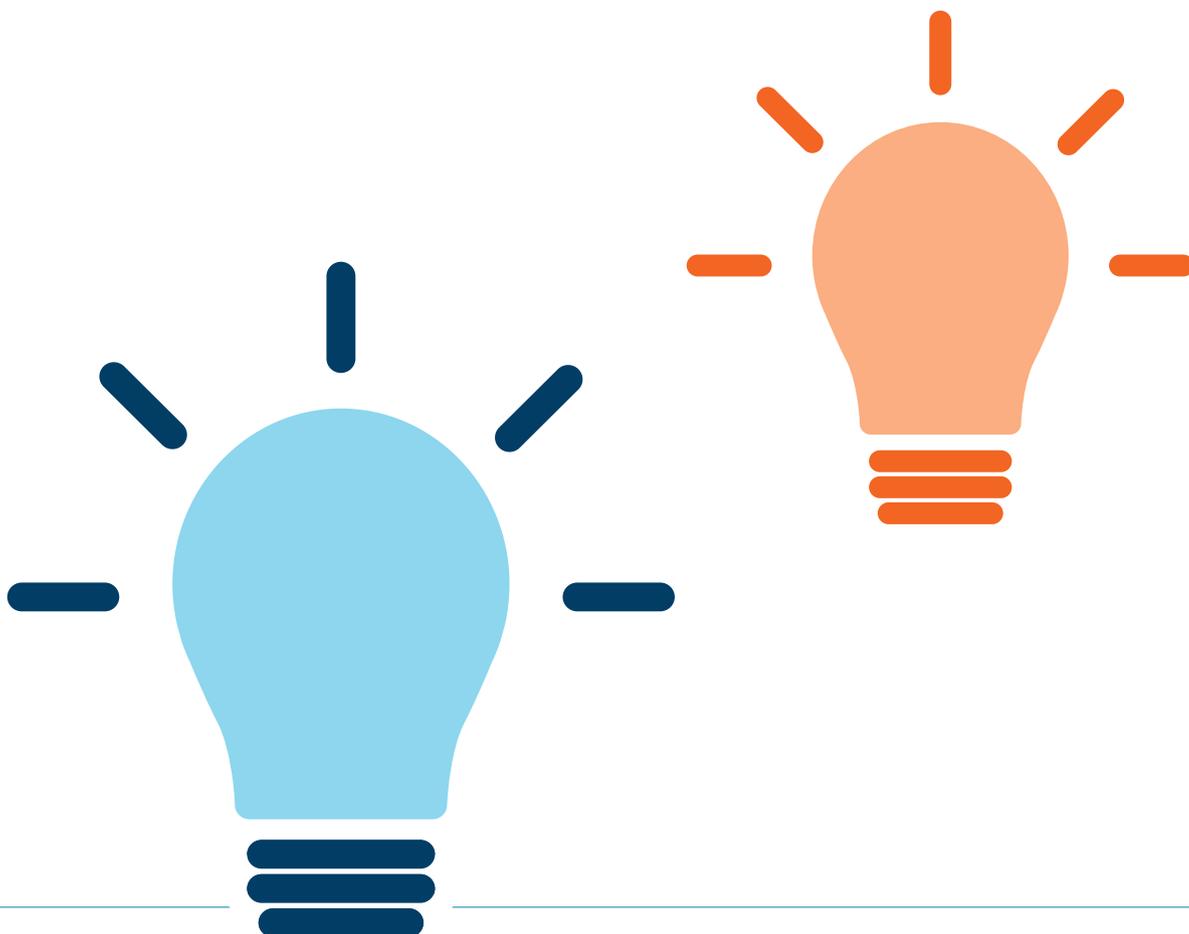
Advice: Advice to the client to make a change in drinking. “Try to have at least one day off alcohol a week, you’ll notice the difference.” “You’ll feel a lot better if you cut down the amount you drink.”

Menu of options: A Menu of alternative strategies for making a change. “There are some suggestions in this leaflet, which of these would work for you?” “You could try switching to a lower strength alcohol, or having fewer drinks when you do drink.”

Empathy: An Empathic and non-judgmental approach. “What are the pros and cons of your drinking at the moment?” “I know when you’re stressed alcohol can seem like a handy pick-me-up.”

Self-efficacy: An attempt to increase the client’s Self-efficacy or confidence in being able to change behaviour. “I’m sure you can do this once you put your mind to it.” “How confident are you that you can make these changes?”

In relation to domestic abuse, if someone does disclose problematic alcohol use, further questions about any experiences or perpetration of abuse should follow the IBA. Details on how to approach this subject are set out in section 9.



In responding to perpetrators who also use alcohol, the key message is that **addressing their alcohol use will not simply stop the abuse**. The reasons for this are set out below in an excerpt from the Stella Project's *Complicated Matters toolkit*.

Rather than the physiological effects of alcohol (or other substances) causing someone to be violent solely when intoxicated, survivors consistently report experiencing violence and abuse from their partner when he has not been drinking. Women also report that even when their partners have seemed “uncontrollably drunk” during a physical assault they routinely exhibit the ability to stop the abuse when there is an outside intervention, e.g. children, police. Substance use is therefore better understood as a ‘disinhibitor’ which gives a perpetrator the belief that they will not be held accountable or responsible for their behaviour.

In addressing perpetrators who use or drink problematically, it is therefore not sufficient to only address their substance use.

Even if alcohol or drug treatment is able to reduce the severity of the violence, it will not address the many social and cultural factors such as perpetrator’s sense of entitlement and attitudes towards women nor the complex dynamics of power and control that underpin domestic violence. Therefore, work that specifically addresses these issues – ideally conducted by appropriately trained staff within the setting of a perpetrator programme – should always accompany a treatment plan. (p.190-191)

Not viewing the perpetrator as the victim of something else, such as their substance use, that causes them to be violent is a key aspect of avoiding collusion. Other ways professionals can avoid colluding with a perpetrator are:

- Inappropriately nodding/smiling as part of active listening.
- Minimising the abuse with words such as ‘just’ and ‘only’. For example, when reflecting back saying “So you just lost it?” or “It was just this once” – particularly if you do not further investigate what happened.
- Copying words that support the excuses, e.g. “When your partner kept going on at you, what did you do?”.
- Accepting the perpetrator’s account without further investigation/exploration.
- Maintaining confidentiality for the perpetrator.
- Providing the perpetrator with information that may put the survivor at risk.
- Being aware that displaying unconditional positive regard for an abusive client may be understood by a perpetrator as support for the behaviour.

9.3 How to screen who does what to whom – bidirectional violence

As previously highlighted, domestic abuse frequently occurs when both parties in a relationship drink problematically and in some cases the abuse then becomes ‘bidirectional’, i.e. both partners use violence. In such cases, it can be hard to discern what is happening in that relationship.

In these circumstances, it is important to remember that domestic violence is a pattern of behaviour comprising various forms of controlling behaviour and not just an individual event.

In most situations, violence and abuse are not perpetrated equally by both parties:

- In some cases, you will be working with a perpetrator and a survivor that uses violence, and
- In others, there will be a so- called primary and a secondary aggressor.

Good practice recommends that, wherever possible, practitioners determine who is the primary aggressor in order to make appropriate referrals.⁷⁹

In assessing mutual allegations of domestic violence, practitioners trained in this field will take into consideration:

- **Context, Intent and Effect.** For example, did the person use violence to induce fear or to protect themselves? And what effect did the violence have?

- **Agency**. i.e. ability to make decisions for oneself. In the context of an abusive relationship, the survivor is less likely to be able to make decisions for themselves and/or the perpetrator will always make the final decision in their own favour.
- **Empathy**. Survivors of domestic violence will empathise with their partner, whilst perpetrators are less likely to empathise and may minimise their partner's feelings.
- **Entitlement**. Linked to a lack of empathy, a sense of entitlement allows someone to assert their will over others (in particular, their partner). This may include particular attitudes towards roles within a relationship or family.
- **Fear**. If someone is in fear of their partner this is a good indication of an abusive relationship. Fear may be expressed verbally or could be evident in terms of behaviour.⁸⁰

In many cases, however, practitioners will not have sufficient information about both parties, nor the dynamics within the relationship to be able to reliably determine the direction of abuse.

When unsure who is the perpetrator and the survivor, or whether they are both perpetrators, it is advisable to contact the national Respect Phonenumber (0808 802 4040) to clarify dynamics in the relationship.

Alternatively, give the number of the Respect Phonenumber to both parties. Staff at Respect are trained to screen all calls to identify perpetrators and survivors; this is in recognition of the fact that many women (and some men) who contact the service with concerns about their own behaviour are more often survivors who use violence as a form of resistance.

10. Working with change resistant drinkers

This guide has shown that many incidents of alcohol-related domestic violence involve people who are change resistant. This is important because it will dictate how services are developed. The sections above have highlighted how workers and services need to adjust their response to meet the needs of this group.

Workers will need skills and techniques to use when faced with a change resistant drinker. Checklist 1 below summarises the approaches in a single table but the full description of these various approaches has already been set out in the Blue Light manual, which is available at:

The one thing you can do more than any other is to demonstrate that you believe the person can change. Promoting self-belief is crucial. You will help them believe they can change if you demonstrate that belief yourself.

At times this will be tough – some clients seem set on a course that will destroy their lives or the lives of others. However, people do change. Even people who seem to have abandoned all hope of a different life can turn themselves around.

If we do not demonstrate a belief in the possibility of change then we will reinforce a sense of hopelessness in clients. (p.17)

www.alcoholconcern.org.uk/wp-content/uploads/2015/01/Alcohol-Concern-Blue-Light-Project-Manual.pdf

This guidance will, however, repeat what was described as *the most important message* in the *Blue Light* manual, i.e. the vital need to retain a positive attitude.

Workers in all services, including substance misuse and domestic violence services, need to be familiar with the techniques set out in the Blue Light manual. It will be important to:

- Ensure the manual is available to all staff;
- Roll out training in working with change resistant drinkers across domestic violence services;
- Encourage a belief in the importance of tackling change resistant drinkers;
- Encourage a belief that action is possible change resistant drinkers.

CHECKLIST 1

| TECHNIQUES FOR WORKING WITH CHANGE RESISTANT DRINKERS AFFECTED BY DOMESTIC ABUSE THIS NEEDS TO BE READ IN CONJUNCTION WITH THE BLUE LIGHT MANUAL, WHICH SETS OUT DETAILS OF EACH STEP IN THIS PATHWAY. | |
|---|---|
| 1 | Has the client been screened with the AUDIT tool, which identifies who is at risk of alcohol related harm and have those scoring 8-19 been given "brief advice"? |
| 2 | Have people scoring 20+ on AUDIT been referred to alcohol services (or have they been placed on an Alcohol Treatment Requirement if on Probation). Has referral also been considered for those scoring 8-19 on AUDIT who are experiencing difficulties in making changes? |
| 3 | Has someone assessed the client to identify barriers to change and engagement? Are there reasons why this person will find it difficult to change? These could include low self-esteem, mental health problems, or in the case of domestic abuse the perpetrator may directly or indirectly sabotage attempts to access support. |
| 4 | Has someone undertaken a risk assessment that adequately reflects the seriousness and dynamic nature of the risk associated with problem drinking in the context of domestic violence? |
| 5 | Have motivational interventions or a motivational interviewing approach been used with the person? |
| 6 | Has the client been asked about any experiences of trauma in their life that may make them reluctant to engage or struggle to address their alcohol use? |
| 7 | If client is identified as a perpetrator, are they encouraged to engage with the service but also held accountable for any abusive behaviour? |
| 8 | Has the client been offered on-going enhanced personalised education, i.e. highlighting the very specific risks that they run due to alcohol? |
| 10 | Have efforts been made to promote self-efficacy, i.e. encouraging the client to believe that change is possible? |
| 11 | Have efforts been made to involve family members, significant others or relevant carers, where appropriate, in care planning? |
| 12 | Has contingency management been used, i.e. incentivising engagement with treatment through the offer of food vouchers, or other small incentives? |
| 13 | Have efforts been made to reduce any potential harms to the client or other people due to the drinking e.g. ensuring a smoke alarm is fitted, thinking about trip hazards in the home? |
| 14 | Does the client have a dual diagnosis of an alcohol problem and a mental disorder and are they receiving adequate input for their mental health condition? |
| 15 | Has a single care coordinator been identified to manage and coordinate the care? |
| 16 | If the client shows motivation to change have arrangements been put in place to enable a fast track into care? |
| 17 | Have assertive outreach or peer support approaches been used? |
| 18 | Has consideration been given to whether anything is supporting the drinking, e.g. is a family member buying alcohol? |
| 19 | Are there legal powers that can be used to contain the drinking e.g. civil injunctions? |

11. Risk

11.1 Risk assessment

It is clear that agencies must consider the effect of substance misuse on the perpetrator and families in DV cases with a view to understanding the dynamics and possible indicators of abusive behaviour.⁸¹

Risk in relation to alcohol-related domestic abuse is primarily assessed using the DASH (Domestic Abuse Stalking Honour Based Violence Risk Identification Checklist) (see appendix 3). This is a risk-screening tool used by the police and other agencies to identify the risk to a victim of domestic abuse. It can also be used by alcohol services.

As set out above, cases of domestic abuse are then classed as standard, medium or high risk.

- Any disclosure of domestic abuse by a victim warrants discussion of a referral to a specialist domestic abuse service.
- Medium and high-risk cases should be referred to an Independent Domestic Violence Advocacy (IDVA) Service.
- Depending on the local referral protocol, victims in cases that are identified as being high risk may also be referred to the MARAC (Multi-Agency Risk Assessment Conference). At the MARAC, the case will be discussed by a panel of senior representatives from a range of local services and actions identified to reduce the risk of future harm as much as is possible.

If alcohol is identified as being used by either the perpetrator or victim, professionals should consider further questions e.g. using the AUDIT tool (see above); ask about drinking levels, frequency and style; is help being sought for the alcohol use; have there been recent changes in the drinking pattern.

11.2 Dynamic risk assessment

A key point about the risk assessment of problem drinkers generally, and specifically in the context of domestic abuse, is that it needs to be a more dynamic and multi-dimensional process.

If risk assessment focuses on a single person at one point in time it will obscure the real situation. The risk of violence generally with drinkers is context specific and fluctuating. The risk:

- rises with the presence or absence of different people;
- is perhaps more likely at specific times e.g. on days people receive money; and
- may develop and change as the couple grow older.

For example, in relation to the last point, five of the eight cases in which men were killed by their female partners had long term patterns of abuse by the man towards the woman plus some violence the other way. However, over time the male went into physical decline due to alcohol; it is at this point that the woman killed the man.⁸² It is unclear from the DHRs what happened at the point of death - but it does highlight the dynamic nature of risk and workers may need to risk assess couples rather than individuals.

The Jane DHR from Newcastle illustrates another dynamic. Until June 2010 the couple drank in pubs, which “*controlled their drinking to a certain extent due to the cost.*” However, in June 2010 Gary was barred from his local pub (due to a fight about the World Cup). This resulted in the couple drinking in the less controlled home environment, thereby increasing consumption and removing the presence of others. This both increased risk and reduced protective factors for Jane.⁸³

There are also known dynamic and static risk factors relating to perpetrators that professionals should be alert to⁸⁴:

| STATIC (historical factors) | DYNAMIC (changing factors) |
|-----------------------------|-----------------------------------|
| » Previous violence | » Employment |
| » Use of weapons | » Isolation |
| » Strangulation | » Transient living |
| » Sexual assault/rape | » Pregnancy |
| » Drug & alcohol use | » Escalation |
| » Mental health (suicide) | » Separation |
| » Criminal history | » Victims reported levels of fear |
| » Assault when pregnant | » Stalking harassment |

The DHR further highlighted some factors that warrant further investigation as potential risk indicators:

- Drink drive convictions appear to be a common feature of drinkers in the DHRs.⁸⁵
- Problem drinkers who form a relationship in treatment could be at risk if they return to drinking.⁸⁶

Conversely those assessing risk need to be aware of the risk between bruising and alcoholic liver disease. This condition means people bruise easily and may be a confounding factor in some assessments. This may have been the case in the Rochdale male 1 DHR.

11.3 Safety planning

Safety planning is a common feature of working with survivors of domestic abuse. It is used to identify ways to manage the risk of further violence or abuse from others. Safety plans for domestic abuse should cover actions to keep safe in a relationship, at the point of leaving and once a relationship has ended. An example safety plan can be found in appendix 4.

Where a survivor has problems with alcohol, a number of additional factors (see checklist 2) should be taken into consideration and discussed with the victim. The factors may have relevance to themselves or, in part, to the perpetrator. The factors relating to alcohol's disinhibiting effects, for example could relate to both partners; victims should be made aware of how these factors could impact on the perpetrator's behaviour as well their own ability to keep themselves safe (including reducing the risk of them using violence in self defence or retaliation). Professionals working with perpetrators may also want to discuss the relevant points to try to reduce the likelihood of them becoming physically violent.

11.4 Information sharing and multi-agency work

Multi-agency work is vital to addressing a problem such as domestic abuse, and even more so when one or both of the parties involved is a change-resistant drinker. Sharing information between agencies is, however, highly problematic. This was highlighted in the workshops and is a feature of many of the DHRs.⁸⁷ This is not a problem unique either to domestic abuse or alcohol misuse. However, it may be particularly acute in association with problem drinkers:

- Alcohol services have traditionally been close to the health sector. Until recently they were commissioned by the primary care trusts, will often employ health personnel such as nurses and doctors and in some cases will be provided by NHS trusts.
- Problem drinkers are often identified in health setting such as A&E or primary care.

Health services have tended to be those where the sharing of information with other agencies has been the most challenging due to patient confidentiality.

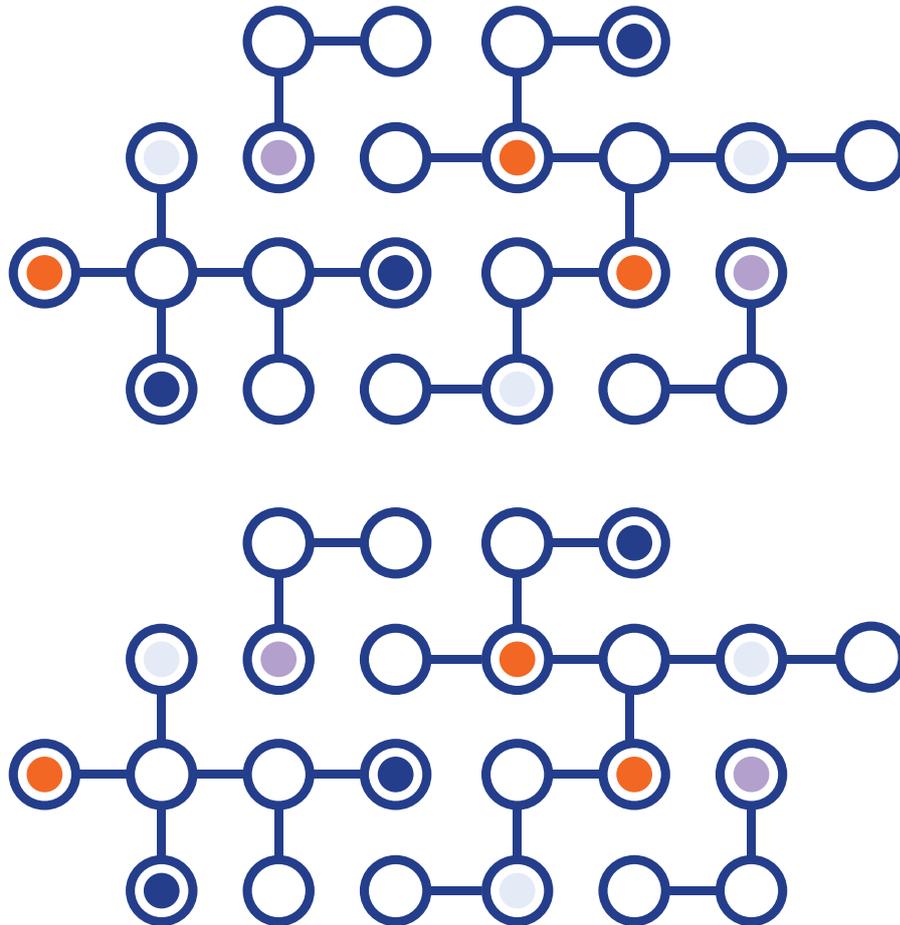
In addition, substance misuse services have often been cautious about confidentiality for fear that the stigma associated with the problem will prevent people seeking help.

However, given the risk involved in domestic abuse, information sharing can be justified under a number of legal frameworks, as set out in checklist 3 below. The comments from the workshops and the examples in the DHRs suggest that information sharing should be constantly under local review and that workers should have good information about when sharing is appropriate.

Good multi-agency work, though, does not only involve information sharing. Agencies can work more collaboratively together, for example, by enabling staff to undertake joint assessments and key working sessions. Such approaches can reduce:

- the number of inappropriate referrals between agencies.
- the number of times someone has to 'tell their story'.
- the number of appointments with and phone calls/letters from professionals to deal with, which can feel overwhelming.
- the time and stress of co-ordinating different professionals.
- the feeling of being "passed from pillar to post" without getting anywhere.
- the likelihood of getting lost in the gaps between services.

Ultimately, this can increase the likelihood of clients being able to engage with one of more services.



CHECKLIST 2

FACTORS TO BE CONSIDERED WHEN SAFETY PLANNING IN CASES OF ALCOHOL - RELATED DOMESTIC ABUSE

Factors which increase alcohol's disinhibiting effects thereby increasing the likelihood or severity of alcohol related domestic violence

- ✓ Changes of level of alcohol use are a key indicator of risk.
- ✓ Perpetrators may drink more to justify and legitimate their violence and this could pose a risk to victims.

It is important not to assume that alcohol causes domestic violence. Rather those that already believe they have a right to control and use violence may be disinhibited when drinking or use it as an excuse. Victims may be disinhibited to violently resist when intoxicated or need to defend themselves from a violent assault. To support with safety planning it may be useful to be aware of factors that may increase levels of intoxication.

- ✓ Low food intake / dieting increases levels of intoxication when drinking.
- ✓ Taking other substances – especially stimulants including caffeinated drinks.
- ✓ Small physical size means the person may become intoxicated more quickly.
- ✓ Hot weather could increase alcohol's disinhibiting impact through dehydration.
- ✓ Returning to drink post pregnancy or after some other period of abstinence could increase the impact on the person.
- ✓ Other prescribed or over the counter drugs could increase disinhibition.
- ✓ Liver decline with age and therefore declining tolerance.

Factors which may increase the likelihood or severity of alcohol related domestic violence

- ✓ The risk may develop and change as the couple grow older, particularly if the perpetrator becomes ill due to their alcohol use (or for other reasons) as this could result in a change in the power balance in the relationship.
- ✓ Problem drinkers who form a relationship in treatment could be at greater risk if they return to drinking.⁸⁸
- ✓ Changes in where people drink e.g. from the public and social setting of the pub to the home where individuals may be isolated and controlled by an abuser.
- ✓ The risk rises with the presence or absence of different people.
- ✓ The risk is perhaps more likely on days people receive money.
- ✓ Liver disease can affect blood clotting and increased blood loss may be a significant factor in increasing the impact of the violence.

| Points relating to alcohol that may affect victim's ability to action safety plan | |
|---|--|
| ✓ | Alcohol use can make it difficult for survivors to assess the severity of the abuse they are experiencing as it can dull their sense of physical and emotional pain. |
| ✓ | Is the plan realistic? Can the victim implement the plan when they're intoxicated? |
| ✓ | Can changes to patterns of alcohol use that may increase safety be included? For example, using at times of day that the perpetrator is unlikely to be around. |
| ✓ | Does the plan incorporate strategies to promote access to substance treatment services? |
| ✓ | What response might survivors receive from services, the police, etc. when they make calls under the influence of alcohol? What previous contact have they had with services (including the police) relating to their alcohol use? |

CHECKLIST 3

| INFORMATION SHARING |
|--|
| <p>Legislation which supports information sharing includes:</p> <ul style="list-style-type: none"> ⊙ The European Convention on Human Rights, incorporated into English law from October 2000, by the Human Rights Act 1998: Article 8: Right to respect for private and family life ⊙ The Crime and Disorder Act 1998 - Section 115 as amended by the Police Reform Act 2002 ⊙ The Criminal Justice Act 2003 |
| Information cannot be shared about individuals unless the basis on which the sharing occurs is clear and agreed. |
| Information can be shared if it is in the public interest allows it. |
| The public interest generally lies in the prevention of abuse or harm, or the protection of others, including the protection of public safety. |
| Information about clients that have been referred to the MARAC can be shared with partner organisations through the MARAC process. |
| Agencies should inform the service user who is the subject of that information of the decision to disclose. This will happen even where their consent is not required, unless it would not be safe to do so or would otherwise undermine the purpose of the disclosure. An important example of when NOT to inform the client is if they are a perpetrator of domestic abuse that is being discussed at MARAC. |
| The parties to the information sharing should record the information shared, the public interest being met and the legal framework used in the client's records. |
| If there are any doubts about the legality of sharing a particular set of information further advice should be sought from the relevant organisation's Information Governance Lead or Caldicott Guardian. |
| Under the Care Act statutory agencies have a duty to share information as relates to the safeguarding needs of individuals if the local authority is undertaking an enquiry. Statutory services should contact their local authority safeguarding team to find out what information would be shared if a section 42 safeguarding enquiry were undertaken. Providers should be aware of their roles and responsibilities under the Act and make contact with local adult safeguarding leads to understand their duties. ⁹⁰ |

12. The role of non-specialist services

12.1 The pathway into alcohol and domestic abuse services – signposting

In the years leading up to the homicide John had never been formally referred for treatment or taken up advice to self-refer to other agencies. He had been provided with advice on how to self-refer to third-sector agencies since 2005. Even though there were statutory NHS providers for substance abuse problems, the formal referral was never made...It is not known what effect any prescribed treatment could have had on the behaviour of John, it is apparent that the offer of self-referral did not work. Whilst it is appreciated that there is a level of personal responsibility to manage health, a more robust referral process between GP, NHS providers and third sector may have compelled John to take up the treatment and support offered. ⁹¹

Once identified, victims and perpetrators with alcohol problems need to be referred into alcohol treatment services. All too often this has not happened.

Ensuring that more problem drinkers are referred to alcohol and domestic abuse services would be a positive step forward. However, the repeated problem in the DHRs is that non-specialist services assume that the provision of information about services or even the making of an appointment is adequate. Clients are simply “signposted” to services:

- *The response to Derek’s possible alcohol and substance misuse by encouraging him to self refer to services is...standard practice.* ⁹²
- *Following an incident of self harm in which KT reported to a psychiatric liaison team drinking 67 units per day he was “advised” to contact alcohol services. A similar response was received when heavy drinking was reported to a custody nurse.* ⁹³

If the level of risk or vulnerability associated with the drinker is genuinely low, then workers can offer a more limited role. It will be sufficient to have:

- Identified the problem;
- Spoken to the drinker about it (brief advice);
- Highlighted the availability of services; and
- Made a referral.

On the other hand, while signposting is useful, it will generally not be enough with risky and vulnerable clients. With regard to situations where drinkers are resistant or reluctant to change, a more assertive response is required. This could involve following up a referral, taking a client to an agency or identifying someone to accompany the person. Workers should consider the ideas set out in checklist 4 below. This requires an investment of time but the level of risk justifies it.

The situation with referrals – particularly in relation to victims – is that many services such as A&E and the police now use the DASH and will automatically refer high-risk cases to their local MARAC. It is not a perfect system by any means, but has resulted in some victims receiving a more proactive response. The difficulty lies with victims that are **i**) not assessed, or **ii**) are (correctly or incorrectly) assessed as being at standard or medium risk. In such cases again, there is a tendency to simply signpost.

This is unlikely to result in a person self-referring, and even less so when the victim is a change resistant drinker. While this research did not look specifically at referrals to domestic violence services, we would still recommend that these referrals are made. In cases of both alcohol and domestic violence we would

encourage speaking to the person being referred about sharing information with those services and supporting joint working between agencies to ensure expertise can be pooled.

The research did not systematically collect data on referrals to perpetrator services, however, they appeared almost non-existent within the DHRs, with the exception of perpetrators involved with probation. This may reflect a lack of services to support perpetrators to make change, but also more widespread reluctance to talk to perpetrators about their behaviour.

12.2 The role of primary care

DHR reports highlight the key role played by primary care with alcohol and domestic violence and identify a series of missed opportunities in that setting

- *The couple's GP did not follow up on background information (of longstanding alcohol dependency by both parties...)*⁹⁴
- *There is also reference to Y's increased alcohol consumption which does not appear to have been followed up.*⁹⁵
- *The initial assessment (in primary care) of Jane was comprehensive but during review consultations the same systematic approach does not appear to have been taken to consider issues such as domestic violence, alcohol use, risk of harm etc. This meant that questions about topics such as these were not routinely discussed and recorded'.*⁹⁶
- *The review notes that both Miss Y and Mr Z had attended new patient checks, Miss Y in August 2004 and Mr Z in October 2007, both in practice 2. This should have included screening for alcohol misuse. There is no record of any assessments on this for Mr Z or Miss Y, this was a missed opportunity to assess current social circumstances and potential risk factors individually and in their relationship.*⁹⁷
- *There is no evidence in any of the GP records reviewed that either Adult A or Adult B indicated or disclosed domestic abuse to any of the practitioners involved in their care. However there is evidence to suggest that there were missed opportunities following Adult A and Adult B's A&E attendances that could have been explored further by the GP.*⁹⁸

Primary care generally is seen as an important location for identifying alcohol problems, offering brief advice and referring to services. In addition, the long-term nature of the GP – patient relationship means that primary care is a key setting for monitoring alcohol-related harm and motivating people to change.

GPs are often the first professional, or the most frequent professional, that victims and perpetrators of domestic abuse approach for help directly or indirectly relating to the abuse. Alongside physical health problems arising from experiencing physical violence, it has already been noted that living with abuse can result in quite complex psychological difficulties that victims see their GP about. Hester (2001) also highlights that perpetrators regularly attend their GP surgery with complaints of depression and anxiety.⁹⁹ Thus GPs should be routinely asking about both experiencing and perpetrating domestic abuse in their practice. The IRIS programme has been running across England since 2007, providing support to GP surgeries wanting to improve their responses to domestic abuse.

It is recognised that primary care is a pressured environment but where the risk of domestic violence has been identified and alcohol is associated, it is important to pursue this issue and ensure that referrals turn into active treatment. This will involve:

- Understanding the relationship between alcohol use and domestic abuse, particularly in terms of it being used to cope with experiences of trauma;
- Routinely asking about alcohol use and domestic abuse;
- Regular use of the AUDIT tool where alcohol use is disclosed;
- The curiosity to probe deeper into problems;
- Making referrals to alcohol services, domestic abuse support services, and, where available, perpetrator support programmes; and
- Using checklist 5 below that sets out suggestions for building more effective pathways into services.

IRIS is a general practice-based domestic abuse training support and referral programme that has been evaluated in a randomised controlled trial. Core areas of the programme are training and education, clinical enquiry, care pathways and an enhanced referral pathway to specialist domestic violence services. It is aimed at women who are experiencing domestic abuse from a current partner, ex-partner or adult family member. IRIS also provides information and signposting for male victims and for perpetrators.

IRIS is a collaboration between primary care and third sector organisations specialising in domestic abuse. An advocate educator is linked to general practices and based in a local specialist domestic abuse service. The advocate educator works in partnership with a local clinical lead to co-deliver the training to practices.



12.3 Identification in the hospital

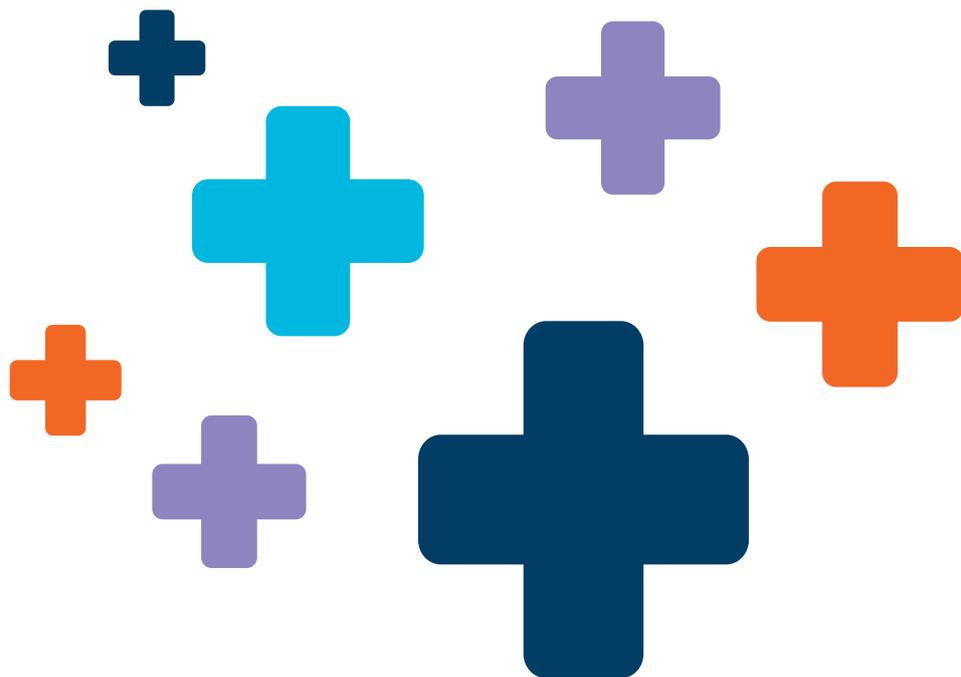
The hospital is a crucial setting for the identification of both domestic abuse and alcohol misuse:

*Both Adult B and Adult A presented separately and together at the A&E department between 2009 and 2011 with a variety of injuries and a mental health episode...Ward staff should provide information on treatment and support options to people who experience drug and alcohol problems as a routine intervention and a system should be in place to support this...Adult B accompanied by Adult A attended A&E following an assault that resulted in a large laceration to his forehead...There is very little recorded in the triage record about what appears to be an assault resulting in a significant head injury. The A&E doctor, who saw Adult B 3 hours later, recorded that Adult B appears to be intoxicated and a bit "high". Adult A is described as being "sober"...Staff should have considered the risk to Adult A on discharge. There is no indication in the record that consideration was given to Adult A returning to a house with Adult B who had been involved in a violent affray, nor was there any consideration of whether there were any children in this relationship. The assault was seen in isolation of wider safeguarding considerations.*¹⁰⁰

The DHRs highlighted a very clear pattern of victims/perpetrators of domestic abuse who are also change resistant drinkers frequently using the police and A&E, yet both services tended to have a narrow focus addressing the critical issue at the time rather than considering the wider context and difficulties people were experiencing.

In recent years hospital alcohol workers have, however, become more commonplace and most general hospitals now have such posts. Similarly, there are a number of hospital-based Independent Domestic Violence Advisors (IDVAs) that are generally located in A&E. Such specialist workers provide a real opportunity to work jointly to tackle alcohol-related domestic abuse.

Workers dealing with domestic abuse and change resistant drinkers need to be aware of these posts and referral pathways. Specific procedures and alerts for dealing with victims or perpetrators of domestic abuse in this context should be established. Psychiatric liaison could also be engaged in this pathway.



CHECKLIST 4

| WHAT SHOULD NON-SPECIALIST STAFF DO? | |
|--|---|
| Recognise the link between alcohol and domestic violence - All frontline staff in non-specialist services need to recognise that: | |
| <input checked="" type="checkbox"/> | While alcohol misuse does not cause or excuse domestic violence, it is a useful predictor of risk and, in particular, serious harm. |
| <input checked="" type="checkbox"/> | An adequate response to the needs of alcohol related domestic violence requires addressing the needs of change resistant drinkers. |
| <input checked="" type="checkbox"/> | People may have problems with alcohol without conforming to the stereotype of the “alcoholic”. |
| Training - All frontline staff should have training in: | |
| <input checked="" type="checkbox"/> | The use of the AUDIT tool. |
| <input checked="" type="checkbox"/> | The Brief Advice model. |
| <input checked="" type="checkbox"/> | Working with change resistant drinkers. |
| <input checked="" type="checkbox"/> | Asking about and responding to disclosures of domestic abuse. |
| <input checked="" type="checkbox"/> | Talking to perpetrators about their behaviour. |
| <input checked="" type="checkbox"/> | Risk assessment and safety planning. |
| <input checked="" type="checkbox"/> | How to develop multi-agency responses to alcohol-related domestic abuse. |
| Assessment and risk assessment - Managers of a range of frontline services should ensure that: | |
| <input checked="" type="checkbox"/> | All staff routinely inquire about use of alcohol and experiences/perpetration of domestic abuse. |
| <input checked="" type="checkbox"/> | Risk assessment systems adequately reflect the seriousness and dynamic nature of the risk associated with problem drinking in the context of domestic violence. |
| <input checked="" type="checkbox"/> | Can changes to patterns of alcohol use that may increase safety be included? For example, using at times of day that the perpetrator is unlikely to be around. |
| <input checked="" type="checkbox"/> | Guidance is available on when information-sharing is appropriate in the context of alcohol-related domestic violence and the legal frameworks that support this. |
| Referring people to services - Workers in a range of frontline services: | |
| <input checked="" type="checkbox"/> | Need to be aware of their local alcohol and domestic abuse services and preferably have visited them to understand how they work. |
| <input checked="" type="checkbox"/> | Need to do more than simply signpost risky or vulnerable drinkers to alcohol and domestic abuse services. |
| <input checked="" type="checkbox"/> | Need to follow up referrals that they make to support client engagement. |
| <input checked="" type="checkbox"/> | Need to be aware of any alcohol liaison workers in local hospitals and hospital-based IDVAs (Independent Domestic Violence Advocates) and recognise the opportunities these provide to identify alcohol misuse and domestic violence. |
| Working with alcohol/domestic violence services - Managers and commissioners of frontline services need to enter a dialogue with alcohol services and their commissioners to ensure that: | |
| <input checked="" type="checkbox"/> | Alcohol services have interventions that assertively engage drinkers involved in domestic abuse. |
| <input checked="" type="checkbox"/> | They record unmet need when they cannot secure appropriate help for perpetrators and victims that drink problematically. |

CHECKLIST 5

| TIPS FOR IMPROVING THE LIKELIHOOD THAT A VICTIM/PERPETRATOR WHO IS A CHANGE RESISTANT DRINKER WILL ACCESS SERVICES | |
|--|---|
| ✓ | To support victims, the majority of whom are women, services should start by being gender responsive. As such they should recognise the specific experiences of women and understand how gender impacts on their experiences of the world. ¹⁰¹ |
| ✓ | Tackle client misconceptions about various services – e.g. alcohol services are not a mental health unit, and domestic abuse services are not all refuges. This will require the worker being familiar, and building links, with the service. |
| ✓ | Remind clients that in terms of alcohol treatment, abstinence is not the only option. Most community alcohol services will allow clients to explore whether they can return to controlled drinking. |
| ✓ | Remind victims that in terms of domestic abuse, leaving is not the only option. Domestic abuse services should provide victims with the information and support to make a decision about what they feel is right for them. |
| ✓ | Tell the alcohol service the person's AUDIT score when a referral is made. This will reassure them that you know what you are talking about and that this is an appropriate referral. |
| ✓ | Be aware of the need for all agencies to be flexible in supporting victims of domestic abuse e.g. in terms of location of appointments. |
| ✓ | Smooth the pathway with services that require self-referral by asking them to be very welcoming and encouraging if the person makes contact. |
| ✓ | Ask for a speedier appointment if a person is someone who is of particular concern. |
| ✓ | Ensure that services are asked to speedily follow people up if they disengage and report this back to the referrer. |
| ✓ | Follow up any referral to ensure the client makes contact with the service. |
| ✓ | Ask whether volunteers or mentors are available to accompany people to their first appointments. |
| ✓ | Consider asking the service to invite the person to "drop in for coffee" rather than "make an appointment" |
| ✓ | Acknowledge to the individual that entering services can be challenging and they will not be seen as failures if it takes time to make changes. |
| ✓ | Alcohol liaison workers and IDVAs (Independent Domestic Violence Advisers) are to be found in most general hospitals now. If someone will not enter community services, it may be worth considering whether they can be contacted by these workers if they enter the hospital at any point. |
| ✓ | Record and report unmet need if services are unable or unwilling to supply the support the client needs. |
| ✓ | Non-specialist services need to be willing to challenge the approaches used in alcohol services if they are not a good fit for vulnerable people. |

13. Improving the specialist alcohol service response

13.1 Promoting engagement with change resistant drinkers

(John) did not feel there was any negligence on behalf of any agency. His only comment was that if a person volunteers that they have substance misuse problems, agencies should follow that up.¹⁰²

A repeated theme in the workshops was the need for alcohol services to work differently. The focus of this concern was the ability of these services to work with change resistant drinkers. Non-alcohol specialist staff expressed disappointment that alcohol services are:

- *setting motivation to change as an entry requirement;*
- *closing cases of people involved in domestic abuse due to lack of engagement;*
- *not providing an assertive outreach approach to risky and vulnerable clients;*
- *not sufficiently persistent;*
- *not taking a more bespoke approach which is tailored to the needs of each individual;*
- *not offering home interventions.*

Workshop quote

Alcohol services should be like a dog with a bone with vulnerable or risky clients

These messages were reinforced in the DHRs:

- When both partners in an abusive relationship are misusing alcohol...an approach that includes home visits and engagement of both partners together could improve the quality of assessment and intervention.¹⁰³
- On 21/04/05 Mr Z self-referred himself to... a drug and alcohol counselling service. He was given an initial assessment and put on the waiting list. He was subsequently offered an appointment on 28/04/05. Mr Z attended his appointment...on 28/04/05 and made a further appointment for 05/05/05...Mr Z did not attend his appointment...a letter was sent offering a further appointment on 12/05/05.¹⁰⁴
- Local recommendation: Proactive...Alcohol services that recognise the link between alcohol and domestic violence and work to reduce risk and increase safety.¹⁰⁵
- YZ commences alcohol treatment...He is seen weekly by the counsellor for three consecutive weeks...YZ is (then) discharged from alcohol counselling. The Counsellor reports that counselling was exacerbating YZ's anger, and that YZ fails to see he has a problem with alcohol.¹⁰⁶
- On the day of discharge he was offered an assessment by the drug and alcohol team, however, he declined. He was given the team's contact details and advised to reconsider contacting them.¹⁰⁷
- Mary attended her appointments with probation but did not attend her appointments with the alcohol services, and was discharged by them.¹⁰⁸

In the workshops it was felt that there should be:

- *More investment in outreach in alcohol services;*
- *Closer and joint working between alcohol and domestic violence services with possible co-location of services;*
- *A multi-agency meeting focused on high-risk drinkers offering a place for referral and management of these clients.*

The sections above have highlighted the need for robust pathways between services: in particular, the need for more “handholding” and less “signposting”. More bridging is required between referral points and more feedback between services about the interventions provided to risky individuals. Alcohol services need to play their part in this and make it easier for risky and vulnerable clients to access help.

13.2 Addressing domestic abuse

Many alcohol services state they already address domestic abuse in their practice by, for example, including questions about previous or current experiences of abuse in the referral and assessment forms.

A more holistic response is still needed. This should be both gender responsive and trauma informed. As women’s problematic alcohol use may stem from experiences of trauma (most often abuse), it is vital that services are aware of the impact of trauma on people’s emotional and psychological well-being. Furthermore, treatment plans should take into consideration the fact that many victims will be using alcohol to manage symptoms of trauma such as flashbacks and general anxiety. If alcohol use is reduced before other coping strategies have been identified, this could result in the alcohol treatment being unsuccessful.¹⁰⁹

Alcohol services should also be aware of how male-dominated they often are. This can be an intimidating and uncomfortable environment for some women. Simple changes such as holding women’s groups in an area where male clients cannot look into the room or harass women leaving can make the service more appealing for women.

As perpetrators also attend alcohol services, staff should be trained to deal with this client group too. The key issues are set out above. As with supporting someone to make change around their alcohol use, when working with perpetrators it is crucial to keep them engaged by showing them positive regard, but at the same time hold them responsible for the actions they knowingly take.

13.3 Services for the family of problem drinkers

National guidance does not require the development of support services for the families of drinkers.¹¹⁰ As a result, interventions for family members vary nationally. Therefore, part of the development of a response from alcohol services to domestic violence may be better family services.

Evidence exists that family or carer involvement in care planning can help improve the drinker’s engagement and increase the likelihood that a care plan will succeed. Family members may also need protection and support that can be provided by family alcohol services.

Non-alcohol specialist workers should certainly consider encouraging the family members of drinkers to go to Al-Anon – the mutual aid organisation that offers 12-step, peer support to the families of drinkers.¹¹¹ Local alcohol services may also have family support groups.

However, a note of caution must be entered. Family alcohol services often try to support family members to change the way they behave with the drinker e.g. stop supporting them to drink. In the context of domestic violence this process of change may involve risk for the family member and, therefore, such interventions need to be thoroughly risk assessed.

CHECKLIST 6

| WHAT SHOULD ALCOHOL SERVICES AND THEIR STAFF DO? | |
|--|--|
| TRAINING - The staff of alcohol services should have training in: | |
| <input checked="" type="checkbox"/> | Understanding the relationship between alcohol and domestic abuse. |
| <input checked="" type="checkbox"/> | Identifying the dynamics of domestic violence. |
| <input checked="" type="checkbox"/> | Understanding when information-sharing is appropriate in the context of domestic abuse and the legal frameworks which support this. |
| <input checked="" type="checkbox"/> | Working with change resistant drinking. |
| SERVICE APPROACH - Alcohol services should: | |
| <input checked="" type="checkbox"/> | Recognise that an adequate response to the needs of alcohol related domestic abuse will require addressing the needs of change resistant drinkers because of the serious risks or vulnerabilities involved. Alcohol services need to have interventions that assertively engage drinkers involved in domestic abuse. |
| <input checked="" type="checkbox"/> | The development of services for the families of problem drinkers may be a useful element in the response to alcohol related domestic abuse. However, these need to be sensitive to the risk involved with change in the context of violent relationships. |
| <input checked="" type="checkbox"/> | Ensure they record unmet need when they cannot secure appropriate help for a drinking client. |
| ASSESSMENT AND RISK ASSESSMENT - Alcohol services should ensure that: | |
| <input checked="" type="checkbox"/> | Staff understand how to identify patterns of domestic abuse and are knowledgeable about the causes of domestic abuse. |
| <input checked="" type="checkbox"/> | At assessment staff are actively curious about possible patterns of domestic abuse. |
| <input checked="" type="checkbox"/> | Risk assessment systems adequately reflect the seriousness and dynamic nature of the risk associated with problem drinking in the context of domestic abuse. |
| <input checked="" type="checkbox"/> | Staff are aware of the support options available to victims, and the services for both victims and perpetrators. |
| <input checked="" type="checkbox"/> | Guidance is available on when information-sharing is appropriate in the context of domestic abuse and the legal frameworks that support this. |
| SPECIALIST ALCOHOL HOSPITAL LIAISON POSTS | |
| <input checked="" type="checkbox"/> | The hospital provides an important opportunity to identify alcohol misuse and domestic violence. |
| <input checked="" type="checkbox"/> | Procedures and pathways should be developed focused on alcohol liaison workers in the hospital. |
| LEGAL POWERS - Alcohol services should consider how they can support: | |
| <input checked="" type="checkbox"/> | The use of civil injunctions and criminal behaviour orders in the context of alcohol related domestic violence. |
| <input checked="" type="checkbox"/> | The use of conditional cautions. |

14 Domestic violence services

14.1 Domestic violence services

AVA's Stella Project has been working on the overlapping issues of domestic abuse, substance use and mental health for over fifteen years. Their research has shown the need for improved multi-agency working and better training and support for all services that work with this group of very vulnerable people. They have a range of toolkits and policy suggestions for improving cross-sector links.¹¹²

Domestic abuse services need to give alcohol due attention. Considering the high level of alcohol use among people who experience abuse and trauma more generally, domestic abuse services should, as a minimum, be trained to use the AUDIT tool and give brief advice (see above), as well as having an understanding of the risk involved with problem drinking and knowledge about harm reduction techniques.

In order to achieve this, good links should exist between domestic abuse and alcohol services. This was highlighted in the Leicester Mary DHR:

- *Given there is a high prevalence of substance and alcohol misuse, for both victims and perpetrators of domestic abuse, referrals from domestic abuse services to (alcohol services) are very low. The author highlighted a need for improved joint working...*¹¹³

The number of referrals between alcohol and domestic violence services across a local authority area ought to be reviewed regularly. If they are low, this may suggest a need for action.

In some areas, it may be felt that there is a need for a specific worker. For example the Safe Newcastle Review Report Into The Death Of Jane highlights that the Newcastle has a specialist IDVA who supports victims that use drugs or alcohol problematically.¹¹⁴ This is an excellent example of a more holistic approach to addressing domestic abuse. Workers that have specialist knowledge across two issues can build relationships with and between sectors. Local authorities should consider whether such a specialist post would be beneficial in their area alongside the more general need for domestic abuse services to adopt the good practice around identification, advice, risk assessment and targeting change resistant drinkers outlined above. See Checklist 7 below.

The subsequent sections highlight further specific developments around refuges, perpetrators and MARACs.

14.2 Refuges

The role of refuges and their ability to manage drinkers did not emerge from the DHRs we reviewed. However, workshop participants did question the ability of refuges to manage victims who were also change resistant drinkers. This is not a new concern, with refuges historically being reluctant or unable to house victims that use alcohol problematically. In some cases, this stems from a worry that children living in refuges will be affected by a resident's alcohol use. In other cases, Stella Project research has identified that refuges lack tools to risk assess, and feel ill-equipped to manage heavy alcohol use, particularly in a residential setting.¹¹⁵

In order to improve access to refuges for women who use alcohol, at the very least refuge staff should have good links with local alcohol services. They should access training to increase their knowledge and confidence in working with this issue. Finally, and possibly most importantly, as with all domestic abuse professionals, refuge staff should be reminded that many victims' problematic alcohol use started with an experience of abuse as a child or in adulthood and that a trauma-informed approach is vital.

14.3 Perpetrators

Alcohol services (should be) available for victims and perpetrators of domestic abuse. ¹¹⁶

Perpetrators of domestic abuse also need help. The DHRs provide a useful picture of the perpetrators. These may be individuals with very complex needs, including their own histories of abuse or neglect. This does not reduce responsibility for the abuse they perpetrate, but indicates the need for perpetrators to be referred to a Respect accredited perpetrator programme that will hold the individual accountable alongside supporting them to access support for their own experiences if needed. ¹¹⁷

Community-based perpetrator programmes – as opposed to probation run programmes – are limited. Very few are open to perpetrators who drink problematically. Local authorities should be encouraged to consider commissioning more perpetrator programmes, including ones that are suitable for perpetrators who use alcohol. Their alcohol use is likely to be an integral part of their abusive behaviour, e.g. using it as an excuse, and this needs to be addressed on any behaviour change programme.

14.4 What should MARACs and other relevant multi-agency groups do differently?

All members of MARACs and other multi-agency groups need to recognise that change resistant drinkers will be a regular feature of the cases coming before them. As with other services they will need to:

- Be curious about whether alcohol is a contributory factor;
- Not assume that addressing a perpetrator's alcohol use will result in less abuse;
- Remember that victims that are change resistant drinkers and may behave antisocially or be reluctant to engage with services are still victims that require support;
- Be positive about the possibility of intervention with problem drinkers, even when someone is resisting change;
- Be aware of the range of techniques that can be used with change resistant drinkers (see *checklist 5*) when developing risk management plans;
- Challenge problems in the pathways into alcohol services.

Checklist 1 sets out a range of questions that workers can ask about a case to ensure that all possible efforts are being made to engage the client and reduce harm. MARACs and other multi-agency groups can use the same checklist to guide their thinking about the management of a change resistant client. This needs to be read in conjunction with the Blue Light manual, which sets out details of each step in this pathway.



CHECKLIST 7

| WHAT SHOULD DOMESTIC VIOLENCE SERVICES AND THEIR STAFF DO? | |
|---|--|
| A change in the approach to alcohol misuse - Staff of domestic violence services need to recognise that: | |
| ✓ | While alcohol misuse does not cause or excuse domestic violence, it can contribute to the frequency and severity of violence used. |
| ✓ | People who experience trauma often use alcohol as a means to cope with subsequent thoughts and feelings about the experience. Thus all interventions with victims should be trauma-informed and include capacity to support victims who drink. |
| ✓ | An adequate response to the needs of alcohol-related domestic violence will require addressing the needs of change resistant drinkers. |
| Training - The staff of domestic violence services should have training in: | |
| ✓ | Understanding that people may have problems with alcohol without conforming to the stereotype of the "alcoholic". |
| ✓ | The use of the AUDIT tool. |
| ✓ | The Brief Advice model. |
| ✓ | Working with change resistant problem drinkers. |
| Assessment and risk assessment - Managers should ensure that: | |
| ✓ | Staff are actively curious about the possible contribution of alcohol misuse to patterns of domestic violence. |
| ✓ | Risk assessment systems need to adequately reflect the seriousness and dynamic nature of the risk associated with problem drinking in the context of domestic violence. |
| ✓ | Guidance is available on when information-sharing is appropriate in the context of domestic violence and the legal frameworks which support this. |
| Referring people to services - Workers in domestic violence services: | |
| ✓ | Need to be aware of their local alcohol services and preferably have visited them to understand how they work. |
| ✓ | Need to be aware of Al-Anon, the self-help group for the family members of drinkers, and other family alcohol services. |
| ✓ | Need to do more than simply signpost risky or vulnerable drinkers to alcohol services. |
| ✓ | Need to be aware of any alcohol liaison workers in local hospital and recognise the opportunities these provide to identify alcohol misuse and domestic violence. |
| Working with alcohol services - Domestic violence services need to enter a dialogue with alcohol services and their commissioners to ensure that: | |
| ✓ | Alcohol services need to have interventions that assertively engage drinkers involved in domestic abuse. |
| ✓ | Services are available for the families of problem drinkers. |
| ✓ | Seamless services for people with both alcohol and mental health problems are essential in the response to alcohol related domestic abuse. |
| ✓ | They record unmet need when they cannot secure appropriate help for a drinking client. |

15 Training

(The) training strategy (should) be reviewed, to ensure ...an increase in questioning around substance misuse and healthy relationships. ¹¹⁸

The rest of this guidance has, by default, highlighted a set of training needs associated with this challenging group of clients. Training in working with problem alcohol use is readily available as is training on how to support victims and work with perpetrators of domestic abuse. General training on both issues has long been recommended for staff in specialist alcohol and domestic abuse services. However, this guidance suggests that both commissioners and managers need to ensure six key training elements:

- More in-depth understanding of the relationship between alcohol use and domestic violence.
- General alcohol awareness including alcohol Identification and Brief Advice. NICE specifically advocates training in alcohol Identification and Brief Advice (IBA).
- Working with change resistant drinkers. All workers encountering domestic abuse need to be aware of approaches that can be used with change resistant drinkers. This could usefully be based on the approaches in Alcohol Concern's Blue Light project manual.
- Risk identification in the context of alcohol-related domestic abuse. The very specific interaction between alcohol and risk needs to be a core part of the training of anyone who encounters domestic abuse.
- Identifying the perpetrator and victim, including in cases of bidirectional violence.
- Working with trauma as a key framework for understanding why many victims (and indeed some perpetrators) use alcohol.



16 Other issues

This section sets out three other issues that have emerged in the research. These have not been turned into separate checklists but are included in the commissioner checklist.

16.1 Dual diagnosis

It has been important for the review to reflect on... the related mental health and alcohol and substance misuse issues...and to identify how these relate to risk factors associated with domestic abuse...¹¹⁹

A significant proportion of problem drinkers also have a mental health problem. This combination is associated with high levels of suicide, self-harm and violence to others and makes clients difficult to engage in services or treat effectively. The DHRs specifically highlight the significance of this issue:

- *Both had needs arising from mental health, drug and alcohol misuse and were involved with local services.*¹²⁰
- *Adult A could be physically, mentally and emotionally abusive towards (her children), due to her mental health problems and her addiction to alcohol.*¹²¹
- *Providers should make clear and accessible to staff the clinical pathways and recommended clinical tools/algorithms for domestic abuse, alcohol misuse and mental health.*¹²²
- *Among health staff there was little understanding that a history and presenting symptoms of depression and excessive alcohol use might be linked with domestic abuse.*¹²³
- *In addition to the issues surrounding domestic abuse and alcohol abuse, mental health is also worthy of note arising from, in particular, the fact that Adult A was on medication for depression and anxiety as early as 2001 when it was noted in the GP records that 'relationship problems' existed. This was a 'toxic trio' but has not received any direct acknowledgement by any single agency.*¹²⁴
- *It was particularly concerning that the elements of poor mental health and alcohol misuse were present in both parents.*¹²⁵
- *KT had been known to mental health services intermittently since 2005 due to concerns about alcohol misuse and depression, including an overdose.*¹²⁶

The role that this combination plays in domestic violence has been flagged previously by the Stella project.¹³² However, the Stella project has identified that terms like dual diagnosis may have a negative impact on individuals due to the impact of a negative label that fails to grasp the relationship between an individual's experiences, structural inequalities and trauma.¹³³ However, the workshops were clear that having co-existing mental ill-health and substance use remains an issue as there are often barriers to accessing services – in this sense the label may mean people can access specialist services for 'dual diagnosis.'

Co-existence has been a perennial problem in the alcohol field as it has created barriers to support. National guidance does exist:

- NICE Guidance on Psychosis and substance misuse (2011)
- The Department of Health's Dual Diagnosis Good Practice Guide (2002)

However, local practice rarely reflects this guidance. The risk of domestic violence ought to encourage local commissioners to prioritise this pathway; however, it is likely that further national guidance will be required to unblock this issue.

16.2 Safeguarding

Concern was consistently expressed in the workshops that some vulnerable people are not being considered as vulnerable adults who may need safeguarding because they are problem drinkers. The Oxford DHR graphically described such a case:

It is hard to explain the impact that my mother's death has had on us, we feel that the last twenty years were leading up to this: my mother's lifestyle was unhealthy, she drank alcohol and chain smoked and had diabetes as well as poor mental health. She would wake up at 7am with only the thought for alcohol and she would drink alcohol until she passed out. She did this almost every day and for over ten year she hadn't gone more than two days without alcohol. The state of my mother's house as the police would have found it is how my mother lived. A few years ago I started taking pictures of my mother and what the house looked like, because on one occasion my sister had been blamed for the state of the house. Rather than the professionals who visited accepting that my mother needed more help than they were providing. A male friend refused to go to the house, because my mother did not keep the house clean. He would go there to get money from her and leave her with no money. She would then sit in the dark and drink alcohol. ¹²⁸

A couple of other DHRs also focused on this issue:

- *no agency assessed that Mary did require referral through safeguarding adults procedures. Though this appeared appropriate in this case, it was noted that the percentage of referrals through Safeguarding Adults Multi Agency Procedures where the individual's support needs relate to drugs and alcohol were very small – out of 1302 referrals in Leicestershire in 2011-12, only 3 (0.2%) were recorded as being for people with substance misuse needs.* ¹²⁹
- ***What action did your agency take to identify and safeguard vulnerable adults and children; and were appropriate referrals made?... Female A was a vulnerable adult because of her victimisation, alcohol misuse, mental health needs and social isolation. Male A was also vulnerable because of his alcohol misuse and mental health needs.*** ¹³⁰

The 2014 Care Act seeks to improve safeguarding nationally. It requires local authorities to set up a Safeguarding Adults Board (SAB) in their area, giving these boards a clear basis in law for the first time. This will provide a framework for discussing how vulnerable problem drinkers are to be managed.

The Act also says that SABs must arrange a Safeguarding Adults Review in some circumstances – for instance, if an adult with care and support needs dies as a result of abuse or neglect and there is concern about how one of the members of the SAB acted.

It will be important to ensure that alcohol is addressed in the safeguarding context to ensure that another set of reviews do not throw up the same message about alcohol related risk.

16.3 Legal powers

At some points the only management approach available may be a resort to legal powers. People in the workshops called for greater clarity on the powers available to contain problem drinkers and the appropriate time to use them.

The range of powers is limited. The Mental Health Act cannot be used to manage people whose mental disorder arises solely from alcohol misuse. However, people with a mental disorder and an alcohol problem may be subject to a section of the Mental Health Act.

Beyond the Mental Health Act, the key legal frameworks are:

- Alcohol Treatment Requirements
- Conditional Cautioning
- The new Anti-Social behaviour powers e.g. the Civil Injunctions.

All of these are limited to certain specific circumstances but given the seriousness of the outcomes to be prevented, it is important to consider them.

The Civil Injunctions offer a very specific opportunity. These replace the Anti-Social Behaviour Orders and allow *requirements* to be placed on people as well as banning people from doing things. The guidance that supports them specifically advocates their use with problem drinkers. At the time of writing these powers have only recently come into force. Therefore, work is required both nationally and locally to determine how these can be used and the possible content of an *alcohol requirement*.

17 Commissioning services for change resistant drinkers involved in domestic violence

17.1 A joint responsibility

The strategic lead for alcohol misuse now lies with the public health teams in local authorities. Nonetheless, the commissioning of services for this client group must be a joint process. Both the Health and Wellbeing Board and the Community Safety Partnership should have ownership and oversight.

Beyond public health, the process should involve:

- The Clinical Commissioning Groups
- The Police
- Fire and Ambulance services
- Social care
- National Probation Service and the Community Rehabilitation Companies
- Housing services

17.2 Evidence-based commissioning

Commissioners rightly seek to develop and specify services that are built on a sound evidence base. However, the danger is that this aspiration leads to an over-reliance on interventions that can be measured by randomised controlled trials.

The view from the workshops and in discussions in other settings ¹³¹ is that this will favour interventions like Cognitive Behavioural Therapy rather than social work type / process interventions which do not and cannot have the same evidence base. It would be, for example, unethical not to communicate about the needs of a particular client in order to compare the effectiveness of information sharing. Commissioners need to ensure that “evidence based” interventions are built on a range of evidence bases including the DHRs and peer learning.

17.3 A national response

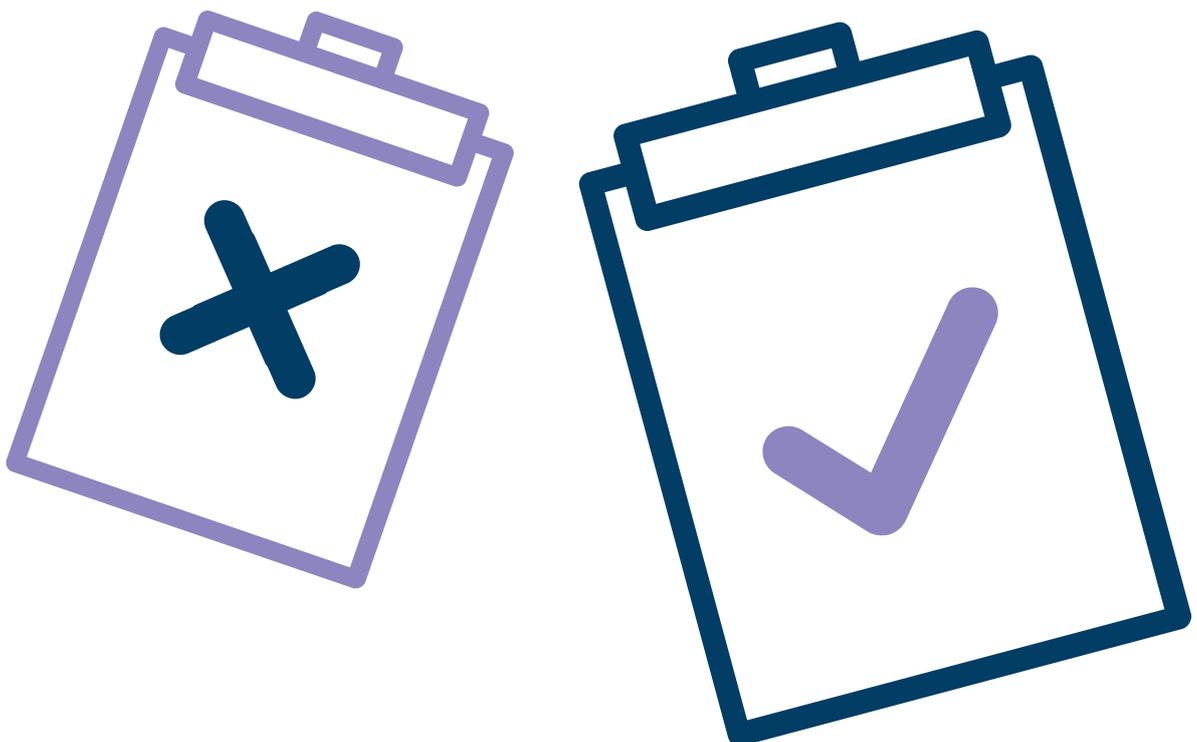
At the national level the pathway for this client group would be improved by three low cost initiatives:

- National work to scope out a more comprehensive and dynamic tool for risk assessing the relationship between alcohol and domestic violence.
- Improving safety planning by ensuring a greater understanding of the circumstances of the homicide, i.e. how did two or more people interact to find themselves in a dangerous situation?
- Guidance on when information-sharing is appropriate in the context of domestic violence and the legal frameworks which support this.

CHECKLIST 8

| COMMISSIONERS AND STRATEGIC LEADS | |
|---|--|
| SETTING THE STRATEGIC CONTEXT | |
| All local commissioners can set the strategic context by: | |
| <input checked="" type="checkbox"/> | Ensuring the messages of this guidance document are presented at the Health and Wellbeing Board (HWB), Community Safety Partnership or other relevant bodies. |
| <input checked="" type="checkbox"/> | Ensuring the impact of this issue is explored in local needs assessments including the Joint Strategic Needs Assessment and is reflected in local strategies such as the HWB strategy, community safety strategy, alcohol or domestic violence strategies. |
| <input checked="" type="checkbox"/> | Publishing a separate strategic statement setting out how this issue will be addressed locally. |
| <input checked="" type="checkbox"/> | Ensuring that the new Safeguarding Adults Board reflects the importance of tackling alcohol problems when protecting vulnerable people. |
| TRAINING | |
| Local alcohol commissioners must ensure that: | |
| <input checked="" type="checkbox"/> | Non-alcohol specialists, both workers and commissioners, understand that people may have problems with alcohol without conforming to the stereotype of the alcoholic. |
| <input checked="" type="checkbox"/> | Non-alcohol specialists working with domestic violence are trained to use the AUDIT tool and Brief Advice model. |
| <input checked="" type="checkbox"/> | All staff working with alcohol and domestic violence are trained in the techniques for working with change resistant drinkers set out in the Blue Light manual. |
| ASSESSMENT AND RISK ASSESSMENT | |
| Local commissioners of both domestic abuse and alcohol services must ensure that: | |
| <input checked="" type="checkbox"/> | People working with domestic violence are actively curious about the drinking patterns of the victim and the perpetrator when undertaking assessments. |
| <input checked="" type="checkbox"/> | Risk assessment systems need to adequately reflect the seriousness and dynamic nature of the risk associated with problem drinking in the context of domestic violence. |
| <input checked="" type="checkbox"/> | Local staff have training in risk assessment. |
| <input checked="" type="checkbox"/> | Local staff have guidance and training on when information-sharing is appropriate in the context of domestic violence and the legal frameworks which support this. |
| SPECIALIST ALCOHOL SERVICES AND THE PATHWAY INTO THEM | |
| All local commissioners need to ensure that non-alcohol specialist workers do more than simply signpost very risky or very vulnerable drinkers to alcohol services. Commissioners should ensure that workers: | |
| <input checked="" type="checkbox"/> | Actively support the person to attend service. |
| <input checked="" type="checkbox"/> | Follow up with the alcohol service and the client to ensure that the person attended. |
| <input checked="" type="checkbox"/> | Follow the client up if s/he does not attend the service. |

| SPECIALIST ALCOHOL SERVICES AND THE PATHWAY INTO THEM | |
|---|--|
| Alcohol commissioners should ensure that: | |
| ✓ | Alcohol services have interventions that assertively engage drinkers involved in domestic abuse. This should include a focus on services that maintain engagement and follow people up if they disengage. |
| ✓ | The response to this group is included in service specifications, service reviews and audit processes. |
| ✓ | Procedures and pathways about the identification and management of alcohol related domestic violence should be developed in each hospital focused on and led by the alcohol liaison workers in the hospital. |
| ✓ | The development of services for the families of problem drinkers may be one part of the response to alcohol related domestic abuse. |
| LEGAL POWERS | |
| Alcohol and domestic violence commissioners, police officers and community safety staff should consider: | |
| ✓ | The potential use of civil injunctions and criminal behaviour orders in the context of alcohol related domestic violence. In particular the positive use of the “requirement” aspect of these powers. |
| LEGAL POWERS | |
| Commissioners in public health and the CCGs should ensure that: | |
| ✓ | Seamless services exist for people with both alcohol and mental health problems and are experiencing or perpetrating domestic violence. |



APPENDIX 1 – The DHR reports

| Area | Date | Number | Alcohol involved |
|----------------|------|--------|------------------|
| Wiltshire | 2012 | 2 | Yes |
| Durham | 2013 | 1 | Yes |
| Medway | 2011 | 1 | Yes |
| Medway | 2011 | 3 | Yes |
| Medway | 2011 | 2 | Yes |
| Norfolk | 2013 | | Yes |
| Southampton | 2011 | | Yes |
| Doncaster | 2011 | 2 | Yes |
| Newcastle | 2012 | | Yes |
| Rochdale | 2012 | | Yes |
| Southend | 2014 | 1 | Yes |
| Chelmsford | 2013 | 1 | Yes |
| Guildford | 2013 | 1 | Yes |
| Stockport | 2012 | 1 | Yes |
| Kirklees | 2011 | 1 | Yes |
| Sheffield | 2013 | D | Yes |
| Sheffield | 2012 | C | Yes |
| Trafford | 2012 | | Yes |
| Oxford | 2014 | | Yes |
| South Notts | 2013 | | Yes |
| Sefton | 2012 | A | Yes |
| South Lakeland | 2014 | | Yes |
| Somerset | 2013 | | Yes |
| Wirral | 2013 | C | Yes |
| Wirral | 2012 | E | Yes |
| Stevenage | 2012 | AA | Yes |
| Peterborough | 2013 | VB | Yes |
| Leicester | 2014 | | Yes |
| Wolverhampton | 2012 | 1 | No |
| Wiltshire | 2013 | 1 | No |
| Medway | 2012 | 1 | No |
| Newham | 2011 | | No |
| Birmingham | 2013 | 1 | No |
| Sheffield | 2011 | A | No |
| Kingston | 2014 | | No |
| Herefordshire | 2014 | | No |
| Essex | 2013 | | No |
| Wirral | 2012 | B | No |

APPENDIX 2 – Audit tool

This is one unit of alcohol...



half pint
of regular beer



1 small glass
of wine



1 single measure
of spirits



1 small glass
of cherry



1 single measure
of aperitifs

...and each of these is more



Pint of Regular
Beer/Lager/Cider



Pint of
Premium Beer/
Lager/Cider



Alcopop or
Can/Bottle of
Regular Lager



Can of
Premium
Lager or
Strong Beer



Can of
Super
Strength
Lager



Glass of
Wine
(175ml)



Bottle of
Wine

| AUDIT | SCORING SYSTEM | | | | | YOUR SCORE |
|--|----------------|-------------------|-------------------------------|----------------------|---------------------------|------------|
| | 0 | 1 | 2 | 3 | 4 | |
| How often do you have a drink containing alcohol? | Never | Monthly or less | 2 - 4 times per month | 2 - 3 times per week | 4+ times per week | |
| How many units of alcohol do you drink on a typical day when you are drinking? | 1 - 2 | 3 - 4 | 5 - 6 | 7 - 9 | 10+ | |
| How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | |
| How often during the last year have you found that you were not able to stop drinking once you had started? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | |
| How often during the last year have you failed to do what was normally expected from you because of your drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | |
| How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | |
| How often during the last year have you had a feeling of guilt or remorse after drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | |
| How often during the last year have you been unable to remember what happened the night before because you had been drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | |
| Have you or somebody else been injured as a result of your drinking? | No | | Yes, but not in the last year | | Yes, during the last year | |
| Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down? | No | | Yes, but not in the last year | | Yes, during the last year | |
| SCORE | | | | | | |

Scoring: 0 – 7 Lower risk | 8 – 15 Increasing risk | 16 – 19 Higher risk | 20+ Dependent

APPENDIX 3 – CAADA-DASH Risk Identification Checklist for use by IDVAs and other non-police agencies when domestic abuse, ‘honour’- based violence and/or stalking are disclosed

| Please explain that the purpose of asking these questions is for the safety and protection of the individual concerned. Tick the box if the factor is present. Please use the comment box at the end of the form to expand on any answer. It is assumed that your main source of information is the victim. If this is not the case please indicate in the right hand column | Yes (tick) | No | Don't Know | State source of info if not the victim e.g. police officer |
|--|--------------------------|--------------------------|--------------------------|---|
| 1. Has the current incident resulted in injury? (Please state what and whether this is the first injury.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 2. Are you very frightened? Comment: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 3. What are you afraid of? Is it further injury or violence? (Please give an indication of what you think (name of abuser(s)...) might do and to whom, including children). Comment: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 4. Do you feel isolated from family/friends i.e. does (name of abuser(s)) try to stop you from seeing friends/family/doctor or others? Comment: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 5. Are you feeling depressed or having suicidal thoughts? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 6. Have you separated or tried to separate from (name of abuser(s)....) within the past year? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 7. Is there conflict over child contact? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 8. Does (.....) constantly text, call, contact, follow, stalk or harass you? (Please expand to identify what and whether you believe that this is done deliberately to intimidate you? Consider the context and behaviour of what is being done.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 9. Are you pregnant or have you recently had a baby (within the last 18 months)? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 10. Is the abuse happening more often? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 11. Is the abuse getting worse? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 12. Does (.....) try to control everything you do and/or are they excessively jealous? (In terms of relationships, who you see, being ‘policed at home’, telling you what to wear for example. Consider ‘honour’-based violence and specify behaviour.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |

| Tick box if factor is present. Please use the comment box at the end of the form to expand on any answer. | Yes (tick) | No | Don't Know | State source of info if not the victim e.g. police officer |
|---|--------------------------|--------------------------|--------------------------|--|
| 13. Has (.....) ever used weapons or objects to hurt you? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 14. Has (.....) ever threatened to kill you or someone else and you believed them? (If yes, tick who.) You <input type="checkbox"/> Children <input type="checkbox"/> Other (please specify) <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 15. Has (.....) ever attempted to strangle/choke/suffocate/drown you? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 16. Does (.....) do or say things of a sexual nature that make you feel bad or that physically hurt you or someone else? (If someone else, specify who.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 17. Is there any other person who has threatened you or who you are afraid of? (If yes, please specify whom and why. Consider extended family if HBV.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 18. Do you know if (.....) has hurt anyone else? (Please specify whom including the children, siblings or elderly relatives. Consider HBV.) Children <input type="checkbox"/> Another family member <input type="checkbox"/> Someone from a previous relationship <input type="checkbox"/> Other (please specify) <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 19. Has (.....) ever mistreated an animal or the family pet? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 20. Are there any financial issues? For example, are you dependent on (.....) for money/have they recently lost their job/other financial issues? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 21. Has (.....) had problems in the past year with drugs (prescription or other), alcohol or mental health leading to problems in leading a normal life? (If yes, please specify which and give relevant details if known.) Drugs <input type="checkbox"/> Alcohol <input type="checkbox"/> Mental Health <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 22. Has (.....) ever threatened or attempted suicide? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 23. Has (.....) ever broken bail/an injunction and/or formal agreement for when they can see you and/or the children? (You may wish to consider this in relation to an ex-partner of the perpetrator if relevant.) Bail conditions <input type="checkbox"/> Non Molestation/Occupation Order <input type="checkbox"/> Child Contact arrangements <input type="checkbox"/> Forced Marriage Protection Order <input type="checkbox"/> Other <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 24. Do you know if (.....) has ever been in trouble with the police or has a criminal history? (If yes, please specify.) DV <input type="checkbox"/> Sexual violence <input type="checkbox"/> Other violence <input type="checkbox"/> Other <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Total 'yes' responses | | | | |

For consideration by professional: Is there any other relevant information (from victim or professional) which may increase risk levels? Consider victim's situation in relation to disability, substance misuse, mental health issues, cultural/language barriers, 'honour'-based systems and minimisation. Are they willing to engage with your service? Describe:

Consider abuser's occupation/interests - could this give them unique access to weapons? Describe:

What are the victim's greatest priorities to address their safety?

Do you believe that there are reasonable grounds for referring this case to MARAC? Yes / No

If yes, have you made a referral? Yes/No

Signed:

Date:

Do you believe that there are risks facing the children in the family? Yes / No

If yes, please confirm if you have made a referral to safeguard the children: Yes / No

Date referral made

Signed:

Date:

Name:

APPENDIX 4 – Safety planning template

Section 1 – General questions to ask

- When was the most recent incidence of violence or abuse? Frequency, severity, where/when etc.?
- What do you currently do to keep you and your children safe? What works best?
- Do the children know how to contact services or friends/family?
- Who can you tell about the violence – someone who will not tell your partner/ex-partner?
- Do you have important phone numbers available e.g. family, friends, refuges, police?
- If you left, where could you go?
- Do you ever know in advance when your partner is going to be violent? e.g. after drinking, when they get paid, after relatives visit?
- When you suspect he is going to be violent can you go elsewhere?
- Can you keep a bag of spare clothes at a friend's or family member's house?
- Are you able to keep copies of any important papers with anyone else? e.g. passport, birth certificates, benefit book?
- Which part of your home do you feel safest in?
- Is there somewhere for your children to go when your partner is being violent and abusive?
- What is the most dangerous part of your house to be in when he is violent?
- Can you begin to save any money independently of your partner?

It is also important to help the survivor to focus on the more positive things going on in her life and/or identify ways she could access activities which would help improve confidence, self esteem, emotional well-being, etc.

Section 2 – Additional considerations and questions about substance use

Issues to consider for safety planning with survivors using substances:

- Some survivors' drug or alcohol use could make it difficult for them to assess the severity of the violence they are experiencing. Their substance use may be 'dulling' both the physical and mental pain they are in.
- Survivors who are using substances may be too ashamed or embarrassed about their substance use to access services
- Some women may feel they cannot disclose their substance use problem for fear of not being given access to refuge accommodation
- Trust is paramount. Problem alcohol or drug-using women caring for their children fear automatic referral to social services departments, if they disclose
- Some survivors may have had previous bad experiences with substance misuse which may hinder their choice to engage with new services

For survivors who use drugs or alcohol, the safety plan should cover the additional risks associated with these needs.

- Is the plan realistic? Can the service user implement the safety plan when they're intoxicated?
- Consideration of how a survivor's drinking may impact on their ability to protect themselves - they are more likely to fight back and receive worse injuries etc.
- Discussion of harm minimization (local alcohol service could assist with this)
- What provisions are made for children when violence happens when drinking?
- What response might survivors receive from services/police, etc. when they make contact under the influence of alcohol/drugs? Survivors may have a history with services, e.g. the police, relating to their alcohol use.

- Staying safe when services arrive? Some women see this as a safe opportunity to challenge their partner/become more aggressive themselves when the police are there - this then impacts on them being seen as the aggressor and taken less seriously
- Does the plan incorporate strategies to promote access to alcohol treatment? It can be empowering for a survivor to realise the abuser wants them to remain alcohol dependent and to plan for interference with their treatment.
- Consider vulnerability/safety when entering new relationships if survivor has problems alcohol.
- Can you include changes to patterns of substance use that may increase safety? For example, drinking at times of day that their partner is unlikely to be around.
- The location of where a survivor goes to drink – how does this impact on safety?
- Anticipating partner’s substance use – how to keep safer when they have been using/drinking?
- Detox/withdrawal/relapse on the part of the perpetrator can be dangerous times in terms of safety

Section 3 – Types of actions to include

What should a safety plan cover?

Safety in the relationship

- Places to avoid when abuse starts (such as the kitchen, where there are many potential weapons).
- People a woman can turn to for help or let know that they are in danger.
- Asking neighbours or friends to call 999 if they hear anything to suggest a woman or her children are in danger.
- Places to hide important phone numbers, such as helpline numbers.
- How to keep the children safe when abuse starts.
- Teaching the children to find safety or get help, perhaps by dialling 999.
- Keeping important personal documents in one place so that they can be taken if a woman needs to leave suddenly.
- Letting someone know about the abuse so that it can be recorded (important for cases that go to court or immigration applications, for example).

Leaving in an emergency

- Packing an emergency bag and hiding it in a safe place in case a woman needs to leave in an emergency.
- Plans for who to call and where to go (such as a domestic violence refuge).
- Things to remember to take: documents, medication, keys or a photo of the abuser (useful for serving court documents).
- Access to a phone.
- Access to money or credit/debit cards that a woman has perhaps put aside.
- Plans for transport.
- Plans for taking clothes, toiletries and toys for the children.
- Taking any proof of the abuse, such as photos, notes or details of people who know about it.

Safety when a relationship is over

- Contact details for professionals who can advise or give vital support.
- Changing landline and mobile phone numbers.
- How to keep her location secret from her partner if she has left home (by not telling mutual friends where she is, for example).
- Getting a non-molestation or exclusion or a restraining order.
- Plans for talking to any children about the importance of staying safe.
- Asking an employer for help with safety while at work.

APPENDIX 5 – Domestic abuse support options

| INTERVENTION | DESCRIPTION |
|--|--|
| Non-molestation order | A type of civil injunction that aims to stop someone from using or threatening violence against another person with whom they have (had) a relationship (either intimate relationship, family members, live together, have a child together, etc.), or intimidating, harassing or pestering the person. The order may state that the person is not allowed to make contact with the other party or come within a certain distance of them. Breaching this order is a criminal offence. |
| Occupation order | A type of civil injunction that regulates who can live in the family home. The order can temporarily remove the abuser's right to live in the home and can also restrict him from entering the area surrounding the home. You can have a power of arrest attached to the order. |
| Domestic Violence Protection Notice/ Order | These are new provisions that give the police to exclude a perpetrator from a property if they believe he has been violent or threatened violence and may do so again. The police can issue a notice for the perpetrator to leave the home immediately. They may follow this with an application to the Magistrate's court for an order that excludes the individual from their home for 14-28 days. |
| Sanctuary Scheme | Many areas provide this scheme but it might have a different name. Often based in the local authority housing team, the scheme provides additional security measures to a victim's home so that they feel safe. |
| Restraining order | This is a type of protection order that the criminal courts can make following conviction or acquittal for any criminal offence whereby the perpetrator and victim/witness may continue to have contact and the court deems there to be an on-going threat of harm to the victim/witness. Victims of stalking and harassment from people they are not 'associated to' can also apply to the civil courts for this order. Breaching this order is a criminal offence. |
| Multi-Agency Risk Assessment Conference (MARAC) | This meeting takes place on a regular basis and involves representatives from multiple agencies coming together to discuss high-risk cases of domestic violence. |
| Sexual Assault Referral Centre (SARC) | Victims of recent sexual violence may be referred here for medical treatment and forensic exams. Counselling and advocacy services are often also available from these centres. |
| Forced Marriage Protection Order | This is a civil order that may be made by the family court to prevent a person being made to marry another person when they do not want to. It also prohibits the removal of a person to another country for the purposes of forced marriage. |

| INTERVENTION | DESCRIPTION |
|--|---|
| Independent Domestic Violence Advisor (IDVA) | This professional provides short-term advice and advocacy to high-risk victims of domestic violence. |
| Destitution Domestic Violence Concession | Usually victims of domestic violence from outside the UK have no recourse to public funds. This means they are unable to access welfare benefits and social housing, which in turn restricts their ability to leave an abusive partner. If a victim is in the UK on a spousal visa, they can apply for this concession which will provide them with twelve weeks of benefits during which time they can make an application for indefinite leave to remain in the UK. |
| Domestic Violence Disclosure Scheme (Clare's Law) | Launched in 2014, this provides the public with 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 violent towards their partner. This is known as the 'right to ask'. |
| Police Marker | If this measure is in place, when the victim calls the police they should attend the incident as a priority. |



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- ¹ Safe Durham Partnership Board - Domestic Homicide Overview Report - 2013 (p.28)
- ² Galvini, S. (2004). Responsible Disinhibition: Alcohol, Men and Violence to Women. *Addiction Research and Theory*, 12:4, pp. 357-371; Gilcrest, E., Johnson, R., Takriti, T. Weston, S., Beech, A. & Kebbell, M. (2003) DV Offenders; characteristics and offending related need, Findings 217, London: Home Office
- ³ We recommend that this document is read in conjunction with Alcohol Concern's, Embrace Project, which contains useful information on the complex relationship between alcohol and domestic violence, Embrace Project – Knowledge Set 1: Domestic Abuse, - 2009, available online: http://www.alcoholconcern.org.uk/wp-content/uploads/woocommerce_uploads/2014/10/Knowledge-set-1.pdf
- ⁴ Throughout this document we will refer to domestic abuse – this reflects that domestic violence encompasses a range of behaviours including financial, physical, sexual, psychological and emotional – however, the term violence often means the controlling and coercion common in domestic violence are not properly understood. In this document we use abuse to reflect the range of behaviours and in recognition of how victim / survivors understand their experiences.
- ⁵ See for example AVA's Stella Project Complicated Matters Toolkit, available online [http://www.avaproject.org.uk/our-resources/good-practice-guidance--toolkits/complicated-matters-stella-project-toolkit-and-e-learning-\(2013\).aspx](http://www.avaproject.org.uk/our-resources/good-practice-guidance--toolkits/complicated-matters-stella-project-toolkit-and-e-learning-(2013).aspx), and Alcohol Concern's Embrace Project, available at http://www.alcoholconcern.org.uk/wp-content/uploads/woocommerce_uploads/2014/10/Knowledge-set-1.pdf
- ⁶ Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews, Revised – applicable to all notifications made from and including 1 August 2013, Home Office, 2013, available online, <https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews> (accessed July 20 2015), p. 5.
- ⁷ Indeed, there is a growing recognition of the need to understand and target multiple needs and have more joined up working for those accessing services, see the MEAM coalition, <http://meam.org.uk/>.
- ⁸ Care and Support Statutory Guidance, Issued under the Care Act 2014, Department of Health, pp. 234-235.
- ⁹ Local Government Association, Adult Safeguarding and Domestic Abuse: A Guide to Support Practitioners and Managers (2015)
- ¹⁰ http://www.alcohollearningcentre.org.uk/_library/Alcohol_Care_in_Englands_Hospitals_An_opportunity_not_to_be_wasted_PHE_Nov_14.pdf
- ¹¹ http://www.alcohollearningcentre.org.uk/_library/Alcohol_Care_in_Englands_Hospitals_An_opportunity_not_to_be_wasted_PHE_Nov_14.pdf
- ¹² Home Office 2012
- ¹³ Embrace Project – Knowledge Set 1: Domestic Abuse, - 2009, available online: http://www.alcoholconcern.org.uk/wp-content/uploads/woocommerce_uploads/2014/10/Knowledge-set-1.pdf, p. 1
- ¹⁴ For guidance on DHRs see: <https://www.gov.uk/government/collections/domestic-homicide-review>
- ¹⁵ Sefton Safer Communities Partnership - Domestic Homicide Review Overview Report Victim Female A (p.64)
- ¹⁶ Kirklees Partnership - Report Into The Death Of Adult A In June 2011- 2013. Although it is important to recognise the limits of the Crime Survey of England and Wales around domestic violence, particularly its recording of one-off-incidents and the limits in recording of repeat incidents, see Sylvia Walby, Jude Towers and Brian Francis, 'Mainstreaming Domestic and Gender-Based Violence into Sociology and the Criminology of Violence,' *The Sociological Review* (2014), pp. 187-214.
- ¹⁷ North Somerset Community Safety Partnership - Domestic Homicide Review Overview Report Into The Death Of Adult Male John - November 2013
- ¹⁸ Kent and Medway Community Safety Partnerships - Domestic Homicide Review: Christopher/2011 (p.36)
- ¹⁹ Sefton Safer Communities Partnership - Domestic Homicide Review Overview Report Victim Female A (pp. 32-38)
- ²⁰ Safe Durham Partnership Board - Domestic Homicide Overview Report – 2013 (p.20)

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- ²¹ Trafford Partnership – Domestic Homicide review in Respect of MLK – 2012 (p.20)
- ²² Rochdale Safer Communities Partnership - Male 1 – 2012 (p.8)
- ²³ Kent Community Safety Partnership FL/2011 – Domestic Homicide Review (p.25)
- ²⁴ Information supplied to the authors by Public Health England - 2015
- ²⁵ Alcohol Concern (2014), Working With Change Resistant Drinkers: The Project Manual, London: Alcohol Concern, available at <http://www.alcoholconcern.org.uk/wp-content/uploads/2015/01/Alcohol-Concern-Blue-Light-Project-Manual.pdf>
- ²⁶ Wiltshire Domestic Homicide Review EXECUTIVE SUMMARY OF THE OVERVIEW REPORT
Into the death of Adult Y on 20th November 2012
- ²⁷ Rochdale Safer Communities Partnership - Male 1 - 2012 (p.31)
- ²⁸ Kirklees Partnership - Report Into The Death Of Adult A In June 2011- 2013 (p.15)
- ²⁹ Sefton Safer Communities Partnership - Domestic Homicide Review Overview Report Victim Female A (p.17)
- ³⁰ Sefton Safer Communities Partnership - Domestic Homicide Review Overview Report Victim Female A (p.17)
- ³¹ A recent study of men asked about their uses and experiences of violence found that 'there were no associations between problematic drinking patterns and negative behaviours, Hester M, Ferrari G, Jones SK, et al. Occurrence and impact of negative behaviour, including domestic violence and abuse, in men attending UK primary care health clinics: a cross sectional survey, *BMJ Open* 2015, p. 8; see also:., Kenneth E. Leonard a,b, 'Alcohol expectancies and intoxicated aggression', *Aggression and Violent Behavior* (2006), pp. 484–496; Galvini, S. (2004). *Responsible Disinhibition: Alcohol, Men and Violence to Women*. *Addiction Research and Theory*, 12:4, pp. 357-371.
- ³² Essex Domestic Homicide Overview Report - Fiona Johnson – April 2013
- ³³ http://www.alcoholconcern.org.uk/wp-content/uploads/woocommerce_uploads/2014/12/Grasping-the-nettle-factsheet-revised-June-2010.pdf
- ³⁴ Wirral Community Safety Partnership - Overview Report of Domestic Homicide Review - December 2012 (p.6)
- ³⁵ Kent and Medway Community Safety Partnerships - Domestic Homicide Review: Christopher/2011 (p.8)
- ³⁶ Safer Guildford - Report into the death of Adult A – March 2013 (p.6)
- ³⁷ Safer Stockport Partnership – Overview Report Subject: MS Date of Death: 4th February 2012 (p.10)
- ³⁸ Safe Durham Partnership Board - Domestic Homicide Overview Report - 2013 (p.10, 13 & 17)
- ³⁹ Kent Community Safety Partnership FL/2011 – Domestic Homicide Review (p.6)
- ⁴⁰ Safer Doncaster - Report Into The Death Of Adult 'X' – 2013 (p.12)
- ⁴¹ Leicestershire - Report Into The Death Of 'Mary' – 2014 (p.54)
- ⁴² Rochdale Safer Communities Partnership - Male 1 – 2012 (p.8)
- ⁴³ Hester, M, *Who does What to Whom? Gender and Domestic Violence Perpetrators*, Bristol: University of Bristol in Association with the Northern Rock Foundation
- ⁴⁴ Hester, M, *Who does What to Whom? Gender and Domestic Violence Perpetrators*, Bristol: University of Bristol in Association with the Northern Rock Foundation; Williams, S. (2006) *How Far Do the Concepts of Diminished Responsibility, Battered Women's Syndrome and Learned Helplessness Account for Women Doing Violence?. M.A. Thesis*, available for download at www.mensadvice.org.uk/research; Hester, M. (2012). *Portrayal of Women as Intimate Partner Domestic Violence Perpetrators*. *Violence Against Women*, 18:9, 1067-1082
- ⁴⁵ National Policing Improvement Agency (NPIA) (2008). *Association of Chief Police Officers' Guidance on Investigating Domestic Abuse*. London: NPIA

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- ⁴⁶ Hester, M, Who does What to Whom? Gender and Domestic Violence Perpetrators, Bristol: University of Bristol in Association with the Northern Rock Foundation; Williams, S. (2006) How Far Do the Concepts of Diminished Responsibility, Battered Women's Syndrome and Learned Helplessness Account for Women Doing Violence?. M.A. Thesis, available for download at www.mensadviceline.org.uk/research; Hester, M. (2012). Portrayal of Women as Intimate Partner Domestic Violence Perpetrators. *Violence Against Women*, 18:9, 1067-1082
- ⁴⁷ Walby, S., & Allen, J. (2004). *Domestic Violence, Sexual Assault and Stalking: Findings from the British Crime Survey*. Home Office.
- ⁴⁸ Monckton-Smith, J., Williams, A. with Mullane, F. (2014), *Domestic Abuse, Homicide and Gender: Strategies for Policy and Practice*
- ⁴⁹ Flood-Page, C & Taylor, J. (eds) *Crime in England & Wales, 2001/2002*, London, Home Office
- ⁵⁰ Karen Ingala Smith, 'Sex Differences and Domestic Violence Murders,' available at: <https://kareningalasmith.com/2015/03/14/sex-differences-and-domestic-violence-murders/>
- ⁵¹ There has been a range of research looking at this: Dugan, L., Rosenfeld, R., & Nagin, D. S. (2003). Exposure reduction or retaliation? The effects of domestic violence resources on intimate-partner homicide. *Law & Society Review*, 37(1), 169-198; Stark, E. (2007). *Coercive control: How men entrap women in personal life*. Oxford: Oxford University Press.
- ⁵² Essex Domestic Homicide Overview Report - Fiona Johnson – April 2013
- ⁵³ Sefton Safer Communities Partnership - Domestic Homicide Review Overview Report Victim Female A
- ⁵⁴ Sefton Safer Communities Partnership - Domestic Homicide Review Overview Report Victim Female A (p.32)
- ⁵⁵ Rochdale Safer Communities Partnership - Domestic Homicide Review - Victim Male 1 - Died August 2011 Section 6.3.3
- ⁵⁶ Kent and Medway Community Safety Partnerships - Domestic Homicide Review: Christopher/2011 (p.57)
- ⁵⁷ Leicestershire - Report Into The Death Of 'Mary' -2014 (p.34)
- ⁵⁸ Trafford Partnership – Domestic Homicide review in Respect of MLK – 2012 (p.20)
- ⁵⁹ www.alcohollearningcentre.gov.uk
- ⁶⁰ Swan, S., Farber, S. and Campbell, D. (2001). *Violence in the Lives of Women in Substance abuse Treatment: Service and Policy Implications*, Report to the New York State Office for the Prevention of Domestic Violence. Rensselaer, New York; International Society for Traumatic Stress Studies (ISTSS) (2001). *Traumatic Stress and Substance Use Problems*. Northbrook: ISTSS; Weaver, T., Madden, P., Charles, V., et al (2003). Co-morbidity of substance misuse and mental illness in community mental health and substance misuse services. *British Journal of Psychiatry*, 183, 304-313.
- ⁶¹ Lankelly Chase's research on severe and multiple disadvantage has similar findings, revealing that many individuals nationally who are within the criminal justice system, use substance and are homeless have experiences lives marked by trauma, Lankelly Chase Foundation. (2015). *Hard Edges: Mapping severe and multiple disadvantage*. Available at: <http://lankellychase.org.uk/multiple-disadvantage/publications/hard-edges/> (last accessed April 28 2015)
- ⁶² Howard, L.M., Trevillion, K. & Agnew-Davies, R. (2010). Domestic violence and mental health. *International Review of Psychiatry*, 22:5, 525-534; Coker, A., Smith, P., Bethea, L., King, M., & McKeown, R. (2000). Physical Health Consequences of Physical and Psychological Intimate Partner Violence. *Archives of Family Medicine*, 9:5, 451-457.
- ⁶³ Judith Herman, outlines the debilitating impact of abuse and the trauma consequences in; *Trauma and Recovery: The Aftermath of Violence – from Domestic Abuse to Political Terror* (London, 1992)
- ⁶⁴ For more information on trauma and support around those experiencing trauma related to domestic violence see: AVA's Stella Project Complicated Matters Toolkit, available online [http://www.avaproject.org.uk/our-resources/good-practice-guidance--toolkits/complicated-matters-stella-project-toolkit-and-e-learning-\(2013\).aspx](http://www.avaproject.org.uk/our-resources/good-practice-guidance--toolkits/complicated-matters-stella-project-toolkit-and-e-learning-(2013).aspx), particularly section 2.
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- ⁶⁵ NICE Public Health Guidance 24 (2010) Alcohol-use disorders: preventing harmful drinking. Accessed at www.guidance.nice.org.uk/ph24
- ⁶⁶ Sheffield First - Report Into The Death Of Adult C - 2012 (p.54)
- ⁶⁷ Safe Durham Partnership Board - Domestic Homicide Overview Report – 2013 (p.37)
- ⁶⁸ Kent and Medway Community Safety Partnerships - Domestic Homicide Review: Christopher/2011 (p.20)
- ⁶⁹ Trafford Partnership – Domestic Homicide review in Respect of MLK – 2012 (p.20)
- ⁷⁰ Safe Durham Partnership Board - Domestic Homicide Overview Report – 2013 (p.36)
- ⁷¹ Kirklees Partnership - Report Into The Death Of Adult A In June 2011- 2013 (p.54)
- ⁷² Southampton Safe City Partnership – Report into the Death of Miss Y (p.33)
- ⁷³ NICE Public Health Guidance 24 (2010) Alcohol-use disorders: preventing harmful drinking. Accessed at www.guidance.nice.org.uk/ph24
- ⁷⁴ Primary Healthcare European Project on Alcohol - Are brief interventions effective in reducing hazardous and harmful alcohol consumption? – 2005 at <http://www.gencat.cat/salut/phepa/units/phepa/html/en/dir354/doc9888.html>
- ⁷⁵ Scottish Intercollegiate Guidelines Network- The management of Harmful Drinking and Alcohol Dependence in Primary Care. Section 3 Brief Interventions for Hazardous and Harmful Drinking – 2013 at <http://www.sign.ac.uk/guidelines/fulltext/74/section3.html#>
- ⁷⁶ Raistrick D., Heather N., Godfrey C. (2006) Review of the Effectiveness of Treatment for Alcohol Problems, National Treatment Agency.
- ⁷⁷ Department of Health data based on unpublished analysis by Dr. Peter Anderson (former WHO advisor) of the Whitlock study
- ⁷⁸ <http://alcoholiba.com/2012/05/15/sips-largest-ever-uk-study-into-alcohol-brief-interventions/>
- ⁷⁹ National Policing Improvement Agency (NPIA) (2008). Association of Chief Police Officers' Guidance on Investigating Domestic Abuse. London: NPIA
- ⁸⁰ This information is based on a screening tool originally developed by GLBT Domestic Violence Coalition in Massachusetts (Intimate Partner Screening Tool for GLBT Relationships) that has been adapted and used by the Dyn Project and the Men's Advice Line (two services for male victims) to assist in determining 'who is doing what to whom and with what effect.' We would strongly recommend that only trained practitioners make use of this screening tool.
- ⁸¹ South Lakeland Community Safety Partnership 2014 (para. 113)
- ⁸² i.e. Safer Guildford, Rochdale, Stockport, Doncaster 2, Medway FL/2011
- ⁸³ Safe Newcastle - Review Report Into The Death Of Jane (p.20)
- ⁸⁴ Information on static and dynamic risk can be found in the Stella Project Briefing Paper: Working with domestic violence perpetrators within drug/alcohol services, available online: <http://www.avaproject.org.uk/media/37355/stella%20project%20briefing%20working%20with%20perps%20nov%2008.pdf>
- ⁸⁵ E.g. Sheffield Adult D 2013, North Somerset Community Safety Partnership - Domestic Homicide Review Overview Report Into The Death Of Adult Male John - November 2013, Safer Stockport Partnership – Overview Report Subject: MS Date of Death: 4th February 2012
- ⁸⁶ Kent Community Safety Partnership FL/2011 – Domestic Homicide Review (p.6)
- ⁸⁷ E.g. Bedford Borough Community Safety Partnership - Review Report Into The Death Of Ms D -2012 (para 3.49) or Leicestershire - Report Into The Death Of 'Mary' - 2014(p.27)
- ⁸⁸ Kent Community Safety Partnership FL/2011 – Domestic Homicide Review (p.6)
- ⁸⁹ Safe Newcastle - Review Report Into The Death Of Jane (p.20)
- ⁹⁰ Local Government Association, Guide to the Care Act 2014 and the implications for providers, available online: <http://www.local.gov.uk/documents/10180/6869714/L14759+Guide+to+the+Care+Act.pdf/>
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- ⁹¹ South Lakeland Community Safety Partnership 2014 para 87 & 88
- ⁹² Kent and Medway Community Safety Partnerships - Domestic Homicide Review: Cydney/2011 (p.28)
- ⁹³ Kent Community Safety Partnership FL/2011 – Domestic Homicide Review (pp.9 & 12)
- ⁹⁴ Kent Community Safety Partnership FL/2011 – Domestic Homicide Review (p.16)
- ⁹⁵ Safer Doncaster - Report Into The Death Of Adult 'X' – 2013 (p.27)
- ⁹⁶ Safe Newcastle - Review Report Into The Death Of Jane (p.46)
- ⁹⁷ Southampton Safe City Partnership – Report into the Death of Miss Y (p.25)
- ⁹⁸ Kirklees Partnership - Report Into The Death Of Adult A In June 2011- 2013 (p.22)
- ⁹⁹ Hester, M. et al. (201). Occurrence and impact of negative behaviour, including domestic violence and abuse, in men attending UK primary care health clinics: a cross-sectional survey. *BMJ Open* 5, 1-10.
- ¹⁰⁰ Kirklees Partnership - Report Into The Death Of Adult A In June 2011- 2013 (Recommendation 15) (pp.43-44)
- ¹⁰¹ For more information on women centered working see: <http://www.womencentredworking.com/>
- ¹⁰² South Lakeland Community Safety Partnership 2014 (Para 46)
- ¹⁰³ Kent Community Safety Partnership FL/2011 – Domestic Homicide Review (p.24-25)
- ¹⁰⁴ Southampton Safe City Partnership – Report into the Death of Miss Y (p.13)
- ¹⁰⁵ Safer Doncaster - Report Into The Death Of Adult 'X' – 2013 (p.50)
- ¹⁰⁶ Southend community safety partnership - Domestic Homicide Review The AB Case - January 2013 (p.11)
- ¹⁰⁷ Kirklees Partnership - Report Into The Death Of Adult A In June 2011- 2013 (p.28)
- ¹⁰⁸ North Somerset Community Safety Partnership - Domestic Homicide Review Overview Report Into The Death Of Adult Male John - November 2013 (p.6)
- ¹⁰⁹ Hien, D., Cohen, L. & Campbell, A. (2005). Is traumatic stress a vulnerability factor for women with substance use disorders? *Clinical Psychology Review*, 25, 813-823; Gutierrez, S.E. & Van Puymbroeck, C. (2006). Childhood and adult violence in the lives of women who misuse substances. *Aggression and Violent Behavior* 11:5, 497-513.
- ¹¹⁰ Department of Health - Models of Care for Alcohol Misuse - 2006
- ¹¹¹ Al-Anon is a sister organisation to Alcoholics Anonymous which supports the family members/loved ones of drinkers see www.al-anonuk.org.uk
- ¹¹² <http://www.avaproject.org.uk/our-projects/stella-project.aspx>
- ¹¹³ Leicestershire - Report Into The Death Of 'Mary' -2014 (p.23)
- ¹¹⁴ Safe Newcastle - Review Report Into The Death Of Jane (p.18)
- ¹¹⁵ AVA and Solace Women's Aid. (2014). Case by case, op cit (see footnote 25).
- ¹¹⁶ Sefton Safer Communities Partnership - Domestic Homicide Review Overview Report Victim Female A (p.68)
- ¹¹⁷ <http://www.respectphoneline.org.uk/>
- ¹¹⁸ South Lakeland Community Safety Partnership 2014 (p.15)
- ¹¹⁹ Sheffield First - Report Into The Death Of Adult C – 2012 (p.12)
- ¹²⁰ Leicestershire - Report Into The Death Of 'Mary' -2014 (p.12)
- ¹²¹ Oxford Safer Communities Partnership - DHR Overview Report – March 2014 (p.21)
- ¹²² Sheffield First - Report Into The Death Of Adult C – 2012 (p.57)

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- ¹²³ Kent Community Safety Partnership FL/2011 – Domestic Homicide Review (p.13)
- ¹²⁴ Safe Durham Partnership Board - Domestic Homicide Overview Report – 2013 (p.30)
- ¹²⁵ Kent and Medway Community Safety Partnerships - Domestic Homicide Review: Christopher/2011 (p.24)
- ¹²⁶ Kent Community Safety Partnership FL/2011 – Domestic Homicide Review (p.7)
- ¹²⁷ See a range of reports on this: <http://www.avaproject.org.uk/our-resources/reports--publications.aspx>
- ¹²⁸ Oxford Safer Communities Partnership - DHR Overview Report – March 2014 (p.16)
- ¹²⁹ Leicestershire - Report Into The Death Of 'Mary' -2014 (p.23)
- ¹³⁰ Sefton Safer Communities Partnership - Domestic Homicide Review Overview Report Victim Female A (p.54)
- ¹³¹ E.g. The New Directions in the Study of Alcohol Group Conference – May 2015



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