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Number: 45/2014

Building Effective Responses: An Independent Review of Violence against Women, Domestic Abuse and Sexual Violence Services in Wales

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Views expressed in this report are those of the researchers and not necessarily those of the Welsh Government

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Welsh Government Social Research, 2014
ISBN 978-1-4734-1339-9
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Glossary of acronyms

AA	Alcoholics Anonymous
A&E	Accident and Emergency
ACT	Assertive Community Based Treatment
AM	[Welsh] Assembly Member
AVA	Against Violence & Abuse
BCS	British Crime Survey
BMER	Black Minority Ethnic Refugee
BPDVP	Bristol Pregnancy and Domestic Violence Programme
BSc	Bachelor of Science
CAADA	Co-ordinated Action Against Domestic Abuse
CAFCASS	Children and Family Court Advisory and Support Service
CBT	Cognitive Behavioural Therapy
CCR	Co-ordinated Community Response
CEA	Cost-Effectiveness Analysis
CISVA	Children's Independent Sexual Violence Advocate
CPN	Community Psychiatric Nurse
CPS	Crime Prosecution Service
CPT	Cognitive Processing Therapy
CSEW	Crime Survey for England and Wales
CVPP	Cardiff Violence Prevention Programme
DA	Domestic Abuse
DAC	Domestic Abuse Coordinator
DACC	Domestic Abuse Conference Call
DAIP	Domestic Abuse Intervention Project
DATE	Dating Assertiveness Training Experience
DELTA	Domestic Violence Prevention Enhancements and Leadership Through Alliances
DPEW	Dialectical Psychoeducational Workshop
DBT	Dialectical Behaviour Therapy
DDV	Destitution Domestic Violence Concession
DV	Domestic Violence
DVPP	Domestic Violence Perpetrator Programme
DVSA	Domestic Violence Survivor Assessment
EMDR	Eye Movement Desensitization and Reprocessing
FGM	Female Genital Mutilation
FMPO	Forced Marriage Protection Order
FMU	Force Marriage Unit
FORWARD	Foundation for Women's Health Research and Development
GP	General Practitioner
HIV	Human Immunodeficiency Virus
IDAP	Integrated Domestic Abuse Programme
IDVA	Independent Domestic Violence Advocate
IOM	Institute of Medicine
IPV	Intimate Partner Violence
IRIS	Identification and Referral to Improve Safety
ISVA	Independent Sexual Violence Advocate
LA	Local Authority

LGBT	Lesbian, Gay, Bisexual, Transgender
LSOA	Lower-Layer Super Output Area
MARAC	Multi-Agency Risk Assessment Conference
MASH	Multi-Agency Safeguarding Hub
MI	Motivational Interviewing
MOCSA	Metropolitan Organisation to Counter Sexual Assault
MoJ	Ministry of Justice
MOSAIC	Mothers Advocate in the Community
MOST	Men of Strength
NFER	National Foundation for Educational Research
NICE	National Institute for Health and Care Excellence
NORAQ	NorVold Domestic Abuse Questionnaire
NRM	National Referral Mechanism
NSAOH	National Sexual Assault Online Hotline
NSPCC	National Society Prevention of Cruelty to Children
NVQ	National Vocational Qualifications
ONS	Office National Statistics
PEACH	Preventing Domestic Abuse for Children
PEERS	The Prostitutes' Empowerment, Education and Resource Society
PHSE	Personal, Social, Health and Economic Education
PTSD	Post-Traumatic Stress Disorder
RAINN	Rape, Sexual Assault, and Incest National Network
RCT	Randomised Control Trial
RIU	Rape Investigation Unit
SAC	Sexual Assault Center (US)
SANE	Sexual Assault Nurse Examiner
SARC	Sexual Assault Referral Centre
SART	Sexual Abuse Response Team
SOCA	Serious Organised Crime Agency
SOIT	Sexual Offences Investigation Trained
STI	Sexually Transmitted Infection
SURGE	Students Upholding Respect and Gender Equity
SV	Sexual Violence
SVC	Sexual Violence Coordinator
TM	Transtheoretical Model of Change
TREM	Trauma Recovery and Empowerment Model
UKHTC	United Kingdom Human Trafficking Centre
UNICEF	United Nations Children's Fund
VAW	Violence Against Women
VAWDASV	Violence Against Women, Domestic Abuse and Sexual Violence
WAVE	Women and Violence Explored
WIMD	Welsh Index of Multiple Deprivation

Building Effective Responses: An Independent Review of Violence against Women, Domestic Abuse and Sexual Violence Services in Wales:

Summary Report

Vashti Berry, Nicky Stanley, Lorraine Radford, Melanie McCarry and Cath Larkins

1. Introduction

Independent researchers from the Connect Centre for International Research on Interpersonal Violence based in the School of Social Work at the University of Central Lancashire were commissioned by the Welsh Government in 2013 to conduct research into violence against women, domestic abuse and sexual violence services in Wales. The research aimed to inform the forthcoming Ending Violence Against Women and Domestic Abuse (Wales) Bill, implementation of the legislation and future policy more generally, as well as informing future funding decisions.

The remit of the review covers:

- Domestic abuse, including that experienced in Lesbian, Gay, Bisexual and Transgender (LGBT) relationships and elder abuse.
- Violence against women, including female genital mutilation (FGM), forced marriage and honour-based violence.
- Sexual violence including rape, sexual assault and harassment
- Sexual exploitation including prostitution and trafficking[1] for sexual purposes.
- Services for women and men who are victims or perpetrators of violence against women, domestic abuse or sexual violence. The review does not encompass criminal justice services or housing services and, with the exception of prevention work, services for children and young people in Wales were also excluded from this study.

2. Aims

The research aims were:

[1] In January 2014 the Welsh Government amended its use of the term trafficking to modern slavery. This report makes use of the term trafficking; referring specifically to those trafficked for the purposes of sexual exploitation.

1. To construct a typology of the range of relevant services in Wales and beyond, which tackle violence against women, domestic abuse and sexual violence.

2. To assess the existing evidence base underpinning these types of service provision in order to examine their effectiveness, both in terms of outcomes and value for money.

3. To map the current landscape of service provision in Wales.

4. To estimate the prevalence of the different forms of violence against women, domestic abuse and sexual violence and identify the associated need for services.

5. To make recommendations related to informing the Welsh Government's Violence Against Women and Domestic Abuse Team's strategic approach to funding.

3. Methods

A mixture of qualitative and quantitative research methods was used to gather evidence from published research and statistics, to map services across Wales and gain insights into the experiences of service providers and service users. There were five components to the research:

1. Analysis of statistical data from the police in Wales, the Home Office, Forced Marriage Unit (FMU) and the Office of National Statistics (ONS) to assess the prevalence of different forms of domestic and sexual violence across Wales.
2. An online mapping survey, in English and Welsh, received a response from 146 organisations providing 349 specialist, public and voluntary sector services across Wales. Services were contacted through three mailing lists compiled with the assistance of the Welsh Government and other organisations and through mailing and membership lists of pan-Wales organisations, such as CAADA[2], AVA[3] and the All Wales Domestic Abuse and Sexual Violence Helpline.
3. Consultation with five groups of women (53 participants in total) who had used services in North and South Wales. Vignettes were used to focus the discussions around three key questions: what services are available, what services should be available and what are the characteristics of a good quality service?
4. Semi structured telephone interviews with 31 purposively selected stakeholders (23 service providers and 8 national and regional strategic leads holding commissioning or policy roles).

[2] Coordinated Action Against Domestic Abuse
[3] Against Violence and Abuse, a UK wide group based in London

5. A review of UK and international research literature on the availability and effectiveness of service responses to violence against women, domestic abuse and sexual violence.

4. Prevalence of violence against women, domestic abuse and sexual violence in Wales

Violence against women, domestic abuse[4] and sexual violence are significant problems in Wales. Although there is a lack of robust data, estimates show that domestic abuse affects 11% of women and 5% of men each year in Wales[5]; sexual violence affects 3.2% of women and 0.7% of men[6]; 3.1% of older people are abused or neglected by carers[7]. The latest available estimates show that 1% of cases handled by the FMU originate from Wales. In 2013, there were 18 women in Wales trafficked for sexual exploitation identified by the National Referral Mechanism (NRM), representing an increase of 80% from 2012. We were unable to find prevalence data for Wales on FGM, however estimates suggest that around 0.4% of all births in Wales are to women with FGM.

Domestic abuse is the most prevalent form of violence. Young people aged 16-24 were significantly more likely to have experienced domestic abuse in an intimate relationship in the last year, in 2011-2012. This increased risk is present even when the confounding effects of their greater risk for alcohol consumption, drunkenness and illicit drug taking are taken into account[8]. Over their lifetime (since the age of 16) significantly more women (31%) than men (18%) in England and Wales are victims of domestic abuse[9].

UK surveys[10] found that the prevalence of domestic abuse in intimate LGBT relationships usually mirrors that in heterosexual relationships, with approximately one in four to one in three individuals in LGBT relationships experiencing domestic abuse at some point. Men are more likely to report violence than women. However the samples in the UK surveys cannot be considered representative and few participants are included from Wales.

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[4] "Domestic Abuse" (Wales), and "Domestic Violence" (England), encompass physical, sexual, psychological, emotional, or financial abuse. In this report "domestic abuse" is used to refer to this broader concept, unless otherwise indicated.
[5] Robinson, et al. (2012)
[6] Ibid, 2012
[7] O'Keeffe et al (2007). "Carers" in this context are a family member, close friend or care worker
[8] Smith (2012)
[9] Smith (2012) op cit
[10] Henderson (2003)

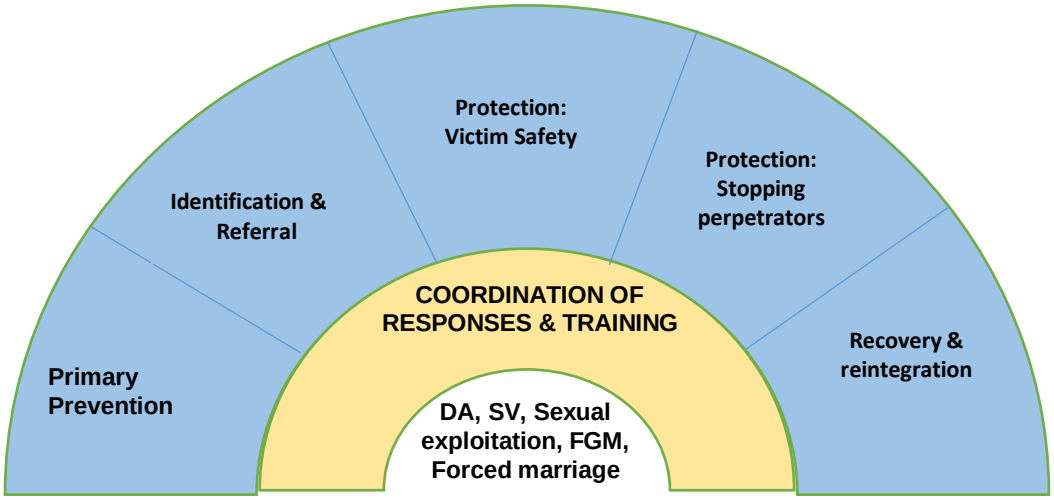
While the proportion of adults in Wales affected by sexual violence is much lower compared with domestic abuse, the last year has seen a rapid increase in rates of reported sexual offences. Disclosure of historic abuse plays a part in this but historic abuse requires a service response in its own right and disclosure of historic sexual abuse prompts disclosure of current abuse. Only 13% of all sexual violence cases reported in the Crime Survey for England and Wales (CSEW) are officially reported to the police[11].
The rate of reported elder abuse in Wales is 3.1%.[12] Using Census 2011 population estimates, this equates to just over 17,000 older people in Wales experiencing some form of elder abuse and neglect.

5. Mapping service provision across Wales

The range of different interventions and responses in Wales was mapped against a typology of services, developed specifically for the purposes of this research. In common with other such models[13], the typology had a rights-based framework, drawing on the commitments to uphold rights to protection, in the Welsh Government's Right to be Safe strategy.

[11] Smith (2012) op cit
[12] O'Keeffe et al (2007) op cit
[13] Radford, L., Allnock, D. & Hynes, P. (2014) *Protecting children and adolescents from sexual exploitation and abuse in development and emergency contexts: evidence review*. New York: UNICEF.

Figure 1: Typology of Service Responses



Second level: At the second level of the typology a further set of more detailed classifications assess:

1. Recipients of the service: female victim; male victim; perpetrator; family; professional.
2. Type of help offered: information; advice; advocacy; befriending; education; finance; recreation; treatment; care/tending; practical assistance; legal support; accommodation; training; assessment; action planning; personal safety and coordination.
3. Sector of delivery: (1) statutory, private or voluntary; 2) education, social care, criminal justice or health; or 3) combination.
4. Specialised or generalist services.
5. Geographic reach: rural, urban or both.
6. Setting of delivery (community, clinic, refuge, home, school, online, other)
7. Amount of intervention: duration and frequency of delivery
8. Theoretical basis, use of research evidence

The typology covers a continuum of services, assessed at two levels. Figure 1 illustrates the first level assessment, classifying services by the type of violence to be addressed (whether it is domestic abuse, sexual violence, sexual exploitation, forced marriage and harmful traditional practices such as FGM) and the type of response. The model recognises that a person might experience several types of violence together and that many services now aim to respond to all these forms of domestic and sexual violence. Service responses in the typology are classified into five main types – prevention (stopping violence and abuse from occurring in the first place); identification and referral of those affected; responses which focus on the safety and protection of victims; responses aimed at increasing safety by dealing with perpetrators; and responses which support recovery and social reintegration.

Coordination efforts are included as an essential service response in the typology. Coordination facilitates responses across a number of different services and is sometimes led by a coordinating agency or a designated key worker. Training is included in this field of the typology as it is often aimed at improving interagency collaboration and communication.

Services responding to domestic abuse were found to be most predominant in Wales with 74% of services addressing this issue. However, results suggest that many services address a broader range of experiences of domestic and sexual violence in line with the Welsh Government's strategy. For example, 49% worked with sexual violence, 28% with sexual exploitation and 32% with forced marriage issues. No information however was given on the number of clients with these specific needs who had been helped so the full extent of experience in working with these issues remains unclear.

The majority of services provided in Wales aim to primarily address immediate protection (40%) or recovery (25%). Fifteen per cent of services described identification as their primary purpose while 12% reported that their main function was coordination of responses and/or training.

Relatively few of those surveyed (8%) saw working to prevent violence from happening in the first place as being their primary responsibility. This may be because services were asked to select just one out of the five types of service response as their main area of work. Many may have included prevention in their overall response. The survey responses from education, where much of the prevention work with children and young people takes place, were also relatively low.

The survey results show that work on violence prevention in Wales could be broadened beyond education to include community-based interventions promoting empowerment, resistance training and assertiveness in vulnerable groups. Few of these types of programmes were reported in the survey. The literature review found that projects drawing on protective resources that exist in communities, such as bystander interventions for domestic abuse and sexual violence, show early promising results. These could be developed and tested in Wales.

Over three-quarters (76%) of services said they were open to work with female victims and 39% with male victims. Just under half (48%) worked with families. Just over a quarter (26%) worked with professionals, 23% with the general public. Despite a large proportion of services defining their function as protection, relatively few of the services said they worked with male (16%) and/or female (13%) perpetrators of violence.

A wide range of different types of help are delivered by agencies in Wales, from advice and information to practical help or accommodation services. Coordinating access to other services was one of the most frequently mentioned forms of help provided (67%). Whilst coordination may reduce the need for victims to make contact with multiple agencies, such activity may take time away from direct work with victims or perpetrators and national information networks or hubs may assist here. Approximately two-thirds of survey respondents described their organisations as offering information and/or advice and work on personal safety, while about half reported providing assessment, action planning, advocacy and/or practical assistance. Around a third offered treatment, education, training, accommodation, legal support

and/or financial assistance. Respondents were able to select more than one type of help provided by their services.

Thirty-seven percent of services responding to the survey were based in the public sector and 48% were voluntary sector organisations, the remainder being mostly private or partnership services. Specialist services tend to be located in the voluntary sector and 47% of services responding to the survey were specialist domestic and sexual violence services, while 38% were generalist services.

The survey asked respondents about the geographical areas covered by their services. The proportional spread of services across the regions was calculated. Around one-third of the services responding to the survey are delivered in the North Wales region. This is unexpected, given that the two largest Welsh cities, with the highest population density, are in the South, whilst mid-Wales constitutes the largest land mass and includes three of the largest local authorities across Wales. It is possible that the survey received better distribution and elicited more interest in North Wales but we have no evidence of this.

The majority of services (55%) worked in an area combining urban and rural locations, 17% were in rural areas and 28% were in urban locations.

The duration of a service intervention varied according to type. Thirty per cent of survey respondents, mostly providing support services to victims, said they provided a service 'as required'. Structured interventions, which follow protocols or prescribed curricula, were more likely to be time limited.

A number of respondents indicated that the service they provided was informed by feminist theory and research, including references to the Duluth model and coercive control models. Other services, informed predominantly by theoretical models, were therapeutic and mental health services, which referenced various psychosocial and psychodynamic models of intervention. Some respondents said an understanding of local unmet need was the rationale for their service. Some organisations were delivering interventions that had been piloted or evaluated in other areas. The majority of services (60%) claimed they had used user satisfaction and individual monitoring of outcomes (56%) to evaluate their impact. Only 31% had undertaken any pre and post-test evaluation.

The educational levels and training of staff in this sector vary considerably and the consultation groups with service users confirmed this. Under 24% of staff were said to have graduate, postgraduate or professional level qualifications.

Just over half the services (53%) reported that service users were consulted or involved in the development of the service but 45% of services did not involve service users in current service delivery.

Less than a quarter of services (24%) were described as having secure funding. A third of those responding described their funding arrangements as short term and insecure.

6. Views of Service Users and Stakeholders

Fifty-three service users were consulted about their experiences of finding help in Wales. Stakeholder views on services were explored through 31 interviews (23 with service providers and 8 with national and regional strategic leads holding commissioning or policy roles).

In keeping with similar research, service users interviewed said they appreciated having specialist domestic and sexual violence services.

> "Without Women's Aid I think we would all be out on the street…it is the support and the knowledge that they have as well." *(Service User)*

Many women were reluctant to approach statutory agencies; they were not confident that information would not be shared without their knowledge or prior approval and they thought that seeking help might be interpreted as a sign of 'not coping' with implications for their parenting role. Moreover, they noted that variations between practitioners in statutory services made it difficult to predict what response they would receive. However, the police and hospitals were often identified as the first port of call. There was a lack of availability of good interpreters for people whose first language was not English, particularly in health settings, and those provided by the Home Office were not trusted.

Accessibility, location and stigma associated with services were key concerns raised by service users and stakeholders. Poor access for Black Minority Ethnic and Refugee (BMER) women was a shared concern. A failure to match provision to need was a common theme and two types of gaps were identified: general gaps relevant to everyone and equity gaps related to specific groups such rural women, disabled women, male victims and women with additional needs such as alcohol misuse issues. Gaps in services mentioned most frequently by service users were refuge accommodation, particularly specialist refuges for BMER women. Stakeholders identified clear gaps in services for female and male adult survivors of childhood abuse and in community based perpetrator services; service coverage across North Wales was judged to compare poorly to that in South Wales. This latter observation contrasted sharply with the findings of the survey, which showed a balance of provision between North and South.

Whilst a number of stakeholders mentioned the increase in male victims, little evidence of service take-up was offered. One interviewee described a refuge specifically for male victims which had received no referrals in the previous year:

> "That service became open to men and we've not had a referral from a male which has been very interesting. We didn't expect tens of them, but certainly we had expected some referrals through and we've not had any in the year." *(Provider 20).*

Both service users and stakeholders considered that men's needs were likely to be different to women's and noted that services needed to be mindful of this before they expand their remit to cater for both female and male victims.

As found in other research with survivors, women consulted in Wales wanted timely responses from services and they valued professionals who treated them with respect and honoured confidentiality. The accessibility of 24 hour services and helplines was emphasised. The service users wanted wider and more open advertising of services addressing violence against women, noting that wider advertising might also help in shifting public attitudes.

Service users emphasised the need for training for all professionals who came into contact with violence against women, domestic abuse or sexual violence. This included practitioners in generalist services such as health and housing. It was considered important to have specialist knowledge and assistance available to all staff in respect of complex issues such as benefits and housing.

One-Stop-Shops were seen as a valuable resource by service users and stakeholders, and they were thought to be valuable in rural areas. However, some queries were raised about variations in quality of service in One-Stop-Shops across Wales.

Difficulties in finding safe accommodation were concerns for women without recourse to public funds and for women with paid employment. Most service users agreed that alternative and affordable housing was difficult to find and increased awareness is needed concerning the housing needs of families who experience domestic abuse.

Stakeholders noted that the focus on risk assessment and risk management for domestic abuse had positive and negative consequences. MARACs provided positive examples of a focus on risk although there could be difficulties in obtaining GP engagement in MARACs. A negative consequence was the concentration of resources on high risk cases seemingly at the expense of women assessed at lower levels of risk. Some interviewees hoped that the proposed Multi Agency Safeguarding Hubs (MASHs) would better address lower level risks and prevent escalation.

A number of examples of innovative practice in work with women and perpetrators in Wales were identified by stakeholders. Innovative practice included: a One-Stop-Shop with gym facilities; printing Helpline numbers on all NHS and Welsh Government employees' payslips; developing working practices with the ambulance service and the police Body Cam pilot (where police officers have cameras attached to their vests when attending a domestic abuse incident).

As with the professionals surveyed, stakeholders raised many concerns about uncertain funding for domestic and sexual violence services. Funding for domestic and sexual violence services in Wales comes from a variety of sources, including the Welsh Government. Lack of secure, long term funding, which would facilitate service planning and contribute to the stability and build the expertise of the workforce, was identified as a significant problem for this sector. Extending joint commissioning, particularly that including health as a partner, was seen as a possible way forward. Some stakeholders also suggested that developing shared minimum service standards could improve both quality of service, in times when resources were scarce and dwindling, and efficiency in working together.

> "I do think it would be much better if we could start off from the beginning going, what services do we need? …. what do we need and let's jointly commission services to make sure, because at the moment, it's like robbing Peter to pay Paul. And we're forever trying to pick up the pieces"
> *(Provider 16)*

7. Service Responses and Evidence for their Effectiveness

A semi-systematic review of published academic research and non-academic reports ('grey literature') was completed to gather together evidence on what services are available and which are most effective in preventing and responding to domestic and sexual violence. Following a thorough search of key electronic research databases and screening for relevance and quality, 397 documents were reviewed.

Globally and across the UK, it is clear that a wide range of services to prevent and respond to domestic and sexual violence are currently being delivered. Many of the interventions described in published literature originated in the USA, although interventions in FGM and honour-based violence are more likely to have developed in low-income nations. One of the difficulties with this literature is the lack of relevance or fit of programmes to the Welsh context.

There is a lack of strong evidence for any one intervention or package of responses. However, some high quality studies exist to suggest some service responses are more likely to be effective. More evidence was identified addressing protection and recovery responses than for other types of response. As yet, there is little robust evidence on the effectiveness of different methods of working together and coordinating service and community responses, so this is clearly a priority for future research development

The research evidence is strongest for domestic abuse advocacy services for women and for violence prevention programmes delivered in schools. There is moderately strong evidence for targeted prevention work with at-risk or vulnerable groups, showing improvements in knowledge and attitudes about

violence among service recipients. Some school based prevention programmes show a limited impact in reducing violent behaviour. Although generally favoured as a prevention strategy by governments, the evidence on the effectiveness of media campaigns is inconsistent with studies showing mixed effects.

The ‘grey literature’ provides some evidence on the effectiveness of integrated responses to sexual violence through models such as the Sexual Assault Referral Centres (SARCs).

One-Stop-Shops working with domestic abuse are an important feature of the service landscape in Wales and are valued by users and stakeholders, but co-location is not the only feature of a coordinated model. The effective features of coordinated models include partnerships, community coalition, information sharing protocols, and clear allocation of roles and case management.

There is moderate evidence to support the introduction of community programmes for male perpetrators of domestic abuse if these include strategies for keeping participants engaged and motivated. The evidence for the effectiveness of interventions for sex offenders is weak and inconclusive.

Evidence on effective responses towards forced marriage, FGM, trafficking and sexual exploitation is currently very limited. However, there is some evidence for the effectiveness of responses in health settings to identify and support women who have experienced FGM. This could be developed further in selected sites in Wales.

There is scope for offering evidence-based recovery responses for all forms of violence, for example, counselling or therapeutic work, by locating them within universal health settings. There is good evidence for use of cognitive behavioural therapy interventions to treat adult victims with trauma symptoms, anxiety and depression. For certain forms of violence, such as sexual assault and FGM, the reach of recovery services may be wider when they sit alongside complementary identification and referral services.
The severe shortage of robust evaluation research is in itself a significant finding from this study. Serious consideration should be given to commissioning and conducting high quality research in Wales on the impact of interventions currently in use to prevent and respond to domestic and sexual violence.

8. Conclusion and Recommendations

Violence against women, domestic abuse and sexual violence are entrenched, widespread and complex problems whose extent, nature and consequences have only recently begun to be widely recognised[14]. In commissioning this research, the Welsh Government has set in motion a challenge to find ways to make a real impact on ending these forms of violence and on reducing the harm they inflict.

[14] Krug, et al. 2002; Walby (2004); Welsh Assembly Government (2010)

Key recommendations to take this project forward, discussed in detail in the full research report, are:

Recommendation 1: The Welsh Government should commission a detailed analysis of the CSEW data (formerly known as the British Crime Survey) at local area level, to obtain more specific data for Wales and its regions.

Recommendation 2: In the light of the gaps in the existing data, the Welsh Government should seek to work closely with those helplines it already funds and with other Welsh or national helplines to obtain data on calls for help/assistance related to violence and abuse in LGBT groups, FGM, honour-based violence, forced marriage and trafficking for the purposes of sexual exploitation.

Recommendation 3: In a context where new definitions and forms of abuse are emerging, it is important to emphasise that domestic abuse is by far the most prevalent form of abuse addressed by this report and services should continue to reflect this.

Recommendation 4: Organisations with knowledge and expertise in those types of violence and abuse where prevalence is lower or less is known about prevalence should be encouraged to retain and build that knowledge. This includes expertise in sexual violence, FGM, honour-based violence, forced marriage and trafficking for the purposes of sexual exploitation as well as skills in working with particular communities such as LGBT groups, older people and BME communities.

Recommendation 5: The Welsh Government should ensure that funding for those interventions for which there is good evidence, such as IDVA services and school based prevention programmes, is secure and available on a continuing basis and is not susceptible to fluctuations in local budgets.

Recommendation 6: The evidence concerning screening for domestic abuse indicates the need to take account of which setting women are seen in and which groups are being screened. There is evidence to support screening in maternity services but in other health and social care settings, targeted enquiry directed at those for whom there are indications that this may be appropriate is advised. The Ask and Act policy needs to be supported by training, referral routes and a supportive organisational culture.

Recommendation 7: The evidence base for perpetrator programmes in domestic abuse is still developing in the UK. At this stage in the development of the evidence base, no particular model stands out, so implementation and testing of a range of perpetrator programmes within the Welsh context is encouraged.

Recommendation 8: Given the lack of evidence for the effectiveness of current interventions for sexual offenders, there is a need to develop new

approaches and models for work with this group; innovation and testing are required in this field.

Recommendation 9: Protective responses to FGM should be delivered in or linked with health settings. Health settings such as maternity services are where the likelihood of identification is highest, and where there is good evidence for medical interventions that promote recovery.

Recommendation 10: In addition to implementing school based prevention programmes, the Welsh Government should consider piloting community based prevention programmes such as the Bystander programmes.

Recommendation 11: The Welsh Government should ensure that training is available for staff in the violence against women, domestic abuse and sexual violence sector to develop skills and knowledge in work with forced marriage, honour-based violence, FGM and trafficking for sexual exploitation purposes. Ensuring easy access to those with specialist knowledge in these fields is another means of improving knowledge and skills across services.

Recommendation 12: The Welsh Government should work with higher education and training organisations to support the goal of ensuring a skilled workforce in this sector across Wales.

Recommendation 13: The Welsh Government should proceed to develop its plans for an All Wales Hub or information network that would take on the task of providing information on and/or access to services for both professionals and for those seeking help.

Recommendation 14: Offering providers longer-term contracts would increase stability and capacity in the sector. The higher costs of delivering services in rural areas should be acknowledged in contracts and grants.

Recommendation 15: Joint commissioning activity, involving health, but also bringing a range of agencies and organisations together in funding arrangements could be developed further in Wales. Perpetrator programmes represent a service where different models of joint commissioning could be piloted and evaluated and where interagency ownership might contribute to the robustness of the intervention. Extending joint commissioning could contribute to a more cohesive sector, remove duplication and save costs.

Recommendation 16: Expertise in delivering services to those experiencing sexual violence should be protected and ways should be found of making these skills and knowledge available to other organisations who may encounter experience of sexual violence as part of their wider remit.

Recommendation 17: Similarly, specialist knowledge and skills in intervening in forced marriage, honour-based violence, trafficking for sexual purposes and FGM need to be shared across organisations through knowledge or information hubs or networks.

Recommendation 18: Generalist services such as health, education and the police have a key role to play in identifying victims of violence and abuse, in providing early intervention for those at low and medium risk and in referring on to relevant specialist services. The Welsh Government should consider supporting implementation of the NICE Guidance[15] on the health and social care response to domestic abuse since this Guidance looks likely to provide a strong impetus for the full range of health services to engage more fully with the issues of domestic abuse and violence against women. The appointment of an NHS Champion for Combatting Violence Against Women, Domestic Abuse and Sexual Violence who is charged with implementation of the NICE Guidance in Wales would be one means of achieving this.

Recommendation 19: Training is essential for staff in generalist frontline services who are involved in identification and referral as well as early intervention. Such training should address attitudes and awareness, safe information sharing and knowledge of local services as well as local referral paths and protocols.

Recommendation 20: Concerns about safety have meant that services for victims of violence and abuse have traditionally not been widely advertised. Service users themselves are now suggesting that the sector needs a more visible public profile and wider advertising might be tested through pilot projects.

Recommendation 21: One-Stop-Shops evoke positive responses from service users and other professionals. There are few rigorous evaluations of their work and the Welsh One-Stop-Shops offer an opportunity for such testing to be implemented.

Recommendation 22: Careful consideration needs to be given to the question of which services could be delivered online and which face-to-face. Further consultation with service users on this issue is recommended.

Recommendation 23: More needs to be done to develop the skills and knowledge of all agencies in this sector to work with the BMER population. Organisations with specialist skills and expertise in working with BMER groups could play a central role in disseminating skills and knowledge through training or via the provision of advice and information. This should include information on support available under the Destitution Domestic Violence (DDV) Concession[16].

Recommendation 24: Professional interpreting services need to be made more easily accessible and interpreters need to be appropriately trained and

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[15] NICE (2014) Domestic Violence and Abuse: how health services and social care and the organisations they work with can respond effectively. NICE Public Health Guidance 50. http://www.nice.org.uk/nicemedia/live/14384/66668/66668.pdf

[16] The DDV Concession allows victims on spousal visas who are escaping domestic abuse access to benefits while they make a claim for indefinite leave to remain in the country.

more closely linked to specialist services working with violence against women, domestic abuse and sexual violence.

Recommendation 25: Protocols for the safe sharing of information in all cases, not just high-risk cases, need to be developed in consultation with service users and providers. Such protocols need to build on existing models currently used in Wales and should be implemented in generalist as well as specialist services.

Recommendation 26: Services should adopt relevant and meaningful approaches for involving service users in the design and delivery of services. The Welsh Government is encouraged to collect and disseminate good practice examples of service user involvement in this sector.

Recommendation 27: Local authorities in Wales should develop a log of services for domestic abuse, sexual violence and violence against women in their area which recognises the links between services and identifies gaps. This should include estimates of capacity or volume of service. There is also scope for linking data on incidence to improve knowledge about service demand at the level of local authorities.

Recommendation 28: More needs to be done to develop the evidence base for interventions; in addition to testing specific interventions such as perpetrator programmes, this could be achieved by building individual outcome monitoring or aggregated data analysis into contracts or grant funding. However, the cost implications of this work would need to be acknowledged.

Recommendation 29: More research should be undertaken with survivors and recent service users to capture their evaluations of new and specific services, for example, services for LGBT communities, FGM, forced marriage, trafficking and honour-based violence services.

Introduction

This review represents the latest step in a series of Welsh Government initiatives aimed at reducing violence against women and protecting victims. In 2005, the Welsh Government published its first national strategy, *Tackling Domestic Abuse* (Welsh Assembly Government, 2005), which adopted a rights-based framework to ensuring every citizen the right to live a life free from violence and abuse. This was followed by the *Right to be Safe* strategy (Welsh Assembly, 2010), a 6-year strategy focused on four key areas: prevention and awareness raising; supporting victims; improving the response of criminal justice services; and improving the response of health (and related) services. The White Paper, *Consultation on legislation to end violence against women, domestic abuse and sexual violence* (Welsh Government, 2012), outlined measures aimed at achieving stronger public sector leadership, improved education and awareness and more integrated services.

The White Paper also included the proposal that key public sector professionals should have a duty to 'ask and act' in relation to violence against women, domestic abuse and sexual violence (VAWDASV). The response to the consultation (Welsh Government, 2013) provides a cross-section of the sector's views on implementation of these proposals. It is worth noting that while some services (policing and criminal justice) working in the field of violence against women, domestic violence and sexual violence continue to be governed by Westminster, the Welsh Government is responsible for health, education and local government services.

This review was commissioned by the Welsh Government in 2013, with the aim of ensuring that its strategic direction and approach to funding in relation to violence against women, domestic abuse and sexual violence (VAWDASV) were grounded in knowledge of both best evidence and the current landscape of service provision in Wales. The review was planned to inform the forthcoming Ending Violence Against Women and Domestic Abuse (Wales) Bill as well as implementation of the legislation and future policy more generally. The objectives of the review as specified in the commissioner's tender document were as follows:

- To construct a typology of the range of relevant services in Wales and beyond, which tackle violence against women, domestic abuse and sexual violence
- To assess the existing evidence base underpinning these types of service provision in order to examine their effectiveness, both in terms of outcomes and value for money
- To map the current landscape of service provision in Wales
- To estimate the prevalence of the different forms of violence against women, domestic abuse and sexual violence and identify the associated need for services
- To make recommendations related to informing the Welsh Government's Violence Against Women, Domestic Abuse and Sexual Violence strategic approach to funding.

The remit of the review is broad, encompassing services for people experiencing the following forms of abuse and violence:

- Domestic abuse, including that experienced in Lesbian, Gay, Bisexual and Transgender (LGBT) relationships and elder abuse
- Violence against women, including female genital mutilation (FGM), forced marriage and honour-based violence
- Sexual violence including rape, sexual assault and harassment
- Sexual exploitation including prostitution and trafficking for sexual purposes.

Perpetrator programmes were included in the remit but the breadth of the review together with time restrictions meant that services for children and young people could not be included. Stanley's (2011) review of research on children experiencing domestic violence provides a recent analysis of the

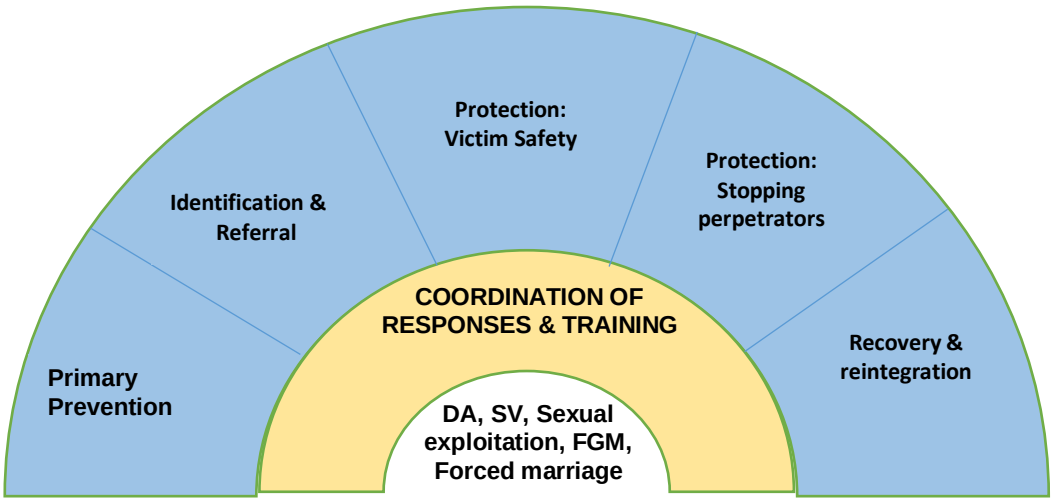
evidence on interventions for children and young people together with data on needs and prevalence. Housing services were not part of the primary focus of this review, which means that evidence for the effectiveness of refuge provision has not been reviewed. However, the interface between generalist services including housing, the police and health services and VAW services is addressed by a number of elements of this review.

The review was independent and was led by a team of researchers from the Connect Centre for International Research on Interpersonal Violence and Harm, at the University of Central Lancashire. However, it drew heavily on the views and experiences of those planning and providing services in Wales as well as on the perspectives of women who used services. In addition, it incorporated UK prevalence data and international evidence on effective interventions.

Typology

The collection of evidence for this review was structured and facilitated by a typology of service responses and interventions shown in Figure 1 below. This typology was influenced by existing models from other fields including a typology of responses to sexual violence developed for ongoing work with UNICEF (Radford, Allnock and Hynes, 2014) and most notably the Institute of Medicine's (IOM) typology (1994), which proposes a continuum of intervention that stretches from prevention, through treatment to health and wellbeing maintenance. It also built on typologies that distinguished by type of violence (Coy, Kelly and Foord, 2007) and which classified by content, provider, setting, mode and duration of delivery, and recipient of the service (Axford, et al., 2010; Ford, et al., 2007; Henricson, et al., 2001; Craig, et al., 2008). The typology drew on a rights-based framework, drawing on the commitments in the Right to be Safe (Welsh Assembly, 2010) strategy.

Figure 1: Typology of Service Responses



Second level: At the second level of the typology a further set of more detailed classifications assess:

1. Recipients of the service: female victim; male victim; perpetrator; family; professional.
2. Type of help offered: information; advice; advocacy; befriending; education; finance; recreation; treatment; care/tending; practical assistance; legal support; accommodation; training; assessment; action planning; personal safety and coordination.
3. Sector of delivery: (1) statutory, private or voluntary; 2) education, social care, criminal justice or health; or 3) combination.
4. Specialised or generalist services.
5. Geographic reach: rural, urban or both.
6. Setting of delivery (community, clinic, refuge, home, school, online, other)
7. Amount of intervention: duration and frequency of delivery
8. Theoretical basis, use of research evidence

At the first level, the typology identifies the type of violence to be addressed, whether it is domestic abuse, sexual violence, sexual exploitation, forced marriage and harmful traditional practices such as FGM, recognising that these may co-exist and that many services now aim to respond to all these forms of gender based violence. This approach reflects the Welsh Government's decision to focus on the three overlapping areas of violence against women, domestic abuse and sexual violence. The type of response is classified into five main types – prevention responses (stopping violence and abuse from occurring in the first place); responses that enable identification and referral of those affected; responses which focus on the safety and protection of victims; responses aimed at increasing safety by responding to perpetrators; and responses which support recovery and social reintegration. The typology also recognises that effective responses in any of these broad service areas often need coordinated efforts, involving a number of different services working together which may be led by a coordinating agency or designated key worker and which may or may not be co-located. Training is

also included in this field of the typology as, in this field, training is often aimed at improving interagency collaboration and communication.

At the second level of the typology, a further set of classifications was utilised which allowed for interventions to be more fully described and distinguished. The two levels of the typology could provide a useful tool for future planning and mapping of services in Wales.

Methods

The different components of the review called for a mixed methods approach, which included both quantitative data collection and an in-depth analysis of qualitative data. The review comprised five key stages:

1. Estimates of the prevalence of violence against women, domestic abuse and sexual violence across Wales

This component of the study used a range of published data such as the Crime Survey for England and Wales, Office of National Statistics (ONS) data, police data on reported incidents of domestic violence, data from the Forced Marriage Unit and a number of research studies to provide a picture of the prevalence of different forms of abuse and violence across Wales.

2. An online mapping survey of specialist, public and voluntary sector service providers across Wales

Existing databases were used to create a distribution list for the survey and to provide a landscape picture of specialist service provision for violence against women, domestic abuse and sexual violence across Wales (shown in Appendix 5). The Survey Monkey online tool was employed to administer a questionnaire to service providers and co-ordinating organisations involved in violence to women, domestic abuse and sexual violence services. The survey was designed in consultation with the review's advisory group; it captured information about each of the services delivered by an organisation using the typology shown above as the framework for collecting this data. For example, it gathered information about services' mode of delivery, recipients, content and funding as well as staff skills and training. The survey was extensively piloted and the survey tool is included in Appendix 6.

The survey was distributed to the full range of relevant organisations in Wales using three mailing lists compiled with the assistance of the Welsh Government and other organisations. Additionally, a number of pan-Wales organisations, such as CAADA (Co-ordinated Action Against Domestic Abuse), AVA (Against Violence and Abuse) and the All Wales Domestic Violence and Sexual Violence Helpline distributed the survey to organisations on their mailing or membership lists. Four reminder emails were sent and a supportive letter from the Welsh Government Minister for Local Government and Government Business encouraging completion of the survey assisted in ensuring the highest possible response. The responses were boosted by

phone calls made to incomplete and non-responders by both Welsh Government staff and the researchers. This approach resulted in some surveys being completed by telephone. A prize draw was offered to promote participation. The survey questions were available in both English and Welsh, and responses in both languages were accepted. Two individuals responded to the survey in Welsh.

In total, 146 organisations took part in the survey providing information on 349 services provided across Wales. There were also 88 blank or insufficiently complete surveys returned which were discounted from the analysis. It is not possible to determine what proportion of services in Wales this represents since there is no previous survey or audit of these services to draw on.

3. Consultation groups with women who used services in North and South Wales

Five consultation groups were held with women who between them had both experience of violence against women, domestic abuse and sexual violence and experience of relevant services. Four groups were held in North Wales and one in South Wales. Women were recruited to the groups by relevant service organisations and they were compensated for their time and travel. Informed consent procedures were utilised and all participants have been anonymised in this report. Fifty-three women participated in these consultation groups and a wide range of ages and ethnic groups were represented along with diverse experience of abuse and violence. Three key questions were used to structure the group discussions; these were: what services are available, what services should be available and what are the characteristics of a good quality service?

4. Stakeholder Interviews

Semi-structured interviews were completed with 31 individuals selected to include service providers from the full range of services (including those targeting minority groups of service users, such as male survivors of domestic violence and Black, Minority Ethnic and Refugee (BMER) groups) and those in strategic or co-ordinating roles at both regional and government level. Most interviews were conducted by telephone and all were recorded and transcribed prior to analysis. Themes addressed included service innovations and challenges, service gaps, experience of collaboration and priorities for the future.

5. A semi-systematic review of the literature on interventions for violence against women, domestic abuse and sexual violence

The literature review was designed to identify the range of services and interventions that existed internationally and to gather evidence of their effectiveness and cost-effectiveness where available. The review focused on literature published in English between 2000 and 2013. In addition to incorporating peer reviewed journal papers, a limited search of the UK grey

literature was completed. Journal papers were identified by systematic searches of key databases and web reference sites, the search terms are included in Appendix 1 of this report. The grey literature was located using Google Scholar, dissertation databases and targeted websites of relevant organisations. A flow-chart outlining the key stages of the literature review is included in Appendix 2. Papers were identified for review with the assistance of a screening checklist and were rated for quality using adapted versions of NICE's rating scoresheets for quantitative and qualitative research (NICE, 2009). The quality appraisal checklists used are shown in Appendix 3. The NICE scoresheet for quantitative intervention studies was simplified, as shown in Appendix 3, to cover the more limited scope of the quantitative studies found in this field. Ratings were conducted by researchers independently discussing those items where the decision about quality was ambiguous. One member of the research team conducted a blind check of included and excluded studies, selecting random samples of papers to screen or exclude and matching results with reviewer decisions. There was a high rate of agreement. Studies where the research was judged to be of high or medium standard were included in this review. Data were extracted into simplified evidence tables, categorised by type of violence and type of service response (see Appendix 4).

The research team was able to draw on some recently published reviews that proved highly relevant for this study. These included the NICE review of Interventions to Identify, Prevent, Reduce and Respond to Domestic Violence (NICE, 2013).

Research Governance

The review was carried out in consultation with representatives of the Welsh Government who commissioned the study. The researchers were advised by an online advisory group - members are listed in Appendix 7. The research involving consultation groups with service users received ethical approval from the University of Central Lancashire's PsySoc Research Ethics Committee.

1 Prevalence of Violence Against Women, Domestic Abuse and Sexual Violence in Wales

Introduction

A key objective of this study was to estimate the scale of the problem of violence against women, domestic abuse and sexual violence in Wales. The scope included elder abuse and abuse in LGBT relationships. The methodology was limited to published sources of prevalence and it was not possible to undertake secondary data analysis of existing sources within the remit of this review.

The source of the most reliable data on the extent of sexual and domestic violence is the Crime Survey for England and Wales (CSEW), formerly known as the British Crime Survey (BCS). This has a self-completion module that addresses domestic violence and sexual assault. These data, collected from about 45,000 households in England and Wales, are more reliable than recorded crime data because of the low rate of reporting such crimes to the police, although even survey data may still underestimate the extent of crime. CSEW published data is only available for England and Wales combined.

The availability of prevalence data on forced marriage, honour based violence, FGM and trafficking for sexual exploitation is very limited, both for the UK and internationally. We have therefore drawn on some published reports describing service use as well as research studies in these fields but acknowledge fully their limitations in providing an estimate of prevalence for these forms of violence in Wales.

1.1 Domestic abuse

Two statistical bulletins analyse CSEW data on violent crime, including domestic violence (this term is used by CESW), for the period 2011/2012 (Smith et al., 2012; ONS 2013a). The reports summarise data gathered from the self-completion module by 16-59 year olds, defining domestic violence as experiences of emotional, financial and physical abuse by partners or family members, as well as sexual assaults and stalking by any person. Intimate sexual violence is also included within this definition, although these statistics are presented separately below.

The BCS/CSEW data defines domestic violence as sexual and non-sexual abuse carried out by a partner or family member. In addition to domestic abuse, respondents are asked about sexual assault or stalking carried out by anyone. Domestic violence includes non-physical abuse, threats, force, sexual assault or stalking carried out by a current or former partner or other family member.

The first report indicates that levels of violence have remained similar between 2008/2009, 2010/2011 and 2011/2012, but current rates are lower when compared with the first self-completion survey in 2004/2005. This decrease is apparent for all forms of intimate violence, with the exception of sexual violence.

According to the CSEW survey, there were over 300,000 incidents of domestic violence in 2011/2012. The rate of **any** domestic abuse experienced since the age of 16 differed by gender, with women significantly more likely to be victims than men. Thirty-one percent of women and 18% of men reported being a victim of domestic abuse since the age of 16. The rates are less distinguishable when examined over the last year, with the bulletins reporting that 7% of women and 5% of men experienced any domestic abuse in the previous 12 months. Using 2011 Census estimates for individuals aged 16-59 years in Wales, this equates to nearly 61,138 female and just over 43,000 male victims. These data, however, are based on incidents of any form of domestic abuse and may mask the gendered nature of violence. An examination of more severe and repeated domestic violence reveals that women are disproportionately affected (Walby and Allen, 2004; Hester, 2013).

In a report to Welsh Government, the Task and Finish Group (Robinson et al., 2012) managed to obtain the most recent BCS data (2011/12), disaggregated for Wales. This data shows that, in Wales, women experienced twice the levels of 'any domestic abuse' within the past year (11.1% compared to 5.1% for men) while rates of 'any sexual assault' were also higher for women (3.2%) than men (0.7%). The data also indicated that more women reported being stalked than men (7.8% compared to 3.5%).

The most common form of domestic abuse was non-sexual partner abuse and stalking (accounting for 4% of women and 3% of men's experiences). The data do not break down by sexuality of the victim or perpetrator. There was a correlation with age, where young people aged 16-24 were significantly more likely to have experienced domestic abuse in an intimate relationship in the last year, compared to the sample as a whole. This increased risk was present even when the confounding effects of their greater risk for alcohol consumption, drunkenness and illicit drug taking were taken into account.

According to the Home Office bulletin (Smith et al., 2012), domestic abuse repeat victimisation accounts for about 24% of overall violent crime. However, respondents were not asked to report on repeat victimisation experiences by the same partner in that year. Thus, whilst we have a picture of the proportion of people affected by domestic abuse across Wales in a given year, the incidence or volume of abusive acts is not estimated.

The official statistics provided by the four police forces across Wales offered a different picture. Table 1 below displays the number of domestic abuse incidents (i.e. every new case) recorded by police forces in Wales for the period 2011/2012. The incidence figures have been divided by the area population to give rate of domestic violence for the police force area. The area

covered by South Wales police has the highest rate of *recorded* domestic violence per capita in the country.

Table 1: Recorded domestic abuse incidents by police force in Wales

Police force area	Incidents 2011/12	Pop/Census 2011	Rate	Rate per 10,000 in population
Dyfed-Powys	2,325	514,938	0.004515	45
Gwent	8,948	577,077	0.015506	155
North Wales	12,901	688,417	0.018740	187
South Wales	27,656	1,283,326	0.021550	216
TOTAL	51,830	3,063,758		

Given the prevalence rates estimated by the CSEW data (approximately 100,000 people affected each year) and the rate of re-victimisation, we might expect the police recorded incidents to be significantly higher than the total of just over 51,000. Requesting the primary CSEW dataset at local geographic level would allow for further analysis by locality, to understand whether the differing rates between police force areas reflect differences in process and/or recording, or real differences in the prevalence of domestic abuse across these areas.

1.2 Elder abuse

There have been very few UK studies examining the incidence and prevalence of elder abuse (Ogg & Bennett, 1992, Ockleford et al., 2003). However, a study commissioned by Comic Relief and the Department of Health examined the abuse and neglect of older people in the UK, the first representative study of its kind (O'Keeffe, 2007). The study published in 2007 reported estimates based on the national prevalence survey of people aged 66 years or more. The research examined neglect, physical abuse, psychological and sexual abuse as well as financial mistreatment. The report claims that 2.6% of people surveyed indicated abuse by a family member, close friend or care worker in the last year. Neglect was the most prevalent form of abuse, followed by financial abuse, and women were more likely to report an experience of abuse or neglect.

Within this study, there was a 54% response rate from households representing Wales. The rate of reported elder abuse in Wales was 3.1%. Using Census 2011 population estimates, this equates to just over 17,000 older people in Wales experiencing some form of elder abuse and neglect. Table 2 presents estimates from the study broken down by different age

bands, highlighting the increased risk of neglect for those people aged 85 years or more.

Table 2: Prevalence rate for elder abuse by age-band (UK)

	66-74	**75-84**	**85+ years**
Neglect	1%	0.7%	3.2%
Interpersonal abuse	1.4%	0.5%	-
Financial abuse	0.4%	0.9%	1%
Any abuse	2.8%	2.1%	4.1%

A local study (Clarke et al, 2012) of 145 incidents of elder abuse reported to a range of agencies in Swansea over a period of 14 months found that of the 131 victims, 95 were female and 36 were male. Nearly one third of victims had a disability. In addition, a recent report from a Daphne-funded study examined data gathered from police files about domestic abuse incidents involving women aged 60 years and older (Penhale and Goreham, 2013). Although the study did not aim to provide reliable prevalence data about the scale of elder abuse, it did examine the intersection between elder abuse and other vulnerabilities, for example, mental and physical illness, alcohol abuse, etc. It found a significant overlap between elder abuse and these issues.

1.3 Domestic abuse in LGBT relationships

Research on domestic violence in same-sex relationships is a recent area of research and has tended to focus on violence in lesbian relationships. The Sigma surveys (Henderson, 2003) found that the prevalence of domestic abuse in intimate LGBT relationships usually mirrored that in heterosexual relationships, with approximately one in four individuals in same sex relationships experiencing domestic violence at some point. Men were more likely to report domestic abuse than women. The majority of women (87%) and men (81%) who said they had experienced abuse also indicated that they had not reported it to the police. Reports to the police were more likely to be made for physical assault, particularly where it had resulted in injury. Women were also more likely to report sexual violence. Less than 2% of the Sigma sample was from Wales, and the sample cannot be considered representative.

Donovan et al. (2006) undertook a non-random, non-representative survey of individuals in same-sex relationships across the UK (746 people) and found that over a third had experienced domestic violence at some time. This was most often emotional abuse, though many reported physical and sexual abuse by a partner.

Finally, data for the helpline run by Broken Rainbow, a charity set up to confront and eliminate domestic abuse within LGBT communities, were requested but no response was obtained. In the latest available annual report (Broken Rainbow, 2009-2010) on the charity's website, they suggest that they

took just over 2,000 calls. Earlier annual reports put the proportion of calls from Wales at 3% (Broken Rainbow, 2004-2005).

1.4 Sexual violence, including rape and sexual assault

Consistent with previous findings, the largest difference between the sexes was found for sexual assault, with CSEW data indicating that 20% of women and 3% of men had experienced sexual assault (including attempts) since the age of 16 (Smith, et al., 2012).

Around 3% of women and around 0.3% of men had experienced some form of sexual assault (including attempts) in the last year. The majority of these were forms of less serious sexual assault, such as indecent exposure, unwanted sexual touching or sexual threats. Prevalence of serious sexual assault was lower than other forms of intimate violence among both women and men, with 0.6% of women and under 0.05% of men experiencing serious sexual assault in the past year. Using Census 2011 data, this translates into approximately 5,240 women and 430 men who experienced serious sexual assault. The Crime Survey also questioned those who experienced sexual assault as to whether they had reported the incident to the police; only 13% said they had done so. This suggests that recorded estimates, such as those presented below, significantly under-estimate the scale of the problem in Wales and the wider UK.

The ONS publish police force area data tables on recorded sexual offences, which include rape and other sexual assault (ONS, 2013b). Table 3 provides recently released data for the year ending June 2013 across the four police forces in Wales. The accompanying bulletin claimed that there had been a 9% increase in sexual violence incidents across England and Wales between the years ending 2012 and 2013, the largest increase since current recording began. It should also be noted that a proportion of these cases would be historical incidents, i.e. not incidents taking place in the last year, and the rates should therefore be interpreted with caution.

Table 3: Recorded sexual offences by police force in Wales

Police force area	Incidents 2012/13	Pop/Census 2011	Rate	Rate per 10,000 in population
Dyfed-Powys	376	514,938	0.00073	7
Gwent	504	577,077	0.00087	9
North Wales	858	688,417	0.00125	13
South Wales	1,198	1,283,326	0.00093	9
TOTAL	55,812	3,063,758		

1.5 Forced marriage and honour based violence

The ONS do not currently produce any statistics on forced marriage in England and Wales. There are no reliable estimates on the extent of forced marriage in the UK (Her Majesty's Government, 2009, p14) and the only official statistics available are those held by the Ministry of Justice (MoJ), which publishes the number of Forced Marriage Protection Orders (FMPO) confirmed each quarter.

FMPOs were introduced on 25th November 2008. Statistics have been collected by the MoJ since that time and, as of June 2011, are now published regularly as official statistics. Of the 15 county courts able to make FMPOs (in addition to the High Court), only one is situated within Wales (Cardiff County Court). Table 4 below presents the number of FMPOs made in the last three years.[17] The MoJ, upon request, also provided FMPOs originating in the Cardiff County Court (used here as a proxy for Welsh cases).[18] Because such a small number of applications and orders were made, they provided an indication only: less than five orders in the two and a half year period.

There are no community-based prevalence studies examining forced marriage or honour based violence, however, two studies deserve mention in their efforts to put a figure to the problem, at least in England. The first, led by Nazia Khanum OBE in 2008, surveyed the city of Luton in England. It estimated that there were over 300 potential cases of forced marriage presenting to agencies in Luton alone, per year (Khanum, 2008). Similarly, the second study, reported in 2009 by Kazimirski and colleagues, estimated the national prevalence of forced marriage in England by surveying ten local authority areas and collating cases known to local and national organisations (Kazimirski et al, 2009). The study suggested that, in 2008, there were between 5,000 and 8,000 cases of actual or threatened forced marriage in the country. Neither of these estimates accounted for victims who did not approach agencies for help; suggesting that in reality the number of cases is far higher. Unfortunately, no similar analyses were available for Wales separately although it is likely the rates will be significantly lower given the differences in population ethnicity and country of origin.

The Forced Marriage Unit (FMU) works across the four nations of the UK. Table 4 displays the cases dealt with by the FMU in the last three years of operation. In the year January to December 2012, 1% of cases handled by the FMU originated out of Wales (approx. 15 cases). Victims of forced marriage are usually female, under 21 years of age and of South Asian origin (mostly Pakistani and Bangladeshi). The All Wales Domestic Abuse and Sexual Violence Helpline, Karma Nirvana and the Freedom Charity are all national

[17] The number of orders made generally exceeds the number of applications, as FMPOs are sometimes made during the course of applications for other family orders, and there is no differentiation between interim orders and final orders.

[18] Enquiry received in email dated 3 October 2013. Note that this is likely to under-report Welsh cases since it is feasible that individuals may have taken their cases out of Wales to English County Courts, particularly cases originating in North Wales where other English Courts may be physically closer.

organisations working across Wales (and UK), dealing with all forms of violence against women, domestic abuse and sexual violence. The All Wales Domestic Abuse and Sexual Violence Helpline confirmed that in 2012/2013, they received five calls to the helpline related to forced marriage, 15 calls related to honour based violence more generally, and 19 in relation to individuals with no recourse to public funds. In the period January to September 2013, Karma Nirvana confirmed they had taken 4,912 calls from victims across the UK, 889 of which were first-time callers. Of the overall total, 104 calls were received from men and 42 calls from couples, who faced issues of honour-based violence and forced marriage. Most cases were British Pakistani in ethnicity, followed by Pakistani and British Indian. It was not possible to isolate calls from Wales in the statistics provided. In addition, the network had made 9,933 outgoing calls to assist victims of forced marriages and honour based violence.

Table 4: Forced Marriage Data for Wales and the UK

FM Protection Orders[19]	**Wales**	**England and Wales combined**
2011 2012 2013	< 5 FMPOs made by Cardiff Court between 1.1.11 and 30.6.13	157 orders 124 orders 42 orders (so far)
Forced Marriage Unit statistics	**Wales**	**All UK**
2010	1.1% of total cases	1735 cases
2011	1.3% of total cases	1468 cases
2012[20]	1% of total cases	1485 cases
Age (of victims)	No published data	13% < 15 years 22% 16-17 years 30% 18-21 years 19% 22-25 years 8% 26-30 years 8% 31 years+
Gender (of victims)	No published data	82% female 18% male
Sexuality (of victims)	No published data	1.5% LGBT

Finally, data from the four police forces across Wales (Forced Marriage Unit website, 2013) indicate that in 2010/2011 and 2011/2012 they dealt with a total of 99 cases of forced marriage and honour based violence cases - almost all in South Wales (95%). North Wales police force recorded no cases of forced marriage or honour based violence in 2010/2011 or 2011/2012, while Gwent police reported only three cases in 2011. Dyfed-Powys force reported two cases in the period 2011/2012 (BBC, 2012). The final section of this chapter examines the volume and geographic spread of BMER groups in

[19] Ministry of Justice: https://www.gov.uk/government/publications/court-statistics-quarterly-april-to-june-2013 (Accessed 29th September 2013)
[20] Forced Marriage Unit website: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/141823/Stats_2012.pdf (Accessed 29th September 2013)

Wales that may be particularly vulnerable to forced marriage (e.g. South Asian groups), revealing one reason for the low rates reported.

Beyond forced marriage, other forms of honour-based violence are poorly monitored. These are largely hidden within general domestic violence cases although on occasion they may be captured as part of homicide investigations. A Home Office report notes that:

> "…there are no published statistics on numbers of "honour" crimes in the UK, but it is widely quoted that there are around 12 honour murders per year." (Her Majesty's Government, 2009, p14)

Walby and colleagues provided several estimates for England and Wales in their report for the Equality and Human Rights Commission (Walby, et al., 2010). They cited the rate of 12 murders per year but suggested that figures from the Metropolitan Police put the number of HBV incidents at over 250 in the year (2008/9).

The data reviewed and presented here suggest that forced marriage and other forms of honour-based violence, while not insignificant in their impact, are likely to be low in prevalence in Wales. They are likely to be concentrated in South Wales, where there is a higher density of communities vulnerable to these crimes. Data from England points to official records vastly undercounting cases, indicating that community prevalence data is required if Welsh Government wish to have an understanding of the true scale of the problem.

1.6 Trafficking and sexual exploitation

The United Nations estimates that over 12 million people are trafficked each year, worldwide, with around 2 million young girls (5-15 years) entering and exploited through the sex industry. The vast majority of trafficked people are girls and women (around 80%), and the chief reason for trafficking is sexual exploitation (around 70% of all cases).

Two of the available reports on trafficking in the UK address child trafficking specifically which is beyond the scope of this report. However, a key finding was that, despite common assumptions, rural areas were as vulnerable spaces for children as urban areas (Save the Children, 2008). In a report to Welsh Government (Watson, 2010), Joyce Watson and members of the cross-party working group examined the issue in relation to women (and children) using data gathered from 20 of the 22 local authorities across Wales.[21] Research findings informing the report are further detailed in a working paper (Jones, 2010). The report suggests that in one year there were

[21] The report indicates that an LA covering a 'major city' was one of the two non-reporters, affecting the reliability of the prevalence data.

15 substantiated trafficking cases across the local authorities making the issue a “nation-wide concern” (p10).

Robust, reliable statistics on the incidence of the problem are difficult to locate, however one source is the UK Human Trafficking Centre (UKHTC), a multi-agency organisation led until October 2013 by the Serious Organised Crime Agency (SOCA). SOCA has now been subsumed into the National Crime Agency (http://www.nationalcrimeagency.gov.uk), however, as a Home Office Non-Departmental Public Body, responsible for operations to respond to crimes such as Class A drugs, trafficking, gun crime and fraud/money laundering. Via SOCA, the UKHTC published the latest statistics on human trafficking in the UK. In a report published in 2012, SOCA examined data from 17 UK police forces[22] as well as other intelligence data held by the UKHTC to provide an indication of the nature and scale of human trafficking in the UK (SOCA, 2012). Their report states that 2255 potential victims of trafficking were encountered in 2012 (a 9% increase on the 2011 baseline assessment they carried out).

Most victims were adults (71%), 24% were children, with the remainder unknown. The most common reasons for trafficking were sexual exploitation (35%) and labour exploitation (23%), though in addition, for minors, criminal exploitation (benefit exploitation, begging, theft, cannabis cultivation) was a motivating factor in 24% of cases. Romania was the most likely country of origin for trafficked victims, followed by Poland and Nigeria. A critical point identified in the SOCA (2012) report was that 65% of the total number of identified potential victims appeared *not* to be recorded on the National Referral Mechanism (NRM).

The NRM is the official route for monitoring and responding to trafficking in Wales and the rest of the UK. It seeks to identify potential victims and offer protection and support. The NRM applies to both internal and external trafficking, however, in published statistics, ‘internal’ is defined only as within the UK, not Wales separately. The UK is one of the top 10 countries of origin for adult and minor victims being trafficked.

In 2013, there were 581 cases of adults trafficked for purposes of sexual exploitation referred through the NRM (18 cases in Wales). This represented an increase of 53% (80% increase in Wales) compared to 2012, although it is not clear to what extent this increase is due to an increase in reporting, rather than an increased incidence rate. Eight-eight non-UK minors and 56 UK minors were trafficked for purposes of sexual exploitation across the UK (no figures were available for minors trafficked for purposes of sexual exploitation in Wales). The vast majority of the cases of adults trafficked for purposes of sexual exploitation were female (97% in the UK; 100% in Wales) (NCA, 2014).

[22] The report does not state whether this includes any or all of the four police forces covering Wales.

Service organisations also hold vital information about the prevalence of the problem. These local level service data suggest the problem is larger than cases processed via the NRM. For example, Bawso Ltd's Diogel project, a sister-project to the London-based Poppy project, running in North and South Wales with the prime purpose of supporting trafficked people, reported supporting 23 service users and 12 children, in one year (Bawso Ltd., 2013). In addition, Walby and colleagues suggest that estimates from different sources on the extent of trafficking in the UK vary widely "from 1450 to 4000" (2010, p40).

One of the objectives of the Welsh Government's Anti-Slavery Leadership Group is to:

> "…as a priority, build an evidence base using 'primary and secondary' data sets to better inform the Leadership Group on the scale of Human Trafficking in Wales". (Welsh Government Website, 2013b)

1.7 Female genital mutilation/cutting (FGM)

The World Health Organisation has estimated that globally 130 to 140 million girls and women have undergone some type of FGM and that about three million girls, most of them under 15 years of age, undergo the procedure every year (WHO, 2011). The majority of FGM takes place in 28 African countries but many immigrant communities continue the practice in Europe, North America, Australia and New Zealand. In Wales and the UK more widely, the practice is largely found among immigrants from these countries. With the increasing dispersal of asylum seekers, FGM is now being seen by GPs and hospitals outside the main cities.

Precise figures for the number of girls and women who have undergone, or who are at risk of FGM, in the UK, are hard to establish due to the secrecy surrounding the practice. No prevalence statistics were available for communities in the UK or Wales so estimates are used below.

A Department of Health funded statistical[23] study by FORWARD found that, in England and Wales in 2001, 65,790 women had undergone genital mutilation with the highest numbers in women from Kenya and Somalia (Her Majesty's Government, 2009). These estimates are likely to have increased since 2001, given the increase in the immigrant population. In 2004, there were 9,032 pregnant women, and women who had recently given birth, with genital mutilation. In Wales, it was estimated that 0.4% of births were to women with FGM. In 2005, over 21,000 girls under the age of 15 in England and Wales were at high risk of genital mutilation. Government guidance notes that, "it is possible that, due to population growth and immigration from practising countries…FGM is significantly more prevalent than these figures suggest" (Her Majesty's Government, 2011). The same study also suggested that while

[23] No primary data was collected. Rather the study pooled published statistics from various sources.

these practices are not confined to major cities, more cases might occur in those areas of the UK with larger communities from the practising countries – for example, London, Manchester, Birmingham and Cardiff.

The FORWARD study applied FGM prevalence statistics from practising countries to the Census 2001 population statistics of migrants in England and Wales. The same could feasibly be done using the updated Census 2011 data, for Wales specifically. A further advance on this, which would almost certainly increase the estimated numbers, would be to give consideration to the second-generation of women and girls in these communities, many of whom will have been subject to the cultural traditions of their families, despite being born in the UK. Table 5 below displays the proportions of ethnic groups in Wales. It should not be assumed that the ethnic minority groups listed in the table practice FGM. Relative to England, the percentage of mixed, Asian, Black or other ethnic groups is small (4.4% c.f. 14.4%), however, the estimated numbers being subjected to FGM are still likely to be significant.

Table 5: Ethnic groups by English regions and Wales, 2011

England and Wales					Percentages
	White	Mixed/ Multiple Ethnic Groups	Asian/Asian British	Black/African/ Caribbean/ Black British	Other Ethnic Groups
England and Wales	86.0	2.2	7.5	3.3	1.0
North East	95.3	0.9	2.9	0.5	0.4
North West	90.2	1.6	6.2	1.4	0.6
Yorkshire and the Humber	88.8	1.6	7.3	1.5	0.8
East Midlands	89.3	1.9	6.5	1.8	0.6
West Midlands	82.7	2.4	10.8	3.3	0.9
East of England	90.8	1.9	4.8	2.0	0.5
London	59.8	5.0	18.5	13.3	3.4
South East	90.7	1.9	5.2	1.6	0.6
South West	95.4	1.4	2.0	0.9	0.3
Wales	95.6	1.0	2.3	0.6	0.5

Source: Census 2011, Office for National Statistics

1.8 Summary Points

- There is very little robust data available on the different forms of violence covered in this report that is specific to Wales. However, it is possible to summarise the estimates obtained in table 6:

Table 6: Estimates for Types of Violence in Wales

Type of violence and prevalence source	Estimates for Wales
Domestic abuse: 'Any' in past year – 8.1%	Approx. 140,000 victims/year
Sexual violence: 'Any' sexual assault in past year – 1.9%	Approx. 34,000 victims/year
Elder abuse: 3.1% of elders in Wales	Approx. 17,000 victims/year
Forced marriage: 1% of official FMPO cases, and FM calls to helpline/s	Between 15 and 100 cases/year
FGM: 0.4% of births in Wales	140 cases/year identified
Trafficking for sexual exploitation: NRM cases	18 cases/year identified

- Future research could obtain the primary datasets from the ONS, via secure access and special license, to examine the Welsh-specific and local authority-level data separately.
- Domestic abuse is the most prevalent form of violence against women in Wales.
- Sexual offence rates have risen steeply in the last year in Wales as in England. While some of this rise represents historic offences, this rise is likely to continue and service provision needs to acknowledge this trend.
- Both domestic abuse and sexual violence are significantly under-reported to the police.
- Interpersonal violence is strongly associated with age, with younger women being most at risk
- The evidence suggests rates of domestic abuse and sexual violence are similar in the heterosexual and LGBT communities.
- Very few cases of forced marriage have been reported to authorities to date, and similar numbers are found in the proportions of calls on forced marriage received by major helplines.
- There are no prevalence estimates published for FGM in Wales, although it would be possible to apply a statistical method to estimate this.

2 Mapping Service Provision Across Wales

Introduction

This chapter presents findings from the mapping of services across Wales. Both specialist and generalist/universal services working with violence against women, domestic abuse and sexual violence were included in the mapping research. The mapping included a desk based synthesis of information on specialist services across Wales and an online survey to map the wider range of general and specialist services by type of violence, issues addressed, the nature of the services provided, their location, resources and impact. Themes and issues identified from the mainly quantitative findings presented here will be discussed further in later chapters where findings from the qualitative research address similar issues.

2.1 Desk based review

Specialist services across Wales were mapped using existing databases and information. This mapping exercise brought together information on specialist service location provided by Welsh Government, service leads and other key informants, Women's Aid Gold Book, DABS directory, online searching, stakeholder and service user interviews. The tables in Appendix 5 detail the 'landscape' of specialist service provision for violence against women, domestic abuse and sexual violence across Wales. Table 5.1 provides a regional breakdown of specialist services and Table 5.2 lists specialist services with a national remit. The services shown in Tables 5.1 and 5.2 are not a comprehensive list but show the regional and national availability of specialist domestic abuse and sexual violence services and the type of needs addressed (from primary prevention to identification and referral, to protection, recovery and reintegration).

More specialist services were identified in the North Wales region than in other regions of Wales. The tables, although an interesting indication of the range of specialist services, do not show service capacity based on reported demand nor capacity matched to the estimated levels of need by population and prevalence.

This aspect of the service mapping highlighted the need for a national hub or centre in Wales to provide up-to-date, consolidated information on gender based violence against women, domestic abuse, sexual violence and violence against women services. This would assist planning and commissioning as well as to provide a resource for busy professionals.

2.2 Responses to the online survey

For the second step in the mapping, data were gathered by means of an

online survey sent to organisations, partnerships and agencies. A copy of the survey questions is available in Appendix 6. Methods for advertising and distributing the survey were described in the Introduction to this report. The online survey provides a fuller picture of service provision across the full range of providers. The survey was completed by 146 organisations (listed in Appendix 8) providing information on 349 services across Wales. Eighty-eight blank and incomplete responses were excluded from the analysis .The survey allowed respondents to enter information on up to three services, but some agencies responded more than once because they wanted to record information for more than three services. Eleven percent of organisations gave information on just one service, 17% gave information on two services, and 38% gave information on three services. Twenty-seven percent completed at least two surveys giving information on four to six services. Seven percent completed three or more surveys giving information on seven or more services.

An accurate estimate of the response rate for the online survey cannot be given because those who were invited to participate may have passed the invitation email and survey link on to colleagues in their own or in other organisations. Responses were obtained from 37% of contacts the research team approached/invited. This response rate was similar for both specialist and generalist services. However, surveys were also returned by 129 services who had not been directly approached, services having received information on the survey through another route, such as via their head office or a local forum. The analysis at the organisation/sector level suggests this is likely to provide a reasonably representative picture of services across the sector at a **national** level. However all results should be interpreted with caution as we cannot claim to have a complete picture of provision on the ground across all communities in Wales. In the current climate of budget restrictions it is also possible that some services may have overstated the extent of their service provision.

The results of the mapping survey are organised around the two levels of the service typology described in the previous chapter.

2.3 Area coverage

The survey asked respondents where their services were located and where they were delivered. Respondents were able to select multiple locations for the service base and multiple locations for service delivery (up to 23 locations for their service base and up to 24 locations for service delivery). Table 7 below shows the results for each local government area in Wales. The base for services and areas of delivery do not match for all services included as some services may be based in a different area to the place of delivery.

It can be seen that there were no large variations in the spread of location and service delivery across the local authority areas of Wales. Slightly more services were reported as located in Cardiff, Denbighshire and Swansea.

Slightly more were described as being delivered in Cardiff, Denbighshire, Swansea and Flintshire.

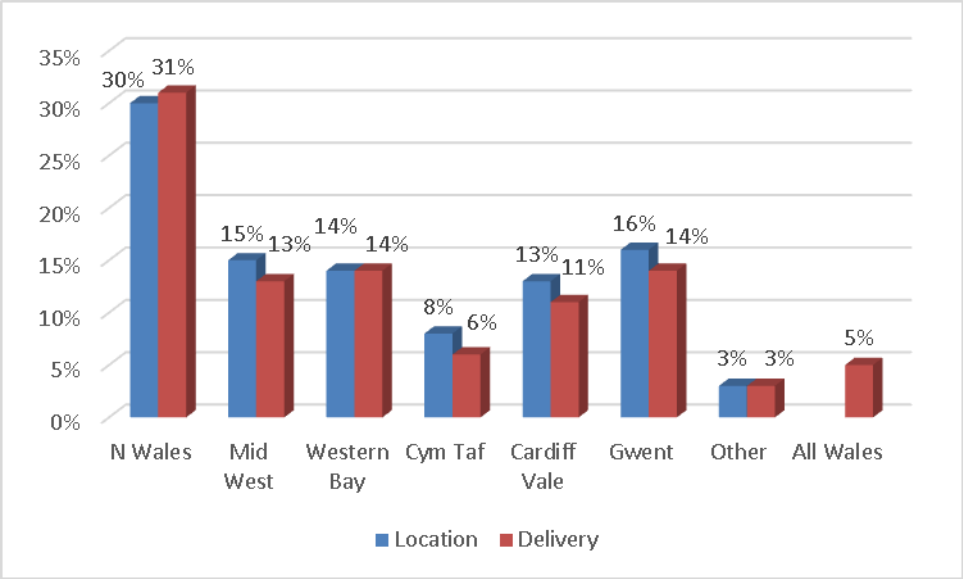
Table 7: Service location and area for delivery by local government area

Area	Based	Delivered
Gwent	3%	3%
Bridgend	4%	4%
Caerphilly	4%	3%
Cardiff	8%	6%
Carmarthenshire	4%	4%
Ceredigion	3%	2%
Conway	5%	5%
Denbighshire	6%	6%
Flintshire	5%	6%
Gwynedd	5%	5%
Anglesey	4%	4%
Merthyr Tydfil	5%	4%
Monmouthshire	3%	3%
Neath	4%	4%
Newport	5%	4%
Pembrokeshire	3%	2%
Powys	4%	4%
RCT	4%	3%
Swansea	6%	6%
Torfaen	4%	4%
Glamorgen	4%	5%
Wrexham	5%	5%
Other	3%	
Outside Wales		3%
All Wales		5%

‘Other’ in Table 7 is used to describe those services based outside Wales but delivered to service users in Wales as well as elsewhere in the UK. Slightly fewer services were said to be delivered in Ceredigion and Pembrokeshire. Five percent of services were described as being delivered across’ all Wales’. Three percent of services were delivered ‘outside Wales’.

Figure 2 below shows the regional spread for service location and delivery. This shows more data on services were provided from the survey for the North Wales region, with around one-third of the services delivered across this region. This is perhaps unexpected, given that the two largest Welsh cities, with the highest population density, are in the South, whilst mid-Wales constitutes the largest land mass and three of the largest local authorities across Wales. It is possible that the survey received better distribution and elicited more interest in North Wales but we have no evidence of this.

Figure 2: Service location and delivery by region



'Other' included services based outside of Wales but also delivered to users in Wales, as well as respondents clarifying that the boundaries of the service were fluid or deployed, centralised in one or two locations but delivering services where required.

When asked whether the service was delivered in a rural location, urban location, or a combination of the two, the majority 55%) claimed to be delivering the service in an area with combined urban and rural locations. The remainder was divided between 17% rural and 28% urban locations.

2.4 Type of response

Respondents were asked to classify each service according to its *primary* function. Five options consistent with the typology developed for this study were available and respondents were asked to select **one** only for each service:

- PRIMARY PREVENTION OR SOCIAL PREVENTION: services or activities whose purpose is to prevent violence or abuse before it occurs.

- IDENTIFICATION, RECOGNITION AND REFERRAL: services or activities whose purpose is to intervene early to identify those at high risk of abuse or those currently in violent relationships and refer them to appropriate providers.

- PROTECTION FOR VICTIMS OR PROTECTION FROM PERPETRATORS: services or activities whose primary purpose is to secure the safety of victims, either working with victims directly or working with perpetrators to prevent re-offending.

- RECOVERY AND RE-INTEGRATION: services or activities whose purpose is to aid recovery and promote well-being following an experience(s) of violence or abuse, and to ensure the victim is able to join society as an active citizen.

- CO-ORDINATION and WORKING TOGETHER: a multi-agency or multi-discipline service where the main focus is to bring together a number of responses under one service. This included second-tier or training organisations.

It is important to stress that the decision about which classification to use was left to the respondent. Some services do not fit neatly into one category (e.g. IDVAs or drop-in centres) and it was the respondents who chose how such services were classified according to their main area of service focus. It is possible that two respondents providing a similar service may have categorised themselves differently and some response types may be under-reported because respondents were asked to limit their selection to just one type. For example, many services responsible for protection are likely to also focus on co-ordination and working together.

The 349 services, for which data were provided, were categorized as follows by the respondents:

Table 8: Primary Function of Organisations, Partnerships and Agencies

	N	**%**
Primary & secondary prevention	29	8%
Identification, recognition & referral	52	15%
Protection for victims / from perpetrators	137	40%
Recovery & reintegration	88	25%
Co-ordination & working together	43	12%
	349	**100%**

These figures are shown diagrammatically in Figure 3 below:

Figure 3: Typology of Service Responses for Wales

The proportion of prevention responses was considerably smaller than expected, given the emphasis that has been placed on this work in recent years by the UK and Welsh Governments. This may, in part, be due to a low response to this survey from the education sector, where much of the prevention work around healthy relationships for children and young people takes place. It was not unexpected to see protection responses still taking the largest slice of provision at 40%. Further on below, the report examines how this divides by victim work and perpetrator work.

2.5 Type of violence

Respondents were asked to identify which form/s of violence the service worked with. They were able to select as many forms of violence as applied.

Table 9: Type of Violence Addressed

	N	**%**
Domestic violence in adult intimate relationships	257	74%
Domestic violence in young people's intimate relationships	209	60%
Domestic violence in other family relationships	190	55%
Sexual violence, including sexual assault and rape	171	49%
Sexual harassment	109	31%
Forced marriage	110	32%
Honour-based violence	111	32%
Sexual exploitation	98	28%
Female genital mutilation/cutting	84	24%
Trafficking (internal and external)	79	23%
Prostitution	60	17%
Other	72	21%

As expected, domestic violence in adult relationships was the most common form of violence addressed. There was a larger-than-expected response from services claiming to work with forced marriage and honour based violence. This may be testament to the emphasis that the Welsh Government has placed on these forms of violence in recent years however, it is difficult to know for what proportion this was core business rather than supplementary to work on other forms of violence against women. Services for women exploited through the commercial sex industry and for those trafficked were the least prevalent service responses in this survey.

'Other' services mentioned here included additional forms of abuse, such as child abuse and neglect or children witnessing domestic abuse.

The survey data shows that services able to address all forms of violence were delivered across each local government area of Wales. No clear gaps could be identified in the type of violence the services said they addressed. A greater number of services addressing *all* forms of sexual, domestic and gender based violence were reported in Cardiff, Newport and Swansea. A higher number of services addressing mostly domestic abuse were reported in Denbighshire, Cardiff and Swansea.

2.6 Service capacity

Respondents were asked about overall service numbers and capacity. The responses were varied. Eighteen percent of services said that the number of clients using the service were ‘unknown’, mostly because the information was not collected, possibly because the service was a generalist service. Others provided exact figures ranging from around five or six clients per year to 29,718. Some services did not work directly with service users as they were strategy or coordinating groups.

Over a third (39%) of the services said that they operated at full capacity for the whole year. Nearly a fifth (19%) operated at full capacity during points of the year while 29% said they were not currently operating at full capacity. Partly this may be because these services were newly established (13% were unsure if they operated at full capacity or not).

The survey invited respondents to state in their own words whether or not they operated waiting lists or had to turn clients away. Some respondents provided figures of the number of clients on their waiting lists. This was commonly the position with housing services for domestic abuse who reported waiting lists that included between 15 to 20 families. Some services noted that waiting lists regularly existed for practical reasons such as the start of the next programme or group intervention. Others replied that waiting lists could not operate in their sector as they were a crisis or policing service with responsibilities to always respond. Some mentioned that their service had become more ‘strict’ in order to manage demand. For example, one respondent said:

> ‘Crisis service, so no waiting list. Strict targets for initial response within 24 hours. Had to implement stricter criteria for access to casework.’

Other services, mostly domestic abuse services, described being unable to meet demands at times:

> ‘51 families could not access local refuge due to being full so found alternative.’
>
> ‘Approximately 50 women were not given a service.’
>
> ‘We are unable to assist most of those who seek help so over 50 men were unable to access our service.’

Second-level of the Typology

2.7 Service recipients

The survey asked respondents to indicate all eligible service users. Many providers delivered services to more than one service-user population, as evidenced by the percentages in the table below. Particularly common in the ‘other’ category were children and young people as a separate service-user

group. In addition, Government was identified as a recipient of services by those organisations involved in campaigning and policy work.

Table 10: Types of Service Recipients Eligible

	N	%
Female victims	263	75%
Families, including children	167	48%
Male victims	134	39%
Professionals	89	26%
General public	79	23%
Male perpetrators	57	16%
Female perpetrators	45	13%
Other	14	4%

Despite a large proportion of services defining their function as protection, relatively few of the services worked with male and/or female perpetrators of violence when compared with those working with victims. Furthermore, as expected, services that worked with victims were largely working with female victims whilst perpetrator programmes served marginally more male users than females. No or few services for male perpetrators were reported for Ceredigion (1), Powys (1) and Carmarthenshire (0). No or few services for female perpetrators were reported for Carmarthenshire (0), RCT (0), Ceredigion (1), Powys (1) and Merthyr Tydfil (1).

A declaration of being open to particular recipients should not be taken to mean services were actively working with these clients. For example, although 13% of services claimed to be open to working with female perpetrators, in reality it is likely that the numbers worked with are small.

When questioned about groups to whom they could *not* offer a service, gender appeared to be a common criteria (23% indicated that males were excluded from the service). Other exclusionary criteria were: certain geographic boundaries/areas (42% of services were limited to a particular area; specific forms of violence (e.g. for victims of sexual violence only or only working with sex workers); particular age bands (over 16 only, or older adults); or individuals with particular co-presenting needs (e.g. service-users must have drug/alcohol misuse problems, a disability or a mental health disorder).

Whilst those with drug and alcohol problems were a target group for some services, the survey also examined the extent to which all services operated from a rights-based perspective. Such a perspective would ensure that the service does not discriminate against people with complex needs. The survey asked respondents whether the service was open or available to these vulnerable groups.[24] The majority of services did not exclude these groups;

[24] Groups included those with drug misuse problems, alcohol problems, significant mental health problems, those that self-harm, care-leavers, disabled people, transgender, the homeless, women exploited through prostitution, those with insecure immigration status, and non-English/Welsh speakers.

however, a number of respondents flagged up the issue of working with women who had insecure immigration status, particularly where this led to no recourse to public funds. In addition, respondents indicated that while co-presenting needs such a mental health disorder or alcohol/drug problems would not exclude an individual from a service, they might make it difficult for the user to engage with generic domestic abuse services. A number of respondents also indicated difficulties in reaching out to LGBT victims of sexual violence and domestic abuse[25].

2.8 Types of services and help offered

Although respondents provided information on 349 different services across Wales in the VAWDASV sector, in reality there were many overlaps between the responses. The table below groups the reported services into 19 main types of provision, showing the proportion of total provision reported. It does not specify type of violence, but simply categorises services by their main remit. Types of service are shown in rank order according to rates reported in the survey.

Table 11: Types of service

Service delivered	**%**
Emergency/temporary accommodation, first-stage refuge, and safety units	32%
Floating support, including emotional and practical support, housing advice	25%
IDVA & ISVA services	23%
Counselling, therapy, mental health services and victim-recovery programmes	18%
Child (and family) services, including safeguarding, contact centres, support for children and young people exposed to DA/SV, and CPV	17%
Advice drop-ins and One-Stop shops	15%
Risk assessment, safety planning and co-ordination services, including DAC, SVC and MARAC	15%
Supported housing provision, including second–stage refuge	14%
Perpetrator programmes/services, including IDAP	10%
Social services and police services, including specialist police DA investigation units and forensic services	8%
Health services, including universal/ public health, drug & alcohol services, midwifery, sexual health services and A&E	8%
Specialist services, including BMER services, honour-based violence, forced marriage, men-as-victims support, sex workers and FGM	7%
Target hardening	6%
Advocacy, including court advocacy	5%

[25] New research, commissioned by the Welsh Government, on barriers to accessing appropriate services experienced by LGBT people is due to report in May 2014.

Campaigning, policy work and training (for professionals)	5%
Screening and referrals to other specialist agencies	5%
Preventative education and early intervention relationship support	3%
Helplines	2%
Sexual Assault Referral Centre	1%

Respondents were asked to categorise the nature or form of the help provided. For example, rather than simply indicating that a service is a 'support service', the survey prompted respondents to be explicit about the nature of the support provided. There were 17 different kinds of help from which to select and respondents were allowed to select as many as applied to that particular service, thus percentages reflect the proportion of services offering that type of help out of the total 349 services captured in the survey. They are presented here in order of the most to least offered. There was also an option to detail other forms not captured by the survey options.

Table 12: Types of help offered

	N	**% / 291**
Advice	235	68%
Information on rights	233	67%
Co-ordinating access/referral to other specialists	232	67%
Information on problems	229	66%
Personal safety	215	62%
Assessment	202	58%
Action planning	188	54%
Advocacy	179	51%
Practical assistance	175	50%
Education	144	41%
Training	131	38%
Treatment (including counselling)	119	34%
Accommodation	103	30%
Financial assistance	100	29%
Legal support	92	26%
Recreation	77	22%
Befriending	63	18%
Care/tending	40	12%

.

Two-thirds of services described themselves as playing a coordination and point of referral role. It is not possible to tell from the survey data what actions were taken under this broad heading. It could cover a wide range of actions from simply 'referring on' to another agency to acting as a single point of contact for initial needs assessments and routing service users towards the most appropriate coordinated package of support.

2.9 Sector

The 349 services included in the survey can be categorised by sector in the following way[26]:

Voluntary / third sector:	n = 193 (56%)
Statutory / public sector:	n = 126 (37%)
Private sector, not for profit:	n = 10 (3%)
Private sector, for profit:	n = 1 (0.3%)
Combination:	n = 15 (4%)

The combination organisations were partnerships between agencies in different sectors, for example, voluntary and statutory sector.

2.10 Specialism

Of the 349 services included, 162 (47%) described themselves as specialist providers of VAWDASV services. In other words, this was the provider's core business or remit. A smaller proportion 133 (38%) claimed to be generalist providers, whose primary remit was not VAWDASV but nonetheless who delivered services to this population. A further 15% of services described their provider status as 'other', indicating that they were specialists in another arena (e.g. child protection, women's services or drug/alcohol services), an umbrella agency, or held a strategic post.

Of those providers that delivered services targeting VAWDASV (i.e. specialist or 'other' above), the majority (80%) provided three or more services under the auspices of that provider. Nine per cent provided only one type of service. This tendency to house more than one service may be an indication that agencies are responding to the need to be varied and holistic to meet women's help-seeking needs, or that in order to be competitive and engage various funding opportunities, agencies have to diversify and expand their remit.

2.11 Delivery Setting

Respondents were asked to indicate all those settings in which the service was delivered. It was most common for services to be delivered out of the provider's office, followed by phone calls (particularly the case for helplines and advice services). Community and home-based delivery were available in 42% of the services surveyed, whilst educational and training facilities were the least prevalent (perhaps reflecting the lower rate of preventative education services surveyed here). It is interesting to note that 17% of services were delivered via the internet/online.

[26] Three services did not complete this question. Total percentage is not 100% because data have been rounded to nearest whole percentages.

Table 13: Settings from which Services Delivered

Setting	N	% / 349
Project organisation's office	163	47%
By phone	152	44%
Users' home	145	42%
In the community	144	41%
Office of a third-party organisation	120	35%
Refuge / emergency accommodation	100	29%
Online	58	17%
Clinic or health centre	54	16%
School (primary or secondary)	49	14%
College	46	13%
Training centre	39	11%
Other	29	8%

'Other' here included additional settings such as prisons and hospitals, or a combination of these settings.

2.12 Amount of intervention

The survey also asked respondents for detail about the frequency and duration of the service provided. The duration of service and amount of provision delivered to an individual client is an important consideration for organisations, both for defining the parameters of support for service users but also in service cost estimation. Where it is open-ended or un-defined, it is difficult to plan and estimate numbers to be served. It may also make it difficult to structure users' exit out of the service. A large number of respondents (~30%) providing support services claimed they did so 'as required' or 'when needed', or indeed that it was 'hard to say'. It was more common for stand-alone programmes or structured interventions to be delivered within a specified timeframe; for example, the Freedom programme is a 12-week programme running for 2 hours each week, while some perpetrator programme provided '2 hours per week over 32 weeks'. Refuge stays were also usually time-limited, for example a maximum of 3 months for 1st stage and 6 months for 2nd stage accommodation.

2.13 Use of theory, evidence, research and evaluation

The final section of the survey captured data about the providers' use of evidence, including the extent to which the design of the intervention was informed by theoretical and empirical research and whether or not the service had been evaluated for its impact on victim/perpetrator outcomes. Eighteen percent of services made specific reference to research studies that supported their service. CAADA's and Cardiff University's research was most frequently mentioned. A number of respondents simply indicated 'yes' or 'evidence-based', thereby not allowing us to judge whether the assertion was valid Thirty-eight percent of services said that their service was either based

on no evidence or they were unsure whether it was or not. For example, one service replied:

> 'It will have been based on evidence, however I don't know what the evidence is.'

There were differing definitions of what constituted an evidence base for a service and a large diversity in the underlying models reported.

Nine percent of respondents indicated that the service they provided was informed by feminist theory and research, including references to the Duluth model and coercive control models. For example, one service was described as underpinned by:

> 'Maslow's hierarchy, person-centred feminist theory, Duluth power and control.'

Other services informed by theoretical models were therapeutic and mental health services, which referenced various psychosocial and psychodynamic models of intervention.

Some respondents cited an understanding of local unmet need as the rationale for the service: for example, rates of domestic abuse in the adult population, or higher than average numbers in care. Some organisations were delivering interventions that had been piloted or evaluated in other areas, for example, a Caring Dads service and the Freedom Programme.

There were a number of references to interventions that were perceived to be based on broader policy or funding frameworks, for example, the Welsh Government 'Right to be Safe' framework; the Supporting People framework; 10,000 Safer Lives (Effective Services for Vulnerable Groups, 2012); as well as Home Office and Ministry of Justice guidance..

Finally, respondents were asked to indicate which types of evaluation, if any, the service had been subject to. They were able to tick all forms of evaluation that applied, so the percentage suggests the proportion of services that have had each form of evaluation.

Table 14: Types of Service Evaluation Undertaken

Evaluation Type	**N**	**%**
User satisfaction survey	207	60%
Expert opinion	99	28%
Individual monitoring of outcomes	195	56%
Pre-post test evaluation	109	31%
Quasi-experimental evaluation	23	7%
Randomised controlled trial	13	4%
Not sure	24	7%
Other	22	6%

As expected, the majority of the services claimed they had used user satisfaction and individual monitoring of outcomes to evaluate impact; almost one in three reported having undergone pre-post test evaluation. Also not unexpected was the low rate of any robust evaluation in the form of quasi-experimental studies or randomised controlled trials. It is clear that some services were over-claiming their evaluation capital, since the number of RCTs claimed (13) in the survey exceeds published trials for these services.

2.14 Involvement of service users

Respondents were asked whether service users had been involved in the design or development of the service, and whether they were currently involved in service delivery. Just over half (53%) said that service users were consulted or involved in the development of the service. A further 24% were not sure, which is perhaps not surprising for services that had been running in Wales for many years. It is now considered good practice to involve users, or their views, in the design of an intervention, if not its delivery (Schehrer and Sexton, 2010). Yet nearly a quarter (23%) said there had been no service user involvement in setting up their service.

When it came to current service delivery, many services did not involve service users (45%). Thirty-eight percent said they included service users in the current delivery; the remainder (15%) were not sure if service users were involved.

2.15 Sharing Information

Sharing information about individual service users between professionals and agencies is a controversial issue; this was discussed by the service users' consultation groups reported in Chapter 3 of this report. Respondents were asked to indicate whether the service shared information about individual service users, either with their knowledge, consent, both or neither. The table below summarises the responses. Most services aimed to inform service users and gained their consent before sharing information, however, one in four did not gain consent each time they shared information and a minority shared information without service users' knowledge or consent.

Table 15: Sharing Information about Service Users

Information Shared	**%**
With their knowledge and consent	56%
With their knowledge but not necessarily consent	26%
Without their knowledge and/or consent	6%
Do not share any information	12%

2.16 Funding

Table 16 shows how services were funded. Since many services obtained funding via several different routes, the percentages indicate the proportion of services reliant on particular types of funding streams. 'Other' included no funding for the service (using unpaid/voluntary staff), funded from reserves or independent fundraising, and charging clients directly. A small proportion of respondents (less than 1%) were not sure how their service was funded.

Table 16: Types of Funding Streams

Type	**%**
Grants	46%
Contracts	20%
Part of a mainstream statutory service	18%
Donations	14%
Other	10%
Not sure	<1%

The interviews with service providers (see Chapter 4) highlighted serious concerns about the stability of funding and resources for services across Wales. This was echoed in the survey. Less than a quarter of services (24%) were described as having secure funding. Nearly a third (34%) of those responding described their funding arrangements as either short term and insecure while 35% described them as moderately secure (6% were in the 'other' category). It was evident that the 'securely' funded services were overwhelming mainstream statutory services such as health services, education and police or well-established voluntary services.

Those funded via grants reported feeling less secure about obtaining repeat or future funding. Equally, projected security for those services funded via contracts was less certain, particularly given the cuts forecast by local authorities to services in this sector. This is more concerning when set against the finding that grant funding was the most prevalent form of funding for services in this sector.

2.17 Staffing

Respondents were asked about staff qualifications and/or experience required to deliver their service. There was wide variability in responses to this question.

Table 17: Staff qualifications

Qualification required	**%**
Postgraduate level	0.8%
Professional/academic qualification and experience	3%
Graduate	8%
Professional qualification	12%

Training specific to the job (includes IDVA, CAB , Counselling)	23%
Diploma/NVQ	11%
Accredited training course	2%
Training given on the job	10%
Experience in the field	21%
No training required	9%

The majority of respondents did not report any particular qualification requirement, although a significant minority of services suggested individuals required degree-level education, diplomas or a minimum of NVQ level 3/4. Some services dictated professional status, for example, registered midwife, nurse, police detective, counsellor, or social worker, which underlined a requirement for a specific degree or training. Equally, certain roles had mandatory training associated with them, such as Home Office accredited training for IDVAs and ISVAs. Some services also specified particular training courses, such as CAADA training, IDAP, Duluth training, child protection training and safeguarding, although it was unclear whether any such training was delivered in post or was a condition of appointment. It was also evident that some respondents had answered the question by reporting the qualifications of their current staff, rather than reporting requirements for training or qualifications, for example “20 years working in front-line DA” or “a BSc in Sociology with Criminology and Criminal Justice”.

The requirement for qualifications was over-shadowed by a clear emphasis on staff bringing relevant experience to their work. Even where respondents were clear that no particular qualification or education was required, there was an expectation that staff would have at least two years’ experience in the field. Where it was specified, there was large variation in the extent of experience required from 6 months to over 5 years and often related to the role; most respondents were non-specific however, simply declaring “experience” was needed.

A second question asked what proportion of the staff group had received formal training on domestic abuse and/or sexual violence. The majority of respondents, particularly those reporting on specialist services, claimed that their entire workforce had received such training. Less than 10% of respondents suggested that a proportion between 25% and 75% had received training on domestic abuse and/or sexual violence; many of these were generalist providers for whom it would be anticipated that training in these issues would be patchier. A few respondents specifically mentioned training provided by CAADA and the Rape and Sexual Abuse Counselling Centre, including cognitive analytic therapy training and sexual violence training.

Given that over two thirds (67%) of the services reported that staff spend over 75% of their time devoted to work with domestic abuse and/or sexual violence, attention to the necessary qualifications, experience and training is a critical component of any development plan for this sector.

2.18 Summary points

- The survey achieved participation from all sectors, as well as from organisations and partnerships representing all forms of violence against women.
- A range of services was found in all local authority areas across Wales however there were some gaps identified in the regional provision of services working with perpetrators of abuse.
- More services were reported in the North Wales region although we cannot be sure whether or not this reflects a true variation in service availability or a greater willingness in North Wales than in other regions to return the survey.
- Using the typology classifications, protective services are the most represented type of response, followed by recovery and reintegration. Preventive work is potentially under-represented here, although this is most likely to be due to a lack of input to the survey from the education sector.
- Services addressing domestic abuse were the most prevalent, with far fewer services responding to trafficking and prostitution.
- Many agencies were able to provide accurate numbers of service users affected by domestic abuse, sexual and gender based violence. There is scope to use this data at local authority levels to provide better linked data estimates of incidence.
- Gaining an accurate picture of service demand from some (generalist) services is very difficult if cases involving violence and abuse are not recorded systematically.
- The survey identified wide variation in the models and approaches adopted by services across Wales. Some services reported using or piloting evidence-based interventions and models (e.g. perpetrator programmes, counselling and therapeutic work, and preventive interventions).
- There is considerable concern over funding for this sector, with many services threatened by insecure and short-term funding as well as proposed future cuts.
- Expectations for the workforce, in terms of qualifications and training, varied considerably.
- User involvement in the design and delivery of services could be strengthened.
- Very little in the way of robust outcome monitoring or evaluation was reported, although there are exceptions.

3 Service Users' Perspectives

In order to incorporate the views of service users, focus groups were conducted with women who had accessed a range of violence against women, domestic abuse and sexual violence services. Relevant organisations assisted the researchers to convene and hold groups with 46 women in North Wales and with seven women in South Wales. Five groups were run in total and these included both women with extensive experience of using VAW services and those with limited experience of doing so; the groups included a substantial number of BMER women and women across a wide age range.

The purpose of the research was explained at the outset of the groups and interpreters were used where required. Vignettes were employed to focus the discussions around three key questions: what services are available, what services should be available and what are the characteristics of a good quality service?

Inevitably, service users' views and comments reflected their own experience of contacting and using services and not all participants were familiar with the full range of services. There was only brief discussion of advocacy services and this was likely to be an indication that group participants had limited experience of such services or perhaps did not distinguish advocacy from other services working with violence and abuse.

Key themes from the focus groups are reported below. In order to maintain participants' anonymity, quotations are not attributed to specific individuals but we highlight where comments were relevant to North or South Wales.

3.1 Service availability

Those women participating in the focus group in South Wales were better informed about the range of services, both specific services and types of services, available to them than those who took part in the groups in North Wales. When asked, they listed a wide range of generic and specialist services in both the statutory and voluntary sectors. This reflected a high level of service use among the women in this group and may not be an indication of regional differences in service availability or provision.

3.1.1 Specialist services

Specialist services were regarded as crucial for women experiencing abuse and violence and the expertise such services offered was emphasised, one woman in the North Wales groups commented:

> "Without Women's Aid I think we would all be out on the street…it is the support and the knowledge that they have as well."

The Freedom Programme was spoken of very highly by women in the South Wales group and a couple of participants had undertaken the course more than once. However, some service users felt that the programme did not welcome women who remained in an abusive relationship:

> "If you have done the Freedom Programme, the expectation is that you won't go back, then if you do go back, the fact that you did that is even more held against you as you should have known better, as you have already done the Freedom Programme."

Given that many women do continue to live with abusive partners, it is important to ensure that they are not excluded from accessing services on these grounds.

Some women were aware of specialist housing providers such as Hafan Cymru, a housing provider which was described as providing 'information and support' as well as assistance with transport and signposting to other agencies.

Bawso Ltd., which provides refuges, outreach and floating support to BMER women experiencing domestic abuse and other forms of abuse, was identified as one of the first places BMER women would approach for help. The value of this specialist service was heightened by the fact that BMER women described barriers to accessing other generic or statutory services such as the police. Bawso Ltd.'s work was seen as expanding:

> "BAWSO [now Bawso Ltd.] started out supporting BMER women and children. Now it is opening up more and more as a One-Stop-Shop and it is now supporting other people and even men. It is now working with women who do not have recourse to public funds."

Some White Welsh women were very interested in the type of support that Bawso Ltd. and a young people's Info Shop provided and regretted that this One-Stop-Shop model (which included offering a high level of confidentiality and advocacy services delivered together with other services from one site) and regretted that this One-Stop-Shop model was not more widely available.

Most participants who expressed a preference stated that they needed women-only services and female staff. Some women were happy for men to be able to access the same services as women but only under specific conditions. Women also wanted face-to-face services particularly where English was not the woman's first language; online services were not regarded as the most appropriate for many of these women. Indeed, many BMER and White women expressed distrust about using the internet as a source of support for those experiencing abuse or violence and they voiced fears about the confidentiality of online services. However, some women noted that they would be happy to access support by telephone.

3.1.2 Generic services

Service users expressed some reluctance about seeking help from statutory services: they were not confident that information would not be shared without their knowledge or prior approval and they thought that seeking help might be interpreted as a sign of 'not coping' with implications for their parenting role. Moreover, they noted that variations between practitioners in statutory services made it difficult to predict what response they would receive.

Hospitals were repeatedly identified as a first point of call in the event of a woman experiencing sexual violence. The police were also seen as the first agency to contact in relation to experiences of abuse or violence by some women. However members of two of the groups held did not mention the police as a resource.

Solicitors were mentioned as a source of advice, principally by those women who had been through the criminal justice or asylum seeking system. The work of Shelter Cymru, which provides advice services, was flagged up in two groups. One person highlighted the value of advocacy services:

> "I had help from the Advocacy Service – the lady I had was fantastic. She came with me to court when I needed. She helped set me up with somewhere to live…even now I'm not with the service anymore, if there is a problem I can still go."

Gingerbread, an organisation working with single parents, was also identified as a source of education and training; involvement with this voluntary sector organisation had assisted one woman to find work. A few women also mentioned that generic housing associations (rather than those specialising in domestic abuse) had enabled them to access training.

3.2 What services should be available?

3.2.1 Age specific services

Two young women argued for services that were specifically for young people. One described the benefits of participating in a youth group while the other noted: "*Coming into a room where there are lots of older people I would feel threatened.*" She also commented that she would not have responded well to older service users advising her what to do and described the value of receiving services via a generic information shop for young people. The group also discussed concerns about the possibility of losing eligibility for age specific services once young people were over 25.

3.2.2 BMER and culturally sensitive services

Whilst Bawso Ltd. was seen to provide a very valuable service, BMER women described barriers to accessing other services. There was a lack of availability of good interpreters, particularly in health settings, and those provided by the

Home Office were not trusted. One focus group called for all workers to have more training in cultural sensitivity and on BMER issues generally.

Another group noted that while it could sometimes be important to have an interpreter from your own language community, this might vary according to both the individual and the issue being discussed.

Not feeling discriminated against and being treated respectfully were key features of a good quality service, and women considered that this aspect of a service was achieved by staff who were helpful and did not have 'an attitude'. Staff should:

- "Know about different cultures
- Know about different situations
- Have an open and relaxed body language
- And show themselves to be people who can be trusted."

Many said that both mainstream and some specialist organisations did not understand immigration status issues which could create difficulties for some women seeking assistance.

3.2.3 Peer support

Peer support was advocated by four of the focus groups, one in the South and three in the North. Two groups suggested offering meetings like AA, where they could meet other people in the same situation and offer one another support. Peer support was seen as valuable because survivors could give each other advice and it is *'good to know you are not the only one'.* Such groups could also provide emotional support after sexual violence. One organisation was already working to facilitate opportunities for women to offer each other informal support. This approach meant that a lot of trust was built up with the women involved getting to know the details of one another's situations. There were questions raised about how easy this would be to implement in a small community where group members were likely to know or be related to some of those involved in abusive situations or experiences. One woman suggested that peer support groups should be externally funded, with access to large venues and able to call on the skills of external professionals to help if personal conflicts arise within the group.

3.2.4 Improving policing

Perspectives on the police varied considerably. As noted above, many participants reported very positive experiences however, other women described insensitive policing:

> "Maybe if there were more females?"

> "Two police officers were crap; I phoned after hiding for two weeks and they said, 'we can come now or at the weekend, but there is no-one here at the weekend'."

Discrepancies between women's experiences might reflect differences between individual officers; as one woman said: '*It depends on what officer you get.'* Another woman noted that these variations could be addressed by training: *'They should have more training'.*

3.2.5 Housing

Housing was not perceived as readily available for women who had experienced violence and abuse. There were examples given of women not being put on the housing list, either because paperwork was not followed through, or because their names were not put forward to housing association lists:

> "When you phone to get put on, make sure you phone up two days later to make sure you have been put on, 'cos you don't get even put on it."

One woman gave an example of the law apparently being wrongly applied or the correct information not being elicited:

> "I'd left domestic abuse but they said you are intentionally homeless… so I had to move back in with the perpetrator as I had nowhere else to go."

Housing associations were generally viewed more positively than local authority housing services: "*housing associations are better than the council*." And that generally, "*housing services should help you stay in your home*".

Housing problems were even more acute for those BMER women with insecure immigration status and hence no recourse to public funds as, with the exception of the refuge provided by Bawso Ltd., there were no other refuges that could accommodate women without access to housing benefit to pay for refuge provision.

However, it was noted that women who worked and might not receive benefits could also struggle to get access to refuges. Women were described as struggling to earn a sufficient salary to cover the costs of the refuge or giving up their jobs in order to qualify for housing benefit to stay at the refuge:

> "It costs £210 a week to live in the refuge. Women who work cannot afford to stay. They had to choose between staying at the refuge or carrying on working."

Some recommendations were made about improving the quality of refuge provision:

> "[refuges should be] simple but a nice environment"

> "There should be kitchens where you can access food that is provided".

The availability of food was particularly important for women who arrived at a refuge without money or late at night.

Two women described support from mental health services as inadequate, whereas another two said that CPNs had been helpful. Those who had received help described CPNs who had facilitated access to a wide range of services including housing and refuges, training and benefits. Another woman who had a mental health diagnosis stated that she was struggling to get mental health services to provide her with any help at all.

3.2.6 Accessibility

There was debate in a few of the groups about the extent to which services were accessible. For example, in one group, one woman stated that services '*are easy to access*' and another group member replied '*I strongly disagree with that*'. Other women believed that access to services had improved over time: '*A few years back there was nowhere to go. Things have got a lot better*.'

Key issues contributing to accessibility were location, stigma and awareness of available services. Town centre locations were preferred and these should be near public transport links. It was suggested that women should be able to make a phone call and then be picked up if necessary, especially if they were in distress, in an unfamiliar place or in a rural area. A similar service model is currently being funded by Welsh Government in substance misuse service provision.

Some of the women explained that they were embarrassed at having to disclose their experience of abuse:

> "It is also embarrassing walking into somewhere and saying this has happened to me …there is stigmatisation out there."

Women felt that in general services for those experiencing abuse and violence were not well advertised: *'why is it not advertised – it is not getting to the right places!*' and others stated that they knew there were services but not everyone did: *'There is information but you have to know where to go for it.'* It was suggested that services should be advertised more widely *'We need to put info in public toilets'* and in workplaces. It was also suggested that such information needed to be made available in different languages. None of them mentioned the Welsh language, but none of them were Welsh first language speakers. Some women also said that women needed access to the internet in order to locate available services.

Participants noted that an increase in specialist services working with abuse and violence contributed to wider public awareness about these issues:

> "It leads to there being more awareness of domestic violence issues in society."

One group pointed out that employers needed to be more aware of domestic violence and its impact. Another group suggested that awareness raising workshops should be available to everyone, '*to educate people so they know about domestic violence and what services are there.'*

Rural services

The issue of accessibility and location was discussed, particularly in relation to women who lived in rural areas. Two groups suggested independently that services that were located in town centres should have small satellite premises in rural areas. At the least, they should have an outreach service which could pick up and drop off women at a safe point like a bus stop so that women could phone for assistance and that someone would come out to them.

Other women called for outreach workers to offer follow-up support after women leave refuges (some women described positive experiences of this sort of support from Hafan Cymru and community psychiatric nurses):

> "Women have learned how to cope with the violence, whereas they haven't learned how to cope with the isolation that comes when you do leave. Support should be on-going when you leave, not just crisis."

Speed of response and 24 hour services

Women emphasised the need for a speedy response to women seeking help for experiences of abuse and violence:

> "You will find that if women do not get help when they need it that they do tend to go back."

One woman noted that waiting lists were a disincentive to seeking help: *'You need houses/shelters where you can go anytime, with no waiting list'.* It was suggested by a member of one group that panic buttons, to which the police responded immediately, should be made available to repeat victims, and other group members were unaware that such a service was available in some places.

Women considered that 24 hour services would increase their ability to access support. However, in more than half of the focus groups, service users were either unaware of the existence of the 24 hour VAWDA helpline or instead identified a Women's Aid number or an informal service run by local volunteers. Concern about 24 hour and weekend cover was repeated across

all groups. The issue of 24 hour access was more related to concerns about lack of support over weekends:

> "I think the problem is the weekends. You can't get any help at the weekends".

Women also suggested that a 24 hour helpline specifically addressing sexual violence issues would be valuable suggesting that they were not aware of the role of the All Wales Domestic Abuse and Sexual Violence Helpline:

> "[Such a] line should be advertised a lot so that every woman know it, just like they know 999."

The need for out-of-hours cover was also an issue in refuges:

> "I had to borrow the money to get there and I was dumped in the house and it was Tuesday before anyone saw us…"

Women also noted that a 24 hour security presence in shelters would assist victims to feel safer.

<u>One-Stop-Shops</u>

One group had an extensive discussion about the concept of a One-Stop-Shop for women and men who had experienced violence against women, domestic abuse and sexual violence. This discussion was replicated in all the other groups, although some wanted such services to be women only. One of the groups stated that the One-Stop-Shop should be in a building like a public building or library so that no one would know if you were accessing it and would therefore be "*non-stigmatising*" and "*protect confidentiality*".

A One-Stop-Shop was described as including professionals from the police, social services and housing and should provide both counselling and practical support. One group suggested that the first point of contact in this service should be someone like a 'psychologist', that is someone who was well trained and who had the authority and knowledge to refer women to all of the other relevant services.

Victims using the One-Stop-Service should be offered a choice between female and male workers (one group felt that all staff should be female), and should be able to access staff who spoke their language.

<u>Activities and training for victims</u>

It was suggested that refuges and other services should offer opportunities for women to gain skills and take up classes, including English language classes. This would assist in building women's confidence and self-esteem. Women could also be given passes to access gyms free or at a reduced price, and it

was argued that this would help reduce stress; other women suggested self-defence classes for women.

Confidentiality and Information sharing

> ‘‘The police make you remember what you have been through…and then you get to another organisation then you have to tell it all again. I think they should tell other people your information’
>
> ‘But then we have got issues of confidentiality’

Two groups suggested that services should be totally confidential, but when this issue was discussed further group members agreed that confidentiality could be broken when it was a matter of protecting children or if women’s lives were at risk. There were differences between these two groups regarding whether services should maintain internal confidentiality. Of the three groups who discussed this issue, one group said that it would be acceptable for all services within a One-Stop-Shop to know about a victim’s case, another said it should be confidential to the support worker, a third group was undecided. Distinctions were made between services providing counselling and emotional support where there was considered to be a need for complete confidentiality (except when risks of significant harm were high), and services providing information and practical resources where factual details about services users could be shared between staff.

Further, where confidentiality was going to be breached because of risks of significant harm, one group stated that this should be explained ‘*in person or over the phone and only a personal support worker should know about this not the whole* team’. Another group said consent should be sought before confidentiality is broken. Information about such child protection matters should be stored in a safe place.

Some BMER women expressed concerns about maintaining confidentiality when interpreters were used and where there was no certainty that the interpreter could be trusted with sensitive information.

3.3 Key messages

The groups concluded with women summarising some of the key messages they wanted communicated to the Welsh Government. BMER women stressed that the government and men in power needed to show concern for the lives of women and children, even when they had no recourse to public funds. BMER women experiencing abuse and violence needed access to solicitors who understood immigration issues and they suggested that information should be made available in audio format as many BMER women could understand spoken English but could not read it.

Other key messages included the need for training for all professionals who came into contact with domestic abuse, sexual violence or violence against

women. It was noted that GPs' responses to women experiencing violence or abuse could be improved on and while a number of BMER women in North Wales reported positive experiences with the police, some White women in South Wales felt that police intervention could be more sensitive and compassionate. It was felt that it was important to have specialist knowledge and assistance available in respect of complex issues such as benefits and housing.

Women also wanted support for their children in relation to their exposure to violence and abuse and felt that this could be provided in education settings. However, they noted that that attempts to seek such help could be interpreted as proof of poor parenting or as a failure to keep children safe.

3.4 Summary points

- Service users emphasised the need for staff, especially those working in generic services, to be appropriately trained and to have relevant specialist knowledge.

- Bawso Ltd.'s services were valued by BMER service users and its One-Stop-Shop service was particularly appreciated. It was felt that other services were not always as knowledgeable about the needs of BMER women.

- Good quality interpreting services were described as difficult to access.

- Women were divided about whether services should be open to men.

- Service users were distrustful of online services although they felt more comfortable about services delivered via the telephone.

- Barriers to accessing accommodation were identified for women without recourse to public funds and for women who were working. Housing staff were not always well informed and housing was seen as difficult to access. Refuge accommodation was not always welcoming or good quality.

- Peer support was considered valuable for those who had experienced violence and abuse but the difficulties of delivering this in small communities where confidentiality might be threatened were acknowledged.

- The accessibility of 24 hour services and helplines was emphasised.

- While women were alert to the stigma that attached to being perceived as a victim of abuse and violence, they also considered that services could be more openly advertised and that this could exert a positive influence on public attitudes.

- Attitudes towards information sharing between professionals varied and the service users consulted suggested that practice in information sharing should be determined by the nature of the service and the information being shared.

4 Stakeholder Perspectives

Two groups of stakeholders were interviewed: direct service providers and strategic leads who included both commissioners and those with policy roles. In total, 23 interviews were completed with service providers and eight with strategic leads who were drawn from both national and regional levels. A couple of those interviewed described themselves as having dual roles as both providers and commissioners of services. These 31 participants were selected to represent the widest range possible of the various services available across Wales and the key individuals and organisations that provided or commissioned these. All interview participants gave consent to be interviewed and recorded. We offered anonymity and so each participant is assigned an identifying code. In this report, direct service providers are referred to as Provider 1 through to Provider 23 and strategic leads are designated Strategic Lead 1 through to Strategic Lead 8.

The stakeholder interviews aimed to build a more detailed picture of services and interventions across Wales and the findings are organised under three key themes: gaps in provision; multi-agency collaboration, coordination and innovative practice; and commissioning and funding arrangements.

4.1 Gaps in provision

In terms of gaps in services for specific groups of people, the respondents concurred that those groups that were least well served were: children and young people; BMER women; women in rural Wales; male victims; perpetrators; older women; disabled women; adult survivors of childhood sexual abuse; Gypsy / Traveller communities; women with additional needs such as alcohol / drug dependency and / or mental health concerns and Polish communities.

A failure to match provision to need was a common theme and two types of gaps were identified: general gaps relevant to everyone and equity gaps related to specific groups such as services for rural women, disabled women and women with additional needs such as alcohol misuse issues. Those areas that were mentioned most frequently were in relation to gaps in refuge accommodation and particularly specialist refuge accommodation for BMER women. It was also flagged up that there were less sexual violence services available than domestic abuse services and few sexual violence services available in North Wales compared to South Wales.

Services for women experiencing domestic abuse and / or sexual violence and experiencing alcohol or substance misuse or with mental health issues were lacking and the problem of services not being able to accommodate women with complex or multiple needs was raised:

> "…they referred into mental health who said they wouldn't see her as she was alcohol dependent and so they tried to refer into the alcohol

misuse services who said they couldn't deal with her while she has on-going mental health issues." (Strategic Lead 5).

The limited availability of counselling services was also identified and the prohibitive costs of private counselling ruled that out as a viable alternative for many women.

Below we focus on BMER women, rural women, male victims and perpetrator programmes, as they were groups whose needs were highlighted by the majority of participants (children and young people were also mentioned but are not included in the remit of this review).

4.1.1 Black, Minority Ethnic and Refugee Women

Participants described a lack of refuge accommodation for BMER women with no accommodation available for them in North Wales. If women were required to travel from North to South Wales then they were then unable to continue to receive the support they were previously receiving from the specialist BMER organisation in the North (which provided community based support and floating/outreach support). Several housing associations had offered to provide accommodation in North Wales for a specialist BMER refuge but there was no funding to support this. The importance of employing staff familiar with the cultural backgrounds of BMER service users was identified by some and the need for interpreting services was emphasised. As some BMER women had insecure immigration status they might not have recourse to public funds and thus were ineligible for refuge accommodation (even if available). One participant from a general domestic abuse service argued that they were well equipped to work with BMER women; another interviewee from a specialist service argued that specialist knowledge such as knowledge of immigration policies and cultural specificities was essential and necessitated specialist service provision.

4.1.2 Rural Wales

There were obvious barriers for women in rural Wales not least of which was the shortfall in service provision in rural areas and the lack of public transport available for women to access services in towns. A number of respondents argued for peripatetic services to be taken into rural communities where "*it is about bringing the services to the victims instead of the victims to the services*" (Provider 8). However, it was also recognised that peripatetic outreach services were labour intensive, more costly and could leave staff in a vulnerable position isolated from team support. One service provider argued that One-Stop-Shops worked well for those in rural areas as women only had to travel to one place to access multiple services. However, Strategic Lead 8 noted that whilst One-Stop-Shops provided a valuable service, the quality was not always consistent:

> "I'm aware of the One-Stop-Shops that operate across Wales. I think they're maybe a prime example of a great idea that's developed but maybe aren't as consistent as they could be, aren't maybe responding to the breadth of need that's out there."

4.1.3 Male victims

Many respondents mentioned the increase in male victims of domestic abuse but little evidence was offered for this. One interviewee described a refuge specifically for male victims, which had received no referrals in the previous year:

> "That service became open to men and we've not had a referral from a male which has been very interesting. We didn't expect tens of them, but certainly we had expected some referrals through and we've not had any in the year" (Provider 20).

It was beyond the remit of the current research to investigate the reasons for the absence of male referrals to this refuge. Provider 23 noted that the needs of men who are adult survivors of childhood sexual abuse should be factored into service provision. There was also a view that those services that do work with men needed to be aware that men's needs were different to women's and that services needed to be mindful of this before they expanded their remit to cater for both female and male victims (Provider 19).

4.1.4 Domestic abuse perpetrator programmes

The lack of perpetrator programmes, and specifically community based perpetrator programmes, was identified by many participants. Perpetrator programmes were considered to be a means of holding perpetrators accountable for their behaviour and also a method of challenging abusive behaviour and thus preventing future abuse. They were also described as cost effective in reducing the need for those services that repeat perpetration and victimisation necessitated:

> "Properly set up perpetrator programmes across the whole of Wales, that is an absolute definite thing that we need to do. And it would be cost effective to do it because it would basically break down the costs of everything else, with the other services... we wouldn't be using quite as much." (Provider 13)

The respondents identified only a couple of non-mandatory perpetrator programmes in Wales and there were calls for more community based perpetrator programmes. Furthermore, whilst the IDAP programme delivered by the Probation Service was accredited and court mandated, one respondent believed that the Welsh Government had part funded a programme that was not Respect accredited and did not meet Respect standards. A number of interviews called for evaluated programmes that "*meet best practice*

standards and are monitored and evaluated effectively" (Provider 3). Indeed it was reported that CAFCASS did not refer any perpetrators to perpetrator programmes due to the lack of an evidence base to support their effectiveness. The lack of perpetrator programmes was regarded as a significant gap, as without programmes: *very little is done when it comes to actual perpetrators and trying to change their behaviour*" (Strategic Lead 7).

4.2 Multi-Agency collaboration, coordination and innovative practice

4.2.1 Impact of shift towards a broader violence against women policy

Although specific questions about violence against women, sexual violence and domestic abuse were asked in the interviews, many of the interviewees focused their responses on domestic abuse (unless in relation to school based prevention work). Most respondents discussed IDVAs and MARACs with only occasional references to the six SARCs in Wales. This suggests that, although the policy agenda has expanded to include all forms of violence against women, the focus of service provision remains on domestic abuse. Despite this, the policy shift to a broader violence against women focus was welcomed as a positive development that would facilitate increased identification and referral. Furthermore, it was argued that routine enquiries into domestic abuse could often lead to individuals disclosing sexual abuse "that they wouldn't otherwise disclose if they hadn't been asked the question" (Provider 6). It was also noted that there had been a recent increase in reported domestic abuse and sexual violence with an emphasis on reporting historic cases of sexual abuse (Strategic Lead 7).

Some drawbacks were raised: broadening the remit had led to an increase in workloads and it was argued that there had been a lack of 'clarity' over how to address these others forms of violence against women. It was also argued that the same response might not be appropriate for different types of abuse. For example, it was noted that when the remit of the domestic abuse helpline was expanded to address sexual violence only 300 calls were taken in relation to sexual violence over a 12 month period, whereas a specialist sexual violence service was described as receiving many more calls per week. This provider was concerned organisations were tendering for projects that were not necessarily within their area of expertise with the potential for a dilution of specialisms within the sector (Provider 23). One interviewee (Strategic Lead 6) argued that, instead of workers regarding wider forms of violence against women as additions to their workload, they should consider the new definition in terms of how service provision operated and met those wider needs.

4.2.2 Promoting service and referral routes

Participants explained that they used a range of methods to promote services including poster campaigns, leaflets, messages on wage slips, adverts on buses and in bus stops, newsletters, community events, open days, leaflets in GPs' surgeries and hospitals, adverts in newspapers at particular times of

year for example, on Mothers Day. Additionally, newer forms of social media were also being employed such as Facebook, Twitter and online campaign material.

Every service provider participating in the interviews offered more than one service and valued collaborative, multi-agency working which was overwhelmingly reported as positive. Many organisations referred clients to other services and the 24 Helpline was frequently mentioned both as a resource for individual clients and a source of information for practitioners (indeed, it was identified that other agencies comprised the largest group using the helpline).

Provider 12, whose organisation offered specialist provision, illustrated the value of multi-agency working:

> "We work in partnership with other organisations all through our work, we couldn't work on our own. ... we will signpost her to other agencies and we'll work alongside these agencies …" (Provider 12)

It was also flagged up that multi-agency working was essential for other family members who might need support in addition to that provided for the victim (Provider 14).

Referral routes varied enormously depending on the service and there was some concern that referral pathways should be standardised (although what this would mean for self-referral was left unexplored):

> "There should be a standardised service and it should be audited, and it should be monitored…. there should be a standard package which offers a tiered service, as you would with substance abuse." (Provider 4)

4.2.3 Information sharing and risk thresholds

Interviewees described a general nervousness about sharing information, which arose from fears of breaching data protection requirements. However, participants also stated that the lack of information sharing caused more harm and "has led to us putting more women and vulnerable people at risk" (Provider 4). Concerns expressed about information sharing were perceived as leading to a lack of participation in MARACs, which then limited their effectiveness. One respondent emphasised the value of sharing information and potential harms of not doing so: "*nobody has died as a result of sharing information, but many people have died as a result of not sharing information, and that's really important to know*" (Provider 8).

Anxiety concerning information sharing was increased in relation to cases that were not regarded as high risk and there were calls for guidance on this from the Welsh Government (Provider 7). The issue of risk thresholds was flagged up in relation to both domestic abuse and sexual violence. There were

concerns expressed about the incident based approach to abuse whereby each individual assault was regarded independently. This was described as unhelpful because it meant that the 'less serious' cases often failed to meet the threshold for intervention but these cases could often prove to be just as serious as those cases with an ostensibly higher level of risk:

> "Where people come to the police to report a sexual assault, if it's a serious sexual assault, if it's rape, or an assault on a child, or a vulnerable person, then there will certainly be a referral through to a SARC. However, lower level sexual assaults … really depends on whether the person dealing [with the case] has done [a] risk assessment for that individual and thinks they would benefit from being referred [to] the SARC. So, it is quite inconsistent and rather dependent on individuals and their skills and knowledge as to whether they are referred through or not." (Strategic Lead 5)

The significance of MARAC and MASH (Multi-Agency Safeguarding Hubs) was discussed by a number of the participants. MASH is a recent development where a multi-agency team usually involving practitioners and administrative staff from social services, the police and health collate information from their respective agencies to inform the screening of all referrals (see Crockett et al, 2013 for an early evaluation of MASH in London). While there is considerable variation in the models implemented across England and Wales to date (Home Office 2013), there are some common features. Interagency information sharing is freed from concerns about confidentiality and data protection by designating the multi-agency team as a 'sealed intelligence hub' (Golden et al 2011, p 2) where information can be released from different agencies' databases and used to inform risk assessment with protocols covering its dissemination outside the hub:

> "The main concern I have with MARAC is that it only deals with high risk cases. … this is where the MASH comes in, to be looking at those medium and low risk cases, for two reasons. One, as a starting point, we need to be sharing information on those cases that are initially identified as low and medium risk, because once you get information in from other partners, you actually might realise that this case is a high risk. And secondly, because even if they are still medium risk, our whole approach would be to stop them becoming high risk." (Strategic Lead 4)

Health professionals were considered to have a key role in screening and identifying victims but there was concern about their lack of engagement in the MARAC process, for example: "*we've always hoped that we might be able to engage GPs within the MARAC process, I think it's fair to say that we've had very, very, very limited success*" (Provider 3). It was suggested that GPs could follow a similar protocol to that employed in child protection cases to ensure that violence against women was treated consistently and to a higher standard:

> "To get GPs referring because I think they would be a big valuable referral source. And certainly we hear through clients, perpetrators and victims, they have often presented there first. But I think that GPs aren't really asking the right questions and are prescribing antidepressants or things rather than asking the questions. I think that it comes down to them not being aware of what to do with the information if they can get it." (Provider 1)

However, when GPs did engage with violence against women, positive outcomes were identified:

> "In areas where health are heavily involved in the SARCs, there's more referral from other health services like GPs, and other sexual health clinics." (Strategic Lead 5)

4.2.4 Innovative practice

There were various examples cited of innovative practice including: a One Stop Shop with gym facilities; printing Helpline numbers on all NHS and Welsh Government employees' payslips; developing working practices with the ambulance service; and the Body Cam pilot where police officers have cameras attached to their vests when attending a domestic abuse incident. The DACC (Domestic Abuse Conference Call) was also described; this involved the police providing Probation and Children's Services with information on domestic abuse incidents within 24 hours (or 48 at weekend). Probation and Children's Services cross-referenced the victim and perpetrator in their own records and within an hour a mini MARAC was called on every case.

One-Stop-Shops were described as having a very positive impact on collaborative working and had engendered more positive working relationships between service providers and clients. One-Stop-Shops were also considered to facilitate joint funding applications.

There was discussion about developing shared minimum standards to ensure all organisations were working towards the same goals: "*no matter where you move in Wales you should be able to expect a certain standard of service*" (Provider 1).

4.3 Commissioning and funding arrangements

4.3.1 The Evidence Base

Many of the domestic abuse services were described as based on the Duluth model (Shepard, Falk and Elliott, 2002) and many service providers reported striving to evaluate their service and using evidence based models: "*at every opportunity we can we try and make sure that our practice is evidence based*" (Provider 3). There has been a significant professionalisation of this field with

increased training and incorporation of standards. However, very few organisations have completed formal evaluations of their services. The limitations of the evidence base were attributed to funding restrictions, lack of time to develop proper evaluations and the disjointed nature of the sector. This was seen to have implications for commissioners who might not have access to evidence regarding the efficacy of interventions. One organisation that conducted routine evaluation commented that this allowed them to illustrate the positive impact of their service (Provider 21).

Another respondent expressed frustration at the lack of systematic attention to establishing a set of service standards. While there had been a set of standards developed and whilst the Welsh Government had provided positive feedback on these, they had not yet been rolled out. If these were endorsed they could "*form the basis as the standard of service required when commissioning processes are being carried out*" and so increase impact and cost effectiveness (Provider 3).

4.3.2 Funding arrangements

Welsh Government funding was described as being channelled directly to local authorities, who then organised commissioning of providers. However, most services in this sector, with the exception of those few organisations funded solely by the Welsh Government, obtained funding from multiple and diverse sources including the Welsh and UK Governments, Trusts and Foundations, banks, voluntary organisations and charitable funds (see also Chapter 2). The overall picture was that funding was precarious. Two main concerns discussed by providers and strategic leads were the lack of funding overall and the issue of short-term funding and part-time staff contracts which could increase job insecurity, staff turnover, training costs and instability of services. In contrast, it was argued that permanent contracts delivered highly trained staff and low staff turnover. Short-term funding also resulted in more staff hours spent on securing funding rather than delivering the service.

Reliance on multiple funding sources required large amounts of staff time to be devoted to providing detailed feedback in a variety of formats to different funding bodies. Many providers received funding from the Supporting People funds but it was reported that of the £136 million Supporting People budget, only £10 million was dedicated to violence against women services across all 22 Welsh local authorities. Although it was noted that the Welsh Government had continued to provide funding and had ring fenced the Supporting People funding, service providers described themselves as continually challenged by the short-term nature of much of the funding in this sector:

> "The main focus for the Welsh Government… is they've got to give contracts, rather than yearly, they've got to give people three yearly contracts because otherwise, you're going to have a high turnover of staff." (Provider 13)

The role of IDVAs was regarded as essential to domestic abuse cases and strong arguments were made for core funding for this service:

> "…there's a huge funding problem in providing that IDVA support. And what we have found is that because the funding isn't approved from one year to the next, people never know where they are and organisations struggle to actually employ an IDVA. And because there isn't enough funding put in place, the IDVAs that they do have are overworked and end up having long periods of sickness absence, they end up with no provision at all." (Strategic Lead 7)

Despite the precarious funding situation, services described themselves as continuing to plan for the future; in the words of one participant: "*we put our own three to five year plan in and pretend the funding is there*" (Provider 14). However, it was also suggested that funding could be used in a 'smarter way' to encourage more collaborative, partnership working and that this could be made a requirement of funding applications (Provider 8).

A further issue identified in relation to limited funding was the rationalisation of service provision with priority given to those cases deemed higher risk. This was seen as problematic as it left some victims in a vulnerable position and did not prevent cases becoming higher risk. Funding shortfalls in statutory services were also described including cuts in non-devolved services such as the specialist domestic violence court "*we haven't got identified lawyers and CPS anymore that pick up those cases*" (Strategic Lead 7). However, Strategic Lead 1 argued that local authorities should carry much of the costs of violence against women services and that the Welsh Government should not necessarily meet all service costs for victims affected by domestic abuse. Strategic Lead 2 identified a tension arising from the development of specialist services to respond to the broader violence against women agenda while at the same time retaining and expanding existing generalist services.

4.3.3 Joint commissioning

Target hardening was often discussed in relation to joint commissioning and joint funding of services. In relation to this theme there were some comments that the system could work more effectively:

> "I do think it would be much better if we could start off from the beginning going, what services do we need? ….what do we need and let's jointly commission services to make sure, because at the moment, it's like robbing Peter to pay Paul. And we're forever trying to pick up the pieces, you know. So when funding runs out from target hardening, we're saying to [name], come on, is there anything you can do? They come back and go, okay, we've just found £10,000, we'll run it as a pilot. That's no way to run a business. I'm very grateful, it's very welcomed but, you know, there's got to be a better way to do it." (Provider 16)

Participants were positive about the value of joint commissioning and of joint "*ownership and leadership*" (Provider 4) in order to make different agencies feel equally invested in initiatives. Another example offered by Provider 8 was a successful joint application for target hardening equipment, which was then available for all those services that were partners on the bid.

However, it was also recognised that joint commissioning should not erode the need for services to be relevant for local communities:

> "Yes, I think that there would be viability in joint commissioning … I think it's still important to keep a local flavour … because each of these areas in North Wales they vary geographically." (Provider 7).

A further concern regarding joint commissioning was that some specialisms might get subsumed under the priorities of the partner organisation (Strategic Lead, 6). Spending restrictions led to services competing for the same budgets and this engendered a competitive climate that was not conducive to joint commissioning:

> "So I mean there are challenges in trying to work really closely with people in joint funding situations. And it does, you know, it requires a lot of time, a lot of resources, a lot of trust, and I think it's the trust issue, which is often difficult to build up. And we're in a climate where we're all competing, you know, all my closest colleagues in the sector are also my competitors, which doesn't make it easy." (Provider, 21)

4.4 Conclusion

The report, *10,000 Safer Lives Minimum Standards* (Effective Services for Vulnerable Groups 2012) appeared to have been influential and many respondents referred to this and described how it had impacted on their service. Nevertheless, some concerns were expressed about the implementation of these standards and the lack of resources to meet training needs (Provider 15). The Ask and Act element of the proposed Bill was also seen as a key element in responding to the challenge of violence against women. Wider issues of regionalism and localism were highlighted:

> "I don't think anybody's adverse to regionalisation from a strategic perspective but I think we've yet to see, or would like to have some kind of vision of how that will manifest on the ground, in terms of service delivery" (Provider 14).

Funding shortfalls emerged as the key obstacle to developing services in conjunction with the lack of secure, long-term funding. Individuals and organisations working in this sector were described as having huge commitment but the sector remained very "*crisis orientated rather than primary prevention*" (Strategic Lead 6), and this shaped the type of services

offered. It also remained the case that the majority of activity was focused on domestic abuse and one reason offered for this was that:

> "most local authorities are not seeing enough of a problem around those issues [prostitution, FGM, honour based violence, forced marriage], to invest in doing anything about them" (Strategic Lead 6).

Service providers and strategic leads suggested that there were excellent examples of innovative practice effecting positive change. However, the wider landscape across Wales was depicted as lacking coherence with gaps in prevention work, service provision and evidence of 'what works'.

Summary Points

- Participants identified gaps in service provision for BMER women, women in rural areas, male victims and children and young people. Older women, disabled women, adult survivors of childhood sexual abuse, Gypsy / Traveller communities and women with additional needs were also identified as being least well served.
- One-stop-shops were seen as a valuable resource for women and had the potential to be particularly useful for women in rural areas but there were also concerns expressed about variations in the quality of service provided by one-stop-shops across Wales.
- There was enthusiasm for developing community based perpetrator programmes that included built-in evaluations.
- Despite the policy shift towards a 'violence against women' agenda, the majority of services continue to focus on domestic abuse.
- Increasing risk thresholds for some services were described as resulting in an absence of interventions for those cases identified as medium to low risk.
- While GP contributions to the work of MARAC were valued, these were difficult to secure in all areas.
- A number of examples of innovative practice in work with women and perpetrators were identified.
- Lack of secure, long term funding, which would facilitate service planning and contribute to the stability of the workforce was identified as a significant problem for this sector.
- Participants argued for more stable core funding arrangements to support the work of IDVAs.
- There were concerns that commissioning arrangements could lead to a loss of specialism in the sector.
- There was support for extending joint commissioning from both service providers and strategic leads participating in these interviews.

5 Service Responses and Evidence for their Effectiveness: Prevention and Identification, Recognition and Referral

Both this and the following chapter have been divided by the five types of service response outlined in the framing typology, and then further categorised by the type of violence. The chapters present findings from the literature review, both on what is delivered and what is evidenced by evaluation studies testing impact. We have drawn on publications providing descriptive evidence of what is delivered because many interventions lack robust evidence of effectiveness. This does not necessarily mean that they are not effective but simply that there is not as yet good evidence for effectiveness.

The sections on what is evidenced provide a synthesis of the evaluation papers identified and reviewed. Evidence tables, providing more detailed descriptions of the contributing studies, are contained in Appendix 4. Studies rated as low quality have not been given any weight in this synthesis because the likelihood of bias is strong; rather the analysis has sought to provide a picture of the research evidence research judged to be of medium or high standard. This review has not used meta-analytic techniques to summarise the findings of the evaluation articles reviewed. This was not possible in the time available and would have required the exclusion of a large number of studies due to the significant heterogeneity in both the outcomes assessed and the delivery models. Rather, a judgement has been made about effectiveness based on the *extent* of the evidence available (i.e. the number of studies showing similar impact) and the *quality* of that evidence. There are very few areas where both the quality and extent of the evidence is sufficient to declare a strong case for a particular intervention; much of the evidence can only be considered moderate at best.

The focus of the review has excluded interventions that are located within the criminal justice system or interventions focused on securing prosecution (e.g. SANE); those where the focus is a medical intervention (e.g. defibulation (reconstructive) surgery or prescription drugs for reducing aggression); or interventions with children exposed to violence. The review has also exclusively focused on directly delivered interventions and services, and has not examined the impact of policies or legislation.

A lack of evidence does not equate to ineffectiveness; rather it is an indication that we simply do not know whether the service or intervention demonstrates what it claims to achieve. The dearth of evaluation research is in itself a significant finding and behoves those in the field to give serious consideration to commissioning and conducting more robust tests of impact for the interventions regularly delivered to this service population.

Finally, where it is available, mention has been made in this section of any cost data or cost-effectiveness analyses. This is a significant gap in the literature, requiring consideration in future research. Research currently heralded in this field - most notably Walby's and colleagues' (2004) paper on

the cost of domestic abuse - has concentrated on estimating the total cost of the social burden, including taxpayer, state and victim costs. While important in estimating the scale of the issue, this research does not allow commissioners or Government to make informed judgements about the benefits and risks of funding one preventative or protective intervention over another.

To that end, an emphasis must be placed on costing individual services and evaluating that cost against the outcomes achieved. Work by the Washington State Institute for Public Policy, in the US, and the Social Research Unit, in the UK, seeks to provide commissioners with such a guide to policy and programme selection, at least in children's services.[27] The reality, however, is that the evidence-base in domestic abuse and sexual violence intervention research is not yet sufficiently robust to achieve this.

5.1. Prevention Responses

Prevention responses include primary prevention activity, where the focus is preventing violence occurring in the first place, and secondary prevention, working with at-risk or vulnerable groups to prevent victimisation. It also includes social prevention, where efforts are focused on preventing the spread of the problem in wider society.

5.1.1 What is delivered?

Domestic abuse

The descriptive literature addressed prevention activities in various settings and the majority of studies were US based. Gibson-Davis, et al. (2005) describes a US State welfare-to-work programme targeted at single mothers which tackles these women's disadvantaged economic positions. One health based initiative also targeted young mothers (Niolon, et al., 2009) in a US state with education interventions including safety planning and a skills-based curriculum. The majority of studies identified were either community or schools based. Interventions aimed at whole communities included the Soul City (South Africa) media campaign, which used television, print booklets and radio to increase public debates about domestic abuse and to advocate for the Domestic Violence Act (Usdin, et al., 2005). In England, the Strength to Change initiative used a social marketing approach delivering messages aimed at motivating abusive men to seek help through posters and other media (Thomson et al, 2012). In Stockholm, Sweden, a county-wide initiative ran training programmes and a public poster campaign against domestic abuse (Leander, 2002). The SASA! Project in Uganda (Abramsky, et al., 2012) was a community mobilisation intervention aimed at preventing violence against women and HIV. In Alaska, US, a home visitation project aimed to reduce domestic abuse through the implementation of a home visitation programme to prevent child maltreatment (Chamberlain, 2008). Home visits

[27] See http://dartington.org.uk/projects/investing-in-children/

were conducted by nurses or paraprofessionals in pregnancy and after the birth. The Within My Reach programme in Kentucky, US, was a healthy relationships programme focusing on relationships and safety that targeted low-income single parents (Antle et al., 2011). Huefner (2007) described a programme aimed at young people in long-term residential care that promoted healthy relationships and communication with peers.

A number of studies addressed preventative interventions based in school settings. Bell and Stanley (2006) described a school based healthy relationships programme comprising a drama production followed by workshops for young people. Leach and colleagues (2012) reviewed 'promising practice' in school based prevention programmes, identifying a range of programmes with a variety of specific aims and approaches. The Cochrane review (2013) (Fellmeth, et al., 2013) evaluated a number of school based interventions on preventing relationship and dating violence in young people's relationships and is discussed further below.

Sexual violence, including rape and sexual assault

Many more prevention programmes were identified focusing on sexual violence and again almost all originated in the US. Bystander programmes appear to be proliferating and these adopt different formats and are delivered in a variety of environments including schools, colleges, universities and army bases. In brief, Bystander programmes are developed from the premise that incidences of interpersonal violence can be reduced by training those who may witness a potential incident to feel confident to intervene to prevent it occurring or escalating. The programmes share an 'empathy based approach' which aims to achieve attitudinal and behavioural change. Banyard and colleagues (Banyard, Eckstein and Moynihan, 2010) utilised the 'transtheoretical model of readiness for change' to develop preventive interventions based on addressing bystander behaviour. Other models informing these initiatives include ecological models and the Men of Strength (MOST) club (Hawkins, et al., 2009) which created a safe space for young men to redefine healthy masculinity through critiquing traditional masculinity and male violence against women.

Most of these interventions were aimed at men and attempted to change behaviour and attitudes. Some referred explicitly to 'rape attitudes' whilst others challenged 'sexual violence attitudes'. However, some of the college based preventive interventions in this field also targeted women, such as the DATE model (the Dating Assertiveness Training Experience) (Rowe, et al., 2012) and some involved training in self-defence techniques for women (Brecklin, 2008).

At the school level, a number of peer education programmes were identified and there were examples of these programmes from a range of different countries including the US and Israel. These school based interventions included female and male only groups as well as mixed sex groups and focused on developing 'positive attitudes, beliefs, and behaviour regarding

sexual harassment and personal boundaries and positive dating relationship norms' (Clinton-Sherrod, et al., 2009). The same paper describes four different interventions, all delivered in the US: Men of Strength (MOST) involving small single sex groups; Safe Place which also delivered single sex group work; Students Upholding Respect and Gender Equity (SURGE) which ran mixed sex groups and Metropolitan Organization to Counter Sexual Assault (MOCSA), a didactic session for both single and mixed sex groups.

Forced marriage, 'honour' related violence and FGM

Only five studies were found addressing prevention on female genital mutilation and none on forced marriage or honour related violence.
The interventions on FGM were health based and were delivered in Mali and Nigeria. Key approaches employed included empowerment, health education and community activities. The Mali based project focused on changing attitudes towards gender transformation while the Nigerian project recommended that campaigns on FGM should located within a development strategy and the 'larger context of reproductive health and gender education' (Asekun-Olarinmoye and Amusan, 2008).

5.1.2 What is evidenced?

Domestic abuse

Much of the evidence for preventive interventions has been summarised in the recent NICE (2013) evidence review of domestic violence interventions. The NICE review examined studies that used experimental and/or case-controlled designs, which reduce bias, and identified four main types of prevention response: approaches for young people; media campaigns; health setting interventions and targeted community-based interventions. It excluded consideration of school-based interventions.

The NICE review highlighted only one study evaluating preventive responses, as high quality, the remaining studies were primarily of moderate/medium quality. Prevention responses for young people tended to be secondary or targeted prevention work with at-risk or vulnerable groups, with moderate evidence for their effectiveness in improving knowledge and attitudes towards violence, as well as some studies demonstrating impacts on reducing violent behaviour. The evidence on the effectiveness of media campaigns was inconsistent, with some studies suggesting improvements to bystander actions and awareness of resources whilst others lacked sufficient reach to guarantee any effect. The evidence on health setting models and targeted community interventions was weak, with low relevance to the Welsh context. Given the criteria for inclusion in the present review allowed for additional evaluation designs and areas of focus not covered by the NICE review, this summary also includes evidence from studies that examined school-based preventative education with children (Fellmeth, et al., 2013; Bell and Stanley, 2006) as well as enhanced home visiting for young mothers (Niolon et al.

2009). There was strong evidence for school-based prevention on immediate outcomes, such as improved knowledge and attitudes, with US interventions such as the 'Fourth R' (David, et al., 2009) and 'Safe Dates' (Foshee, et al., 2000; Foshee, et al., 2004) achieving strong impact and potential cost-effectiveness. While these programmes could demonstrate success in changing attitudes, there was only moderate evidence available on their capacity to prevent abusive behaviour.

The 'Fourth R'

The Fourth R is a universal programme, developed in Canada, for secondary school-aged children designed to reduce violence and promote healthy and safe behaviours related to dating, bullying, sexuality and substance use. The programme is based on social learning theory and comprises units on personal safety, healthy growth and sexuality, and substance use. Each unit is delivered as seven 75-minute classes, integrated within the school's PSHE curriculum. The Fourth R makes extensive use of role-playing, with feedback from peers and teachers, to increase students' interpersonal skills and problem-solving abilities. Boys and girls participate in slightly different exercises and activities, which are intended to raise their level of awareness of social norms and minimize gender-based defensive or hostile reactions. In a study (Wolfe et al, 2009) testing the programme using a randomised control trial design, students (particularly boys) receiving Fourth R showed significantly lower rates of physical dating violence and increased condom use two and half years later, compared to those not receiving the programme.

The cost study for the 'Fourth R' programme (Wolfe, et al., 2009) examined the delivery cost and impact of the programme on physical dating violence as well as condom use in boys and girls. It did not conduct cost-effectiveness analysis (CEA) however, making it difficult to establish whether the investment resulted in savings in the short- or long-term. The study found that the programme cost an average of CA$16 per student, and that the risk of physical dating violence in those that did not receive the programme was more than double that than those that participated. A Campbell Collaboration systematic review is underway currently examining the effectiveness of school-based interventions for dating and sexual violence, which is likely to extend the evidence for this area (De La Rue et al., 2013).

There were no studies identified evaluating elder abuse prevention interventions, or interventions for same-sex couples although it is reasonable to assume some of the approaches evidenced above could be tailored for these audiences.

Sexual violence, including rape and sexual assault

A total of 29 articles were identified on interventions preventing sexual violence. Four main approaches were evidenced: bystander programmes;

educational interventions; empathy-based rape prevention and assertiveness, risk reduction and self-defence programmes.

More studies were identified for bystander interventions than any other approach; however the quality of the evidence was largely low with weak or inconsistent effects demonstrated. One high quality evaluation conducted in the US (Gidycz, Orchowski and Berkowitz, 2011) found significant effects in reducing sexual aggression and association with sexually aggressive peers. This paper also found that the greatest gains were for self-reported previous offenders, suggesting secondary prevention or targeted approaches might be more successful.

The Sexual Assault Prevention Programme (SAPP)

The SAPP programme is a prevention intervention, developed in the US, working with college students to prevent sexual violence. Bystander theory suggests all community members are affected by violence and are involved in perpetuating social norms about the acceptability of violence against women. SAPP aims to improve men's ability to intervene when witnessing risky peer behaviour. Men in the programme complete a 1.5-hour intervention and a 1-hour booster session four months later. The programme content comprises units on fostering empathy, norms correction, discussion about consent, and how to intervene as a bystander. A study (Gidycz, Orchowski and Berkowitz, 2011) using a randomised control trial design, found that men who received SAPP showed fewer associations with sexual aggressive peers at follow-up, compared to those who did not receive the programme. In addition, sexually aggressive men who received SAPP showed a reduction in perpetration at follow-up compared to similar men in the control group. However, the study did not find the programme had any significant impact on the likelihood of intervening as a bystander.

There was moderate evidence for educational and psycho-educational programmes, with some improvements to attitudes towards rape and factual knowledge demonstrated across seven studies. One paper examined the factors influencing effectiveness of four different sexual violence educational interventions (Clinton-Sherrod, et al., 2009). It found that the evidence favoured mixed gender groups in structured, classroom-style settings, rather than single-sex or small group work.

There was also moderate evidence for rape prevention programmes, many focusing on victim-empathy. A meta-analysis of 45 studies found positive reductions on pro-rape attitudes but these effects were not sustained over time (Brecklin and Forde, 2001). All of the rape prevention studies identified here confined their measurements to attitudinal change, which may not translate into behaviour change. In addition, one randomised study showed differentiated results for high risk versus low risk men, with no impact on the high risk population (Stephens and George, 2009). Finally, there was moderate evidence from seven articles on the benefits of assertiveness and

risk reduction training, including self-defence. Three of these were rated as high quality (Rowe, 2012; Brecklin, 2008; Orchowski, Gidycz and Raffle, 2008), providing evidence that this form of training reduced victimisation experiences, increased self-protective behaviours and self-efficacy as well as improved assertive sexual responses/communication. One of these papers was a systematic review of self-defence studies (Brecklin, 2008), relating to violence against women more generally, which stressed the need for behavioural outcome measures and more longitudinal research in this field.

Forced marriage, honour based violence and FGM

A total of five evaluation papers were found examining prevention responses to FGM and two papers for forced marriage. There were no evaluations concerned with other forms of honour-related violence. One of the papers identified was a systematic review of FGM services, including eight evaluation studies (Berg and Denison, 2012). All studies were judged to be of low quality by the review; however three different prevention approaches in this field were identified: empowerment; health education and community activities. Although limited effects were demonstrated in the evaluations, interventions were more likely to succeed when they were tailored to the local context and framed in relation to health. There was good evidence from one study for community capacity strengthening through mass media and targeted advocacy, where significant impacts were found on changing attitudes towards FGM and intentions to use with children (Babalola, et al., 2006). Finally, the evidence from the two papers examining the prevention of forced marriage, through community mentors (Erulkar and Muthengi, 2009) and conditional cash transfers (Baird, Chirwa, McIntosh and Ozler, 2010), was weak and lacked relevance to a Welsh context.

Trafficking, sexual exploitation and prostitution

No evaluation studies of prevention responses for this area of violence against women were identified.

Combined violence

There were two further articles identified where the focus of the prevention activity was on multiple forms of violence or violence against women in general (Keleher and Franklin, 2008; Moynihan, et al., 2010). These studies largely centred on changing gender norms and community strategies. There was weak evidence for their effectiveness in preventing violence, although one paper identified community readiness to change, strong community coalitions and strong leadership as critical to implementation success.

5.2. Identification, recognition and referral responses

5.2.1 What is delivered?

Domestic violence

A considerable amount of literature sourced addressed screening in health care settings. This included universal screening, targeted screening in emergency departments and antenatal enquiry. Additional studies identified described different screening models and training for health professionals in administering screening tools. Given the large amount of screening interventions available, this section will consider them by setting: public health/GP screening environments; maternity screening; Emergency Departments and screening in more specialist health departments such as oncology and paediatric settings.

Primary Care:
Primary care health professionals are described as well positioned to screen women for domestic violence. The IRIS (Identification and Referral to Improve Safety) protocol is a primary care intervention developed in the UK for GPs to use with women experiencing domestic violence (Gregory et al., 2010). IRIS offers training and support to GPs in order for them to identify and then refer women experiencing domestic abuse on to specialist agencies. A USA study encouraged the use of online self-completion screening which the primary health care provider then followed up by mobilising the range of necessary services including social work assessment and community agencies on the same day (Hawkins, Pearce, et al., 2009). Overall, there were many studies encouraging primary health care providers to screen for domestic abuse and these ranged from GPs in the UK (Richardson, et al., 2002) and New Zealand (Goodyear-Smith, 2002), to community health centre care providers in Canada (Thurston, et al., 2007), physicians, including general practitioners, residents and specialists in relevant primary care fields from outpatient and inpatient settings, in Israel (Shefet, et al., 2007) and nurses in primary health care in Sweden (Sundborg, et al., 2012). In New South Wales, Australia, a screening programme developed for public health services has been rolled it out to antenatal, early childhood, substance misuse and mental health services. This programme was reported to screen approximately 10,000 women per month with 7.3% reporting domestic abuse within the previous 12 months (Spangaro, 2007). A Canadian model identifying re-victimisation through the use of Campbell's Danger Assessment (Snider, et al., 2009) was available for physicians to use to identify women at increased risk of severe injury and potentially lethal assault.

Maternity services:
The papers on screening in maternity services came from a range of countries and described a range of models, with screening conducted at various points in pregnancy and into the post-partum period. Within the UK (England and Wales only) context, a number of different interventions were described and some questioned the value of introducing mandatory screening. The Bristol

Pregnancy and Domestic Violence Programme (BPDVP) (Baird, Salmon and Price, 2005) promotes routine antenatal enquiry for domestic violence. Some interventions used self-administered questionnaires such as the NORAQ model in Jordan (Haddad, et al., 2011) while a Japanese study (Kataoka, et al., 2010) debated the appropriateness of self-administered questionnaire against an interview method for screening. One post-partum home screening programme in Canada (Jack, et al., 2008) found that universal screening was too difficult to implement in home visits and favoured a more 'case-finding' approach rather than a screening approach.

Emergency Departments:
Screening in Emergency Departments appeared likely to be triggered by women evidencing physical harm, particularly injuries with non-verifiable aetiologies. All those departments implementing a pilot screening project appeared to have subsequently implemented the programme, for example, an early identification and intervention based in South Eastern Sydney, Australia (Ramsden and Bonner, 2002). A US screening intervention utilised a computerised health-risk assessment (Rhodes, et al., 2002) in order for women to confidentially disclose intimate partner violence. The authors argued the need to ensure that women received appropriate follow-up services. A UK based model outlined a three level programme to be delivered by nursing staff in Emergency Departments: providing physical, psychological and emotional support; enhancing safety; and promoting self-efficacy (Olive, 2007).

Screening in Specialist Settings:
Fourteen papers described screening in other specialist medical settings such as sexual health clinics (McNulty, Andrews and Bonner, 2006), gynaecology departments (Bird, Edi-Osagie and Macrory, 2012), paediatric departments (Scribano, et al., 2011), mental health services (Chang, et al., 2011; Todahl and Walters, 2009) and oncology departments (Mick, 2006). Screening was also implemented through home visits by nurses delivering the Nurse-Family Partnership for socially disadvantaged first time mothers in Ontario, Canada (Jack, et al., 2012).

Screening by Welfare and Community Services:
A few studies described the involvement of other services in screening for domestic violence. A study in Washington, US, explored the work of welfare professionals in administering screening questions to female clients (Lindhorst, Meyers and Casey, 2008). A unique service was offered in Victoria, Australia, where hairdressers were trained on how to 'enhance communication relating to mental health issues, including family violence' (McLaren, et al., 2010). Two training sessions, a manual and coordinator contact, were delivered to hairdressers involved in the project. One article in relation to screening for elder abuse was found (Ejaz, et al., 2001) and this described a project in Ohio, US, that screened and referred individuals experiencing elder abuse.

Screening Models:
A US study (Chen, et al., 2007) reported on three different screening models: self-administered, medical staff-administered and physician administered screening; within this third model, two different screening tools were employed. The Delphi model (Dienemann, et al., 2003) used a validated tool but there was insufficient information available to determine whether other models were evaluated. The Systems model (McCaw, 2001) was described as using a range of tools for effective referral, evaluation and reporting. A South African study reported on a three tier model which screened for domestic abuse, offered treatment for STIs and referred patients for psychological social or legal support and then to a community based support group (Joyner and Mash, 2012). A study of the environment for screening found that women preferred a woman of the same race, aged 30-50, to administer the screening and for it to be conducted without anyone else present (Thackeray, et al., 2007).

Training for Health Professionals in Screening for Domestic Abuse:
Training health professionals to implement screening for domestic abuse is considered essential. Training ranged from lectures delivered by external experts (Wallace, 2002) to on-line material (Harris, et al., 2002). A Greek study (Papadakaki et al., 2013) identified various barriers to implementing screening for domestic violence including professionals' lack of knowledge about where to refer victims, how to respond to disclosure and confidentiality issues.

Sexual violence, including rape and sexual assault

Fewer studies were found describing identification in relation to sexual violence. The seven articles located all addressed screening in health environments. One of the studies described building screening for intimate partner violence on to an established alcohol screening tool (Hewitt, et al., 2011). Sexual Assault Centers (SACs) in the US, Ireland, Oslo and Kenya provide forensic medical examinations for victims and other forms of assistance. An Italian study of Ve.R.S.O (Argo, et al., 2012) outlined a protocol for the management of sexual assault victims and described a specialised service for women and children who had experienced sexual assault. A health related screening programme for sexual assault similar to those found in relation to domestic abuse was provided by an outreach health service for women in Tanzania (Laisser, et al., 2011).

Two articles discussed the Rape, Sexual Assault, and Incest National Network (RAINN) National Sexual Assault Online Hotline (NSAOH) (Washington, USA). This hotline develops supportive and therapeutic services for both crisis and long term needs (Finn and Hughes, 2008).

Training for Health Professionals in Screening for Sexual Violence
Only two articles were located that described training for health professionals in relation to identifying sexual violence. One addressed training for postgraduate students in forensic medical care (Parekh, et al., 2005) and

another focused on medical professionals working in Emergency Departments (Fitzpatrick, et al., 2012).

5.2.2 What is evidenced?

All of articles identified in relation to identification and referral were concerned with domestic violence, often termed intimate partner violence (IPV). As noted above, although descriptive accounts were found which addressed the issue of identification of sexual violence, there were no evaluations available that specifically related to the identification of sexual violence, forced marriage, FGM, trafficking or prostitution. It is reasonable to assume that many of the evidenced-based interventions for identifying and referring domestic abuse, discussed below, could be applied to other forms of violence, even though there were no evaluations testing this hypothesis or specific tools. In addition, almost all of the papers concentrated on identifying violence experienced by women and screening in health care settings. There were very few studies, or weak evidence, for sub-groups such as elders (Ejaz, et al., 2001) or screening for perpetrators (Ernst, et al., 2012), and no research evaluating identification tools in social care or integrated settings.

The NICE review identified six categories of evidence: screening tools; screening formats; additional protocols such as cueing (which refers to providing information about a woman prior to an encounter with a practitioner that 'cues' them to domestic violence); education; organisational-level support for recognition; and work with pregnant women. In addition, the NICE Guidance distinguished between universal and targeted screening, and identified the importance of engagement strategies for ensuring high risk victims' take-up of referral. There was moderate evidence that self-administered screening instruments were more likely to encourage disclosure than face-to-face (Chen, et al., 2007; Kataoka, et al., 2010; MacMillan, et al., 2006). It was not possible to identify any particular screening tool as more effective than another, given the variability in studies. The NICE review concluded that there was moderate evidence for cueing in improving detection and disclosure rates.

A recent Cochrane systematic review examined the benefit of universal screening for partner violence in healthcare settings, including antenatal care (Taft, et al., 2013). It included 11 studies and concluded that while screening doubled identification rates, referral rates to specialist agencies did not increase. None of the studies examined the costs of delivering screening. The authors suggest that there is "insufficient evidence to justify universal screening for intimate partner violence in healthcare settings" (p3).

The lack of long-term follow-up in the majority of studies reviewed precludes this synthesis from being conclusive about the effectiveness of these identification responses, either in translating into the take-up of protective and recovery services or improved outcomes. Only one study (MacMillan, et al., 2009) examined the longer-term physical and psychological outcomes in women identified by universal screening. The evidence suggested no long-

term impact on physical health and mixed effects for mental health measures, with the authors concurring that the results “do not provide sufficient evidence to support IPV screening” (ibid, p493).

A significant study (Feder, et al., 2011) evaluated the effectiveness of a programme of training and support in primary health care settings for the Identification and Referral to Improve Safety (IRIS). The study found that individuals in the intervention were 22 times more likely to be referred to advocacy services than those in general practices that did not receive the programme. Furthermore, intervention practices were three times more likely to secure a disclosure of domestic violence than those in the control group. An associated study (Devine, et al., 2012) concluded that the programme was ‘likely’ to be cost effective, both in the additional quality-adjusted-life-years for women and in savings to society. Better outcome data beyond disclosure and referral is needed to establish this with confidence.

The exception to this is universal screening with pregnant women, where there is moderate evidence to support screening practices for IPV (Jahanfar, et al., 2013). In this review, we have considered this as a form of targeted screening, since pregnancy is well established as a period during which women become especially vulnerable to more intensive or the onset of violence from an intimate partner (Brownridge, et al., 2011).[28] Three papers examined the benefits of screening for domestic violence alongside screening for other issues, such as alcohol misuse (Hewitt, Bhavsar and Phelan, 2011) and substance misuse (Kraanen, et al., 2013; Spangaro, et al., 2010). There was moderate evidence from these studies that included screening protocols for domestic abuse within screening/entry assessment for alcohol or substance misuse improved rates of identification. There was also preliminary evidence from one study in the US for the use of intensive engagement strategies to both identify and retain high-risk young mothers using a multi-component ‘Circle of Care’ model (Antle, et al., 2011). There were no costs for screening published in these papers.

Summary

Prevention responses:

- There was very little or no evidence for effective prevention responses to trafficking, forced marriage or FGM. One of the difficulties with this literature is the lack of relevance or fit of programmes to the Welsh context.
- There is greater evidence for prevention responses to domestic abuse than sexual violence.
- There was strong evidence for domestic abuse school-based prevention on immediate outcomes, such as improved knowledge and attitude. There is not sufficient evidence demonstrating long term impact on behaviour. There was moderate evidence for targeted prevention work with at-risk or vulnerable groups, in improving

[28] Violence Against Women 17:7 (2011), pp. 858–881; doi: 10.1177/1077801211412547

knowledge and attitudes towards violence, with some impacts on reducing violent behaviour.

- The evidence on the effectiveness of media campaigns was inconsistent with studies showing mixed effects.
- Despite a large number of evaluations of bystander interventions in working to prevent sexual violence, the quality of the evidence was low with weak or inconsistent effects. Where effects were shown, they suggested secondary prevention or targeted approaches might be more successful.
- There was moderate evidence for educational and psycho-educational sexual violence prevention programmes, with improvements to attitudes towards rape and knowledge.
- There was moderate evidence for rape prevention programmes, with impacts demonstrated on attitudinal change but not behaviour.
- There was moderate evidence for the benefits of assertiveness and risk reduction training, including self-defence in preventing sexual violence.

Identification and referral responses:

- Evidence of effectiveness was restricted to the identification and referral of domestic violence; no evaluations were found specifically related to the identification of sexual violence, forced marriage, FGM, trafficking or prostitution.
- It is reasonable to assume that many of the interventions for identifying and referring domestic abuse could be applied to other forms of violence. In addition, almost all of the papers concentrated on identifying violence experienced by women and screening in health care settings.

6 Service Responses and Evidence for their Effectiveness: Protection, Recovery, Coordination and Training

6.1 Protection responses

Protective responses include interventions and services providing protection for victims to secure immediate safety from current abuse as well as protection from re-victimisation from a known perpetrator. These responses also include perpetrator or batterer programmes – treatment for offenders to ensure the safety of potential victims.

6.1.1 What is Delivered?

Domestic violence

We identified a wide variety of studies addressing protection, these predominantly aimed to provide protection for victims through community programmes; IDVAs; workplace based projects; technology related interventions; interventions focused specifically on teenage mothers; interventions focussing on substance misuse and health based projects. Protective interventions also included perpetrator programmes for male perpetrators of domestic violence. One study that is unique describes the Welsh Government funded Dyn Project in Wales (Nolan, 2011) which is a support service for male victims of domestic abuse. The service works alongside Welsh Women's Aid and carefully evaluates men who present as victims to ensure they are not perpetrators.

Independent Domestic Violence Advisors (IDVAs):
The IDVA service which co-ordinates multiagency services for high-risk victims and provides them with advocacy and support has been rolled out across England and Wales. Most IDVA training is now delivered via accredited programmes. Williamson and Boyle (2012) describe an IDVA service delivered within a hospital trust in England. Howarth, et al.'s (2009) evaluation notes that IDVAs were conceived as a means to keep women and their children safe in their own homes rather moving them to temporary refuge accommodation.

Skill Building Approaches:
Motivational Interviewing (MI) is a technique used in the US with women in shelters escaping domestic abuse (Hughes and Rasmussen, 2010). It aims to enhance the impact of other interventions and to empower those women who receive it. In addition to these programmes, two interventions in Australia and the Netherlands targeted at young mothers or pregnant teenagers offered home based mentor support (Loeffen, et al., 2011, Taft, et al., 2009). McWhirter's (2007) study addressed the needs of women who were victims of domestic abuse and experienced substance misuse and mental health problems.

Using Technology in Protection:
A couple of papers focused on the use of technology. Walker (2001) described a safety alarm system that was adapted and installed to allow women and children who had experienced domestic abuse to stay safely in their homes. Van Schaik, Radford and Hogg (2010) discussed the appropriateness of online sources, within a UK context, as a means of support for obtaining information about domestic abuse. In a US context, Bennett, et al. (2004) reported on their evaluation of services provided by 54 Illinois domestic abuse agencies, focusing on the hotline, advocacy, counselling and shelter services (refuges) for victims of domestic abuse. Finn and Atkinson (2009) described the Technology Safety Project, Washington, US, which increased awareness of technology safety issues in relation to domestic abuse for victims and service providers. An innovative intervention was described by Thomas, et al (2005) involving the use of telemedicine for women in rural areas who accessed services including psychiatric screening, evaluation, treatment and referral for ongoing care via the telephone.

Workplace Interventions:
Two US studies described workplace interventions; Pollack, Austin and Grisso (2010) reviewed the effectiveness of Employee Assistance Programmes, confidential services that employees or their families could access. Another study (Yragui, et al., 2012) focused on the role that workplace supervisors could adopt with women who had experienced domestic abuse.

Community Based:
Four articles addressed community wide interventions; these included one Indian programme (Krishnan, et al., 2012) on intergenerational empowerment, which also addressed the impact of domestic abuse on women's health. A US community based study (Sullivan, 2003) trained paraprofessional advocates to support women victims. The Community Advocacy Project (Allen, et al., 2013), also US based, was originally developed in the mid-1980s with domestic violence survivors and emphasised a strengths-based and survivor-centred approach.

Perpetrator programmes:
The largest group of interventions found addressing protection from domestic violence were perpetrator programmes including both court mandated, referral and self-referral programmes. The literature described programmes in the UK, US, Australia, Taiwan and Israel as well as elsewhere and programmes are delivered in a range of settings including clinical environments and domestic abuse organisations. CBT, MI, psychotherapy, online, group and individual approaches are all employed. Mills, Barocas and Ariel (2013) identified the mandated group-based Batterer Intervention Program (BIP) as the most commonly used perpetrator programme and also discussed the development of an alternative restorative justice based model.

The US based Dialectical Psychoeducational Workshop (DPEW) (Cavanaugh, Solomon and Gelles, 2011) employed an eight week anger management programme and was based on Dialectical Behaviour Therapy (DBT); it has been used with people with borderline personality disorders. Fathers for

Change (Stover, 2013), a US based intervention targeting men's substance use, domestic abuse and fathering, was designed for men with children under the age of 10 years. It combined psychodynamic family systems and CBT techniques and was delivered over a period of four to six months. An Australian approach, South Metro Men's Respite (Pennebaker and Olesen, 2002) used Assertive Community-Based Treatment (ACT) for violent men with mental health problems. It offered 24 hour walk-in or caller crisis response.

The Strength to Change model (Stanley, et al., 2012) is a UK model for men who self-refer that offers ten individual sessions and group sessions for a further year. It utilises a range of therapeutic approaches including cognitive approaches, counselling and behavioural techniques. Strength to Change also delivers individual support to men's partners. The Domestic Violence Perpetrator Programme (DVPP) (Bowen, Gilchrist and Beech, 2005) offered convicted male offenders in the UK an induction session, 24 group sessions, and five follow-up sessions. The sessions were delivered once or twice weekly and offered during the day and in the evenings. Unlike the Strength to Change programme, a 'fixed intake' policy aimed to ensure that the same group of men remained in the programme through its duration. Those men who failed to attend a minimum of 21 out of the 24 sessions were returned to court for resentencing.

Motivational Interviewing (MI) is also used with male perpetrators of domestic violence (Musser and Murphy, 2009). In this context, MI was described as promoting engagement in a CBT group session for court mandated and other men.

A therapeutic intervention, which included group work and anger management for women perpetrators of partner violence, was described by Walker (2013). Carney and Buttell (2004) also described a batterer treatment programme for women offenders. The treatment approach aimed to change psychological variables such as stress coping abilities for women who were mandated to attend the treatment.

Sexual Violence, including rape and sexual assault

The protective interventions addressing sexual violence included perpetrator programmes or college based approaches mainly aimed at male perpetrators. Some targeted women students and some aimed at the student population as a whole. Clinton-Sherrod, et al. (2011) used MI in an alcohol intervention aimed at female college students. Marx et al. (2001) also focused on changing women's behaviour through using a psycho-educational program administered in two 2-hour group sessions.

The Cochrane Review (Kenworthy et al, 2004) described a range of psychological interventions for adults who had sexually offended or were at risk of sexual offending. It reported on ten interventions: five involved CBT, four were behavioural programmes, and one comprised a psychodynamic intervention. Three other articles described different programmes for sexual

offenders. These included a prison-based programme in Ireland (O'Reilly, et al., 2010) that used a CBT based approach delivered over 10 months by a team that included a clinical psychologist and probation officers. A UK based study (Mandeville-Norden and Beech, 2004) described a number of probation service based interventions. The interventions varied slightly in content and duration in each probation area but all meet the Home Office principles for working with sex offenders. A US paper (Webster, et al., 2005) discussed the efficacy of role play in interventions with male sex offenders.

Forced marriage, honour based violence and FGM

In 2009-10, the UK Ministry of Justice piloted a Forced Marriage IDVA (Ministry of Justice, 2010). This Forced Marriage Protection Orders-IDVA (FMPO-IDVA) was envisioned as liaising between the client, solicitors and other statutory agencies. The FMPO-IDVAs were required to provide monthly data on the clients supported, number of referrals, applications and orders made.

Trafficking, sexual exploitation and prostitution

The articles described under this sub-heading mainly addressed interventions for women exploited through prostitution. Interventions included economic enhancement programmes, community programmes, diversion programmes, therapy and other health related interventions and perpetrator programmes. The Jewel Project was an innovative programme adopting an economic enhancement approach and delivered in the developed world; it targeted drug using women in prostitution in Maryland, USA (Sherman, et al., 2006). The six 2-hour sessions delivered teaching on HIV risk reduction, jewellery making and marketing. Similarly, the PEERS project in Canada aimed to empower women in prostitution by involving them in the planning, development and delivery of its programmes and developing a policy response to sex trade work (Rabinovitch and Strega, 2004).

A project in India, focused on both prostitution and trafficking, aimed to mobilise community resources to facilitate an enabling environment for women who were extremely marginalised. Another study reported on women who were trafficked from Nigeria into prostitution in Italy (Cole, 2006) and identified the challenges facing women who were trafficked into prostitution and needed to learn how to integrate into a new country once they exited from prostitution.

An American intervention examined the psychosocial treatment needs of female street prostitutes (Arnold, Stewart and McNeece, 2000). A diversion programme offered in the US (Roe-Sepowitz, et al., 2011) comprised three levels of involvement to account for the often chaotic lifestyles of women exploited through prostitution. Clinical psychologists, social workers, members of the vice unit and women who had successfully exited prostitution were involved in delivery of this programme. Another intervention employed Integrative Therapy Techniques (Napoli, Gerdes and DeSouza-Rowland, 2001), a form of 'psychological counselling designed to address the major

aftereffects of sexual abuse,' since it was argued that most women exploited through prostitution were survivors of childhood sexual abuse. Health related projects in Mongolia and Bali (Carlson, et al., 2012; Ford, et al., 2002) aimed to reduce the risk of HIV/STIs by delivering testing for HIV/STIs and condoms.

Three articles described interventions for men who solicited sex and all focused on the 'John Schools' for men which provided an alternative (or in some cases in additional intervention) to 'being processed through the court system' (Kennedy, et al., 2004) in North America. These diversion programmes aim to re-educate 'johns' but there is some debate about their objectives.

Combined – Domestic abuse and sexual violence

Of the few papers describing interventions focused on both domestic abuse and sexual violence, two concentrated on interventions delivered in family planning settings and targeting women who had experienced intimate partner violence. These interventions aimed to reduce the risks of 'pregnancy coercion' (Miller, et al., 2011; Miller and Silverman, 2010). Another study described a methadone programme aimed at reducing drug use amongst women who had experienced intimate partner violence. One US primary care based intervention provided either a referral card or a 20 minute nurse case management protocol to women who had experienced sexual or physical violence within the previous 12 months (McFarlane, et al., 2006).

6.1.2 What is evidenced?

Domestic abuse

The NICE review combines protection and recovery responses into one group of evidence statements; the current review has separated the evidence for each. The main categories of evidence for protection responses are advocacy for victims; skill-building interventions to promote safety behaviours and perpetrator programmes and treatment.

There was moderate evidence, both from the NICE synthesis and the additional papers reviewed as part of the current review (Sullivan, 2003; Bacchus, et al., 2010; Tiwari, et al., 2012), for victim advocacy as a protection response, of which the IDVA service in England and Wales is an example. Studies indicated that advocacy can reduce rates of victimisation, improve safety and improve access to community resources. This approach underpins the IDVA role and the evidence for effectiveness, while only moderate due to the quality of the studies conducted, is encouraging.

MOSAIC: Mothers Advocate in the Community

MOSAIC is a community-based advocacy service, developed in Melbourne, Australia, which uses non-professional mentor support for reducing intimate partner violence (IPV) and depression among pregnant and postpartum women who have experienced, or are at risk of experiencing IPV. The programme is designed to sit within primary care services, with training provided to GPs and nurses to identify, respond to and refer women to the community based services. The programme recruits and trains community mentors who offer befriending, domestic violence advocacy, parenting support, and self care assistance to women. It includes 12 months of weekly home visits and regular telephone calls between the advocate and the woman with the aim of reducing isolation, improving access to resources and encouraging safety behaviours. A randomised trial (Taft et al, 2009) of the programme demonstrated a significant impact on reducing experiences of partner violence for those assigned an advocate. The study highlighted a significant challenge for the model, however, in relying on GPs and clinicians to identify and refer women.

Similarly, there was moderate evidence from the NICE review and additional studies (Gillum, Sun and Woods, 2009; McFarlane, et al., 2002; Miller, et al., 2011) that skill-building interventions are effective at promoting safety behaviours, improving decision-making abilities and reducing re-victimisation.

The evidence for the effectiveness of perpetrator programmes is mixed, influenced by the wide variation in forms or service models, the duration of the interventions, whether attendance was mandated, and the audience (male v. female perpetrators). Overall, there was moderate evidence for the effectiveness of male perpetrator programmes, with improvements demonstrated largely on attitudinal change and management of emotions, and inconsistent evidence for reductions in violent behaviour or offending (Bowen, 2010; Taft, et al., 2013; Gondolf, 2000, Mills, Barocas and Ariel, 2013; Buttell, 2001; Loeffler, et al., 2010). No particular model of intervention (Duluth, CBT, restorative justice, solution-focused therapy or motivational interviewing) stood out as more successful than another. The NICE review examined whether effectiveness was related to the length of the intervention, however there was inconsistent evidence for distinguishing the benefits of short (less than 16 weeks) and long (over 16 weeks) duration programmes. Attrition or drop-out is a significant problem affecting both the quality of the evaluation and the potential success of the programmes. Strategies to keep participants engaged in sessions and motivated to change may be key to achieving success with these service responses (Hellman, et al., 2010).[29]

[29] Hellman, C. Johnson, C. & Dobson, T (2010) 'Taking Action to Stop Violence: A Study on Readiness to Change Among Male Batterers', Journal of Family Violence (2010) 25:431–438).

In addition to the three studies included in the NICE review, there was weak evidence from two further papers that examined female perpetrator programmes. One was a qualitative study of women's experiences of the WAVE programme, based on the Duluth model (Walker, 2013). It found some positive changes for the women interviewed in their connections with others and in anger management and managing emotions. The authors suggested, however, that these women were still framing "their world through having power and control" (p425). The second study (Carney and Buttell, 2004) examined evidence for a feminist informed, cognitive-behavioural model and found positive impacts on aggression and the use of force in programme completers. In the face of no experimental evidence, however, it is likely that these results were biased by selection.

Sexual violence, including rape and sexual assault

Ten papers reported evaluations of protective interventions for sexual violence. These can be categorised as perpetrator programmes; resistance programmes; motivational interviewing; and medical/health related interventions. Perpetrator programmes largely divided into models testing CBT for sexual offenders and models testing behaviour therapy, such as aversion, covert sensitisation and olfactory conditioning. The Cochrane review (Kenworthy, et al., 2004) finds that the success of these interventions was worryingly limited, with CBT showing negligible effects on reoffending (O'Reilly, et al., 2010). There were 'encouraging' results from two studies for behavioural programmes although these provided insufficient evidence to be confident in its use. The authors conclude, "randomised controlled trials are urgently needed… so that society is not lured into a false sense of security" (Kenworthy, et al., 2004, p3).

There was weak evidence that motivational interviewing, alongside alcohol treatment, could be used to protect victims from re-victimisation of sexual violence (Clinton-Sherrod, et al. 2011). The findings did not support the mechanism of the intervention, however, since the reductions in victimisation demonstrated were not linked to reductions in the use of alcohol. The area where there is perhaps the best quality evidence was in a sector outside the scope of this review, namely medical interventions related to criminal justice. The SANE services, which entail forensic nurses gathering information to secure prosecution of offenders, offered good evidence for increasing prosecution rates (e.g. Derhammer, et al., 2000) but there is scant evidence currently for their impact on victims' safety or protection from further victimisation.

Finally, while there are no specific studies devoted to advocacy with sexual violence victims, it is reasonable to assume that the evidence underpinning advocacy interventions and approaches for domestic abuse could be applied to work with sexual violence, with some adaptations. This underpins the ISVA role in Wales and wider UK.

Forced marriage, honour based violence and FGM

No evaluation studies of protective responses in this field were identified.

Trafficking, sexual exploitation and prostitution

Only three articles were found that evaluated a protective response to prostitution and sexual exploitation (Sherman, et al., 2006). The first provided weak evidence that economic enhancement and health (HIV) education reduced risky sexual encounters, increased use of protective prophylactics; and reduced drug use. Two articles related to outreach services with sex workers; both were of low quality but provided some promising ideas for further investigation. In particular, 90% of women accessing a mobile service provided by a van in Canada reported feeling safer as a result of the intervention (Janssen, et al., 2009).

Combined forms of violence

Three further papers were identified where the intervention targeted multiple forms of violence. One of these adopted an empowerment-training model for abused women in China (Tiwari, et al., 2005); a second examined a specialist domestic and sexual violence nurse system in an emergency department (Sampsel, et al., 2009); and the third combined microfinance with gender and health training in South Africa (Pronyk, et al., 2006). None of these papers provided strong evidence on their own for a particular protective approach; however, the study that focused on empowerment training demonstrated positive effects on reductions in re-victimisation, suggesting this may be a promising approach. Further, the South African study demonstrated that social and economic development has the potential to significantly alter risks for violence.

6.2 Recovery responses

Recovery responses include services and programmes focused on promoting the psycho-social adjustment and well-being of victims, providing support to help them deal with their experiences and enable them to re-integrate and relate within a community or society.

6.2.1 What is delivered?

Domestic violence

There was considerable variation across the range of interventions found. The majority were therapeutic interventions such as couple therapy (Jackson-Gilfort, Mitrani and Szapocznik, 2000) which uses a family ecological

intervention to work on conflict management and strengthening support networks. Other interventions (e.g. Johnson, Zlotnick and Perez, 2011) use CBT to target women survivors of domestic abuse who are in shelters. Other counselling models such as the Domestic Violence Survivor Assessment (DVSA) offers individual counselling for women victims of domestic abuse and is based on the Transtheoretical Model of Change (TM) which assists individuals to consciously change their behaviour (Dienemann, 2007). The Weave Project is a 'readiness to change' intervention that both counsels women victims of domestic abuse and trains health professionals to deliver the programme (Hegarty, et al., 2008). Short and Hadley (2002) discussed the WomanKind programme, based in Minneapolis USA. This was a 24-hour health service response that offered in-house health services. Young et al (2008) described a mental health counselling service provided through the police department that was offered at the scene of the incident for women experiencing domestic violence. One article was found on elder abuse and recovery (Brownell and Heiser, 2006) and this described a psycho-social support group for cognitively unimpaired older female victims.

Other studies addressed social support interventions for domestic violence victims in different settings including shelters (Constantino and Crane, 2005) and other community environments. Fowler and Faulkner (2011) reported on a meta-analysis of interventions targeting substance misuse among domestic abuse survivors (USA). One article (Neergaard, et al., 2007) described the effects of female victims of domestic abuse confiding in religious leaders in California, and two papers described workplace interventions for survivors of domestic violence (Chronister and McWhirter, 2006; Keim, Strauser and Olguin, 2009).

Sexual violence, including rape and sexual assault

Unsurprisingly, the majority of studies related to recovery for women who had experienced sexual violence described interventions such as CBT, CPT (Cognitive Processing Therapy), psychotherapy or counselling delivered in health settings. One study (Littleton, et al., 2012) described an online programme for rape victims, completed in a laboratory setting. Another study (Wasco, et al., 2004) discussed a range of interventions for women survivors of rape including a 24 hour telephone hotline, advocacy and counselling service in Illinois, USA. Some of the interventions identified were delivered directly following a sexual assault whilst others were offered at a later stage. Some offered both immediate and longer term interventions; for instance, a US psychotherapeutic service provided a service in the period immediately after an attack and then delivered follow-up sessions four weeks and six months later (Tarquinio, et al., 2012).

The Women's Hospital in Brazil has developed a Special Care programme delivered by a multidisciplinary team which aims to prevent unwanted pregnancy, sexually transmitted diseases and promoting the physical, psychological and social recuperation of sexually assaulted women (dos Reis, et al., 2010). CBT interventions were delivered by a number of North

American services to address post-traumatic stress disorder (PTSD) in women who had experienced sexual assault (e.g. Billette, Guay and Marchand, 2008). Imagery Rehearsal Therapy has also been used to tackle the chronic nightmares that women with post-traumatic stress disorder (PTSD) as a result of sexual violence may experience (Krakow, et al., 2001). Eye Movement Desensitization and Reprocessing (EMDR) psychotherapy has also been used in the 'treatment' of women who have been raped and is described in a French study (Tarquinio, et al., 2012).

One article (Acierno, et al., 2003) described an intervention using video aimed at the prevention of substance use and misuse following a rape or sexual attack. The Trauma Recovery and Empowerment Model (TREM) (Lee, Kim and Lim, 2010) was delivered by mental health agencies for women trauma survivors with complex needs such as drug use and mental health problems. The intervention delivered closed group sessions over 33 weeks.

Trafficking, sexual exploitation and prostitution

Only one article on recovery was identified addressing prostitution. The Esuba programme was delivered to prostituted women in prison in Arizona, US; it took the form of a 12 week psychoeducational therapy group that included anger management training, communication skills and a community exiting programme (Ward and Roe-Sepowitz, 2009).

6.2.2 What is evidenced?

Domestic abuse

Recovery responses for domestic abuse can be divided into four main types: social support groups; advocacy; brief therapy and counselling interventions, and intensive therapy. There was weak evidence for the effectiveness of social support groups within and outside of shelters, where small samples hampered conclusions. A paper dedicated to recovery from elder abuse showed no impact of the intervention on depression, self-esteem or anxiety (Brownell and Heiser, 2006), while a second study evidenced some impact on reduced distress and use of health services (Constantino, Kim and Crane, 2005). The NICE (2013) review identified moderate evidence for behavioural couple's therapy within substance abuse treatment in improving abuse outcomes and, in some cases, reductions in substance misuse.

In line with protective responses, there was moderate evidence for the use of advocacy for recovery purposes. The evidence suggested that advocacy decreased depression (NICE, 2013), increased empowerment and reduced PTSD symptoms, though not PTSD as a whole (Bybee and Sullivan, 2005). There was also moderate evidence for counselling or brief therapeutic interventions (Kaslow, et al., 2010; Dienemann, et al., 2007; Chronister and McWhirter, 2006; NICE, 2013). Some of these interventions were delivered within shelter contexts as groups but some as outreach services with

individuals, and one as a telephone intervention (Thomas, et al., 2005). Some of the studies reviewed demonstrated modest reductions to PTSD symptoms, depression, anxiety and reported stress and increased self-esteem.

HOPE: Cognitive Behaviour Therapy delivered in shelters

The HOPE (Helping to Overcome PTSD through Empowerment) programme uses CBT to address the need for PTSD treatment in domestic violence victims who are resident in refuges and shelters. HOPE is a multistage model of recovery, focusing on establishing safety, remembrance and mourning, and reconnection. Cognitive behavioural theories suggest that individuals with PTSD process the trauma according to existing belief systems about themselves and the world. These appraisals can lead to an exaggerated sense of current threat, sustaining the negative emotions and coping strategies. HOPE targets these cognitions in five areas of dysfunction (safety, trust, power/control, esteem and intimacy) helping women to recognise the impact these are having on their ability to use the resources available to them. The programme comprises a maximum of 12 sessions, offered biweekly over a maximum of 8 weeks. Each session lasts 1-1.5 hours and follows the same structure. HOPE clients are also given an 'empowerment' toolbox containing positive coping strategies to cope with their PTSD symptoms. Homework is given between sessions. In a randomised controlled study (Johnson et al, 2011), women attending HOPE showed improvement on levels of depression and certain PTSD symptoms although broad PTSD diagnoses in the programme group were not significantly reduced. In addition, women who received the programme were less likely to be re-victimised at 6 months follow-up, compared to those in the control group.

Finally, there was moderate evidence for more intensive therapeutic work with domestic abuse survivors (NICE, 2013; Johnson, Zlotnick and Perez, 2011; Kaslow, et al., 2010). All of these studies demonstrated some positive impacts, though the outcome focus varied too widely to synthesise this as strong evidence. These interventions showed impacts on trauma symptoms, PTSD symptoms, depression and other psychological outcomes.

Sexual violence, including rape and sexual assault

Four evaluations of recovery interventions for sexual violence were identified. All these approaches were focused on reducing post-traumatic stress disorder (PTSD), or its associated symptoms in sexual violence victims. The categories of evidence were cognitive-behavioural therapy (CBT); eye movement desensitisation and reprocessing (EMDR), and psychotherapy. All three forms of therapy are recommended in NICE clinical guidelines as evidence-based interventions to respond to PTSD in adults.[30] One critical observation of the

30 http://www.nice.org.uk/nicemedia/live/10966/29771/29771.pdf

literature is that it seems to be overly focused on PTSD in evaluating sexual violence recovery responses, perhaps a reflection on the fact that most studies have emerged from the US. However, we might argue that other forms of personal and psycho-social adjustment, for example, sexual functioning, depression and anxiety, as well as the ability to form healthy relationships would be worthy of study and intervention focus.

There was moderate evidence for the use of CBT to reduce symptoms and diagnoses of PTSD in sexual violence survivors. One study identified tested the impact of an additional partner relationship support component (Billette, Guay and Marchand, 2008), which showed positive but potentially biased results. Another paper provided evidence for person-centred psychotherapy, working with victims of sexual assault who also had learning difficulties (Barber, Jenkins and Jones, 2000).

There was some evidence for the use of EMDR with rape victims. One study tested EMDR with women who had survived intimate partner rape within a period of 12 weeks (Tarquinio, et al., 2012), while a second study tested an emergency EMDR protocol for rape victims, who had been victimised within 72 hours (Tarquinio, et al., 2012). Both were small, non-comparative samples but both evidenced a significant impact on PTSD symptoms that was stable over time, suggesting this may be a promising recovery intervention.

Forced marriage, honour based violence and FGM

Only one paper was identified for interventions aimed at improving outcomes for women who have experienced FGM (Balogun, et al., 2013). This was a Cochrane systematic review published in 2013, which concluded that it did not identify a single evaluation study for this population meeting the study design for inclusion (i.e. a study with comparison group). The paper indicates that most research in this field has looked at the consequences of FGM for women, and that the experimental evaluation required to provide definite evidence for any particular intervention may be ethically difficult to achieve.

It should be mentioned that, whilst outside the remit of this review, a number of evaluation papers were identified focused on medical interventions for the recovery of FGM victims. In particular, a growing evidence-base appears to be developing for defibulation surgery in pregnant women (e.g. Nour, Michels and Bryant, 2006; Krause, 2012; Safari, 2013) and other forms of surgery to rectify negative gynaecological consequences of FGM, such as pelvic infection, cysts, etc. (Thabet and Thabet, 2003). Given that the identification of FGM is often via maternity/pregnancy services, other complementary recovery responses, for example counselling or therapeutic work, that might be developed for this population may find more effective reach and impact by locating them within health settings.

There were no papers identified evaluating recovery interventions for honour based violence or forced marriage. The NICE review reiterates this finding:

> "there is a lack of research to address 'honour' based violence or forced marriage, and a lack of evidence on tailored approaches for diverse women and women at different levels of risk." (NICE, 2013, p15)

Trafficking, Sexual Exploitation and Prostitution

No evaluation studies were identified for protective responses in this field.

6.3. Co-ordination and Training

The final synthesis examined interventions where the primary aim was integration or co-ordination of responses, or where the intervention sought to engage workers from different disciplines in working effectively with abuse and violence. This included training of non-specialist professionals in domestic abuse and sexual violence.

6.3.1 What is delivered?

Domestic violence

More articles were located on service co-ordination and training in domestic abuse than on other forms of abuse. These included co-ordinated service models, of which there were a number including Co-ordinated Community Responses, training or education for professionals. Salazar, et al. (2007) discussed Co-ordinated Community Responses implementation in two counties in Georgia, US. The Domestic Violence Prevention Enhancements and Leadership Through Alliances (DELTA) programme (Cox, et al., 2010) is a CCR operating at federal, state and community levels in the US. The paper by Florence, et al. (2011) describes the Cardiff Violence Prevention Programme (CVPP) (UK), a data sharing multi-agency partnership between city government, police, city licensing regulators, and health service partners. For patients who present at a hospital with an injury due to a violent incident, all information about this injury, including location, time it occurred and weapon used is captured electronically and shared with relevant partners.

The influential model developed in Duluth, Minnesota, through the Domestic Abuse Intervention Project (DAIP) (Shepard, Falk and Elliott, 2002), involved implementing a range of interventions and uniform policies across agencies for tackling domestic abuse, including working with the police and with offenders through perpetrator programmes.

Lia-Hoagberg, et al. (2001) addresses training of professionals from a range of backgrounds such as health, social services and public policy with the aim of increasing competence and confidence in working with domestic abuse. Another paper described integrating a domestic violence education programme into a medical school curriculum (Weiss, et al., 2000).

Sexual violence, including rape and sexual assault

One article describing US Sexual Assault Response Teams (SARTs) was located (Greeson and Campbell, 2013). SARTs are “community-level interventions that seek to build positive relationships and increase collaboration amongst sexual assault responders”.

Combined – Domestic abuse and sexual violence

Three papers described training for health professionals aimed at improving their knowledge and skills in working with both domestic abuse and sexual violence. This form of training was designed for nurses working within Emergency Departments (Sampsel, et al., 2009); medical students (Hill, 2005) and obstetricians and gynaecologists (Haley, et al., 2002).

6.3.2 What is evidenced?

Domestic abuse

The current review identified 16 papers focused on coordinated or training responses to domestic abuse. These can be categorised as training or education initiatives with professionals and coordinated service models. The majority of papers in this response type concerned training non-specialist service providers in domestic violence. This included hospital staff and GPs (Coben, 2002; Edwardsen, et al., 2004; Salmon, et al., 2006; Papadakaki, et al., 2013; Klevens, et al., 2008; Korenstein, et al., 2003; Short and Hadley, 2002). The evidence from these papers is inconsistent, some indicating improved awareness and knowledge of domestic abuse as well as improved detection, while others showed little or no change.

There was evidence from one study for the ineffectiveness of Coordinated Community Responses (Klevens, 2008), which showed no overall impact on rates of IPV in 10 CCR areas compared to matched communities. However, further analyses revealed increased rates of contact with specialist services in CCR areas, leading authors to suggest that, “it may be premature to conclude that CCRs are ineffective” (Klevens, 2008, p356). A second study (Salazar, et al., 2007) provided moderate evidence for an increase in criminal justice process outcomes, e.g. an increase in arrests of male offenders, but did not examine rates of IPV or health outcomes. A third paper (Bennett and O'Brien, 2007) examining a coordinated model, though not a CCR, found evidence for effectively integrating domestic abuse with drug misuse services to impact both reduced use of substances and self-efficacy in responding to abuse. However, the study also found greater fearfulness of the consequences of domestic abuse.

One further model deserves mention, given it is local to Wales: the Cardiff Violence Prevention Programme, a coordinated information-sharing partnership between health services, police and local government partners (Florence, et al., 2011; Florence, et al., 2013). There is strong evidence from these high quality studies for the effectiveness of this model in reducing injury related to violent behaviour. The associated cost-benefit analysis demonstrated significant savings for the health service in Cardiff, as well as the criminal justice system, compared to 14 other similar cities in England and Wales where the intervention was not implemented. In particular, the authors claim a benefit of £82 for every £1 invested.

The Cardiff Violence Prevention Programme

The CVPP is a coordinated response to violence, developed in Wales, which rests on a data sharing partnership between local government, health services and the police. The programme uses anonymised information obtained from emergency department patients about the type of violence (including stranger, acquaintance and domestic violence), precise location of violence, weapon use, assailants and day/time of violence. This information was used to make decisions every 6 weeks about how to deploy police resources and to agree other violence prevention initiatives. In addition, in face injury and trauma clinics, where people injured have their stitches removed and their wounds dressed, clinic nurses deliver Identification and Brief Advice (IBA) to those who abuse alcohol, motivating them to reduce their alcohol consumption. The community safety partnership combines information from emergency departments with police data to produce a regularly updated list of violence hotspots, violence times and weapons used. A recent quasi-experimental evaluation (Florence et al, 2011) has shown that this model enhances the effectiveness of targeted policing and local authority effort, and significantly reduces serious violence recorded by the police and violence-related hospital admissions.

Sexual violence, including rape and sexual assault

Two papers were identified that provided evidence for Sexual Assault Response Teams (SARTs) (Greeson and Campbell, 2013; Johnston, 2005), one of which was a review of the empirical evidence (Greeson and Campbell, 2013). There was moderate evidence from these high quality studies that SARTs impacted on improved screening and communication between victims and responders; improved victim help-seeking; and improved treatment for substance misuse; however both studies pointed to implementation concerns with case management and follow-up, role confusion and organisational barriers.

Forced marriage, honour based violence and FGM

As with the evidence presented under domestic abuse, there was weak evidence (Berg and Denison, 2012) for the effectiveness of training health professionals about FGM. Contrary to expectation, the evidence suggested that these professionals were less inclined to advocate following training. However, the context for this evidence was a country with strong cultural acceptance of FGM and very high prevalence (over 90% of the female population). It is likely that such a service response might be differently realised in a Welsh context, where both acceptance and prevalence rates are significantly lower.

Trafficking, sexual exploitation and prostitution

No studies were identified.

Summary

Protection responses

- There was moderate evidence for victim advocacy, of which the IDVA service in England and Wales is an example. It is reasonable to assume that the evidence underpinning advocacy interventions and approaches for domestic abuse could be applied to work with sexual violence.
- There was moderate evidence for skill-building interventions promoting safety behaviours, improving decision-making abilities and reducing re-victimisation.
- The evidence for the effectiveness of domestic abuse perpetrator programmes is mixed but is largely moderate for the effectiveness of male perpetrator programmes, with improvements demonstrated largely on attitudinal change. No particular model of intervention stood out as more successful than another.
- Perpetrator programmes for sexual violence are largely divided into models testing CBT or behaviour therapy, with mostly negligible effects on reoffending.

Recovery responses

- There was weak evidence for the effectiveness of social support groups within and outside of shelters.
- The evidence suggested that the use of advocacy decreased depression, increased empowerment and reduced PTSD symptoms.
- There was moderate evidence for counselling or brief therapeutic interventions in reducing trauma symptoms.
- There was moderate evidence for more intensive therapeutic work with domestic abuse survivors, with impacts on trauma symptoms, PTSD symptoms, depression and other psychological outcomes.
- There was moderate evidence for the use of CBT to reduce symptoms and diagnoses of PTSD in sexual violence survivors.

Co-ordination responses

- The evidence from evaluations of training programmes is inconsistent; some indicating improved awareness and knowledge of domestic abuse as well as improved detection, while others showed little or no change. Further, applied to FGM, there was weak evidence for the effectiveness of training health professionals.
- There was weak and inconsistent evidence for the effectiveness of CCR models. However, a model developed in Cardiff provided strong evidence of a coordinated response between health and police services in reducing violence-related injuries. This could be focussed and tested more specifically for its impact on domestic abuse and sexual violence.
- There was moderate evidence that SARTs impact on improved screening and communication between victims and responders; improved victim help-seeking; and improved treatment for substance misuse;

7 Interrogating the Grey Literature

In addition to the literature identified through searching academic databases, we also gathered informally published material, including a number of key reports and documents not published in conventional peer-reviewed journals. Typically, these were sourced from research centre websites, charitable organisations or from Government departments. We restricted this literature to the UK context and acknowledge that it is only a proportion of such material available. However, these identified reports offer an important layer of description that contributes to an up-to-date picture of provision in the sector.

In total, 44 items of grey literature were sourced. Many of these documents were service descriptions or small-scale evaluations that did not meet our criteria for robust evidence. A proportion was reports of evaluations not covered in the articles reviewed earlier and, where the literature discussed below is judged to provide evidence of effectiveness rather than simply a descriptive account, this is indicated. Most of the reports identified concerned responses to domestic abuse, five described interventions for sexual violence, one report addressed sexual exploitation, one was found on FGM and one reported an intervention aimed at sexual trafficking.

7.1 Grey literature addressing domestic abuse

The 26 domestic abuse publications can be categorised against the typology levels used throughout this report: prevention; identification, recognition, identification and referral; protection for victims and work with perpetrators; recovery and re-integration and co-ordination.

Of the three prevention studies, one provided a description of a sanctuary scheme and two provided accounts of interventions addressing domestic abuse and alcohol misuse. The sanctuary scheme piloted in England was a target hardening scheme aimed at increasing the safety of victims of domestic abuse by installing alarms, locks on doors and windows with alarms linked directly to police stations (Nottingham City Council, 2007). The Sanctuary Plus scheme offered on-going support for a further six months once the sanctuary had been established. Such schemes are, of course, only useful for women who wish to remain in their homes and will not be relevant for all women. The two preventive interventions addressing alcohol and domestic abuse included a drama-based intervention in England that worked with survivors and perpetrators (Murphy and Hill, 2008) and a Scottish publicity campaign aimed at raising awareness (Almond, George and McIntosh, 2004).

A review of preventive work in schools in Wales (NFER, 2011), funded by the Welsh Government, corroborated evidence found for primary preventive education with children and young people (see Chapter 5). This study was judged to provide evidence of effectiveness. It mapped existing work in schools and other educational settings, and examined how current models of violence prevention might fit with curriculum requirements. It identified a total

of 22 domestic abuse initiatives being delivered across Wales, largely in secondary schools. Some of these were stand-alone programmes but many were incorporated within the PHSE curriculum. There has been limited monitoring and evaluation of the effectiveness of these initiatives in Wales and, given that they vary considerably in their form, methods, focus and content, there are likely to be significant differences in the impact achieved. The PEACH study is a UK based scoping study which will report its findings in 2014, exploring the evidence for the effectiveness of preventive domestic abuse interventions for children and young people; its findings will be relevant for implementation of these interventions (PEACH, 2013).

Six publications on identification, recognition and referral initiatives provided descriptions of domestic abuse programmes. These included the All Wales Domestic Abuse and Sexual Violence Helpline (Bathgate, 2006) and an evaluation of Welsh Women's Aid (Joshua, Rix and Robinson, 2008) In its first operational year (2004-05), the All Wales Domestic Abuse and Sexual Violence Helpline received over 6,000 calls of which over 80% were made by young people aged 16-25 years. The Helpline provides a listening service, an information and signposting service and identifies refuge space for victims. Welsh Women's Aid is an umbrella organisation covering the 34 local Women's Aid groups in Wales (Joshua, Rix and Robinson, 2008). These 34 local groups deliver support in the community and refuges to women and children experiencing domestic abuse (Joshua, Rix and Robinson, 2008). The Phoenix programme (Monckton Smith, 2010) offered awareness raising and skills training to assist in building non-abusive relationships. An evaluation (Donovan, et al., 2010) of two integrated domestic abuse projects in North East England which aimed to provide victims with early intervention through advocacy, caseworking and coordination reported success in reducing repeat referrals and reports of domestic abuse incidents. Other initiatives identified in this category included the Pathways Project (Granville and Bridge, 2010); and the primary care based IRIS Project (Abbasi, 2011) discussed in Chapter 5 of this report.

Four protective interventions for female victims of domestic violence who also had alcohol problems were also identified (London Borough of Camden, 2004; Ranzetta, 2005; Carter, 2003; and Carter, 2006). These services were all based in England and offered a combination of action planning, advice, advocacy and co-ordinated access and referrals to other agencies.

Three reports provided evaluations of perpetrator programmes. The *Strength to Change* programme (Stanley, et al., 2011) described in the previous chapter was developed subsequent to a social marketing campaign aimed at abusive men in the general population (Stanley, et al., 2009). The other perpetrator programme evaluation identified (Williamson and Hester, 2009), also based in England, took the form of a 26-week course comprising 75 hours spread over two days followed by weekly sessions.

A two-year evaluation of the Caring Dads programme delivered in Wales examined the effectiveness of the programme in changing men's abusive attitudes and behaviours (McCracken et al. 2012). This report was considered

to provide more robust evidence. The model, originally developed in Canada, rests primarily on cognitive-behavioural therapy and motivational models for working with perpetrators. It was adapted for Wales, funded by the Welsh Government and delivered by NSPCC Cymru. This was a voluntary, group intervention for high-risk men, which focused primarily on the relationship between fathers and their children as the mechanism for motivating behaviour change. The evaluation comprised a pre-post test as well as qualitative analysis of interview data, and found improvements in the men's aggressive responses. There were, however, participants who did not demonstrate improvements in taking responsibility for their behaviour. Although the evaluation was limited by a small sample and no comparison group data, the authors suggest further development of the programme is warranted within Wales.

Four studies (Donovan et al, 2010; Siddiqui and Patel, 2010; Thiara, 2011; Thiara, 2012) on recovery and reintegration described services based in England offering information and education, advice and personal safety. These programmes were more targeted and worked with women with insecure immigration status and asylum seekers; women with mental health difficulties; BMER women and eastern European women.

Six publications described coordinated or coordinating services such as the Domestic Abuse Co-ordinators (DAC) role, (K.M. Research and Consultancy Ltd, 2011). This review of the DAC role highlighted some important points arguing that DACs should not provide services themselves but rather should identify gaps and services to fill them. It found that the largest proportion of DACs' time is spent organising training and awareness sessions for other organisations and concluded that there was no overlap between the DAC role and the IDVA role. Other publications on coordinated services addressed IDVAs (Coy, and Kelly, 2011) and the Phoenix programme (this differed from the Phoenix programme discussed above), a sixteen-week programme focused on high-risk cases and working on the mother/child relationship where appropriate (Abrahams and Williamson, 2011).

The evaluation of the MARAC system in Wales in 2003/2004 was judged to provide evidence of effectiveness. The report (Robinson and Tregidga, 2005) examined whether this multi-agency approach resulted in increased safety for women and children, through increased communication, improved risk assessments, advocacy for victims, increased action, and greater accountability for perpetrators. Findings demonstrated that "taking a holistic approach to domestic violence can reduce recidivism" (Robinson and Tregidga, 2005, p31). Furthermore, victims claimed they received the support they needed. A process evaluation of IDVAs undertaken in 2007/2008 examined the perceived impact of these workers, and their contribution to the Coordinated Community Response (CCR) (Robinson, 2009). The evidence review reported in the previous chapter noted that there is weak evidence for CCRs as a coordinated model. The methodology of this study prohibits strong conclusions being drawn; however, the report raises important considerations for Wales, in particular the co-location of IDVAs within statutory settings and the allocation of specific remits. Finally, the evaluation concluded that the

IDVA can only be effective in the context of sufficient and relevant local services.

7.2 Grey literature addressing sexual violence

Of the five publications on interventions for sexual violence, one addressed prevention; three covered identification, recognition, referral; and one focused on co-ordination and working together. The primary prevention study described a feminist-informed poster campaign that ran in Scotland (Progressive, 2009). An English evaluation of Rape Investigation Unit (RIU) (van Staden and Lawrence, 2010) which piloted the role of Sexual Offences Investigation Trained (SOIT) Officer, showed the role was viewed as a positive development. An evaluation of an English SARC (Jackson, 2009) which offered medical examinations, counselling, information and support to women who had experienced sexual violence focused on identification and referral.

A good quality Home Office funded study of the SARCs (Lovett et al. 2004) included three SARCs in England and three comparison areas with no SARC provision. It analysed both qualitative and quantitative data in over 3,500 cases tracked prospectively. It found that SARCs increased victims' referrals and access to specialist services and support where no report was made to the police; that users rated the service highly; and that the proactive model of support resulted in greater take-up of advocacy and support. There were a number of challenges that influenced the effectiveness of the model, including a requirement for national leadership, and the authors present an 'ideal' SARC model in their recommendations, indicating the range of services and multi-agency infrastructure required. A Welsh review of SARCs is due to report in 2014.

Rape Crisis England and Wales (Women's Resource Centre, 2008) is a coordinating umbrella organisation that works in the area of rape and sexual violence. The report describes the responses of 35 of the 38 affiliated Rape Crisis members who responded to an in-depth survey of their members. The service user perspectives included emphasised the range of positive impacts of the service on them, their families and the wider community.

7.3 Grey literature addressing FGM, sexual exploitation and trafficking

The report on FGM comprised an evaluation of the FGM Initiative delivered across the UK and addressed prevention, identification, recognition and referral (Brown and Hemmings, 2013). The FGM Initiative aimed to protect children from FGM through community-based preventive work, which 'incorporated FGM into other messages', offered safe spaces for discussion, included religious leaders, adopted a rights-based approach to work with young people and trained Community Champions. In Wales, Bawso Ltd. participated in this initiative through a range of activities including training student midwives and collaboration with Wales National Theatre on a drama developed by young Sudanese people. The national evaluation also

emphasised that FGM prevention required buy-in from various stakeholders and argued for this issue to be mainstreamed.

The report addressing sexual exploitation described the NIA project based in London (Coy, et al., 2011). This preventive project delivered training and education to professionals working with children and young people. The Poppy Project (Sachrajda, 2008) offers accommodation and specialist support to women in England who have been trafficked; it works with vulnerable women without recourse to public funds. The Welsh Diogel project run by Bawso Ltd. is the sister project to the Poppy Project and adopts a similar model.

Summary

- The literature summarised as 'grey' literature represents a good understanding of the UK/Welsh evidence for violence against women, domestic abuse and sexual violence services. It should be interpreted with caution however since the quality of the research is variable and has not been peer-reviewed (and in this respect it differs from the evidence discussed in Chapters 5 and 6).
- A review of preventive work in schools in Wales corroborated evidence found for primary preventive education with children and young people, however, these initiatives vary considerably and there is likely to be significant differences in the impact achieved.
- There were a number of small evaluations providing evidence for work with perpetrators and men/fathers. Most were limited by small samples or no comparison data; however, there was change evidenced in the expected direction suggesting these interventions have potential in Wales.
- There is some evidence for coordinated services, such as DACs, MARACs and IDVAs as part of a CCR. Findings from an evaluation of the MARACs demonstrated that they have potential to reduce violence recidivism. Furthermore, victims reported that they received the support they needed.
- SARCs increased victim referrals and access to specialist services and support where no report was made to the police; the proactive model of support resulted in greater take-up of advocacy and support.
- A national evaluation of training on FGM emphasised that FGM prevention required buy-in from various stakeholders and argued for this issue to be mainstreamed.

8 Conclusion and Recommendations

The evidence collected for this review derives from a range of different sources including statistical data on prevalence, a mapping study of service providers in Wales, stakeholder interviews, consultation groups with service users and a semi-systematic literature review. We have used a typology of service responses to draw these different evidence sources together; this classifies services not only by type of violence but also by response type: prevention, identification and referral, protection, recovery and reintegration, and coordination. The typology facilitates a read-across between the mapping of interventions and services currently offered across Wales with the evidence gathered from the international literature on effectiveness. In addition, such a typology may prove useful for future service planning and funding allocation, where it is possible to agree how a portfolio of investment might be balanced across service types. For example, greater investment in prevention services now is likely to result in lower demand for protective services in the future. Equally, investment in more robust identification and referral services will be of little value if adequate provision to protect victims or respond to perpetrators is not available. Providing an estimate of the current balance of provision across Wales (see Figure 3) allows the Welsh Government to consider where to place future investment to achieve a balance an appropriate balance.

Figure 3: Typology of Service Responses for Wales

We have synthesised the evidence collected for this review into a series of key questions and answers. These have been used to generate recommendations and these questions provide a structure for this final section of the report.

8.1 What do we know about the scale of violence against women, domestic abuse and sexual violence in Wales?

In answering this question we have drawn on a range of sources that included the CSEW data for England and Wales; reported crime figures; independent studies of elder abuse and of violence in LGBT communities; statistics reporting state interventions in forced marriages and in cases of trafficking and statistical estimates of FGM. Chapter 1 described the various limitations of these data, some of which are not specific to Wales, and some of which describe service activity rather than true prevalence. True prevalence data are costly to collect and, in the field of violence against women, community surveys that examine emerging issues such as forced marriage or FGM are particularly difficult to implement. However, these data do allow us to distinguish some clear patterns and to identify where there are key gaps in our knowledge. We were also able to consider the data on prevalence in relation to the findings of the mapping study and to examine the balance between services addressing different forms of harm. The preponderance of services addressing domestic abuse appears, in the light of prevalence data, to be appropriate. We are able to draw the following conclusions from the data on prevalence:

- Violence against women, domestic abuse and sexual violence represent a significant problem in Wales. Although there is a lack of robust data, estimates show that domestic abuse is estimated to affect 7% of women and 5% of men each year in Wales; sexual violence is estimated to affect 3% of women and 0.3% of men; 3.9% of elderly women and 2.1% of elderly men are abused or neglected by carers. The latest available estimates show 1% of cases handled by the FMU and 18 cases of human trafficking for sexual exploitation handled by the NRM originate from Wales. We were unable to find data for Wales on FGM.
- Domestic violence is the most prevalent form of abuse. While the proportion of those affected by sexual violence is much lower, the last year has seen a rapid increase in rates of reported sexual offences. Disclosure of historic abuse plays a part in this but historic abuse requires a service response in its own right and disclosure of historic sexual abuse prompts disclosure of current abuse.
- Honour-based violence accounts for a small minority of overall victimization in Wales, compared to English proportions. This may be due to the largely homogenous population in Wales (95.6% white) and the fact that only one of the 15 courts dealing with forced marriage is situated in Wales.
- Estimating prevalence is hampered by the absence of specific published data for Wales, or its localities. Data is bound up with data covering England and Wales and significant differences in ethnic populations, deprivation levels and other factors are likely to distort the picture for Wales. Robust prevalence data is not available for the LGBT communities, for FGM, honour-based violence, forced marriage and trafficking for the purposes of sexual exploitation.
- There is reported crime data at a local level but these should be interpreted with caution. In particular, there are large differences between

police forces in reported crimes, which may be an artefact of arrest and reporting processes rather than reflecting real differences.

- Similar problems are found for trafficking for sexual exploitation, where NRM reported numbers are low for Wales (18 cases). These reported cases are typically an under-estimate but even so the prevalence is likely to be relatively low in Wales.
- The FORWARD method which applied FGM prevalence statistics from practising countries to migrant populations identified by the Census could be used to estimate FGM rates in Wales, using Census 2011 data and country of origin; however, second and third generation members of these families will be missed by these statistics (because their country of birth is UK). New methods are needed to estimate FGM, possibly through hospital/health records.
- Girls and women aged 16-24 are most at risk of experiencing violence and abuse.

Recommendation 1: The Welsh Government should commission a detailed analysis of the CSEW data (formerly known as the British Crime Survey) at local area level, to obtain more specific data for Wales and its regions.

Recommendation 2: In the light of the gaps in the existing data, the Welsh Government should seek to work closely with those helplines it already funds and with other Welsh or national helplines to obtain data on calls for help/assistance related to violence and abuse in LGBT groups, FGM, honour-based violence, forced marriage and trafficking for the purposes of sexual exploitation.

Recommendation 3: In a context where new definitions and forms of abuse are emerging, it is important to emphasise that domestic abuse is by far the most prevalent form of abuse addressed by this report and services should continue to reflect this.

Recommendation 4: Organisations with knowledge and expertise in those types of violence and abuse where prevalence is lower or less is known about prevalence should be encouraged to retain and build that knowledge. This includes expertise in sexual violence, FGM, honour-based violence, forced marriage and trafficking for the purposes of sexual exploitation as well as skills in working with particular communities such as LGBT groups, older people and BME communities.

8.2 What does the international literature tell us about what is currently delivered in this field and how much of it is evidence-based?

This question was addressed by the semi-systematic literature review reported in Chapters 5, 6 and 7, which identified those interventions for which there is moderate evidence of effectiveness. The literature review was structured using the six service responses identified at the first level of the

typology and included both the international literature that described recent and current interventions and the international literature that provided evidence of effectiveness of interventions and that was judged to be of medium and good quality using recognised indicators. We were also able to include findings from a review of selected grey literature from the UK. In research in this field, moderate evidence of effectiveness is generally considered to represent good evidence. We have considered the findings of the literature review alongside the views of the stakeholders reported in Chapter 4 as these interviews provided an indication of which developments would be acceptable to and welcomed by those planning and delivering services in the sector.

- The literature documents a wide range of services that is currently delivered. Many of the interventions described in published literature originate in the US, although interventions in FGM and honour-based violence are more likely to be developed in low-income nations.
- Since evidence is still in the process of accumulating, there is a lack of strong evidence for any one intervention. However, this review did identify some high quality studies and a weight of moderate support for some service responses.
- Interventions where the evidence is strongest include advocacy services for women experiencing domestic abuse and prevention programmes delivered in schools. The grey literature provides evidence for the impact of SARCs.
- There is moderate evidence to support the introduction of programmes for male perpetrators of domestic abuse, which should include strategies for keeping participants engaged and motivated. The stakeholder interviews revealed enthusiasm for the development of perpetrator programmes within the sector in Wales.
- The evidence for interventions in forced marriage, FGM, trafficking and sexual exploitation is currently very limited. However, there is some evidence for the effectiveness of responses to FGM in health settings and these are the settings where FGM is most likely to be identified.
- The evidence for the effectiveness of interventions for sexual offenders is weak and inconclusive.
- More evidence was identified addressing protection and recovery responses than for other types of response. While there is evidence in the grey literature for the effectiveness of MARACs and for SARCs, there is as yet very little evidence for other coordination models.
- There is scope for offering evidence-based recovery responses for all forms of violence, for example, counselling or therapeutic work, by locating them within universal health settings. There is good evidence for CBT in addressing common sequelae of violence, such as trauma symptoms, anxiety and depression. For certain forms of violence, such as sexual assault and FGM, the reach of these recovery services may be wider when they sit alongside complementary identification and referral services.

Recommendation 5: The Welsh Government should ensure that funding for those interventions for which there is good evidence, such as IDVA services and school based prevention programmes, is secure and available on a continuing basis and is not susceptible to fluctuations in local budgets.

Recommendation 6: The evidence concerning screening for domestic violence indicates the need to take account of which setting women are seen in and which groups are being screened. There is evidence to support screening in maternity services but in other health and social care settings, targeted enquiry directed at those for whom there are indications that this may be appropriate is advised. The Ask and Act policy needs to be supported by training, referral routes and a supportive organisational culture.

Recommendation 7: The evidence base for perpetrator programmes in domestic violence is still developing in the UK. At this stage in the development of the evidence base, no particular model stands out, so implementation and testing of a range of perpetrator programmes within the Welsh context is encouraged.

Recommendation 8: Given the lack of evidence for the effectiveness of current interventions for sexual offenders, there is a need to develop new approaches and models for work with this group; innovation and testing are required in this field.

Recommendation 9: Protective responses to FGM should be delivered in or linked with health settings. Health settings such as maternity services are where the likelihood of identification is highest, and where there is good evidence for medical interventions that promote recovery.

8.3 What is the current service landscape in Wales and how does it appear in the light of the evidence review?

The questions asked in the mapping study of services in Wales were informed by the typology developed for this review. The first step was to identify what services existed and where they were located. This exercise provides a framework for undertaking future mapping of services in Wales. Further information on the nature of service provision, including responses made by universal statutory providers, was provided in the online survey. This was open to all service providers in Wales. It achieved a balanced response from 349 specialist and generalist sector services. The survey provides a useful picture of provision across Wales and we have brought the survey findings together with the prevalence data discussed in Chapter 1, the findings of the semi-systematic literature review and with the perceptions of stakeholders and of services users and stakeholders reported in Chapters 3 and 4.

- The mapping study revealed a reasonable spread of provision in Wales across the response types included in the typology although more could be delivered in respect of preventive interventions that are delivered outside schools (the remit of this review did not allow for schools to be surveyed about their provision although the research evidence on preventive interventions in schools was included in the literature review).
- In particular, the work on prevention could be broadened to include community based interventions promoting empowerment, resistance training and assertiveness in vulnerable groups. The literature review found that bystander interventions for domestic and sexual abuse were promising and these could be tested in Wales.
- The largest group of respondents to the survey were providers of refuge and emergency accommodation who were delivering protective responses. Service users valued the work of refuges but also identified a need for community based services following a refuge stay and services for those women who stay in abusive relationships.
- The mapping survey indicated that32% of services in Wales have the capacity to deliver services to those experiencing forced marriage, honour based violence and sexual exploitation, whilst 24% of respondents described their organisations as working with FGM and 17% with trafficked women. It was not clear whether these services had specialists within them who could work with these needs or whether staff were considered to have the relevant skills and knowledge to undertake this work. Funding imperatives may lead organisations to overclaim expertise in new areas of work.
- The mapping survey suggested that the educational levels and training of staff in this sector varies considerably and the consultation groups with service users confirmed this. Experience has traditionally been the route to employment in this sector, but service users argued the need for a skilled workforce.
- The survey found that the most common type of work undertaken by responding organisations was providing advice and information or coordinating access to other services or specialists. Whilst coordinating activity is valuable and may reduce the need for victims to make contact with multiple agencies, such activity may take time away from direct work with victims or perpetrators. National information networks or hubs may have a role to play here.
- Access to appropriate recovery services, such as CBT, might be improved by training the primary care workforce to deliver this within health settings (e.g. IAPT) and by supporting counselling and brief therapeutic work as part of community outreach work. The evidence does not support informal social support groups, although service user consultation suggests the networks gained via these groups may be beneficial.
- Although there is no robust evidence supporting the effectiveness of MARACs and other multi-disciplinary forums, these are widely adopted across Wales and have support from stakeholders and from the grey literature. There is consensus that their success is dependent upon commitment from the various partners and that this can be difficult to secure where there is no designated funding or co-ordinating role to ensure this.

Recommendation 10: In addition to implementing school based prevention programmes, the Welsh Government should consider piloting community based prevention programmes such as the Bystander programmes.

Recommendation 11: The Welsh Government should ensure that training is available for staff in the VAWDASV sector to develop skills and knowledge in work with forced marriage, honour-based violence, FGM and trafficking for sexual exploitation purposes. Ensuring easy access to those with specialist knowledge in these fields is another means of improving knowledge and skills across services.

Recommendation 12: The Welsh Government should work with higher education and training organisations to support the goal of ensuring a skilled workforce in this sector across Wales.

Recommendation 13: The Welsh Government should proceed to develop its plans for an All Wales Hub or information network that would take on the task of providing information on and/or access to services for both professionals and for those seeking help.

8.4 Where are the service gaps and shortfalls in Wales and how might these be met?

In answering this question we have brought together findings from the mapping survey, the stakeholder interviews and consultation groups with service users. We have also used the literature review to establish whether there is evidence to support providers, planners and service users' recommendations for service development.

- Funding streams for the sector are very diverse and this has resulted in fragmented services. There is competition within the sector for the funding available and organisations can position themselves in opposition to one another rather than viewing themselves as part of the same solution.
- Funding is experienced as unstable and short-term. This pattern of funding restricts service planning and undermines the development of a skilled and expert workforce.
- The stakeholder interviews elicited enthusiasm for joint commissioning and calls for greater involvement from health services in joint commissioning.
- Almost half (49%) of the services responding to the mapping survey described their organisations as providing sexual violence services. These services need to be informed by expertise developed in specialist services.
- Services have widened their remit in response to the Violence Against Women agenda. More needs to be done to ensure specialist knowledge and skills concerning forced marriage, honour based violence, trafficking for sexual purposes and FGM are shared across organisations.

- One-Stop-Shops are an important feature of the service landscape and are valued by users, but co-location is not the only feature of a coordinated model. The effective features of coordinated models include partnerships, community coalition, information sharing protocols, and clear allocation of roles and case management.
- Services are being delivered in rural areas but there are challenges involved in delivering services in these parts of Wales – costs are high in terms of resources as staff have to travel to service users. One-stop-shops mean that if women have to travel for support, they can access a number of services with one journey.
- Concerns regarding the ability of women with no recourse to public funds to access services were raised by both the stakeholders consulted and by service users.
- Cases that do not meet high-risk thresholds may fall through the gap between services and most victims will be assessed as falling in the middle band of a risk scale. The evidence concerning the effectiveness of targeting services is mixed; while MARACs appear successful, some perpetrator programmes make no impact on high-risk cases.
- More coordinated responses are required. MARACs are working reasonably well at the high-risk level but coordination at lower levels of intervention is described as poor. In particular, health services need to engage more fully with violence against women and domestic abuse.

Recommendation 14: Offering providers longer-term contracts would increase stability and capacity in the sector. The higher costs of delivering services in rural areas should be acknowledged in contracts and grants.

Recommendation 15: Joint commissioning activity, involving health, but also bringing a range of agencies and organisations together in funding arrangements could be developed further in Wales. Perpetrator programmes represent a service where different models of joint commissioning could be piloted and evaluated and where interagency ownership might contribute to the robustness of the intervention. Extending joint commissioning could contribute to a more cohesive sector, remove duplication and save costs.

Recommendation 16: Expertise in delivering services to those experiencing sexual violence should be protected and training and knowledge transfer strategies should be utilised to make these skills and knowledge available to other organisations who may encounter experience of sexual violence as part of their wider remit.

Recommendation 17: Similarly, specialist knowledge and skills in intervening in forced marriage, honour based violence, trafficking for sexual purposes and FGM need to be shared across organisations through knowledge or information hubs or networks.

Recommendation 18: Generalist services such as health, education and the police have a key role to play in identifying victims of violence and abuse, in providing early intervention for those at low and medium risk and in referring

on to relevant specialist services. The Welsh Government should consider supporting implementation of the NICE Guidance (2014) on the health and social care response to domestic violence and abuse since this Guidance looks likely to provide a strong impetus for the full range of health services to engage more fully with the issues of domestic violence and violence against women. The appointment of an NHS Champion for Combatting Violence Against Women, Domestic Abuse and Sexual Violence who is charged with implementation of the NICE Guidance in Wales could be one means of achieving this.

8.5 What do service users say they need and want from a service?

This section draws primarily on the five consultation groups held with service users. Information provided by the mapping survey and findings from the literature review also inform these conclusions and recommendations.

- Health services are often the first point of contact for women; this indicates the importance of health professionals being trained and confident to provide screening, early intervention and referral to specialists.
- Service users value knowledgeable staff with expertise; they stressed the importance of training for all practitioners but for some groups such as police officers in particular.
- Good quality accommodation needs to be readily accessible to victims in crisis. The quality of accommodation offered is seen to reflect wider public perceptions of victims of abuse and violence.
- The service users consulted were clear that they would welcome wider and more open advertising of services addressing violence against women and noted that wider advertising might assist in shifting public attitudes.
- There was considerable support expressed by both service users and the stakeholders interviewed for the One-Stop-Shop model; as many commentators have noted, service divides in traditional service configurations often fail to recognise the interaction and combination of needs that service users experience and report. However, the literature found that the evidence base for the effectiveness of One-Stop-Shops is currently limited.
- Service users suggested that satellite services were needed in rural areas to combat the problems experienced in accessing services in towns and cities.
- Many service users were distrustful of internet-based support, despite this being an emerging line of response from many organisations. Agencies need to do more to convince service users that these forms of support are confidential and trustworthy. Online services could serve particular functions, such as increasing awareness or providing factual knowledge, whilst direct services are needed for support work.
- Survivors interviewed reported benefiting from meeting and connecting with others in the same situation as themselves.

- While Bawso Ltd.'s services were much appreciated by BMER women, other services across Wales need to develop the necessary expertise to work with BMER victims.
- Concerns expressed by service users about the position of women with no recourse to public funds suggest that information about new arrangements for supporting this group may be difficult to access. Information needs to be available for service users and providers in both specialist and generalist services regarding the Destitution Domestic Violence (DDV) Concession and women's rights to support under this provision.
- Service users reported difficulties in accessing good quality interpreting services and these concerns are consistent with those raised by the Task and Finish Group (Robinson et al 2012).
- Whilst the literature review provided evidence for the benefits of professionals sharing information and the mapping survey showed that many organisations do this, with and without women's consent, service users themselves were divided about whether information should be shared between agencies without their consent.
- Involving service users in the design and delivery of services is a means of ensuring that those services are responsive to the needs of the target audience. The mapping survey found that involving service users in the design and delivery of services was not standard practice across this sector.

Recommendation 19: Training is essential for staff in generalist frontline services who are involved in identification and referral as well as early intervention. Such training should address attitudes and awareness, safe information sharing and knowledge of local services as well as local referral paths and protocols.

Recommendation 20: Concerns about safety have meant that services for victims of violence and abuse have traditionally not been widely advertised. Service users themselves are now suggesting that the sector needs a more visible public profile and wider advertising might be tested through pilot projects.

Recommendation 21: One-Stop-Shops evoke positive responses from service users and other professionals. There are few rigorous evaluations of their work and the Welsh One-Stop-Shops offer an opportunity for such testing to be implemented.

Recommendation 22: Careful consideration needs to be given to the question of which services could be delivered online and which face-to-face. Further consultation with service users on this issue is recommended.

Recommendation 23: More needs to be done to develop the skills and knowledge of all agencies in this sector to work with the BMER population. Organisations with specialist skills and expertise in working with BMER groups could play a central role in disseminating skills and knowledge through training or via the provision of advice and information. This should include information on support available under the Destitution Domestic Violence (DDV) Concession.

Recommendation 24: Professional interpreting services need to be made more easily accessible and interpreters need to be appropriately trained and more closely linked to specialist services working with violence against women, domestic abuse and sexual violence.

Recommendation 25: Protocols for the safe sharing of information in all cases, not just high-risk cases, need to be developed in consultation with service users and providers. Such protocols need to build on existing models currently used in Wales and should be implemented in generalist as well as specialist services.

Recommendation 26: Services should adopt relevant and meaningful approaches for involving service users in the design and delivery of services. The Welsh Government is encouraged to collect and disseminate good practice examples of service user involvement in this sector.

8.6 What questions remain to be answered?

- The mapping survey received an adequate response but cannot provide a complete picture of provision across Wales. This could be developed by local authorities completing a service log of all provision in their area and the connections between them. The Gwent Domestic Abuse Pathfinder Project offers one example of an attempt to log provision at a regional level, which could be adopted by other regions in Wales.
- The sector in general and in Wales lacks a strong approach to evaluation. Some of the models of intervention currently being used such as IDVAs have an evidence base in the literature but many do not. This is not a unique problem and does not mean interventions are ineffective. Evidence could be generated for interventions such as perpetrator programmes and community based empowerment and resistance training initiatives.
- There is very little evidence available on costs, or cost effectiveness. Currently, the evidence is not sufficient to inform decisions about which preventive, protective or recovery responses would yield best results against investment. Different models could be tested for efficiency and cost effectiveness.
- There is insufficient evidence from evaluations of interventions and responses to honour-based violence to make recommendations for service responses in Wales beyond noting the need for some evaluation research

to be done. The criminal justice system also has a role in developing such responses.

Recommendation 27: Local authorities in Wales should develop a log of services for domestic abuse, sexual violence and violence against women in their area which recognises the links between services and identifies gaps. This should include estimates of capacity or volume of service. There is also scope for linking data on incidence to improve knowledge about service demand at the level of local authorities.

Recommendation 28: More needs to be done to develop the evidence base for interventions; in addition to testing specific interventions such as perpetrator programmes, this could be achieved by building individual outcome monitoring or aggregated data analysis into contracts or grant funding. However, the cost implications of this work would need to be acknowledged.

Recommendation 29: More research should be undertaken with survivors and recent service users to capture their evaluations of new and specific services, for example, services for LGBT communities, FGM, forced marriage, trafficking and honour based violence services.

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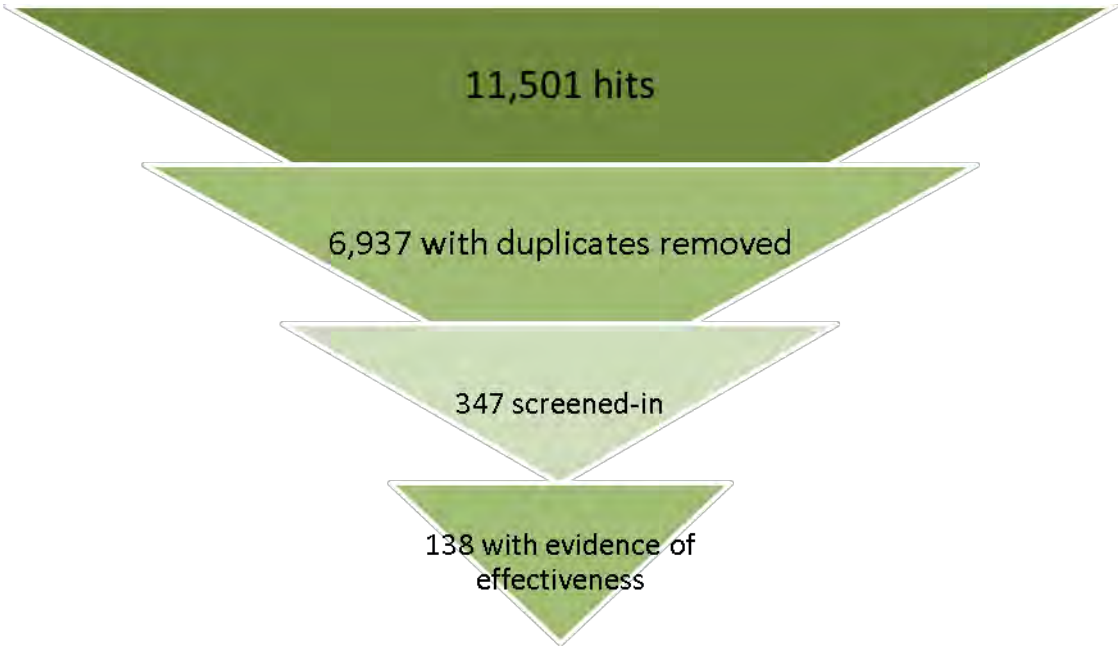
Appendix 1: Literature Review Search Terms

Sexual violence/ domestic abuse terms	
Sexual violence terms	Sexual abus* OR sexual violence OR rape OR sexual assault OR sexual exploit*
FGM terms	Female genital mutilation OR FGM OR female circumcision OR female genital cutting OR FGC
DV terms	Domestic violen* OR intimate partner violen* OR IPV OR spouse abus* OR domestic abus* OR batter* wom* OR elder abus* OR relationship violen* OR family violen*
Trafficking and prostitution	Sex traffick* OR commercial sexual exploitation OR prostitut*
Forced marriage and honour based violence	Early marriage* OR force* marriage* OR dowry OR child marriage OR hono?r violen*
Traditional practices	Harmful traditional practic* OR traditional practic* OR culture* practice*
Interventions	
	Intervention OR support OR mechanism OR program* OR service* OR therap* OR prevent* OR protect*OR screening OR advice or advise OR outreach OR hotline* OR helpline* OR refer* OR identif* OR promotion OR multi-agency OR (perpetrat* AND treat*) OR (victim and service*)
Evaluations	
	Evaluation OR outcome*OR impact OR value for money OR cost benefit OR trial OR pilot OR feasibility OR validation OR quantitative OR qualitative research OR dissemination OR protocol

Limit to titles and abstracts
Limit to English language and year 2000-current

Appendix 2: Flowchart of literature review

The search terms in Appendix 1 yielded over 11,500 hits, which when duplicate were removed was reduced to just under 7,000 potentially relevant papers. The abstracts for each paper were read and the paper was judged for suitability, according to whether it was within the remit of the review and might provide information about an intervention relevant for violence against women, domestic abuse, or sexual violence, and/or evidence of effectiveness. These papers were obtained in full-text and further screened for suitability. A total of 347 papers were screened-in, providing either information of interventions delivered in this sector and/or results from an evaluation study. The latter (n = 138) were further screened for quality using the checklists in Appendix 3 and data were extracted for the evidence review (Appendix 4).



Appendix 3: Quality Appraisal Checklists

This set of quality appraisal checklists are based on the NICE methods manual (appendix F and H). They have been modified to suit the purposes of this review project. There is a checklist for quantitative studies and one for qualitative studies. Where a mixed method approach is taken, we have used the quantitative checklist to assess for quality (where deemed acceptable, data extraction is completed for both methods). The method for rating is the same for quantitative and qualitative studies:
Each of the critical appraisal checklist questions covers an aspect of methodology that research has shown makes a significant difference to the conclusions of a study. Checklist items are worded so that one of five responses is possible:
++ Indicates that for that particular aspect of study design, the study has been designed/ conducted in such a way as to minimise the risk of bias.

+ Indicates that either the answer to the checklist question is not clear from the way the study is reported, or that the study may not have addressed all potential sources of bias for that particular aspect of study design.

− Should be reserved for those aspects of the study design in which significant sources of bias may persist.

Not reported (nr) Should be reserved for those aspects in which the study under review fails to report how they have/might have been considered.

Not applicable (na) Should be reserved for those study design aspects which are not applicable given the study design under review (for example, allocation concealment would not be applicable for case control studies).

Each study is then awarded an *overall* study quality grading:

++ (High) All or most of the checklist criteria have been fulfilled, where they have not been fulfilled the conclusions are very unlikely to alter.

+ (Medium) Some of the checklist criteria have been fulfilled, where they have not been fulfilled, or not adequately described, the conclusions are unlikely to alter.

− (Low) Few or no checklist criteria have been fulfilled and the conclusions are likely or very likely to alter.

Table 3.1: Quantitative Intervention Studies

Study ID (Refworks) number		
Study design (see attached flowchart)		CEA/CBA? Y / N
Associated papers on same intervention? Y / N		
	Rating	**Notes**
Section 1: Population		
1.1 Is the sample representative of the source population or area? Were important groups under-represented?		
1.2 Are findings generalisable to source population? Is there sufficient information to determine external validity: whether findings can be generalised beyond the study?		
Section 2: Design		
2.1 Does the study have a comparison group? Refer to study design flowchart. (randomly allocated = ++; matched control/QED = + and no comparison = -)		
2.2 Are the interventions (and comparison conditions if applicable) well described (sufficient for replication) and appropriate?		
2.3 Is the sample size sufficient to detect effects? Is power calculation given?		Indicate size:
Section 3: Outcomes		
3.1 Were outcomes relevant? Did they measure what the intervention is intended to impact?		
3.2 Were all outcomes reported on? Did they provide results for all the outcomes observed/ measured?		
3.3 Was the measurement time meaningful? Was it sufficiently long enough to detect expected effects?		
Section 4: Analyses		
4.1 Were comparison and intervention groups similar at baseline? Have any confounding factors been controlled for?		
4.2 Were all participants accounted for in the analyses? Did the study follow-up with all that started study. What was % attrition?		
4.3 Were the analyses appropriate? Were analyses pre-specified and confounders controlled? Any sub-group analysis?		Main analytical method:
Summary (tick one based on summary)		
All or most of the items are ++		
Some of the items are ++ but most are +		
Items are mostly + and/or -		
Any concerns?		

Table 3.2: Qualitative Studies

Study ID (Refworks) number		
Study design		
Associated papers on same intervention? Y / N		
	Rating	**Notes**
Section 1: Theoretical approach		
1.1 Is a qualitative approach appropriate? Could a quant. study have addressed the research question better?		
1.2 Is the study clear on what it seeks to do? Are aims given and underpinning theory discussed?		
Section 2: Design		
2.1 Is design appropriate to the question?		
2.2 Is the selection of the cases or the sampling strategy justified?		
2.3 Is the sample size appropriate given the methods?		Indicate size:
Section 3: Data collection		
3.1 Are data collection methods clearly described and appropriate to address the question(s)?		
3.2 Was the data collection and record keeping systematic? How were data stored?		
Section 4: Analyses and conclusions		
4.1 Is the data analysis sufficiently rigorous? The procedure is explicit and it is clear how themes and concepts are derived from the data.		Method:
4.2 Is the data analysis reliable? Was more than one researcher involved in coding and interpretation? How were differences resolved?		
4.3 Are findings clearly presented, appropriately references and extracts from original data included to support themes or concepts?		
4.4 Are results plausible? Is there any discussion of the limitations?		
Summary (tick one based on summary)		
All or most of the items are ++		
Some of the items are ++ but most are +		
Items are mostly + and/or -		
Any concerns?		

Appendix 4: Evidence Tables

The semi-systematic literature review used search terms outlined in Appendix 1 above. 347 papers met the inclusion where papers described services delivered. Of this, 138 papers met the inclusion for evaluation of effectiveness (evidence). Studies included in the recent NICE meta-review (2014) are not tabled here but may be referred to in the report. These papers are summarised below according to the type of violence they addressed, the type of response they comprised, and quality of the study according to criteria outlined in Appendix 3.

The main outcomes presented in the paper are summarised, with an indication of whether the study found significant evidence of impact:
(-) Indicates a non-significant or negative effect on the outcome at post-intervention test.
(+) Indicates a significant positive effect on the outcome at post-intervention test. All follow-ups are assumed to be immediately post-intervention, unless otherwise stipulated.

Reference	Type of violence	Type of response	Details of study	Quality	Impact
DOMESTIC ABUSE					
Antle et al. 2011	DA	Prevention	Within my Reach: Education and skills on healthy relationships for high-risk groups.	Low/ Medium	Physical and emotional abuse (+) Isolation behaviours (+)
Bell and Stanley 2006	DA	Prevention	Drama-based Healthy Relationships prevention programme with Year 8 students.	Low	Understanding of DV (+)
Cavanaugh et al. 2011	DA	Prevention	Psycho-educational workshop using dialectical behaviour therapy with high-risk men. Country = US	Medium	Awareness of anger management skills, empathy skills and adaptive coping skills (+)
Donovan et al. 2000	DA	Prevention	Mass media campaign aimed at potential perpetrators in Australia. Qualitative study.	Low	Understanding of message (+) Identification as a perpetrator (+)
Ekhtiari et	DA	Prevention	Health education /	Low	Preventive

Reference	Type of violence	Type of response	Details of study	Quality	Impact
al. 2012			promotion based on PRECEDE-PROCEED model		behaviours (+) at 2 month FU.
Fellmeth et al. 2013	DA	Prevention	Cochrane review of 38 studies of educational and skills-based interventions for relationship and dating violence. A meta-analysis of 33 studies.	High	No evidence of effect on episodes of relationship, attitudes, behaviour and skills related to relationship violence (-). Small but significant increase in knowledge (+).
Foshee et al. 2000	DA	Prevention	Safe Dates, school-based relationship programme. An RCT in 10 schools. Country = US	High	Reduction of perpetration and victimisation (+) at 1-month post intervention. At 1 year, cognitive effects (+) but behavioural effects (-)
Foshee et al. 2004	DA	Prevention	Long-term effects of Safe Dates and testing the benefits of providing students with a booster (newsletter and contact with health educator).	High	At 4 year FU, impact on experience of physical, serious physical and sexual dating violence perpetration and victimisation (+) Booster did not increase effects (-)
Finn and Atkinson 2009	DA	Prevention	Technology safety education for victims of IPV	Low	Computer safety confidence and knowledge (+)
Niolon et al. 2009 Feder et al. 2011	DA	Prevention	Enhanced Nurse Family Partnership. Home visiting programme tailored to prevent IPV.	High	Results in press. Psychological violence perpetration (+) and re-victimisation (+) but only for those with no prior exp. Targeted victim/ perpetrator outcomes (-)
Wolfe et al. 2009	DA	Prevention	Cluster-RCT of school-based relationship programme called	High	At 2.5 year FU, reduced dating violence (+) relative to

Reference	Type of violence	Type of response	Details of study	Quality	Impact
			Fourth R. 21 lessons delivered by teachers.		controls, especially for boys. Cost CA$16/student.
Bacchus et al. 2010	DA	IRR and protection	Qualitative study of domestic violence intervention in maternity and sexual health services, incl. guidelines, staff training, routine enquiry and advocacy. Country = UK	Medium	Maternity and sexual health services good intervention points. Majority of women who received advocacy left abuser. Post-separation service needed to avoid return. Training led to improved knowledge and practice in staff
Baird et al. 2005	DA	IRR	Qualitative study of pregnancy and DV programme supporting routine antenatal enquiry Country = UK	Low	More systematic approach to teaching needed, and inter-professional training.
Bullock et al. 2006	DA	IRR	Nursing case management intervention on mental and physical well-being of pregnant women at risk of abuse. Private ad Medicaid patients evaluated. Country = US	Low/ Medium	Incidence of reporting abuse higher in Medicaid-funded women than privately-funded. Overall low rate of disclosure achieved.
O'Campo et al. 2011	DA	IRR	Systematic review of universal screening programmes in health care settings	High	Comprehensive approaches led to IPV identification Self-efficacy associated w. institutional support, effective protocols, training and immediate referrals to support.
Chen et al. 2007	DA	IRR	Three screening methods tested: self-administered screening, medical staff interview and	High	Disclosure rates, patient and GP comfort, and time spent screening similar for all 3 methods.

Reference	Type of violence	Type of response	Details of study	Quality	Impact
			physician interview. Country = US		
Datner et al. 2004	DA	IRR	Universal screening in emergency departments using standard protocol. Country = US	Medium/ High	Identification of victims (+) Referral and/or offer of services(-)
Devine et al. 2012	DA	IRR	Cost-effectiveness of identification and referral to improve safety (IRIS), a DV training and support programme for primary care. A modelling study based on an RCT. Country = UK	High	Cost savings of £37/women per year, as well as improved quality-adjusted life year of 0.001/women.
Ejaz et al. 2001	DA (Elder)	IRR	Screening and referral protocols on elder abuse and domestic violence. Survey of 160 practitioners.	Low	Protocols were revised to be simpler, less lengthy and more relevant.
Ernst et al. 2012	DA	IRR	Validation of screening tool in emergency departments for perpetrators of IPV Country = US	Low	Validated three-question screening tool to identified perpetrators.
Falk et al. 2002	DA	IRR	Screening in the workplace using an employee assistance programme (EAP).	Low rele-vance to Welsh context	Identification (+) Referrals to specialist services (-)
Florence et al. 2011	DA	IRR	Evaluation of a co-ordinated approach between health, police, and local gov. preventing violence-related injury. Cardiff Violence Prevention	High	Reduction in admissions related to violence (+) Increase in recording of minor assaults (+)

Reference	Type of violence	Type of response	Details of study	Quality	Impact
			Programme (CVPP) Country = Wales		
Florence et al. 2013	DA	IRR	Economic evaluation of the CVPP evaluating its cost effectiveness. Country = Wales	High	£82 benefit for every £1 spent. Benefit-cost ratio of 14.80 for health service and 19.1 for the criminal justice system
Hewitt et al. 2011	DA	IRR	Targeted screening by nurses using unscripted questions versus a protocol linked to alcohol screening tool (SBIRT) Country = US	Medium	Linking IPV screening to alcohol screen is better at detecting IPV than unscripted nurse questions.
Kataoka et al. 2010	DA	IRR	Testing method of screening: Face to face interview versus self-administered questionnaires. Country = Japan	High	Identification rate in self-administered questionnaire sig. greater than interview (+)
Koziol-McLain et al. 2010	DA	IRR	Screening in emergency departments Country = New Zealand	High	Short-term violence exposure (-)
Kraanen et al. 2013	DA	IRR	Targeted screening tool (J-IPV) for identifying IPV with substance abuse. 4 items – takes 2 minutes.	Medium	Tool has good psychometric properties to detect perpetrators and victims.
Krasnoff and Moscati 2002	DA	IRR	Targeted intervention in emergency departments, incl. screening, on-site advocacy and telephone counselling. Country = US	Medium/ Low	84% agreed to speak to advocate, 54% agreed to case management. Almost half of these left abuser.
MacMillan et al. 2006	DA	IRR	Trial of 3 screening approaches: self-administered,	High	Face to face least preferred. But no differences in rates of detection

Reference	Type of violence	Type of response	Details of study	Quality	Impact
			computer-based, and face-to-face screening. In health care settings. Country =Canada		in 3 methods.
MacMillan et al. 2009	DA	IRR	RCT of universal screening in health care settings Country = Canada	Medium	Not sufficient evidence to support universal screening in health care settings (-).
Paluzzi et al. 2000	DA	IRR	Nationwide DV education project, encouraging universal antenatal screening for DV. Country = US	Medium/ Low	Cautious results in knowledge, attitudes and clinical behaviour after training at 6 and 12 months
Spangaro et al. 2010	DA	IRR	Screening for DA via antenatal and substance abuse services. Country = Australia	Medium	Lower rate of current abuse at 6 month FU (+) Attitudes towards abuse (+)
Taft et al. 2013a	DA	IRR	Cochrane systematic review of 11 universal screening studies for IPV in healthcare settings.	High	No evidence to justify universal screening in health care settings (-).
Trabold 2007	DA	IRR	Systematic review of studies of screening in health care	High	Identification of IPV (+) No causal link established for screening and increased safety practices or decreased violence.
Bennett and Vincent 2001	DA	Protection	Standards for batterer programmes	Low	Improved structure for programmes, better collaboration and increased judicial confidence.
Bowen 2010	DA	Protection	Duluth (male) perpetrator programme – testing different	Low/ Medium	Leader style (+) Group organisation (+)

Reference	Type of violence	Type of response	Details of study	Quality	Impact
			formats.		
Buttell 2001	DA	Protection	Standard CBT group treatment for perpetrators (mandatory)	Low	Moral reasoning (-)
Bybee and Sullivan 2005	DA	Protection	Short-term advocacy following exit from shelters	Medium	Re-victimisation (+) at 2 years but not significant at 3 years post-intervention.
Carney and Buttell 2004	DA	Protection	Treatment programme for female batterers (mandatory)	Low	
Gillum et al. 2009	DA	Protection	Health clinic counselling programme promoting safety-behaviours	Low/ Medium	Safety-promoting behaviours (+)
Gondolf 2000	DA	Protection	Male perpetrator programmes (mandatory) with range of formats	Medium	Re-assault (+)
Laisser et al. 2011	DA	Protection	Study of new IPV screening in hospital. Observed 7 professionals screening 102 women. Focus groups with 21 professionals Country = Tanzania	Medium	Screening is feasible in LIC setting but raises ethical dilemmas if resources are not there to provide help to identified victims.
Loeffler et al. 2010	DA	Protection	Perpetrators treatment –shame transformation	Low	Self-esteem (+) Empathic concern (+), Locus of control (-) Perspective taking (-), Personal distress (-)
McFarlane et al. 2002	DA	Protection	Telephone counselling intervention providing education on safety behaviours	Medium	Safety-behaviours (+) at 3 and 6 month FU.
McFarlane et al. 2006	DA	Protection	2-arm RCT in clinical setting testing wallet size referral card and 20-minute nurse	High	Less violence and threats (+), lower risk of homicide & wok harassment (+). No differences

Reference	Type of violence	Type of response	Details of study	Quality	Impact
			interview Followed up after 2 years.		in use of community resources. Declined over time for both groups.
Miller et al. 2011	DA	Protection	Enhanced screening and behavioural strategies using trained family planning counsellors	Medium	Pregnancy coercion (+) Relationship status (+)
Mills et al. 2013	DA	Protection	Circles of Peace: Restorative justice perpetrator programme (mandatory)	High	Recidivism (+) at 12 month FU but not significant at 24 months. DV re-arrests (-)
Sullivan 2003	DA	Protection	ESID model of victim advocacy using paraprofessionals.	Medium	Violence/abuse (+) Social support (+) Quality of life (+)
Taft et al. 2013b	DA	Protection	Group CBT for perpetrators in military populations	Low	Physical and psychological IPV (+) at 6 month FU.
Tiwari et al. 2005	DA	Protection	RCT of empowerment training for abused pregnant women in Hong Kong. Country = China	Medium	Physical functioning (+) Less psychological and minor physical abuse (+) Post-natal depression (+) Sexual and severe violence (-)
Tiwari et al. 2012	DA	Protection	RCT of community-based empowerment and advocacy for abused women – (Chinese population)	Medium	Safety-promoting behaviours (+) at 9-month FU.
Walker 2013	DA	Protection	Female perpetrator programme (voluntary). Qualitative study.	Medium	Positive impact on connections formed, anger management and emotions (+). But some participants still holding a world view of power and control
Brownell	DA (elder	Recovery	Psycho-	Low	No significant

Reference	Type of violence	Type of response	Details of study	Quality	Impact
and Heiser 2006	abuse)		educational support groups for older women		changes on any outcomes measures
Chronister and McWhirter 2006	DA	Recovery	Group career counselling interventions. The first contains 5 most effective components of career interventions. The second includes empowerment for self-protection.	Medium	Self-efficacy (+) Critical consciousness (+)
Constantino et al. 2005	DA	Recovery	Social support intervention (SSI) within shelters. An 8-week, 90-minutes/week programme led by a trained nurse. Country = US	Medium	Distress (+) and belonging (+). Reduced use of health services (+)
Johnson et al. 2011	DA	Recovery	HOPE model – Helping to Overcome PTSD through Empowerment. CBT for PTSD in shelters.	High	Re-abuse (+) PTSD diagnosis(-) Depression (+) Empowerment (+) Social support (+)
Kaslow et al. 2010	DA	Recovery	Empowerment psycho-educational group therapy for abused, suicidal women. Culturally informed model for African American women.	High	Depressive symptoms (+ and distress (+) PTSD (-) Suicidal ideation(-)
McNamara et al. 2008	DA	Recovery	Short-term individual counselling within shelters Country = US	Low	Life functioning and coping (+)
Thomas et al. 2005	DA	Recovery	Tele-psychiatry programme providing screening, evaluation, treatment and referral for care for victims in rural areas.	Low	31 out of 38 women contacted were diagnosed with disorder and received treatment.

Reference	Type of violence	Type of response	Details of study	Quality	Impact
			Country = US		
Brackley 2008	DA	Co-ordination (training)	Safe Family Project: staff development programme training nurses and other hospital staff in knowledge, attitudes and skills to respond to DV.	Low	Patient satisfaction (+) Improved documentation and referral (+)
Korenstein et al. 2003	DA	Co-ordination (training)	Education programme for internal medicine residents. 3 hour seminar followed by screening for 2 weeks and follow-up discussion. Country = US	Low	54% of residents correctly identified DV in at least 2 out of 3 cases, cf. 20% in controls.
McLaren et al. 2010	DA	Co-ordination (training)	Initiative to increase skills and confidence of hairdressers to act as a resource and referral for family violence. Country = Australia	Low	Self-confidence to respond (+)
Papadakaki et al. 2013	DA	Co-ordination (training)	Intensive IPV training programme offered to GPs and residents. Country = Greece	Low	Perceived preparedness (+) and perceived knowledge (+) at 12 month FU. No improvements in detection of IPV.
Salmon et al. 2006	DA	Co-ordination (training)	Educational programme training midwives to conduct routine antenatal enquiries for domestic violence. Feasibility study. Country = UK	Medium	Programme well received. Improvements in knowledge, attitudes and efficacy (+), declining but still sig. at 6 month FU.
Short et al. 2006	DA	Co-ordination (training)	Online CPD education of GPs in management of IPV Country = US	Medium	Improvement on 8 out 10 outcomes, including self-efficacy and reported IPV management

Reference	Type of violence	Type of response	Details of study	Quality	Impact
					practices (+)
Zachary et al. 2002	DA	Co-ordination (training)	Multifaceted system of care to improve recognition and management of DV in pregnant women, incl. training for medical providers and DV protocol. Feasibility study. Country = US	Low	Self-efficacy to respond (+) Protocols rarely used but good use of DV coordinator to enhance practice.
Bennett and O'Brien 2007	DA	Co-ordination	A coordinated service for drug-abusing women who are victims of IPV. Country = US	Medium	Frequency of substance use (+) Self-efficacy (+) Fearful of DV consequences (-)
Edwardsen et al. 2004	DA	Co-ordination	Multimodal educational outreach with physicians to improve screening and documentation of IPV.	Low	Improved screening and documentation (+)
Gadomski et al. 2001	DA	Co-ordination	Multi-faceted intervention in health, involving training for health care professionals and dissemination of clinical protocol.	Low	Nine of 13 scales show increase (+) including screening, referrals and victim understanding.
Klevens et al. 2008	DA	Co-ordination	Review of Coordinated Community Responses (CCRs) across 10 sites.	Low	No overall impact of CCRs on exposure to IPV(-) or contact with services (-). Specific components were significant in certain sites – variation in quality of delivery.
Salazar et al. 2007	DA	Co-ordination	Coordinated Community Response (CCR) to DV Country = US	Low/ Medium	Arrests of male offenders (+) Increase in sentencing to attend batterer programme (+)

Reference	Type of violence	Type of response	Details of study	Quality	Impact
Short et al. 2002	DA	Co-ordination	WomenKind Programme – an integrated model of 24-hour health care response to domestic violence.	Low	Improved knowledge, attitudes, beliefs and behaviours of hospital staff and advocates (+)
FGM, FORCED MARRIAGE AND SEX-TRAFFICKING/PROSTITUTION					
Asekun-Olarinmoye and Amusan 2008	FGM	Prevention	Health Education sessions conducted daily over 10 days – Country = Nigeria	Medium	Reduction in positive attitude towards FGM (+) Increase in % (of men) who are opposed to the practice (+)
Babalola et al. 2006	FGM	Prevention	Community capacity strengthening called Community Action Cycle (CAC), Mass media and targeted advocacy activities. Country = Nigeria	High	FGM-related attitudes (+) and intentions not to use FGM on daughters (+)
Berg and Denison 2012	FGM	Prevention	Systematic review of interventions designed to prevent FGM. 3 types of service identified: empowerment; education and community activities.	High	All 8 studies included were of low quality (by review criteria). Only 2 were in published lit. The studies show limited effectiveness but suggest that interventions may be promising when they are tailored to local context.
Monkman et al. 2007	FGM	Prevention	Village empowerment programme focused on knowledge acquisition and critical awareness raising	Low/ Medium	Transition is facilitated where issues are communicated in ways that resonate with local understanding, e.g. as a cultural practice and

Reference	Type of violence	Type of response	Details of study	Quality	Impact
			Country = Mali		framed in relation to health and human rights.
Balogun et al. 2013	FGM	Recovery	Cochrane systematic review of interventions for improving outcomes for pregnant woman who have FGM	High	No studies found meeting the criteria for inclusion. Authors conclude that most research has looked at consequence of FGM, and intervention research typically case studies. FGM may not suit experimental evaluation (ethics).
Baird et al. 2010	FM	Prevention	Conditional Cash Transfer	Low rele-vance to Wales context	Declines in early marriage, teenage pregnancy, and self-reported sexual activity (+)
Erulkar and Muthengi 2009	FM	Prevention	Female mentors; support for education	Low rele-vance Rural Ethiopian context	Girls' school enrollment, age at marriage, reproductive health knowledge and contraceptive use (+)
Harcourt et al. 2010	Sex-trafficking	Prevention	Evaluation of decriminalising sex work and impact on health of sex workers. Country= Australia	Medium	Better health care in all three areas resulting from licensed brothels but adverse impact on unlicensed brothels where trafficked women were employed and less able to access peer or health support.
Arnold et al. 2000	Sex-trafficking	Protection	Qualitative research with 10 sex workers on experiences of outreach service	Low	Women do not see them-selves as ‘victims’, concerns about getting back their children; problem of glamorising prostitution,

Reference	Type of violence	Type of response	Details of study	Quality	Impact
					challenge of rehabilitation into other employment if women know they earn more in prostitution, difficulty engaging with women on the streets.
Ford et al. 2002	Sex-trafficking	Protection	Evaluation of intervention for sex workers in Bali involving 600 female sex workers at a clinic who had behavioural surveys and 6 monthly STD checks for 4 rounds data collection Country = Bali	Medium	Knowledge about AIDS and STDs (+), Reduction in some bacterial STDs (+)
Sherman et al. 2006	Sex trafficking	Protection	Economic enhancement through making and selling jewellery. HIV education. Country = US	Low	Median sex contacts/month (+) Drug use and use of condoms (+)
Wortley et al. 2002	Sex trafficking	Protection	Evaluation survey of 'John School' Diversion programme in prisons for men convicted for using prostitutes. Alternative sentencing - given education programme on social harms of sex-trade. Country = Canada	Medium	Found positive shifts in attitudes (+) and identification of addiction (+) but not in intent to use prostitutes in future (especially among 'veteran' sex trade users)
Roe-Sepowitz et al. 2011	Sex-trafficking	Recovery	Prostitution diversion programme evaluation of risk factors associated with re- arrest of women	Medium/ Low	Found risks for re arrest were physical abuse as child, drug and alcohol problems and not completing

Reference	Type of violence	Type of response	Details of study	Quality	Impact
					diversion programme
SEXUAL VIOLENCE, INCLUDING SEXUAL ASSAULT AND RAPE					
Foubert and La Voy 2000	SV (rape)	Prevention	Educational intervention "the Men's Program" for college men. A one-time, 1-hour programme. 4 male presenters. Qualitative study looking at attitudes and behaviour. Country = US	High/ Medium	Over half of participants felt programme had lasting impact on attitudes and/or behaviour. Those that reported no change said that it was because they already agreed with programme's message.
Foubert and Perry 2007	SV (rape)	Prevention	Empathy-based rape prevention programme with college men and athletes. Qualitative study with 24 men.	Low	Participants reported attitude changes and behaviour change.
Orchowski et al. 2008	SV	Prevention & Recovery	Prospective evaluation of SV risk reduction programme on college women compared 234 women with programme with 266 without looking at impact on attitudes and also wellbeing of those sexually assaulted after programme.	Medium	Lower levels of self blame if sexually assaulted (+) More protective behaviours at 6 months FU (+)
Campbell et al. 2004	SV	Prevention & Protection	Study of setting up model to teach SV prevention and protection services how to evaluate their service using 'empowerment evaluation methods' Country = US	Medium	From 1977 to 1999 success implementation of evaluation model, continued state funding in 8 out of 10 services and 20 out of 24 victim protect services. Evaluation model does not show if responses to victims were good.

Reference	Type of violence	Type of response	Details of study	Quality	Impact
Ahrens et al. 2011	SV	Prevention	Sexual assault drama programme, including skills development and bystander intervention. Country = US	Medium	Mixed outcome on perceived benefits of intervening: no sense of personal benefit. Mixed effects on likelihood of intervening: some level off while others increase over time.
Amar et al. 2012	SV	Prevention	Bystander programme impacting community norms Country = US	Low	Significant effect on rape myth accept., denial, intention to help and taking responsibility (+).
Banyard et al. 2009	SV	Prevention	Pre and post test of SV bystander training programme on 196 university students in USA	Low	Increased confidence in ability to implement bystander programme.
Barger et al. 2009	SV	Prevention	Review of educational interventions for learning disabled women.	Medium/ Low	Review of literature found < 100 articles about topic. Most not evaluated. Suggests service design in this area needs to draw on what is known to work generally, i.e. be comprehensive, intensive, theoretically based and tailored.
Barone et al. 2007	SV	Prevention	Qualitative study based on 4 focus groups with 28 men on college rape prevention programme	High	Good descriptions on how men saw the impact, relating this to theories of masculinity
Brecklin 2008	SV	Prevention	Systematic literature review of self defence studies for women	High	Mixed results but mostly positive. Measures mostly attitudinal. Need longitudinal studies to look at impact on risks.

Reference	Type of violence	Type of response	Details of study	Quality	Impact
Brecklin and Forde 2001	SV	Prevention	Meta analysis of 45 studies on college student rape prevention education programmes	High	Change in pro rape attitudes (+). Effects decline with time; men in single sex groups have better outcomes than men in mixed gender groups.
Clinton-Sherrod et al. 2009	SV	Prevention	Factors affecting educational interventions success. Review of 4 school-based SV interventions, incl. MOST, Safe Place, SURGE and MOCSA	Medium	Significant effect on positive attitudes, beliefs and behaviour for sexual harassment and personal boundaries (+). Greater increases found for larger, mixed-gender groups.
Edwards 2009	SV	Prevention	Psycho-educational, multi-media sexual assault prevention using a social change approach. Country = US	Medium control = alternate program	Rape myth and definitions (+) for both interventions at 3 month FU. Change greatest for this intervention on definitions of rape and SA.
Gidycz et al. 2001	SV	Prevention	Risk reduction programme for college women. Country = US	Medium	No differences between groups at follow-up on any outcomes but those in programme who were victimised were less likely to be victimised at 6-months.
Gidycz et al. 2011	SV	Prevention	Social norms and bystander intervention programme with college men. 635 men. Country = US	High/ Medium	Self-reported sexual aggression (+), associations with sexually aggressive peers and (+) less exposure to sexually explicit media (+). Effects were moderated by being a SA offender

Reference	Type of violence	Type of response	Details of study	Quality	Impact
					previously – greater gain.
Kernsmith and Hernandz-Jozefowicz 2010	SV	Prevention	Peer education programme for sexual assault in schools	Low (High attrition)	Attitudes and beliefs (+), moderated by higher rates of school connectedness.
Lonsway and Kothari 2000	SV	Prevention	1st year university campus rape education 76 with education compared with 67 without 93 who attended education4-6 months earlier compared with 77 without Country = USA	Medium	Immediate impact on rape beliefs (+) maintained for 7 weeks. Increased support for rape prevention (+) after 4- 6 months FU, especially students who had more than one education programme.
Marx et al. 2001	SV	Prevention	Assault resistance programme – preventing re-victimisation Country = US	Medium	SV re-victimisation (+) Improved well-being and self-efficacy (+)
Moor 2011	SV	Prevention	Pre-post test prevention of pro rape attitudes among 378 16 -18 year old school children. Country = Israel	Low	Positive shifts in attitudes in many areas of pro rape beliefs apart from boys' use of porn-ography.
Moynihan and Banyard 2008	SV	Prevention	Bystander prevention programme with >100 athletes and Greek students. Country = US	Low	Attitudes and self-efficacy (+). Some groups may require a higher dose.
O'Donohue et al. 2003	SV	Prevention	Video-based prevention programme. Pre and post test of pro rape attitudes male under-graduates. Country = US	Medium	Rape myth acceptance (+) Attitudes towards IPV (+), Adversarial sexual beliefs (+), Rape empathy (+)
Potter and Stapleton 2011	SV	Prevention	Bystander programme with military personnel. Country = US	Low	Awareness of role and sense of responsibility (+)

Reference	Type of violence	Type of response	Details of study	Quality	Impact
Potter et al. 2009	SV	Prevention	Bystander programme – poster campaign in one University in US.	Low	Increase awareness in knowledge of pro-social bystander behaviours and willingness to intervene (+).
Potter et al. 2011	SV	Prevention	Bystander programme with military personnel. Country = US	Low	Reported bystander actions (+) Suggestion that schools programme can be adapted for military pop.
Rau et al. 2011	SV	Prevention	Psycho-educational intervention with Navy personnel. Country = US	High	Factual knowledge about rape (+) Empathy with victims (+) Reduction in rape myth acceptance (-).
Rowe et al. 2012	SV	Prevention	RCT of the DATE programme, an assertiveness training to prevent sexual assault. Country = US	High	Women in the intervention group were sig. less likely to be victimised (+). Assertive responses (+).
Senn 2013	SV	Prevention	Assault resistance programme	Low	Belief and attitudes towards risk of acquaintance rape (+) and self-efficacy in self-defence (+).
Shultz et al. 2000	SV	Prevention	Education to reduce pro-rape attitudes among 60 volunteer college students	Low	Decline in pro rape attitudes (+)
Stephens and George 2009	SV	Prevention	146 college men randomly assigned to control or rape prevention programme to test impact on pro rape attitudes pre and post programme with 5 week follow up	Medium	High-risk men unaffected. Low risk only retained positive results on rape myth acceptance and victim empathy (+), Not attraction to sexual aggression or rape intent (-)
Testa et al.	SV	Prevention	Longitudinal RCT	High	Lower rates of

Reference	Type of violence	Type of response	Details of study	Quality	Impact
2010			of Parent based interviews (PBIs) to prevent SV to college women. Country = US		alcohol related sexual victimisation in first year at college (+)
Webster et al. 2005	SV	Prevention	Prison-based sex offender treatment programme where role play was added to programme as method to enhance victim empathy.	High/ Medium	Some impact on victim empathy (+) but more limited than expected
Wasco et al. 2004	SV	Protection & recovery	Evaluation of statewide rape services covering helpline, crisis and counselling services Country = US	Medium/ Low	Many service users (up to a quarter) too upset to complete evaluations. Different methods used to evaluate different areas of service. 259 hotline callers, most felt needs met. 231 women used counselling services and 76 matched back to initial intake interviews to assess change in wellbeing (+)
Kenworthy et al. 2004	SV	Protection	Cochrane systematic review of interventions for sexual offenders. Three types of service identified: CBT; behavioural interventions and psychodynamic.	High	Included 10 studies with data on 944 adult males. Trials on CBT showed no impact on reconviction rates. Some encouraging support for behavioural interventions and psychodynamic interventions (over std. probation). More RCTs needed.
Clinton-Sherrod et	SV	Protection	Motivational interviewing, with	Medium	Reduced alcohol use for MI and

Reference	Type of violence	Type of response	Details of study	Quality	Impact
al. 2011			(MIF) and without (MI) feedback women to prevent sexual violence in the context of incapacitation. Country = US		MIF (+) Reduced violence for MIF but NOT due to reduced alcohol use.
Finn et al. 2011	SV	Protection	Evaluation of SV helpline based on user survey after call (4609 or 23% of users) and 731feedback forms completed after calls by 54 helpline volunteers	Low	Found volunteers and service users surveyed rated helpline positively but no follow up impact measures covered and no controls.
Fitzpatrick et al. 2012	SV	Protection	Use of simulation methods to train SV forensic examiners. 17 assessed. Country = US	Low	Competence (+) Knowledge (+)
Janssen et al. 2009	SV	Protection	Impact of mobile access van on women sex worker's safety. Country = Canada	Low	Found 90% women felt safer
Johnston 2005	SV	Protection	Survey on implementation of SV integrated health response model. Measured SART indicators via survey of 25 SART implementers and retrospective review of 17 female victim responses.	Low	Found positive features from SART implementation on victims, incl. increased screening, better drug treatment but also some concerns – lack of case review and case tracking means hard to evaluate outcomes. Poor documentation Few victims opted to have follow-up counselling.
O'Reilly et al. 2010	SV	Protection	CBT for prison-based sexual offenders. 10-month programme involving three 2-	Medium	Improvement on some cognitive distortions, empathy, interpersonal

Reference	Type of violence	Type of response	Details of study	Quality	Impact
			hour group sessions/week.		skills, self-regulation (+)
Barber 2000	SV	Recovery	Therapy for women sexually assaulted with learning difficulties. Country = UK	Low	Self-esteem, anxiety, depression and assertiveness immediately (+) not sustained at 3 month FU.
Billette et al. 2008	SV	Recovery	CBT for PTSD with additional component of partner support and couple relationship work. Sample of 3 people. Country = Canada	Low	PTSD (+) Satisfaction with support strong.
Krakow et al. 2001	SV	Recovery	RCT of self selected sexual violence victims with PTSD to nightmare reduction treatment versus wait to treat response	Medium	Reduced nightmares and better quality sleep (+) PTSD symptoms(+)
Resick et al. 2012	SV (rape)	Recovery	Long-term follow up 5 to 10 years of CBT on PTSD symptoms with severe exposure. 171 SV victims	High	Found sustained decreases in PTSD symptoms after treatment (+)
Sobel et al. 2009	SV (rape)	Recovery	Part of larger RCT Testing Cognitive Processing Therapy (CPT) with 37 rape victims	Medium	Found positive impact on unhelpful beliefs about the rape (+) that may be linked with recovery.
Tarquinio et al. 2012a	SV (rape)	Recovery	Early (within 72 hours) EMDR for PTSD in rape victims (not necessarily intimate partner).	Medium	Positive impact on PTSD symptoms, which are stable over time.
Tarquinio et al. 2012b	SV (rape)	Recovery	EMDR for PTSD in cases of intimate partner rape. Victims within an 8-12 weeks period of the assault. No	Medium/ Low	Small sample with only immediate post-test. Impact on PTSD symptoms (+).

Reference	Type of violence	Type of response	Details of study	Quality	Impact
			other complex needs.		
Greeson and Campbell 2013	SV	Co-ordination	Sexual Assault Response Teams (SARTs) – an empirical review of effectiveness. Community-level intervention to increase collaboration between service responders. Country = US	Medium	Improved help-seeking, communication and response (+) Identifies various barriers to implementation.
COMBINED VIOLENCE					
Keleher and Franklin 2008	Combined	Prevention	A review of the evidence in changing gender norms about women and girls at level of household and community. Community strategies. Country=developing countries	Medium	Little evaluation of change but targeting is 'sound investment'. Outcomes dependent on integrated approaches and policy/ legislative actions.
Pronyk et al. 2006	Combined	Prevention	Structural (social and economic development) to prevent IPV in SA	Medium - High	Violence experience (+) Unprotected sex (-)
Moynihan et al. 2010	Combined SV & DA	Prevention	Bystander programme with college athletes. "Bringing in the Bystander"	Medium	Confidence and intention to act (+) Attitudes related to SV (+), with no negative side effects.
Conway et al. 2010	Combined SV & DA	Prevention	Study of 3 community prevention programmes and factors that influenced implementation success of first step in creating an assessment of needs and resources in the	Medium	Factors that influenced success in implementation were readiness of community to change; personnel; organisational support; strong community coalitions; having

Reference	Type of violence	Type of response	Details of study	Quality	Impact
			community		clear conceptual /theory driven framework; national support for work.
Sampsel et al. 2009	Combined SV and DA	Protection	Emergency dept. case analysis pre and post introduction of new specialist SVDV nurse system Country = Canada	Low	Found increase in cases detected and improved patient care (+)
Fallot et al. 2011	Combined SV & DA	Recovery	QED study of trauma empowerment model of recovery (TREM) compared with usual support given to SV and IPV victims in USA	Medium	Reduction in alcohol and drug abuse severity (+), anxiety symptoms (+) and increase in perceived personal safety (+). PTSD, global mental health, exposure to abuse and QoL (-)

Appendix 5: Landscape of Service Provision in Wales Table 5.1

		North Wales Isle of Anglesey Conwy Denbighshire Flintshire Wrexham Gwynedd	Mid and West Ceredigion Carmarthenshire Pembrokeshire Powys	Western Bay Swansea Neath Port Talbot Bridgend	Cwm Taf Rhondda Cynon Taff Merthyr Tydfil	Cardiff and Vale The Vale of Glamorgan Cardiff	Gwent Blaenau Gwent Monmouthshire Caerphilly Torfaen Newport	Typology of Service Responses
Domestic Abuse	Women's Aid (WA)	Aberconwy Domestic Abuse Services (Llandudno) Anglesey Domestic Abuse Service (Gorwel) WA Bangor (and District) WA Colwyn WA Deeside Domestic Abuse Safety Unit (DASU) De Gwynedd (Blaenau Ffestiniog) WA Delyn (Holywell) WA Glyndwr (Denbigh) WA North Denbighshire Domestic Abuse Service (Rhyl) Wrexham WA	Brecknock WA Carmarthen WA Llanelli WA West Wales (Aberystwyth, Cardigan) WA	Amman Valley (Ammanford) WA Bridgend WA Calan Domestic Violence Service Port Talbot & Afan WA Swansea WA	LLamau Ltd Merthyr Women's Services Women's Aid RCT	Atal Y Fro WA Cardiff DVS Cardiff WA	Newport WA Torfaen WA WAIMON (Monmouthshire, Abergavenny) WA	✓ Identification & Referral ✓ Protection (victim safety) ✓ Protection (stopping perpetrators) ✓ Recovery & Reintegration ✓ Coordination of Responses & Training
	Domestic Abuse Services	Anglesey Domestic Abuse Service (Gorwel) De Gwynedd Domestic Abuse Services Domestic Abuse Safety Unit	Carmarthenshire Independent Domestic Abuse Advocacy Service Ceredigion Domestic Abuse Forum Montgomeryshire Family Crisis Centre	Neath Port Talbot Domestic Abuse Forum Neath Port Talbot Domestic Abuse Strategy Group Neath Port Talbot Domestic Abuse		BAWSO Ltd The Dyn Project Freedom Programme Men's Helpline Co-ordinator	Blaenau Gwent Domestic Abuse Services (BGDAS) (covers Blaenau Gwent and Caerphilly) Monmouthshire DA & SV Coordinator	

	DV & SV Coordinator DV & SV Forum		Forum Swansea Independent Domestic Violence Advocacy Project (SIDVAP) Swansea Women's Centre			Monmouthshire Domestic Abuse Forum	
DAC	Wrexham DAC Anglesey DAC Conwy DAC Denbighshire DAC (shared post with Conwy) Gwynedd DAC (shared post with Anglesey) Flintshire DAC	Ceredigion DAC Powys DAC Pembrokeshire DAC	Ammanford County DAC Bridgend DAC Swansea DAC Neath Port Talbot DAC Ammanford DAC	Merthyr Tydfil DAC	Cardiff DAC Pontypridd DAC Vale of Glamorgan DAC (no DAC in post)	Caerphilly DAC (no DAC in post) Monmouthshire DAC Newport DAC Pontypool DAC Torfaen DAC	✓ Coordination of Responses & Training
IDVA[31]	Conwy IDVA Denbighshire IDVA Flintshire IDVA Gorwel IDVA Gwynedd IDVA Wrexham IDVA Ynys Mon IDVA	Carmarthenshire IDVA Ceredigion IDVA Pembrokeshire IDVA Powys IDVA West Wales (Cardigan) IDVA	Bridgend IDVA Neath Port Talbot IDVA Swansea IDVA Port Talbot and Afan IDVA	Merthyr Tydfil IDVA Rhondda Cynon Taff IDVA	Cardiff IDVA Vale of Glamorgan IDVA Cardiff IDVA	Blaenau Gwent IDVA Caerphilly IDVA Monmouthshire IDVA Newport IDVA Torfaen IDVA	✓ Protection (victim safety) ✓ Coordination of Responses & Training
MARAC	Anglesey and Gwynedd MARAC Conwy and Denbighshire MARAC Flintshire and Wrexham MARAC	Carmarthenshire MARAC Ceredigion MARAC North and South Powys MARAC Pembrokeshire MARAC	Swansea and Neath Port Talbot MARAC	Merthyr Tydfil and Rhondda MARAC Cynon Taff MARAC	Cardiff MARAC Vale of Glamorgan and Bridgend MARAC	Gwent MARAC Blaenau Gwent Domestic Abuse Services, Caerphilly MARAC	✓ Identification & Referral ✓ Protection (victim safety) ✓ Coordination of Responses & Training
One-Stop-Shop (OSS)	Anglesey OSS (plus mobile bus for rural areas) Conwy OSS Denbighshire OSS Flintshire OSS Gwynedd OSS Wrexham OSS	Carmarthen OSS Ceredigion OSS [Pembrokeshire OSS being developed but not completed and no service provider allocated]	Neath Port Talbot OSS Swansea OSS	Merthyr Tydfil OSS Rhondda Cynon Taf OSS	Cardiff OSS Vale of Glamorgan OSS	Blaenau Gwent OSS Caerphilly OSS Monmouthshire OSS Newport OSS Torfaen OSS	✓ Identification & Referral ✓ Protection (victim safety) ✓ Protection (stopping perpetrators) ✓ Recovery & Reintegration ✓ Coordination

[31] Some areas have more than one IDVA with both full time and part time posts.

							of Responses & Training
Refuge	Aberconwy Refuge Bangor and District Refuge Colwyn Refuge De Gwynedd Refuge Delyn Refuge Deeside Refuge Glyndwr Refuge Gorwel Refuge Hafan Cymru Wrexham Refuge North Denbighshire Domestic Abuse Refuge Wrexham Refuge Wrexham Refuge – Bawso Ltd. Wrexham Refuge for Trafficked Women – Bawso Ltd.	Brecknock Refuge Carmarthen Refuge Llanelli Refuge Montgomery Family Crisis Centre offers a 'female safe house' and a 'male safe house' Pembrokeshire Women's Refuge Radnorshire Refuge West Wales (Cardigan) Refuge	Amman Valley Refuge Bridgend Refuge Calan Refuge Port Talbot and Afan Refuge Swansea Refuge Swansea Refuge Bawso Ltd.	Cwm Cynon Refuge Merthyr Refuge	Atal Y Fro Refuge Cardiff Refuge (and 2nd stage refuge) Cardiff Bawso Ltd. refuge Cardiff Men's Refuge Pontypridd Refuge	Blaenau Gwent Refuge Caerphilly Refuge Monmouthshire Refuge Newport Refuge Newport Refuge Bawso Ltd. Torfaen Refuge	✓ Protection (victim safety) ✓ Recovery & Reintegration
Perpetrator Programmes	Choose 2 Change, Relate Cymru – Colwyn Bay, Bangor, Wrexham (Respect accredited) Caring Dads programme (Conwy) Caring Dads programme (Wrexham)	Carmarthenshire Domestic Violence Abuse Forum programme on Perpetrators in Ammanford (Respect accredited) Carmarthen perpetrator programme Montgomery Family Crisis Centre – Newton, Powys Hafan Cymru run IDAP		Perpetrator programme (Safer Merthyr)	Atal Y Fro run Community IDAP – called EPIC Caring Dads programme	Blaenau Gwent perpetrator programme	✓ Protection (stopping perpetrators)

Sexual Violence	Sexual Violence Services	Beacon Foundation (survivors of sexual abuse) DV & SV Coordinator DV & SV Forum Rape and Sexual Abuse Support Centre (North Wales) Standing Ground (men and women who have suffered any form of abuse) Stepping Stones (adult survivors of childhood sexual abuse)	New Pathways Sexual Assault Centre (Aberystwyth) New Pathways Sexual Assault Centre (Carmarthen) SEREN (adult survivors of childhood sexual abuse)	New Pathways Sexual Assault Centre (Bridgend) New Pathways Sexual Assault Centre (Swansea) New Pathways offer Counselling for women and men in	New Pathways Sexual Assault Centre (Merthyr Tydfil) New Pathways offer Counselling and Advocacy for offenders and ex-offenders in Merthyr Tydfil Office	Ynys Saff Sexual Assault Referral Centre New Pathways offer Counselling for women and men in Cardiff Royal Infirmary New Pathways offer Counselling and Advocacy for offenders and ex-offenders in Cardiff Probation Office	Monmouthshire DA & SV Coordinator New Pathways Sexual Assault Centre (Risca) New Pathways Sexual Assault Centre (Newport) New Pathways offer Counselling and Advocacy for offenders and ex-offenders in Newport Probation Office New Pathways offer group therapy for women in Torfaen WA	✓ Identification & Referral ✓ Recovery & Reintegration
	ISVA	North Wales ISVA	Aberystwyth ISVA Carmarthen ISVA	Bridgend ISVA Swansea ISVA	Merthyr Tydfil ISVA	Cardiff ISVA	Blaenau Gwent ISVA Risca ISVA Torfaen ISVA	✓ Protection (victim safety) ✓ Coordination of Responses & Training
	SV – CISVA		Carmarthen CISVA Aberystwyth CISVA	Bridgend CISVA Swansea CISVA	Merthyr Tydfil CISVA		Risca CISVA	
	SARC	Amethyst North Wales SARC	New Pathways Carmarthen SARC	New Pathways SARC	New Pathways Merthyr Tydfil SARC	Cardiff - Safe Island/Ynys Saff SARC	New Pathways Torfaen SARC	
BME	BME	Bawso Ltd. (Wrexham)		Bawso Ltd. (Swansea)	Bawso Ltd. (Merthyr)	Bawso Ltd (Cardiff) Migration Partnership The Sudanese Community Association of South Wales	Bawso Ltd. (Newport) South East Wales Racial Equality Council (SEWREC)	✓ Identification & Referral ✓ Protection (victim safety) ✓ Recovery & Reintegration ✓ Coordination of Responses & Training

LGBT	LGBT					LGBT Excellence Centre (Wales) Limited Dyn project (men only)		
Preventive Work	Preventive Work / Children & Young people	The All Wales Schools Liaison Core Programme (Anglesey) The All Wales Schools Liaison Core Programme (Conwy) The All Wales Schools Liaison Core Programme (Denbighshire) The All Wales Schools Liaison Core Programme (Flintshire) The All Wales Schools Liaison Core Programme (Gwynedd) The All Wales Schools Liaison Core Programme (Wrexham) The Crucial Crew (Anglesey) The Crucial Crew (Conwy) The Crucial Crew (Denbighshire) The Crucial Crew (Flintshire) The Crucial Crew (Gwynedd) Expect Respect (Gwynedd) Expect Respect (Flintshire)	The All Wales Schools Liaison Core Programme (Ceredigion) The All Wales Schools Liaison Core Programme (Carmarthenshire) The All Wales Schools Liaison Core Programme (Pembrokeshire) The All Wales Schools Liaison Core Programme (Powys) The Crucial Crew (Ceredigion) The Crucial Crew (Carmarthenshire) The Crucial Crew (Pembrokeshire) The Healthy Relationships Programme (Ceredigion) The Healthy Relationships Programme (Carmarthenshire) The Healthy Relationships Programme (Pembrokeshire) Tommy Teddy Be Safe (Carmarthenshire)	The All Wales Schools Liaison Core Programme (Bridgend) The All Wales Schools Liaison Core Programme (Neath Port Talbot) The All Wales Schools Liaison Core Programme (Swansea) The Crucial Crew (Neath) The Crucial Crew (Port Talbot) The Crucial Crew (Swansea) Reduce Abuse in Youth (RAY) (Swansea) Dating Abuse Prevention (Bridgend) Welsh Baccalaureate sessions (Bridgend) Let's Talk About It (Neath Port Talbot) All Wales Schools programme delivered by Police to year 10s	The All Wales Schools Liaison Core Programme (Merthyr Tydfil) The All Wales Schools Liaison Core Programme (Rhondda Cynon Taff) Dating Abuse Prevention (Rhondda Cynon Taf) Building Safer Relationships (Rhondda Cynon Taff)	The All Wales Schools Liaison Core Programme (Cardiff) The All Wales Schools Liaison Core Programme (Vale of Glamorgan) Breaking the Cycle of Domestic Abuse - Healthy Relationships and Respect (Vale of Glamorgan) Expect Respect (Cardiff) Welsh Baccalaureate sessions (Cardiff) Welsh Baccalaureate sessions (Vale of Glamorgan) Intervention does not have a name – explored the links between homelessness and domestic abuse (Cardiff)	The All Wales Schools Liaison Core Programme (Blaenau Gwent) The All Wales Schools Liaison Core Programme (Caerphilly) The All Wales Schools Liaison Core Programme (Monmouthshire) The All Wales Schools Liaison Core Programme (Newport) Challenging Attitudes - Healthy Relationships (Monmouthshire) Safer Relationships (Monmouthshire) The Lizard's Tale and Safer Relationships (Torfaen) Hands Off (Newport)	✓ Identification & Referral

		The Safe Relationships Programme (Denbighshire) The Safe Relationships Programme (Wrexham) Intervention with no name - delivered with funding from the Youth Justice Board (Denbighshire) Intervention with no name - delivered with funding from the Youth Justice Board (Wrexham) Intervention with no name - delivered to pupils with additional learning needs (Gwynedd) White Ribbon (Anglesey) Cats Paw Theatre schools and college prevention work on domestic abuse and sexual violence.	Safer Relationships (Carmarthenshire) The Millbrook Tapes (Pembrokeshire) Welsh Baccalaureate sessions (Carmarthenshire) Welsh Baccalaureate sessions (Pembrokeshire) Understanding Adults (Powys)			
Other	Freedom Programme	North Wales Womens Centre Domestic Abuse Safety Unit (Flintshire) run Freedom Programme Colwyn WA run Freedom	Gwalia Care and Support Montgomeryshire Family Crisis Centre Radnorshire WA runs Freedom Programme	Merthyr Women's Services Star Programme – (Children's version of the Freedom Programme)	Cardigan WA run Freedom Programme Blaenau Gwent Domestic abuse service deliver a modified version of the Freedom Programme.	

Table 5.2

All Wales Services	
Domestic Abuse	All Wales Domestic Violence and Sexual Violence Helpline Polish DV Helpline Wales and England The IRIS Trust for Inspiration and Wellbeing (based in England) Welsh Women's Aid 11 Specialist Domestic Violence Courts (SDVCs) IDAP (perpetrator programme) in some areas The Healthy Relationships SAR (Perpetrator programme shorter than IDAP) [1-2 non mandatory perpetrator programmes in Wales – and one is non Respect accredited] CAADA – 2012 trained 50 IDVAs in Wales Hafan Cymru (housing organisation with specialist focus on victims of domestic abuse)
Sexual Violence	All Wales Domestic Violence and Sexual Violence Helpline CIS'ters (surviving rape and/or sexual abuse) (based in England) Rape Crisis (England and Wales) (based in England) Survivors Trauma and Abuse Recovery Trust (START) New Pathways provide face to face services for 16 of the 22 local authority areas. New Pathways run a 'Safety Awareness Vehicle' across Wales – raise awareness and counselling and consultation facilities. Beacon Foundation (National helpline for survivors of ritual abuse)
BME	FGM National Helpline karma nirvana (based in England) The Henna Foundation (Formerly All Wales Saheli Association)
Preventive Work / Children & Young people	'The Spectrum Programme' delivered in 18 of the 22 LAs by Hafan Cymru, sometimes in conjunction with Welsh Women's Aid 'Keeping Safe' delivered in 17 of the 22 LAs in Wales
Other	RELATE Wales Wales Migration Partnership

Appendix 6: Survey

<b>REVIEW OF VIOLENCE AGAINST WOMEN, DOMESTIC ABUSE

Thank you for your interest in this study. This survey has been put together by a team of researchers at the University of Central Lancashire. We are aiming to gather important information about all services across Wales that work, directly or indirectly, with adult victims or perpetrators of violence against women, domestic abuse and sexual violence. This includes all forms of domestic violence, including LGBT violence, elder abuse, honour-based violence, forced marriage, FGM, sexual assault, trafficking, sexual exploitation and prostitution.

We are interested in both specialist providers of these services, as well as generalist services who deal with victims or perpetrators but where violence prevention or treatment may not be the core service focus. We are interested in hearing from voluntary, public and private sector agencies and organisations. Although the focus is on adult services, we recognise that many adult services also work with children and families as part of their service. We are also interested in hearing from preventative services working with young people.

The survey should take approximately 30 minutes to complete on a service. The study is funded by the Welsh Government. Since this is a mapping exercise of services available across Wales, please be aware that it will not be possible to anonymise the names of organisations or agencies in the report to Welsh Government. We may also wish to follow up on some of the answers you have provided, or to conduct a more in-depth interview with you about your service. If you are happy for us to do this, there will be an opportunity at the end of the survey to complete your name and contact details.

The survey allows you to provide information on up to three services that your organisation delivers. We are aware that many organisations deliver projects in different locations. Please provide answers for particular services that you run rather than individual local projects. For example, if you provide a refuge service in 10 different locations then please provide answers for all your refuge provision together, not each of the 10 projects. If you provide more than one type of service (e.g. a refuge and IDVAs) please answer for each service separately. If you deliver more than three services, please complete a second survey.

Click Next to continue. You may scroll back at any point to previous answers, using the Prev button. If you exit the survey for any reason, your answers will be saved. When you re-enter the survey (using the same machine) you will be taken you back to the last question you answered. If you have any concerns or difficulties please contact Vashti Berry or Melanie McCarry as per the attached email.

Diolch am eich diddordeb yn yr astudiaeth hon. Lluniwyd yr arolwg gan dîm o ymchwilwyr yn yr University of Central Lancashire. Ein nod yw casglu gwybodaeth bwysig am bob gwasanaeth yng Nghymru sy'n gweithio'n uniongyrchol neu'n anuniongyrchol gydag oedolion sy'n dioddef trais yn erbyn menywod, trais domestig a thrais rhywiol neu oedolion sy'n cyflawni'r trais hwn. Mae hyn yn cynnwys pob math o drais domestig, yn cynnwys trais ymhlith pobl lesbiaidd, hoyw, deurywiol a thrawsrywiol, cam-drin pobl hŷn, trais er anrhydedd, priodasau dan orfod, enwaedu benywod, ymosodiadau rhywiol, masnachu mewn pobl, cam-fanteisio'n rhywiol a phuteindra.

Mae gennym ddiddordeb nid yn unig mewn darparwyr gwasanaethau arbenigol, ond hefyd mewn darparwyr gwasanaethau cyffredinol sy'n ymdrin â dioddefwyr neu gyflawnwyr trais o'r fath er efallai nad triniaeth yw prif ffocws eu gwasanaeth. Rydym yn awyddus i glywed gan asiantaethau a sefydliadau yn y sectorau gwirfoddol, cyhoeddus a phreifat. Er bod y pwyslais ar wasanaethau i oedolion, sylweddolwn fod llawer o wasanaethau i oedolion yn gweithio gyda phlant a theuluoedd hefyd fel rhan o'u gwasanaeth. Hoffem glywed hefyd gan wasanaethau atal sy'n gweithio gyda phobl ifanc.

Dylai gymryd tua hanner awr i ateb cwestiynau'r arolwg am wasanaeth. Ariennir yr astudiaeth gan Lywodraeth Cymru. Gan mai ymarfer i fapio'r gwasanaethau sydd ar gael ledled Cymru yw hwn, bydd rhaid cynnwys enwau sefydliadau neu asiantaethau yn yr adroddiad i Lywodraeth Cymru. Mae'n bosibl y byddwn yn gofyn i chi ymhelaethu ar rai o'ch atebion, neu'n gofyn am gyfweliad manylach â chi am eich gwasanaeth. Os ydych yn fodlon i ni wneud hyn, bydd cyfle ar ddiwedd yr arolwg i roi'ch enw a manylion cyswllt.

Gallwch roi gwybodaeth am hyd at dri gwasanaeth a gynigir gan eich sefydliad. Rydym yn ymwybodol bod gan lawer o sefydliadau brosiectau mewn gwahanol leoliadau. Dylech roi atebion ynglŷn â'ch gwasanaethau penodol yn hytrach na phrosiectau lleol unigol. Er enghraifft, os ydych chi'n darparu gwasanaeth lloches mewn 10 lleoliad gwahanol, rhowch atebion ar gyfer pob un o'ch llochesi gyda'i gilydd, nid ar gyfer pob un o'r 10 prosiect. Os ydych chi'n darparu mwy nag un math o wasanaeth (e.e. lloches ac eiriolwyr trais domestig annibynnol (IDVA)), atebwch ar gyfer pob gwasanaeth ar wahân. Os ydych chi'n cynnig mwy na thri gwasanaeth, dylech gwblhau ail arolwg.

Cliciwch Nesaf i barhau. Gallwch ddychwelyd at eich atebion blaenorol unrhyw bryd gan ddefnyddio'r botwm Blaenorol. Os byddwch yn gadael yr arolwg am ba reswm bynnag, cedwir eich atebion. Pan fyddwch yn ail-gydio yn yr arolwg (ar yr un cyfrifiadur) byddwch yn mynd i'r cwestiwn diwethaf i chi ei ateb. Os oes gennych unrhyw bryderon neu os cewch unrhyw drafferth, cysylltwch â Vashti Berry neu Melanie McCarry fel y nodir yn y neges e-bost sydd ynghlwm.

Page 1

<b>REVIEW OF VIOLENCE AGAINST WOMEN, DOMESTIC ABUSE

SECTION A: ABOUT YOU AND YOUR ORGANISATION/AGENCY
ADRAN A: GWYBODAETH AMDANOCH CHI A'CH SEFYDLIAD/ASIANTAETH

1. What is the name of your organisation / agency / group / partnership?

1. Beth yw enw eich sefydliad / asiantaeth / grŵp / partneriaeth?

2. What is your role in the organisation?

2. Beth yw eich rôl yn y sefydliad?

3. Is your organisation / agency part of the:

3. A yw eich sefydliad / asiantaeth yn perthyn i'r:

- ◯ VOLUNTARY / THIRD SECTOR • SECTOR GWIRFODDOL / TRYDYDD SECTOR
- ◯ STATUTORY / PUBLIC • SECTOR STATUDOL / CYHOEDDUS
- ◯ PRIVATE SECTOR NOT FOR PROFIT • SECTOR PREIFAT DI-ELW
- ◯ PRIVATE SECTOR FOR PROFIT • SECTOR PREIFAT ER ELW
- ◯ COMBINATION. Please specify • CYFUNIAD. Rhowch fanylion.

<b>REVIEW OF VIOLENCE AGAINST WOMEN, DOMESTIC ABUSE

4. Is your organisation / agency / group a specialist provider of violence against women, domestic abuse or sexual violence services, i.e. this is the core service or remit of the organisation?

4. A yw eich sefydliad / asiantaeth / grŵp yn arbenigo mewn darparu gwasanaethau trais yn erbyn menywod, trais domestig a thrais rhywiol, h.y. dyma yw gwasanaeth neu gylch gwaith craidd y sefydliad?

- ◯ YES, A SPECIALIST PROVIDER whose primary remit is working with violence against women, domestic abuse or sexual violence • YDY, DARPARWR ARBENIGOL a'i brif gylch gwaith yw gweithio gyda thrais yn erbyn menywod, trais domestig a thrais rhywiol.
- ◯ NO, THE SERVICE IS PART OF A GENERALIST SERVICE PROVIDER (e.g. health, education, police) which has a different primary remit • NA, MAE'R GWASANAETH YN RHAN O DDARPARWR GWASANAETH CYFFREDINOL (e.e. iechyd, addysg, yr heddlu) sydd â phrif gylch gwaith gwahanol.
- ◯ OTHER. Please specify • ARALL. Rhowch fanylion

5. How many different types of service(s) targeting violence against women, domestic abuse and/or sexual violence does your organisation/agency/partnership provide?

5. Sawl math o wasanaeth(au) gwahanol sy'n mynd i'r afael â thrais yn erbyn menywod, trais domestig a/neu drais rhywiol mae'ch sefydliad/asiantaeth/partneriaeth yn ei ddarparu/yn eu darparu?

- ◯ 0 (A generalist service that serves this population as part of its wider focus) • (Gwasanaeth cyffredinol sy'n gwasanaethu'r bobl hyn fel rhan o'i ffocws ehangach)
- ◯ 1
- ◯ 2
- ◯ 3
- ◯ 4+

BEFORE WE CONTINUE • CYN I NI BARHAU

<b>REVIEW OF VIOLENCE AGAINST WOMEN, DOMESTIC ABUSE

A reminder: This survey will allow you to give information on up to three services that your organisation provides. If you are a generalist provider, please provide information on the service(s) that is accessed by victims or perpetrators of violence against women, domestic abuse or sexual violence.

Please provide answers for particular services that you run rather than individual local projects. For example, if you provide a refuge service in 10 different locations then please provide answers for all your refuge provision together, not each of the 10 projects. If you provide more than one type of service (e.g. a refuge and IDVAs) please answer for each service separately. If you deliver more than three services, please complete a second survey.

Gair i'ch atgoffa: Gallwch roi gwybodaeth am hyd at dri gwasanaeth a gynigir gan eich sefydliad. Os ydych yn ddarparwr cyffredinol, rhowch wybodaeth am y gwasanaeth(au) a ddefnyddir gan ddioddefwyr neu'r sawl sy'n cyflawni trais yn erbyn menywod, trais domestig neu drais rhywiol

Dylech roi atebion ynglŷn â'ch gwasanaethau penodol yn hytrach na phrosiectau lleol unigol. Er enghraifft, os ydych chi'n darparu gwasanaeth lloches mewn 10 lleoliad gwahanol, rhowch atebion ar gyfer pob un o'ch llochesi gyda'i gilydd, nid ar gyfer pob un o'r 10 prosiect. Os ydych chi'n darparu mwy nag un math o wasanaeth (e.e. lloches ac eiriolwyr trais domestig annibynnol (IDVA)), atebwch ar gyfer pob gwasanaeth ar wahân. Os ydych chi'n cynnig mwy na thri gwasanaeth, dylech gwblhau ail arolwg.

SECTION B: ABOUT THE SERVICE(S)
ADRAN B: GWYBODAETH AM Y GWASANAETH(AU)

6. What is the name of the service(s)? If you choose to provide information on more than one service, please take a note for yourself now of which service you have allocated to Service 1, 2 or 3, to ensure you are able to answer the follow-up questions easily. If you are providing information on only one service, then ignore boxes 2 and 3.

6. Beth yw enw'r gwasanaeth(au)? Os ydych chi'n dewis rhoi gwybodaeth am fwy nag un gwasanaeth, nodwch pa wasanaethau rydych chi wedi'u dynodi'n Gwasanaeth 1,2 neu 3, er mwyn i chi allu ateb unrhyw gwestiynau ychwanegol yn hawdd. Os ydych chi'n darparu gwybodaeth am un gwasanaeth yn unig, anwybyddwch focsys 2 a 3.

1.
2.
3.

7. Please provide a brief description of the purpose/aim of the service(s)

7. Rhowch ddisgrifiad byr i ddiben/nod y gwasanaeth(au).

1.
2.
3.

8. Which type of response best describes the PRIMARY aim of the service(s)? Select ONLY ONE - the most applicable - for each service.

8. Pa ymateb sy'n disgrifio orau PRIF nod y gwasanaeth(au)? Dewiswch UN YN UNIG – y mwyaf perthnasol – ar gyfer pob gwasanaeth.

	Service 1. Gwasanaeth 1.	Service 2. Gwasanaeth 2.	Service 3. Gwasanaeth 3.
PRIMARY PREVENTION OR SOCIAL PREVENTION: services or activities whose purpose is to prevent violence or abuse before it occurs • ATAL SYLFAENOL NEU ATAL CYMDEITHASOL: gwasanaethau a gweithgareddau i atal trais neu gamdriniaeth cyn iddo/iddi ddigwydd.	☐	☐	☐
IDENTIFICATION, RECOGNITION AND REFERRAL: services or activities whose purpose is to intervene early to identify those at high risk of abuse or those currently in violent relationships and refer them to appropriate services • CANFOD, ADNABOD AC ATGYFEIRIO: gwasanaethau neu weithgareddau i ymyrryd yn gynnar i ganfod pobl sydd mewn perygl mawr o gael eu cam-drin neu sydd mewn perthynas dreisgar a'u hatgyfeirio i wasanaethau priodol.	☐	☐	☐
PROTECTION FOR VICTIMS OR PROTECTION FROM PERPETRATORS: services or activities whose primary purpose is to secure the safety of victims, either working with victims directly or working with perpetrators to prevent re-offending • AMDDIFFYN DIODDEFWYR NEU AMDDIFFYN RHAG Y SAWL SY'N CYFLAWNI'R TRAIS: gwasanaethau neu weithgareddau i ddiogelu dioddefwyr, naill ai trwy weithio gyda dioddefwyr yn uniongyrchol neu weithio gyda'r sawl sy'n cyflawni'r trais i'w hatal rhag aildroseddu.	☐	☐	☐
RECOVERY AND RE-INTEGRATION: services or activities whose purpose is to aid recovery and promote well-being following an experience(s) of violence or abuse, and to ensure the victim is able to join society as an active citizen • ADFER AC AILINTEGREIDDIO: gwasanaethau neu weithgareddau i gynorthwyo adferiad a hybu lles yn dilyn profiad(au) o drais neu gamdriniaeth, ac i sicrhau bod y dioddefwyr yn gallu cymryd rhan mewn cymdeithas fel dinasyddion gweithgar.	☐	☐	☐
CO-ORDINATION and WORKING TOGETHER: a multi-agency or multi-discipline service where the main focus is to bring together a number of responses under one service. This would include second-tier or training organisations • CYDGYSYLLTU a CHYDWEITHIO: gwasanaeth amlasiantaeth neu amlddisgyblaeth sy'n rhoi'r pwyslais ar uno nifer o ymatebion gwahanol mewn un gwasanaeth. Byddai hyn yn cynnwys sefydliadau ail-haen neu hyfforddi.	☐	☐	☐

9. In which local authority area is the service(s) BASED (this is not necessarily the LAs where you deliver)?

9. Ym mha awdurdod lleol mae PENCADLYS y gwasanaeth(au) (nid yr ALlau lle rydych chi'n darparu'r gwasanaeth(au) o reidrwydd)?

	Service 1. Gwasanaeth 1.	Service 2. Gwasanaeth 2.	Service 3. Gwasanaeth 3.
BLAENAU GWENT COUNTY • BLAENAU GWENT	☐	☐	☐
BRIDGEND COUNTY • PEN-Y-BONT AR OGWR	☐	☐	☐
CAERPHILLY COUNTY • CAERFFILI	☐	☐	☐
CARDIFF • CAERDYDD	☐	☐	☐
CARMARTHENSHIRE COUNTY • SIR GÂR	☐	☐	☐
CEREDIGION COUNTY • CEREDIGION	☐	☐	☐
CONWY COUNTY • CONWY	☐	☐	☐
DENBIGHSHIRE COUNTY • SIR DDINBYCH	☐	☐	☐
FLINTSHIRE COUNTY • SIR Y FFLINT	☐	☐	☐
GWYNEDD • GWYNEDD	☐	☐	☐
ISLE OF ANGLESEY COUNTY • YNYS MÔN	☐	☐	☐
MERTHYR TYDFIL COUNTY • MERTHYR TUDFUL	☐	☐	☐
MONMOUTHSHIRE COUNTY • SIR FYNWY	☐	☐	☐
NEATH PORT TALBOT COUNTY • CASTELL-NEDD PORT TALBOT	☐	☐	☐
NEWPORT CITY • CASNEWYDD	☐	☐	☐
PEMBROKESHIRE COUNTY • SIR BENFRO	☐	☐	☐
POWYS COUNTY • POWYS	☐	☐	☐
RHONDDA CYNON TAF COUNTY • RHONDDA CYNON TAF	☐	☐	☐
CITY & COUNTY OF SWANSEA • DINAS A SIR ABERTAWE	☐	☐	☐
TORFAEN COUNTY • TORFAEN	☐	☐	☐
VALE OF GLAMORGAN • BRO MORGANNWG	☐	☐	☐
WREXHAM COUNTY • WRECSAM	☐	☐	☐
OTHER • ARALL	☐	☐	☐

Please specify • Rhowch fanylion

10. In which local authority area(s) do you deliver services? Tick all that apply.

10. Ym mha ardal(oedd) awdurdod lleol rydych chi'n darparu gwasanaethau? Ticiwch bob un sy'n berthnasol.

	Service 1. Gwasanaeth 1.	Service 2. Gwasanaeth 2.	Service 3. Gwasanaeth 3.
OUTSIDE OF WALES • Y TU ALLAN I GYMRU	☐	☐	☐
ACROSS ALL/MOST LOCAL AUTHORITIES IN WALES • AR DRAWS POB UN/Y RHAN FWYAF O AWDURDODAU LLEOL CYMRU	☐	☐	☐
BLAENAU GWENT COUNTY • BLAENAU GWENT	☐	☐	☐
BRIDGEND COUNTY • PEN-Y-BONT AR OGWR	☐	☐	☐
CAERPHILLY COUNTY • CAERFFILI	☐	☐	☐
CARDIFF • CAERDYDD	☐	☐	☐
CARMARTHENSHIRE COUNTY • SIR GÂR	☐	☐	☐
CEREDIGION COUNTY • CEREDIGION	☐	☐	☐
CONWY COUNTY • CONWY	☐	☐	☐
DENBIGHSHIRE COUNTY • SIR DDINBYCH	☐	☐	☐
FLINTSHIRE COUNTY • SIR Y FFLINT	☐	☐	☐
GWYNEDD • GWYNEDD	☐	☐	☐
ISLE OF ANGLESEY COUNTY • YNYS MÔN	☐	☐	☐
MERTHYR TYDFIL COUNTY • MERTHYR TUDFUL	☐	☐	☐
MONMOUTHSHIRE COUNTY • SIR FYNWY	☐	☐	☐
NEATH PORT TALBOT COUNTY • CASTELL-NEDD PORT TALBOT	☐	☐	☐
NEWPORT CITY • CASNEWYDD	☐	☐	☐
PEMBROKESHIRE COUNTY • SIR BENFRO	☐	☐	☐
POWYS COUNTY • POWYS	☐	☐	☐
RHONDDA CYNON TAF COUNTY • RHONDDA CYNON TAF	☐	☐	☐
CITY & COUNTY OF SWANSEA • DINAS A SIR ABERTAWE	☐	☐	☐
TORFAEN COUNTY • TORFAEN	☐	☐	☐
VALE OF GLAMORGAN • BRO MORGANNWG	☐	☐	☐
WREXHAM COUNTY • WRECSAM	☐	☐	☐
OTHER • ARALL	☐	☐	☐

Please specify • Rhowch fanylion

<b>REVIEW OF VIOLENCE AGAINST WOMEN, DOMESTIC ABUSE

11. When was the service(s) first established?

11. Pryd sefydlwyd y gwasanaeth(au)?

1.
2.
3.

12. Which form(s) of violence does the service(s) primarily address? Tick all that apply

12. Pa fath(au) o drais mae'r gwasanaeth(au) yn ymdrin ag ef/â nhw yn bennaf? Ticiwch bob un sy'n berthnasol

	Service 1. Gwasanaeth 1.	Service 2. Gwasanaeth 2.	Service 3. Gwasanaeth 3.
DOMESTIC VIOLENCE IN ADULT INTIMATE PARTNER RELATIONSHIPS • TRAIS DOMESTIG MEWN PERTHYNAS GARWRIAETHOL RHWNG OEDOLION	☐	☐	☐
DOMESTIC VIOLENCE IN YOUNG PEOPLE'S (16-25) INTIMATE RELATIONSHIPS • TRAIS DOMESTIG MEWN PERTHYNAS GARWRIAETHOL RHWNG POBL IFANC (16-25)	☐	☐	☐
DOMESTIC VIOLENCE IN OTHER FAMILY MEMBER RELATIONSHIPS, E.G. ELDER ABUSE • TRAIS DOMESTIG MEWN PERTHYNAS RHWNG AELODAU ERAILL O'R TEULU, E.E. CAM-DRIN POBL HŶN	☐	☐	☐
FORCED MARRIAGE • PRIODASAU DAN ORFOD	☐	☐	☐
HONOUR-BASED VIOLENCE • TRAIS ER ANRHYDEDD	☐	☐	☐
FEMALE GENITAL MUTILATION • ENWAEDU BENYWOD	☐	☐	☐
SEXUAL VIOLENCE, INCLUDING SEXUAL ASSAULT AND RAPE • TRAIS RHYWIOL, YN CYNNWYS YMOSODIAD RHYWIOL A THREISIO	☐	☐	☐
SEXUAL HARASSMENT • AFLONYDDU RHYWIOL	☐	☐	☐
TRAFFICKING • MASNACHU MEWN POBL	☐	☐	☐
PROSTITUTION • PUTEINDRA	☐	☐	☐
SEXUAL EXPLOITATION • CAMFANTEISIO'N RHYWIOLOTHER	☐	☐	☐
OTHER • ARALL	☐	☐	☐

Please specify • Rhowch fanylion.

13. Who are the main recipients/users of the service(s)? Tick all that apply.

13. Pwy yw prif dderbynwyr/defnyddwyr y gwasanaeth(au)? Ticiwch bob un sy'n berthnasol.

	Service 1. Gwasanaeth 1.	Service 2. Gwasanaeth 2.	Service 3. Gwasanaeth 3.
FEMALE VICTIMS • DIODDEFWYR BENYW	☐	☐	☐
MALE VICTIMS • DIODDEFWYR GWRYW	☐	☐	☐
FEMALE PERPETRATORS • Y SAWL SY'N CYFLAWNI'R TRAIS - BENYW	☐	☐	☐
MALE PERPETRATORS • Y SAWL SY'N CYFLAWNI'R TRAIS - GWRYW	☐	☐	☐
FAMILIES, INCLUDING CHILDREN • TEULUOEDD, YN CYNNWYS PLANT	☐	☐	☐
PROFESSIONALS • GWEITHWYR PROFFESIYNOL	☐	☐	☐
GENERAL PUBLIC • Y CYHOEDD	☐	☐	☐
OTHER • ARALL	☐	☐	☐

Please specify • Rhowch fanylion

14. Does the service(s) serve any particular target group, or are there any exclusion criteria that would make someone ineligible for the service(s)? For example, do the users have to live within a particular geographic area; does the service only apply to a certain age group or sex/gender; perhaps the service does not work with victims of sexual violence, etc. If yes, please provide details. If no, state none.

14. A yw'r gwasanaeth(au) yn gwasanaethu grŵp targed arbennig, neu a oes meini prawf eithrio sy'n golygu nad yw rhywun yn gymwys i dderbyn y gwasanaeth(au)? Er enghraifft, oes rhaid i'r defnyddwyr fyw o fewn ardal ddaearyddol benodol; a yw'r gwasanaeth yn berthnasol i grŵp oedran a/neu ryw/rhywedd penodol; efallai nad yw'r gwasanaeth yn gweithio gyda dioddefwyr trais rhywiol, ac ati. Os felly, rhowch fanylion. Os na, nodwch na.

1.
2.
3.

<b>REVIEW OF VIOLENCE AGAINST WOMEN, DOMESTIC ABUSE

15. Is the service open or available to any of the following VULNERABLE groups? Tick all that apply.

15. A yw'r gwasanaeth yn agored neu ar gael i unrhyw un o'r grwpiau AGORED I NIWED isod? Ticiwch bob un sy'n berthnasol.

	Service 1. Gwasanaeth 1.	Service 2. Gwasanaeth 2.	Service 3. Gwasanaeth 3.
THOSE WITH DRUG MISUSE PROBLEMS • POBL Â PHROBLEMAU CAMDDEFNYDDIO CYFFURIAU	☐	☐	☐
THOSE WITH ALCOHOL PROBLEMS • POBL Â PHROBLEMAU ALCOHOL	☐	☐	☐
THOSE WITH SIGNIFICANT MENTAL HEALTH DIFFICULTIES • POBL Â PHROBLEMAU IECHYD MEDDWL SYLWEDDOL	☐	☐	☐
THOSE THAT SELF-HARM • POBL SY'N HUNAN-NIWEIDIO	☐	☐	☐
CARE-LEAVERS • POBL SY'N GADAEL GOFAL	☐	☐	☐
DISABLED PEOPLE • POBL ANABL	☐	☐	☐
TRANSGENDER PEOPLE • POBL DRAWSRYWIOL	☐	☐	☐
HOMELESS PEOPLE • POBL DDIGARTREF	☐	☐	☐
WOMEN EXPLOITED THROUGH PROSTITUTION • MENYWOD SYDD WEDI DIODDEF CAMFANTEISIO TRWY BUTEINDRA	☐	☐	☐
PEOPLE WITH INSECURE IMMIGRATION STATUS OR ASYLUM SEEKERS • POBL Â STATWS MEWNFUDO ANSICR NEU GEISWYR LLOCHES	☐	☐	☐
PEOPLE FOR WHOM ENGLISH/WELSH IS NOT THEIR FIRST LANGUAGE • POBL AG IAITH GYNTAF HEBLAW CYMRAEG/SAESNEG	☐	☐	☐
OTHER • ARALL	☐	☐	☐

Please specify • Rhowch fanylion

16. Are there any groups the service(s) finds hard to reach? If no, state none.

16. A yw'r gwasanaeth(au) yn ei chael hi'n anodd cyrraedd rhai grwpiau? Os na, nodwch na.

1.
2.
3.

17. What does the service(s) provide? Tick all that apply.

17. Beth mae'r gwasanaeth(au) yn ei gynnig? Ticiwch bob un sy'n berthnasol.

	Service 1. Gwasanaeth 1.	Service 2. Gwasanaeth 2.	Service 3. Gwasanaeth 3.
INFORMATION ON RIGHTS • GWYBODAETH AM HAWLIAU	☐	☐	☐
INFORMATION ON PROBLEMS • GWYBODAETH AM BROBLEMAU	☐	☐	☐
ADVICE • CYNGOR	☐	☐	☐
ADVOCACY • EIRIOLAETH	☐	☐	☐
BEFRIENDING • CYFEILLIO	☐	☐	☐
EDUCATION • ADDYSG	☐	☐	☐
FINANCE • CYLLID	☐	☐	☐
RECREATION • HAMDDEN	☐	☐	☐
ASSESSMENT • ASESU	☐	☐	☐
TREATMENT (including counselling) • TRINIAETH (yn cynnwys cwnsela)	☐	☐	☐
TRAINING (professionals) • HYFFORDDIANT (gweithwyr proffesiynol)	☐	☐	☐
PERSONAL SAFETY • DIOGELWCH PERSONOL	☐	☐	☐
CARE/TENDING • GOFAL/TENDIO	☐	☐	☐
PRACTICAL ASSISTANCE • CYMORTH YMARFEROL	☐	☐	☐
LEGAL SUPPORT • CYMORTH CYFREITHIOL	☐	☐	☐
ACCOMMODATION • LLETY	☐	☐	☐
ACTION PLANNING • CYNLLUNIO CAMAU GWEITHREDU	☐	☐	☐
COORDINATE ACCESS/REFERRAL TO OTHER SPECIALIST SERVICES • CYDGYSYLLTU MYNEDIAD/ATGYFEIRIO I WASANAETHAU ARBENIGOL ERAILL	☐	☐	☐
OTHER • ARALL	☐	☐	☐

Please specify • Rhowch fanylion

SECTION C: MORE DETAIL ABOUT THE SERVICES(S)
ADRAN C: RHAGOR O FANYLION AM Y GWASANAETH(AU)

<b>REVIEW OF VIOLENCE AGAINST WOMEN, DOMESTIC ABUSE

18. How many users did the service(s) work with in the last financial year (2012-2013)? If the service is a generalist service, how many users were referred on for violence-related concerns? If you are answering for a service delivered in more than one location, please provide a total for all.

18. Faint o ddefnyddwyr wnaeth y gwasanaeth(au) weithio gyda nhw yn y flwyddyn ariannol ddiwethaf (2012-2013)? Os yw'r gwasanaeth yn un cyffredinol, faint o ddefnyddwyr gafodd eu hatgyfeirio i wasanaethau eraill oherwydd pryderon yn ymwneud â thrais? Os ydych chi'n ateb ar ran gwasanaeth a ddarperir mewn mwy nag un lleoliad, rhowch y cyfanswm ar gyfer yr holl leoliadau.

1.
2.
3.

19. Was this the maximum capacity for the service(s)?

19. Ai dyma'r uchafswm y gall y gwasanaeth(au) ei helpu?

	Service 1. Gwasanaeth 1.	Service 2. Gwasanaeth 2.	Service 3. Gwasanaeth 3.
YES, AT CAPACITY THE WHOLE YEAR • IE, GWASANAETH YN LLAWN DRWY GYDOL Y FLWYDDYN	☐	☐	☐
YES, AT CAPACITY AT POINTS IN THE YEAR • IE, LLAWN AR RAI ADEGAU YN YSTOD Y FLWYDDYN	☐	☐	☐
NO • NA	☐	☐	☐
NOT SURE • DDIM YN SIŴR	☐	☐	☐

20. Did the service(s) operate a waiting list in the last year or turn people away you were unable to serve? If so, approximately how many people were on the waiting list or turned away at any given point? If not, leave blank.

20. Oedd gan y gwasanaeth(au) restr aros yn y flwyddyn ddiwethaf neu a fu'n rhaid gwrthod pobl na allech eu gwasanaethu? Os felly, tua faint o bobl oedd ar y rhestr aros neu a gafodd eu gwrthod ar unrhyw adeg benodol? Os na, gadewch yn wag.

1.
2.
3.

21. Have the thresholds for entry changed in the last year? If yes, please state in what way. If no, state none.

21. A yw'r trothwyon mynediad wedi newid yn y flwyddyn ddiwethaf? Os ydynt, nodwch ym mha ffordd. Os nad ydynt, nodwch nac ydynt.

1.
2.
3.

22. Where is the service(s) delivered? Tick all that apply.

22. Ble darperir y gwasanaeth(au)? Ticiwch bob un sy'n berthnasol.

	Service 1. Gwasanaeth 1.	Service 2. Gwasanaeth 2.	Service 3. Gwasanaeth 3.
THE USER'S HOME • CARTREF Y DEFNYDDIWR	☐	☐	☐
A SCHOOL (PRIMARY OR SECONDARY) • YSGOL (CYNRADD NEU UWCHRADD)	☐	☐	☐
COLLEGE • COLEG	☐	☐	☐
A REFUGE / EMERGENCY ACCOMMODATION • LLOCHES / LLETY BRYS	☐	☐	☐
IN THE COMMUNITY • YN Y GYMUNED	☐	☐	☐
A CLINIC or HEALTH CENTRE • CLINIG neu GANOLFAN IECHYD	☐	☐	☐
TRAINING CENTRE • CANOLFAN HYFFORDDI	☐	☐	☐
PROJECT/ORGANISATION'S OFFICE • SWYDDFA PROSIECT/SEFYDLIAD	☐	☐	☐
OFFICE OF A THIRD PARTY ORGANISATION • SWYDDFEYDD SEFYDLIAD TRYDYDD PARTI	☐	☐	☐
BY PHONE • DROS Y FFÔN	☐	☐	☐
ONLINE • AR-LEIN	☐	☐	☐
OTHER • ARALL	☐	☐	☐

Please specify • Rhowch fanylion

23. Is the area where the service(s) is principally delivered a:

23. A yw'r ardal lle darperir y gwasanaeth(au) yn bennaf yn:

	Service 1. Gwasanaeth 1.	Service 2. Gwasanaeth 2.	Service 3. Gwasanaeth 3.
RURAL LOCATION • ARDAL WLEDIG	☐	☐	☐
URBAN LOCATION • ARDAL DREFOL	☐	☐	☐
COMBINATION OF RURAL AND URBAN • CYFUNIAD O WLEDIG A THREFOL	☐	☐	☐

24. What is the typical length/duration and frequency of the service/intervention? For example, one session of 2-hours; 10-weekly sessions of 1-hour; once a week for 4 months; once a month for a year; or as required.

24. Beth yw hyd ac amlder y gwasanaeth/ymyriad fel arfer? Er enghraifft, un sesiwn ddwy awr; 10 sesiwn wythnosol awr o hyd; unwaith yr wythnos am 4 mis; unwaith y mis am flwyddyn; neu fel sydd angen.

1.
2.
3.

25. Did service users or survivors of violence participate in the design or development of the service(s)?

25. A wnaeth defnyddwyr y gwasanaeth neu bobl sydd wedi goroesi trais gyfrannu at lunio neu ddatblygu'r gwasanaeth(au)?

	Service 1. Gwasanaeth 1.	Service 2. Gwasanaeth 2.	Service 3. Gwasanaeth 3.
YES • DO	☐	☐	☐
NO • NADDO	☐	☐	☐
NOT SURE • DDIM YN SIŴR	☐	☐	☐

<b>REVIEW OF VIOLENCE AGAINST WOMEN, DOMESTIC ABUSE

26. Are service users / survivors of violence involved in the delivery of the service(s) currently?

26. A yw defnyddwyr y gwasanaeth / pobl sydd wedi goroesi trais yn helpu i ddarparu'r gwasanaeth(au) ar hyn o bryd?

	Service 1. Gwasanaeth 1.	Service 2. Gwasanaeth 2.	Service 3. Gwasanaeth 3.
YES • YDYNT	☐	☐	☐
NO • NAC YDYNT	☐	☐	☐
NOT SURE • DDIM YN SIŴR	☐	☐	☐

27. Is the service mandatory for users?

27. A yw'r gwasanaeth yn un gorfodol ar gyfer defnyddwyr?

	Service 1. Gwasanaeth 1.	Service 2. Gwasanaeth 2.	Service 3. Gwasanaeth 3.
YES, FOR ALL USERS • YDY, I BOB DEFNYDDIWR	☐	☐	☐
YES, FOR SOME USERS • YDY, I RAI DEFNYDDWYR	☐	☐	☐
NO • NAC YDY	☐	☐	☐
NOT SURE • DDIM YN SIŴR	☐	☐	☐

28. Can service users or survivors self-refer to the service(s)?

28. A yw defnyddwyr y gwasanaeth neu oroeswyr yn gallu atgyfeirio'u hunain i'r gwasanaeth(au)?

	Service 1. Gwasanaeth 1.	Service 2. Gwasanaeth 2.	Service 3. Gwasanaeth 3.
YES • YDYNT	☐	☐	☐
NO • NAC YDYNT	☐	☐	☐
NOT SURE • DDIM YN SIŴR	☐	☐	☐

29. Do service users or survivors have a choice about which aspects of the service(s) they use?

29. A yw defnyddwyr y gwasanaeth a goroeswyr yn gallu dewis pa agweddau ar y gwasanaeth(au) maent yn eu defnyddio?

	Service 1. Gwasanaeth 1.	Service 2. Gwasanaeth 2.	Service 3. Gwasanaeth 3.
YES, ENTIRELY • YDYNT, YN GYFAN GWBL	☐	☐	☐
YES, PARTIALLY • YDYNT, YN RHANNOL	☐	☐	☐
NO • NAC YDYNT	☐	☐	☐
NOT SURE • DDIM YN SIŴR	☐	☐	☐

30. Are service users able to re-enter or re-use the service after they have left?

30. A yw defnyddwyr y gwasanaeth yn gallu ailymuno â'r gwasanaeth(au) neu ddechrau ei ddefnyddio eto ar ôl gadael?

	Service 1. Gwasanaeth 1.	Service 2. Gwasanaeth 2.	Service 3. Gwasanaeth 3.
YES • YDYNT	☐	☐	☐
NO • NAC YDYNT	☐	☐	☐
NOT SURE • DDIM YN SIŴR	☐	☐	☐

<b>REVIEW OF VIOLENCE AGAINST WOMEN, DOMESTIC ABUSE

31. In general, do you share information about service users' use of the service(s)?

31. Yn gyffredinol, ydych chi'n rhannu gwybodaeth am ddefnydd defnyddwyr y gwasanaeth o'r gwasanaeth(au)?

	Service 1. Gwasanaeth 1.	Service 2. Gwasanaeth 2.	Service 3. Gwasanaeth 3.
YES, WITH THEIR KNOWLEDGE AND CONSENT • YDYM, MAENT YN YMWYBODOL O HYN AC WEDI RHOI CANIATÂD	☐	☐	☐
YES, WITH THEIR KNOWLEDGE BUT NOT NECESSARILY CONSENT • YDYM, MAENT YN YMWYBODOL O HYN OND HEB ROI CANIATÂD O REIDRWYDD	☐	☐	☐
YES, WITHOUT THEIR KNOWLEDGE AND/OR CONSENT • YDYM, HEB YN WYBOD IDDYNT A HEB GANIATÂD	☐	☐	☐
NO • NAC YDYM	☐	☐	☐
NOT SURE • DDIM YN SIŴR	☐	☐	☐

32. Are there other initiatives or services in your local or regional area that this service (s) ACTIVELY collaborates with, for example through shared funding or joint delivery? Please state all that apply. If no, please state none.

32. Oes unrhyw fentrau neu wasanaethau eraill yn eich ardal leol neu ranbarth y mae'r gwasanaeth(au) hwn yn cydweithio'n WEITHREDOL â nhw, er enghraifft drwy rannu cyllid neu ddarparu ar y cyd? Nodwch bob un sy'n berthnasol. Os na, nodwch nac oes.

33. How is your service(s) funded? Tick all that apply.

33. Sut mae'r gwasanaeth(au) yn cael ei ariannu/eu hariannu? Ticiwch bob un sy'n berthnasol.

	Service 1. Gwasanaeth 1.	Service 2. Gwasanaeth 2.	Service 3. Gwasanaeth 3.
GRANT • GRANT	☐	☐	☐
CONTRACT • CONTRACT	☐	☐	☐
PART OF MAINSTREAM STATUTORY SERVICE, e.g. NHS, education, probation • RHAN O WASANAETH STATUDOL PRIF FFRWD, e.e. GIG, addysg, gwasanaeth prawf	☐	☐	☐
DONATIONS • RHODDION ARIANNOL	☐	☐	☐
NOT SURE • DDIM YN SIŴR	☐	☐	☐
OTHER • ARALL	☐	☐	☐

Please specify • Rhowch fanylion

34. How many years has this service been funded?

34. Ers sawl blwyddyn mae'r gwasanaeth wedi'i ariannu?

	Service 1. Gwasanaeth 1.	Service 2. Gwasanaeth 2.	Service 3. Gwasanaeth 3.
LESS THAN 1 YEAR • LLAI NA BLWYDDYN	☐	☐	☐
1 YEAR • 1 MLYNEDD	☐	☐	☐
2 YEARS • 2 FLYNEDD	☐	☐	☐
3 YEARS • 3 BLYNEDD	☐	☐	☐
4 YEARS • 4 BLYNEDD	☐	☐	☐
5-7 YEARS • 5-7 MLYNEDD	☐	☐	☐
8-9 YEARS • 8-9 MLYNEDD	☐	☐	☐
10+ YEARS • 10 MLYNEDD A MWY	☐	☐	☐
NOT SURE • DDIM YN SIŴR	☐	☐	☐

35. How securely has your service been funded over the past three years (since start up if less than 3 years)?

35. Pa mor sicr fu cyllid eich gwasanaeth dros y tair blynedd diwethaf (neu ers dechrau'r gwasanaeth os yw'n llai na 3 blynedd)?

	Service 1. Gwasanaeth 1.	Service 2. Gwasanaeth 2.	Service 3. Gwasanaeth 3.
SHORT TERM - INSECURE • TYMOR BYR – ANSICR	☐	☐	☐
MODERATELY SECURE • GWEDDOL SICR	☐	☐	☐
SECURE • SICR	☐	☐	☐
OTHER • ARALL	☐	☐	☐

Please specify • Rhowch fanylion

36. For how long to come does (do you anticipate) this service have secure funding?

36. Am faint eto (rydych chi'n rhagweld) y mae gan y gwasanaeth gyllid sicr?

	Service 1. Gwasanaeth 1.	Service 2. Gwasanaeth 2.	Service 3. Gwasanaeth 3.
LESS THAN 1 YEAR • LLAI NA BLWYDDYN	☐	☐	☐
1 YEAR • 1 MLYNEDD	☐	☐	☐
2 YEARS • 2 FLYNEDD	☐	☐	☐
3 YEARS • 3 BLYNEDD	☐	☐	☐
4 YEARS • 4 BLYNEDD	☐	☐	☐
5+ YEARS • 5 MLYNEDD A MWY	☐	☐	☐
NOT SURE • DDIM YN SIŴR	☐	☐	☐

SECTION D: EVALUATION AND EVIDENCE
ADRAN D: GWERTHUSO A THYSTIOLAETH

37. Is the service(s) based on any particular theory or evidence? If so, please provide a short description. If not, state none.

37. A yw'r gwasanaeth(au) yn seiliedig ar unrhyw ddamcaniaeth neu dystiolaeth arbennig? Os felly, rhowch ddisgrifiad byr. Os na, nodwch nac ydy.

1.
2.
3.

38. Is the service based on, or related to, any other programme, initiative or intervention, from within the UK or elsewhere? If so, please provide a short description. If not, state none.

38. A yw'r gwasanaeth(au) yn seiliedig ar, neu'n gysylltiedig ag, unrhyw raglen, menter neu ymyriad, o'r DU neu du hwnt? Os felly, rhowch ddisgrifiad byr. Os na, nodwch nac ydynt.

1.
2.
3.

<b>REVIEW OF VIOLENCE AGAINST WOMEN, DOMESTIC ABUSE

39. Has the service(s) been subject to any of the following forms of evaluation? Tick all that apply.

39. A yw'r gwasanaeth(au) wedi cael ei werthuso/eu gwerthuso drwy un o'r ffyrdd canlynol? Ticiwch bob un sy'n berthnasol.

	Service 1. Gwasanaeth 1.	Service 2. Gwasanaeth 2.	Service 3. Gwasanaeth 3.
USER SATISFACTION SURVEY: service users indicate their level of satisfaction with the service and any areas for improvement, via a questionnaire, focus groups, interviews or other user involvement strategies • AROLWG BODDHAD DEFNYDDWYR: mae defnyddwyr y gwasanaeth yn nodi pa mor fodlon ydynt â'r gwasanaeth a ble gellid ei wella, drwy gyfrwng holiadur, grwpiau ffocws, cyfweliadau, neu strategaethau eraill i gynnwys defnyddwyr.	☐	☐	☐
EXPERT OPINION: a recognised expert has assessed the likelihood of the service's effectiveness • BARN ARBENIGWR: mae arbenigwr cydnabyddedig wedi asesu effeithiolrwydd tebygol y gwasanaeth.	☐	☐	☐
INDIVIDUAL MONITORING OF OUTCOMES: case records are kept of individual service recipients' progress over time, and then collated for analysis • MONITRO CANLYNIADAU UNIGOLION: cedwir cofnodion achos o gynnydd defnyddwyr y gwasanaeth dros amser, cyn eu coladu i'w dadansoddi.	☐	☐	☐
PRE-POST TEST EVALUATION: outcomes (e.g. knowledge, skills, attitudes, emotions, or behaviour) for a group of service recipients are assessed by measuring the recipients before they receive the service and then again after they receive the service. The two measurements are compared to assess whether there has been significant change over time (positive or negative) • GWERTHUSO CYN AC AR ÔL: caiff canlyniadau (e.e. gwybodaeth, sgiliau, agweddau, emosiynau, neu ymddygiad) ar gyfer grŵp o ddefnyddwyr y gwasanaeth eu hasesu drwy fesur y defnyddwyr cyn iddynt dderbyn y gwasanaeth ac yna ar ôl iddynt dderbyn y gwasanaeth. Caiff y ddau fesuriad eu cymharu i asesu a fu newid sylweddol dros amser (cadarnhaol neu negyddol).	☐	☐	☐
QUASI-EXPERIMENTAL EVALUATION: outcomes (e.g. knowledge, skills, attitudes, emotions, or behaviour) for a group of service recipients are assessed, by comparing the recipients' change over time (as per the pre-post test) with a matched comparison group who did not receive the service • GWERTHUSO LLED-ARBROFOL: caiff canlyniadau (e.e. gwybodaeth, sgiliau, agweddau, emosiynau, neu ymddygiad) ar gyfer grŵp o ddefnyddwyr y gwasanaeth eu hasesu, drwy gymharu'r newid yn y defnyddwyr dros amser (fel yn y gwerthuso cyn ac ar ôl) gyda grŵp cymharu cyfatebol sydd heb ddefnyddio'r gwasanaeth.	☐	☐	☐
RANDOMISED CONTROLLED TRIAL: outcomes (e.g. knowledge, skills, attitudes, emotions, or behaviour) for a group of service recipients are assessed, by randomly allocating recipients to receive the service (group 1) or not (group 2) and then comparing the two groups' change over time • HAP-DREIAL WEDI'I REOLI: caiff canlyniadau (e.e. gwybodaeth, sgiliau, agweddau, emosiynau, neu ymddygiad) ar gyfer grŵp o ddefnyddwyr y gwasanaeth eu hasesu drwy glustnodi defnyddwyr ar hap i dderbyn y gwasanaeth (grŵp 1) neu i beidio derbyn y gwasanaeth (grŵp 2) ac yna cymharu'r newid yn y ddau grŵp dros amser.	☐	☐	☐
NOT SURE • DDIM YN SIŴR	☐	☐	☐
OTHER • ARALL	☐	☐	☐

Please specify • Rhowch fanylion

40. Are there any evaluation reports of the service available?

40. Oes unrhyw adroddiadau gwerthuso ar y gwasanaeth ar gael?

	Service 1. Gwasanaeth 1.	Service 2. Gwasanaeth 2.	Service 3. Gwasanaeth 3.
YES • OES	☐	☐	☐
NO • NAC OES	☐	☐	☐
NOT APPLICABLE • AMHERTHNASOL	☐	☐	☐

SECTION E: QUESTIONS ABOUT THE WORKFORCE
ADRAN E: CWESTIYNAU AM Y GWEITHLU

41. How many full time equivalent staff are currently employed to deliver the service(s) (indicate administrative staff separately in brackets)?

41. Faint o staff cyfwerth ag amser llawn sy'n cael eu cyflogi ar hyn o bryd i ddarparu'r gwasanaeth(au) (nodwch staff gweinyddol ar wahân mewn cromfachau)?

1.
2.
3.

42. Approximately what percentage of the staff group is female?

42. Tua pha ganran o'r staff sy'n fenywod?

1.
2.
3.

43. Approximately what percentage of the staff group is from Black or ethnic minority cultures?

43. Tua pha ganran o'r staff sydd o ddiwylliannau Du neu leiafrifoedd ethnig?

1.
2.
3.

44. What experience and/or qualifications do the staff members delivering the service(s) require?

44. Pa brofiad a/neu gymwysterau sydd eu hangen ar aelodau staff sy'n darparu'r gwasanaeth(au)?

1.
2.
3.

45. What proportion of staff have received formal training on domestic abuse or sexual violence?

45. Pa gyfran o staff sydd wedi cael hyfforddiant ffurfiol ar gam-drin domestig neu drais rhywiol?

1.
2.
3.

<b>REVIEW OF VIOLENCE AGAINST WOMEN, DOMESTIC ABUSE

46. What proportion of their time on average do staff devote to direct work with violence against women, domestic abuse or sexual violence?

46. Ar gyfartaledd, pa gyfran o'u hamser mae staff yn ei threulio ar waith uniongyrchol ar drais yn erbyn menywod, cam-drin domestig neu drais rhywiol?

	Service 1. Gwasanaeth 1.	Service 2. Gwasanaeth 2.	Service 3. Gwasanaeth 3.
LESS THAN 10% • LLAI NA 10%	☐	☐	☐
BETWEEN 10% AND 50% • RHWNG 10% A 50%	☐	☐	☐
BETWEEN 50% AND 70% • RHWNG 50% A 70%	☐	☐	☐
OVER 70% • MWY NA 70%	☐	☐	☐
NOT SURE • DDIM YN SIŴR	☐	☐	☐

47. Are staff required to work irregular hours?

47. A yw staff yn gweithio oriau afreolaidd?

	Service 1. Gwasanaeth 1.	Service 2. Gwasanaeth 2.	Service 3. Gwasanaeth 3.
YES, REGULARLY • YDYNT, YN RHEOLAIDD	☐	☐	☐
YES, OCCASIONALLY • YDYNT, O BRYD I'W GILYDD	☐	☐	☐
NO • NAC YDYNT	☐	☐	☐
NOT SURE • DDIM YN SIŴR	☐	☐	☐

ANYTHING ELSE • UNRHYW BETH ARALL

48. Is there anything else about your organisation or the service(s) you would like to tell us?

48. Hoffech chi sôn am unrhyw beth arall am eich sefydliad neu'r gwasanaeth(au)?

IN CLOSING • I GLOI

49. Thank you for your time in completing this survey. We would like to enter you into a prize draw to win one of five £100 vouchers. We may also wish to follow up on some of the answers you have provided, or to conduct a more in-depth interview with you about your service. If you are happy for us to do this, please complete your name and contact details below:

Diolch am roi o'ch amser i gwblhau'r arolwg hwn. Byddem yn hoffi i fynd i chi i mewn i raffl i ennill un o bum £100 talebau. Mae'n bosibl y byddwn yn gofyn i chi ymhelaethu ar rai o'ch atebion, neu'n gofyn am gyfweliad manylach â chi am eich gwasanaeth. Os ydych yn fodlon i ni wneud hyn, rhowch eich enw a'ch manylion cyswllt isod.

Appendix 7: Advisory Group Membership

Dr Khatidja Chantler, University of Central Lancashire

Sam Edwards, Independent Researcher, Wales

Professor Liz Kelly, London Metropolitan University

Dr Amanda Robinson, Cardiff University

Appendix 8: List of Organisations and Agencies That Took Part

1. .Aberconwy Domestic Abuse Service
2. Abertawe Bromorgannwg NHS University Health Board
3. ABMU Local Health Board
4. Action for Caerau and Ely
5. Age Concern North East Wales
6. Age Cymru
7. All Wales Domestic Abuse and Sexual Violence Helpline
8. Amethyst, Sexual Assault Referral Centre
9. Aneurin Bevan Health Board
10. Anglesey and Gwynedd Community Safety Partnership
11. ARCH Initiatives
12. Atal Y Fro
13. Bangor & District Women's Aid
14. Barnardo's / Community Safety
15. Bawso
16. Betsi Cadwaladr University Local Health Board
17. Blaenau Gwent County Borough Council
18. Blaenau Gwent Domestic Abuse Services
19. Brecknock Women's Aid
20. Bridgend County Borough Council
21. Bridgend County Borough Council Community Safety Partnership
22. Bridgend Women's Aid
23. British Transport Police Authority
24. Broken Rainbow UK
25. Bron Afon Community Housing Ltd
26. CA HA Women's Aid (formerly Delyn WA)
27. Caerphilly Multi-Agency Centre (MAC)
28. CAFCASS Cymru - part of Welsh Government
29. CAIS
30. Calan Domestic Violence Services
31. Cardiff And Vale Sexual Assault Referral Centre
32. Cardiff and Vale University Health Board
33. Cardiff Council
34. Cardiff Women's Aid
35. Carmarthen Domestic Abuse Services
36. Carmarthenshire County Council
37. Carmarthenshire Domestic Abuse Forum Ltd.
38. Ceredigion Domestic Abuse Forum & Ceredigion Community Safety Partnership
39. Chester Sexual Violence Support Service
40. Choose2Change
41. Cisters
42. City and County of Swansea – Family Partnership Team
43. City and County of Swansea – Social Services
44. City and County of Swansea - Tenancy Support Unit
45. Community Safety
46. Conwy & Denbighshire Community Safety Partnership
47. Crown Prosecution Service

48. Cymdeithas Tai / Housing Association
49. DART Safer Merthyr Domestic Abuse Resource Team
50. DASU (Deeside)
51. De Gwynedd Domestic Abuse Service
52. Denbighshire County Council
53. Denbighshire Social Services
54. Domestic Abuse Safety Unit - Deeside
55. Domestic Abuse Safety Unit - Flintshire
56. Dyfed Powys Police
57. Flintshire County Council Team Around the Family
58. Flintshire County Council Community Safety Partnership
59. Flying Start
60. Glyndwr Women's Aid
61. Gorwel
62. Gorwel Anglesey Domestic Abuse Service
63. Gwent Police
64. Gwynedd Local Authority
65. Hafan Cymru
66. Hafod Care Association
67. Hafod Housing Association
68. Home Dash Bute
69. IOIS
70. Kaleidoscope
71. Llamau
72. Llanelli Women's Aid Ltd
73. Merthyr Tydfil County Borough Council
74. Merthyr/RCT/S Powys Probation
75. Mid Wales Rape Support Centre
76. Minority Ethnic Women’s Network (MEWN) Swansea
77. Monmouthshire County Council
78. Monmouthshire County Council , Housing Support Services
79. Monmouthshire Women’s Aid
80. Montgomeryshire Family Crisis Centre
81. Neath Talbot County Borough Council
82. Neath/Port Talbot IDVA Service
83. New Pathways, Rape Crisis and Sexual Abuse Support Service
84. Newport City Council
85. Newport IDVA
86. Newport Women's Aid
87. Newydd Housing Association
88. North Denbighshire Domestic Abuse Service
89. North Wales Police
90. North Wales Women's Centre
91. Nowe Zycie Bez Przemecy (A new life without violence)
92. NSPCC
93. NSPCC Cymru
94. Office of the Police & Crime Commissioner Gwent
95. Office of the Police & Crime Commissioner North Wales
96. Pembrokeshire County Council
97. Port Talbot & Afan Women's Aid
98. Powys Domestic Abuse Forum
99. Public Health Wales

100. Radnorshire Women's Aid
101. Rape and Sexual Abuse Support Centre North Wales
102. Rape Crisis England and Wales
103. RCT Community Safety & RCT Homes
104. Reduce Abuse for Youth RAY
105. Relate Cymru
106. Rhonda Cynon Taff County Borough Council
107. Rhondda Cynon Taff County Borough Council, Community Safety Partnership
108. Safer Caerphilly Community Safety Partnership
109. Safer Merthyr Tydfil
110. Safer Neath Port Talbot Partnership
111. Safer Pembrokeshire (Community Safety Partnership)
112. Safer Swansea Partnership (Substance Misuse Action Team)
113. Safer Vale Partnership
114. Safer Wales Ltd
115. SARC Betsi Cadwaladr University Health Board
116. Sexual and Reproductive Health Directorate, Aneurin Bevan Health Board
117. South Wales Police
118. START (Survivors Trauma and Abuse Recovery Trust)
119. Supporting People Team, Social Services Directorate, Swansea
120. Swansea Domestic Abuse Forum
121. Swansea Women's Aid
122. Swansea Women's Centre
123. Taff Housing Association
124. The Wallich
125. Torfaen County Borough Council
126. Torfaen Women's Aid
127. United Welsh
128. Vale of Glamorgan Citizens Advice Bureau
129. Vale of Glamorgan Flying Start
130. Victim Support
131. Wales and West Housing
132. Wales Migration Partnership
133. Wales Probation
134. Wales Probation Trust
135. WCADA
136. Umbrella organisation for the rape, sexual abuse and sexual exploitation voluntary sector in the United Kingdom and Eire.
137. Welsh Government, Department for Education & Skills
138. Welsh Women's Aid
139. West Wales Women's Aid
140. Women in Need
141. Women’s Aid Monmouthshire
142. Women’s Aid RCT
143. Wrexham County Borough Council
144. Wrexham MARAC
145. Wrexham Women's Aid
146. Youth Offending Services