DVA Stakeholder Event - Summary Feedback July 2019

Barriers previously identified	contract solutions	System solutions
Limitations in refuge as an accommodation solution – capacity issues, sex and gender identity issues, complexity of need	• Use of outreach/joined up working for people with complex needs (mental health and addiction) • Introduce dispersed model of accommodation (already underway)	• Introduction of DVA Bill will introduce a national data set to evidence best practice re: accommodation -based solutions
Support for Children –	• Develop outcomes for Children within DVA services • Awareness building on healthy relationships, DVA etc • Trauma and emotional support made available to children	• Joint working – strategic and operational – CS, ASC and Health • Jt commissioning between CS and ASC • Sustainable funding for children's support – not one- off grants – a consistent offer • Shared assessment process for children • Include children's outcomes in system work • Development of key flags for educational staff
Referrals agencies and mechanisms	• Simplify referral process and improve awareness of the referral process • Data cleaning to understand real picture of referrals – how many agencies encourage self -referral? • Understand DPOC referrals to other supporting agencies	• Simplified pathway including referral process
Key information sharing	• Improve feedback to referrals • Improved offer to children in DVA services – CYP unlikely to refer into services where there is limited support for the child/children	• Automatic referrals from agencies CRM processes i.e. MOSAIC • Online referral process • Single integrated referral process • One stop shop for victims

Efficacy and targeting of pattern changing	• Consistent offer of pattern changing programmes as well as earlier interventions such as Freedom Programme • available across Dorset • Should be available more than once – behaviour change needs consistent input • Improved follow up of attendees • Currently only available for people who have left an abusive relationship – need to introduce courses for those still in relationships	• Interventions should be made available at schools • Differing organisations and outcomes measurement – needs lead organisation to pull together • Offers for perpetrators – anger management classes • Shared intervention with D&A treatment
Duties and expectations of DVA Bill	• Develop improved accessibility for people with LD, MH and OP • Data cleaning, understanding demand and need • Links with safeguarding	• Need to understand what is included • Improve understanding of Bill for MH and LD health services – needs development and planning • Other interventions for perpetrators • Develop understanding of multiple and complex relationship circles
Responding to VAWG	• Offer assertiveness and self-esteem within prevention work • Safeguarding issues vs DVA response – not seeing males as victims of DVA	• Ensure links to workstreams focussing on sexual exploitation and modern slavery
Impacts of housing consultation	• Developing awareness of DVA in housing work	
New barriers id'd		
Measuring outcomes/success	• Developing an outcomes response	• Links to DVA Bill national picture
Schools and Education		• DVA awareness offer within schools – not just one -off events

System issues	• Improved handoffs between differing parts of the system • Transitional support for those in-between Maple and DVA services • Links with MARAC	• Responding to changing risk in a manageable way
Determine need/demand	• Currently demand-led	• Links to DVA bill national work • Understanding Dorset's picture
Support for children as perpetrators		• Develop picture of need in Dorset and evidenced base responses
Understanding Early Help and Prevention	• Links between Adverse Childhood Experience and poor outcomes	• Links to wider objectives of DVA Bill • Links to parental conflict work
Reluctance to report to police / association of agencies as a risk to escalation		• Whole system work – partnership working with agencies to develop a positive picture of intervention
Can service provision respond to increased demand from improved referral approach?	• Data development for Dorset	• Aligns with DVA Bill national picture

Full notes from event:

Problem Statements Workshop - Problems & Barriers:

1. Limitations in refuge as an accommodation solution – capacity issues, sex and gender identity issues, complexity of need
• Outreach services can work effectively with people with complex need (mental health/addiction) but it needs more time to develop relationship • Have one consistent offer by one organisation for all DVA services and leads on DVA across victims/perpetrators/children – Co-commissioning • Refuge only meets limited number of victims needs • If people could agree to engage in substance misuse treatment (and the REACH service did outreach) could we make it easier for them to access mainstream provision, or do we need something separate? • Include family intervention service as part of the DPOC
2. Support for Children
• Trauma/emotional support needs to be available to children of all ages • Support around children needs better 2-way communication/joint working between DVA services & CS (Social care & FPZ) • Support for children often grant funded e.g. BBC Children in Need, lottery funded. Data may be available from providers regarding outcomes • Outreach in schools: awareness raising of DVA to both staff & pupils • Children & adults to commission together • Increasingly seeing children becoming perpetrators of DVA – big gap in support (needs to fit in with APVA strategy) • Better partnership working between services to support DVA victims & children, e.g. liaison between DVA worker, HV/SU & FPZ when a family comes to a refuge • Joint Commissioning – wide ranging service to support victims, perpetrators and children – Joined up working • Share assessments with children's services • CYP services are unlikely to refer into a service where there is limited support for the child

3. Referrals agencies and mechanisms
• Need to ensure that key partners are not only aware of referral pathways but are actively using these • Simplified referral process • Could there be referral mechanisms in other services' case management systems, e.g. being able to do this direct from MOSAIC? • Lack of feedback to referring officer/individual • Referrals – Needs to be clearer pathway for agencies • Attend team meetings & promote the service • Better understand of Early Help and Early Intervention • Online referral with P&S consent, name & tel no, look at Live Well Dorset Approach • Due to complex childhood trauma experiences victims reporting abuse have issues responding to services (especially police) and though response become seen as the risk and the perpetrator – See DHR • How many people/services ask people if they are experiencing DVA to start the process of referral? GP/Doctor/Work/Sexual Health Clinics/Counsellors? • Can we make referral much simpler for professionals? Online referral meeting with patient consent • Single integrated approach, ongoing CPD, Police – single pathway across Dorset • Single Pathway aligned Strategic direction, BCP/Dorset, learning culture • Raising Awareness – can capacity cope? • Promotion of new services with key agencies so they know how to refer • Need to have simple one stop for victims to understand • Many agencies encourage self-referral – maybe ask the question 'how did you find out about this service?' to make the link to support more accurate data

4. Efficacy and targeting of pattern changing
• People may need to attend more than once (research suggests it takes several attempts to change behaviour) Needs to be available at several points • Consistent offer of pattern changing programmes • Share intervention with schools key – consent should not get in the way • Robust assessments from the offset, Information its often not what it seems • Freedom programme and pattern changing (freedom programme precedes pattern programme as a programme that assists clients with identifying abuse and unhealthy relationships • Better follow up of referrals & linking in with CSC re outcome, e.g. engaged or not engaged! • Can we provide some form of treatment/support that looks at both substance use and DVA at the same time? • Need consistent offers across county • Delivery of course is Pan Dorset but by different organisations needs/organisation responsible for organising the delivery and measuring outcomes • PC it only for people who have left the relationship. Awareness programmes also required for others • Fairness to access for all courses is required across county for victims and perpetrators
5. Duties and expectations of DVA Bill
• Include anger management courses for perpetrators • Improve accessibility for people with LD, mental health issues and older people • Long term commitment to DVA perpetrator programme on part of a universal offer – VPLU • MH & LD health services understanding if role includes new DVA Act responsibilities. Need joined up development and planning. • DVA from people not living with the victim including complex and multiple relationship circles

6. Responding to VAWG
• Ensure links establish with workstreams focussing on sexual exploitation and modern slavery • Offer assertiveness and self-esteem sessions within prevention work • DSAB – into DVA & LD (draft) identified issue with overuse of safeguarding response vs. DVA response and not seeing male victims as DVA
7. Impacts of housing consultation
• Are they trained enough to potentially identify and ask questions for DVA
8. Additional Queries
• Schools and education • Links with MARAC? • Positive recently at system within the Dorset Care Record • One lead integrated team skill link with DVA as a key process – would tick the box, look at the Doncaster model • Victim & perpetrator, e.g. inappropriate relationships including with children related to victimisation and abuse • Capacity vs coercive, control – key issue in LD • Mate crime and Friday night friends (friend abuse) in LD population including those assessed as having capacity • What are your outcome qualitative objectives? Outcome star model. In Poole the outcome model is used in refuge, pattern changing and family intervention • Limitations of system based on scores on a risk assessment when we know risk is fluid and can change quickly • How will we measure success? Value? Value for Money? • How do number of referrals equate to estimated need? What is the capacity of this service?

Strategic and Tactical Solutions Workshop

We have identified the follow key tactical areas to address in the service going forward. How can we address these?

1. Improving referrals from key agencies
• Easier referral process that reflects time constraints/skills/priorities of agencies and the commissioned service completes the risk assessment (Safe Lives) and appropriate next steps. Professional don't know where to go for information (DFY is not easy to navigate and most outside of FC don't think to look here) • Make it simpler – raise aware of how to do • Number of self referrals probably reflects the fact that services are giving clients choice about accessing services • Training for front-line staff • Standardised information self-referral form • Simpler pathway for referrals • Sharing of key information regarding risk, can be confusing as to how this can be shared and collated, MARM, MARAC, MASH etc. • Awareness raising with housing providers, shared training events, not just once – needs to be ongoing programme
2. Improved links for children identified within services
• Regular link discussion meetings between DVA service workers and FPZ and health & education etc (e.g. low-level local MARAC approach) • GP monthly safeguarding children meetings – link FPZ in, and 'frail' adults – link Adults services in • Specialist services to do dash risk assessment • Co-locate a team of adult and children workers. • Ensure work with children is stored with those working with adults and vice versa • What links are we wanting to improve – links to FPZ's/CSC or community links • How are outcomes for children monitored? • Multi-disciplinary, school-education nurses and children's services and any other relevant organisations • Earlier identifications of signs by key staff • Healthy relationships training jointly delivered

3. Developing an evidence base for pattern changing interventions
• Bournemouth university to lead on a research project • Also need an agreed approach to measuring outcomes for all services delivering programmes and a central point for collating these and reporting on impact. • Potential funding from a university • Commission a partner to collate information at beginning, through and at the end • Need standard IT system • Local evidence base? Needs analytical support • Need to be able to keep in touch with clients for a period after closing cases to track outcomes • Use current research and see what works and use this • Wellbeing rating sales – pre and post intervention and follow up 6 months or longer • Track cases over a longer period. Feedback as part of contract monitoring
4. What are we missing?
• National and local data sets required • Information sharing agreement across statutory and voluntary services needs promoting so people are aware they can share in relation to DVA • Whole family approach • Standardised IT system • MARAC is it working? this needs to be looked at alongside this piece of work • PPN, a process, needs to be appropriate, sent to relevant agencies

Approaches to development work to support a future contract model:

1. Who should be involved?
• CMHT • Hospitals • Drug & alcohol services • Need to re-procure new contract. as soon as contract is procured need to start looking at longer term. Jointly commissioned (needs to be part of current project plan. • Frontline provider staff to get clear picture of how things work on the ground. Coproduced.
2. How do we link up?
• Single IT system/central database
3. How do we integrate approaches?
• Ensure that agencies are aware of overall aim but also clear on how their workstream fits the whole • Single service regardless of risk scoring
4. Funding and commission collaboratively
• Joint commissioning of services
1. Giving survivors a voice in development?