

PREVENTION NOT PREDICTION?

**A preliminary evaluation of the Metropolitan Police Domestic
Violence Risk Assessment Model (SPECSS⁺)**

Final Report

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Research Team

Dr Cathy Humphreys

Dr Ravi K. Thiara

Linda Regan

Jo Lovett

Lorna Kennedy

Andy Gibson

Centre for the Study of Safety and Wellbeing,
University of Warwick

and

Child and Woman Abuse Studies Unit,
London Metropolitan University

Contact: cathy.humphreys@warwick.ac.uk, r.k.thiara@warwick.ac.uk (co-authors) or
jane.beeko@ncs.police.uk (ACPO Domestic Violence Steering Group)

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Abbreviations

ABH:	Actual Bodily Harm
ACPO:	Association of Chief Police Officers
ACT:	Australian Capital Territory
BME:	Black and Minority Ethnic
CDTP:	Complainant Declines to Prosecute
CIS:	Criminal Intelligence System
CPS:	Crown Prosecution Service
CRIS:	Crime Report Information System
CRIMINT:	Criminal Intelligence System
CSU:	Community Safety Unit
DCI:	Detective Chief Inspector
DS	Detective Sergeant
DV:	Domestic Violence
DVC:	Domestic Violence Co-ordinators
DVU:	Domestic Violence Unit
FL officers:	Front-line officers
GBH:	Grievous Bodily Harm
L1:	London Site 1
L2:	London Site 2
MAPPPA:	Multi-Agency Public Protection Panel
MARACS:	Multi-Agency Risk Assessment Conferences
NFA:	No Further Action
PFHA:	Protection from Harassment Act
The Met:	London Metropolitan Police
VIVID:	Vulnerable and Intimidated Victims Database
WY1:	West Yorkshire Site 1
WY2:	West Yorkshire Site 2

Executive Summary

Section 1: Background and Evaluation Design

The implementation of The Metropolitan Police Domestic Violence SPECSS⁺ Risk, Identification, Assessment and Management model (SPECSS⁺ model) is at an early stage. The emphasis of this report has been on a process evaluation which can shed light on how the implementation of the SPECSS⁺ risk assessment model is proceeding; what lessons can be learnt to inform future phases of implementation; and whether and under what circumstances it could be recommended to other forces. The evaluation team was asked to address the following questions in relation to the SPECSS⁺ risk assessment model:

- Does it comply with the ACPO guidelines on risk assessment?
- Does it address victims' needs in terms of risk?
- Does it complement safety planning?
- Can the model be managed within force limitations?
- Can it be applied irrespective of geography, community or policing variables?

The SPECSS⁺ risk assessment model was developed through a series of consultations between the Met and multi-agency partners based on the evidence from the London multi-agency murder reviews and serious sexual and physical assaults (Richards, 2004; Richards, 2003). It is a three-stage model which involves an initial response, an assessment of risk and intervention to manage the risks identified. The assessment of risk is based on six prominent risk factors outlined in SPECSS⁺ (Separation (child contact), Pregnancy (new birth), Escalation, Culture (community isolation and barriers to reporting), Stalking and Sexual Assault). A further six additional factors are also included as prompts for front-line (FL) officers to consider (abuse of children, abuse of pets, access to weapons, either victim or perpetrator being suicidal, drug and alcohol problems, jealous and controlling behaviour, threats to kill, and mental health problems).

To support the implementation of the risk assessment model the 124D form was developed for use in London, the VIVID data collection system for use in West Yorkshire, and the MPS Domestic Violence Policy and Standard Operating Procedures written. Risk assessment and risk management processes also need to comply with the ACPO *Guidance on Investigating Domestic Violence* (2004), which provides operational, tactical and strategic advice – the priorities of the police service in responding to domestic violence.

Evaluation design

To meet the evaluation brief a multi-methodological design was adopted by the evaluation team. Research was conducted in both The Met and West Yorkshire police forces. In each area, two police divisions were chosen as the evaluation sites. The following process was then undertaken:

- Semi-structured interviews with 10 'key informants' who were either currently or recently involved with the development of the risk assessment model.
- 71 structured interviews with FL officers.

- 20 face-to-face interviews with senior and specialist officers.
- 7 interviews with partner agencies.
- 4 interviews with victims.
- Analysis of 120 case files drawn from the 4 different research sites.
- Aggregate data analysis provided by West Yorkshire and the two London sites on specified variables such as: total number of incidents; total number of arrests; number of cases at each risk assessment level.
- Documentary analysis of the ACPO risk assessment guidance was undertaken to assess the extent of harmony or contradiction between the guidance and the implementation of the SPECSS⁺ model.

Section 2: One model – three different forms of implementation

Within the four evaluation sites there were three different forms of implementation, which had a marked effect on the way in which intervention occurred and the attitudes of the police officers towards the model. These differences included:

- the role of FL and specialist police officers in relation to victim support and investigation;
- administrative support;
- data inputting systems;
- support staff for victims.

The three different models seen in this evaluation revealed different strengths and limitations which should be considered if other forces are to implement the SPECSS⁺ model with its components of assessment, safety planning and risk management. Any force considering future implementation would need to undertake an audit of their local administrative and data inputting practices to understand where the vulnerabilities and strengths lie if a new process of risk assessment is to be implemented. This evaluation of sites in West Yorkshire and London suggests that risk assessment and risk management can be applied irrespective of geography, community or policing variables, but that it will operate very differently in different areas depending upon the policing variables.

Section 3: The SPECSS⁺ factors

The SPECSS⁺ model is based on giving priority to six factors which are seen to pose the highest risks to victims. A further ‘plus six factors’ are also listed for police officers to consider.

- When addressing the question of whether the SPECSS⁺ model addresses victim needs in terms of risk, consideration needs to be given to whether the six SPECSS⁺ factors are the key high risk factors. Evidence from the literature, experienced police officers, and the Cardiff Safety Unit evaluations suggests that other factors (two of which are currently in the ‘plus six factors’) such as ‘threats to kill self or others’, use of drugs and alcohol, and controlling and obsessive jealousy may be of equal or more significance than some of the current six heightened factors.
- The application of the model across the country does raise the issue of whether ‘Culture’ is the most appropriate term to signify heightened risk through isolation, attitudes, and barriers to help seeking. In spite of training,

there was very limited use of the category of ‘Culture’ beyond families of BME origin and hence it was not being used to designate more general risks associated with isolation and barriers to help-seeking. Note, for example, that none of the 30 cases in Site 1 in Yorkshire had ticks against ‘Culture’ as a risk factor. The very strong opinions, both positive and negative, about using the term ‘Culture’ also raise questions about its appropriateness. While some were concerned that the dangerousness of ‘crimes of dishonour’ was not minimised, others argued that it was a term too easily conflated with all BME groups and therefore open to stereotyping and racism. The latter point is of utmost importance when considering the ACPO emphasis that the police force delivers a service to all without discrimination as required under the Race Relations (Amendment) Act 2000 and the Human Rights Act. The fact that, in spite of great efforts by the two forces involved in the pilot, significant numbers of police officers miss (and possibly continue to miss) out on the training where the complexities in understanding and interpreting the category of ‘Culture’ are explained further creates concern about retaining ‘Culture’ as a heightened risk factor.

- Any re-working of the SPECSS⁺ factors needs to be considered in the context of ‘force limitations’. A simple limited factor model is one of the most attractive features of SPECSS⁺ and allows early risk assessment by FL officers prior to a more comprehensive enquiry by the CSU officers – an issue which makes it manageable in terms of force limitations.¹
- The West Yorkshire Guide is clearly written and the 124D should stand as a model of clarity and concision in relation to how the risk factors are laid out. FL officers frequently commented upon how they liked the simplicity and accessibility of the guidance. The clarity of the guidance is a strength of the model.

Section 4: Police use of the SPECSS⁺ model to inform risk assessment

West Yorkshire Police and the Met have demonstrated that it is possible to ‘roll out’ a new risk assessment procedure across large police forces. A number of issues are relevant in informing the process through which the SPECSS⁺ model is being used in different areas and have implications for other police forces.

- The FL officers are generally using the SPECSS⁺ model in a ‘mechanistic’, though quite standardised, way through adding up the number of risks. This process highlights the importance of which factors inform the risk assessment. A number of officers also spoke of conducting a more complex analysis of cases.
- Specialist officers appreciated having a formal framework for risk assessment, though felt there was not a significant change to the quality of their work with the introduction of the SPECSS⁺ model. They actively supported the introduction of the model for FL officers as they saw a positive difference in some aspects of FL policing, particularly in the number of witness statements taken, the permission for medical evidence, and providing an initial risk assessment. In relation to the Part 2 guidelines they suggested a number of

¹ An alternative mnemonic has been suggested – the 4 ‘S’s SPECIAL (Separation, Sexual Assault, Stalking, Substance Misuse and mental health problems, Pregnancy, Escalation, Child Abuse, Isolation, Attempts/threats of suicide or homicide, Legal Obligations).

changes: questions needed to be re-worded or changed, especially those on sexual violence where the order could be changed, with questions on weapons not coming directly after those on sexual violence; providing more room on the form for recording details; and the number of 'yes/no' questions was considered inappropriate at the secondary level, where the 'story' needed to be told in more detail, particularly as this could also be used as disclosable evidence for the CPS.

- An overall recommendation is that interested FL officers, CSU officers and representatives from partner agencies be brought together to provide input on changes which need to be made now that there has been some experience with the 124D, the second-stage process and administrative and data inputting systems. Officers at different levels expressed enthusiasm about contributing to improving a system which they felt generally positive about, but where small changes could make a difference.
- Further work is needed to ensure that high levels of repeat victimisation are responded to within the risk assessment framework. Repeat victimisation was much more obvious in its influence on the risk assessment level in West Yorkshire, where there has been greater previous experience of incorporating this into the police risk assessment (Hanmer et al., 1999) than in London.
- There is some variation between areas about the response to different levels of risk and the use of different categories. There is no evidence that the high-risk category is being overused and in some areas may not be being used enough. Several police officers mentioned that local resources and staffing levels within the CSU influenced categorisation, as they did not have the staff to provide too many responses to high-risk victims. However, one area (WY2) performing well in terms of arrest rate, suspect tracing and safety planning had few cases in the high-risk category. This may be because they were actively bringing down the risk at the incident scene or directly afterwards.
- The process is not cost neutral. CSU officers/DVCs commented that they have seen a substantial rise in their workloads as a result of the significant numbers of high- and medium-risk cases which require concerted action. They commented that this was due to these cases being flagged earlier and that a more comprehensive policing response by FL officers was leading to a considerable increase in their workload.
- Acting on agreed protocols for risk assessment and risk management, particularly in relation to the FL officers, still requires further development. The most frequent comment made was that FL officers needed to take some responsibility for taking action to decrease high risk cases, and that this was not just a specialist officers' responsibility. It is recommended that future models always refer to 'risk assessment and risk management', as 'risk assessment' does not imply that action needs to be taken.
- The case file analysis showed some evidence that the risk assessment and risk management process is dynamic, with changes in the risk categories as cases moved through the CSU. However, there were also comments that the staffing levels meant that police officers were always dealing with the crisis situations as new incidents came through, rather than having time to follow up. The fact that one area showed several cases with quite extreme levels of repeat victimisation on CRIS is indicative that more work is needed by officers to target these cases to bring the risk level down, including through greater inter-agency co-operation.

Section 5: Impact of the SPECSS⁺ model on enhancing police work, responding to the incident, evidence gathering and data inputting

The research reports on which the SPECSS⁺ model is based (Richards, 2003; 2004) alongside the ACPO Guidance highlight the fact that the introduction of risk assessment and risk management should improve the police response to domestic violence in relation to: increased victim safety, managing lethal situations; making better use of intelligence; and increasing the standard of investigation and supervision. Increased arrest and prosecution rates should result.

- Police officers at all levels were generally positive about the use of the SPECSS⁺ model as a risk assessment tool. Some senior police officers were unconvinced that the SPECSS⁺ model had enhanced the quality of police work in terms of taking forward a case for prosecution. This was particularly in L1 where FL officers were not inputting the data from the 124D onto the CRIS database². There were, however, a range of other findings relevant to this aspect of implementation.
- The 124D booklet was generally viewed positively by London FL officers, who saw it as a useful model at the incident, particularly for 'jogging the memory' about the questions to ask and the evidence to collect. Sensible recommendations were made for changing the wording and ordering of questions.
- West Yorkshire FL officers (without the 124D) were less positive about the usefulness of the SPECSS⁺ model at the incident. The DVCs, however, recognised a marked difference in the work of the FL officers at the incident, which they said assisted their work.
- Arrest rates as a proportion of reported domestic violence incidents are up in West Yorkshire as a whole (by 6%) and in WY2 (from 35% to 54% – a substantial 19% increase) but down in WY1 by six per cent. Similarly, in London based on the analysis of 30 cases in each site, L1 had a higher rate than L2, though this difference is not mirrored in the aggregate data for London.
- In each of the areas, the suspect leaving the scene is an issue. However, the rate of tracing is much higher at WY2 than at L2 and WY1, where they have similar problems.
- FL officers reported that the 124D assisted them with evidence gathering. Witness statements were being taken in 36 per cent of the London cases and 36 per cent of the West Yorkshire cases. Initial officer statements were noted in 22 per cent of London cases and 42 per cent of West Yorkshire cases (a significant difference) and other witness statements taken in 42 per cent of London cases and 36 per cent of West Yorkshire cases.
- Other forms of evidence gathering were negligible with few photos, no DNA and a small number of reports of damage to the property. This would suggest that the high level policing required on high-risk cases is not yet occurring.
- On the basis of the case data, the rate of prosecution was very low. Of 60 London cases, eight per cent were cautioned and three per cent involved a first instance of harassment. In West Yorkshire, of 60 cases, five per cent were

² By the end of this evaluation process L1 had changed its data inputting process to direct FL officer inputting.

cautioned. Fifteen per cent of 60 cases in London and 18 per cent of 60 cases in West Yorkshire were ongoing. These figures suggest that further work needs to be undertaken to enhance the policing on medium and high-risk cases so that higher prosecution rates can occur.

- The high workloads discussed in earlier sections may influence the level of police intervention, which is constrained by staff shortages.
- In two areas, repeat victimisation had increased over the past year and the arrest rate also decreased in one area, though significantly increased in other areas. These data do not imply that the SPECSS⁺ risk assessment undermines aspects of the evidence gathering process, however, neither will it be a panacea. Training, high levels of supervision, and commitment and leadership at senior level are essential to improving the intervention response.
- It should be noted that the two areas of London with the highest detection rates were also the areas with no high level repeat victimisation.

The complexities of responding to the domestic violence incident, evidence gathering and data inputting are related.

- Most officers using it spoke very favourably of the VIVID system and it was seen as a vast improvement on the previous system.
- On the negative side, it is less helpful for FL officers at the incident itself than the 124D in London and there are potential problems in the evidence collection being separated and not necessarily clearly documented on the database.
- Both areas have issues around fragmentation/duplication/possible omission of information due to the use of multiple information systems.
- The complex processes for data inputting in London have a substantial impact on the ‘bedding down’ of the SPECSS⁺ model and have cost implications. The 124D takes a substantial amount of time to input, particularly for FL officers if they are not good word processing or IT literate.
- While FL officers see the sense in this for serious domestic violence incidents, they were less happy both taking and inputting full reports for verbal incidents and what were seen as minor incidents (including incidents under the expanded ACPO definition of domestic violence). Any response to this issue would need to be balanced against the problems which arise when front-line officer discretion is given on what to treat as domestic violence incidents.
- An issue raised by officers at all levels was that the new definition of domestic violence under the ACPO guidance which includes violence and abuse between relatives, resulted in police officers being called to incidents they considered to be relatively minor and not necessarily domestic violence. They were unhappy about filling out the full 124D in these cases. Further training may serve to explain and clarify this to officers, especially the issue of escalation and the need to gather the history related to the incident.
- The immediate way through the ‘London IT problem’ was not clear. The process of FL officers inputting data from their 124D booklets to data inputters, either by telephone or verbally, could be piloted, though it requires the 124D to be re-worked as a tool for data inputting not an Aide Memoire. An electronic version of the 124D could be developed and piloted.

- Higher levels of administrative support are required to tighten the system so that evidence is not being lost between sections of the police force with different responsibilities.

Section 6: Supporting safety

The ACPO Guidance clearly specifies that victim safety and support is a central aspect of the police response to domestic violence and that multi-agency working is crucial to developing this work. Victim support enhances other aspects of policing including enabling cases to be prosecuted. Moreover, risk alleviation can only occur once victims trust that they will be supported in their actions to access other forms of help. The role of safety planning is to depress the risks a victim faces and this will often involve a complex process of multi-agency support.

- A huge amount of work appears to have been achieved by a very small number of staff in some areas in relation to victim support and safety enhancement. Caseloads in some offices are extremely high.
- The full range of support (including solicitors) does not always appear to be accessed. Panic alarms and home security were used less frequently in the London sites than West Yorkshire.
- Further supervision of FL officers is required to support the documentation of safety planning which was frequently not filled in on the 124D.
- Initial police follow-up of victims to gain a full history is an essential part of investigation. However, ongoing victim support is also a role which other agencies or non-police staff co-located at a police station can play, and which can potentially free up police officers to concentrate on the investigation and rapid response. Some areas in London (L1) are now working with the latter model and it has been reported upon very positively at all levels.
- The notion of victim safety is one which has generally been well understood within the police service with the development of CSUs and DVCs who are often highly committed individuals working with attention to safety planning. Limitations are created by very high workloads and the need for greater attention to the development of multi-agency work.
- Opportunities for multi-agency working have been under-utilised in the implementation of the SPECSS⁺ model at a local level.
- The 124D has a section providing important information that can be given to victims – again this is a strength of the booklet. The extent to which the victim is regularly updated and reviewed was unclear from the data and we have too little information from victims to know how this element of the intervention is working.

Section 7: Training processes

Training is central to the implementation of the SPECSS⁺ domestic violence risk assessment model and an important aspect of the ACPO Guidance and supporting framework.

There are some lessons which can be learned from the implementation of training across London and West Yorkshire. These issues were raised in interviews with key informants and from interviews with workers from partner agencies.

- Several interviewees recommended that Commanders and senior police officers be trained first so that they can facilitate the processes through which training is implemented in their units. It was continually mentioned that without senior officers championing the introduction of the SPECSS⁺ model it would not be used appropriately.
- A range of different training models are developing for FL officers, from the 40-minute focused input on SPECSS⁺ to the full one-day training. The recommended model is the full-day training, but some revisions to the training may need to occur to make it directly relevant to FL officers. Clearly, there are different resource implications for different models. 'Stage 2' training should not necessarily occur after 'Stage 1'.
- The speed with which training was expected to be 'rolled out' prior to the implementation of the SPECSS⁺ model meant that the substantial number of days required for training FL officers, and the second phase with CSU officers, needs forward planning. Training plans for the year had already been established and agreed prior to the notification that SPECSS⁺ training was mandatory. This is a problem which needs to be forestalled if other areas of the country are involved in implementing the SPECSS⁺ model.
- The training was mainstreamed and therefore needed to be funded from existing police resources which compounded the problems associated with the 'fast tracking' of the training schedule.
- Careful planning is required to ensure that the training on the SPECSS⁺ model is also an opportunity for the development of joint working. The role of support agencies in providing the advocacy and resources to support safety for victims is essential to the SPECSS⁺ model and needs to be seen as integral, not 'an add on' at least for the specialist officer training. In many areas, the amount of training, the timescale and the lack of budget have meant that a joint training model has not been implemented. It has also created problems rather than bridges between the police and other agencies.
- Monitoring systems need to be put in place to establish who has been trained. While supervision and data inputting processes provide an extra check on how to categorise risk, this is not necessarily a compensation for missed training, which will still need to be addressed if ACPO compliance is to be achieved. In our sample of 71 FL officers all of whom should have been trained, 51 per cent had attended training on the SPECSS⁺ model.
- Not all data inputters and support workers have been trained and they mentioned that, given the level of work they undertake, their training in the use of the SPECSS⁺ model is also important, suggesting that staff at all levels need to be trained.

Conclusion: A change opportunity

The SPECSS⁺ risk assessment model is not just a new procedure, but part of a 'change process' in policing domestic violence. This process needs to be 'sold' particularly to FL officers who are implementing the risk assessment, especially if they are to act on their responsibility to intensify their efforts on evidence gathering, take immediate action to manage high- and medium-risk cases to decrease that risk, and produce detailed reports (either verbal or written) which are able to be used by the CPS and the specialist officers.

To be ACPO-compliant, the process of implementation needs to take account of complexities and the impact of change. A small and committed project team is required. The experience in London suggests this should occur at Borough level as well as within The Met. It also requires that a senior officer champions the implementation process and provides support, vision and resources. The experience of the pilot projects suggests that the team needs to plan:

- Training at all levels of the police force.
- The development of data inputting and administrative systems (and their co-ordination with existing systems).
- The development of internal guidelines which delineate the expected responses from police officers at standard, medium and high level, and the expectations in relation to evidence gathering and follow-up.
- The requirements and processes for supervision and monitoring.
- Liaison with partner agencies in relation to training, safety planning and data sharing processes.
- Liaison with the CPS to develop the protocols and understandings by the CPS of the different levels of risk and the requirements for evidence gathering for prosecution purposes.

At this stage, one of the most significant shortcomings of the implementation process lies in the lack of attention to the multi-agency processes. A major initiative such as this within the police force could be an opportunity to enhance partnership working. Joint training, agreed responses to high-risk victims and suspects (through the development of MAPPPA) and enhanced safety planning are all areas where opportunities could be developed.

In short, the implementation of the model is not cost neutral. The costs are comparatively small but need to be budgeted for if a promising initiative is not to be undermined by low staff morale induced by the increased workloads resulting from a more comprehensive approach to policing domestic violence. If the model is implemented well, there are also systems changes which need to be acknowledged and worked with to reap the full potential of the risk assessment and risk management model.

Section 1: An overview of risk assessment and evaluation design

Background and context

Risk assessment as a model to aid the policing of domestic violence is growing in popularity. Numerous forces in the UK, as well as internationally, are either using risk assessment models/tools or assessing their value with a view to implementation. A particularly attractive feature of police risk assessment models is their potential to fulfil multiple functions. A summary of this is provided by Robinson (2003:8) and includes:

- a) Providing a structured guide for responding officers to gather detailed and relevant information at the scene of the incident.
- b) The ability to provide other agencies with information which will give a better service to victims by specifying their particular needs, especially in relation to safety.
- c) A more systematic recording of a 'paper trail' of evidence with which to inform prosecutors, particularly if victims are not in a position or willing to be involved in the criminal prosecution.
- d) The prioritisation of scarce criminal justice resources to help assist police and other agencies to identify those victims in the most dangerous situations who need more resources from the police and other agencies to support their safety and prevent the escalation of severity over time.
- e) The enhancement of multi-agency partnership working through a shared view of risk and information sharing processes to support the safety of workers from other agencies involved with the family, e.g. health visitors and social workers, as well as the victim and children.

Indirect benefits may be further provided through the need for awareness raising and training for all police and support staff using the risk assessment model/tool (Hanmer et al., 1999) and the support for an integrated criminal justice approach to domestic violence, of which high quality evidence gathering is the first essential plank (Humphreys and Holder, 2002).

Models and evidence base

The evidence base for the development of risk assessment models/tools draws on several different, though overlapping, areas (Radford et al., forthcoming).

- Murder and serious crime reviews (Richards, 2003; Websdale, 1999).
- Victimisation and crime surveys and reviews of policy and agency data (Walby and Myhill, 2002; Campbell et al., 1995).
- Analysis of perpetrator characteristics and contexts (Dobash and Dobash, 2002; Gilchrist et al., 2003).

A number of different risk assessment models have now been developed both in the UK and elsewhere. These include:

- 1) SPECSS⁺, the Metropolitan Police Risk Assessment model, developed and piloted by The Metropolitan Police (The Met) and West Yorkshire Police and the subject of this evaluation, based upon data analysed from the London

Multi-Agency Murder Reviews and Sexual Assault and Serious Incident Analysis, literature reviews, consultation with academics, practitioners and survivors (Richards, 2003; Richards, 2004).

- 2) SWP, South Wales Police Victim Initial Risk Indicator Form, a model developed following a police analysis of 47 domestic homicides, relevant research and information from multi-agency partnership working (Robinson, 2004). It closely models the Danger Assessment Scale (Campbell et al., 1995) in drawing out 15 risk factors.
- 3) SARA, Spousal Assault Risk Assessment, a model currently used in the probation service to assess risk.
- 4) The Killingbeck model developed in West Yorkshire to assist in prioritising their response to domestic violence incidents, which is more suspect than victim focused (Hanmer et al., 1999).

Together these models have been used to develop and enhance both police and multi-agency working in relation to domestic violence.

Risks of risk assessment models

A number of debates are currently 'live' in the area of risk assessment. While the current climate is generally very positive about the role of risk assessment, there are also a number of cautionary 'flags' which need to be foregrounded when evaluating the role of risk assessment for policing domestic violence.

First, there are concerns that in poorly performing forces the model will be used **only as a rationing device**, leaving all but the high-risk cases without an adequate service (Radford et al., forthcoming). While the intention of a risk assessment model/tool is to ensure that the police intervention at all domestic violence incidents is of high quality, good training and supervision are needed to ensure that this occurs.

Second, it is argued that risk assessment can provide **too narrow a focus** for policing and multi-agency work. Safety planning which goes beyond the assessment of the risk of further physical attack and re-victimisation to explore the steps required for psychological safety, freedom from fear and the steps towards recovery should also be considered (Radford et al., forthcoming; Davies et al., 1998). Such developments are particularly relevant for both police and other providers within the multi-agency context.

Third, concerns arise about the potential to use a 'risk assessment model' as a **checklist procedure**, which may undermine rather than facilitate the dialogue police officers need to have with victims to appropriately assess risk. 'Adding up' risk factors may provide very useful baselines but may also miss important aspects of dangerousness. In this instance, the Duluth Model, which is often cited as a good practice model, is of interest. Having undertaken some initial exploration of risk assessment models, Ellen Pence and her colleagues believed that the most effective form of risk assessment was for police to create a *dialogue* with the victim (usually woman), to understand the context of the latest incident (Pence, 2005). They were

concerned that issues such as threats to kill, controlling jealousy, and isolation were not necessarily easily assessed without a good dialogue with the victim.³

Fourth, the factors associated with risk are **not predictive or causal**. There are many false positives as well as highly dangerous situations where few risk factors are present (Sinclair and Bullock, 2002). The research in this area is relatively new and not yet comprehensive. Hence it is not clear which are the most sensitive measures for predicting risk (see Section 5 for further discussion).

The Metropolitan Police Domestic Violence SPECSS⁺ Risk, Identification, Assessment and Management model (SPECSS⁺ model)

The SPECSS⁺ model, which provides one response to policing domestic violence, is currently being piloted by West Yorkshire Police and The Met. The role envisaged for the SPECSS⁺ risk assessment is summarised by Richards (2004: 9):

The argument for the requirement of a risk assessment process is based on the need to enhance victim safety, manage lethal situations, to make better use of intelligence and to increase the standard of the investigation and supervision.

The model is about prevention rather than prediction.

The Met were called to more than 109,500 incidents of domestic violence in 2004 (Richards, 2004). High rates were also recorded in West Yorkshire, where 35,103 incidents of domestic violence came to the attention of the police in 2004. All domestic violence has potentially serious consequences for those involved. However, the police response can further increase risk if officers are overwhelmed by large numbers of incidents with no mechanism to sift out those perpetrators who pose a particularly high risk and those victims, including children, who need a very high level police response to avert further serious crimes being committed. This is a primary role of risk assessment.

While homicide rates over the past five years are disturbingly high (2 per week in London and constituting 25% of all murder in London and 35% of murder in England and Wales), in 2002-2003 the domestic violence murder rate fell to 15 per cent of murders in London (Richards, 2004). It is too early to say what created this dip, particularly as there seems to be a worrying rise again in 2005. It may be that, as seen in some cities in the US and some states in Canada, a concerted response to domestic violence can affect the homicide and serious crime rate.

The SPECSS⁺ risk assessment model was developed through a series of consultations between the Met and multi-agency partners (DV Murder Review Group; MPS DV Working Group; GLA DV Forum) based on the evidence from the London multi-agency murder reviews and serious sexual and physical assaults (Richards, 2004; Richards, 2003). It is recognised that there are terminology problems in referring to the SPECSS⁺ model, which is a complex three-stage model. The first stage involves front line (FL) police officers undertaking an initial response and investigation of the domestic violence incident and ensuring that they gather sufficient evidence at the scene and take 'positive action' where appropriate. The second stage involves an

³ This was a theme reiterated by specialist police officers interviewed in this evaluation who continually emphasised their role in gaining 'the story' of domestic violence, not a checklist.

assessment of whether the risk is standard, medium or high. This assessment is based on six prominent risk factors outlined in SPECSS⁺ (Separation (child contact), Pregnancy (new birth), Escalation, Culture (community isolation and barriers to reporting), Stalking and Sexual Assault). A further six factors are also included as prompts for FL officers to consider (abuse of children, abuse of pets, access to weapons, either victim or perpetrator being suicidal, drug and alcohol problems, jealous and controlling behaviour, threats to kill, and mental health problems).

The third stage involves both the FL officer but also specialist officers in the management of risk and taking appropriate steps to minimise risk through the RARA model (remove, avoid, reduce, accept). Specialist officers are referred to slightly differently in different police forces – Community Safety Officers (CSU officers) or Domestic Violence Co-ordinators (DVCs) and their supervisors. These specialist officers carry out a more comprehensive assessment and take further action on the case. In some areas, this involves more intensive follow-up of the suspect and the investigation, whilst in others the specialist officers are primarily involved in lowering the risks of domestic violence by supporting victims and attending to their safety needs.⁴

To speak of the SPECSS⁺ model is therefore shorthand for a complex three-stage process of initial response, risk assessment and risk management.

To support the implementation of the risk assessment model the 124D form was developed for use in London, the VIVID data collection system was developed in West Yorkshire, and the MPS Domestic Violence Policy and Standard Operating Procedures were written.

ACPO guidance

In *Guidance on Investigating Domestic Violence* (2004) produced on behalf of ACPO, which provides operational, tactical and strategic advice, the priorities of the police service in responding to domestic violence are outlined as the following:

- To protect the lives of both adults and children who are at risk as a result of domestic violence.
- To investigate all reports of domestic violence.
- To facilitate effective action against offenders so that they can be held accountable through the criminal justice system.
- To adopt a proactive multi-agency approach in preventing and reducing domestic violence (2004:5).

In order to ensure that the police response to domestic violence supports and achieves these priorities, it is suggested that all chief officers establish and implement appropriate policies. The role of partnership working with both criminal justice agencies and other statutory and voluntary sector organisations in achieving these priorities is also emphasised. The guidance highlights the strategic issues that emerge for chief officers: implementing a comprehensive force policy; developing information systems which support the implementation of the guidance; focusing on police responsibility for investigating domestic violence related offences and

⁴ This latter model is currently under review.

fulfilling its role in the criminal justice system to ensure that offenders are held to account; ensuring that the training needs of all staff are met (2004:5).

ACPO issued further guidance on *Identifying, Assessing and Managing Risk in the Context of Policing Domestic Violence* in 2005, aimed at police forces which are either developing or already have in place particular tools/processes for risk assessment. In order to assist police forces in meeting the obligation to protect individuals within the Human Rights Act and the Race Relations (Amendment) Act 2000, the core aims of risk assessment in the context of policing domestic violence are outlined by ACPO as:

- To **reduce the likelihood of future harm** including the effects of further violence, serious injury and homicide (original emphasis).
- To **facilitate the effective use of police powers** including investigating, reducing and preventing crime, intelligence-led policing, targeting offenders, and narrowing the justice gap by holding offenders accountable (original emphasis).

The guidance also presents 17 principles for identifying, assessing and managing risk effectively, as well as the intended objectives/outcomes of this for: the victim, children and other vulnerable persons; the police service; other criminal justice and partner agencies (2005:2-8). Taken together, these principles set the framework through which forces throughout England and Wales can develop their own risk assessment procedures which are sensitive to local conditions, but compliant with a national set of principles. The SPECSS⁺ model, developed prior to the ACPO Guidance, is therefore one response to risk assessment and this evaluation will examine the question of the extent to which it is compliant with the ACPO guidance.

Evaluation brief

This is an 'early days' evaluation of SPECSS⁺. Implementation began in London and West Yorkshire just over a year ago (June/July 2004) and has been staged across different London boroughs. This evaluation was undertaken between January and May 2005 when the model was still in the process of being embedded in the respective police forces.

Clearly, the impact on outcomes of the implementation of the SPECSS⁺ model cannot be assessed at this point, although it may be possible to highlight some trends in certain areas. However, a process evaluation can shed light on how the implementation of the risk assessment model is proceeding; what lessons can be learnt to inform the future phases of implementation; whether and under what circumstances it could be recommended to other forces; the gathering of baseline data which can be used to inform future evaluations; and whether the early phase indicates that victims' needs in terms of risk and safety are being met.

A brief was given to the evaluation team, who were asked to independently establish the effect of the Metropolitan Police Risk Assessment model (SPECSS⁺) in relation to the following questions:

- Does it comply with the ACPO guidelines on risk assessment?

- Does it address victims' needs in terms of risk?
- Does it complement safety planning?
- Can the model be managed within force limitations?
- Can it be applied irrespective of geography, community or policing variables?

Evaluation design

To meet the evaluation brief a multi-methodological design was adopted by the evaluation team.

Research was conducted in both The Met and West Yorkshire police forces. In each area, two police divisions were chosen as the evaluation sites because they were either typical of the standard within the area, or were seen to be where 'good practice' could be found. In London Site 1 (L1), training for the implementation of the SPECSS⁺ model occurred in February and March 2004, but implementation did not begin until June/July 2004 when the 124D books became available. In London Site 2 (L2), the 124D has been implemented for about six months though, as with many other areas of London, the Stage 2 training for Community Safety Unit (CSU) staff was still to occur when this evaluation began. Implementation of SPECSS⁺ began on 1st July 2004 in West Yorkshire and again two sites (WY1 and WY2) were chosen within this force area.

At each site an initial interview was held with senior police officers and those in the force area with responsibility for ensuring that the SPECSS⁺ model was 'rolled out'. Permission was sought for interviewing officers, gaining access to aggregated police data and supervised access to detailed, anonymised data. A high level of co-operation occurred. The following process was then undertaken:

Key informant interviews

Semi-structured interviews were undertaken with **10 'key informants'** who were either currently or recently involved with the development of the risk assessment model. These included eight who were employed by The Met or West Yorkshire police and two from the voluntary sector. Eight were women and two were men. These interviews provided invaluable background information about the context, development and implementation of the SPECSS⁺ model.

Interviews with police officers

Interviews were undertaken with a range of police officers in the two police forces who were involved in either the implementation or the management of police officers in relation to the risk assessment model.

71 structured interviews were undertaken with FL officers

Selected days were spent at police stations at each of the four sites, where it was found that shift changes and handovers were times when officers were available to undertake the face-to-face structured questionnaire and interview. Particular attention was given to the perceived strengths and weaknesses of SPECSS⁺ in relation to their

work, the implementation issues, and their perceptions and feedback in relation to the safety of victims. Table 1 provides a breakdown of the FL police officer sample.

Table 1: Front line officer sample group

Research site	Number interviewed		Sex				Rank					
			Male		Female		PC		PC Probationer		Sergeant	
	N	%	N	%	N	%	N	%	N	%	N	%
London												
L1	11	16	6	12	5	23	7	13	4	27	-	-
L2	13	18	10	20	3	14	8	15	5	33	-	-
Total	24	34	16	32	8	37	15	28	9	60	-	-
West Yorkshire												
WY1	25	35	15	31	10	45	23	42	2	13	-	-
WY2	22	31	18	37	4	18	16	30	4	27	2	100
Total	47	66	33	68	14	63	39	73	6	30	2	100
Overall totals	71	100	49	69	22	31	54	76	15	21	2	3

The officers were almost all White British (n=69, 97%), with one officer identifying as White European and the other as Mixed Race. The average age of officers interviewed was 31, (mean 31.4). The average length of service was just under five and a half years (mean 5.45). The largest group (n=32, 45%) had served for less than three years. Six officers (8%) had less than one year's service.

20 face-to-face interviews with senior and specialist officers

Semi-structured interviews were held with a further 20 police officers. These included: 11 CSU officers or DVCs; one DCI; three Detective Sergeants; two Chief Inspectors; two Deputy Chief Inspector; one police training officer for the SPECSS⁺ model. These interviews were spread relatively evenly across all four sites. They provided an in-depth perspective on the strengths and weaknesses of the model as they perceived it and could be checked for similarities and differences with the views of FL officers.

7 interviews with partner agencies

7 semi-structured interviews were conducted with workers in partner agencies which support survivors to ascertain their views on the police risk assessment process in relation to the women they support and other multi-agency work issues. These interviews created a further check on whether the 'police perspective' was shared across the domestic violence sector, whether the SPECSS⁺ model enhanced or undermined multi-agency working and how it contributed to victim safety.

4 interviews with victims

It was initially planned that survivors referred to the evaluation team by either the police or support agencies would be interviewed. Because of the time needed by police officers and support agencies to contact victims and gain permission, this proved particularly difficult to achieve within the pressurised timescale of the

evaluation. Victim satisfaction surveys were accessed from West Yorkshire headquarters to provide some information from victim perspectives. Clearly, a future evaluation will need to explore this perspective in greater depth.

120 case file analysis

120 cases were analysed from the police files (60 in West Yorkshire and 60 in London) for information relevant to the implementation of the SPECSS⁺ model:

- To ascertain the consistency with which the risk assessment process is being used.
- To explore the extent to which police practice is guided by the use of the risk assessment in relation to victims.
- To explore other impacts of the risk assessment process.

In London and West Yorkshire different processes were used to suit the requirements of the research sites. In West Yorkshire, 30 cases were drawn from each site – 10 standard-risk, 10 medium-risk and 10 high-risk cases were selected for January 2005. The insufficient number of high-risk cases at one site meant that the period was extended to February and March 2005 for this category.

In London, in L1 the researcher selected every sixth case, and a group of cases were pre-selected by the CSU officers for the researcher to examine in L2. Again, a total of 30 cases were selected from each of the two sites.

Aggregate data analysis

Analysis was conducted of aggregated data provided by West Yorkshire and the two London Sites on specified variables such as: total number of incidents; total number of arrests; number of cases at each risk assessment level.

Documentary analysis

A documentary analysis of the ACPO risk assessment guidance was undertaken to assess the extent of harmony or contradiction between the guidance and the implementation of the SPECSS⁺ model.

The aim of the evaluation design was to gain an overview from a range of different sources. Data were triangulated to provide different ways of cross-checking information and to build up a rich picture across themes to address the evaluation questions. For instance, the London and Yorkshire aggregated data was used to check the representativeness of the case file data; the interviews with officers at different levels could be checked for similarities and differences within and between areas and to look for congruity or differences with the case file data; the interviews with victims and multi-agency partners provided alternative perspectives to those of the police and could provide supporting evidence for the operation of the risk assessment model.

Ethical clearance in relation to all aspects of the project was gained through the Social Science Faculty Ethics Committee at the University of Warwick and specific clearances were obtained through the Police via the URHC Unit and Performance Review Unit. Researchers were supervised on site when looking at confidential data. All cases were anonymised.

The report

This report provides a preliminary evaluation of the SPECSS⁺ risk assessment model for domestic violence. Each section introduces the specific theme to be explored against the evaluation criteria. Section 2 explores the variation between sites; Section 3 discusses the appropriateness of the six SPECSS⁺ factors; Section 4 explores how the police officers are using the risk assessment model and making judgements; Section 5 looks at the impact on police investigation and the significance of data inputting systems; Section 6 follows the evidence of police support for safety planning; Section 7 focuses on training issues. The final section outlines the main conclusions from the evaluation findings and makes recommendations for future considerations or action.

Section 2: One model – three different forms of implementation

The SPECSS⁺ model is being implemented across West Yorkshire and London and needs to be compliant with the ACPO Guidance on *Identifying, Assessing and Managing Risk in the Context of Policing Domestic Violence* (2005). In spite of similarities between areas there are also important differences in the following:

- the role of FL and specialist police officers;
- administrative support;
- data inputting systems;
- support staff for victims.

This section explores these similarities and differences, as they are significant in relation to current implementation and highlight issues which other forces need to consider if they are exploring the implementation of a risk assessment model. Discussion with FL officers and CSU officers about data inputting and administrative issues indicated that these are fundamental to the successful implementation of the SPECSS⁺ model. While these issues are returned to for further discussion in Section 5, they are discussed here because the SPECSS⁺ risk assessment model is being implemented in three different ways across the four sites (WY1 and WY2; L1 and L2).

These issues are particularly pertinent to exploring the questions of whether and how the SPECSS⁺ model could be managed within force limitations and applied irrespective of geography, community or policing variables.

West Yorkshire

In West Yorkshire, FL officers attend the incident. They use the SPECSS⁺ prompts as guidance at the incident. There is no notebook such as the 124D used in London, which takes FL officers through the questions to be asked at the incident and integrates the victim and witness statements into one evidence/information booklet.

Following the incident, FL officers should consult with their supervisor to agree a course of action and risk assessment level. They then telephone the data inputters for the Vulnerable and Intimidated Victims Database (VIVID). The data inputters prompt FL officers for the relevant information, which is then inputted directly into the VIVID information system. Over time it is expected that this prompting process will become ‘muscle memory’ and that officers will be automatically drawing out all relevant data from the incident scene. No log can be closed until the risk level has been entered.

Every morning all the VIVID entries from the previous 24 hours are looked at by support staff (or Domestic Violence Co-ordinators in some divisions) attached to the Domestic Violence Unit (DVU). They assess them, check the Criminal Intelligence System (CIS) reports for each incident (victim and suspect) and look at the history and pass on the Level Cs (under the Killingbeck graded response model) and medium- and high-risk cases to the DVCs or others if the FL officers have indicated an intervention is needed. Support staff send out letters to all cases.

The DVCs co-ordinate the response to, and support for, victims. They are not involved with the suspect, though they attempt to monitor the crime and continually raise the case if arrests have not occurred.⁵ The role of the DVC is dependent upon the level of risk. They rarely take original statements but do victim withdrawal statements when requested; they also go to court. Once they have completed the Part 2 risk assessment, the DVC or clerical worker records it on the VIVID system. The paper copy is filed away or, if there is a court case, it goes as disclosable evidence to the Crown Prosecution Service (CPS) – classed as a court document.

London

The two London sites use the SPECSS⁺ model for both FL officers and CSU officers. While the two London sites both use the SPECSS⁺ model, there are three main differences between the sites which affect its implementation and which result from trying to find different solutions to the London IT problems. The first difference is that L1 responds to approximately half the number of domestic violence incidents as L2 (see Table 2), and this significantly affects the administrative complexities associated with the SPECSS⁺ model. The proportion of domestic violence incidents remained similar between January 2004 and January 2005 in each area.

Table 2: Recorded domestic violence incidents (London)

Research site	2004		January 2004		January 2005	
	N	%	N	%	N	%
London	109480	100	9356	100	9776	100
L1	2447	2	221	2	208	2
L2	5495	5	440	5	444	5

In London, FL officers take information at the incident scene by using the 124D, an oblong notebook in which all information from the incident, including witness statements, photographs and medical consent, are collected together and used to inform the SPECSS⁺ risk assessment, which is integrated into the booklet.

In L2, FL officers then return to the police station to input all data from the 124D onto the Crime Report Information System (CRIS). They may also need to input data onto the Missing Persons and Linked Indices Database (Merlin) and the Criminal Intelligence System (CRIMINT). For each incident, this process can take from 40 minutes to four hours in complex cases and is dependent upon the officer's word processing skills.

In contrast, at L1 the lengthy process of inputting the data from the 124D onto CRIS is left for a data inputter.⁶ FL officers, on returning to the office, leave the booklet in a tray to be inputted by restricted duty staff on to CRIS. This is the point which is vulnerable to breakdown if the 124D is not inputted immediately.

⁵ This process is now being reviewed following an examination of arrest rates and the increase in the level of repeat victimization. The work of the DVCs may be moved to within crime rather than community safety. This will create problems about who will offer the victim support in areas where there are few services.

⁶ Since the completion of the evaluation, this process has now changed and the model for L2 is now being used at L1.

Prior to this you would put the report on CRIS. Now you fill a 124D. Can be delay between 124D being done and being put on CRIS. Usually 124D put on CRIS by following day. If a serious incident would put on CRIS straight away myself (406).

The FL officers are still expected to input emergency/high risk cases and also to input on to CRIMINT and Merlin systems. This is then accessed directly by CSU staff through CRIS.

At both sites (L1 and L2), the Detective Sergeant (DS) picks up all crimes that have come in from the crime management unit overnight – a different process from the sorting often undertaken by support staff at West Yorkshire, due to the role of the CSU with the suspect. The DS reads all the crimes to see if anyone has been detained overnight and, on the basis of all the crime reports, allocates cases to CSU officers. Through this process an overview should be kept on all domestic violence cases.

In an area with very high crime levels, such as L2, the process of getting the 124Ds completed by the FL officers to the CSU is not systematic or straightforward. This is an important administration and resource issue. At L2 there is a difference between those cases where an arrest is made and those where there is no arrest. If someone is arrested, the 124D goes with the prisoner to the police station where it stays with the custody sergeant or at the police station until it is picked up by a CSU officer. If there is no arrest, the 124D is put into an envelope and sent through dispatch to the CSU. These come through at different times or they are put in trays at the police station until trays fill up and then either a CSU officer picks them up or they are posted to them. It was stated that there is an absence of a robust system *'for getting the non-arrest ones back to us...and some go missing'* (CSU staff). It was an issue confirmed in the case file analysis where there were problems tracking some of the 124Ds.

It was suggested that this could be improved by stopping the officers posting them individually and instead putting them in a tray so that they can be collected daily by someone from the CSU.

Moreover, since 124Ds go with case papers to court and civil proceedings, keeping track of them was seen as very labour intensive and, again, some go missing – *'In April alone we had 440 and we haven't got 440 in our system. So we've got lots missing...the officer puts them in dispatch system and they don't get here. It's very hard to find out where they've gone or what's happened to them'* (CSU officer).

It was stated that a full-time staff member was needed just to deal with this aspect, especially as some of the missing ones are needed in court proceedings. A secure system, which ensures they all get passed on to the CSU, was seen as necessary. A part-time sergeant at L2 does this when he can, but it is seen as having generated considerable administrative problems.

Storage of the 124Ds was another issue that was flagged up, as they need to be stored securely. The length of time they need to be kept was another source of uncertainty – *'it's a shame that in this modern day and age we couldn't get them scanned onto the CRIS report...paperwork is a nightmare'* (Senior police officer).

In cases where there is a suspect and the victim has given a statement CSU officers make an effort to retrieve those books, but otherwise they have to wait *'for it to sort of land on your desk'*. Time lag was therefore an issue for CSU staff picking up 124Ds in a large area with many police stations – *'you walk around and you'll see a lot of 124Ds just sitting on officers' desks...because we're so used to working from our crime reports'* (CSU officer).

One further inputting issue was raised for areas such as London where there is such a diverse population. It was found that surnames that are difficult to spell are often not thrown up in the initial data base searches because they are spelt incorrectly.

Once the case is with the CSU, officers are guided by the risk assessment done by the FL officers but also they *'go back to the beginning...not just what happened on the day of the incident but we need to go back a lot further than that'* (CSU). When the FL officer has done the initial intervention it is then the job of the CSU officer to carry out the interview with the suspect, especially the repeat ones. Clearly, this is different from the West Yorkshire model where the CSU is not involved with the suspect – though as stated earlier, this aspect of the process is currently under review.

The CSU officers also make contact with the victim once they have built up the history of the case – to find out how they are, what action they want to take, discuss the options and devise a safety plan. This is done for all high- and medium-risk cases. If necessary, CSU officers liaise with other agencies. This aspect of the work is similar to West Yorkshire.

In L1 the other crucial difference is that, as with about 15 other police divisions in London, there is a victim support worker who takes referrals from the CSU officers. In L1, she undertook a very substantial amount of the support work. Her role and her individual work were spoken of highly by everyone in L1 including interviewed victims.

Summary and evaluation issues

FL officers, CSU and senior officers all spoke of the crucial differences which policing structures made to the implementation of the SPECSS⁺ model. This included the differing roles of CSU staff, the systems for data inputting, the level of administrative support, and the supervision processes. In implementing a risk assessment model these are clearly important issues for consideration by other forces. Three different models seen in this evaluation revealed different strengths and limitations, which are discussed later in the report.

- In relation to data inputting, clearly the VIVID system is far more efficient than the manual and multiple data processing systems used in London.
- London developed the 124D booklets in response to the IT problems of the Met. Robust administrative systems need to be in place to ensure that these reach the second-stage officers and that they are filed and stored. This implies that while administrative costs are not excessive, the implementation of a risk assessment model is not 'cost neutral' and needs to take into account the administrative processes and IT constraints.

- Gaining the balance between the essential role of victim support and progressing the case against the suspect through high-quality police intervention on the part of specialist officers is under review by a number of police forces. A victim support worker/s based within the CSU provides extensive support to both CSU officers and victims and appears to be a cost effective means of providing this service. Where this existed in L1, police officers, victims and partner agencies spoke of it positively.

Section 3: The SPECSS⁺ factors

The SPECSS⁺ model is based on training RL police officers to understand and identify risk based on priority given to six heightened factors which are seen to pose the highest risks to victims. Police are also trained to consider a further ‘plus six factors’. While it is likely that some police officers will assess cases against the SPECSS⁺ plus the six additional factors highlighted on the 124D and the West Yorkshire Domestic Violence Guide, other officers are likely to focus on the six heightened SPECSS⁺ factors. To some extent this is likely to be determined by experience and attitudes.

An attraction of SPECSS⁺ is its simplicity in providing a straightforward model which FL officers with basic training can remember and use. This needs to be balanced against whether this is an over-simplification which might inadvertently increase dangerousness by missing crucial issues at the incident. A further question is whether the six factors are the most crucial and well supported by both research evidence and practice experience.

A strength of the model is that it allows room for some discretion and flexibility. Numbers are not rigidly applied and while the six factors are given, other prompts for consideration are also provided. For some FL officers this was also reported as a weakness, as weighing up the risks to ascertain a risk level was not something that fell within their role and/or experience.

Several sections of the ACPO guidance on risk assessment are relevant when evaluating whether the SPECSS⁺ model is compliant with the guidance. These include:

- i) 5.5g *‘All risk assessment models should be in accessible language to both staff and victims with clear information about why certain issues are relevant’.*
- ii) 5.5.a *‘Any such [risk assessment] systems must be implemented on a firm evidence base and should be designed to capture emerging local and national information and research. Such systems should also undergo an independent evaluation of the process and its implementation’.*
- iii) 5.5 k *‘...the need for all models/systems and their implementation to be kept under a constant process of review’*
- iv) That the police service delivers a service to all without discrimination as required under the Race Relations (Amendment) Act 2000.

The issues of victim safety and whether the model can be applied irrespective of geography, community or police variables are questions which are explored further in this section.

Evidence base

The SPECSS⁺ model is based on evidence drawn from 104,000 allegations of domestic violence, 56 London multi-agency domestic violence murder reviews (with a detailed analysis of 30) and an additional analysis of 252 domestic violence sexual offences and 149 ‘serious’ domestic violence offences where these included

allegations of ABH or above (Richards, 2003; 2004). From these cases, the analyst drew out six key factors: separation (including child contact); pregnancy; escalation; culture; stalking; and sexual assault. While a strength of the model is its basis in research evidence, it was also recognised that significant amounts of evidence were often missing from the reports which came through for analysis and which may affect some aspects of the evidence base (Richards, 2004; 2003; key informant interviews). The process is dynamic and continues to be reviewed.

Five of the factors have been highlighted elsewhere in the risk assessment literature, though others have also been raised (Radford et al., forthcoming; Campbell, 1988; Davies et al., 1998). The issue of 'Culture' is much more controversial and not seen in the risk assessment literature, though the heightened barriers to help seeking for some black and minority ethnic (BME) women are often mentioned (Batsleer et al., 2002), as are the issues relating to 'crimes of dishonour'⁷ (Siddiqui, 2000).

Of the London domestic violence homicides, 47 per cent (n=14) involved issues of cultural sensitivity for women from BME communities. In a number of these cases, 'crimes of dishonour' were flagged where the rationalisation of breaking perceived cultural norms was cited as a factor in the women's homicide. In the guidance and training provided around the 'Culture' factor, the issues which enhance vulnerability and danger for all victims due to increased isolation and barriers to help-seeking are presented to 'open out' the 'Culture' factor beyond simply ethnicity (BME) increasing the level of risk. The 'Culture' factor could therefore include other hard to reach groups where there are barriers to help-seeking – due to issues such as disability, homophobia, rural isolation – resulting in increased vulnerability to isolation.

A question arises about whether 'Culture' sufficiently allows police officers to think beyond BME status in ways which do not stereotype communities that are already subjected to racism and whether it provides an appropriate way of encapsulating the issues of increased isolation and barriers to help-seeking. The factor as it stands could be open to significant misinterpretation, especially if training does not adequately address and explain what is meant by this factor and how it is to be used to identify risk by FL officers.

Beyond the issue of 'Culture', there are other concerns about the six risk factors which arise from further research in the UK. For instance, an evaluation of high-risk cases flagged by the multi-agency risk assessment conferences (MARACS) in Cardiff raised a number of questions about high-risk factors. While several of the six factors highlighted through SPECSS⁺ were confirmed as especially significant, there were two factors which the Cardiff study particularly emphasised:

Partners with drug problems inflicted significantly more violence and injuries on their partners and was therefore considered a heightened risk factor (Robinson, 2003, p. vii).

⁷ While these are often called 'honour crimes' we have used the alternative terminology of 'crimes of dishonour' to more accurately reflect what we see as the reality of such crimes.

A finding such as this is backed up by other literature, which consistently shows that the presence of Class A drugs, and/or alcohol heightens the severity of violence, including the level of injuries requiring hospitalisation (Pernamen, 1991).

A further factor was also raised which to an extent is already covered in the training in relation to Sexual Assault and also Stalking:

Analysis of the risk factors revealed that 'perpetrator is jealous or controlling' is a particularly important risk factor, as its presence makes 11 of the 14 other risk factors significantly more likely to occur (Robinson, 2004, p. 3).

Obsessive jealousy and controlling behaviours are continuously cited in the literature as points of danger (Campbell, 1988). CSU officers also cite this as an important reason for gaining a fuller story to gain a picture of both escalation and obsession. The compounding influence of this factor is evidently worth noting.

Similarly, threats to kill either self or others which is one of the 'plus six factors' in the SPECSS⁺ model is also a significant barometer of dangerousness, making each of the other factors more dangerous. Hence, the dangers of stalking are increased when there are threats to kill oneself or others, as are the problems of isolation, separation, and attack during pregnancy (Davies et al., 1998).

While obsessive jealousy and controlling behaviour and threats to kill self or others are issues raised in the 'plus six factors' and also Sexual Assault and Stalking, and should be picked up by the CSU officers if not by some FL officers, it is apparent that they may need to be further foregrounded for FL officers to consider.

Views of key informants on the six factors

The 10 key informants were in agreement that most of the six heightened factors outlined in SPECSS⁺ were relevant, though the issue of 'Culture' was problematic for some.

In London, the development of the 124D ensured that while the six heightened risk factors (SPECSS⁺) are in the foreground, when the specific questions about risk are raised the 'other six factors' all appear on the same page. In this way, a more rounded view of the complex factors which could inform a risk assessment are easily available.

The most controversial factor was 'Culture' and this raised very strong feelings amongst several of the key informants. One of the key informants with an Asian background was unequivocal that given the history of 'crimes of dishonour' and the consequences for many women of calling the police within communities where such action is seen as shameful, this is indicative of a heightened risk factor. Women would not be calling in these circumstances unless they were terrified. Their added vulnerability to isolation due to issues such as immigration status or language difficulties further compound the risks. 'Culture', it was argued, was thus a legitimate descriptor to have in the SPECSS⁺ mnemonic.

Other key informants raised both positive and negative issues in relation to 'Culture', with two key informants expressing very strongly negative opinions about the way in which attention to 'Culture' over-played issues for BME women at the expense of officers being cognisant of other issues which create vulnerability and compound the isolation.

Because my experience has borne this up... It is. When people hear the word 'Culture' they think race. And that's all they think. So all those kind of other issues that they were trying to subsume under Culture really just kind of aren't going into police officer's heads (Key informant 9).

Front line officer perspectives

FL officers were generally positive about the SPECSS⁺ six heightened risk factors, with 80 per cent (n=57) agreeing they were appropriate. The 124D, in particular sets out very clearly the factors to be addressed.

The main headings are useful for doing assessments (FL 105).

Before SPECSS⁺ would only have asked about a couple of risks, so are useful in developing a broader picture and understanding (FL 410).

However, there is variation between research sites among the FL officers on this issue, with a greater proportion of those who disagreed with their appropriateness coming from L1.

Interestingly, while a majority of officers agreed that SPECSS⁺ appropriately covered risk factors, a significant minority wanted other factors added. Alcohol, drugs and mental health (particularly suicide threats) were risks which 10 officers wanted added to the more prominent list.

In London, jealous and controlling behaviour appeared to be one of the most significant factors on medium- and high-risk cases noted on the 124D in the majority of cases. For example, the case file analysis showed that in 14 (47%) cases in L2 'jealous and controlling behaviour' was noted on the 124D. This was a higher prevalence rate than any other risk factor. It was not an issue appearing on the West Yorkshire case data analysis because it is not prompted as part of SPECSS⁺.

The case file analysis also showed that while 23 per cent (n=14) of London cases ticked 'Culture' as a factor, no cases in WY1 and only two in WY2 noted this as an issue. Although the numbers are small, with a few exceptions this information indicates that 'Culture' is generally not being understood and used beyond BME groups in these areas. In London, in L1, in five cases 'Culture' was ticked as a risk factor, and in each case the woman was from a BME background. In L2, there appeared to be a more complex understanding of the issue of isolation as a factor. In the category of 'Culture' as a risk factor there were five White women (2 of whom were foreign nationals) and four women from a BME background.

While 'Culture' did not appear to be used by police officers in three areas to denote issues of isolation and barriers to help-seeking outside BME groups, the case file analysis also indicates that it is not always being used stereotypically. That is,

'Culture' is not being routinely ticked for all BME women. The West Yorkshire data indicated that there were eight Asian women in the sample; however, 'Culture' was only (and appropriately) considered a risk factor in the two cases where there were issues of isolation and ongoing abuse by both the partner and relatives. In London, where over 60 per cent of cases involved at least one person with a BME background, the relatively low numbers of cases where 'Culture' is identified as a risk factor suggests that this category is also not being routinely identified with BME status.

Senior and specialist officers from the Community Safety Units

A somewhat ambiguous picture emerged from the specialist officers. Most saw the value of the SPECSS⁺ factors for FL officers. However, the CSU/DVCs' work involved gaining a fuller story.

While some were happy with the six heightened factors, others were vociferous in their views about the 'Culture' category, seeing it as worthless and lacking clarity:

Because all you get is well if it's a cultural issue then it's a high risk factor...if you imagine standing up in court and saying 'well there is a cultural issue here', what is a cultural issue? 'Well because they come from a minority community then there must be a problem'. Well it's nonsense that' (Senior Officer).⁸

Others were clearly not using the SPECSS⁺ model in the initial allocation of resources with one senior officer saying categorically that he prioritises on the basis of GBH (severity) and threats to kill combined with victim vulnerability.

High risk can be the vulnerability of the victim. So if a victim's got no place of safety or the kiddies are in difficulties, we'll allocate resources to that immediately' (Senior Officer).

Others again mentioned drugs and alcohol as heightening the level of dangerousness.

Summary and evaluation issues

- When addressing the question of whether the SPECSS⁺ model addresses victim needs in terms of risk, consideration needs to be given to whether the six SPECSS⁺ factors are the key high-risk factors. Evidence from the literature suggests that other factors such as 'threats to kill self or others', use of drugs and alcohol, and controlling and obsessive jealousy may be of equal or more significance and should not be overlooked in addressing the early assessment of risk. FL officers, senior officers and officers from the CSU made similar comments based on their experience.
- The application of the model across the country does raise the issue of whether 'Culture', is the most appropriate term to signify heightened risk through isolation, attitudes, and barriers to help-seeking. In spite of training, in three of the four research sites, there was only limited use of the category of 'Culture' beyond families of BME origin and hence it was only being used in a limited way to designate more general risks associated with isolation and barriers to help-seeking.

⁸ This needs to be seen in the context of the previous information that suggested that police officers were making more judicious decisions about 'Culture'.

Section 4: Police use of the SPECSS⁺ model to inform risk assessment

This section explores whether police officers, both FL and CSU, are using SPECSS⁺ for the purposes of risk assessment, and if so how. Relevant aspects of compliance with ACPO guidance will also be assessed, namely:

5.5 e ‘Any specialist domestic violence officers who are required to categorise risk using information gathered must have full understanding and knowledge of how such decisions are made and how to justify a particular categorisation of risk’.

5.5c ‘Risk assessment and management are dynamic processes’.

Front line officers

Over three quarters of FL officers (n=56, 79%) said that they used SPECSS⁺ to decide risk levels. There was some variation across the evaluation sites with a higher proportion of officers finding the SPECSS⁺ useful in WY2 (88%).

The older, more experienced police officers were more likely to be among the minority of those (21% n=15) who said ‘no’ or ‘not really’ to the question of whether SPECSS⁺ helped them decide risk levels. Due to the low numbers of police officers over 34 years old, this constitutes a discernable trend rather than a clear finding and has some implications for training

Officers used the SPECSS⁺ model in a number of different ways to assess risk. The largest group of officers (n=27, 39%), shown in Table 3, provided a relatively ‘mechanistic’ description of how they used SPECSS⁺ with an increase in the number of factors representing an increase in the risk level.

Table 3: Process used to categorise incident

Process	London				West Yorkshire				Total	
	L1		L2		WY1		WY2		N	%
	N	%	N	%	N	%	N	%		
Number of risk factors	3	27	3	25	9	41	12	48	27	39
Severity of force/violence	2	18	2	17	9	41	5	42	18	26
Include previous history as a factor	2	18	2	17	9	41	4	16	17	24
Going through SPECSS ⁺ influences the decision	1	9	3	25	4	18	8	32	16	23
Aggravating factors (children in house, state of house, alcohol, etc) as important	4	36	4	33	6	27	2	8	16	23
Escalation a key indicator	-	-	-	-	5	23	3	12	8	11
Each case is individual	1	9	2	17	1	5	1	4	5	7
Use own experience as well as SPECSS ⁺	2	18	-	-	1	5	2	8	5	7
Overall totals	11	16	12	17	22	31	25	36	70	100

Percentages based on cases, multiple responses possible.

Comments from FL officers included:

One or no risk factors = standard, two or more = medium. However, severity/gravity is important. So one risk if severe could lead to a high-risk assessment. High = multiple risks present or one or more severe risks (FL 116).

Look at history and severity of current incidents when making a decision on this (FL 204).

If one of SPECSS⁺ risk factors is present will designate case a medium. Means most cases are medium. Decides a case is high risk based on overall picture and in particular how nasty the offence (FL 209).

From the interviews conducted, escalation and separation emerged not only as the two most commonly noted SPECSS⁺ risk factors, but also the ones which officers said most affected their assessment (see previous section for discussion of relevant risk factors). The evidence from the London case analysis showed that ‘jealousy and control’ were more frequently recorded (despite not being part of the six primary heightened risk factors).

The data from the case file analysis supports this ‘snapshot’ assessment from FL officers. The data from West Yorkshire showed a clear pattern of increasing levels of risk as the number of factors rose, and similar patterns were seen in both the London sites.

Table 4: Risk assignment by number of risk factors (West Yorkshire)

Number	Standard		Medium		High	
	N	%	N	%	N	%
None	18	90	1	5	-	-
One	2	10	13	65	7	35
Two	-	-	5	25	9	45
Three	-	-	1	5	4	20
Total	20	100	20	100	20	100

The level of offence did not necessarily relate to the level of risk (See Appendix 1). The more detailed case analysis indicated that in several situations this was because of a move to safe housing or gaining a non-molestation order, which rapidly brought the level of risk down. Other times, however, the rationale did not seem to be so clear. It is noteworthy that in the L1 sample there were five cases of ABH which were classified as standard risk, whereas in the L2 sample cases involving this type of offence were always rated higher.

A similar pattern emerged in West Yorkshire, where one area had four ABH charges which were designated standard risk, though there were also medium- and high-risk cases involving these charges.

The other factor which may have been significant in determining risk was the number of previous allegations made by the victim. Both forces showed that approximately 50 per cent of victims had called the police on at least one occasion during the previous 12 months. In the London sites an analysis of the risk assessment level in relation to previous incidents indicates that the information about previous incidents was not always known/recorded and that there was no clear pattern between these two variables.

Recent data have also been gathered from the Understanding and Responding to Racial and Violent Crimes Task Force where patterns of repeat victimisation have been highlighted through identifying victims (usually women) who have been subjected to either five or more incidents of domestic violence in the last six months or 10 or more incidents in the last 12 months. In some boroughs, there are worryingly high rates of this high-level repeat victimisation. In L1 there was only one high-level repeat victim with three high-level repeat victims in L2. Further work is needed to explore whether the SPECSS⁺ model is picking up these chronic patterns of repeat victimisation, which severely undermine the safety of victims and often their children, or whether the focus on escalation is not necessarily picking up low-level, chronic violence. It also needs to be kept in mind that calling the police to incidents may reflect greater confidence in the police rather than an actual increase in repeat victimisation.

A clearer pattern emerged in West Yorkshire (Table 5), where previous reports in the last 12 months indicated a trend towards medium and high categorisation. This suggests that the Killingbeck model may have a greater influence on the risk assessment process in this area. The data only show whether there were previous calls, not the number of calls.

Table 5: Risk assignment by previous incidents reported (West Yorkshire)

Level	WY1		WY2		Total	
	N	%	N	%	N	%
Standard	3	18	1	10	4	15
Medium	6	35	3	30	9	33
High	8	47	6	60	14	52
Total	17	100	10	100	27	100

There was considerable variation in the allocation of risk levels between the four sites. In part, this could be due to less serious domestic violence occurring in particular areas. However, the qualitative analysis of case files combined with that of the aggregated data from West Yorkshire suggests there are differences in the ways in which risk is categorised.

The aggregate data on risk assessment levels for West Yorkshire from July-December 2004 shows some variation in the categorisation of risk assessment levels. The data in Tables 6 and 7 show that while the general patterns of standard, medium and high categorisation are similar across West Yorkshire, there are also some real variations. Neither of the two areas mirrors West Yorkshire as a whole for January; the main difference being that WY1 has a higher level of medium-risk cases recorded than

either WY2 or West Yorkshire as a whole. There is a corresponding lower level of standard-risk cases. WY2 also has fewer cases designated as high risk. This could indicate an under-utilisation of the high-risk category or, alternatively, that the risk assessment process is dynamic and working well. High-risk cases should be moved relatively swiftly to medium on the basis of the safety issues being addressed.

Table 6: Risk assessment level July-December 2004 (West Yorkshire)

	Standard		Medium		High		Total cases with risk assessment level recorded*
	N	%	N	%	N	%	
West Yorkshire	9,881	57	5,781	34	1,500	9	17,162
WY1	1,387	53	935	36	302	11	2,624
WY2	891	64	374	27	121	9	1,386

*These figures are not the same as the 'recorded domestic violence incidents' figures because in some cases there is no risk assessment level recorded.

Table 7: Risk assessment level – January 2005 only (West Yorkshire)

	Standard		Medium		High		Total cases with risk assessment level recorded*
	N	%	N	%	N	%	
West Yorkshire	1541	51	1294	42	220	7	3055
WY1	188	40	244	51	44	9	476
WY2	127	56	90	40	9	4	226

*As before, there is a slight difference between the number of recorded domestic violence incidents and the number where there is a risk assessment level recorded. WY2 has now corrected a problem emerging in 2004 where there were a number of cases without a designated risk assessment level. WY1 is similar to West Yorkshire as a whole with one per cent of incidents missing an assigned level of risk. This information shows that while the system is not perfect, there is generally a high level of compliance with allocating risk assessments to cases.

Senior officers and trainers commented that the system took time to bed down and a lot of discussion and supervision was needed in relation to ascertaining risk levels.

And I've got to say initially they did tend to put high risk more than perhaps they should. But now they seem to have, you know if they don't see any risks then they write standard or medium' (DVC).

Similarly, irregularities/differences can be seen when examining the two sites in London.

Table 8: Breakdown of cases by risk assessment level (London)

Risk assessment level	L1		L2		Total	
	N	%	N	%	N	%
Standard	16	53	9	30	25	42
Medium	6	20	14	47	20	33
High	2	7	5	17	7	12
Other*	-	0	2	7	2	3
No classification/ classification unknown	6	20	-	-	6	10
Total**	30	100	30	100	60	100

*Risk assessment straddled two levels, i.e. Standard/Medium.

**Totals may not sum to 100 due to rounding.

L2 has a higher percentage of high-risk cases and a much higher percentage of medium-risk cases compared to L1, where just over half the cases are designated standard risk. In both sites there were also a number of cases initially entered as standard/medium and awaiting a further assessment from the CSU.

The ‘No classification/classification unknown’ was an issue in some of the cases examined in L1. In L1, six cases were unclassified, in five cases there was no 124D available and information on the risk assessment was not available from the CRIS records.

Resource implications affecting the level of risk assessment

A number of senior officers mentioned that availability of resources also influences the risk assessment level. In one sense, this is exactly what the risk assessment model was designed to assist with – namely allocating intensive resources to high-risk cases in order to lower the level of risk.

If we raised too many of these [medium and high] then we’re never going to be able to give the quality service to all those people that need it. So even then we have to be a little bit selective (Senior Police Officer).

An alternative perspective was put forward by several CSU officers at different sites who felt that there had been a substantial increase in their workloads and that the prioritisation of risk into standard, medium and high was not necessarily helping them prioritise their workload in the face of staff shortages combined with the significant numbers of high and medium cases coming through.

We didn’t treat domestic violence as it should have been treated. Now they’ve gone to the opposite end of the spectrum and everything is reported. Which is good. But there’s a tremendous burden upon us and it’s really quite difficult to weed out ones that you can say, well, they can wait while we get on with these (CSU officer).

Officers in WY1 were struggling with 500 incidents per month and a staff team comprising 2.5 DVCs, a new DS in the process of being appointed and three clerical

support staff to respond to the necessary interventions in an area with few multi-agency support services.

Use of the risk assessment

Risk assessments are something that's now becoming part of our culture, (Senior Police Officer).

The VIVID system in West Yorkshire and the supervisory system at the London sites ensures that every incident logged as domestic violence should have a risk assessment made by the FL officer which is then checked by either the specialist officers in the CSU or a DS. The case file analysis suggests that while the system is not perfect, there is a high level of compliance with making risk assessment decisions.

An issue for FL officers is whether they actually take action on the third stage of the model, namely management to reduce the risk. This would normally relate to the period between the report being taken and the case being investigated or referred to the CSU. There were different assessments about the extent to which this was being undertaken by FL officers. In West Yorkshire, for instance, it was suggested that some FL officers have a tendency to 'pass the buck' to the DVCs after attending the initial incident because they feel 'they have done their bit'.

'It's all very well everybody knowing about what the risk assessment is but it's actually doing something with it' (Senior Officer).

In West Yorkshire, the specialist and senior officers believed that the implementation of SPECSS⁺ was going well and it was seen to be adding to the Killingbeck model.

SPECSS⁺ is seen as safer and giving 'us a bit more point and purpose' (Senior Police Officer).

SPECSS⁺ is much easier to understand and identify though it has not yet superseded Killingbeck. Also enables high risk to come to attention more quickly than under Killingbeck, where the first incident might have obscured the severity (Senior Police Officer).

It also makes officers do a RA [risk assessment] and gives them ownership of risk assessment and holds them accountable for their decisions (Senior Police officer).

However, comments were also made by a number of FL and specialist officers that operating under both the Killingbeck (level A, B, C) and SPECSS⁺ (standard, medium, high risk) models was confusing at times and that it would be better to have one system.

Where the risk assessment process is working well, there should not be a large number of high-risk cases because all efforts should have been made to immediately create a strategy which shifts the risk from high to at least medium.

Clearly, care needs to be taken with these processes, as deliberately deflating the number of high-risk cases can mean that they are simply being designated as medium risk, without necessarily seeing concerted action to bring down the real risks. The evidence from the case file analysis was unclear. Some areas, such as WY2, were clearly designating very few cases as high-risk even in the first instance.

Stage 2 processes for assessing risk

In spite of extensive piloting, the views of the specialist officers from the CSU were more equivocal about the use of the SPECSS⁺ model in the Stage 2 process. In one area formal training had not yet occurred.

CSU officers/DVCs reported that they placed a lot more weight on their experience than on the formal Stage 2 risk assessment process.

Though you can have all these strategies in place, you can do all the searches on the computer and you can do all the background searches on intelligence databases, the importance is really when you look at the crime and the alarm bells start to ring. And that only happens through experience really...we've got some inexperienced officers who may not just pick up on some of the things on the reports' (DS officer).

While CSU officers are guided by the risk assessment done by the FL officers, they also spoke of taking the time to hear the whole story and history of the case.

[I] go back to the beginning...not just what happened on the day of the incident but we need to go back a lot further than that (CSU officer).

After a while you get to know the suspect and you have that continuity which is very important within this unit (CSU officer).

Several CSU officers said in different ways that their response was the same as before and that they were asking similar questions to the 35 suggested in the Stage 2 assessment.

'We're not dealing with people any differently (CSU officer).

While recognizing that the SPECSS⁺ model may highlight high risk earlier it was also commented that: *'we would pick up that it is high risk anyway' (DVC).*

In the end you can tick all the boxes you like, but eventually you have to come down to a decision (CSU officer).

Nevertheless, there are indications of a change in practice, as in each area officers commented that their workload had increased as more medium- and high-risk cases are highlighted earlier than they would have been previously.

A number of CSU officers/DVCs commented that aspects of the questions in Part 2 needed to be changed. Suggestions included:

- A number of the questions needed to be re-worded or changed, especially the ones on sexual violence.
- The order could be changed with questions on weapons not coming directly after those on sexual violence.
- Providing more room on the form for recording details. The number of 'yes/no' questions was considered inappropriate at the secondary level, where the 'story' needed to be told in more detail, and this could also be used as disclosable evidence for the CPS.

On the positive side, many officers commented that the attention to risk gave a more formal framework through which they justified their decisions and actions.

Finally, there is an issue about whether the risk assessment actually helps police officers to prioritise cases, about which two different views emerged. A number of officers said quite categorically that it helped flag up high-risk cases and bring them to the fore. An equal number of interviewed officers, though, were concerned about the opposite effect, summed up by the following:

You're getting a lowering of material that's being considered anyway, a diluted version or a lower level that's being managed...and that in its very process it's excluding those in most need (DVC).

Clearly, staffing levels will affect the level of response. At this stage, the number of high-risk cases requiring a high-level response appear to have been kept to a relatively small percentage of overall incidents.

A formal framework

If you introduce anything that adds extra focus then the most important thing you've introduced is a process...because everything is so busy, the officers have got so many other things to consider. And SPECSS⁺ introduces a process of assessment and there's no way out of it. It standardises the response (Senior police officer).

Interviews with 20 CSU and senior officers suggests that SPECSS⁺ is seen to provide clear guidance on action to be taken in relation to standard, medium and high risk. Views and practice varied between sites, particularly in relation to whether standard risk victims were seen in a second stage process by the CSU officers/DVC. In each area, however, there appeared to be a process through which FL officers could recommend that a standard case be seen by a CSU officer, thus indicating that while there is a formal framework for response it is not overly rigid.

Summary and evaluation issues

On the basis of the interviews conducted there is evidence that police officers are using SPECSS⁺ to inform their risk assessments.

- FL officers are generally using the SPECSS⁺ model in a 'mechanistic' though standardised way, adding up the number of risks to designate the category. This process highlights the importance of the six factors which inform the risk assessment.

- The severity of violence was taken into account in some areas and in West Yorkshire there was evidence that repeat victimisation was also a factor which influenced the category of risk. There was not such a trend in London.
- Specialist officers are also using previous history of reported incidents, not just the Part 2 risk assessment, to inform their decisions about the level of risk. Further work is needed to ensure that high levels of repeat victimisation are responded to within the risk assessment framework.
- There is considerable variation between areas about how levels of risk are allocated and the response to different levels of risk.
- There is a difference in officers making decisions about risk assessments which are logged on the database and getting FL officers to recognise that they have a responsibility to act on these risk assessments particularly in high-risk cases.
- The process is not cost neutral. CSU officers/DVCs commented that they have seen a substantial rise in their workloads as a result of the significant numbers of high- and medium-risk cases which require concerted action.

Section 5: Impact of the SPECSS⁺ model on enhancing police work, responding to the incident, evidence gathering and data inputting

The ACPO guidance and the research reports on which the SPECSS⁺ model is based (Richards, 2003; 2004) highlight the fact that the introduction of risk assessment should improve the police response to domestic violence. This should include increased victim safety, managing lethal situations; making better use of intelligence; and increasing the standard of investigation and supervision. Relevant sections of the ACPO guidance include:

3.4 *'Early intervention and appropriate intervention in domestic violence incidents is a key element of the police response to domestic violence. Risk assessment and management should enhance rather than undermine the police response to domestic violence'*.

4.2.5 *'To inform police decision-making and action, including effective investigation and evidence gathering'*.

4.2.7 *'To prevent and reduce repeat victimisation'*.

In this section we address the question of whether police officers are using the SPECSS⁺ model to increase the quality of their response at the initial incident and collecting evidence which can then be used by the CPS or specialist CSU officers/DVCs for follow up work with either the victim or suspect.

A clear remit of the police in lowering risk and increasing victim safety is to provide high-quality evidence gleaned at the incident to enhance the possibility of a case being prosecuted and to support the arrest and charging of the offender. It should be noted here that the two London boroughs where there were no serious repeat victims (five or more incidents in the last six months or 10 or more in the last 12 months) also recorded the two highest detection rates for London (URHC Unit, 2005). There may be, therefore, some relationship between lowering victim risk and police taking assertive action with offenders.

At this early stage in the SPECSS⁺ model implementation different views emerged about whether the quality of evidence gathering, target hardening and active follow-up of suspects had been enhanced. For example, in the area where FL officers were not inputting data from the 124D to CRIS except in high-risk cases, there was a strong view that the SPECSS⁺ model improved risk assessment but not evidence gathering and action towards prosecution.

Strategically I think it's worse. When you're talking about victim safety and you're talking about risk assessing every single case, I think the 124D is an advantage. But when you're talking about the job overall and putting a case before Court and getting history and getting exactly what she said and all the rest of it, it's a disadvantage. Now for you I suppose measuring what's right and what's wrong, the good news would be that the 124D addresses the risk. But further on down the line with a little bit of lateral thinking a conviction is also a form of risk assessment. He gets brought to Court. Arrested, brought to Court. And it's the best form of intervention we have as a police agency.

And if he gets convicted it's the ultimate as far as hopefully we and the victim are concerned. So if you look at it from that point of a risk assessment it's not as good. But for assessing that initial risk and saying look out for these points, yes it is an advantage (Senior police officer).

This section will look more closely at this issue and for the purposes of discussion will make an artificial divide between a) decision making at the incident; b) evidence gathering; and c) data inputting.

Responding to the incident

Just over half of the FL officers who knew about/had received training/used the new system (n=66) said that they had found the DV Guide/ SPECSS⁺ helpful as a model at the initial point of responding to an incident. Table 9 demonstrates that although the raw figures are low⁹, there was a difference here between the two research areas with officers in London more likely to report finding the model helpful.

Table 9: Use of DV Guide/SPECSS⁺ at initial response to DV incident

Research Site	Officers	Helpful	
	Trained/Used	N	%
	N		
London			
L1	11	6	55
L2	13	11	85
Total	24	17	71
West Yorkshire			
WY1	23	9	39
WY2	19	9	47
Total	42	18	43
Overall totals	66	35	53

There were a wide range of reasons given for why the model was useful, and again there was variation between the two research areas as seen in Table 10.

Table 10: How DV Guide/SPECSS⁺ is helpful at initial response

	London		West Yorkshire		Total	
	L1	L2	WY1	WY2	N	%*
	N	N	N	N		
Memory jogger/everything there	4	8	-	2	14	40
Access to previous DV history	-	1	3	2	6	17
Allows assessment of risk level	1	-	4	1	6	17
Helpful in collecting information	1	3	2	-	6	17
Comprehensive	2	2	-	-	4	11
Overall totals**	8	14	5	5	35	100

*Percentages based on cases, multiple responses possible.

**Totals may not sum to 100 due to rounding.

⁹ These data need to be seen in conjunction with the data from specialist officers at each site.

For the largest group here, the model functioned as a ‘memory jogger’ (n=14, 40%). However, it should be noted that almost all of these officers (n=12) were from the London area and this is unsurprising given that the 124D booklet, in use in London, is completed at the scene during the initial response to an incident.

Works well as a memory jogger when asking questions (FL124).

Helps me to ask the appropriate question at the incident in order to do a thorough assessment (FL211).

Stops you from missing anything out. Very thorough (FL309).

The evidence from the interviews with the 20 senior police officers and CSU officers/DVCs provides further information about the use of the SPECSS⁺ model when responding to the incident.

Overall, in West Yorkshire it was felt that the FL officers were responding better to domestic violence with more accurate information being generated. The VIVID entry meant that there was closer supervision and clearer prompting about the information needed. The process of ‘mainstreaming’ domestic violence work was seen to be helpful.

Most of the officers here are quite switched on to domestics...if there are any marks on the victim and she says the suspect has done it, then the suspect is arrested (DVC).

It has also been useful to raise the profile of domestic violence among officers – *there’s more importance put on the subject as a result*’ (Senior Police Officer).

Similar issues were raised in L2 and amongst some specialist officers in L1.

The new system was viewed as a lot better than processes which existed in the past. The process of double-checking by CSU officers who can now look over what the FL officers have already done was seen as positive:

So really it’s quality control to verify everything and make a reasoned assessment where the case is going next and sort of point it towards a good disposal (Senior police officer).

Mainstreaming the issues of domestic violence through SPECSS⁺ was seen as a positive contribution to front-line work and not just a function of the specialist officers: *‘it affects every officer’* (CSU). Points raised included:

- 124D seen as an invaluable record/original document which can be used as evidence in court cases. They also double up as an arrest book as all the arrest notes go in the 124D.
- 124D also seen as a protection for officers who attend the scene to show they have dealt with things properly – *‘if anything goes wrong in the future they*

can say we did this, this and this and followed the guidelines' (Senior police officer).

- 124D is an important guide for FL officers who are relatively young and inexperienced at dealing with domestic violence incidents so they won't miss anything out. It acts as an aide memoir for them.
- 124D gives uniformity to the enquiry – *'every officer's got varying abilities and the 124D makes the officers ask the question'* (Senior police officer). It prevents inconsistency and ensures that all officers are collecting the information needed for the crime reports and by the CSU – *'it's more or less an idiot's guide to make sure that everyone does the same investigation'* (Senior police officer).

On the less positive side, 30 FL officers cited a wide range of reasons why the model was not helpful at the point of responding to an incident. The majority of these officers (n=23) were from West Yorkshire and, although this could be seen as a reflection of the larger number of officers interviewed, there is a discrepancy in the percentage of officers from each research site who noted that the model was unhelpful at the incident. The reasons given by officers from West Yorkshire were:

More useful after attending incident/at follow-up (n= 7).

Use their own experience/knowledge to assess risk at an incident (n=4).

Get minimal information before attending an incident (n=3).

Decision-making at the incident

The decision to arrest the suspect is a significant aspect of the police response to domestic violence. Assertive action has been taken by the different police forces supported by the ACPO Guidance on Domestic Violence and Police Circulars to take 'positive action'¹⁰ at a domestic violence incident. This policy was introduced prior to the SPECSS⁺ model and was seen by FL officers as the most significant influence on their decision-making at the incident. This section briefly explores this issue. It highlights the fact that police officers see 'positive action' and the SPECSS⁺ model as complementary rather than contradictory. It is essential that the risk assessment model does not override decisions about arrest. It is a very explicit part of the ACPO guidance that *'Risk assessment and management processes must NOT be used to decide whether or not to conduct an effective investigation or in place of an effective investigation'* (Section 3.7). By definition, an arrest should lead to an investigation.

Well over three quarters of FL officers did not think that the SPECSS⁺ model assisted them in making decisions regarding the incident and whether or not to arrest the offender (n=63, 89%). Almost half of the officers who explained their decision-making process (n=69) said that they would arrest based on whether a crime had been committed, a power of arrest existed or there was a risk of a repeat assault (n=31,

¹⁰ In practice, positive action policy will usually mean that where a power of arrest exists it will need to be exercised to allow the investigation to be completed and/or to prevent further offences.

45%). Only eight officers said that SPECSS⁺ explicitly influenced their decision-making process.

However, one senior officer pointed out that the arrest rate could be affected by the more comprehensive work at the incident. He commented that *'because they are asking more questions, they should be in a better position to arrest'*.

The following Table 11 outlines the influences on FL officers' decisions to arrest and shows the role of 'positive action' in the decision making process.

Table 11: Decision to arrest at incident

	London		West Yorkshire				Total			
	L1		L2		WY1		WY2		N	%
	N	%	N	%	N	%	N	%		
Crime committed/power of arrest/risk of repeat	4	36	6	46	9	45	12	48	31	45
Strict policy on 'positive action' before SPECSS ⁺ system	4	36	4	31	4	20	6	24	17	25
Risk criteria influences decision	1	9	2	15	3	15	2	8	8	12
Use own judgement rather than SPECSS ⁺	2	18	-		2	10	1	4	5	7
Decision based on assessment of situation	-		1	8	3	15	1	4	5	7
Each scenario different	-		-		2	10	2	8	4	6
Deal with incident, consider SPECSS ⁺ later	1	9	1	8	-		1	4	3	4
Must arrest when can/justify no arrest	-		1	8	2	10	-		3	4

Percentages based on cases, multiple responses possible.

FL officers made comments such as:

Would arrest if a crime committed, but might arrest under a breach of peace as a last resort. SPECSS⁺ doesn't really come into this (FL103).

Have to go in with an open mind. Sometimes victims accuse husband of assault just to get him removed after a row. However SPECSS⁺ helps you to constitute an offence via the risk factors. Need to have open mind about who is the victim. However would arrest if DV had happened, in line with the positive arrest policy (FL203).

The case file analysis from both London and West Yorkshire supports the information given by FL officers about arrest rates though shows some interesting differences in these arrest rates. Table 12 presents the aggregated data from West Yorkshire.

Table 12: Domestic violence-related arrests as a proportion of domestic violence-related incidents (West Yorkshire)

	Incidents		Arrests		Incidents		Arrests	
	January 2004		January 2004		January 2005		January 2005	
	N		N	%	N		N	%
West Yorkshire	3,151		1,182	38	3,089		1,361	44
WY1	506		210	42	481		171	36
WY2	293		102	35	226		122	54

A comparison of the figures for January 2005 and January 2004 reveals that arrest rates, as a proportion of reported domestic violence incidents, have increased both in West Yorkshire as a whole (by 6%) and in WY2 (by a substantial 19%). However, interestingly, in WY1 they have decreased by six per cent.

The case file analysis of 60 cases each in West Yorkshire and London reveal a similar trend, with WY2 again showing a substantially higher arrest rate in the cases sampled for case analysis.

Table 13: Suspect arrested (West Yorkshire)

Arrested	WY1		WY2		Total	
	N	%	N	%	N	%
Yes	10	33	20	67	30	50
No*	20	67	10	33	30	50
Total	30	100	30	100	60	100

*For WY1, cases where the suspect was not arrested were mainly where the allegation was a verbal dispute (n=15 of 20). However, the remaining five cases were: threats to kill (n=1); Section 47 assault and criminal damage (n=1); offence against adult – emotional (n=2); and harassment and verbal dispute (n=1). In three of these cases the police had yet to locate/trace the suspect.

For WY2, all but one of the cases where the suspect was not arrested involved a verbal dispute (n=9 of 10). In the remaining case the allegation was Section 47 assault, however the incident log stated that on attending the scene, police established there had been a verbal argument but no physical assault, and that this was the first reported incident between the couple.

Unevenness is also evident when comparing the arrest rates between the different sites in London, with the case file data indicating that L1 has more than three times the arrest rate of L2. In the aggregated data for both London and the research sites these differences are not as significant, though the arrest rate continues on average to be higher in L1 than L2. From April 2005 to September 2005 the arrest rate each month fluctuated between 38 per cent and 49 per cent in L2 and from 40 per cent to 71 per cent in L1.

Table 14: Suspect arrested (London)

Suspect arrested	L1		L2		Total	
	N	%	N	%	N	%
Yes	16	53	05	17	21	35
No*	14	47	25	83	39	65
Total	30	100	30	100	60	100

*For L1, in two cases of arrest the suspects were not arrested initially, but were subsequently following a further incident. In one case all parties were arrested for Section 47 assault. In another, the victim took some time to substantiate the allegations.

For L2, in the majority of cases where the suspect was not arrested (n=14 of 25) case data indicated that an arrest was not applicable. In one case the suspect was arrested but was later released in accordance with the victim's wishes.

The reasons for not arresting varied between the London sites. In L1 the main reason for not arresting was no crime, whereas for L2 the main reason was that the suspect could not be found.

Table 15: Reasons for not arresting suspect (London)

Suspect – why not arrested	L1		L2		Total	
	N	%	N	%	N	%
Suspect had left scene/ unknown whereabouts	2	14	10	38	12	30
Victim wanted NFA*	3	21	5	19	8	20
Combination of victim NFA & unknown whereabouts	-	-	3	12	3	8
No officers available	-	-	1	4	1	2
No crime	9	64	7	27	16	40
Total*	14	100	26	100	40	100

*NFA – No Further Action

**Totals may not sum to 100 due to rounding.

A clear problem highlighted by these data is the number of offenders leaving the scene prior to the arrival of the police. However, the case file analysis suggests there may be differences in the level of active follow up to apprehend the offender. These are reflected in the annual arrest rate for WY2 where the level of follow up was high.

Table 16: Suspect left prior to police arrival (West Yorkshire)

Suspect left	WY1		WY2		Total	
	N	%	N	%	N	%
Yes	12	40	15	50	27	45
No	15	50	15	50	30	50
N/a	1	3	-	-	1	2
Unknown	2	7	-	-	2	3
Total	30	100	30	100	60	100

Table 17: Suspect traced if left scene (West Yorkshire)

Suspect traced	WY1		WY2		Total	
	N	%	N	%	N	%
Yes	4	33	10	67	14	52
No	7	58	4	27	11	41
Unknown	1	8	1	7	2	7
Total*	12	100	15	100	27	100

*Totals may not sum to 100 due to rounding.

A similar pattern emerged in London, where the case file analysis suggests that in L2 the suspect leaving the scene was a major issue.

Table 18: Suspect left prior to police arrival (London)

Suspect left prior to police arrival	L1		L2		Total	
	N	%	N	%	N	%
Yes	6	20	17	57	23	38
No	15	50	3	10	18	30
N/a	9	30	8	27	17	28
Unknown	-	-	2	6	2	3
Total	30	100	30	100	60	100

However, again, the level of tracing is significant. In London, few suspects were tracked down and in only four cases were details of the suspect circulated. This is a very significant issue for victims. One of the victims interviewed was deeply unhappy with the lack of police action in relation to arresting her husband when she had been very assertive about following through with her witness statement, giving information on his whereabouts and demanding police action. Clearly, this is a factor which creates a heightened risk for victims and also affects the arrest rate for the area.

Table 19 presents the London case file data on this issue and shows that in an area such as L2, where a high proportion of suspects are leaving the scene, a lack of suspect tracing becomes a significant problem.

Table 19: Suspect traced if left scene (London)

Suspect traced	L1		L2		Total	
	N	%	N	%	N	%
Yes	3	50	5	29	8	35
No*	2	33	9	53	11	48
Unknown	1	17	3	18	4	17
Total	6	100	17	100	23	100

*In most cases where the suspect had left the scene they were not traced, and this happened more often in L2. For L1, for both cases where the suspect was not traced it was described as N/A.

In short, the positive action policy has had a significant impact on police action at the scene, and this has been as more influential than the introduction of SPECSS⁺. However, there were differences in the arrest rates between areas, some of which were influenced by the proportion of suspects leaving the scene before the police arrived and the extent to which these suspects were actively traced and followed up. This latter issue is one that the SPECSS⁺ model, which asserts the need for a high-level police response, particularly on medium and high-risk cases, should be relevant for. Future outcome data will be needed to explore this further.

Evidence gathering

The research on which the development of SPECSS⁺ is based (Richards, 2003; 2004) suggests that domestic violence perpetrators were frequently involved in crime outside the family. The analysis of domestic violence sexual assault showed that 49 per cent of perpetrators had a previous criminal history, while 70 per cent of domestic violence 'serious' assault perpetrators had a previous criminal history (Richards, 2004, p.6). There are clear recommendations that high-quality evidence gathering and the use of criminal intelligence are essential. To this end, the 124D prompts officers on a range of areas for evidence gathering: victim forensic evidence; suspect forensic evidence; medical consent form; victim witness statement; victim audio tape; initial officer statement; other witnesses; local neighbourhood enquiries; photos of the victim; damage to venue recorded; photos of the scene; video footage; CCTV; DNA (victim, suspect, scene); property seized; identification office request; details of suspect circulated; and criminal intelligence.

The VIVID system in West Yorkshire comprehensively covers information details. However, it was less useful in relation to evidence gathering and case progress, where there were either no specific fields for recording some of the types of detail that are given on the 124D, or they were not filled in routinely. The other police data systems available to officers in this force area (for example, CIS and Viewdata) may collect this information and complement the VIVID system.

Because the VIVID system is not used at the incident, West Yorkshire officers were not as positive about the evidence-gathering potential associated with SPECSS⁺ than those in London, where the 124D acted as an on-the-spot prompt for evidence gathering. However, officers at L2 were also more positive about this than those at L1, where they were not directly inputting the data.

There was a view amongst specialist and senior officers interviewed in West Yorkshire that more can be done by FL officers at the scene – speaking with neighbours, looking for injuries on the victim, checking for damage to the house. It is expected that an arrest will be made especially if the case is high risk. However, it was also emphasized that there was a need to look at action beyond the arrest.

What we're getting at the moment is short-term leads where we remove somebody or take them to a relative's house. They're there for the night and there'll be no other problems that night or perhaps even that week. And the weekend after the same situation repeats itself and that's where we're not achieving as much as we can do (Senior police officer).

Eleven of the 13 officers from L2 confirmed that they used the sections in the 124D on evidence and witnesses and found these sections useful. Almost half (n=11, 45%) noted that one advantage of the 124D was that everything they needed, including these two sections, was in one book and in one place. That information would be 'fresh' at the time of recording was also noted.

Keeps all your paperwork in one place. Takes more time, but this because we are doing better investigation as a result of 124D (FL312).

Allows you to get it all down at the time, so info fresh (FL301).

A minority commented that there were advantages in taking the victim/witness statements at the time of responding to the incident, which the 124D facilitates:

It's good in the sense you get a statement straight away rather than going back later when they've had second thoughts (FL309).

Very good because all the paper work is in one place. Also victim more likely to sign statement at the time than later on (FL311).

There was concern from a number of officers about using the 124D for cases they perceived as 'minor'.

A lot of it is not relevant, but in a serious case will be/would be very relevant (FL303).

Very good for serious cases of DV, but still have to do it for minor cases (FL306).

Happy to do this for serious DV, but not for minor arguments etc. Could be handled as a breach of the peace (FL307).

Some of this negative commentary related to the extension of the definition of domestic violence, where it was perceived that many incidents that police were now called to were between relatives, were minor, and did not fit their understanding of domestic violence.

In spite of positive reports from police officers about the raised level of evidence gathering, some of the information from the case files was disappointing in relation to this issue.

The file analysis of 120 cases summarised in Table 20 shows that victim witness statements were the primary form of evidence gathered, taken in 36 per cent (n=22) of cases in West Yorkshire and 42 per cent (n=25) of those in the London sites. Initial officer statements ran at 42 per cent in West Yorkshire and 21 per cent in London (a significant difference). Other witness statements were also taken in a significant number of cases. Generally, interviewed CSU officers commented positively about the number of witness statements which were now available compared with the pre-124D period. However, it was also felt that the quality of statements could be further improved for both the officer and witness.

Some statements are too short and we (CSU officer) are having to go back to the victim for a further statement and there can then be problems finding the victim. (CSU officer)

Given that witness statements were taken in less than half the cases sampled, there is some room for improvement in quantity as well as the quality issues raised.

Little other evidence was collected and this suggests that FL officers are not making the connection that domestic violence offenders are also involved in other crimes (Richards, 2003; 2004). Hence, while identification (and therefore DNA collection) may not be an issue for domestic violence, it is crucial for linking the offender to other crimes.

Table 20: Evidence collection

Form of evidence	London		West Yorkshire	
	N	%	N	%
Victim witness statement	25	42	22	36
Initial officer statement	13	22	25	42
Other witnesses	25	42	10	16
Local neighbourhood enquiries	6	10	7	11
Victim photos	8	13	6	10
Photos of the scene	2	3	4	7
DNA victim	-	-	1	2
DNA suspect	-	-	2	3
Damage to venue recorded	9	15	8	13

When there are a significant number of high-risk cases, as in the 120 cases examined, this suggests that greater attention to high-quality evidence gathering is needed.

The lack of development of photographic evidence gathering indicates that further training and resources may also be needed in this area. Evidence from the evaluation of the Crime Reduction Programme – Violence Against Women Initiative indicated that photo evidence was helpful in enhancing the arrest rate and supporting victims who were then significantly less likely to retract their statements (Hester and Westmarland, 2005). More powerful evidence comes from the Australian Capital Territory (ACT) in Canberra, where the systematic taking of photos at the scene of the incident has been considered to be the most significant factor in increasing the guilty plea rate from 24 per cent to 76 per cent between 1999 and 2003 (ACT Director of Public Prosecutions, 2002/03) alongside a 320 per cent increase over four years in the number of domestic violence cases prosecuted (Humphreys and Holder, 2004).

In the final analysis, while the arrest rate is promisingly high in some of the sites evaluated, the evidence gathering to support prosecution could be significantly improved. This might also impact on the high levels of attrition as seen in other studies (Hester et al., 2003).

At this stage, while one would hope to see improvements in evidence gathering as a result of the 124D prompts and the accompanying supervision, it is too early for outcome data to be related to the SPECSS⁺ implementation. The case file analysis showed that a number of cases were ongoing and these data will in the future need to be compared with aggregated data in the different areas over a much longer time period.

West Yorkshire and London use different categories for recording, making comparisons between areas difficult. For instance, the West Yorkshire category of CDTP (Complainant Declined to Prosecute) is not a category that arises in the London site data, though some of the cases under NFA (No further action) could well be in this category. The outcomes of the 120 cases are as follows:

Table 21: Case outcome (London)

Outcome	L1		L2		Total	
	N	%	N	%	N	%
NFA by police*	12	40	24	80	36	60
Discontinued on CPS advice	2	7	-	-	2	3
1 st instance harassment warning	1	3	1	3	2	3
Cautioned	5	17	-	-	5	8
Ongoing	5	17	4	13	9	15
Sentenced	3	10	-	-	3	5
Unknown	2	7	1	3	3	5
Total**	30	100	30	100	60	100

*NB: Eight out of 10 victims also wanted NFA.

**Totals may not sum to 100 due to rounding.

Table 22: Case outcome (West Yorkshire)

Outcome	WY1		WY2		Total	
	N	%	N	%	N	%
CDTP (Complainant Declined to Prosecute)	3	10	6	20	9	15
NFA by police	18	60	11	37	29	48
Discontinued on CPS advice	1	3	-	-	1	2
Refused charge – insufficient evidence	1	3	1	3	2	3
Cautioned	-	-	3	10	3	5
Ongoing	5	17	6	20	11	18
Unknown	2	7	3	10	5	8
Total*	30	100	30	100	60	100

*Totals may not sum to 100 due to rounding.

The case file outcomes showed that a number of cases were ongoing. In London, in five cases sentencing had occurred, while a small amount of action was also being taken under the Protection From Harassment Act (PFHA) 1997. However, the

majority of cases are not proceeded with. In London, 68 per cent of cases were NFAs, discontinued, or outcome unknown, while in West Yorkshire, 75 per cent of cases involved NFAs, CDTPs, refused charge or outcome unknown.

It is very early for outcome data to be relevant to an evaluation of SPECSS⁺ and the development of complementary policing practices such as ‘positive action’. However, it is clear that more development is possible and needed in the area of arrest, evidence gathering, tracking and follow-up of suspects who are leaving the scene prior to the arrival of the police. Indeed, when one considers that 36 per cent of the 60 cases at the two London sites involved ex-partners, the lack of action under the PFHA 1997 seems surprising.

The assessment of medium and high risk is not useful or relevant unless it leads to highly proactive action on the part of the police to apprehend suspects using all the models at their disposal. Victim risk will not be reduced unless this is able to occur. A senior police officer from West Yorkshire summed up the issue:

I feel that the police need to tighten up and be much clearer about where they sit in the investigation of assaults and abuse in the family...I think the police need to police domestic violence and that's primarily to fulfil their function around investigation and evidence gathering, taking cases before the courts and through the criminal justice system where possible...I feel that we're still focusing on the needs, dare I say, of the victim and we still continue to ignore the perpetrators...Police staff are actually spending more time doing non-police work than police work and yet they're enormously talented and perhaps could make a bigger impression on more women's lives (Senior police officer).

Summary and evaluation issues

A significant aspect of long-term risk management is to be able to arrest and prosecute the domestic violence offender. Key informants, combined with the ACPO guidance, suggest that the SPECSS⁺ model should not only impact on a more accurate risk assessment, but also enhance the policing response generally. It should be noted that the two London boroughs with the highest detection rates also had no serious repeat victimisations (five or more incidents in the last six months or 10 or more incidents in the past 12 months).

- The 124D booklet was generally viewed positively by London FL officers, who saw it as a useful tool at the incident, particularly for ‘jogging the memory’ about the questions to ask and the evidence to collect.
- West Yorkshire FL officers (without the 124D) were less positive about the usefulness of the SPECSS⁺ model at the incident. The DVCs, however, recognised a marked difference in the work of the FL officers at the incident.
- The positive arrest policy has had a significant impact on police action at the scene, and this was seen to have been more influential than the introduction of SPECSS⁺ by 89% of FL officers.
- Differences in the arrest rates between areas suggest that ‘positive arrest’ is being interpreted differently in different places. Arrest rates as a proportion of all reported domestic violence incidents are up in West Yorkshire as a whole

(by 6%) and in WY2 (from 35% to 54% – a substantial 19% increase) but down in WY1 by six per cent.

- Similarly in London, based on the analysis of 30 cases in each site, L1 had a higher rate than L2, though this difference is not mirrored in the aggregate data for London.
- In each of the areas, the suspect leaving the scene is an issue. However, the rate of tracing is much higher at WY2 than at L2 and WY1, where they have similar problems.
- FL officers reported that the 124D assisted them with evidence gathering. Witness statements were being taken in 36 per cent of the London cases and 36 per cent of the West Yorkshire cases. Initial officer statements were noted in 22 per cent of London cases and 42 per cent of West Yorkshire cases (a significant difference) and other witness statements taken in 42 per cent of London cases and 36 per cent of West Yorkshire cases.
- Other forms of evidence gathering were negligible, with few photos, no DNA and a small number of reports of damage to the property. This suggests that not every avenue of intervention on high-risk cases is being pursued.
- On the basis of the case file data, the rate of prosecution and cautions were low, though 15 per cent of 60 cases in London and 18 per cent of 60 cases in West Yorkshire were ongoing.
- The high workloads discussed in earlier sections may influence the level of police intervention, which may be further constrained by staff shortages.
- In two areas repeat victimisation has increased over the past year and the arrest rate also decreased in one area, though significantly increased in other areas. These data do not imply that the SPECSS⁺ risk assessment undermines aspects of the evidence gathering process, however, neither will it be an over-arching solution. Training, high levels of supervision, and commitment and leadership at senior level are essential to improving the intervention response.

Data inputting

The processes of data inputting cannot be disconnected from the issues of evidence gathering and responding to incidents. In turn, it is an issue which impacts on the evaluation of whether or how the model can be managed within force limitations.

While London FL officers were more positive about the use of the SPECSS⁺ model as an aid at the incident, West Yorkshire FL officers were far more positive about the data inputting process than their London colleagues. While each area is using the SPECSS⁺ model, the processes for seeking and recording information are different and this in turn can cause the actual response to victims and suspects to differ due to timing, focus and the evidence gathered.

West Yorkshire

Verbal inputting to operators

The VIVID system was generally very positively received, with 85 per cent (n=40) of FL officers approving of the process. Table 23 shows a breakdown of the reasons for positive feedback.

Table 23: Why VIVID process works well (West Yorkshire research area only)

Reason	WY1		WY2		Total	
	N	%	N	%	N	%
More detailed/relevant information recorded	13	76	12	48	25	61
Saves time – information on system instantly	4	24	4	16	8	20
Standardises information recorded	1	6	7	28	8	20
Information accessible, useful for repeat calls	1	6	5	20	6	15
System works well	2	12	3	12	5	12
Overall totals*	17	41	25	61	41	100

Percentages based on cases, multiple responses possible.

*Totals may not sum to 100 due to rounding.

A minority of officers from WY2 also commented that the data inputters/operators are well trained and prompt them for data, ensuring that vital information is not missed.

Operators are knowledgeable re: procedure and give guidance. Much better than a paper system because of this and quicker too (FL125).

Quicker if someone else inputs and they help you risk assess. They will spend time with you. Will advise you. Information recorded is relevant and can check past VIVID reports and MO. This can change risk assessment, e.g. evidence of escalation (FL203).

There was also a minority of officers (n=8, 17%), however, who, despite improvements in data recording and accessibility, find the system too time consuming.

Can be on phone for 40 minutes and sometimes cannot get through (FL122).

Too time consuming. Can be queuing on phone. Do VIVID then write off log and SPECSS⁺. Seems to be duplication. In some cases also a CIS entry and don't see a result for it (FL201).

Senior officers supported the positive assessments from FL officers. It was generally agreed that the phone prompting was much easier and user-friendly than form filling and was a vast improvement on the old system. The introduction of the Airwaves System should also further increase the access to supervision and information from the scene.

The 'joined up' process of introducing the SPECSS⁺ model and the VIVID system together was also commented upon favourably and a contributory factor to the 'selling points' of the SPECSS⁺ model. A slight negative mentioned was that it may have taken longer to 'bed down' the risk assessment model when there was a new data inputting system introduced at the same time.

The VIVID system enables access to historical data on the nature and number of previous incidents involving both victims and offenders, as well as escalation, thereby contributes to the efficiency of the risk assessment process. On the negative side, not all evidence is held together. The fields on witness statements were not routinely completed and details of DNA sampling, photographic and other forensic evidence are all separate from the VIVID entry, meaning the progress of an investigation is not easily followed.¹¹ While there are easy links to other police data systems (CIS and Viewdata) where this information may be held, these systems are somewhat 'archaic' relative to VIVID and not as user friendly. In terms of the data analysis for this evaluation, there may be underestimates about some of the data gathered as it was found in 'free text fields' or in other data systems where it would need to have been recorded in an obvious way in order to be picked up.

London

The non joined-up approach we have in IT...To expect someone to put three lots of details on three different systems is a joke in this day and age. But no one seems to have the money or the will (Senior police officer).

Manual inputting to different systems

Whereas officers in West Yorkshire were overwhelmingly positive about the data inputting processes, the most consistent criticism of the SPECSS⁺ model in London lay with the data inputting. Given that the SPECSS⁺ model and the investigative processes have been integrated through the use of the 124D, the data inputting is also experienced as integral to the SPECSS⁺ model. As already mentioned, two different processes are used in London. In L1, police support staff are responsible for transferring information from the 124D onto the police data systems except in cases of serious incidents requiring immediate action.

Table 24 shows the range of issues identified by officers related to recording information under this system.

¹¹ There is a free text field within VIVID where the progress of the criminal investigation can be logged but the format is not standardised, meaning information about evidential issues will not necessarily be recorded here.

Table 24: Issues with recording information (London research area only)

Issue	L1		L2		Total	
	N	%	N	%	N	%
124D and CRIS are duplications	3	30	5	56	8	42
124D awkward – make ‘pocket book’ size	3	30	2	22	5	26
Page 7 on 124D far too small	3	30	-	-	3	16
Very time consuming	-	-	2	22	2	11
Leads to lots of unnecessary recording/ intervention in ‘minor’ cases	2	20	-	-	2	11
DETs duplicates CRIS so why do DETs?	-	-	2	22	2	11
Overall totals	10	53	9	47	19	100

Percentages based on cases, multiple responses possible.

While the number of officers interviewed was small¹², the comments are consistently critical in three areas:

- The design of the booklet which, while seen to be a good ‘aide memoire’ at the incident, could be re-worked to improve its size and the sensitivity of some of the questions. There were many objections, for instance, to the asking of the abuse of pets and children in one question.
- The time-consuming process of duplicated data transfer from the 124D form to the different and non-compatible information systems used within The Met.
- The time spent inputting on what were seen to be minor incidents.

The CSU officers and senior police officers who were interviewed made similar comments to the FL officers. There were real concerns expressed by senior police officers about the amount of time which data inputting took for FL officers.

The 124D has created heavy workloads as there are so many being recorded, partly because the FL officers are anxious not to miss something and about making a mistake (especially since there have been a couple of murders in the borough recently (Senior police officer).

You get a call to a domestic violence incident and if you’ve done it properly you’ll be there an hour. Then there’s the writing up afterwards. Potentially forty-five minutes to an hour with that...That’s two hours out of an eight-hour day for two officers. When they’ve only got seven officers on the streets. You know three domestic violence calls. They don’t want to know (Senior police officer).

There are further issues about the way in which the data inputting processes are undermining a useful process for domestic violence intervention.

¹² Further information from specialist and senior officers needs to be seen in conjunction with the FL data.

Some front line officers are very vocal against the 124D seeing it as too bureaucratic but most of them see sense and are wanting to do it and are frustrated by the time. But they will do it to quite a good standard. On average a good standard. Not a very good standard, but not a poor standard (Senior police officer).

The increase in the amount of data now gathered through the 124D also created pressures on more senior and specialist officers.

You spend all your time dealing with the ones that are on the go and going back over the historical ones is quite difficult to find the time (Senior police officer).

This is primarily a resource issue, as it can easily be argued that this is the level of work which should be done if domestic violence is to be treated as a serious crime. The problem arises when there is no increase in resources to deal with the inevitable increase in workload as the work is undertaken more systematically.

The time consuming process of data inputting raised questions in the minds of officers at all levels about the amount of recording of ‘minor crimes’. Table 25 shows the data on the number of incidents of violent crime related to domestic violence.

Table 25: Recorded domestic violence incidents – violent offences (S.18, 20, 39, 47)

	2004		January 2004		January 2005	
	N	%	N	%	N	%
London	61815	100	5109	8	4513	100
L1	1199	2	116	2	92	2
L2	3207	5	261	5	210	5

Approximately half of the incidents at each site can be categorised as violent offences based on the inputted data. This suggests that FL officers respond to a high number of incidents which, while frightening and serious for victims, may not ‘fit’ the violent crime categories. The principled stance taken by the forces involved has been to recognise that a victim does not ring tend to call the police at the first incident, but usually has experienced a high level of repeat victimisation before they are called. Hence, it is important that these incidents receive a full response. Moreover, when discretion is given to FL officers policing at the incident, past experience would suggest that many serious incidents are not recorded and responded to appropriately (Hanmer et al. 1999).

A particular issue continuously raised by FL and senior officers was that the expanded ACPO definition of domestic violence, while appropriately recognising the role of relatives in abuse and violence, was also resulting in officers being called to attend a greater number of more ‘minor’ incidents between relatives for which they were required to fill in a VIVID entry or a 124D.

When data inputting processes are cumbersome, the complexities of responding to every incident with the full 124D and data inputting response may require further discussion.

Variation in quality between sites

The case analysis of the 60 London cases provides further evidence of the strengths and weaknesses of the data inputting processes.

First, the standard of information on the 124Ds was generally more detailed at the L2 site. In this division, officers input the data themselves onto the information systems. CSU officers at L2 commented that the standard of information had improved and that all information was held together.

We're not going through wads of paper trying to find things...it goes in the case file and when the officer goes to court they're not looking for different bits and pieces (Senior police officer).

There was much less detail on the reports in L1. It was a concern echoed at senior level, where it was commented upon on a number of occasions that the quality of report had gone down. CSU officers in L1 also commented that while they understood that the system of officers not inputting the data themselves saves FL officer time, CSU officers were worse off with the 124Ds, as the quality of information was affected and the history of domestic violence got lost.

But there's definitely a lack of detail in the reports... You don't get so much of it... I mean I can even put it as basically as you don't get so much of a story. Because there's a tiny little bit in this book that they're supposed to write the details of what's gone on. Now the whole teaching around DV ever since I've been in the department, and I don't consider myself an expert by any means, has been that DV is about the story. History. It's about how many times she's been assaulted, about it getting worse, it's about control and so on and so forth. And they give you a box like that to write it all in. So needless to say the officers on the street, fantastic. They've only got four lines to write on. And that's exactly what happens (CSU officer).

In both London sites there were many uncompleted 124Ds. In L1, five 124Ds were unavailable (in 2 cases it was because the evidence was elsewhere – with the Sapphire team and being used in a trial). An additional three cases had no risk classification assigned, and a number of the 124Ds contained very sparse information.

In L2, this was viewed as less of a problem as the details missing from the 124D may well be present in the CRIS entry. The details section of the 124D was not completed in 14 cases, although in several of these cases relevant data were available on CRIS. There were similar issues in relation to information about the incident, which also may not be on the 124D but may be on CRIS. (In some cases the 124D notes actually referred to CRIS n=5). Again, there were some 124Ds which contained hardly any information at all on the incident (n=5). It is possible that these discrepancies arise out of FL officers' perceptions of the duplication of data between the 124D and CRIS.

In L1, in a small number of cases, information was inconsistent between the 124D and CRIS. This could be attributed to the administrative processes but could have serious consequences. For example:

- Information from the officer's statement on the 124D was not transferred, namely that the suspect was armed with a knife and had threatened to smash the place up. The victim also stated that his wife and children (who had been objects of attack) did not speak very good English, yet the 124D did not indicate that an interpreter was required.
- The 124D documented that the husband had left the location to calm down and was very co-operative, while victim was not co-operative and was an alcoholic – which was not transferred to CRIS.
- The suspect in an alleged common assault incident was categorised as a victim in CRIS.

Some significant omissions were also made in a number of cases by officers in L2, where relevant data from the 124D were not transferred to CRIS, and information appeared on CRIS which was not noted on the 124D. In two cases provided to the researcher by the CSU, cases had not been flagged appropriately as domestic violence on the CRIS system.

The administrative problems mentioned in an earlier section also were commented upon as undermining the usefulness of the 124Ds.

I might look at the crime report first and the risk assessments already been carried out by a sergeant on the community safety unit so what the officer has put on the 124 is then going to be irrelevant. And by the time the 124D's sort of filtered through to the community safety unit, I might already have carried out some actions (CSU officer).

Summary and evaluation issues

The complexities of responding to the domestic violence incident, evidence gathering and data inputting are related.

- Most officers spoke very favourably of the VIVID system and it was seen as a vast improvement on the previous system.
- On the negative side, it was seen as less helpful for FL officers at the incident itself than the 124D in London and there were potential problems in the evidence collection being separated from the documentation on the database.
- Both areas have issues around fragmentation/duplication/possible omission of information due to the use of multiple information systems.
- The complex processes for data inputting in London have a substantial impact on the 'bedding down' of the SPECSS⁺ model and have cost implications.
- While FL officers saw the sense of 124D for serious domestic violence incidents, they were less happy both taking and inputting full reports for verbal incidents (including incidents under the expanded ACPO definition of domestic violence).

Section 6: Supporting safety

While we initially thought it would improve investigation, it was really about safety planning around the victim and positive action (Senior police officer).

The ACPO Guidance clearly specifies that victim safety and support is a central aspect of the police response to domestic violence and that multi-agency working is crucial to developing this aspect of the work. In assessing this, the following sections of the Guidance are particularly relevant:

3.12 *'Effective multi-agency information sharing is crucial to a comprehensive process of risk assessment and risk management. There is a positive duty to share information. The decision process to share information should be careful, balanced and should always focus upon ensuring the safety of victims'*.

4.1.4 *'To assist in delivering effective multi-agency support for the victim, children and other vulnerable persons'*.

4.1.3 *'To inform and build upon the safety planning processes of the victim, children and other vulnerable persons'*.

5.i *'Mechanisms should exist to inform victims or the nature of risk...communication with victims should be regularly updated'*.

Enhancing the safety of the victims of domestic violence, including children, is an integral part of the SPECSS⁺ model. While this will primarily be undertaken through high quality evidence gathering and arresting the perpetrator of abuse wherever possible, it will also involve supporting the victim in a variety of other ways depending upon the level of risk.

Different police forces have different models for providing this support. Some forces now have non-police advocates based in the CSU, while others use police officers in this role. At the time of this evaluation, there was considerable discussion about how aspects of victim support and safety planning could be tackled by non-police personnel in order to free police officers to be more involved with investigation, evidence gathering and pursuing cases through the criminal justice system. Evaluations have shown strong evidence for effective policing being undertaken with co-located victim support and advocacy programmes, such as those in Cardiff and Northampton (Hester and Westmarland, 2005; Robinson, 2003). These programmes are showing the most robust results in relation to effective safety planning, decreased repeat victimisation, and work to support prosecutions.

An aspect of the SPECSS⁺ model is to alert FL officers to their role in initial safety planning based on their assessment of risk as well as the continued management of risk and safety through specialist workers.

Recorded safety planning

There were differences across the evaluation sites in relation to safety planning. This may reflect real differences in the level of work undertaken with victims or a lack of compliance with the data inputting in this area.

The West Yorkshire figures appear to be higher than those in London, with a particularly good response from WY2 (see Tables 26 and 27).

Table 26: Safety planning (West Yorkshire)

Safety planning	WY1		WY2		Total	
	N	%	N	%	N	%
Yes	19	63	26	87	45	75
No	11	37	4	13	15	25
Total	30	100	30	100	60	100

In many of the cases where safety planning was not recorded on a particular incident, there had been previous call outs where a substantial amount of safety planning had been undertaken with the victim.

Types of safety planning ranged from letters and/or packs being sent, visits, to a combination of letter and visit, depending on the perceived seriousness. In a small number of cases (WY1 n=2), contact was made by telephone and a subsequent visit/support were declined. It should be noted that in the evaluations of support and safety planning for women undertaken through the Crime Reduction Programme, those areas which provided personalised packages of support showed significant differences in re-victimisation levels and cases going through the courts (Hester and Westmarland, 2005).

An issue raised by CSU officers in London was that there were often problems of delay created by finding experienced interpreters. This meant that instead of victims from BME backgrounds gaining a heightened response (as recommended through the SPECSS⁺ model), the response was often slower, and this had implications for the secondary investigations when victims were less responsive than immediately following an incident.

Levels of recorded safety planning with victims in London were lower, possibly reflecting the different roles of the specialist officers, but there was a clear difference between sites.

Table 27: Safety planning (London)

Safety planning	L1		L2		Total	
	N	%	N	%	N	%
Yes	3	10	12	40	15	25
No	7	23	8	27	15	25
Unknown	20	67	10	33	30*	50
Total	30	100	30	100	60	100

*In 5 of these cases there was no 124D, in the remainder the relevant section had not been completed. Further, information as to whether the 124D was completed was not available for 1 case, where copies had been provided with certain sections missing.

Again, in some, though not all, cases where no safety planning was recorded in relation to this incident, there were other incidents where this had been undertaken. However, it is also clear that this is the section on the 124D which many officers are not filling in (n=30, 50% of all London cases).

A wide range of other strategies was used to support safety. One of the biggest differences between London and West Yorkshire was the fact that there was an automatic referral of children to social services in West Yorkshire, which substantially raised the amount of referrals occurring there. At one level, this may be seen as a positive aspect of multi-agency working, however, it can also ‘swamp’ social services children and families’ teams unless they too have a clear risk assessment process in place with which to filter the referrals.

Agency referrals

The amount of referrals to other support agencies was comparatively small. This would seem to be a missed opportunity in terms of advocacy and support, particularly when there are concerns that this aspect of domestic violence intervention lies with non-police workers. There may also be some other possible explanations: consent not being given by the victim; no appropriate permissions sought for referral; few support agencies to refer to; support agencies not known about by FL officers and the CSU. Particularly in the area covered by WY1, the lack of support services to refer to may seriously curtail the amount of victim support work which can be referred elsewhere.

Table 28: Victim referred to support agency

Victim referred	London		West Yorkshire		Total	
	N	%	N	%	N	%
Yes	12	20	9	15	21	18
No	31	52	46	77	77	64
Declined	-	-	4	6	4	3
Unknown	17	28	1	2	18	15
Total	60	100	60	100	120	100

There were also almost no recorded referrals to solicitors (n=1) in West Yorkshire in the 60 cases examined. In London, this happened more frequently (n=11; 18%), though again it was not a strong aspect of the support work. When non-molestation orders and occupation orders or the first steps under the PFHA (1997) should be an important step in safety planning, this low level of referrals to solicitors is minimal and of some concern.

There seemed to be substantially more use of panic alarms in West Yorkshire compared to the London sites. Ten alarms were supplied in West Yorkshire compared to only two across the London sites. When the evaluation of Crime Reduction Projects suggests that having both a panic alarm and home security has the most impact on reducing the number of repeat recorded incidents post intervention (Hester and Westmarland, 2005 p.83), then this, again, appears to be an under-utilised strategy.

There was no use of emergency accommodation recorded in any of the 60 West Yorkshire cases (this may be due to lack of a field recording this information), though it was only minimally used in the 60 London cases (n=7; 12%), where there is a clear recording category. This could suggest that many women may be feeling more protected within their communities or else have informal support systems in place and highlights the significance of non-refuge based survivor support services.

In West Yorkshire, 'target hardening' is reported on the VIVID system (but only in free-text fields where they log their contact and actions). This occurred in 18 (30%) of the 60 cases. This is not necessarily an accurate reflection of the amount of support provided through target hardening, as where there is repeat victimisation action may have been taken previously. However, it does raise questions about what action is being taken, or can be taken, if further victimisation is occurring. Since repeat victimisation was an issue in all sites, this should invoke higher levels of safety planning rather than less.

Multi-agency working

While the SPECCS⁺ model conceived that multi-agency working was a key aspect of the work, at this stage it seems not to have been held a high priority. Some areas have undertaken joint training with one key agency. However, 'selling' the police model to the wider multi-agency networks and involving partners in the process of understanding the different levels of risk and its relationship to safety planning appears to be 'a next stage' process in some areas.

Interviewed partner agencies often spoke highly of committed senior police officers and CSU/DVCs. However, they also expressed concern that the SPECCS⁺ risk assessment had not been taken through and agreed as a strategy with multi-agency forums. It was felt that a better process could have been used to enhance multi-agency working.

I would really have liked to be involved in the development of the risk assessment and how it will work, it is a missed opportunity. (DV Trainer)

A DV Forum co-ordinator pointed out that one police area in West Yorkshire in conjunction with the multi-agency forum was adopting the 'Cardiff model of risk assessment' as the preferred model. It was commented that this sort of flexibility to meet the needs of different areas was important in choosing the risk assessment process to be used.

Multi-Agency Public Protection Panels (MAPPPs)

Currently, the development of MAPPPs taking referrals of high-risk offenders is still in its early stages, though several sites involved in the evaluation planned to introduce them. This system was a strong recommendation following the analysis of the multi-agency murder reviews and serious sexual assault and domestic violence incidents (Richards 2003; 2004), where it was pointed out that these serious offenders were not being tackled through this important multi-agency mechanism. The Cardiff Multi-Agency Risk Assessment Conferences (MARACS) provide an important evaluated model for these developments (Robinson, 2004). However, it should be noted that an aspect of this form of multi-agency working highlighted by the Cardiff evaluation was that it is local and small scale and a development of a sustained programme of multi-

agency working (The Cardiff Women's Safety Unit) which required very high levels of co-operation and trust between partner agencies. It is, therefore, a process which requires planning and development over time.

Summary and evaluation issues

Victim support enhances other aspects of policing, including cases being able to be prosecuted. Moreover, risk alleviation can only occur once victims trust that they will be supported in their actions to access other forms of help. The role of safety planning is to decrease the risks a victim faces and this will often involve a complex process of multi-agency support.

- An extraordinary amount of work appears to have been achieved by a very small number of staff in some areas in relation to victim support and safety enhancement. Caseloads in some offices were extremely high. One office, for instance, has 2.5 DVCs, one new supervising officer and more than 500 incidents per month. Three support staff also provided very substantial help.
- The full range of support (including solicitors) does not always appear to be accessed. Panic alarms and home security were used less frequently in the London sites than West Yorkshire.
- The level of referral to services external to the police is low.
- Further supervision is required to support the documentation of safety planning.
- To date, opportunities for multi-agency working have been under-utilised in the implementation of the SPECSS⁺ model at a local level.
- The 124D has a section which can be given to victims which provides important information – again this is a strength of the booklet. The extent to which the victim is regularly updated and reviewed was unclear from the data, and we have too little information from victims to know how this element of the intervention is working.

Section 7: Training processes

Training is central to the implementation of the SPECSS⁺ domestic violence risk assessment model and an important aspect of the ACPO Guidance and supporting framework. Sections relevant to ACPO compliance include:

3.2 – *‘All police personnel who have contact with victims and suspects of domestic violence should have appropriate training to ensure knowledge and understanding of established risk factors’.*

5.5f *‘Simplification of the complex risk in the context of policing domestic violence by assigning categories of risk (e.g. high, medium and standard) may be misleading and potentially unsafe, particularly if it is not accompanied by detailed supporting training, information about the nature of risk, guidance as to how to categorise risk and the consequences/meaning of different categories of risk. It is important to remember that risk can always change’.*

5.2 *‘Effective risk assessment ...requires a shared understanding of the nature of risk, domestic violence, positive action/intervention strategies and safety planning’.*

An agreed strategy in both London and West Yorkshire was that training should be mandatory for all FL and specialist officers. A further aspect of the model suggests that training should be delivered by police trainers working jointly with domestic violence specialists from partner agencies in the multi-agency domestic violence forum.

To meet these ends, a national training programme was developed and delivered by the CSU Service Delivery Team to Police forces and submitted to the Home Office Policing Standards Unit for use nationally. The model is based on a cascade form of training whereby a pack and training materials were made available to support police trainers and their multi-agency partners.

The scale of this undertaking should not be under-estimated. In West Yorkshire there are 5,000 officers to be trained and 1,500 police support staff. In London it is estimated that 23,000 FL officers, sergeants, inspectors, community safety officers, station reception officers and communication staff need to be trained. By March 2005, 28 of the 32 London boroughs had completed the initial round of training for FL officers, with many areas planning ‘catch up’ training. It is unclear exactly how many staff have actually been trained due to problems with monitoring the training, though there is an estimate of 80 per cent of FL officers (Riley, forthcoming).

An issue raised consistently was that without high-level support for the implementation of the SPECSS⁺ model, its usefulness and effectiveness will be undermined. CSU officers, key informants and trainers all mentioned the significance of having a champion for domestic violence leading the implementation process. To this end it was suggested that Police Commanders and other high-ranking police be introduced to the model in the first instance.

The implementation of the 124D requires support from the senior management team – without that it would fail miserably because it's seen as an extra piece of work (Senior Police Officer).

Training gaps

In both forces there have been problems with providing a comprehensive training programme for all FL officers over a relatively short period of time. Our interviews with a 'snapshot' of FL officers suggest that there are substantial gaps in spite of the huge efforts made by those responsible in each area for 'rolling out' the training.

Just over half of the 71 FL officers interviewed had attended training on the SPECSS⁺ model (n=36, 51%), although it was hoped that all officers should have been trained at the evaluation sites by this point. For the majority, this had been a one-off training (n=31, 86%). Five officers, all from West Yorkshire (WY1 n=2, WY1 n=3), said they had never seen the SPECSS⁺ booklet, the DV guide or received any training. With the exception of these five, all other officers (n=66) knew about, had been trained in using, or had used the SPECSS⁺ system through 'learning on the job', with the help of supervising sergeants, or the VIVID data inputters.

Different training models

Different models of training were adopted in the four sites.

West Yorkshire sites

WY1 training was initially delivered by Laura Richards, the research analyst who was instrumental in developing the SPECSS⁺ model, to the DVCs as part of the pilot in 2003 (August to December) and funded by the Police Standards Unit.

The SPECSS⁺ model training for FL officers was delivered over a day to different shifts. This was a comprehensive training with a presentation on the background to SPECSS⁺ and the links between domestic violence and the more serious crimes, followed by an input on the practical implementation issues and a further input from the CPS. In addition, the DVCs have carried out training for regular FL officers, special constables and CID. This has involved training five teams and the CID. Six blocks have been presented twice. The DVCs commented that this seems to have been a good way to reinforce SPECSS⁺ and have discussions about practice – '*And then they can ask us questions, if they've got any problems with it*' (DVC). It is intended that this will be repeated when necessary and if the DVCs think the quality of front-line work is going down.

Interestingly, through this cascade model of training, the CSU officers were being trained first, whereas in L2 one of the complaints was that FL officers were being trained on the SPECSS⁺ model prior to the specialist officers. The recent review of training in London (Riley, forthcoming) suggests that ideally this should not have happened and that CSU staff should have attended front line training.

An issue raised by a number of West Yorkshire officers was that the pivotal role of the data inputters was not necessarily being recognised and they also needed training, support and supervision.

Training in WY2 was delivered to the DVCs by their line manager, a DS. Unlike the one-day training in WY1, this training took about one hour and was focused on the implementation of the SPECSS⁺ model. Training was backed up by information the DVCs could access from their computers.

Training to FL officers was also delivered by the same senior officer. It was originally envisaged that it would be delivered by the divisional trainers, however it was felt that they were not specialised in this area of work, so the senior officer in the CSU took on the role himself. It was supposed to be delivered over a day but due to time pressures and constraints it was adapted and done through 40-minute sessions on SPECSS⁺ and risk assessment generally. This training model does not provide the background and attitudinal education which may be helpful for FL officers' understanding of the broader context of domestic violence.

In neither West Yorkshire site was training undertaken with multi-agency partners with a specialism in domestic violence. This was not seen to be ideal from the perspective of partner agencies.

London sites

In London there is now a one-day mandatory training for FL officers which is followed up by Part 2 training for CSU officers. In the future it is planned that this second-stage training will be part of the generic training for CSU officers at L1.

In both sites the training had been delivered jointly by police and an experienced trainer from the voluntary sector. The interviews with key informants suggested this was not the model everywhere and it was clear that particularly in L2, with a large number of FL officers to train, this was hugely demanding of the voluntary sector trainer where the roll out for training had been hastily planned. The trainer nevertheless felt highly committed and believed that it was an opportunity to develop multi-agency links and input into essential police training. In many other areas to date, this joint training model has not been implemented.

A particular issue raised by the London case file analysis is that of training on issues of diversity and ethnicity in relation to domestic violence. The London data showed that in L1 68 per cent of cases involved at least one party from a BME background and L2 showed 63 per cent. Asian backgrounds were more frequent in L1 and African Caribbean backgrounds in L2.

Overview from front line officers

Overall, FL officers were positive about the training they had received.

Was OK, told us about SPECSS⁺. Formalised good practice (FL 110).

Very thorough, very good (FL 305).

Unsurprisingly, the most noted 'new thing' learnt at the training was the 'SPECSS⁺' model. However, more than half of the officers who had attended training said they had not learnt anything new (n=16, 44% - from London n=10, from West Yorkshire n=6).

Apart from SPECSS⁺ a number of issues were cited as new learning: 'higher awareness /understanding of domestic violence'; 'facts and figures'; 'taking positive action at scene'; 'cultural awareness'; 'need to liaise with other agencies'; 'cycle of abuse'; 'violence starts/escalates in pregnancy' and 'new policy/procedures'. Some officers said that they were surprised by the prevalence statistics presented during the training.

A small number of officers, all from London, reported a negative experience of the training. Some officers from L2 complained that the training had taken a whole day and that this was too long, while a minority also reported that there had been hostility from other officers to the training on the day.

While there was recognition that a training pack was a good idea, senior officers and voluntary sector workers involved in implementing the training were also not happy with the training pack and some were highly critical of the original training pack. Many thought that revisions were required to make it more practical and relevant for FL officers.

The training pack that came out with it, to be perfectly honest, I didn't think was as relevant as it should have been.... and I didn't deliver it because I'd have felt embarrassed delivering it. (Senior police officer)

The majority of trained FL officers thought they could implement the risk assessment model (n=29, 81%) on the basis of the training. A further six officers noted that they were 'a little' prepared (n=6, 17%). Only one officer said the training had not left them prepared to implement the model.

A third of trained officers noted that the model was straightforward.

Felt system was straightforward to use. If in doubt, refer to little booklet (FL103).

Didn't have any problem implementing it, received a code on VIVID and was told to start using SPECSS⁺. Was straightforward (FL207).

Consolidates what already doing or supposed to be doing. Pretty self-explanatory (FL405).

Eight officers (London n= 3, West Yorkshire n= 5) commented that it took a little while to get used to implementing the model.

A relevant issue is that many officers are not using their training as they rarely attend domestic violence incidents (Riley, forthcoming). It was also clear from the interviews with FL officers and CSU/DVCs that some police officers become specialists in domestic violence incidents and always respond to these calls when they come through, while it was commented that others studiously avoid these call outs if they can.

Summary and evaluation issues

There are some lessons which may be learned from the implementation of training across London and West Yorkshire, many of which will be highlighted in the concluding section. In summary:

- It was recommended that Commanders and senior police officers be trained or introduced to the model first so that they can facilitate the processes through which training is implemented in their units. It was continually mentioned that without senior officers championing the introduction of the SPECSS⁺ model it would not be used appropriately.
- A range of different training models are developing for FL officers, from the 40-minute focused input on SPECSS⁺ to the full one-day training. The recommended model is the full-day training, but some revisions to the training may need to occur to make it directly relevant to FL officers. Clearly, there are different resource implications for different models. ‘Stage 2’ training should not necessarily occur after ‘Stage 1’.
- Careful planning is required to make the training on the SPECSS⁺ model also an opportunity for the development of joint working. The role of support agencies in providing the advocacy and resources to support safety for victims is essential to the SPECSS⁺ model and needs to be seen as integral, not ‘an add on’ at least for the specialist officer training. In many areas, the amount of training, the timescale and the lack of budget have meant that a joint training model has not been implemented. It has also created problems rather than bridges between the police and other agencies.
- Monitoring systems need to be put in place to establish who has been trained. While, supervision and data inputting processes provide an extra check on how to categorise risk, this is not necessarily a compensation for missed training, which will still need to be addressed if ACPO compliance is to be achieved.

Conclusions and Summary

The implementation of the SPECSS⁺ model is at an early stage. The emphasis of this report has been on a process evaluation, which can shed light on how the implementation of the SPECSS⁺ risk assessment model is proceeding, what lessons can be learnt to inform future phases of implementation, and whether and under what circumstances it could be recommended to other forces. The evaluation team was asked to address the following questions in relation to the SPECSS⁺ risk assessment model:

- Does it comply with the ACPO guidelines on risk assessment?
- Does it address victims' needs in terms of risk?
- Does it complement safety planning?
- Can the model be managed within force limitations?
- Can it be applied irrespective of geography, community or policing variables?

One model – 3 different forms of implementation

Within the four evaluation sites there were 3 different forms of implementation, which had a marked effect on the way in which intervention occurred and the attitudes of the police officers towards the model. These differences included:

- the role of FL and specialist police officers in relation to victim support and investigation;
- administrative support;
- data inputting systems;
- support staff for victims.

The three different models seen in this evaluation revealed different strengths and limitations which should be considered if other forces are to implement the SPECSS⁺ model with its components of assessment, safety planning and risk management. Any force considering future implementation would need to undertake an audit of their local administrative and data inputting practices to understand where the vulnerabilities and strengths lie if a new process of risk assessment is to be implemented. This evaluation of sites in West Yorkshire and London suggests that a risk assessment can be applied irrespective of geography, community or policing variables, but that it will operate very differently in different areas depending upon the policing variables.

The SPECSS⁺ factors

The SPECSS⁺ model is based on giving priority to six factors which are seen to pose the highest risks to victims. A further 'plus six factors' are also listed for police officers to consider.

- The ACPO guidance recommends that '*[risk assessment] systems must be implemented on a firm evidence base and should be designed to capture emerging local and national information and research. Such systems should also undergo an independent evaluation of the process and its implementation*' (5.5). Moreover, that '*...the need for all models/models/systems and their implementation to be kept under a constant process of review*' (5.5.k). When

addressing the question of whether the SPECSS⁺ model addresses victim needs in terms of risk, consideration needs to be given to whether the six SPECSS⁺ factors are the key high-risk factors. Evidence from the literature, experienced police officers, and the Cardiff Safety Unit evaluations suggests that other factors (two of which are currently in the ‘plus six factors’ for consideration) such as ‘threats to kill self or others’, use of drugs and alcohol, and controlling and obsessive jealousy may be of equal or more significance than some of the current six heightened factors.

- The application of the model across the country does raise the issue of whether ‘Culture’ is the most appropriate term to signify heightened risk through isolation, attitudes, and barriers to help-seeking. In spite of training, there was very limited use of the category of ‘Culture’ beyond families of BME origin and hence it was not being used to designate more general risks associated with isolation and barriers to help-seeking. Note, for example, that the 30 cases in WY1 had no ticks against ‘Culture’ as a risk factor. The very strong views, both positive and negative, about using the term ‘Culture’ again raise questions about its appropriateness. While some were concerned that the dangerousness of ‘crimes of dishonour’ was not minimised, others were concerned that it was a term too easily conflated to all BME groups and therefore open to stereotyping and racism. The latter point is of utmost importance when considering the ACPO emphasis that the police force delivers a service to all without discrimination as required under the Race Relations (Amendment) Act 2000 and the Human Rights Act. The fact that, in spite of great efforts by the two forces involved in the pilot, significant numbers of police officers miss (and possibly continue to miss) out on the training where the complexities in understanding and interpreting the category of ‘Culture’ are explained further creates concern about retaining ‘Culture’ as a heightened risk factor.
- Any re-working of the SPECSS⁺ factors needs to be considered in the context of ‘force limitations’. A simple limited factor model is one of SPECSS⁺ most attractive features and allows early risk assessment by FL officers prior to a more comprehensive enquiry by the CSU officers and is an issue which makes it manageable in terms of force limitations.¹³
- 5.5 g ‘*All risk assessment model/models should be in accessible language to both staff and victims with clear information about why certain issues are relevant*’. The West Yorkshire Guide is clearly written and the 124D should stand as a model of clarity in relation to the risk factors being written clearly and concisely. FL officers frequently commented upon how they liked the simplicity and accessibility of the guidance. The clarity of the guidance is a strength of the model.

Police use of the SPECSS⁺ model to inform risk assessment

West Yorkshire Police and the Met have demonstrated that it is possible to ‘roll out’ a new risk assessment procedure across large police forces. A number of issues are pertinent including the ACPO guidance.

¹³ An alternative mnemonic has been suggested – the four ‘S’s’ SPECIAL (Separation, Sexual Assault, Stalking, Substance Misuse and mental health problems, Pregnancy, Escalation, Child Abuse, Isolation, Attempts/threats of suicide or homicide, Legal Obligations).

5.5e *'Any specialist domestic violence officers who are required to categorise risk using information gathered must have full understanding and knowledge of how such decisions are made and how to justify a particular categorisation of risk'.*

5.5c *'Risk assessment and management are dynamic processes'.*

A number of issues are relevant in informing the process through which the SPECSS⁺ model is being used in different areas and which have implications for other police forces.

- The FL officers are generally using the SPECSS⁺ model in a 'mechanistic', though quite standardised, way through adding up the number of risks. This process highlights the importance of the factors which inform the risk assessment. A number of officers also spoke of conducting a more complex analysis of cases.
- Specialist officers appreciated having a formal framework for risk assessment, though felt there was not a significant change to the quality of their work with the introduction of the SPECSS⁺ model. They actively supported the introduction of the model for FL officers as they saw a positive difference in some aspects of FL policing, particularly in the number of witness statements taken, the permission for medical evidence, and providing an initial risk assessment. In relation to the Part 2 guidelines they suggested a number of changes: questions needed to be re-worded or changed, especially the ones on sexual violence where the order could be changed, with questions on weapons not coming directly after those on sexual violence; providing more room on the form for recording details; and the number of 'yes/no' questions was considered inappropriate at the secondary level, where the 'story' needed to be told in more detail, particularly as this could also be used as disclosable evidence for the CPS.
- An overall recommendation is that interested FL officers, CSU officers and representatives from partner agencies be brought together to provide input on changes which need to be made now that there has been some experience with the 124D, the second-stage process and administrative and data inputting systems. Officers at different levels expressed enthusiasm about contributing to improving a system which they felt generally positive about, but where small changes could make a difference.
- Further work is needed to ensure that high levels of repeat victimisation are responded to within the risk assessment framework. Repeat victimisation was much more obvious in its influence on the risk assessment level in West Yorkshire where there has been previous experience of incorporating this into the police risk assessment (Hanmer et al., 1999) than in London.
- There is some variation between areas in the response to different levels of risk and the use of different categories. There is no evidence that the high-risk category is being overused and in some areas may not be being used enough. Several police officers mentioned that local resources and staffing levels within the CSU influenced categorisation, as they did not have the staff to provide too many responses to high-risk victims. However, one area (WY2) performing well in terms of arrest rate, suspect tracing and safety planning had few cases in the high-risk category. This may be because they were actively bringing down the risk at the incident scene or directly afterwards.

- The process is not cost neutral. CSU officers/DVCs commented that they have seen a substantial rise in their workloads as a result of the significant numbers of high- and medium-risk cases which require concerted action. They commented that this was due to these cases being flagged earlier and that a more comprehensive policing response by FL officers was leading to a considerable increase in their workload.
- Acting on agreed protocols for risk assessment, particularly in relation to the FL officers, still requires further development. The most frequent comment made was that FL officers needed to take some responsibility for taking action to decrease high risk cases, and that this was not just a specialist officers' responsibility.
- The case file analysis showed some evidence that the risk assessment process is dynamic, with changes in the risk categories as cases moved through the CSU. However, there were also comments that the staffing levels meant that police officers were always dealing with the crisis situations as new incidents came through, rather than having time to follow up. The fact that one area showed several cases with quite extreme levels of repeat victimisation on CRIS is indicative that more work is needed by officers to target these cases in order to bring the risk level down, including through greater inter-agency co-operation.

Impact of the SPECSS⁺ model on enhancing police work, responding to the incident, evidence gathering and data inputting

The ACPO guidance and the research reports on which the SPECSS⁺ model is based (Richards, 2003; 2004) highlight the fact that the introduction of risk assessment should improve the police response to domestic violence in relation to: increased victim safety; managing lethal situations; making better use of intelligence; and increasing the standard of investigation and supervision. Increased arrest and prosecution rates should result. Relevant sections of the ACPO guidance include:

3.4 'Early intervention and appropriate intervention in domestic violence incidents is a key element of the police response to domestic violence. Risk assessment and management should enhance rather than undermine the police response to domestic violence'.

4.2.5 'To inform police decision-making and action, including effective investigation and evidence gathering'.

4.2.7 'To prevent and reduce repeat victimisation'.

Police officers at all levels were generally positive about the use of the SPECSS⁺ model as a risk assessment tool. Some senior police officers were unconvinced that the SPECSS⁺ model had enhanced the quality of police work in terms of taking forward a case for prosecution. This was particularly in L1 where FL officers were not inputting the data from the 124D onto the CRIS database¹⁴. There were, however, a range of other findings relevant to this aspect of implementation.

¹⁴ By the end of this evaluation process L1 had changed its data inputting process to direct FL officer inputting.

- The 124D booklet was generally viewed positively by London FL officers, who saw it as a useful model at the incident, particularly for ‘jogging the memory’ about the questions to ask and the evidence to collect. Sensible recommendations were made about changing the wording and ordering of questions.
- West Yorkshire FL officers (without the 124D) were less positive about the usefulness of the SPECSS⁺ model at the incident. The DVCs, however, recognised a marked difference in the work of the FL officers at the incident, which they said assisted their work.
- Arrest rates as a proportion of reported domestic violence incidents are up in West Yorkshire as a whole (by 6%) and in WY2 (from 35% to 54% – substantial 19% increase) but down in WY1 by six per cent. Similarly, in London based on the analysis of 30 cases in each site, L1 had a higher rate than L2, though this difference is not mirrored in the aggregate data for London.
- In each of the areas, the suspect leaving the scene is an issue. However, the rate of tracing is much higher at WY2 than at L2 and WY1, where they have similar problems.
- FL officers reported that the 124D assisted them with evidence gathering. Witness statements were being taken in 36 per cent of the London cases and 36 per cent of the West Yorkshire cases. Initial officer statements were noted in 22 per cent of London cases and 42 per cent of West Yorkshire cases (a significant difference), and other witness statements taken in 42 per cent of London cases and 36 per cent of West Yorkshire cases.
- Other forms of evidence gathering were negligible, with few photos, no DNA and a small number of reports of damage to the property. This would suggest that the high-level policing required on high-risk cases is not yet occurring.
- On the basis of the case data, the rate of prosecution was very low. Of 60 London cases, eight per cent were cautioned and three per cent involved a first instance of harassment. In West Yorkshire, of 60 cases, five per cent were cautioned. Fifteen per cent of 60 cases in London and 18 per cent of 60 cases in West Yorkshire were ongoing. These figures suggest that further work needs to be undertaken to enhance the policing on medium and high-risk cases so that higher prosecution rates can occur.
- The high workloads discussed in earlier sections may influence the level of police intervention, which is constrained by staff shortages.
- In two areas, repeat victimisation had increased over the past year and the arrest rate had also decreased in one area, though significantly increased in other areas. These data do not imply that the SPECSS⁺ risk assessment undermines aspects of the evidence gathering process, however, neither will it be a panacea. Training, high levels of supervision, and commitment and leadership at senior level are essential to improving the intervention response.
- It should be noted that the two areas of London with the highest detection rates were also the areas with no high-level repeat victimisation.

The complexities of responding to the domestic violence incident, evidence gathering and data inputting are related.

- Most officers using it spoke very favourably of the VIVID system and it was seen as a vast improvement on the previous system.
- On the negative side, it is less helpful for FL officers at the incident itself than the 124D in London and there are potential problems in the evidence collection being separated and not necessarily clearly documented on the database.
- Both areas have issues around fragmentation/duplication/possible omission of information due to the use of multiple information systems.
- The complex processes for data inputting in London have a substantial impact on the ‘bedding down’ of the SPECSS⁺ model and have cost implications. The 124D takes a substantial amount of time to input, particularly for FL officers if they are not good word processors or IT literate.
- While FL officers see the sense in this for serious domestic violence incidents, they were less happy both taking and inputting full reports for verbal incidents and what were seen as minor incidents (including incidents under the expanded ACPO definition of domestic violence). Any response to this issue would need to be balanced against the problems which arise when FL officer discretion is given on what to treat as domestic violence incidents.
- An issue raised by officers at all levels was that the new definition of domestic violence under the ACPO guidance, which includes violence and abuse between relatives, resulted in police officers being called to incidents they considered to be relatively minor and not necessarily domestic violence. They were unhappy about filling out the full 124D in these cases. Further training may serve to explain and clarify this to officers, especially the issue of escalation and the need to gather the history related to the incident.
- The L1 site should actually provide a sensible way around the problems of the ‘London IT system’ and its heavy cost implications in terms of FL officer time and morale – namely that serious incidents are inputted by the FL officers and less serious incidents by support staff. However, it was clear that the overall standard of domestic violence work was suffering in L1 under this system. CSU and senior officers all reported the fall in recording standards and evidence gathering. (At the time of writing the Final Report L1 had changed its procedure to the L2 process.) The immediate way through the ‘London IT problem’ was not clear. The process of FL officers inputting data from their 124D booklets to data inputters, either by telephone or verbally, could be piloted, though it has been pointed out that the 124D is an Aide Memoire not a tool for data inputting.
- An electronic version of the 124D could be developed and piloted.
- Higher levels of administrative support are required to tighten the system so that evidence is not being lost.

Supporting safety

The ACPO Guidance clearly specifies that victim safety and support is a central aspect of the police response to domestic violence and that multi-agency working is crucial to developing this work. The following sections of the Guidance are particularly relevant:

3.12 *‘Effective multi-agency information sharing is crucial to a comprehensive process of risk assessment and risk management. There is a positive duty to share*

information. The decision process to share information should be careful, balanced and should always focus upon ensuring the safety of victims’.

4.1.4 ‘To assist in delivering effective multi-agency support for the victim, children and other vulnerable persons’.

4.1.3 ‘To inform and build upon the safety planning processes of the victim, children and other vulnerable persons’.

.5.i ‘Mechanisms should exist to inform victims or the nature of risk...communication with victims should be regularly updated’.

Victim support enhances other aspects of policing including cases being able to be prosecuted. Moreover, risk alleviation can only occur once victims trust that they will be supported in their actions to access other forms of help. The role of safety planning is to decrease the risks a victim faces and this will often involve a complex process of multi-agency support.

- A huge amount of work appears to have been achieved by a very small number of staff in some areas in relation to victim support and safety enhancement. Caseloads in some offices are extremely high. One office, for instance, has 2.5 DVCs, one new supervising officer and more than 500 incidents per month. Three support staff also provided substantial help. However, the level of victim support and the extent to which risk assessment can be a dynamic process is said to be constrained by such workloads.
- The full range of support (including solicitors) does not always appear to be accessed. Panic alarms and home security were used less frequently in the London sites than West Yorkshire.
- Further supervision of FL officers is required to support the documentation of safety planning which was frequently not filled in on the 124D.
- Initial police follow up of victims to gain a full history is an essential part of investigation. However, ongoing victim support is also a role which other agencies, or non-police staff co-located at a police station, can play and which can potentially free up police officers to concentrate on the investigation and rapid response. Some areas in London are now working with the latter model (L1) and it has been reported upon very positively at all levels.
- The notion of victim safety is one which has generally been well understood within the police service with the development of CSUs and DVCs who are often highly committed individuals working with attention to safety planning. Limitations are created by very high workloads and the need for greater attention to the development of multi-agency work.
- Opportunities for multi-agency working have been under-utilised in the implementation of the SPECSS⁺ model at a local level.
- The 124D has a section which can be given to victims which provides important information – again this is a strength of the booklet. The extent to which the victim is regularly updated and reviewed was unclear from the data and we have too little information from victims to know how this element of the intervention is working.

Training processes

Training is central to the implementation of the SPECSS⁺ domestic violence risk assessment model and an important aspect of the ACPO Guidance and supporting framework. Sections relevant to ACPO compliance include:

3.2 'All police personnel who have contact with victims and suspects of domestic violence should have appropriate training to ensure knowledge and understanding of established risk factors'.

5.5f 'Simplification of the complex risk in the context of policing domestic violence by assigning categories of risk (e.g. high, medium and standard) may be misleading and potentially unsafe, particularly if it is not accompanied by detailed supporting training, information about the nature of risk, guidance as to how to categorise risk and the consequences/meaning of different categories of risk. It is important to remember that risk can always change'

5.2 'Effective risk assessment ...requires a shared understanding of the nature of risk, domestic violence, positive action/intervention strategies and safety planning'.

There are some lessons which can be learned from the implementation of training across London and West Yorkshire. These issues were raised in interviews with key informants and from interviews with workers from partner agencies.

- Several interviewees recommended that Commanders and senior police officers be trained first so that they can facilitate the processes through which training is implemented in their units. It was continually mentioned that without senior officers championing the introduction of the SPECSS⁺ model it would not be used appropriately.
- A range of different training models are developing for FL officers, from the 40-minute focused input on SPECSS⁺ to the full one-day training. The recommended model is the full-day training, but some revisions to the training may need to occur to make it directly relevant to FL officers. Clearly, there are different resource implications for different models. 'Stage 2' training should not necessarily occur after 'Stage 1'.
- The speed with which training was expected to be 'rolled out' prior to the implementation of the SPECSS⁺ model meant that the substantial number of days required for training FL officers, and the second phase with CSU officers, needs forward planning. Training plans for the year had already been established and agreed prior to the notification that SPECSS⁺ training was mandatory. This is a problem which needs to be forestalled if other areas of the country are involved in implementing the SPECSS⁺ model.
- The training was mainstreamed and therefore needed to be funded from existing police resources which compounded the problems associated with the 'fast tracking' of the training schedule.
- Careful planning is required to make the training on the SPECSS⁺ model also an opportunity for the development of joint working. The role of support agencies in providing the advocacy and resources to support safety for victims is essential to the SPECSS⁺ model and needs to be seen as integral, not 'an add on' at least for the specialist officer training. In many areas, the amount of training, the timescale and the lack of budget have

meant that a joint training model has not been implemented. It has also created problems rather than bridges between the police and other agencies.

- Monitoring systems need to be put in place to establish who has been trained. While supervision and data inputting processes provide an extra check on how to categorise risk, this is not necessarily a compensation for missed training, which will still need to be addressed if ACPO compliance is to be achieved. In our sample of 71 FL officers all of whom should have been trained, 51 per cent had attended training on the SPECSS⁺ model.
- Not all data inputters and support workers have been trained and they mentioned that, given the level of work they undertake, their training in the use of the SPECSS⁺ model is also important, suggesting that staff at all levels need to be trained.

A change opportunity

The SPECSS⁺ risk assessment model is not just a new procedure, but part of a 'change process' in policing domestic violence. This process needs to be 'sold' particularly to FL officers who are implementing the risk assessment, especially if they are to act on their responsibility to intensify their efforts on evidence gathering, take immediate action to manage high- and medium-risk cases to decrease that risk, and produce detailed reports (either verbal or written) which can be used by the CPS and the specialist officers.

To be ACPO-compliant, the process of implementation needs to take account of complexities and the impact of change. A small and committed project team is required. The experience in London suggests this should occur at Borough level as well as within The Met. It also requires a senior officer to champion the implementation process, providing support, vision and resources. The experience of the pilot projects suggests that the team needs to plan:

- Training at all levels of the police force.
- The development of data inputting and administrative systems (and their co-ordination with existing systems).
- The development of internal guidelines which delineate the expected responses from police officers at standard, medium and high level, and the expectations in relation to evidence gathering and follow-up.
- The requirements and processes for supervision and monitoring.
- Liaison with partner agencies in relation to training, safety planning and data sharing processes.
- Liaison with the CPS to develop the protocols and understandings by the CPS of the different levels of risk and the requirements for evidence gathering for prosecution purposes.

At this stage, one of the most significant shortcomings of the implementation process lies in the lack of attention to the multi-agency processes. A major initiative such as this within the police force could be an opportunity to enhance partnership working. Joint training, agreed responses to high-risk victims and suspects (through the development of MAPPPA), and enhanced safety planning are all areas where opportunities could be developed.

The interviews with police officers suggested that it was not necessarily lack of commitment to inter-agency working, but rather the very short implementation timescale and the lack of resources to support the SPECSS⁺ implementation which meant that opportunities for development could not be taken in many areas.

In short, the implementation of the model is not cost neutral. The costs are comparatively small but need to be budgeted for if a promising initiative is not to be undermined by low staff morale induced by increased workloads resulting from a more comprehensive approach to policing domestic violence. If the model is implemented well, there are also systems changes in relation to the change process which need to be acknowledged and worked with to reap the full potential of the risk assessment model.

Effective data recording and data inputting systems and victim support are not ‘cost neutral’, but neither are they excessive in their costs. The implementation of a risk assessment model requires these relatively minimal costs to be met if the model is to be effectively utilised.

Future evaluation

The ACPO guidance clearly states that risk assessment is a dynamic process which needs to be continually reviewed to account for changes in the evidence base. This evaluation has explored the early processes of implementation.

A future evaluation will need to look at outcome data to see whether significant changes in policing practice in relation to both victims and offenders have occurred over time.

A shortcoming of this evaluation has been the lack of attention to victim/survivor perspectives on police intervention. A future evaluation, undertaken over a longer period of time, should prioritise this perspective.

Concluding comments

There are no simple answers to the evaluation questions posed in the briefing.

1. The ACPO guidance makes it clear that risk assessment is a complex process requiring training which should be used to enhance victim safety and improve the standard of investigation. The SPECSS⁺ model, as seen in the two pilot sites, is ACPO-compliant in so far as it has trained police officers and developed systems to support the risk assessment process. The six key SPECSS⁺ factors will need to be kept under review as data is already emerging, particularly from the Cardiff Safety Unit, which suggests that other risk factors may be of equal or greater importance in cases of serious domestic violence offences. It would not be recommended that any other forces use ‘Culture’ as a category as it is generally under-utilised except in relation to black and minority ethnic families – ‘isolation’ or ‘barriers to help-seeking’ or ‘attitudes’ may be more accurate. While there was not evidence in the case file data from either London or West Yorkshire that it was being used in a discriminatory or stereotyped way, it is a category which runs this risk and would then fall outside the Race Relations (Amendment) Act, 2000. The strength of feeling expressed about its use as a category suggests that if the risk assessment model is to enhance multi-

agency working then it is unnecessarily controversial and has the potential to be used in a discriminatory way.

2. The risks to victims are detected by the more comprehensive work by FL officers at the incident through the use of the 124D and prompting through the VIVID system.

3. The use of the 124D, where FL officers are prompted for responses, is complementary to the safety planning, as are the target hardening processes used in West Yorkshire. Greater supervision is required for this work to be developed.

4. The implementation of the SPECSS⁺ model 'on a shoestring' suggests that it can be undertaken within the limitations of most police forces. However, this evaluation would strongly recommend that data inputting and administrative systems, training, partnership working, and victim support would all be greatly enhanced by relatively small amounts of funding.

5. This evaluation has shown that while there is an overall SPECSS⁺ model, the local variations in the role of FL officers, specialist officers, data inputting systems, the strength of multi-agency working and support services create very different ways of working which will need to be taken into account if other police forces implement the model.

References

- ACPO (2004) *Guidance on Investigating Domestic Violence*, ACPO Centrex.
- Batsleer, J., Burnman, E., Chantler, K., McIntosh, S.H., Pantling, K., Smailes, S. and Warner, S. (2002) *Domestic violence and minoritisation: Supporting women to independence*, Manchester: Women's Studies Research Centre, Manchester Metropolitan University.
- Campbell, J. (1995) *Assessing dangerousness: Violence by sexual offenders, batterers and child abusers*, Thousand Oaks, CA, Sage.
- Davies, J., Lyon, E. and Monti-Catania, D. (1998) *Safety Planning with Battered Women*, London, Sage.
- Dobash, R. and Dobash R. (2002) *Homicide in Britain: Risk Factors Situational Contexts and Lethal Intentions*, Research Bulletin No 1, Manchester, Department of Applied Social Sciences, DASS.
- Gilchrist, E., Johnson, R., Takriti, R., Weston, S., Beech, A. and Kebbell, M. (2003) *Domestic violence offenders: characteristics and offending related needs*, Findings 217, London, Home Office.
- Hanmer, J., Griffiths, S. and Jerwood, D. (1999) *Arresting Evidence: Domestic Violence and Repeat Victimisation*, Police Research Series Paper No. 104, London, Home Office.
- Hester, M. and Westmarland, N. (2005) *Tackling Domestic Violence: Effective Interventions and Approaches*, Home Office Research Study 290. <http://www.homeoffice.gov.uk/rds/pubsintro1.html>.
- Hester, M., Hanmer, J., Coulson, S., Morahan, M. and Razak, A. (2003) *Domestic violence: Making it through the criminal justice system*, Sunderland University, University of Sunderland and Northern Rock Foundation.
- Humphreys, C. and Holder, R. (2004) 'Presenting the evidence', *SAFE Domestic Abuse Quarterly*, 9 (Spring) 10-12.
- Humphreys, C. and Holder, R. (2002) 'An integrated criminal justice response to domestic violence': 'It's challenging, but it's not rocket science' *SAFE, The Domestic Abuse Quarterly* 3 16-19.
- Pernanen, K. (1991) *Alcohol in Human Violence*, New York, Guilford.
- Radford, L., Blacklock, N. and Iwi, K. (forthcoming) 'Domestic violence risk assessment and safety planning in child protection – Assessing perpetrators' in C. Humphreys and N. Stanley (eds.) *Domestic Violence and Child Protection: Directions for Good Practice*, London, Jessica Kingsley Publications.

Richards, L. (2004) *'Getting away with it': A strategic overview of domestic violence sexual assault and 'serious' incident analysis*, London, Metropolitan Police.

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

Riley, C. (forthcoming) *MPS Domestic Violence Training*, London, Metropolitan Police.

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

<http://www.cf.ac.uk/socsi/whoswho/robinson.htm>.

Robinson, A. (2003) *The Cardiff Women's Safety Unit: A Multi-agency Approach to Domestic Violence*, Cardiff, Cardiff University.

Siddiqui, H. (2000) *The Ties That Bind*, Index on Censorship, 1, 50-53.

Sinclair, R. and Bullock, R. (2002) *Learning from Past Experience: A Review of Serious Case Reviews*, London, Department of Health.

Walby, S. and Allen, J. (2004) *Domestic violence, sexual assault and stalking: Findings from the British Crime Survey*, Home Office Research Study 276, London, Home Office Research Development and Statistics Directorate.

Websdale, N. (2000) *Lethality Assessment Models: A Critical Analysis*, VAWnet, National Resource on Domestic Violence.

Appendix 1

Table 29: Risk assessment by allegation type (L1)

Allegation Type*	High		Medium		Standard		No classification/ unknown	
	N	%	N	%	N	%	N	%
Section 47 assault	1	50	1	17	5	31	2	33
Common Assault	-	-	2	33	1	6	-	-
Harassment	-	-	1	17	1	6	-	-
Rape	1	50	-	-	-	-	-	-
Criminal Damage	-	-	-	-	1	6	1	17
Theft	-	-	-	-	-	-	1	17
Non Crime Book	-	-	2	33	8	50	2	33
Domestic Incident								
Totals**	2	100	6	100	16	100	6	100

*Note that only one case involved multiple charges, which were Section 47 assault, theft and criminal damage – this was counted as a Section 47 assault, standard risk level case.

**Totals may not sum to 100 due to rounding.

Table 30: Risk assessment by allegation type (L2)

Allegation Type*	High		Medium		Standard		No classification/ unknown	
	N	%	N	%	N	%	N	%
Section 20 assault	1	20	-	-	-	-	-	-
Section 47 assault	3	60	2	14	-	-	-	-
Common Assault	1	20	5	36	3	33	2	100
Rape	-	-	1	7	-	-	-	-
Criminal Damage	-	-	3	21	2	22	-	-
Non Crime Book	-	-	3	21	4	44	-	-
Domestic Incident								
Totals*	5	100	14	100	9	100	2	100

*Totals may not sum to 100 due to rounding.

A similar pattern emerged in West Yorkshire where one area had four Section 47 charges, which were designated as standard risk, though there are clearly medium- and high-risk cases where there have also been these charges.

Table 31: Risk assessment by allegation type (WY1)

Allegation type*	Standard		Medium		High	
	N	%	N	%	N	%
Verbal dispute	7	70	6	60	4	40
Section 47 assault	-	-	1	10	1	10
Criminal damage	1	10	-	-	-	-
Threats to kill	1	10	2	20	1	10
Section 39 assault	1	10	-	-	-	-
Harassment	-	-	-	-	2	20
Offence against adult – emotional	-	-	1	10	1	10
Rape	-	-	-	-	1	10
Total	10	100	10	100	10	100

*Taking the most serious offence, where there is more than one allegation in a case.

Table 32: Risk assessment by allegation type (WY2)

Allegation type*	Standard		Medium		High	
	N	%	N	%	N	%
Verbal dispute	4	40	5	50	2	20
Section 47 assault	4	40	5	50	6	60
Damage	1	10	-	-	-	-
Section 39 assault	1	10	-	-	2	20
Total	10	100	10	100	10	100

*Taking the most serious offence, where there is more than one allegation in a case.