Preventing perpetrators of intimate partner abuse in Southampton;

A needs assessment

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Executive summary

Domestic and sexual abuse (DSA) is an umbrella term that encompasses any form of abuse between any family members. Intimate partner abuse (IPA) is a term for DSA that occurs between adults in an intimate partner relationship. Where possible this needs assessment (NA) focusses specifically on preventing perpetration of IPA within Southampton, however much of the available data and information is for DSA as a whole.

Nationally, it is estimated that 6.3% of women aged 16-59 had experienced IPA in the 2017/2018 financial year. In 2017/2018, Hampshire (including Southampton) had a rate of 21.9 domestic abuse incidents and crimes per 1,000 population, which is more than the South East region average of 20.0[2]. Applying national rates to Southampton suggests that we can estimate that 10,200 adults are likely to have been victims of DSA in the last year[3]. In 2017/18 there were over 3,000 police recorded incidents of DSA in Southampton. In addition, police data suggests that DSA related offences are increasing in Southampton year on year. Whilst some of this may be due to increased reporting and recording, there can be no doubt that IPA in Southampton is an issue that needs tackling.

In recent years the need to focus on preventing perpetration of DSA, alongside and complementary to supporting victims and survivors of DSA, has become increasingly clear. This includes preventing people from ever becoming perpetrators of abuse, as well as supporting perpetrators to stop their abusive behaviour. The potentially lifelong repercussions of being a victim of DSA, or being exposed to DSA as a child make reducing DSA a key factor in improving the wellbeing of people living in the Southampton.

Southampton is a diverse city with high levels of deprivation and several challenges, one of which is the levels of DSA. The majority of perpetrators arrested for DSA related offences in the city are male and aged 26-40. The number of offences in the city varies by month of the year, with more offences being committed in the summer months and over Christmas. DSA is affecting the children in our city, a large number of children's assessment undertaken by Children's Services found that DSA was a factor in that child's life. We know that being exposed to DSA as a child increases the risk of poor future outcomes for that child.

As a city, Southampton is already leading the way in some of its perpetrator service provision, however, given the rates of DSA in the city we know that more needs to be done. There are several gaps in current service provision, including in children's support services and perpetrators services for those in LGBTQ relationships or with additional needs that must be met (such as a substance use disorder). In addition, the number of recorded offences involving DSA suggest that current service provision is not adequately tackling the issue. During this NA, stakeholders working in services related to DSA or in contact with victims or perpetrators of DSA were contacted to gather their views. Stakeholders felt that better education and support for children, support for parents and earlier intervention were key in breaking the cycle and reducing levels of IPA.

A review of the literature revealed that the evidence base is in its early stages. There are initial indications that some interventions may be effective in preventing IPA, but further research is needed. As a result the best approach may be to work to reduce risk factors for IPA where possible, to continue to build the evidence base and to be responsive as new evidence becomes available.

To conclude this NA, recommendations have been made to illustrate potential next steps in reducing IPA in Southampton. Some of the key recommendations made include;

Children

Universal primary prevention

- *Relationship Education – to ensure that all children receive healthy relationship education.* We must work with schools to ensure that healthy relationships, IPA, harmful gender stereotypes and other key topics are covered in mandatory PSHE from 2020

Targeted interventions

- *Adverse Childhood Experiences – to consider what SCC can do to reduce the burden of ACEs for our children.* This may involve convening a task force exploring ACEs within Southampton and potential interventions to support those at risk or experiencing ACEs
- Increase provision of parenting support for families who are struggling

Adults

Universal primary prevention

- Community engagement, introducing positive role models and tackling gender stereotypes, acceptance of violence and acceptance of controlling behaviour.
- *Communications Campaign – i.e. white ribbon campaign, to induce cultural shift and social change such that even low levels of abusive behaviour are no longer acceptable in our communities, and those worried about their behaviour feel able to come forward and ask for help.*

Perpetrator services and whole system approach

- *Perpetrator services – Increase both awareness of and referrals to perpetrator services, through awareness raising campaigns, staff training and earlier identification of perpetrators.*
- *Co-location of Hampton Trust staff within the key service areas – to share skills and knowledge in identifying and engaging perpetrators.*
- Improve links between mental health services and perpetrator services (this should be actioned shortly)
- Improve links between substance use and perpetrator services and consider combining substance use treatment programmes with PPs where applicable and if possible
- *Resources – where possible pursue resources to support perpetrator services (currently 11% of total DSA funding).*
- As far as possible address the service gaps identified in section 7

Evidence based decision making

- Develop local network of academics, commissioners and service leads to translate research into practice and evaluate interventions that are innovative
- Undertake a literature review on how best to support children who are affected by IPA
- *Evaluation of perpetrator services – to add to the evidence base in this area and ensure that interventions are effective.* Ensure that any new and existing interventions are evaluated, including primary prevention interventions where possible
- *Alcohol and Substance use – to consider the impact on DSA and ensure joined up working.* Specifically, explore the relationship between alcohol licencing and IPA
- Be able to respond flexibly to the evidence base as it emerges

For full recommendations please see section 9.2

Glossary

ACE	Adverse Childhood Experience
BBR	Building Better Relationships
CARA	Conditional Cautioning and Relationship Advice
CAMHS	Child and adolescent mental health services
CBT	Cognitive Behavioural Therapy
CCG	Clinical Commissioning Group
CDC	The Centers for Disease Control and Prevention
CRC	Community Rehabilitation Company
CSR	Creating Safer Relationships
DA	Domestic Abuse
DAPP	Domestic Abuse Prevention Partnership
DART	Domestic Abuse Recovering Together
DSA	Domestic and Sexual Abuse
DV	Domestic violence
EIF	Early Intervention Foundation
HCC	Hampshire County Council
HRDA	High Risk Domestic Abuse
ICU	Integrated Commissioning Unit
IP	Intimate Partner
IPA	Intimate Partner Abuse
IPV	Intimate Partner Violence
JSNA	Joint Strategic Needs Assessment
LGA	Local Government Association
LGBTQ	Lesbian, Gay, Bisexual, Transgender and Queer
MARAC	Multi-Agency Risk Assessment Conference
MASH	Multi Agency Safeguarding Hub
MATAC	Multi-Agency Tasking And Co-ordination
MoJ	Ministry of Justice
NA	Needs Assessment
NICE	National Institute for Health and Care Excellence
NPS	National Probation Service
OPCC	the Office of the Police and Crime Commissioner
PP	Perpetrator Programme
PSHE	Personal, Social, Health and Economic education
RAR	Rehabilitation Activity Requirement
RSE	Relationships and Sex Education
RCT	Randomised Controlled Trial
SCC	Southampton City Council
SPOC	Single point of contact
SYOS	Southampton Youth Offending Service
WHO	World Health Organization

Definitions

Term	Definition
Adverse Childhood Experiences	ACEs have been defined as *'intra-familial events or conditions causing chronic stress responses in the child's immediate environment. These include notions of maltreatment and deviation from societal norms, where possible to be distinguished from conditions in the socioeconomic and material environment.'*[4]. ACEs can include witnessing abuse or being abused, parental poor mental health or substance use disorders, neglect, parental divorce, being taken into care or parents being incarcerated.
Domestic and sexual abuse	Any incident of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to, psychological, physical, sexual, financial or emotional abuse.
Intimate partner abuse	Any incident of controlling, coercive, threatening behaviour, violence or abuse between intimate partners aged 18 or over regardless of gender or sexuality. The abuse can encompass, but is not limited to, psychological, physical, sexual, financial or emotional abuse.
Primary prevention	Preventing someone from ever perpetrating IPA
Secondary prevention	Intervening after early warning signs or first occurrence of IPA to stop it happening again and minimising the harm to others
Tertiary prevention	Stopping serial perpetrators from continuing to perpetrate IPA and minimising the harm to others

Acknowledgements

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1. Introduction

1.1. Scope

The Government definition states that Domestic and Sexual Abuse (DSA) refers to any incident of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to, psychological, physical, sexual, financial or emotional abuse. DSA can also be referred to as domestic violence (DV), domestic abuse (DA), and DSA between intimate partners can be referred to as intimate partner violence (IPV) and intimate partner abuse (IPA). In general, DA and IPA are broader terms which encompass both physical and non-physical abuse, and DV and IPV refer to physical abuse alone. However, DV and IPV are also commonly used to refer to both physical and non-physical abuse, and may be used interchangeably with DA and IPA.

This needs assessment will focus on intimate partner abuse (IPA), which, for the purpose of this needs assessment, will be defined as any incident of controlling, coercive, threatening behaviour, violence or abuse between intimate partners aged 18 or over regardless of gender or sexuality. The abuse can encompass, but is not limited to, psychological, physical, sexual, financial or emotional abuse. This needs assessment will not consider other forms of abuse such as elder abuse, child abuse or sexual assault and violence outside of intimate partner relationships.

This needs assessment (NA) uses both quantitative and qualitative information to describe the needs relating to prevention of perpetrators of DSA. Further information about NAs is available in Appendix 1.

1.2. Background

1.2.1. DSA impact and risk factors

In the 2017/18 financial year there were an estimated 2,006,000 victims of DSA, which included 1,316,000 women and 695,000 men[5]. This equates to 6.3% of women aged 16-59 experiencing IPA, and 599,549 police recorded offences (and 598,545 incidents not recorded as offences) in the year ending March 2018[5]. The police recorded offences are likely to be a huge underestimate of actual levels of abuse, as many incidents of DSA are never reported. At its worst, DSA can result in murder. Between 2015 and 2017 there were 400 domestic homicides in adults (aged over 16) in England and Wales, 4 of which were in Hampshire[5]. As is clear from the figures, IPA is a gendered issue, with far more women experiencing abuse than men, and far fewer female perpetrators. This needs to be considered in any approach aimed at preventing IPA, although services need to cater for everyone, regardless of their gender, background or sexual orientation.

For many of the adults experiencing DSA there are also children living in the family home, who are being abused themselves, witnessing abuse between relatives and being otherwise affected by the wider impacts of an abusive relationship. Whilst there are no official numbers of children affected[6], it is estimated that between one quarter and one third of children in the country have been exposed to DSA at least once[7].

The impact of DSA on victims extends beyond the physical impacts such as bruising, broken bones and missing teeth. Over 50% of victims who experience violence resulting in an injury also report feeling fearful, experiencing depression and experiencing anxiety[7]. These psychological impacts often outlast the physical impacts of violent DSA[7]. Those who experience coercive control or psychological abuse without violence are also at risk of long term impacts[8]. There are also long-term

impacts for others aside from the immediate victim of abuse. Witnessing abuse as a child is an Adverse Childhood Experience (ACE)[9]. Qualitative research tells us that children are affected by witnessing coercive control and psychological abuse as well as physical abuse[10]. ACE's are predictors of poor outcomes across a spectrum of areas, including poor school performance, substance use disorders, mental health issues, incarceration and violent behaviour including going on to become perpetrators of DSA themselves[9]. The more ACE's a child is exposed to, the more likely it is that the child will have poor outcomes[9].

A recent Home Office research report estimated the cost of DSA for victims in England and Wales to be £66 billion from 1st April 2016 to 31st March 2017[7]. This figure is based on the reported prevalence of DSA from the Crime Survey for England and Wales, which is then used to calculate estimated health costs and productivity losses, for example as a result of days off work[7]. The average estimated cost for each individual victim is £34,015[7].

There are many risk factors at the individual level that increase the likelihood of someone becoming a perpetrator of DSA. In addition to ACEs these include, but are not limited to, poor educational achievement and unemployment, younger age, low income, stress, attitudes such as strict gender norms and acceptance of violence, substance use, poor communication skills and anti-social personality traits[11]. Within relationships, poor communication, a partner's pregnancy and relationship breakdown can increase the risk of DSA[11], or contribute to an escalation of DSA that is already occurring. At a societal level factors such as attitudes towards women and violence, poverty and community cohesiveness are also risk factors for perpetration of DSA[11]. Of course, the presence of one or more of these risk factors does not mean that becoming a perpetrator of DSA is inevitable, and many people who experience these risk factors do not go on to become perpetrators of DSA.

1.2.2. National context

In recent years there has been increased focus on perpetrators of DSA and perpetrator programmes (PP). This change is nicely summarised by the DRIVE project[12], which advocates *'Moving the conversation on from 'why doesn't she leave?' to 'why doesn't he stop?''*[13]. This is also reflected in the NICE guidance[14] which calls for further research and the draft Domestic Abuse Bill[15].

NICE guidance

In 2014 the National Institute for Health and Care Excellence (NICE) produced *'Domestic violence and abuse: multi-agency working'*[14], a public health guideline covering all aspects of DSA. This guidance was then updated in 2018. The guidance covers all aspects of DSA including a section that focusses on perpetrators (recommendation 14). This section explores current primary prevention and PP and makes numerous recommendations in order to reduce levels of DSA perpetration. These include

- Evaluating new and current interventions to add to the evidence base
- Use national standards when designing new interventions
- Interventions should aim to increase safety of those affected by DSA and should gather outcome data from perpetrators such as changes in attitude and understanding.
- Ensuing that perpetrator and victim services are linked and can share information.

In addition to recommendation 14, recommendations 2, 3 and 4 are also relevant. These recommendations focus on creating multi-agency partnerships and integrating all the relevant services together. The 2018 update highlighted the lack of substantial evidence supporting PPs and primary prevention of DSA in the literature and stated that the newly available evidence did not

change the previous (2014) recommendations. They suggest that further research is needed in these areas.

Draft Domestic Abuse Bill

In January 2019 the Government published their consultation on the draft domestic abuse bill entitled *'Transforming the Response to Domestic Abuse'*[15]. This bill emphasises the need for education and support for children, whole family approaches and multi-agency working[15]. It also advocates for ensuring that substance use services are linked with DSA perpetrator services, that specialist services are targeted to include all types of relationship and background and that innovations in technology are investigated, such as the use of GPS trackers ensure that protection orders are not being broken and to administer swift consequences for breaches[15]. Finally it supports: the use of conditional cautions, such as those trialled in Southampton[16]; improved access to PPs including for lower risk early offenders; improved data sharing between agencies; and ongoing research and evaluation of PPs[15].

1.2.3. Local context

Southampton City Council (SCC) and the Safe City Partnership's current multi-agency strategy *'Southampton Against Domestic and Sexual Abuse'* began in 2017 and runs until 2020[17]. This strategy encompasses many key objectives including a focus on perpetrators and protecting children and young people. The strategy aims to tackle all forms of DSA and includes planned actions such as evaluation of existing services, improving links between perpetrator services and mental health and substance use services, and supporting behaviour change in perpetrators.

1.2.4. Prevention of perpetration of IPA

The substantial damage caused by IPA to the health and wellbeing of many people in the UK, and to society as a whole is clear. Whilst victim services are well established in our area, and do all that they can to protect and support victims and their families after IPA has occurred, it seems evident that preventing IPA in the first place should be a priority, therefore preventing many victims and their families from suffering the long term effects of IPA. For those who are already perpetrating IPA the goal should be to change those behaviours so that no further harm is done to current victims, and that no future partners are at risk of abuse. Prevention can be broken down into three main categories, primary, secondary and tertiary prevention (Table 1).

Table 1 Categories of prevention

Category of prevention	**Definition**
Primary,	Preventing someone from ever perpetrating IPA
Secondary	Intervening after early warning signs or first occurrence of IPA to stop it happening again and minimising the harm to others
Tertiary	Stopping serial perpetrators from continuing to perpetrate IPA and minimising the harm to others

Examples of primary prevention may include working to reduce the risk factors for IPA, such as introducing parenting classes for parents who are struggling to build healthy relationships with their children, or providing treatment and support for a parent's substance use disorder so that they are better able to care for their child. As such many of these interventions will be aimed at children, hoping to reduce their exposure to risk factors before any patterns of abusive behaviour are established. Examples of secondary prevention on the other hand, may include healthy relationship counselling for those showing early signs of controlling or abusive behaviour, or support for communication

difficulties. In this instance many (but not all) of the interventions will be aimed at young adults who are just beginning to establish relationship behaviours, or those who have had a first instance of IPA, to try and change behaviours before they become engrained. Finally tertiary prevention is aimed at serial perpetrators, and may include PPs. These programmes will try to change patterns of abusive behaviour and teach skills for healthy relationships.

One approach to prevention is a life course approach. This involves looking at risk factors at each point along someone's life course from conception to death and trying to address these risk factors as they occur. The World Health Organisation (WHO) states that a life course approach aims to *"increase the effectiveness of interventions throughout a person's life. It focuses on a healthy start to life and targets the needs of people at critical periods throughout their lifetime. It promotes timely investments with a high rate of return for public health and the economy by addressing the causes, not the consequences, of ill health"*[18]. In the case of IPA, this approach would hope to reduce risk factors and increase protective factors for IPA, such that fewer people ever go on to become perpetrators. It would also hope to intervene early for those who have begun to show abusive behaviour in early adulthood, and help to support people at key life stages so that they never begin to perpetrate abusive behaviour.

Any and all of these approaches must be undertaken in combination with continued support for victims and survivors of IPA. The intention of the focus on perpetrators is to be complementary to the work done with victims and survivors, rather than to move the focus away from these vital services.

1.2.5. Perpetrator programmes

Perpetrator programmes aim to break the cycle and stop perpetrators of IPA from continuing to behave in an abusive manner. There are many different types of PP currently being used to try and prevent ongoing abuse worldwide. Historically, the Duluth model was ground-breaking and has been used extensively since the 1980's but faces fierce debate in the literature[19]. The Duluth model is based on feminist theory, and states that IPA occurs because of the inequality between men and women, and the man's need to exert 'power and control' over their partner[19]. Thus Duluth based models try to change male perpetrators perceptions of women, and reduce their need to retain the 'power' in a relationship. However, the Duluth model discounts other factors that impact on IPA, and there is limited evidence for its efficacy in the literature[19]. In addition it is not applicable in situations with abuse between those who identify as lesbian, gay, bisexual, transgender and queer (LGBTQ) or female perpetrators of violence.

There are now a broad spectrum of approaches taken in PPs, including those based on cognitive behavioural therapy (CBT), motivational interviewing, restorative practice, and criminal justice and family based approaches[20]. In addition, some programmes aim to link PP with services that deal with major risk factors for abuse, such as substance abuse services[21-23] and mental health services.

1.2.6. Southampton City Council Scrutiny Inquiry; Reducing and Preventing Domestic Abuse in Southampton.

The Overview and Scrutiny Management Committee (OSMC) at SCC were informed of increasing rates of DSA offences in Southampton and recommended that a Scrutiny Inquiry was undertaken. This process involves looking at the issue, the level of need and services available in the city, albeit in less detail that in this NA. The Scrutiny panel then made recommendations, with the aim of preventing DSA where possible and reducing the number of perpetrators of DSA in the city.

The inquiry found that Southampton has a high rate of DSA, which is higher in deprived communities than more wealthy communities. It also has a range of DSA services, which are comparable to other areas and in some cases Southampton is already at the forefront of the field, creating and testing new approaches. They also felt that working with perpetrators directly, as well as supporting victims, was a key element for reducing the prevalence of DSA. Where possible, these interventions should take place early, to minimise harm and have the best chance of effecting behaviour change in perpetrators.

The scrutiny panel suggest that there are three key elements to prevention of DSA, firstly a whole system approach, ensuring that all appropriate agencies are joined up and working together. Secondly, a life course approach and finally, universal primary prevention is also key, which involves approaches that aim to reach everyone, regardless of whether they area at particular risk of perpetrating DSA. These approaches may also help to effect social change, making DSA less acceptable in the eyes of the general public[24].

The scrutiny panel made several recommendations[25] as a result of the inquiry, which are summarised here as follows;

Universal primary prevention

1. Communications Campaign – i.e. white ribbon campaign, to induce cultural shift and social change such that even low levels of abusive behaviour are no longer acceptable in our communities, and those worried about their behaviour feel able to come forward and ask for help.
2. Reporting of DSA – encourage the local media to follow Level Up reporting guidelines, which encourage accurate reporting and dignity for victims, amongst other things (https://act.welevelup.org/campaigns/54)
3. Relationship Education – to ensure that all children receive healthy relationship education
4. Adverse Childhood Experiences – to consider what SCC can do to reduce the burden of ACEs for our children.

Perpetrator services and whole system approach

5. Perpetrator services – Increase both awareness of and referrals to perpetrator services, through awareness raising campaigns, staff training and earlier identification of perpetrators.
6. Routine enquiry – establish routine enquiry for perpetrators, as is currently undertaken for victims.
7. Resources – where possible pursue resources to support perpetrator services (currently 11% of total DSA funding).
8. MATAC (Multi-Agency Tasking and Co-ordination) – a new approach in Southampton which identifies and intervenes with or tracks high risk offenders, that should be rolled out if evaluations continue to be positive.
9. Co-location of Hampton Trust staff within the key service areas – to share skills and knowledge in identifying and engaging perpetrators.

Evidence based decision making

10. Update the DSA Strategy – the current strategy runs out in 2020.
11. Evaluation of perpetrator services – to add to the evidence base in this area and ensure that interventions are effective
12. Calculate the return on Investment for perpetrator services – to support decision making
13. Alcohol and Substance use – to consider the impact on DSA and ensure joined up working.

14. The role of Public Health – to consider funding for DSA services.
15. Consideration of the impact on DSA when making Council decisions – include DSA in the Equality and Safety Impact Assessments (e.g. as if they were a protected characteristic).
16. Working with Government – make use of opportunities offered and work with the government to enable investment in innovative practice in the city.

The full report and recommendations from the Scrutiny Inquiry is available here https://www.southampton.gov.uk/modernGov/documents/s40119/Final%20Report%20-%20DRAFT%20v5.docx.

1.2.7. Aims of this needs assessment

There are several aims to this needs assessment as follows;

- To explore the level of domestic abuse in Southampton
- To identify local services that may prevent perpetrators of IPA from continuing to perpetrate abusive acts
- To identify local services that may prevent people from ever becoming perpetrators of IPA by reducing risk factors for IPA
- To identify any gaps in service provision or mismatching between level of need and level of provision
- To review the literature around IPA and evaluate the evidence base for interventions
- To make recommendations for next steps

2. Methodology

This NA used both an epidemiological, comparative and corporate approaches in order to gather as much information as possible (see Appendix 1 for more information on these approaches). In addition, a systematic literature review was undertaken to gather and summarise the available evidence in this area.

2.1. Epidemiological data

The epidemiological data used in this NA was gathered from a range of sources including Hampshire Constabulary, the Office for National Statistics, the 2011 census, the Crime Survey for England and Wales and service data from relevant local services. Where possible, comparators have been used.

2.2. Corporate information

Stakeholder views were gathered via a number of different means including face to face and telephone meetings, email contact and questionnaires. These views have then been compiled to inform the descriptions of local services and give a picture of the views of those working in the relevant services. See Appendix 2 for more information on stakeholder involvement and the questionnaire.

2.3. Literature review

A systematic literature review was undertaken in order to understand the evidence base for primary, secondary and tertiary prevention of IPA. The literature review was limited to those papers published from 2017 onwards (to capture those not included in the 2018 NICE review update), English language and research conducted in developed countries. A Grey literature search for key literature from 2010 onwards was also undertaken. Full details of the literature review methodology including search terms and strategy, inclusion and exclusion criteria and a PRISMA flow chart are available in section 8 and Appendix 3.

2.4. Limitations of the NA and associated risks

2.4.1. Limitations

There are several limitations to this NA, primarily those around accuracy of data. DSA is a taboo topic and it is suspected that rates of DSA are vastly underreported[26,27]. This means that data must be interpreted cautiously, and that the level of need may be far greater than depicted by the available data. Another limitation is the limited evidence base in this area, which is a result of a historical focus on victim services, and the pragmatic difficulties in conducting research and measuring meaningful outcomes in this area (see section 8 for further information on the available evidence and its limitations). Time and resource constrains were also limitations for this project, and this combined with the sensitive nature of the topic meant that it was not appropriate to gather views from victims or perpetrators of DSA as part of the stakeholder analysis.

2.4.2 Risks

There were several risks associated with this project, including that the difficulties with data accuracy would lead to misleading findings. This has been mitigated by stating the limitations of the data and advising cautious interpretation. Other risks included inducing apathy towards tackling the issue, given the lack of a clear evidence supporting interventions and the difficulties and changing behaviour. Finally, there was a risk of not successfully completing the project given the tight time and resource constraints.

3. Local Need

This section has been written using the most up to date data available at the time of writing, and data relating to DSA in Southampton will be reviewed again in autumn 2019 as part of the Safe City Strategic Assessment. Data has been collected from as many sources as possible, time constraints allowing and using a pragmatic approach. It is important to note that much of the population data in section 3.1 are estimates based on the 2011 census, which is now quite out of date. Whilst the figures will attempt to take into account trends, it is likely that there will be some inaccuracies. It is also important to note that DSA data is particularly vulnerable to inaccuracies, given its hidden nature and the underreporting that is likely to occur. Additionally, there may be differences in how people identify themselves as a victim or perpetrator of abuse, depending on age and cultural background[28]. This means that the information in the sections 3.2 to 3.5 should be interpreted with caution.

3.1. Southampton background

Southampton is a busy port city with an estimated population size of 253,989 in 2017[29]. There is a high proportion of young adults (aged 15-24) in the city (20%) when compared with the national average[29] (Figure 1). There is a relatively even split between men and women, and a smaller proportion of older adults that average[29]. In the 2011 census, Southampton had a higher proportion of single residents (33%) than the national average (26%), as may be expected given the larger proportions of young adults in the city[29].

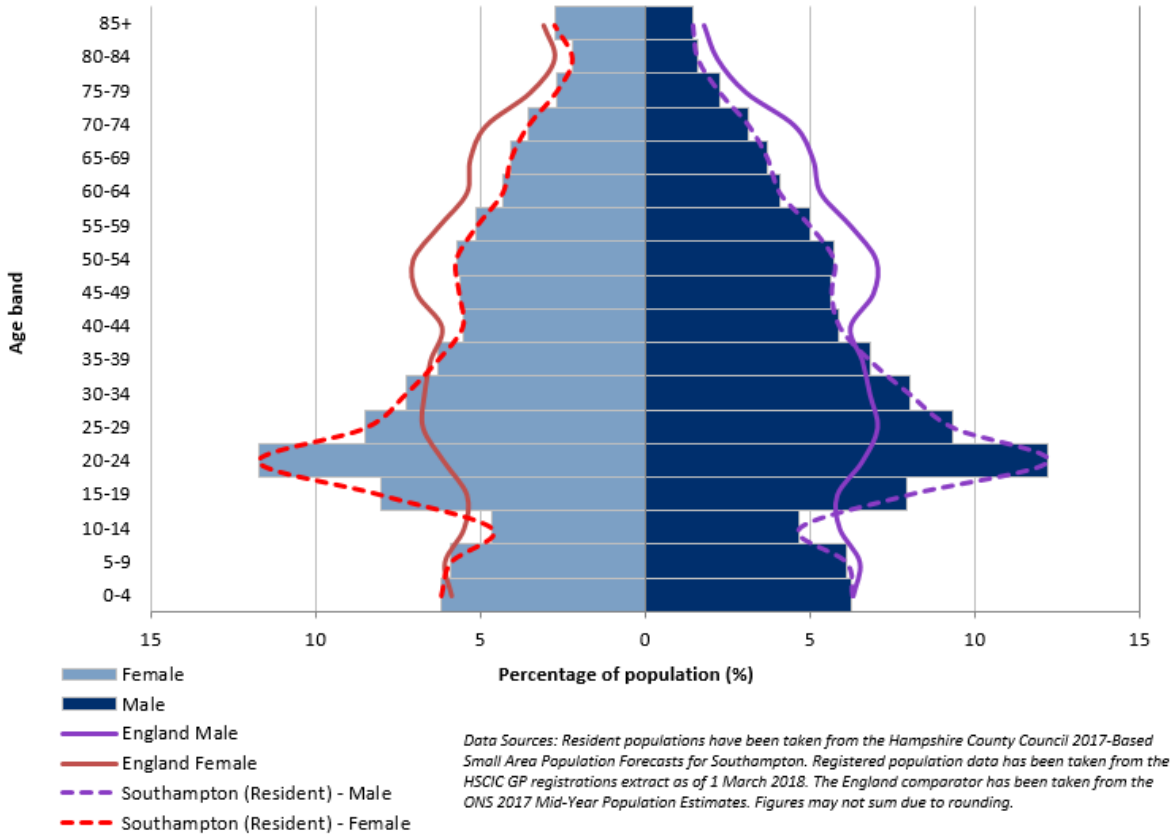
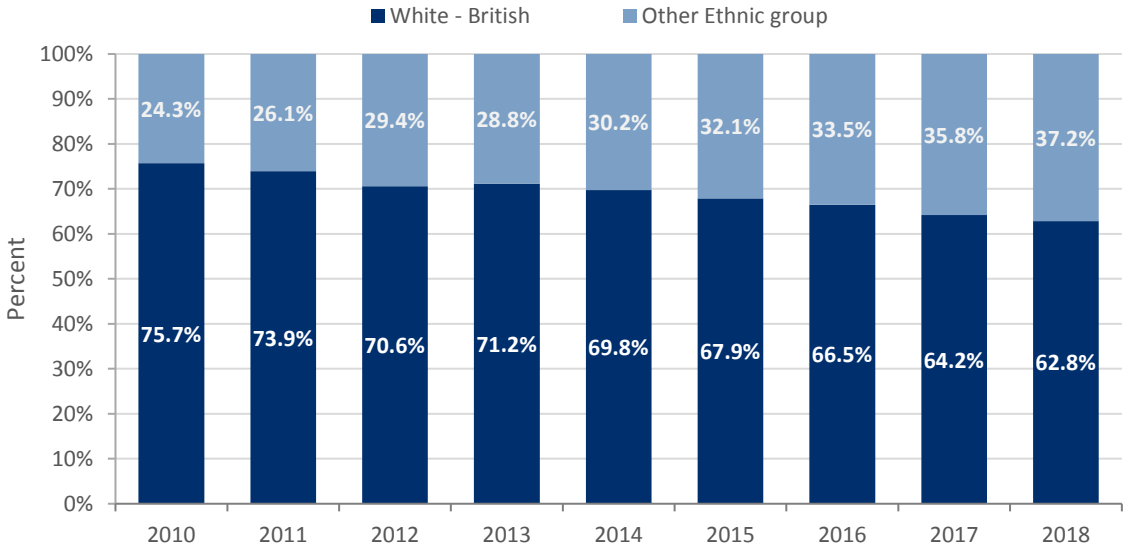


Figure 1 Population pyramid for Southampton LA (HCC resident population): 2017

Figure from Southampton City Council, Southampton Safe City Strategic Assessment (2016/17). Available from: http://www.data.southampton.gov.uk/community-safety/safe-city-assessment/ accessed on 20/05/2019

Southampton is a multicultural city with 77.7% of residents describing themselves as 'White British', 8.4% 'Asian or Asian British', 8.3% 'Other White', 2.4% 'Mixed Ethnic background', 2.1% 'Black/African/Caribbean/Black British' and 1.1% 'Other' in the 2011 census[29]. In 2018, 62.8 of school children in Southampton described themselves as 'White British', with 37.2% describing themselves as being from another ethnic background, this reflects the increasing diversity of the city since the 2011 census (Figure 2).



Source: Annual School Census, Southampton City Council
Notes: Does not include Oasis Academies for 2010 & 2011 or unknown ethnicities

Figure 2 Trends in ethnicity of school pupils in Southampton from 2010 to 2018
Figure from Southampton City Council, Southampton Strategic Assessment (2019). Available from: https://data.southampton.gov.uk/population/ethnicity-language/

As a whole, Southampton is a city that has high levels of deprivation, being ranked 67th most deprived local authority area in England (out of a total of 326 areas). Deprivation is associated with many adverse outcomes including poor health, poor educational achievement for children and IPA[11,30].

3.2. DSA in Southampton

Hampshire including Southampton had a rate of 21.9 domestic abuse incidents and crimes per 1000 population in 2017/2018, compared to the South-East area average of 20.0 per 1000 population[2]. Southampton alone had over 3,000 crimes with a DSA element in 2017/18, which accounted for nearly 30% of all violent crime (Figure 3). Data collected over recent years suggests that DSA related crimes are increasing in the city (Figure 3, Figure 4). In recent years there has been increasing focus on DSA in the media, including several high profile historic sex abuse crimes. It is possible that this has resulted in more people coming forward to report DSA crimes to the police, and so the steep increase in numbers of DSA related crimes should be interpreted with caution. However, given that substantial amounts of DSA are likely to go totally unreported, it stands to reason that even accounting for increased reporting and historic reporting of recent years, these police figures are still likely to be an underestimate of the prevalence of DSA in the community.

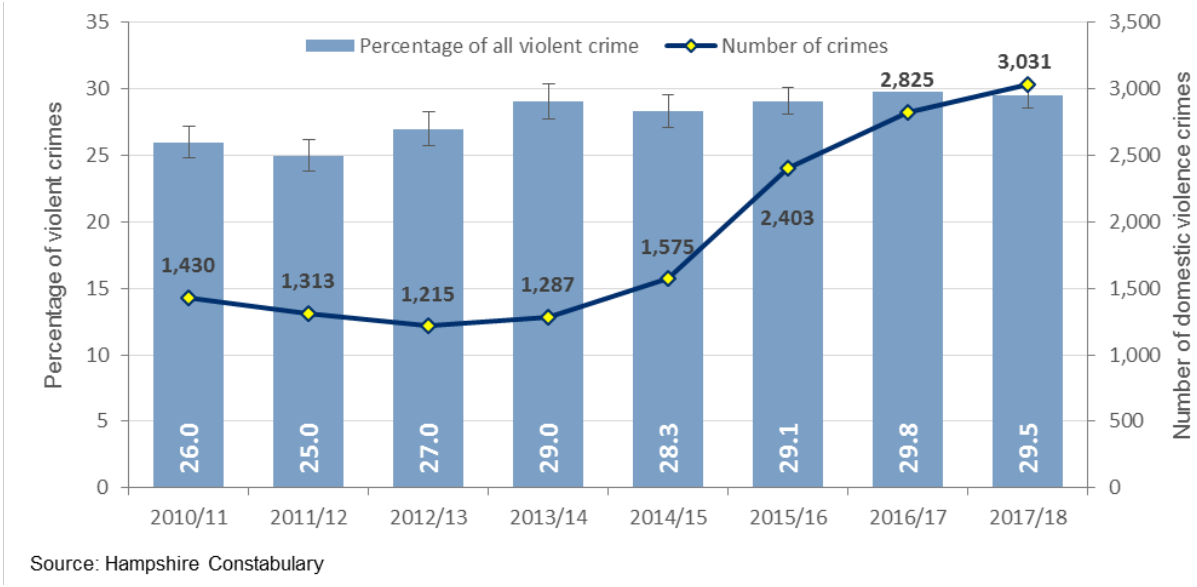


Figure 3 Number of domestic violence crimes, with and without injury, as a percentage of all violent crime: Southampton trends 2010/11 to 2017/18[3]
Figure from: King, D. and Marsh, K. (2019). Domestic Abuse in Southampton & IDVA, pg. 10, 11. Available at: https://www.southampton.gov.uk/modernGov/documents/s39388/Domestic%20Violence%20-%20Southampton.pdf accessed on 29/05/2019

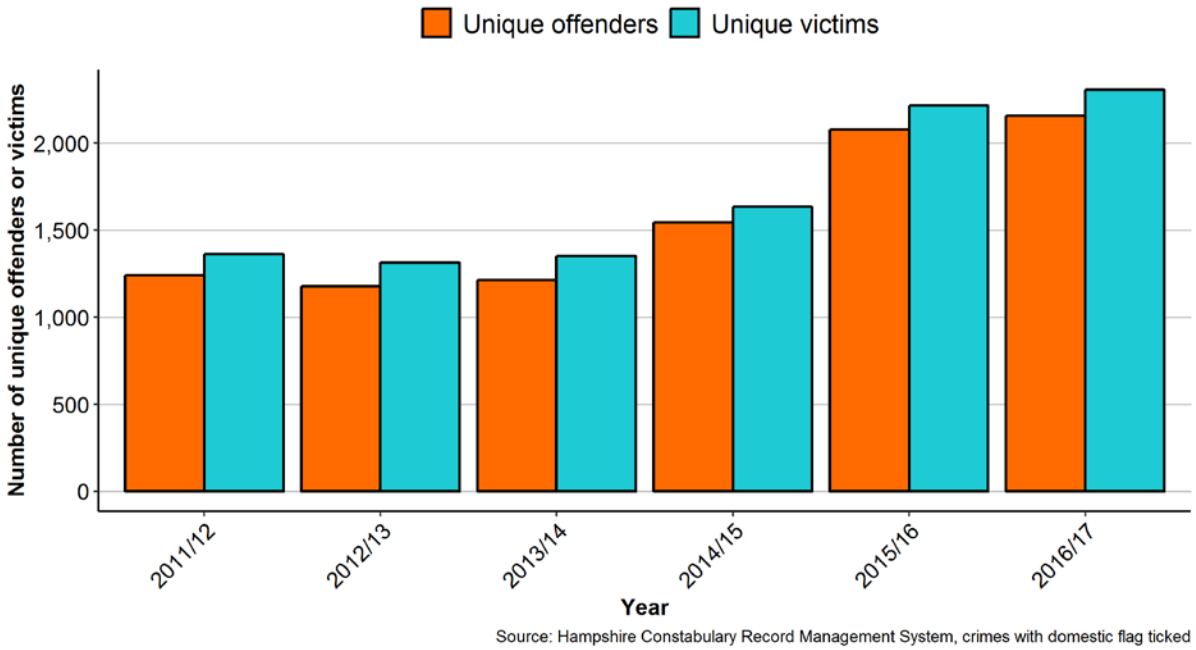


Figure 4 Number of unique offenders and victims in Southampton, by year 2011/12 -2016/17

In 2016/17, the number of offences committed varied by area (Figure 5). However, this data groups several wards together, which makes it difficult to interpret. When using 2017/18 data to create rates of police recorded DV crime per 1,000 population (Figure 6), Bitterne had the highest rate of DV crime in the city, and Bassett had the lowest. Interestingly, Bitterne is the most deprived ward in the city, and Bassett the least. The links between deprivation and many poor outcomes[30] including DSA[31] have been clear for some time. In Southampton, the rate of DSA amongst the 20% most

deprived communities is approximately eight times higher than in the 20% least deprived (Figure 7). Whilst some of this variation may be due to differences in reporting, it is important to note these differences and that those in the more deprived parts of our city may need additional support in order to reduce levels of IPA.

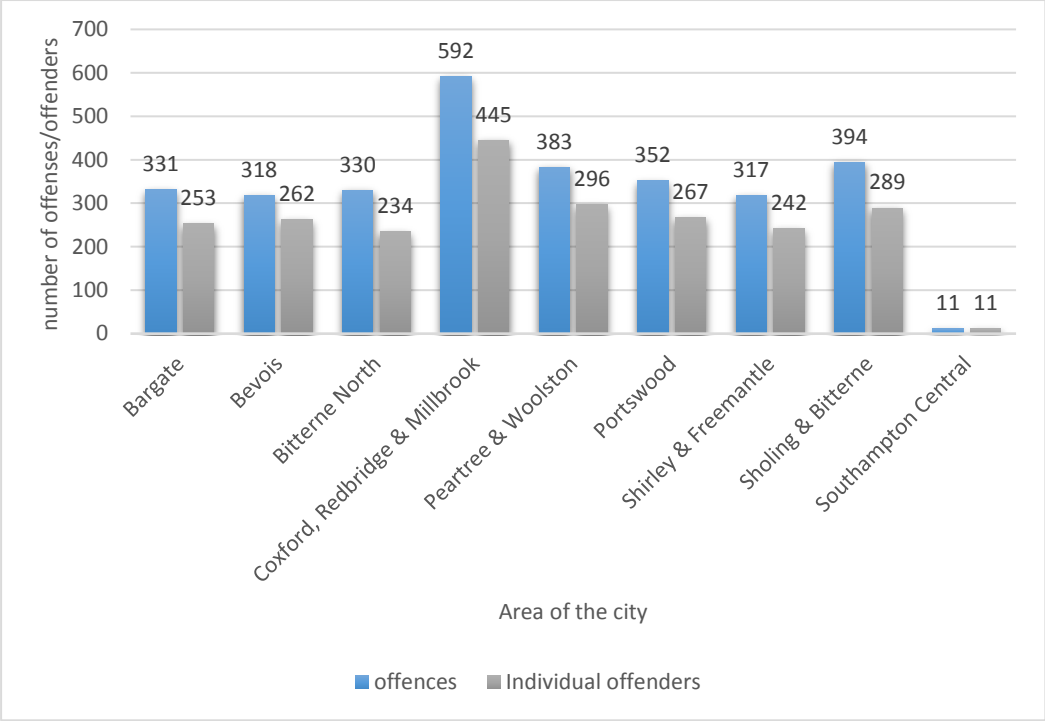
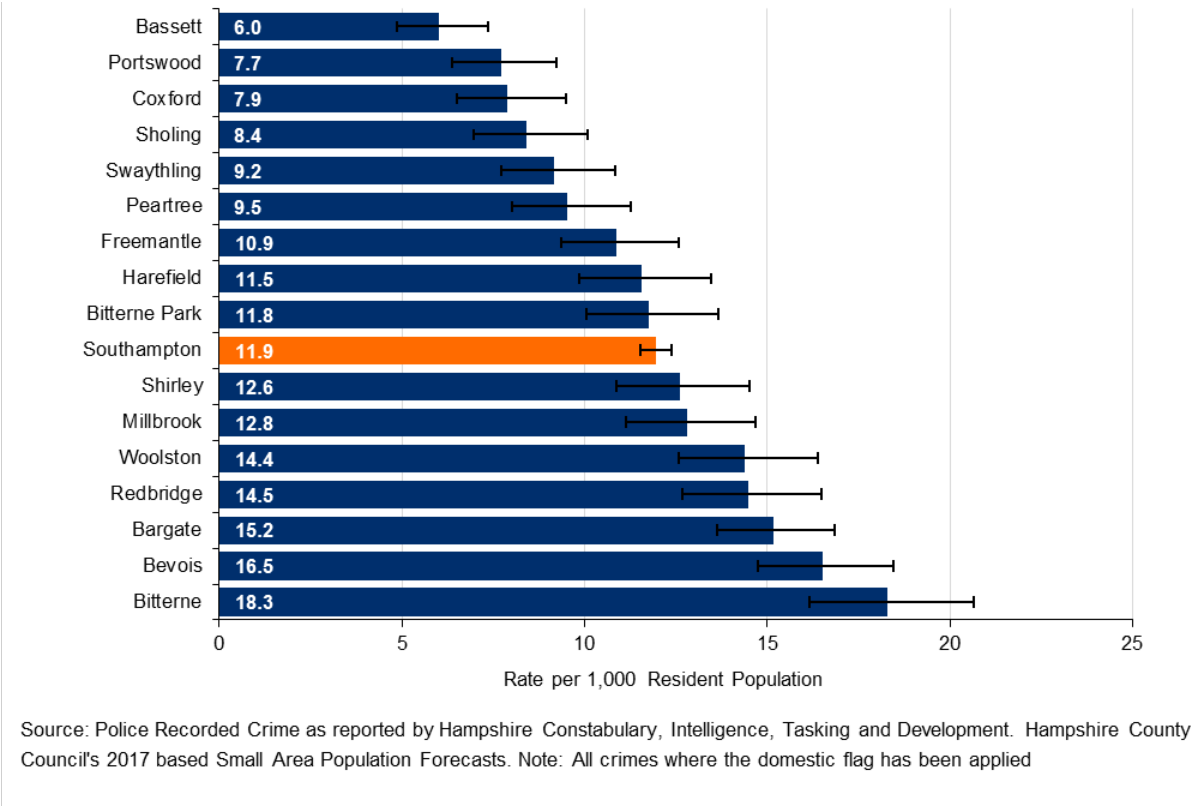
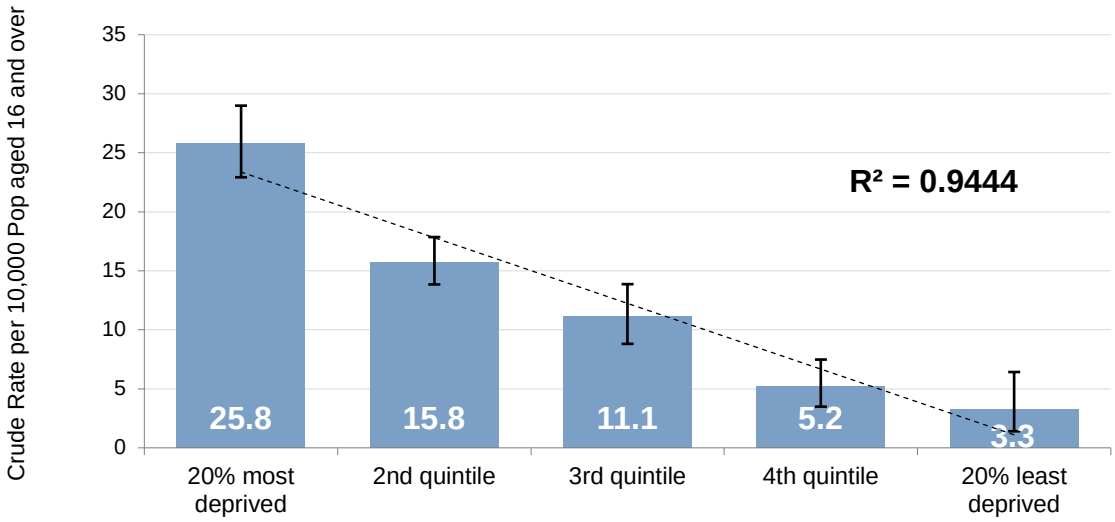


Figure 5 Domestic violence offences and individual offenders by area, in Southampton City 2016/17. Data source Hampshire Constabulary.



Source: Police Recorded Crime as reported by Hampshire Constabulary, Intelligence, Tasking and Development. Hampshire County Council's 2017 based Small Area Population Forecasts. Note: All crimes where the domestic flag has been applied

Figure 6 Police Recorded Domestic Violent Crime, rate per 1,000 resident population: Southampton Wards 2017/18
Figure from Southampton City Council, Southampton Safe City Strategic Assessment (2017/18). Available from: http://www.data.southampton.gov.uk/community-safety/safe-city-assessment/ accessed on 20/05/2019



Sources: IDVA service and Hampshire County Council

Figure 7 New IDVA referral rate per 10,000 population aged 16 and over analysis by England deprivation quintile: October 2016 to August 2018 (pooled)[3]. The 'R²' value of 0.9444 indicates that there is a strong level of agreement between rate of DSA and deprivation.
Figure from: King, D. and Marsh, K. (2019). Domestic Abuse in Southampton & IDVA, pg. 10, 11. Available at: https://www.southampton.gov.uk/modernGov/documents/s39388/Domestic%20Violence%20-%20Southampton.pdf accessed on 29/05/2019

Offences also vary by time of year, with more offences being committed in the summer months and over the Christmas period than at other times (Figure 8). Christmas can be a stressful time, with many families spending more time together than usual, increased cost pressures and often increased alcohol consumption, all of which could potentially contribute to the increased rates of DSA at this time of year.

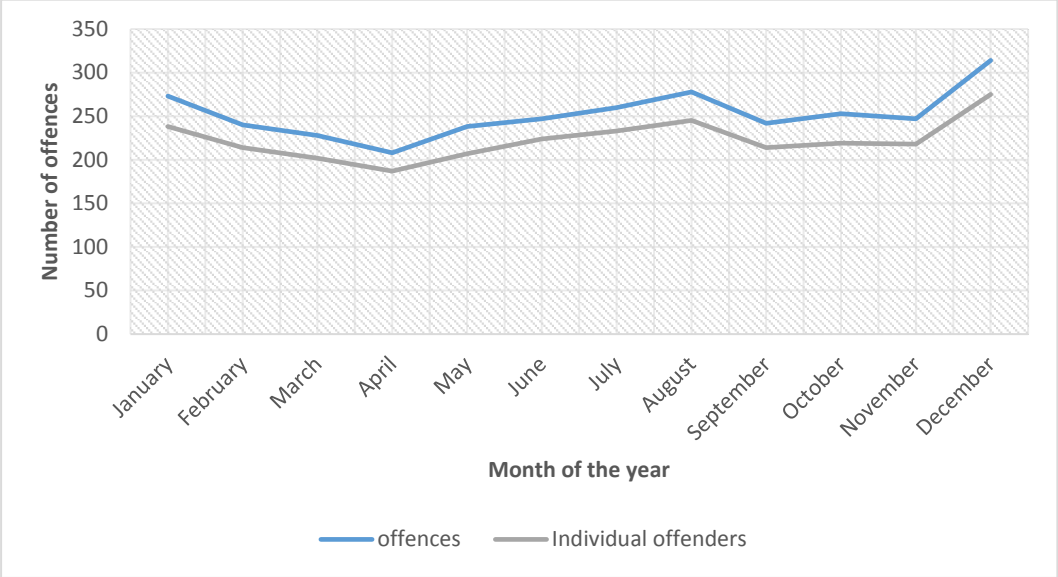


Figure 8 Police recorded offences and individual offenders in Southampton by month 2016/17. Data source Hampshire Constabulary.

Figure 9 shows the breakdown of the number of standard, medium and high risk offences, as assessed by the responding police officer using the DASH risk assessment tool from SafeLives and professional judgement[32]. A high risk victim is defined as someone who is currently at risk of 'serious physical harm or death'[33]. A medium risk victim has indicators that serious harm may occur, but this is unlikely unless circumstances change (such as the offender uses drugs or alcohol). A standard risk victim is unlikely to be at risk of serious harm at this time. The figure shows that there were a large number of high and medium risk offences in Southampton, in 2016/17, and that there were over 2,000 individual offenders involved in these incidents. It is important to note that some perpetrators could be effectively counted twice in this chart, if they were involved in two separate incidents with different risk levels. This means that the total number of individual offenders in each risk category adds up to more than the total number of individual offenders.

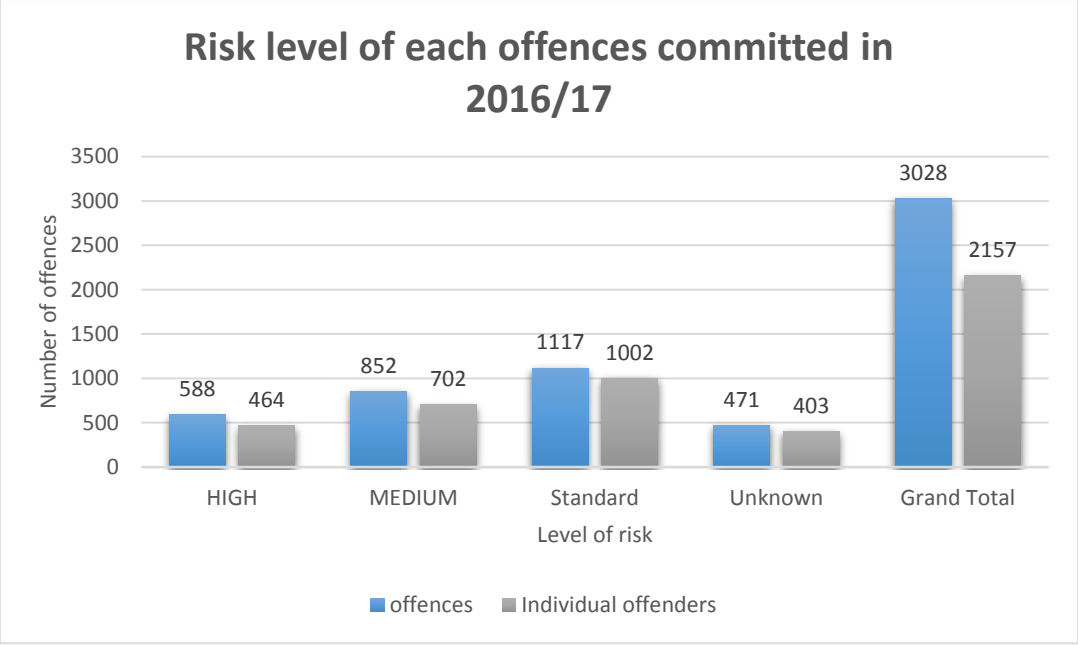
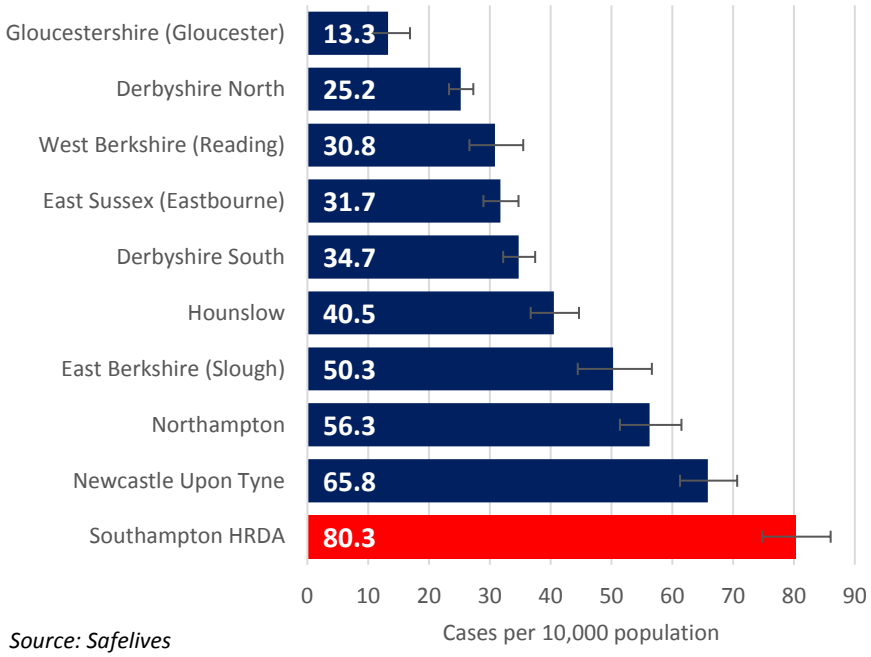


Figure 9 Risk level of offences committed and for individual offenders in Southampton, 2016/17. Data source Hampshire Constabulary.

Historically, all high risk DSA victim referrals in Southampton would go through a Multi-Agency Risk Assessment Conference (MARAC), where professionals from all related agencies share information and create a plan to protect that victim. In 2016, this was changed so that all cases now go through the Multi-Agency Safeguarding Hub (MASH) meetings, who deal with all high risk domestic abuse and children's and young people's safeguarding issues. The MASH then refer all high risk DSA cases to the High Risk Domestic Abuse group (HRDA), who meet daily. HRDA works in a very similar way to the MARAC meetings, involving information sharing between agencies and action planning, taking a whole family approach. Only a few very complex cases will then go on to have a MARAC meeting as well. Currently, many other areas still use the MARAC model, which made it difficult to compare whilst Southampton was changing models. However, now that the MASH/HRDA process has been embedded, the numbers of cases at HRDA and MARAC are now broadly comparable. When comparing the number of high risk cases in Southampton with those in other, similar, areas, Southampton has a much higher rate than might be expected (Figure 10). Figure 11 shows the rate of HRDA referrals per 1,000 population for each ward of the city, and once again the more deprived areas of the city (Bitterne, Redbridge and Bevois) have higher rates.

SafeLives, a DSA charity organisation, suggest that an expected figure for high risk cases for an area like Southampton city should be 45 per 10,000 population, when the actual rate in Southampton is 80.3 per 10,000 population[3] (Figure 10). This means that the burden of IPA in Southampton is larger than expected given are city size and population, and suggests that DSA may have a higher prevalence in Southampton than comparator area. However, there may be other explanations for this high rate of high risk victims, such as more willingness to report DSA amongst those affected, more cautious risk assessment and better or clearer referral pathways. Additionally, this is a small list of comparators and it may be that other areas have more similar rates to Southampton. When looking at rates of police recorded incidents with a domestic flag, once again Southampton has a higher rate than many neighbouring areas (Figure 12), which again may indicate that Southampton has high rates of DSA.



Source: Safelives

Figure 10 High Risk Domestic Abuse cases per 10,000 population: Southampton HRDA and comparator MARACs: October 2017 to September 2018
Figure from: King, D. and Marsh, K. (2019). Domestic Abuse in Southampton & IDVA, pg. 10, 11. Available at: https://www.southampton.gov.uk/modernGov/documents/s39388/Domestic%20Violence%20-%20Southampton.pdf accessed on 29/05/2019

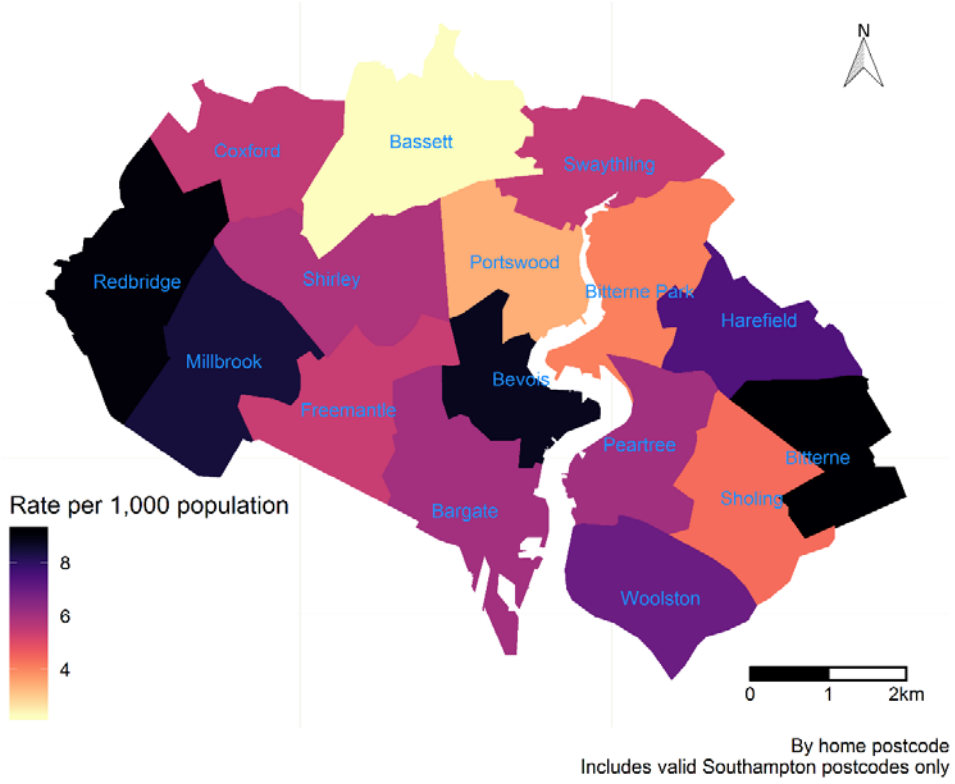


Figure 11 HRDA referrals per 1,000 population in wards in Southampton, from 27th June 2016 to 30th April 2019. Source: SCC PARIS system

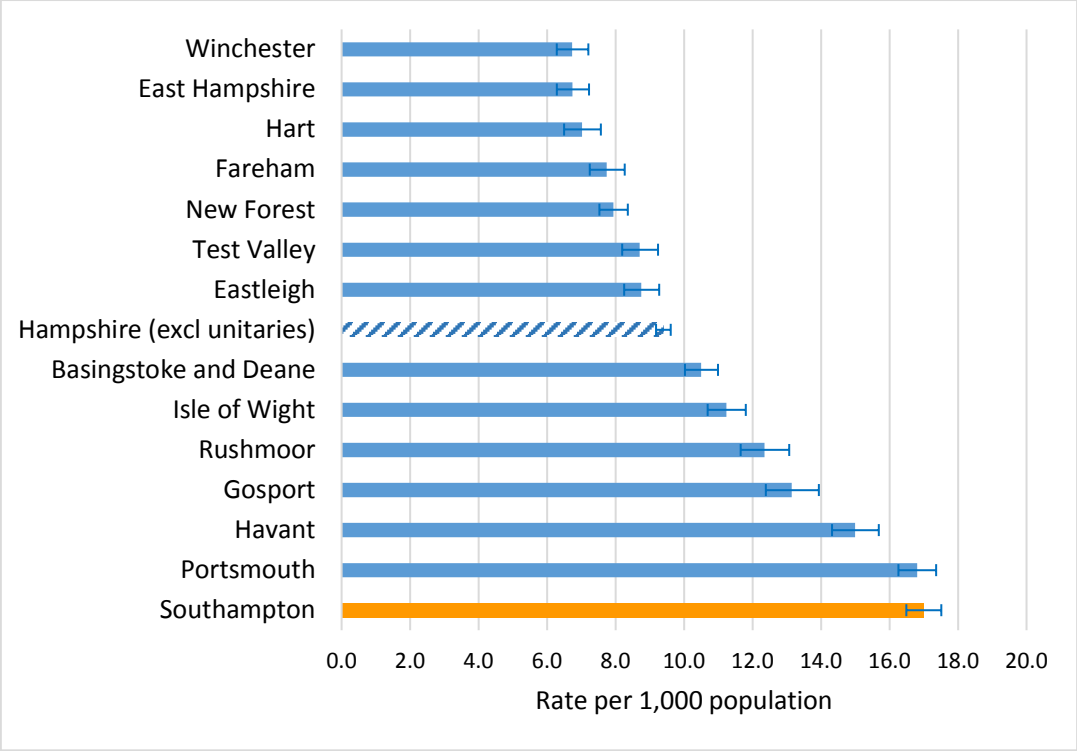


Figure 12 Comparison of rates of police recorded domestic flagged incidents, per 1,000 population in different areas, in 2018/19. Source: OPCC Hampshire InterACT online tool

3.3. DSA perpetrators in Southampton

The most common age group for DSA offenders arrested in 2016/17 was 25 to 30 years old (Figure 13). The city has a large proportion of young people in comparison to the national average, and so some of the peaks at younger ages could be due to having a large number of people in that age bracket, rather than a higher prevalence in those groups, although we do know that younger age is a risk factor for IPA[11].

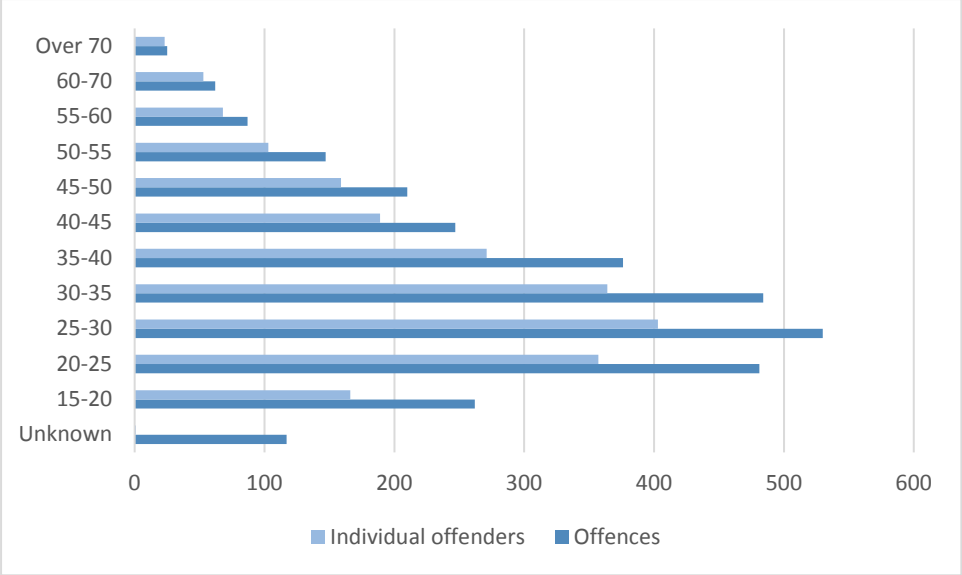


Figure 13 Age of offenders committing DSA related crimes in 2016/17 by age group. Data source Hampshire Constabulary.

Stakeholder feedback (see section 6) commented on different features of DSA amongst different population groups, but it was not possible in the time available to gather and triangulate data on ethnicity, nationality or language. Some initial police data on ethnicity of offenders' appeared to show a pattern by ethnicity that reflects the wider population of Southampton. However, it has not been possible to explore how this data is captured and reported.

Between 2011/12 and 2016/17, there were more male perpetrators than female perpetrators and more female victims than male victims (Figure 14). However, once again this should be interpreted with caution. It is important to note this these figures reflect all DSA and not just IPA, and as such some of the male victims may have been sons abused by their fathers, and not necessarily men abused by their female partners, although there will undoubtedly be some men who are abused by their female partners. It is also important to note that sex is recorded as a binary output, either male or female in this data set, and so again the results must be interpreted with caution.

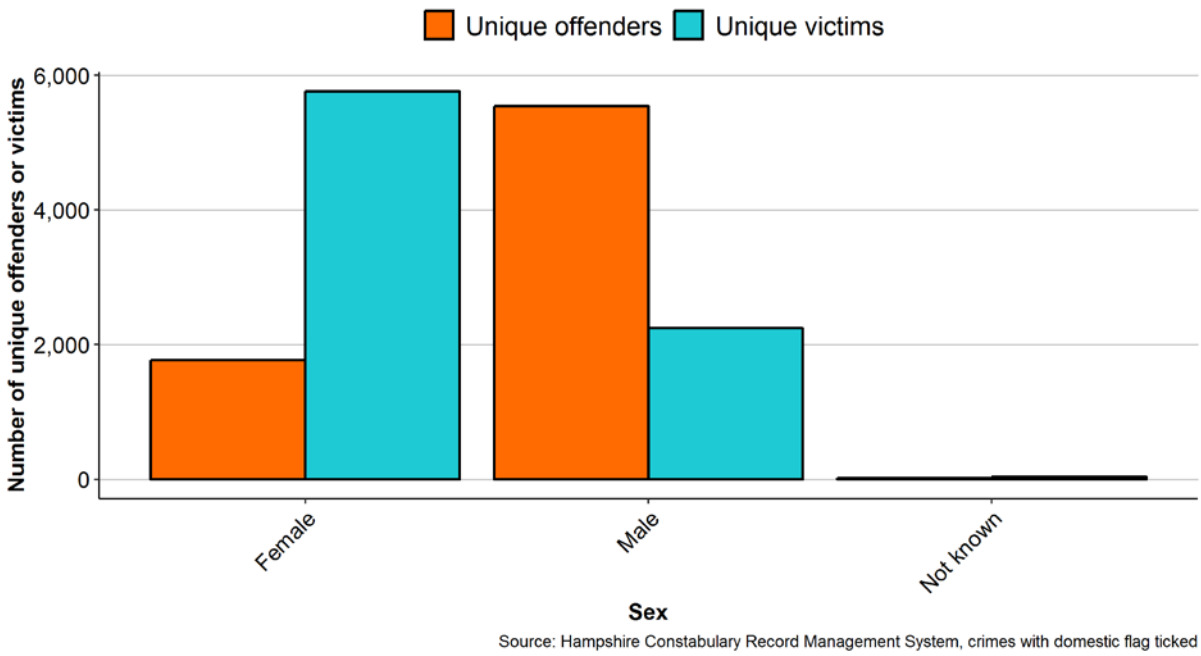


Figure 14 DSA offenders and victims in Southampton by sex, 2011/12 to 2016/17

3.4. Prevalence of children affected by IPA

As previously discussed, witnessing or being subject to abuse can potentially have a detrimental effect on children's long term outcomes, including increasing the risk that they will go on to become perpetrators of abuse themselves. As previously discussed these poor outcomes are not inevitable, but certainly can contribute in some cases. Figure 15 illustrates that large numbers of children who need children's services assessments in Southampton have DSA as a factor in their referral. In total, 5,480 children in the city were found to have some exposure to DSA at assessment between 2014/15 and 2018/19. Figure 16 indicates the rate of children affected by DSA in each ward in the city, and unsurprisingly, given the high rates of DSA offences in these areas, Bitterne and Redbridge have the highest rates. When considering the rate of looked after children who have a DSA flag, Bitterne and Redbridge have high rates once again (Figure 17).

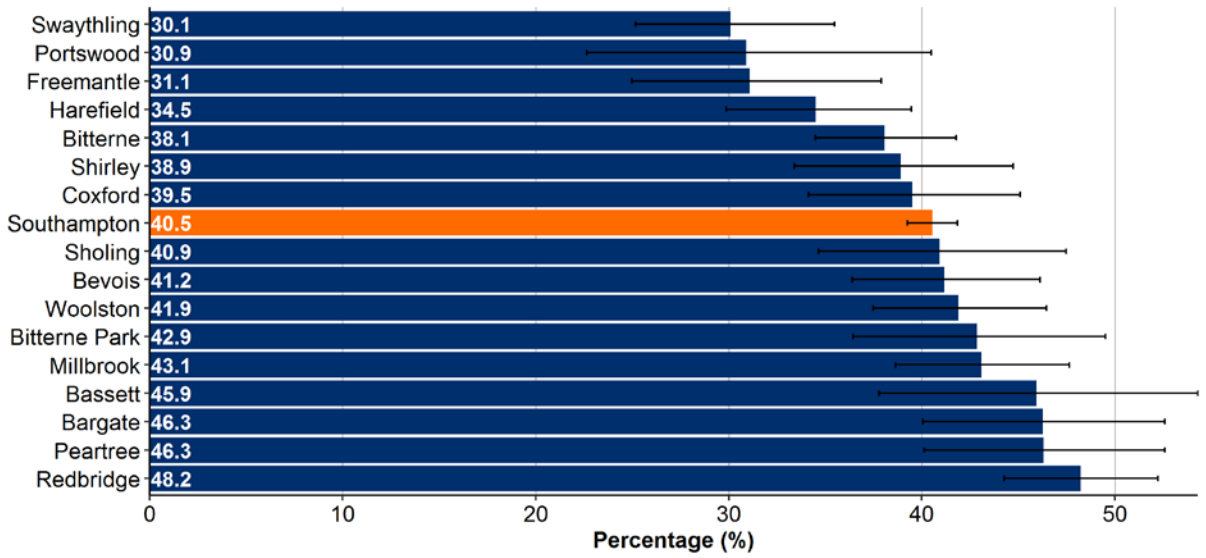


Figure 15 Percentage of Child referrals with DV flagged as a factor in their assessment. Southampton wards, 2014/15 to 2018/19. Source: SCC PARIS system

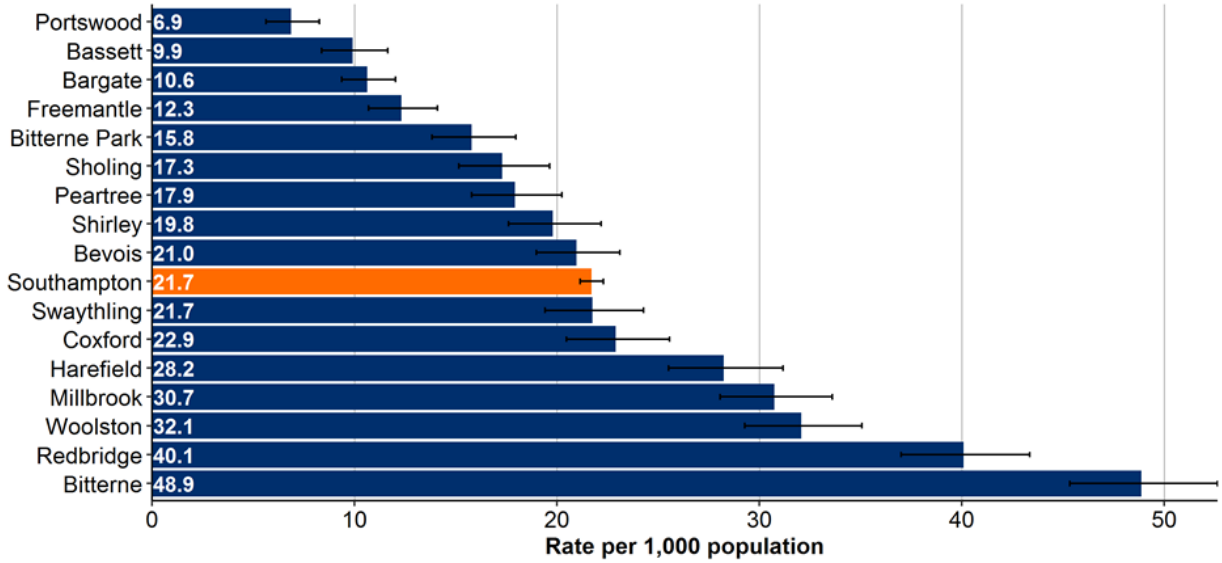


Figure 16 Rate of child referrals who had a DSA flag on their assessment per 1,000 population, split by area, from 2014/15 to 2018/19. Source: SCC PARIS system

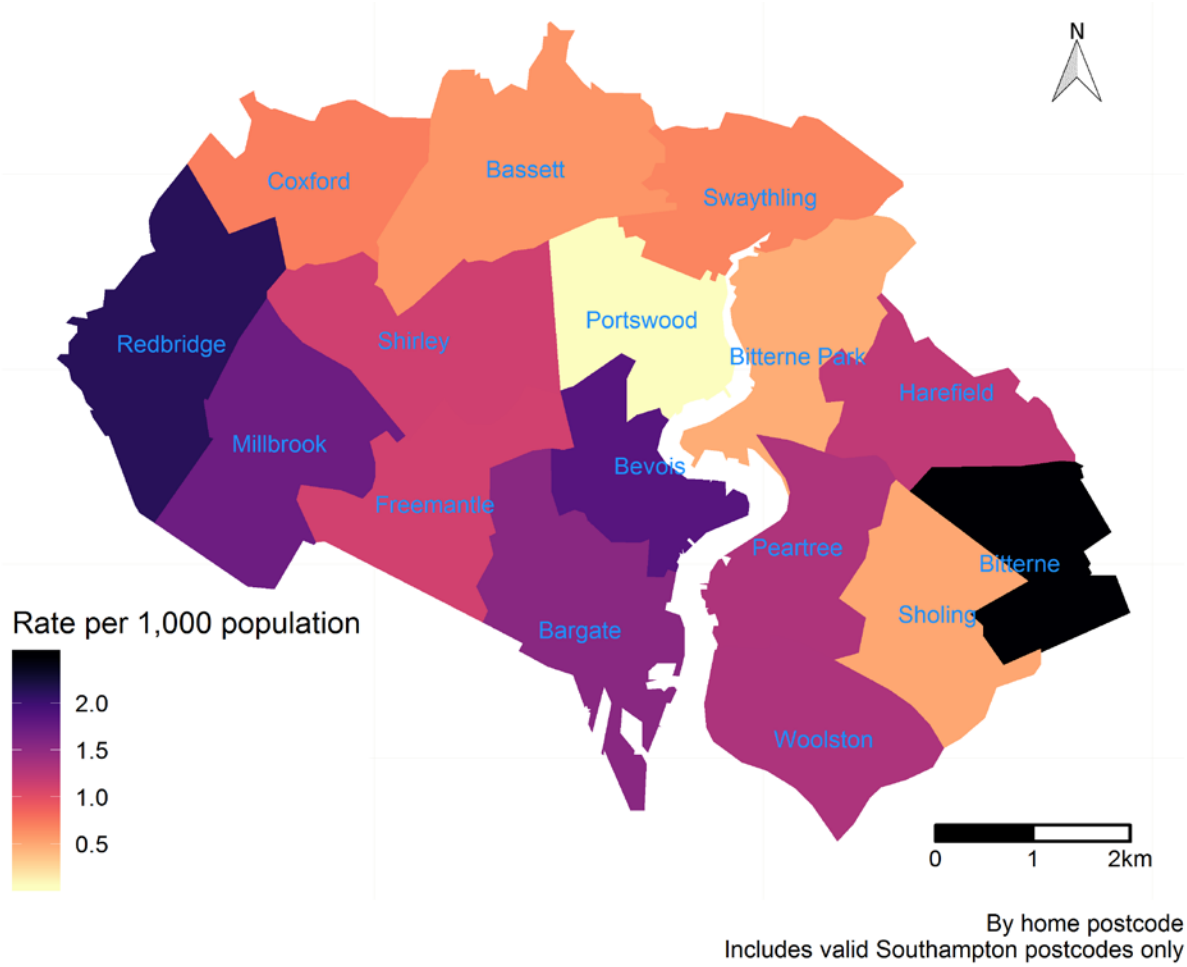


Figure 17 Rate, per 1,000 population, of looked after children who had a DSA flag on their assessment, by Southampton ward, 2014/15 to 2018/19. Source: SCC PARIS system

3.5. Service use in Southampton

Hampton Trust is the only PP provider (for those not in the criminal justice system) in Southampton. They accept referrals from multiple sources as well as self-referral. Between 2016 and 2018 the vast majority of referrals were male (Figure 18). The most common age group over the same time span was between 26 and 40 years old (Figure 19). The number of referrals into the Hampton Trust is currently far fewer than the number of police recorded DSA offenders. Given that it is likely that the police data underestimates the number of offenders it is clear that there are far more individuals in need of Hampton Trust's services than are being referred or self-referring into the service. It is also interesting to note that a substantial number of people referred into Hampton Trust have known additional needs at the time of referral, such as mental health conditions (22.6%) and substance use disorders (19.4%) (Figure 20). It is not clear from the data whether some individuals are counted twice (for instance if they have both a mental health condition and a substance use disorder they may be counted in both statistics), but even if this is the case there is still a large amount of additional need (for example for substance use disorder treatment) amongst those who are referred into perpetrator services.

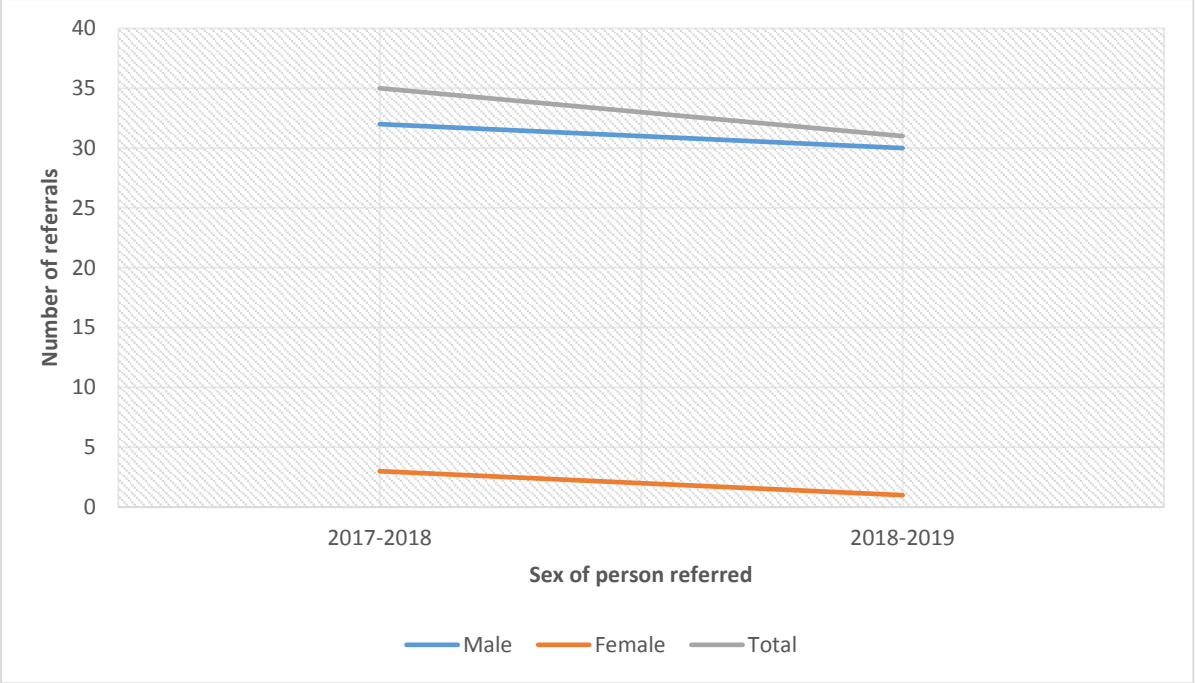


Figure 18 Referrals into Hampton Trust from Southampton by sex, for the 2017/18 and 2018/19 financial years. Source: Hampton Trust, referrals to Radar

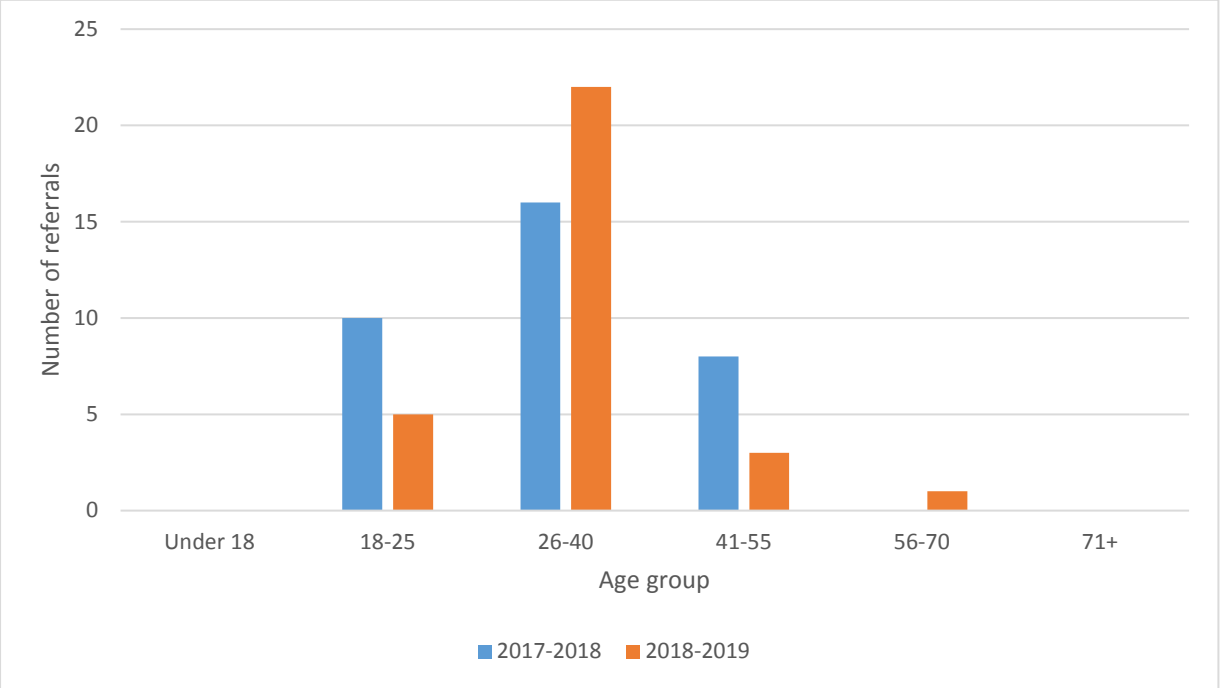


Figure 19 Referrals into Hampton Trust from Southampton by age group, for the 2017/18 and 2018/19 financial years. Source: Hampton Trust, referrals to Radar programme

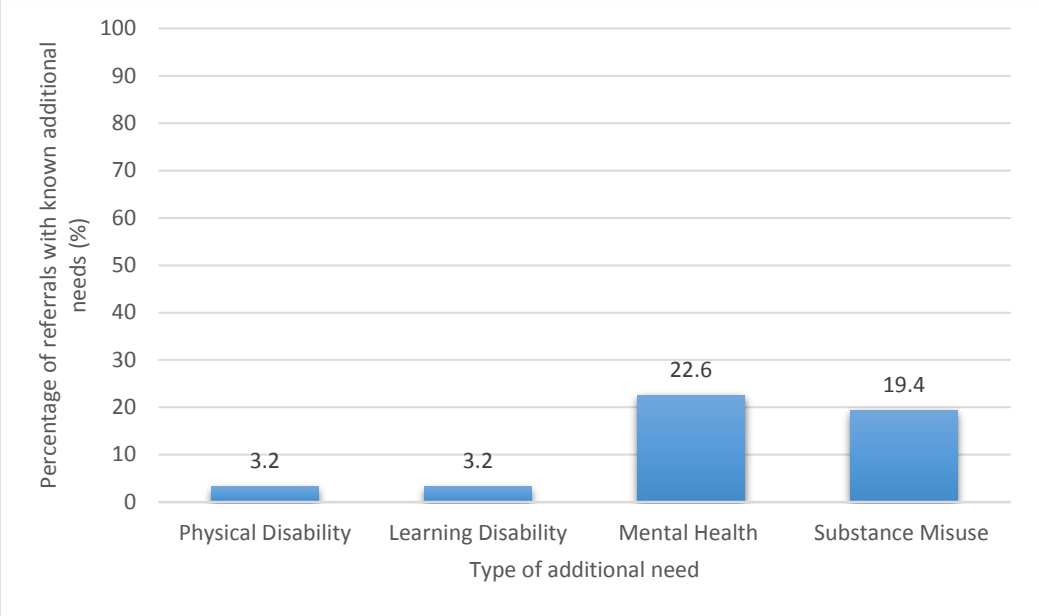


Figure 20 Percentage of referrals into Hampton Trust with known additional needs at point of referral, split by type of additional need, for the 2018-2019 financial year. There were 31 referrals to Hampton Trust in total in the financial year 2018/19. Source: Hampton Trust, referrals to Radar programme

As part of the contract with Hampton Trust, Aurora New Dawn work with the police in identifying and tracking high risk and serial perpetrators. Similarly to Hampton Trust, the most common age group for people referred into or picked up by Aurora New Dawn was 26 to 40 (Figure 21). Anecdotally, services report that some young people do not identify as either victims or perpetrators of DSA, leading to difficulties engaging with services[28]. This may mean that the number of referrals in the 18-25 year old age group is actually an underestimate of the true levels of perpetration in this age group.

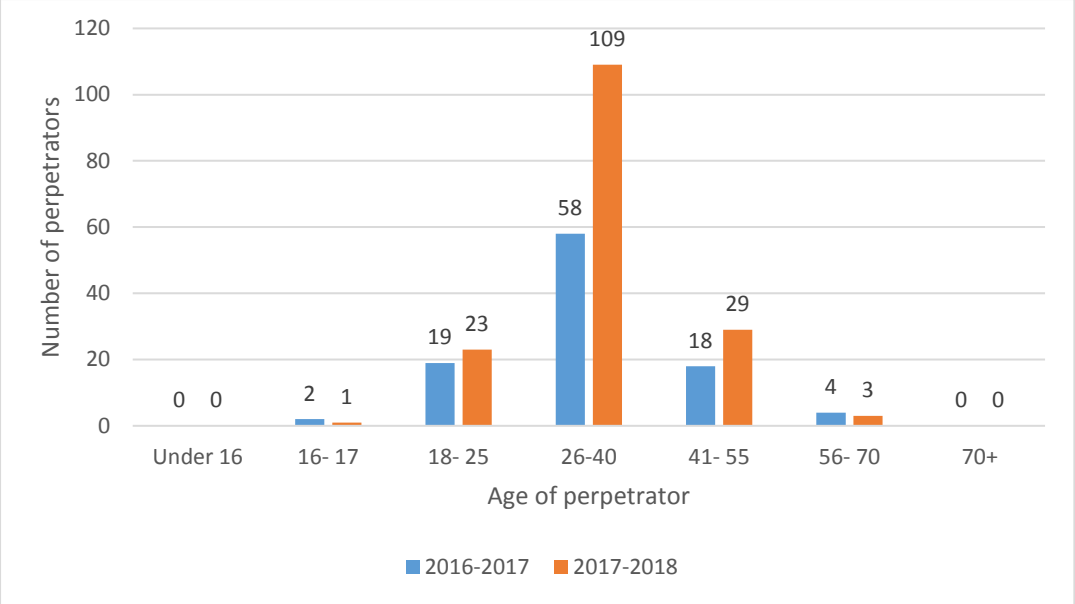


Figure 21 Referrals into Aurora New Dawn by age group, from October 2016 to September 2017 and October 2017 to September 2018. Source: Aurora New Dawn

4. Service provision

The following section outlines the services available at local and national level. Please see Appendix 4 for more information about who funds/commissions each service.

4.1 Local services

This section covers local services for those who perpetrating IPA, such as services providing PP. it is also covers services for those who are at risk of perpetrating IPA in the future. This includes any service that aims to reduce or provide support for the risk factors associated with IPA. As mentioned in the introduction, there are many risk factors for IPA, including adverse childhood experiences (ACEs), an example of which would be someone who witnessed IPA between their parents whilst they were a child. Therefore, this section will include services and interventions that are aimed at improving outcomes for children who are affected by IPA, and breaking the cycle of intergenerational abuse. The services are described following a life course approach, starting with maternity services, progressing to services for children and finally those available for adults. It is important to note that there are also a wide range of services and support offered in the city for victims of abuse, but these are outside the scope of this report and thus not described here.

4.1.1. Maternity services

A new system is in place in maternity services and all pregnant women in the local area who have been referred to maternity services now receive a screening phone call from a triage midwife in order to make a booking appointment. The screening questions include asking if the woman is alone at the time of the phone call and each women is asked a screening question about IPA in her relationship. If a woman indicates that she is undergoing IPA she will be referred into services via the MASH. If available, the name of the perpetrator will also be passed on in the onward referral, although it is not clear how often this happens. Most women are asked a second time, at an in person appointment later in pregnancy, as long as their partner is not present. There is a specialist midwife for domestic violence who ensures that staff training is up to date. This aims to identify women who are experiencing IPA and connect them with DV services to protect both the woman and her child from further harm. An audit undertaken in June 2018, before the introduction of the telephone

screening call, found that 44% of women were screened for DSA, and 11% of those screened disclosed that they were affected by DSA, either currently or historically. All of these cases were referred on to the appropriate service. Of those not screened, 94% had no documentation around screening, or why the question was not asked. A re-audit to assess the impact of the changes to services and ongoing training is expected in July 2019.

4.1.2. Services for children exposed to risk factors for future IPA

Southampton City Council Children's Services

This section will outline some of the services that provide support for children who require input from children's services. Children's services undertake assessments and can place children on a range of plans to suit the child's needs. This involves multiagency working and children's services are also able to link in with many providers across the city, including those mentioned in this needs assessment, such as Yellow Door, No Limits, Hampton Trust and Child and Adolescent Mental Health Service (CAMHS). The following services all aim to support children who are affected by IPA and to try and reduce the impact of this ACE on their future outcomes.

Domestic Abuse Recovering Together (DART)

This 10 week programme for mothers and children aims to improve outcomes for children who have been affected by DA and has been running since September 2018. It combine group and individual work and aims to improve parent-child relationships and create positive home environments for children. There is ongoing evaluation of this programme through the NSPCC, as part of a national evaluation programme. Maximum capacity for this programme is 10 families per group, with two groups (7-10 year olds and 11-14 year olds) running three times per year.

Sure start special

This group work programme delivered by play therapists is designed for children aged 3-4 who have been exposed to DA, again trying to improve outcomes. There is a co-located group work for their mothers held at the same time, delivering parenting skills and communication training. This project is run jointly with Southampton Women's Aid (which now functions under the umbrella of Yellow Door) and has additional finding from Children in Need. The programme runs for 8 weeks at selected children's centres in the city, there are some issues with attendance if children are at nursery and sessions clash with these days.

Children's centres (universal service)

There numerous children's centres spread across the city, which provide a route to access support and many other general resources including Incredible Years parenting classes. They are universal and therefore available for all families across the city. These classes aim to equip parents with parenting skills and create stronger family units.

Children's safeguarding line

- 02380 833336

This phone line is available for anyone who has concerns about a child's safety.

Yellow Door

Star project

This outreach project run by Yellow Door delivers healthy relationship and sex education to young people in the city (aged 11+). This Programme is delivered through workshops or assemblies, at least once yearly in all secondary schools across the city, and in some primary schools and other educational/youth settings, reaching 11,895 young people in 2017/18. The programme aims to raise

awareness of and explore healthy relationships, abuse, bullying, sexual consent and conflict resolution amongst other relevant topics. It also signposts where to go for help for those who are affected by any of the topics covered.

Other Yellow Door projects

Yellow Door also offers a range of other services, including both family support and family therapy, for families that have been affected by DA. Their Bright Starts programme is open to young people aged 11-18 who have witnessed or been affected by DA. It aims to improve self-esteem, empathy and emotional resilience and covers topics such as healthy relationships, consent and communication. Yellow Door also offer a counselling service for those aged under 11, although this intermittently closes to new referrals due to service pressures and capacity issues. Yellow Door have recently merged with Women's Aid, and so Women's Aid's DA services have been added to the Yellow Door delivery portfolio.

No Limits

No Limits is a charity offering free information, support, advice and counselling to young people (aged 11 to 25), for a range of issues. They provide support online, over the phone and through an advice centre and drop in sessions at local schools. Young people can self-refer or be referred to No Limits from other organisations. No Limits provide substance use advice, mentoring for young parents and emotional resilience classes that include anger management amongst other topics. They also provide individual counselling, help and support and undertake case holding for those who require it. They offer counselling for victims of DA and will refer perpetrators onto Hampton Trust, however, there is currently no formal perpetrator service to refer perpetrators onto for those under 16 years of age. No Limits also provide a counselling service for children aged 5-11.

Southampton Family Trust

This charity run a range of free courses focussing on parenting and healthy relationships, including the adapted FAB (feelings affect behaviours) course, which runs over 6 weeks and targets parents who are at low-medium risk of DA.

Schools

Many schools across Southampton currently deliver relationship education through Personal, Social, Health and Economic (PSHE) education and Relationships and Sex Education (RSE). From September 2020, it will become mandatory for all schools to provide RSE to children aged 5 to 16, and the Government has provided guidance as to the suggested content of this education[34]. This includes healthy relationships, DSA and codes of acceptable behaviour, including acceptable behaviour within intimate relationships. SCC has commissioned resource development based on this guidance so that all schools in Southampton will have access to a bank of resources that they can use to deliver RSE sessions. These resources will also be available to providers of education for 16 and 17 year olds. The resources are designed to match the recommended curriculum and to support delivery across the first year of the mandatory RSE programme, however it is up to the individual school how they provide RSE.

Refuge provision

There are two refuges in Southampton, both provide recovery programmes and have a Children and Young Person's worker to support children who have been affected by DA. The refuges house women and families from across the country, as well as from Southampton itself.

Housing

The SCC housing team are working towards accreditation with the Domestic Abuse Housing Alliance (DAHA), which aims to improve identification of DSA through workforce training and DSA champions within housing teams. This may lead to earlier identification of DSA and thus earlier referral to support services and hopefully a reduced impact of DSA on victims and any children in the family home.

4.1.3. Services for young people displaying abusive behaviour;

The following service is for young people who are already displaying problematic or abusive behaviour.

Southampton Youth Offending Service (SYOS)

The Youth Offending Service works with some young people that have come into contact with the criminal justice system. In 2018, 119 assessments were undertaken by SYOS, and 31% of these had a flag for DA. Historically, SYOS had a LINX worker (see section on LINX), but this service is no longer available in the city, with the exception of Regent's Park School.

Nationally, there are currently no specific accredited domestic violence programmes for those aged under 16.

4.1.4. Services who work directly with those who perpetrate domestic abuse

The Domestic Abuse Prevention Partnership (DAPP)

The DAPP is a multiagency group, working across Hampshire and Southampton, led by the Hampton Trust and commissioned by HCC, SCC and the OPCC. This partnership works with the police and aims to prevent domestic abuse through delivery of the PPs; individual work with perpetrators and the victim safety service; by ensuring that information is shared including through a single point of contact (SPOC); and co-locating experienced staff into other front line services to up-skill staff in these services in assessing risk and working with perpetrators. Other partners include Aurora New Dawn and Baseline Connections. The DAPP has recently been evaluated by Southampton University with some promising early findings[28].

Hampton Trust

Hampton Trust is a charity which has been delivering PPs in various forms in the local area since 1996. They provide 20 week group based PPs for all who are referred, aged 16 and over and suitable for group work. Hampton Trust will work individually with those not deemed suitable for group work (i.e. those with additional needs or who are too chaotic for group work). Those who are not yet ready for group work may be invited to attend two awareness raising sessions, in an effort to prepare them for group work. Currently, most female perpetrators are offered individual support due to there being insufficient number to form a group. All of Hampton Trust's activities are completed on a voluntary basis. The recent DAPP evaluation found that younger perpetrators (aged 18-25) were not engaging with services well[28]. As a result the Hampton Trust is now developing a programme specifically for younger perpetrators with the aim of increasing engagement. The literature suggests that combining substance use programmes and PPs (where possible) may be beneficial[14]. At present, there are no formal links between substance use services and the DAPP, although there is willingness to undertake work to improve pathways between the two services. This work will require a coordinated approach.

Hampton Trust also have an 'integrated victim safety service', which supports partners and ex-partners of those completing PPs with Hampton Trust. This allows the service both to 'check in' with victims, ensure that reports from participants on the programme are accurate and also explain

some of the techniques used on the course so that partners understand how they work, and know what to do such as when a participant wants to use a 'time-out strategy'.

Hampton Trust phone line

The Hampton Trust provide contact phone numbers for professionals and members of the public who have concerns about their behaviour;

- 023 8000 9898 (Programmes)
- 023 8000 1061 (Office).

Linx

Historically, Hampton Trust have also offered a programme for young people displaying difficult behaviours or unhealthy relationships. This programme is open to 12-17 year olds and focusses on healthy relationships, conflict and empathy, aiming to help young people develop healthier relationships and empathy for others. Currently, this service is only available in Regents Park School in Southampton. Hampton Trust are currently seeking additional funding to increase provision of this programme.

Baseline connections

In some cases, individuals may benefit from group sessions but are too chaotic to attend group sessions or may have issues (such as homelessness or substance use disorders) that present a significant barrier to successful completion of a PP. In this case the Hampton Trust may choose to refer that individual to Baseline Connections, a partner organisation that can undertake individual work with clients who may benefit. This individual work will aim to stabilise difficulties in a perpetrator's life so that they are then able to participate in a group programme. If the participant is still unsuitable for group work then Hampton Trust may work with them individually.

Aurora New Dawn

Aurora New Dawn work in partnership with Hampshire Constabulary to identify and track high risk and serial offenders using police data. If the perpetrator consents to contact then Aurora New Dawn can refer into PPs at Hampton Trust. If they do not consent and engage then Aurora New Dawn will track their activities and participate in disruption activities (such as letters to perpetrators warning to them to stop their behaviour or face consequences).

Project CARA (conditional cautioning and relationship advice)

This Hampshire Constabulary-led pilot project[16] is a conditional caution which includes mandatory relationship education for those who have committed a lower-risk first offence. The conditional caution lasts for four months and means that if the perpetrator is re-arrested in the period they will face charges for both the original offence and the new offence.

The relationship education course is run by the Hampton Trust and takes place over two days, a month apart. The course is mandatory and failure to attend results in a breach of the conditional caution, and the perpetrator being charged with the original offence. Project CARA has recently been evaluated[16], with some promising early findings. CARA is now being rolled out to other areas in the UK.

CRC/ Probation

The Hampshire and Isle of Wight Community Rehabilitation Company (CRC) offer one court mandated PP and two additional PP that can be delivered under the Rehabilitation Activity Requirement (RAR) with the appropriate programme being selected based on the level of risk for each perpetrator and their suitability for group work.

Building Better Relationships (BBR)

This is a compulsory group work programme for medium and high risk adult male perpetrators, which aims to reduce risk of re-offending. BBR is a nationally accredited programme governed by the Ministry of Justice (MoJ) and is based on MoJ accreditation principles. This programme will run in every probation area for both National Probation Service (NPS) and CRC service users. The programme focusses on improving self-awareness, relationship skills, and emotional regulation, as well as working on reducing impulsive behaviour and negative influences. BBR is multi-agency and includes police data, information from those supporting partners and ex-partners and other key agencies. This programme does not cater for women, those in same sex relationships or perpetrating other types of familial abuse, those who don't speak English or first time offenders (in most cases).

Help

This 15 session group work programme has been developed for Interserve led CRC's and is delivered under the Rehabilitation Activity Requirement (RAR) if given from Court. This is for those individuals who are lower risk adult males displaying abusive behaviour within relationships. Unlike BBR, this programme is a rehabilitation programme but can also be enforced under the RAR to ensure participants attend. Participants must speak English and be able to work in a group setting. Help aims to improve empathy, confidence and positive relationship skills, and encourages participants to take responsibility for their behaviour.

Creating Safer Relationships (CSR)

This is a one to one course for those who are not suitable for group work and are experiencing relationship difficulties and is delivered under the Rehabilitation Activity Requirement (RAR) if given from Court. The course consists of 8-14 individual sessions, roughly following a modular pattern but allowing personalisation for the individual. It aims to improve empathy, personal responsibility, confidence and understanding of the impact of their behaviour on others, leading to improved relationships. This is open to adult men, who are not able to undertake group programmes.

Prisons

The prison service run a healthy relationships programme for high risk perpetrators, which runs over 2 years.

Hampshire constabulary

The Hampshire constabulary currently work with both victims and perpetrators of DSA, working to try and reduce offending in Southampton. They are in partnership with Aurora New Dawn, who identify and track serial DSA offenders, and refer them into perpetrators services or participate in disruption activities. Hampshire constabulary are also currently in the process of establishing a higher harm team. The higher harm team aims to focus on high risk perpetrators, including high risk DSA perpetrators. The team will take a longer term, preventative approach, by working with perpetrators to reduce their risk of re-offending. This may involve referring perpetrators into support services such as counselling or PP as required.

4.1.5. Other local services

PIPPA (Prevention, Intervention, Public Protection Alliance) phone line

- 023 8091 7917

This services provides a single point of access for all professionals and members of the public who want advice on dealing with DA. This service can then refer on to the appropriate support agency.

MASH

- 023 8083 3336 (in hours)
- 023 8023 3344 (out of hours)

The MASH provides a single point of entry to DA services for all high risk victims. The referrals to this group are then assessed in a daily, multi-agency HRDA meeting, which considers the whole family including the perpetrator.

HRDA

This daily meeting reviews the cases of all high risk DSA victims and any children who are affected by DSA. This meeting involved information sharing, risk assessment and planning to ensure that victims are safe and have access to the appropriate support.

MARAC

This is another multi-agency meeting with professionals from all related agencies. Only very complex high risk victims are referred on from HRDA to MARAC. The agencies share information and create a plan to protect that victim.

MATAC (Multi-Agency Tasking And Co-ordination)

The most harmful perpetrators of DSA are referred into MATAC meetings, a multi-agency meeting, which aims to support perpetrators to change their behaviour and stop perpetrating, or to disrupt and intervene where perpetrators are unwilling to engage in behaviour change.

4.2. National services

Respect

- 0808 802 4040

Respect provide a national helpline for perpetrators who give advice and signpost to accredited PPs.

5. Good practice in other areas.

There are no clear examples of best practice elsewhere that Southampton can adopt to tackle this issue. There are many different services available across the country, the majority of which are similar to those provided in Southampton. In fact, in some areas, such as project CARA in the criminal justice system, Southampton is leading innovation in the field. Southampton was a pilot area for HRDA before these services were rolled out across the country. Southampton is also the pilot area for MATAC.

6. Stakeholders

In order to better understand the local picture and seek the views of those working in local services several key stakeholders were contacted for individual conversations and a questionnaire was send out to services that may interact with those experiencing and perpetrating IPA. For a full list of all organisations contacted and a blank stakeholder questionnaire please see Appendix 2. The topics covered in discussions and through the questionnaire can be summarised into four areas, discussed in sections 6.1 to 6.4.

6.1. What are the life experiences and characteristics that are commonly found amongst perpetrators?

Figure 22 displays a summary of the life experiences and characteristics that are common in perpetrators or domestic abuse, as described by local stakeholders.

Life Experiences

- Childhood trauma
- Time spent in care as a child
- Childhood neglect
- ACEs
- Parental mental ill health or substance use
- Abuse (witnessing abuse or being abused themselves)
- Chaotic family circumstances
- Lack of control in other aspects of life
- Drug use
- Trauma
- Low income/unemployment
- Stress

Characteristics

- Attitudes towards women
- Beliefs in strict gender roles
- Need for control
- Feeling powerless
- Entitlement
- Low self esteem
- Lack of insight into the impact of their behaviour
- Difficulty regulating emotions
- Difficulies with impulse control
- Difficulty expressing themselves

Figure 22 Stakeholders experiences of life experiences and characteristics that are commonly found in perpetrators of IPA.

6.2. Prevention of IPA

Stakeholders were also asked about prevention of IPA, see Figure 23 for their responses on primary and secondary prevention. For tertiary prevention stakeholders suggested PPs, stronger criminal justice sanctions and societal changes in attitudes towards women and acceptability of violence.

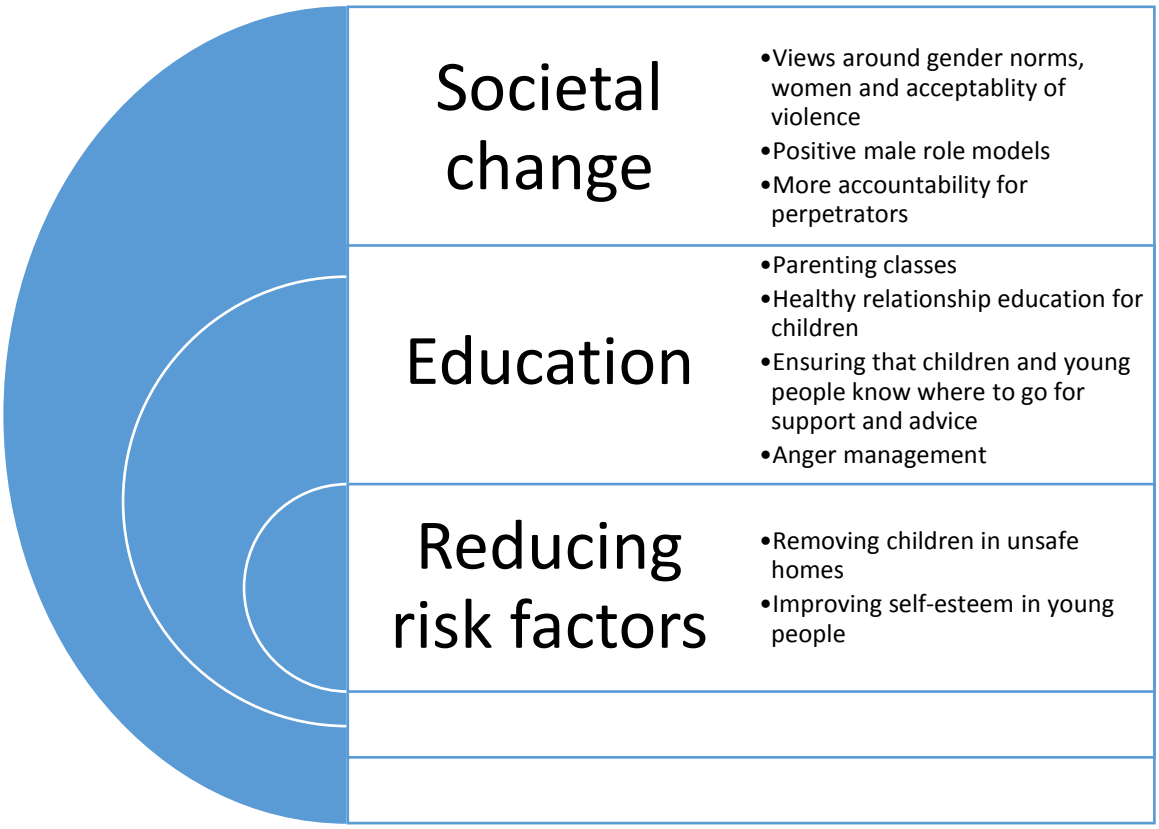


Figure 23 Stakeholder views on effective primary and secondary prevention interventions to prevent people from ever becoming perpetrators, split into three broad categories, reducing risk factors, education and overarching societal change.

6.3. Barriers to behaviour change in perpetrators

Stakeholders were asked to describe the barriers that they had encountered in working with perpetrators to change their behaviour. Several stakeholders reported that longstanding beliefs and cultural differences can play a role. For example, acceptance of abusive behaviour as a normal part of a relationship in some groups, and resentment of outside interference. Motivation and willingness to engage were also reported as key barriers. Other barriers included difficulties in finding or accessing services that cater for those from different backgrounds, those with support needs, those in LGBTQ relationships and female perpetrators. Finally, in some areas a lack of understanding or awareness of perpetrator services could be a barrier to referral from other agencies in Southampton, and availability of places on PPs was mentioned as being problematic at times.

6.4. Suggested interventions

Finally, stakeholders were asked questions around what they would do to tackle IPA in Southampton. Their responses are displayed in Figure 24.

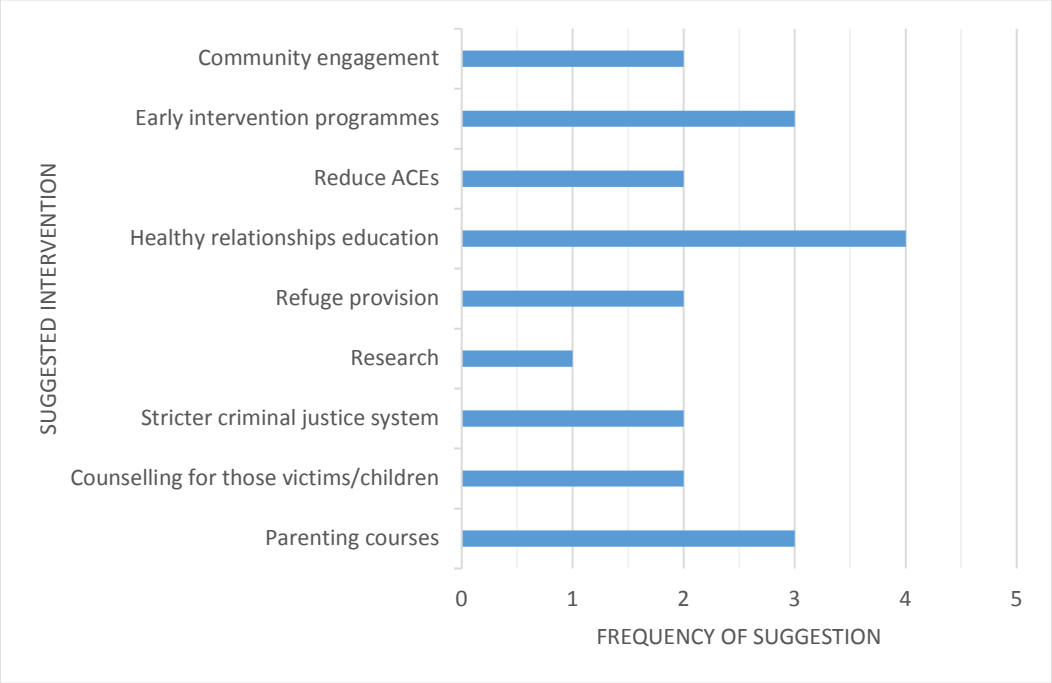


Figure 24 Interventions suggested by stakeholders when asked what they thought would prevent IPA in Southampton

7. Unmet need

The rates of DSA in Southampton clearly point to unmet need in terms of preventing IPA in the city. It is worth noting that much of the data is for DSA rather than IPA, and as DSA encompasses a wider range of relationships this is likely to be an overestimate of IPA. However, we also know that DSA is underreported, and that it is likely that the burden of IPA is larger than reflected in current police DSA figures. Additionally, many of the risk factors and interventions for DSA and IPA are the same, and there is so much crossover between the two that tackling one could be reasonably expected to also impact on the other.

During the course of this NA some specific areas of unmet need have also emerged. For example, there appear to be gaps in specific service provision supporting children who have been affected by DSA, for those who are aged between 1 and 3 and between 5 and 7. This means that these children may not receive support to minimise the impact of their experiences, or may have to wait until they reach the appropriate age group for a specific support service. Whilst those who are aged 1-3 may be too young for a specific intervention themselves, they may benefit from family and parenting based interventions. For those children who are the right age, there are often long waiting lists for services (4-12 months), some of which are closed to new referrals from time to time due to service pressures.

Another gap in service provision is for those who are demonstrating abusive behaviour and are under the age of 16. There is no formal perpetrator service to refer these individuals into, and more generic behaviour change programmes such as the Linx programme are currently only available on a very restricted basis in Southampton. There are no specific perpetrator services for this age group available nationally.

Another gap in service provision is for those in LGBTQ relationships, female perpetrators and those with additional needs such as learning disability or mental health or substance abuse disorders. Those in LGBTQ relationships may be able to attend standard PPs but they will not be tailored to their circumstances or specific needs. In many cases female perpetrators will receive one on one sessions rather than group sessions, due to there being insufficient numbers to make up a group. However, one of the main benefits of PPs in groups is the peer influence, which female perpetrators therefore miss out on. In some cases those with learning disabilities, acute mental health issues or substance use disorders may be able to take part in standard PPs, but in some cases this is not appropriate and there are no standard alternatives to offer at present.

When considering the level of need in Southampton there also appears to be significant unmet need. For example, there were over 3,000 recorded incidents with a DSA element in Southampton in 2017/18, yet only 35 referrals made to Hampton Trust in the same period. It may be that some of these perpetrators were receiving support through CRC run perpetrator programmes, but it is not likely to be a significant number. This suggests that there are large numbers of people who could potentially benefit from perpetrator services but are not reaching them. There are many possible causes for this, including but not limited to: insufficient service provision; confusion regarding referral pathways; and unwillingness on the part of the perpetrator to engage with services, as participation in Hampton' Trust's PPs is currently voluntary. Children's services referrals with a DSA flag also reflect the level of unmet need, with 5,480 children in the city found to have some exposure to DSA at assessment between 2014/15 and 2018/19. It is unclear at this time how many of these children received specialist support to help them deal with their experiences. More work is needed to establish the level of service provision for children, so that this can be compared to need.

8. Literature review

A systematic literature review was undertaken to better understand the evidence base behind PP and primary prevention strategies. The review aimed to look specifically at preventing IPA between adults in established relationships, and did not consider other forms of abuse or abuse between those outside of this context.

8.1. Methodology

Search terms were developed using key terms from the literature on this topic and Mesh terms for respective databases. Databases searched included Cochrane, Ovid Medline and Web of Science. Citation chaining was also used to look for key papers in the field. The search was limited to papers from 2017 onward (as a large NICE evidence review[35] addresses this topic prior to 2017), English language and studies from similar countries to the UK. Both quantitative and qualitative papers were reviewed, as well as systematic reviews and service evaluations. Full details on the search strategy including a PRISMA flow chart can be found in Appendix 3. In addition to those papers identified through the search strategy, key papers including grey literature used for the coinciding scrutiny process at SCC were included in the review[20,22,35-40].

8.2. Findings

In general, the evidence base supporting interventions to prevent IPV is limited, hampered by a historical lack of focus on and investment in primary prevention and PP[36], and pragmatic difficulties with assessing outcomes given the hidden nature of IPA. Other difficulties include ethical quandaries around the use of control groups for PP and the length of follow up time required for primary prevention interventions, often leading to methodological difficulties[20,36]. These issues make it difficult to confidently and accurately determine whether an intervention has had the desired impact on behaviour. However, in recent years the amount of research in this field has increased substantially and the evidence base is slowly growing. Several studies have attempted to quantify the impact of interventions to prevent IPA, and several key bodies have produced recommendations and guidance[6,11,20,35,36,38-40] around beginning to tackle IPA, at both an individual level (for those already perpetrating abuse) and societal level (to try and reduce IPA rates nationwide).

8.2.1. Grey literature and key policy documents

In the course of this literature review, several overarching documents including key policy documents and approaches to tacking IPA were reviewed. One such document was the NICE DA guidelines[35], which were updated in 2018 to include the latest evidence. NICE make several recommendations, including multi-agency working and integrated commissioning, early intervention and evaluation of existing PP to add to the available evidence base[35]. Similarly, '*Ending violence against women and girls',* an HM Government strategy document also calls for collaborative working, early intervention and whole family approaches[38]. It also advocates for stronger legal powers and sanctions for abuse, the use of technology such as GPS trackers and education and support for young people[35], something which is a recurring theme across the majority of the key documents[11,39,40]. A review looking specifically at multiagency working around children who live with DA emphasised the need for societal change in order to facilitate primary prevention of IPV[6].

The Early Intervention Foundation (EIF) has produced an evidence summary around DA, which emphasises the importance of evidence based practice and calls for an improved evidence base in this area[40]. They also suggest working with young people in primary prevention, and working with families experiencing DA to minimise harm and ensure secondary and tertiary prevention[40]. Finally, the EIF highlight the need for workforce planning to ensure that we have an adequate numbers of workers who can deliver early interventions[40]. When considering violence in a broader context, the Local

Government Association (LGA) emphasises that violence is multifactorial, and also suggest supporting children, young people and families, in particular targeting additional support for high risk groups[39]. In addition to those recommendations listed above, the CDC suggest that safe environments (with low rates of crime, cohesive communities and facilitates) and financial stability are key in preventing IPV[11]. The also advocate for the use of positive role models and a focus on vulnerable children to give them the best start in life[11].

The Welsh government have recently undertaken a review of PP[20]. They found that, whilst further research is needed, there was evidence to support several interventions. These included whole system approaches, family based interventions and treating coexisting substance use in combination with DA PPs[20]. They found mixed evidence for several other strategies, including the use of CBT in PP and bystander programmes as primary prevention tools[20]. Bystander programmes encourage people witnessing inappropriate or abusive behaviour to intervene, and provide individuals with the tools to do so[41]. They also aim to promote equality and change beliefs to reduce the acceptability of violence and abusive behaviour in a wider context, by stimulating discussion and challenging beliefs[41].

In summary, there is consensus within the field that multi-agency working, supporting young people and a focus on societal change and primary prevention may be key elements in reducing the ongoing burden of IPA. In addition, ongoing focus on perpetrators and preventing IPA is key.

8.2.2. Academic literature

Systematic reviews

A good quality, UK focused review of school based interventions for primary preventions of IPV found evidence to suggest some improvement in 'soft' outcomes such as increasing knowledge and awareness[37]. The authors note that group work allowing peer feedback and the use of drama may be useful, and suggest that efforts should be made to include more diverse relationships in materials, and including discussion of issues around ethnicity, sexuality and disability within relationships[37]. A review of interventions for young people found that many focussed on preventing victimisation rather than perpetration, and found mixed evidence for effectiveness[42]. A large review of PP across Europe concluded that using self-reported outcomes biases results, and that those participants who completed a PP were less likely to re-offend than those who dropped out[43]. In their review of interventions in healthcare settings, Tarzia et al[44] conclude that the available evidence is weak, but that, for those where substance use is an issue, combining substance use programmes with PP may be beneficial. Finally, a review of the addition of motivational interviewing to PPs to increase engagement found that there was not enough evidence to reach a firm conclusion about any beneficial effect[45].

Controlled trials

Several studies evaluating the impact of PP in the UK and Europe have been published since the NICE review update[16,46-49]. In the UK, two randomised controlled trials (RCTs)[16,49] evaluating PP found some evidence of positive benefits. However, one (which was based in Southampton) had strict entry criteria, which limits the generalisability of their findings[16] and both had methodological issues which make it difficult to confidently draw conclusions based on this research. In Europe, an RCT evaluating an internet based, CBT programme for aggressive behaviour within an IP relationship found

improvements in self-reported outcomes[47]. This effect was sustained at follow up but the selection process (self-selected participants with stringent exclusion criteria) limits the generalisability of this study. A controlled trial in Sweden found no benefit from a group-based PP using the Duluth model for those convicted of IPV[46]. A Spanish RCT found that adding motivational interviewing techniques to a PP improved self-reported measures, but not re-arrest rates[48].

A reasonably well designed American RCT found that combining substance use treatment with PP reduced substance use, although this did not produce a significant difference in the number of violent episodes at follow up[22]. Similarly, in a small American pilot study[21], adding an IPV intervention to substance use treatment did not have a significant impact on levels of violence at 6 months follow up. Another American RCT found that a brief motivational alcohol reduction intervention before a PP did not offer significant improvements in substance use or IPV when compared to their control, and alcohol education intervention[23]. However, a reduction in substance use and IPV was found in both groups after completing the PP following their respective interventions[23].

Non-controlled trials

Locally, a mixed methods evaluation of the Hampshire DAPP was undertaken by the University of Southampton[28]. The authors found positive changes in behaviour after the programme, but that nevertheless, one in five participants then went on to re-offend or were suspected of re-offending[28]. They also noted that younger perpetrators in particular were poorly engaged with the available perpetrator services[28]. The authors suggest ongoing development of the programme for young people and those in LGBTQ relationships, as well as further research and evaluation[28].

In their UK based qualitative evaluation, Walker et al[50] found that several factors appeared to be associated with successful cessation of abusive behaviour. These included peer influence, support, reduced substance use, motivation to change and recognition of abusive behaviour amongst others[50]. They suggest that PP should aim to target these areas to increase efficacy of the programme. One mixed methods evaluation[36] found that Respect accredited PPs lead to an improvement in self-reported outcomes, but the lack of a control group reduces confidence in these results. A British evaluation of multi-agency working found that good communication and information sharing were key to success[51]. One qualitative study explored the use of 'victim impact panels', as an adjunct to the criminal justice system[52]. They report that the panels induced emotional responses and a desire to change in some participants, but did not follow up participants so it is not possible to know if these responses resulted in any change in behaviour. Another criminal justice based study[53] found that a new 'no tolerance' approach to IPV reduced the number of calls, arrests and victim injuries as a result of IPV. In this study, the 'no tolerance' approach involved sending letters to offenders warning them of the consequences of continuing their abusive behaviour and making arrests where appropriate[53]. However, it was unclear whether these reductions were due to result of a true reduction in IPV, or reduced reporting of IPV due to a fear of the consequences of reporting. An American feasibility study[54] focussing on integrating an IPV/parenting programme into residential substance use

treatment found positive changes in levels of self-reported anger. However, this small study did not follow up participants outside of the programme and had no control group[54].

In summary, despite some methodological difficulties there is preliminary evidence in the literature that some approaches may be beneficial, including motivational techniques, combining substance use treatment with PP (where appropriate) and school based primary prevention programmes.

There is a clear need for more research in this area, particularly for primary prevention interventions, and a need for a consensus on the best approach to measuring outcomes, given the inherent difficulties with self-reported outcomes. Where possible, outcomes should be measured for at least 12 months, and ideally longer.

8.3. Comparison to NICE Guidance

This literature review did identify that a life course approach and primary prevention may be key in reducing IPV, which was not fully explored within the NICE guidance. It also found that combining substance use services with PPs may be beneficial, and again this is not fully explored within the guidance. Most other findings of this review are included within the guidance.

8.4. Further reading

In addition to the NICE guidance, the following documents may be useful for those who wish to explore some of the concepts or issues raised here in further detail.

- The Welsh government rapid review of PPs (2019)[20]
- The CDC's *Preventing intimate partner violence across the lifespan* (2017)[11]
- The Local Government Association (LGA)'s *Public health approaches to reducing violence* (this discusses prevention of all violence, but many of the principles are transferable to IPA, 2018)[39]
- The NICE review underpinning their domestic violence guidance (2013, updated in 2018)[35]

9. Conclusions and recommendations

9.1. Conclusions

IPA is responsible for a large amount of ongoing harm in Southampton. Whilst Southampton is already leading innovation in some areas, there is still more that needs to be done to tackle this difficult issue. There are several areas in which there is unmet need that could be addressed in order to try and reduce the prevalence of IPA in the city. There is a need to focus on all three types of prevention (primary, secondary and tertiary) in order to reduce the rates of IPA and ensure that these reductions continue for future generations.

9.2. Recommendations

The following recommendations are based on this NA and build on the recommendations of the scrutiny inquiry (these are included for completeness here and listed in italics). The recommendations may help us to better understand and begin to tackle the rates of IPA in Southampton. The recommendations are for both the council and all service providers to consider how they can be met within the remit of each organisation. The recommendations are listed without detailed consideration of cost, and clearly it may not be possible to meet all of them. Each organisation should consider if any can be delivered without any additional funding. If additional funding becomes available then it may be possible to meet more of the recommendations.

Children

Universal primary prevention

- *Relationship Education – to ensure that all children receive healthy relationship education.* We must work with schools to ensure that healthy relationships, IPA, harmful gender stereotypes and other key topics are covered in mandatory PSHE from 2020
- In 2021, to consider exploring how the roll out of mandatory RSE has been implemented across the city and what ongoing support is needed to ensure that healthy relationships and IPA are on the agenda.

Targeted interventions

- *Adverse Childhood Experiences* –SCC take a strategic approach to ACE's, possibly by convening a strategic oversight group, which would allow work across many different areas to be coordinated.
- Increase provision of parenting support for families who are struggling to parent for any reason
- Conduct a review of level of service provision for children and how this compares with need in the city

Adults

Universal primary prevention

- Explore the potential benefits of bystander programs in inducing cultural change and increasing likelihood of witnessing intervening if they see inappropriate behaviour.

- Community engagement, introducing positive role models and tackling gender stereotypes, acceptance of violence and acceptance of controlling behaviour.
- Explore the views and understand of IPA within different groups and the impact the cultural differences and beliefs have on this understanding
- *Communications Campaign – i.e. white ribbon campaign, to induce cultural shift and social change such that even low levels of abusive behaviour are no longer acceptable in our communities, and those worried about their behaviour feel able to come forward and ask for help.*
- *Reporting of DSA – encourage the local media to follow Level Up reporting guidelines, which encourage accurate reporting and dignity for victims, amongst other things (https://act.welevelup.org/campaigns/54)*
- To consider how we might target resources into areas of high need, which may overlap with areas of high deprivation

Perpetrator services and whole system approach

- Ensure a whole system joined up approach to DSA (this is already underway)
- All services relating to DSA should be clearly advertised, particularly targeting key staff groups, who may encounter perpetrators through their work and groups that are at highest risk of perpetrating (in 2016/17 in Southampton, men aged 20-40 committed more DSA related offenses than other groups)
- Check capacity of services against need across all service areas relevant to IPA, particularly in preventative interventions and PP, where the level of needs seems to surpass provision
- *Perpetrator services – Increase both awareness of and referrals to perpetrator services, through awareness raising campaigns, staff training and earlier identification of perpetrators.* This includes using these pathways at an earlier stage where possible
- *Co-location of Hampton Trust staff within the key service areas – to share skills and knowledge in identifying and engaging perpetrators.*
- Where possible and appropriate introduce DSA champions into service that may have contact with perpetrators or victims of DSA (such as housing)
- Improve links between mental health services and perpetrator services (this should be actioned shortly)
- Improve links between substance use and perpetrator services and consider combining substance use treatment programmes with PPs where applicable and if possible
- Ensure that substance use services have capacity to treat amphetamine and cocaine addiction in addition to services currently offered
- Consider online CBT based relationship skills courses for those with concerns about their behaviour, possibly through IAPT
- Consider that different groups may need different approaches and different assistance to access services/referral pathways
- Using family-based approaches where possible
- Veterans work steam should consider DSA in their work
- *Routine enquiry – establish routine enquiry for perpetrators, as is currently undertaken for victims.*
- *Resources – where possible pursue resources to support perpetrator services (currently 11% of total DSA funding).*

- *MATAC (Multi-Agency Tasking and Co-ordination) – a new approach in Southampton which identifies and intervenes with or tracks high risk offenders, that should be rolled out if evaluations continue to be positive.*
- Further evaluate CARA using less strict inclusion criteria and therefore a more representative population group
- As far as possible address the service gaps identified in section 7

Evidence based decision making

- Develop local network of academics, commissioners and service leads to translate research into practice and evaluate interventions that are innovative
- Undertake a literature review on how best to support children who are affected by IPA
- *Update the DSA Strategy – the current strategy runs out in 2020.* The next DSA strategy should continue to have a strong focus on prevention
- *Evaluation of perpetrator services – to add to the evidence base in this area and ensure that interventions are effective.* Ensure that any new and existing interventions are evaluated, including primary prevention interventions where possible
- To review local data as it becomes available and for the safe city strategic assessment in autumn 2019
- Further investigate how we compare to other areas, and consider whether high rates in Southampton may be inflated by higher levels of reporting, or truly high levels of DSA
- If found to be truly higher than comparable areas, consider the reasons behind high levels in Southampton
- *Calculate the return on Investment for perpetrator services – to support decision making*
- *Alcohol and Substance use – to consider the impact on DSA and ensure joined up working.* Specifically, explore the relationship between alcohol licencing and IPA
- *Working with Government – make use of opportunities offered and work with the government to enable investment in innovative practice in the city.*
- Implement NICE guidance and other key recommendations as they emerge, and consider making use of more detailed technical guidance where it exists, such as the CDC's technical package for preventing IPV using a life course approach[11]
- Be able to respond flexibly to the evidence base as it emerges
- *The role of Public Health – to consider funding for DSA services*
- *Consideration of the impact on DSA when making Council decisions – include DSA in the Equality and Safety Impact Assessments (e.g. as if they were a protected characteristic).*

9.3. Next steps

This report will be considered by the DSA strategy group and used to inform their next strategy (due in 2020). It will also be made publically available on SCC's Joint Strategic Needs Assessment (JSNA) website, where it will be accessible for reference.

Appendix 1 Needs Assessments

The ultimate aim of an NA is to improve the health of a population group and reduce inequalities. NAs are designed to collect and collate information that helps us to understand about the health and other needs of a particular group of people[55]. The group of people can be based on geographical area, such as people living within Southampton City limits, or can be focussed on a group of people with a characteristic in common in a defined area, such as military personnel in England or people who have diabetes and live in Hampshire.

The needs assessment process involves gathering information about the chosen group of people, gathering information about the services that already exist to support those people and identifying gaps in service provision or areas of unmet need[56]. This will include using surveillance data, finding comparator areas (if required) and discussion with key stakeholders. In this case, need can be defined as potential to benefit from an intervention[55]. Additionally a review of the evidence or other areas of good practice may help to identify potential interventions to address these gaps. The collated information is then used to create recommendations and an action plan, which hopes to address some of the unmet need identified in the NA.

There are three main approaches to NAs, comparative, epidemiological and corporate[55]. An epidemiological approach relies on collecting data that describes the population of interest, such as looking at the prevalence of a particular disease and confirming the age range of the population of interest. A comparative approach involves comparing your chosen area to another similar area, looking to see if your area has higher or lower levels of both need and service provision. Finally, a corporate approach involves seeking the views of stakeholders, to inform understanding of unmet need and shape any potential recommendations or actions suggested[55]. These stakeholders may include healthcare service providers, local community groups, charities, the public, a sample of the population of interest, social care providers and any other affiliated agencies. In many cases a NA will contain elements from all three approaches.

Appendix 2 Stakeholder involvement and questionnaire

Table 2 Stakeholder groups contacted through NA process and whether responses were received.

Stakeholder group	Invited for individual discussion	Had individual discussion	Sent questionnaire	Responded to questionnaire
Commissioning	Yes	Yes	No (involved in questionnaire construction)	N/A
Children's services	Yes	Yes	Yes	No
Hampton trust	Yes	Yes	Yes	No
Yellow door	Yes	Yes	Yes	No
Aurora New Dawn	Yes	Yes	Yes	Yes
University Hospital Southampton	Yes	No	Yes	No
CCG	Yes	Yes	Yes	No
No Limits	Yes	Yes	Yes	Yes
Maternity services	Yes	Yes	Yes	No
Hampshire Police	Yes	No	Yes	No
Schools	Yes	No	No	N/A
Southampton Family Trust	No	No	Yes	Yes
Southampton voluntary services	No	N/A	Yes	Yes
Solent NHS trust	No	N/A	Yes	No
Refuge providers	No	N/A	Yes	No
Housing	No	N/A	Yes	No
IDVA service	Yes	Yes	Yes	Yes
Adult services	No	N/A	Yes	Yes

The questionnaire (see below) had a response rate of 37.5%.

Stakeholder questionnaire: Preventing people from becoming perpetrators of domestic abuse in Southampton.

The public health and data intelligence teams at Southampton city council are currently undertaking a needs assessment (NA) in Southampton, focussing on how to reduce perpetration of domestic abuse and how to prevent domestic abuse from occurring in the first place. For the purpose of this project, we are focusing solely on domestic abuse between intimate partners. This includes any mental, physical, emotional, economic or sexual abuse, as well as coercive and controlling behaviour.

In order to help us with this project we are asking key stakeholders like yourself to complete the following questionnaire. We are looking specifically for your experiences whilst working in Southampton, to help us understand more about this issue on a local level. Please focus your answers towards perpetrators (rather than victims) of domestic abuse. **Please do not include any confidential information in your answers**, we are looking for general comments only.

1. In your experience, are there any key life experiences that many people who commit domestic abuse seem to have undergone?

2. Are there any patterns of characteristics that many people who commit DA seem to share?

3. When thinking about preventing domestic abuse, what do you think would be the single most effect thing to reduce the number of under 12 year olds who grow up to commit acts of domestic abuse?

4. When thinking about preventing domestic abuse, what do you think would be the single most effect thing to reduce the number of 12-25 year olds who go on to commit any act of domestic abuse?

5. When thinking about preventing domestic abuse, what do you think would be the single most effect thing to reduce the number of those who are 25 or older who go onto commit any act of domestic abuse?

6. If you work directly with perpetrators then what barriers do you face in helping perpetrators to change their behaviour?

7. Have you come across any perspectives on domestic abuse that are barriers to changing the behaviour of those who are behaving abusively (such as cultural factors or religious beliefs)?

8. Does your organisation have any policies around what to do if someone is worried that their behaviour is abusive, (for example, a referral pathway into perpetrator services)?

9. With current funding, what changes would you make to improve our chances of preventing domestic abuse in the first place, or improving the impact that our services have in reducing domestic abuse (this could be anything, not necessarily something that your organisation could do)?

10. If funding were no object, what changes would you make to improve our chances of preventing domestic abuse in the first place, or improving the impact that our services have in reducing domestic abuse (this could be anything, not necessarily something that your organisation could do)?

11. Any other thoughts or comments?

Team/organisation ……..

Email address for further discussion of comments (optional) ……

Thanks for your help, it is much appreciated.

Appendix 3 Search strategy and detailed literature review methodology

The search strategy was developed using the PICO (population, intervention, control and outcome) framework[57] as displayed in Table 3.

Table 3 PICO framework for search strategy

Element of framework	**Descriptor**
Population	Adult perpetrators of domestic abuse in a relationship with an intimate partner and/or those likely to become perpetrators of domestic abuse
Intervention	Interventions aimed at preventing domestic abuse or preventing repeat domestic abuse
Control	Those not undertaking interventions/areas offering victim support services only
Outcome	reduced levels of domestic violence, reduced re-offending

Once the PICO framework was completed, the following search terms were selected and included in the search;

- Domestic violence
- Intimate partner violence
- Spouse abuse
- Battered women
- Domestic abuse
- Intervention
- Prevention
- Perpetrator programme

The search terms were then used to search several different databases. Once the searches had been completed the papers were screened by title and abstract and then full text, as depicted in Figure 25 and using the criteria displayed in Table 4.

Table 4 Literature inclusion and exclusion criteria

Inclusion	**Exclusion**
Intimate partner relationships between adults	Non- English language
Intervention to prevent IPV	Published prior to 2017
Any study type	Low income setting
Grey literature including key documents prior to 2017	Military setting/veterans only
Literature accessed and appraised for scrutiny process outside of search criteria	Bystander programmes
	Protocol/conference abstract only

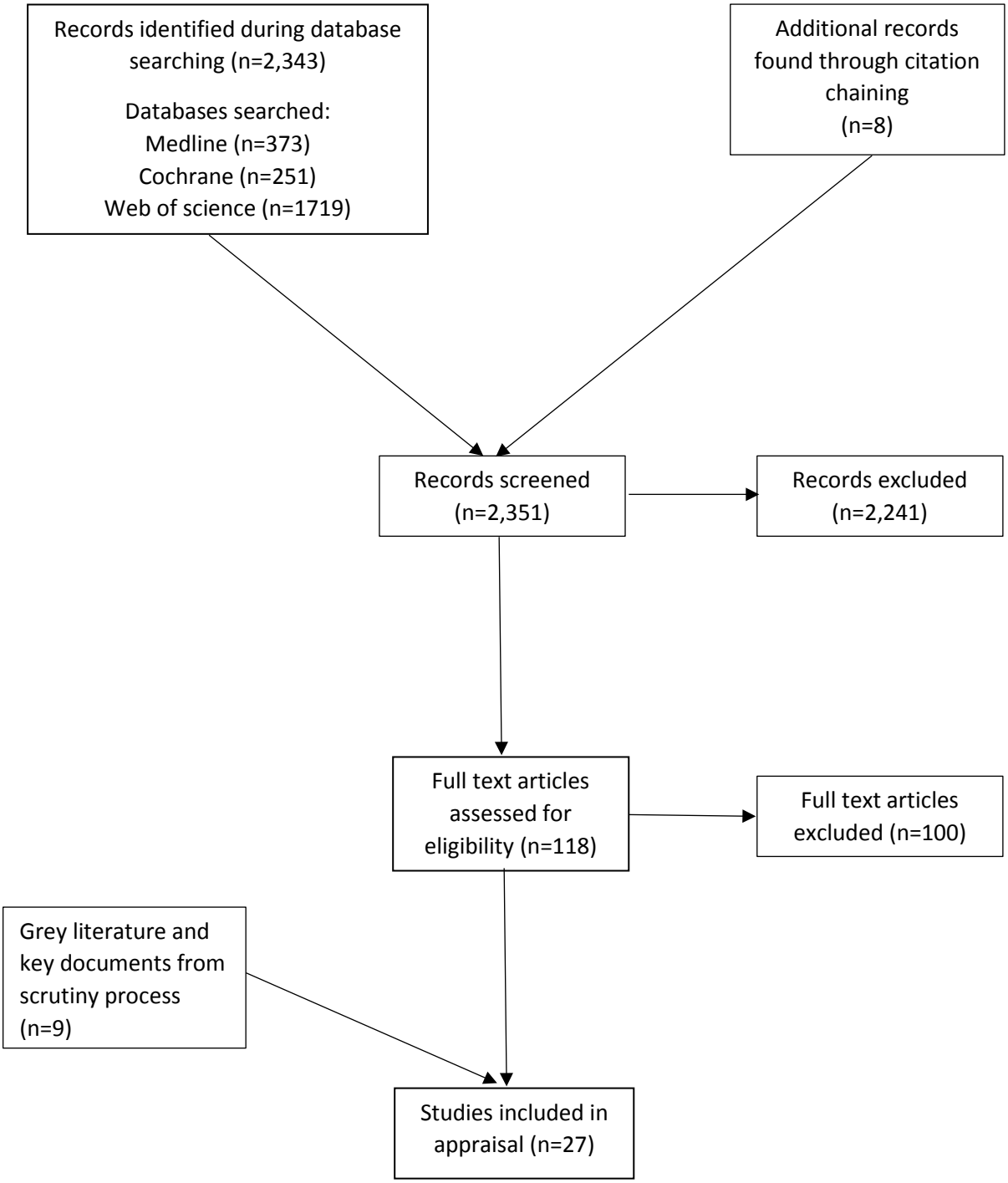


Figure 1 A flow diagram demonstrating literature searching and final paper selection for critical analysis, using preferred reporting items for systematic reviews and meta-analyses (PRISMA) format[1].

PRISMA format available from Liberati A, Altman DG, Tetzlaff J, et al. The PRISMA Statement for Reporting Systematic Reviews and Meta-Analyses of Studies That Evaluate Health Care Interventions: Explanation and Elaboration. PLOS Medicine 2009;6(7):e1000100. https://doi.org/10.1371/journal.pmed.1000100. (accessed 09/07/2018).

Appendix 4 Funding/commissioning of services available in Southampton city

Organisation	Programme/service	Commissioned/funded by
Maternity services	Ante/postnatal care	Clinical Commissioning Group (CCG)/ Integrated Commissioning Unit (ICU)
Southampton City Council Children's Services	Domestic Abuse Recovering Together Sure start special Children's centres Children's safeguarding line	SCC
Yellow door	Star project Other Yellow door projects	ICU/SCC/ additional fundraising
No Limits	Various	ICU
Southampton Family Trust	adapted FAB	Part funded by ICU
Refuge	Safe housing and support	One funded by SCC, one self-funded
Housing		SCC
The Domestic Abuse Prevention Partnership (DAPP)	Various, see Hampton trust, Aurora new dawn and baseline connections	ICU/SCC, Hampshire County Council (HCC) and the Office of the Police and Crime Commissioner (OPCC)
Hampton Trust	Various	ICU/SCC, HCC and OPCC
Baseline connections	Stabilisation of perps	HT on behalf of DAPP
Aurora New Dawn	Tracking and intervention	Part funded by OPCC and HT, on behalf of DAPP
CRC/ Probation	Building Better Relationships Help Creating Safer Relationships	Government funding to CRC
PIPPA	Phone line	SCC and part of ICU contract with Yellow Door
MASH	Referral point	SCC

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