# SOUTHAMPTON AGAINST DOMESTIC VIOLENCE AND ABUSE PLAN 2015 - 2017

**See DVA Plan-on-a-Page at www.southampton.lscb.co.uk**

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**Appendices:**

# SOUTHAMPTON AGAINST DOMESTIC VIOLENCE & ABUSE PLAN 2015-2017

***"Our Aim is for Southampton to be a city united in speaking out against Domestic Violence and Abuse. Our message is that we will not tolerate, ignore or excuse violence and abuse. Our ambition is to be an 'Early Intervention City' - together with services, agencies, communities and residents, we will act now to prevent, reduce and end domestic violence and abuse in our City."***

*Cllr Kaur, Cabinet Member for Communities*

## INTRODUCTION

1. This multi-agency Plan outlines the core ambitions and proposed new developments to improve the city-wide response to Domestic Violence & Abuse (DVA). It covers the period 2015 – 2017 with specific detailed actions for 2015-2016. This Plan reflects the very high priority given to DVA across Southampton Partnerships. It will contribute to the City Strategy, Safe City Strategy, Prevention & Early Intervention Strategy, Health & Well-bring Strategy, Local Safeguarding Children & Adult Board priorities and more.

2. The approaches and actions in this Plan have been developed and will be implemented through the Domestic Violence Strategy Group, which reports to the Local Safeguarding Children's Board and the Safe City Partnership.

3. This Plan has been developed in consultation with the key agencies represented at the Partnerships listed above, plus Connect, Southampton City Council Strategy Group and Cabinet. In addition, the voice of survivors of DVA, voluntary and statutory DV service providers, stakeholders and frontline workers in Children & Families services have helped to shape the Plan. The core proposals are underpinned by evidence-based research and practice. Some aspects of this Plan – specifically integration of MARAC (multi-agency risk assessment conferences) and MASH (multi-agency safeguarding hub) have involved Safe Lives, the leading national Domestic Violence charity, with responsibility for monitoring and accrediting MARAC at a national level.

## SCOPE & DEFINITIONS OF DOMESTIC VIOLENCE & ABUSE

4. The cross-government definition of DVA is "any incident or pattern of incidents of controlling, coercing, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members, regardless of gender or sexuality." This is not a legal definition. DVA is not of itself a specified crime, but behaviours or incidents such as harassment and assault within a DVA context are crimes. The Police record both DVA incidents and crimes.

5. For the purposes of this Plan and our operational responses, DVA is:
   - The misuse of physical, emotional, sexual or psychological and/or financial control by one person over another, who is or has been in a relationship. This includes family members, for example older children abusing a parent.
   - DVA covers a wide range of behaviour and may be actual or threatened physical or psychological harm.

- DVA can include Forced Marriage, so called “Honour-Based Violence”, Sexual Violence and Stalking.
- DVA can significantly impact on children and is recognised in Southampton MASH and Children & Families threshold documents, as well as Local Safeguarding Children’s Board policy as a specific child protection and safeguarding risk.
- DVA is a continuous pattern of events and behaviours with exceptionally high recidivism (repeated incidents of abuse). It includes coercive and controlling behaviour which is defined as acts designed to make a person subordinate and/or dependent, by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape, and/or regulating their everyday behaviour. Coercive behaviour is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish or frighten a victim.

## WHO EXPERIENCES DVA?

6. DVA is usually perpetrated by men against women, but not exclusively. Nationally, the ONS[1] estimates around 1.2m women and 784,000 men experience DVA a year. However, evidence shows women are significantly disproportionately affected by DVA at high risk levels and are more likely to experience serious physical harm or death from a partner, as well as serious coercive and controlling behaviour. In Southampton 7% of high risk cases are male victims and 96% of high risk victims engaged with IDVA (a specialist DVA service) are female. Male victims of DVA include men in same-sex relationships. There is also a recognition of complex co-offending/co-dependency, where both male and female partners are victim and perpetrator.

7. Underpinning this Plan is the recognition that both genders, as well as the wider communities we live in, are part of the solution to preventing and reducing violence and abuse. Our DVA delivery model will require services to victims to be available to male victims, while also recognising boys and men may be significantly affected by growing up in a violent home (see paragraph 23). Interventions that change offending behaviours and intervene to stop cycles of inter-generational or repeat abuse, are a crucial part of DVA responses. This will be targeted at, but not exclusive to men. In addition, it is clear that men have an important role to play in challenging DVA and may be a powerful voice, particularly to young boys and men in our city-wide campaigns against violence and abuse.

8. DVA is non-discriminate; it occurs in all groups and sections of society, but DVA may be experienced differently due to, and compounded by race, sexuality, disability, age, religion, culture, class or mental health.

*1 Office of National Statistics*

9. In Southampton, 12.7% of high risk DVA cases are (self-identified) from black & minority ethnic groups which is broadly representative of our local communities, 1.2% have a disability which is under-representative. This figure significantly under-counts mental health. 0.5% of high risk victims are LGBT (lesbian, gay, bi-sexual, trans-gender), also likely to be under-representative of this group.

## THE IMPACT OF DOMESTIC VIOLENCE AND ABUSE

### The National Position:

10. It is estimated that 2 women a week are killed by a partner, ex-partner or lover in the UK; 400,000 women are sexually assaulted of which 70,000 are raped. 1,500 cases were supported by the Forced Marriage Unit with many more not reported. Police recorded crime figures showed an increase of 17% in all sexual offences for the year ending December 2013 and recorded rape increased by 20% compared to the previous year. This is now the highest level since the National Crime Recording Standard was introduced in 2002/3.

11. An estimated 130,000 children in the UK live in households with high-risk domestic abuse. 1 in 7 (14%) of children under 18 will have lived with severe DVA at some stage in their childhood. Thousands more live with other levels of domestic abuse (CAADA in Plain Sight 2014). DVA between parents is the most frequently reported trauma for children (NICE 2014). Studies suggest that a child who witnesses DVA shows more emotional or behavioural problems than the average child, while the psychological impact of living with DVA is no smaller than the impact of being physically abused. Partner violence is also prevalent in young people's relationships and this is a rising trend. In 2009 31% of girls and 16 % of boys (aged 16-17 years) reported sexual violence in their relationships and 25% and 18% respectively experienced physical violence (Meltzer 2009).

12. All data used in this area is likely to be an under-estimate as reporting levels are low.

### The Southampton Position:

13. There were 4,702 DVA calls to police last year. Police data shows 4,037 risk assessments were completed in 2013/14 - following a Police call-out or report to Police, of which 556 were high risk (the victim is at risk of serious physical harm or death) 1090 medium risk, with 2391 standard risk. There were 217 victims reporting sexual violence to the police in 2012/13 and 236 in 2013/14. There were 1,605 calls to Rape Crisis Helpline in 2012/13 and 2,611 in 2013/14.

[2] *MARAC data – this may count repeats*

14. Police data on Domestic Crimes & Incidents is provided below. This shows 5404[3] incidents of DVA in 2014 of which 1761 were recorded by Police as crimes. Although there has been an increase in criminal DVA in the latter part of 2014, this reflects a national increase in recording DVA crimes in compliance with Police recording standards, following a national review of Police responses to DVA. It is not regarded as a spike in incidents.

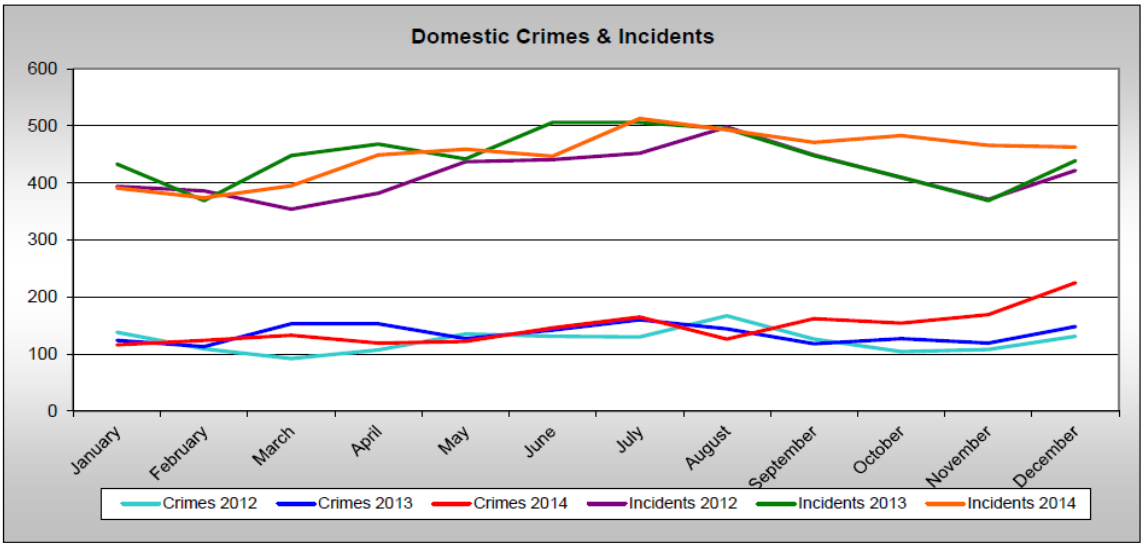
## Domestic Crimes & Incidents in Southampton

**Incidents**

| | January | February | March | April | May | June | July | August | Septembe | October | Novembe | Decembe | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2012 | 394 | 386 | 354 | 382 | 437 | 441 | 452 | 498 | 449 | 409 | 371 | 422 | 4995 |
| 2013 | 433 | 369 | 448 | 468 | 442 | 506 | 506 | 495 | 448 | 410 | 369 | 439 | 5333 |
| 2014 | 391 | 374 | 395 | 449 | 459 | 447 | 513 | 493 | 471 | 483 | 466 | 463 | 5404 |
| % Diff 2013 vs 2014 | -10% | 1% | -12% | -4% | 4% | -12% | 1% | 0% | 5% | 18% | 26% | 5% | 1% |

**Crimes**

| | January | February | March | April | May | June | July | August | Septembe | October | Novembe | Decembe | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2012 | 138 | 109 | 92 | 107 | 135 | 131 | 130 | 167 | 126 | 104 | 108 | 131 | 1478 |
| 2013 | 124 | 113 | 153 | 153 | 127 | 142 | 160 | 144 | 118 | 127 | 119 | 148 | 1628 |
| 2014 | 116 | 124 | 133 | 119 | 122 | 146 | 165 | 126 | 162 | 154 | 169 | 225 | 1761 |
| % Diff 2013 vs 2014 | -6% | 10% | -13% | -22% | -4% | 3% | 3% | -13% | 37% | 21% | 42% | 52% | 8% |




## The Comparative Position:

15. Comparative data to really evaluate Southampton's position regarding DVA with other areas is difficult, as Police and Crime data is not aggregated to city level in comparative data tables. However, where there are national comparators, Southampton is not well positioned; for example, in areas such as Violence with Injury Southampton is ranked worst compared to our 16 "most similar" areas.

[3] *Variations in incident & crime figures reflect slightly different reporting periods*

The volume of DVA in our city is substantially above national average; we have more than twice the national average high-risk cases (going to MARAC) and above national average reporting rates - locally 5.2% of the female population report DVA to the police compared to 3.6% nationally. In Southampton there are twice as many children of high-risk victims than national average 606 in 2012/13, 875[2] in 2013/14 – compared to national average of 289 for the same period. Southampton is highest of 15 "most similar" cities (for high risk cases). Our high risk cases per 10,000 population is 63, compared to national average and "most similar" group of 25 and 27 respectively.

A crude comparison with Bristol (based on published commissioning papers) shows:

| | *Population* | *Police Reports* | *Crime Reports* | *MARAC/ High Risk* | *Repeats to MARAC* | *DVA Commissioned Service Investment* |
|---|---|---|---|---|---|---|
| Bristol | 432,000 | (12/13) 6,178 | 2,986 | 14 ticks on RA 595 *1 | 22% | £1.2m |
| Southampton | 253,000 | 5,333 | 1,628 | 15 ticks on RA 620 | 23% | £566k |
| Differences Bristol to Southampton | 58%↑ | 14%↓ | 54%↓ | 25 ↑ | -1% | £634 |

*1 Bristol have a pre-MARAC discussion of the lower end of high risk cases to determine which of those cases go to MARAC - with these cases 946 cases were MARAC + pre-MARAC, compared to 620 in Southampton = ↓ 326.


## Reasons for a Higher Volume of DVA:

16. As explained, it is difficult to assess the comparative impact of DVA in Southampton. However, the evidence available does indicate a very high volume of DVA locally. There are a number of reasons for this, including a positive multi-agency approach to identifying and referring DVA, for example, there was a 20% increase in non-police reports to MARAC between 2012 - 2014, primarily encouraged or facilitated by Health and other services improved "identification and response". High levels of reporting may also reflect confidence by victims to call the

police and good engagement with services that encourage reporting as part of safety planning for victims. For these reasons, reporting is a good indicator and exposes DVA which may be hidden in other areas. Other factors such as a high proportion of young people in our demographic profile will be a factor, as will police recording practice. However, high levels of reported incidents also matches our comparatively poor Violent Crime ranking and may reflect both a failure to break inter-generational and/or entrenched DVA in families. The significantly high proportion of "high risk" DVA is also likely to reflect a gap in earlier interventions and prevention that could stop abuse escalating.

## The Impact of DVA on Children & Young People:

17. The impact of DVA on children and young people in our city is high and also appears to be significantly higher than other areas. In Southampton (Children & Families Services in 2012/13) 28% of safeguarding referrals had DVA as a factor; Child Protection Conferences include DVA in 80% of cases – this appears to be higher than similar profiles of other cities, however, the figure is subjective in that it does not weight the significance or risk levels of DVA in each case and thus comparison with Children's Services in other areas is not robust and is not collected as part of national data requirements. Police data for Hampshire-wide Safeguarding Boards show the number of children linked to high risk DVA incidents in Southampton was 1324 in 2013/14. This is a very similar figure to Portsmouth (1329). National comparative data shows the number of children of high risk DVA adults is 875, compared to 281 nationally and average 308 in our most similar group. Of the 15 most similar areas, Southampton is higher with significantly more children living with high risk DVA. 60% of adults at highest risk have children under 18 and, of these, 50% are under 5 years old.

### The Impact of DVA on Public Services:

18. Research shows the impact of DVA on Health services. NICE[4] guidance identifies risks of experiencing DVA increase where there is a long-term illness or disability – this almost doubles the risk - or a mental health problem. Separation and pregnancy or a recent birth are risk factors for DVA and there is a strong correlation between DVA and post-natal depression. The role played by alcohol and substance misuse in violence and abuse is evident. NICE suggest a high proportion of people attending health settings including Emergency Departments and Primary Care are likely to have experienced DVA and between 25 and 56% of female psychiatric patients report experiencing DVA in their lifetime. DVA is one of the strongest risk factors for suicide attempts.

*19.* DVA has a significant and direct impact on other statutory services including Children & Families Services, Education, Housing, Probation and Police. Every minute Police in the UK receive a domestic assistance call. In 90% of DVA incidents in family households, children were in the same or the next room. In over 50% of known DVA cases, children were also directly abused (NSPCC 1997).

[4] *NICE – National Institute for Health & Care Excellence – DVA Report 2014*

DVA also impacts on business and the workplace; the loss to the economy, where women take time off due to injuries, is estimated to be £1.9b per year.

## The Cost of DVA

20. The cost of DVA is evidenced in the Walby[5] research suggesting nationally a cost of over £15.7 billion per annum. Extrapolating national figures it is estimated the cost of DVA in Southampton is £44,127,469 per annum. This includes estimated costs relating to physical and mental health care, criminal justice costs, Social Care and other costs such as Refuges. National research shows for every £1 invested in High Risk DVA services at least £6 of public money is saved. In 2010 the estimated indirect cost savings to the public purse of investment in high risk DVA in Southampton was £4,820,970 per annum.

## WHERE WE ARE NOW:

21. Southampton has a strong history of partnership working and this is reflected in the current approach to tackling domestic and sexual violence. For example, the PIPPA alliance has been established through collaboration between Southampton City Council and specialist voluntary sector organisations to provide a single point of contact for professionals and joint training provision. PIPPA has successfully increased identification, assessment and pathways to support (an increase in non-police referrals of 20% since 2012 when it was set up).

22. Other key strengths include:

- The IRIS project is funded by CCG to deliver DVA training for General Practitioners also provides specialist advocates who are linked to GP surgeries. This educator-advocate role increases identification and access to support. IRIS has been nationally evaluated as an effective practice model and commended locally by GP's and service users.

- The Multi-Agency Risk Assessment Conferences (MARAC) and IDVA team (Independent DV Advocates) deliver the national model for shared identification of risk and support to high-risk victims of DVA. This produces above national average outcomes in reducing repeat victimisation and risk. All cases identified at high risk in Southampton are seen at MARAC are offered support by IDVA. In 80% of cases the abuse ends after this intervention. The IDVA service has Leading Lights status (national quality standard).

[5] *S Walby et al 2008; also reported Safety in Numbers report by Dr E Howarth for CAADA, local figures are for 2010.*

- Housing Services are well engaged in supporting victims of DVA and refuge provision is rated good.

- Voluntary Sector Sexual and Domestic Violence services provide some therapeutic work, a dedicated helpline, family therapy, adult and young person counselling, creative arts groups and young person's outreach.

- STAR education/prevention outreach programme delivered in schools and other youth settings – In 2013 named as 1 of 10 international examples of best practice in a report commissioned by the European Parliament.

- A Community-Educators programme led by Public Health has improved advice and support in diverse communities.

- Hampshire Constabulary has one of the highest DVA arrest rates in the country: 90 in every 100 DVA crimes led to an arrest, compared to 45-90 for most police forces.

## WHAT DOES EVIDENCE TELL US?

23. Based on our local performance and trend data, learning from local and national Serious Case Reviews, Domestic Violence Homicide Reviews and stakeholder feedback, we can identify key challenges, gaps and duplication in current provision. In addition there is a wealth of evidence-based practice and research that identifies 'what works best' to prevent and reduce violence and abuse. We are particularly drawing on recommendations from the NICE report on DVA (2014), the Early Intervention Foundation report on DVA (2014), the Co-ordinated Community Response model and research from Safe Lives, NSPCC and Home Office on the impact of violence and abuse on women and children[6]. This Plan is also influenced by the Centre for Social Justice Report, Beyond Violence 2012. We are specifically addressing the recommendations from local Domestic Homicide Reviews (DHR). Since legislation was introduced in 2013, Southampton has held 1 full DHR and 1 Partnership Review involving suicide of a DVA victim. In that time, there have also been 2 Serious Case Reviews (into child deaths) where DVA was a significant factor. Recommendations from these Reviews relevant to DVA have shaped this Plan. In addition, consultation with survivors and with key frontline workers took place in November 2014 and further consultation with children and young people, perpetrators and Universal Services is planned for early 2015.

**Domestic Homicide Reviews tell us we need to:**

- Ensure workforces across agencies are well trained in identifying, assessing and responding to DVA.
- Sustain a clear point of contact for professionals seeking advice and information about DVA.

[6] *References for national research: Co-ordinated Community Response Model www.ccrm.org.uk/children&familyact. The Legislation in Practice DOH 2014; Home Office VAWG Strategy 2013; CAADA in Plain Sight 2014; NSPCC.*

- Ensure clear, simplified pathways to advice and support.
- Ensure multi-agency identification and assessment of all risks including (victim) self-harm and risks to children and young people.
- Ensure DVA responses include effective and joined-up advice, support and interventions where mental health is a factor.

**Frontline workers tell us:**

- Inter-generational DVA is high.
- We need to provide help much earlier.
- Fathers are often excluded and skills to work with fathers who are perpetrators is lacking
- There is a "missing link" to address the impact of DVA on children's behaviour and experience in school.
- Males are often left "unchallenged".
- Child contact is a significant risk point and needs better responses.
- We need a far more co-ordinated approach and consistently good practice.

**Survivors tell us:**

- ***Children Services:*** Children services did offer some help and access some services for children, but the dominant theme in the focus groups was around the pressure placed on mothers to break off the relationship and stay away from the perpetrator.
- ***Police, CPS and Courts:*** The police, Crime Prosecution Service (CPS) and courts came in for particular attention. Many felt strongly the action taken against perpetrators was neither sufficient, timely nor proportionate to the offences committed.
- ***Cultural Differences:*** Culturally different attitudes towards women and their role in society came across strongly.
- ***Housing:*** Housing options are very limited, accessing refuge meant relinquishing property and furniture
- ***Use of Services (Refuge & Community):*** Where people knew about them, IDVA and ISVA services were cited as being very helpful and offering a good service, however only available once situation had reached high risk level. Some individuals using refuge services would have preferred to remain in their own home.
- ***Perpetrators:*** The focus groups provided strong views about how services must better address the issue of perpetrators.

## 24. Collective Evidence Tells Us About Current Provision:

- Current multi-agency responses are not making an impact on preventing the escalation of DVA (to high risk). This also impacts on the evident failure to break the often inter-generational cycles of abuse.

- The high volume of DVA reports in Southampton inevitably has impact on capacity of provision and the quality of time given to each case especially at high-risk level can be compromised.

- MARAC (multi-agency risk assessment conferences) are adversely impacted by high volume of cases, but our Case Reviews also suggest gaps and duplication in our joint work at this level, including taking account of risks such as self-harm by victims or integration of risk assessments across the whole family.

- There is no continuum of support to victims, especially at medium-risk level enabling families to step down from high risk or preventing them from escalating to high risk.

- Funding of domestic and sexual violence provision is predominantly at high-risk level. Over 75% of (commissioned) investment in DVA is spent on high and high-medium risk responses, with refuge provision accounting for most expenditure. Up to a third of current funding is from national grants resulting in short-term contracts and an unstable funding position.

- There are gaps and duplication in the multi-agency response to DVA, particularly gaps in joint work with Adult Mental Health, child and adolescent mental health and substance misuse services.

- Despite PIPPA providing a single point of contact and some joining-up of Domestic and Sexual Violence specialist services there is no resource to co-ordinate violence and abuse responses strategically or operationally. Therefore, synergies and efficiencies between services are not exploited to the full.

- The national risk-based model for DVA is adult victim focused, and although there is evidence that protecting the adult victim does help protect their children, the complex nature of violence and abuse suggests an adult-led service can mask the needs and experience of children affected. This is reinforced by our local Case Review findings.

- The widely recognised problems practitioners face and the tensions and contradictions between Domestic Violence specialist services, Child Protection and contact duties[7] requires robust and joined-up multi-agency responses. In particular, recognising and improving the impact that DVA has on parenting and child contact concerns is essential.

- There is no investment in perpetrator schemes aimed at changing attitudes and behaviour in the city other than those mandated by court. There is little evidence of "what works" to reduce and prevent DVA offending. Although recent research (Mirabel) does suggest an increase in safety to both victim and children, from perpetrator programmes this is still within a limited

[7] *The Three Planets Model – Towards an Understanding of Contradictions in Approaches to Women & Children's Safety in the context of Domestic Violence: Marianne Hester 2011*

range of tested interventions. All local evidence including views of survivors, front line workers and partnerships, as well as our Case Reviews, strongly emphasised the need for a step change from assessment to interventions that can enable attitude and behaviour change of perpetrators and those at risk of becoming violent and abusive. We also need to re-assess "what success looks like" in terms of perpetrator programmes and responses, with risk reduction to victims and their children as the primary measure.

- Refuges in Southampton provide 20 bed spaces for short-term crisis accommodation for victims of DVA and their children. As part of informal reciprocal arrangements these occupants may not be local residents - currently 69% of refuge spaces are occupied by DVA victims from outside Southampton. Our local accommodation needs are therefore affected by refuge provision cross-border. Other factors such as the length of stay, the levels of risk and outcomes in terms of reduced re-victimisation also affects the effectiveness of this provision. Other safe housing options that enable victims and their children to stay in their own homes is often preferable. Local housing and homelessness responses, as well as new legislation to remove perpetrators from their homes for up to 28 days can positively change the way safe accommodation is delivered in the City. A small reduction in this high-cost provision could contribute to the increase in earlier interventions occupied by DVA victims from outside Southampton.

- There is no current network or forum co-ordinating the wide range of services that could be involved in this area, such as those at universal level (for example schools, primary health care) as well as local communities, service-users or survivors. Again, a consistent view from partner agencies is that more focus and support to the wider range of services such as schools and health providers, needs to continue and be strengthened, while positive action to build community participation in this areas is also needed.

## 25. Our Ambitions (Aims)

Evidence tells us we need 4 clear Ambitions to underpin our Plan and all our future work in this area, as follows:

i. **Put Safeguarding Children and Young People (CYP) at the heart of our city-wide ambition for reducing violence and abuse**: We need to provide both specialist support for CYP and families, and to improve identification and responses to violence and abuse within Universal and mainstream services that have contact with CYP. Local systems and processes for safeguarding children need to be part of clear pathways to support and integral to the partnership response to violence and abuse, for example joining-up MARAC and MASH. We need to address the emotional, psychological and physical harm to CYP of violence and abuse and should match responses to the child's developmental stages. Interventions that aim to strengthen the relationship between child and non-abusing parent, such as effective parenting and family Recovery programmes or therapeutic support are identified as effective in

reducing harm. Our interventions need to reach young people including those experiencing violence and abuse in their own relationships.

In light of the evidence that suggests childhood exposure to DVA and child physical abuse are two of the most powerful predictors of both perpetrator and victimisation as an adult, interventions with CYP must address the longer-term harm caused by DVA. In addition, witnessing violence and abuse may increase the risks of broader family violence (child on parent), this familial abuse can also be a precursor to and cause of abuse in couples relationships later in life. Therefore, CYP interventions must seek to break the cycle of abuse.

A central element of our approach must include a "whole family" response focused on the risks and impact of DVA on the whole family. This will include exploring effective parenting models in the context of DVA, for example the Safe Engagement Model (Minnesota) and the Nia Project (Jacana Parenting Service).

ii. **Establish More Preventative and Early Intervention Provision**

While the Early Intervention Foundation (EIF) acknowledge a paucity of evidence-based preventative practice in this area, it is widely accepted that earlier intervention, both in the early years of a child's life and as problems are emerging are most effective in terms of cost and outcomes. It is suggested by EIF that there is an imperative to develop a suite of stronger preventative practice including that targeted at perpetrators or those at risk of offending. This should include cognitive behaviour therapy, relationship and family work, early help with substance misuse treatment, and all should be culturally specific.

We should be providing awareness campaigns and education in schools and youth settings that promote healthy relationships and challenge attitudes that tolerate violence as preventative measures. Evidence (Social Justice Centre) also suggests that universal and targeted well-being and mental health services available in schools can ensure children who have experienced DVA, receive the timely and non-stigmatising help they need to flourish. We should also ensure that existing early help interventions such as Family Nurse Partnerships, Early Help teams, parenting programmes and family work pro-actively includes identification, assessment and responses to DVA. Local interventions should also specifically include males, for example in Family Man or other fathers' programmes.

There is increasing evidence of the effectiveness of building "resilience" in children so they are more able to adapt well to adversity, stress or trauma. Building a co-ordinated whole systems response, involving schools, universal services and family support is a way of disrupting potential mental health problems early. HeadStart and other programmes (a CAMHs co-commissioning project) aim to improve CYP resilience and DVA will be an important element of this emerging area of activity.

iii. **Have a Co-ordinated Community Response (CCR)**

CCR is a widely recognised blueprint against which local services can map provision and strengthen partnerships. It requires co-ordination of partner agencies, survivors, communities, families and friends of those experiencing DVA. This embraces the broad principles of a "whole systems" approach. Here we need to ensure effective partnership working, strategic and operational co-ordination and joint commissioning of services. A co-ordinated approach requires evidence that interventions and support reach and benefit those who find it difficult to access services including people from black and minority ethnic groups or with disabilities, older people, trans people and lesbian, gay or bisexual people and includes those with no recourse to public funds. Through strategic co-ordination quality assurance standards are set, monitored and performance measures are used to shape and change service delivery. A specific role or resource needs to be identified to ensure the requirements of a co-ordinated community approach are achieved.

A CCR approach must also recognise the role of Universal Services, including Health settings, schools and voluntary sector provision in the identification of DVA, assessment and referral (Ask & Act approaches). Evidence suggests a single point of contact (such as PiPPA in Southampton) for professionals to get advice, co-ordinated training and workforce development, with clear multi-agency care pathways to support, does significantly improve outcomes. There is also a case, based on evidence and local feedback to this Plan, for exploring innovative ways in which Universal Services, particularly schools, colleges, early years settings and health services can provide support to children and families experiencing or impacted by DVA.

iv. **Ensure We Protect and Prosecute**

We need to co-ordinate multi-agency services and expertise to reduce risks to victims and their children, specifically reducing repeat victimisation and the longer term harm caused by violence and abuse. At the same time, we also need to ensure perpetrators are held to account, brought to justice and provided with opportunities for change in a way that maximises safety and reduces repeat offending.

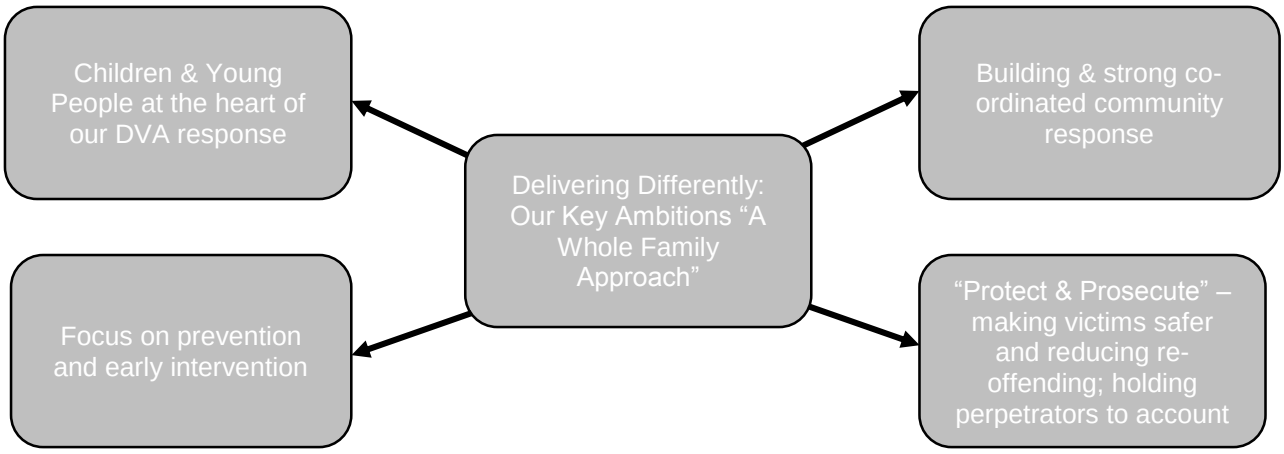
The evidence shows the most effective risk reduction intervention for DVA at highest risk level is IDVA (Independent Domestic Violence Advocates) providing intensive crisis advocacy including criminal and civil remedies and a wide breadth of support. Southampton performance from IDVA support is above national average in terms of reducing repeat victimisation; 78% of high risk victims do not experience violence or abuse after an IDVA intervention. 70% of IDVA clients report risk reductions across a breadth of risk types. Whereas research has failed to evidence effective outcomes from the limited range of perpetrator programmes (reduced risk of recidivism of only 5% after perpetrator interventions, with very high "drop out" rates 37-40%). Both nationally and locally, it is well recognised that new ways of working with perpetrators, including models that recognise co-offending and co-dependency (both parties offending) and situations where families remain

together, need to be developed. This must include more effective, timely and appropriate risk assessment and a "menu" of interventions (rather than "one size fits all"). Interventions must be timely, for example, after release from custody and should be innovative, with a clear focus on reducing harm and increasing victim safety. Skills development of key workers needs to include approaching and working with perpetrators. Some restorative justice models, are also identified as potentially effective in addressing perpetrator behaviour at low risk and early intervention stages. Community-based and universal provision should include early intervention work with perpetrators and those at risk of offending, but partnership working must also specifically and proactively focus on serial and prolific perpetrators and increasing successful prosecutions.

Partnership working must also recognise and address the well-established links between Adult Mental Health, Substance Misuse and DVA. By harnessing expertise in these areas within a co-located partnership team, as well as ensuring violence and abuse are key elements of these commissioned services, improved collective responses and outcomes will result. Specifically, risk assessments must include identification of self-harm as well as perpetrator abuse, and support must be tailored to meet individual needs, including evidence-based treatment for those with mental health conditions.

## WHAT WE NEED TO DO NOW

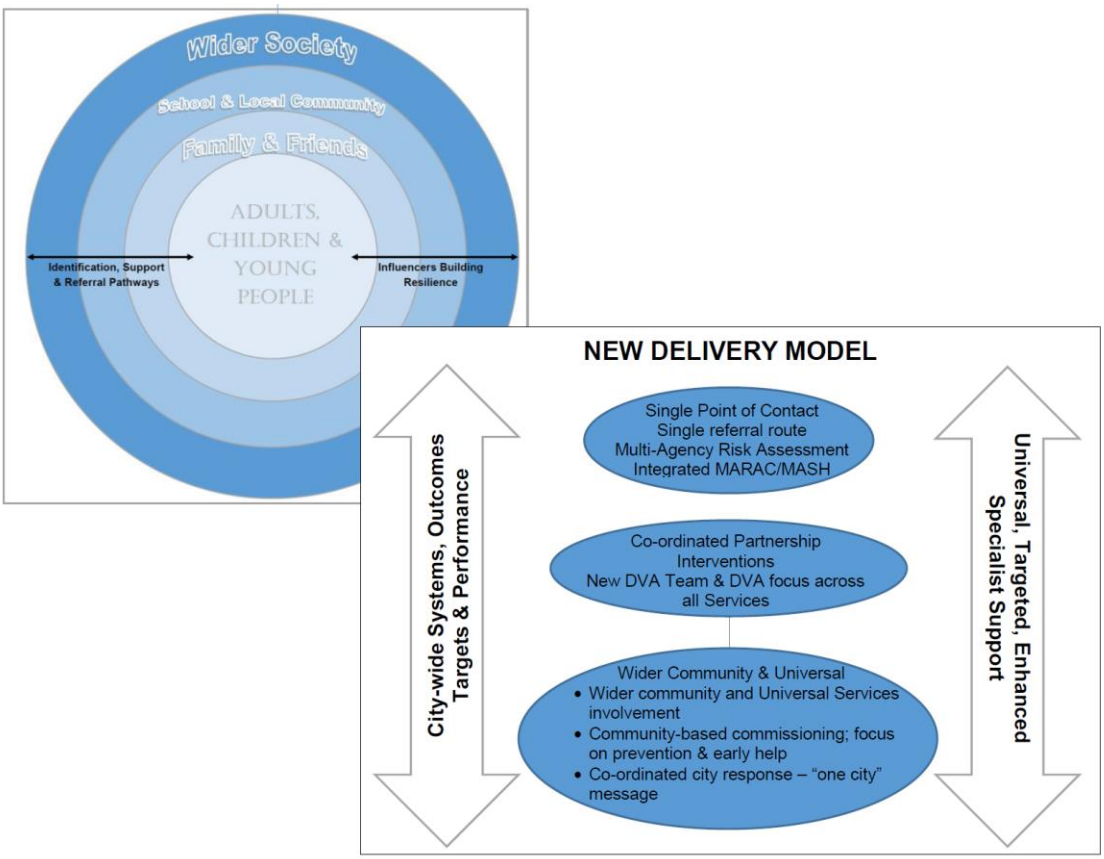
26. Based on the research, evidence and consultation described in this Plan, we propose to develop and deliver a cohesive response to DVA, embracing a co-ordinated community approach and driven by a new joined-up delivery model. This model will be underpinned by our 4 key ambitions, as described in paragraph 25.




27. Our new approach to DVA will place adults, children and young people at the heart of our city-wide response, so we ensure our existing and new actions to prevent and reduce DVA reflect the views and needs of those affected directly or indirectly by violence and abuse. We will recognise the key people influencing and shaping the lives of every child and family and the importance of all working together.

Therefore, our approach will pro-actively engage and involve families, friends, universal services such as schools, health providers and workplaces, communities, as well as specialist services. By looking at the whole community or system response, we will not only maximise capacity to identify and respond to DVA, but we will begin to influence and shape attitudes and behaviours, and build resilience in individuals, families and communities.

28. In this way, we will make tackling DVA "everyone's business". We will support our co-ordinated community response through commissioning services in a single framework that specifically includes funding to support voluntary, peer and community involvement. We will also build community networks and forums, and provide joint communications and campaigns as part of our new Delivery Model. All new services and activities should reflect the evidence in this Plan and the views and experiences of stakeholders. With additional external partnership grants, we will ensure DVA is a key element of wider programmes such as HeadStart.




29. We will also establish a new Delivery Model that has 4 critical elements:

1. A single commissioning framework for community-based domestic and sexual violence provision and responses.
2. A new multi-agency, integrated DVA Team.
3. A new joint risk assessment model, integrating MARAC (DV multi-agency risk assessment) and MASH (multi-agency safeguarding hub).

4. A co-ordinated community response. This embraces a "whole systems" approach.

## 30. COMMISSIONING OF DOMESTIC SEXUAL VIOLENCE PROVISION

We will commission a co-ordinated community and voluntary sector response that focuses on prevention & early intervention. This includes support to children and adults after violence or abuse has ceased to prevent recurrence of abuse or repeat behaviour (breaking cycles of abuse) and to address the longer-term harm caused.

It also covers community involvement ensuring our diverse communities and vulnerable community groups are engaged and supported. This element of the Plan will include Sexual and Domestic Violence and Abuse provision, recognising the synergies and efficiencies of joint work, especially at a community-based level, across these two areas.

31. This element of our model includes:
- Education and public awareness – city-wide and targeted campaigns.
- Recovery measures including group and therapeutic support or counselling with a focus on children and families affected by DVA or Sexual Violence & Abuse
- Contributing to a multi-sector helpline or other access to advice, such as PiPPA single point of contact
- Actions to develop a strong volunteer involvement, peer support and community-led approach
- Access to advice and support particularly at standard and medium risk levels. This could include an Educator-Advocate model and will require work in Health settings as well as other Universal Services such as schools.
- Elements of perpetrator interventions to compliment perpetrator work of the integrated partnership team. Here focus will be on earlier interventions.
- This will also include refuge provision.

32. This element of the Model will be funded through re-shaping currently commissioned and grant-aided services focused on Domestic & Sexual Violence via Integrated Commissioning and a single Domestic & Sexual Violence framework. This element of the model could be additionally supported by maximising external grant opportunities. This area of activity will also be supported through linked strategies and programmes, including the Prevention & Early Intervention Strategy, commissioned Parenting Programmes, HeadStart (including activities to promote emotional well-being and resilience in schools) and Families Matter (Troubled Families).

## DEVELOPING AN INTEGRATED MULTI-AGENCY TEAM

33. We will establish a new multi-agency team that will bring together statutory partners to directly provide comprehensive interventions for Domestic Violence and Abuse at high risk levels. We will also pro-actively improve practice and response to medium risk DVA through mainstream provision including Early Help teams.

34. This new team will also develop and deliver new interventions to change perpetrator behaviours and reduce re-offending. The focus here will include safeguarding children and young people through improved joint practice across services & agencies.

    This element includes:
    - Direct response to reduce risks to victims and their children at high or high/medium risk of harm from DVA.
    - This team will include IDVA's (Independent Domestic Violence Advocates) and statutory Child Protection response.
    - Joint working with Police and Probation to maximise use of civil and criminal justice remedies; increase successful prosecutions, and reduce re-offending.
    - Perpetrator work – casework and group work challenging and changing patterns of behaviour, where safe and appropriate as part of a whole family response. This will include parenting support and improved responses to child contact.
    - Workforce development-training, systems and pathways to support to integrate and strengthen safeguarding children and adults in this area through joint work with Early Help and specialist social work teams
    - Close links with Housing and homeless services to provide a breadth of safe housing options, and links to refuge provision.
    - Drawing on expertise in Adult Mental Health and Substance Misuse to ensure effective co-ordinated responses to need.
    - Close working with Public Health and Health partners to ensure joint work with Health providers and outcomes relate to Health prevention and promotion.
    - Development of joint work with Education, Schools and Colleges.

## ESTABLISHING A NEW JOINT RISK ASSESSMENT MODEL

35. This element of the model will identify and assess risk, to strengthen multi-agency partnership working to protect victims and children and hold perpetrators to account for their behaviour.

    This element includes:
    - Development of an integrated MARAC/MASH bringing DVA and Safeguarding risk assessment together.
    - Strengthening MAPPA and Integrated Offender Management links to the DVA Model.
    - Developing through new partnership arrangements better means of identifying and pursuing priority, multiple and/or serial perpetrators.

- Ensuring effective and maximum use of new powers and legislation such as DV Protection orders (to remove and keep perpetrators from their homes for up to 28 days – to provide time for victims to determine options and actions).

36. Most costs attached to the latter two elements of the Model (multi-agency team and joint risk assessment) are already part of mainstream partnership budgets. By bringing key partners together under a co-located, multi-agency team, there will be cost efficiencies as well as improved outcomes. Although most of the resources for this element will be achieved through reshaping existing staff and resources, additional funding will be identified, for example from the Office of the Police & Crime Commissioning, Troubled Families and other external funding streams.

## A CO-ORDINATED COMMUNITY RESPONSE

37. As part of the new DVA Delivery Model, an alliance of both specialist services working together, plus a wide forum of partner agencies and communities will join-up under the 'Co-ordinated Community response' model.

    This element includes:
    - Statutory and voluntary sector services co-managing and staffing the PIPPA single point of contact for advice and referral, including case support.
    - Cross-sector training for professionals.
    - Co-ordinated development and delivery of parenting programmes and DVA responses from Universal Services.
    - Development and co-ordination of networks and forums.
    - Communications and campaigns.
    - Stakeholder and User consultation and involvement.
    - Workplace policies and awareness of DVA.
    - Co-ordination of voluntary, peer and community support.
    - Strategic and performance management.

38. This element of the DVA Delivery Model will be overseen by the Service Manager of the new DVA Partnership Team, working closely with the Lead Commissioner for DVA provision. Resources will be identified to develop the CCR approach.

## MAKING A DIFFERENCE: OUTCOMES

39. As part of the DVA model, we will be developing a single performance and outcomes framework for DVA. This will include collation of a key data set from all relevant services and developing a comprehensive set of measures to assess "success". This Plan provides early draft performance measures that will be further developed in 2015/16.

40. By 2017, we aim to:
    - Ensure every child & young person receives intensive multi-agency support where DVA risk to parents is high and seen by MARAC).
    - Reduce repeat victimisation - in at least 85% of high risk cases DVA ends after intervention.
    - Increase support to “medium risk” adults by 20% and reduce escalation to high risk and high cost provision.
    - Increase the number of perpetrators engaged in interventions by 25%.
    - Increase public, universal and community awareness of DVA.
    - Increase take-up of early intervention activities by 30%.
    - Increase the identification and response to DVA within diverse communities and amongst disabled people.
    - Increase the number of children and young people participating in activities that build their resilience.

    Longer term, we aim to:
    - Reduce the number of adults and children experiencing DVA.
    - See a reducing trend in high risk referrals.
    - Reduce re-offending.

# DVA OUTCOMES & PERFORMANCE FRAMEWORK

- Outcomes and monitoring data will be collected and reported to the DVA Strategy Group and on to the DVA Operations Group, LSCB, LSAB and Safe City Partnership.
- The outcome measures here seek to measure success against the core ambitions set out in the DVA Plan 2015 – 2017.

## Children are at the heart of our DVA response

**AIMS:**
- Children & Young People (CYP) are safer and no longer live in violent homes.
- CYP are helped to build resilience and the long term impact of DVA is mitigated.

**OUTCOME MEASURES:**
- Increased number of CYP in high risk families receive intensive support.
- More CYP participate in activities that build resilience.
- More victims and their children receive integrated, multi-agency support based on a whole family assessment of risk and needs, resulting in increased safety and well-being.
- Reduced repeat referrals (for DVA & safeguarding) to MASH in 12 months.
- Increased number of 16-17 year olds (perpetrating or experiencing DVA) access help.
- Reduction in child Protection Conferences where DVA is a factor (due to successful earlier interventions).
- CYP views and needs are heard.

## Provide more prevention and Early Intervention measures

**AIMS:**
- Adults & families are helped earlier and fewer victims escalate to higher risk levels.
- More people are aware of DVA and its' impact

**OUTCOME MEASURES:**
- Increase in number of adults and children taking up Early Intervention services (with evaluated outcomes).
- Increase in non-police referrals (identification & "screening" by other services).
- Increase in the number of families experiencing DVA with CYP receiving age appropriate family interventions.
- Service-user satisfaction and feedback shapes services and evaluates outcomes.

## Protect & Prosecute

**AIMS:**
- Reduction or cessation in risk and experience of DVA
- Reducing re-offending

**OUTCOME MEASURES:**
- Reduction in repeat victimisation by reducing re-referrals to MARAC/MASH in 12 months.
- Increase the number of medium risk victims receiving help.
- Increase the number and percentage of risk cessation or reduction (measured by risk scales) after intervention.
- A reducing trend in high risk referrals.
- Increase number of successful prosecutions, victimless prosecutions and/or Court outcomes and/or use of legal powers.
- % reduction in proven offences of DVA for service-users.
- Increase in identification & assessment of perpetrator risks in whole family assessments.
- Increase number of perpetrators engaged in interventions.
- Increase engagement rates in services.

## Establish a co-ordinated community response

**AIMS:**
- Increase the involvement of families & friends, Universal Services and communities in DVA responses.
- Ensure DVA support reaches all communities and groups.
- Increase awareness of DVA and its impact.

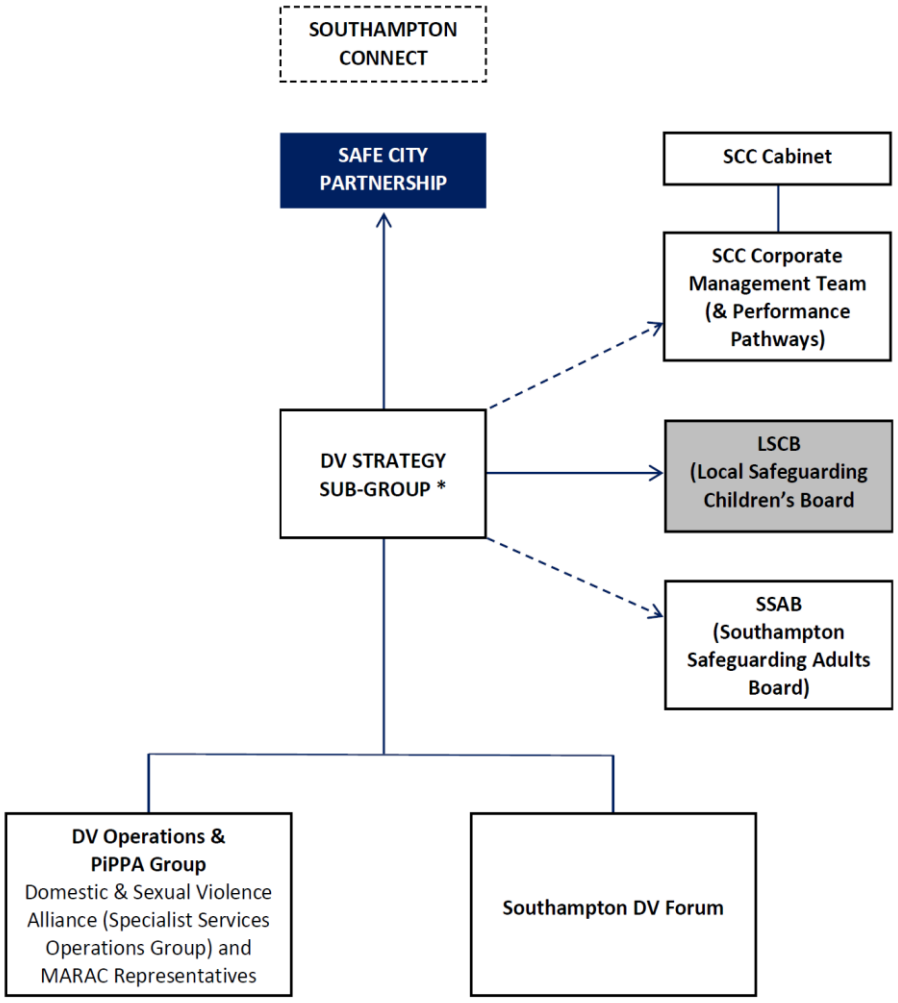
**OUTCOME MEASURES:**
- Increase public awareness of DVA, its' impact and where to go for help.
- Service usage reflects demographic profiles – including men.
- Increase number of volunteers & peers engaged in DVA responses.
- Increase number of employees trained & aware of DVA.
- Increase of identification assessment and response to DVA in Universal Services

## 41. HOW WE GET THERE:

**Action Plan:** A separate Implementation Plan is available from March 2015. This provides details of the next stage of development and delivery. It also provides a detailed Action Plan.

**Finances:** There is no additional or new funding from SCC or Partners to deliver this Plan. Some external grants, for example Office of Police and Crime Commissioner and Troubled Families (Families Matter), Home Office funding, will support these ambitions. However, relevant partner agencies have agreed to pool existing budgets and bring together existing resources to maximise our joint capacity and achieve efficiencies that will help to drive the Model and outcomes in this Plan.

**Governance:** This Plan and related matters regarding DVA is led by the Domestic Violence Strategy Group, chaired by the People Director, with senior-level multi-agency membership. That group reports to the LSCB and Safe City Partnership.



## APPENDIX 1: Draft DVA Dataset

| Core Goals Outcomes | Measures | Baseline @ Apr 2015 | Q1 Latest Results | | | | Source | Target | Direction of Travel | National Comparison |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | Q1 | Q2 | Q3 | Q4 | | | | |
| 1. **Put Safeguarding Children at the heart of DVA Response** | • Increase the number of CYP in high risk families seen at MARAC receiving intensive support (from Children's Services). | 49% | | | | | C&F Services | ↑50% | ☝ | - |
| | • Reduce repeat referrals for DVA to MASH within 12 months. | TBC | | | | | MASH | ↓5% | ☟ | • For CIN but not CIN with DVA |
| | • Increase number of YP aged 16 or 17 identified and receiving support. (Measures improved identification) – includes both perpetrating & experiencing DVA. | (High risk) 16 2.7% of all MARAC cases | | | | | MARAC & IDVA | No target set | ☝ | • MSG & National<br>• Average 5.5<br>• Rank is best of 15 |
| | • Reduction in Child Protection Conferences where DVA is a factor (due to earlier successful interventions). | 80% | | | | | C&F Services | 70% | ☟ | - |
| | • More CYP participate in activities that build resilience | TBA | | | | | C&F Services HeadStart | TBA | | - |
| | • Number of whole family DVA assessments completed at identified risk levels. | Whole assess:<br>High risk –<br>Med.risk –<br>Low risk – | | | | | All providers | TBA | ☝ | - |
| | • CYP views are heard; number of consultations and/or service-user feedback activities. | TBA | | | | | All providers | TBA | ☝ | - |

| Core Goals Outcomes | Measures | Baseline @ April 2015 | Q1 Latest Results | | | | Source | Target | Direction of Travel | National Comparison |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | Q1 | Q2 | Q3 | Q4 | | | | |
| **2. Provide more prevention and Early intervention measures (this includes improved identification of DVA)** | • Increase in number of adults and children taking up Early Intervention services (and evaluation evidences positive outcomes). | Not yet available | | | | | All commissioned providers | ↑30% | ☝ | - |
| | • Increase in non-Police referrals (identification & screening) by other (non-Police) services. | 19% | | | | | MARAC & PiPPA | 29% | ☝ | • Average of MSG 56% |
| | • Increase in the number of families experiencing DVA receiving age-appropriate family interventions | X number of family interventions | | | | | All providers | ↑10% | ☝ | - |
| | • Number of service-user feedback comments received.<br>• Number of service-user consultation reports. | TBA | | | | | All providers | | | |

| Core Goals Outcomes | Measures | Baseline @ April 2015 | Q1 Latest Results | | | | Source | Target | Direction of Travel | National Comparison |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | Q1 | Q2 | Q3 | Q4 | | | | |
| **3. Protect and Prosecute** | • Reduction in repeat victimisation % re-referrals (repeats) to MARAC/MASH within 12 months. | 22% | | | | | MARAC | 17% ↓5% | ☝ | • National average 24% |
| | • Increase in the number of medium risk victims receiving help. | TBA | | | | | C&F & other case-holding providers | ↑25% | ☝ | - |
| | • % reduction in proven offences of DVA for service-users (perpetrators) | Number of proven offences at entry to intervention | | | | | Police | ↓20% after inter-vention | ☝ | - |
| | • Increase in no. of:<br>Successful prosecutions:<br>Victimless prosecutions:<br>Successful Court outcomes: | TBA* | | | | | Police/CPS IDVA/DV Team | TBA | ☝ | - |
| | • Increase use of DVPO | TBA | | | | | Police | TBA | ☝ | - |
| | • % of risk cessation and reduction (overall and by type) before and after intensive intervention. | 70% | | | | | IDVA/DV Team | 80% | ☝ | - |
| | • % engagement rate in services (victims, CYP and perpetrators) | Victims 63% | | | | | IDVA/DV Team | Victims 70% | ☝ | - |
| | • Number & % of high risk referrals fallen below "high risk" threshold (as measured by CAADA dash) after intervention. | TBA | | | | | DV Team | 70% | ☝ | • Troubled Families indicator |
| | • Increase in identification and assessment of perpetrator risks in whole family assessments. | | | | | | | | | |
| | • Increase in number of perpetrators engaged in interventions. | TBA | | | | | All | ↑25% | ☝ | |
| | No. (and trend) of high risk referrals to MARAC/MASH<br>Total + CYP | Total – 620<br>CYP = 875 | | | | | MARAC/ MASH | ↓10% | ☝ | • Total – 322 MSG/289<br>• CYP: 303 MSG<br>• 281 Nat. Ave. |

| Core Goals Outcomes | Measures | Baseline @ April 2015 | Q1 Latest Results | | | | Source | Target | Direction of Travel | National Comparison |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | Q1 | Q2 | Q3 | Q4 | | | | |
| **4. C-ordinated community responses** | • % reduction in proven offences of DVA for service-users. | TBA | | | | | All perpetrator service providers | ↑5% | ☝ | - |
| | • Increase in public awareness of DVA, its' impact and where to go for help. | Measure to be agreed | | | | | C&F Services | TBA | ☝ | - |
| | • Service usage reflects demographic profiles for the City (range of service-users to be expanded):<br>• % of BME referrals (high risk)<br>• % LGBT referrals<br>• % Disability referrals<br>• % male victim referrals<br><br>Target based on profile gap | 12.7%<br>0.5%<br>12%<br>7.7% | | | | | MARAC but to be expanded | To match community profiles | ☞<br>☝<br>☝<br>☝ | To be added |
| | • Increase number of volunteers supporting DVA objectives | TBA | | | | | Commissioned Services | TBA | ☝ | |
| | • Increase number of referrals to services from family & friends | TBA | | | | | Community MASH | TBA | ☝ | |
| | • Number of public awareness activities and public feedback. | 1 | | | | | LSCB | TBA | ☝ | |
| | • Number of DVA training sessions and number of attendees (PiPPA) | | | | | | | | | |
| | • Increase of identification and assessment response to DVA in Universal Services | | | | | | | | | |