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Executive Summary

Hampshire’s strategy to tackle the serious and significant problem of domestic violence and abuse (DVA) is built around the four key aims of: promoting healthy relationships and preventing abuse from starting; ensuring victims are protected and supported, reducing the impact of abuse on children, families and communities; and reducing the number of those who perpetuate abuse.

This is a strategy that recognises that many, if not most DVA situations are complex. It recognises that domestic violence and abuse takes many forms, and can happen to anyone, regardless of age, sex, income, ethnicity, geography or status. DVA is often hidden, and is vastly under-reported. Because of this, the true prevalence can only be estimated; and in this report we refer to around 38,000 women, 17,000 men and 40,000 children in Hampshire who are likely to have been affected by DVA in the last year alone. It is a problem which has huge personal, social and economic costs and consequences.

The scale and the nature of DVA requires us to put in place services which are both responsive and proactive; providing timely and appropriate help to those who need it most and at the same time focusing on preventive activity. Prevention takes many forms, but it is essential that we tackle the behaviours and attitudes which allow DVA to continue. This means engaging with victims, perpetrators, children and communities, so that the causes of DVA can be understood and addressed.

As we come to consider how DVA services should be delivered from 2019, our commissioning process must be informed by a comprehensive understanding of the need in our community. This report aims to provide an assessment of those needs and to make recommendations based on best available evidence and local intelligence.

We have found that a large proportion of referrals into victim services come from police, indicating that many victims do not seek specialist help until the point where police become involved. There are very low numbers of referrals from healthcare and from vulnerable adults’ services, despite the fact that we know that many victims of DVA will have been in contact with these services. We need a strong and continuing focus on early identification, and support for healthcare professionals in particular, with clear and simple referral pathways and processes.

The effect of DVA on children is profound. We know that children who experience adversities in childhood go on to have higher rates of mental and physical health problems, and evidence suggests that children who see DVA in the home are more likely to become victims or perpetrators themselves. We have high numbers of children in these situations, yet relatively few of them are supported by specialist DVA workers. However, DVA is often experienced alongside other adversities, and alternative services for children are frequently involved. It is important to understand
the place of specialist DVA services in the system with regard to supporting children experiencing domestic abuse. A wider piece of work needs to be undertaken to ensure the services and interventions meet the needs of the population.

Compared to the number of victims, a small number of perpetrators are participating in prevention programmes. Although there is not yet a strong body of evidence supporting the effectiveness of perpetrator prevention programmes, for every victim there is a perpetrator and we know that a large proportion of both victims and perpetrators are ‘repeats’. Unless perpetrator behaviour is addressed, victimisation will continue. Victim and perpetrator services should work more closely together to ensure, as far as possible, a coordinated approach aimed at reducing the risks of re-victimisation and reoffending.

Services are accessed largely, and perhaps disproportionately, by heterosexual women. While there are many and varied reasons for this, we must ensure that services are available, accessible and sensitive to the needs of all our residents. This includes people with disabilities and people with specific cultural requirements, for whom shared refuge accommodation presents a particular problem.

Crisis accommodation (refuge) is highly valued as an essential element of service, providing a place of safety to those in immediate danger. However, it is not suitable for all people in need, particularly men, or women with high levels of need and complexity such as ongoing substance abuse or mental ill-health. It is also highly disruptive for victims and their children, who may wish to remain in their home and have the perpetrator removed instead. ‘Target hardening’ schemes, coupled with police-issued prevention orders, are showing early evidence of effectiveness and may in some cases avoid the need for victims and children to enter crisis accommodation.

This report gives us some insight into the challenges our services will have to address, but also allows us to reflect on the feedback we have received from stakeholders who work in, or refer to, Hampshire victim and perpetrator services. They value highly the advice and support they and their clients/patients receive from skilled, experienced, professional staff. Services are generally regarded as highly effective, flexible, empathetic and non-judgemental.

Moving forward, we must retain and build on these essential attributes. We need to work closely with the service providers and all relevant agencies to ensure that Hampshire’s DVA services for victims, perpetrators and families are coordinated, efficient and effective and that we make measurable steps toward prevention of DVA in our communities.
1. Background

1.1 Definition of domestic violence and abuse (DVA)

The most important legislative change in recent years concerning DVA was the recognition, in 2015, of ‘coercive control’ as a specific criminal offence. This led to a new cross-Governmental definition of DVA as:

‘...any incident or pattern of incidents 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 and emotional.

Controlling behaviour

Controlling behaviour is a range of 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 regulating their everyday behaviour.

Coercive 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 their victim.¹

1.2 National picture

Domestic violence and abuse is a significant problem which can affect people from any background, at any age. In England and Wales, for the year ending March 2016, an estimated 2 million adults aged 16-59 experienced domestic abuse in the last year.² This represents an estimated 1.3 million women and 700,000 men. For the same year, 1,031,120 domestic abuse-related incidents and crimes were recorded by the police, of which 41% were subsequently recorded as crimes.³ Overall, 26% of women and 14% of men have experienced domestic abuse in their adult lifetime.⁴

Of the >1 million domestic abuse-related incidents and crimes, 78% were recorded as violence against the person offences. 3% - 13,120 cases – were sexual offences. Overall, 11% of all crimes recorded by the police (excluding fraud) were domestic abuse-related.⁵

While both men and women can be victims or perpetrators of domestic abuse, women and girls are disproportionately affected. Women are more likely to experience more severe, more prolonged abuse. They are also less likely to be
economically independent and thus less able to escape from their situation. This is further compounded by the presence of children; it is easier for a single person to leave an abusive relationship than it is for a person with primary childcare responsibilities.

There were 432 domestic homicides recorded by police in England and Wales between April 2012 and March 2015. 73% (315 victims) were women. 77% of the 315 female victims were killed by a partner or ex-partner. 51% of the 117 male victims of domestic homicide were killed by a partner or ex-partner. 97% of the female victims were killed by a male suspect. 32% of men were killed by a female suspect. In the year ending March 2016, 92% of defendants in domestic abuse-related prosecutions were men. 83% of victims were women, 17% of victims were men.

It is important to note that, regardless of the gender of the suspect or victim, DVA is not limited to intimate partner situations. It can and does occur within other domestic relationships between family members. For example, there is increasing understanding of child to parent and adolescent to parent violence, and the need for supporting services. A number of recent domestic homicide reviews (DHRs) in Hampshire alone have also involved family members other than intimate partners, particularly where there is a caring role involved.

DVA situations can be complex and there is increasing recognition of bi-directional interpersonal violence (IPV); women can be abusive and violent too. However the way women are treated tends to be different – research indicates that female perpetrators are less likely to be arrested but actually more likely to externalise blame and to regard their own behaviour as in some way acceptable. Violence perpetuates violence – mutuality appears to be a risk factor for more frequent and more serious incidents. This emphasises the need for an approach which recognises the complex dynamics and personal histories which often underlie violent and abusive behaviours, and addresses them.

Domestic abuse is an under-reported and under-recorded crime. Estimates based on adults interviewed in the Crime Survey for England and Wales (CSEW) during the year ending March 2015 showed that around 4 in 5 victims (79%) of partner abuse did not report the abuse to the police.

The causes and effects of domestic violence and abuse are complex and multifactorial. As such, no response or preventive strategy can be unilateral. All will require multi-agency working involving police, victim and perpetrator services, health care, local authority (upper and lower tier), and other agencies, at local and national level.

Prevention of domestic abuse is everyone’s business.
1.3 HM Government’s Ending Violence against Women and Girls: Strategy 2016 – 2022

Reflecting the fact that domestic violence and abuse crimes are disproportionately gendered, the UK Government frames its approach within a violence against women and girls (VAWG) strategy, however with explicit recognition that men can be victims of domestic violence and abuse. Its approaches are intended to benefit all victims, regardless of gender. Building on its 2010 strategy ‘Our Call to End Violence against Women and Girls’; it sets out four ‘pillars’: prevention; provision of services; partnership working and pursuing perpetrators. It identifies a number of clear outcomes in its vision, which include the following aims (by 2020):

- There is a significant reduction in the number of VAWG victims;
- All services make early intervention and identification a priority;
- Women and girls are able to access the support they need, when they need it;
- Specialist support will be available for the most vulnerable victims;
- Services in local areas will work across boundaries in strong partnerships;

Women will be able to disclose experiences of violence and abuse across all public services, including NHS. Trained staff will help people access specialist support whether as victims or perpetrators

There will be a lower level of offending . . . and a greater focus on changing the behaviour of perpetrators;

A stronger evidence base of what works, and victim safety, will be embedded into all interventions.

The strategy recognises deep-rooted attitudes, beliefs and behaviours, based in discrimination against women and girls, which need to be challenged. It emphasises the importance of working with young people to build awareness of abuse and the ability to recognise unhealthy patterns and behaviours in relationships. It restates the 2010 strategy’s emphasis on primary prevention, early intervention and supporting professionals to identify and deal with abuse at its earliest stages; and recognises the need to provide services which can meet the needs of people from the many diverse sectors of society who may need support.

1.4 Hampshire Domestic Abuse Strategy 2017 – 2022

Hampshire’s strategy covers the Hampshire Local Authority Area, which includes 11 district councils. It does not include the cities of Southampton and Portsmouth.

Generally reflecting the UK VAWG strategy, it identifies four key aims (read across to UK strategy in parentheses):

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1 Promoting healthy relationships and preventing domestic abuse from starting (prevention);
2 Ensuring victims are protected and supported (providing services);
3 Reducing the impact of abuse on children, families and communities (providing services and partnership working);
4 Reducing those who perpetuate abuse and reducing unhealthy behaviour (prevention and pursuing perpetrators).

The strategy was co-written by the pan-Hampshire Domestic Abuse Steering Group (see Appendix i) and its aims are shared jointly by all relevant services and agencies represented on the Group. It is inclusive of all victims and perpetrators of violence and also aims to address the needs of children and young people affected by domestic abuse. It recognises that a coordinated effort is required to reduce and prevent domestic abuse in all its forms, and emphasises the need for an educative, preventive approach to ensure that attitudes which tolerate abuse are challenged.

1.5 Joint Targeted Area Inspection (JTAt)

Between 5 and 9 December 2016, Ofsted, the Care Quality Commission, HMI Constabulary, and HMI Probation undertook a joint inspection of the multi-agency response to abuse and neglect in Hampshire. This inspection included a ‘deep dive’ focus on the response to children living with domestic abuse. While the resulting report was largely very positive and recognised many areas of excellent practice, we are also mindful of the report’s comments on areas for improvement. Without repeating these recommendations in full, they included: improved consistency in approaches to children living with DVA and greater focus on routine enquiry; greater emphasis in healthcare setting on completing DASH risk assessments, and emphasis on a ‘think family’ approach in instances where multiple issues are evident.

1.6 Rationale for and aims of this needs assessment

As a local commissioner of DVA services, Hampshire County Council is guided by The National Institute for Health and Care Excellence (NICE) Public Health Guideline 50 ‘Domestic Violence and Abuse: Multi-Agency Working’. The recommendations state that we should:

**Recommendation 1: Plan services based on an assessment of need and service mapping**

- [In partnership] . . . assess the need for domestic violence and abuse services as part of the joint strategic needs assessment. Consult with women, men and young people who have experienced domestic violence and abuse
as part of this assessment. Commissioners of domestic violence and abuse services and related services should be aware of the importance of consulting communities that are rarely heard on this matter.

- . . . undertake a comprehensive mapping exercise to identify all local services and partnerships working in domestic violence and abuse. Map services against the Home Office-endorsed Coordinated Community Response Model and identify any gaps.
- . . . use the results of the needs assessment and mapping exercise to inform commissioning. They should develop referral pathways that aim to meet the health and social care needs of all those affected by domestic violence and abuse. This includes people with protected characteristics and those who face particular barriers trying to access domestic violence and abuse support services.
- . . . work [with regional and national commissioners of domestic violence and abuse services and related services] to ensure service support extends across local authority boundaries, where necessary, for services such as prisons that cover broader geographical areas.
- . . . work [with regional and national commissioners] to provide specialist services across local authority boundaries where there is not enough local need to justify setting them up within a particular local authority area.

Strategic partnerships should use the results of mapping in the joint strategic needs assessment and other strategic planning tools. They should also make the results widely available to all relevant services and the general public – for example, by publishing a directory of local and national services.

We are also informed by the Home Office ‘Violence Against Women and Girls: Supporting Local Commissioning’, December 2016 publication. This document aims to assist local commissioners in implementing the recommendations of the VAWG strategy through the commissioning cycle. It recommends that a needs assessment should consider the needs of all groups, framed in an equalities-based approach, and suggests that the needs assessment should enable commissioners to answer these questions:

- What do individuals who are part of the community identify as their needs?
- What needs are not being met by service providers?
- Does the identified need fit with your existing strategy?
- Do commissioners have the knowledge, skills and experience to consult with service users affected by violence and abuse?

Working on the basis of these recommendations, this needs assessment aims to quantify current need, describe current services, and thereby inform the commissioning of domestic abuse services in Hampshire.
1.7 DVA: Risks and Impact

In this report we refer to around 38,000 women and over 17,000 men in Hampshire who are likely to have been victims of domestic abuse in the last year. These are figures derived from combining national statistics on crime rates or other known UK prevalence rates with population statistics specific to Hampshire. This means that we are assuming that Hampshire is not significantly different to the rest of the UK in terms of patterns and rates of domestic abuse and violence. In reality, it may be better, or worse, but sufficient research has been conducted into domestic violence and abuse such that we may safely generalise some of the findings to our local population.

While legislation is gender neutral, as we have noted previously, women and girls are disproportionately affected by domestic violence and abuse. In addition, there are other risk factors associated with increased prevalence of domestic violence. These include:

- **Age:** Risk is highest in the younger age groups (16-19 and 20-24, for both men and women).\(^{13}\)
- **Having a long-term illness or disability** – women with a long standing illness or disability were more than twice as likely to report having been a victim of domestic abuse (15.7% compared to 6.2% who had no long standing illness or disability. An increased risk is also seen for men (7.3% compared to 3.9%))\(^{14}\)
- **Being divorced or separated:** over 20% of women and 13% of men who were separated/had legally dissolved partnerships, and nearly 19% of divorced women and 13.2% of men, compared to 3.6% (women) and 2.9% (men) of married respondents had experienced domestic violence in the last year\(^{15}\). Risk also increases around the time of separation\(^{16}\)
- **Employment status:** closely associated with long term illness/disability (above), 22.6% women classed as ‘inactive: long term/temporary sick/ill’ compared to 6.9 or women classed as ‘employed’ (men: 10%:3.8%)\(^{17}\)
- **Being pregnant or recently having given birth**\(^{18}\). Around 14,500 births are registered to women normally resident in Hampshire each year.
- **Sexuality/sexual identity:** Research by Stonewall\(^{19}\) indicates that 1 in 4 lesbian or bisexual women, and almost half of all gay or bisexual men report having experienced some form of domestic abuse. The extent of under-reporting may be higher than for people in heterosexual relationships, since coming forward will require the victim to disclose their sexuality to police or other authorities. Additionally, fear of being involuntarily ‘outed’ may in itself provide a means for an abuser to exert control. Although there is not a great deal of research into domestic abuse in the transgender community, there are indications that they
may experience even higher levels of abuse within intimate partner relationships.\textsuperscript{20}

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**In Hampshire, we estimate that there are . . .**

15,607 men and 30,083 women aged 16-59

734 men and 2,306 women aged 60-65

1,345 men and 5,615 women aged 66 and over

Including:

- at least 544 men and 705 women who identify as lesbian, gay or bisexual
- 1000 women and 368 men of Asian origin
- 481 women and 323 men of Black origin
- 13,296 women and 5,799 men with some degree of limiting disability or health problem

And over 40,000 children and young people under 18

**who have been affected by DVA in the last year.**

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The effects of DVA are serious and can be long-lasting, impacting the physical and mental health of victims and, very commonly, their children. In a study by Meltzer \textit{et al} in 2011, exposure to domestic violence and abuse was the most frequently reported form of trauma for children.\textsuperscript{21} It is often experienced alongside other forms of maltreatment, such as child abuse and neglect,\textsuperscript{22} further contributing to the risk of the children developing emotional and behavioural difficulties. Meltzer’s study reports that 30% of children who had witnessed severe domestic abuse had also been exposed to other trauma events, the most common being witnessing violence to other family members or friends, and the child having a serious and frightening accident. Importantly, there is also considerable evidence to suggest that adverse childhood experiences, including being exposed to domestic violence and abuse, lead not only to higher rates of ‘health harming behaviour’ as adults such as drug and alcohol misuse, smoking and poor diet;\textsuperscript{24} but also to a higher risk of being an adolescent\textsuperscript{25} and/or adult perpetrator or victim of violence, including intimate partner violence.\textsuperscript{26} Childhood exposure to inter-parental violence specifically, has been linked to increased risk of adult depression, alcohol dependence, intimate partner violence and child maltreatment.\textsuperscript{27} Thus, domestic abuse does not stop with the
primary victim – its effects on children contribute to an inter-generational perpetuation of violence, abuse, and poor health.

Domestic violence and abuse also creates significant social and economic costs. The last comprehensive analysis of the cost of domestic violence in the UK was in 2009\textsuperscript{28}, and concluded that costs to public services (criminal justice, health and social care, housing and civil legal services combined) totalled £3.85 billion in 2008. Additional cost to the UK in lost economic output as a result of domestic abuse for the same period was in the region of £1.92 billion. Human and emotional costs, in so far as it is possible to express these in financial terms, totalled nearly £10 billion – a combined total of almost £16 billion in 2008.

People’s experiences of domestic violence are vastly different. Services for victims must be responsive and flexible enough to offer support at different levels of intensity, depending on the victim’s needs or wants. This can range from emergency accommodation provision for individuals or families in immediate danger, to community based outreach or specialist safety advice, to referral for group, individual or on-line courses such as the Freedom Programme\textsuperscript{29}. However, it is not only specialist services that will come into contact with victims of domestic abuse – primary care, social services, emergency medicine and maternity services are key contact points, and simply responding appropriately to an initial disclosure, or having the skills and confidence to initiate a discussion with a client or patient who is giving cause for concern, can open a door and a way out of an abusive situation.

Domestic abuse frequently occurs or coexists alongside other adversities, often in complex relationship and family situations. Multiple disadvantages, such as mental health or substance misuse problems, and involvement with criminal justice services and social services – particularly in relation to children – are not uncommon. As the individual situations and circumstances vary, so does the type and degree of abuse suffered, and the individual’s perception of, and response to it. This again underlines the requirement for services to be flexible and responsive and for agencies to work together in an effective and coordinated manner.

1.8 Scope
In this report we will include:

- domestic abuse and violence, as defined above
- interventions for women, men and children who have been affected by domestic abuse
- interventions aimed at perpetrators
• children who have been affected by domestic abuse, and the services which support them.

We exclude:

• other children’s services, as these are covered by Local Authority Children’s Services
• female genital mutilation (FGM) and so-called honour based violence (HBV) because these are offences of a particularly complex nature which require a more specialised and detailed approach than this needs assessment can provide.
2. Assessment of need

2.1 Methodology and data sources
Obtaining data which are reliable enough to be used as a basis for service planning can be problematic for a number of reasons. First of these is that, while there is no shortage of data in terms of quantity, the way it is collected is complex - data are collected by a number of different agencies, in different formats and for different purposes. Secondly, the various agencies responsible for collecting data may not share the same geographical boundaries and therefore their datasets cannot be joined together – as examples; the geography covered by Hampshire Constabulary is not the same as that covered by Hampshire County Council, and there is also no relation between the districts within Hampshire and the boundaries of the area’s Clinical Commissioning Groups. While we can in some cases sub-divide and combine datasets, this report will necessarily include data from a number of sources and we will make clear where there are caveats around its interpretation.

Thirdly and most importantly is the problem of assessing need where the need is universally and consistently under-reported. Crime figures relating to domestic violence and abuse represent only a part of the problem; in many cases victims will not come forward either through fear, shame, or habituation to the abuse such that they minimise its seriousness. In other cases, what has occurred will fall short of the threshold for further action, and even where that threshold is passed and police are initially involved, a significant proportion of cases, for a number of possible reasons, will not be taken further.

Service usage data also cannot give a complete picture of the level of need. While we can assess the presenting need (the number of people using the various services) and the resource required to meet that need, there is also undoubtedly an unmet need in the community with potentially significant numbers of people who could benefit from services, not making contact. They may not know where to get help, or feel that services are ‘not for them’. They may come from a culture where engagement with services is discouraged, or they may actually be prevented from accessing services by an abusive or controlling partner. Admitting and accepting that domestic abuse is taking place, and seeking help – with all the consequences that may entail – is not a simple matter and it is safe to assume that the ‘numbers’ we see accessing services, or appearing in crime statistics, is an under-representation of the true level of need.

The Crime Survey of England and Wales (CSEW), formerly known as the British Crime Survey, is a face-to-face victimisation survey in which people resident in England and Wales are asked about their experiences of crime in the previous 12 months. Analysed and reported by the Office for National Statistics (ONS), it provides a better picture of the level of crime than police recorded statistics, as it includes
crimes which were never reported to, or recorded by the police. Self-completion modules are also included in the CSEW, for topics which respondents might feel uncomfortable about disclosing to an interviewer. This includes domestic abuse and sexual assault, thus providing privacy to the respondents and encouraging honest disclosure.

The CSEW definition of domestic abuse includes partner abuse (non-sexual), family abuse (non-sexual) and sexual assault or stalking carried out by a current or former partner or other family member. It may not completely capture the new category of ‘coercive or controlling behaviour’. Additionally, it does not include the experiences of adults 60 years of age and older.

For the purposes of estimating need in this report, we have used CSEW data for the year ending March 2016 and applied the published prevalence rates to the Hampshire population to derive our prevalence estimates for adults aged 16-59, and alternative sources for adults aged 60 and over. It is important to note that the true figure may be lower or higher, as for the reasons outlined above we can only estimate need from the data we have.

2.2 Descriptive data

2.2.1 Age and sex of victim
CSEW reports that in the year ending March 2016, 4.4% of men aged 16-59 and 7.7% of women in the same age group had been victims of domestic abuse within the last year. Broken down by age group and applied to the Hampshire population, this suggests that 15,607 men and 30,083 women in Hampshire in this age group have been victims of DVA in the last 12 months. Although risk is greatest in the 16-19 age group for both sexes (6.9% for men and 11.9% for women), in women the highest absolute numbers are in the 40-44 and 45-49 age groups. High prevalence in age groups of people most likely to have dependent children means of course that a large number of children will be involved in DVA situations.
Chart 1: number of adults aged 16-59 in Hampshire estimated to have been victims of domestic abuse in the last 12 months, by age group and sex.

### 2.2.2 Older adults

Older adults are not included in the CSEW. A 2007 UK Department of Health funded study estimated the prevalence of mistreatment among adults aged 66 and older and living in private households, at 2.6% (3.8% for women, 1.1% for men)\(^{30}\). The figure includes abuse perpetrated by partners and close family members, and excludes other possible perpetrators such as friends or care workers. Although the definition of ‘mistreatment’ is somewhat different to ‘domestic abuse’, it does include deliberate neglect, financial abuse, psychological, physical abuse and sexual abuse, and therefore may serve as a reasonable parallel.

Patterns in this age group largely reflect those seen in younger adults: higher prevalence in divorced or separated respondents compared to married respondents, increased risk associated with poorer health, and higher rates corresponding with lower socio-economic groups.

The reported rates are considerably lower than those suggested by the CSEW for the next nearest age group, those aged 55-59, which are 5.7% (women) and 2.2% (men). This may be partially explained by the method of data collection; CSEW uses an electronic self-reporting tool whereas the older adults were surveyed by face to face interview, except for the most sensitive questions on sexual abuse. This may have affected willingness to disclose abuse. Additionally, the authors note that adults with dementia or poor health which prevented them from participating in the survey were excluded. As we know that risk of abuse increases with increasing illness/dependency, it is very likely that this is an under-representation of the true figure. However, applying these conservative estimates to the Hampshire population
indicates that **1345 men and 5615 women in Hampshire aged 66 and over** may have experienced domestic abuse in the last year.

For the 60-65 age group, who are counted neither in the CSEW nor the UK report, applying a mid-point prevalence figure between the 55-59 age group and the 66+ age group of 4.8% for women and 1.6% for men indicates a **further 734 men and 2306 women aged 60-65 in Hampshire**, likely to have experienced DVA in the last year.

Added together, this gives an estimate of **38,004 women and 17,686 men in Hampshire**, likely to have been victims of DVA in the last year.

### 2.2.3 Ethnic group of victim

**Table 1: Percentage of adults aged 16-59 who were victims of intimate violence in the past year, by headline categories, personal characteristics and sex, year ending March 2016 (CSEW)**

<table>
<thead>
<tr>
<th></th>
<th>Any domestic abuse</th>
<th>Partner abuse (non-sexual)</th>
<th>Family abuse (non-sexual)</th>
<th>Sexual assault</th>
<th>Stalking</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M%</td>
<td>W%</td>
<td>M%</td>
<td>W%</td>
<td>M%</td>
</tr>
<tr>
<td>ALL ADULTS</td>
<td>4.4</td>
<td>7.7</td>
<td>2.8</td>
<td>5.4</td>
<td>1.8</td>
</tr>
<tr>
<td>White</td>
<td>4.7</td>
<td>7.9</td>
<td>3.1</td>
<td>5.6</td>
<td>1.8</td>
</tr>
<tr>
<td>Mixed/multiple ethnic</td>
<td>2.6</td>
<td>10.8</td>
<td>1.3</td>
<td>6.4</td>
<td>1.3</td>
</tr>
<tr>
<td>Asian/Asian British</td>
<td>1.8</td>
<td>4.6</td>
<td>0.6</td>
<td>2.6</td>
<td>1.5</td>
</tr>
<tr>
<td>Black/African/Caribbean/Black British</td>
<td>6.0</td>
<td>8.4</td>
<td>2.7</td>
<td>7.0</td>
<td>2.8</td>
</tr>
<tr>
<td>Other ethnic group</td>
<td>0.8</td>
<td>6.0</td>
<td>0.0</td>
<td>3.3</td>
<td>0.0</td>
</tr>
</tbody>
</table>

While the table above generally indicates a near-average prevalence in most categories for respondents from a White ethnic background, apparently higher prevalence in Black/African/Caribbean/Black British and Mixed/multiple ethnic groups and average or lower prevalence among Asian/Asian British respondents, it is difficult to draw any firm conclusions from this – other than the fact that domestic abuse and violence is experienced by people from all ethnic origins. Cultural values and norms will affect people’s perceptions of, and responses to, domestic abuse and violence, so under-reporting may be more of a problem for some communities than
others. Additionally, although the CSEW aims to capture responses from a diverse cross-section of the population, it is likely that some sectors, such as the Gypsy and traveller community, will not have been surveyed in sufficient numbers to enable a reliable prevalence estimate to be derived.

Hampshire’s population is predominantly White British – 89% of its inhabitants identifying as of White British origin in the 2011 census; significantly higher than the national average of 85%\(^\text{32}\). The next highest category is White Other, at 4%. 3.8% of the population is of Asian origin, 1.7% identify as ‘other’, and 1% as Black. However, patterns of ethnicity vary within the county; with greater diversity generally seen within urban areas. There are also some distinct populations within small areas, such as the Nepalese community in Rushmoor, which makes up 6.5% of that district’s total population. The 2011 Census recorded 2,069 Gypsies and Travellers living in Hampshire. However local data suggest that this is a significant underestimate.

On the basis of 2011 census data and assuming that the ethnicity-specific CSEW estimates are adequately representative of the experiences of the Hampshire population, we would expect numbers of people affected by domestic abuse to be as follows:

**Table 2: Estimated number of adults aged 16+, by ethnic origin, who have been affected by DVA in the last year, Hampshire**

<table>
<thead>
<tr>
<th></th>
<th>Women</th>
<th>Men</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of adults (16+) in Hampshire</td>
<td>572,048</td>
<td>537,612</td>
</tr>
<tr>
<td>%age of population of white origin</td>
<td>93%</td>
<td></td>
</tr>
<tr>
<td>Prevalence estimate (White)</td>
<td>7.9%</td>
<td>4.7%</td>
</tr>
<tr>
<td>Number of people affected (White)</td>
<td>42,028</td>
<td>23,499</td>
</tr>
<tr>
<td>%age of the population of Asian origin</td>
<td>3.8%</td>
<td></td>
</tr>
<tr>
<td>Prevalence estimate (Asian)</td>
<td>4.6%</td>
<td>1.8%</td>
</tr>
<tr>
<td>Number of people affected (Asian)</td>
<td>1,000</td>
<td>368</td>
</tr>
<tr>
<td>%age population of Black origin</td>
<td>1.0%</td>
<td></td>
</tr>
<tr>
<td>Prevalence estimate (Black)</td>
<td>8.4%</td>
<td>6.0%</td>
</tr>
<tr>
<td>Number of people affected (Black)</td>
<td>481</td>
<td>323</td>
</tr>
<tr>
<td>%age of population of ‘other’ origin</td>
<td>1.7%</td>
<td></td>
</tr>
<tr>
<td>Prevalence estimate (‘other’)</td>
<td>6.0%</td>
<td>0.8%</td>
</tr>
<tr>
<td>Number of people affected (‘other’)</td>
<td>583</td>
<td>73</td>
</tr>
</tbody>
</table>

*note that the overall number is higher than that previously quoted. This is because the table above uses an overall prevalence figure for the entire adult population rather than the more precise age-stratified estimates, which indicate lower prevalence in the older age groups.*
2.2.4 Marital status of victim
As noted earlier, there appears to be a significantly higher prevalence of DVA perpetrated against people who are single\textsuperscript{1}, divorced or separated, compared to married respondents.

Table 3: Percentage of adults aged 16-59 who were victims of intimate violence in the past year, by marital status, year ending March 2016 (CSEW)\textsuperscript{33}

<table>
<thead>
<tr>
<th>Marital status</th>
<th>men %</th>
<th>women %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married/ civil partnered</td>
<td>2.9</td>
<td>3.6</td>
</tr>
<tr>
<td>Cohabiting</td>
<td>4.5</td>
<td>6.6</td>
</tr>
<tr>
<td>Single</td>
<td>5.3</td>
<td>11.5</td>
</tr>
<tr>
<td>Separated</td>
<td>13.2</td>
<td>18.9</td>
</tr>
<tr>
<td>Divorced/ legally dissolved partnership</td>
<td>13.0</td>
<td>20.2</td>
</tr>
<tr>
<td>Widowed</td>
<td>-</td>
<td>7.6</td>
</tr>
</tbody>
</table>

A number of factors are likely to contribute to this pattern. Firstly, the CSEW asks about historic experiences and as such, victims of domestic abuse are quite likely to have been married or cohabiting at the time of the abuse, but single/separated/divorced at the time of responding. We also know that the risk of abuse and violence increases around the time of separation, so abuse may begin or escalate around this time\textsuperscript{34}. People who have already left an abusive relationship may also be more likely to disclose their past experiences than those who are still living with abuse.

2.2.5 Employment status of victim
There appears to be a marked increase in risk associated with the employment status of the victim – those in employment are less likely to have been victims than those recorded as ‘inactive’. As well as an increased risk where the employment status is described as ‘looking after family/home’ there is a markedly higher risk, particularly for women, where the status is ‘temporary/long-term sick/ill’. This appears to demonstrate an inverse relationship between whether people are economically active and in good health (and, by extension, independence) and victimisation.

\textsuperscript{1}‘single’ in this context means never married or recorded in a civil partnership and may therefore include people who are in a relationship but not co-habiting, according to the ONS Primary Set of Harmonised Concepts and Questions, v 3.1 May 2015 available at http://webarchive.nationalarchives.gov.uk/20160106185646/http://www.ons.gov.uk/ons/guide-method/harmonisation/primary-set-of-harmonised-concepts-and-questions/index.html
Table 4: percentage of adults aged 16-59 who were victims of intimate violence in the past year, by employment status, year ending March 2016 (CSEW)\textsuperscript{35}

<table>
<thead>
<tr>
<th>Respondent’s employment status</th>
<th>Men%</th>
<th>Women%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employed</td>
<td>3.8</td>
<td>6.9</td>
</tr>
<tr>
<td>Unemployed</td>
<td>7.6</td>
<td>9.4</td>
</tr>
<tr>
<td>Inactive</td>
<td>7.4</td>
<td>10.1</td>
</tr>
<tr>
<td>- Student</td>
<td>6.4</td>
<td>7.8</td>
</tr>
<tr>
<td>- Looking after family/home</td>
<td>11.6</td>
<td>8.2</td>
</tr>
<tr>
<td>- Long-term/temporary sick/ill</td>
<td>10.0</td>
<td>22.6</td>
</tr>
<tr>
<td>- Retired</td>
<td>4.3</td>
<td>3.6</td>
</tr>
<tr>
<td>- Other inactive</td>
<td>6.0</td>
<td>10.5</td>
</tr>
</tbody>
</table>

2.2.6 Presence of long-standing illness or disability

Looking more closely at long-standing illness or disability, we see similar patterns for both men and women, with the risk of victimisation increasing along with level of dependency/limitations of disability. Compared with a background figure of 4.4% for men and 7.7% for women, disabled people are twice as likely to have been victims of some form of domestic abuse.

Table 5: Percentage of adults aged 16-59 by illness/disability category, who were victims of intimate violence in the past year, year ending March 2016 (CSEW)\textsuperscript{36}

<table>
<thead>
<tr>
<th>Disability/illness status</th>
<th>men</th>
<th>women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long-standing illness or disability</td>
<td>7.3</td>
<td>15.7</td>
</tr>
<tr>
<td>- Limits activities</td>
<td>8.3</td>
<td>16.9</td>
</tr>
<tr>
<td>- Does not limit activities</td>
<td>5.2</td>
<td>11.0</td>
</tr>
<tr>
<td>No long-standing illness or disability</td>
<td>3.9</td>
<td>6.2</td>
</tr>
</tbody>
</table>

It should be noted that these figures cover only adults aged up to 59 years. As disability tends to be acquired or become more severe with age, it would be expected that a high proportion of people aged 60+ will be living with disability, and potentially, abuse. Although a link is clear, explaining the relationship between abuse and
disability is not easy. It may be that impairment increases the risk of abuse, or that abuse is causing or contributing to the impairment, or both.

In addition to being more likely to suffer domestic abuse, disabled people also experience more severe and more prolonged abuse. They are also more likely to suffer significant health impacts as a result. They are more likely to be isolated, and/or dependent and less able to access help or support. Evidently, there is a gender difference, as there is for non-disabled people. More specifically:

- More than one in three people with mental illness have experienced domestic abuse in the last year;
- Women with anxiety disorder are over four times more likely to experience domestic abuse;
- Men with PTSD are over seven times more likely to experience domestic abuse;
- Women with depressive disorder are over twice as likely than women without a mental illness to experience domestic abuse;
- People with intellectual disabilities were 1.6 times more likely to experience violence in the last year.

In the 2011 census, for the South East region, 9% of people reported being limited ‘a little’ by a health problem or disability, and 7% were limited ‘a lot’. This includes children and is not specific to Hampshire; therefore we cannot derive a precise estimate for the number of disabled adults in Hampshire who may be affected by domestic abuse. However, assuming the South East estimates are reflective of the Hampshire picture and that around 15% of the adult population (9% ‘a little’ and 7% ‘a lot’) are limited to some degree by health problems or disability, and applying the CSEW prevalence estimate of 7.3% of men and 15.7% for women, we find that 5799 men and 13,296 women in this group may have been affected by DVA in the last year.

2.2.7 People in same-sex relationships/LGBT+

Prevalence estimates of domestic abuse in same-sex relationships vary greatly, and there is comparatively little reliable research into the extent of the problem in the transgender population. Stonewall’s research suggests that around a quarter of lesbian women and a half of gay men will have experienced domestic abuse at some point. This is around the same as estimated lifetime prevalence in the general population for women (26%) and far higher than the lifetime prevalence for men in the general population (14%). A recent meta-analysis of literature relating to intimate partner violence between lesbian women (based on US studies) puts the estimated lifetime prevalence at 48% - however, as the authors note, sexual orientation can have fluidity over an individual’s lifetime: reported abuse may have happened in a previous same-sex relationship. They note also that lifetime
prevalence estimates tend to assume heterosexuality; in that they ask about the sex of the victim, not of the perpetrator, so that same-sex partner violence cannot easily be separated out from that experienced by the general population. This is certainly true of the CSEW prevalence estimates; which do not differentiate between abuse experienced by people in same-sex or heterosexual relationships.

Data on sexual identity in the UK is collected by the Office for National Statistics via the Annual Population Survey. 2016 statistics show that 2.3% of men and 1.6% or women in the UK identify themselves as gay, lesbian or bisexual. Regional estimates are not available, but if we apply the UK figures to the adult (16+) population of Hampshire, we can estimate that there are around 12,365 men and 9,153 women in Hampshire who identify as gay, lesbian or bisexual. If we further assume that the prevalence of domestic abuse is at least the same as that experienced in the general population (4.4% for men and 7.7% for women) it would suggest that in Hampshire, at least 544 men and 705 women who identify as gay, lesbian or bisexual have experienced domestic abuse in the last year. For gay men especially, this is likely to be an underestimate.
2.3 Prevalence of other factors

As outlined in 1.5 above, domestic abuse is often not experienced as a single issue. It frequently exists alongside other problems, in complex family or relationship situations. It is often difficult to disentangle these factors or to establish cause and effect in mental illness, for example: does mental illness increase the risk of being a victim of domestic abuse, or does being a victim of domestic abuse cause or exacerbate mental illness? What role does substance abuse play in increasing risk? As well as emphasising the complexity of issues at play, data from other services can serve a useful purpose: it can provide an alternative route to connect with people who may not identify domestic abuse as their primary problem, but who are affected nonetheless.

2.3.1 Vulnerable Adults

Joint working is integral to working with clients who have complex needs. The client group that Adult Social Care teams work with is by definition complex. They are vulnerable adults and adults at risk, with a raft of complexities – many of which will in fact overshadow the presence of domestic abuse, making it all the more important to identify to DVA and subsequently work with them. For example, in the MASH audit (2017) alone, the following issues were identified: older people & frailty, mental health, substance misuse, missing persons, attempted suicide, physical disability, dementia and sexual assault.

2.3.2 Substance abuse

Collecting prevalence data for domestic abuse within adult substance misuse services is not a mandatory requirement, so no routinely collected data are available. However, as part of a recent Joint Targeted Area Inspection, the adult substance misuse service in Hampshire is compiling a snap-shot audit of current clients who are experiencing domestic abuse. In terms of the Young Peoples Substance Misuse Service, data is collected on wider vulnerabilities and in Quarter 1 (17/18), 24% of young people accessing support for their substance misuse were also experiencing domestic abuse.

There are well established referral routed into DA services from substance misuse services, however relatively few new cases recorded by the commissioned services are flagged as being referrals from substance misuse services.
2.3.3 Domestic abuse and alcohol

Alcohol use and its link to domestic abuse and violence is a complex issue. Research quoted by the Institute for Alcohol Research report ‘Alcohol, Domestic Abuse and Sexual Assault’ indicates that in between 25% and 50% of cases of domestic abuse, the perpetrator had been drinking at the time of the assault. This was as high as 73% in some studies. However, cases involving severe violence were twice as likely to involve alcohol as other cases, and the severity of violence in incidents where violence occurs is significantly higher where one or both partners have been drinking.

Alcohol misuse may also feature as a ‘coping mechanism’ for victims of long-standing DVA. One study found that women victims were twice as likely as their violent partners to drink after an incident of abuse. However, as the report points out: ‘Where alcohol is involved in domestic abuse, much of the evidence suggests that it is not the root cause, but rather a compounding factor, sometimes to a significant extent. Domestic abuse agencies agree that alcohol misuse should not been seen as taking responsibility away from those who commit domestic violence’.

2.3.4 Criminal Justice

Nationally, around half of women within the criminal justice system (as perpetrators of crime) have been affected by domestic violence. While this is of course not a linear cause-and-effect relationship, this statistic can be seen as illustrative of the often complex and multiple needs that may be experienced by women. This is borne out by informal analysis of local Community Rehabilitation Company (CRC) data: approximately half the caseload at any one time is thought to be affected by DVA. Anecdotally, a commonly seen pattern appears to be experience of DVA, leading to or exacerbating substance abuse (frequently alcohol), then subsequent offending – a significant number of women offenders are in the system because of drink-driving offences. Overall, 63% of women on the caseload are identifying as having need related to emotional well-being; which includes concerns such as self-harming and ability to cope.

2.4 Children affected by domestic violence and abuse

The effects of domestic abuse on children are well-researched and there is a wealth of good evidence on its significant impact on children’s mental, emotional and physical health, and on the development of their subsequent choices and behaviours.
as adults. The importance of early identification and intervention is stressed in national and local strategies – both to prevent further immediate harm to the children concerned; and to promote healthy relationships for those children’s futures. Data from a number of sources has been used to estimate the number of children in Hampshire who are affected by domestic abuse.

National research indicates that 12% of under 11s and 18% of 11-17s had been exposed to domestic violence between adults in their childhood\(^49\). If these percentages are applied to the Hampshire population, it suggests that **21,034 under 11s and 19,351 children and young people aged 11-17** have experienced domestic abuse between adults in their homes – **40,385 children and young people in total**.

Not all of these children and young people will be known to any services, and those who are, are likely to be those with most severe or complex need. We have a number of data sources that we can draw on to illustrate the scale and complexity of the picture in Hampshire.

For the first quarter of 2017, Hampshire Constabulary report a total of 2802 domestic abuse crimes in the Hampshire County Council administrative area, of which 588 were classed as high risk. Linked to these 588 high risk cases alone, were 759 children\(^50\). In the same quarter, there were 318 new multi-agency risk assessment conference (MARAC) referrals where a child or children were linked. It is important to note that these figures do not include children linked to incidents (i.e., instances of domestic abuse which fall below the threshold to be classified as a crime).

Previous work by Hampshire County Council has attempted to draw together data from Children’s services, crime data, MARAC and service data to help quantify the scale of the problem in Hampshire. In 2015/16 there were 14,589 new episodes of Children in Need and in 3,660 of these (25%) domestic abuse was recorded as a factor. As at 18 November 2016, there were 9,860 active Children in Need cases, of which 1,146 were living/had lived with domestic abuse.

On the same date, there were 1,368 active Child Protection Plan cases. Domestic abuse was the primary reason for a CPP for 352 of these cases.

MARAC data for the second quarter of 2017 indicates that 2,403 cases were discussed across the HCC area in that 3-month period. 24% of these were repeat cases. Between the 2,403 cases, there were 3,595 children living in the households discussed.

It is acknowledged that this is a particularly difficult area to accurately quantify need since there are several data sources and it is not always clear to what extent they overlap (e.g., some children will appear linked to domestic abuse crimes and CPPs, some to one and not the other, some will appear in neither of these but may be
counted elsewhere). However it is clear that there are significant numbers of children known to services, and likely to be many more who are not.

2.5 Children and young people as perpetrators of domestic violence and abuse

While child to parent violence and adolescent to parent violence (CPV and APV) are becoming more widely recognised and acknowledged, quantifying the local need is not straightforward. CPV/APV tends to appear as a pattern of behaviour rather than single incidents. As it is only relatively recently that policy has begun to be developed which identifies this as a specifically defined issue, there is no agreed definition or method of recording incidents in any nationally consistent manner. However, research used by the Home Office\textsuperscript{51} found in the Greater London area alone 1,892 incidents of violence, threats of violence, or criminal damage in the home, perpetrated by a 13-19 year old towards their parent(s)/carer(s), in a one-year period 2009-2010. Perpetrators were overwhelmingly male (87.3%) and adult victims predominantly female (77.5%), with the most common situation being son to mother abuse (66.7%).

In considering this figure, perhaps more so even than in adult to adult DVA, it is important to bear in mind the likely very significant extent of under-reporting. These are only cases which were reported to the police – it is not difficult to imagine that the social and emotional impact of disclosing abuse by a child would deter many parents or carers from reporting such incidents.

In Hampshire, police recorded 123 and 89 domestic abuse incidents where the perpetrator was a child, in the first and second quarters of 2017-18 respectively. However it is not possible to ascertain how many of these were CPV/APV, as no information about the victim or the relationship is recorded in routine datasets; these could also be incidents of DVA in teenage relationships or other family relationships.
2.6 Service usage, incident, and reported crime data

2.6.1 Service usage data
The Integrated Domestic Abuse Service (IDASH) for Hampshire has brought together domestic abuse victim services across Hampshire since 2015.

IDASH is jointly commissioned by Hampshire County Council and the Office of the Police and Crime Commissioner (OPCC). At present it is organised into three lot areas and provided by two organisations: Lot 1 (North) and Lot 3 (West) by the YOU Trust and Lot 2 (South/South East) by Southern Domestic Abuse Services (SDAS).

The core objectives of the service are to:

- improve safety and reduce risk to those affected by domestic abuse
- improve the access to services and referral pathways for those requiring advice, guidance and support relating to domestic abuse
- improve outcomes for adult victims, their children and their families affected by domestic abuse.

IDASH consists of evidence based service provision and the core elements are:

1. Community based floating support and outreach services  
2. Independent Domestic Violence Advisers (IDVA) support  
3. Dedicated support services for children and families  
4. Crisis accommodation (refuges)  
5. Move on and resettlement services  
6. Personal support networks and group work.

Over and above the basic contracted services, they also provide additional services (see section 4.3), sources of funding for which are varied.

Combined service usage data

For service usage data in each individual lot area, please see Appendix 2.

The following tables give data on the number of referrals received, by referral source where this is available, and initial information on the services accessed by service users.

The commissioned service receives around 400-500 referrals per month, roughly 15% of which are self-referrals. The majority of referrals from other agencies are from police, at 40%.

After initial assessment, service users are offered one or more of a range of services depending on their needs. Where no service is offered, the service providers record and report the reasons for this, which may be varied but are generally around the individual's willingness or ability to engage with available options.
Chart 2: Referral source, all new referrals to IDASH, 6 month period April – September 2017

Table 6: referral source, all referrals, April 2016 – March 2017

<table>
<thead>
<tr>
<th>Referral source</th>
<th>%</th>
<th>n</th>
<th>Referral source</th>
<th>%</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Police</td>
<td>40.2%</td>
<td>1918</td>
<td>Refuges online</td>
<td>0.69%</td>
<td>33</td>
</tr>
<tr>
<td>Self referral</td>
<td>14.8%</td>
<td>706</td>
<td>CAB</td>
<td>0.59%</td>
<td>28</td>
</tr>
<tr>
<td>Children's Services</td>
<td>10.7%</td>
<td>509</td>
<td>Early Help Hubs</td>
<td>0.54%</td>
<td>26</td>
</tr>
<tr>
<td>Other</td>
<td>7.8%</td>
<td>370</td>
<td>Substance Misuse Services</td>
<td>0.50%</td>
<td>24</td>
</tr>
<tr>
<td>Housing options team</td>
<td>7.4%</td>
<td>353</td>
<td>MARAC</td>
<td>0.42%</td>
<td>20</td>
</tr>
<tr>
<td>Other IDASH provider</td>
<td>4.9%</td>
<td>233</td>
<td>Maternity professional</td>
<td>0.38%</td>
<td>18</td>
</tr>
<tr>
<td>3rd sector</td>
<td>2.1%</td>
<td>101</td>
<td>Solicitors</td>
<td>0.38%</td>
<td>18</td>
</tr>
<tr>
<td>Victim support</td>
<td>1.6%</td>
<td>74</td>
<td>A&amp;E</td>
<td>0.36%</td>
<td>17</td>
</tr>
<tr>
<td>Women's Aid</td>
<td>1.4%</td>
<td>66</td>
<td>GP</td>
<td>0.34%</td>
<td>16</td>
</tr>
<tr>
<td>Health Visitor</td>
<td>1.3%</td>
<td>60</td>
<td>Supporting Troubled Families Programme</td>
<td>0.25%</td>
<td>12</td>
</tr>
<tr>
<td>Registered landlord</td>
<td>1.2%</td>
<td>55</td>
<td>DAPP</td>
<td>0.00%</td>
<td>0</td>
</tr>
<tr>
<td>School/college</td>
<td>0.9%</td>
<td>45</td>
<td>Foster carers</td>
<td>0.00%</td>
<td>0</td>
</tr>
<tr>
<td>Adult Services</td>
<td>0.8%</td>
<td>37</td>
<td>Residential care homes</td>
<td>0.00%</td>
<td>0</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>0.7%</td>
<td>35</td>
<td>TOTAL</td>
<td></td>
<td>4774</td>
</tr>
</tbody>
</table>

TOTAL 4774
2.6.2 Clients accessing victim services
For the year ending March 2017, we found that 228 out of 4774 (4.8%) clients accessing victim services were male. While this is a low percentage compared to the number of men in Hampshire we expect to be experiencing DVA, it may to an extent reflect that men may need or want to access services in a different way, and/or be more able to extricate themselves from DVA situations without the help of specialist agencies. Conversely, it may indicate considerably more reluctance or difficulty for men who need help to seek or accept it.

Analysis of local MARAC data shows that across the Police Force Area, 8% of cases coming to MARAC involved a male victim. This compares to the national average of 4.8% and is within the Safe Lives recommendations of 4-10%.
Of clients who were asked/disclosed their ethnic origin, the largest group was White British (67%) followed by British (4%). Asian/Asian British represented 2% and Black/Black British 1%. In Hampshire (see table 2) 3.8% of the population is of Asian origin and 1% of Black origin.

During the year, the service was accessed predominantly by heterosexual people. Due to differences in the way the two providers report their data it is not possible to be absolutely precise about proportions, but 20 victims in same-sex male relationships and 19 females in same-sex relationships accessed victim services during the year. We estimate that this is slightly less than 1% (for each group) of the total number of people who disclosed their sexuality. Nationally, 2016 statistics show that 2.3% of men and 1.6% of women in the UK identify themselves as gay, lesbian or bisexual, which suggests that people in same-sex relationships may not be accessing victim services in the numbers we might expect. No transsexual people accessed victim services in the year.

Again, due to slight differences in the way service providers report data, we are unable to provide precise data but in the year, services were accessed by around 700 people with some form of self-reported disability. For those who specified what type of disability they had (583 people), the majority were people with a mental health issue (85%, 490 people). Disability relating to physical health was identified by 12% (71 people), and learning disabilities by 2% (14 people). A small number of people reported hearing or visual impairment. Referring to Table 5, if we assume that 15% of Hampshire’s population is affected to some extent by disability, 700 people as a proportion of the 4774 total referrals is 14.6%, suggesting that the prevalence of disability in people accessing services is broadly the same as in the general population. However, we know that people with disabilities are more likely to be victims of domestic abuse, so we might expect this figure to be higher than it is.

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ii Services reported on multiple ethnicities/nationalities. For ease of illustration we have excluded categories where less than two responses were found. This included Turkish (2), Caribbean (1) Eastern European (2), and ‘don’t know’ (2).
We know that DVA is under-reported and that many people who experience violence and abuse do not access services. If we compare our expected numbers to actual numbers presenting to victim services, it gives us an indication of what proportion of people affected by DVA are accessing the support of specialist DVA services.

Table 7: Estimated proportion of people receiving service/people expected to be affected by DVA, by category

<table>
<thead>
<tr>
<th>Category</th>
<th>Expected numbers affected per year</th>
<th>Number receiving service in year</th>
<th>Proportion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women (all ages and ethnic origins)</td>
<td>38,004</td>
<td>4,546</td>
<td>12%</td>
</tr>
<tr>
<td>Men (all ages and ethnic origins)</td>
<td>17,683</td>
<td>228</td>
<td>1.3%</td>
</tr>
<tr>
<td>People with a disability</td>
<td>19,095</td>
<td>700</td>
<td>3.7%</td>
</tr>
<tr>
<td>LGBT+</td>
<td>1249</td>
<td>20</td>
<td>1.7%</td>
</tr>
<tr>
<td>People of Asian origin</td>
<td>1368</td>
<td>51</td>
<td>3.7%</td>
</tr>
<tr>
<td>People of Black origin</td>
<td>704</td>
<td>45</td>
<td>6.4%</td>
</tr>
</tbody>
</table>

While these figures can only be taken as a rough estimate, and bearing in mind that the reasons why people do not seek help are complex and varied, they do show that there is considerable variation between categories. This seems to support the view that heterosexual women are more likely to access services than other groups who may be in equal need. Men, and people in same-sex relationships, appear to be least likely present to victim services.

2.6.3 Crime/incident data

Crime and incident data has been supplied by Hampshire Constabulary and refers to the period 1st April 2016 – 31st March 2017.

For the period, there were 18,675 recorded incidents and 10,879 crimes categorised by the police as domestic. Of all crimes, the majority (80%) involved violence, either with or without injury.
Of incidents, the largest category was ‘domestic dispute between adults’ at 38.6%, closely followed by ‘assault’ at 38.1%. The next largest were harassment (4.9%), criminal damage (4.7%), ‘other crime’ (3.8%), rape (1.7%) and theft (1.4%).

In the rolling 12-month period ending April 2017, 32.1% of aggrieved persons were recorded as ‘repeat’ aggrieved, this is, had previously been a victim in a DVA incident or crime.

Hampshire figures show that in 58.2% of occurrences initially reported and classified as DVA ‘incidents’ after investigation result in a charge against the perpetrator. At this point they are reclassified as a recordable ‘crime’.

As can be seen from the maps below, crime and incident prevalence are similarly distributed through the HCC area’s districts – both having highest prevalence in the Havant/Hayling Island, Gosport and Rushmoor and Hart districts, followed by Basingstoke and Dean.
Chart 5: Recorded DVA incidents and crimes, per 100,000 population, by district

Number of crimes crude rate per 1,000 resident population, 2016/17

District authority
Number of crimes per 1,000 pop'n
- ≤5 crimes per 1,000 pop'n
- >5 to 7 crimes per 1,000 pop'n
- >7 to 8.5 crimes per 1,000 pop'n
- >8.5 to 10 crimes per pop'n
- >10 to 12.5 crimes per pop'n

Number of incidents crude rate per 1,000 resident population, 2016/17

District authority
Number of incidents per 1,000 pop'n
- ≤9.5 incidents per 1,000 pop'n
- >9.5 to 12 incidents per 1,000 pop'n
- >12 to 14 incidents per 1,000 pop'n
- >14 to 18 incidents per 1,000 pop'n
- >18 to 22 incidents per 1,000 pop'n

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2.6.4 Perpetrator programme data

The Hampshire Domestic Abuse Prevention Partnership (DAPP) programme is commissioned by the Office of the Police and Crime Commissioner (OPCC), Hampshire County Council and Southampton City Council and is delivered jointly by three provider organisations: Aurora New Dawn, The Hampton Trust and Baseline Consultancy. The purpose of the programme is to engage with perpetrators and thus change their abusive behaviour towards partners. Most work is delivered in a group setting; however some individuals may be referred for more intensive 1:1 work, delivered by the Baseline Consultancy. Participation is voluntary, and participants may self-refer or be referred by (e.g.,) social services or police. Participants must also consent to their partner or ex-partner being contacted.

Data for the year ending 31 March 2017 indicates that there were 259 referrals to the programme from the Hampshire County Council area, of which 98% were male. 100% identified as heterosexual. Over half (54%) of participants were in the 26 – 40 years of age range. 25% were aged 18-15, and 18% were aged 41-55. 88% of participants were White British. 4.7% were Asian/Asian British and 3.3% were Black/African/Caribbean/Black British.

Referral sources were varied:

**Table 8: DAPP programme referral sources, referrals received year ending March 2017**

<table>
<thead>
<tr>
<th>Referral source</th>
<th>Number (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Police</td>
<td>2 (0.6%)</td>
</tr>
<tr>
<td>DVA victim services provider</td>
<td>2 (0.6%)</td>
</tr>
<tr>
<td>Probation</td>
<td>17 (5.5%)</td>
</tr>
<tr>
<td>Social services</td>
<td>207 (66.8%)</td>
</tr>
<tr>
<td>Substance misuse services</td>
<td>2 (0.6%)</td>
</tr>
<tr>
<td>Mental health services</td>
<td>7 (2.2%)</td>
</tr>
<tr>
<td>CAFCASS</td>
<td>9 (3.0%)</td>
</tr>
<tr>
<td>Self-referral</td>
<td>52 (16.8%)</td>
</tr>
<tr>
<td>Other</td>
<td>12 (3.9%)</td>
</tr>
</tbody>
</table>

As there is limited capacity for conducting initial assessments and running group sessions, waiting lists are in operation both for assessment and group work. At both stages there is drop-out where potential clients either cannot be contacted or do not...

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**iii** 98% refers to the 302 out of 309 participants across Southampton and Hampshire who were male.

**iv** Of the 306 participants across Hampshire and Southampton where age was recorded.

**v** Of the 299 participants across Hampshire and Southampton where ethnicity was recorded.

**vi** Of 310 referrals across Southampton and Hampshire where referral source was recorded.
attend. After assessment, the majority of clients are deemed suitable either for group work or 1:1 work and allocated accordingly.

For the year, 29 Hampshire clients fully engaged with and completed the programme, and in the last quarter of that year a further 39 were currently actively involved. An evaluation of the programme is currently being conducted by the University of Southampton and is a first draft is expected in Spring 2018.
3. Evidence base

The National Institute for Health and Care Excellence (NICE) conducted a review of the effectiveness of a range of prevention and response initiatives to inform its recommendations in ‘Public Health guideline ‘Domestic violence and abuse: multi-agency working’’. The review data were published as a separate report, examining strength of evidence, cost-effectiveness and outcomes of each intervention studied. The following sections (3.1, 3.2, 3.3, 3.5 and 3.6) summarise the findings of the NICE review.

3.1 Primary prevention

The aim of primary prevention is to address the root cause of domestic violence and abuse and thus prevent people from becoming victims or perpetrators. This includes education and awareness initiatives aimed at promoting healthy relationships and recognising abuse for what it is. Addressing the attitudes and behaviours that allow abuse to occur is a key part of Hampshire’s domestic abuse prevention strategy and, as we know that children exposed to domestic violence and abuse (as well as other childhood adversities) are at higher risk of becoming victims or perpetrators themselves, support and intervention for this group may be particularly desirable.

Assessing the effectiveness of general PHSE programmes in schools at preventing domestic violence is problematic, since the attribution of the intervention to the specific outcome is not straightforward. NICE found only limited evidence on the effectiveness of primary prevention programmes aimed at young people, but programmes which focus more intensively on children already known to have been affected by DVA in their own homes are generally easier to evaluate reliably. There is modest evidence to suggest that prevention programmes which target young people already at risk for partner violence have a positive impact on attitude change in relation to violence and gender roles, and can lead to a reduction in violent behaviour.

3.2 Secondary prevention

Secondary prevention strategies and initiatives aim to encourage and promote detection and intervention at an early stage, thus preventing continuation or escalation of DVA and limiting the impact of harm that may already have occurred. Secondary prevention may be targeted at victims or perpetrators of DVA. Both require consistent and easily accessible pathways, high levels of awareness among people likely to come into contact with victims or perpetrators, and a general readiness to initiate discussion about DVA.
Secondary prevention can include (for example):

- training for front-line healthcare professionals (typically general practice and midwifery staff, due to their high likelihood of coming into contact with DVA victims and their already existing relationship with their patient);
- general public awareness-raising and promotion activities, prompting victims and/or perpetrators to think about what is happening in their relationships and providing information on sources of help;
- recovery programmes aimed at victims (adults and/or children), which help them both to recover from recent or current trauma, and to identify and recognise unhealthy behaviours or relationships and reduce their risk of re-victimisation;
- developing options for early intervention and education in cases where more serious action against the perpetrator is not warranted, e.g., conditional cautioning.

NICE found that the majority of interventions studied were secondary prevention initiatives, across a wide range of settings. They found inconsistent evidence of effectiveness in awareness-raising campaigns, suggesting that while they may be effective at their primary objective of raising awareness, in some cases the supporting pathways or actions could not be implemented.

Moderate evidence was found to support initiatives aimed at improving the detection of DVA, however a wide range of screening tools was used making comparisons of effectiveness difficult. Self-reported, rather than face-to-face screening seems more likely to encourage disclosure. Inconsistent evidence was found to support the effectiveness of healthcare provider education aimed at encouraging discussion and/or documentation of DVA. There was moderate evidence that routine screening in pregnancy, when supported by staff training and organisational support, improved practice and documentation of DVA. They note that:

‘While interventions and approaches examined do reveal some modest improvements in rates of identification or practices and knowledge related to the identification of DV, there appear to be significant challenges in achieving identification, referral and support goals. Although few studies examined interventions beyond the point of identification, some studies reported low rates of follow-up with women who had been identified as at risk. Further research is required to examine and address the barriers providers face in identifying and responding to DV’.

NICE found moderate evidence to support individual interventions for abusers, with improvements being reported in aggressive feelings towards partner, attitudinal change, understandings of violence and accountability, and short-term help seeking. Some interventions also reported improvements in violent behaviours or recidivism. There is moderate evidence that short-term (less than 16 weeks) group programmes
improve attitudinal and interpersonal outcomes among perpetrators, but inconsistent evidence that they are effective in reducing recidivism or abuse outcomes. Evidence of effectiveness of longer-term programmes for perpetrators was inconsistent.

For victims, there was moderate evidence in support of counselling, advocacy and therapeutic interventions, with reported improvements in safety, empowerment, access to community resources; reductions in stress and depression levels; and reduced incidence of violence. Interventions providing advocacy and ‘skills-building’ approaches seemed particularly effective.

### 3.3 Interventions for children

NICE drew on a 2011 systematic review and additional studies to categorise reviewed interventions, distinguishing between those which were child-only or child and parent-focused, single or multi component, and therapy or psycho-education focused. The strongest evidence appeared to be in favour of single-component therapeutic interventions focused on mother and child. Inconsistent evidence was found for single-component psycho-educational interventions for mother and child, though of the studies reviewed some had ‘significant methodological weaknesses’. All other types of intervention had moderate evidence of effectiveness. The authors note that:

> ‘The diversity of the interventions and the lack of reporting of benefits specific to sub-components of multi-component interventions also make it difficult to compare and discuss the benefits of different modalities. However, in the case of single focus interventions, interventions aimed at mothers and children together appear to be more beneficial for improved outcomes for both, than for single focused interventions for children only.’

### 3.4 Tertiary prevention services

Under the heading of tertiary prevention, we include those activities and services which are more responsive in nature and tend to be called upon where there is a risk of serious harm to the victim. These include refuge provision, ‘target hardening’ (practical support to improve immediate safety and security for victims who are remaining in their own homes), intensive support such as that provided by Independent Domestic Abuse Advisors (IDVAs) and the use of Domestic Violence Prevention Orders (DVPOs) and other police or criminal justice sanctions.

However, even where work with victims is driven by the need to respond to an immediate threat to safety, there will be a future preventive element as well. Thus the separation between secondary and tertiary prevention is not always clear. For high-risk victims in refuge for instance, as well as providing for their immediate safety, services will also be working to provide support to promote their recovery and
minimise their risk of future victimisation. For this reason it is difficult to separate out strictly tertiary prevention strategies and evaluate their effectiveness in isolation from the wider range of support that a service user may be accessing. However, it would logically be reasonable to accept that refuge accommodation, where it is available and accessed in a timely manner, is effective in providing a place of safety for victims who are in need of immediate help. It might also be reasonable to assume that DVPOs, carrying with them as they do the threat of arrest if they are breached, are an effective deterrent. That said, there are some issues to take into account around both refuge provision and preventive orders.

3.4.1 Refuge

It may be difficult for some people to access refuge either due to their personal situation of their own behaviours. Feedback from our local stakeholders suggests that difficulties may be encountered in particular where a woman’s residence status is unknown or uncertain such that she has no recourse to public funds. Particular issues have also been identified in regard to the availability of single-unit refuge accommodation suitable for men, though the demand for this is small. People with specific physical needs may also find shared accommodation difficult. The practicalities of some cultural requirements, such as segregation of halal/non-halal foodstuffs, may also affect the acceptability of refuge as an option for some women.

As refuge accommodation is commonly in the form of shared housing, consideration must be given to the needs of those entire resident in the property. As such, an individual’s own behaviours and lifestyle may also impact their suitability for placement – for example, where there are issues with violence, antisocial behaviour or substance abuse.

Also, there is a wider issue of whether an individual’s safety might be equally well be ensured without the inevitable disruption for the victim (and possibly children) that moving into temporary accommodation will entail. With a focus on improving safety and enabling the victim to feel safe to remain in his/her own home, ‘target hardening’ schemes, and/or a focus on perpetrator management, may offer a preferable alternative to refuge accommodation for some victims.

3.4.2 DVPOs/DVPNs

Domestic Violence Protection Orders (DVPOs) and Domestic Violence Protection Notices (DVPNs) were introduced in 2014. They provide protection to victims where there is insufficient evidence to charge a perpetrator (and thus impose bail conditions). The notice is issued to provide emergency protection by imposing
prohibitions on the suspected perpetrator from contacting the victim or returning to the victim's home. It must be authorised by a police superintendent and may be issued where there are reasonable grounds for believing that:

- the individual has been violent towards an associated person
- the individual has threatened violence towards an associated person
- the DVPN is necessary to protect that person from violence or a threat of violence by the intended recipient of the DVPN

A DVPO can prevent the perpetrator from returning to a residence and from having contact with the victim for up to 28 days. However, there is evidence that as a relatively new option, their use is not fully understood or utilised by front-line officers. The latest progress report on police responses to domestic abuse, having found the use of DVPOs actually decreasing in some police force areas, identifies ‘appropriate use of DVPNs/DVPOs’ as the second-highest competency ‘requiring improvement’\(^56\).

3.4.3 Independent Domestic Violence Advocates (IDVAs)

IDVAs are specialist case workers who predominantly work with high-risk victims, offering intensive, short to medium term support and coordinating other agencies who may be involved with the specific case. A large, multi-site evaluation carried out in 2009\(^57\) when the introduction of IDVAs was relatively new, found them to be effective in reducing both the severity and frequency of abuse for the service users they supported, with 57% of victims experiencing a cessation in the abuse they were suffering. The evaluation also reported significant improvements in victims social networks in 47%of cases and coping abilities improved for 63%. Overall, it found that victims receiving intensive support were more likely to do better than those receiving more limited support.

IDVA training is an accredited programme which provides a recognised qualification and a common framework for practitioners. It is coordinated by SafeLives (formerly CAADA), a domestic abuse charity which also sets a national recommended level of provision across a range of service areas, including IDVAs.

3.5 Partnership working

All of the studies reviewed had a moderate quality rating. They included collaborations between various service providers, multi-agency approaches to specific client groups, and a partnership model for children who witness domestic abuse.

NICE found that partnership approaches were associated with improvements in various measures including an increase in referrals, reducing further violence and
supporting victims. They also found moderate evidence of improved relationships, practices and policies in partner organisations. They conclude that:

‘Studies identified the following enabling factors as key to partnership working: strong leadership, management and coordination, active membership, community involvement, strong relationships and communication, training and resources, are associated with effective partnership working. However, the following barriers were reported: lack of resources (financial and human), differences in the culture of agencies/organizations, leadership and management issues, lack of commitment, limited monitoring, and addressing diverse populations. Issues related to the inconsistent following of protocols or guidelines, and confidentiality issues among multi-disciplinary case review teams were commonly cited challenges.’
4. Current service provision

4.1 IDASH commissioned service

4.1.1 Southern Domestic Abuse Services (SDAS): Lot 2 (South/South East)

Southern Domestic Abuse Service (SDAS) is a local charity providing services to women, children, young people and men affected by domestic abuse in South East Hampshire with the majority of services delivered in Fareham, Gosport & Havant Boroughs, East Hampshire District & Portsmouth City. SDAS currently deliver HCC’s commissioned service in Lot 2: Fareham, Gosport, Havant and East Hampshire. SDAS are a member of the Women’s Aid (awarded Women’s Aid National Quality Standards Kitemark December 2017) and the organisation is managed by a board of Trustees.

Services include:

- Refuge and crisis accommodation
- Adult Outreach & Resettlement Service (including Target hardening/Sanctuary Scheme)
- Young People & Children’s Service
- Independent Domestic Violence Advocate (IDVA) Service
- Telephone advice/24 hour support (including partnership with The You Trust on a single point of contact (SPOC) for Hampshire residents.
- Group work for young people & children
- Family support work (including Troubled Families)
- Women only group work
- Perpetrator Programme
- Group Work for non-abusive adults with violent & abusive children
- Holiday activities
- Specially provided workshops
- FGM Community Work/Development
- Domestic abuse preventative work/awareness raising/training services.

SDAS work in partnership with many other agencies to ensure there is a co-ordinated community response model to domestic abuse. SDAS are key partners in local Domestic Abuse Fora and work very closely with local Community Safety Partnerships, other multi-agency groups include the Local Children’s Partnerships, and the countywide Domestic Abuse Partnership Forum Group. SDAS also work in partnership with a variety of agencies to deliver jointly provided services to victims and survivors of domestic abuse. Examples of innovative/successful partnership working covering South East Hampshire include: a Female Genital
Mutilation (FGM) Community Champions Project with support from The British Red Cross, a partnership with Hampshire County Council Children’s Services to deliver a Family Intervention Project with SDAS workers seconded to three multi-disciplinary teams working to reduce the number of children going into care, and a partnership with Portsmouth City Council to deliver Up2U: Healthy Relationships.

4.1.2 The YOU Trust: Lot 1 (North) and Lot 3 (West)

You First delivers the Hampshire commissioned integrated domestic abuse service in the West and North of the county, delivering a co-ordinated community response to tackling and addressing domestic violence and abuse. They offer bespoke help and support including:

- offering practical and emotional support and advocacy for female and male victims and survivors of domestic abuse
- risk assessments and risk management
- supporting people to develop independent living skills
- delivering groups in the community and in refuge - such as Pattern Changing, Freedom Programme and Recovery Toolkit
- delivering an innovative service for children and young people who have experienced domestic abuse
- support young instigators with specialist face to face sessions
- work with families to help develop great parenting skills

You First services include – Outreach, Refuge, Resettlement, 24/7 on-call service and IDVA and a number of specialist projects:

- Bounty Project – working alongside the police and supported troubled families
- Workshops in schools and colleges
- Sanctuary – making homes a safe place to live following incidents of domestic abuse
- Community awareness
- DV Training

4.2 Access points to services, referral routes and pathways

Across the three lot areas of the commissioned service, the number of self-referrals as a proportion of total referrals received is relatively low, but generally stable and consistent between the areas. This may suggest a lack of awareness of the services available and/or the facility to self-refer. Since there is a far larger proportion of the caseload having been referred via other sources, there is clearly a willingness to engage with and receive services once a referral has been made.
The high proportion of referrals from police suggests that specific incidents or escalations sufficiently serious to warrant police involvement are responsible for a large part of the commissioned service caseload. This combined with the very low level of referrals from healthcare and other agencies indicates that help is not proactively being sought by victims, or signposted by other agencies, at an early stage in a large number of cases. This is not inconsistent with what we know about reasons why victims do not seek help – but a focus on early identification and intervention is a key part of the Hampshire (and national) strategy.

Referrals from other agencies including social services are also lower than might be expected. There are currently very low levels of referrals from HCC Adults Health and Care to the Integrated Domestic Abuse Service for Hampshire (IDASH) – similar is reported anceodtally across the whole SHIP area. Analysis undertaken in one of the 3 lot areas for the IDASH service for 2016/17 showed just 15 referrals to IDASH from HCC AHC across the whole financial year.

**Table 9: Lot 2 referrals received 2016/17 from Adult Services**

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advice/information given to professional</td>
<td>1</td>
</tr>
<tr>
<td>Moved to SDAS refuge</td>
<td>1</td>
</tr>
<tr>
<td>Passed to adult group work</td>
<td>2</td>
</tr>
<tr>
<td>Passed to IDVA</td>
<td>3</td>
</tr>
<tr>
<td>Passed to outreach service</td>
<td>3</td>
</tr>
<tr>
<td>Required refuge, unable to accommodate</td>
<td>1</td>
</tr>
<tr>
<td>Telephone advice only</td>
<td>2</td>
</tr>
<tr>
<td>Unable to contact</td>
<td>2</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>15</strong></td>
</tr>
</tbody>
</table>

Over a similar 12 month period (September 2016 to August 2017) HCC Adults’ Health and Care had a total of 2433 safeguarding contacts opened to them, with 1181 meetings being held. The 15 referrals received by IDASH (lot 2) constitute just 0.6% of the overall safeguarding contacts opened.

A short audit was undertaken in July 2017 in the Hampshire MASH, which revealed:

- Of the 10 cases considered, 70% had a DA element.
- Of the 70%, 57% did not have the DA recognised, and only 28% had all appropriate actions taken.
Based on this figure of 70%, it would suggest that upwards of 1,700 safeguarding contacts that were opened in 2017-17 (as above) may have had an element of DA – as opposed to the 15 referrals that we made to IDASH.

It also showed that both victims and perpetrators are being referred to the MASH, and in no cases was a perpetrator referred on for support to the DAPP (Domestic Abuse Prevention Partnership). There was also an interesting breakdown of ages, with 57.2% of the cases involving DA being with clients over the age of 60 years. This is also reflected by some of the local Domestic Homicide Review data where cases have involved older people.

We believe that this information clearly demonstrates a need for further investigation into process and knowledge within Adult Social Care teams. Also, that a pilot study with a worker embedded in a MASH team will further demonstrate the importance of closer joint working, increased input and upskilling of staff in adult social care settings.

MARAC data also indicates that levels of referrals from ‘partner agencies’ (in this context, this means any organisation other than police referring a case to MARAC) are lower than might be expected – 21% for quarter 2 of 2016/17 against a SafeLives recommended level of 25-40%.

Informal referrals and signposting are more difficult to identify. We conducted a survey of staff from organisations and agencies likely to come into contact with people affected by DVA (see Appendix 3) which indicated a high levels of awareness of how to refer a client in to victim services, (89% of respondents). Knowledge of referral routes into services for perpetrators was less good at 63% probably reflecting the lesser likelihood of professional services coming into contact with a known perpetrator of domestic abuse. However, actual referrals were low, with 67% of client-facing staff saying they had ‘never’ referred to victim services and 89% ‘never’ having referred to perpetrator services. This is backed up by our analysis of referral sources into victim services, which indicate very low levels (<1% of total number referred) for GPs, maternity staff, mental health services, and A&E.

While NICE found, overall, inconsistent evidence for education and training programmes to support early identification and referral, they did identify four high quality (++) studies including one UK based evaluation of the Identification and Referral to Improve Safety (IRIS) programme. This found that implementation of a primary care-based training and support programme increased referral rates (adjusted intervention rate ratio 22:1) and disclosure rates (3:1) in participating practices.

The IRIS programme has been implemented in a number of UK locations, not including Hampshire. Local evidence, however does point to a low level of referrals and evidence suggests that this could be increased with targeted intervention.
A programme of Joint Targeted Area Inspections (JTAIs) began in January 2016. The programme brings together inspectorates Ofsted, Care Quality Commission (CQC), HMI Constabulary and Fire & Rescue Services (HMICFRS), and HMI Probation (HMIP) to ‘examine how well agencies are working together in a local area to help and protect children’.

Hampshire was part of the JTAI programme and was inspected in December 2016, with the focus of the inspection being DVA. The findings from the overarching report published in 2017, highlighted that there is:

“A lack of attention to prevention means that intervention is too late. The ‘incident-led response’ of many professionals is a response driven by ‘blue-light’ crises. A measured response driven by prevention would move upstream. When a universal service first recognises that domestic abuse may be a factor, the first line of action should be to give access to specialist support that will target the perpetrator’s behaviour. GPs, midwives (...) health visitors and many more see children on a regular, if not daily basis. If we are to focus more on preventing abuse, and repairing the damage it has done after the fact, multi-agency working and coordination between these frontline professionals are crucial. Sophisticated and targeted information sharing processes and policies lie at the heart of this joined-up approach’ (p 27).

One of the actions following the JTAI was in relation to ‘Health Services are not routinely completing the DASH risk assessment tool when domestic abuse is suspected, disclosed or reported’. There has now been an extensive piece of work to develop a health pathway to screen for Domestic Violence and Abuse and to support the launch; and there is general agreement that an IRIS model or similar is required to work across Hampshire services, including GPs, Midwifery and Emergency Department Settings. The model supports intervention and in-reach services to support staff and encourage them to ask about DVA. The overarching report also cited that inspectors found that professionals across health asked about domestic abuse when prompted, but sometimes, even when there were prompts, they could be ignored and this was most often observed in health services.

The IRIS model (or similar) could support the training and development of health care professionals, support the roll out of the newly developed screening tool, support referrals into the existing DVA Services and work with services to support referrals to MARAC.

4.3 Service mapping

The following sections will describe current service provision, coverage and commissioning arrangements for services in the Hampshire County Council area, and their read-across to national and local strategy.
4.3.1 Primary prevention services
Within Hampshire there is a need for schools to respond to domestic abuse as it affects their students; whether they are directly experiencing or witnessing domestic abuse as well as helping them to identify healthy and unhealthy relationships.

Whilst the government is currently consulting on new statutory requirements on schools around health relationships for implementation from September 2018, up to now the decision is taken at individual school level as to what, if any input is given to students.

There are however many examples of good practice with Childline volunteers visiting primary aged children to talk about what constitutes abuse (including domestic and sexual abuse) as well secondary schools working in partnership with external agencies to deliver domestic and dating abuse input. In addition, a range of resources are available to schools, which include a Domestic Abuse Information Booklet for Schools as well as national resources which give lesson plans and resources for each school year.

4.3.2 Secondary prevention services

Operation Encompass
Hampshire Constabulary is partnered with local schools to deliver Operation Encompass across Hampshire. This is an early intervention safeguarding partnership, which recognises exposure to domestic violence as an adverse childhood experience and aims to mitigate its effects. In practice, what this means is that for any occasion where police are called to attend a DVA incident where a child is present, that child’s school will be notified before they attend the following day. This enables the school to support the child, depending on their needs and wishes. Three project workers are also to be appointed who will work with schools countywide to support their responses and understanding around domestic abuse issue.

Operation Encompass is a key element of Hampshire’s stated aims to reduce the impact of abuse on children, families and communities and to ensure victims are supported and protected.

CARA programme
Conditional Cautioning and Relationship Abuse (CARA) offers nominated individuals the opportunity to gain insight into the impact of domestic abuse and to identify their own needs for the future. The use of conditional cautions for domestic abuse is the first of its type in the country. Project CARA is an exemplary model of statutory and third sector agencies bringing their expertise together with a willingness to try new approaches. Delivered by The Hampton Trust and commissioned by the OPCC, the CARA programme focuses on reducing perpetrators and addressing unhealthy behaviours.
Outreach provision/community-based support
As described earlier, community support is provided via the HCC/OPCC commissioned IDASH service. Community-based support and outreach services are core elements of the service. As defined in the service specification, the service provider(s) will provide services which focus around:

a. key worker role in relation to risk assessment and action planning
b. consistent case management, support planning based on initial contact / identification, assessment of need and referral covering, accommodation; Education Training Employment; physical & mental health; drugs and alcohol; finance, benefit and debt; children and families; building confidence
c. provision of housing related floating support
d. provision of assertive outreach and re-engagement of clients, where appropriate
e. joint work with the Supporting Troubled Families Programme ‘intensive family support’ services.

These services will be provided for a maximum of 2 years.

IDVA support
Hampshire commissioned services currently provide IDVA support to high-risk cases. As described in the service specification:

a. provide key worker link to Multi Agency Risk Assessment Conferences (MARAC) for ensuring the safety of high-risk victims.
b. provide IDVA role, responsible for developing the safety plan (and its management) for high risk victims within the integrated services
c. have expertise to support teenage victims
d. be responsible for ensuring that the plan is implemented and the safety of the victim is maintained
e. provide key point of contact for issues related to the Criminal Justice and Civil legal system (e.g. court cases, restraining orders, sanctions and remedies available through the courts).
f. co-ordinate referrals and information exchange in-between MARAC meetings
g. co-ordinate effective use of community resources, both commissioned and non-commissioned
h. maintain engagement with clients until the high risk has been reduced and stabilised; ideally for a period not exceeding twelve weeks, unless there are exceptional circumstances. After this period, IDVA’s will normally provide advice and support only at key points, such as court cases.
**DAPP**
The Domestic Abuse Prevention Partnership (DAPP) has been developed to better identify and assess perpetrators and introduce a wider range of support interventions. DAPP aims to achieve a sustainable county-wide response to engaging domestic abuse perpetrators, reducing risk to victims and thus improving long-term outcomes for children. It includes the following elements:

a. Single Point of Contact (SPOC): a single point of contact to receive and record information on perpetrators:
   - To enable target hardening and closer tracking of serial perpetrators
   - To assess, plan and monitor risk in context of perpetrators

b. RADAR (Raising Awareness of Domestic Abuse in Relationship): RADAR is aimed at men and women aged 18+ who would like to stop their abusive behaviour toward their current, ex- or future partners. Individuals will be encouraged to think about why they abuse, the impact of this and explore strategies and techniques to avoid using abusive behaviour.

c. Assertive Outreach Individual Asset Building Module: for individuals 18 years and over who are assessed as high-risk, chaotic domestic abuse perpetrators who require stabilisation. This module is delivered individually and considers multiple and complex factors in the client’s world which are preventing behaviour change. Domestic abuse, mental health and substance misuse are addressed and the client is supported to access appropriate services. This module provides intense individual support and tackles dynamic risk factors.

d. Integrated victim safety service: this service is for all partners of individuals referred to all DAPP interventions. Pro-active engagement is made with current and ex partners of all perpetrators accessing RADAR. The victim service prioritises risk management and ensures that safeguarding functions are robust, outward facing and sit within a wider community response.

### 4.3.3 Interventions for children and families

From the service specification, the commissioned service is expected to:

a. provide a coordinated package of support that takes individual needs and preferences into account.

b. ensure the support matches the child’s developmental stage
c. be timely, and children and young people will be supported to access appropriate longer term services where required.

d. deliver evidenced based interventions to reduce the impact on children and young people affected by domestic abuse and to improve outcomes in their health, safety, wellbeing, development, behaviour and achievement.

e. provide interventions that aim to strengthen the relationship between the child or young person and their non-abusive parent/carer. This may involve individual and/or group sessions. The sessions should include advocacy, or other support that addresses the impact of domestic abuse on parenting. Sessions should be delivered to children and their non abusive parent/carer in parallel or together.

f. be aligned to and fully engaged with the local Early Help Hubs

g. provide support for the family to maintain links with their normal mainstream services, e.g. education, health and leisure

h. where appropriate, support children and young people to engage with other services providing support for children/young people experiencing emotional difficulties including Child and Adolescent Mental Health Services.

i. provide support and services for young people experiencing domestic abuse in their own intimate relationships (including teen parents)

In addition to the children and family work carried out by the IDASH commissioned service, a range of other interventions are currently in place to support families affected by DVA.

- Supporting (Troubled) Families Programme: Now referred to as the Supporting Families Programme, this is a voluntary programme for families with multiple and often complex need. Although it is a long-term programme of transforming culture and behaviours, there are early signs that it is making a real difference for many families. The ethos of ‘on family, one plan, one coordinated approach’ seeks to minimise the impact on families of repeating their accounts to numerous professionals/partners.

- Family Intervention teams (FIT): A significant project within the Innovation Fund has involved Children’s Social Care working closely with partner organisations and agencies to develop the model of family Intervention teams (FITs). The model adopts a whole-family approach with specialist workers in domestic abuse, substance misuse and parental mental health being co-located within children in need teams. It is acknowledged that families experiencing issues relating to the ‘toxic trio’ are often complex situations with more than one issue in play. However, there are often other broader, underlying issues impacting on a parent’s wellbeing and family functioning that will also need addressing in order to facilitate change. The programme has demonstrated some emerging positive impacts and outcomes, helping families to develop and sustain their own motivation to change.
4.3.4 Tertiary prevention services

Refuge provision
Hampshire currently has 92 refuge accommodation units, providing short-term accommodation typically for a period of not more than 12 weeks, subject to risk. As defined in the service specification:

Crisis accommodation based services
a. Accommodation based services must meet Health & Safety standards
b. The accommodation should be suitable for supporting clients and their families with facilities to support interventions for both adults and children.
c. The accommodation will be staffed at an appropriate level to provide a safe and supportive environment.
d. Accommodation based services must:
   i) focus on provision of short term ‘crisis’ or ‘emergency’ accommodation for individuals / families experiencing domestic abuse
   ii) provide both emergency crisis and short term supported accommodation.
   iii) actively pursue housing options for clients and develop access to a range of accommodation based services, for example rent bond schemes; short term ‘safe house’; sanctuary style schemes; housing services

Move on and resettlement services
a. Move on and resettlement services that enable clients to:
   i) live independently in their own accommodation
   ii) avoid eviction and homelessness
   iii) access appropriate housing support services

Target hardening/Hampshire Making Safe Scheme
This additional service is funded outside the commissioned service by a non-recurrent Department for Communities and Local Government (DCLG) grant. The purpose of the scheme is to focus on improving safety through practical measures such as security assessment and risk reduction, in order to keep victims safe in their own homes rather than having to enter refuge. A brief snapshot survey conducted in July 2017 across the IDASH providers gathered views from 114 recipients of the service found the following:

- 114 (100%) recipients said the service had helped them feel safer
- 76 (67%) said that without the service, they would have had to move house/access refuge

vii ‘unit’ being accommodation for a single person or a family, typically a room in a multi-unit refuge.
• 113 (99.1%) said it had made a positive change to their situation

Although brief, the consistency of responses seems to indicate a high level of user satisfaction with the service, as well as some evidence that it may be effective in reducing the need for refuge accommodation. At a more qualitative level, it could be suggested that in some cases this type of proactive support shifts the control of the situation back to the victim by taking measures to exclude the perpetrator, rather than further disrupting the victim while leaving the perpetrator in the family home.

**DVPO/DVPNs**

As mentioned earlier, national monitoring suggests that the use of DVPOs/DVPNs is lower than might be expected and is inconsistent between police force areas. In Hampshire, considerable effort has been put into increasing the use of both orders and notices and we have seen a steady but small increase in the numbers being issued. This has been under review and an implementation plan, begun in September 2017, should see further increases. Compliance is generally high with only a small number of breaches being reported.

**Table 10: DVPO/N issues and breaches, April 2016 – July 2017**

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<tr>
<th></th>
<th>Apr-16</th>
<th>May-16</th>
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<th>Oct-16</th>
<th>Nov-16</th>
<th>Dec-16</th>
<th>Jan-17</th>
<th>Feb-17</th>
<th>Mar-17</th>
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<td>0</td>
<td>1</td>
<td>0</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

**4.3.5 Specialist services for specific groups**

**Lesbian and Gay Liaison Officers (LAGLOs)**

Established in 1996, LAGLOs are a mix of police officers and police staff members who have additional awareness and training on lesbian, gay, bisexual and transgender issues.

Their role includes enhancing the relationship between the police and lesbian, gay, bisexual and transgender communities in an effort to boost people’s trust and confidence in coming forward to report hate crime incidents and/or incidents of same sex domestic abuse. They also work to develop ways in which the constabulary can improve its service delivery.

Following reports of same-sex Domestic abuse, LAGLOs will be tasked to make contact with victims and offer support.
Recognising that services should be tailored to meet the needs of the individual, LAGLOs are currently participating in a pilot (May 2017 – 18) which sees the completion of an additional risk assessment for people experiencing same sex DVA.

There are currently over 100 LAGLOs across Hampshire and the Isle of Wight.

The role of the LAGLO will be:

a. To liaise with the lesbian, gay, bisexual and transgender communities, in order to encourage co-operation with the police, increase confidence in the police, and encourage the reporting of crimes and incidents.

b. Give information, advice and support to victims & witnesses of crimes/incidents.

c. Give support and advice to officers dealing with homophobic, bi-phobic and transphobic incidents.

d. Promote an understanding amongst colleagues about the needs of local lesbian, gay, bisexual and Transgender communities.

4.4 Stakeholder views

4.4.1 Survey method
In October and November 2017, we conducted a stakeholder survey to gather views on a range of topics pertinent to the DVA commissioning process. A copy of the questionnaire is at Appendix 3.

We wanted to know more about the level of awareness and knowledge in the professional community about the services available and the referral routes to those services. We also wanted to know how easy (or not) it was to get advice and support for patients/clients and specifically, for clients in groups with particular characteristics. We also asked for views about the elements of service that were most valued, and about any perceived barriers to accessing services.

The survey questions were designed and agreed jointly by Hampshire County Council and Southampton City Council. Invitations to participate were sent out to all relevant contacts in victim and perpetrator services, adults and children’s services, primary care and maternity services, voluntary organisations, police, probation services, and all other known stakeholders likely to come into contact with people affected by DVA. Contacts were invited to send on the survey to their own colleagues and networks as appropriate. Although this was not intended to be a service user survey (which will be conducted later in the service commissioning process) the survey offered participants the opportunity to reflect their service user’s views in their responses. The survey was open, online, for two weeks.
4.4.2 Survey respondent characteristics

222 responses were received from respondents working either in Hampshire County Council area or in both Hampshire and Southampton. Additional responses from people working exclusively in Southampton City Council area were filtered out and passed to SCC for separate analysis.

The majority of respondents (68%) identified themselves as ‘Professional – I refer clients to domestic abuse services’. However, closer inspection of the ‘Other – please specify’ category (18%) showed a number of respondents who listed their involvement with DVA services by job title, such as ‘specialist nurse’; ‘nurse’; ‘AHP’, ‘health care professional’ – which we would have classed as ‘professional’. Although this indicates differences in the way the question was interpreted, we were pleased to have a high number of responses from potential referrers. 13% of respondents were from DVA service providers. 1% were commissioners.

69 respondents (46%) worked in health services. 45 (30%) were from children’s services. 7 respondents (5%) came from adults’ services, 6 (4%) each from probation services and housing, and only 2 (1%) of respondents worked in the police force. 14 respondents (9%) worked for ‘Other’ covering a variety of sectors – voluntary/charity, military, legal and court services, and schools.

Included in ‘health services’ we had 9 general practitioners, 13 midwives/obstetric doctors, and 29 nurses in a variety of roles: community nurses, nurse specialists and A&E nurses.

The majority (86%) of our respondents describes their work as client-facing. As previously mentioned, 89% said they were aware of how to access/refer to victim services, and 63% said they know how to access/refer to perpetrator services.

The majority of our respondents (81%) said that they regularly worked with specific vulnerable or hard to reach groups, e.g., homeless people, people with substance misuse issues, children subject to child protection plans, youth offenders, and people with mental health problems. Most worked with more than one of the groups we listed.
4.4.3 Awareness and referral activity

Awareness of individual services was more mixed. National services appeared to have a higher awareness rating with Police, Victim Support and Women’s Aid scoring 92%, 88% and 82% respectively. Local services appear to be less well-known, although we have not conducted a stratified analysis to look at levels of awareness in different professional groups.

Chart 7: Survey respondents’ awareness of Hampshire DVA victim services
Looking at referral activity in our respondents, the majority had never referred directly to Hampshire services, whether they identified those services as IDASH or as the individual providers.

Chart 8: Survey respondents’ referral activity to Hampshire victim services

<table>
<thead>
<tr>
<th>Service</th>
<th>Never Referred</th>
<th>Occasionally</th>
<th>Regularly</th>
</tr>
</thead>
<tbody>
<tr>
<td>IDASH</td>
<td>67%</td>
<td>14%</td>
<td>19%</td>
</tr>
<tr>
<td>SDAS</td>
<td>63%</td>
<td>17%</td>
<td>22%</td>
</tr>
<tr>
<td>The YOU Trust</td>
<td>63%</td>
<td>14%</td>
<td>14%</td>
</tr>
</tbody>
</table>

Levels of awareness and referral activity are lower for perpetrator services. We know from our referral source data that the vast majority of referrals into the DAPP programme are either from social services (c. 67%) or self-referrals (c. 17%). Although the programme is able to accept referrals from all agencies including police, there are very few referrals in from other sources other than social care. While it is possible that the self-referrals are signposted or prompted by contact with other agencies, this pattern might suggest that increasing knowledge of the perpetrator services might result in a greater diversity of referral sources. Unfortunately we had very few responses from police, so it is not possible to assess whether officers are generally aware of, or referring in to, the perpetrator programme.
4.4.4 Ease of access – respondent views

We asked our respondents to grade how easy it was to access services in the following four questions:

Q. How easy is it to access domestic abuse services for your clients when trying to access services and support?

Q. How easy is it to access domestic abuse services for your clients with specific needs, (e.g. LGBT+, BAMER groups, disabilities) when trying to access services and support?

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viii In our analysis of this question we have excluded ‘not applicable’ responses as these are likely to be from people who do not refer to services, and recalculated the percentages accordingly.
Q. How easy is it for you and your organisation to access support or advice for your clients in general?

Q. How easy is it for you and your organisation to access support for clients with specific needs (e.g. LGBT+, BAMER groups, disabilities)?

4.4.5 Barriers to accessing services

While the responses indicate a generally positive experience in terms of accessibility, there clearly are some perceived issues, especially around accessing support for clients with particular needs. We asked our respondents to give us some comments about barriers to accessing services. Responses were very varied, but a thematic analysis of the responses received grouped them into five main themes:

- professional knowledge;
- client issues;
- service access issues;
- resource and staffing;
• gaps in provision/accessibility.

**Professional knowledge**
The largest number of individual responses (42) concerned professional knowledge. Interestingly, only one respondent felt their own uncertainty about how to discuss the topic was a potential barrier, and one other cited lack of understanding of the problem. The majority (38) felt that the main problem was their knowledge of what services were available, how to refer and who to refer to. A few respondents suggested that a directory of services might be helpful.

**Client issues**
Not far behind, 34 respondents cited general client issues such as fear of further violence, reluctance to engage, stigma, failure to recognise abuse, confidence and knowledge of what services are available as barriers to access.

**Service access issues**
33 respondents noted potential barriers which we have categorised as ‘service access issues’. These were generally around waiting times to access services, particularly refuge (9 responses) and the complexity of the referral process (11 responses). More than one GP respondent suggested that the referral process was so time consuming that they would not have time to complete the forms in a routine consultation and would signpost the client to self-refer instead. On-line self-referral was suggested by a small number of respondents. Communication/information flow between services was mentioned by 6 respondents, and 6 respondents mentioned difficulties in getting hold of services.

**Resources and staffing**
27 respondents cited resources and staffing as barriers to accessing services, mainly general comments suggesting that lack of resources led to a downgrading/contraction of the services available, e.g., phone support instead of 1:1 contact or IDVA support only available for the highest-risk cases. Concern was also expressed around general service pressure leading to access and waiting time problems. Four respondents specifically mentioned a lack of capacity to support children and families as a barrier.

**Gaps in provision/accessibility**
The remaining comments received (23) were more particular in nature and pointed to specific gaps or barriers to service provision around a number of areas:

• Access to refuge, esp. NRPF/complex needs
• Information and service provision for men as victims
• Lack of perpetrator services
• Support for older people
• Difficulties for young people accessing services
• Services too victim-focused
• Lack of resettlement accommodation leading to refuge bed-blocking.

4.4.6 Priority areas/key elements of service
We asked respondents to identify what they felt were the priority areas for, or key elements of, a domestic abuse service. Again we had a very wide range of responses, with many respondents identifying more than one area, which gave us a rich and detailed source of information. We have grouped these into themes, listed below in descending order of number of responses received:

• A service which is well-known and easily accessible to clients and referrers (45 responses)
• Support for children and young people/family-focused support (33)
• Refuge provision (25)
• Supportive, non-judgmental trained staff (20)
• Outreach (16)
• Immediate safety (15)
• Flexible, responsive service tailored to client’s needs (13)
• IDVA (13)
• Services available and accessible to all with need (12)
• Group work (10)
• Emotional support and counselling (10)
• Confidential and safe environment (7)
• Practical advice and signposting (7)
• Preventive education/awareness raising (6)
• Longer term follow-up (2)

Common responses from some of the key themes are discussed below:

Easily accessible/well-known service
Responses under this team were in general, fairly generic and focused around all services – not just refuge - being easy for clients to find, easy for referrers to contact and refer in a quick and simple process, and information on services being easily available. The requirement for services to be available quickly was also raised. Several responses suggested a need for clearer communication/advertising for a single point of access contact and/or advice line. Clear advice and guidance from DVA services to healthcare referrers was valued, as was 24/7 access. Several referrers wanted to have feedback/be kept in touch with what was happening with their client.

CYP/family support
This was also frequently identified as a key element of service: counselling, CPY outreach and support, accommodation, Children’s IVVAs/play therapy, children and family teams, whole family approach and safeguarding being most commonly listed.
Several respondents suggested that primary prevention/relationship education work should be a key element of service. The importance of ensuring that the views of children and young people were heard was also mentioned. Perpetrator services were also mentioned under this theme: ‘... the whole family including those who offend. I see a real need for specific services for those who use abusive/unhealthy behaviours in their relationships – targeted at reducing offending behaviour and recuing victimisation’.

Refuge provision
Responses fell into two categories: having sufficient resource to provide general access without delay/waiting lists to a safe, secure place, and accessibility for people with specific characteristics/needs: e.g., men, NRPF, high complexity clients.

Supportive/trained staff
Responses generally commented on the qualities and/or experience they would expect and value from staff: ‘qualified trained staff’; ‘experienced knowledgeable practitioners’; ‘someone to talk to and be heard by’; ‘supportive non-judgmental staff’. There was also emphasis on staff being coordinators for collaborative work with other agencies ‘to provide the best possible support’.

Outreach/immediate safety
Respondents generally commented simply that these were essential elements of service.

Flexible, responsive service
Comments in this theme were usually around the need to provide services (whether practical or emotional/psychological support) tailored to the client’s particular needs, at a time and in a manner which suited the client and maintained their trust/confidence in the service: ‘a focus on putting the client at the centre of all work being done’. The need for effective communication and a sense of shared purpose between agencies was also identified as necessary to underpin a quality service.

IDVA
Generally again, comments simply stated IDVA support as a key element of service.

Available/accessible
The need for services to be available and accessible to people with specific needs was frequently raised and there is an element of crossover with comments categories in the ‘refuge’ theme. Services for men and for people in same-sex relationships were most commonly mentioned, along with older/vulnerable people ‘... .need to ensure that the services really do want to help male and same-sex victims of abuse... also need to endeavour to ensure they can reach the most vulnerable and have an understanding of the issues and needs they face to access help and support’.
5. Conclusions

1. There is a general absence of unequivocal evidence of effectiveness of any single intervention – but also recognition that it can be difficult to define or measure quality or ‘success’ of any particular intervention. Individual needs and circumstances are varied and often complex and the response needs to be flexible and tailored to meet those needs. Therefore we need a flexible approach to tackling domestic abuse and protecting victims.

2. The multiplicity of, and overlap between the various services which may support children affected by DVA and other adversities makes it difficult to ascertain a true picture of the level of unmet need. Children and young people affected by exposure to DVA will be supported by various statutory and voluntary services, with a relatively small number being supported by specialist DVA services. It is important to understand the place of specialist DVA services in the system with regard to supporting children experiencing domestic abuse. A wider piece of work needs to be undertaken to ensure the services and interventions meet the needs of the population.

3. We know that DVA is often experienced alongside other adversities and that children living with DVA may be in complex family situations. People working with children need to be mindful of the impact of domestic abuse in a family where there may be multiple issues. This requires both specific and general work depending on the needs of the individual child.

4. Crisis Accommodation provision is seen as a key element of service and is highly valued as a place of safety for the most at-risk clients. However, it is only one solution to keeping a victim safe. It may not be suitable or equally accessible to all, partly due to the nature of shared accommodation and other practical considerations. ‘Target hardening’ and other risk reduction measures, along with a focus on removing the perpetrator from the environment using DVPNs, may present a preferable and equally safe alternative for clients and safety measures need to be considered. As part of service development, crisis accommodation needs to be flexible and be part of a total approach to meeting victims needs.

5. Both our analysis of referral sources into services and the qualitative feedback from our stakeholder survey indicates a degree of uncertainty among referring professionals about who to refer to and how to contact them. Referral routes and thresholds should be defined to ensure a clear, referral pathway is shared with all agencies.
6. From research, backed up by what we know from local data where available, many DVA victims will have had contact with other services, whether for themselves or their children. However, we still see a very low level of referrals into victim services from healthcare in particular. Too many referrals come from police, indicating that the majority of cases do not access specialist services until the point where police are involved. Evidence suggests that efforts to train and support health services in early detection and intervention for DVA (similar to the IRIS model) significantly increases referral rates and this should be further developed for the Hampshire population.

7. Similarly low levels of referrals are seen from adult Multi-Agency Safeguarding Hub (MASH). This should be addressed through work with local Children's and Adults' safeguarding teams.

8. Victim services are predominantly accessed by heterosexual women. There are low levels of access by men (albeit within the nationally expected range). While this may reflect that men need or want to access services in different ways, or are better able to extricate themselves from abusive situations without the help of DVA agencies, services need to be equipped to deal with this need and to promote the availability of help, advice and practical support to male victims.

9. Low numbers of same-sex victims of DVA have been supported by Hampshire DVA services in the last year. It is unclear whether this is due to a lack of awareness in the LGBT+ community that services are available to all, or an unwillingness to seek help from such services. Further work to ensure that clients from the LGBT+ community can access the services they require is needed.

10. Victim services have been accessed by people from a wide variety of ethnic backgrounds, in patterns which are broadly representative of Hampshire’s population profile. The exception to this is people of Asian/Asian British origin, who appear to be under-represented. Further work on ensuring services are available, accessible and culturally sensitive is required.

11. Perpetrator services are predominantly accessed by heterosexual men, and referrals come primarily from social services. It might be expected that more referrals should come from police, but we have been unable to explore the reasons for this and some further work in this area may be informative.

12. While perpetrator work is seen by many as an essential element of service, the DAPP programme is yet to be fully evaluated in terms of its effectiveness in reducing offending behaviour or changing attitudes to DVA. At present, a relatively small number of perpetrators are completing the programme and
there are waiting lists both for initial assessment and placement on either the group or 1:1 courses. There is a paucity of evidence of the effectiveness of perpetrator programmes - without the local evaluation it is not possible to know the impact of this programme. Furthermore the complexity of family units means that couple co-violence is present in many families. We need to ensure that services take a family based approach tackling both the needs of the victim and tackling the perpetrator behaviour.

13. Consideration should be given to how we interpret data to assess service quality and how we define key performance indicators for the core elements of the DVA service.
6. Appendices

Appendix 1: Membership of the Hampshire Domestic Abuse Steering Group

Organisational membership of the Steering Group includes:

- 5 Clinical Commissioning Groups (CCGs)
- Community Safety Partnerships – representation on behalf of all the districts and boroughs
- Community Rehabilitation Company (CRC)
- Contracted Service Provider representation – IDASH, DAPP
- Crown Prosecution Service
- Hampshire Constabulary
- Hampshire County Council

  - Adult services
  - Children’s services
  - Public Health
  - Supporting (Troubled) Families Programme

Hampshire Safeguarding Adults’ Board
Hampshire Safeguarding Children’s Board
Housing – representation on behalf of all the districts and boroughs
Police and Crime Commissioner
National Probation Service
Victim Support
Neighbouring Councils in Hampshire and Isle of Wight

  - Southampton City Council
  - Portsmouth City Council
  - Isle of Wight Council

The Steering Group is equally accountable to the two Safeguarding Boards (Adults and Children) with regular information and updates also being sent to the Children’s Trust and the Health and Wellbeing Board.
Appendix 2: Service usage data by lot area

IDASH service LOT 1: (Basingstoke and Rushmoor & Hart)
Lot 1 area covers a population of 183,278

Chart 1: Number of new referrals by referral source April – September 2017
LOT 1

Chart 2: Services received after initial assessment, April – September 2017
LOT 1
Chart 3: Services received after initial assessment, combined 6-month period April – September 2017 LOT 1

- Needs met at initial assessment
- Crisis accommodation (single person = 1 family unit)
- Required crisis accommodation - no vacancies
- Community outreach
- Children & Young People
- Independent Domestic Violence Advocacy
- Group work
- No service taken up
- No service offered
IDASH service LOT 2: East Hampshire, Fareham & Gosport, Havant
Lot 2 area covers a population of 226,459.

Chart 4: Number of new referrals by referral source, April – September 2017 LOT 2

Chart 5: Services received after initial assessment, April – September 2017 LOT 2

Chart 6: Services received after initial assessment, combined 6-month period April – September 2017 LOT 2
Chart 7: Disability by type, clients reporting a disability October 2016 – September 2017

- **Physical**: 68%
- **Mental Health**: 12%
- **Hearing**: 10%
- **Visual**: 8%
- **Learning**: 2%
- **More than one disability**: 2%
- **No service taken up**: 8%
- **No service offered**: 0%
- **Other**: 2%

Legend:
- Needs met at initial assessment
- Crisis accommodation (single person = 1 family unit)
- Required crisis accommodation - no vacancies
- Community outreach
- Children & Young People
- Independent Domestic Violence Advocacy
- Group work
- No service taken up
- No service offered
- Other
IDASH service LOT 3: (New Forest, Test Valley, Winchester, and Eastleigh)
Lot 3 area covers a population of 284,572.

Chart 8: Number of new referrals by referral source April – September 2017
LOT 3

Chart 9: Services received after initial assessment, April – September 2017
LOT 3

Chart 10: Services received after initial assessment, combined 6-month period
April – September 2017 LOT 3
Combined service data

The following chart compares key measures of activity across the three lot areas (represented as a rate per 100,000 population to take account of the differing lot sizes).

Chart 11: Activity per 100,000 population by lot area

Some differences between the three lot areas are suggested, such as the number of clients supported with community outreach in Lot 1, and the higher number of clients referred for crisis accommodation and apparently lower use of community support in Lot 2. Differences are likely to arise for three main reasons:

- Data are reflecting genuinely different patterns of need in the three areas;
- Services are responding to the need in different ways, depending on the resources and alternative pathways available to them;
- Services are reporting activity in different ways (data quality).

While there are known demographic differences between the three areas which would account for some variation in the level and type of need, it is likely that the...
data presented above reflect differences in the way the services respond to clients and how they define and record their activity. It should also be noted that additional activity, not commissioned by HCC Adults and Social Care, flows through the domestic abuse services, such as work with families and children funded via Children’s Services and/or the Supporting (Troubled) Families programme.
Appendix 3: Stakeholder survey questionnaire

Hampshire County Council and Southampton City Council Domestic Abuse Needs Assessment

Hampshire County Council and Southampton City Council are working in partnership to undertake Domestic Abuse Needs Assessments for both areas. We would like to gather views from a wide range of stakeholders and practitioners involved in services and roles which come into contact with people affected by domestic abuse.

At present, commissioned Domestic Abuse victim and family services in Hampshire are provided through the Integrated Domestic Abuse Service for Hampshire (IDASH) which is delivered by two providers: Southern Domestic Abuse Services (SDAS) in south/south east Hampshire, and The YOU Trust in the west and north of the County. Services in Southampton City are provided by Yellow Door and Homegroup.

Your views and experiences are essential to allow us to understand current services and identify priority areas of need. The data will be shared between Hampshire County Council and Southampton City Council and used to inform planning for future provision of services in both areas. Please be as open as you wish in your responses and we will ensure that these cannot be attributed to you.

We would also encourage you to pass this survey on to any of your colleagues or other relevant contacts within the Hampshire and Southampton areas – we are keen to hear from as many people as possible.

The survey will close on Friday 24th November 2017.

Thank you for your help.

Data Protection Statement

Hampshire County Council adheres to the requirements of the UK Data Protection Act 1998. Hampshire County Council is registered on the public register of data controllers which is looked after by the Information Commissioner. Under the Data Protection Act the information you have provided in this questionnaire will not be used for any other purpose. All individual responses will be kept confidential, will only be shared with our partner Southampton City Council for the purposes of developing Domestic Abuse Needs Assessments, and will comply with the requirements of the Hampshire County Council Privacy Policy and Southampton City Council Privacy Policy.
Firstly a bit of information about you....

**Q1 Which Local Authority area do you work in? (Please tick one)**
- Hampshire County Council
- Southampton City Council
- Both Local Authority areas

(Hampshire County Council area includes: Basingstoke & Deane, East Hampshire, Eastleigh, Fareham, Gosport, Hart, Havant, New Forest, Rushmoor, Test Valley and Winchester District and Borough Council areas)

**Q2 Which of these best describes your involvement with domestic abuse services? (Please tick one)**
- Commissioner
- Professional - refer clients to domestic abuse services (q3 applies only to this group)
- Domestic abuse service provider
- Other

**Q3 Please tell us where you work**
- Police
- Probation
- Health Services
- Children's Services
- Adult's Services
- Housing
- Other local authority
- Other

**Q4 Please tell us your role? (Please specify - for example social worker, midwife, housing officer, commissioning manager)**

**Q5 Is your role client-facing? (Please tick one)**
- Yes
- No

**Q6 Does the organisation you work for have a staff policy on domestic abuse/violence?**
- Yes
- No
- Don't know
Q7 Are you aware of how to access and/or refer to domestic abuse services for victims in your area?
- Yes
- No

Q8 Are you aware of how to access and/or refer to domestic abuse services for perpetrators in your area?
- Yes
- No

Q9 Which domestic abuse services are you aware of? (Please select as appropriate)

I am aware of this service/I am not aware of this service
- Integrated Domestic Abuse service for Hampshire (IDASH)
- Southern Domestic Abuse Service (SDAS)
- You Trust
- Yellow Door
- Southampton Women's Aid
- Domestic Abuse Prevention Partnership (DAPP)
- The Hampton Trust
- Aurora New Dawn
- Baseline Consultancy
- SafeLives
- Police Services
- Women's Aid
- National Centre for Domestic Violence
- Victim Support
- Homegroup
- Other service

Q10 How often do you refer to domestic abuse services? (Please select as appropriate)

I refer regularly to this service/I refer occasionally to this service/I have never referred to this service
- Integrated Domestic Abuse service for Hampshire (IDASH)
- Southern Domestic Abuse Service (SDAS)
- You Trust
- Yellow Door
- Southampton Women's Aid
- The Hampton Trust
- Aurora New Dawn
- Baseline Consultancy
- SafeLives
- Police Services
- National Centre for Domestic Violence
- Victim Support
- Homegroup
- Other service you refer to

**Q11** Do you regularly work with any specific vulnerable or hard to reach groups e.g. homeless people, people with substance misuse issues, children subject to child protection plans, youth offenders, mental health?  *(Please tick one)*
- Yes
- No

**Q12** If yes, please tell us which groups you work with: *(Please tick all that apply)*
- Looked after children/children with Child Protection Plans/children in need
- Disabled people
- Black, Asian, Minority Ethnic and Refugee (BAMER)
- Offenders/ex-offenders
- Older people
- Migrants and asylum seekers
- Special Educational Needs (SEN)
- Learning disabilities - adults, young people, children
- Teenage parents
- Homeless adults and young people
- Those living with a mental health condition
- Young carers
- People with substance misuse issues
- LGBT+ communities
- Other

**Q13** How easy is it to access domestic abuse services? *(Please rate)*
*Very easy/Easy/Neither easy nor difficult/Difficult/Very difficult/Not applicable*
- For your clients when trying to access services and support
- For your clients with specific needs (e.g. LGBT+, BAMER groups, disabilities) when trying to access
- For you and your organisation when trying to access support or advice for your clients in general
• For you and your organisation when trying to access support for clients with specific needs (e.g. LGBT+, BAMER groups, disabilities)

**Q14 What do you value most in your interactions/relationships with domestic abuse services?**

**Q15 In your view, what barriers to accessing domestic abuse services and support exist? (Please comment)**

**Q16 What would you identify as the priority areas for, or key elements of, a domestic abuse service? (Please give details)**

**Q17 Are you happy to be contacted in future regarding your response? (Please tick one)**

- Yes
- No

Thank you for taking the time to complete this survey.

If you have a query regarding this survey and would like to discuss further please contact: Jude.Ruddock-Atcherley@hants.gov.uk (HCC area) or Hilary.Linssen@southampton.gov.uk (SCC area)

If you have a query about someone you support or need advice, please contact one of the following numbers: for Southampton PIPPA on 02380 917917 and for Hampshire IDASH on 03300 165 112
7. References

3. Ibid
5. See 4
7. Excludes 17% of total cases, where the gender of the victim was not recorded. ONS statistical bulletin ‘Domestic abuse in England and Wales: year ending March 2016’ accessible at https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/domesticabuseinenglandandwales/yearendingmarch2016
8. Millar P and Brown G ‘Explaining gender differences in police arresting and charging behaviour in cases of spousal violence’ Partner Abuse v1(8) July 2010
10. See 2
12. NICE PH50 accessible at https://www.nice.org.uk/guidance/ph50
13. ONS, Domestic abuse in England and Wales, year ending March 2016 – Bulletin Tables
14. ONS Focus on: Violent Crime and Sexual Offences, year ending March 2016 - Appendix Tables
15. Ibid
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