SOUTHAMPTON AGAINST VIOLENCE & ABUSE PLAN 2014 -17

"In Southampton our message is loud and clear – we will not tolerate violence and abuse. We recognise violence and abuse as chosen behaviour for which there is no excuse. Underpinning our message is a bold new partnership approach that will robustly tackle this issue; holding perpetrators to account, supporting and protecting children, adults and families. And as an 'Early intervention City' we will work together to intervene as early as possible to prevent violence and abuse, to reduce escalation and to stop repeat victimisation. "

SUMMARY

This multi-agency plan covers all forms of gender-based and family violence and abuse including: Domestic Violence & Abuse; Sexual Assault & Rape; 'Honour Based' Violence; Female Genital Mutilation; Forced Marriage; Human Trafficking; Child Sexual Exploitation; Stalking; and Family Violence. While it is recognised that women and girls are significantly disproportionately affected by these forms of violence and abuse, this strategy also covers the smaller number of male victims as well as boys and young men affected by living with violence. We recognise both genders and local communities are part of the solution in preventing violence and abuse.

Our key actions for 2014 – 2015 are to develop the PIPPA model covering the scope of this plan and integrating our key ambitions. This will feed into commissioning and re-shaping of services. Key Actions are:

1. **PREVENTION**: To commission a co-ordinated community & voluntary sector response that focuses on prevention & early intervention. This includes support to children & adults after violence or abuse has ceased, to prevent recurrence of abuse or repeat behaviour (breaking cycles of abuse) & to address the longer-term harm caused. It also covers community involvement ensuring our diverse communities & vulnerable community groups are engaged & supported.

   This element of Pippa includes:
   - Education and public awareness
   - Group and therapeutic support or counselling, Recovery programmes with a focus on children and families
   - Helplines or other access to advice
   - Developing strong volunteer involvement and peer support.
   - Case-holding (at medium risk level). This will specifically but not exclusively cover Sexual and

Our ambition is to ….

1. Ensure safeguarding children and young people is at the heart of our multi-agency response to Violence & Abuse, with an integrated whole family approach.
2. Provide more Prevention and Early Intervention measures.
3. Protect and prosecute through robust multi-agency interventions.
4. Build a strong co-ordinated community response.
5. Establish a new delivery model called PIPPA.

Domestic Violence. This could include an educator-advocacy model and will require work in Health settings as well as potentially other Universal Services.
- Perpetrator interventions (elements of).

2. **INTERVENTION:** To establish a strong multi-agency team that will bring together statutory partners to directly provide comprehensive interventions for Domestic Violence and Abuse and other types of violence at high and medium risk levels. This team will also co-ordinate partner responses to other forms of gender violence and abuse. The focus of this new multi-agency team will be joining-up expertise across Police, Probation, Children & Families, Adult Mental Health, Public Health, Housing, Substance Misuse and specialist advocacy (IDVA and ISVA). It will also develop new interventions and skills of frontline workers to change perpetrator behaviours and reduce re-offending. The focus here will include safeguarding children and young people through improved joint practice across services & agencies.

   This element includes:
   - Strategic co-ordination of Gender-based Violence & Abuse
   - Direct responses to reduce risks to victims and their children at high or medium risk of harm from Domestic Violence, Sexual Violence, Forced Marriage, HBV and Family Violence (child to partner/siblings). This will include IDVA (Independent Domestic Violence Advocates) team and ISVA (Independent Sexual Violence Advocate) functions.
   - Joint working, particularly with the Police and Probation, to maximise use of civil and criminal justice remedies, increase successful prosecutions and reduce re-offending.
   - Perpetrator work – casework and group work challenging and changing patterns of behaviour, where safe and appropriate as part of a whole family response
   - Workforce development -training, systems and joint working – to integrate and strengthen safeguarding children and adults in this area and joint work with Early Help and specialist social work teams.
   - Close links with Housing and homeless services to provide a breadth of safe housing options.
   - Drawing in expertise in Adult Mental Health and Substance Misuse and Public Health.

3. **PUBLIC PROTECTION**: To strengthen multi-agency partnership working to identify and assess risks, protect victims and hold perpetrators to account for their behaviour.

   This element includes:
   - Review and development of an integrated MARAC/MASH
   - Strengthening MAPPA and Integrated Offender Management links to the Pippa model
   - Developing through new partnership arrangements better means of identifying and pursuing priority, multiple and/or serial perpetrators

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

4. **ALLIANCE:** The Alliance is both specialist services working together, plus a wider forum of partner agencies and communities joining up under the 'Co-ordinated Community Response' model. This element includes statutory and voluntary sector co-managing and staffing the PIPPA single point of contact for advice and referral, as well as joint training to professionals.

INTRODUCTION & SCOPE

1. This Plan aims to identify a multi-agency vision and action plan to improve outcomes for adults, children, young people and communities impacted by gender-based and family violence and abuse.

2. The scope of this Plan is to include all types of gender-based violence recognised under the term 'Violence Against Women and Girls'. The UN Convention on the Elimination of all forms of discrimination against women defines 'violence against women' as 'violence directed at a women because she is a women or actions of violence which are suffered disproportionately by women'. The UK Government Violence Against Women and Girls Strategy uses the same definition.

3. In addition, the scope of this Plan extends to familial violence including specifically child and young persons involvement in broader family violence and abuse (child on parent; sibling on sibling). This position recognises the growing body of evidence that associates family violence with childhood experience of DVA or child abuse.

4. Therefore this Plan is the multi-agency Domestic Violence & Abuse (DVA) Plan for the City, but it also covers Rape and Sexual Violence, Female Genital Mutilation, Forced Marriage, crimes in the name of 'honour', human trafficking, stalking and child sexual exploitation, plus family violence and abuse.

5. Although it is recognised and well evidenced that these forms of violence and abuse significantly disproportionately affect women and girls (both in terms of the numbers experiencing abuse and in the severity of that abuse) this Plan and the actions and responses in it, will also cover the smaller number of male victims, as well as boys & young men affected by violence in the home or family. Also underpinning this Plan is the recognition that both genders as well as the wider communities we live in are part of the solution to preventing and reducing violence and abuse.

6. In applying a wide scope to this Plan it is recognised that there are clear commonalities and synergies across the types of gender-based violence and the services that respond to it. However it is important to consider where joint responses are most effective and efficient, for example in co-ordination of

services, or promoting healthy relationships and raising awareness, and where it is appropriate to draw distinctions between the different types of gender-based violence for example in providing counselling for historic sexual abuse cases. The Delivery Models proposed here reflect joint and singular issue responses.

THE IMPACT OF VIOLENCE AND ABUSE

7. **Nationally:** In 2012-2013 it is estimated by the ONS[1] that around 1.2m women and 784,000 men experience domestic violence and abuse a year; 2 women a week are killed by a partner, ex-partner or lover. 400,000 women are sexually assaulted of which 70,000 are raped. 1,500 cases were supported by the Forced Marriage Unit with many more not reported. 66,000 women are estimated to be living with the consequences of FGM and 20,000 girls under 15 are estimated to be at risk. Police recorded crime figures showed an increase of 17% in all sexual offences for the year ending December 2013 and recorded rape increased by 20% compared to the previous year. This is now the highest level since the National Crime Recording Standard was introduced in 2002/3.

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

9. All data used in this area is likely to be an under-estimate as reporting levels for gender-based violence and abuse is low. For example, more than 1 in 3 children (34%) who experienced contact sexual abuse by an adult did not tell anyone else about it; 4 in 5 children (87%) who experienced contact sexual abuse from a peer did not tell anyone else about it (NSPCC April 2014). British Crime Surveys suggest less than 1 in 5 incidents of intimate partner violence are reported to the police; only 15% of rapes are reported and the hidden harm of other types of violence and abuse such as Forced Marriage and FGM is also known to be significant.

10. **In Southampton:** The volume of DVA in our city is substantially above national average; we have more than twice the national average high-risk cases (going to MARAC); above national average reporting rates - locally 5.2% of the female population report DVA to the police compared to 3.6% nationally. There were 4,702 DVA calls to police last year. In Southampton there are twice as many children of high-risk victims than national average 606 in 2012/13, 878[2] in

[1] Office of National Statistics: identified in the National violence Against Women & Girls Strategy

2013/14 – compared to national average of 289 for the same period. There were 217 victims reporting sexual violence to the police in 2012/13 and 236 in 2013/14. There were 1,605 calls to Rape Crisis Helpline in 2012/13 and 2,611 in 2013/14.

11. **The impact of violence and abuse on public services** is also very high. In Southampton (Children & Families Services in 2012/13) 28% of safeguarding referrals had DVA as a factor; Child Protection Conferences include DVA in 80% of cases – this is around 10% higher than similar national case profiles. DVA accounts for around 20% of violent crime in Southampton (Strategic Assessment 2012), which is higher than national average and this is reflected in our poor comparative position for violent crime against other most similar cities.

12. Research shows the impact of gender-based violence and abuse on Health services. NICE[3] guidance identifies risks of experiencing DVA increase where there is a long-term illness or disability – this almost doubles the risk - or a mental health problem. Separation and pregnancy or a recent birth are risk factors for DVA and there is a strong correlation between DVA and post-natal depression. The role played by alcohol and substance misuse in violence and abuse is evident. NICE suggest a high proportion of people attending health settings including Emergency Departments and Primary Care are likely to have experienced DVA and between 25 and 56% of female psychiatric patients report experiencing DVA in their lifetime. DVA is one of the strongest risk factors for suicide attempts.

13. **The cost** of DVA is evidenced in the Walby[4] research suggesting nationally a cost of over £15.7 billion. Extrapolating national figures it is estimated the cost of DVA in Southampton is £44,127,469 per annum. This includes estimated costs relating to physical and mental health care, criminal justice costs, Social Care and other costs such as Refuges. National research shows for every £1 invested in High Risk DVA services at least £6 of public money is saved. In 2010 the estimated indirect cost savings to the public purse of investment in high risk DVA in Southampton was £4,820,970 per annum. There is no available research on the wider costs of gender-based violence and abuse.

WHERE WE ARE NOW:

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

[2] MARAC data – this counts repeats

[3] NICE – National Institute for Health and Care Excellence – DVA Report 2014

[4] S Walby et al 2008; also reported I Safety in Numbers report by Dr E Howarth for CAADA – local figures are for 2010

police referrals of 20% since 2012 when it was set up). A diagram of current DVA services in the City is provided in Appendix 1.

- Other key strengths include:

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

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

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

  Specialist Sexual Violence services include therapeutic work, a dedicated helpline, family therapy, adult and young person counselling, creative arts groups and young person's outreach.

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

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

  The LSCB has begun to co-ordinate approaches to children and young people that go missing, are at risk of being exploited or trafficked (called MET).This is significantly improving the co-ordinated responses to this issue and raising both the profile and priority given by agencies to this issue.

WHAT DOES EVIDENCE TELL US?

15. Based on our local performance and trend data, learning from local and national Serious Case Reviews and stakeholder feedback we can identify key challenges, gaps and duplication in current provision. In addition there is a wealth of evidence-based practice and research that identifies 'what works best' to prevent and reduce violence and abuse. We are particularly drawing on recommendations from the NICE report on DVA (2014), the Early Intervention Foundation report on DVA (2014), the Co-ordinated Community Response model and research from CAADA, NSPCC and Home Office on the impact of violence and abuse on women and

children[5] . This Plan is also influenced by the Centre for Social Justice Report, Beyond Violence 2012. Consultation with survivors and with key frontline workers is taking place in November 2014. The findings will be added to this Plan shortly.

16. **Evidence Tells Us about Current Provision**:

- The exceptionally high volume of DVA reports in Southampton has remained high for more than 5 years with a rising trend. This inevitably has impact on capacity of provision and the quality of time given to each case especially at high-risk level including MARAC.

- Current multi-agency responses are not making an impact on preventing or reducing DVA and lack of intervention earlier is contributing to the high number of cases escalating to high-risk level. This also impacts on the evident failure to break the often inter-generational cycles of abuse.

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

- Funding of domestic and sexual violence provision is predominantly at high-risk level. Over 90% of investment in DVA is spent on high and high-medium risk responses, with refuge provision accounting for 60% of expenditure. Up to a third of current funding is from national grants resulting in short-term contracts and an unstable funding position.

- There are gaps and duplication in the multi-agency response to DVA and possibly across other gender-based violence, particularly gaps in joint work with Adult Mental Health

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

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

- The widely recognised problems practitioners face and the tensions and contradictions between Domestic Violence specialist services, Child Protection

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

and contact duties[6] requires robust and joined-up multi-agency approaches to violence and abuse, that are integrated into the new ways of working in Children and Families Services including MASH and Early Help.

- There is no investment in perpetrator schemes aimed at changing attitudes and behaviour in the city other than those mandated by court. There is little evidence of successful outcomes from traditional and established perpetrator programmes.

- Refuges in Southampton provide 20 bed spaces for short-term crisis accommodation for victims of DVA and their children. As part of informal reciprocal arrangements these occupants may not be local residents. Our local accommodation needs are therefore affected by refuge provision cross-border. Other factors such as the length of stay, the levels of risk and outcomes in terms of reduced re-victimisation also affects the effectiveness of this provision. Other safe housing options that enable victims and their children to stay in their own homes is often preferable. Local housing and homelessness responses, as well as new legislation to remove perpetrators from their homes for up to 28 days can positively change the way safe accommodation is delivered in the City. More analysis of the level of need in this area and potential to reduce this to shift resources to earlier intervention needs to be undertaken.

- There is no current network or forum co-ordinating the wide range of services that could be involved in this area, such as those at universal level (for example schools, primary health care) as well as local communities, service-users or survivors.

Evidence tells us we need to set our <u>Ambitions</u> (Aims) as follows:

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

18. In light of the evidence that suggests childhood exposure to DV and child physical abuse are two of the most powerful predictors of both perpetrator and victimisation

[6] The Three Planets Model – Towards an Understanding of Contradictions in Approaches to Women and Children's Safety in the Context of Domestic Violence: Marianne Hester 2011

as an adult, interventions with CYP must address the longer-term harm caused by DVA. In addition, witnessing violence and abuse may increase the risks of broader family violence (child on parent), this familial abuse is also often a precursor to and cause of abuse in couples relationships later in life. Therefore, CYP interventions must seek to break the cycle of abuse.

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

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

21. **Have a Co-ordinated Community Response (CCR**):
CCR is a widely recognised blueprint against which local services can map provision and strengthen partnerships. It requires co-ordination of partner agencies, survivors, communities, families and friends of those experiencing DVA. In CCR there is a strong focus on ensuring effective co-ordination of responses to DVA that can be applied more widely to all types of gender-based abuse. Here we need to ensure effective partnership working, strategic and operational co-ordination, joint commissioning of services. A co-ordinated approach requires evidence that interventions and support reach and benefit those who find it difficult to access services including people from black and minority ethnic groups or with disabilities, older people, trans people and lesbian, gay or bisexual people and includes those with no recourse to public funds. Through strategic co-ordination quality assurance standards are set, monitored and performance measures are used to shape and change service delivery.

22. A CCR approach must also recognise the role of Universal Services, including Health settings, schools and voluntary sector provision, in identification of DVA and other gender-based violence, assessment and referral (Ask & Act approaches). Evidence suggests a single point of contact for professionals to get advice, co-

ordinated training and workforce development and clear multi-agency care pathways will significantly improve outcomes.

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

24. **Establish a local delivery model** that includes our core "Ambitions" and what we have learnt from evidence as outlined above. The PIPPA model was developed locally as an Alliance between specialist Domestic & Sexual Violence services. It is a model, with core elements of Prevention, Intervention, Public Protection (and Alliance). It is proposed PIPPA is expanded to cover all gender-based and family violence and abuse, and adapted to ensure the interventions and activities identified here are co-ordinated and delivered.

25. The evidence shows the most effective risk reduction intervention for DVA at highest risk level is IDVA (Independent Domestic Violence Advocates) and MARAC (Multi-Agency Risk Assessment Conferences). Southampton performance from IDVA/MARAC support is above national average in terms of reducing repeat victimisation. Whereas numerous studies have failed to evidence effective outcomes from traditional perpetrator programmes (reduced risk of recidivism of only 5% after perpetrator interventions, with very high "drop out" rates 37-40%). Both nationally and locally, it is well recognised that new ways of working with perpetrators, including models that recognise co-offending (both parties offending) and situations where families remain together, need to be developed. This must include more effective, timely and appropriate risk assessment and a "menu" of interventions (rather than "one size fits all"). Skills development of key workers needs to include approaching and working with perpetrators. Some restorative justice models, including Family Group Conferences, are also identified as more effective than established perpetrator programmes. Partnership working must focus on serial and prolific perpetrators and increasing successful prosecutions.

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

WHAT WE NEED TO DO NOW: THE PIPPA MODEL

27. The key actions required to develop and deliver of the new model are:

PREVENTION:
To commission a co-ordinated Community and voluntary sector response that focuses on prevention & early intervention. This includes support to children and adults after violence or abuse has ceased to prevent recurrence of abuse or repeat behaviour (breaking cycles of abuse) and to address the longer-term harm caused. It also covers community involvement ensuring our diverse communities and vulnerable community groups are engaged and supported.

This element of Pippa includes:

- Education and public awareness across all forms of gender-based violence
- Recovery measures including group and therapeutic support or counselling with a focus on children and families
- Helplines or other access to advice
- Developing strong volunteer involvement, peer support and community-led approaches
- Access to advice and support particularly at medium risk levels, this will specifically include support to Sexual and Domestic Violence victims. This could include an Educator-Advocate model and will require work in Health settings as well as potentially other Universal Services such as schools.
- Elements of perpetrator interventions to compliment perpetrator work of the integrated partnership team.

It is estimated that this element of the PIPPA model will be funded through re-shaping currently commissioned and grant-aided services via Integrated Commissioning. This element of the model could be additionally supported by maximising external grant opportunities. This area of activity will also be supported through linked strategies and programmes, including the Prevention & Early Intervention Strategy, commissioned Parenting Programmes, HeadStart (including activities to promote emotional well-being and resilience in schools) and Families Matter (Troubled Families).

INTERVENTION:
To establish a strong multi-agency team that will bring together statutory partners to directly provide comprehensive interventions for Domestic Violence and Abuse and other types of violence experienced by victims and their families at high and medium (and crime) risk levels. This part of the model will also co-ordinate partner responses to other forms of gender violence and abuse. This new team will develop and deliver new interventions to change perpetrator behaviours and reduce re-offending. The focus here will include safeguarding children and young people through improved joint practice across services & agencies.

This element includes:

- Strategic co-ordination of Gender-based Violence & Abuse including oversight of service responses and activities; performance management and quality assurance, delivery of this Strategy and governance arrangements.
- Direct response to reduce risks to victims and their children at high or medium (and crime) risk of harm from Domestic Violence, Sexual Violence, Forced Marriage, HBV or Family Violence.
- This will include IDVA (Independent Domestic Violence Advocates) team and ISVA (Independent Sexual Violence Advocate) functions.
- Joint working with Police and Probation to maximise use of civil and criminal justice remedies;, increase successful prosecutions, and reduce re-offending.
- Perpetrator work – casework and group work challenging and changing patterns of behaviour, where safe and appropriate as part of a whole family response
- Workforce development-training, systems and pathways to support to integrate and strengthen safeguarding children and adults in this area through joint work with Early Help and specialist social work teams
- Close links with Housing and homeless services to provide a breadth of safe housing options.
- Drawing on expertise in Adult Mental Health and Substance Misuse to ensure effective co-ordinated responses to need.
- Close working with Public Health and Health partners to ensure joint work with Health providers and outcomes relate to Health prevention and promotion.

28. **PUBLIC PROTECTION**: To strengthen multi-agency partnership working to identify and assess risks, protect victims and hold perpetrators to account for their behaviour.

    This element includes:
    - Review and development of an integrated MARAC/MASH
    - Strengthening MAPPA and Integrated Offender Management links to the Pippa model
    - Developing through new partnership arrangements better means of identifying and pursuing priority, multiple and/or serial perpetrators
    - Ensuring effective and maximum use of new powers and legislation such as DV Protection orders (to remove and keep perpetrators from their homes for up to 28 days – to provide time for victims to determine options and actions)
    - Refuge provision for DV victims and their children in crisis

29. Most costs attached to these elements of the Model (Intervention and Public Protection), are already part of mainstream partnership work, although the Refuge provision is part of existing commissioned services. By bringing key partners together under a co-located, multi-agency team, there will be cost efficiencies as well as improved outcomes. Although most of the resources for this element will be achieved through reshaping existing staff and resources, additional funding will be identified, for example from the Office of the Police & Crime Commissioning, Troubled Families and other external funding streams.

30. **ALLIANCE:** The Alliance is both specialist services working together, plus a wide forum of partner agencies and communities joining up under the 'Co-ordinated Community response' model.
This element includes:

- Statutory and voluntary sector services co-managing and staffing the PIPPA single point of contact for advice and referral, including case support.
- Cross-sector training for professionals.
- Co-ordinated development and delivery of parenting programmes.
- Development and co-ordination of networks and forums supporting gender-based violence.
- Communications, campaigns and increasing the profile of Southampton against Violence & Abuse.

31. MAKING A DIFFERENCE: OUTCOMES

Appendix 1 provides a table of outputs and outcomes. The core outcomes include:

- Reduce harm.
- Reduce risks to safety.
- Increase earlier identification and responses.
- Reduce repeat victimisation and repeat offending.
- Lower the threshold for intensive, specialist support.
- Reduce escalation of safeguarding/child protection following interventions.

32. HOW WE GET THERE:

A separate Implementation Plan is available. This provides details of the next stage of development and delivery.

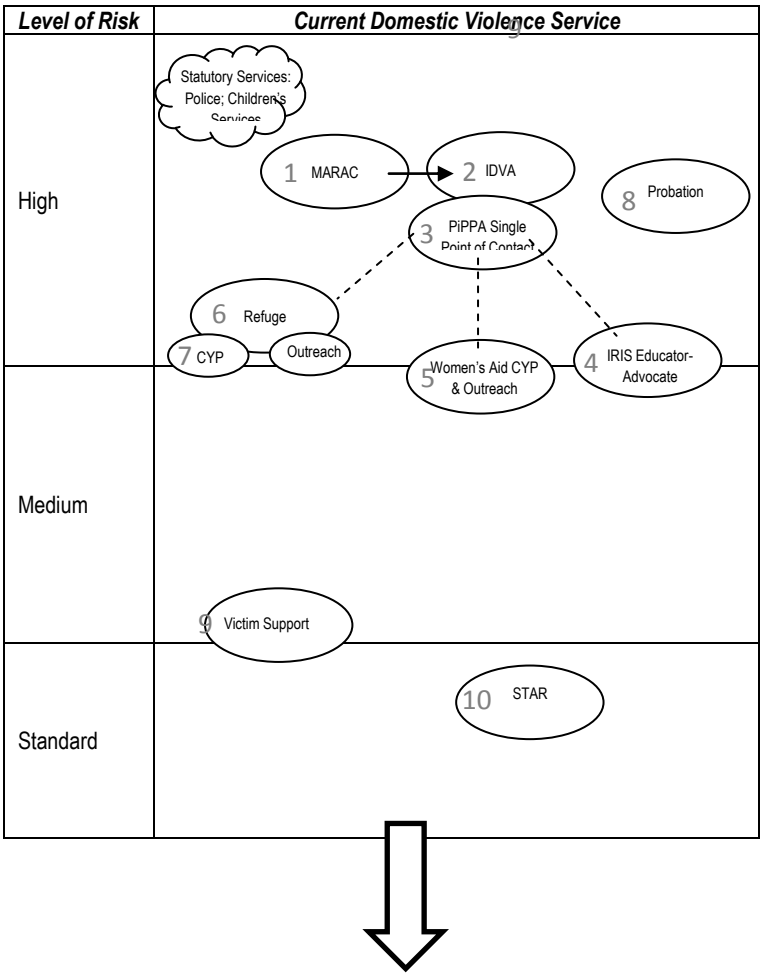
Appendices 2 and 3 show the current map of provision for DVA and the proposed new model.

The key elements to implementation will be a single commissioning framework for specialist provision in the voluntary sector, plus the development of a new single, co-ordinated multi-agency team to provide robust, intensive, specialist responses, together with development of the co-ordination and alliance of services and agencies to oversee this Plan and all activities under it.

APPENDIX1: SOUTHAMPTON AGAINST VIOLENCE & ABUSE OUTPUTS & OUTCOMES

<table>
<tr><td>Co-ordination</td><td colspan="9">PiPPA ALLIANCE
• Co-ordination and oversight of all violence and abuse responses, activities and issues.
• Established forum and networks.
• Single governance route.
• Co-ordinated communications, messages and profiles.
• Single point of contact for professionals.</td></tr>
<tr><td>Type</td><td>Domestic Violence & Abuse</td><td>Sexual Violence</td><td>Honour-Based Violence</td><td>Family Violence (child-parent; siblings)</td><td>Forced Marriage</td><td>Stalking</td><td>Female Genital Mutilation</td><td>Human Trafficking</td><td>Child Sexual Exploitation</td></tr>
<tr><td>Response</td><td colspan="6">• Integrated commissioning of specialist provision in the voluntary sector under a single framework.
• Multi-agency team of statutory and specialist partners.
• MASH and single front door for DV referrals (medium-high risk) and safeguarding concerns.
• MARAC – integrated with MASH.
• Clear care and support pathways.</td><td colspan="2">• Lead Health
• Co-ordinated under PiPPA
• Multi-agency action plan & protocols</td><td colspan="2">• Lead LSCB
• Own process and procedures
• Own strategy</td></tr>
<tr><td>Outputs</td><td colspan="9">• Identification, assessment and referral from a wide range of services, agencies and earlier (in risk levels).
• Reduced time between MARAC and MASH; multi-agency decisions; agreed prioritisation and referred swiftly.
• Agreed city-wide common tool for risk assessment; consistently match to child & adult risk assessment
• Increase range and types of safe housing options.
• Longer-term tracking of children and young people from MARAC (and high) risk to monitor outcomes.
• Increase in provision especially at prevention and early help stages.
• Increase in multi-agency and community participation.
• Increase in provision and options for working with perpetrators.
• Increase in public awareness of the issues and knowledge of where to go for advice.</td></tr>
<tr><td>Outcomes</td><td colspan="9">• Reduce risks and increase safety.
• Reduce repeat victimisation.
• Reduce re-offending.
• Reduce child protection escalation after intervention and repeat Child Protection referrals.
• Increase successful prosecutions and use of sanctions for perpetrators.
• Increase percentage of earlier identification and interventions.
• Increase engagement with services, including across equality strands and city locations..
• Reduce demand for crisis housing.
• Evaluation of cost savings.</td></tr>
</table>

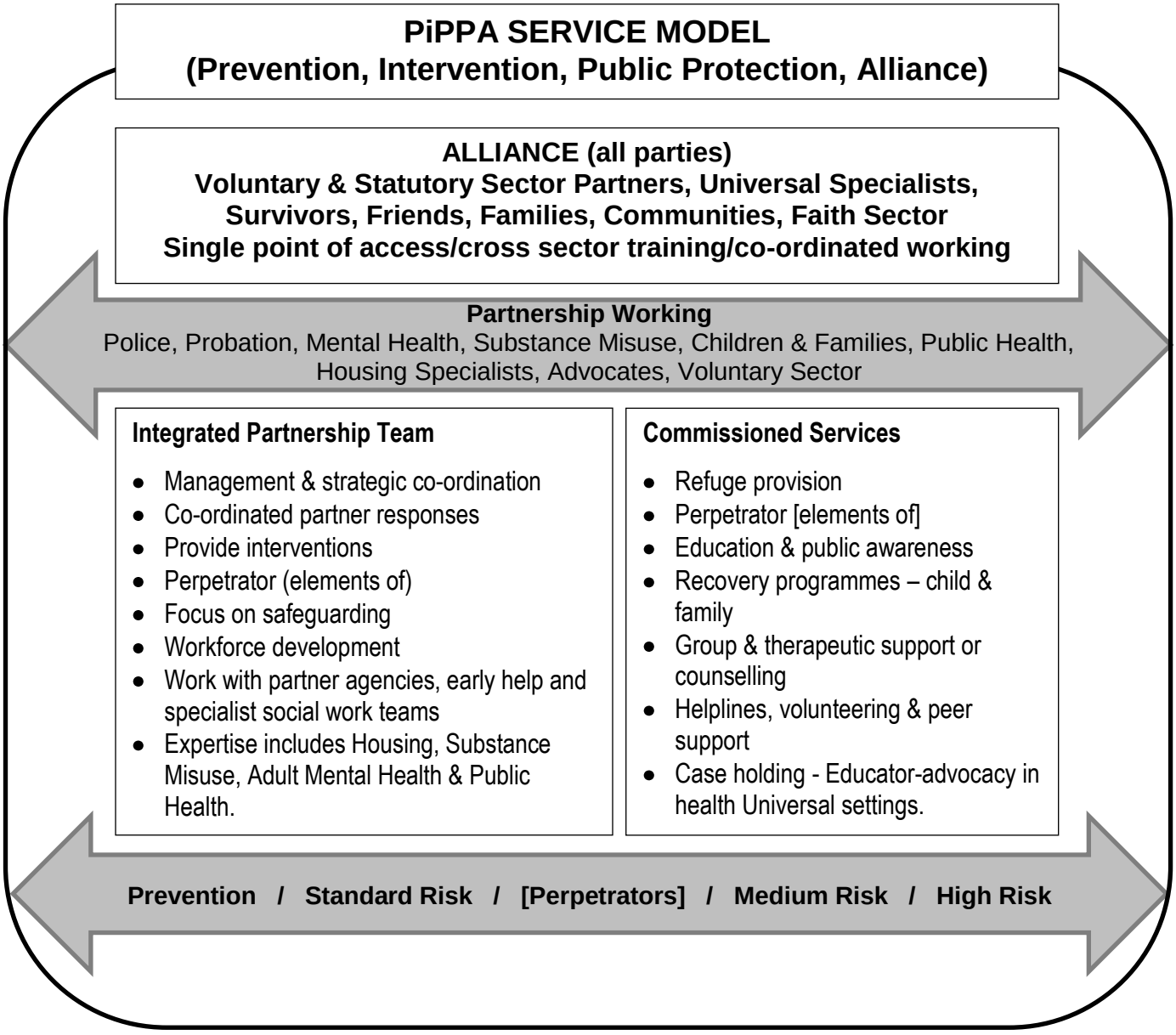
APPENDIX 2: Current DV & SV Provision



- Disparate services predominantly at high risk level.
- No joining up with statutory partners.
- No co-ordination.
- No agreed priorities and focus.

	Key Services:		Provider:
	MARAC	Multi-agency risk assessment conferences. Part of risk based model. Key agencies meet fortnightly to jointly assess risks and action plan. Highest risk cases only services involved.	Multi-agency
	IDVA	SCC high risk DV service. Part of risk based model. Also provide PiPPA = single point of contact for agencies.	Southampton CC
	PiPPA	DV services alliance. Collaborative working between services especially IDVA, Women's Aid, Stonham (refuge provider) and Rap Crisis. Provide agency advice line. Case holding referrals; training & support to agencies.	Southampton CC & other DVA Providers
	IRIS	DV education and advocacy project. Provides training & direct referral to GP's.	NHS & Southampton CC: Voluntary Sector Provider
	Women's Aid	Voluntary sector organisation provides helpline, outreach, grant funded CYP programmes.	Voluntary Sector
6	Refuges	Refuge provision in the city, bed spaces plus an Outreach Worker.	Southampton CC commissioned Housing Provider
7	CYP Outreach	Support to CYP in refuge or recently in refuge.	Southampton CC commissioned
8	Probation IDAPT	Perpetrators programme for offenders as part of licence.	Probation
9	Victim Support	National voluntary sector provides contact and advice to standard risk victims.	Voluntary Sector
10	STAR	Voluntary sector, works with young people about positive relationships and safety.	Voluntary Sector

APPENDIX 3: PiPPA Model



The new delivery model:

- Co-ordinates all services and provision.
- Shifts resources and interventions to prevention and early help.
- Joins up statutory partners and expertise.
- Works to agreed priorities and outcomes.