CLAHRC Wessex
Collaboration for Leadership in Applied
Health Research and Care

UNIVERSITY OF
Southampton

The Hampshire Domestic Abuse Prevention Partnership 2016 - 2018: Process and Outcomes Evaluation

TECHNICAL REPORT
FINAL VERSION
September 2018
Dr Sara A Morgan & Professor Julie Parkes

Acknowledgements

Executive Summary

Background

According to recent Crime Survey Statistics (2013/14), around 8% of women and 4% of men experienced domestic abuse within the previous year. The UK response to domestic abuse has had a strong focus on providing support for victims, whilst perpetrator programmes were later developed to address the root cause, by making perpetrators accountable for their actions. According to evidence, effective perpetrator programmes should be embedded within a community response, aim to engage all types of perpetrators regardless of risk, and involve an educational/behavioural approach that integrates the victim's own voice.

The Domestic Abuse Prevention Partnership (DAPP) is a developmental partnership based in Hampshire. The Partnership aims to bridge gaps for specialist services in domestic abuse, by providing an approach that integrates: a robust information sharing system on perpetrators, colocation with frontline services, dynamic risk management for perpetrators with wider health and social needs, an integrated victim safety service; and a targeted behavioural programme for perpetrators of any type of risk.

The aims of this study were to evaluate the process and outcomes of the DAPP in Hampshire, UK. The process evaluation aimed to address: *how the intervention was defined (including aims and outcomes); its causal assumptions; the quantity (including recruitment and retention) and quality of what was being delivered; the key barriers to implementation; and the mechanisms through which the DAPP brings about change.*

Methods

The study was conducted as a pragmatic mixed-methods study with a triangulation design; and using a conceptual framework based on the Medical Research Council's Framework for evaluating complex interventions. Routine quantitative data were collected by the third sector organizations, Hampton Trust and Aurora New Dawn, as well as Hampshire Police. Furthermore, in-depth interviews, observations and focus-group discussions with key groups (including victims, perpetrators, practitioners and commissioners) were conducted. Quantitative analysis was undertaken using Stata, to provide summary statistics and significance tests, where applicable. Qualitative analysis was based on a thematic approach, and was undertaken using Nvivo.

Key findings

Process evaluation

Between April 2016 and October 2017, 80 individuals completed the main educational/behavioural programme (RADAR/ADAPT). The majority of individuals that engaged with the programme had been referred by Children's Services. Relationships with children were a common motivation for men joining the programme. Men aged between18-25 were less likely to refer on to the programme, and there was under-representation from Black Asian and Minority Ethnics. Approximately 30% of perpetrators that referred to the Single Point of Contact (SPOC) per year, who did not engage with a programme, were considered 'high risk.' Following initial assessment with the Hampton Trust, a high number of individuals failed to join the programme; which may be attributed to the long waiting lists reported by clients.

In one year approximately 6% of those assessed were deemed appropriate for dynamic risk management; and approximately 21 individuals were referred on, where 1 in 5 individuals had both

housing and mental health needs. In one year, 200 victims engaged with a victim support officer. Of those referred for services, 1 in 2 were referred on to a domestic abuse service (e.g. Women's Aid) indicating an unmet need amongst victims. Over the course of the DAPP the number of individuals referred into the SPOC increased (a total of n=288 in 2017), which is attributed to colocation activities with front-line services. However, there were still uncertainties around the role and responsibilities of front line agencies, particularly around engaging with perpetrators.

Outcomes Evaluation

Following completion of the RADAR/ADAPT programme, there were positive changes in both emotional behaviours and physical behaviours amongst men (n=34) which was also supported by examples of improved relationships with their children, both from the victim and client perspective. For the majority of those completing programme, however, both the length and content of the group programme were effective at directing positive change and improving relationships. Reoffending data showed that 1 in 5 individuals were either suspected or convicted of domestic abuse crimes following the programme, which suggests that further maintenance of positive behaviours and reinforcements are required for some individuals.

Implications & Recommendations

Young adults aged 18-25 did not engage with the RADAR/ADAPT programme, and may not engage with perpetrator services, if they do not have motivation to do so. The implications are that, at the population-level, this poses a risk to victims, particularly if perpetrators have high risk behaviours. To address this, more work should be done to disrupt high risk individuals and refer them on to workshops that require less time commitment; in order to initiate self-awareness around their behaviors and their impact on others. Given that children were a strong motivation for completing a programme, it seemed almost paradoxical that there were no specialist services made available for children within the DAPP model. Although there is compelling evidence to suggest that men changed their behaviours following the programme, police reoffending data suggests that, for a minority of individuals, more work is required to fully embed positive behaviours. A mentoring service may support such aims. To further support evidence on behavioural change, long term outcomes related to victim harm should be measured; for example, through a short questionnaire filled out by current or former partners. The RADAR/ ADAPT programme is specific to the domestic abuse experienced between intimate partners within heterosexual relationships. The implications are that a number of individuals may not find the programmes appropriate to their context. Therefore pilot programmes should be developed to tackle different relationship dynamics and types of abuse, including lesbian gay bisexual transgender queer (LGBTQ) relationships, and Elder Abuse. Finally, to full achieve a community coordinated response, and make the most of the resources available, pathways of referrals and a mutual understanding of roles and responsibilities should be clearly set out, to cover both statutory and non-statutory organisations.

Key messages

- 18-25 year olds were under represented amongst those who completed the programme
- The length of the course was considered an important factor for enabling behavioural change
- Men showed positive differences in emotional and physical behavior at the end of the programme; however, 17% continued to be suspected of, or charged for, domestic abuse crimes in the monitoring period following completion
- To improve the quality of evidence, future research should be aimed at collecting prospective and linkable data, from both victim and perpetrator, to support an independent evaluation

Glossary

Aurora New Dawn	A registered UK charity that offers safety, support, advocacy and empowerment to survivors of domestic abuse, stalking and sexual violence. Aurora New Dawn work within the DAPP, and provide specialist expertise in identifying perpetrator risk
Baseline Consultancy	A specialist Consultancy that offer training in Criminal Justice, Safeguarding courses and Offender Management. Baseline Consultancy work to stabilise chaotic perpetrators by through the 'seven pathways to reoffending'
CLAHRC	Collaboration for Leadership in Applied Health Research and Care
Clients	Refers to perpetrators on a programme
CRC	Community Rehabilitation Company
DAPP	The Domestic Abuse Prevention Partnership; a multi-agency complex intervention based in Hampshire
DV	Domestic Violence
DVPP	Domestic Violence Perpetrator Programmes
DVPN	Domestic Violence Protection Notice
DVPO	Domestic Violence Protection Order
Hampton Trust	Established in 1996, the Hampton Trust is a third sector organisation that works with domestic violence perpetrators across the South of England. The Hampton Trust run the 20 week perpetrator programme within the DAPP
HBV	Honour – based Violence
HC	Hampshire Constabulary
HCC	Hampshire County Council
IDVA	Independent Domestic Violence Advisor
LGBTQ	Lesbians Gay Bisexual Transgender Queer
MAPPA	Multi-agency Public Protection Arrangement
MARAC	Multi-agency Risk Assessment Conference
MRC	Medical Research Council
NOMS	National Offender Management Service
NPS	National Probation Services

PPIT	Priority Perpetrator Identification Tool; tool to assess the type of perpetrator by offences committed – with the aim of triggering an intervention
REDAMOS	Hampton Trust's in-house database developed by the organization Respect
Respect	Respect is the UK membership organisation for work with domestic violence perpetrators, male victims and young people
SPPC	Serial Priority Perpetrator Coordinator
SCC	Southampton County Council
Seven Pathways to Reoffending	The seven pathways include the determinants of reoffending including health, housing support, education training and employment; drugs and alcohol; families; finance and debt; and attitudes, thinking and behaviour .
SPOC	Single Point of Contact; this is the point through which all the information about the perpetrators are collected; screened and referred to. The appropriate programme will be triggered from the single point of contact.

Contents

1 Introduction

1.1 Prevalence and patterns of domestic abuse in the population

National statistics for England and Wales estimate that close to 8.2% of women and 4.0% of men have experienced any type of domestic abuse within the last year. [1] These estimates are based on the latest definition of domestic abuse, 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.'* [2]

In 2011 the Istanbul Convention was set out to provide the minimum standards for the State's commitment to domestic abuse. Despite signing the agreement, the UK are still yet to ratify the laws, which has become a cause of growing concern amongst many human rights groups, lobbyists and activists. [3] The incidence of domestic abuse, both in the UK and internationally, is of significant public health importance, particularly in relation to the burden of morbidity and mortality afflicted. According to evidence in the UK, USA and Australia, pregnancy remains a high-risk period for the initiation and escalation of intimate partner violence and lead to poor health outcomes for mother and child. [4] Domestic abuse has wider cost implications for the health and social care system, with direct medical and mental healthcare costs approximating £1,730 million per annum in the UK. [5] Intimate partner violence is particularly prevalent among both victims and perpetrators receiving mental health services. Although the relationship is likely bi-directional, domestic violence is associated with mental health problems, including depression and post-traumatic stress disorder (PTSD). [5-7]

Recent evidence suggests that cases of domestic abuse follow a particular demographic profile. In a recent study in Northumbria, 90% of the 692 perpetrators reported to the police for domestic violence, were male. Furthermore, most of their victims were female, with few same-sex cases being reported. [8] Further evidence from the British Crimes survey suggest that female victims are more likely to be of low educational attainment, low household income, and living with a child. [1]

1.2 Perpetrator programmes: a brief summary

Given that the majority of domestic abuse victims are women, the development and implementation of perpetrator programmes are often based on a gendered view. Most perpetrator programmes apply cognitive behavioural, pro-feminist or psychodynamic treatments; and 50% reportedly use a combination of multiple treatment approaches. [9] The most commonly applied model for domestic violence perpetrator programmes (DVPPs) is the Duluth model, derived from an educational programme in Duluth, Minnesota. [10] The Duluth model addresses several types of abuse – ranging from financial control and intimidation, to explicit threats and actual physical assaults. Ultimately, the aims of the Duluth model, and perpetrator programmes that draw on its approach, are to reduce harm to victims and their families. In line with this, perpetrator programmes in the UK (commonly known as DVPPs) are carried out in close collaboration with community agencies that work with victims and their families. [11]

Over the years, DVPPs have developed through a process of critical reflection and engagement using the National Practitioners Network (NPN), as well as from listening and responding to perpetrators. [12] The NPN has since disbanded, and the organisation 'Respect' was developed as the umbrella organization, which sets out the minimum standards of practice for domestic violence perpetrator programmes in the UK. In 2005 perpetrator programmes became a requirement that could be placed by the courts on a supervision order, formalised under the Criminal Justice Act 2003. Probation services

developed their own Program for men mandated by the criminal court, known as the Integrated Domestic Abuse Program (IDAP); also based on the Duluth Model. Recent changes in probation services, however, including public sector reforms and increased privatisation, meant that such criminal justice based programs have become less responsive.   By contrast, voluntary community based programmes work with perpetrators of domestic abuse referred from community services, such as Children's Services and the family courts. Such programmes often involve multiple agencies, meaning that there is increased opportunity for inefficiency, duplication and poor decision making. [13] Many community agencies, with a victim-focus, also lack the adequate knowledge and competency of working with perpetrators. To circumvent some of the issues around dealing with perpetrators, voluntary community based programmes may use *co-location*, whereby referral agencies are supported through training and engagement. Some DVPPs also integrate offender management pathways as a means of improving outcomes related to reoffending. The Home Office recently outlined seven offender management pathways, formulated by the Reducing Reoffending National plan, as a means to guide service provision and reduce reoffending [14]. Broadly speaking, the seven pathways consider the effect of the wider determinants (social, economic and health) and its impact on the individual. Offender management therefore works to manage these pathways, commonly considered as *de-stabilising risks,* which include 'attitude, thinking and behaviour' 'education training and employment,' 'housing support,' 'health,' 'finance and debt', 'children and families; and 'drugs and alcohol.'

Given the complexity of embedding DVPPs within the community, and concerns around quality and efficiency, there is particular interest in modelling a multi-agency approach and evaluating the process of undertaking DVPPs, in addition to reporting the outcomes of such programmes. [15] Common measurable outcomes of DVPPs include the rate of reoffending, victim satisfaction; as well as overall changes to reported patterns of behaviour and type of abuse. [13]

1.3   DVPPs: Understanding what works

The effectiveness of perpetrator programmes has long been debated. However, such programmes are difficult to evaluate in terms of 'effectiveness' primarily due to the difficulties arising from study methodology. Limitations in study design include small sample sizes, low response rates during follow-up, and no equivalent comparison or control group. [11] Whilst randomised control trials (RCTs) may be the gold-standard, they are not always feasible for perpetrator programmes. For example, random allocation may disrupt the natural settings, whilst judicial influence may override certain cases, making random allocation difficult to achieve. Therefore an experimental study design does not necessarily make a programme evaluation more rigorous. A few randomized controlled trials conducted in the USA showed no programme effect, although their study implementation were fraught with limitations, making generalisability a common issue.[16] A quasi-control study conducted by Gondolf et al., designed to compare different kinds of programmes, suggested that perpetrators programmes improve reassault modestly. [17] Qualitative evidence also supported this conclusion. There were also two notable observations: firstly, longer interventions (e.g. 15 months) were no more effective than brief therapy and managed care (e.g. around 3 months). Secondly, a substantial proportion of men repeatedly re-assaulted and caused serious harm, which suggests more needs to be done to identify high risk perpetrators.

A recent systematic review of European evidence on the effectiveness of domestic perpetrator programmes identified 65 studies; of which 37 reported moderately positive or promising results, although none were statistically significant. There were a wide range of impact measures, including reduction in actual re-offending, changes in attitudes towards women, and change in motivation. Although some evaluations use 'pre-defined' markers of success, this made comparability to other studies and contexts limited. [3] The review highlighted the need for a clear and consistent approach to the reporting of outcomes, so that the evidence base can be made more applicable and accessible. [13]

Evidence suggests that programmes embedded within a coordinated community response, that aim to identify, treat and retain perpetrators, lead to the most positive response in terms of re-assault prevention. According to Edelson, there are still a number of concerns around perpetrator programmes; notably, how to assess and respond to men with multiple, co-occurring problems, and how to incorporate the victim's safety through their own assessment. [15] As consistently reported, the effectiveness of the programmes are invariably dependent on both the context and process of implementation.

1.4 The Domestic Abuse Prevention Partnership

The Domestic Abuse Prevention Partnership (DAPP) was developed by the Hampton Trust, and commissioned by Hampshire Police and Hampshire County Council. The Hampton Trust was established in 1996 to work with court mandated perpetrators and did so until 2006 when they moved away from court mandated perpetrators and developed community based perpetrator programmes. Due to the nature of the work, they have continued to work within and outside of the criminal justice system.

The aim of the DAPP was to provide a tiered, flexible and needs-led approach; which bridged gaps between specialist services for domestic abuse. This approach has several components, including:
- The creation and delivery of an identification and information sharing system on perpetrators regardless of their risk type – includes a single point of contact (SPOC);
- Co-location of expertise into front line services to increase knowledge and competency of working with perpetrators;
- Rapid response and assertive outreach for high risk and 'chaotic' perpetrators – offering specialist supporting services related to the seven pathways of reoffending;
- An integrated victim safety service;
- Targeted programme (up to 20 weeks) for perpetrators of any type of risk (serial, repeat and high risk); including 'modules' in behaviour awareness, empathy and parenting, and relationship dynamics.

1.4 Aims and research questions of study

The aims of this study was to evaluate the *process* and *outcomes* of the Domestic Abuse Prevention Partnership; by using a mixed methods triangulation study design.

To meet these aims, this research study addressed several key research questions, including:
- *How the intervention was defined and what were the causal assumptions?*
- *What were the key uncertainties and the important questions to address?*
- *What were the external barriers to the implementation of the DAPP?*
- *What were the external barriers to the effects of the DAPP?*
- *What was the quantity (includes recruitment and retention) and quality of what was being delivered?*
- *What were the mechanisms through which the intervention brings about change?*
- *What was the effectiveness of the intervention at achieving the named outcomes?*

2 Methodology

2.1 Study design and Conceptual Framework

The study was carried out as a *pragmatic mixed methods study with a triangulation design model*. The aim of this design model was to triangulate both quantitative and qualitative data at the same time, and to integrate the two forms of data to best understand the feasibility and effectiveness of the DAPP intervention. [18] The mixed method design is based on the central premise that the use of both approaches, quantitative and qualitative, provide a more comprehensive understanding of research issues than either approach alone.[19]

As is common to most complex interventions, the DAPP contains several interacting components. Complex interventions are commonly characterised by '*complex behavioural patterns that arise from a combination of relatively simple interactions, unpredictability, and non-linear outcomes.*' To evaluate the effectiveness of a complex intervention, the Medical Research Council (MRC) recommend a Framework approach, which integrates a dynamic view and considers the underlying complexity of the intervention. Furthermore the **MRC Framework aims to inform policy and practice by capturing not only whether the complex intervention worked, but how it was implemented; its causal mechanisms; and how the effects may differ from one context to another.** Within this Framework approach, the aim was to integrate both the process and outcomes evaluation in order to examine the overall effectiveness of the DAPP. The relationship between Process and Outcomes Evaluation is shown below.

Figure 1: The relationship between Process and Outcomes Evaluation

Process Evaluation
To interpret findings;
To understand how it might be applied elsewhere

Outcomes Evaluation
To identify if course of action was effective in time and place

2.2 Qualitative data

Based on the methodological principles of a realistic evaluation, the primary focus of the qualitative data was on process-orientation – about 'learning the processes of implementation and gaining acceptance and analysing failures and objections.' [20] [21] Some of the qualitative interviews were also used to inform an evaluation of outcomes based on self-report and critical feedback.

2.2.1 Types of qualitative data used

The qualitative methods included focus group discussions, in-depth interviews and participant observation.

In-depth interviews

The in-depth interview was chosen to explore both implementation and outcomes, for key individuals from implementing agencies and victims. One-to-one interviews were considered to be the most appropriate means for personal experiences and perceptions, as compared to any other qualitative methods.

Focus Group Discussions

The DAPP includes group-work for the majority of perpetrators; there are some exceptions, where group work is deemed inappropriate for the individual due to their behaviour and lifestyle. Focus group discussions were considered as the most appropriate way to draw on the experiences and perceptions of the majority of clients (perpetrators) – as their experiences of the DAPP are constructed as a group.

Participant and colocation observation

Observations were taken at one time point to ascertain the context of the DAPP and what is being delivered. Groups undertaking the 20 week programme (DAPP) were observed. Combined with other methods, observations provide an understanding of the context, show how what is being described in interviews (e.g. interviews with implementers) is being enacted in practice, and provide potential explanations for apparent inconsistences in spoken accounts. [22] An additional observation was undertaken at a colocation training delivery session.

2.2.2 Sampling Strategies

The sampling strategy, and inclusion/exclusion criteria, differed for each type of participant. Although random sampling is preferred in research methods, it was not possible to select participants at random, as discussed below.

For commissioners, implementers and co-locating agencies,

The key individuals involved in the conception, development and implementation had already been identified.

For victims

Given the sensitive nature of the DAPP, a number of victims did not want to be contacted. The Hampton Trust currently have a victim support worker, who contacted and identified any victims who were willing to be interviewed. In-depth interviews were undertaken with victims (current or former partners). The inclusion criteria included: victims that have acknowledged incidence of abuse through case reporting; victims that are currently in contact with staff at the implementing agency, Hampton Trust; and victims that have expressed willingness for feedback of clients' progress through DAPP.

For client groups

Two observations and two focus groups were held with clients during the research period. Due to the nature of running a 20 week programme, it was not possible to choose groups at random, as selection occurred during a short research period window of three months, when only a small number of groups were running.

2.2.3 Analysis of Qualitative data

Using the thematic approach as outlined by Braun and Clark, a six phase process was carried out; in which patterns are identified, analysed and reported within the data set. [23]

2.3 Quantitative data

Quantitative routine data related to the DAPP has been collected since the start of its implementation in April 2016. To facilitate this, a formal data sharing agreement was drawn up between all agencies and the University of Southampton. <u>Apart from the IMPACT data, which allowed a paired-sample of 34 individuals to be achieved over time (longitudinal), all the data was presented as aggregated data, taken at several 'snap-shots' in time (cross-sectional). Without the ability to assess change over time, a pragmatic approach was taken to compare data-sets and draw conclusions using the cross-sectional data.</u>

2.3.1 Types of quantitative data used

Routine data outputs

The routine data collected by the agencies involved in the delivering the DAPP includes, but was not limited to (i) risk/type of perpetrators and their social and demographic profiles (ii) through-put - including numbers of drop-outs and reasons for dropping out (iii) level of service intervention, or engagement, required as part of DAPP (iv) case studies including information and nature of domestic abuse and (v) numbers of victims involved in the victim safety service. The routine data outputs were provided as (i) aggregated quarterly outputs for stakeholder meetings, as well as (ii) outputs through REDAMOS (in-house data-base from the Hampton Trust) and (iii) police routine data. The police data were provided by Hampshire Constabulary (HC). The report provided by HC included aggregated police monitoring data on individuals who completed the DAPP, and includes the total number of individuals that were linked to a crime (either as a suspect or convicted).

IMPACT Toolkit

The IMPACT Tool was developed by the Work with Perpetrators European Network, to harmonise and enhance the monitoring and evaluation of work with perpetrators across Europe. [24] The IMPACT Tool consists of a questionnaire, which examines their behaviour (towards partner) including type of abuse; their well-being; the impact on children; and the current relationship with their partner. As part of the DAPP monitoring, clients (perpetrators) fill out the Impact questionnaire before (T0) and after the main programme (T3).

PPIT

The Priority Perpetrator Identification Tool (PPIT) was recently developed in order to support the identification of serial, repeat and high-risk offending perpetrators; and to trigger an intervention [25]. The PPIT identifies perpetrator scores based on 10 questions; each scored at 0 (absent), 1 (present) and 2 (critical).

2.3.2 Analysis of Quantitative data

Statistical analysis was undertaken using Stata version. 14. For all quantitative data, descriptive statistics such as number (%) were used to assess the process indicators; as well as median (IQR) and mean (SD) where applicable. For data from IMPACT, PPIT, Police and REDAMOS, which were based on individual data, complete case analysis was used. Using the IMPACT data, descriptive statistics were used to summarise client's individual variables, including their age, employment, education and income. The type of abusive behaviours (e.g. emotional, physical) reported were used to produce an overall score on a continuous scale, and are presented as prevalence (%).Reoffending rates were determined using aggregated police data for those completing the DAPP over one year; showing the total crimes committed (as suspect or convicted) amongst completers, the proportion of total crimes that related specifically to domestic abuse; and the total number of individuals (completers) that were implicated.

2.4   Research Ethics

Ethical permissions were granted by the University of Southampton Ethical Committee *(ID: 26211)*. Upholding ethics, good governance and quality in practice was central to all processes. These include the moral principles guided by four main principles of bioethics – as suggested by Beauchamp and Childress. [26] The principles are autonomy (informed consent), non-maleficence (do no harm), positive beneficence (benefits of research outweigh the risks) and justice (research strategies and procedures are just and fair). During the programme, the social workers sought consent from participants and victims, for their routine data to be used for the purposes of the evaluation. No additional permissions were required to access the routine data. All individual data was anonymized. During the evaluation, analysis, and write-up, no data was linked to the names of participants. Most of the qualitative quotes have been pseudonymised. The exception was where, due to the specific topic discussed, the individual's identity may become obvious (for example, in stakeholder interviews). For primary data collection (e.g. qualitative interviews), formal informed consent was obtained for each participant.

3 Main Findings

During the research period, several data sources were used to extract the main findings. These are outlined in more detail in Table 1 and a summary is shown as Figure 2.

Figure 2: Summary of data used for the DAPP Evaluation by time period covered
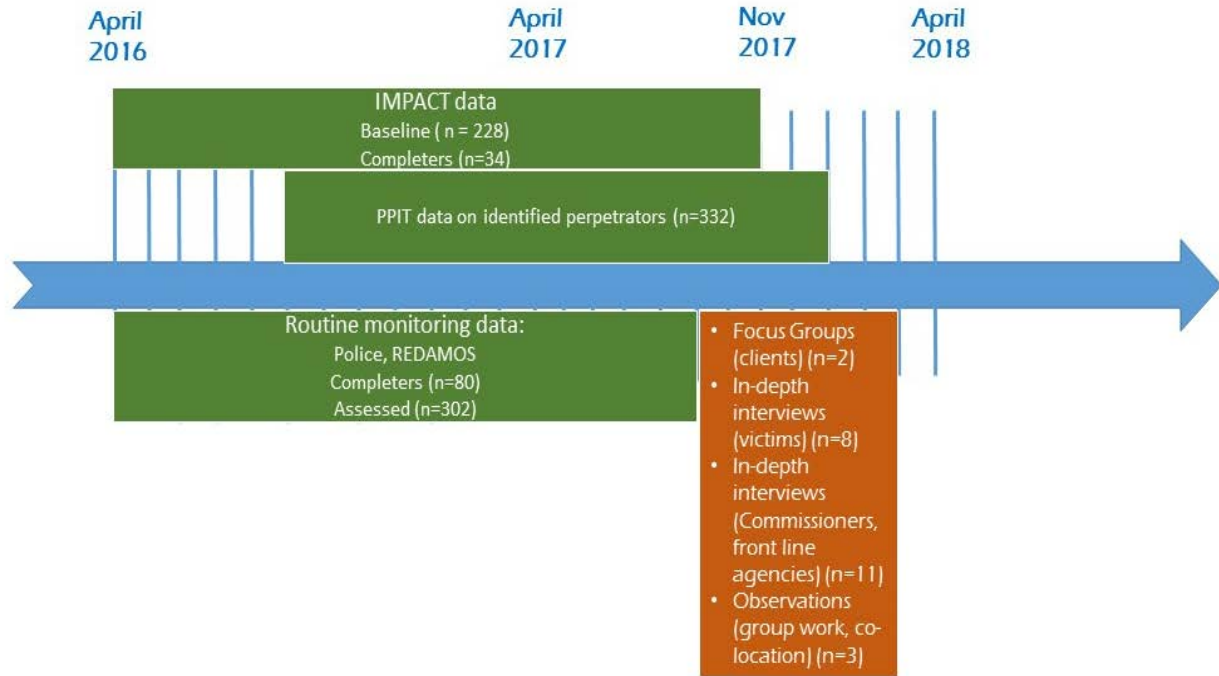
Note: As the IMPACT toolkit was being introduced at the time of evaluation, there were inconsistent practices in handing out questionnaires to clients, therefore the number of completers who filled out the end of programme questionnaire (n=34) is significantly lower than the number of actual completers over the same time period.

Table 1: Description of data used for the DAPP Evaluation

Description of Data Source	Type of Data (e.g. Quantitative/ Qualitative)	Number of participants
Focus Group Discussions with clients	Qualitative primary data	N=12 (2 groups)
IMPACT Toolkit, Baseline	Quantitative secondary data (individual level)	N=228
IMPACT Toolkit, End of programme	Quantitative secondary data (individual level)	N=34
Interviews with implementing agencies, commissioners and front-line agencies	Qualitative primary data	N=11
Interviews with victims	Qualitative primary data	N=8
Observations of colocation training	Qualitative primary data	N=1
Observations of main programme	Qualitative primary data	N=2
Priority Perpetrator Identification Tool data	Quantitative secondary data (individual level)	N= 332
Routine monitoring data for those assessed (Commissioners)	Quantitative secondary data (aggregated) and qualitative case studies	N=302 (quant) N=4 (qual)
Routine monitoring data for completers (REDAMOS and Police routine data)	Quantitative secondary data (individual level)	N=80

Process Evaluation: Description of intervention and causal assumptions

To evaluate the DAPP effectively, it was necessary to develop a current understanding of the intervention and its causal assumptions, answering the research questions:

➤ How was the intervention defined and what were the causal assumptions?
➤ What were the mechanisms through which the intervention brings about change?
➤ What were they key uncertainties and important areas to address?

The above research questions were met through in-depth interviews with *commissioners* (Hampshire Police, Hampshire County Council and Southampton City Council) *implementing agencies* (Aurora New Dawn, Baseline Consultancy and Hampton Trust) as well as *co-locating agencies* (IDVA and Safeguarding Adults Team). In so far as the broader aims of the DAPP were concerned, there was an agreed understanding that the **DAPP aimed to reduce harm to victims and their families**, as conveyed in the following quote,

"manage the risk and try and prevent homicide and keep people safe"

(Interview with stakeholder 09)

In order to meet this aim, many felt that perpetrator work should take the priority,

"I think there's always been just the priority being the victim and there's a lot of sense behind that because obviously those people need to be protected but, unless we actually deal with the source of the problem which is the perpetrator, we're never going to stop that victim cycle."

(Interview with stakeholder 01)

The components and pathways of the DAPP were described by all stakeholders, and are summarised in Figure 4, using the key on page 26. The five main components of the DAPP model were most commonly summarised as **colocation with other agencies, delivery of perpetrator programmes, integrated victim safety service, stabilisation and dynamic risk management (of perpetrators); and tracking, monitoring and disruption (of perpetrators)**.

The long term outcomes of the DAPP were commonly described as a reduction in harm to victims, and specifically, the number of victims affected; as well as the level of offending observed from the point of view of the victim. Furthermore there was an element of tackling abuse 'earlier in the cycle,'

"a reduction in the amount of domestic abuse that there is. So, ultimately, we would hope to see fewer people either coming through the system and needing support because there are fewer victims ultimately....if we're able to intervene and get to people when they're either from a perpetrator's point of view where they're at a lower level of offending or from a victim perspective where we get to them earlier in the cycle."

(Interview with stakeholder 01)

'Colocation with other agencies' was set up by the Hampton Trust to engage with community agencies, and provide specialist knowledge about working with perpetrators through training and advice. To achieve this, colocation sites were selected from a number of teams working in domestic abuse, and who required specialist support in dealing with perpetrators of domestic abuse. A support worker from the Hampton Trust was then 'co-located' within that environment for a period of time.

Training was also provided in conjunction with the Serial Priority Perpetrator Coordinator. The training was used to educate and inform community teams about working with perpetrators, pathways for referrals and the use of the Priority Perpetrator Identification Tool (PPIT).

The main objectives of colocation were,

- Increasing front-line staff confidence in working with domestic abuse perpetrators.
- Increasing front-line staff competency in working with domestic abuse perpetrators.
- Increasing front- line staff knowledge around domestic abuse and domestic abuse perpetrators.
- Improving partnership working between perpetrator services (DAPP Partners) and other agencies.

Causal Assumptions	Key Uncertainties/ Important areas to address
- Community agencies required advice and support on working with perpetrators - Community agencies were willing to collaborate and share information with the Hampton Trust	- How many colocation sites were selected and how were resources applied? - What was the feedback (qualitative/ quantitative feedback) about colocation? - How effective was colocation at increasing knowledge and competency in working with priority perpetrators? - What were the outcomes of colocation?

'Delivery of main perpetrator programmes' was led by third sector organisation, the Hampton Trust, specialised in delivering perpetrator programmes across the south of England.
The systemic push towards the provision of community-based perpetrator services is understood to stem from a gap in service provision, where the majority of perpetrator programmes are offered through court, for which perpetrators of domestic abuse may not be eligible,

So if you've gone to court and you've been referred to that service you can have it, but they've got lots of other offenders they're managing that are not eligible, if you like, for their in-house service, their perpetrator programmes, so that's why they want to refer them to community-based work which is funded by local commissioners.
(Interview with stakeholder 09)

Traditionally perpetrator programmes, or DVPPs, have offered a one-size fits all approach. In such programmes, clients engaged with a 20 week group programme, alongside other perpetrators of domestic abuse. Within the DAPP model, however, the level of intervention offered is dependent on the individual, and their associated lifestyles or behaviours. If considered unsuitable, individuals may not be referred directly onto a 20 week programme at the Hampton Trust. Instead they will be referred for stabilisation and dynamic risk management, to promote the stabilisation of their risks, and enable engagement with the main programme. The Single Point of Contact (SPOC) therefore plays a key role in identifying which individuals are suitable for a direct referral to the main programme, and which individuals require dynamic risk management.

Within the approach offered by the main programme, known as the RADAR/ ADAPT programme, the main objective is to change behaviour. In order to attain this, however, many acknowledge that an individual should show a willingness to change, as conveyed by the following quote,

"think it would be partly around how open the person on the programme is to that change and to acknowledging their own behaviour. So, unless someone is going to acknowledge it and accept that that is not okay, then that in itself will limit what they're going to be willing to move on and change and do in the future."
(Interview with stakeholder 01)

Overall the programme uses the Duluth power and control model, consistent with the model used by other DVPPs. The programme itself is split into modular components, each with a specific focus on a key area or theme. One important consideration is therefore around understanding which modules are effective, or least effective, at initiating change,

"Again, is there something about that particular module for that particular part of domestic abuse that's effective, or four of them not really doing anything, but that one is so good that it's making all the difference?"
(Interview with stakeholder 07)

Causal Assumptions	Key Uncertainties/ Important areas to address
- Individuals are referred onto main programme - Individuals engage with main programme - Main perpetrator programme leads to changed behaviour	- How many eligible perpetrators do not engage with the main programme? - What are the motivations for accessing a programme? - How is attendance/ engagement on the programme? - Which modules are least/most effective? - At what point do individuals drop off from the main programme? - What are the potential enablers/ facilitators and barriers to achieving change?

'Stabilisation and dynamic risk management' is run by Baseline Consultancy, who receive referrals from the SPOC. Baseline specialise in working with:

"high-risk offenders who are notoriously chaotic and hard to work with, and often times they are resistant as well...For one reason or another this group, or this cohort of people are so chaotic, the things happening in their lives, that they're unable to engage with mainstream services...So this group of people, whilst they aren't a terribly high percentage of all the offenders we work with (through DAPP model), this group does represent a disproportionately high number of the ones that go on to reoffend, and they're also a disproportionately high percentage of the highest risk people."
(Interview with stakeholder 05)

Within this approach, Baseline Consultancy use 'Assertive Outreach' and mentoring services for high-risk offenders, who are considered inappropriate to go straight onto the RADAR/ ADAPT programme. Such individuals may show no accountability or ability to participate in group work. The Consultancy work with the individual, for a minimum of 6 weeks, to deliver a brief intervention that directly tackles the barriers to programme engagement; otherwise known as 'risks,' which are linked to the seven pathways to reoffending,

"The areas that we look at are based on the models, seven pathways to change and those seven areas are things like substance misuse, mental health issues, housing, et cetera, et cetera. These are usually the areas that prevent somebody from changing and what we do basically is we encourage and support change...We have to determine in a triage fashion, we have to decide in what order we're going to introduce interventions."
(Interview with stakeholder 05)

Causal Assumptions	Key Uncertainties/ Important areas to address
- The individuals accessing stabilisation and dynamic risk management are high risk, chaotic individuals - The majority of individuals can be referred to the main programme (RADAR/ ADAPT) following stabilisation and dynamic risk management	- How many individuals engage with Baseline Consultancy? - What sort of intervention are they offered? - How long do they spend within Assertive Outreach? - Are the challenges/ barriers linked to the seven pathways of offending? - How do we know if their risk is escalating/de-escalating? - What percentage of individuals managed through Baseline go on to reoffend?

'Integrated victim safety service' is provided through the Hampton Trust, with intelligence offered by the Serial Priority Perpetrator Coordinator through the SPOC. The objective of the integrated victim safety service is to ensure that the victim (e.g. current or former partner of the client accessing services) is not at potential risk harm (safeguarding), to offer mentoring whilst their partner (current or former) are in programme; and to offer additional on-going support e.g. signposting to further services,

"It's about being responsible, engaging with the current partner or the ex-partner of the perpetrator

you're working with."

(Interview with stakeholder 07)

Causal Assumptions	Key Uncertainties/ Important areas to address
- Victims are engaged and accept to be involved with the Victim Safety Service - The offered service assists in managing risks to safety	- How many current / former partners were contacted? - How many engaged with the Victim Safety Service? - What are the potential outcomes of the victim safety service? - How were risks managed?

'Tracking monitoring and disruption' is currently being delivered by victim agency, Aurora New Dawn, and involves an individual co-located within a police setting; leading on the tracking, monitoring and disruption of serial and priority perpetrators.

....access to RMS, which is a record management system for the police, which holds all of their intelligence and I basically look at perpetrators that get referred into the project, build a profile using the PPIT, which is Priority Perpetrator Identification Tool, and look at ways that we can manage or disrupt that perpetrator's behaviour either through the other charities' interventions, that's Hampton Trust or Baseline, or we're just tracking the case and getting other agencies involved to speak to one another.

(Interview with stakeholder 02)

The Serial Priority Perpetrator Coordinator (SPCC) acts as a Single Point of Contact (SPOC); whose role involves gathering information related to the perpetrator, engaging other agencies through training and attending meetings, such as MARACs; as well as running a robust risk and case management system for perpetrator, and victim(s), using Safety Net. Furthermore, The SPOC is involved in engaging front-line staff in the referral of the perpetrator to the Hampton Trust or to Baseline Consultancy, depending on their needs. If individuals are unwilling to engage with a perpetrator programme, and if they are deemed high risk, then they will be actively monitored by the SPOC,

"If they're high risk and there's no one pro-actively engaging with them, Jane will keep them on the safety net, keep them as a live case and keep trying to find that professional who can get in there and engage."

(Interview with stakeholder 07)

Causal Assumptions	Key Uncertainties/ Important areas to address
- **Frontline agencies feel confident and comfortable about sharing information with the SPOC** - **There is no cut off for perpetrators i.e. all offenders are offered a level of intervention regardless of need**	- How many perpetrators are now identified that weren't before? - How can/should the information used by the SPOC feed-back to frontline services e.g. IDVAs? - How and where are referrals coming from? - What proportion of these perpetrators are high risk? - How many are being tracked and monitored? - What proportion of these perpetrators go on to reoffend? - How many perpetrators not currently/previously on a programme are still being tracked? - How many perpetrators have multiple victims? - How do we know if their risk is escalating/de-escalating?

Figure 3 below provides a simple process summary of how perpetrators (clients) are referred into the RADAR/ ADAPT programme, whereas Figure 4 shows the expanded detailed DAPP model.

Figure 3: Summary of referrals of perpetrators into RADAR/ ADAPT programme

Single Point of Contact (SPOC) identify perpetrators through community intelligence

SPOC requests referral onto RADAR/ ADAPT perpetrator programme

Agency identified to refer perpetrator to programme. Victim and perpetrator willing to engage.

Hampton Trust contact victims and perpetrators, and undertake assessment

Hampton Trust refer clients (perpetrators) to Baseline Consultancy if dynamic risk management required

Key to Figure 4

SPOC

Baseline Stabilisation/ Dynamic risk management

Hampton Trust : main programme

Actions within community (outside of referrals)

Actions through Hampton Trust once referred (as part of RADAR/ ADAPT)

Actions through Baseline once referred (as part of RADAR/ ADAPT)

Summary of Evidence: DAPP Model

The main aim of the DAPP is to reduce harm to victims, including current and potential future harm. Through a community-led approach, the DAPP also aims to tackle domestic abuse earlier in the cycle. Within this model, the main perpetrator programme, offered by the Hampton Trust, is a 20 week group intervention for all perpetrators of domestic abuse, based on the Duluth wheel of power and control. By acknowledging the seven pathways of offending, and managing the associated risks, the DAPP also engages individuals who may not be able to engage with the main programme, as their lifestyles are 'too chaotic.' Within the DAPP model, the Hampton Trust offer colocation expertise within front-line services in order to increase staff's knowledge, competency and knowledge in dealing with perpetrators. Furthermore, the Single Point of Contact (SPOC) consists of a Serial Priority Perpetrator Coordinator (SPPC) sat within a police setting; running a robust risk and case management system for each perpetrator alerted to the SPOC; and identifying serial and priority perpetrators, by using the PPIT. The SPOC is further involved in: engaging front line services in information sharing, and referrals to a perpetrator intervention within the DAPP. An integrated victim safety service has also been set up within the DAPP to manage potential risk(s) to victims, and signpost for further services.

Figure 4: DAPP Model

Integrated Victim Safety Service

Requests referral of perpetrators

Client Referrals

Hampton Trust : Assessment

Identified as 'chaotic/ high risk' and unsuitable to go straight to 20 weeks program

Identification of clients e.g MARAC, IDVA, MAPPA

Community e.g.
- Police
- Social care: Children services
- Military services
- Youth agencies

Programme : Awareness raising course (All referrals)

Identified as having motivation and accountability (for group work)

Colocation

Drop-outs (any time)

Relationship dynamics

Stabilisation/ Dynamic risk management
"intensive rapid response assertive outreach model"
- Develop 'care plan' through analysis of service requirements
- Stabilisation based on '7 pathways' to reoffending model, with view to referral to 20 week programme

Deliverables: e.g. Workshops / Training
Types of colocation: (i) those who work directly with perpetrators (ii) those who work indirectly with perpetrators e.g. child services

Children and domestic abuse course

Single Point of Contact (SPOC) Profiling, tracking, monitoring targeting of cases

Parenting course (Pilot programme)

Identification

Unsuitable for 20 week programme Recommended for other programmes

Process Evaluation: Implementation and Mechanisms of Impact

To evaluate the DAPP, the process and outcomes evaluation was set out to address what was being delivered, using both quantitative and qualitative data; answering the research questions:

  ➢ What was the quantity and quality of what was being delivered?
  ➢ What were the external barriers to its implementation?
  ➢ What was the effectiveness of the intervention at achieving the named outcomes?
  ➢ What were the external barriers to its effects?

Based on stakeholder discussions, the main aim of the DAPP model was commonly described as a reduction in risk, and incidence of harm, to victims, both current and future. Therefore to meet this aim, the assumption is that the components within the DAPP model interact to reduce harm to victims, as a resultant effect of meeting each individual objective within the model. In a logic model, these would be described as SMART objectives. Although there may be other residual outcomes, which will be discussed later, the main objectives could be summarized as:

Objective 1: to change offending behaviour (for example, by frequency);**
Objective 2: to track and monitor serial priority perpetrators;
Objective 3: to stabilise and manage the risk factors of offending;
Objective 4: to improve competency, confidence and knowledge in working with perpetrators;
Objective 5: to improve partnership and information sharing;
Objective 6: to safeguard victims, whose partner or former partner, are engaged through the DAPP.
**Note: These findings have been presented independently in Section 3.6.

The findings of the process and outcomes evaluation have been reported according to the thematic areas described as the five components of the DAPP: 1) Single Point of Contact, 2) Victim Safety Service, 3) Colocation, 4) Stabilization and dynamic risk management; and 5) the main perpetrator programme: RADAR/ ADAPT. (see Figure 4 to see how these components interact).

3.1   Tracking, monitoring and disruption: Single Point of Contact (SPOC)

As discussed in the intervention description, in order to 'track monitor and disrupt', the role of the SPOC involves engaging agencies, for information sharing and referrals; undertaking PPIT to identify suitable course of action; and prompting further action, such as continuous tracking and monitoring by police. The process indicators related to these have been outlined further below.

3.1.1 Process Indicators

The process indicators below are based on routine monitoring data which were provided as aggregated quarterly outputs to the stakeholders meetings.

In one year, of those referred to the SPOC, an agency was identified to refer the individual in approximately 47.6% of cases. A proportion of those referred onto the SPOC through community intelligence (e.g. the police), however, do not refer to the RADAR/ ADAPT programme; either as there was no agency identified to engage them or they were unwilling to engage with a perpetrator programme. If an agency could not be identified to refer the individual onto a programme, then the SPOC would continue to track and monitor them if they scored 10 or above in a PPIT, of if they already had some engagement with the criminal justice system. If they scored less than 10 on the PPIT, they would not be tracked and monitored. Based on the process data from 2017, approximately 31.9% of total referrals did not refer to the programme and were considered high enough for tracking and monitoring. By contrast approximately 20.5% did not refer to the programme and were not eligible for tracking and monitoring.

3.1.2 Perpetrator characteristics and offending behaviour

Routine Monitoring Data

The routine monitoring data was provided as aggregated quarterly outputs to the stakeholders meetings. Based on data taken from 2017, the age distribution is shown below.

Figure 5: Age distribution of referrals into SPOC, % over first 12 months of DAPP
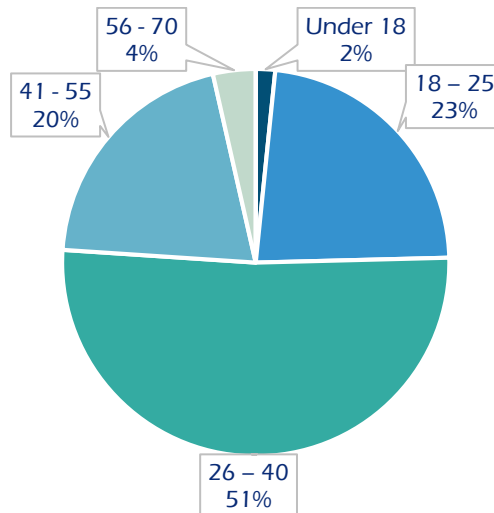
Based on this data, the breakdown of ethnicities included those that reported themselves: *White British* (87.2%), *Black, Asian and Minority Ethnic* (7.5%), or other Ethnic Group (1.6%), and Unknown (3.6%).

PPIT data

The individual PPIT data was obtained from the Serial Priority Perpetrator Coordinator (SPPC) within the SPOC. Using complete case analysis, N=332 individuals were identified with completed PPITs at the time of data collection. Based on each item in the PPIT questionnaire, the individual is given a score. If there is evidence to prove that the specific item is present, then the individual is given a score of '1.' Based on this, the PPIT ranges from 0-20.

The summary statistics for the completed PPITs included: <u>9.4 (mean), 2.51 (standard deviation) and 2-17 (range)</u> of a possible 20. A histogram of the PPIT score showed a normal distribution.

Figure 6: PPIT distribution based on individual data from the SPOC
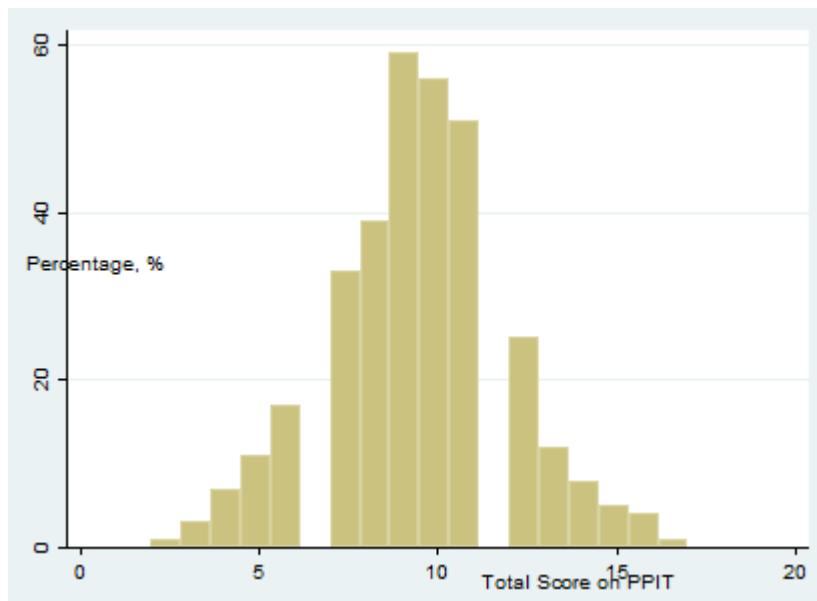
The 10 items on the PPIT relate to the characteristics of offending (1-5) and the characteristics of the offender (6-10).

Table 2: Characteristics of the offending and offender, based on individual data using the PPIT

Item No.	Description	Historic (more than 6 months ago)		Recent (in last 6 months)	
		n	%	n	%
Characteristics of the offending					
1	RECENT: Domestic Abuse against victims. (Identifying if the perpetrator is actively offending)	307	92.5	319	96.1
2	ESCALATING: Offending in Frequency and/or severity	255	76.8	300	90.4
3	REPEAT: Two or more incidents against any victim	291	87.7	303	91.3
4	SERIAL: Two or more victims	109	32.8	234	70.5
5	Related offending (any other violent or abusive behaviour)	161	48.6	165	49.7
Characteristics of the offender					
6	Subject of a MARAC or MAPPA	66	19.9	25	7.5
7	High level of harm to victims from psychological and/or physical abuse	25	7.5	44	13.3
8	Noticeable worsening of mental health	35	10.5	46	13.9
9	Noticeable increase in alcohol and/or drug misuse	39	11.8	72	21.7
10	Known history and/or current access to weapons	177	53.3	135	40.7

Note: Each offender may have more than one item characteristics of offending (< 5) or characteristic (< 5).

3.1.3 Interviews with stakeholders and frontline staff

One stakeholder felt that the tracking and monitoring system held by the SPOC permits long term monitoring of perpetrators, and enables an understanding of programme success; by using new crimes being reported, or repeat referrals, as a marker,

So the repeat referrals, people will pop back up again, so that in itself, that tracking system allows us to see whether the interventions have been successful - and to what extent. It might be that actually they've finished their programme and there's a longer gap before they reappear back on the tracking system, so what we know is we are reducing the level of violence or aggression.

(Stakeholder interview)

One of the main roles of the SPPC within the SPOC is to engage front-line services, for sharing information and to initiate the referral process. Some described the difficulty in engaging victim agencies, as they were first unwilling to share information,

"Although again we have problems there, we have problems getting - I think we should have done maybe workshops around the county to try and explain a bit about what we were trying to achieve, because we had lots of victims services going into meltdown saying, 'How dare you ask me to share information? Oh my God, this is outrageous."

(Stakeholder interview)

Information sharing in considered to be a key outcome of through the DAPP model, contributing to the high referrals coming into the Hampton Trust,

"We have always shared a client group by the very nature of what we do, we have never talked to each other about that client group. We've never shared information with each other, which is crazy now I look back on it. That's the switch-change, we're all just sharing information now and talking to each other about it."

(Stakeholder interview)

Although information sharing from victim agencies is becoming increasingly acceptable, however, victim agencies still have a degree of uncertainty about how the information shared directly benefits victims.

"Now I tend to find, this is dreadful, if I get an email from the Perpetrator Hub, I will respond to it, but it goes nowhere. It doesn't benefit my victim; it's not actually helping my victim whatsoever, just amassing loads of data on a database. Actually, I've got a victim here who's at risk of significant harm, and I need productive work put in place. That productive work will only come from a conviction with probation, or voluntarily, Hampton Trust, in respect of that kind of work that happens."

(Front line agency)

Summary of evidence: SPOC

Over one year of the DAPP (2017) the SPOC was able to identify a front line agency to refer the individual onto a programme, in approximately 52.4% of total cases. Of those that could not be referred onto a programme, only 31.9% were considered at high enough risk for tracking and monitoring through the SPOC. The PPIT scoring was used to identify the characteristics related to offender and offending. Of the PPITs conducted, there was a normal distribution and an average score of 9.4. A high percentage of individuals showed recent (96.1%), escalating (90.4%), repeat (91.3%) and serial (70.5%) offending within the last 6 months of the PPIT being conducted. The tracking and monitoring system offered by the SPOC could provide monitoring outcome about the success of programmes in the population, as well as changes in the characteristics of offending. Feedback from frontline staff involved in providing information to the SPOC suggested that there was initial resistance from victim agencies. Although information sharing between front line agencies and the SPOC is now common, frontline agencies are still uncertain about how the information shared with the SPOC benefits victims.

3.2   Integrated Victim Safety Service

The integrated victim safety service is provided through the Hampton Trust for perpetrators referred to the RADAR/ ADAPT programme. Under the requirements of the DAPP, contact details of victims, such as partners (or former partners), should be provided to the Hampton Trust. This is to provide support to victims whilst perpetrators are engaged within the DAPP. Information about victims is held by the SPOC, and is informed by community intelligence. With the information held at the SPOC, the average number of intimate partner victims, per perpetrator, could be estimated. This figure, covering one year of the DAPP, is reported in Table 3.

Table 3: 'Average number of intimate partner victims' (over one year)

Indicator		Range
Average number of intimate partner victims per offender (over one year)	2.1	1.8 – 2.5
Average number of intimate partner victims per perpetrator when the perpetrator scores over 10 on the PPIT	2.6	2.3 - 3.2

Note: The figures above were estimated from one year of the DAPP (2017), provided by the SPOC at quarterly outputs and informed by community intelligence. The range was 1.8 – 2.5.

3.2.1 Process Indicators

Reporting over one year of the DAPP, a high proportion of victims accepted a service with the safety worker (76.9%). Furthermore, 34% of victims were referred onto other agencies. A breakdown of these process indicators, including engagement and referrals, are shown in Table 4 and Figure 7. A case study is described on pg. 35.

Table 4: Process indicators for Integrated Victims Safety Service

Indicator	Total	Average per quarter (if applicable)
Number of new clients offered a service from the safety worker	260	65
Number of new clients accepting a service from the safety worker during this quarter	200	50
Total number of clients engaged with a safety worker service	200	50
Total number of clients referred onto other agencies	68	17

Note: The figures above were estimated from one year of the DAPP (2017)

Figure 7: Signposted services for victims engaged through the integrated victim safety service, over one year, percentages shown (%)
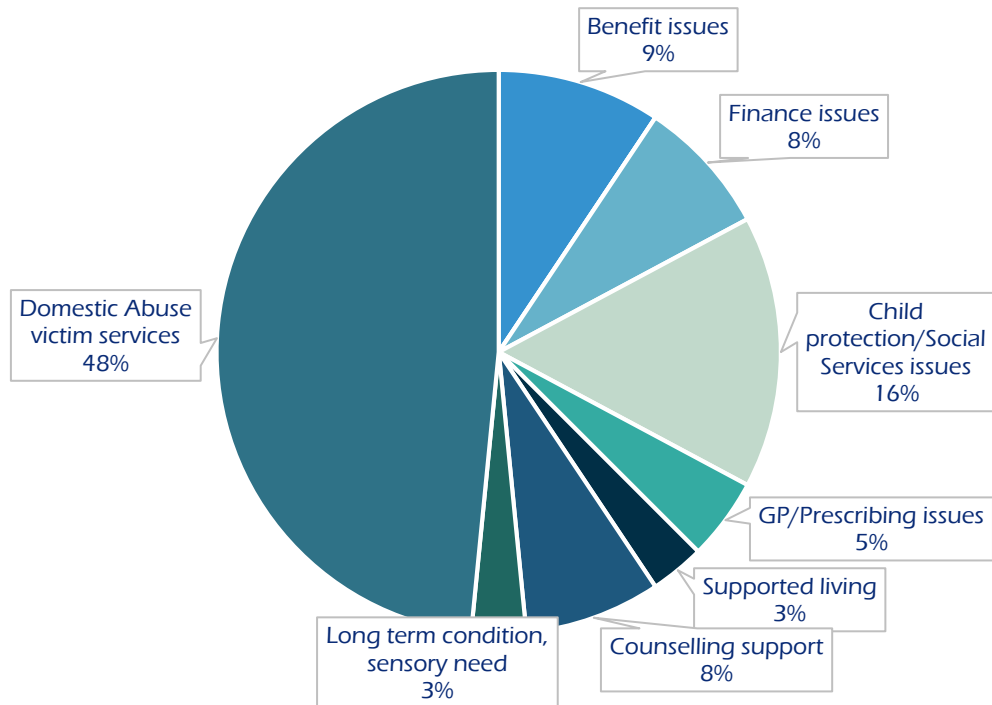
Note: The figures above were estimated from one year of the DAPP (2017)

3.2.2 Case study

<div style="background-color:#0d3c61;color:white;padding:20px;text-align:center;">

CASE STUDY: INTEGRATED VICTIM SAFETY SERVICE

</div>

Background

Mr K, currently attending group while living separately from wife, Mrs K. Mrs K. is in the process of filing for divorce, living in Mr K's flat, having custody of children. History of Domestic Violence (DV) throughout arranged marriage, history of family interference and pressure to not report breaches of Restraining Order, and ostracism for reporting DV.

Concern Arisen

Mr K disclosed in group family are very involved, control his actions and actions of ex, Mrs K, trying to influence her not to file for divorce. Mr K was asked for Mrs K's contact number as was not provided in self-referral. Reported his family were suspicious and questioning why Hampton Trust would need to be in contact with her. Increasing concern for honour-based violence alongside casual remark regarding Mrs K's shame if she were to have dated anyone before marriage and violence she would receive if she had.

Action Taken

Without contact number and no response from contact letter sent to Mrs K by post introducing Safety Advisor service, police safeguarding unit were contacted to report concerns. Police Officer disclosed over the telephone that Mrs K had engaged with victim services and IDVA previously, and had reported pressure and control of both her family and Mr K's family. Police provided Mrs K's mobile number, encouraged Hampton Trust to make contact but to report back if unsuccessful, at which point police would make welfare check visit.

Outcomes

Hampton Trust Domestic Abuse Safety Advisor successfully made contact with Mrs K, spoke at length about concerns and safety and facilitated referral and smooth handover to Southampton Women's Aid, highlighting risk for confidentiality in case with honour-based violence concerns. Process for reporting concerns for adult victim of honour-based violence shared with Hampton Trust staff for future.

3.2.3 Interviews with victims

In addition to the quantitative process indicators, in-depth interviews were used to examine the extent to which the integrated victim safety service, offered by the Hampton Trust, was effective at meeting its objectives. As described earlier, the process should involve the engagement of victims, such as partners, or former partners, with the view of safeguarding that individual and, if necessary, offering mentoring and support through referrals.

In dialogue with a former partner, one victim support officer mentored the individual, and offered practical advice about next steps,

> *"So Rebecca would phone me regularly to check if I was okay and to **give me advice** which she's just been brilliant with, her advice, and just being really black and white about things and not beating around the bush. Just telling me how it is and giving me some insight into the - what's the word - sort of psychology around my husband's behaviour and so that's been, yes, really, really helpful for me and it was also practical advice. It was **about having a safety plan** and it was **about getting help myself** and recommending legal help if I needed it, being able to recommend specialist solicitors, so that was really, yes, the practical help and also just having **somebody checking in** and making sure I was okay."*
>
> *(Interview with Victim, 002)*

However, one interviewee felt that although the relationship with the safety service had since been established, it was difficult to make contact at first,

> *I think I had to be quite proactive, particularly in the beginning, to get that communication established. The letter stated that there would be weekly check-ins and phone calls and I would be quite involved, but actually I really wasn't. I'd phone and not get phoned back and for a little while that didn't feel massively supportive, actually. Yes, eventually it did and once I'd spoken to D* and it - that felt a little bit better, then. I feel like I could access that support if I needed to now.*
>
> *(Interview with Victim, 005)*

This was consistent with findings with another interviewee, who would have liked to have heard from the support officer more frequently, and was still awaiting specific information around 'anger management,'

> *I suppose I'd probably like to hear from them maybe once a month, even if they just asked me how I feel like I'm getting on. But I did ask for help with my anger because I feel like I have a few issues with my anger, but there was talk of me doing anger management and things but I haven't actually heard anything since*
>
> *(Interview with Victim, 001)*

By contrast, another interviewee was content with the support that was offered, as well as its frequency, and acknowledged the specialist knowledge offered by the support officer,

> *"Well, for me, it was probably once every couple of weeks but she was always available if I wanted to phone her. She always said, 'If you need to phone me, here's my number', so **I always knew that there was somebody there I could speak to who understood because not everyone understands. It's quite I suppose specialist area. So, yes, I think she knew what to say to me and the right sort of advice to give me."***
>
> *(Interview with Victim, 002)*

In discussion around gaps in the service offered, the same interviewee felt that there could be more engagement with the wider family unit, for example through workshops with children, which would help to integrate with the needs of the whole family,

"...some sort of family or help for the children or workshops for the children would be fantastic. I'm looking into it to see if there are other organisations that can offer it but, yes, I want to get something because I want to rebuild the relationship with my children now that it's a smaller family unit."

(Interview with Victim, 002)

Most participants were not informed about the details of the programme attended by their partner, or former partner. Some felt that it may be beneficial to learn a bit more about the programme offered to them, and specific details around its outcomes.

One interviewee felt that, alongside the programme, there could be an individual session for victims, around the impact of the abuse, held either as a women's session or as a couple's session,

Actually, well, I don't know but I was thinking the other day it would be good if you could, maybe not bring the partners to the appointment but maybe have like a side meeting with the partner, if there is any partner. If there is any partner, individual sessions with that partner, that could be very good also because obviously as the other half, also we need help. Maybe we are even violent ourselves or we need to have this type of like attention, because it can be like very self-esteem detrimental to one person... It could be a couple. Yes, it could be a couples' session, that would be a very good idea, or it could be a women's session.

(Interview with Victim, 003)

Summary of Evidence: Integrated Victim Safety Service

Evidence over one year of the DAPP suggest that, on average, each perpetrator has committed domestic abuse with 2 victims. The Single Point of Contact facilitates the process of referring and engaging victims within the DAPP, by coordinating referrals to the Hampton Trust for the RADAR/ADAPT programme. Under the requirements of the DAPP, contact details of victims, such as partners (or former partners), should be provided to the Hampton Trust. A victim safety support officer will also work to safeguard and manage the risk to the victim. In one year of the DAPP approximately 200 victims accepted some form of service from the DAPP. Of these victims, 34% were referred to other agencies; and of those who were referred, approximately 1 in 2 were referred for a domestic abuse service e.g. Women's Aid. For victims who were willing to engage with the victim support officer they were given specialist advice and mentoring. Some victims felt that there should be earlier and more frequent contact from the Hampton Trust. There was also a suggestion for referrals for children's domestic abuse programmes or workshops, as well as individual couple sessions.

3.3   Colocation

The majority of colocation activities occurred early in the implementation of the DAPP. During the period of colocation, staff from the Hampton Trust were co-located within the front line agency, and the Hampton Trust hosted a series of workshops around:

- Domestic abuse awareness and legislation
- Engaging with perpetrators of domestic abuse
- Working with victims of domestic abuse
- The impacts of domestic abuse on children
- Cultural sensitivity, sexual violence and stalking

3.3.1   Process indicators

As the colocation activities were held early in the commissioning cycle, the outputs of 2016 and 2017 are reported in Table 5. Following colocation, questionnaires were sent out to staff within front-line agencies previously engaged in colocation. Only a small sample completed the questionnaire, these have been included as Appendix 1. Overall, those who worked directly with perpetrators, reported increased competency and confidence in doing so following co-location.

Table 5: Outputs of colocation during 2016 and 2017.

Year	Quarter	Number of Team / Sites*	No. of frontline staff DAPP have undertaken work with. (This includes staff based in that team and staff who have visited for co-location activities such as workshops)	No of Teams/ Services DAPP has worked with
2016	Q1	3	46	17
	Q2	6	89	31
	Q3	7	118	27
	Q4	4	91	12
2017	Q1	2	44	10
	Q2	4	81	8
	Q3	2	37	4
	Q4	0	0	0
	TOTAL	28	506	109

Note: * Examples of sites/ teams: Substance Misuse Services (Inclusion), Family Intervention Teams, Family Nurse Partnership, Child Protection/ MASH

3.3.2 Interviews/ Observations with stakeholders and colocating agencies

From interviews with both stakeholders involved in the delivery of the DAPP, as well as agencies engaged through colocation, several important discussion points were raised, in relation to the quality of the deliverables. As discussed by one stakeholder, colocation was broadly delivered as intended,

*"The co-location that the Hampton Trust did and **raising awareness of what the programme was, and how to recognise domestic abuse, and how frontline workers might be able to give advice over the phone to perpetrators**....they don't seem to be confident to know what to say or what to do. That's part of that training. Yes, I'd say implementation worked well in terms of getting it up and running, getting people through the door, getting them on the programme, doing the co-locations."*

(Interview with stakeholder)

When asked about the content of the training offered through colocation, one agency felt that an understanding into the impact of domestic abuse on victims proved invaluable,

*"The training was **really good in terms of talking about the impact of coercion and control.** That was really useful in terms of actually the practical side of engaging people who were experiencing coercion and control and actually, the practical points around engaging them, around recording that bit? "*

(Interview with co-locating agency)

However, these aspects were mostly described in relation to working with victims, and not in relation to working with perpetrators. Some agencies do not work directly work with perpetrators, and although training may increase their competency to do so, the knowledge from training may not be fully applied to their daily work. Further to this point, one co-locating agency recognised that although they do not directly work with perpetrators, they do come into contact with them,

*"but I think we, in our line of work, we do come in to contact with them, so **I think there being a more clear training pathway for us, or a clearer point of contact for us in terms of actually, this is how you manage it, and also, this is the point at which you don't manage it.** This is the point at which you don't get involved and if that's a decision that is made across the board then that needs to be disseminated, do you know what I mean? "*

(Interview with co-locating agency)

Based on this respondent's viewpoint, it was felt that a clearer training pathway should be set out for frontline agencies, so that they can better understand how to engage with perpetrators, and to what extent. One further objective of colocation, as outlined earlier, was in improving partnership working between perpetrator services (DAPP Partners) and other agencies. One unexpected outcome of partnership working was improved quality around referrals,

*"What that did was that helped us immensely with the **quality control aspects around a referral, so the referrals were actually accurately made, the paperwork was filled out completely accurately and also the people being referred met our thresholds and criteria for being referred.** One of the surprises was we knew that we would have a lot to offer and we anticipated that we'd be working with the community mental health teams closely."*

(Interview with stakeholder)

Summary of Evidence: Colocation

In the first two years of the DAPP, the Hampton Trust offered training and expertise to 506 front-line staff; in order to improve knowledge and competency in working with perpetrators of domestic abuse. Specifically colocation aimed to raise awareness about the DAPP, domestic abuse and, how frontline workers can give advice over the phone to perpetrators. Although sample sizes were small, feedback from front line staff indicated that colocation increased confidence and competency for those working directly with perpetrators. However, future colocation activities should be directed by the front-line agencies; to ensure that activities are responding directly to their needs, and will therefore benefit their teams. One unexpected outcome of colocation was improved quality of referrals, and accuracy in filling out paperwork. Feedback from a front-line victim agency representative suggested that more clarity is needed on referral pathways in the community, and in understanding at which point, and to what extent, victim agencies should engage with perpetrators.

Increased referrals to the Hampton Trust could be considered as a key indicator of partnership working. However not all frontline services were fully cooperative in colocation, and working with the Hampton Trust,

*"What surprised me personally was their **resistance to wanting to adopt our co-location and work with us,** it took us a long, long time to get community mental health teams on board, that was surprising."*

(Interview with stakeholder)

Although not explicitly mentioned, this resistance could stem from a lack of knowledge or uncertainty around working with perpetrator agencies,

"Only 25 per cent said they'd know how to refer to the DAPP, so we were in a room with over 200 people, so I was like, oh, so that's something that I think needs work but the other side of that is the DAPP currently with the funding doesn't have the capacity to take on everyone."

(Interview with stakeholder)

In terms of future directions for colocation, clearer objectives should be set out in terms of what colocation can achieve; through a process of learning about what each site (front line agency) wants to achieve, and ensuring that the deliverables are specific to those requirements,

*"I think we were extremely generous, and that was about trying to get into as many teams as possible. So in implementing it again I would say really have - whoever goes and has meetings and discusses what we can offer as an agency coming into your teams. ....I would say **be clear with colocation, how will it benefit you, what benefit can we bring to your teams, what are you looking to get out of this, how it benefits us in terms of you referring to our service, and what would we like to see afterwards."***

(Interview with stakeholder)

3.4   Stabilisation and dynamic risk management

The outputs of activities related to 'stabilisation and dynamic risk management' were reported as aggregated quarterly outputs, and have been presented below to cover one year of the DAPP.

3.4.1 Process Indicators

In one year of the DAPP, a total of 21 clients were offered support by Baseline, averaging at around 5 per quarter. The majority of clients were aged between 26-40 years old (57.1%) and the most common interventions required related to housing needs, mental health needs and finance needs. In one year 13 individuals were referred back to the Hampton Trust, as stabilization and risk requirements were met. Of these, 7 were referred onto the group programme (RADAR/ ADAPT), whereas 6 were offered individual programmes as they were not considered suitable for group work.

Table 6: Process indicators for 'stabilisation and dynamic risk management'

Process Indicators for SPOC over one year of DAPP (from 1st January 2017 – 31st December 2017)		Total over one year	Per quarter (if applicable)
Total number of new clients offered support by Baseline Consultancy		21	5
Age	18 – 25	4	
	26 – 40	12	
	41 - 55	3	
	56 - 70	2	
	71+	0	
Of new Baseline Consultancy clients from area during this quarter main objectives/intervention required (Based on PPIT & LSIR) include:		0	
	Number with housing needs:	12	
	Number with mental health needs:	12	
	Number with substance misuse needs:	5	
	Number with learning disabilities:	1	
	Number with benefit issues:	5	
	Number with employment issues:	2	
	Number with finance issues:	11	
	Number with child protection/Social Services issues:	2	
	Number with GP/Prescribing issues:	3	
	Number needing supported living:	1	
	Number needing Counselling support:	0	
	Long term condition, sensory need:	0	
	Complex needs (2 or more of above):	15	

Total number of clients actively engaging with Baseline Consultancy	40	6
Average number of weeks a client would work with Baseline Consultancy	14	
Number of clients who stopped engaging with Baseline Consultancy prematurely	2	
Number of clients referred back to Hampton Trust due to stabilisation and objectives (Based on PPIT and Level of Service Inventory Requirement assessment tools scores) being met by Baseline Consultancy.	13	
Number of those above who were referred into RADAR	7	
Number of those above, who are referred into alternative individual interventions when return to Radar/group work not appropriate.	6	

Figure 8: Distribution of intervention requirements, for clients in stabilisation and dynamic risk management over one year, percentages shown (%)
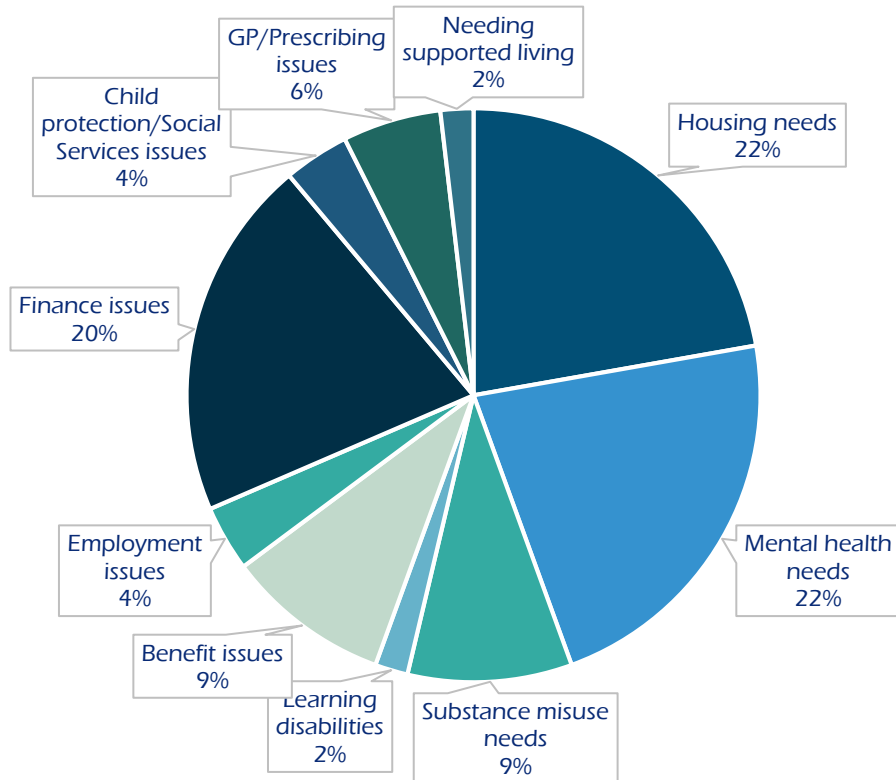
3.4.2 Case study

GH (PPIT of 13) was convicted of breaching a non-molestation order and sentenced to 6 months imprisonment. Upon release he was licensed to live at an Approved Premises (AP) and when this finished moved back to Hampshire where he moved into hotel accommodation. The DAPP Outreach Practitioner jointly with Probation Services met GH at this point and it was identified that his priority needs were for Housing and matters relating to his health. Several meetings were set with the Housing Department of his local council but he did not fit the criteria for immediate housing. GH had access to finances but failed to provide references or security and could obtain neither of these. This, coupled with the fact that GH was subject to a court order preventing him from approaching his family home, together with GHs reluctance to move too far away, limited the DAPP Outreach Practitioner's options. As a result, and despite exhaustive enquiries the Practitioner was unable to find suitable premises through estate agents. The Practitioner, however, had previous knowledge of local private landlords and eventually located a bedsit which provided temporary respite. Because of GHs lack of references, this landlord required 6 months of rent in advance and one months' deposit. GHs banking was fragmented and it required the assistance of the Practitioner to rectify this before his rent could be paid. Once paid, GH took up residence but had no bedding, curtains or other basic necessities and again the Practitioner obtained these and had them delivered. Had this not been done, it would have heightened the risk of GH returning to the family home to collect these necessities and in so doing he would breach his order. Once GH was in secure accommodation, the Practitioner was able to deal with the high priority of GH's health. Due to his failing health, it was urgent that he was rapidly enrolled with a local Health Centre as he only had 4 days of medication remaining. However, further complications arose when it was discovered that his new GP could not see him for 7 days and could not issue a prescription until then, but because he had moved area, he had already been removed from his previous GP's books. GH was unable to resolve this himself and was becoming increasingly agitated. The situation was resolved by the Practitioner making numerous phone calls to both Surgeries and finally resulted in a prescription being issued 2 days later.

Due to GH's volatile and previous threatening behaviour the DAPP Outreach Practitioner decided to accompany him to Probation Meetings; she was trusted and not perceived as a threat.

About one month later GH advised the Practitioner that there were maintenance issues with his bedsit and as a result the Practitioner challenged the landlord and GH was then moved to a one bedroom unfurnished flat. The Practitioner then contacted a local charity who were able to supply some furnishings. Further complications arose over the Electricity Key which resulted in the Practitioner spending a considerable amount of time in identifying and then sourcing a replacement, before GHs electricity would work.

Over time, it was observed that as GH became more secure in his environment, due to the interventions and representations made by the DAPP Senior Outreach Practitioner on his behalf, his mental well-being improved and he became more rational and calmer. At this point he was provided with details of other supporting agencies and he was referred back to Hampton Trust.

Summary of Evidence: Stabilisation and Dynamic Risk Management

Stabilisation and dynamic risk management was offered to individuals within the DAPP, who were considered to have chaotic lifestyles, which meant that accessing the main group programme (RADAR/ ADAPT) would be too challenging. The approach offered by Baseline Consultancy includes a rapid assertive outreach, that addresses the seven wider determinants of offending. According to one year of data, approximately 21 individuals were managed; of which the majority had housing (22%) and employment needs (22%). The practitioner provided a supportive role - whose responsibilities aimed to create a stable environment, which included, for example, attending Probation meetings and providing bedding. In one year of the DAPP, 7 clients were deemed suitable for further referral on to the main RADAR/ ADAPT programme and 6 were offered individual treatment.

3.5   Main perpetrator programme: RADAR/ ADAPT

Overall the quantitative data for the RADAR/ ADAPT were based on three data sources: the quarterly outputs provided by the Hampton Trust at the stakeholders' quarterly meetings, individual secondary data from the in-house database (REDAMOS); and individual secondary data using the Impact Toolkit (questionnaire).

Based on the aggregated quarterly outputs, a summary of key quantitative findings were described. It is important to note that these figures are based on aggregated quarterly outputs, and therefore do not show follow-up of individuals over time. The figures have been used to indicate the level of throughput during one year of the DAPP and; notably, to show the level of engagement, and potential barriers to engagement. As follows:

- Over 2017, a total of 302 of referrals were made to the Hampton Trust. In the same year 160 assessments were made (53.0% of total referrals). Of the 302 referrals, a total of 51 individuals were contacted or booked for assessment, but failed to attend assessment (16.9% of total referrals in one year). Of those who attended their assessment approximately 82% were deemed suitable for RADAR. (This estimate is based on the proportion of those deemed suitable for RADAR following those who attended their assessment, and of referrals received in the same quarter).

- Of the total number of assessments made in one year, approximately 6% were deemed suitable for dynamic risk management at Baseline.

- Over 2017, 70 clients attended their first sessions of RADAR; however during the year 2017, 155 individuals actively engaged in a group.

- In 2017, 36 individuals completed the RADAR programme.

- Drop out data shows that the highest drop-out occurred following assessment (Step 1) and before the start of the RADAR programme (Step 2). According to individual level data on drop-outs, obtained from the Hampton Trust, a total of 57 individuals did not start the programme following assessment; which corresponds to approximately 18.9% of total referrals.

- Following the start of the RADAR programme, 31 individuals were recorded as not engaging and therefore considered as 'dropping out of the programme.' Taking 70 new clients per year as the denominator, approximately 43% will be expected to drop out during the programme.

- Approximately, 11.9% of those that are referred onto the DAPP complete the programme.

3.5.1 Process Indicators

The process indicators for the RADAR/ ADAPT were further described using two data sources: the aggregated quarterly outputs provided by the Hampton Trust at the stakeholders' quarterly meetings, and individual data from the in-house database (REDAMOS). The period covered is shown in the Tables and Figures below.

Table 7: Process Indicators over one year of DAPP (from 1st January 2017 – 31st December 2017)

Process involved for main perpetrator programme	Indicator	Total in one year	Average per quarter
Step 1: Referrals	Referrals for intervention	302	76
Step 2: Assessment	Assessments made (of referrals received at any time)	160	40
Drop-outs	Number attempted to contact, or booked assessment but failed to attend assessment	51	13
Attendants	Number who attended their assessment (of referrals received in the same quarter)	67	17
Outcome of assessment (Main programme)	Number deemed suitable for RADAR following assessment (of referrals received in the same quarter)	N/A	14
Outcome of assessment (Dynamic risk management)	Number deemed suitable for dynamic risk management following assessment	9	2
Waiting time for assessment	Average length of time on the waiting list for assessment/ in days	34	N/A
Step 3: Main programme Waiting list for main programme	Of number of clients referred during year, number that have had an assessment and are on a waiting list for Radar	48	12
Waiting list for programme	Number on waiting list following referral and assessment	60	15

Waiting time for programme	Current average number of weeks on the waiting list for Radar	4	N/A
Engagement	Total number of clients actively engaging in Radar (on group)	155	39
New clients	Number of new clients who attended their first sessions of programme	70	18
Completion*	Total number of clients who fully engaged and completed programme	36	9
Drop outs	Total number of clients who dropped out from programme	30	8

Note: Figures have been rounded up to a whole number * The number of completers over 2017. The total number completed between April 2016 – September 2017 was reported as 80.

Figure 9: Estimated through-put by end of 2017 (one year of the DAPP); based on cross-sectional data

| DROP OFF | | PROCESS IN MAIN PERPETRATOR PROGRAMME | | Estimated waiting list numbers |

DROP OFF

PROCESS IN MAIN PERPETRATOR PROGRAMME

Estimated waiting list numbers

Number attempted to contact and booked assessment but failed to attend assessment so closed
N= 51

Step 1: Referral to Hampton Trust N= 302

Number not contacted/ currently on waiting list for assessment ~ 90*
Average waiting time = 34 days

Number booked on course but failed to attend start of programme e.g. not motivated/ found other suitable course **N= 57**

Step 2: Assessments made N= 160 (of which N=9 are for dynamic risk management)

Number assessed/ currently on waiting list for RADAR programme ~60**
Average waiting time = 4 weeks

Step 3: RADAR programme attended. (Number of clients who attended first sessions) N= 70

Number stopped engaging after initiating workshops or main programme **N= 31**

Step 4: Completion of RADAR programme N= 36

Notes: Please note that these estimates are based on cross-sectional and not longitudinal data. All total numbers (N) were based on aggregated quarterly data outputs (Jan 1st to Dec 31st 2017); with the exception of 'Number booked on course but failed to attend start of programme' which was based on drop-out data provided by the Hampton Trust. *True estimate of numbers on waiting list for assessments have not been reported. The figure shown is an estimation based on through-put. **This is an estimate of the "number of people on the waiting list of those assessed during the year."

3.5.2 Social, demographic and behavioural characteristics of clients assessed

Next, the social demographic and behavioural characteristics of clients assessed were estimated using the IMPACT Toolkit (questionnaire) at Baseline i.e. before the start of the programme, and at the point of assessment. The Impact Toolkit (questionnaire) is based on individual self-report to a list of questions related to personal characteristics, behaviour and impact of behaviour.

The following Tables show the social (employment and income) status, and the relationship status of those that were assessed at Step 2, from April 2016 – November 2017.

Table 8: *"Employment status"* of those assessed at Step 2 over the period of April 2016 – November 2017, using the Impact questionnaire.

EMPLOYMENT	Frequency, n	Prevalence, %
Full time employment	133	58.3
Part time employment	7	3.1
Combining part-time employment with caring for children/family	2	0.9
Unemployed	35	15.4
Unemployed and caring for children/family	3	1.3
Full time caring for children/family	3	1.3
In education or training	1	0.4
Retired	2	0.9
Unable to work because of sickness	29	12.7
Self employed	10	4.4
Agency work	2	0.9
Immigrant - can't work	1	0.4
Total	228	100.0

The majority of those assessed declared full time employment (58.3%), although a high number declared themselves as unemployed (15.4%) or unable to work because of sickness (12.7%).

*Table 9: "**Income**" of those assessed at Step 2 over the period of April 2016 – November 2017, using the Impact questionnaire*

INCOME	Frequency, n	Prevalence, %
Struggling to pay for the essentials (home, bills, food, child support, travel to work)	27	11.8
Managing to pay for essentials but nothing left over	71	31.1
Managing to buy the occasional treat or save sometimes	68	29.8
Managing regular treats and saving or holiday	21	9.2
Comfortably managing – don't have to worry	36	15.8
High income	5	2.2
Total	228.0	100.0

Over 1 in 10 individuals (11.8%) reported struggling to pay for essentials, and close to 1 in 3 individuals (31.1%) reported managing to pay for essentials but having nothing left over. In terms of relationship status, most clients reported the relationship as having ended and living apart (33.8%) whereas still a high proportion of clients were reported as together and living together (27.2%).

*Table 10: "**Relationship status**" of those assessed at Step 2 over the period of April 2016 – November 2017, using the Impact questionnaire*

RELATIONSHIP STATUS	Frequency, n	Prevalence, %
Together and living together	62	27.2
Together but living apart	55	24.1
In the process of splitting up	11	4.8
The relationship has ended and we are living apart	77	33.8
I am not sure	12	5.3
Something else – please say:*	11	4.8
Not answered	0	0
Total	228	100

Note: Examples of quotes:

'Not together yet but need to do some hard work first. We are going to give a try one more time.' 'Have an injunction out against me.' 'Friend. Divorced. Living apart.'

The majority of individuals reported their relationship as having ended and living apart (33.8%), whereas 1 in 4 were still together and living with their partner (27.2%).

Table 11: Reasons for coming to the programme (self-report), of those assessed at Step 2 over the period of April 2016 – November 2017, using the Impact questionnaire

REASON FOR COMING TO PROGRAMME	Frequency, n	Prevalence, %
Reason: I have to come as part of my criminal court sentence or bail or parole conditions	1	0.4
Reason: I have to come because the family court told me to	10	4.4
Reason: I have to come because the child protection services told me to	54	23.7
Reason: I don't want to go back to prison again	2	0.9
Reason: I want to be a better parent to my children	13	5.7
Reason: I want to stop using abusive behaviour	7	3.1
Reason: I don't want my partner to be afraid of me	3	1.3
Reason: I don't want my children be afraid of me	6	2.6
Reason: I want my partner/ex to feel safe around me	15	6.6
Reason: Social worker told me to	1	0.4
Reason: Solicitor told me to	1	0.4
Reason: I want my relationship to be better	107	46.9
Reasons: Quote given (See note below**)	8	3.5
Total	**228**	**100.0**

**Note: Examples of quotes:

'Understand myself and learn more about self-control.' 'I want to be a better person and help others.' 'I want to see my son.' 'I want to do the best I can for my daughter.'

Figure 10: Number of emotional behaviours used (related to domestic abuse) of those assessed, shows prevalence (%) based on N=228
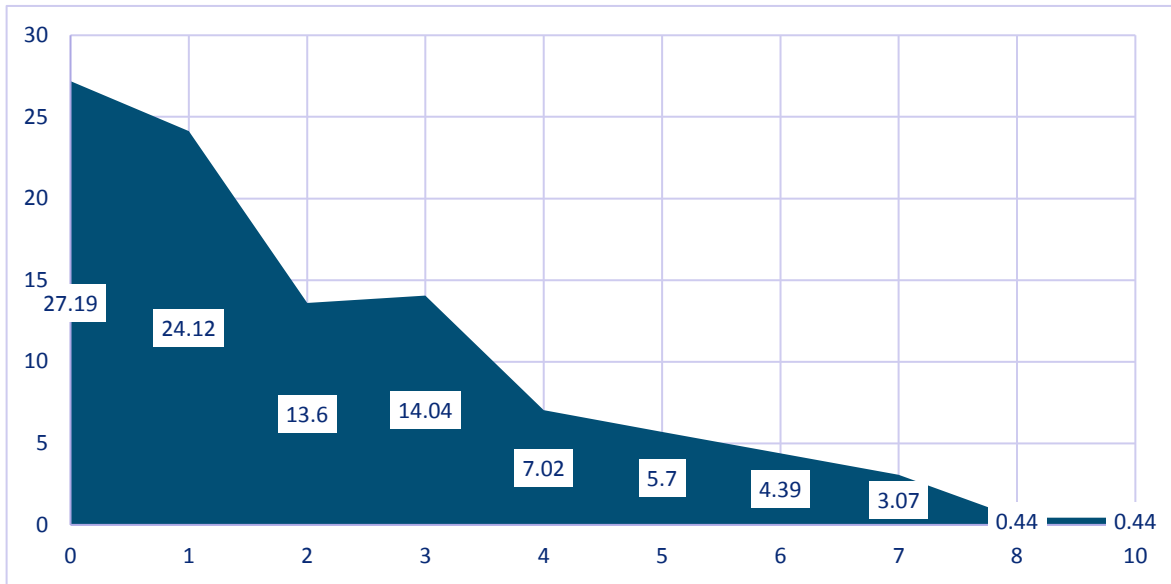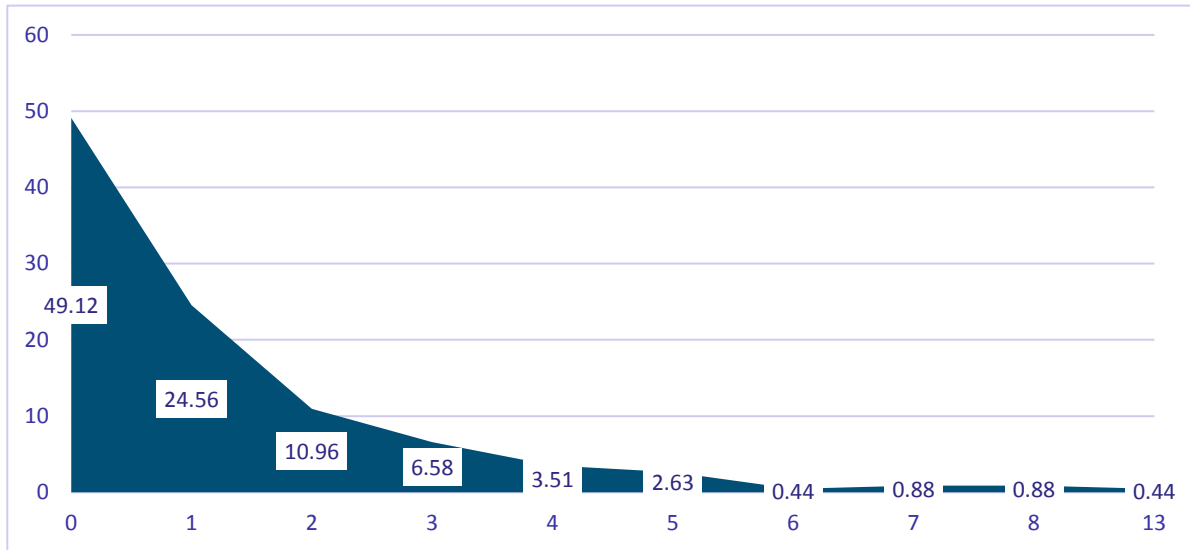

Note: Responses were given on a Likert scale: 'never', 'sometimes' or 'often.'

Presence of emotional behaviour was determined by those who responded either 'sometimes' or 'often.'

Figure is based on total number of individuals exhibiting behaviours, from 11 emotional behaviours, including: 1) Emotional behaviour: Isolated from friends or family WITHIN the last 12 months; 2) Emotional behaviour: Told partner what to do/not do, where to go/not go, who to see/not see WITHIN the last 12 months; 3) Emotional behaviour: Made partner feel she had to ask permission to do certain things such as going out, seeing friends, etc. (above and beyond being polite) WITHIN the last 12 months; 4) Emotional behaviour: Threats to hurt the children WITHIN the last 12 months; 5) Emotional behaviour: Made them feel afraid by things you did/said WITHIN the last 12 months; 6) Emotional behaviour: Prevented partner/ex from leaving home WITHIN the last 12 months; 7) Emotional behaviour: Controlled the family money WITHIN the last 12 months; 8) Emotional behaviour: Threats to hurt partner/ex WITHIN the last 12 months; 9) Emotional behaviour: Extreme jealousy or possessiveness WITHIN the last 12 months; 10) Emotional behaviour: Told partner/ex what to wear or not to wear or how to do hair/makeup WITHIN the last 12 months; 11) Emotional behaviour: Humiliated/embarrassed partner/ex in front of others WITHIN the last 12 months.

Over 1 in 5 individuals reported '0' of the total 11 emotional behaviours listed. However, close to 1 in 5 reported showing 4 emotional behaviours or more.

Figure 11: Number of physical behaviours used (related to domestic abuse) of those assessed, shows prevalence (%) based on N=228
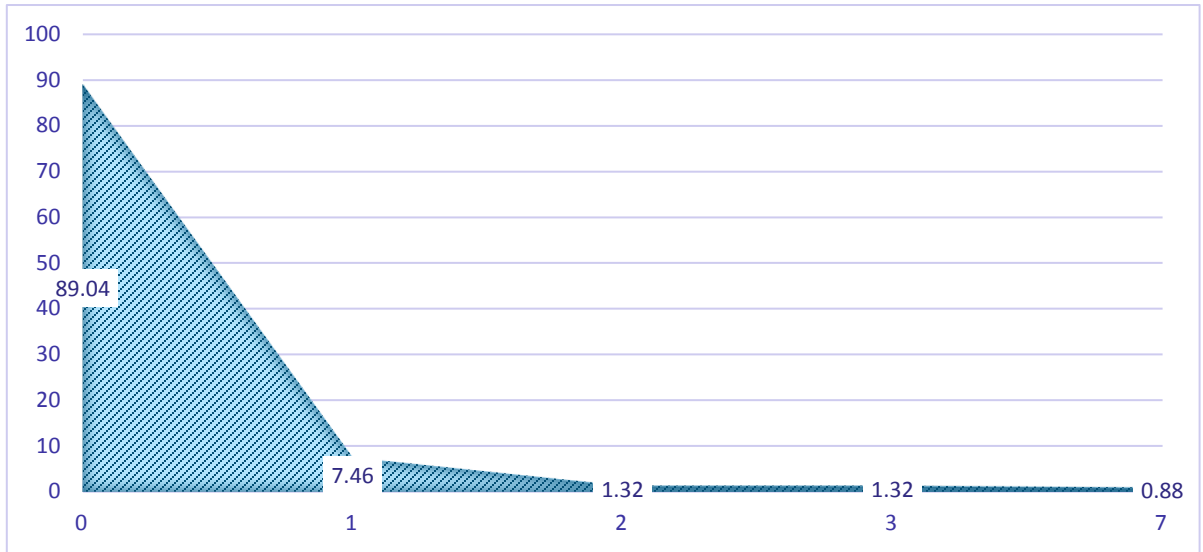

Note: Responses were given on a Likert scale: 'never', 'sometimes' or 'often.'
Presence of physical behaviour was determined by those who responded either 'sometimes' or 'often.'
Figure is based on total number of individuals exhibiting behaviours, from 14 physical behaviours, including: 1) Physical behaviour : Slapped / pushed / shoved WITHIN the last 12 months; 2) Physical behaviour : Kicked / punched WITHIN the last 12 months; 3) Physical behaviour : Beaten up WITHIN the last 12 months; 4) Physical behaviour : Burned WITHIN the last 12 months; 5) Physical behaviour : Bitten WITHIN the last 12 months; 6) Physical behaviour : Restrained/held down/tied up WITHIN the last 12 months; 7) Physical behaviour : Put your hands on her throat or face (trying to choke or strangle or suffocate) WITHIN the last 12 months; 8) Physical behaviour : Physically threatened WITHIN the last 12 months; 9) Physical behaviour : Hit with object or weapon WITHIN the last 12 months; 10) Physical behaviour : Threatened with object/weapon WITHIN the last 12 months; 11) Physical behaviour : Threatened to kill her WITHIN the last 12 months; 12) Physical behaviour : Prevented her getting help for injuries WITHIN the last 12 months; 13) Physical behaviour : Stalked/followed/harassed her WITHIN the last 12 months; 14) Physical behaviour : Locked her in house or room WITHIN the last 12 months

Over 1 in 2 individuals reported '0' of the total 14 physical behaviours listed. By contrast 1 in 4 reported exhibiting 1 physical behaviour.

Figure 12: Number of sexual behaviours used (related to domestic abuse) of those assessed, shows prevalence (%) based on N=228

Note: Responses were given on a Likert scale: 'never', 'sometimes' or 'often.'
Presence of sexual behaviour was determined by those who responded either 'sometimes' or 'often.'
Figure is based on total number of individuals exhibiting behaviours, from 7 sexual behaviours, including: 1) Sexual behaviour: Touched in way which caused her fear/alarm/distress WITHIN the last 12 months; 2) Sexual behaviour: Forced her into doing something sexual she didn't want to WITHIN the last 12 months; 3) Sexual behaviour: Hurt her during sex WITHIN the last 12 months; 4) Sexual behaviour: Disrespected boundaries or safe words WITHIN the last 12 months; 5) Sexual behaviour: Made her have sex when she didn't want to or didn't stop when she wanted to WITHIN the last 12 months; 6) Sexual behaviour: Sexually assaulted/abused her in any way WITHIN the last 12 months; 7) Sexual behaviour: Threats to sexual assault/abuse her WITHIN the last 12 months.

A high percentage of individuals reported exhibited '0' sexual behaviours out of the list of seven; and only 1 in 10 reported 1 or more sexual behaviours.

3.5.3 Impact on others as reported by those assessed (Step 2)

The following Tables report the impact of the domestic abuse on others, including partner and family, as well as the reason for the violence shown.

Table 10: Impact on Partner concerned from the perspective of client (self-report)

Impact on Partner concerned	Percentage, %
Impact: Felt sadness	65.8
Impact: She lost respect for you	53.1
Impact: Felt angry/shocked	53.1
Impact: Made her want to leave you	48.7
Impact: She stopped trusting you	45.2
Impact: Felt worthless or lost confidence	40.4
Impact: Felt anxious/panic/lost concentration	31.6
Impact: She felt unable to cope	30.7
Impact: She had to be careful of what she said/did	30.7
Impact: Injuries such as bruises/scratches/minor cuts	27.6
Impact: Depression/Sleeping problems	26.3
Impact: Felt isolated/stopped going out	14.9
Impact: Feared for her life	13.6
Impact: Didn't have an impact	10.5
Impact: Injuries needing help from doctor/hospital	7.5
Impact: Self-harmed/felt suicidal	7

Note: Percentage displayed corresponds to proportion of individuals from total sample (n=228) who indicated (ticked) the presence of named impact.

Table 11: Impact on children concerned from the perspective of client (self-report)

Impact on children	Percentage, %
Children: One or more of my children is currently registered with the state child protection as in need of protection because of the violence/abuse in our relationship	28.5
Children: One or more of my children is angry or upset with me	22.4
Children: The courts or state child protection have stopped me from living with my children	20.6
Children: I don't think our children were affected by the abuse	16.7
Children: The courts or state child protection have stopped me having contact/access	10.1
Children: My children have been removed and are being looked after by foster parents	9.7
Children: One or more of my children is angry/upset with my partner/ex because of what's happened	9.7
Children: I have applied to the court for contact with our children	8.3

Note: Individuals may have marked more than one category.

Table 12: Reason for Violence from the perspective of client (self-report)

Reason for Violence	Percentage, %
Reason for Violence: Didn't feel good enough/felt insecure	27.2
Reason for Violence: Because you didn't trust her	24.1
Reason for Violence: To stop her from doing something	23.7
Reason for Violence: Because of your alcohol/drug use	22.8
Reason for Violence: Because she betrayed/rejected you	21.5
Reason for Violence: Because you were jealous/possessive	18.9
Reason for Violence: To make her do something you wanted her to do	12.7
Reason for Violence: Made you feel in control	12.3
Reason for Violence: To stop her from leaving you	11.8
Reason for Violence: Because she was laughing at you	7.5

Note: Individuals may have marked more than one category.
.

3.5.4 Social and demographic characteristics of clients who complete the programme

Next, the social demographic and behavioural characteristics of clients who completed the RADAR/ ADAPT programme was described using both the IMPACT Toolkit (questionnaire) at Baseline as well as the individual data from the in-house database (REDAMOS)

- According to individual data from the in-house database (REDAMOS), between 01 April 2016 and 30 September 2017, 80 individuals completed the RADAR programme.
- Approximately 75% of those who completed the programme lived in Southampton, whereas 25% lived in Hampshire (excluding Southampton).

As shown in Figure 13, the majority of referrals occurred through social services (54%), and the second highest was through self-referral (28%).

Figure 13: Referral Source, for those who completed the programme between April 2016 and September 2017
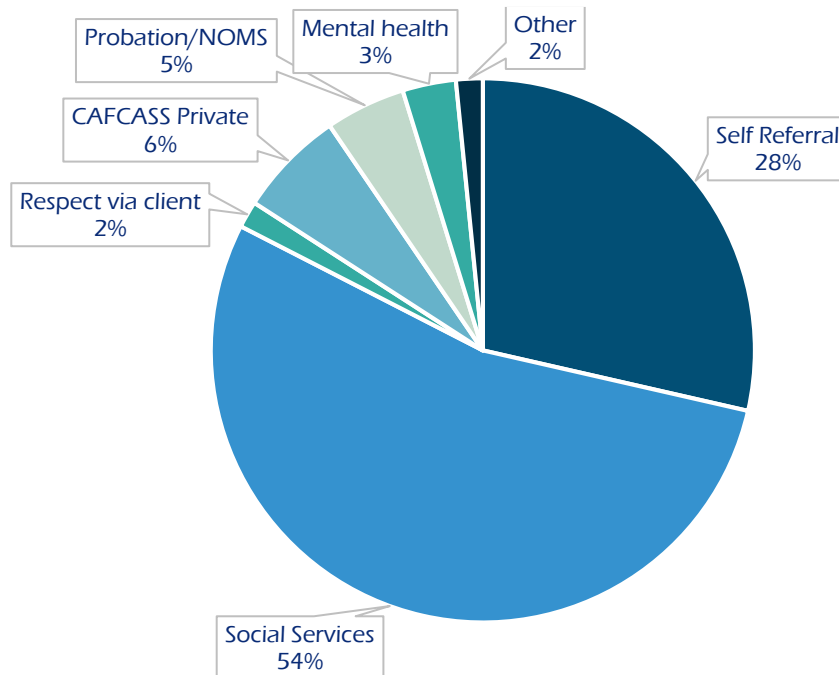
Note: The above is based on completed data for N= 63 individuals in this time period

The next figure and table examines the age differences of those who completed the RADAR/ ADAPT programme, with those who were referred through the Single Point of Contact, and onto RADAR.

Figure 14: Age distribution of completers, based on individual level data over one year of the DAPP
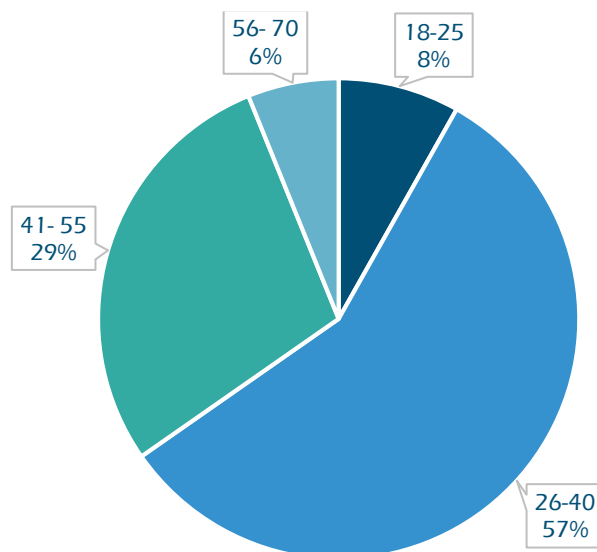
Table 13: Summary statistics comparing the age distribution of those "Referred" versus those that "Complete"

Age category	Referral to SPOC	Referral to RADAR	Completers
Under 18	2%	0%	0%
18-25	**23%**	**23%**	**8%**
26-40	51%	59%	57%
41- 55	20%	16%	29%
56- 70	4%	3%	6%

Note: Referral data is based on aggregated data from quarterly outputs, whereas data on completers is based on individual data. All figures are based on data over one year. Highlighted in purple is the largest discrepancy between those referred and those that complete.

The next section examines reasons for dropping out of the RADAR/ ADAPT programme, based on individual data collected by the Hampton Trust at the time of drop off (lack of engagement).

3.5.5 Reasons for dropping out of the RADAR/ ADAPT programme

The reasons for dropping-out have been categorised by time period: following assessment at the Hampton Trust (Step 2) and following the start of the programme (Step 3). Most commonly individuals failed to attend the start of the programme following assessment.

Table 14: Reasons for dropping-out from RADAR/ ADAPT programme, shown by stage following referral

Reason for drop-off following Assessment (Step 2)	n	Total
Not motivated/ interested to continue	10	
Failed to attend programme	33	
Completing another course	9	
Signposted to other services	1	
Couldn't attend dates of programme due to other commitments	2	
Not suitable for programmes	2	57
Reason for drop-off following start of programme (Step 3)		
Suspended due to lack of attendance	16	
Attended 2 part workshop but not motivated/ interested to continue to main programme	10	
Moved away from Hampshire	5	31
		88

Note: Estimates shown in Table were based on routine data from REDAMOS. Estimates were based on complete data i.e. when descriptions and characteristics were reported.

3.5.6 Focus Group Discussions/ Observations

The above information has so far indicated the 'quantity' of what was delivered through the RADAR/ADAPT programme within the DAPP. In so far as the 'quality' of what was delivered, this was informed by two focus group discussions and two observations; of two RADAR/ADAPT groups. The experiences and opinions of the programme were thematically grouped according to:

- The design and content of the programme
- Factors related to getting onto the programme

Related to the **design and content of the programme;**

Many felt that the length of the programme was important, and that one needed to attend for a considerable period of time to reinforce particular ideas, as conveyed by the following quote,

"I feel the length of the course is important because it does take a while to open up. It is important to get into a routine about talking about these sorts of things. If you were able to condense it into a six-week course, you might be able to cover the ground, but I think that just the reinforcement of actually coming for a fairly considerable period of time is important, but it might not feel like it as you're going through it possibly."

(Client 2, Focus Group Discussion 2)

One described the programme as 'intense,' as a lot of complex things were condensed in a fairly short amount of time. In terms of the design, a few felt that the end of the programme should have a particular focus on transitioning into independence. One person described a 'dependency' on the facilitators which continued after the end of the programme, and suggested that this issue may have been better tackled before the end of the programme. He noted that although a post-programme mentoring scheme is in place, which should help this transition, he was still dependent on his facilitator, having built up a rapport throughout the course of the programme,

"Oh, you know there are other mentors,' and gave me the phone number for the mentors, which I've never used. It occurred to me that I was becoming a bit dependent on Rosa, and I wonder if part of when you finish the programme, there should be, within the last module, a moving on module. If that makes sense."
(Client 6, Focus Group Discussion 1)

Although all modules were commonly described as important, the Children's module was singled-out by a few clients, on the basis that it was the most relevant,

"All of it, really. The whole lot. I can't single out any- I mean, the modules, the course content's very comprehensive, but I think you said [referring to another member in group] the child one particularly. It's so tangible to, if you've got children, how things have impacted on them."
(Client 1, Focus Group Discussion 1)

One person even felt that the time spent on the Children's module could be increased,
"certainly the child module would be one I would easily double the time that they have on that."
(Client 4, Focus Group Discussion 1)

When asked about the most relevant , or important tools covered, which could be put in to practice, one person described the 'pressure gauge' and the Duluth wheel of power and control.

"We've got the domestic abuse wheel and then the equality wheel, and where we want to come from to where we want to go. That is probably the most effective tool that they use, along with the pressure badge, I think is something... Everyone learning how to use your time out right. Guys when they first come in here, they don't use the time out. They don't know what it's all about. Then, throughout the 25 weeks, I think it does actually take that long for people to start putting that into practice and using it because at first everyone thinks that they don't need it."
(Client 3, Focus Group Discussion 2)

The one-size fits all approach used through the RADAR/ADAPT was reflected upon by the members; one member felt that the Duluth model may not be completely applicable to their situation.
On further discussion, however, treating all clients equally despite their differing situations, was considered a better approach,

"It's difficult to categorise who goes in what group, if you were to split groups up in any way.

....'Right, you go in that group. You go in that group.' It's almost saying that they're worse than them. That's not very equal. I wouldn't want to know that I'm in the bad group or the good group."
(Client 4, Focus Group Discussion 2)

Another positive attribute of the programme, commonly described, was the pragmatism used to acknowledge unhealthy behaviours. This pragmatism, practiced by the facilitators, was what encouraged self-reflection and acknowledgement of behaviours, as conveyed by the following quote,

"I mean, the way it was facilitated, if you would bring something up, you would be questioned on it. You would be sat in this room and you would think, well, hold on a minute, and then you would start questioning yourself. Then you would start questioning it as you go home, and then as things progress along, you just realise that almost every little thing you can do, that you think, as they've said previously, you think is normal behaviour, is actually not."
(Client 2, Focus Group Discussion 2)

On **factors related to attendance of the programme:**

Waiting lists were considered a concern for clients. Despite the waiting lists, however, the clients continued onto the programme,

"Month after month went by and nothing was arranged. Eventually I phoned up Rosa and said, 'Can you enrol me because I'm in ...She said, 'No problem.' They said I could be about six or eight weeks bit of a shock."
(Client 5, Focus Group Discussion 2)

To attend the programme, one client had to travel a fair distance, which was also considered a deterrent for some people,

"Yes, because I come from .... so it's about an hour and three quarters. I did try and suggest to the social workers that was there something nearer, but I think they obviously thought I was trying to get out of it, so I kept coming."
(Client 6, Focus Group Discussion 2)

In relation to both the waiting lists, and the choice of programme locations on offer, many felt that there were not enough programmes available to meet the demands,

"I think, it took a lot of courage and it took a lot of time to come...There's nowhere near enough of these happening to support the demand at the moment."
(Client 5, Focus Group Discussion 2)

3.5.7 Interviews with Victims

The majority of victims approached for interview were not actively engaged in their partners' progress through the RADAR/ ADAPT programme, and therefore did not have any views or opinions in relation to the quality of what was being delivered, nor the process of engaging in the programme.

One individual, however, had been actively engaged in the referral process, and actively encouraged her partner to seek a programme.

"Well, we first got in contact because obviously we thought that we needed some help, so we started to do our own research about how we can get some help with the style of our conversations, how to get it... We wanted

to have actually like couples therapy when we started to look for some type of help, and then we came across this programme."
(Victim, In-depth Interview, 003)

Throughout the duration of the programme, she learnt about her partner's progress,

"We have learned so much. Even myself. I am not going to the sessions but how my partner talks about it and the way they explain it. We discuss it after he comes back and actually we really like the way they do it; that they discuss it and there is turns for them. I think that looking at other types of - maybe not looking into their life but looking into their experiences and making you think about your own, and that type of therapy, I think that's very like constructive."
(Victim, In-depth Interview, 003)

By contrast, one victim challenged her former partner's motivation to the course, suggesting that his motivation was to gain access to his child; rather than to encourage any change in behavior,

"What I would personally like is to call a spade a spade. To actually not allow somebody like this to come in and do a course to help them to get what they want. Children aren't a piece of meat, women aren't a piece of meat. Yes, my perspective on that is that people would see it for what it is, and actually not enable men like this through just doing a course. He's clearly shown that he would stop at nothing."
(Victim, In-depth Interview, 006)

On further discussion on the impetus to change behaviour, the respondent felt that although motivations to attend the programme may alter throughout its duration, the perpetrator should fully acknowledge a need to change their behaviour at first,

"Somebody coming on a course to do this, if the motive isn't right and the motive is that actually, 'I don't recognise I'm a perpetrator', so - if somebody's coming on a course that says, 'Yes, I know I'm a perpetrator and I want to sort myself out,' then anything can happen."
(Victim, In-depth Interview, 006)

Finally, in comparison to other courses and therapies attended, one respondent felt that the RADAR/ADAPT had the biggest impact on her former partner,

"Definitely, it was because he's had counselling for years and he saw a psychiatrist once and he's had all sorts. He's had CAT, cognitive analytical therapy, and he's had CBT, and things would improve for a while but not to this extent and then they would get worse again. Obviously, it's fairly short, he's only just finished it in December, mid-December, so obviously it's fairly quite fresh in his mind still, so I don't know how, whether it will have changed him forever but he is telling me that it's revelation and that he's changed. But, yes, out of everything or, over the years, out of everything that he's done, definitely, this has had the biggest impact on him, his behaviour
(Victim, In-depth Interview, 002)

Summary of Evidence: Main perpetrator programme

Over 2017, a total of 302 of referrals were made to the Hampton Trust. In the same year 160 assessments were made and 36 individuals completed the RADAR programme.

Based on data taken on those assessed (step 1), over 1 in 5 individuals self-reported exhibiting no emotional behaviours (out of a list of 11). However, close to 1 in 5 self-reported exhibiting 4 emotional abuse behaviours or more. Over 1 in 2 individuals self-reported no physical behaviours (out of a list of 14). By contrast 1 in 4 reported exhibiting one physical behaviour. A high percentage of individuals self-reported exhibiting no sexual behaviours; and only 1 in 10 self-reported exhibiting one or more sexual behaviours.

The highest drop-out occurred following assessment (Step 1) and before the start of the RADAR programme (Step 2). Based on the same year's data, the current average waiting time for assessments (Step 1) was 34 days. Of those assessed, the majority declared full time employment (58.3%), although a high number declared themselves as unemployed (15.4%) or unable to work because of sickness (12.7%). Once assessed the waiting list for the main programme (Step 2) was, on average, 4 weeks. Both waiting lists and distance travelled were a concern for those on the programme. Approximately 1 in 5 of perpetrators accessing the main programme had come because of child protection.

Of those who complete, around 1 in 2 have been referred through social services. 18-25 year olds were under represented amongst those who complete, and therefore most likely to drop out at the point of assessment. Feedback from clients indicated that the length of the course was important to initiate change and that the one-size-fits-all approach, offered through the group work, was suitable. Furthermore, the children's module seemed to have a particular impact on individuals. As confirmed by the victim interviews, children were a major motivating factor for those pursuing the programme.

Outcomes Evaluation: Evidence of Behavioural Change

3.6. Impact Data

A total of 34 clients completed the individual Impact questionnaire following completion of the RADAR/ ADAPT programme. The clients were asked to report on the changes in their behaviour since starting the programme. This is shown in Table 28. Based on available data on completers, approximately 73.5% stated that they 'have stopped using abuse behaviour' and 58.8% felt that their future relationships would not be abusive.

Table 15: Changes in behaviour since participating in the RADAR/ ADAPT programme, using the Impact questionnaire (end of intervention)

Reported behaviour	n	%
Changes: I have stopped using violence	22	64.7
Changes: I have stopped using abusive behaviour	25	73.5
Changes: I believe my partner is not afraid of me	15	44.1
Changes: I believe my partner/ex feels safe around me	16	47.1
Changes: I believe my children are not afraid of me	22	64.7
Changes: My current new relationship is non-abusive	13	38.2
Changes: I believe my future relationships will be non-abusive	20	58.8
Changes: My ex-partner and I ended the relationship without any more abuse	4	11.8
Changes: My partner (ex-partner) and I can work well together on the upbringing of our children	17	50.0
Changes: Nothing has changed	1	2.9
Changes: I fulfilled my criminal court sentence or bail or parole conditions	3	8.8
Changes: I am allowed to have contact with my children	10	29.4
Changes: I haven't gone back to prison again	3	8.8
Changes: I believe I am a better parent to my children	20	58.8
Changes: My partner decided not to end the relationship	6	17.6
Changes: our relationship is better	14	41.2

Using the responses before the start of the programme and at the end of the programme, a comparison was made in the type/number of behaviours reported. The results are shown in Table 16 for emotional behaviours, Table 17 for physical behaviours and Table 18 for sexual behaviours. Due to small sample sizes, significance tests were not applied.
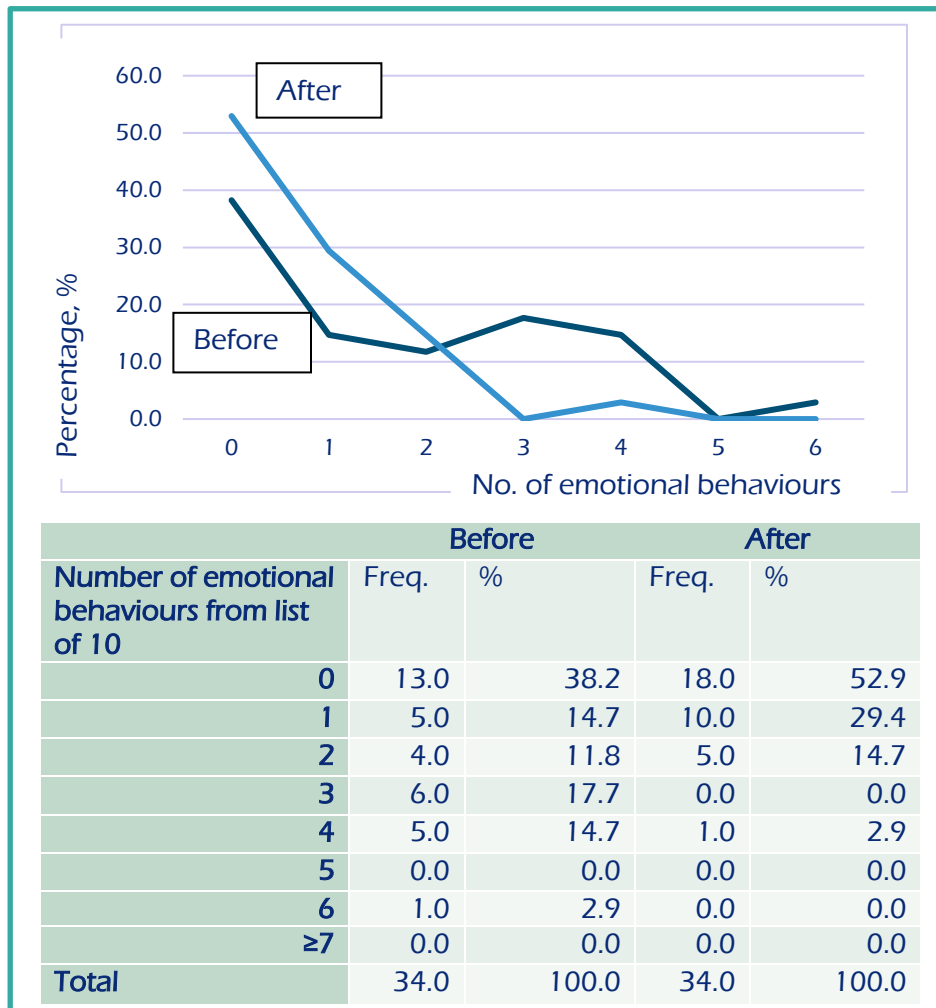
Table 16 shows the difference in the number of emotional behaviours before and after the programme. After the programme, fewer individuals had higher emotional scores, and the number of individuals that exhibited lower scores (e.g. 2 or less behaviours) increased.

Table 17 shows the difference in the number of physical behaviours before and after the programme. After the programme, fewer individuals had higher physical scores, and the number of individuals that exhibited zero behaviours increased.

Table 18 shows the difference in the number of sexual behaviours before and after the programme. Responses to sexual behaviour appeared to be very similar before and after the programme.
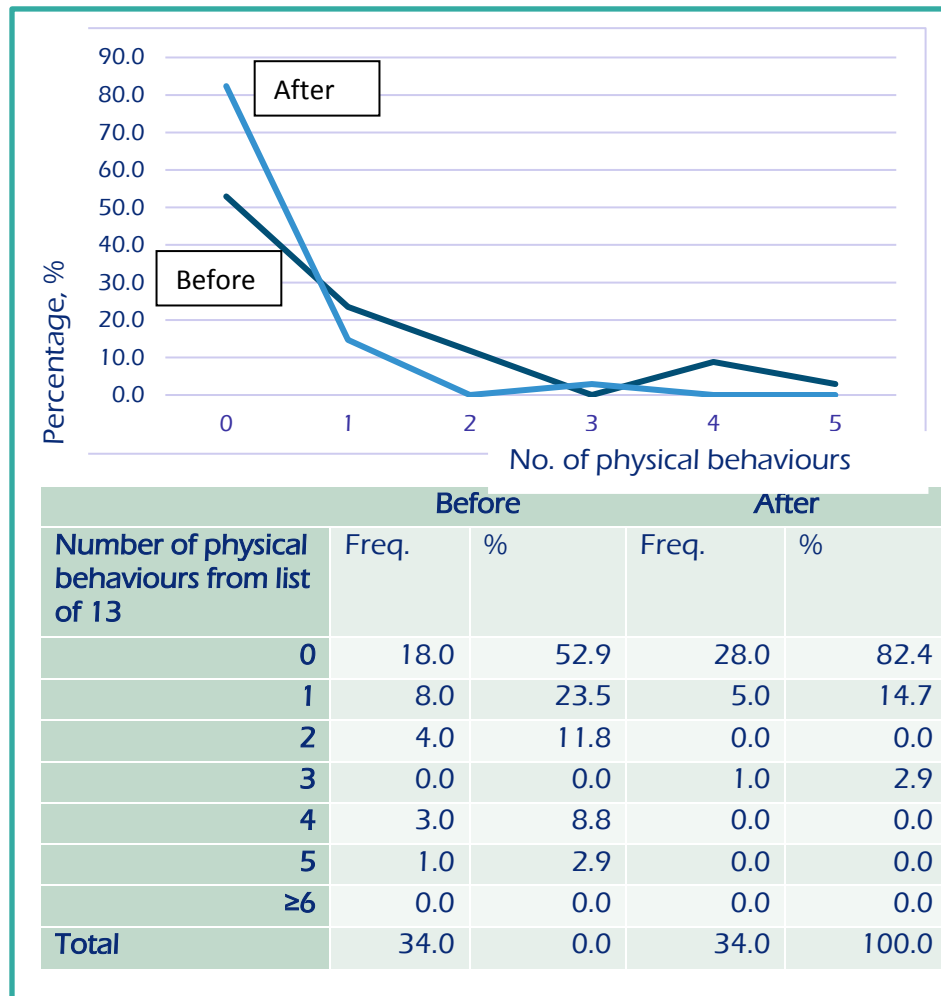
Table 16: Changes in emotional behaviour since completing the programme, using Impact questionnaire at start of programme ('Before') and end of programme ('After')

Number of emotional behaviours from list of 10	Before		After	
	Freq.	%	Freq.	%
0	13.0	38.2	18.0	52.9
1	5.0	14.7	10.0	29.4
2	4.0	11.8	5.0	14.7
3	6.0	17.7	0.0	0.0
4	5.0	14.7	1.0	2.9
5	0.0	0.0	0.0	0.0
6	1.0	2.9	0.0	0.0
≥7	0.0	0.0	0.0	0.0
Total	34.0	100.0	34.0	100.0

Presence of emotional behaviour was determined by those who responded either 'sometimes' or 'often.'
Figure is based on total number of individuals exhibiting behaviours, from 10 emotional behaviours since starting the programme ('After') and in last 12 months before start of the programme ('Baseline'), including: 1) Emotional behaviour: Isolated from friends or family; 2) Emotional behaviour: Told partner what to do/not do, where to go/not go, who to see/not see; 3) Emotional behaviour: Made partner feel she had to ask permission to do certain things such as going out, seeing friends, etc. (above and beyond being polite); 4) Emotional behaviour: Threats to hurt the children; 5) Emotional behaviour: Prevented partner/ex from leaving home; 6) Emotional behaviour: Controlled the family money; 7) Emotional behaviour: Threats to hurt partner/ex; 8) Emotional behaviour: Extreme jealousy or possessiveness; 9) Emotional behaviour: Told partner/ex what to wear or not to wear or how to do hair/makeup; 10) Emotional behaviour: Humiliated/embarrassed partner/ex in front of others.

Table 17: Changes in physical behaviour since completing the programme, using Impact questionnaire at start of programme ('Before') and end of programme ('After')

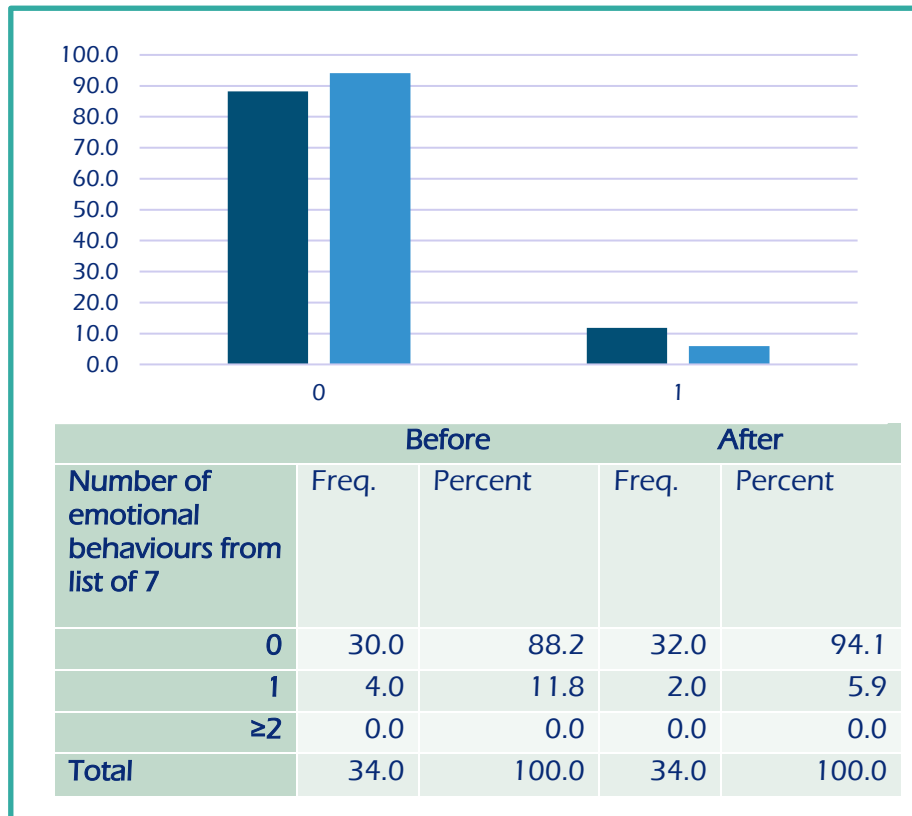|	Before		After	
Number of physical behaviours from list of 13	Freq.	%	Freq.	%
0	18.0	52.9	28.0	82.4
1	8.0	23.5	5.0	14.7
2	4.0	11.8	0.0	0.0
3	0.0	0.0	1.0	2.9
4	3.0	8.8	0.0	0.0
5	1.0	2.9	0.0	0.0
≥6	0.0	0.0	0.0	0.0
Total	34.0	0.0	34.0	100.0

Note: Responses were given on a Likert scale: 'never', 'sometimes' or 'often.'
Presence of physical behaviour was determined by those who responded either 'sometimes' or 'often.'
Figure is based on total number of individuals exhibiting behaviours, from 13 physical behaviours, since starting the programme ('After') and in last 12 months before start of the programme ('Baseline'), including: 1) Physical behaviour : Slapped / pushed / shoved; 2) Physical behaviour : Kicked / punched; 3) Physical behaviour : Beaten up; 4) Physical behaviour : Burned; 5) Physical behaviour : Bitten; 6) Physical behaviour : Restrained/held down/tied up; 7) Physical behaviour : Put your hands on her throat or face (trying to choke or strangle or suffocate); 8) Physical behaviour : Hit with object or weapon; 9) Physical behaviour : Threatened with object/weapon; 10) Physical behaviour : Threatened to kill her; 11) Physical behaviour : Prevented her getting help for injuries; 12) Physical behaviour : Stalked/followed/harassed her; 13) Physical behaviour : Locked her in house or room.

Table 18: Changes in sexual behaviour since completing the programme, using Impact questionnaire at start of programme ('Before') and end of programme ('After')

	Before		After	
Number of emotional behaviours from list of 7	Freq.	Percent	Freq.	Percent
0	30.0	88.2	32.0	94.1
1	4.0	11.8	2.0	5.9
≥2	0.0	0.0	0.0	0.0
Total	34.0	100.0	34.0	100.0

Note: Responses were given on a Likert scale: 'never', 'sometimes' or 'often.' **Presence of sexual behaviour was determined by those who responded either 'sometimes' or 'often.' Figure is based on total number of individuals exhibiting behaviours, from 7 sexual behaviours, since starting the programme ('After') and in last 12 months before start of the programme ('Baseline'), including:** 1) Sexual behaviour: Touched in way which caused her fear/alarm/distress; 2) Sexual behaviour: Forced her into doing something sexual she didn't want to; 3) Sexual behaviour: Hurt her during sex; 4) Sexual behaviour: Disrespected boundaries or safe words; 5) Sexual behaviour: Made her have sex when she didn't want to or didn't stop when she wanted to; 6) Sexual behaviour: Sexually assaulted/abused her in any way; 7) Sexual behaviour: Threats to sexual assault/abuse her.

3.7 Interviews with Victims

Several victims were interviewed to explore the extent and nature of any behavioural change observed in their partners, or former partners. Of the women interviewed, approximately five were in contact with the partner concerned. (Note: All qualitative quotes have been psuedonymised). Based on their feedback, the majority of respondents did not observe or experience any on-going abuse whilst their partners, or former partners, were attending the course. By contrast the majority of victims observed some degree of behavioural change, when discussing their relationship with their partner,

"It's changed it for the better, obviously because the arguments have stopped. It's more like if we've got something to say we'll say it to each other without shouting or building it up inside and not saying anything and then that's when it all gets out of hand. He's just been a lot calmer, I think it's brilliant, it's really helped him."

(Interview with victim, 004)

The same respondent acknowledged that this change was initiated through an increased sense of self-awareness, and understanding of where blame lies,

"Yes, he's definitely, his attitude towards life, I think, has changed a lot more. He's actually realised that it was him, because I think that's a major step in that sort of self-awareness in domestic violence where they have to realise that it's them, because his before was like, 'Oh, it's not me, it's you, you make me do this, you're the one who made me angry.' He actually stops and thinks about things before he says them and his just whole perspective, the whole, I don't know, it's weird! Definitely a lot calmer though and he's able to talk a bit more now....It weren't that long after, to be honest. It was probably about a month after the course."

(Interview with victim, 004)

One respondent felt, however, that despite the number of apologies offered by her former partner, certain behavioural traits still persisted, such as anger,

"Still quite volatile and he has apologised a lot - which is something he's never done before - but then he'll follow that with getting very angry if I don't do what he wants after he's apologised. He's still very manipulative with the children and with me. Yes, he is quite prone to getting very angry."

(Interview with victim, 005)

Of the feedback offered on behavioural change, a number of comments were made in respect to the treatment, and behaviour towards the children,

"I don't think he's talked much about the relationship between the two of us; he's focused on children - which is, its fine, I don't want a relationship with him. I just want to support something with the children as they grow up. I don't think he's really delved into that very much."

(Interview with victim, 005)

One respondent described the emotional influence of the RADAR/ ADAPT course on her partner, particularly in relation to acknowledging passed behaviours towards her child. One session was particularly singled out, as it had created a noticeable impact on her partner's behaviour towards their daughter,

"I think he's done really, really well, to be honest. He's surprised me and I think he's surprised himself. He's opened up a lot more to me. He's been in tears when he's come home, I mean I've been with him eight years,

I've never seen him cry or anything. After one session at the course he came home, he apologised to my older daughter. I think it was the child thing that they had to do and pretend like they were in darkness and asleep and people shouting, just put themselves in the child's point of view, if you know what I mean? I think that really done him in and made him realise and he come home and he was in tears and he apologised, like I say, to my older daughter and he's apologised to me a million times. Yes, I think it's a great eye-opener, I think it's a wonderful course."

(Interview with victim, 004)

Evidence of behavioural change towards the children was also acknowledged by another respondent,

"I think initially it gave him quite an insight because he maybe just didn't appreciate how damaging it is for them. I think maybe that has changed; he probably has understood that this is wrong for them, but whether that has in time - he does seem to be different with them."

(Interview with victim, 005)

Another respondent explained the types of therapy her partner had sought in the past and, based on observations on his current behaviour, felt that the RADAR/ ADAPT programme has had the biggest influence on her partner's behaviour.

"Definitely, it was because he's had counselling for years and he saw a psychiatrist once and he's had all sorts. He's had CAT, cognitive analytical therapy, and he's had CBT, and things would improve for a while but not to this extent and then they would get worse again. Obviously, it's fairly short, he's only just finished it in December, mid-December, so obviously it's fairly quite fresh in his mind still, so I don't know how, whether it will have changed him forever but he is telling me that it's revelation and that he's changed. But, yes, out of everything or, over the years, out of everything that he's done, definitely, this has had the biggest impact on him, his behaviour."

(Interview with victim, 002)

In relation to his past behaviour, she identified the 'power and control' as an issue in their relationship. Since her partner had been attending the RADAR/ ADAPT programme, however, her partner has exhibited less controlling behaviours towards their children,

"It was very much about power and control before. Very much he had to be in control of everything and he got very stressed if things weren't as he thought they should be or people didn't do or the children or me or I didn't do things the way he thought. Yes, it's difficult because obviously I'm not really, yes, I'm not in that [signal breaks up] separate lives but under the same roof but I can see with the boys that he's definitely letting them make more decisions and not dictating when they're allowed to have a shower or things where before he was very much controlling every aspect and he's making a big, big effort with the boys now. So he knows he's got to repair the relationship with them, he's really trying hard to improve his relationship with them, so he's spending a lot more time with them whereas before he just went and he was very self-absorbed before and he would just go and do his own thing. He would go off or bike rides for the whole day a lot of the time and just, yes, but he seem a lot more constructive with his time with them."

(Interview with victim, 002)

3.8 Police Data outcomes

Table 19 (Summary table) and 20 (Full table) reports the crimes linked to those completing the DAPP programme in one year. These results indicate that over the monitoring period covered, approximately 1 in 4 individuals were linked to crimes after completion. The total number of crimes reported over the monitoring period were 37. Of these crimes reported, however, only 43.2% were related to domestic abuse.

Table 19: Summary statistics on crime associated with individuals completing the RADAR/ADAPT programme over one year (n=57)

Of people in cohort already known to police, percentage linked to crime after completion, %	86.0
Of total of people who completed the DAPP programme, percentage linked to crime after completion, %	28.1
Of total people who completed the DAPP programme, percentage linked to domestic abuse (DA) related crime after completion, %	17.5
Of total crimes linked after completion, percentage that are DA related, %"	43.2
Of total individuals linked as suspect/ offender to a crime after completion, percentage of individuals linked to DA crimes, %	62.5

The police data indicates the crimes suspected of, or committed, over the monitoring period (up to 19 months), for those completing the DAPP over one year. A high number of individuals were already known to police, and approximately 28% of completers were linked to any crime after completion. Of those who complete, 17.5% were linked to domestic abuse crimes after completion. Of those individuals linked to crime, 63% of individuals were linked to domestic abuse crimes. Less than half of the crimes, around 43% were related to domestic abuse.

Table 20: Police reoffending data linked to individuals completing the RADAR/ADAPT programme between 01 October 2016 – 30th September 2017 (one year), by quarters

Time period, quarters	No. of people completed DAPP programme	Cum. %	No. of people in cohort known to police	Cum. %	No. linked as suspect/offender to a crime after completion	Cum. %	No. of crimes linked after completion	Cum. %	No. of DA crimes linked after completion	Cum. %	No of individuals linked to DA crimes after completion	Proportion of individuals linked to DA crimes after completion, of total linked as suspect/offender to a crime after completion, %	Follow-up period, months
01/10/2016 - 31/12/2016 (a)	19.0	33.3	18.0	41.9	7.0	43.8	23.0	62.2	11.0	68.8	5.0	71.4	17-19m
1/01/2017 - 31/03/2017 (b)	11.0	19.3	8.0	18.6	2.0	12.5	3.0	8.1	2.0	12.5	2.0	100.0	14-16m
01/04/2017 - 30/06/2017(c)	16.0	28.1	10.0	23.3	5.0	31.3	9.0	24.3	1.0	6.3	1.0	20.0	11-13m
01/07/2017 - 30/09/2017(d)	11.0	19.3	7.0	16.3	2.0	12.5	2.0	5.4	2.0	12.5	2.0	100.0	8-10m
	57.0	100.0	43.0	100.0	16.0	100.0	37.0	100.0	16.0	100.0	10.0	62.5	

Notes: (a) Crimes recorded between 01/10/2016 & 07/06/2018; (b) Crimes recorded between 01/01/2017 & 07/06/2018; (c) Crimes recorded between 01/04/2017 & 07/06/2018; (d) Crimes recorded between 01/07/2017 & 07/06/2018

3.9 Focus Group Discussions and Observations with Clients

A closer analysis into how the ADAPT/ RADAR programme brought about change was made through focus group discussions with clients who had completed, or were close to completing, the programme; and through observations of two sessions. At the focus groups, the clients were asked about how their behaviours had been influenced by the programme. One respondent felt that the programme had enabled him to accept responsibility for his behaviour; and suggested that the relationship with his wife had improved as a result of this,

*"Obviously I can't speak for my wife, truthfully, but I do touch wood that our relationship has started to actually repair, to at least make positive progress. Not least because **I've actually accepted responsibility for what I was actually doing, and realising that my behaviour just was completely unacceptable**. I think almost that has had- I'm trying to think, but that has been part of what the course has actually worked on me to actually come to terms with."*

(Client 4, Focus Group Discussion 1)

Another client explained his current situation, admitting that his ex-partner had since contacted him. In relation to this, he acknowledged that the time he had spent doing the programme is what had convinced others to recognize the 'positive steps' he was making, as the programme was acknowledged as an investment in time and effort,

"I've already, for the first time in two years, I've had an email off my ex-partner because she wants to talk. That's literally a massive step, the biggest step that I could have ever taken because of being on this course, and because we've been consistent in direct contact. That's the first step of trust. That's the key really, I think. I hope it's because of this course, and perhaps a link with it and the amount of time I've taken to do it. If it was six weeks, I don't think she'd be convinced. I know some of the other guys instantly within... Just by turning up, their families, they're in relationships now, their families have all rallied up round them and supported them because they're making the positive step. Is anyone actually in a relationship here?"

(Client 5, Focus Group Discussion 2)

Another respondent suggested that the effort and time put into the programme was also acknowledged by the judge reviewing his custody case. He further described the change in the relationship with both his wife and his children, reporting that his relationship with his wife is 'amicable' and that his children want to spend time with him,

"Like yourself, I have great shame that I've affected and hurt my children. Coming from a place of seeing them supervised six times a year for a couple of hours, to seeing them now pretty much when I want, or when they want. I think it was the reports that Kim and her colleagues filled in that I could present to social services, then they questioned me, and examined and interviewed me. They made a report, and these two reports go to the courts. Basically, the judge has got something to go on then, hasn't he? He said to me, 'You've done the work. You've put this effort in. We've got a report from Hampton Trust. We've got a report from social services that interviewed you,' and now it's a family on the mend. My wife and I are amicable, and I'm seeing the children on a, basically, when they want, really. I mean, they want to go fishing, they want to go swimming. They're two boys, ten and 12. I mean, they're enjoying it now, which is great, and they're coming to stay with me at Christmas."

(Client 2, Focus Group Discussion 1)

In their discussion around change many focussed their attention on spending time, and repairing relationships, with children. However one respondent further acknowledges that, even though children may be the motivation, spending time with them may not necessarily be the best thing for them, indicating the critical self-reflection experienced during the programme,

"It's tough getting up every day and trying not to be a dick, and if it weren't for the programme, then I would be way back, but be on the line in terms of even thinking about changing behaviour. Like the other guys, I've had some small real positives in that we're working towards contact with my children. Even back then, I think if I'd have had contact with my children two or three years ago, when I was still in that mind-set, I would have just sort of thought yes, I've won. I've won. I've got an opportunity to see my children. As opposed to now I'll think what's best for them? That might not be seeing me, and that's really hard to deal with."

(Client 6, Focus Group Discussion 1)

By contrast to the feedback on changed relationship, one respondent could not comment on his relationships as he was no longer with his wife and family,

"The only thing I find is I can't put anything into practice because I'm not with my wife and family, I haven't been for three years. I'm not meant to be having anything to do with them, so time out and all the other things, I can see the benefit, but I can't really put it into practice, so it's a little bit difficult."

(Client 4, Focus Group Discussion 2)

In terms of understanding how relationships may change, or improve, as a result of attending the programmes, the reports from the Hampton Trust and partner agencies also facilitated the process,

"....but because social services are involved, they actually presented the reports to my wife, and made their own report. If not, no one would have really explained what I'd been doing. Even then, even though the report was given to her and explained to her, it wasn't until about three months after court, and the relationship started to improve, and I was seeing the children normally, and my wife and I were amicable."

(Client 3, Focus Group Discussion 1)

Furthermore, as conveyed in the quote above, a positive outcome or a noticeable change in relationship could take months.

On explaining the impact of the change, one client felt that his wife was less fearful I their relationship,

"She suddenly came out with the phrase, 'You've really changed.' Now, I couldn't see that. I think I've changed. I think, in other words, I could change, but she actually could see. To me that was really positive, because it has made her, because she was very fearful, and suddenly she wasn't fearful anymore. Suddenly she realised that I was nothing to be afraid of, anymore. 'He's changed enough for me to be able to relax and trust,' which was great, really."

(Client 4, Focus Group Discussion 1)

In discussing the need to acknowledge change, it was clearly important for family members to acknowledge that,

"So I'm asking for everything, but recognise that it's not necessarily all about me, but I some days think yes, I wish people would see that I have changed."

(Client 6, Focus Group Discussion 1)

In contrast, the personal will to change behaviour, to prove to oneself, was less important than having others observe the change,

"Actually, you have to, in my view, go through every day thinking I want to change my own behaviour and I don't necessarily need for other people to fully know that change."

(Client 3, Focus Group Discussion 1)

This point of view was further supported by a quote from another client, who felt proud to acknowledge a change in his own behaviour,

"The best thing of all is, as time progresses and you realise that if you take away the most important things of the course that you're told to take away, and you actually think about them, the cleverness of it is that you don't trip yourself up. You don't go out and you don't think oh, I'm all on my own. You feel proud that you've done it right. Every time you respond differently, you feel proud and you can just say, 'Look at how I was, and look at how I am now.' That's the biggest thing I've found, is that you can feel, if no one else says that you're any different, you know yourself that you've responded differently. Everybody has got different situations. Everyone has got different circumstances to why they're there, and all I've seen from coming out of the course, is that my behaviour had obviously affected lots of things, because things have improved significantly since I left."

(Client 6, Focus Group Discussion 1)

When discussing the point at which the clients observed changes in themselves, one client noted that it was during the children's modules. In particular this led him to understand the transgenerational effect of his behaviour, linking to his own adverse childhood experiences, and understanding how that may impact his own children,

"Going back to the question you said about, 'At what point on the programme did you feel a change?' For me it was when we covered the children's modules, because you learn about your own childhood. You have a real look at yourself, and your own upbringing, and the negative behaviours that you took from that, albeit learned. The facilitators didn't allow you to blame yourself, or your parenting, but to look at the negative aspects of your own childhood experiences, and how that then progressed to your behaviour towards women, towards your partners, and towards your children. Ultimately I could see that I did not want history to repeat itself, however it already had started."

(Client 4, Focus Group Discussion 1)

Finally, one client considered the potential role of mentors to help sustain change, and in supporting others to reinforce the ideas and behaviours necessary, suggesting that he was willing to act as a mentor for others who had taken part in the group programme,

"That's over and done with, so perhaps the mental things, I'm looking forward to finding out... I can imagine it just drops off completely and my behaviours could just go back to the way they were because there isn't any reinforcement there after the 26 weeks, 25 weeks, so I think that's one of the disadvantages. I don't know because I haven't been here, so it's difficult for me to say that. We know we've got a mentoring scheme. I can't imagine what that's like. I imagine that's us ringing the mentor rather than them ringing us, just to see how things are going. I think there may need to be a little bit more... Look into that, perhaps the after effects. You find out the good and the bad stories afterwards, what's going on down the line. I've already said that I'd quite happily be a mentor."

(Client 6, Focus Group Discussion 1)

Summary of Evidence: Behavioural change

Of the 34 participants who responded to the Impact questionnaire on completion of the programme, almost 2 out of 3 individuals reported stopping violent behaviour since the start of the programme; whereas, almost 3 out of 4 reported stopping abusive behaviour. By the end of the programme, fewer individuals scored highly in the emotional and behaviour scales, and more individuals had lower scores. By contrast, no such difference was shown for sexual behaviour. Of victims who were in contact with their partners, the majority witnessed some degree of behavioural change; through improved self-awareness, and in their partner', or former partner's, relationship with their children. Power and control was considered as integral to understanding the abuse experienced, from the victim perspective. Discussions with those who had completed the programme indicated an increased acceptance of responsibility, changed relationships, and that the time on the programme was critically recognised as a positive step. Equally, the time invested (duration) on the programme was an important consideration when building trust with others, ranging from former partners to Judges involved in custody cases. Although time was needed to mend relationships, there was evidence that some completers were still out of touch with family members; and that further reinforcements, such as mentoring schemes, might help to embed changed behaviour.

Police data indicated that in one year just over 1 in 4 individuals were suspected of, or convicted for, any crime after completion of the DAPP. However of those who completed the programme less than 1 in 5 individuals were suspected of, or convicted for, any DA crime.

4 Discussion

4.1   Outputs of the DAPP

The following is a summary of the main outputs (key findings) related to the DAPP, based on the *process evaluation*. Between 01 April 2016 and 30 September 2017, 80 individuals completed the RADAR/ADAPT perpetrator programme across Hampshire.

Motivations and characteristics of perpetrators

Consistent with findings from an evaluation of DVPPs across 11 sites, the majority of individuals were referred by Children's services. [27] [28] Based on the profile of those who complete, and compared to those who refer into the programme, completers were more likely to be older than 25 years old and have children. Of those assessed, the majority of men attended the programme as they wanted 'their relationship to be better.' Approximately 87% were White British and 9% were Black Asian Minority Ethnic (BAME). However, it was not possible to establish the proportion of those that were considered White European which, according to the 2011 Southampton data, constitute 7% of the population. The percentages recorded as BAME were slightly less than expected for the Southampton population which is reported as 14% in 2011.

Drop out from the programme

Drop-out data, and process indicators related to the programme, show that the majority of individuals dropped off after attending assessment and before starting the programme. In an evaluation of the 26 week Action for Change programme in Tyneside, men described "nervousness" in attending the Phase 1 assessment but felt reassured by the practitioner. In the same evaluation, a high number of men who made initial contact did not progress further. [27] This is consistent with findings in the DAPP, where a referral agency could not be identified to refer men to programme for a high number of cases or they failed to attend programme once referred. Once on the programme the proportion who dropped out reduced, indicating that men are more likely to finish a programme once engaged with a programme.

Assertive Outreach

For those referred for stabilisation and risk management, the most common needs included housing, finance and mental health. On average clients engaged with this 'Assertive Outreach' service for 14 weeks. However, a high proportion of these individuals were still considered unsuitable for group work following engagement. Instead of attending the RADAR/ ADAPT programme, these clients were offered individual treatment.

Victim engagement, Colocation and the Single Point of Contact (SPOC)

In one year approximately 200 victims engaged with a victim support officer as part of the integrated safety service. Of those referred onto services, approximately 1 in 2 were referred for a domestic abuse service (e.g. Women's Aid), which indicates an unmet need among victims. Within the DAPP, those who did not refer on to the programme, and whose PPIT score was considered high enough for tracking (score over 10 or engagement with the criminal justice system), were also monitored through the SPOC. However, during the time of evaluation, there were no plans to disrupt individuals who did not engage within the community. Those who colocated with the Hampton Trust generally felt there was improved knowledge and competency in working with perpetrators. However, this was only reported by those who work directly with perpetrators. Other benefits of colocation were indicated, however, by increased referrals into the DAPP and improved paperwork to facilitate this process.

4.2   How the DAPP brings about change

Within the DAPP, change occurred at different levels, that relate to the intervention delivery: *population*, *community*, and *individual-* level changes as shown in Figure 15. Firstly, evidence shows that both colocation and the SPOC were essential to facilitate *community-level* and *population-level* changes. The colocation activities within the community, such as workplace training and events, increased both the quantity and quality of referrals into the perpetrator programmes. Consistent with other evaluations, however, there was initial scepticism from victim agencies, although information sharing and partnership working improved as implementation progressed. [28]As reported in an evaluation of the PPIT, this multiagency approach has facilitated a more consistent multiagency risk language for those working with domestic abuse perpetrators across police, probation and the third sector. [29] Previous evidence suggests that the presence of perpetrator programmes add value to MARACs, by raising awareness on perpetrator behaviours. [28] This finding is consistent with feedback from colocation agencies who reported having improved knowledge on the impact of coercion and control; and improved partnership working. However, they stated that more strategic work was needed to: embed working relationships and, for victims' agencies, to map out routes of referrals, delineate where responsibilities lie, and create a common understanding on the benefits of information sharing. The SPOC facilitated referrals from front-line agencies; and enabled the tracking and monitoring of high risk individuals who did not refer onto the programme. However there was a lack of clarity on the potential outcomes of tracking and monitoring; and how these would inform the disruption of individuals, through further attempts to refer them into programme.

Secondly, although the integrated victim safety service was not intended to improve outcomes for victims directly, the management and safeguarding of victims was necessary to ensure that risks were being managed for the *individual*. However, there was a degree in variability in the frequency of engagement with victim support workers, and a lack of follow-up in some cases. Although not addressed through the current DAPP model, it would be useful to gauge the level of on-ward engagement with referral agencies.

Thirdly, also operating at both an *individual-level*, the Assertive Outreach provided through Baseline Consultancy addressed the seven pathways of re-offending on a case-to-case basis, providing individualised support. However, on-going monitoring data is necessary to understand whether these needs were met over the long-term and, along with police data on reoffending, would provide evidence to support this approach.

Fourthly, at the *individual-level*, the data provided through the Impact Toolkit showed positive changes in both the physical and emotional behaviours related to domestic abuse, after completion of the programme. This is consistent with previous evaluations which note, in particular, reductions in both physical and sexual violence between baseline and 12 months after programme, taken from the victims' perspective. [28] [30] Within the DAPP, victims also reported improved relationships, with a particular emphasis on changed relationships with children. The police data indicated that just over 1 in 4 individuals will go on to commit, or be suspected of, any crime after completion of the DAPP. However, that domestic abuse crimes amounted to less than half of these total crimes; and were committed by 1 in 5 individuals.

These individual level changes were attributed to the quality and length of the programme. In particular, men felt that the time invested in the programme was necessary to embed new behaviours. This finding is consistent with the evaluation conducted on the Tyneside DVPP, whose programme was 'specifically designed' to be long enough to effect real change in men's abusive behaviour. [27] Furthermore, clients on the RADAR/ ADAPT programme cited that both the intensity and peer support were required to facilitate change. In the Mirabel evaluation, which examines DVPPs across 11 sites, group work sessions were described as being both informative and useful in promoting change; and that a one-size fits all was the most acceptable approach. Input from both facilitators and other men within the group context enabled this change process. Consistent with previous findings elsewhere, developing self-perception or self-awareness was a critical step in initiating change.

In terms of the specific content of the programme that enabled change, both clients and victims mentioned the 'time out technique' as a useful tool, which is consistent with other evaluations, as well as the pragmatism offered by the facilitators. Similar to previous evaluations, the children's modules were consistently mentioned by clients, particularly the sessions where clients were asked to put themselves in the position of children living with domestic abuse. The power-control wheel was also frequently mentioned by clients as a useful framework for conceptualising abusive behaviour.

Figure 15: Diagram representing the Aims and Objectives of the DAPP intervention model, by the levels of engagement
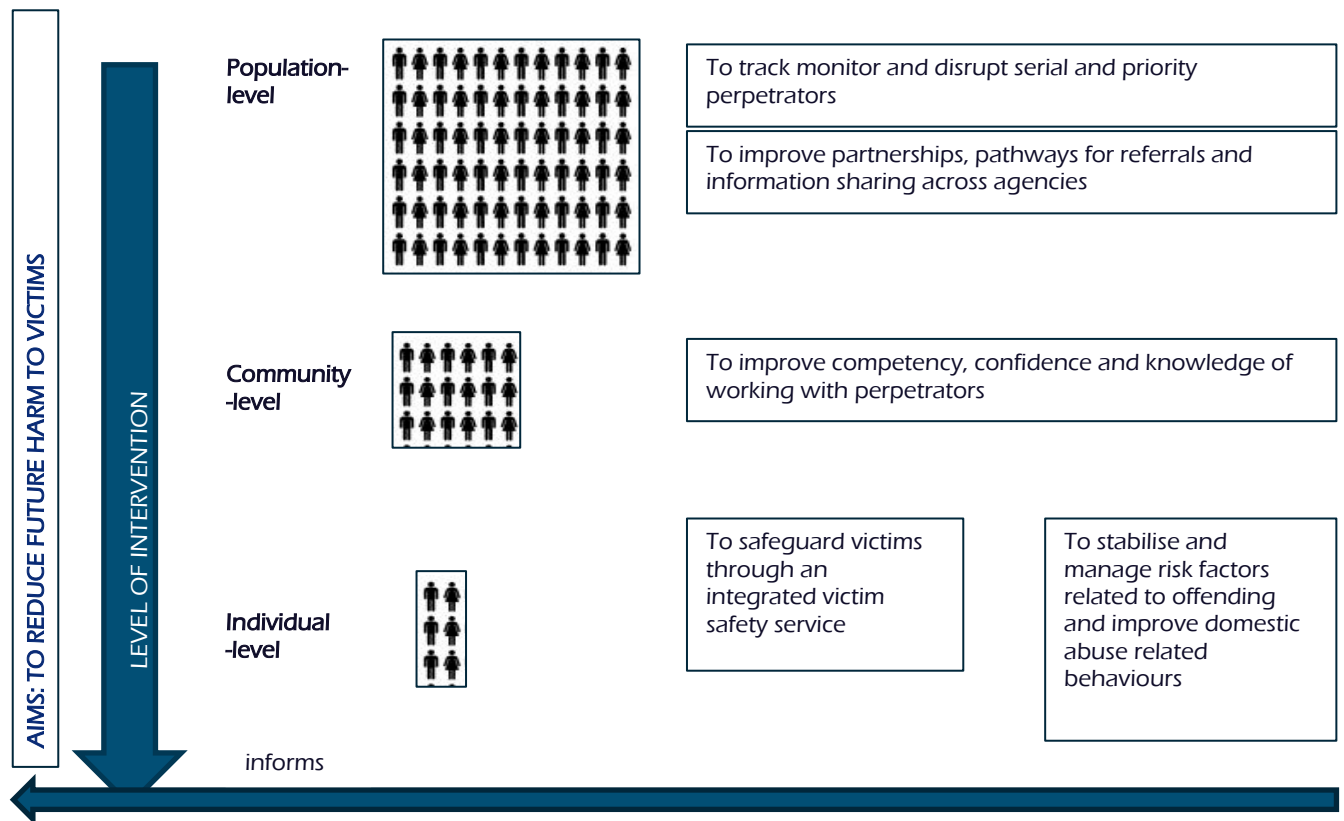
4.3   Potential barriers to achieving change at the population level

The representativeness of perpetrators who complete

The aim of the DAPP is to reduce future harm to victims of domestic abuse. Change in this regard, however, is contingent on the ability to recognise domestic abuse in the community and to engage perpetrators with a programme. Through colocation and the Single Point of Contact, the number of perpetrators identified has notably increased through the presence of the DAPP. However there still remains a question around whether those that refer onto a programme (for assessment) are representative of a population that commit the most harm. [31] Those that come onto a programme are undoubtedly motivated by extrinsic factors, such as familial relationships and, in particular, to improve their relationships with their children. As a result, the population on a programme has been skewed slightly towards an older population who are in heterosexual relationships. The RADAR/ADAPT programme particularly tackles intimate partner violence, which makes it specific to those who are experiencing such dynamics, rather than non-spousal domestic abuse, such as *child maltreatment* or *elder abuse*. [32] Furthermore, there is still uncertainty around whether those from rural communities can be easily referred onto, and access programmes, through the DAPP. Further work is needed to examine any urban-rural differences in detail.

High attrition within DVPPS is widely common and acknowledged. [33] However, proactive measures can improve retention and delay dropout. [34] Retention is dependent on age and may still be influenced by

79

residence (e.g. urban or rural). In line with previous evidence, attrition occurs most frequently at the point of assessment, and before the core sessions, which makes Stage 1 of the DAPP model (assessment) an effective point of contact to establish proactive measures. [35] To circumvent this, a shorter programme such as 'DAPP lite' and/or case-work may help to engage younger cohorts earlier in the cycle.

Unwillingness to refer onto the programme

Information from the SPOC highlights an undercurrent issue related to the referral onto a programme. In particular, those that may be deemed high risk perpetrators of domestic abuse may refuse to access a programme. The recent DRIVE model, currently undergoing evaluation, proposes 'disruption' as a means of engaging high risk perpetrators through community led agencies. Emergent findings from the DRIVE project demonstrate a need for a coordinated community response, where direct contact may not be possible. Consistent with participants in the DAPP, the population studied had a high number of substance and alcohol misuse issues, which suggest an opportunity to work with front-line alcohol and substance misuse services, in order to promote engagement. Disruption is likely to increase the resources and capacity within the DAPP model, and therefore further work is necessary to examine the most cost-effective means of disruption, and identify feasibility issues around contacting and engaging an individual. Likewise, there are high mental health concerns amongst this population group. A recent study reported prior history of suicide attempts as the most powerful predictor of attempting or committing domestic homicides. [36]Improved contact with community mental health teams, GPs and A&E services, may help to engage those reaching 'crisis points'. [30]

Furthermore, evidence showed that once assessed for a programme, a high proportion of individuals were unlikely to continue on to the programme. Waiting lists and the distances required to travel for group sessions may act as a deterrent. As discussed in the previous section, men feel nervousness and uncertainty in attending perpetrator programmes, compounding the risk of not engaging. Long term, the presence of waiting lists may also de-motivate individuals, and contribute towards a lack of trust or scepticism due to being let down by the system. Across DVPPs, waiting lists contribute towards frustrations and a reluctance to refer in. [28] In Tyneside, for example, an inherent lack of services for perpetrators had an impact on men looking for a service. [27]

Sustaining behaviour change

As discussed previously, the majority of men are motivated to join a programme due to a willingness to improve relationships, particularly in relation to their children. However, there were a number of individuals that engaged with a programme who do not have children. Consistent with other evaluations, men have different motivations, and may be at different stages in their 'journey' in terms of addressing their own behaviour. [35]According to the transtheoretical model, individuals could be at any stage within the behavioural change process. [37] Some men took steps to initiate change before even starting the programme. Some had already taken action, by talking to other counsellors or therapists. As with other models of behavior change, change is not a linear process, and some individuals may regress to old behaviours. The RADAR/ ADAPT programme, however, is specifically designed to reinforce notions around positive behavior (using the Duluth model), moving them towards positive action. Based on results, 1 in 5 will go on to be a suspect or convicted of a domestic abuse crime after completion, which suggests that, for some individuals, it is difficult to embed new behaviours. Evidence shows that it may take between 6 months to 5 years to embed new behaviours, supporting the need to maintain new behaviours beyond the end of the programme. [38]

Uncertainties around roles and responsibilities within the coordinated community response

The multi-agency arrangement through the DAPP, and presence of the DVPP, is essential for establishing a coordinated community response to domestic abuse. There were still uncertainties, however, around the roles and responsibilities of front line agencies, particularly in relation to dealing with perpetrators. A wariness or scepticism from front line agencies was apparent. Therefore, information shared with front-line staff could have been clearer, in terms of what colocation (and the broader DAPP) aimed to achieved. For victims, there was a lack of information about onward engagement from the integrated victim safety service, which meant that there was limited evidence supporting a coordinated community approach to victims engaged with the DAPP. Consistent with other evaluations, and with reports from victims within the DAPP, there was also a lack dedicated support services for children of men on the programme. Consistent with other evaluations on DVPPs, there is a need for a more dedicated support service for children of men on DVPPs, as we all as an opportunity to safeguard children. Recent national strategies advocate for early prevention and intervention for domestic abuse, addressing issues 'earlier in the cycle.' [27] [28] [30] [39] [40]

A recent evaluation of the DVPP in Doncaster suggests that goals and objectives should be focused on the wider relationships within the multiagency model, and not just on individual outcomes. This strategic, joint-up thinking ensures that each partner has a shared purpose. [41] The risk management of perpetrators, particular those under NPS/ CRC, has led to 'blurred lines' in some DVPPs. Furthermore statutory agencies, such as the police, are increasingly involved in front-line work related to trauma. [40] Whilst the DAPP is a non-statutory lead response to domestic abuse, any reiteration of the DAPP model should also outline the roles of both statutory and non-statutory partners.

Limitations

In light of these findings, it is important to also take stock of some limitations related to this study. Firstly, as this was a pragmatic evaluation, which drew on existing routine datasets, data was often incomplete and/or missing. For example, the outcome data was limited to small numbers (n=34) which meant that significance testing could not be applied. The IMPACT Toolkit was relatively new to the DAPP, and therefore it took some time to implement its use, which led to missing data on outcomes. Secondly, the end of intervention questionnaire was only completed by clients of the group, and not by victims (partners or former partners), due to the practicalities around doing this. It was therefore not possible to triangulate these results, with the victims' perspective. Thirdly, all victim interviews were voluntary and therefore represent those who were willing to talk, resulting in potential bias. Finally, there was very little information around the exact reason for 'dropping out' of a programme, which should be explored through further work.

5 Recommendations & Conclusion

The previous section highlighted the implications of the study evidence, by identifying key barriers to achieving reduction in harm to victims. In line with these, **the following recommendations have been suggested, as a means to improve effectiveness through the DAPP model (in order of priority).**

Recommendation 1: Establish proactive measures to improve retention, by engaging clients as early as possible e.g. through case- work or 'DAPP-lite' with a focus on engaging 18-25 year olds

Recommendation 2: Establish referral pathways to ensure safeguarding, and provide specialist interventions, for children afflicted by abuse (directly or indirectly) within the DAPP

Recommendation 3: Co-produce strategy and training content, related to domestic abuse, alongside colocation sites

Recommendation 4: Plan and coordinate activities to disrupt high risk perpetrators who do not refer into the DAPP

Recommendation 5: Delineate and clarify responsibilities through the coordinated community response, that also covers statutory organisations such as the police

Recommendation 6: Increase colocation activities that specifically target rural areas or minority neighbourhoods

Recommendation 7: Assign "DAPP champions" to mentor others referring into the DAPP, to improve retention; and after completion of the programme, to improve sustainability

Recommendation 8: Develop and pilot specialist programmes that addresses abuse between lesbian, gay, bisexual, transexual (LGBTQ) couples and other non-spousal forms of abuse (e.g. Elder Abuse) that are increasingly common in the community

Recommendation 9: Establish pathways, and increase stakeholder events, to communicate how information from the SPOC benefits victims and front line services

RESEARCH RECOMMENDATIONS (IN ORDER OF PRIORITY)

Recommendation 1: Measure long term outcomes related to victim harm, that are feasible within the DAPP model e.g. a shorter version of the IMPACT survey that could be filled out by the victim 6 months after completion

As suggested previously, follow-up periods to DVPPs may be too short. [33] Both nationally, and internationally, there is a necessity to demonstrate long term outcomes related to domestic abuse, and to triangulate data with victims' views. Given that victim engagement may be poor, shorter versions of questionnaires undertaken by a phone interview would be more practical solution. [35]

Recommendation 2: Explore the contextual factors that lead to lack of engagement among 18-25 year olds

Through communication and partnerships with front-line agencies, the contextual factors that influence unwillingness to refer into the programme, and increased likelihood of disruption, can be explored.

Recommendation 3: Record and monitor the proportion of those receiving dynamic risk management (Baseline Consultancy) who go on to reoffend to examine whether stabilisation can be achieved other the long term

Conclusion

Between 2016- 2018 the DAPP model has achieved several outcomes related to keeping victims safe within the community. Where there was less front-line collaboration previously, partners within the DAPP have addressed key gaps around engaging perpetrators, through front line training, and referring them onto an appropriate programme for their needs. Still there are men who are unwilling to engage with a programme. Men who abuse may not yet be willing to acknowledge change, so clearly more front-line work is needed to inform and educate within the community and promote healthy behaviours. For the majority of those completing programme, however, both the length and content of the group programme are effective at directing positive change and improving relationships. Future reiterations of the DAPP model should address, at least, some of the issues related to retention, working with children, engaging minority populations and piloting programmes that address different abuse and relationship dynamics.

6 References

1. National Office of Statistics. (2015) Crime Survey for England and Wales, 2013-2014. In: 7619 UDSS, ed. 2nd Edition.

2. Home Office. (2013) Domestic abuse: guidance and support for the armed forces community and Domestic Violence.

3. Kelly L, Westmarland N. (2015) *Domestic violence perpetrator programmes: Steps towards change. Project Mirabal Final Report.* London and Durham: London Metropolitan University and Durham University.

4. Bailey BA. (2010) Partner violence during pregnancy: prevalence, effects, screening, and management. *International Journal of Women's Health*;2:183-97.

5. Trevillion K, Oram S, Feder G, et al. (2012) Experiences of Domestic Violence and Mental Disorders: A Systematic Review and Meta-Analysis. *PLOS ONE*; 7(12):e51740. doi: 10.1371/journal.pone.0051740.

6. Golding J M. (1999) Intimate partner violence as a risk factor for mental disorders: A meta-analysis. *Journal of family violence*;14(2):99-132.

7. Campbell J, Jones A S, Dienemann J, et al. (2002) Intimate partner violence and physical health consequences. *Arch Intern Med*;162(10):1157-63.

8. Hester M, Westmarland N. (2005) Tackling Domestic Violence: Effective Interventions and Approaches: Development and Statistics Directorate.

9. Hamilton L, Koehler JA, Losel FA. (2013) Domestic violence perpetrator programs in Europe, Part I: A survey of current practice. *Int J Offender Ther Comp Criminol*; 57(10):1189-205. doi: 10.1177/0306624x12469506.

10. Pence E, Paymar M. (1993) Education groups for men who batter. In: Springer, ed. London.

11. Gondolf E W. (2002) Batterer intervention systems: Issues, outcomes, and recommendations. Thousand Oaks, CA: Sage.

12. Phillips R, Kelly L, Westmarland N. (2013) Domestic violence perpetrator programmes : an historical overview. London and Durham: DU.

13. Lilley-Walker S J, Hester M, Turner W. (2016) Evaluation of European domestic violence perpetrator programmes: toward a model for designing and reporting evaluations related to perpetrator treatment interventions. *International journal of offender therapy and comparative criminology*.

14. Edelson J L. (2012) Groupwork with Men Who Batter: What the Research Literature Indicates. In: Women NORCoVA.

15. Feder L, Austin S, Wilson D B. (2008) Court-mandated interventions for individuals convicted of domestic violence. *Oslo: Systematic Reviews*.

16. Gondolf E W. (2002) Batterer intervention systems: Issues, outcomes, and recommendations. Thousand Oaks, CA: SAGE.

17. Tashakorri A M, Teddlie C B. (2003) Handbook of Mixed Methods in Social & Behavioral Research. Thousand Oaks: Sage.

18. Robins C S, Ware N C, dosReis S, Willging C E, Chung J Y, Lewis-Fernández R. (2008) Dialogues on Mixed-Methods and Mental Health Services Research: Anticipating Challenges, Building Solutions. *Psychiatric Services*.

19. Pawson R, Tilley N. (1997) Realistic evaluation: Sage.

20. Craig P, Dieppe P, Macintyre S, et al. (2008) Developing and evaluating complex interventions: the new Medical Research Council guidance. *BMJ*;337 doi: 10.1136/bmj.a1655.

21. Flick U. (2014) An Introduction to Qualitative Research. London: SAGE.

22. Braune V, Clarke V. (2006) Using thematic analysis in psychology. *Qualitative Research in Psychology*;3: 77-101.

23. European Network for the Work with Perpetrators of Domestic Violence. (2015) Working Paper: Impact Working Paper. [Accessed online at: http://impact.work-with-perpetrators.eu/index.php?id=14 on 17.03.2017].

24. Robinson A L, Clancy A. (2015) Development of the Priority Perpetrator Identification Tool (PPIT) for domestic abuse. Project Report. Cardiff, UK: Cardiff University.

25. Beauchamp T L, Childress J F. (2001) Principles of Biomedical Ethics.

26. Williamson E, Hester M. (2009) Evaluation of the South Tyneside Domestic Abuse Perpetrator Programme 2006-2008. Brisol University of Bristol.

27. Kelly L, Westmarland N. (2015) *Domestic Violence Perpetrator Programmes: Steps Towards Change.* Project Mirabal Final Report. London and Durham: London Metropolitan University and Durham University.

28. Robinson A L, Clancy A. (2017) *New initiatives to tackle domestic violence using the Priority Perpetrator Identification Tool (PPIT).* Cardiff: Cardiff University.

29. Hester M, Eisenstadt N, Jones C, et al. (2018) *Executive Summary: Evaluation of the Drive Project - a pilot to address high-risk perpetrators of domestic abuse Year 1 Feasibility Study November 2017.* Bristol: University of Bristol.

30. Bland M, Ariel B. Targeting Escalation in Reported Domestic Abuse: Evidence From 36,000 Callouts. (2015) *International Criminal Justice Review*,25(1):30-53. doi: 10.1177/1057567715574382.

31. World Health Organisation (2014) Global Status Report On Violence Prevention. Luxembourg: World Health Organisation.

32. Lilley-Walker S J, Hester M, Turner W. (2016) Evaluation of European Domestic Violence Perpetrator Programmes: Toward a Model for Designing and Reporting Evaluations Related to Perpetrator Treatment Interventions. *International Journal of Offender Therapy and Comparative Criminology*.

33. Prochaska J O, Velicer W F. (1997) The transtheoretical model of health behavior change. *American journal of health promotion : AJHP*,12(1):38-48. doi: 10.4278/0890-1171-12.1.38 [published Online First: 1997/08/05].

34. Ory M G, Smith M L, Mier N, et al. (2010) The Science of Sustaining Health Behavior Change: The Health Maintenance Consortium. *American Journal of Health Behavior*, 34(6):647-59.

35. Her Majestys Government. (2016) Ending violence against women and girls strategy: 2016 to 2020. London.

36. Her Majestys Government. (2018) Serious Violence Strategy. London.

37. Thornton S. (2011) Predicting serious domestic assaults and murder in the Thames Valley. Unpublished thesis for the M.St. in applied criminology & police management. University of Cambridge.

38. Institute of Education. (2016) Evidence for impact of Domestic Violence Perpetrator Programmes: College of Policing evidence commentary.

39. Subirana-Malaret M, Andrés-Pueyo A. (2013) Retención proactiva y adherencia terapéutica en programas formativos para hombres maltratadores de la pareja. *Psychosocial Intervention*,22(2):95-104. doi: https://doi.org/10.5093/in2013a12.

40. Team S E. (2017) Domestic Violence and Abuse Perpetrator Programme: An Evaluation: NIHR School for Public Health Research.

7 Appendices

Appendix 1: Routine feedback from co-location agencies

The following figures are based on feedback from staff immediately after colocation and 3 months post co-location. It is important to note, however, that the majority of feedback was sent by those who work directly with perpetrators, and therefore feedback from those that do not work directly with perpetrators is not presented, as numbers were too small (apart from Figure 11). These have been reported according to the main objectives of colocation:

- Increasing front-line staff confidence in working with domestic abuse perpetrators
- Increasing front-line staff competency in working with domestic abuse perpetrators
- Increasing front- line staff knowledge around domestic abuse and domestic abuse perpetrators
- Improving partnership working between perpetrator services (DAPP Partners) and other agencies.

Figure 1: Feedback from frontline staff working directly with perpetrators, reporting on **'increased confidence in working with perpetrators',** *total numbers shown*
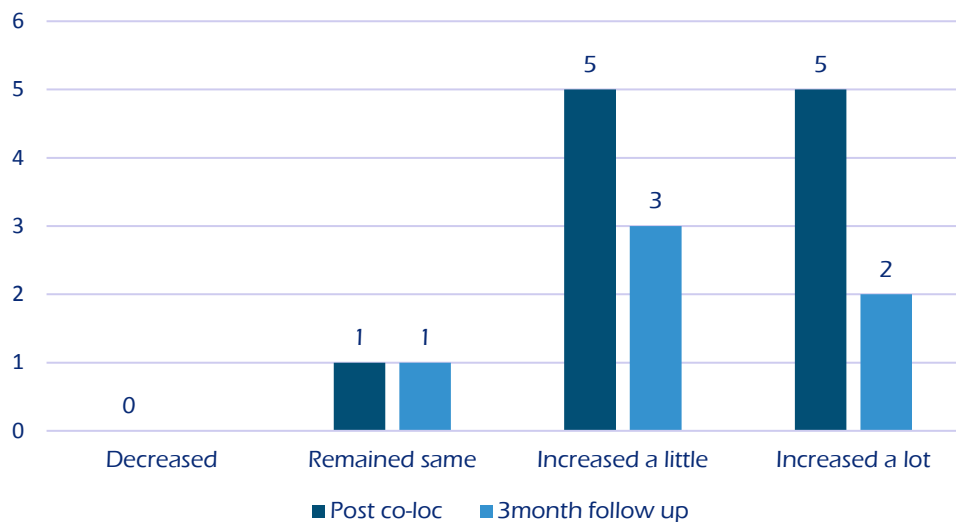
Figure 2: Feedback from frontline staff working directly with perpetrators, reporting on **'increased confidence in working with perpetrators who use denial minimization and blame',** *total numbers shown*
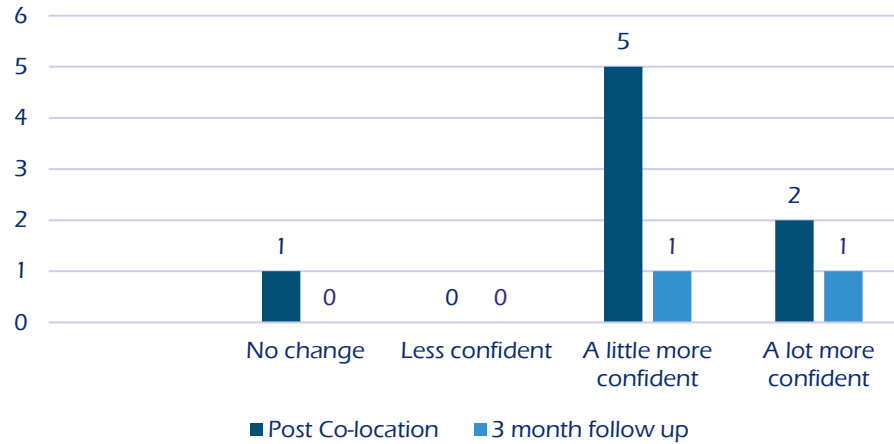
Figure 3: Feedback from frontline staff working directly with perpetrators, reporting on **'increased confidence in undertaking preparatory work for DVPPs',** *total numbers shown*
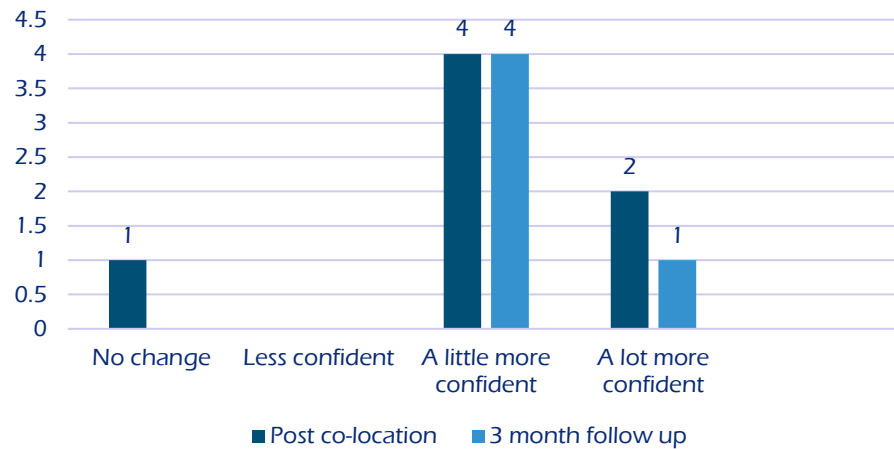

Figure 4: Feedback from frontline staff working directly with perpetrators, reporting on **'increased competency in working with perpetrators',** *total numbers shown*
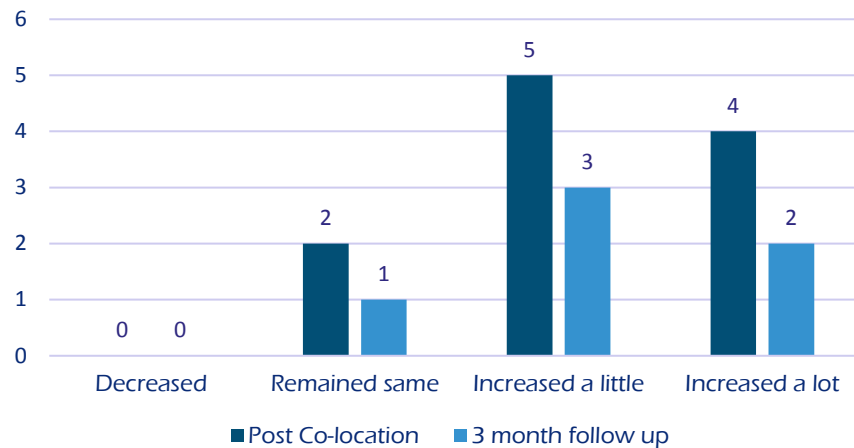
Figure 5: Feedback from frontline staff working directly with perpetrators, reporting on **'increased awareness and knowledge around domestic abuse and coercive control' (after colocation),** *total numbers shown.*
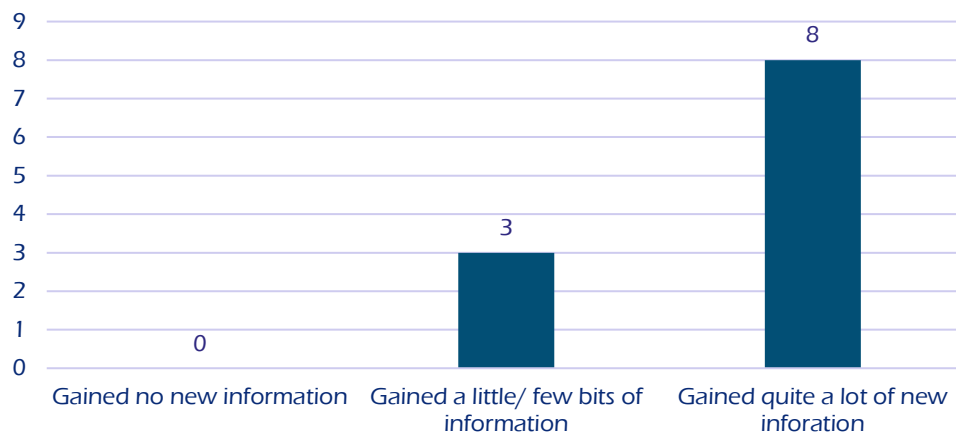

Figure 6: Feedback from frontline staff, reporting on **'tools for working with DA as useful', (3 months after colocation)** *total numbers shown.*
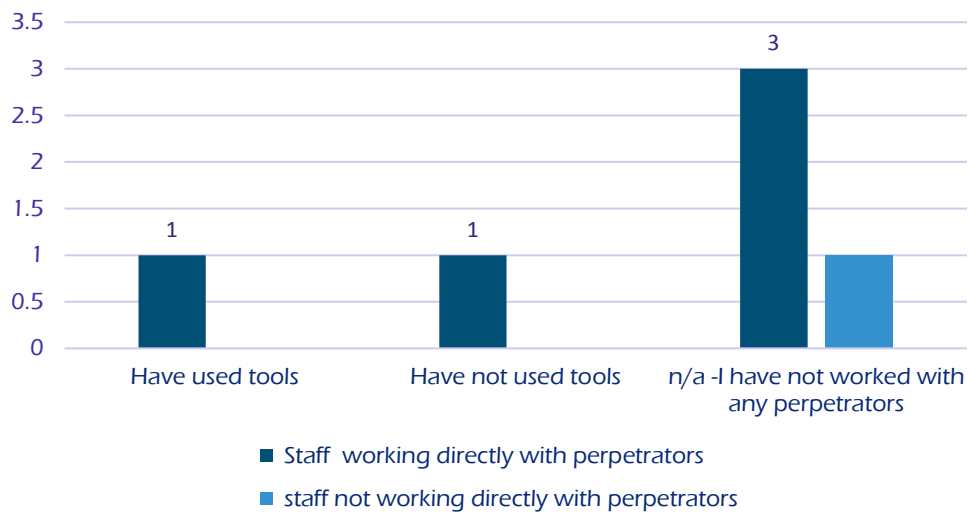
Figure 7: Feedback from frontline staff, reporting on **'improved partnership working with DAPP partners,** *total numbers shown.*

Staff working directly with perpetrators

Legend: ■ Post co-location ■ 3 month follow up

Data values:
- not at all: 0, 0
- improved a little: 4, 3
- improved a lot: 8, 3