

Annual Report of the Director of Public Health 2018-19

Reducing Serious Violence



Contents

Foreword.....	3
Acknowledgements	4
Executive Summary.....	5
1. Introduction	6
Costs and impacts.....	7
Risk and protective factors for violence	8
Rationale for public health approach.....	9
2. Violence in Hampshire - what we know	11
Overview of violence in Hampshire	11
Knife crime	12
3. Preventing interpersonal violence, drug and alcohol related violence	13
Drug related violence.....	13
Alcohol related violence.....	13
In Hampshire	14
Evidence for drug and alcohol related violence prevention.....	15
Programmes in Hampshire.....	15
Case study 1	16
4. Domestic violence.....	17
Children.....	18
In Hampshire	18
Evidence for domestic violence prevention	19
Perpetrators of abuse.....	19
Programmes in Hampshire.....	20
5. Child to Parent Violence (CPV) and Adolescent to Parent Violence and Abuse (APVA)	21
In Hampshire.....	22
Evidence for CPV/ APVA prevention.....	22
Programmes in Hampshire.....	22
Case study 2	23
6. Sexual violence.....	24
Overview of sexual violence	24
In Hampshire	25
Evidence for sexual violence prevention	27
Programmes in Hampshire.....	27
7. Summary	28
8. Further support.....	29



intervene to prevent violence, focusing on those services for which Public Health has direct responsibility. We know that most violence is preventable and I want to embed a public health approach to reducing violence across Hampshire. I will lead by example to ensure the services that I am responsible for are all doing what they can to reduce this trend.

The Director of Public Health's annual report is one of the ways in which I can highlight specific issues to improve the health and wellbeing of the people of Hampshire. By acting early to explore the issues and understand this upward trend, I hope that we can identify what we can do to prevent further increase and protect our residents, especially those who are most vulnerable.

Simon Bryant
Interim Director of Public Health,
Hampshire County Council

Foreword

I am delighted to introduce my first report as Interim Director of Public Health for Hampshire. I have chosen to focus on serious violence, an issue which has had much national focus over the past year. Whilst the numbers of violent incidents in Hampshire are low compared to many other parts of the country, the impact of each incident is devastating for the individuals and communities affected. Serious violence has a range of complex causes and takes many forms, not all of which are visible. It has negative economic and social consequences and is a significant cause of physical, mental and emotional ill health.

Across the country more violence is being reported and despite Hampshire being a relatively safe place, we too have seen an increase in reported violence. The report defines violence and the value of taking a public health approach to reducing it; it explores what we know about violence locally and identifies where we can

I am delighted to have been asked to contribute to this annual report.

This report highlights the fact that many of the issues facing Public Health are the same as those that challenge us in the Police and show more than ever how important it is that we take a multi-agency approach through early intervention and prevention and working together. I note with specific interest the reference to childhood adversity. Within Hampshire Constabulary, we are working across the public sector to understand what that means for policing, how we can contribute and what trauma-informed policing can do to reduce harm and violence.

This report describes what a public health approach is and reinforces the work already done by Public Health England and the College of Policing to develop what a public health approach to policing is.

Acknowledgements

I hope that you find this report helpful and that it stimulates your interest. I would like to thank everyone in the Public Health team who has contributed to the report. Special thanks go to Jenny Bowers, Ileana Cahill, Rob Carroll, Kate Lees, Jo Lockhart, Fiona Maxwell, Kate Raines, Jude Ruddock-Atcherley and Megan Saunders.

Additional thanks go to colleagues at Hampshire Constabulary, the Office of the Police and Crime Commissioner for Hampshire, Inclusion Recovery Hampshire and Stop Domestic Abuse.

The work that we have been doing with Simon Bryant and his team across the county to reduce violent crime and the causes of violent crime by reducing harm caused to vulnerable people, demonstrates that the relationships we have are strong and continue to be so.

We are committed in Hampshire Constabulary to protecting vulnerable people at risk of violent crime and are proud of the relationships fostered to achieve this. We look forward to the year ahead and making further inroads to reduce harm and protect our communities. Without doubt we are stronger together.

Craig Dibdin
Assistant Chief Constable,
Hampshire Constabulary

I would also like to thank Dr Sallie Bacon, Director of Public Health for Hampshire until June 2019, both for her valuable contribution to this report, and for her years of leadership, advice and support.

Simon Bryant



Executive Summary

Despite Hampshire being a relatively safe place to live, the numbers of violent incidents are increasing. Every incident has a devastating impact on the individuals involved, their families and communities. A public health approach to reducing violence helps us to explore what we know about violence locally, identify where we can intervene to prevent it, and to develop and scale up these interventions.

Quantifying serious violence in Hampshire



This report highlights the significant amount of work going on across Hampshire to reduce serious violence. However, there is more we can do. I recommend the following priorities for action.

- Work with universal services for children and young people to reduce risk factors for violence.
- Reduce children and young people's risk factors for violence, through both Relationships Education, and Relationships and Sex Education.
- Improve children and young people's emotional health by implementing the Starting Well for Emotional Wellbeing and Mental Health Strategy.
- Ensure schools are aware of the comprehensive drugs and alcohol services available to them.
- Limit the availability of alcohol in local areas, where appropriate.
- Raise public awareness of preventative services and the public's role in safeguarding.
- Ensure all frontline health and care services work together to identify, support and refer those at risk of violence, those experiencing violence and those who perpetrate violence.
- Lead and contribute to multi-agency partnerships to reduce serious violence, through a 'whole system' approach.
- Work in partnership to improve the identification of and support for those who are vulnerable and at risk.

1. Introduction

Violence is present in many forms in almost every society in the world. Its personal, social, economic and environmental consequences are immeasurable - from the destructive and severely traumatic violence of war and global conflicts, to the more locally recognised problems of domestic violence and violent crime. Its impacts can go beyond the immediate victim to adversely affect our societies, creating fear and apprehension, increasing isolation, contributing to poorer mental and physical health and adding to the burden on health and social care services, police, courts and the criminal justice system.

Violence is defined as

'the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation'.

Violence is not always physical; many forms of violence are more commonly understood in terms such as 'neglect' or 'coercive control'. These are examples of the use of power to harm and to the detriment of another and so are included in definitions of violence. Similarly, injuries from violence are not always physical. Violence can have long-term impacts on psychological and social development and functioning.

Figure 1.1 shows how the World Health Organisation (WHO) categorises types of violence under three broad headings: self-directed, interpersonal and collective. The focus of this report is interpersonal violence. Collective violence includes social, political and economic violence, and is outside the scope of this report.

Self-directed violence includes suicide, self-harming behaviour and attempted suicide. It is a particular type of violence which requires very specific and sensitive approaches to prevention and support for those affected. Hampshire's Suicide Prevention Strategy, incorporating self-harm as a key risk, is overseen by a multiagency partnership and includes a range of measures to reduce the suicide rate, which is now on a downward trajectory¹. This is not considered as part of this report.

¹ Suicide Prevention Strategy for Hampshire, 2018-21. <https://democracy.hants.gov.uk/documents/s13600/2018-03-15%20Appendix%20Suicide%20Prevention%20Plan%202018.pdf>

Figure 1.1 A Typography of Violence, World Health Organisation

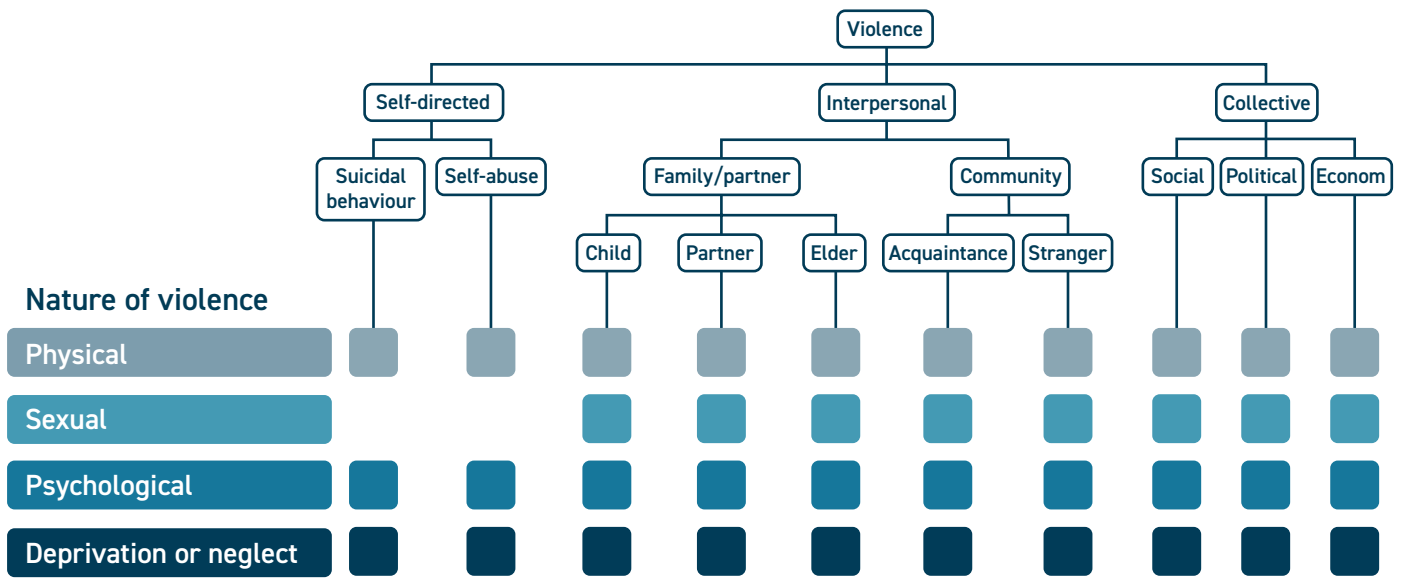


Figure 1.1 also shows there are many different types and perpetrators of interpersonal violence. All interpersonal violence has a significant burden in our society and it is important we work together to reduce it. In this report I have chosen to focus on areas of family and community violence that Public Health has most influence over or responsibility for. This enables me to reflect on what more I can do to reduce serious violence through the services Public Health commissions and partnerships we contribute to or lead.

Costs and impacts

There are an estimated 1.2 million violent incidents in England and Wales every year². Violence is estimated to cost the NHS £2.9 billion every year, and to result in 300,000 emergency department visits and 35,000 emergency hospital admissions³. Overall costs are difficult to quantify, but also include economic loss through days off work and additional costs to police and the courts system.

The human cost of violence is immeasurable: pain, injury, disability, grief, death and psychological harm. Much violence is hidden and frequently perpetrated against the most vulnerable and least able to speak up about their suffering. Therefore, the impacts of many common types of violence are often unseen and unknown. The more visible types of violence, such as violent disorder and crime, can have profound effects through creating fear and apprehension in both individuals and communities. This can lead to individual isolation and limited social opportunities and networks, or alternatively to defensive or retaliatory violence.

For children growing up with violence, the impact on their future development and life chances can be severe and long lasting. Domestic violence is the single most commonly experienced form of adverse childhood experience (ACE). ACEs also include child maltreatment and sexual abuse and are associated with a wide range of serious problems in later life, such as mental ill-health, drug and alcohol misuse, and an increased risk of being either a perpetrator or a victim of violence in adulthood.

2 Public health approaches to reducing violence, Local Government Association, 2018. <https://www.local.gov.uk/public-health-approaches-reducing-violence>

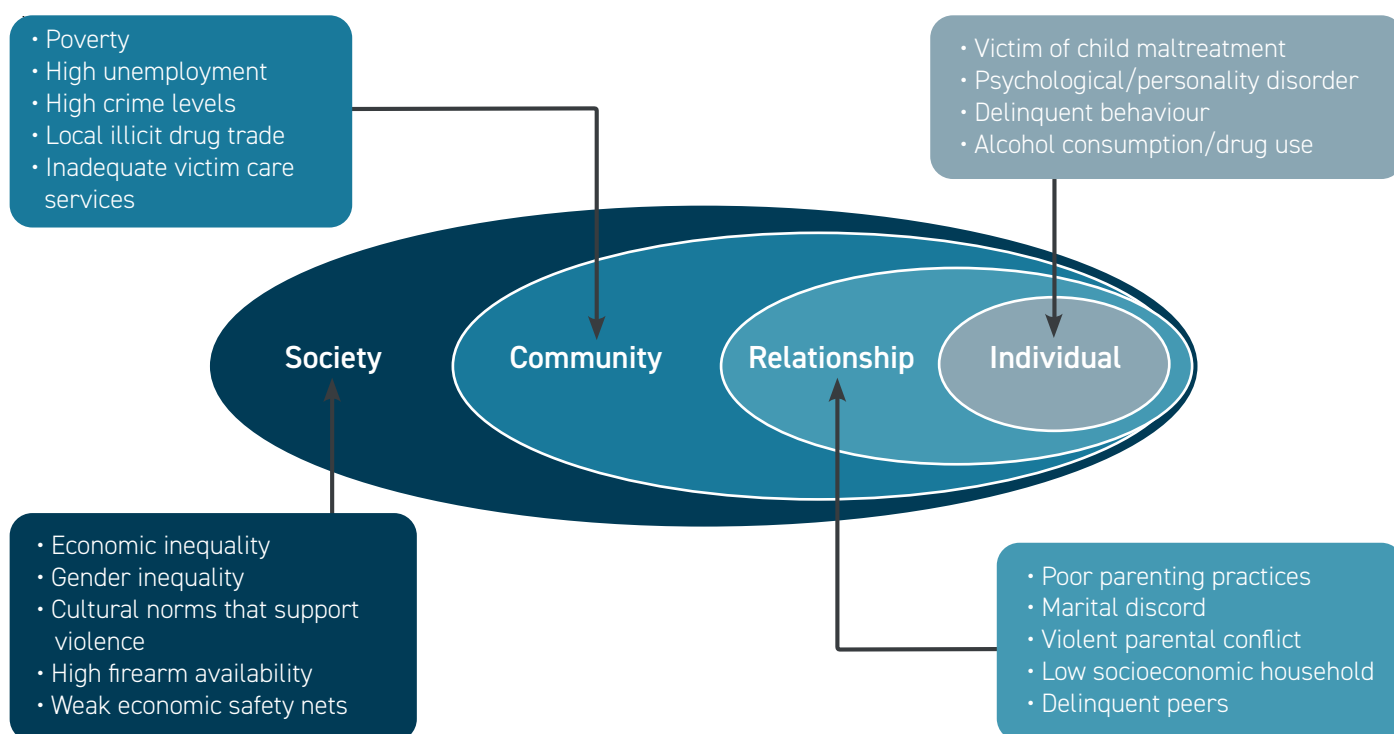
3 Protecting people, promoting health: A public health approach to violence prevention for England DoH, October 2012. <https://www.gov.uk/government/publications/a-public-health-approach-to-violence-prevention-in-england>

Risk and protective factors for violence

There is no single reason to explain why some people or populations are vulnerable to violence. A wide range of factors relating to individuals, their relationships, and the communities and societies in which they live interact to increase or reduce vulnerability to violence⁴. These are known as risk and protective factors and might be considered as opposite ends of a continuum. It is important to understand that a risk factor does not mean it is a direct cause of violence.

Understanding risk and protective factors and how they relate to one another helps us understand how we might intervene to prevent violence. Figure 1.2 shows how these factors inter-relate.

Figure 1.2 Cross cutting risk factors for violence⁵



Adapted from World Health Organization, 2004

4 UK Faculty of Public Health: The role of public health in the prevention of violence. 2016.

5 Protecting people, promoting health: A public health approach to violence prevention for England DoH, October 2012. <https://www.gov.uk/government/publications/a-public-health-approach-to-violence-prevention-in-england>

Rationale for a public health approach

A public health approach to prevention recognises the need to understand and address the underlying causes of violence and to determine which factors may increase risk and how those might be modified.

WHO states that 'almost all violence is predictable and therefore preventable'. Evidence supports the effectiveness of prevention activities in a range of settings. Public Health in Hampshire works alongside colleagues in relevant agencies to prevent violence from happening, to mitigate harm where violence occurs, and to deliver evidence-based interventions that contribute to an overall reduction in violence and harm.

Public Health tends to focus on populations and communities rather than individuals. By bringing an evidence-based, prevention-focused approach to violence prevention, we work to improve the health, safety and wellbeing of individuals within those communities with the following principles:

- Understanding the causes and consequences of violence and conflict in our society and communities.
- Using best available evidence to address those causes and effects.
- Advocating, developing, implementing and monitoring programmes which show evidence of success in reducing or preventing violence and/or lessening its negative impacts at all stages.

These principles underpin the four steps of a public health approach to violence prevention shown in Figure 1.3.

Figure 1.3 The four steps of the public health approach to violence prevention, World Health Organisation



Reducing the causes and impacts of violence (in common with many other of the complex issues affecting the health and wellbeing of our population) cannot be achieved alone. We have a role in facilitating other agencies to come together to work across different systems, professional boundaries and localities. We need a co-ordinated approach, sharing evidence and information on known or emerging risks. This will help us all understand and challenge the actions, beliefs and attitudes that allow violence to persist in our communities.

2. Violence in Hampshire - what we know

Overview of violent crime in Hampshire

This chapter provides some headline figures regarding violent crime in Hampshire, then focuses on knife crime, a specific type of interpersonal violence which has received a lot of media attention this year.

During 2016/17 violence with and without injury accounted for over one third of the total crimes across Hampshire. Data show an increasing rate per 1,000 population⁶, which is comparable to the regional and national trend.

Conversely hospital admission rates due to violent crime are significantly lower in Hampshire than the national and regional rates and have decreased over the last six-year time periods. Between April 2014 and March 2017 there was an average of 306 people in Hampshire admitted every year to hospital due to violent crime.

From April 2017 to March 2018 there were 31,294 street violent and sexual offence crimes across Hampshire (source: Police.uk). There is a strong correlation between crime and deprivation - 90% of the variation in the violent and sexual offences crime rate in Hampshire can be explained by deprivation. The crime rate in the most deprived areas (decile 1) is over six times higher than the least deprived areas (decile 10).



⁶ Care must be taken when interpreting these data as the increases reported may not be indicative of an actual increase in the number of crimes occurring but reflective of an improvement in recording practices and increased public confidence to report crime.

Knife crime

This report presents an opportunity to reflect on knife crime in Hampshire, given the current national focus on this type of violence. Knife crime has been rising nationally since 2014/15⁷ and Hampshire is no exception with an increase in recorded knife crime of 14% between 2015/16 to 2016/17. Whilst some of this may be linked to better recording, there has been an increase in offences where a bladed article has been reported, including increases in violence against a person (VAP).

Victims, suspects and offenders for knife crime are more often over 25 years of age. For younger age groups, suspects and offenders are more likely to be under 18 than victims, a finding which needs further investigation.

Basingstoke has the highest number of knife crimes in Hampshire, however Test Valley experienced the greatest rise in knife crime (93%, from 60 crimes to 116), followed by Rushmoor, which recorded a 59% year on year increase (69 to 110). These higher percentage increases over time reflect the relatively small numbers of baseline knife crime.

Offenders of knife related violence in Hampshire are associated with drug use and supply, serious violence and poor mental health⁸. Mental health markers were also present. Young offenders have been linked with Adverse Childhood Experiences (ACE), including emotional/physical abuse and episodes of going missing.

Drug related harm is a known driver for knife related crime and violence. A police strategic review of Most Serious Violence (MSV) revealed that a knife is used in around 16% of MSV occurrence, but this increases significantly to 60% when the MSV incident is linked to drug supply activity. For this reason, the following chapter explores drug and alcohol related crime in Hampshire in more detail.

7 HM Government Serious Violence Strategy, April 2018.

8 Hampshire & IOW Constabulary Partnership Force Strategic Assessment 2017/18

3. Preventing interpersonal violence, drug and alcohol related violence

I have chosen four examples of family and community violence to explore through this report. These are areas that Public Health has a strong influence over or responsibility for. They are alcohol and drug related violence; domestic violence; child and adolescent to parent violence and sexual violence.

Using the principles of a public health approach highlighted in chapter 1, I explore what we understand about this type of violence, both generally and in Hampshire, the evidence of what works and the programmes available to prevent violence in Hampshire, including the challenges faced. The learning from this informs my recommendations in the final chapter.

Drug and alcohol related violence

Investing in effective prevention, treatment and recovery interventions is essential to tackle the harm (including violence) that drugs and alcohol can cause.

Drug related violence

The harms caused by drug misuse are extensive and include crime committed to fuel drug dependence, organised crime and violence⁹. An increasing focus is being given to the problem of 'county lines'. This is the term used to refer to drugs networks which are established by urban gangs which supply Class A drugs (such as heroin and crack cocaine) to suburban and rural areas. Violence is often used by these gangs to establish their presence in local areas. Very often children and vulnerable adults will be used to carry out illegal activity on their behalf. The increasing use of violence within county lines has been identified as a key issue within the Government's Serious Violence Strategy. Nationally between 2014/15 and 2016/17, homicides where either the victim or suspect were known to be involved in using or dealing illicit drugs increased from 50% to 57%¹⁰.

Alcohol related violence

Alcohol consumption is a risk factor for many types of violence, including child abuse, youth violence, intimate partner violence and sexual violence.¹¹ Whilst the relationship between alcohol and violence is complex, it has been shown that the more alcohol a population consumes, the higher the rates of violence related death and injury¹².

9 Drug strategy, Home office, 2017. <https://www.gov.uk/government/publications/drug-strategy-2017>

10 Serious Violence strategy, HM Government, 2018. <https://www.gov.uk/government/publications/serious-violence-strategy>

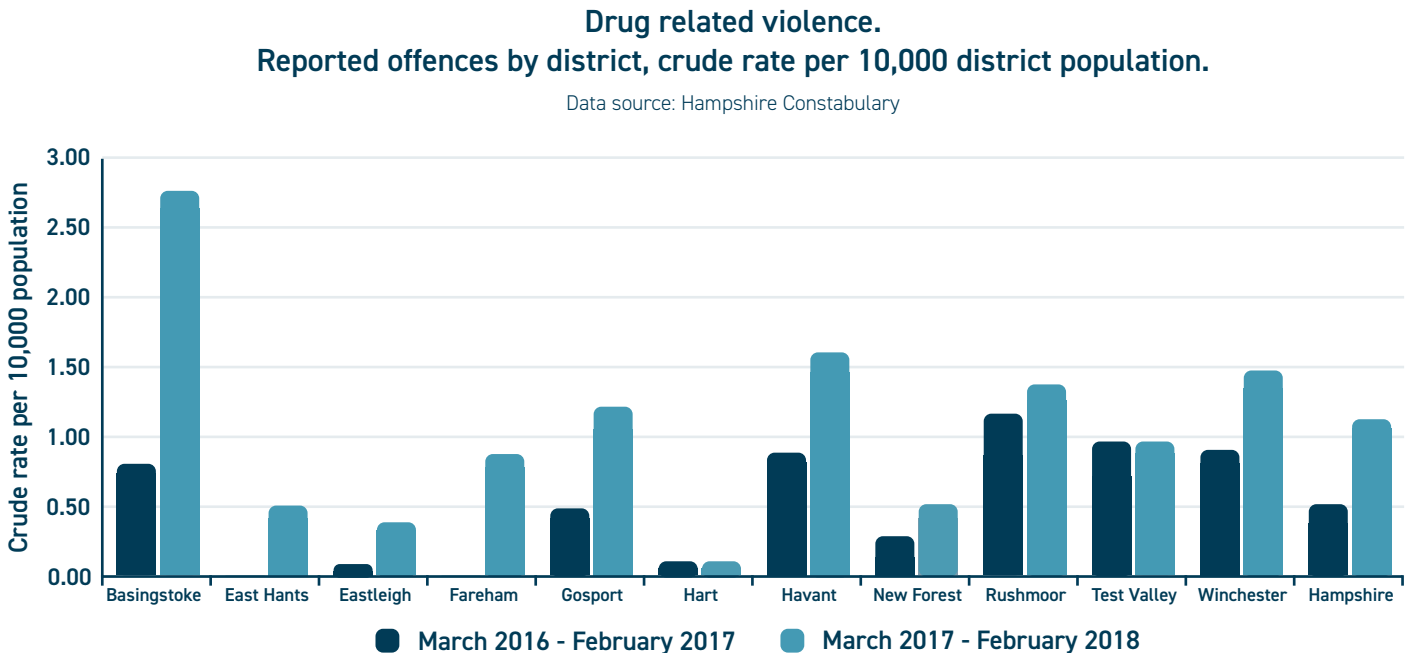
11 Alcohol and drug prevention, treatment and recovery: why invest? PHE. February 2018. <https://www.gov.uk/government/publications/alcohol-and-drug-prevention-treatment-and-recovery-why-invest/alcohol-and-drug-prevention-treatment-and-recovery-why-invest>

12 Graham and Livingston, The Relationship between Alcohol and Violence – Population, Contextual and Individual Research Approaches, *Drug Alcohol Rev.* 2011 Sep; 30(5): 453–457. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3170096/>

In Hampshire

In 2016/17 there were 70 drug related violence offences recorded by Hampshire Constabulary and this reportedly increased to 152 in 2017/18. The main type of offences was assault (41%) and robbery (18%). Reported increases in drug related violence offences in some districts correlate with the districts where networks such as county lines are mapped as operating. These networks are considered to present the greatest impact in terms of threat, risk and harm in vulnerable communities in driving demand for Class A drugs and stimulating a level of violence. It is thought that much drug related violence goes unreported.

Figure 3.1 Drug related violence crude rate per 10,000 population in Hampshire's Districts, 2016-17 & 17-18



Parental substance misuse can negatively affect children. A quarter of cases on the Child Protection register are related to parental substance misuse and it is estimated that substance misuse is involved in over a third of Serious Case Reviews. Nationally Public Health England reports that 48% of convicted domestic abuse perpetrators had a history of alcohol dependence and 73% had consumed alcohol prior to the event¹³.

13 Alcohol and drug prevention, treatment and recovery: why invest? PHE. February 2018. <https://www.gov.uk/government/publications/alcohol-and-drug-prevention-treatment-and-recovery-why-invest/alcohol-and-drug-prevention-treatment-and-recovery-why-invest>

Evidence for drug and alcohol related violence prevention

Reducing drug and alcohol use is a vital part of reducing violence in communities. Part of this is ensuring comprehensive drug and alcohol misuse services are available for people who need support to reduce or stop their drug and alcohol use. Among offenders, treatment for substance misuse has been successful in reducing future intimate partner violence¹⁴.

At a community level, restricting the availability of alcohol (e.g. through increasing price) has been associated with reductions in intimate partner violence and other interpersonal violence including child maltreatment¹⁵.

We know that the supply and demand of drugs are closely linked with serious violence. Working in partnership to share intelligence enables supply lines to be disrupted and violence prevented.

Programmes in Hampshire

A Hampshire-wide substance misuse service helps people overcome their dependency on drugs and alcohol. This in turn reduces their involvement in crime and any associated violence.

The service also provides comprehensive drugs and alcohol support to schools which includes bulletins, workshops, training for staff and targeted work with young people who are vulnerable and at risk.

Effective partnership working with criminal justice, health and social care organisations, is needed to tackle drug and alcohol related violence. Public Health in Hampshire is working in partnership with these key organisations to tackle county lines activity and to protect vulnerable adults and young people who are at most risk of drug related harm and exploitation. Robust multi-agency safeguarding processes are in place to protect children, young people and vulnerable adults from the harm caused by county lines. Substance misuse services work with domestic abuse services to support both the victim and perpetrator of violence, where both problems are identified together.

14 Prevention of Intimate Partner Violence. A review of evidence for prevention from the UK focal point for violence and injury prevention. Wood et al. Liverpool John Moore University. 2010. <http://www.cph.org.uk/wp-content/uploads/2012/08/intimate-partner-violence-a-review-of-evidence-for-prevention.pdf>

15 Sexual violence A review of evidence for prevention from the UK focal point for violence and injury prevention. Wood et al. Liverpool John Moore University. 2010. <http://www.cph.org.uk/wp-content/uploads/2012/08/sexual-violence-a-review-of-evidence-for-prevention.pdf>

Case Study 1

Sarah* was in her late twenties when she became reliant on prescription opiates to manage chronic pain and started to use illicit drugs. She had a history of abusive relationships dating back to her teenage years. Sarah's local substance misuse service supported her to become abstinent. However, a subsequent relationship breakdown led to difficulties and as a result, her children were placed on a Child Protection Order and removed from the family home.

She later began a relationship with a local drug user and dealer, which became violent. Sarah's home was taken by drug dealers to use as a base for dealing and serious violent offences were reported at the address.

Through outreach work, the substance misuse service was able to re-engage Sarah and encourage her to access treatment and harm reduction support, including the needle exchange programme, one-to-one counselling and key worker support. She was also prescribed methadone to reduce her reliance on illicit drugs. The substance misuse service has ensured that all safeguarding processes are in place and is working with other agencies such as the police, housing and adult social services to protect her from violence and assist her in her future goals.

* name has been changed

4. Domestic violence

Until both communities and agencies have a zero tolerance of domestic violence and abuse, there will continue to be challenges in preventing, identifying and then effectively dealing with it.

We need to continue working towards identifying and supporting people at the earliest possible stage, as well as making greater efforts around preventative work.

I have chosen to focus on reducing domestic violence because this accounts for a significant proportion of serious violence. Action to reduce domestic violence is required to directly reduce overall serious violence. However, there is also an indirect effect because exposure to domestic violence increases vulnerability to violence.

Overview of domestic violence

Domestic violence and abuse (DVA) is a significant problem which can affect people from any background, at any age. In England and Wales, for the year ending March 2016, an estimated 2 million adults aged 16-59 experienced domestic abuse in the last year. Overall, 26% of women and 14% of men have experienced domestic abuse in their adult lifetime.

Domestic abuse is an infringement on someone's basic human rights and has devastating effects including risk of serious physical harm or death, wide-ranging impacts on physical, mental and emotional health and wellbeing, and long-lasting negative effects on children and young people. Domestic violence and abuse cost the UK an estimated £15.7 billion in 2008 (Walby 2009).¹⁶

16 The Cost of Domestic Violence, Sylvia Walby, 2009. https://www.lancaster.ac.uk/fass/doc_library/sociology/Cost_of_domestic_violence_update.doc

Children and domestic violence

The effects of domestic violence are serious and can be long-lasting, impacting the physical and mental health of victims. Exposure to domestic violence is the most frequently reported form of trauma for children and is often experienced alongside other forms of maltreatment, such as child abuse and neglect¹⁷.

Exposure to domestic violence and abuse is the most frequently reported form of trauma for children and is often experienced alongside other forms of maltreatment, such as child abuse and neglect. In 2017, there were almost 1,700 children in need, due to abuse or neglect in Hampshire.

Ninety per cent of domestic abuse is witnessed by children. Consequences include children becoming withdrawn, depressed and finding it difficult to communicate; others may act out the aggression they have witnessed or blame themselves for the abuse. In adulthood children affected by domestic abuse have increased risk of poor mental health, substance misuse and behavioural problems. This is why we should intervene early and support families to deal with domestic abuse.

In Hampshire

Domestic violence and abuse (DVA) accounts for 12% of total crime, with DVA occurrences increasing by 5% between 2016/17 and 2017/18. The increase in DVA could be attributed to improved recording, confidence in reporting, or increased counter allegations following on from the increased arrest rate. 'Violence against the Person' accounts for 80% of DVA crime, one third of this is 'Violence against the Person with Injury', almost exclusively Actual Bodily Harm (ABH). Twenty three murders occurred in 2017/18, three were domestic related. In 2017/18, over one third (34%) of all domestic crime involved repeat victims. Despite the increases in DVA crime many incidents stay unreported, so police data gives only part of the picture.

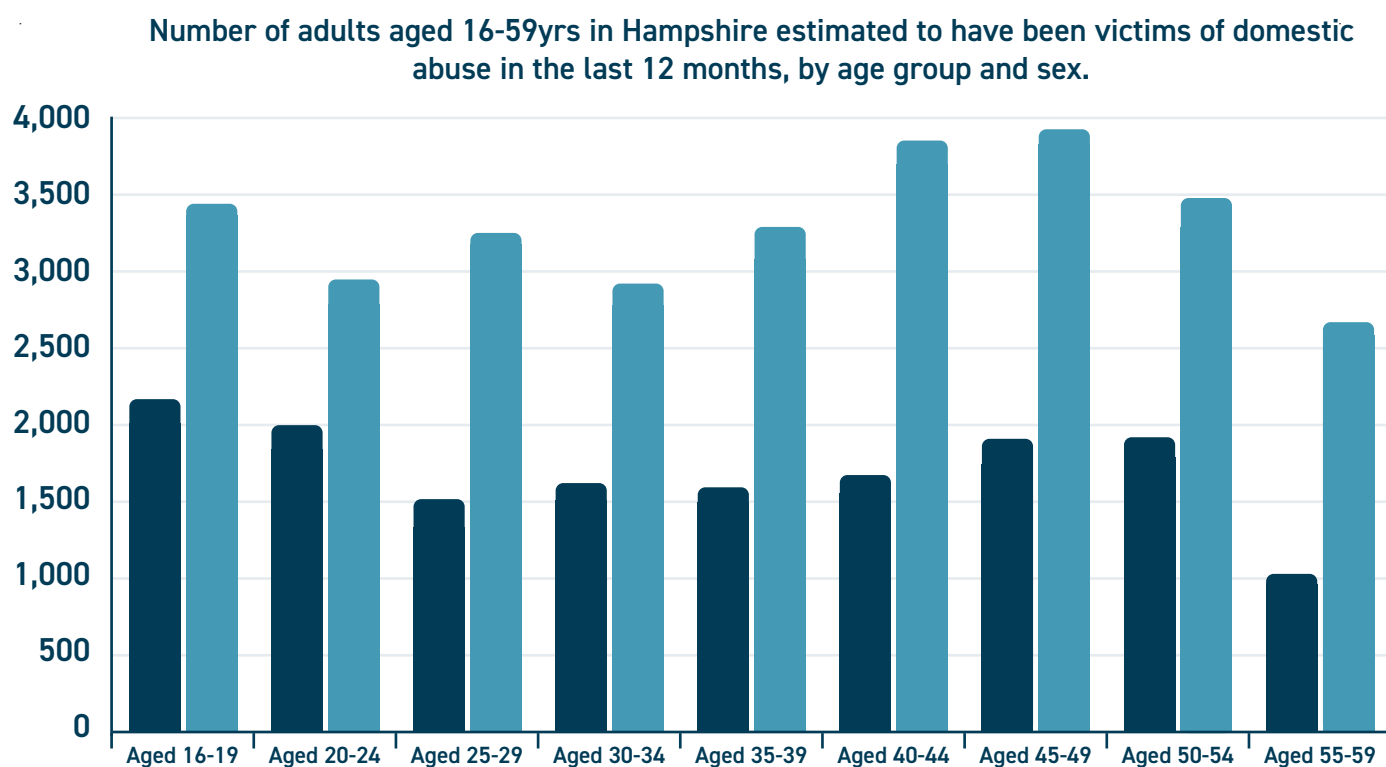
An estimated 15,607 men and 30,083 women aged 16-59, and 734 men and 2,306 women aged 60-65 were affected by DVA in Hampshire last year. Over 40,000 children and young people under 18 were affected during the same period¹⁸.

In Hampshire we are committed to taking a whole family approach to domestic abuse, recognising that for every victim there is a perpetrator. We need to address the needs of all members in a family, including the children, to properly address domestic violence and abuse, and prevent it reoccurring in the future.

¹⁷ Hampshire CC Domestic Violence and Abuse in Hampshire Needs Assessment, May 2018.

¹⁸ Hampshire Domestic Abuse Needs Assessment 2018

Figure 4.1 The number of adults aged 16-59 years estimated to have been victims of domestic abuse during 2017 in Hampshire, by age and gender.



Crime Survey for England and Wales Domestic Abuse estimates applied to Hampshire County Environment Department's 2017 based Small Area Population Forecasts

Evidence for domestic violence prevention

There are a variety of ways in which we can seek to prevent DVA and where it cannot be prevented, intervene early. Public awareness and challenging attitudes and tolerance of DVA within communities is vital. We can engage communities and train community champions, sensitive to the cultural differences that may exist within communities, to ensure DVA is identified and picked up at its earliest stage and addressed before escalation. We can provide parenting programmes and support for families, and work with children and young people in schools regarding healthy relationships and engage with the locally delivered Relationships and Sex Education (RSE) curriculum. We can work to embed knowledge and understanding of DVA throughout frontline services such as hospitals, GPs, maternity services, mental health settings and substance misuse services by training professionals in multi-agency settings to identify, challenge and address domestic abuse at its earliest stages.

Perpetrators of abuse

We must also work with perpetrators of DVA and seek long term changes to their behaviour and attitudes, particularly with young perpetrators of DVA before their behaviour becomes embedded. Without this the cycle of abuse will continue.

Programmes in Hampshire

In Hampshire, Public Health commissions the county's victims service which provides refuge, outreach, high risk Independent Domestic Violence Advisor support, group work, therapeutic children's support, resettlement and move on support services. We know there is much under-reporting of DVA and that the services and support we provide only reach a handful of victims, children and perpetrators. All too often, people seek help too late, when their risk of serious harm or murder is very high. The service has been recommissioned to include a range of preventative interventions, including a public awareness programme; community engagement and training and advice for frontline staff working in a variety of services and settings.

Educating children and young people about healthy relationships is a priority for action in Hampshire. We are working with schools and other youth settings to build their confidence to implement the new Relationships and Sex Education curriculum from September 2019.

Hampshire also has a range of interventions which aim to tackle perpetrator behaviour, including a community perpetrator service. This service seeks to provide a whole family approach with safeguarding and risk management at its centre. It aims to increase perpetrators' accountability and responsibility and is delivered through a variety of tailored interventions including one-to-one and group work. We will learn from these interventions to find the best way of engaging with and changing perpetrators' behaviours. We will build on these interventions to develop a clear strategic, organised and sustainable approach to dealing with perpetrators of domestic abuse, aiming to reduce the cycle of abuse.

There are various other initiatives in place that support our domestic abuse response. Operation Encompass (which informs schools of DVA incidents that the police have attended in the previous 24 hours) is supported by an education programme being taken into schools to upskill and train school staff in DVA and how to respond and support a child. Hampshire Domestic Abuse Partnership has also published a referral pathway for agencies to use to help victims, children and perpetrators access help and support, with a further version tailored specifically towards our health services. Hampshire County Council and several other employers have also implemented DVA workplace policies to support staff who may be experiencing violence and abuse at home.

Grant funding will allow us to extend our nationally recognised 'Hampshire Making Safe Scheme', helping to keep families safe in their own homes rather than needing to access refuge accommodation. It will also enable us to create DVA workers placed in key health settings, train community DVA champions, and provide additional refuge space to people not traditionally able to access refuges such as male victims, trans victims and women with male children over 16 years.

5. Child to Parent Violence (CPV) and Adolescent to Parent Violence and Abuse (APVA)

Child to Parent Violence (CPV) or Adolescent to Parent Violence and Abuse (APVA) is any behaviour used by a young person to control, dominate or coerce parents.

I have chosen to focus on child to parent and adolescent to parent violence because it is an emerging issue. This means there are significant gaps in our knowledge and understanding which we can work together to start to fill. I also hope that focusing on this area will help to raise awareness of this type of violence.

Overview of CPV and APVA

Child to parent violence and adolescent to parent violence is gradually becoming recognised and acknowledged. It is a complex issue and tends to appear as a pattern of behaviour rather than single incidents. Whilst it is normal for adolescents to demonstrate healthy anger, conflict and frustration during their transition from childhood to adulthood, anger should not be confused with violence. Violence is about a range of behaviours including non-physical acts aimed at achieving ongoing control over another person by instilling fear. These behaviours are intended to threaten and intimidate and put family safety at risk.

Most abused parents have difficulty admitting even to themselves that their child is abusive. They may feel ashamed, disappointed and humiliated, and blame themselves for the situation which has led to this imbalance of power. There may also be an element of denial where parents convince themselves that their son or daughter's behaviour is part of normal adolescent conduct.

Policy has only relatively recently recognised CPV/APVA as a defined issue. There is no agreed definition nor method of consistently recording incidents so it is difficult to quantify its scale. Estimates suggest 3-5% of adolescents may be seriously abusive to parents¹⁹.

Research used by the Home Office²⁰ found in the Greater London area alone 1,892 incidents of violence, threats of violence, or criminal damage in the home, perpetrated by a 13-19-year-old towards their parent(s)/carer(s), in a one-year period 2009-2010. Perpetrators were overwhelmingly male (87.3%) and adult victims were predominantly female (77.5%), with the most common situation being son to mother abuse (66.7%). The Metropolitan Police have reported a 95% increase in CPV violence offences between 2012 and 2016. However, this figure may reflect significant under-reporting. The social and emotional impact of disclosing abuse by a child is likely to deter many parents or carers from reporting such incidents.

¹⁹ Gallagher, E. (2008). Children's violence to parents: A critical literature review, from 19.

²⁰ Information guide: Adolescent to parent violence and abuse' The Home Office. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/732573/APVA.pdf

In Hampshire

In Hampshire, police recorded 312 domestic abuse incidents where the perpetrator was a child in the first half of 2017-18. However, it is not possible to ascertain how many of these were CPV/APVA, as no information about the victim or the relationship is routinely recorded; these could also be incidents of DVA in teenage relationships or other family relationships.

Evidence for CPV/APVA prevention

Evidence for interventions to prevent CPV/APVA is developing. We can work with families to provide preventative measures such as parenting programmes, identify early risk factors, intervene early and prevent crisis situations. Whilst we can learn from other violence such as domestic violence, once violence has occurred we need to recognise differences. These include the stigma families may feel, potential parental fear of their children becoming criminalised and the balance between parental and child responsibilities. Violence should be considered in the context of the whole family and family dynamics. The family should be recognised as a system and whole family approaches utilised to intervene.

Programmes in Hampshire

In Hampshire the Office of the Police and Crime Commissioner has funded programmes which aim to prevent CPV/APVA, including a parenting programme for parents who have experienced domestic abuse and whose child is being violent towards them, another targeting young people who are seeing the Youth Offending Team and their parents.

We know that most CPV and APVA goes under-reported and that our knowledge and understanding of this type of violence is developing. Funding for interventions is often short-term, so that provision varies across the county and over time. We need to embed this work and consider how it should align to services such as DVA services. We will work with partners to better understand needs to enable us to work together towards enabling appropriate interventions to become available and sustainable.

Case Study 2

A Mum was scared of her 9-year-old son's physical violence towards her and her young daughter. She was referred to the 'Who's in Charge?' Programme by the school following an Early Help Hub Meeting. There was a history of domestic abuse between Mum and Dad before their relationship ended several years ago.

Mum gained valuable insights through the programme's talks and activities and put in place practical and meaningful consequences for her son's unacceptable behaviour. Her confidence increased, she took control of the home environment, identified areas to work on and implemented a plan to help her children manage their experiences.

She also engaged with the school and with Child and Adolescent Mental Health Services to get a diagnosis for her son, which allowed her to understand and cope better with his challenging behaviour, and to put support in place for him.

As a result of the programme the son's violence has reduced, the family feels safer and home life has improved.



6. Sexual violence

Sexual violence is the term we use to describe any kind of unwanted sexual act or activity, including rape, sexual assault, sexual abuse and many others

I have chosen to include a chapter on sexual violence because it has a large and negative impact on our health. The sexual health services which I am responsible for commissioning have a significant part to play in identifying and intervening in incidents of sexual violence, alongside many other agencies who have a role in preventing and identifying those at risk of this type of violence.

Sexual violence has been defined as any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances directed against a person's sexuality, using coercion, threats of harm or physical force, by any person regardless of relationship to the victim, in any setting, including but not limited to home and work²¹. The term sexual violence therefore covers a wide range of abusive acts directed towards an individual's sexuality, including rape, sexual assault, sexual coercion, sexual exploitation, trafficking, sexual bullying and female genital mutilation.

Information about prevalence, associated factors, and consequences for health in the population is scarce. Whilst there is increasing public confidence to report offences, sexual violence is still widely under-reported to the police. The third British National Survey of Sexual Health Attitudes and Lifestyles (Natsal-3)²², undertaken between 2010-2012 included questions about sexual violence for the first time and was the first population-based survey in Britain to explore the issue of sexual violence outside the context of crime.

Non-consensual sex was reported by 9.8% of women and 1.4% of men in the Natsal survey. The most recent episode occurred most commonly at age 18 years (age range 14 - 32) for women and at age 16 years (age range 13 - 30) for men. Non-consensual sex varied by family structure and in women by age, education, and area-level deprivation. It was associated with poor health, longstanding illness or disability, treatment for mental health conditions, smoking, and use of non-prescription drugs in the past year in both sexes, and with binge drinking in women. Non-consensual sex was also associated with reporting of first heterosexual intercourse before 16 years of age, same-sex experience, more lifetime sexual partners, having ever being diagnosed with a sexually transmitted infection, and low sexual function in both sexes. In women, it was associated with abortion and pregnancy outcomes before 18 years of age.

In most cases, the person responsible was known to the individual, although the nature of the relationship differed by age at most recent occurrence. Participants who were younger at interview were more likely to have told someone about the event and to have reported it to the police than older participants.

21 Harvey A, Garcia-Moreno C, Butchart A. Primary prevention of intimate-partner violence and sexual violence: Background paper for WHO expert meeting May 2-3, 2007 https://www.who.int/violence_injury_prevention/publications/violence/IPV-SV.pdf?ua=1

22 Macdowall et al. (2013) Lifetime prevalence, associated factors, and circumstances of non-volitional sex in women and men in Britain: findings from the third National Survey of Sexual Attitudes and Lifestyles (Natsal-3)

In Hampshire

In 2017/18 Hampshire Police recorded a 17% increase in reported Serious Sexual Offences (SSO) when compared to the last year. Although almost a third of these relate to historic offences, current reported serious sexual offences also appear to be increasing. Rape accounts for a significant proportion of SSOs (45%). In 2017, 31% of all 'current' rape was flagged as 'domestic' related, namely against a partner or spouse²³.

The rates of sexual offences in Hampshire's statistical neighbours are presented in Figure 6.1. Whilst Hampshire has a slightly lower rate of sexual offences compared to the national average (2.2 and 2.4 per 1,000 respectively), seven of Hampshire's 15 statistical neighbours had lower rates of sexual offences in 2017/18.

Figure 6.1 The rate of sexual offences in Hampshire's statistical neighbours in 2017/2018

1.12iii Violent crime (including sexual violence) - rate of sexual offences per 1,000 population

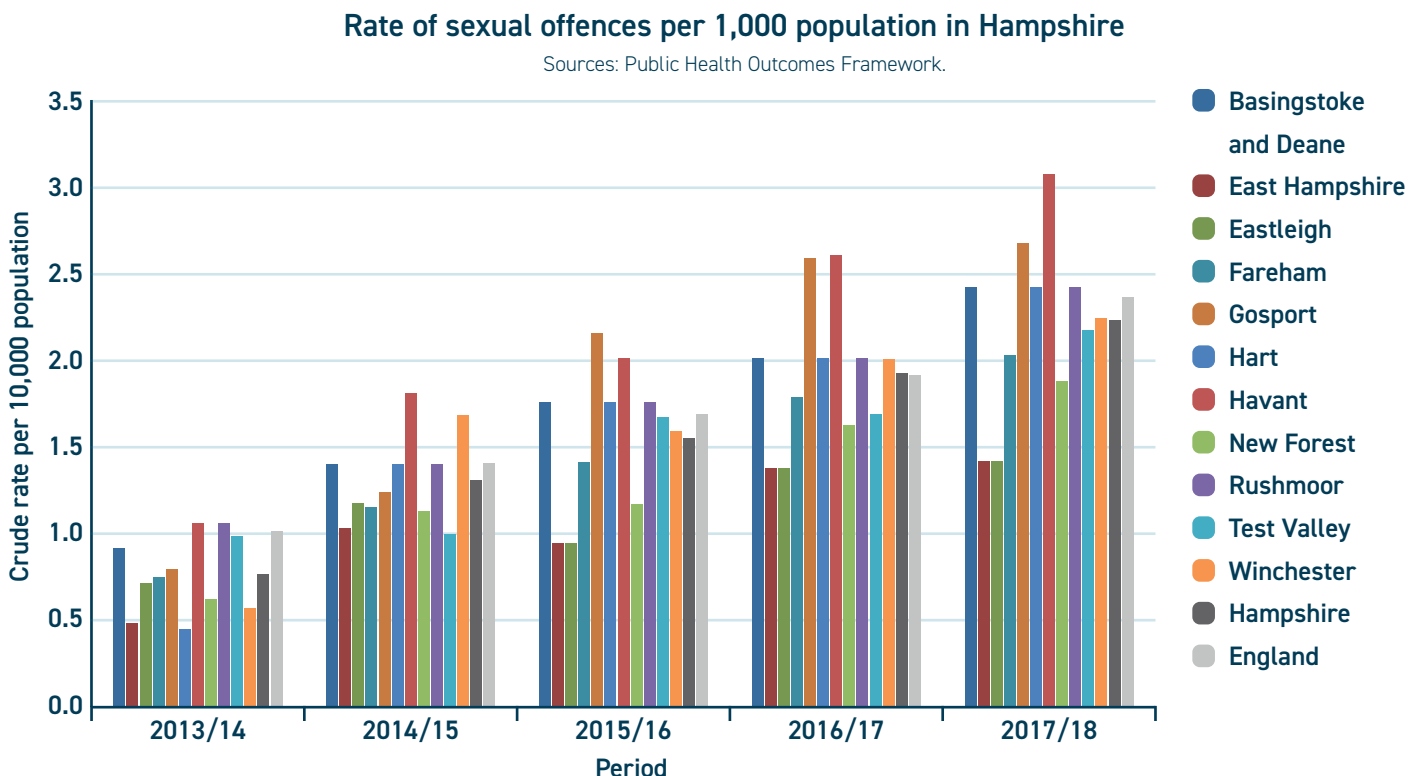
Area	Neighbour Rank	Count	Value	2017/18 Crude rate - per 1000	
				95% Lower CI	95% Upper CI
England	-	130,895	2.4	2.4	2.4
Kent	4	5,026	3.3	3.2	3.4
Suffolk	13	1,913	2.5	2.4	2.7
Worcestershire	7	1,485	2.5	2.4	2.7
Warwickshire	3	1,372	2.5	2.3	2.6
Staffordshire	10	2,096	2.4	2.3	2.5
Northamptonshire	15	1,748	2.4	2.3	2.5
East Sussex	12	1,267	2.3	2.2	2.4
Hampshire	-	3,050	2.2	2.2	2.3
Devon	5	1,677	2.2	2.1	2.3
West Sussex	2	1,671	2.0	1.9	2.1
Oxfordshire	8	1,298	1.9	1.8	2.0
Essex	1	2,703	1.9	1.8	1.9
Hertfordshire	14	2,033	1.7	1.7	1.8
Cambridgeshire	9	1,011	1.6	1.5	1.7
Gloucestershire	6	932	1.5	1.4	1.6
Leicestershire	11	964	1.4	1.3	1.5

Source: Figures calculated by PHE Knowledge and Intelligence Team (North West) using crime data supplied by the Home Office and population data supplied by Office for National Statistics (ONS).

23 Hampshire & IOW Constabulary Partnership Force Strategic Assessment 2017/18

Figure 6.2 shows the trend of increasing sexual offences rate within Hampshire's local authorities from 2013/14-2017/18. In 2017/18, five of Hampshire's local authorities had a higher rate of sexual offences than the national rate, namely Havant, Gosport, Basingstoke and Deane, Hart and Rushmoor.

Figure 6.2 Rate of sexual offences in Hampshire by Local Authority, 2013/14- 2017/18



Domestic rapes account for just over 30% of the rape offences reported to Hampshire Police. Peer on peer rapes currently account for 12% of all current reported rape in Hampshire and there has been a 37% increase in reported peer on peer offending since 2014. Almost four in ten cases of peer on peer rape in Hampshire is reported as by an acquaintance. 68% of victims and suspects/offenders were approximately the same age.

The profile of known rape suspects/offenders in Hampshire is typically opportunistic young males with existing police records. The average age of a rape suspect/offender is 30 years old, with 16% being under the age of 18 at the time of the offence. Twenty nine per cent had also gone on to commit further offences following their substantive rape offence, namely assaults and domestic offences. There is evidence that half of these perpetrators are likely to be linked to further sexual offences in their adult life.

The profile of known rape victims suggests a number of vulnerability factors; they are predominantly female and 26% of victims were under the age of 18, 18% had been flagged as a vulnerable person, over three quarters also linked to domestic abuse, and one in five had been the subject of child protection/child abuse occurrences. These findings are consistent with current research suggesting an increased risk of harm and adversity from those experiencing Adverse Childhood Experiences (ACEs) in their formative years.

Evidence for sexual violence prevention

Risk and vulnerability factors demonstrate the importance of identifying vulnerable children and families for early multi-agency intervention and engagement. Offender and victim profiles also reinforce the importance of the early identification of those presenting harmful sexual behaviours (HSB) and vulnerabilities.

Teaching young people about well-functioning and acceptable behaviour in relationships may prevent sexual violence. Peer-led sex education programmes such as Apause (Added Power and Understanding in Sex Education) teach negotiated sexual behaviours and mutual respect. Peer education has also been found to be effective in relation to drug and alcohol education and to be a key element of successful youth programmes²⁴.

In the UK, students can take part in a 'Bystander intervention' training. It aims to give students the confidence to take action when witnessing domestic and sexual violence in peers and question certain social attitudes surrounding sexual violence victims²⁵.

Programmes in Hampshire

Relationships Education in primary schools and Relationships and Sex Education in secondary schools will become a statutory requirement from September 2020, and the guidance²⁶ suggests that this should include teaching in primary school of the features of healthy friendships and relationships and the differences between appropriate and inappropriate forms of contact. Teaching in secondary school should include a range of topics such as healthy friendships, bullying, how to determine whether peers, adults or sources of information are trustworthy, whether relationships are safe and how to seek help or advice, as well as what constitutes sexual harassment and sexual violence, sexual exploitation and abuse.

Our sexual health services use guidance to support them in the early identification and intervention for violence, especially domestic violence. We will ensure guidance is embedded throughout the service.

There are a number of services in Hampshire to support men and women who have experienced sexual violence, including rape and sexual assault.

24 Butler G, Hodgkinson J, Holmes E, Marshall S. Evidence Based Approaches to Reducing Gang Violence. A Rapid Evidence Assessment for Aston and Handsworth Operational Group. Birmingham: Government office West. Midlands and Home Office Regional Research Team, July 2004. http://www.civilservice.gov.uk/wpcontent/uploads/2011/09/rea_gang_violence_tcm6-5863.pdf

25 NICE. Bystander interventions: A new approach to reduce domestic violence in universities 2014. <https://www.nice.org.uk/news/blog/bystander-interventions-a-new-approach-to-reduce-domestic-violence-inuniversities>

26 Relationships Education, Relationships and Sex Education (RSE) and Health Education Guidance for governing bodies, proprietors, head teachers, principals, senior leadership teams, teachers. Draft for consultation: July 2018. Department for Education.

7. Summary

In this report I have introduced the rationale for a public health approach to preventing violence and described the impact of interpersonal violence in Hampshire. Despite Hampshire being a relatively safe place to live, the numbers of violent incidents are increasing. Every incident has a devastating impact on the individuals involved, their families and communities. This report gives me a chance to reflect on this and consider the actions we can take to reverse this trend, recognising that all violence is preventable.

Whilst recognising the many forms interpersonal violence can take, I have focused on four types of violence. These are all areas where Public Health commissioned services play a direct or indirect role: alcohol and drug related violence; domestic violence; child and adolescent to parent violence and sexual violence. For each area I have explored what we understand about this type of violence including quantifying the scale of the issue in Hampshire where possible, the evidence of what works and the programmes available to prevent violence in Hampshire, including the challenges faced. There are shared themes across these four areas, from which I have pulled together the following recommendations for actions.

Priorities for action in Hampshire

- Reduce children and young people's risk factors for violence, by working with schools and other youth settings to raise awareness of the new requirements for both Relationships Education, and Relationships and Sex Education and to implement them from September 2020.
- Improve children and young people's emotional health by implementing the Starting Well for Emotional Wellbeing and Mental Health Strategy.
- Ensure that schools are aware of the comprehensive drugs and alcohol service available to them which includes bulletins, workshops, training for staff and targeted work with young people who are vulnerable and at risk.
- Shape the availability of alcohol in local areas, by providing public health advice to district/borough Statement of Licensing Policies and supporting the licensing decision process.
- Raise public awareness of preventative services and the public's role in safeguarding through a range of different channels and media, and by utilising a range of messengers including community champions.
- Ensure all frontline health and care services work together to identify, support and refer those at risk of violence, those experiencing violence and those who perpetrate violence, by ensuring appropriate staff training and care pathways are in place and by monitoring the impact.
- Lead and contribute to multi-agency partnerships to reduce serious violence, through a 'whole system' approach to dealing with DVA, with all areas of the system acknowledging, owning and resourcing their responsibilities in addressing the complex issues relating to DVA for all members of the family.
- Work in partnership to improve the identification of and support for those who are vulnerable and at risk by contributing to multi-agency intelligence systems.

8. Further Support

Substance Misuse Services

Hampshire drug and alcohol treatment and recovery services <https://www.inclusionhants.org/>

- Services for those 25+ 0300 124 0103
- Services for young people up to 25 years 0845 459 9405
- Family and carer support service 023 8039 9764

Hampshire Domestic Abuse Service

Hampshire Domestic Abuse Service is the first point of contact for information, advice, assessment and triage for victims, their children, perpetrators and professionals. This will allow anyone to gain information or be referred into the right service for them, depending on their need and assessed risk level. This will include signposting and referral to partner services, where appropriate.

The telephone number is 0330 016 5112 and the email address for referrals is advice@stopdomesticabuse.uk and/or advice.hampshire@stopdomesticabuse.cjsm.net

Professionals who wish to submit written referrals can do so via www.hamptontrust.org.uk

Child or Adolescent to Parent Violence

Family Lives – Information and advice and helpline. <https://www.familylives.org.uk> 0808 800 2222

Sexual Health Services

Integrated sexual health services including contraceptive services, advice testing and treatment for sexually transmitted infections.

<https://www.letstalkaboutit.nhs.uk/> 0300 300 2016

Treetops Sexual Assault Referral Centre

For anyone over the age of 13 who has been a victim of rape or serious sexual assault within Hampshire. Specially trained staff provide a range of sensitive and well-informed support in a non-judgmental manner.

<https://www.solent.nhs.uk/treetops/> 0300 123 6616

Rape Crisis Services

Provide a range of support services for people who have been affected by rape, sexual assault or sexual abuse, at any time in their lives.

Basingstoke Rape and Sexual Abuse Crisis Centre (BRASACC) www.brasacc.com

Winchester Rape & Sexual Abuse Counselling (RASAC) www.rasac.org.uk

Portsmouth Abuse & Rape Counselling Service (PARCS) www.parcs.org.uk

Southampton Rape Crisis (SRC) www.southamptonrapecrisis.com

Hampshire Multi-Agency Safeguarding Hub (MASH)

To discuss or report safeguarding concerns in adults or children.

<https://www.hants.gov.uk/socialcareandhealth/childrenandfamilies/safeguardingchildren/childprotection/mash>

For all emergency cases dial 999.

Children

0300 555 1384 during office hours 8.30-5pm Monday to Thursday, 8.30-4.00pm on Friday.
Or 0300 555 1373 Out of Hours.

Adults

0300 555 1386 during office hours 8.30-5pm Monday to Thursday, 8.30-4.00pm on Friday.
Or 0300 555 1373 Out of Hours.