



**Evaluation of the Drive Project
– A Three-year Pilot to Address High-risk, High-harm
Perpetrators of Domestic Abuse**

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CONTENTS

GLOSSARY	6
INTRODUCTION	8
THE DRIVE PROJECT	9
The Drive Pilot Model	10
THE EVALUATION	12
METHODOLOGY.....	13
Intervention and Control Groups.....	13
Follow-up.....	14
Interviews	16
Case Notes Analysis	17
WHAT IS THE PROFILE AND WHAT ARE THE NEEDS OF DRIVE SERVICE USERS AND VICTIMS-SURVIVORS?	18
Drive Service Users.....	18
Victim-survivor demographic profile.....	19
Service User Needs.....	20
Needs at midpoint.....	21
Service users' needs and their association with DVA behaviours.....	23
Service user engagement with Drive case managers and the presence of needs	25
Needs as a lever for engagement – the words of service users	28
WHAT WERE THE INTERVENTIONS DELIVERED?	30
Indirect work and direct work by case managers	31
Indirect work	33
Direct work.....	41
Direct Work – Evidence from the interviews with service users and case managers	41
Direct work on service user behaviour	43
<i>Creating Alternatives for Positive Self-redefinition</i>	47
Multi-Agency Direct Work as 'Deep' Institutional Advocacy	50
Step-down work	51

CHANGE IN BEHAVIOUR OF DRIVE SERVICE USERS	52
Charting behaviour change.....	53
Change in service users' use of DVA behaviours – data from the Drive case management system.....	54
Reducing DVA behaviours across the Drive intervention	54
Behaviour change by Drive service users over time	56
Physical abuse.....	57
Sexual abuse	59
Harassment and Stalking.....	60
Jealous & controlling behaviours.....	62
Case Managers' Perception of Change in Risk from Service Users.....	64
Drive-DASH (Domestic Abuse, Stalking and 'Honour'-Based Violence) Risk Assessment Scores	64
Direct work by case managers and impacts on service users' behaviour.....	66
Why and How Did Service Users Change their Behaviour?	68
Change in the behaviour of Drive service users according to victims-survivors	69
The Views of Victims-survivors – Did Service Users Change Their Behaviour?	71
Sustaining behaviour change after the end of the Drive intervention.....	74
MARAC data regarding re-perpetration	75
Reducing Serial perpetration.....	76
Sustaining behaviour change – assessment using police data	78
Police data for Site 2 – Drive service users and control group.....	79
ARE VICTIMS-SURVIVORS AND THEIR CHILDREN SAFER?	91
IDVA Support to Victims-survivors.....	91
Victim-survivor view of support – evidence from interviews.....	91
Victim-survivor support – evidence from Insights data.....	92
Before IDVA support: Victim-Survivor Self-Mobilised Interventions	92
Length of Support from IDVAs	92
Number of contacts with IDVA contacts with victims-survivors.....	93
Number of support interventions mobilised	93
IDVA Perceptions of Change in Risk to Victim-Survivor.....	96
IDVAs' Views about Safety of Victims-survivors.....	97
DRIVE CASE NOTE ANALYSIS – DEEPENING UNDERSTANDING OF BEST PRACTICE	104
GROUP 1:.....	107
GROUP 2: Reductions in risk and/or positive behaviour change are not clearly attributable to Drive but exemplary casework is present. N=3/16.	108
GROUP 3: Reductions in risk and/or positive behaviour are not clearly attributable to Drive where case work is standard. N=7/16.....	110

HOW DOES THE MODEL GENERATE OR REQUIRE AGENCY OR SYSTEMS CHANGE?	112
REFERENCES	121
Appendix 1: Study Flow Diagrams	122
Flow Diagram for Perpetrators.....	122
Flow Diagram for Primary Victim-survivor.....	123
Appendix 2: Service user needs additional information	124
Appendix 3: Statistical methods	125
Section 1: Latent Class Analysis.....	125
Section 2: Pooled ordered logistic regression for behaviour change and possible predictors	127
Section 3: Random effect Poisson regression to assess changes in risk scores.....	128
References for statistical methods.....	128
Appendix 4: Other statistical results	129
Section 1: Difference in Difference regression results.....	131
Section 2: Results from the pooled logistic regression between direct work action and DVA behaviours.....	133
Appendix 5: Police data analysis for site 1	137
Appendix 6: Case studies	145
Institutional Advocacy with Children’s Social Services and the Child Protection Process as a Lever for Service User Engagement.....	145
Case Manager, Social Worker and IDVA Collaborative Working	149
Victim-Survivor Rent Arrears Paid Off to Enable Priority Re-Housing	151
Appendix 7: Cost of high-risk, high-harm domestic abuse.....	152
Differences between how the needs information was used in analysis for the main report and for the costing analysis report.....	152
Appendix 8: Estimating the cost of domestic abuse	153
Summary.....	153
Limitations.....	155
Criminal Justice System	156
Physical health	160

Mental Health	163
Other health services Costs.....	168
Substance use disorders	169
Children's Services.....	173
Housing.....	176
Appendix 8.1 Victim data	180
Appendix 8.2 Drive service user (perpetrator) data	183
Appendix 8.3 Police unit costs	185
Appendix 8.4 Scott and McManus 2016, Hidden Hurt	186
Appendix 8.5 Counselling costs	187
Appendix 8.6 The economic and social cost of domestic abuse 2019; HORR107	188
Appendix 8.7 Summary cost per case at MARAC by agency	189

GLOSSARY

ABJ – Actual bodily harm

ACL – Average Custody Lengths

APMS – Adult Psychiatric Morbidity Survey

CAF – Common Assessment Framework

CIN – Children in need

CJS – Criminal Justice System

CM – Case Manager

CMD – Common mental disorder

CP – Child Protection

CPS – Crown Prosecution Service

CRC – Community Rehabilitation Company

CSEW – Crime Survey for England and Wales

CSS – Children’s Social Services

CYPS – Children and Young People’s Services

DAPP – Domestic Abuse Perpetrator Panel

DfE – Department for Education

DHR – Domestic Homicide Review

DOH – Department of Health

DVA – Domestic Violence and Abuse

DVDS – Domestic Violence Disclosure Scheme

GBH – Grievous bodily harm

H&S – Harassment and Stalking Behaviours

IA – Institutional Advocacy

IAPT – Improving Access to Psychological Therapies

IDVA – Independent Domestic Violence Advisor

IOM – Integrated Offender Management

J&C – Jealousy and Controlling Behaviours

LAC – Looked-after children

MAPPA – Multi-agency Public Protection Arrangements

MARAC – Multi-agency Risk Assessment Conference

MARAT – Multi-agency Referral & Assessment Team

MASH – Multi-agency Safeguarding Hub

MHTO – Mental Health Treatment Orders

NDTMS – National Drug Treatment Monitoring System

NICE – National Institute for Health and Care Excellence

NPS – National Probation Service

OIC – Officer in Charge

OM – Offender Manager

PHE – Public Health England

PTSD – Post-traumatic Stress Disorder

QALY – Quality-adjusted life year

RA – Rehabilitation Activity

RCT – Randomised Control Trial

RFG – Recency Frequency Gravity

RO – Restraining Order

SD – Standard Deviation

SHPO –Sexual Harm Prevention Order

SU – Service Users (perpetrators allocated to the Drive intervention)

SUDs – Substance use disorders

URICA – University of Rhode Island Change Assessment Scale

VAWG – Violence Against Women and Girls

VS – Victims-survivors

INTRODUCTION

There has been a long running debate as to whether interventions to change the behaviour of domestic abuse perpetrators actually ‘work’ in the sense of reducing perpetrators’ violent and abusive behaviour and making the lives of victims-survivors and their children safer. In this report we outline the findings from the evaluation of the Drive Project (‘Drive’), showing that Drive does indeed ‘work’. As the report indicates, Drive enabled perpetrators to reduce their use of abusive behaviour. As a result of Drive, victims-survivors were safer and more likely to be free from abuse, and the work with perpetrators created space for victims-survivors to make decisions for themselves.

The Drive Project is unique in focusing specifically on high-risk, high-harm perpetrators, including serial perpetrators who are deemed to cause the most harm (Robinson, 2016). As we show, the perpetrators using the most severe violence and abuse were also the ones who changed to the greatest extent. The positive changes in perpetrators’ behaviour was sustained over time, and more than a year after they had completed Drive.

We evaluated the Drive Project over three years, between early 2016 and the end of 2019, seeing what happened during the ten or so months the 506 perpetrators were on the intervention, and whether change was sustained during the twelve months after they had completed Drive.

It should be noted that this is the largest evaluation of a perpetrator intervention ever carried out in the UK, and the largest with a randomised control design.

Our evaluation approach builds on insights from previous evaluations (Kelly and Westmarland, 2015; Lilley-Walker et al, 2016), which have indicated that robust evaluation design requires randomisation of perpetrators into the intervention, control groups to compare changes for those in the intervention and those who are not, using data from victims-survivors to assess perpetrator behaviour change, post-intervention follow-up, and including detailed contextual data from service users, victims-survivors and the wider ‘system’. We incorporated all these elements into the evaluation of Drive. The Drive evaluation therefore provides a sophisticated ‘third-generation’ evaluation, with randomisation, control groups, longitudinal comparison of perpetrator behaviour, consideration of victims-survivors and children’s safety and ‘space for action’, and an analysis of impacts on and effects of the wider system of agencies.

Another strength of the evaluation is that we have documented the complex practice in Drive, including the skills of case managers in using indirect and direct work with perpetrators, co-ordination with IDVAs, and the centrality of the multi-agency ‘ecosystem’ around Drive. We show how indirect work, where case managers do not see the perpetrator face to face but co-ordinate multi-agency action, is an important feature. Also, we show how Drive has resulted in new working practices across agencies where victims-survivors, children and perpetrators are considered together. For instance, the work of Drive has realistically and pragmatically incorporated a ‘perpetrator perspective’ in child protection work, thereby changing the perspectives of social workers in relation to their understanding of the dynamics of domestic abuse and enabling practitioners to shift away from victim-blaming.

Echoing recent evaluations, we wanted to use data from victim-survivors to assess the effectiveness of Drive. We felt it was important to see whether the experiences of the victims-survivors associated with perpetrators on Drive (the Drive victim-survivor group) differed from the experiences of victims-survivors who did not have associated perpetrators on Drive (the control victim-survivor group). To ensure that the Drive victim-survivor and control victim-

survivor groups were comparable we used IDVA data for both groups (see Methodology section below). In this way we overcame the problems faced by previous evaluations¹, although limiting victims-survivors included to those engaging with IDVAs also meant that we introduced a very stringent test in the comparison between the Drive victims-survivors and the control victims-survivors. We already know that IDVA intervention can have a positive effect for victims-survivors (Howarth et al, 2009; SafeLives, 2019), and we also see a strong 'IDVA effect' in this evaluation. This means that reduction in DVA for victims-survivors and increases in their safety attributed to Drive are probably smaller when compared to the control group than if we had used a control group of victims-survivors without similar support, yet it remains important.

Yet another important feature of this evaluation is the longitudinal element: that we have followed the perpetrators in both the Drive and in control groups for at least twelve months after completion to see if they were re-perpetrating. Previous evaluations of domestic abuse perpetrator interventions that include follow-up have tended to use police data for assessing re-perpetration, but this has limitations (Lilley et al, 2016). To ensure our follow-up approach was more robust, we used both MARAC and police data, seeing if perpetrators were reported to have used DVA behaviours again to the same or another victim. Using MARAC data meant that we could assess the same cohort over time, whether the individuals were allocated to Drive or control groups. It also meant that we could compare the impact of Drive directly with 'business as usual', since the victims-survivors and perpetrators identified through MARAC who were allocated to the control group would be subject to multi-agency activities to ensure safety for victims². This allowed us to see whether Drive made a difference beyond the usual MARAC approach. As we show, while 'business as usual' also reduced re-perpetration, Drive led to a greater reduction in re-perpetration of high-risk, high-harm serial perpetrators and this reduction was sustained to a greater extent than for the control group. These findings were echoed in the police data.

THE DRIVE PROJECT

Drive is an innovative response to domestic abuse that aims to reduce the number of child and adult victims by disrupting and changing perpetrator behaviour.

Drive focuses on priority (high-risk, high-harm and/or serial) perpetrators, as this group carries the greatest risk of serious harm, and engagement with available services is low. Drive implements a whole-system approach using intensive case management alongside a coordinated multi-agency response, working closely with victim services, the police, probation,

¹ The Mirabel evaluation of voluntary perpetrator programmes in the UK (Kelly & Westmarland, 2015) used data from victims-survivors to assess the effectiveness of the programmes. To increase robustness of the evaluation approach they attempted to set up a control involving victims-survivors whose associated perpetrators were not on programmes. However, it did not prove possible for them to use the control group data as the two victim cohorts were very different, and thus could not justifiably be compared.

² A MARAC, or multi-agency risk assessment conference, is a meeting where information is shared on the highest-risk domestic abuse cases between representatives of local police, probation, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists from the statutory and voluntary sectors. The role of the MARAC is to facilitate, monitor and evaluate effective information sharing to enable appropriate actions to be taken to increase public safety. It should be noted that our evaluation adds to the evidence for the effectiveness of MARAC, where outcome data and especially longitudinal data have been lacking (Steel et al., 2011)

children's social services, housing, substance misuse and mental health teams. Drive focuses on reducing risk and increasing victim safety by combining disruption, support and behaviour-change interventions alongside the crucial protective work by victim services. Drive has been developed to knit together existing services, complementing and enhancing existing interventions.

Drive is being run by a partnership between Respect, SafeLives and Social Finance. The costs of the three-year pilot were met by a combination of local funding from police and crime commissioners, local authority budgets, the Home Office Police Innovation Fund and philanthropic grants from Lloyds Bank Foundation for England and Wales, The Tudor Trust and Comic Relief.

Drive launched in April 2016 and was piloted in three areas across England and Wales (Essex, South Wales and West Sussex) with the aim of reducing the number of child and adult victims of domestic abuse by deterring perpetrator behaviour.

By addressing perpetrators' behaviour, Drive targets the cause of domestic abuse and improves outcomes for victims-survivors and children. The key objectives are to:

- Reduce the number of serial perpetrators of domestic abuse
- Reduce the number of repeat and new victims
- Reduce the harm caused to victims and children
- Intervene earlier to safeguard families living with high-risk, high-harm domestic abuse

This report provides the findings from the evaluation of the three-year pilot of the Drive Project, and the costs associated with high-risk, high-harm domestic abuse. The evaluation and cost analysis for the Year 3 report have been carried out by a team from the University of Bristol, led by Professor Marianne Hester, with Nathan Eisenstadt, Ana Ortega-Avila, Karen Morgan, Sarah-Jane Walker and Juliet Bell. The analysis of the cost of high-risk, high-harm domestic abuse is reported in Appendix 8.

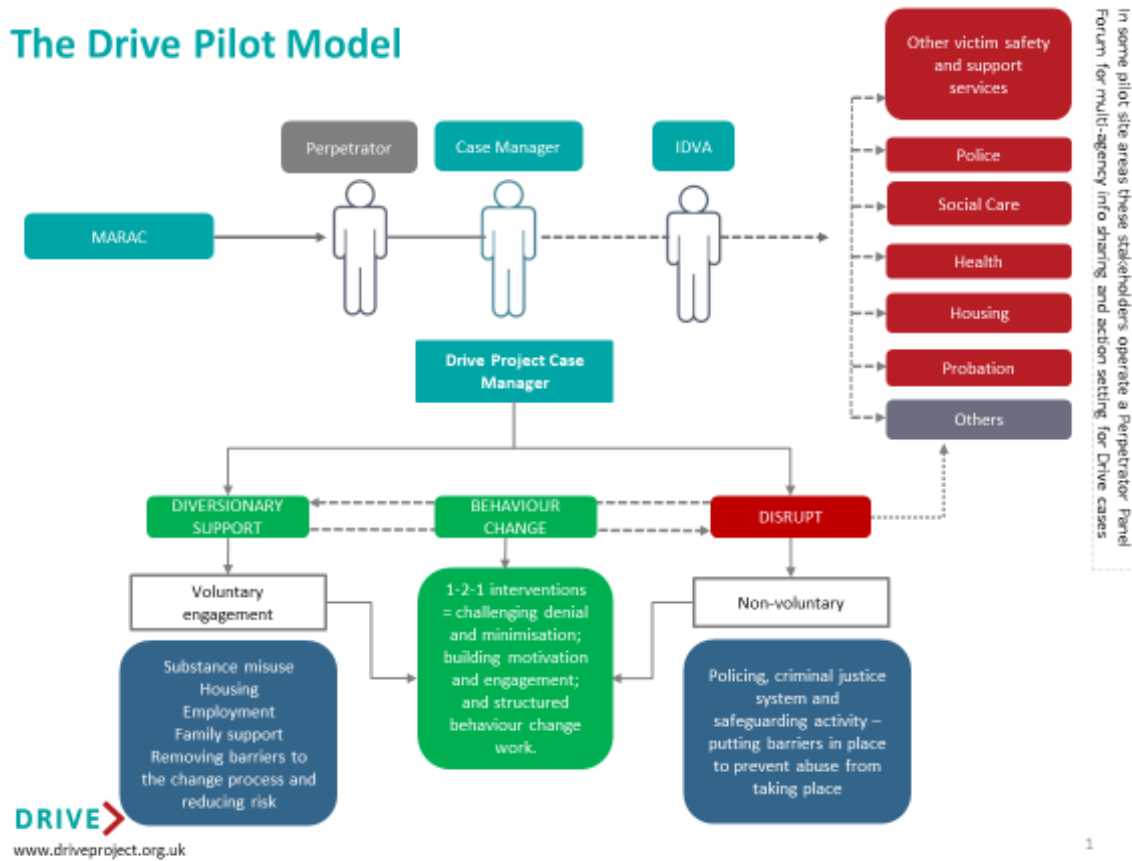
The Drive Pilot Model

The first three years of Drive constituted a 'Pilot Model' phase that is the focus of this evaluation. During this period the allocation of perpetrators to Drive was randomly controlled to ensure that the evaluation was robust. High-risk, high-harm perpetrators associated with victims-survivors who had been referred to Multi-Agency Risk Assessment Conferences (MARAC) were randomly allocated to Drive or to the control group.

The intervention was intended to last 10 months and comprised: direct one-to-one work carried out by case managers with service users; indirect work carried out at a multi-agency level primarily to share information, manage risk and disrupt perpetration; and one-to-one IDVA support for the associated victims-survivors. Where engagement with a perpetrator is difficult and/or perpetration continues, strategies are used to disrupt perpetration. To the extent that case managers both assist service users to meet needs with the aim of reducing risk to victims-survivors (eg around housing or substance misuse treatment) *and* intervene to disrupt perpetration via the criminal justice system, the intervention can be characterised as comprising a 'support' and a 'disrupt' element (see Figure 1).

Figure 1 The Drive Intervention

The Drive Pilot Model



THE EVALUATION

The University of Bristol team, led by Professor Marianne Hester, was commissioned to evaluate the Drive pilot over the three years.

There have been three phases to the evaluation:

- Phase 1 – January to March 2016: this was a short development phase to establish processes of data collection and protocols with Drive staff and relevant agencies and to obtain ethical approval from the University of Bristol Ethics Committee.
- Phase 2 – March 2016 to June 2017: this was an initial testing phase covering Year 1 of the intervention, to ascertain whether the intervention was feasible: looking at the acceptability of the pilot intervention to perpetrators and victims-survivors of DVA, the feasibility of recruitment, randomisation and follow-up, outcome measure completion for the first year of the intervention and process evaluation.
- Phase 3 – June 2017 to October 2019: this was the main phase, where it was possible to assess behaviour change for the whole cohort of perpetrators and life quality for victims and their children, as well as longer-term outcomes. It was also possible to assess the costs associated with high-risk, high-harm domestic abuse.

This Evaluation Report presents the overall findings from the three-year evaluation.

The University of Bristol evaluation team were tasked with providing ongoing assessment of the efficacy of the Drive intervention (see Figure 1), to demonstrate how outcomes are sustained over time, and to provide both quantitative and qualitative insights into outcomes achieved and the processes involved. To this end, the evaluation team were asked to consider a number of key research questions, as follows:

1. What is the profile of the perpetrators worked with?
2. How and why have perpetrators changed their behaviour? Is this change sustained over time?
3. Are adult victims-survivors and children living in households where domestic abuse is present safer?
4. What were the interventions delivered and how did these differ between different types of case?
5. In what ways does the model generate/require changes in agency behaviour, leadership and interaction/modes of operation?
6. What are the costs and fiscal benefits of the approach?

This report provides answers to questions 1 to 6. Regarding question 6, the report details the costs associated with high-risk, high-harm perpetrators linked to the MARAC process but it was not possible to assess overall fiscal benefits of such a complex approach (see Appendix 8).

METHODOLOGY

The evaluation used a pragmatic random control trial (RCT) design to assess key outcomes combined with qualitative interviews with practitioners, Drive service users, and the associated victims-survivors to provide a deeper understanding of the process and practices related to the Drive pilot, and MARAC and police data to assess longer-term outcomes.

In this report, we outline findings related to the six research questions (above), based on the following methods:

- Analysis of quantitative monitoring data (MARAC demographic profile data set, Drive case management system [CMS] data and Insights³ data) – to measure outcomes for reductions in abuse, reductions in risk and increases in victim-survivor safety.
- Interviews with practitioners, Drive service users and associated victims-survivors, as well as detailed case note analysis – to assess feasibility and applicability of Drive and provide detail regarding positive practice, and for outcome and process evaluation.
- Analysis of police and MARAC data – to assess disruption via the criminal justice system for Drive service users and control group perpetrators, and re-perpetration post-Drive.
- Analysis of MARAC, Insights and police data to assess cost.

Intervention and Control Groups

Randomisation took place when high-risk, high-harm perpetrators were identified via the MARAC referral pathway for associated victims-survivors. Computer-assisted randomisation was carried out by the SafeLives Research, Evaluation and Analysis team, and the University of Bristol team were provided with anonymised data regarding the perpetrators allocated to either the Drive or control groups. Once allocated to Drive, service users were not able to drop out and attrition was therefore not a problem⁴, unlike in previous DVA perpetrator RCTs and evaluations (Lilley et al, 2016).

Randomisation resulted in:

- A Drive intervention cohort – Drive service users and a comparison group of associated victims-survivors in contact with IDVAs.
- A control cohort – perpetrators not allocated to Drive (the MARAC profile group) and whose associated victims-survivors were in contact with IDVAs (control victims-survivors).

(See Table 1 for an overview of the intervention and control groups, and Appendix 1 for a flow chart with detail regarding these samples).

The establishment and samples for these intervention and control groups will now be outlined in more detail.

³ Insights is an outcome measurement system for domestic abuse services, run by SafeLives.

⁴ Drop-out only occurred of three service users due to death or a move to another area.

All Drive work began with information gathering regarding the service user. Attempts were made by the Drive case managers (unless it was deemed not safe to do so) to make direct contact with all the service users allocated to Drive in order to carry out direct one-to-one work, disruption, support and behaviour-change interventions as appropriate in each case. Where direct contact was not possible, indirect work would still be carried out, including risk management and disruption, via the co-ordination of information sharing and multi-agency activity. Indirect work also formed part of the work where service users were in direct one-to-one contact with case managers.

Drive case managers retained oversight of the cases and carried out direct or indirect work for a period of 10 months. All cases that had been allocated to Drive over the three years and had been completed and closed were included in the evaluation (N=509)⁵. Case managers used the Drive case management system to record all case details, activity, start and closure dates. The case management system included a wide range of often detailed information regarding the needs, interventions, referrals, risks and behaviours of the service users concerned. This data was exported from the case management system to an Excel workbook, anonymised, and shared with the University of Bristol team.

To assess whether the outcomes recorded for Drive service users were reflected in the outcomes for Drive associated victims-survivors, we studied outcomes data for victims-survivors whose perpetrators were on Drive and who were themselves engaging with an IDVA. This included 104 victims-survivors of a possible 509, for whom entry and exit Insights forms were completed. IDVAs recorded a wide range of often detailed information regarding the victim-survivor on a data system called Insights (comparable to the data recorded for the service users). IDVAs also asked victims-survivors to complete a direct victim-survivor exit questionnaire, which provides information for analysis. The University of Bristol team were provided with anonymised Insights IDVA data for the associated victims-survivors. A wider control group was also established, consisting of victims-survivors associated with those perpetrators randomly allocated to the control group rather than the Drive intervention, and who were engaging with IDVAs. Of the 2085 associated victims-survivors allocated to the control, 610 were engaging with an IDVA. The University of Bristol team were provided with anonymised Insights IDVA data for these 610 associated victims-survivors, who thus constituted the victim-survivor control group.

As noted earlier, using Insights data for victims-survivors engaging with IDVAs for both the Drive and control victim-survivor groups provides a very stringent test for the measurement of Drive outcomes.

Follow-up

The evaluation team were also provided with longitudinal MARAC and police data from one of the Drive sites, covering the period before, during and up to at least 12 months after Drive, to

⁵ The total number of service users on Drive was 509, but three service users did not complete (see footnote 3). Statistics presented in the report are therefore for the 506 completed and closed service user cases – see flow chart, Appendix 1. If statistics are for a sub-group of the 506, the number of service users in the analysis will be presented as: n = number of service users in analysis. N can vary due to unknown or missing data, where 'n= xx' is present, it gives the new sample size.

assess post-Drive re-perpetration and involvement by the criminal justice system. This resulted in:

- A longitudinal MARAC cohort for one site – perpetrators in Drive intervention group, and perpetrators in the control group.
- A longitudinal police cohort for one site – perpetrators with police involvement in the Drive intervention group, and a subsample from the control group of perpetrators with police involvement.

The MARAC data included all perpetrators allocated to the Drive intervention or control groups (N=1323), with 184 in the Drive intervention group and 1139 perpetrators in the control group (see Table 1). The evaluation team were provided with anonymised MARAC data collated by SafeLives regarding the number of times the same perpetrators were identified at MARAC.

The police data included all the perpetrators in the Drive intervention group with police involvement. However, in order to limit the extra work required by the police data team, we use a randomly chosen subsample from the control group. Data recorded by the police for Drive service users in the six months before, during, and in the 12 months after completion of Drive was accessed by the University of Bristol team in anonymised form. The University of Bristol team provided SafeLives with the anonymous profiles of the perpetrators associated with Drive and a control victim-survivor sample (randomised by site to provide a similar-sized sample). SafeLives shared the actual profiles of perpetrators with the police, who downloaded the information needed for the evaluation. Using this approach, the police identified incident and crime data (DVA-related and non DVA) for 149 Drive service users and 173 control perpetrators, which was provided in anonymised format to the University of Bristol team for analysis (Table 1).

Table 1 Intervention and Control Groups: Outcome and Longitudinal Data

Intervention groups	Control groups
<p>Drive service users</p> <p>Perpetrators identified at MARAC and randomly allocated to Drive (case management system data) (N=509, with 506 completed)</p>	
<p>Drive victims-survivors</p> <p>Drive associated victims-survivors engaging with IDVA (Insights data) (N=196, of whom 104 had both entry and exit date)</p>	<p>Control victims-survivors</p> <p>Victims-survivors associated with perpetrators not allocated to Drive but engaging with IDVA (Insights data) (N=610, of whom 353 had both entry and exit data)</p>
<p>Police data for Drive service users for site 2</p> <p>Data from before, during and after Drive (N=149)</p>	<p>Police data for random subsample of perpetrators for site 2 (N=173)</p>

MARAC data for Drive service users for site 2	MARAC data for control service users for site 2
Data from before, during and after Drive (N=184)	Data from before, during and after Drive (N=1139)

Interviews

Semi-structured interviews were carried out with service users, victims-survivors, and a range of practitioners (including Drive case managers, IDVAs, and staff from agencies in contact with Drive, such as probation, police, and social services). Interview data provided insight into questions on what the interventions delivered were; how, why and to what extent Drive service users changed behaviour; and in what ways the Drive model generates/requires changes in agency behaviour, leadership and interaction/modes of operation. This report incorporates or refers to interview data across the three years (see Table 2 for detail regarding interview samples).

Table 2 Interview Samples: Qualitative Data

	Year 1	Year 2	Year 3	Total interviews
Practitioners	43	33	12 (8 were follow-up)	88
Service Users	11	16	3 (2 were follow-up)	30
Victims-survivors	2	15	2	19

We conducted 30 interviews with 28 Drive service users over the three years of the evaluation. The majority of interviews were conducted in Years 1 and 2 with a further three conducted in Year 3. These service users were all engaged with Drive case managers, and can possibly be classified as 'high engagers'.

It proved especially difficult to arrange interviews with victims-survivors due to a number of factors, including strong gatekeeping by IDVAs who were concerned about re-traumatisation of victims-survivors and constraints on resources for face-to-face interviews. Most of the victims-survivors we interviewed (15/19, 14 female and 1 male) were partners/ex-partners of the Drive service users and had experienced intimate partner violence. The remaining interviews were conducted with other family members who had experienced abuse from the Drive service user (n=4: two parents, a grandfather and an aunt). Sixteen of the victims-survivors' interview participants were female, and three were male. Ages ranged from 22 to

64, with a mean age of 43.2. All described themselves as 'White English,' 'White Welsh,' or 'White British'.

Case Notes Analysis

In Year 1 of the evaluation we carried out in-depth analysis of 30 Drive case manager case notes to assess fidelity, use by Drive case managers of the case management system, and the range of actions and interventions being applied. This led to changes in the case management system (see Hester et al., 2017).

Given the difficulty throughout the evaluation of accessing Drive service users and associated victims-survivors for interview, we decided in Year 3 to carry out an in-depth analysis of Drive case manager case notes, analysing service-user and associated victims-survivors notes for 18 cases, which were sampled in relation to outcome. We selected cases for analysis that had been scored as having achieved considerable risk reduction and/or positive behaviour change across two or more abuse types. Within these cases we identified 'exemplary practice' where actions taken by Drive case managers or service managers aimed at risk reduction, disruption and or behaviour change were, by our analysis, innovative, skilful, accountable and risk-aware. The initial aim of this analysis was to deepen the insight into best practice that we had already identified in Years 1 and 2. In addition, we wanted to know if those 'exemplary practices' were the key reason that risk was recorded as having reduced and/or behaviour was recorded as having positively changed. In other words, we wanted to assess the key question that emerged in Years 1 and 2: are the positive changes we are seeing attributable to Drive or to some other variable?

WHAT IS THE PROFILE AND WHAT ARE THE NEEDS OF DRIVE SERVICE USERS AND VICTIMS-SURVIVORS?

In this chapter we provide an overview of the biographical profiles of the Drive service users (SU) and their associated victims-survivors (VS), as well as the needs identified for the Drive service users and whether having particular needs might be associated with DVA behaviours.

Summary:

- Drive service users had a high level of needs
- Drive service users who reported having ‘other addictions’ were likely to commit more physical abuse than those without, service users with employment difficulties were less likely to use physical abuse than those without such difficulties, and service users who had a combination of drugs misuse, other addiction and parenting capacity issues were more likely to use sexual violence than those who did not have these needs.
- No statistical effect was found that indicated that belonging to a specific needs class/group would predict or inform the DVA behaviour of service users
- Where contact was made with the service user, those with financial difficulties (61%), poor physical health (62%) and mental health difficulties (51%) were the most likely to engage with case managers
- Where contact was made with the service user, the most prevalent needs for those who engaged with case managers were alcohol misuse (51%), mental health difficulties (45%) and employment difficulties (43%)

Drive Service Users

A total of 509 service users were allocated to Drive at intake, all with demographic data (see Table 3). Drive service users ranged in age from 17 to 81 years. The average age was 32 years (standard deviation=13.8) and most were identified as men (94%). When ethnicity was known, most (92%) identified as White British/White Other.

Table 3. Descriptive demographics of service users at intake

SUs (n=509)	n/Mean	%/ SD
Age (years)	32	13.8
Men	476	93.5%
Women	33	6.5%
Ethnicity		
White British	226	44.5%
White Other	8	1.6%
Asian/Asian British	6	1.2%
Arab	1	0.2%
Black/Black British	6	1.2%
Mixed race	6	1.2%
Prefer not to say	1	0.2%
Unknown ethnicity	254	50%

Missing values	1	0.2%
SUs' relationship to primary VS		
Current intimate partner	65	12.8%
Ex-intimate partner	251	49.3%
Family member	36	7.1%
Another known person/associate	2	0.4%
Don't know	29	5.7%
Missing values	126	24.8%
Living arrangements with the victim		
Living together	44	8.6%
Living together intermittently	6	1.2%
Not living together	302	59.3%
Don't know	31	6.1%
Missing values	126	24.8%

SUs: service users; VS: victims-survivors; SD: standard deviation

Victim-survivor demographic profile

Table 4 provides IDVA Insights data for victims-survivors, including both Drive and control primary victims.

Overall, most of the victims-survivors identified as women (97%), and when ethnicity was known, 93% were White British. The majority of victims (75%) reported no longer living with the perpetrator and being ex-intimate partners (60%). More than half of victims-survivors reported having one or more need including drugs and alcohol misuse and mental health problems (59% - similar to the service users, at 63%). It is important to consider that not all Drive victims-survivors were in contact with an IDVA during the Drive period, preventing the access by the evaluation team to some biographical and needs information of victims-survivors whose perpetrator was allocated to the Drive arm.

Table 4. Biographical information on victims-survivors using IDVA data

	All victims-survivors (n=806)		Drive victim-survivor group (n=196)		Control victim-survivor group (n=610)	
	n/mean	% /SD	n/mean	% /SD	n/mean	% /SD
Age (years)	34	12.4	33	12.5	34	12.3
Men	26	3.2%	5	3%	21	3.45%
Women	780	96.7%	192	97.4%	588	96.5%
Ethnicity						
White British	746	92.7%	178	90.8%	568	93.4%
White Other	17	2.11%	6	3%	11	1.8%
Asian British/Asian	29	3.5%	11	5.6%	18	2.9%
Black British/Black	9	1.2%	1	0.5%	8	1.3%
Other ethnic background	3	0.3%	0	0%	3	0.4%
Sexual orientation						

Heterosexual	776	97%	191	97.9%	585	96.6%
LGB	12	1.5%	2	1%	10	1.5%
No disclosure	12	1.5%	2	1%	10	1.6%
Living situation						
Living together	149	18.4%	32	16.2%	117	19.2%
Living together intermittently	47	5.8%	12	6%	35	5.7%
Not living together	608	75.4%	153	77.6%	455	74.7%
Don't know	2	0.2%	0	0%	2	0.3%
Relationship to perpetrator						
Intimate partner	246	30.5%	54	27.4%	192	31.5%
Ex-Intimate partner	484	60%	127	64.4%	357	58.6%
Intermittent intimate partner	18	2.2%	4	2%	14	2.3%
Family member	55	6.8%	11	5.8%	44	7.2%
Other	3	0.3%	1	0.5%	2	0.3%
Children						
Children present	491	60.9%	123	62.4%	368	60.4%
Children not present	313	38.8%	74	37.5%	239	39.2%
Don't know	2	0.2%	0	0%	2	0.3%
Number of needs						
0 needs	334	41.4%	91	46.1%	243	39.9%
1 need	223	27.6%	49	24.8%	174	28.5%
2 needs	103	12.7%	24	12.1%	79	12.9%
3 or more needs	146	18%	33	16.7%	113	18.5%

SD: standard deviation

Service User Needs

Across the three years, the information regarding needs for the Drive service users showed this to be a group with a high degree of needs. This was a greater degree of needs than usually seen in voluntary sector Domestic Violence Perpetrator Programmes (DVPPs), where those with needs involving mental health, alcohol and/or drugs may be excluded (Lilley et al, 2016).

Case managers recorded whether service users had any of the following needs throughout the intervention: parenting capacity, relationship with family members, relationship with children, social and community ties, financial difficulties, employment difficulties, alcohol misuse, drug misuse, other addiction, housing needs, and/or mental health difficulties.

Case managers also recorded statutory involvement (Community Children and Young People's Services and criminal and civil justice) with service users at intake. Children and Young People's Services information was recorded for 503 of the 506 service users and out of the 503, Children and Young People's Services were involved with 104 service users (20%). At intake, criminal and civil justice information was recorded for 401 service users of the 506. Under half (43%) of service users had 'current legal proceedings' in relation to criminal and civil justice involvement.

Of the 506 completed cases, not all service users had needs information recorded. 468 cases had some needs information at intake⁶. 487 cases had some needs information at midpoint⁷. 497 cases were present at case closure⁸. Table A2.1 in Appendix 2 indicates variations in sample size at the different time points. Within a given time point, we assumed, the sample size variations are due to non-responses (ie case manager did not respond to a given question).

It appears from Table A2.1 (Appendix 2) that the proportions of service users with certain needs doubled from intake to midpoint. Changes in proportions from midpoint to case closure by contrast appeared minimal. Possible explanations for the increase in sample size between intake and mid-point and decrease in missing values across the same time points are that service users felt more comfortable disclosing their needs information to case managers as time passed, and/or case managers were able to find more information about the needs of service users. Because of these data issues we decided to use mid-point data as the more accurate to evaluate prevalence of needs among service users.

Needs at midpoint

From those service users with needs data at midpoint, 37% reported having no specific needs. 63% reported having one or more needs (see Figure 2). It should be noted that the absence of a recorded need does not necessarily indicate that the service users had no needs. Case managers were not able to make contact with many service users and therefore might not have had access to this information.

⁶ 501 service users had data at intake data and of those 34 service users had missing information in all the needs questions at intake, and were therefore removed from the needs analysis.

⁷ 499 service users had midpoint data but 12 cases were removed as data was missing in all needs questions.

⁸ 502 service users had data at case closure but 5 cases were removed for having missing data in all needs questions.

Figure 2 Proportion of number of SU needs at mid-point (n=487)

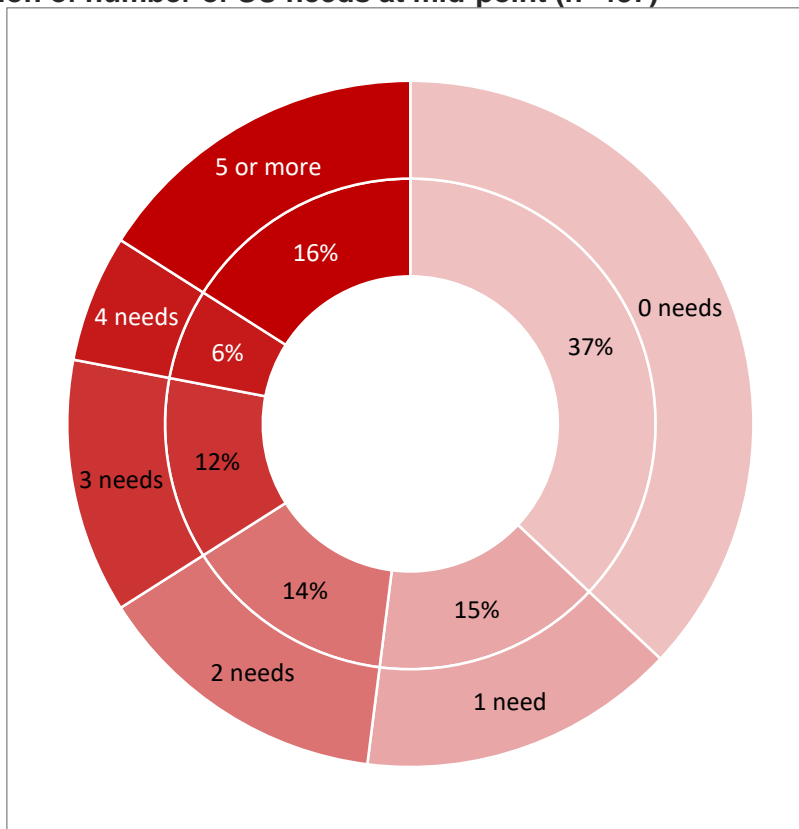
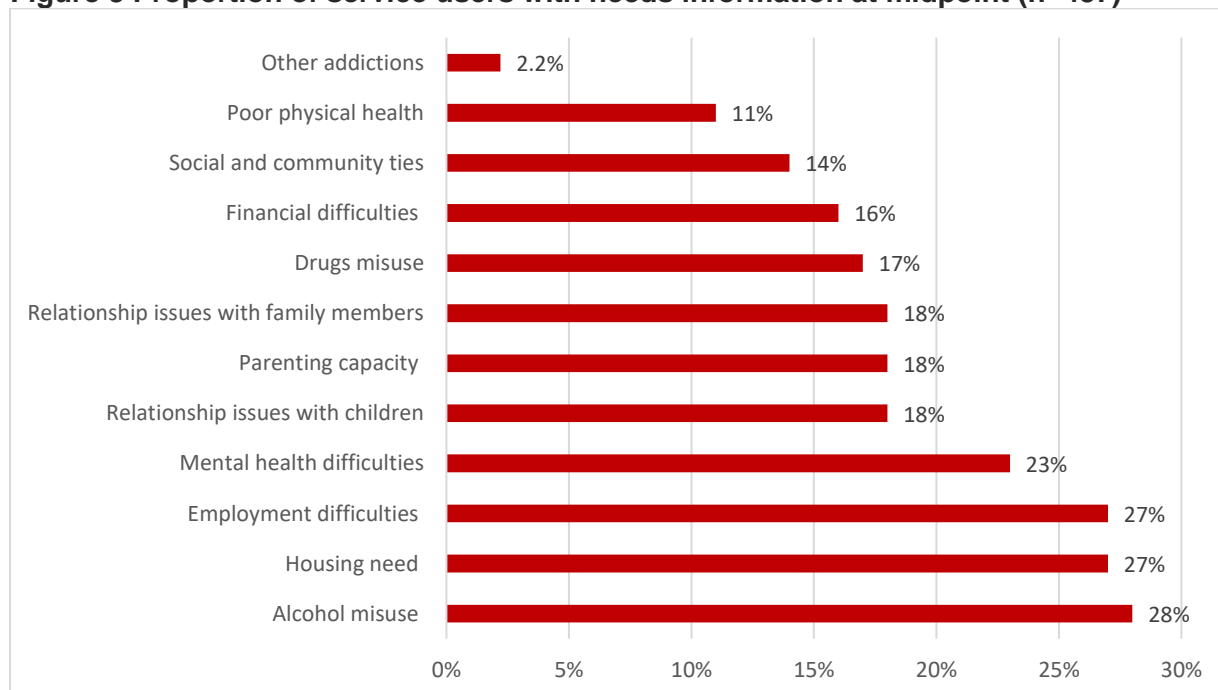


Figure 3 shows the proportion for each of the needs recorded for service users at midpoint and indicates that housing, unemployment and alcohol misuse were the three most prevalent service user needs, closely followed by having a mental health issue.

Figure 3 Proportion of service users with needs information at midpoint (n=487)



Service users' needs and their association with DVA behaviours

We looked at whether particular needs correlate with the physical, sexual, harassment and stalking (H&S) and jealous and controlling behaviours (J&C). To assess association between the four DVA behaviours and the 12 needs reported by service users, we ran four separate logistic regressions. Results indicated that those service users who reported having 'other addictions'⁹ were likely to commit a higher severity of physical abuse than those service users who did not have 'other addictions' (OR=6.14, p-value=0.01). Service users with employment difficulties were less likely to use physical abuse compared to those who did not have employment difficulties. Service users with drugs misuse, other addiction and parenting capacity issues were more likely to use sexual violence than those who did not have these needs. For harassment and stalking (H&S) and jealousy and control (J&C) none of the service user needs showed an association.

Although results from the regression provided some information on the association between needs and DVA behaviour, this provides a limited rationale for more targeted resourcing to inform service user selection criteria or any course of action. We therefore set out to test whether groupings of needs equated to particular outcomes, using Latent Class Analysis.

Latent Class Analysis (LCA) is a probabilistic model that groups people, in this instance, in accordance with the needs they reported at certain time points, by assigning a class membership to each of the service users. A class membership is the probability of an individual being assigned to a specific group or class. For example, service users with similar class membership will have similar needs and therefore be grouped together (detailed statistical methods for LCA are presented in Appendix 3, Section 1).

Applying LCA showed that service users' needs cluster in 6 different groups/classes at midpoint¹⁰ (Figure 4). These classes are as follows:

Class 1 "No needs": This group was established a priori, and it related to the proportion of service users who reported having no needs. This is the largest group, with 35% of service users.

Class 2 "Children and parenting issues": 10% of the service users were classified in this group as they reported having children and parenting difficulties.

Class 3 "Low needs": This is the second largest group (28%) and consisted of service users with a very low probability of having any of the 12 needs. This class includes those service users for whom we had no information on the presence or absence of any needs.

Class 4 "Multiple needs children and family": This group was the smallest with 8% of service users. It is characterised by high probability of having needs, particularly drugs and alcohol misuse, employment difficulties, mental health difficulties, financial difficulties, relationship issues with family, social and community ties and poor physical health.

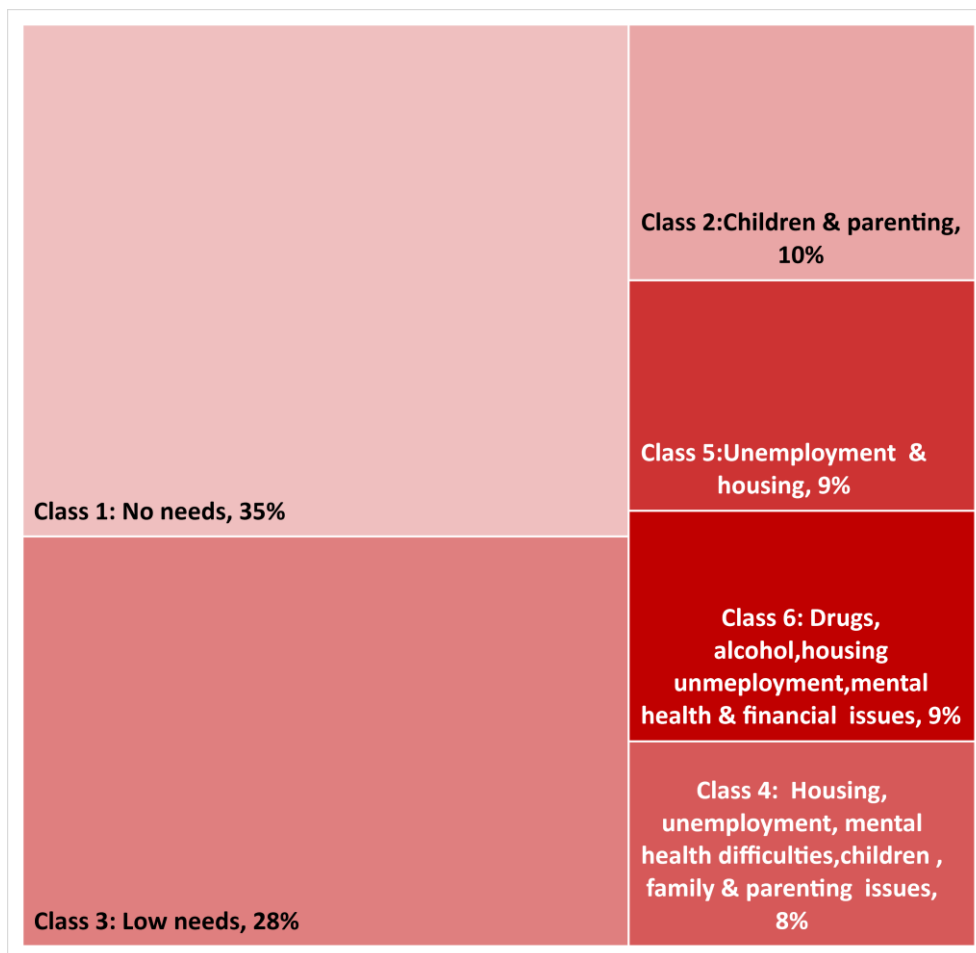
Class 5 "Housing and unemployment": 9% of the service users were classified in this group, and the prevalent needs for them were unemployment and housing issues.

⁹ It is not entirely clear what needs were included in the 'other addictions' category. In the needs data monitoring questions for case managers the question was asked: Does the service user have any other addiction problem? Yes/No/Don't know.

¹⁰ As explained previously, midpoint data was used as it was deemed to more accurately reflect the extent of service users' needs.

Class 6 “Multiple needs alcohol and drugs”: This group, with 9%, is similar to Class 4 as both classes can be considered multiple needs, however the types of needs change slightly for each of the classes. Thus, both groups share some core needs related to housing, unemployment and mental health issues, but class 6 also includes needs related to drugs, alcohol and financial issues.

Figure 4 Results of the latent class analysis of the needs at midpoint (n=487)



To ascertain whether there was a correlation between belonging to a particular service user 'needs class' and DVA behaviour we used the class assignment for each service user to see whether belonging to a certain class/group predicted any of the four DVA behaviours (physical abuse, sexual abuse, H&S, J&C). To assess this, we ran a multinomial logistic regression using needs and behaviour data (n=487 service users) and the results obtained from the LCA.

Results indicated that the service user needs class/groups do not predict service users' DVA behaviour. In other words, no statistical effect was found that indicated that belonging to a specific needs class/group would predict or inform the DVA behaviour of service users¹¹.

Service user engagement with Drive case managers and the presence of needs

We were also interested to see whether engagement with case managers varied based on the presence of service user needs. We used service users' engagement and needs data (midpoint only) recorded in the case management system. First, we examined the level of engagement for those service users with and without specific needs. Table 5 shows that those service users with financial difficulties (61%), poor physical health (62%) and mental health difficulties (51%) were the most likely to engage with case managers.

Table 5 Percentage of type of engagement by the presence or absence of needs (n= 487 service users).

	Engaged	Partially engaged	Non-engaged	No contact made
Other addictions				
Yes	27.7%	18.1%	27.2%	27.3%
No	13.1%	6.5%	13.1%	55.1%
Relationship with children				
Yes	36.5%	5.9%	16.5%	41.2%
No	23.5%	6.5%	12.9%	57.1%
Housing need				
Yes	40.2%	10.2%	25.2%	24.4%
No	20.9%	5.8%	9.6%	63.8%
Relationship with family members				
Yes	39.0%	14.6%	15.9%	30.5%
No	23.4%	4.5%	13.7%	58.5%
Parenting capacity				
Yes	32.5%	4.8%	19.3%	43.4%
No	24.7%	6.1%	12.5%	56.7%
Drugs misuse				
Yes	32.1%	11.1%	21.0%	35.8%
No	24.6%	5.4%	12.2%	57.8%

¹¹ A reason for this lack of association could be the low power of the model, due to small sample size. In this case, having 6 smaller subgroups limits the ability of the model to find any significant effect that could inform how needs class/group affects behaviours. The lack of statistically significant finding could therefore indicate either that there is actually no effect or that the effect is so small that the model cannot detect it because of the small sample.

Social and community ties				
Yes	40.3%	14.5%	21.0%	24.2%
No	24.1%	5.2%	12.4%	58.2%
Financial difficulties				
Yes	60.5%	7.9%	25.0%	6.6%
No	19.6%	6.2%	11.6%	62.5%
Mental health difficulties				
Yes	51.4%	9.4%	15.0%	24.3%
No	18.5%	5.8%	13.3%	62.4%
Alcohol misuse				
Yes	48.1%	5.4%	22.5%	24.0%
No	17.8%	7.1%	10.4%	64.8%
Employment difficulties				
Yes	41.6%	12.0%	18.4%	28.0%
No	20.8%	4.8%	12.2%	62.2%
Poor physical health				
Yes	61.5%	13.5%	15.4%	9.6%
No	21.8%	6.1%	13.3%	58.8%

Looking at this in a slightly different way, we also examined the percentage of needs for those service users who engaged, did not engage or were only partially engaged. Table 6 shows that among those service users who engaged, the most prevalent needs were alcohol misuse (51%), mental health difficulties (45%) and employment difficulties (43%).

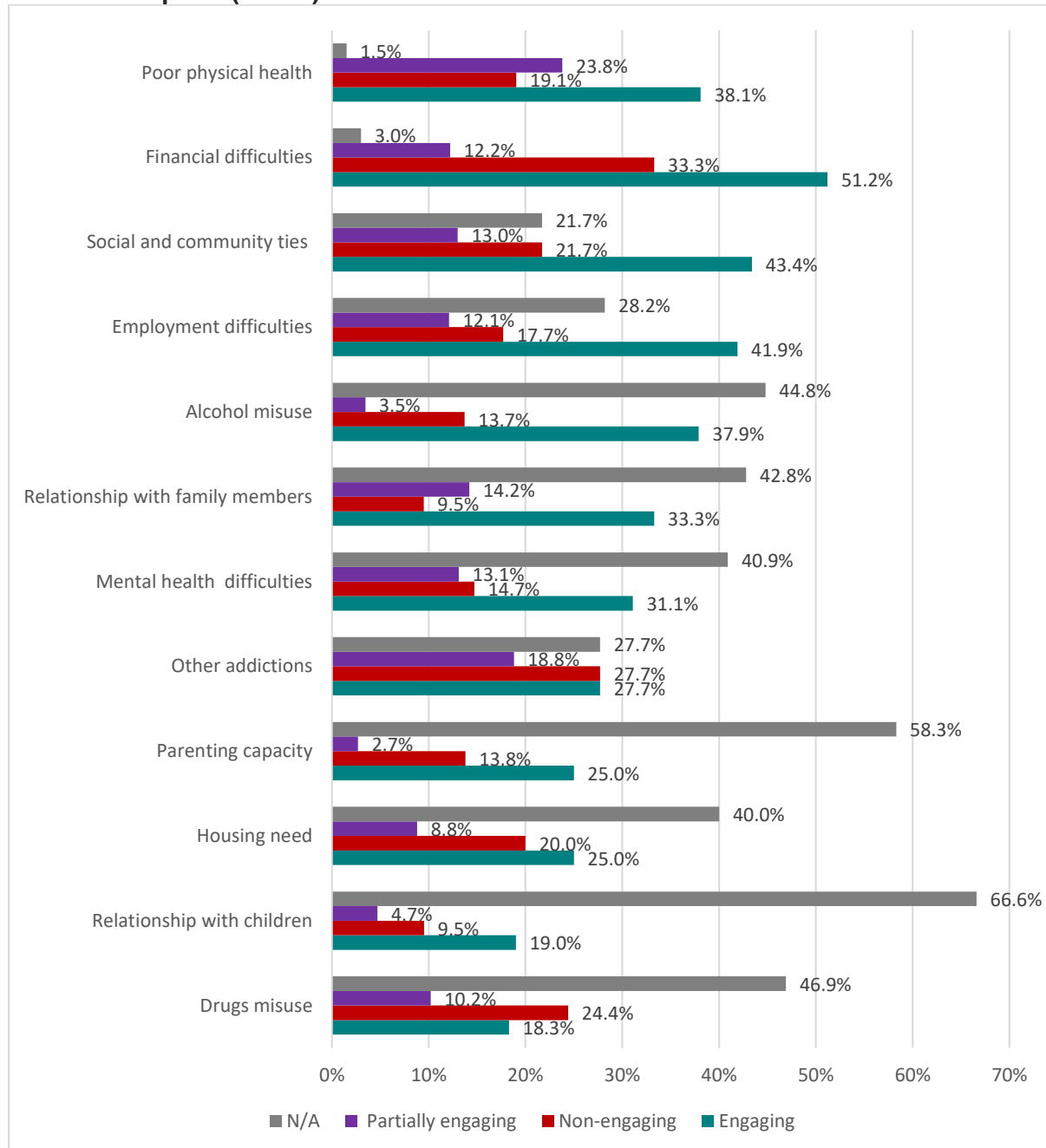
Table 6 Prevalence of needs by level of engagement with case managers (n= 487 service users).

	Engaged	Partially engaged	Not engage	No contact made
Other addictions				
Yes	2.4%	6.0%	4.6%	1.1%
No	97.5%	93.9%	95.3%	98.8%
Relationship with children				
Yes	25.4%	16.6%	21.8%	13.6%
No	74.5%	83.3%	78.1%	86.3%
Housing need				
Yes	41.4%	39.3%	49.2%	12.0%
No	58.4%	60.6%	50.7%	87.7%
Relationship with family members				
Yes	26.4%	41.4%	20.0%	10.0%
No	73.6%	58.6%	80.0%	89.9%
Parenting capacity				
Yes	22.5%	14.8%	25.4%	14.4%
No	77.5%	85.1%	74.6%	85.5%

Drugs misuse				
Yes	21.4%	30.0%	26.5%	11.5%
No	78.5%	70.0%	73.4%	88.4%
Social and community ties				
Yes	20.4%	30.0%	20.6%	6.0%
No	79.5%	70.0%	79.3%	93.9%
Financial difficulties				
Yes	37.7%	20.0%	29.6%	20.2%
No	62.3%	80.0%	70.3%	97.8%
Mental health difficulties				
Yes	45.0%	32.2%	25.0%	10.3%
No	54.9%	67.7%	75.0%	89.6%
Alcohol misuse				
Yes	50.8%	22.5%	45.3%	12.4%
No	49.1%	77.4%	54.6%	87.6%
Employment difficulties				
Yes	42.6%	48.4%	35.9%	14.3%
No	57.3%	51.6%	64.1%	85.7%
Poor physical health				
Yes	26.2%	21.9%	12.7%	2.0%
No	73.8%	78.1%	87.3%	98.0%

Additionally, we inspected engagement level only for those service users who were categorised by case managers as having a high level of need (excessive or high response categories) in relation to the various types of needs. We found that those with a high level of financial difficulties had the highest prevalence of engagement (full engagement) (51%); this was followed by social community ties (43%) and employment difficulties (42%). On the other hand, those service users with a high level of other addictions and drug misuse showed the highest percentage of non-engagement (28% and 24% respectively) (see Figure 5).

Figure 5 Percentage of Drive service users with High Level Need and Engagement levels at midpoint (n=487)



Needs as a lever for engagement – the words of service users

They've succeeded because... like I said when I started with them I just wanted to end it. Now, you know, that's not even a thought that ever came to mind, and I just want to keep bettering myself now. So... like I said, I was just sceptical at the beginning because I didn't think there was people out there who would or could help. I thought of myself as a lost cause. But... like I said, I'm a sceptic and I was proved wrong (SU110).

Echoing the quantitative findings, levels of need for the service users who were interviewed was high, with 27 out of the 28 interviewed across the three years needing assistance with

housing, drug or alcohol misuse or their mental health. Meanwhile, Drive case managers we interviewed often described service users with no additional needs as some of the hardest to engage due to a lack of available ‘levers’ or incentives to elicit engagement. This case manager explains how for one of his cases, the support offered around the service user’s mental health worked as a powerful lever for engagement:

A case of mine, suffering anxiety and depression and sort of mood swings and stuff, he recognised that he needed... he’d been diagnosed with anxiety and depression, but he didn’t feel it was the right diagnosis and he didn’t think that the medication was helping him in any way. So, I booked appointments for him and went with him to the appointments to get assessments and he was eventually referred to a consultant to hopefully get a better diagnosis. And that was a big lever for engagement for us, because he could see the value in doing that work (case manager 101).

Echoing the quantitative data on needs and engagement with case managers, levels of mental health needs were particularly striking both in number and severity for the service users interviewed – 20 out of 28 reported being helped with their mental health by their Drive case manager (with problems described ranging from high levels of anxiety and depression to psychosis). As indicated earlier, four out of the 16 interviewed in Year 2 disclosed feeling suicidal at the start of the Drive intervention. While some service users did seem to use their mental ill health at the time of their Drive-triggering incident/crime to reduce their level of responsibility, it was also the case that those interviewed with very high mental health needs at the start of Drive seemed to make striking progress on behaviour change that was corroborated by their case managers. For these service users, phrases like ‘*Drive saved my life*’ were common and they were keen to differentiate Drive from other interventions they had received previously, including mental health interventions. Differentiating features included the intensity of engagement and their perception that their Drive case manager was not judging them – this experience of non-judgement was in one case reported in direct comparison to the service users experience of mental health professionals. One service user talked specifically about seeking help with their mental health previously but not finding it and the irony that it was not until they committed a serious crime that they received assistance on Drive:

I’ve been trying for two years to try and get the help and support, [...] I tried mental health, everything, trying to get all the help I needed. It did seem like no one did want to help. It took me to get myself into trouble (inaudible 15:38) get done or something to get the help I needed (SU113).

While there is minimisation and diminishing of responsibility here in the sense that ‘getting himself into trouble’ is presented as in some way inevitable, this service user does position himself as the actor in this process, stating that this was something *he* did. Moreover, while service user responsibility must be the focus of work with individuals, this quote nonetheless highlights the importance of a functioning wider multi-agency ecosystem, and in particular, mental health provision for dealing with this group of service users.

WHAT WERE THE INTERVENTIONS DELIVERED?

Summary:

Indirect work:

- *Information sharing to heighten risk awareness* – while information sharing might be considered a ‘pathway to disruption’ rather than the disruption itself, it is a critical component to disruption activity.
- *Providing the service user’s address to police or social services* – case managers will often have done significantly more research on service users than other agencies have been able to.
- *MAPPA referrals* – in cases where the likelihood of behaviour change in the short to medium term was judged to be very low and the risk remained high, referrals to MAPPA were made.
- *Referrals to social services* – while aimed specifically at the protection of children or vulnerable adults, referrals to social services can serve as a key disruption strategy by initiating a home visit.
- *Initiating a response to breach of a court order without reliance on victim-survivor to report.*

Direct work:

- Drive’s one-to-one work is a bespoke offer that resists standardisation as a strict set of activities or programme that could be delivered to each service user.
- *Relationship building with the service users* came up as critical to cultivating and sustaining engagement in behaviour-change work. This was attained in part through the material and psychological support provided by the case managers, through much more subtle modes of conduct.
- Case managers threaded a delicate balance between building trust, setting boundaries and *critically challenging service users*. The effectiveness of this hinged on the quality of the case manager-service user relationship, the presence of meaningful levers to engage (eg forms of statutory compulsion or perceived benefits to the service user) and information sharing on service user behaviour from other agencies, in particular the IDVA service.
- High-engaging service users we interviewed were quick to *differentiate Drive* from other interventions they had received, while case managers described ways in which they would work to actively enable services users to see Drive as something different. For service users, key to the difference was the degree to which they felt like their case manager cared and really listened without judgement.
- *Work on impulse control and emotional regulation* stood out in interviews with service users - at a minimum enabling them to take ‘time outs’, at best facilitating their ability to intervene on their own harmful thought patterns and enabling them to see perspectives other than their own.
- High-engaging service users seemed to connect with *avenues for positive self-redefinition* offered to them by their case manager.

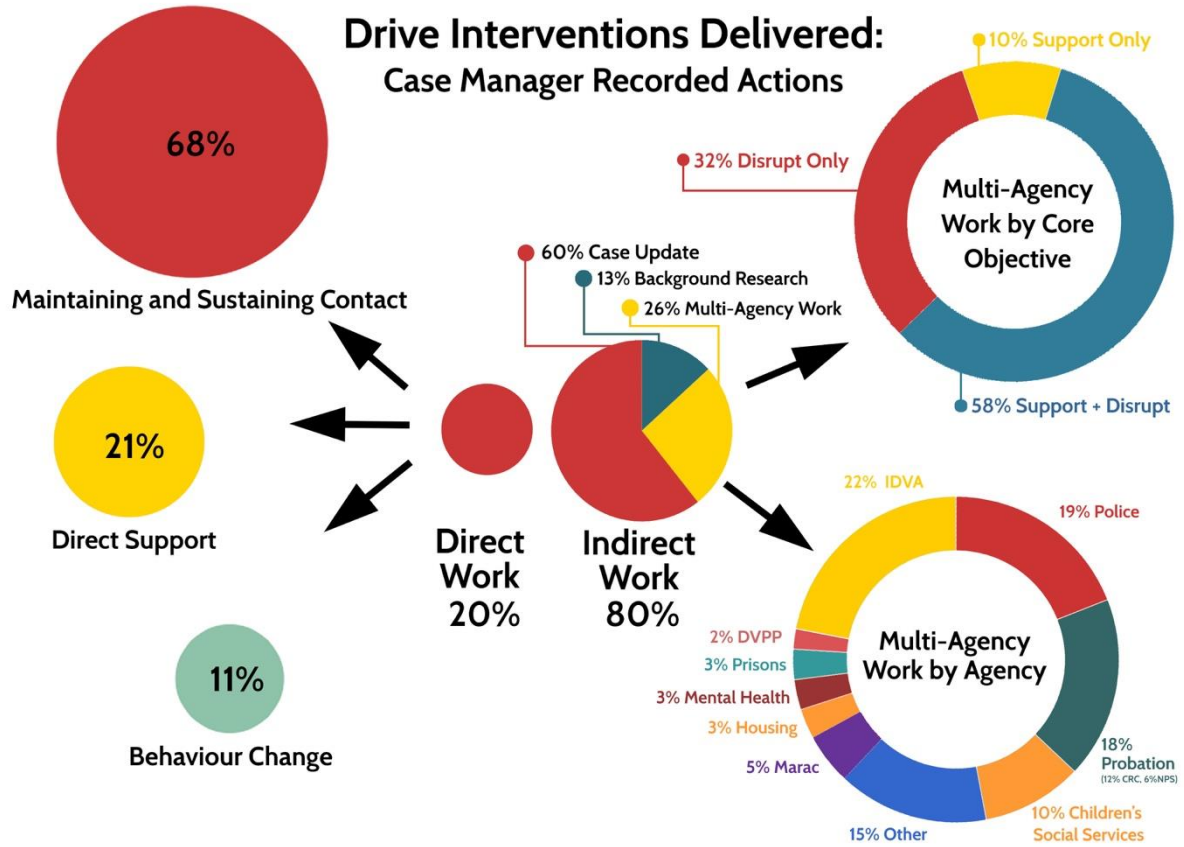
- Especially for service users with children, *working with past trauma* was a route to acknowledging the impact of abuse and developing empathy with their children.
- *'Counselling' from a trained Domestic Violence Prevention Programme (DVPP)* facilitator was deployed at one site alongside the Drive case manager's one-to-one work – those service users interviewed that received this support reported it to have been highly impactful in their change process.
- *Multi-Agency Direct Work as 'Deep Institutional Advocacy'* - Drive case managers worked in partnership with social workers enabling a level of service user engagement that had not previously been possible, as well as changing the perspectives of the social workers involved in relation to their understanding of the dynamics of abuse in the case.
- *Step-down work is a crucial component of the work for Drive service users* where: initial engagement and change was very slow to get started and more time was needed; where engagement was high to consolidate change; and/or to ease the transition to greater self-reliance.

Indirect work and direct work by case managers

The Drive intervention is designed to focus on the needs of individual service users and involves a mix of activities related to the support/disrupt continuum. The three pilot sites shared the core of the central Drive model but varied in approaches to delivery, management of caseload, associated administrative work and in the wider multi-agency ecosystems that they were situated within. In what follows, we look at Drive case managers' involvement with service users, multi-agency working and the work of IDVAs with the victims-survivors.

Although Drive cases varied, once a service user had been allocated to a case manager the first step was generally for the case manager to carry out background research about the service user. Then case managers would use a mixture of indirect and direct work as appropriate. Findings from Years 1, 2 and 3 demonstrated that case managers undertook both direct and indirect work with service users. Indirect work included information gathering, information sharing and multi-agency working, while direct work referred to all communication between Drive case managers and service users, including behaviour-change work, direct support to service users, and making and sustaining contact. The overall work carried out in Year 3 is shown in Figure 6.

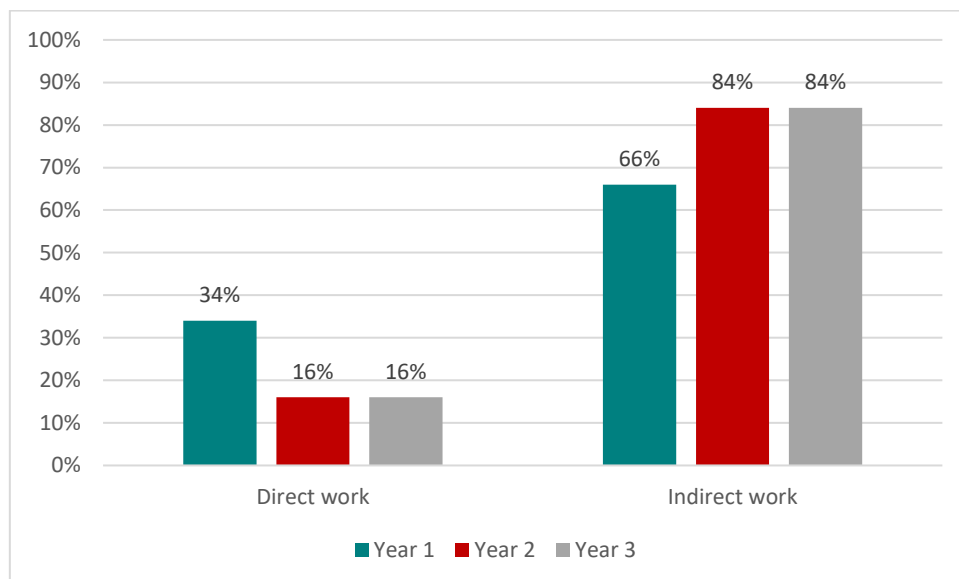
Figure 6 Drive interventions



Indirect work was generally much more common than direct work with service users (see Figure 7). Findings from the analysis of case managers' recorded actions showed that indirect work accounted for 84% of case managers' activities and direct work accounted for 18% in both Year 2 and 3. There was less indirect work in Year 1 as the multi-agency links required for this had not embedded to the same extent at that stage.

Analysis in Years 1 and 2 demonstrated that the Drive intervention lasted longer than 10 months for some service users. While three-quarters (74.5%, n=158) of the 212 cases closed in 11 or 12 months, a further 49 (23.1%) cases closed after more than 13 months. The reason for the intervention lasting longer than 10 months was because case managers were completing a particular activity with the service user, and/or because case managers were carrying out 'step-down' work (see end of this chapter).

Figure 6 Type of work undertaken by case managers in during the three years of Drive (n=509)



In what follows we begin by outlining indirect work and then provide detail regarding direct work.

Indirect work

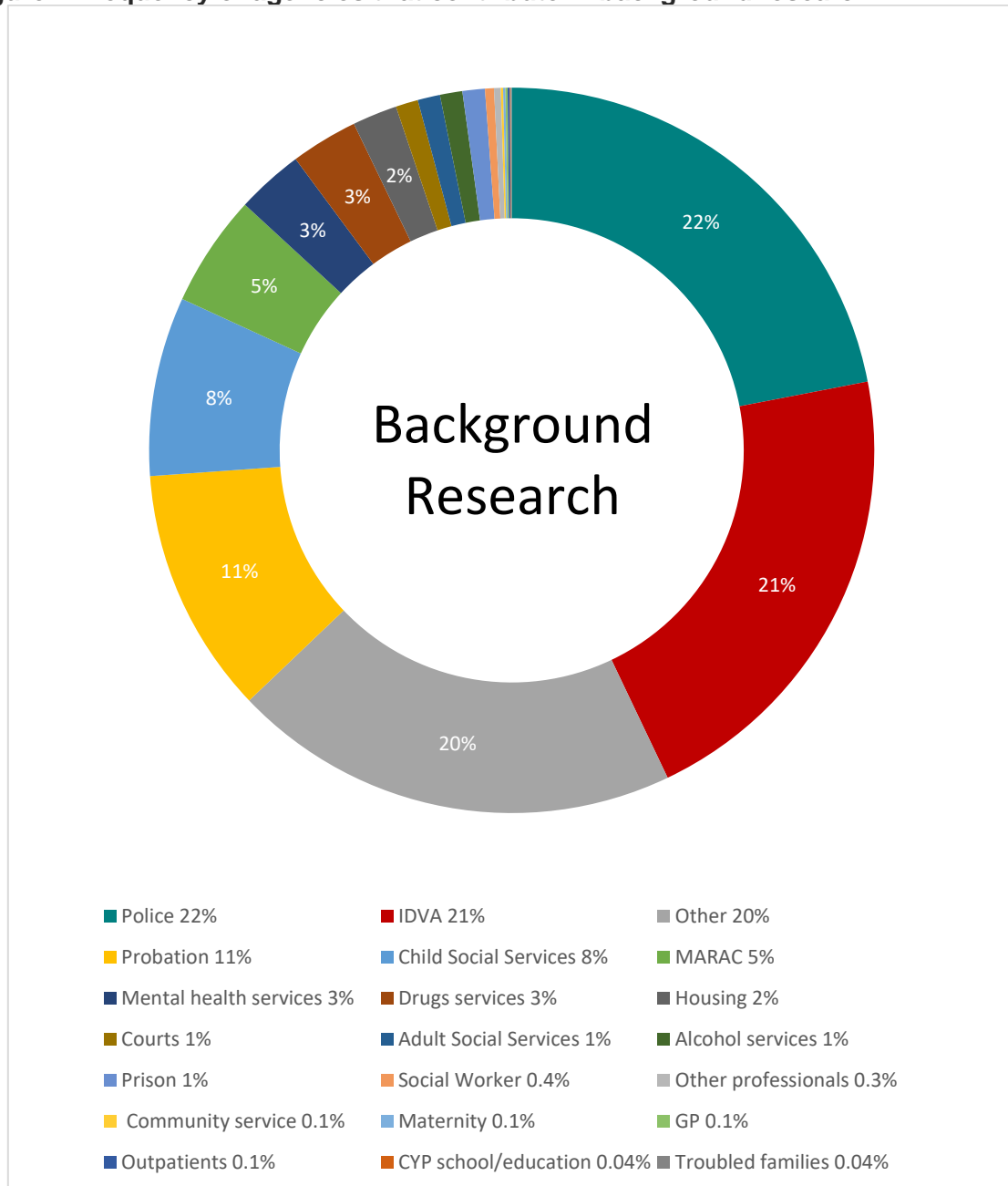
Indirect work was primarily composed of co-ordinated multi-agency activity. When direct work with a service user was not possible, or where additional checks, information, engagement levers or expertise were required, Drive worked with a multitude of agencies to conduct indirect work around the service user. Multi-agency work accounted for 26% of indirect work, case updates (information sharing) accounted for 60%, and background research (information gathering) accounted for 13%. It is worth noting that case updates necessarily involved other agencies and thus, while not counted as such in the case management system, can also be understood as another form of multi-agency work.

Background research

Drive case managers captured which agency they did background research or information gathering with on a service user. This was often concentrated at the start of the intervention to facilitate safe contact with the service user. The frequency of agencies engaged for background research is shown in Figure 8. The most common agencies engaged with background research were police (22%), followed by IDVA and other agencies that were not specified in the case management system records (20%)¹².

¹² 'other' is an artefact of the monitoring system, and relates largely to agencies contacted in Year 1, where type of agency was not specified.

Figure 7 Frequency of agencies that contribute in background research



Multi-agency working

Within indirect work, case managers recorded the multi-agency they engaged with. The most common agencies case managers worked with were: IDVAs (22%), police (19%), probation (Community Rehabilitation Company [CRC] and National Probation Service [NPS], 18%) and children's social services (10%) (see Figure 6).

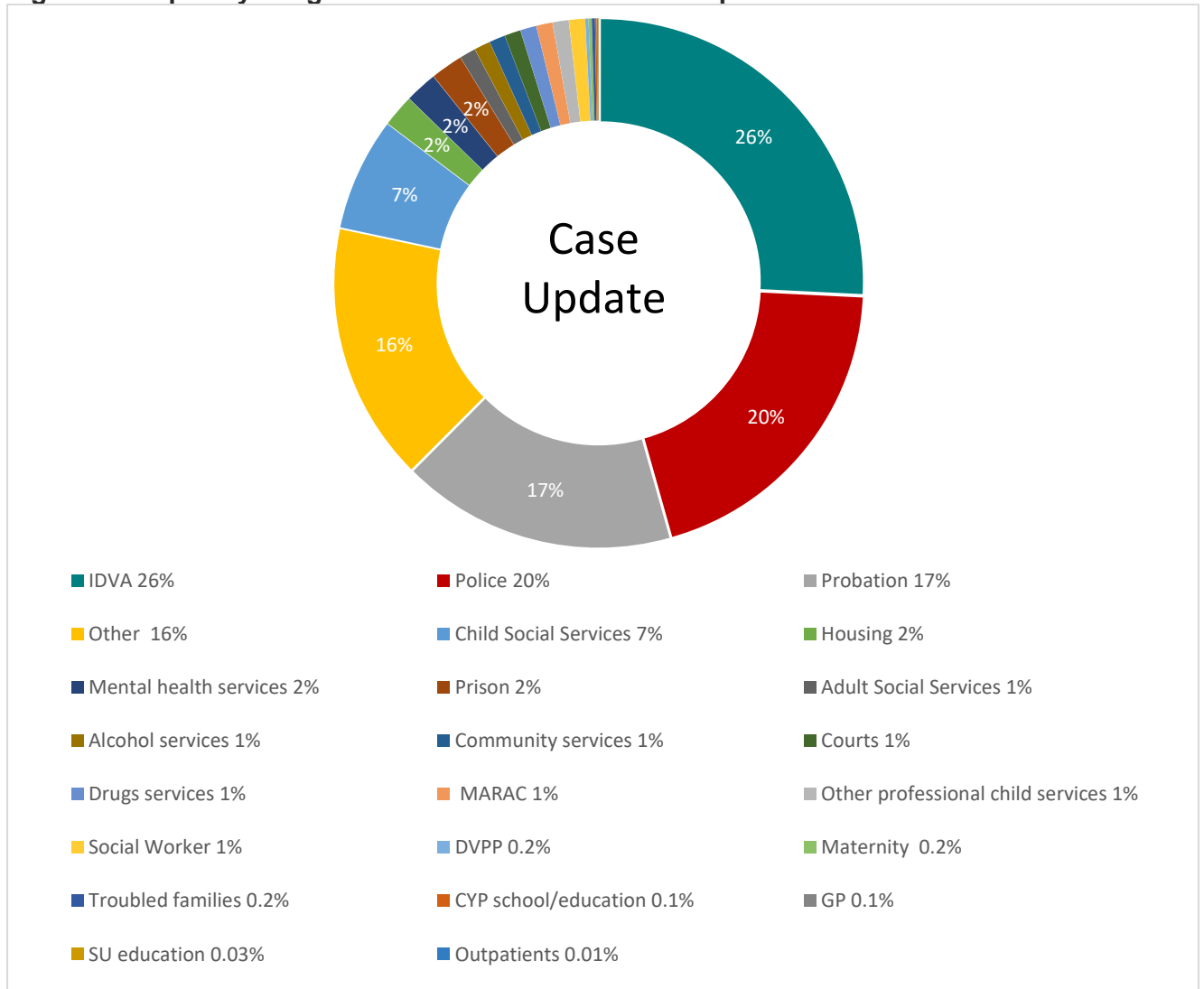
Multi-agency work had three objectives: disrupt, support, or support and disrupt. Disrupt activities aimed to stop further perpetration. Support activities aimed to help service users address needs and achieve a level of stability to overcome barriers to behaviour-change work. Support-and-disrupt activities included activities that aimed to both address service users' needs and prevent further perpetration. For example, to ensure separation and prevent abuse, support with housing was provided when the service user's only place to stay was the victim-survivor's accommodation.

Nearly two-thirds of multi-agency work was support and disrupt, 32% was disrupt only, and 10% was support only (see Figure 6). The most prevalent agency within multi-agency disrupt working was the police (28%), followed by IDVA (20%), probation (CRC and NPS; 17%) and children’s social services (9%). Within multi-agency support working, the most prevalent agency was probation (NPS and CRC, 17%), followed by housing (13%), mental health and wellbeing (13%). Finally, the agencies worked with within support-and-disrupt activities differed from agencies worked with for disrupt only or support only. The most prevalent was IDVA (25%), followed by probation (19%), police (18%) and children’s social services (9%).

Case Update (Information sharing)

Case managers updated external agencies about the cases. From Year 2 onwards, case managers recorded information about agencies they shared information with. Figure 9, shows all the interaction with other agencies not related to support, disrupt, or support and disrupts. IDVA was the most prevalent agency (26%) for information sharing, followed by the police (20%) and probation (17%).

Figure 8 Frequency of agencies that contribute in case updates



Disruption

We identified a diversity of disruption strategies – from simply raising the service user’s profile on police systems as recounted below by a police DI), to more subtle techniques involving a range of other agencies. Some notable examples of indirect work oriented to disruption and risk management were:

- *Information sharing to heighten risk awareness* – while information sharing might be considered a ‘pathway to disruption’ rather than the disruption itself, it is a critical component in disruption activity.
- *Providing the service user’s address to police or social services* – case managers will often have done significantly more research on service users than other agencies have been able to. It can be as simple as providing an address to police or social services when it was not previously known, which can open an avenue for disruption work.
- *MAPPA referrals* – in cases where the likelihood of behaviour change in the short to medium term was judged to be very low and the risk remained high, referrals to MAPPA were made.
- *Referrals to social services* – while aimed specifically at the protection of children or vulnerable adults, referrals to social services can serve as a key disruption strategy by initiating a home visit. They can also ensure the process and requirements being placed on the service user as part of the child protection plan are being followed.
- *Breach without reliance on victim-survivor to report* – for example, in one case, the service user was making repeated calls to the victim-survivor’s address in breach of his restraining order. The victim-survivor was too scared to make a complaint, in part due to complicity in the abuse from other family members. The case manager notified the housing provider and requested that they call the police if the service user attended the property. The housing provider agreed and did call the police. Unfortunately, officers attended but were unaware of the case history and the restraining order so failed to act. The case was, at the time of interview, under review within the police as a result of institutional advocacy by the case manager.

Indirect work – evidence from interviews with practitioners and service users

I can think of an individual who [...] is a Drive service user who has said ‘thanks but no thanks’ to Drive, but he’s actually a disqualified driver and there’s actually a non-molestation order in place. So, we’re able to raise his profile within our own organisation and locally to [area] officers, which led to more proactive policing, which led to him being found driving a vehicle when he was disqualified. So, there’s that disruption – well okay, if we can’t address his DV offending, then we’ll target him by the approach of what other criminality is that individual engaging in? And I can think of drug warrants that have been executed purely because their profile has been raised as an adopted Drive service user, but perhaps they wouldn’t have had that disruption had they not have been on the Drive register (Police DI 113).

As the analysis of the case manager recorded actions shows, indirect work within a multi-agency framework was a central function of the Drive intervention across the three years of the pilot. Analysis of interviews with practitioners and service users echoed these findings showing ‘deeper,’ that is, more collaborative, multi-agency working as Drive became established at the three pilot sites. While challenges remained in some areas in terms of blockages to information sharing and/or agency responsivity, generally in Year 2 and 3 relationships and joint/multi-agency working practices were much more established in comparison to Year 1 and this is evident in the breadth of multi-agency working presented in the case studies in this report (see Appendix 4). As found in Year 1, the fact that multi-agency working had continued to grow highlights not only that embedding multi-agency practice takes time, but that it is ongoing. It is always and necessarily incomplete as the multi-agency landscape changes, reorganisations of services occur, and individuals move roles. Consistent with Year 1, the overwhelming majority of indirect multi-agency work was oriented to disruption and risk management activity, often in tandem with support activity.

Case Studies: Disruption and Indirect Working

Disruption, of course, overlaps with other kinds of activity – direct and indirect, single and multi-agency work – and can take subtle forms. The following two case studies offer an insight into the complexity of disruption and indirect multi-agency working, and present some of the varied strategies used by case managers to manage risk where direct engagement is either not possible or not leading to adequate behaviour change.

Case Study: *Cross-Border Multi-Agency Working – Disruption While in Prison*

Keywords: cross-county/cross-border multi-agency work, prison, disruption, breach, engagement

Background information

The service user had been convicted of coercive control for abuse of the victim-survivor and had a restraining order in place. The service user and victim-survivor were accessing services across two counties and providing different information to the various agencies involved. While the Drive case manager was working with the service user, the victim-survivor was being supported by two IDVAs across counties in differing capacities.

The service user was obsessed with the victim-survivor, with whom he was in an intermittent and coercively controlling relationship. He had breached his bail conditions by attending her place of work. He had also breached his restraining order conditions on multiple occasions in a short period of time.

The victim-survivor disclosed to the IDVA that she felt unsafe and trapped in the relationship. Within the context of understanding the dynamics of coercive control and the impact that this has on a victim-survivor’s space for action, Drive pursued actions around disrupting the service user’s ability to use coercively controlling behaviours and contact the victim-survivor.

The Drive case manager worked closely with the IDVAs to conduct a dynamic risk assessment to reduce the risk posed by the service user.

Cross-border multi-agency working

The Drive case manager initially started an email group of agencies involved in the case to share information, but as the case escalated and developed quickly, professionals were beginning to miss crucial information, either by being missed off the information-sharing group, or through information shared bilaterally in conversation.

To remedy this, the case manager called a cross-county multi-agency meeting to bring the involved professionals together and ensure the risks were noted by all agencies involved.

This revealed inconsistency in what was thought to be known by different professionals, provided insight into the victim-survivor's thoughts and feelings, and helped develop an understanding of the dynamics of the relationship. Led by the advocacy of the Drive case manager, this meeting also provided additional information about the service user, which further elevated the risk level. This was a fundamental turning point in the case, as all agencies involved fully understood the risks after the meeting. The Drive case manager and the IDVAs acted as a crucial advocate on behalf of the victim-survivor due to their understanding of the intensity of coercive control being perpetuated by the service user.

Information sharing and disruption

For example, a critical piece of information that was shared early on was that the service user had been sending letters to his mother's house when in prison. These letters were addressed to the victim-survivor's children, sometimes using their known nicknames, but they were for the victim-survivor.

As a result, the prison was requested to put a hold on all the service user's letters and to check that they were not intended for the victim-survivor.

Drive continued to engage with the service user while in prison but were unable to elicit any acceptance of responsibility for the abuse from the service user.

Upon release, the service user continued to engage with the Drive case manager and the victim-survivor continued to engage with IDVAs. From the information disclosed by both parties, it was suspected that they were arranging to meet.

As noted above, within the context of understanding the dynamics and risk associated with coercive control, disruption actions were taken to reduce the service user's risk to the victim-survivor by sharing this information with the police. As a result, the police found the service user in contact with the victim-survivor, in breach of his restraining order, and he was returned to prison.

During his time in prison, the victim-survivor applied for the restraining order to be lifted. Aware of this application through the information sharing in place, probation, Drive and the IDVA services across the two counties wrote to the court urging the judge to reject the application due to safety concerns for the victim-survivor. At the time of writing, the service user remains in prison and is engaging with his Drive case manager. Safety planning for the victim-survivor was also being undertaken.

Salient Questions & Learning

This case is an excellent example of effective and efficient multi-agency collaboration and risk management. Information sharing was essential for the quick responses to the rapid developments in the case. The multi-agency working also provided a holistic approach to the work, enabling a thorough understanding of the case from all possible angles.

A key question remains – what happens after Drive?

Case Study: Case manager, Social Worker and IDVA Collaborative Working

Keywords: deep institutional advocacy, what can be done when service users don't change, the value of collaboration.

Background information

This family's case was open to social services due to the risk posed by the father (the Drive service user) to the mother (the victim-survivor) and the children, who were on a child protection plan. The victim-survivor was engaging with the IDVA, and the service user was engaging with the Drive case manager, but was, according to the social worker, 'not in a place where he wanted to change any of his behaviours' (T1.15 social worker).

Information sharing and multi-agency working:

The Drive case manager attended and provided written reports to the core group formed at the child protection meetings. The case manager acted as a bridge between children's social services and the service user – as a check and balance on the service user and what he was saying about his own improvement/change, and as an advocate for the victim-survivor by highlighting the patterns of abuse and control that other professionals were not aware of or did not previously understand as abuse (this was reported by a social worker present T1.15).

This provided a venue and communication channel for information sharing between the Drive case manager, social worker, and the IDVA. In the words of the social worker, the Drive case manager would 'liaise with me, keep me updated about what the service user (the dad) was doing, any police involvement, how their sessions are going, engagement – things like that" (T1.15. social worker). For the social worker, hearing about the service user's behaviour from someone working directly with the service user was reported as being particularly 'valid' and impactful.

The case manager shared information with the social worker and IDVA, who communicated with the victim-survivor. The case manager fed back his assessment that the service user was engaging with Drive as a 'box-ticking exercise' without real commitment to change. As the social worker reports:

And I suppose just like really highlighting with me and the [IDVA], the patterns of control within the relationship. I think... so when I was first working the case, mum was very hopeful that he would change and that actually things were going to be different now that they had had a baby, and dad would be very much obviously saying those things to her, and she would say 'oh well, he is meeting with [the case manager], like he's trying to change, he's working with Drive' – but actually just meeting with [the case manager], he's not trying to change, it's almost just ticking the box. And [the case manager] was really... yeah, he was really clear about that – actually [the service user] the dad has not really done very much at all in terms of being able

to reflect even anything that he would want to change within his behaviour or take any responsibility. So... yeah, that was helpful for her to hear as well.

For the social worker, of particular importance to this case was having someone to work specifically with the father and the extent to which this offered insight into his behaviour and accountability in relation to his claims to have changed:

... like [the IDVA], she would work really closely with the woman and would keep me updated and support her... but when Drive's not involved it feels like there's a kind of gap. Often the dad's... well the dad in this case, he wouldn't be wanting to really engage with me because I'm the social worker and I have to kind of... yeah, my focus is on the children's safety, and I didn't really feel it was safe for him to see the children... but yeah, it just meant that he had someone working specifically with him.

[...]

It hasn't necessarily led to positive outcomes in that if dad is particularly difficult to engage... so I think [the case manager] has struggled with that [...] but it has helped in terms of me knowing more about what's going on I suppose, and [the case manager]'s been really helpful in that respect. And I think it's helped because somebody is... [the case manager]'s been trying to build a relationship with him, with the dad, so we have got some insights that I wouldn't have got necessarily had there not been a professional involved specifically working with dad around his patterns of behaviour within relationships and that kind of thing. And also it meant that... so... there being a consistent working with dad throughout the time that the [children's cases] have been open has meant that when dad's tried to tell me one story, and then I speak to [the case manager], we can kind of piece together where he's trying to... not play us off against each other, but he's trying to portray things in one way to me when actually [the case manager] knows differently (T1.15. social worker).

The information shared by the case manager was thought by the social worker to have directly influenced their child protection decisions. The mother and children were subsequently moved to a refuge out of the area.

Social workers are closely monitoring the service user's requests for and actions in relation to contact with the children, recognising that this may be used to continue perpetration against the victim-survivor. Their focus is on what the service user is or is not demonstrating in terms of evidence of behaviour change, including addressing substance misuse issues. Crucially, the focus is on the service user's behaviour, not that of the victim-survivor.

Salient Questions & Learning:

This case demonstrates the utility of information sharing and collaborative working even in the absence of behaviour change – as a tool both to understand the whole picture and proactively exercise a continuous assessment of the case. Drive was impactful here in two key aspects – first, in providing information to allow the other professionals to better assess and manage risk, and second, in helping to change the focus of professionals away from the conduct of the victim-survivor to that of the service user, who is wholly responsible for the abuse.

Direct work

As outlined earlier, direct work included a range of face-to-face and other work by case managers, which was often detailed and highly skilled. Table 7 indicates the range of activities and the complexity of direct work carried out in Year 3.

Table 7 Classification of direct work activities used in this report

Direct contact categories	Actions as recorded by case managers	% of actions
Behaviour change	Face to face + other agency + behaviour change	0.3
	Face to face + other agency + general + behaviour change	0.8
	One to one, behavioural session	3.2
	One to one, general + behaviour change	6.7
Direct support	Face-to-Face Contact	4.6
	Direct contact made	4.6
	Face to face + other agency + general	2.1
	Support service user to appointment/meeting	0.4
	One to one, general	9.5
Maintaining and sustaining contact	Email	12.1
	Home visit	0.3
	Telephone call	31.0
	Text message sent	19.3
	Letter	2.1
	Message left	3.1

Case managers had direct contact with 65% of service users (n=330). The number of direct contacts per service user varied, ranging from 15 to 336, with an average of 137 direct contacts (standard deviation=79.5).

Direct work consisted primarily of maintaining and sustaining contact with service users (68%) mainly through emails, letters, text messages, telephone calls, and home visits. The next most prevalent type of direct work action was the provision of direct support to service users (21%), consisting mainly of one-to-one meetings with case managers or other agencies and service users. The third type of direct work was behaviour-change work, where only 36 service users (11%) received direct behaviour-change work sessions.

Direct Work – Evidence from the interviews with service users and case managers

In working ‘directly’ with Drive service users, case managers deployed high levels of skill and sensitivity both to support service users to engage and challenging them to change. In the following sections we identify in some detail the key components of the direct work that, based on interviews with high engaging service users and their case managers, were both prevalent and seemingly effective at cultivating engagement.

For detail on the direct work with service users who did not engage so readily, and on the intersection between Drive direct, indirect and multi-agency working, we provide an analysis of Drive case notes in the chapter later in this report on ‘Drive Case Note Analysis’.

A range of ‘levers’ appeared especially important in ensuring that service users engaged with their case manager:

Levers for engagement

- *Some statutory involvement* in the case is a key enabler of engagement – 26 out of the 28 high-engaging service users interviewed had some statutory involvement in their case.
- Drive case managers skilfully elicited willing participation of high-engaging service users by *combining statutory measures with a ‘sense of service user agency’* such that even when compelled, service users reported their participation as voluntary.
- The aspiration to ‘be a better father’ was a powerful motivation for engagement/change for service users interviewed, while the presence of child protection proceedings functioned alongside this as an effective ‘lever’ or ‘push factor’.
- Complex needs can work as an effective lever for engagement where levels of need position the case manager as able to offer meaningful support to the service user.

Importance of some statutory involvement

Reflecting the wider pattern of criminal justice system involvement with Drive service users, 26 of the 28 service users interviewed across the three years had some police involvement, with a majority of those having been convicted for a crime against an intimate partner. The high level of police involvement supports the views of Drive case managers and Drive service managers who were interviewed, that service users with some statutory involvement¹³ were easiest to contact and engage. Case managers also made efforts to distance or differentiate themselves from statutory service practitioners and this was something that high-engaging service users noticed and reported as being key to their engagement (saying for example, ‘*my case manager is not like my probation officer...*’ for positive reasons). For those service users who had initially been compelled to engage by statutory services, engagement commonly continued after that compulsion had been removed/ended. This suggests, in line with the findings from Year 1, that the key factor for the success of behaviour-change work is ‘to get the service user in the room.’ That is, if we can get them to engage in the first instance, thereafter they will often be motivated to stay/continue engaging for other reasons (see below).

Compulsion/Voluntarism

A common theme in service-user narratives of their experience of engagement across Years 1, 2 and 3 was a combination of some initial compulsion to engage alongside, or shortly followed by, a degree of voluntary engagement. Service users who were initially engaged in prison, who were doing Drive as part of their Rehabilitation Activity Requirement (RAR), or who had Drive engagement written into their child protection plan, often described their participation in Drive as voluntary. This is a testament to the skill of the Drive case managers who opened a space or possibility for service user agency, even when the service user was obligated to attend. This *sense of agency* seemed to enable service users to ‘own’ their processes of change – that is to commit to them as their own, rather than something imposed on them. As mentioned above, many stuck with Drive after their legal compulsion to do so had

¹³ Statutory involvement here refers to cases with the involvement of: police (with or without arrest or conviction), probation – service user on probation (with or without Drive engagement written into their rehabilitation activity requirement), children’s social services – aware of the abuse and taking action (with or without Drive engagement being written into the child protection plan).

ended, realising the inherent benefits of engaging for themselves (see also Hester et al. 2006, where DVA perpetrators were making positive changes in behaviour once they perceived change as a gain).

Children and Child Protection

The positive aspiration to be a better parent was a common theme in service user narratives. 26 of the 28 service users interviewed across the three years had children and within the wider sample (n=212), service users with children were more likely to engage – of those service users who at least partially engaged, 70% had children. Where the information was available, 32% of those service users interviewed had ongoing child protection proceedings. Similarly, within the wider sample, the service users who engaged were more likely to have child protection involved – 64% of the 212 service users with child protection concerns engaged with Drive case managers. As we discuss further in the section on interventions delivered (below) and through the case studies presented, multi-agency work with children's social services was particularly notable in Years 2 and 3. This ranged from relatively simple activities like enhanced information sharing and Drive engagement being written into the child protection plan, through to detailed partnership working including joint visits, shared and/or coordinated actions/tasks and close communication between social workers and Drive case managers.

Direct work on service user behaviour

We identified a number of key features employed by case managers in their direct work with service users to change their behaviour, as detailed below:

Relationship Building for Behaviour Change

Relationship building with the service users by case managers came up as critical to cultivating and sustaining engagement. This was attained in part through the material and psychological support provided by the case managers, but also through much more subtle modes of conduct, as one case manager describes:

So, you know, even things like how I sit – I would never sit like this opposite someone, engaging with a service user, because that kind of, in their head, frames that as an interview rather than a conversation, do you know what I mean? You've got the barrier of the table. So I'll sit alongside them, or where it's available there's rooms with like sofas and big comfy chairs, and I always offer them a cup of tea or a coffee – which you don't get in probation or police interviews, [...] so I do everything I can to, in their mind, distance the Drive case manager as much as possible from statutory services as they perceive them. (case manager 101).

Through such embodied techniques, the case manager actively differentiated Drive from statutory service provision. Accordingly, service users were very clear that Drive was 'not like other interventions they had received' and this was key to their engagement.

Eliciting Accountability Through Skilful Challenging

In Year 1, we reported that where direct challenge to service users by case managers had been conducted unskilfully – that is, too directly or deploying shame – service users were quick to disengage, which, in turn, resulted in them posing a higher risk. Years 2 and 3 saw the development and extension of the already-existing subtle challenges made by case managers. As one case manager reported, while direct challenge could be counterproductive:

If you can plant that seed of doubt in their head, you know... and the next time they go to do something my voice is there in the back of their mind... or there's something there and they think oh... it'll make them think about it. Might not make them stop, but

it might give them some kind of way to think... do you know what I mean? It might put something in their head, that self-talk of thinking, 'oh hang on now, is this really right?' You know it's just chipping away, constantly chipping away (case manager 104).

Another case manager described using a seemingly innocent conversation around the service user's weekend as a form of "*behaviour change under the radar*." The case manager recalled subtly and repeatedly bringing the service user back to consideration of the service user's partner's perspective during the conversation.

Thus, Drive's one-on-one work is a bespoke offer that resists standardisation as a strict set of activities or programme that could be delivered to each service user - instead it operates as an ethos or way of being. This individualisation begins at the detailed tailoring of the initial contact letter using research on what might be a feasible 'hook' for an individual, right through to the language – embodied and verbal – used by the case manager in the context of a one-on-one session.

Differentiating Drive: Listening, Care, Non-Judgement

Interviewer: ...and what was different about how she worked?

Respondent: Everything basically. Compared to probation people, they're just ... don't even know what words to put to them but um... yeah, she was nice, she came along, she'll talk to you, she'll listen to your side of things as well... whereas people wouldn't. And then obviously she goes from there, she hears what I need, and then she built the programme around me, basically to help me with everything I needed (SU109).

While not a therapeutic intervention, the *therapeutic character* of Drive one-on-one work, to the extent that case managers practiced or embodied active listening, care and non-judgement, was reported by high-engaging service users as profoundly impactful.

High-engaging service users were keen to differentiate Drive from other interventions they had received including: probation (SU101; SU106; SU110; SU109; SU116), mental health services (SU109; SU114) and private counselling (SU104; SU114). As the following quote demonstrates, service users perceived the care expressed by case managers to be central to their emerging ability to see things differently – or to change. When asked what was different about Drive, this service user responded:

I don't know, he cares, do you know what I mean? *Like he cares, and we have really got... I don't know, he just asks me questions that... and he unlocks sort of answers that I didn't really know were there, sort of thing, like certain things he'd make me talk about that I didn't realise were happening maybe or a different perspective on stuff really. He's always got something to bounce back off whatever I say, do you know what I mean, to make me sort of think about things a little bit differently or something like that – just little things, you know (SU104).*

Another service user, who compared Drive to his experience of mental health services, similarly linked the Drive approach to his ability to 'open up' and see beyond his immediate situation. Like the previously quoted service user, he found this particular character of Drive difficult to articulate, prefacing his response with 'I don't know':

*I don't know what it was about [the case manager], or what it was about the project, but her approach was fantastic, you know... for me personally. And it just gave me that little lift that I probably needed at that time in December when she was... **you know she was very understanding of the mental health side of it which... and I was like wow, okay she doesn't even know me ... and it just opened me up a little bit.** And I'm quite a reserved guy really, and so for me to talk to [the case manager] who I've never met before, it just kind of threw me a little bit. But it was great because, you know, she made me feel comfortable, she made me feel like all right fine, look you're inside here [in prison], it is what it is, but you've still got a life outside (SU114).*

For this same service user, as for others, the non-judgement he experienced remained a strong theme, in this case compared to his prior experience of mental health services, and was linked to his self-understanding of ability to change:

*You know, I didn't feel like... it wasn't a stereotypical kind of... you know, with the mental health side of it **everyone has this judgement, and [the case manager] didn't judge me for that,** do you know what I mean? She didn't like 'Oh, here we go again' – none of this 'you have mental health' kind of things. Cos some people look at it like that, **and maybe that was why I ended up opening up to [the case manager], you know.** And... because she made me feel comfortable to be able to talk. And then, yeah, that just gave me a boost really... boost in all aspects you know, knowing that I can still go out and work, knowing that I can work on mechanisms myself to cope with things (SU114).*

Non-judgement was also a method by which service users compared one-to-one work with group work around domestic abuse. One service user expressed his aversion to group work as a fear of judgement by peers. While this precise feature of DVPPs may for some be what facilitates change, for others it means they simply will not attend and one-to-one work may be more appropriate. The irony here, and in the non-judgement by practitioners, is that non-judgement seems to be the best tactic for encouraging a service user to take responsibility for what they have done wrong:

R: I was doing these RAR sessions with probation, I was put in rooms with other people with similar crimes. They weren't getting anywhere because neither person is going to open themselves up in front of other people without thinking, 'they're going to be judging me now,' you know. I wouldn't have opened myself up in front of other people because my general (inaudible 30:22) is they're going to judge me if I see them out in public now.

I: Yeah.

R: But because they worked with me as a one-on-one, and they managed to get me actually talking and helped me along all this time. And like I said me, I feel actually rehabilitated, I never would have believed it (SU110).

Working on Impulse Control and Emotional Regulation

I: And what kind of stuff did you do, or what do you do in the sessions?

R: Um... it varies really, it's all like digging deep into how you react and how you could react, what should be the best way of looking at other people's perspective and how you can deal with things differently and... yeah... specially retraining your brain to do things better (SU116).

For the Drive cohort, getting service users to a place where it was possible to address deeply held attitudes and beliefs in relation to gender, masculinity and violence seems to have only been possible for a small minority, and these types of activities were not commonly recalled by the service users who were interviewed (which is common across many interventions with perpetrators). More commonly recalled by service users (and case managers) was work around impulse control and emotional regulation. This work aimed to open a space of reflection between stimulus and service-user response in order, at its most basic, to help service users 'manage' strong/impulsive responses, and more profoundly, to enable connection to perspectives other than their own – as in the above case. In some cases, this also led to more gender-oriented work.

As is common in research on DVPPs¹⁴, for service users interviewed, 'time-outs' were particularly memorable. The following service user, for whom 'time-outs' were not a new practice, reflected on the difference in the way he used them, and how others consequently saw him pre- and post-Drive:

R: Well if you spoke to everyone that knew me 6 months ago, they would have said that I was evil, and I was just a horrible person, that basically I wouldn't do anything for anyone else, I was controlling... blah blah blah. But now that I've been seeing [my case manager] and... like for example, my mum, if you spoke to my mum, she would have been like yeah, 'he's evil, I didn't like him at the time, and didn't want to talk to him' and everything. But now that I've been speaking to [the case manager] she's over the moon because I'm so much happier with everything, and I'm getting along with everyone now.

I: And what about how you respond to a stressful situation now?

R: I try and avoid stressful situations. You never can be stress-free but whenever there is a stressful situation, I either walk away from it and have a cigarette and calm down for 5, 10 minutes, and then come back and talk it through. Beforehand it was... I would try and go out for a cigarette and it just brought back up everything, basically when I come back, because I'll be thinking... at the time I'll be having a cigarette, to try and calm myself down, but I'll be thinking what I should say to the person I'm angry at. And then as soon as I go there, it all blurts out and starts another argument (SU115).

Of interest here is the reported shift in the use of the time out – from something that paused but did nothing to reduce abusive behaviour to something that enabled the service user to return to the argument without using abuse. Central to these tools is the idea that difficult emotions and challenging situations will not go away – instead the aim is to enable service users to manage them without using violence and abuse. This involves not only learning the skill of 'sitting with' discomfort, but also the service user being sufficiently committed to doing

¹⁴ See eg Wistow, R., Kelly, L. & Westmarland, N. (2017). 'Time out' a strategy for reducing men's violence against women in relationships? *Violence Against Women* 23(6): 730–748

so, since even for someone with skills, discomfort remains uncomfortable. A key way of developing this commitment was through attention to the impact of behaviour. One service user articulated this link cogently when asked what he thought the impact of his behaviour had been on his partner:

“I mean my ex-partner and me haven’t spoke since the day I got arrested, there’s an indefinite restraining order against me. So I don’t really know how my behaviour’s affected her. But obviously she’s scared to the point that she doesn’t ever want to see me again ... it’s resulted in me not seeing my son. So it’s had major impacts. As for my family and friends, you know they saw the sorry state of the man that I was when I went to prison, I was at rock bottom, and to see where I’ve got to this point, I’m a lot more ... I’m a lot more chilled, a lot more open. I don’t know just slower to react to bad situations. Like I’ve really learnt how to sit with a bad feeling and mull it over and make a more conscious informed decision rather than just instinctively reacting to situations.”
(Drive SU4)

Encouraging positive self-talk was also key to work done on impulse control and emotional regulation. One service user interviewed particularly connected with the analogy presented to him by his case manager of ‘feeding the good’:

“I was getting angry, you know, I was getting angry. [...] Well now I’ve calmed down you know.... when I’m angry I walk away. He’s tells me ‘go an ’ave a little walk’ ‘go an do whatever you’ve got to do’ and ‘just keep feeding the good dog’. If you fed the bad dog, take the food back off him. You know, it’s... it’s just one of them things you know – I was ready to blow all the time you know. It’s really nice you know. Taking things out on people which support me the most, you know – you shouldn’t be doing that.” (Drive SU1)

This service user was having obsessive and paranoid thoughts imagining his partner’s infidelity and, in an attempt to quell these thoughts, would exhibit highly controlling behaviours. He was also feeling angry and expressing that anger through abusive behaviours. The case manager used the analogy of ‘feeding the good dog or the bad dog’ to refer to the way in which the service user cultivated negative or positive self-talk/mental narratives about his partner and children. Framing his experience in this way offered the service user an opportunity both to observe his thought process and, crucially, to exercise some choice about which process to follow. It functioned then as an anger-management tool, but more profoundly as a technique for addressing jealousy and control - a way of interrupting the ‘jealousy-to-anger’ thought process. This seemed to really stick, with the service user coming back to it again and again at interview and both the IDVA and case manager reporting positive behaviour change.

Creating Alternatives for Positive Self-redefinition

Very much linked to work on impulse control and emotional regulation and seemingly key to commencing behaviour-change work with high-engaging service users was the creation of alternative avenues for positive (ie less harmful) self-redefinition – getting service users to acknowledge and seek to cultivate a ‘better side’ of themselves:

R: My girlfriend’s noticed it the most.

I: Right, and what does she say?

R: Cos when I was first going out ... we used to talk all the time, we broke up because I just talked to her like a twat and I was worried about what she was doing. More-so like when she was going out, talking to boys and that, if she was talking to boys – you get scared. Cos you don’t know what they’re doing out there ... but now I’ve realised that she ain’t a cheat and she knows me for who I am ... but the better side of me now. (Drive SU3)

To do this, case managers explored and/or validated positive traits, skills and behaviours and attempted to explore, challenge and/or redirect problematic aspects of the service user's self-view and/or views of others. Redefining masculinity in ways that incorporated responsible fatherhood (as mentioned above) and allowed for attention to feeling and vulnerability - 'you get scared' - were common themes, as this case manager recounts:

"And so we analysed it, [...] you know, when I mentioned 'Well you were obviously vulnerable' – 'I'm not vulnerable, I'm not vulnerable' – didn't like the term 'vulnerable'. So I said 'Well tell me about how you felt then?' – 'Well I was pissed off like' – 'Yeah but that's entitlement' I said, 'but what did you really feel?'. And he said, 'Well I don't want someone else bringing up my kids' – boom 'That's your vulnerability then!' and I said 'and that's nothing to be ashamed of, that is a genuine real concern that if you split up with your partner, and she meets somebody else, your daughter's going to be ... whether you like it not, they're gonna be living with somebody else [...] 'and that is a perfectly acceptable vulnerability for you to have'." (Drive case manager 32)

Here, the case manager uses what is quite a traditional (albeit fragile) component of masculinity - the biological father guarding 'his' children - as a way of connecting the service user to his own vulnerability. Through the reinforcement, 'that is a perfectly acceptable vulnerability', he grants permission, allowing the service user to feel no shame - a technique made possible perhaps by the case manager's own gender status as a respected male.

Working with past trauma as a route to acknowledging the impact of abuse

Especially for service users with children, cultivating some reflection on their own experience of abuse (if relevant) seemed to be a critical tool mobilised by case managers to develop empathy and recognition of the impact on their children:

He was showing me a few video clips of people talking about how the brain works and how it causes us to do certain things sometimes. Obviously, had to do like a timeline. Obviously, we sort of went back over like my childhood and obviously my teenage years, you know, tried to sort of unpick through all that as to why I may behave the way I do or do certain things that I may have done. You know, a lot of my problems in the past are problems with substance and alcohol misuse, which was brought on by a crappy childhood with crap parents, you know, so obviously they didn't really give me much of a great start in life to be honest. You know, at a time of my life when I should have been sort of like shown the right way and nurtured and sort of like cared for, I was almost just sort of like given up on basically (SU108).

Of course, the risk here is that the service user may slip into a frame of mind where they come to position themselves as the victim, or excuse their behaviour on the basis of what they experienced. Another service user navigated precisely this tension, taking responsibility to some extent for his 'choices', yet acknowledging the 'reasons behind them':

"Yeah and if I talk about my previous history, the police and stuff like that, she doesn't judge me for the things I've done, she kind of wants to help me. She kind of realises that it may not be my ... it's my choices for what I think I've done, but there is a reason behind the choices that I've made, and she wants to kind of get to the root of them and try and change my way of thinking." (Drive SU7)

Recurring in this quote is the question of judgement/non-judgement in relation to the taking of responsibility. This suggests that some engagement with past trauma worked to build the trust necessary to then take the service user through more challenging and discomfort-producing activities. Storyboarding from the child's perspective was one tool that both produced

discomfort, and in rare but important instances, took the work in a more empathic direction, as this case manager describes:

...Sometimes I think actually storyboarding from a child's point of view, perspective, is actually really quite beneficial. Because whilst they'll still try and minimise, deny, sometimes after a while they can't really wriggle [...] you've got to sort of think in that mindset of 'okay, this is potentially how a child of this age might understand the situation, and these are the types of emotions that they may feel – and so let's work in that space for a moment, let's try and empathise and imagine how they sort of experience it.' [...] And it then acts as a little bit of a... it's a route in, it's a route in to actually probe into their emotions and how they think and then feel, to try and turn it round and get them talking about that emotional language. But it's hard work, and it's often... it's quite rare (case manager 107).

'Counselling' from a trained Domestic Violence Prevention Programme (DVPP) facilitator

Although only used at one site, one-to-one work provided by the local DVPP facilitator was reported by the service users who had received it as highly impactful. This one-to-one work was presented to service users as 'counselling' and certainly had a therapeutic component. However, the one-to-one work differed from counselling to the extent that the facilitator used the space as an additional opportunity to address and challenge problematic talk and behaviour. This was reported by service users as both personally transformative and key to their behaviour change:

I've always been a shy person myself and talking about myself was one thing I thought I'd never want to do. I don't know, I've always had trouble growing up... not me causing trouble but... sort of trusting someone with... you know, basically telling them the past is a big thing. [...] By the end of the second session I could see myself changing in the way my attitude was and the way I felt towards other people. I didn't feel so in on myself and... cos I always felt other people are judging me... even if they're not. I just... I don't know, it's just something which stuck with me. But as the sessions went by with [the DVPP one-on-one worker], we talked about things, personal things, which I've never been able to speak about, and she guided me through everything... and fair play, my 10 sessions with her, and the only word I can use to describe it is I'm a changed man (SU110).

Another service user described the way in which the one-to-one worker enabled him to better see and understand his former partner's perspective:

I welcomed the counselling because I needed to sort myself out, and by discussing things I find that it eases me. I also wanted to find out more about myself, you know. Because not only do I get through [the DVPP one-on-one worker] my point of view over, I also get the opposite – you know, my former [partner]'s side, which helps me to reason better (SU112).

In this quote, we see the common pattern by which the service user initially becomes involved in the intervention based on his perception of how it will benefit him individually – 'sorting himself out' and feeling more at 'ease' – but then goes on to see how understanding his ex-partner's point of view brings its own inherent benefits.

While the explicitly therapeutic work (as opposed to the therapeutic component of work that is not counselling) was reported by service users as a transformative benefit, these particular service users commonly benefited from a kind of ‘double service,’ to the extent that they often received one-on-one work from their case manager in parallel to one-on-one work from the counsellor. As such, while service user testimony is a reliable measure of what stood out to them as most important, it is difficult to specify exactly what enabled their change – was it therapy, or did they simply have a much higher frequency of one-on-one work than service users who only saw their case managers?

Crucially, counselling alongside Drive one-on-one would have significant cost implications if rolled out widely (even if some of that additional one-on-one work would need to occur anyway prior to service user inclusion in a DVPP group).

Multi-Agency Direct Work as ‘Deep’ Institutional Advocacy

While multi-agency work was the dominant feature of indirect work, we also encountered examples of multi-agency working directly with Drive service users. As the following quote from a social worker demonstrates, there was also evidence of close partnership working between the case manager and social worker, enabling a form of ‘deep’ institutional advocacy, to the extent that it changed the perspectives of the social workers involved in relation to their understanding of the dynamics of abuse in the case:¹⁵

R: So, the actual contents of the session really were [the social worker] talking to mum about what's acceptable and what's not in terms of domestic violence and behaviour from the son, and me doing it to the son [service user]... but also swapping that role round, so I'd be talking to mum, [case manager] would be talking to [the son], just to get that kind of extra opinion and influence into a situation.

I: And did that change the way that you saw the situation?

R: It did, yes it did. I think for me as an individual worker... I can't speak for the other people in my service, but certainly as an individual worker, you kind of get used to blurring the boundaries and trying to engage with families whose behaviour may not be the norm shall we say. So, to have somebody say well actually you know this is abuse, this isn't correct, you know you shouldn't be... and whilst I know that and I'm sure my colleagues know that, it's so difficult to engage with some people that you're making allowances, aren't you? So, having somebody from the project kind of spelling it out... especially to [service user], [service user]'s mum – spelling out that this behaviour isn't acceptable, and she shouldn't be living her life with this kind of constant anxiety around [service user]'s behaviour and his outbursts (Social work practitioner).

¹⁵ It should also be noted that such focus on perpetrators in work involving children was recommended in the recent JTAI report: Ofsted, Care Quality Commission (CQC), HMI Constabulary and Fire & Rescue Services (HMICFRS), and HMI Probation (HMIP) (2017) *The multi-agency response to children living with domestic abuse*, No. 170036.

In this case, the service user had been regarded as 'difficult to engage' by professionals due to his mental health condition, waking hours and reluctance to trust others.

The case manager acted both as advocate for the victim – helping the social worker to recognise the abuse as such and act accordingly – and as a support for the social worker by enabling an intensity of engagement that would not otherwise have been possible. This was institutional advocacy – with one agency challenging and changing practices and perceptions at a front-line level by helping to meet a need in the absence of more comprehensive provision.

Step-down work

As indicated earlier, Drive cases commonly remained open after the 10-month allocated time, and there were a considerable number of actions within this period. While step-down work was delivered with differing levels of intensity and formality across the three sites, the need for some type of lower intensity casework post 10-month intervention came through strongly in practitioner interviews. Step-down work was carried out for several reasons:

- Some service users simply take a long time to engage. In some cases, it was only as the case was coming to a close that engagement was really flourishing. In these cases, step-down was used as way of opening some flexibility around the length of the intervention.
- For high-engaging service users, the step-down window was used simply as a space for a monthly 'check-in' phone call where service users could report on the impact of learning, success and challenges in sustaining changes made, and to get a second perspective on difficult life issues.
- While case closure plans for service users who had received a high degree of support during Drive does this to some extent anyway, step-down functioned as way of easing them into self-reliance more gradually.

CHANGE IN BEHAVIOUR OF DRIVE SERVICE USERS

Summary on the use of abusive behaviours:

- Service users who began the intervention causing high levels of DVA showed a major decrease in abusive behaviour, particularly in physical abuse, followed by harassment and stalking (H&S) and jealousy and controlling (J&C) behaviours.
- Drive had a greater impact on those who reported high severity of any of the DVA behaviours.
- Drive may be particularly equipped to work in settings where it is possible to mobilise additional pressure and incentive for service users to change via family members.
- There was a statistically significant (p -value <0.001) reduction in Drive-DASH scores for service users from intake to case closure.
- Behaviour-change sessions by case managers were consistently associated with a reduction in all four DVA behaviours: physical abuse, sexual abuse, harassment and stalking and jealous and controlling behaviours.
- Service users who partially engaged with case managers showed the greatest reduction in physical abuse, sexual abuse and jealous and controlling behaviours from intake to case closure. Service users who were fully engaged showed the greatest reduction in harassment and stalking behaviours from intake to case closure.
- The majority of the service users interviewed in Years 1 to 3 reported changes in their thought processes, with improvements in their impulse control being the most common of these. Other service users reported feeling happier and abstaining from drugs and alcohol. Many of those interviewed reported positive changes in their relationships, including with their partner, children, wider family and colleagues.

Summary of victim-survivor experiences of abusive behaviour:

- Positive changes in DVA behaviours reported by case managers were echoed by victims-survivors and IDVAs.
- A statistically significant reduction was observed for all DVA behaviours reported by both Drive victims-survivors and control victims-survivors from intake to exit. The reduction in DVA behaviours reported by the Drive arm was higher for physical abuse, harassment and stalking and jealous and controlling behaviours than the reductions reported by the control victims-survivors.
- In terms of DVA severity, Drive victims-survivors and control victims-survivors showed similar trends in reduction, however, a higher reduction in the severity of some DVA behaviours was observed for Drive victims-survivors compared to control victims-survivors.
- Reduction in DVA behaviours reported by victims-survivors in the Drive arm was 8% greater for physical abuse, 9% for harassment and stalking and 4% for jealous and controlling behaviours than the reductions reported by the control group.
- Victims-survivors who were living together with the perpetrator compared with those not living together were more likely to show a reduction in the severity of H&S (OR=0.49, 95% CI: 0.29-0.83, p -value=0.01). Victims-survivors of service users who had Children and Young People's Services (CYPS) involvement compared with those without were more likely to have greater odds of high severity of harassment and stalking (OR=1.71, 95% CI: 1.23-2.39, p -value= <0.001).
- Those victims-survivors who were family members were more likely to report a greater reduction in high jealous and controlling behaviours than those who were current intimate partners.

Summary of victim-survivor experiences of risk reduction and safety:

- Consistent with the Year 2 evaluation report, IDVAs perceived that risk was permanently eliminated for a higher proportion of Drive victims-survivors than for control victims-survivors.
- According to IDVAs, there was reduction in risk for both Drive and control victims-survivors, with a greater reduction in risk for Drive victims-survivors.
- Drive victims-survivors talked about feeling safer and seemingly having more 'space for action' as a result of Drive.

Summary of reductions in repeat and serial cases presenting at MARAC:

- MARAC data showed considerable reduction in repeat appearance by service users during Drive, which continued in the 12 months post-Drive.
- Drive helped to reduce high risk, high harm perpetration, including by serial perpetrators, and this was sustained for a year after the cases were closed.
- MARAC control cases appeared slightly more frequently in MARAC (mean= 3.3 times) than those perpetrators who were allocated to Drive (mean=2.7 times). This difference was statistically significant ($p<0.001$).
- Serial perpetrators in the control group appeared more times in MARAC (mean=1.5 times) than serial perpetrators who were allocated to Drive (mean=0.8 times). This difference was statistically significant ($p<0.001$).

Summary of police DVA incident recording:

- Drive service users showed a greater reduction in both DV-related and non-DV incidents recorded by the police than the control perpetrators during and up to 12 months following the Drive intervention period.
- The percentage of Drive service users recorded by the police as committing DV-related incidents was greatly reduced during and after the Drive intervention in comparison with those in the control group. Moreover, Drive service users were able to sustain the reduction in DV-related incidents 12 months after case closure (13 to 30 months), whereas the percentage of control cases with DV-related incidents increased after more than 12 months post-Drive.

Charting behaviour change

In this chapter we look at changes in service user behaviour resulting from Drive as shown by the quantitative outcome analysis. To do so we look at possible changes from intake to completion of Drive and assess whether service user needs or other factors such as involvement with the criminal justice system had an association with changes in behaviour. We also compare any behaviour changes by service users with those reported to IDVAs by the associated victims-survivors, and by victims-survivors in the control group.

We also look at whether any change is sustained in the longer term, post-completion, using MARAC and police data.

Where appropriate we also use the more detailed insights from interviews to contextualise and help to explain the quantitative findings.

Change in service users' use of DVA behaviours – data from the Drive case management system

Overall, as we show in the different sections below, Drive was more effective in reducing DVA behaviours for those service users who reported high severity of physical abuse, H&S and J&C behaviour.

Reducing DVA behaviours across the Drive intervention

Based on data from the Drive case management system, Figure 10 shows the percentages of service users displaying abusive behaviours at different points in time during the Drive intervention: at intake, at mid-point and at completion of Drive. Figure 11 shows the change in severity for each of the types of DVA for those allocated to Drive. A major decrease in use of DVA was observed for those service users who reported high levels of DVA, in particular for physical abuse, followed by harassment and stalking (H&S) and jealousy and controlling (J&C) behaviours.

Figure 9 Percentages of SUs displaying abusive behaviours at different time points during Drive intervention (n=varies)

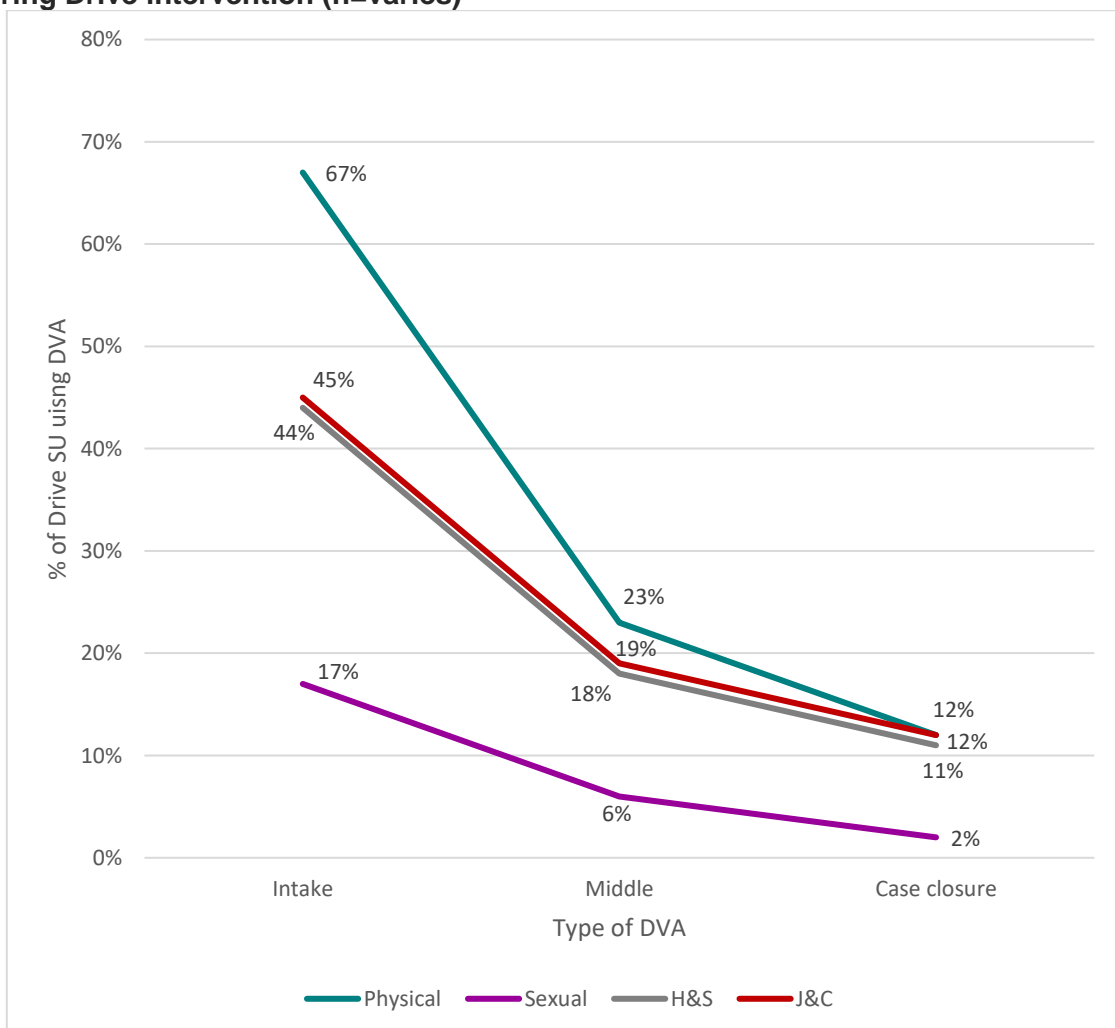
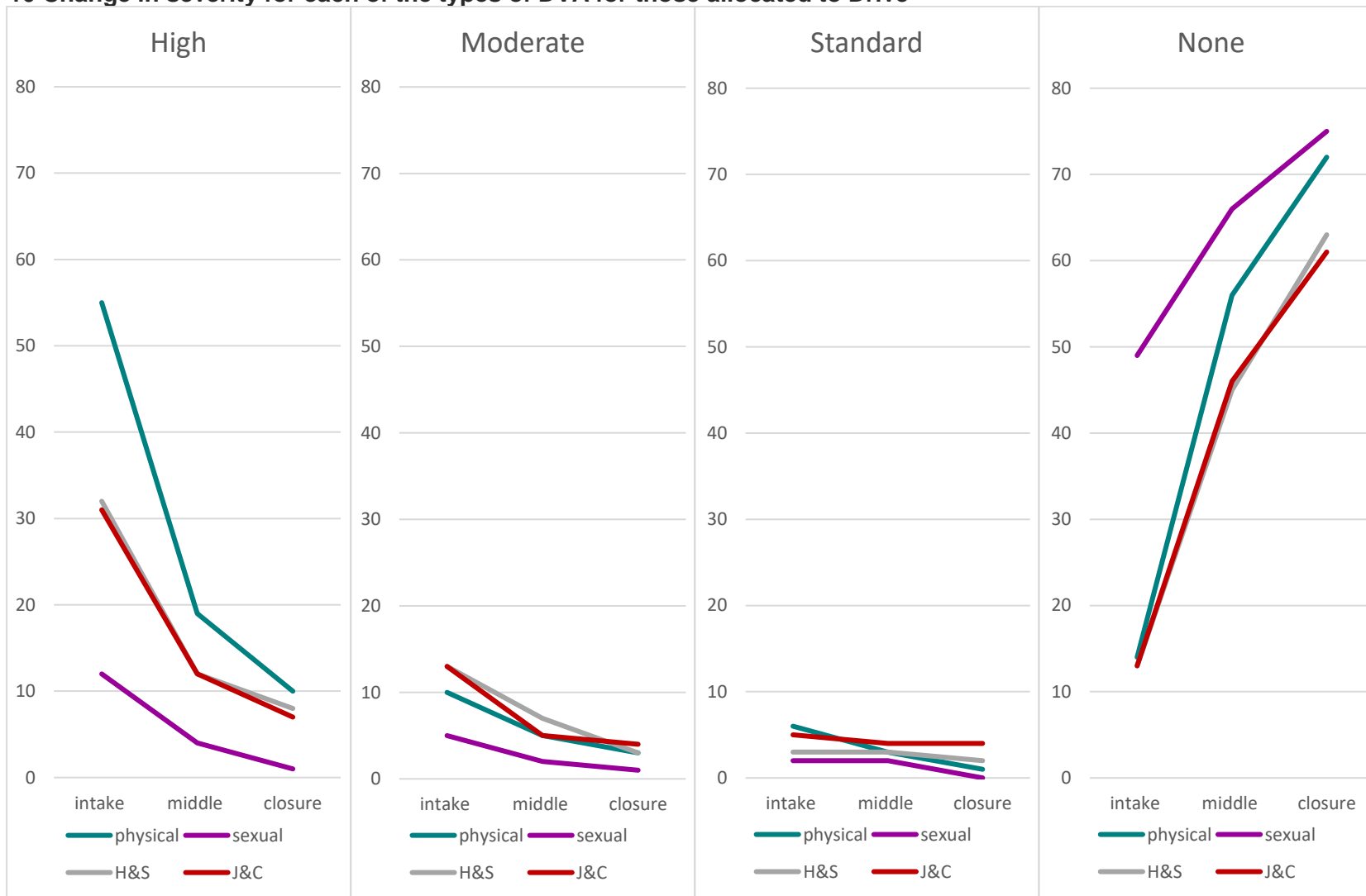
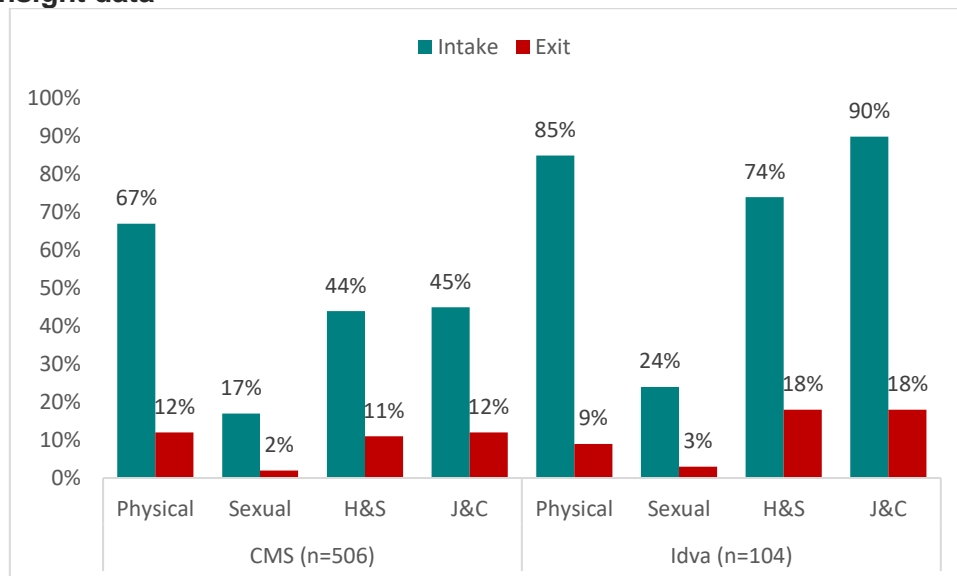


Figure 10 Change in severity for each of the types of DVA for those allocated to Drive



When comparing service users' use of DVA behaviours as recorded by case managers with the experiences of DVA as recorded by IDVAs, the patterns are similar with regards to reductions in the use of DVA. However, the victim-survivor data showed a greater level of DVA, especially at intake (Figure 12). This could be in part due to the differences in sample size, but it is also likely to be due to differences in reporting behaviours from victims-survivors and reporting from service users. The victim-survivor may tell the IDVA more information when they meet, and this may take place after the case manager has carried out their first risk assessment with the service user.

Figure 11 Proportion of SU DVA behaviours from the case managers system and from IDVA's Insight data



Behaviour change by Drive service users over time

We assessed whether any of the following factors (all recorded by case managers) might have made a difference: time point, age, living arrangements, victim/perpetrator relationship status, being contacted or not by case managers, DVA charges being brought, Children and Young People's Services (CYPS) and/or criminal and civil justice (CCJ) involvement.

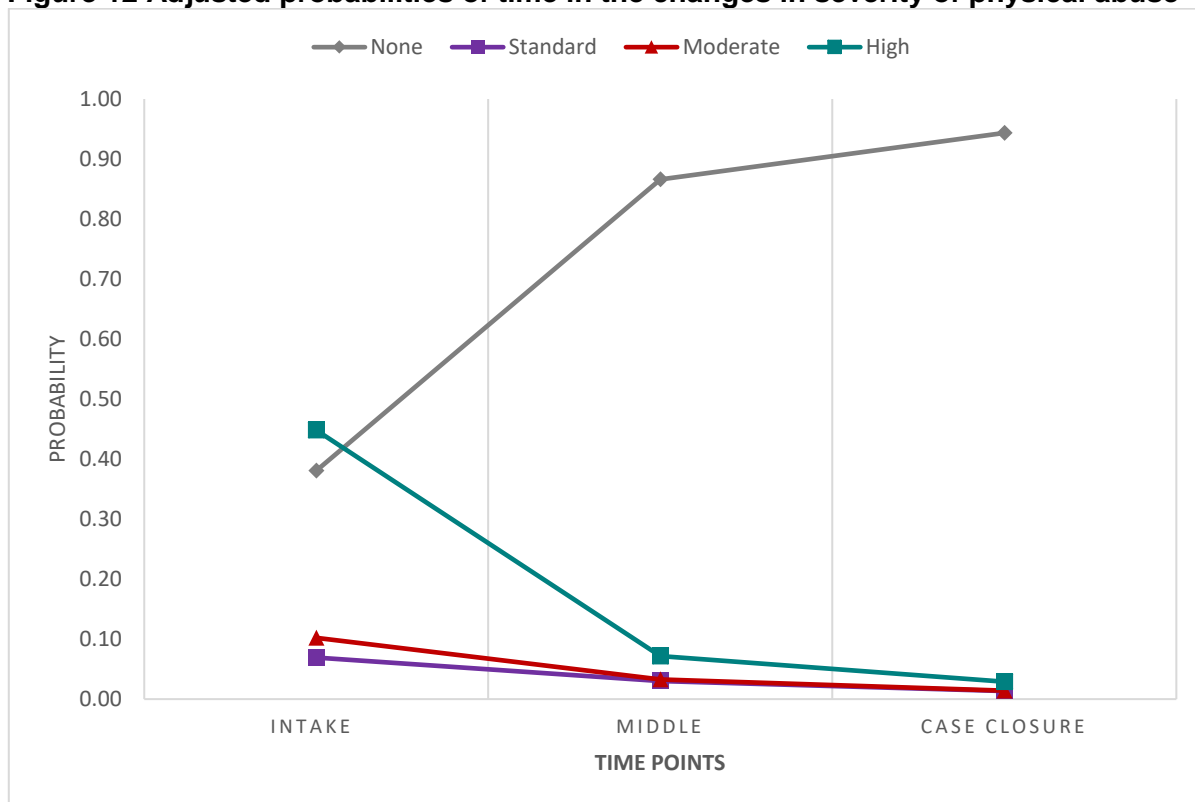
Four pooled ordered logistic regressions were run for each of the DVA behaviours (physical, sexual, H&S and J&C) (see detailed statistical methodology in Appendix 3, Section 2). To have a robust assessment of whether the behaviour change could be attributable to Drive, it was important to include all the aforementioned variables in the models at the same time. The results presented below are the overall effect that these factors had on each of the DVA behaviours for all service users over the duration of Drive¹⁶.

¹⁶ Case managers assess DVA behaviour from a variety of sources including service user, from victim-survivor (through IDVA support) and other information from multi-agency partners such as police, children's social services, probation etc.

Physical abuse

Figure 13 shows that high levels of physical abuse by service users reduced considerably by mid-point and further by the end of Drive. The probability of high levels of physical abuse by service users was 45% at intake but reduced to around 7% at midpoint and to around 3% at case closure. Conversely, the probability of no physical abuse started at 38% by intake and increased to around 87% at midpoint and further up to 94% at case closure.

Figure 12 Adjusted probabilities of time in the changes in severity of physical abuse



CCJ involvement at intake was associated with an increase in physical abuse (Figure 14), with service users who had CCJ involvement more likely to have a higher probability of standard, moderate and high physical-abuse behaviour than those who did not have CCJ involvement. We would expect this result, ie that service users using physical abuse would be more likely to have some CCJ involvement. This also reflects the emphasis on violent offences by the criminal justice system and the fact that physical abuse is more visible to police and criminal courts.

Figure 14 Adjusted probabilities of CCJ involvement on the changes in severity of physical abuse



Current relationship status between the service user and associated victim-survivor were found to affect the severity of physical abuse to different extents. Where the service user and victim-survivor were family members there was likely to be a greater reduction in high physical abuse (to 7%) than with those who were ex-intimate partners (to 10%) or current partners (only to 15%). A similar pattern was observed for those service users using moderate and standard levels of physical abuse against victims-survivors (see Figure 15).

Case analysis and interviews with practitioners across Years 1 to 3 reflect these results. Interviews indicated the ability of Drive to work effectively with service users whose primary victim was a family member – especially so in cases of child-to-parent abuse where case managers often worked with the whole family to call the service user to account. The outcome data analysis here suggests, in line with these qualitative findings, that Drive may be particularly well equipped to work in settings where it is possible to mobilise additional pressure and incentives for service users to change via family members, as well as having the opportunity for service users to try out the new ways of relating they are learning through one-to-one behavioural-change work (see earlier chapter on intervention including direct work with service users).

Figure 13 Adjusted probabilities of victim-perpetrator relationship status on the changes in severity of physical abuse



Sexual abuse

In the statistical model for sexual abuse, the time point was the only significant factor that affected changes in severity of sexual abuse during Drive (ie there was a slight reduction). Because very few service users reported sexual abuse, very few observations were included in the model. Therefore, the effects are very small and hard to see in the graph (see Appendix 4, Figure A4.1). It should be noted that sexual violence was underreported compared with what we might expect (ONS, 2018).

In Table 8 the changes in probability estimates are shown. Although there is a small reduction in the probability of standard, moderate and high sexual abuse over time this is very small and not statistically significant. With regard to no sexual abuse ('none') this increased over time and was statistically significant by case closure (p-values=0.001).

Table 8 Probability changes of severity of sexual violence by different time points

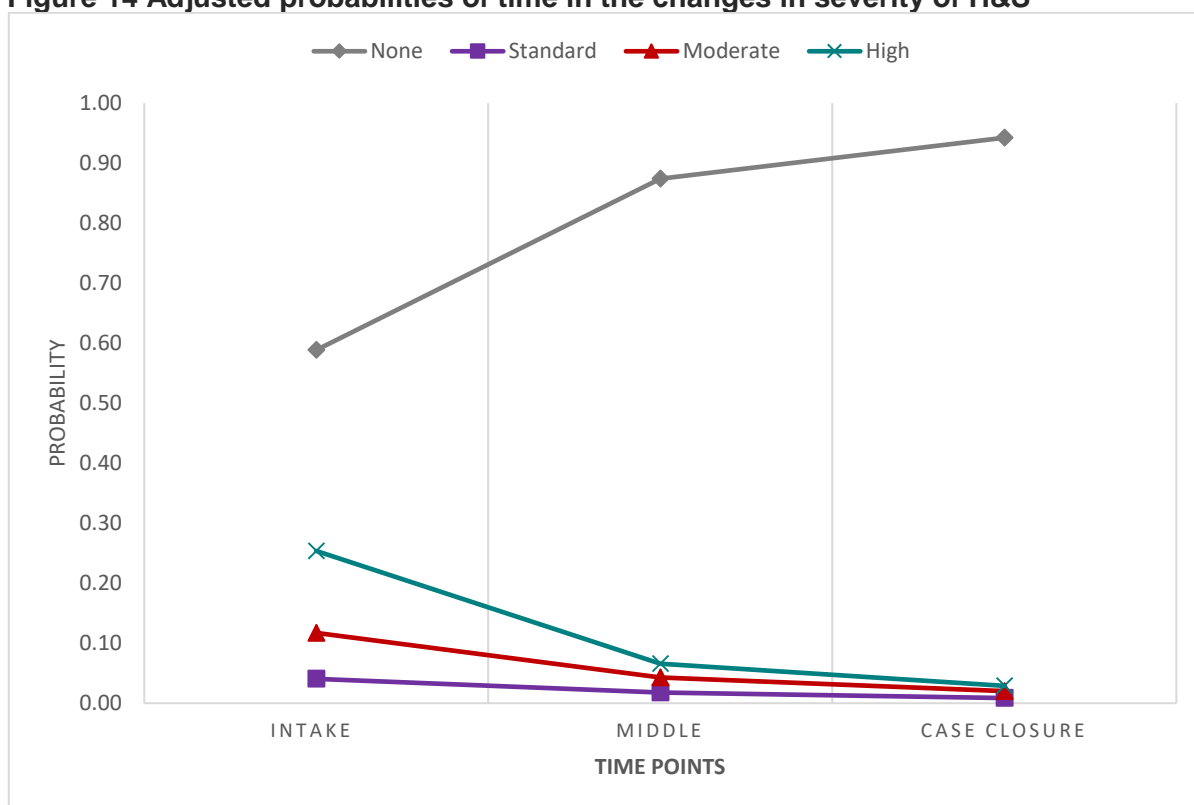
	Probability	Std. Err.	P-value	95% CI	
None-Intake	0.97	2.10	0.64	-3.14	5.07
None-Middle	0.99	0.53	0.06	-0.04	2.03
None-Case closure	1.00	0.04	0.001	0.92	1.08
Standard- Intake	0.01	0.67	0.99	-1.31	1.33
Standard-Middle	0.003	0.18	0.99	-0.34	0.35
Standard-Case closure	0.0002	0.01	0.99	-0.03	0.03

Moderate- Intake	0.01	0.47	0.99	-0.91	0.93
Moderate-Middle	0.002	0.12	0.99	-0.23	0.23
Moderate-Case closure	0.0001	0.01	0.99	-0.02	0.02
High-Intake	0.01	0.95	0.99	-1.86	1.89
High-Middle	0.004	0.23	0.99	-0.45	0.46
High-Case closure	0.0003	0.02	0.99	-0.04	0.04

Harassment and Stalking

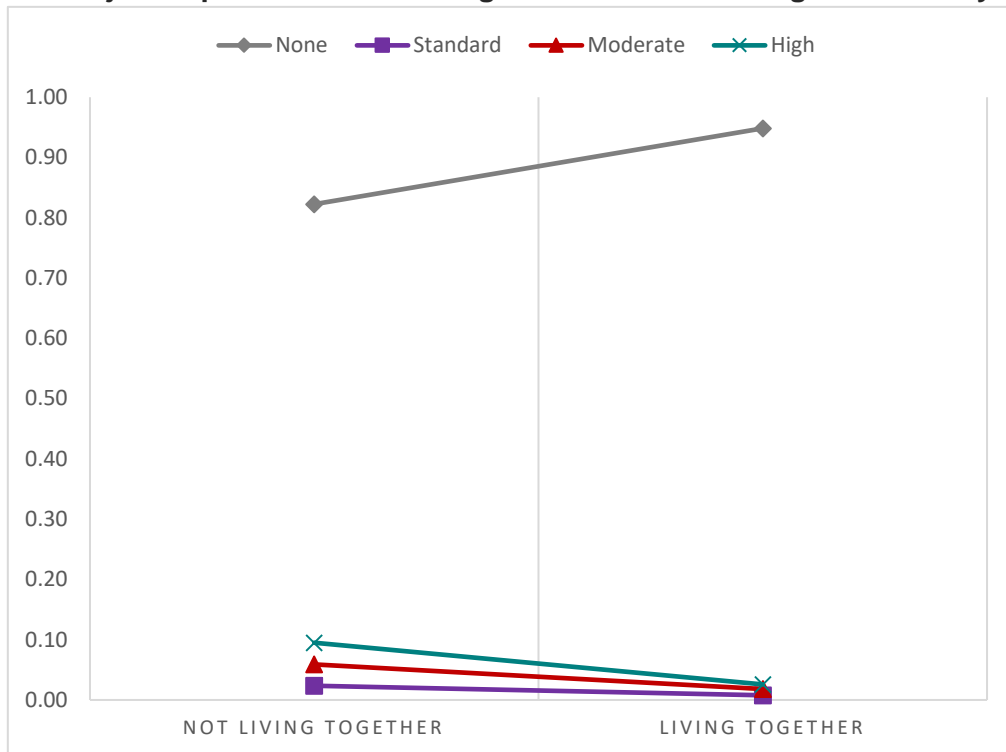
There was a reduction in moderate and high severity of H&S over time (see Figure 16) from 12% at intake, to 4% at midpoint and 2% at case closure. Conversely, the probability of no H&S was 58% at intake and increased to around 87% at midpoint, to end up at around 94% at case closure.

Figure 14 Adjusted probabilities of time in the changes in severity of H&S



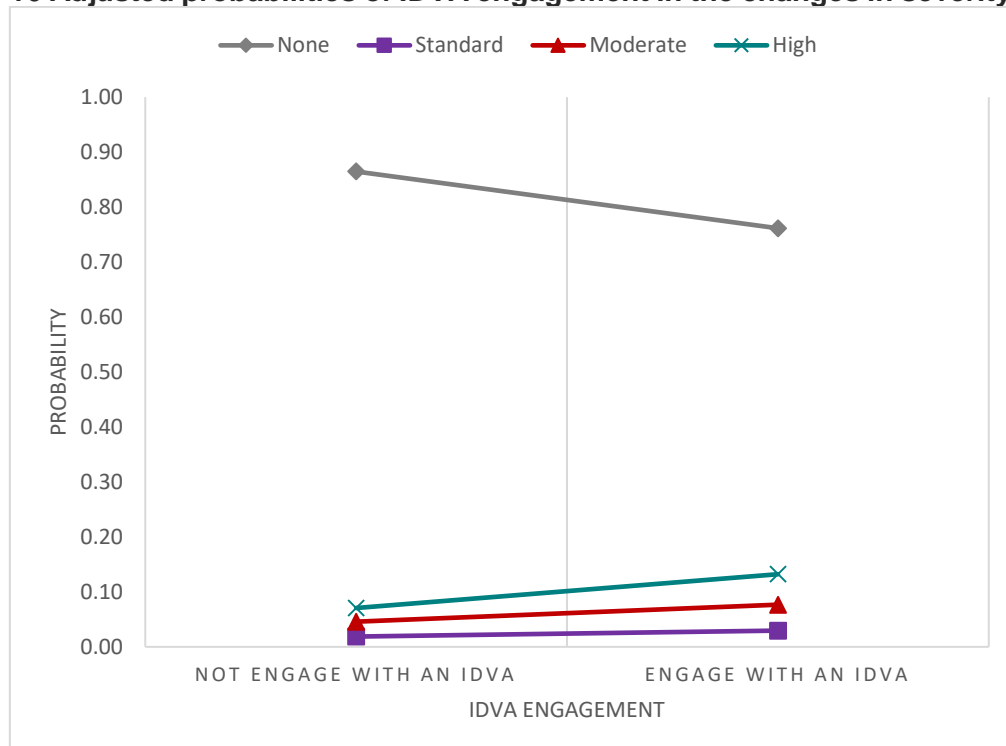
Service users who were living together with the victim-survivor were likely to see a greater decrease in high H&S compared with those not living together (9% and 3% respectively) (Figure 17). A similar pattern but smaller effect was observed for moderate (6% and 9%) and standard (2% and 1%) H&S. This may indicate that victims-survivors are more likely to stay if such abuse decreases and we know from other research that abusers are likely to increase their DVA, especially H&S, when victims-survivors leave the relationship (Radford and Hester, 2006).

Figure 15 Adjusted probabilities of living situation in the changes in severity of H&S



Service users whose victims-survivors engaged with an IDVA had higher probabilities of high, moderate and standard H&S than those who did not engage with the IDVA (see Figure 18). This may indicate that victims-survivors are especially likely to seek help when they experience H&S, but also that case managers will have more information available when an IDVA is involved.

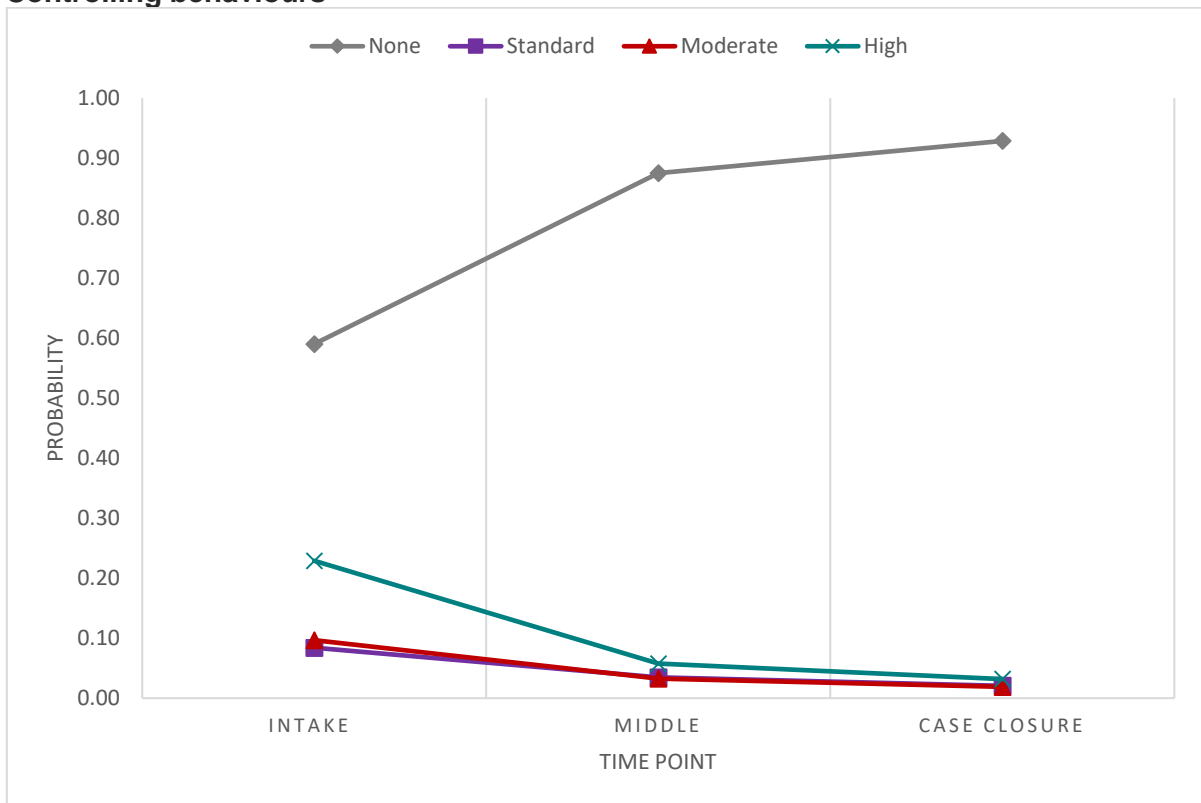
Figure 16 Adjusted probabilities of IDVA engagement in the changes in severity of H&S



Jealous & controlling behaviours

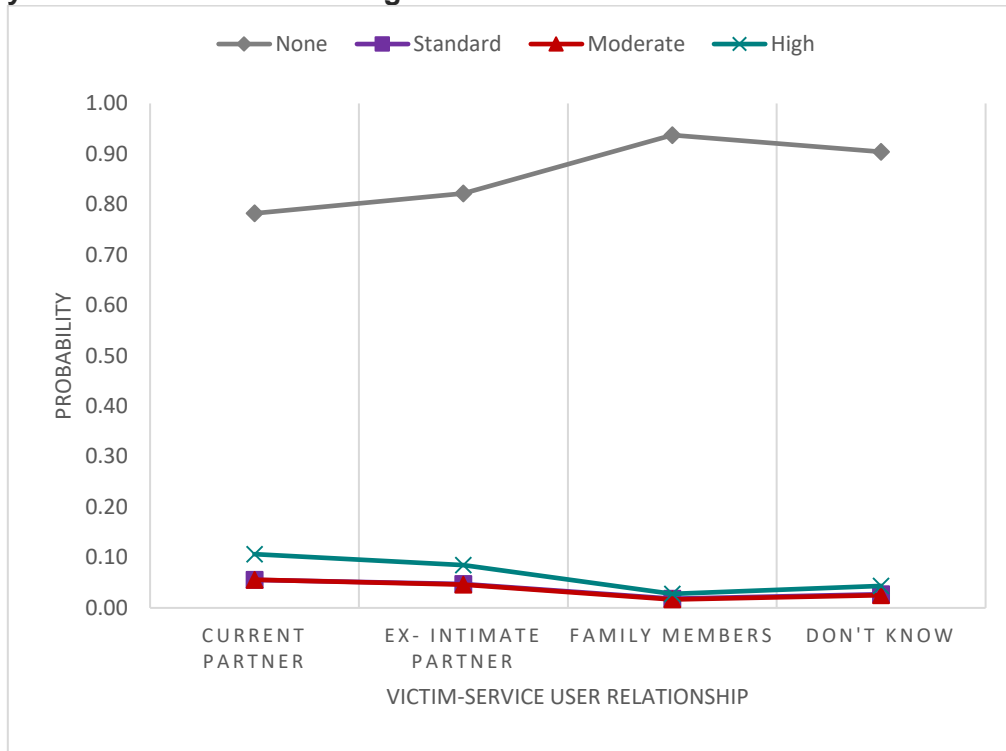
There was a reduction in standard, moderate and high levels of J&C behaviours by service users over time (Figure 19). Those with high J&C were more likely to show a greater reduction from intake to case closure (23% to 3%) than those with moderate (10% to 2%) and standard (8% to 2%) J&C.

Figure 17 Adjusted probabilities of time in the changes in severity of Jealous and Controlling behaviours



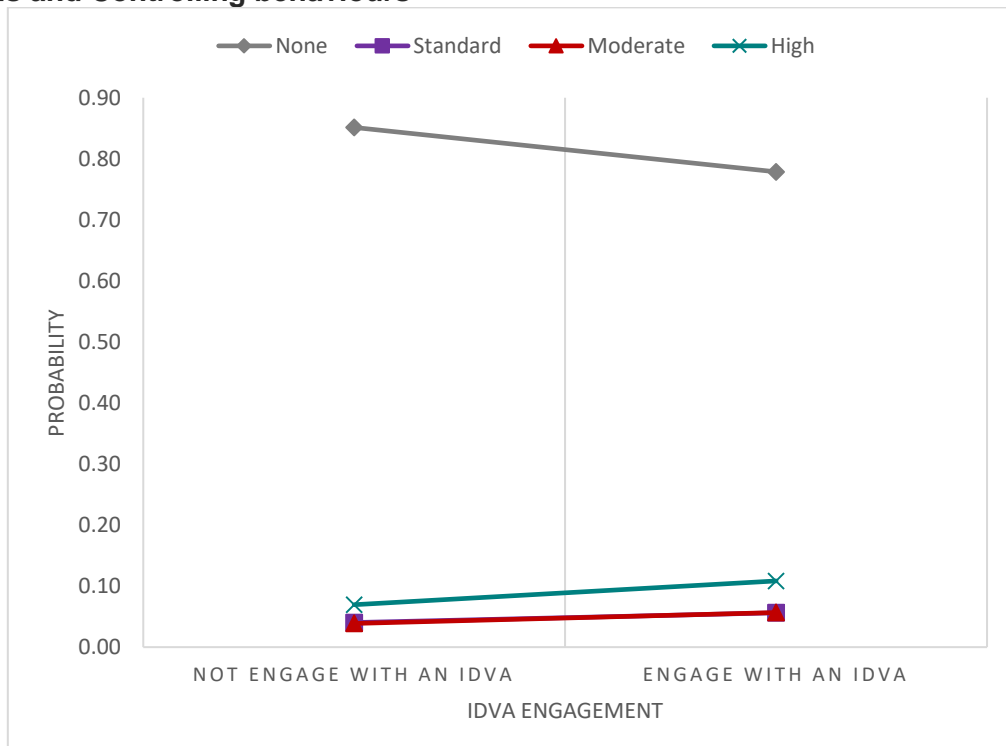
Relationship status between the perpetrator and victim-survivor also affected changes in the severity of J&C, and in a similar way to changes in physical abuse. Those service users and victims-survivors who were family members were more likely to show a greater reduction in high J&C (3%) than those who were current intimate partners (11%) or ex-intimate partners (8%). Similar patterns were observed for those showing moderate and standard J&C (Figure 20).

Figure 18 Adjusted probabilities of service user relationship status in the changes in severity of Jealous and Controlling behaviours



Again, as in the case of physical abuse, service users whose victim-survivor engaged with an IDVA had higher probabilities of high, moderate and standard J&C than those who did not engage with the IDVA (Figure 21). This may also reflect the fact that when victims-survivors engage with IDVAs more information is available.

Figure 19 Adjusted probabilities of IDVA engagement in the changes in severity of Jealous and Controlling behaviours



Case Managers' Perception of Change in Risk from Service Users

Drive-DASH (Domestic Abuse, Stalking and 'Honour'-Based Violence) Risk Assessment Scores¹⁷

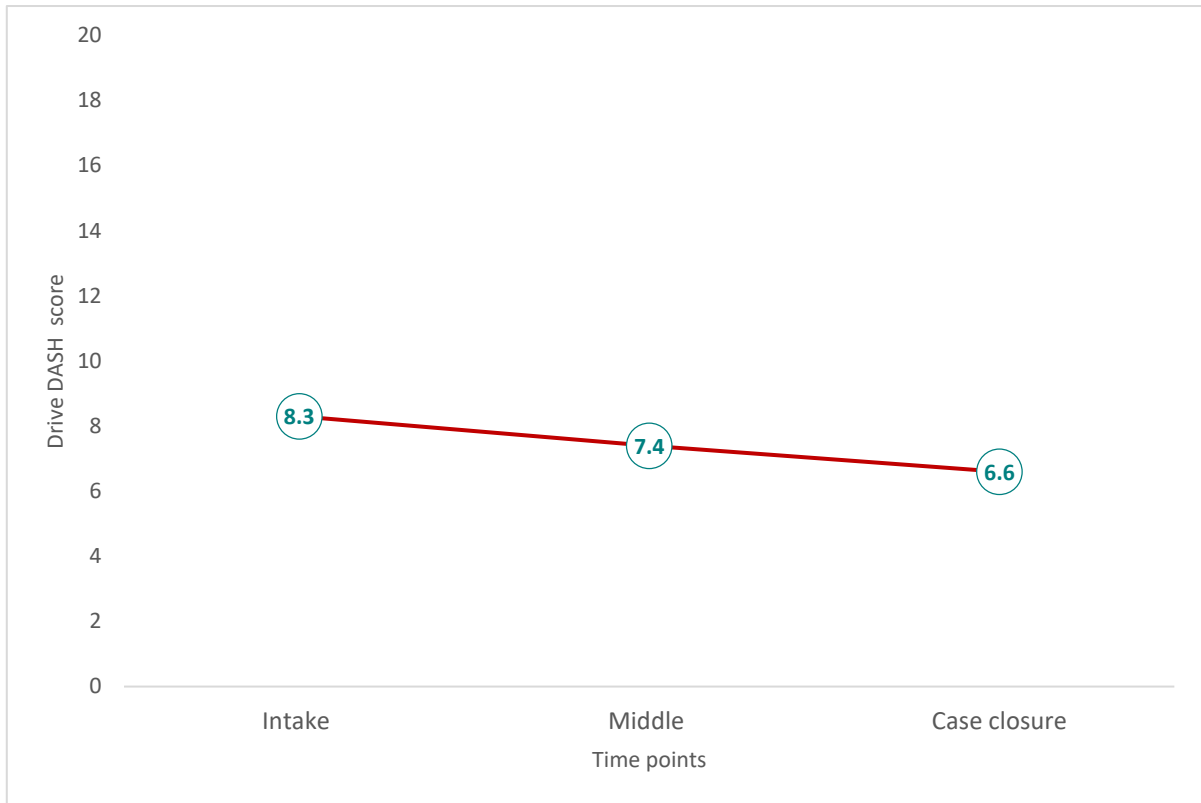
The Drive case managers used the Drive-DASH risk indicator checklist as a basic indicator of the risk of significant harm from further DVA posed to the victim-survivor. The Drive-DASH is adapted from DASH, but has a few key differences – for example, while the DASH is completed by victims-survivors, the Drive-DASH is completed by the case manager based on any available information, including information from service users, police, IDVAs, etc. The case manager fills out the Drive-DASH to the best of their knowledge, enabling them to sift through information provided and make assessments. The Drive-DASH helps to assess and create risk profiles, using the score as guidance and prompting the case manager to think about risk factors.

Case managers completed the Drive-DASH at intake, midpoint and case closure. The number of questions on the Drive-DASH was reduced between Year 1 and Year 2, remaining consistent for Year 3. After matching questions as closely as possible, 20 questions were included in the analysis we present here. A total of 503 service users had completed Drive-DASH scores across the three time points. For each time point the “yes” responses were totalled to construct the Drive-DASH score (ranging from 0 to 20, the higher the number the higher the risk).

Nonetheless, there were a significant amount of “not applicable/not known” responses across time points. Although a decrease in “not applicable/not known” responses from intake to case closure was observed, 49% of service users had 11 or more “not applicable/not known” responses in their score and therefore were not included in the analysis (23% intake, 14% midpoint and 12% case closure). Figure 22 graphically shows the average Drive-DASH score at intake, middle and case closure.

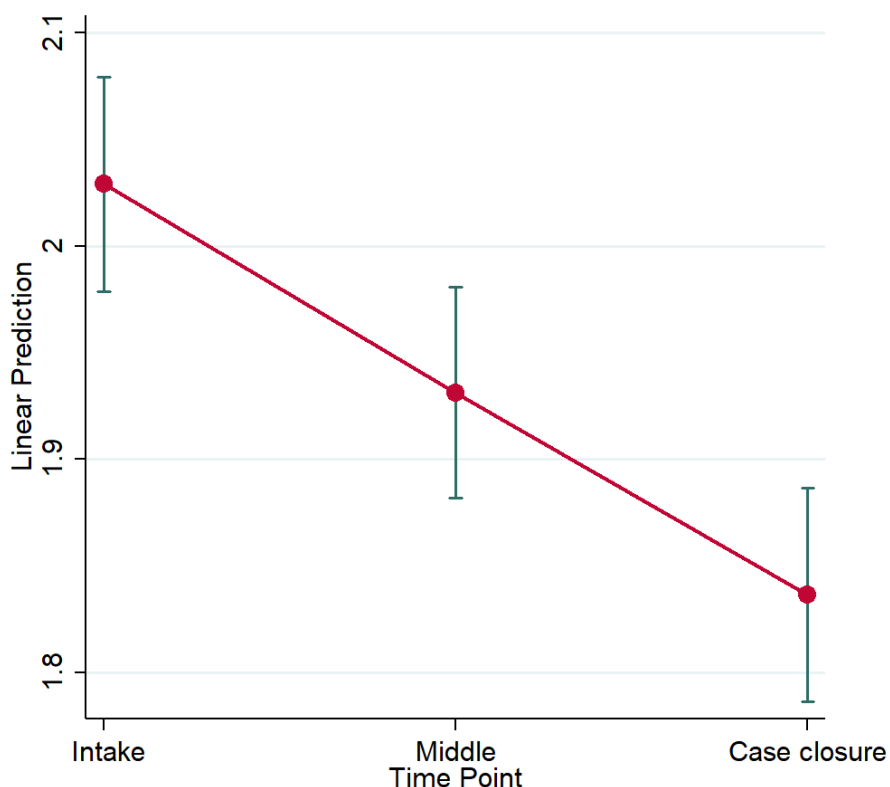
¹⁷ The Drive-DASH tool was created to assist frontline staff working with perpetrators and victims-survivors of DVA, assessing the level of risk posed to the victim-survivor. It is separate to the Domestic Abuse, Stalking and Harassment and Honour-based violence risk (DASH) identification tool and scoring is not comparable.

Figure 20 Change in service users' Drive-DASH scores during the Drive intervention (n=varies)



To assess whether the reduction in risk score was statistically significant a random effect Poisson regression was conducted. Results indicated that the reduction in Drive-DASH scores for service users from intake to case closure was statistically significant (p -value <0.001) (Figure 23).

Figure 21 Linear prediction of Drive-DASH score over time (n=469)¹⁸



Direct work by case managers and impacts on service users' behaviour

It was also important to ascertain quantitatively whether types of intervention with service users had an impact on their behaviour. We therefore assessed what type of direct work action (ie maintaining and sustaining contact, direct support and behaviour change) was associated with the reduction of DVA behaviours during the Drive intervention. In order to explore this, four unadjusted pooled ordered logistic regressions were run.

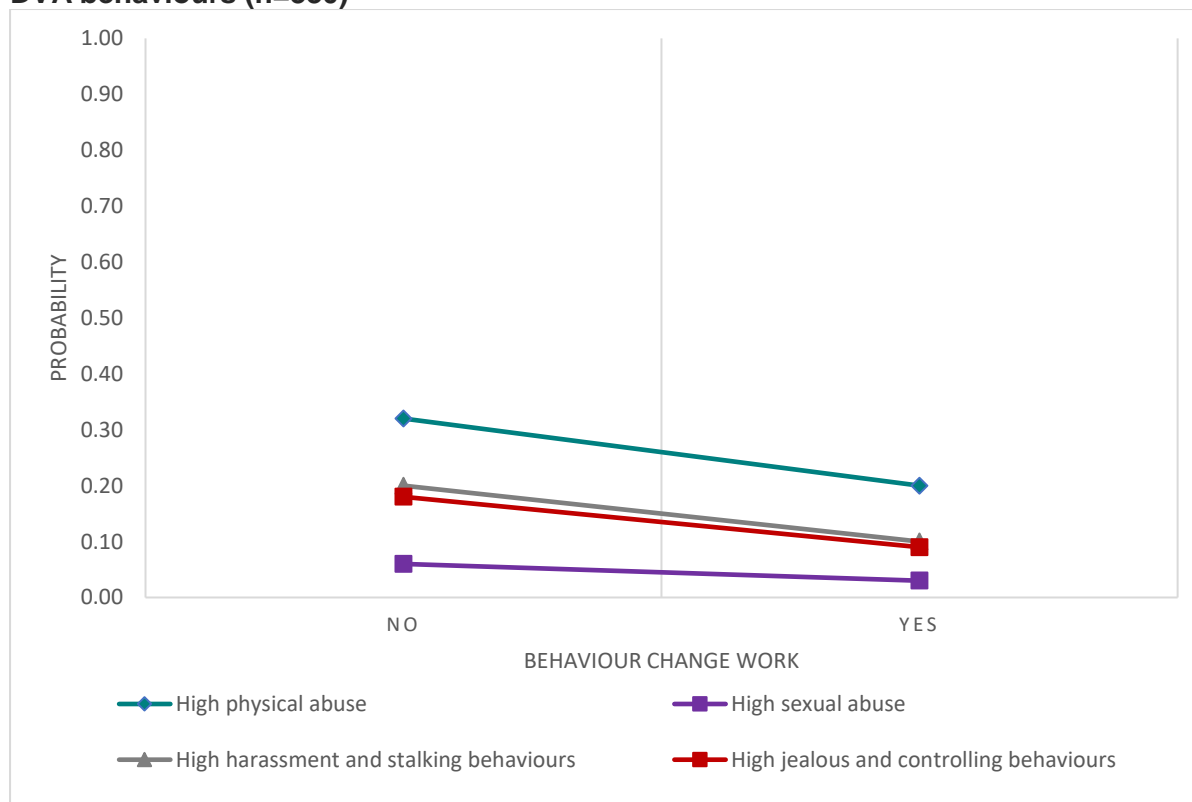
We also explored whether other variables could influence the association between the type of direct work and DVA, therefore the four models were run again, this time controlling for living situation (whether the service user and victim-survivor were living together or not) and the service user's age.

As detailed earlier in this chapter, high severity of DVA was the category that showed the greatest change in service user behaviour. We therefore only present regression results for this category below (results for the other severity categories, ie standard and moderate, can be found in Appendix 4, Section 2). Results suggested that behaviour-change sessions by case managers were consistently associated with a reduction in all four DVA behaviours,

¹⁸ This is the model that results when those who responded to 11 or more DASH question as n/a or don't know are removed. This shows a better result, but we lose sample size.

namely physical abuse, sexual abuse, H&S and J&C. As shown in Figure 24, those service users who received one or more behaviour-change sessions were more likely to reduce a high severity of DVA behaviours than those service users who did not receive such sessions. However, when we adjusted for living situation and the service user's age, behaviour-change work was only associated with H&S.

Figure 22 Adjusted probability of behaviour change work in changes in high severity of DVA behaviours (n=330)



While 'Maintaining and sustaining contact' was the most prevalent direct work action, results from the unadjusted model showed that this action had the opposite effect on high physical violence and J&C trends over time. That is, those service users who were subject to 'maintaining and sustaining contact' were less likely to reduce a high severity of physical violence and J&C behaviours than those service users who were not subject to this type of work. When adjusting for living situation and age no associations were found between 'Maintaining and sustaining contact' and any DVA behaviours.

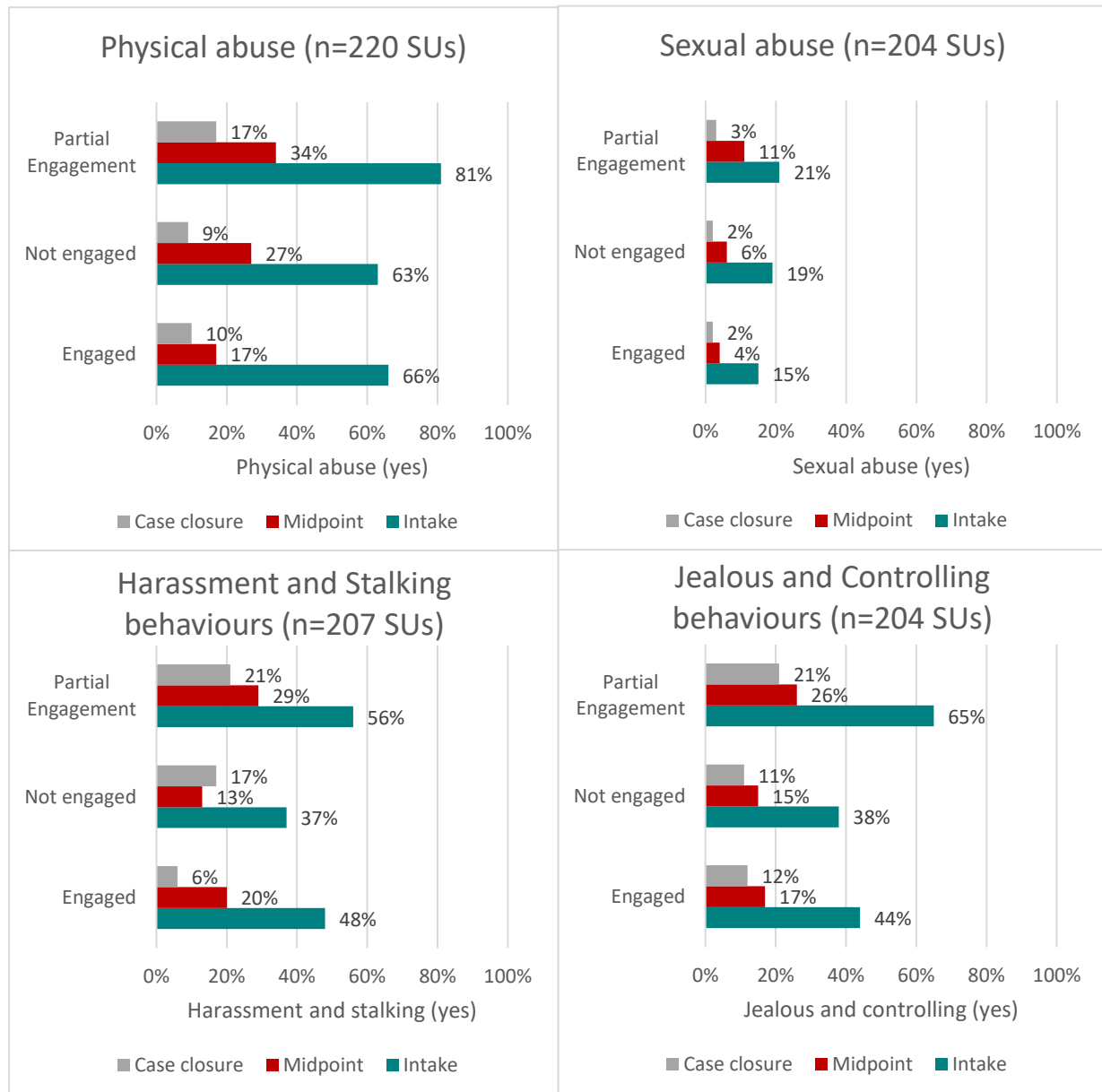
Finally, those service users who received one or more 'direct support' actions from the case managers were more likely to reduce high physical violence than those who did not receive direct support. This finding changed when adjusting for living situation, showing that direct support could increase physical violence. The other DVA behaviours showed no association with 'direct support' in the adjusted model.

Engagement with case managers

Level of engagement with case managers was measured for those service users who were worked with directly by case managers. Out of those with direct work, 54% engaged with case

managers, 31% did not engage and 15% were partially engaged. In terms of behaviour change, those service users who partially engaged with case managers were the ones who showed the greatest reduction in physical abuse, sexual abuse and J&C behaviours from intake to case closure. However, those service users who were fully engaged showed the greatest reduction in H&S behaviours from intake to case closure (Figure 25).

Figure 23 Prevalence of DVA behaviours at intake, midpoint and case closure by engagement type



Why and How Did Service Users Change their Behaviour?

The majority of the service users interviewed in Years 1 to 3 reported changes in their thought processes, with improvements in their impulse control being the most common of these. Service users commonly reported improvements in their ability to reason when stressed, to

hear criticism and having a 'different outlook on life.' For some, this was as stark as no longer being suicidal – for instance, 4 of the 16 interviewed in Year 2 reported feeling suicidal at the start of Drive. Other service users reported feeling happier and abstaining from drugs and alcohol. Many of those interviewed reported positive changes in their relationships, including with their partner, children, wider family and colleagues. Some also reported reduced fear of group or social interaction. Although less common in the interviews, some service users also recognised the impact of abuse on their partner and/or children. For more detail on the intricacies of what case managers did with service users see the 'direct work' (in chapter on interventions); for the intersection of direct work, indirect work and multi-agency work, see the analysis of Drive case notes (in chapter on Drive case note analysis).

Change in the behaviour of Drive service users according to victims-survivors

Positive changes in DVA behaviours reported by case managers were echoed by victims-survivors and IDVAs.

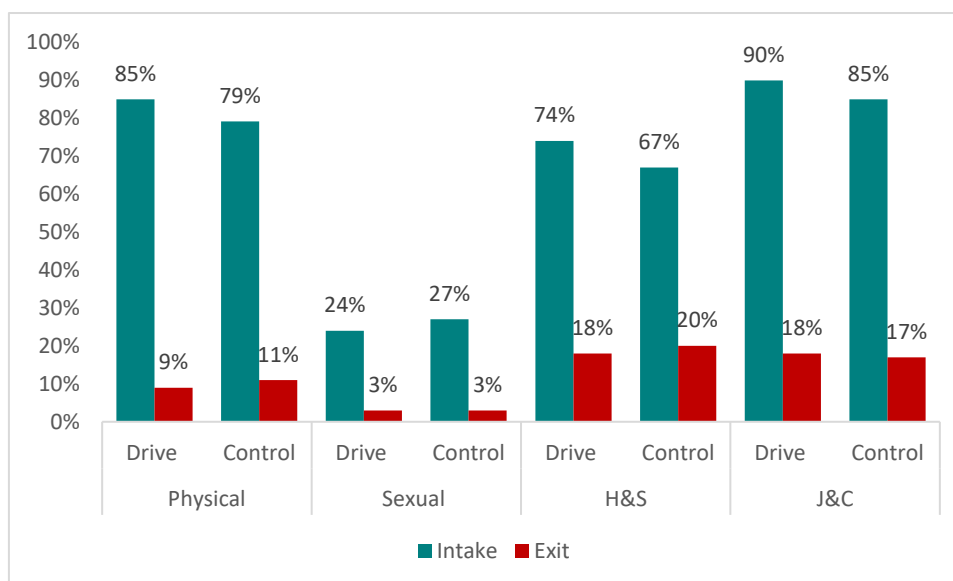
To ascertain whether Drive made a greater difference to victims-survivors than no intervention by Drive, we compared changes in DVA behaviours reported by victims-survivors (via IDVAs) whose perpetrator was receiving Drive and DVA behaviours reported by victims-survivors (via IDVAs) whose perpetrator was not receiving Drive (the control group). It should be noted, however, that using the IDVA data to assess the effectiveness of Drive has limitations as not all victims-survivors engaged with an IDVA, and due to the randomisation process there were fewer victims-survivors in the Drive victims-survivors sample than in the control victims-survivors sample. Also, not all IDVAs sent their forms, meaning the sample is based on a smaller number than the overall number of victims-survivors that engaged with an IDVA. Nonetheless, using IDVA data was the most robust and viable option to obtain data regarding DVA behaviours experienced for either group of victims-survivors.

When comparing the Drive victims-survivors with control victims-survivors, similar trends are observed for both groups (see Figure 26). A McNemar's test¹⁹ was used to make sure that the difference in proportions from intake to exit were statistically significant. The tests were run separately for each type of DVA and for each group (Drive victims-survivors and control victims-survivors). Results showed that changes in proportions from intake to exit were statistically significant.

Although the trends are similar for the Drive and control groups, the reduction in DVA behaviours for the Drive victims-survivors arm was 8% higher for physical abuse, 9% for H&S and 4% for J&C than the reductions in the control victims-survivors group. The exception was for sexual abuse for which the control group show a slightly greater reduction.

¹⁹ McNemar's test is a non-parametric test applying only to dichotomous data.

Figure 24 Changes in proportion of DVA behaviours between Drive victim-survivor and Control victim-survivor



In terms of DVA severity, again, the Drive victim-survivor group and control victim-survivor group showed very similar trends in the four severity categories (see Appendix 3, Figure 2). However, a higher reduction in the severity of some DVA behaviours was observed for the Drive victim-survivor group than for the control victim-survivor group. For instance, in the high severity category, the Drive victim-survivor group showed a 10% greater reduction in H&S and 8% greater reduction in J&C than the control victim-survivor group. For the moderate category, the Drive victim-survivor group showed a 6% greater reduction in physical abuse. For the standard category, the Drive victim-survivor group showed an increase of 2% in J&C while the control victim-survivor group showed a decrease of 2%. Finally, “None” prevalence (ie showing no further use of DVA behaviours) increased as expected across all behaviours and among both Drive and controls. Moreover, the Drive victim-survivor group showed a greater increase in those experiencing no further DVA behaviours than the control victim-survivor group for physical abuse (9% difference), for H&S (10% difference) and for J&C (4% difference).

Considering that the difference between groups did not appear to be very high in the descriptive analysis of DVA behaviours for the Drive victim-survivor group and Control victim-survivor group (Figure 24), it was important to assess whether these differences were statistically significant. Difference in Difference (DD) regression was used to ascertain statistical significance²⁰. As we wanted to assess whether the changes in DVA were due to Drive and not due to other factors, the DD regression was controlled for victim-perpetrator living arrangement, victim-perpetrator relationship status, perpetrator CCJ and CYPS involvement. Four regression models were run for each of the DVA behaviours (physical abuse, sexual abuse, H&S and J&C). Results indicated that the difference in changes of the four DVA behaviours from intake to exit were not statistically different between the Drive and

²⁰ Difference in Difference is an estimator used to assess the difference in average outcome in the intervention group (Drive victim-survivor group) before and after the intervention minus the difference in average outcome in the control group before and after treatment.

control victim-survivor groups as indicated by p-values (see regression results in Appendix 4, Section 1).

Consistent with the finding from the service-users-only analysis presented earlier, those victims-survivors who were living together with the perpetrator compared with those not living together were more likely to show a reduction in the severity of H&S (OR=0.49, 95% CI: 0.29-0.83, p-value=0.01). Victims-survivors of service users who had CYPs involvement compared with those without were more likely to show high severity of H&S (OR=1.71, 95% CI: 1.23-2.39, p-value=<0.001). Also, those victims-survivors who were family members were more likely to show a greater reduction in high J&C than those who were current intimate partners.

The Views of Victims-survivors – Did Service Users Change Their Behaviour?

The interviews with Drive-associated victims-survivors, across Years 1, 2 and 3, to some degree echoed the wider findings regarding trends in behaviour change identified by Drive case managers and IDVAs. Victims-survivors talked about feeling safer and seemingly having more ‘space for action.’ One victim-survivor who was in contact with her ex-partner because of the children thought Drive was a ‘*really good idea*’ and reported that her ex-partner had really surprised her because ‘*he’s accepted that he was in the wrong and he needs to change the way he is basically for his children*’. However, she attributed this positive change to him being willing to accept any help and he was ‘*reaching out and trying to get as much help as he can including reaching out to Mind and trying to get anger management*.’

I mean the children never tell me anything negative about him anymore. They used to get really upset and say ‘Oh daddy ...’ ... my little girl used to say ‘I don’t like daddy’ ‘I want daddy to go’ ‘Daddy shouts at you’. And then they go to school and tell the school that he’s making them cry all day – this is horrific. But now he’s really changed ... but that doesn’t mean ... I’m obviously not going to go back with him, but I mean he’s changed for the better for the children’s sake more than anything. (VS119)

She could not, however, attribute the change to Drive’s intervention specifically as she was not quite sure what happens within Drive and suggested that this effect could be due to the different courses she thought he was doing.

It is important to note, however, that not all the victims-survivors interviewed had ongoing contact with the Drive service user, and consequently were not always aware whether there had been any behaviour change at all. Furthermore, it is possible that because not all interviewed victims-survivors were sure about the service user’s level of Drive engagement (although all knew that the service user was a Drive client and one victim-survivor even reported taking the Drive service user to his one-to-one meetings with the Drive case manager herself), when they did notice behaviour change, they were not sure whether this was because of Drive or for other reasons.

One victim-survivor, for example, said that she felt her ex-partner (with whom she did have contact because they had children) did need help with his behaviour (‘*A bit of counselling, bit of support, [...] he was quite obsessive, controlling, so he needed help with that*’), however, she was sure that he had refused to engage because he did not really want to change. Notwithstanding her scepticism about his level of engagement, she also said that the service user did appear to have changed for the better:

Has changed a little bit. [...] Obviously we're not together anymore, he's not controlling me for that. But um... yeah, I don't know, he's not like he used to be. [...] He doesn't speak to me like he used to either. [...] He used to be like 'Well, it's your fault' [...] but he's not like that anymore, he doesn't do it anymore (VS115).

The most positive views were from four victims-survivors who commented that the help provided by Drive was '*totally worth it*', '*unbelievable*' and a '*really good idea*' (VS116, VS117, VS119). For these victims-survivors, the key element seemed to be the close working relationship between the IDVA and the Drive case manager, which meant that they felt they were being kept informed and that there was holistic support. They mentioned that they had seen a '*big difference*' in the service user's behaviour and that he seemed to be '*turning himself around*'.

One victim-survivor attributed her partner's change to him accepting that his behaviour was wrong and the severity of the situation. She suggested that was probably due to a combination of him serving a prison sentence for the assault as well as the one-to-one support he was receiving from the Drive case manager to help him recognise the triggers of his behaviour:

[Drive service user] is making good progress, you know we're making good progress as a couple, and the sessions that my partner is having, you know it is helping. So it's having a positive impact...obviously you know he did serve a prison sentence for it ... and then obviously like you know seeing [Drive case manager] ... I don't know, I think it just brought it all home to him, you know the severity of it, and you know the wrong-doing... he opens up I think to [Drive case manager] as well as he does to me now about you know the triggers ... you know things for us to both avoid if we feel things are going to get heated in an argument, you know that sort of thing. So yeah, it's definitely having a good impact. (VS118)

She suggested that, now a few months into the Drive intervention, they were working on their relationship together and things had changed in that her partner [Drive service user] now recognises the triggers and reacts differently to prevent situations escalating, compared to how they would have before the intervention:

Like before the meetings you know it used to get heated, and you know arguments and you know shouting and that sort of stuff, whereas now you know if we find ourselves in that sort of situation, before it escalates you know ... now he takes himself out of the situation and he goes home. (VS118)

In this case the victim-survivor and her partner did not live together (at the time of interview) which meant he could remove himself from the situation when things started to escalate. Thus, he would react in a positive way by removing himself from the situation. This was a small but significant step.

A few of the victims-survivors referred to the importance of Drive as a means of monitoring the service user. This gave them some level of confidence regarding their safety, even if they were not entirely sure that it was working in other ways. One victim-survivor remarked that: '*I think it was just good that somebody was aware of where he was and what he was doing*' (VS111). The same victim-survivor also felt that the case manager was able to point out to the service user exactly what he was doing that was unacceptable – for example, pointing out when he was exhibiting controlling behaviour. As a result of this, the victim-survivor felt that it meant he had someone to talk to.

Victim-Survivor Concerns

While victims-survivors' reports on the effectiveness of Drive included concerns, this did not mean that they were critical about Drive itself, simply about the likelihood of the Drive involvement to have any real, lasting impact. One victim-survivor felt that, in theory, at least, Drive was useful, but that the only thing that really made a difference to the abusive behaviour was a police caution:

I think it's really good for him to try and perhaps understand, or perhaps make sense of the way, you know, he was feeling and perhaps make sense of the way that he'd made me feel. Helped him make sense. [...] I think he has learned quite a lot from it. However, I don't think it has had an impact on his behaviour towards me. I think the only reason he's sort of curbed his behaviour is because he was cautioned by the police (VS107).

For this victim-survivor, although she saw Drive involvement as useful, she felt there had been no fundamental difference made to the way she was treated. Drive, she said, had helped the service user to:

Make sense of his feelings and it went way back and stemmed back to when his father died and things like that. You know, I think it helped him make sense, but I think the way he sees me and treats me, I don't think ... he still has no regard for me, you know. [...] it hasn't made him change his opinions or views of me as a mother, his wife, or a woman (VS107).

Similarly, another victim-survivor noted that although she had observed a few signs of positive change, such as an increasing awareness of his abusive behaviour, the service user had still never apologised and still tended to justify his behaviour (by commenting on how difficult she was to live with).

Another reported that while her ex-partner was making a real effort to improve his relationship with their children and while she was on 'good terms' with him currently, his behaviour towards her was still a concern (he had only been out of the house for 3.5 months and might be on best behaviour so as to see children unsupervised) and she was sceptical about him being able to change completely:

There has been a few occasions where he's got a bit funny again, cos he's still quite controlling and he doesn't like the fact that I'm out doing what I want to do cos he's not living with me anymore. He's got much better but there's still a little inkling of him being a bit controlling. I mean I don't think he'll ever be able to stop that, but he just needs to learn that we're not actually together anymore and he can't control what I do. (VS119)

While this victim-survivor was satisfied that her children were much happier in terms of their relationship with their father, and that she had always been supportive and positive about his efforts with the children, she was not satisfied that he had accepted the blame for him having to move out of the family home, as he was still 'unpredictable', being nice to her one minute while the next he would 'fly off the handle and get quite angry'.

Yet another victim-survivor mentioned that although he was initially optimistic about Drive – thinking that it would provide the female service user with someone that '*she can shout at, scream at, they'll take notice and they'll help*' – actually, he did not feel that she engaged at all. This lack of engagement by service users was repeated by several other victims-survivors, who felt that their abusers were never going to make use of the help that was offered to them.

One stated that her ex-partner was never going to be able to access the support offered because:

I don't think a psychopathic narcissist can leave their own child trauma behind. He doesn't want to. You've got to want to leave it behind, haven't you? And he doesn't – it's not him with the problem. It's everybody else, and that's what's so sad (VS113).

Difficult to sustain change?

Another element that stood out was concern about relapse after Drive finished, and two of the victims-survivors had experienced this directly. They mentioned that although the service user appeared to be making progress and engaging well, as soon as Drive stopped, and the case manager involvement was removed, the service user reverted to previous abusive behaviours. For at least one victim-survivor, this was a final tipping point, and she had now decided to leave the relationship.

One of the IDVAs we interviewed commented that no one is really expecting miracles in terms of behaviour change. However, she added that: *I think that's about being realistic isn't it that we're not expecting it to be perfect but be open and honest and then we can work with it (IDVA109).*

Similarly, although it may be more difficult to effect behaviour change, for example because of mental health problems or substance abuse issues, working around that could be useful in engaging the service user. As this IDVA explained:

we had a case where ... he was engaging, but there wasn't so much sort of behaviour change stuff going on because of his mental health. But he would ring and report things or you know how he was doing but there wasn't sort of in-depth work that could be done because his mental health wasn't in the right place. (IDVA109).

The ability (or lack of ability) of some service users (and perhaps also victims-survivors) to sustain behaviour change was also acknowledged by IDVAs. One case was described where despite initially doing well, with a planned slow return of the service user to the family home, there was a further and unexpected 'nasty, nasty assault' (potentially exacerbated by substance abuse). Despite the assault (or possibly because of it), the victim-survivor was back in the relationship with the service user and stopped engaging with any professionals. Consequently, their children had been removed from her, and the IDVA felt that the victim-survivor was unlikely to get her children back from care. As the IDVA remarked:

I know that might sound harsh, but I think the amount of time and support that they've had, I don't know what else anyone could have done to make it work. And you know you're kind of having to accept that as a worker that as much as you put in or think is going a certain way, things can change so quickly as well (IDVA109).

Sustaining behaviour change after the end of the Drive intervention

Our aim to was to assess whether behaviour change was sustained 6 months and 12 months after the intervention ended. In order to do this we examined how many service users

appeared back in MARAC and/or in the police system during the 6 months and 12 months following case closure, and compared this with the extent to which perpetrators in the control group re-appeared at MARAC or were recorded by the police across the same time periods. It should be noted that there has been no similar use of MARAC data analysis in previous evaluations of perpetrator interventions. Data from both MARAC and police for this analysis was only available for Site 2 of Drive.

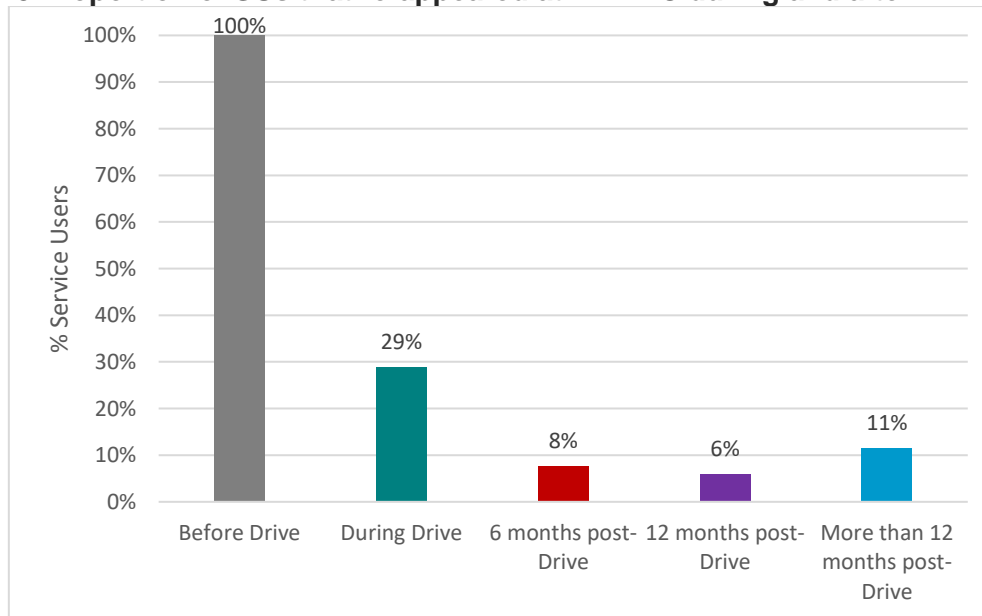
MARAC data regarding re-perpetration

Out of the 506 closed cases, 184 service users (37%) were from Site 2. As shown in Figure 27, a clear reduction in the MARAC appearance from service users is evident during and continuing in the period after completion of Drive. Around three-quarters of the service users did not appear again in MARAC during Drive, with a further reduction after the end of the intervention. A total of 15 service users (8%) re-appeared at MARAC in the 6-month post-intervention period. The majority of these service users appeared only once during this period, with the exception of two service users who re-appeared four and three times respectively.

Data for 12 months after case closure was available for 64% of service users (n=117). The number of service users who appeared back in MARAC at 12 months post-intervention, was 12 service users (6%) showing an overall reduction in re-appearance by service users at MARAC during this period.

For 11% of service users (n=20) it was possible to calculate what their re-appearances were more than a year after case closure. Although this might not be representative of the service users as a whole for site 2, the number of service users who appeared back in MARAC after more than a year post-case-closure increased to 11% of service users.

Figure 25 Proportion of SUs that re-appeared at MARAC during and after Drive (n=184)



Furthermore, we wanted to assess whether Drive service users appeared fewer times in MARAC during intervention and in the post-intervention period than the wider MARAC cohort of perpetrators from whom the Drive service users had been randomised. The data, including

the total MARAC cohort for Site 2, indicated that from the beginning of Drive (February 2016²¹) up to the last available date provided by MARAC (September 2019), control cases²² appeared slightly more frequently in MARAC (mean= 3.3 times) than those perpetrators who were allocated to Drive (mean=2.7 times). This difference was statistically significant ($p<0.001$).

While this analysis was only carried out with a subsample of the Drive cohort (only Site 2), the findings nonetheless indicate that Drive helped to reduce high-risk perpetration, and this was sustained for a year after the cases were closed.²³

Reducing Serial perpetration

Among the Drive objectives was the reduction of serial perpetration, that is the reduction in perpetrators going on to use DVA against another partner or family member. Using MARAC longitudinal data, it was possible to assess whether serial perpetration was reduced during and after Drive.

Out of the 1323 total MARAC cases for Site 2 (both Drive and control), 385 cases were considered serial perpetrators (29%). Serial perpetration was assessed by identifying whether the victim-survivor was a different individual on the different occasions the perpetrator appeared in MARAC²⁴. Among the 184 Drive service users, 22% were identified in this way as serial perpetrators ($n=42$).

Figure 28 shows the percentage of serial perpetrators allocated to Drive who appeared in MARAC at different time points. There was a clear reduction in the proportion of serial perpetrators appearing at MARAC by 6 months and 12 months post-intervention. Moreover, the percentage of serial perpetration increased after one year, post-intervention.

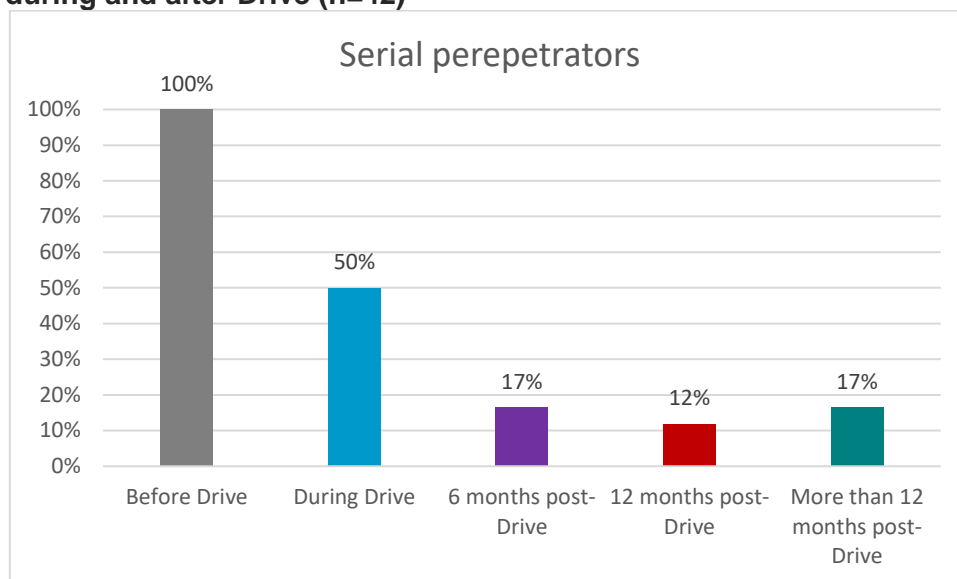
²¹ We considered initial contact date for control cases the first MARAC date of each individual. For some control group perpetrators their first Drive MARAC date was end of February 2016. That is why for this purpose February was considered the start date for some.

²² It is important to note that time periods for MARAC control perpetrators were more difficult to define, as they did not receive an identifiably formal intervention and therefore there was a lack of initial contact and case closure dates. This hampered the definition of an intervention period for control perpetrators. Thus, in order to be able to compare the two groups, we used the average duration of the Drive intervention (10.5 months) to define the endpoint of the Drive period for the control perpetrators.

²³ In order to draw further conclusions regarding what happened in relation to behaviour change for more than a year post-intervention it would be necessary to have more data on all cases.

²⁴ If the victim-survivor had a different ID from the perpetrator's that meant that the perpetrator had another victim-survivor associated. If, however, the perpetrator appeared in MARAC several times and the victim-survivor and perpetrator had the same ID, this was considered repeated victimisation.

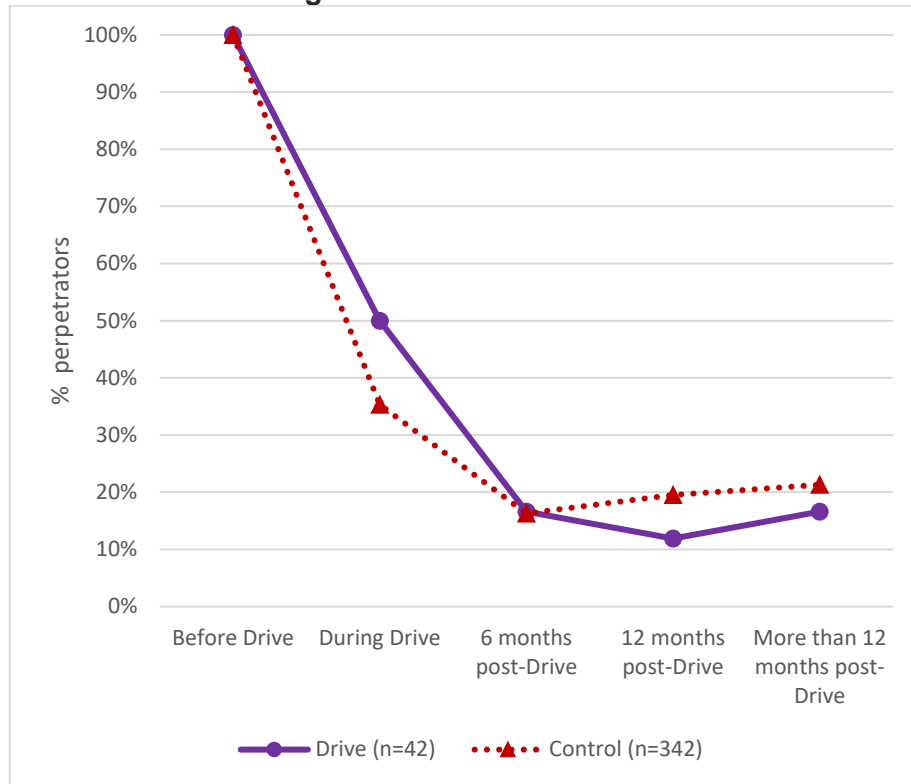
Figure 26 Proportion of SUs flagged as serial perpetrators that appeared back in MARAC during and after Drive (n=42)



When we compared serial perpetrators allocated to the MARAC control group with the Drive cases, control serial perpetrators appeared more times in MARAC (mean=1.5 times) than those serial perpetrators who were allocated to Drive (mean=0.8 times). This difference was statistically significant ($p < 0.001$).

The control cases appeared less in MARAC during the Drive intervention period than the Drive cases (50% and 35% respectively, see Figure 29). At 6 months post-intervention the percentage was very similar in both groups (17% Drive and 16% control), however, at 12 months post-intervention and beyond, Drive serial perpetrators showed a greater reduction in appearance at MARAC than the control serial perpetrators. This finding suggests that Drive was more effective at reducing high-risk DVA behaviours among serial perpetrators.

Figure 27 Percentage of Drive and control cases flagged as serial perpetrators that appeared back in MARAC during and after the Drive



Sustaining behaviour change – assessment using police data

As indicated in the Methodology chapter, due to the larger size of the control cohort we had to select a subsample of control perpetrators to enable the police forces for the three sites to identify the relevant data. Therefore, a random sample of control cases²⁵ was selected that was proportional to the number of service users (n=506) and was also proportional to the number of cases per site. Below we present the analysis of site 2, in order to compare findings between the MARAC and police analyses for this location (analysis of police data for site 1 is in Appendix 5).

Overall, police data shows that the reduction of DVA behaviours we identified from the Drive case management data were also sustained post-Drive. As can be seen in the sections below, Drive service users consistently reduced the number of DV-related incidents across time, for all service users, repeat and serial perpetrators, including during and more than 12 months post-Drive. There was also a reduction in DV-related incidents recorded by the police for the control groups, but the reductions were not as great nor as consistent as we observed for the Drive service users.

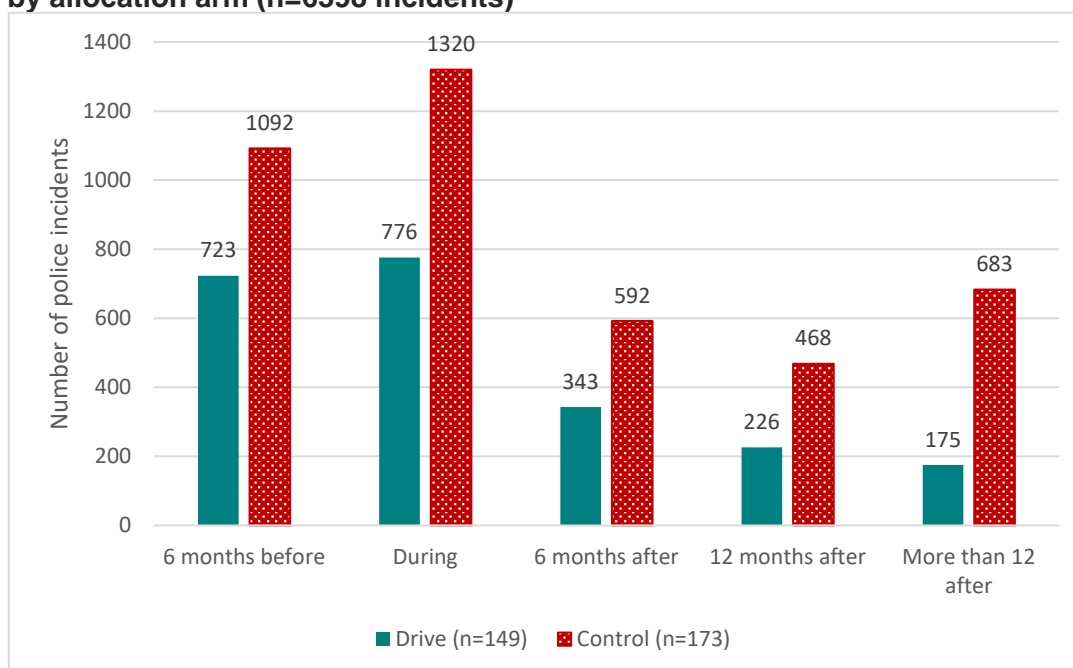
²⁵ Stata version 14 was used to randomly select a sample of control cases that was proportional to the number of Drive service users.

Police data for Site 2 – Drive service users and control group

A total of 6398 incidents were recorded by police forces from Site 2 within the Drive evaluation period.

Out of the 184 service users from Site 2, 149 service users (81%) had police information of at least one police-recorded incident in a period of 4 years. From the randomly selected control group for Site 2 (n=184 control perpetrators) 173 cases (94%) had police data. When looking at all type of incidents together (DV and non-DV), the number of police incidents for Drive service users ranged from 1 to 80 in a four-year period (mean=29.6, SD=19.9) whereas for the control group the number of incidents ranged from 1 to 308 (mean=72.4, SD= 79.3). When looking at the total number of incidents distributed by period (before, during and after Drive intervention²⁶) it is possible to observe a reduction in the number of incidents after the Drive intervention for both groups. However, a greater reduction was observed for those who received the Drive intervention (see Figure 30).

Figure 28 Number of police incidents by different time periods before and after Drive and by allocation arm (n=6398 incidents)



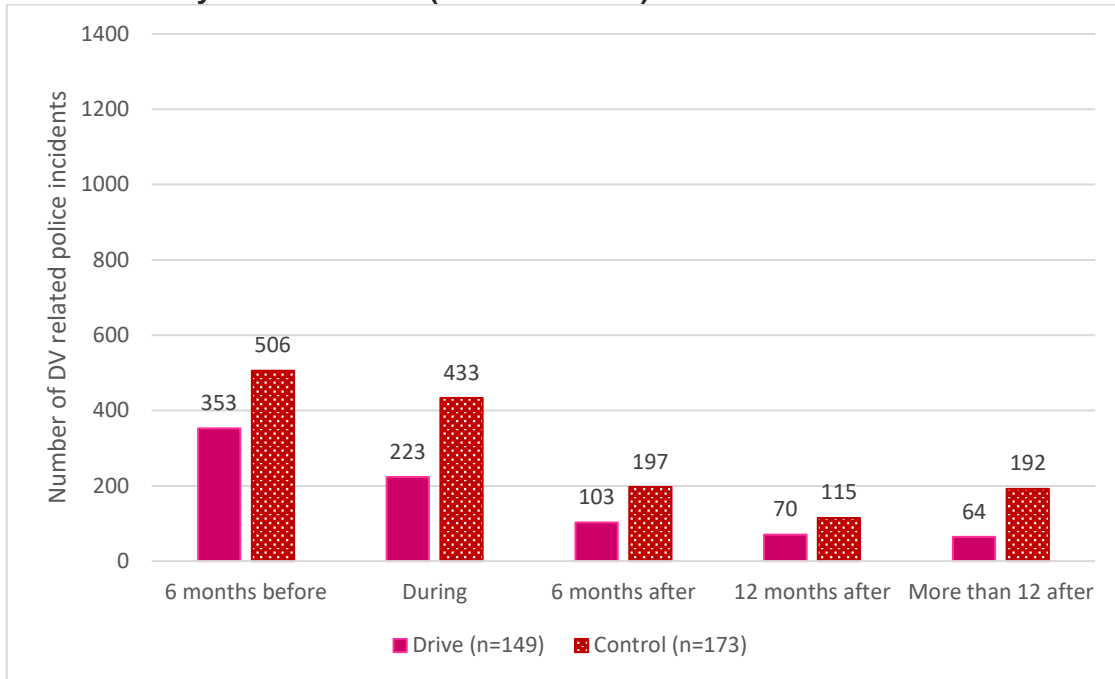
Domestic-violence-related police incidents

From the total number of incidents, 35% were related to domestic violence (n=2256). The number of police incidents per Drive service user ranged from 0 to 41 in a four-year period (mean=9.4, SD=8.0), whereas for the control group the number of incidents ranged from 0 to 134 (mean=24.4, SD= 33.4). When looking at the total number of DV-related incidents distributed by periods it is possible to observe a reduction in the number of DV-related

²⁶ It is important to note that police data for 12 months after case closure was available for 45% of cases (n=147) and police data for more than 12 months after case closure was available for 39% of cases (n=125).

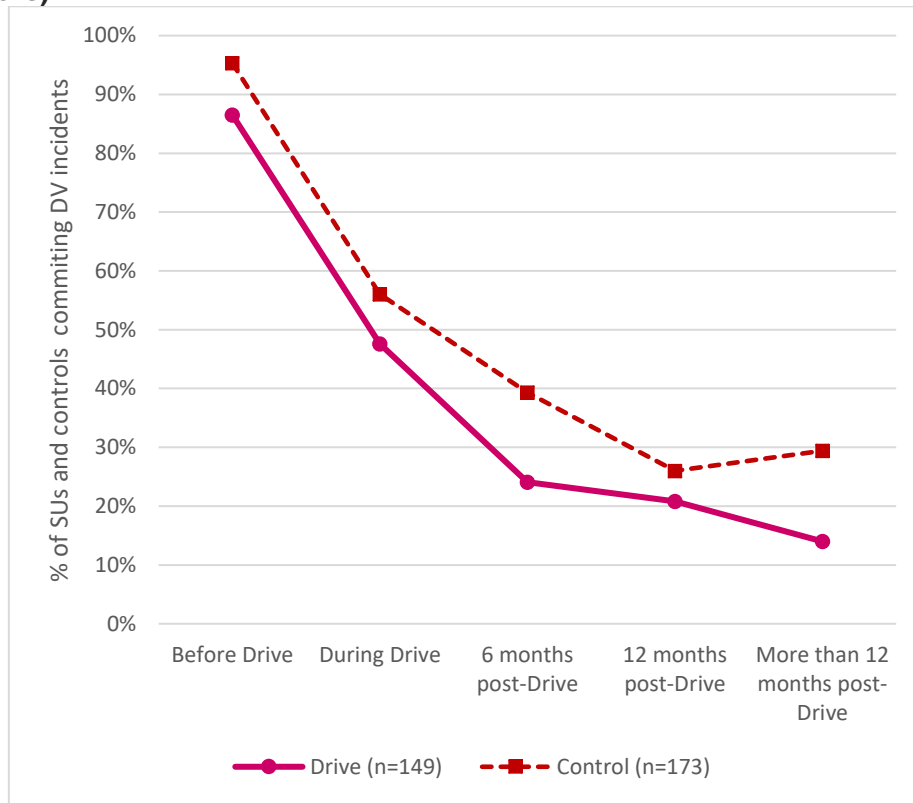
incidents during and after for both groups, and again the greater reduction was observed for those who received the Drive intervention (see Figure 31).

Figure 29 Number of DV related police incidents in different time periods before and after Drive and by allocation arm (2256 incidents)



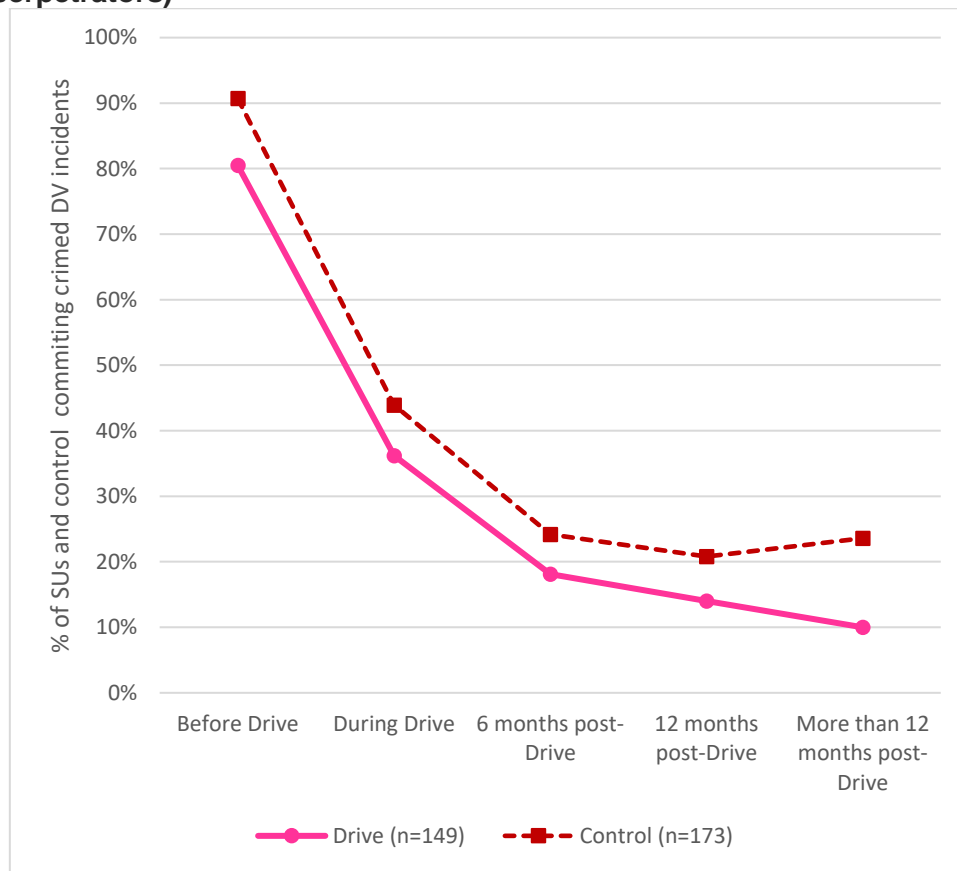
In order to compare these findings with those based on the MARAC data (outlined above), we were interested in assessing the percentage of perpetrators (both Drive and control) that committed a DV-related police incident. Figure 32 shows a significant difference in the percentages of Drive and control cases with DV incidents throughout the evaluation period. However, it is important to note that from the 6 months before the Drive period there was already an important difference between Drive and control perpetrators, that is, the group of control perpetrators already had a higher proportion recorded by the police as committing DV-related incidents before the Drive project began. Even so, the percentage of Drive service users committing DV-related incidents was greatly reduced during and after the Drive intervention in comparison with those in the control group. Drive service users were able to sustain the reduction in DV-related incidents 12 months after case closure (13 to 30 months), whereas the percentage of control cases increased after more than 12 months post-Drive.

Figure 30 Percentage of Drive and control cases that committed DV related police incidents in different time periods before and after Drive and by allocation arm (n=322 perpetrators)



Not all DV-related incidents were crimed by the police, and less than half of the DV-related incidents were crimed during the evaluation period (46%, n=1190 DV incidents). We would expect crimed incidents to be more severe than those not crimed. Echoing the findings regarding all DV-related incidents, there was also a reduction in the percentage of perpetrators who committed crimed DV-related incidents (Figure 33), and this reduction was greater for those in the Drive arm compared to the control group.

Figure 31 Percentage of Drive and control cases that committed crimed DV related police incidents in different time periods before and after Drive and by allocation arm (n=322 perpetrators)



Non-domestic-violence incidents recorded by police

Among the total police incidents there was a higher number of non-DV incidents than DV-related incidents (n=4142 vs. n=2256 respectively). The number of police non-DV incidents per Drive service user ranged from 0 to 61 in a four-year period (mean=20.1, SD=15.4), whereas for the control group the number of incidents ranged from 0 to 174 (mean=47.9, SD=48.9). When looking at the total number of non-DV incidents distributed by period it is possible to observe a reduction in the number of non-DV incidents during and after Drive for both groups, but again the greater reduction was observed for those who received the Drive intervention (see Figure 34).

Figure 35 shows a significant decrease in the percentages of Drive and control cases that committed non-DV incidents throughout the evaluation period. The percentage of Drive service users committing non-DV incidents consistently reduced after the Drive intervention. However, it is not the case for those in the control group, who after 12 months post-case closure had an increase in the number of non-DV incidents recorded.

Figure 32 Number of non-DV related police incidents by time periods and by allocation arm (4142 incidents)

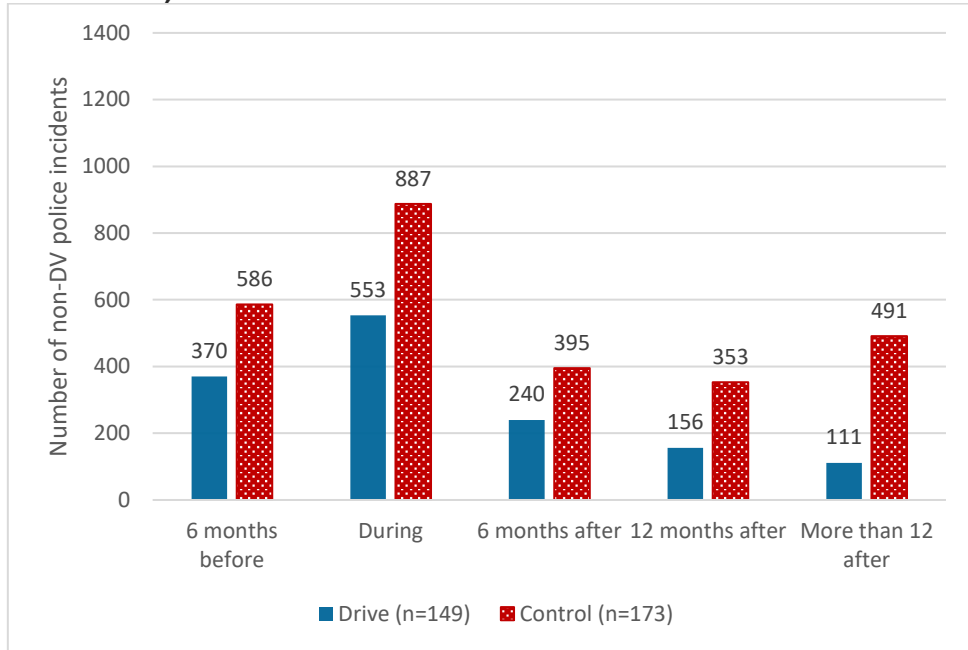
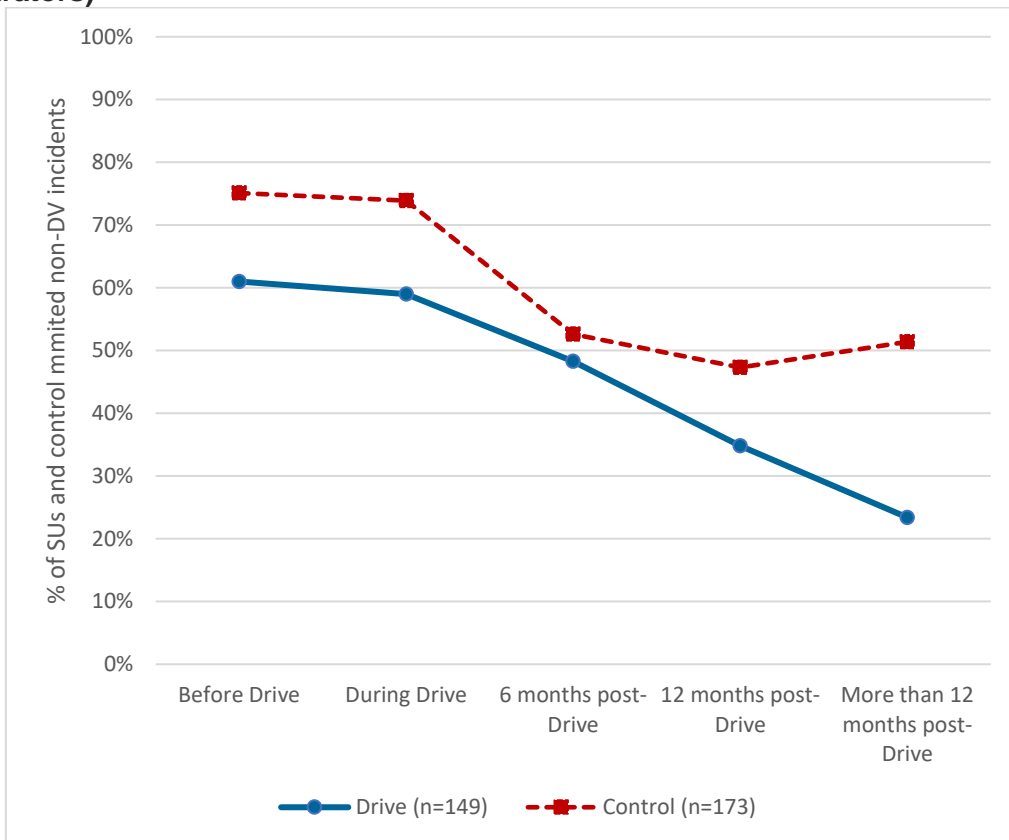
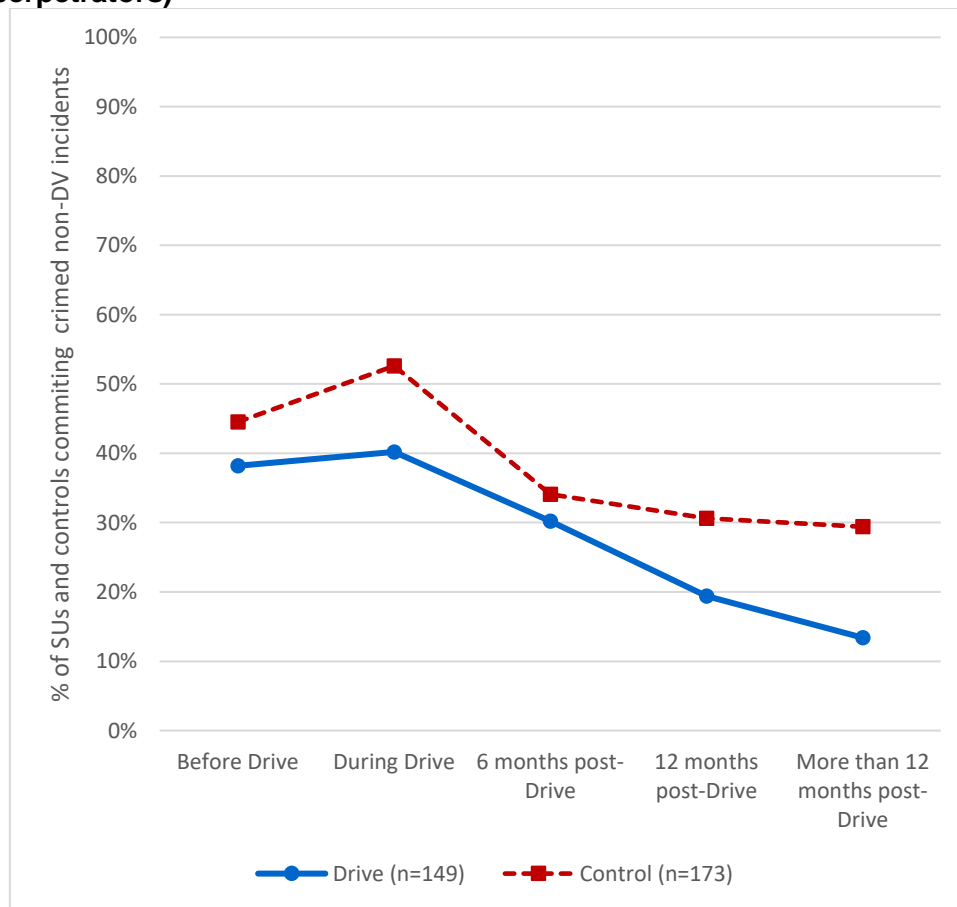


Figure 33 Percentage of Drive and control cases that committed non-DV related police incidents in different time periods before and after Drive by allocation arm (n=322 perpetrators)



From those non-DV incidents recorded (n=4142), 33% of non-DV incidents were crimined during the evaluation period (n=1376 incidents). An increase in the percentage of perpetrators that committed crimined non-DV incidents was observed in the “During Drive” period (Figure 36); this increase was more notable for those in the control group than for Drive service users, but we do not know why. In the post-Drive time periods, both groups showed a reduction in the percentage of cases; this reduction was higher for those in the Drive arm compared with the control group. Drive service users kept reducing their crimined non-DV police incidents more than 12 months post-intervention (6% reduction); those in the control group only reduced a further 2%.

Figure 34 Percentage of Drive and control cases that committed crimined non-DV related police incident in different time periods before and after Drive and by allocation arm (n=322 perpetrators)



Police data on serial and repeat perpetrators for site 2

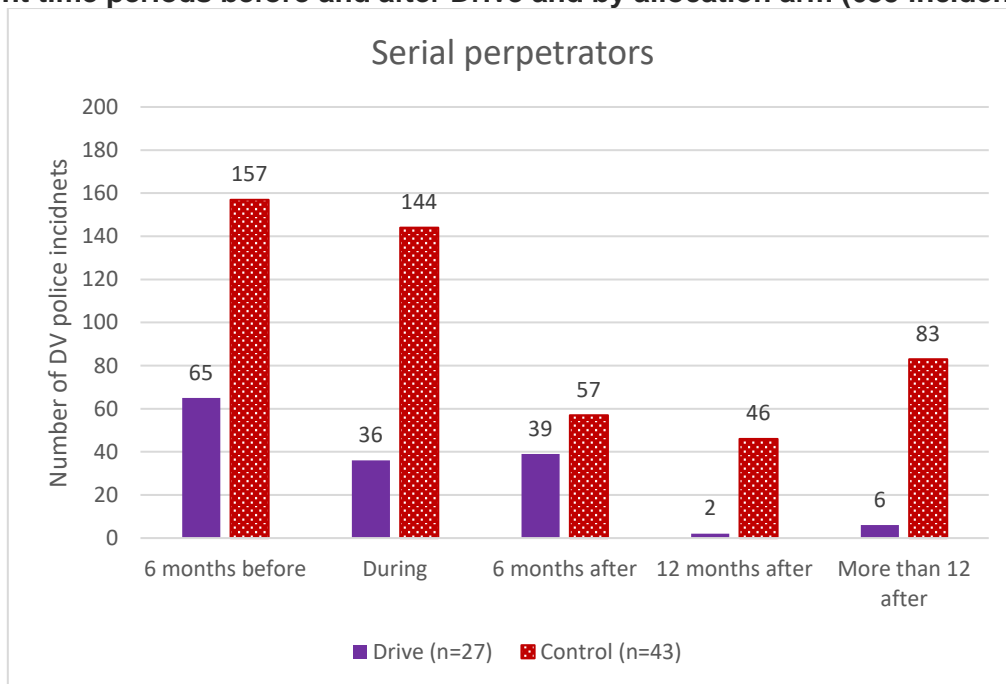
We were interested in assessing police incidents by serial and repeated perpetration. This was possible by merging MARAC and police data for site 2. Out of the 322 total cases in both the MARAC and police data, 70 cases were identified as serial perpetrators (22%) and 260 cases were repeat perpetrators (81%). It should be noted that these proportions of serial and repeat perpetrators were similar to those found previously in tracked police samples: Hester and Westmarland (2007) found 18% of DVA perpetrators perpetrated against a different partner to the one they were originally reported for to the police, and Hester (2013) found that 83% of DVA perpetrators were repeat.

Serial perpetrators

The total number of police incidents committed by serial perpetrators was 2010 incidents in a period of four years, of which 32% were DV-related incidents and 68% were non-DV incidents.

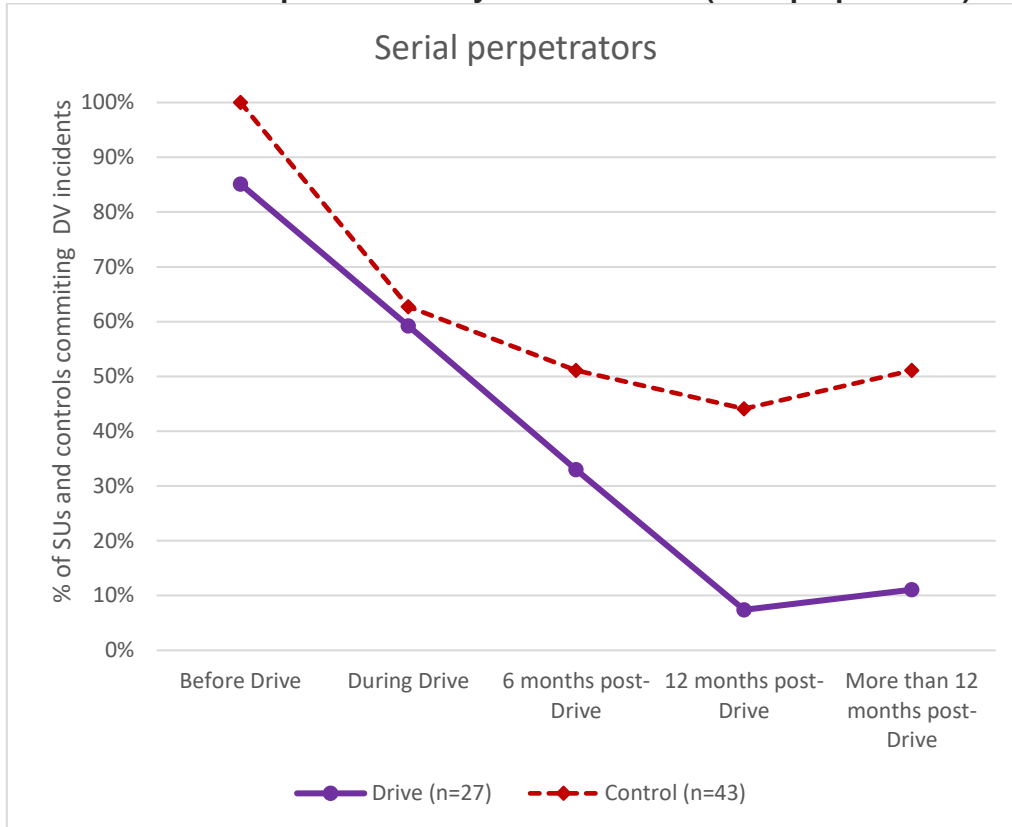
Of those serial perpetrators, 41% committed DV-related incidents (n=29). The mean number of DV-related incidents per serial perpetrator was 5.4 (SD=11.4). For Drive serial perpetrators the number of incidents ranged from 0 to 19 incidents per case (mean 1.5, SD=3.5), whereas for control serial cases the number of incidents ranged from 0 to 59 incidents (mean 7.5, SD=13.5). Figure 37 shows the number of DV-related incidents committed by serial perpetrators across different time periods for the Drive and control groups.

Figure 35 Number of DV related police incidents committed by serial perpetrators in different time periods before and after Drive and by allocation arm (635 incidents)



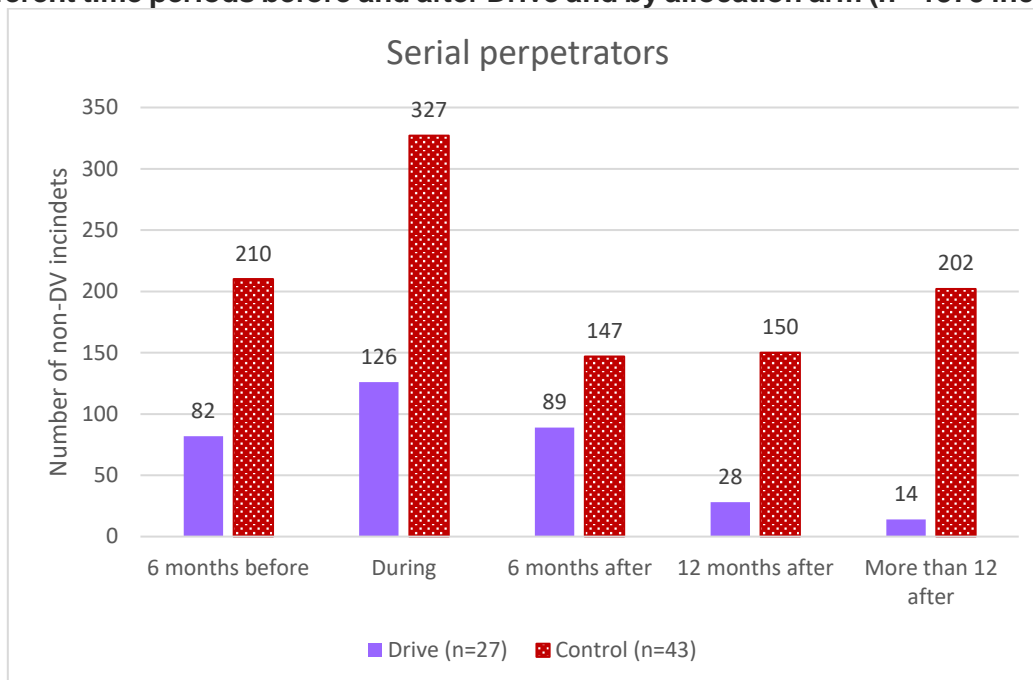
A major drop in the percentage of Drive and control serial perpetrators committing DV-related incidents was observed post-intervention (see Figure 38). Echoing the MARAC findings outlined earlier, these findings suggest that the Drive intervention and the embeddedness of the multi-agency ecosystem in the Drive localities (see chapter on interventions) might have had a considerable impact in reducing DVA behaviours among all serial perpetrators within the locality, including both Drive and controls.

Figure 36 Percentage of Drive and control serial perpetrators that committed DV related incidents in different time periods and by allocation arm (n=70 perpetrators)



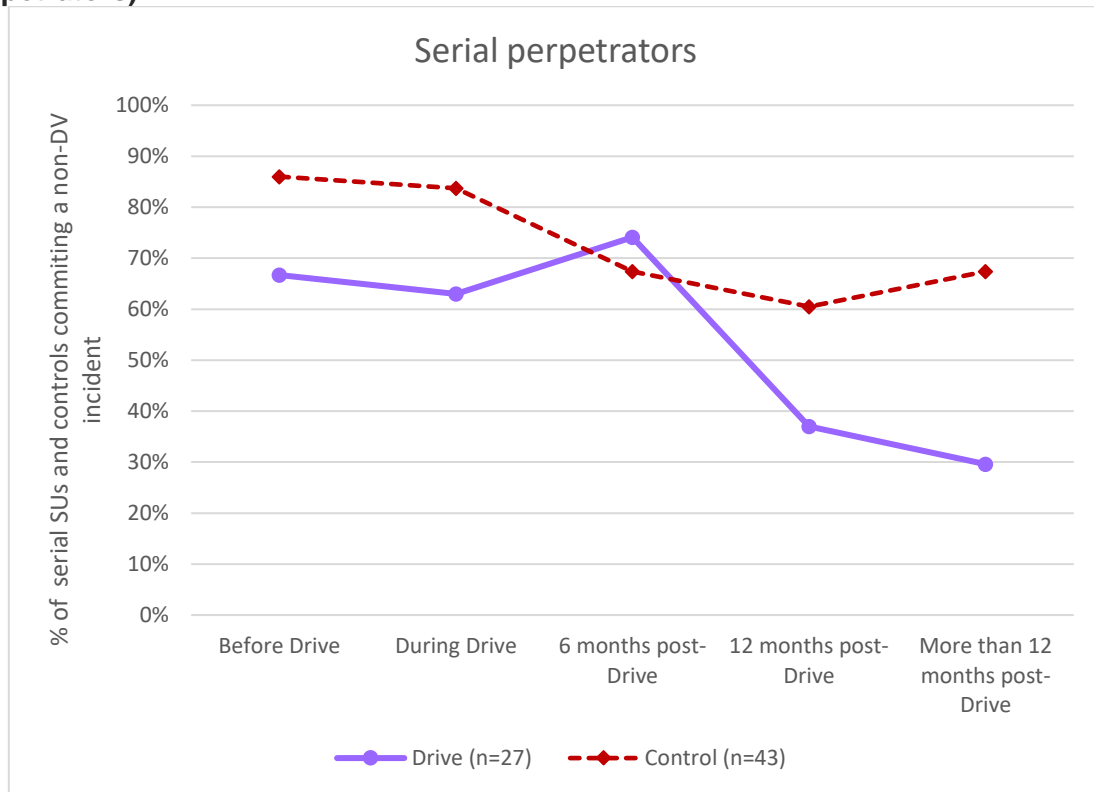
Fifty-nine percent of serial perpetrators committed non-DV incidents (n=41). The mean number of non-DV incidents per serial perpetrator was 14.5 (SD=31.0). For serial perpetrators the number of incidents ranged from 0 to 50 incidents per case (mean 4.2, SD=11.0), whereas for control serial cases the number of incidents ranged from 0 to 130 incidents (mean 19.8, SD=36.6). Figure 39 shows the total number of non-DV incidents committed by serial perpetrators across different time periods.

Figure 37 Number of non-DV related police incidents committed by serial perpetrators in different time periods before and after Drive and by allocation arm (n= 1375 incidents)



The greater percentage reduction was for serial service users committing non-DV police incidents (see Figure 40), however, there was a 'drawback' of this group 6 months after Drive where they showed an increase in non-DV incidents but then reduced significantly for the rest of the evaluation period. The 'drawback' may have resulted from the Drive emphasis on disruption for service users, which would have included pursuing non-DV incidents. Although the control group also show a reduction this was not as steep as that of the service users.

Figure 38 Percentage of Drive and control serial perpetrators that committed non-DV related police incidents in different time periods and by allocation arm (n=70 perpetrators)



Using police data to identify repeat perpetrators

Echoing previous literature, we used police data to identify repeat perpetrators, defining this as committing two or more DV-related incidents recorded by the police. Out of the 322 total cases in site 2, 260 cases were identified as repeat perpetrators (81%). The total number of DV-related incidents committed by repeat perpetrators recorded by the police was 2204 incidents in a period of four years. The mean number of DV-related incidents per repeat perpetrator was 21.6 (SD 30.7). For Drive repeat perpetrators the number of incidents ranged from 2 to 41 incidents per case (mean 10.9, SD=8.8), whereas for control repeat cases the number of incidents ranged from 2 to 134 incidents (mean 16.9, SD=34.4). Figure 41 shows the number of DV-related incidents committed by repeat perpetrators across different time periods, showing that repeat Drive service users had a greater reduction in the number of DV-related incidents up to 6 months post-intervention; after that the control group reduced their number of incidents more.

Figure 39 Number of non-DV related police incidents committed by repeat perpetrators in different time periods before and after Drive by allocation arm (n= 2204 incidents)

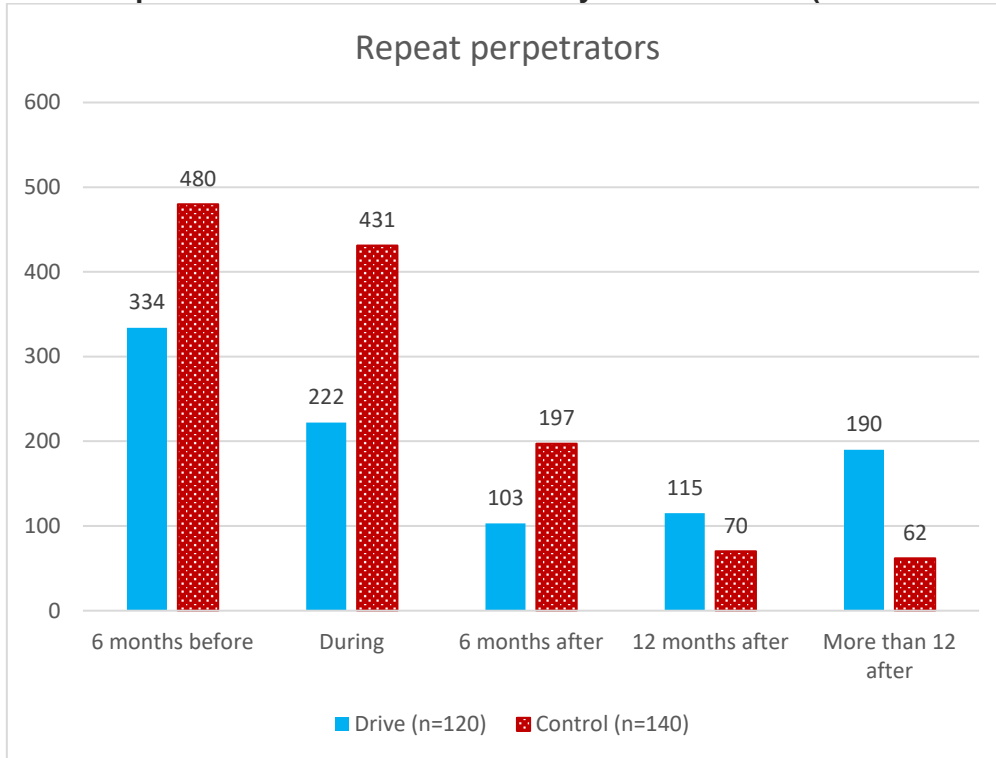


Figure 40 Percentage of Drive and control repeat perpetrators that committed DV related police incidents in different time periods and by allocation arm (n=260 perpetrators)

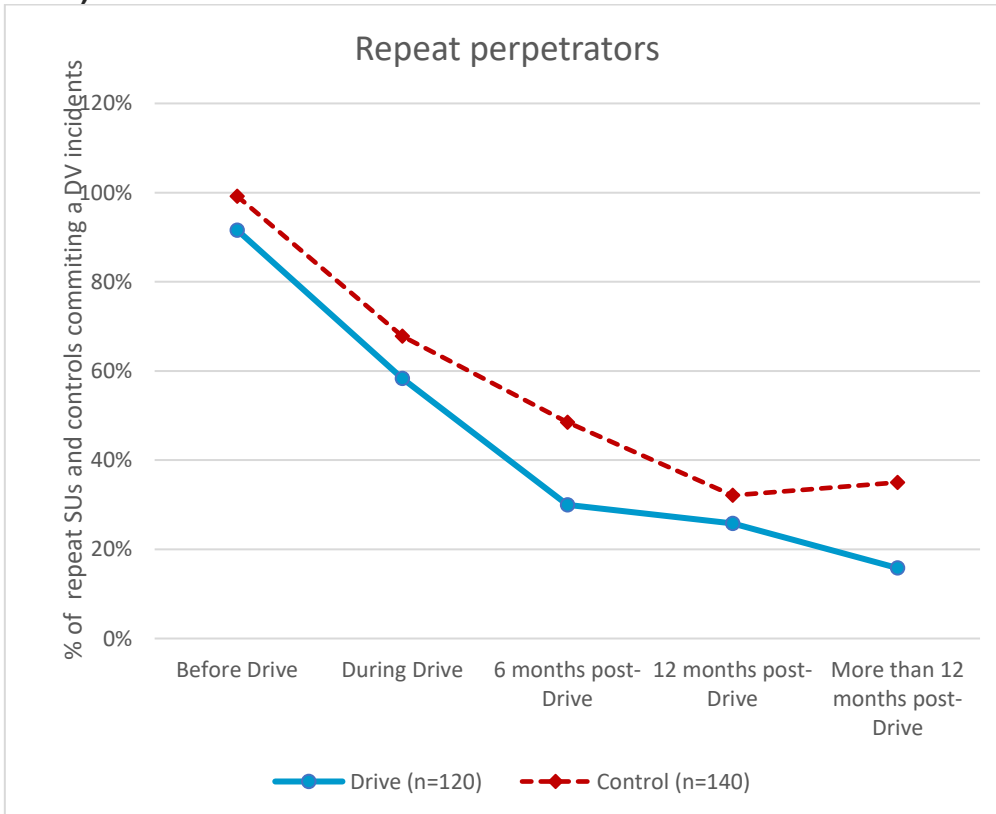


Figure 42 shows the reduction in repeat perpetrators committing DV-related incidents across the different time points. The reduction for Drive service users is greatest up to 6 months post-intervention, and continues after that, if less sharply. There was also a reduction for the control repeat perpetrators, but less than for the service users, and with an increase rather than a reduction after 12 months.

ARE VICTIMS-SURVIVORS AND THEIR CHILDREN SAFER?

Summary

- The Drive victim-survivor group received a longer period of contact, but a similar range of support interventions when compared with the control victim-survivor group.
- According to IDVAs, there was a reduction in risk for both the Drive and control victim-survivor groups, with a greater reduction in risk for the Drive victim-survivor group.
- The Drive victim-survivor group was more likely to experience a significant reduction in risk compared to the control victim-survivor group.
- The victims-survivors associated with Drive generally felt safer.
- IDVAs indicated that safety for victims-survivors was due to both victims-survivor and Drive support users engaging and receiving support at the same time, and/or case managers and IDVAs working closely together.

IDVA Support to Victims-survivors

Victim-survivor view of support – evidence from interviews

Overwhelmingly, victims-survivors reported positively about the support they had received from IDVAs, stating for example, *'it's not easy to put into words what she's done for me.'* and *'just been an amazing support really. She's helped me so much and I wouldn't be in this position now if it wasn't thanks to them'.*

Most IDVAs seem to have had continual contact with the victim-survivor they were supporting, usually by phone, but also accompanying the victim-survivor to court or to meetings with solicitors, for example, or signposting to other services such as the police, GP or counselling. One victim-survivor described the way her IDVA would help her to keep calm and focused, and stated that *'emotionally and practically [...] she worked wonders with me'* (VS106). A couple of victims-survivors mentioned having suicidal thoughts and that the IDVA had helped them through these.

During the interviews some victims-survivors described other sources of support they had received. For example, one talked about receiving help from a family support worker (before she accessed support from the IDVA), who had recognised the victim-survivor's experiences as emotional abuse and referred her to a CBT programme, which she says first opened her eyes to the fact that what she was experiencing from her partner was abuse:

<family support worker> was amazing, she's the one that put me in touch with <programme>, she said I really think you should do it [...] I've also had a lot of like liaison officers at school, I've had a lot to deal with them as well, like they're helping me at the moment as well (VS119).

Some victims-survivors also felt supported by the Drive case manager. One male victim-survivor, for example, mentioned that as well as support from the IDVA, he talked a great deal to the case manager. In this case, the victim-survivor explicitly referred to gender, stating that in talking to the (male) Drive case manager rather than the (female) IDVA, he was able to *'talk in a man-to-man situation [...] I'd be letting rip'* – something he did not feel able to do with the IDVA.

We found that consistent support that ensured victims-survivors did not feel let down was deemed by victims-survivors to work well. In contrast, where IDVA support did not seem to have worked so well, was where the victim-survivor felt let down by a lack of contact or broken promises. One victim-survivor talked about the IDVA who had been supporting her and who had been unexpectedly off work. Unfortunately, no one seemed to have got in touch with the victim-survivor to take over the absent IDVA's support. As the victim-survivor was stressed about attending court without IDVA support, it was the Drive case manager who stepped in to support her.

Victim-survivor support – evidence from Insights data

As we indicate in the sections below, quantitative exploration of support received by victims-survivors from IDVAs demonstrates that the Drive victim-survivor group received a longer period of contact, but a similar number of support interventions when compared with the control victim-survivor group. Given the 'IDVA effect' we outlined earlier, it may be the support interventions that are especially pertinent.

Before IDVA support: Victim-Survivor Self-Mobilised Interventions

With regard to the previous 12 months before a victim-survivor engaged with a Drive or other IDVA, we used the IDVAs' recorded information on the Insights database to see the number of times victims-survivors attempted to leave the perpetrator, attended A&E because of the abuse, called the police, accessed other specialist domestic abuse support, and attended a GP for any reason. Independent sample t-tests were run to compare the Drive victim-survivor group with the control victim-survivor group. The results showed that the Drive group victims-survivors had attempted to leave the perpetrator more times than the control group victims-survivors (p -value = 0.01) before engaging with IDVAs. However, on the remaining self-mobilised interventions there were no statistical differences between the groups (see Table 9).

Table 9 Average number of self-mobilised interventions victims-survivors did before receiving IDVA support

	Mean All	Mean Control	Mean Drive	t-test P- value
Attempt to leave the perpetrator	2	2	3	0.01
Attended A&E	0.3	0.3	0.3	0.51
Called the police	2	2	2	0.84
Attended their GP for any reason	3	3	3	0.66
Accessed other specialist DVA support	0.2	0.2	0.1	0.07

Length of Support from IDVAs

The data recorded by IDVAs on the Insights Intake form was used to mark the beginning of the victim-survivor receiving support and the date recorded on the Exit form was used to mark the end of receiving support. The number of days between the Intake date and the Exit date was used to calculate the number of days of support received by the control victim-survivor group or Drive victim-survivor group.

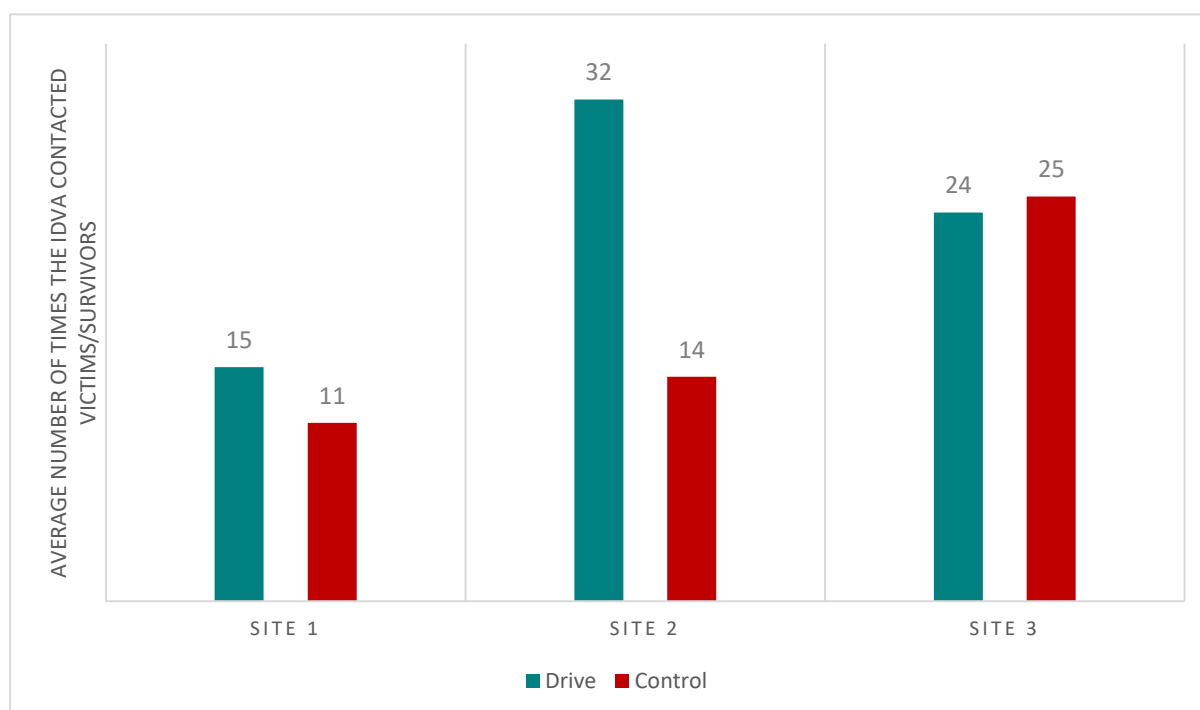
As would be expected, IDVA support for the Drive victim-survivor group lasted a similar length of time as the Drive intervention, ie nearly 10 months (average = 251 days, SD = 119 days, Median= 259 days, Min = 0, Max = 504), while IDVA support for the control victim-survivor

group was for approximately 4 months (average = 125 days, SD = 88 days, Median=101 days Min =0, Max = 508). To compare the groups, an independent t-test was run, showing that there was a statistical difference in the length of support from IDVAs between the Drive and control victim-survivor groups (p -value < .001).

Number of contacts with IDVA contacts with victims-survivors

IDVAs recorded how many times they contacted victims-survivors while providing support. IDVAs contacted Drive victims-survivors an average of 23 times (SD = 22, Median= 17, Min. = 3, Max. = 174) and control victims-survivors an average of 16 times (SD = 6, Median= 10, Min. = 1, Max. = 103). An independent group t-test showed that the number of times the IDVAs contacted Drive victims-survivors was statistically higher than the number of times they contacted control victims-survivors (p -value<0.001).

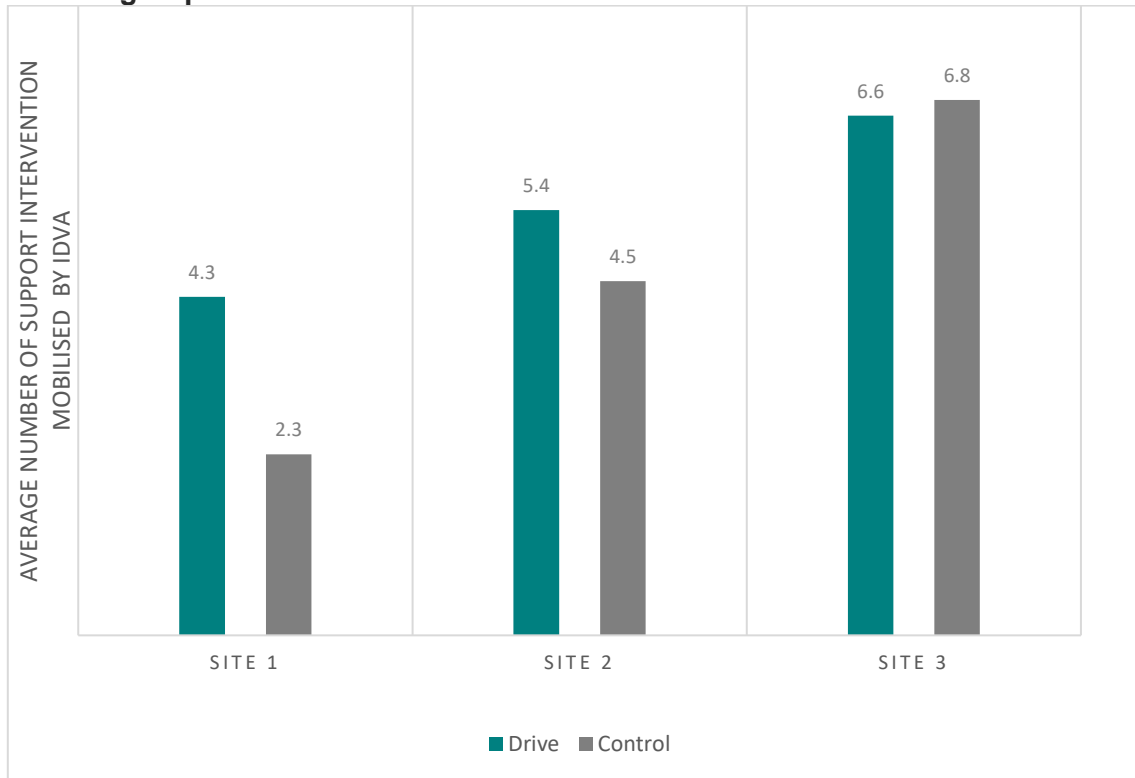
Figure 41 Average number of times IDVAs contacted VS by site and allocation group



Number of support interventions mobilised

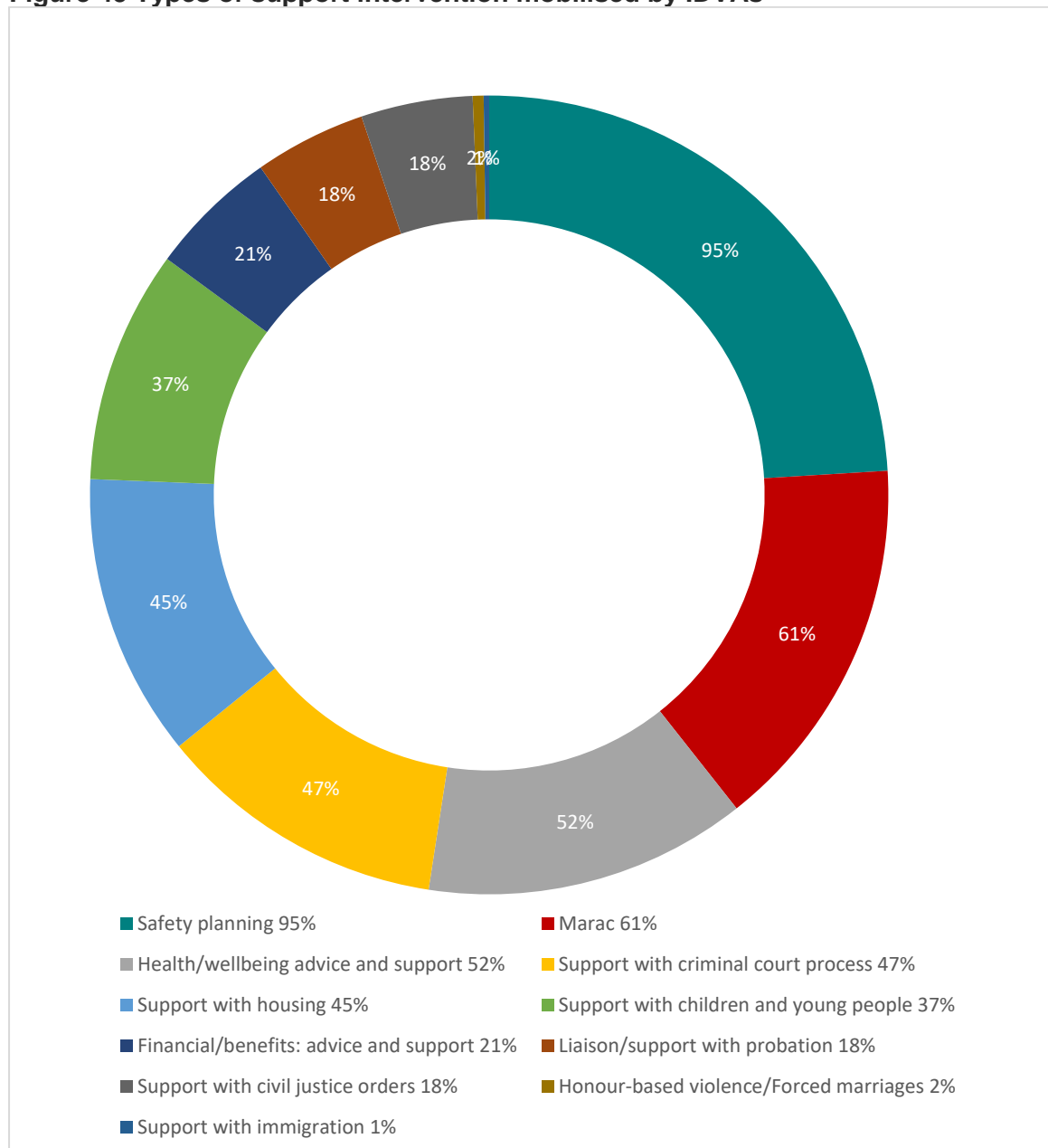
IDVAs recorded the support interventions mobilised for the Drive and control victim-survivor groups. When the victims-survivors at all three sites were analysed together with an independent sample t-test, the results indicated that the number of supports mobilised was similar for the Drive victim-survivor group (average= 5.4, SD = 1.7) and for the control victim-survivor group (average = 4.6, SD = 1.8) but it was slightly higher for the Drive victim-survivor group ($p > 0.05$). Figure 44 shows the average support intervention mobilised by IDVA according to the allocation group of victims-survivors and site.

Figure 42 Average number of support interventions mobilised by IDVAs, site and allocation group



In terms of type of support the victims-survivors received, nearly all received safety planning (95%), 61% MARAC, 52% received health/wellbeing support and 47% received support from the criminal court process (Figure 45).

Figure 45 Types of support intervention mobilised by IDVAs



The following Case Study indicates how Drive, with the IDVA, was able to mobilise housing support to increase safety for the victims-survivors.

Case Study #5

Victim-Survivor Rent Arrears Paid Off to Enable Priority Re-Housing

Keywords: housing, local authority, multi-agency work, IDVA

Background information

While the victim-survivor and service user were separated, the victim-survivor remained under surveillance from the service user and his family and friends, who would report back to him on her whereabouts.

For this reason, the victim-survivor wanted to move but was given very low priority by the council due to rent arrears (of approximately £200–300). To be prioritised, the victim-survivor would have to make ten consecutive monthly payments or pay the arrears in full. Paying in full was not an option at her income level and a ten-month delay before getting on the priority list exposed her to significant risk.

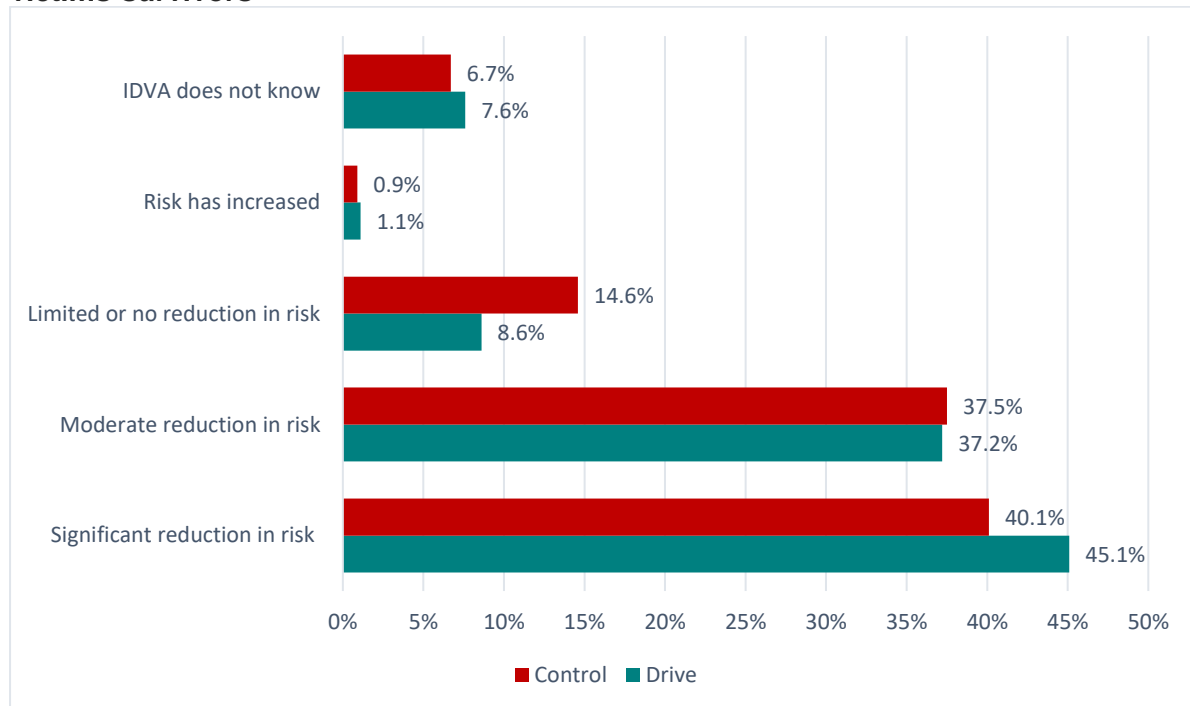
Disruption work with the IDVA

Working closely with the IDVA, the Drive team identified, facilitated, and enabled the housing officer to access a ring-fenced fund within the local authority that was specifically designated for assisting victims of domestic abuse. This was used to pay the arrears and get the victim-survivor on the priority housing list, so she could relocate.

IDVA Perceptions of Change in Risk to Victim-Survivor

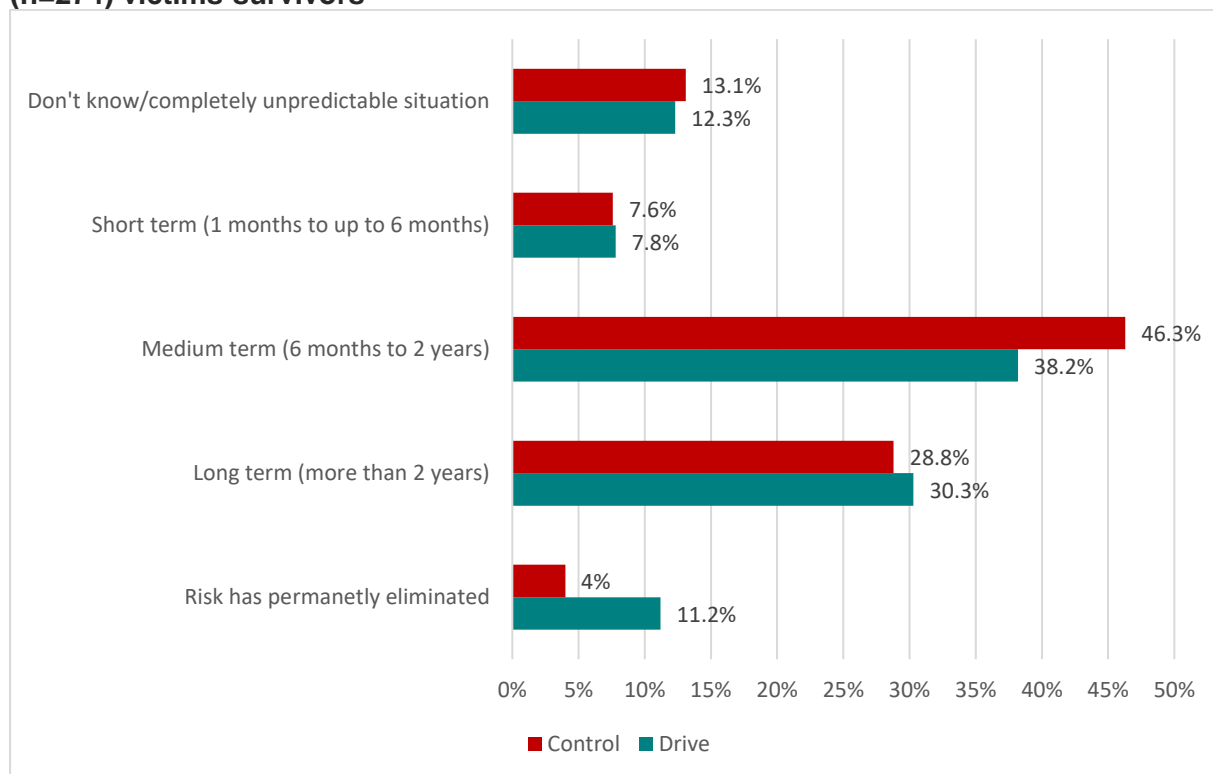
Following their intervention with victims-survivors, at exit, IDVAs recorded on Insights the extent to which they thought the risk posed to victims-survivors had changed since intake. Figure 46 provides a summary of IDVAs' recorded descriptions for both Drive and control victims-survivors' risk. The overall trend was a significant or moderate reduction in risk for both groups, with the Drive victim-survivor group more likely to experience significant reduction.

Figure 43 IDVA perception of change in risk to Drive (n=104) and Control (n=353) victims-survivors



The IDVAs also recorded their perception of sustainability of changes in risk (Figure 47). Consistent with the Year 2 report, IDVAs perceived that risk was permanently eliminated for a higher proportion of the Drive victim-survivor group than for the control victim-survivor group. These results confirm that the core IDVA support is effective for both groups, and that Drive provides further reduction in risk.

Figure 44 IDVA perception of sustainability of change in risk to Drive (n=89) and Control (n=274) victims-survivors



IDVAs' Views about Safety of Victims-survivors

Echoing the data on Insights, interviews with IDVAs indicated that some of the victims-survivors they had been working with were now safer. Some indicated that this was as a result of both victim-survivor and Drive service user engaging and receiving support at the same time:

[she] is taking steps to protect herself...what I feel is good is that we've been able to sort of work that, and the fact that he's working with the Drive worker I think is really good too, because sometimes they don't engage and we get one of them engaging and the other one not. (IDVA111)

Others indicated that this was because of the way Drive case managers and IDVAs were working together because of Drive:

The working relationship [between IDVAs and Drive Case managers] is really positive. And there's been some really positive outcomes and some quite creative working. [...] An example would be from a couple of weeks ago where one of the IDVAs and one of the case managers were due to meet with the [victim-survivor] at housing [...] to discuss what Drive could do, what Housing could do and what the IDVA could do. And that was the first time that client had engaged. (IDVA102)

One IDVA said that working closely with the case manager meant they had access to information they would not usually have in other circumstances, adding:

I've got a good relationship with the [case manager], and I think when it works, it really does work. I mean we're all working to the same goal, which is improving safety and lowering risk to victims and children. And obviously if we can help the Drive clients as well with whatever issues they've got, that's great isn't it? If you're helping them in that way, that has a knock-on effect to my client – when it works well, it does work well. (IDVA101)

IDVAs described the importance of the information exchange between the IDVA and case manager in terms of having a clearer understanding of the 'full picture' of the dynamics of a particular relationship, and thus the ability to better manage risk:

IDVAs work Drive cases in a similar manner to their non-Drive cases 'but always keeping that eye on the impact on the perpetrator's behaviour, what it is – is it an escalation of risk, or is it de-escalating the risk, are the clients taking on board that actually they may not be whole-heartedly – you know sometimes perpetrators can engage with a programme and say 'yeah, yeah, absolutely, I'm changing'. When actually the reality is they're not. So it's about keeping that at the forefront of the client's mind as well as saying 'if there is real change, then that's positive'. But we need a real measure of what that looks like. (IDVA102)

Another IDVA (Year 3) suggested that where a victim-survivor is not ready to leave the service user and finding it hard not to have any contact with that service user then at least having access to this information presents an additional resource and helps the IDVA to better manage the potential risk posed to the victim-survivor.

Interviews in Year 3 suggested that the working relationship between IDVAs and case managers had improved as the Drive intervention had progressed, with one IDVA reporting that the joint working had gone 'from strength to strength' adding:

I think one of the things that I've noticed is we've embedded better with Drive, whereas before when we first started it was more like a case was just something that sat on our caseloads, we'd ring them once a month and that sort of thing. But now there's a lot of real active work that goes on between Drive and the IDVA...I think when you've got two workers involved – one focussing on the perpetrator and one focusing on the victim - then you've got more of a likelihood of that happening [good outcome] because you know you can both alert each other to what's going on. (IDVA111)

Another IDVA emphasised the benefits of being co-located, or at least of meeting regularly, in terms of developing a good working relationship between the IDVAs and the case managers. When they were able to meet regularly in the same space, there was more opportunity to have informal discussions:

Yeah it works really well, obviously because we're in the same buildings ... we communicate you know regularly, we have our case reviews. Cos we're often you know in the same place, you have those kind of like one-off conversations and things like that 'Oh by the way this, by the way that' ... and yeah I do feel that it works well, the communication is open. ... So you know you can always contact people and pass things on or share things or ... yeah I think the dialogue and communication is really good. (IDVA109)

This close working relationship and sharing of information gives additional insight into what is going on with both the victim-survivor and the service user. One of the IDVAs described a particular case where the victim-survivor had been engaging for a while and the service user was more recently engaging with the Drive Case manager. This, according to the IDVA, meant that she was able to think about things a bit differently:

... it gives me a different view on things. Whether or not I 100% think it's genuine, but obviously I take on board the Drive worker's feeling that if he's genuine or not ... so it just gives me a bit of a different take that I didn't see before So then I suppose I would look at it differently and maybe ask different questions or be a little bit more curious than I suppose, rather than sort of ... not colluding, but obviously my role is there to, you know, believe what I'm being told unless something shows that it's not. But yeah, so that's been interesting that the Drive has come back and said oh actually he's saying this. So that surprises me, and it surprised me that he's engaged really because he's quite a well-known figure in the community, quite a bully, known as a bully, and I didn't think that he would like being told or challenged from her, from what I pick up – so I'm really surprised he has engaged. But you know it's a good thing isn't it? It could only be a positive that he's opened up and talking – whether it's what we want to hear or not, we've got additional information coming in, which helps me then to look at her perspective differently. (IDVA109)

As the IDVA explained, it's not necessarily that they always get the full 'truth', but in getting the different perspectives from the victim-survivor and the service user, then a 'fuller picture' begins to develop and more questions can be asked.

However, other IDVAs we interviewed felt unable to comment on whether safety had improved (although they also felt unable to comment on whether things had become less safe). This was because it was generally not possible for them to say what might have happened in other circumstances for non-Drive victims-survivors.

A key issue in relation to IDVA perceptions of safety, identified in two out of the three Drive sites, was that not all victims-survivors were apparently made aware that the service users were involved with Drive. This also had implications for who could be approached to be interviewed. Although the Drive pilot model, and training for Drive case managers and IDVAs, was built on the expectation that all victims-survivors would be informed of Drive involvement with a perpetrator, there were a number of reasons why this did not happen in all cases. For example, some IDVAs may have been working with the victim-survivor months before Drive became involved with the service user, and one IDVA explained that in such instances they had to consider possible benefits or negative impacts:

It would have to be sort of evaluated whether it would be any benefit to the actual client to notify them that their ex-partner is on the Drive Project... [In one case] she was back into work, she had her life back on track... and then, when we discussed the Drive Project that actually caused her to go into a depression state, she had to go back to the doctor's – just because we had brought up those memories which she had obviously gotten over. It's really on a case by case sort of situation. If you've got a client who's still in a relationship, then that could obviously be beneficial to mention the Drive Project to them. But certainly, when it's an ex-partner and perhaps several months since the incident has actually taken place, there's no real benefit to sort of notifying them that their ex-partner is going to be on the Drive Project. (IDVA102)

Another IDVA explained that *'we made the decision that we weren't going to tell [the victim-survivor] about the Drive involvement for safety reasons.'* For another victim-survivor, a similar decision was made because of the complex on-off relationship the victim-survivor had with the service user in the past, which now, finally, seemed to be ended:

I think there was a fear that if she was told that [the service user] had been selected then it would perhaps prompt her to get back involved with him again. (IDVA101)

Whilst not directly related to safety, but more to the appropriateness of keeping the victim-survivor informed, some IDVAs explained that victims-survivors might not be informed about Drive involvement where the Drive case managers had been unable to make contact with the service user. For example:

So, I would generally only tell a client if Drive are looking to make contact. If [...] they're looking to make contact, I would generally only tell the client about Drive, then. [...] I just think if I tell them now and obviously sell it as a good thing, and then Drive decides it's not appropriate or it's a few months before they're able to make contact and get to the point where they're able to do the contact strategy, I just think... I just wonder if the client would get a bit fed up or a bit dubious you know... so I sort of wait until it's definite and do it then. (IDVA105 and see also IDVA101)

The decision to tell the victim-survivor about Drive involvement was, therefore, made depending on the IDVA's assessment of the best interests of the victim-survivor. If the victim-survivor and service user were still in a relationship, there appeared to be no question of *not* telling the victim-survivor so that they could be reassured that there was *'another set of eyes'* – but if the relationship was over and the incident leading to Drive involvement was several months ago, then it was not always seen as appropriate.

Victim-Survivor Feelings of Safety

Overall, interviews with victims-survivors revealed that they felt safer. One reported feeling *'a lot safer'* because *'I don't feel like I have to explain myself to him anymore and I can just go and do what I want to do'* (VS115). While this victim-survivor was no longer in a relationship with the Drive service user, she was still in contact with him because of child contact arrangements. In many cases, though there was some degree of ambiguity about feeling safer as a result of the intervention, which is indicative not only of the trauma they have suffered, but also of their awareness that if things changed in relation to the service user, the abusive behaviour might start again. Echoing their views on the service user's DVA behaviour change, they appeared uncertain that the service user would not continue the abuse in some way and were not convinced that those potentially intervening with the service user would contain the service user or protect them in the longer term.

This uncertainty was summed up by an interviewee who said, *'I do feel safer, but I don't as well'* (VS108). Because she knew that the service user *'has terrible [...] grudges,'* she felt that he was still *'waiting in the shadows.'* Although she now lived some way away from him, and was unlikely to bump into him, she was still having panic attacks if she thought she saw the service user in the street. A similar, although more positive, response was received from a victim-survivor who said she definitely felt safer, although still occasionally would have dreams about *'that knock at the door,'* and would wake up in the night, thinking that the service user might have come back to the family home (VS104). Another said that she felt safer for now, but only because he was in prison (about which she also felt guilty). She was scared and

anxious about what would happen when he came out in a couple of years' time. In this case, therefore, the feelings of safety were somewhat transient, and it seems highly likely that unless she were able to completely leave the area (which would involve leaving work, family and friends), she would feel less safe when she knows he is out of prison (VS101). Another victim-survivor reported feeling safer since her ex-partner had been ordered to move out of the family home by social services, saying '*I do feel a lot safer now, ... he hasn't set foot in the house since he was told to leave the house ... but he does want to come in ... cos it's his house, so he does want to come in*' (VS119).

However, while a number of the victims-survivors felt safer, it was not always entirely clear whether this was as a result of the support the service user had been receiving on Drive or whether it was because of the support the victim-survivor was receiving from the IDVA (and perhaps, other agencies). For example, one victim-survivor mentioned that she felt sure that if the service user were not involved with Drive, he would be trying to come home – and she hinted that she would find it difficult to stay firm and refuse to allow him back. Because he was involved on Drive, there was someone watching over him all the time and forcing him to justify his actions. Furthermore, because he was effectively being prevented from living at home, she did not have to worry about what mood he would be in every time she walked in through the front door. As a result, in response to being asked about the ways in which she felt safer, she said '*there's not that tension anymore*' (VS111). Another victim-survivor commented that she felt safer now because there was a restraining order against the service user and because other services had been involved as well. She said that the support she received from her IDVA '*definitely helped,*' and that the fact she felt safer was probably due to a '*bit of both*' in terms of the support for both her and the service user (VS112). Similarly, one victim-survivor was aware that the case manager was keeping in close contact with the IDVA and she was kept informed by the IDVA, and as a result of this, she felt safer because '*I know where he is, I know where he's feeling and where his head is at.*' In this case, her feelings of safety did appear to be both because of the support from the IDVA, and because she was more secure in knowing that the service user was receiving support. In addition, there were several practical steps that had been taken because of Drive, including safety features such as instalment of a camera at the door and a flag on the address, which helped in improving her overall sense of security (VS103).

IDVA views on what a successful outcome looks like

It was suggested by one IDVA that a successful outcome would be getting the victim-survivor to the point where she could recognise the cycle of abusive behaviour perpetrated by her partner and to accept that even though she still loves her partner that is not going to keep her safe. Success in a scenario where the victim-survivor is not ready to leave the relationship would be that the risk to her is at least reduced and that she is empowered to at least recognise and manage the risk to her safety:

The worker said that she felt it was a really successful case. Overall the risk to this girl and the perpetrator has reduced. She's following the safety plan; however, she still remains in love with him, but is beginning to realise the cycle of abuse and that he's repeating his abusive behaviour, and is taking steps to protect herself. (IDVA111)

Another IDVA reported there were at least two Drive cases that she classed as a success and in both of these cases, the outcome had been that the victims-survivor and the service user had managed to stay together as a family and there had been no reported incidents since the case had been closed (IDVA110). One case, which '*worked very well indeed and was a good result*' involved a couple whose children were eventually allowed to remain in the home as a

result of the work conducted with both victim-survivor and Drive case manager. Purely by chance, the IDVA had seen the perpetrator while out at a football match and he had been with his eldest daughter – with whom he had had a particularly fractious relationship before the Drive intervention. The IDVA commented: *'It was lovely to see them together and smiling and getting on it was lovely to see. Anyway, they were out as a family and getting on and having fun at this football match'*. In this instance the IDVA and case manager had worked intensively with the couple to make it a much safer relationship. There were four children involved and as a result of Drive intervention they were all back together as a family and safer (no further incidents were reported and all was fine as far as the IDVA was aware). The IDVA suggested that this was a particularly difficult case because the victim-survivor had entrenched beliefs about gender roles and parenting but it worked because both the victim-survivor and service user fully engaged and were motivated to change by the shared goal of having their children remain with them in the family home.

Similar findings were made by a third IDVA, who described the one-to-one support the service user had received, which had helped him to acknowledge his abusive behaviour. This, in turn, meant that the victim-survivor was no longer minimising the abuse she and their children were experiencing. The victim-survivor had been reluctant to simply walk away from the relationship 'but then at the same time he needed to show change, [and] she was quite clear about that he needed to demonstrate that.' As explained by the IDVA:

[']t's been a positive [case], yeah it has, but I think it was good that she ... she sort of demanded that you know something needed to happen, for them to engage in something. They couldn't just sort it out themselves, it needed to be something more. And in all fairness to him you know he would come to child protection conference and say 'my behaviour was you know totally unacceptable' and be open about that. You know which is not easy, it's not easy as a dad, and you know the children going to prison to visit him and saying you know they deserve better than that. So in all fairness to him he did, you know he did recognise and own up to things, and hopefully yeah it will be, it will be a positive outcome. (IDVA109)

In another case, both service user and victim-survivor also fully engaged with the support offered on both sides with the ultimate aim of getting their child returned to their care (their young child had been removed by children's social services and placed with a family member). According to the IDVA both the victim-survivor and service user *'went above and beyond'* and despite facing a lot of pressure from family and the wider community they *'did everything they could'* to get their daughter back home. The child was returned to the family home and, as far as the IDVA is aware, there have been no further problems since.

IDVA views on the value of Drive

One of the IDVAs reported that victims-survivors tended to react 'really positively' to Drive working with the service users. This was particularly the case where they might want to resume the relationship (IDVA109). This impression was supported by another of the IDVAs who suggested that Drive was 'definitely' worth continuing, as it is about 'keeping people together safely if that's what they want to do'. It is worth it to prevent further abuse happening in the future to other potential victims. The IDVA suggested that 'we can't just walk away and wash our hands of these perpetrators'. The value of intervention with perpetrators, according to the IDVA, is in protecting the children's future and thus could save resources in the long run. Work with perpetrators is 'something that is needed, and you can't deny that people want to stay together because many of them do'. Educating perpetrators and teaching children what is

acceptable and what is not works towards the prevention of abusive relationships in the future. Domestic abuse will not reduce if we ignore those who perpetrate such abuse:

it's been ignored for a long, long time. And it's not something that can be ignored anymore, I think it's something that has to be done – people have to work with victims and with perpetrators [...] they are ultimately the people that you know we need to get to, to stop this [...] there's perhaps a little argument for [saying perpetrators] need it more than victims because if we change their behaviour we won't have as many victims will we, you know. (IDVA110)

There are some caveats in relation to the potential for positive impact for victims-survivors, however. As explained by one of the IDVAs, there may be less benefit where there is no wider social network. As the IDVA explained, whereas professional services can offer interim support:

a lack of support network is huge - you know that's where people go isn't it when things get to crisis point. Maybe they've managed for so long with whatever, and then at the crisis point it's 'I can't do this no more'. And as much as you can ... you know there's professionals involved ... it's your support network isn't it that you need.' The isolation caused by the lack of a personal support network means that people 'feel stuck' and are unable to engage in support – and perhaps also don't learn how to be open with others. (IDVA109)

This IDVA felt that for one of the particularly complex cases she discussed, a strong, supportive network might have resulted in very different (and more positive) outcomes for the victim-survivor. Nevertheless, Drive involvement did mean that the risk of harm to her and her child from the Drive service user was minimised.

DRIVE CASE NOTE ANALYSIS – DEEPENING UNDERSTANDING OF BEST PRACTICE

Summary

The case note analysis conducted in Year 3 of the evaluation confirms the following findings from evaluation of Drive in Years 1 and 2 and the selection/referral guidance that emerged partially in response to these findings²⁷:

- *Current Drive case referral and early closure guidance are on the right track – 7 out of 10 pilot cases where risk reduction could not be attributed to Drive did not pass current selection criteria for Drive. Meanwhile, 5 out of the same 10 would have qualified for early closure.*
- *It was possible to have a positive impact on cases that did not fit the current selection criteria, but a positive impact was twice as likely on cases that did fit the criteria.*
- *A degree of statutory involvement is a key factor in engaging service users.*
- *A degree of service user 'need' is a key factor in engaging service users.*
- *Drive works best where there is a combination of statutory compulsion and meeting a service user's needs (ie support).*
- *IDVA work is absolutely critical to the reduction in risk.*
- *Significant risk reductions can be achieved without making contact with the service user – by working with the victim-survivor and through multi-agency disruption activity.*
- *Where other agencies are not involved with the service user and/or the victim-survivor is not in contact with the IDVA, it is extremely challenging to engage the service user or to manage risk effectively.*

Case Note Analysis Method and Rationale

In Year 3, we conducted an in-depth analysis of 18 Drive cases using case notes recorded on the Drive case management system and, where available, the corresponding case notes on the IDVA case management system. As indicated in the Methodology chapter earlier, the initial

²⁷ Under the conditions of the Pilot study (from which these cases were selected), cases were randomly allocated either to Drive or the control. To have chosen cases for inclusion in Drive without knowledge/evidence of whether Drive works, or for whom, would have undermined the study. Since the end of the Pilot, where Drive has been rolled out further or provision continued, Service Managers and (where present) Domestic Abuse Perpetrator Panel (DAPP) members have selected cases for referral to Drive using criteria that draw on learning from the evaluation of Drive in Years 1 and 2. These criteria include there being opportunities for engagement/disruption, levels of complex need, recency frequency and gravity of the offences, potential for harm/lifelong learning for that individual and length of custodial sentence. All of this is alongside contextual expert practitioner judgement.

aim of this analysis was to deepen the insight into best practice that we had developed in Years 1 and 2. We used the quantitative data on risk and DVA behaviours as a way of selecting cases. We selected cases for analysis that had been scored as having achieved risk reduction and/or positive behaviour change across two or more abuse types. Within these cases we then identified 'exemplary practice' where actions taken by case or service managers aimed at risk reduction, disruption and or behaviour change that were by our analysis, innovative, skilful, accountable and risk-aware.

In addition to identifying and deepening our understanding of best practice, we wanted to know whether those 'exemplary practices' were the key reason that risk was recorded as having reduced and/or behaviour was recorded as having positively changed. In essence, this is the question that emerged in Years 1 and 2 of the evaluation: 'would the positive changes we see have happened anyway (ie without Drive)?' We defined an outcome (for example, a report of positive behaviour change or the recall of a service user for breach of licence conditions) as attributable to Drive where it was evidenced as the result (directly or indirectly through advocacy) of an action taken by a Drive case manager or service manager or by an IDVA in between month 4 and case closure (since the victim-survivor would have received IDVA support for three or four months regardless). We recognise that assigning causation to outcomes is fraught with ambiguity – it is impossible to state categorically that particular actions would *never* have happened otherwise. Moreover, it is *possible* that actions not directly attributable to Drive (in the way described above), may be *indirectly* attributable to the extent that the presence of Drive in an area may contribute to a culture change that enables or encourages other practitioners to be more proactive in response to DVA than they otherwise would have been (interviews with practitioners suggest that this may well be the case – and there appears to be evidence of this with regard to the longitudinal police data in the chapter on Change in Behaviour of Drive service users). With these caveats noted, it is possible nonetheless to make an assessment of whether or to what extent a particular action seems attributable to Drive. For example, if it is recorded in the case notes that the Drive case manager passed information to the service user's offender manager that the service user was breaching his licence conditions and the offender manager subsequently recalled the service user, this we would class as attributable to Drive. Conversely, if the offender manager passed information to the case manager that the service user had been recalled, we would not class this recall as attributable to Drive though it may contribute to a reduction in risk.

In our analysis then, there are two components to a 'good' case – firstly that it demonstrated good practice and secondly that risk reduction or positive behaviour change (ie a 'good' outcome) was achieved as a result of those practices – that is, as far as it is possible to tell, it appears unlikely that the good outcome would have been achieved if Drive had not been involved in the case.

In accordance with this approach, we identified three categories of cases and the analysis of these are below:

1. Reductions in risk and/or positive behaviour change are clearly attributable to Drive. N=8/18
 - a. Risk reduction predominantly via work with service user (N=5)
 - b. Risk reduction predominantly via work with victim-survivor (N=3)
2. Reductions in risk and/or positive behaviour change are not clearly attributable to Drive but exemplary casework is present. N=3/18.

3. Reductions in risk and/or positive behaviour are not clearly attributable to Drive where case work is standard. N=7/18.

Of the 18 cases we examined, we found eight that demonstrated exemplary practice (meaning particularly innovative, rigorous or skilful attempts at achieving risk reduction or behaviour change were attempted) where reductions in risk and/or positive changes in behaviour could be clearly attributed to Drive. In the analysis below, we have divided these cases into two groupings – those where the risk reduction achieved was predominantly via work with the service user and those where it was predominantly achieved via work with the victim-survivor. While all cases involve some working focused around the victim-survivor *and* service user it is nonetheless the case that the weighting of work that was possible with one or the other varies and this seemed important to make clear. If it were the case that all of the risk reduction that occurred as a result of Drive were through work with the victim-survivor, for example, then this would require a change to the current approach.

A further three cases demonstrated exemplary practice, but it was not clear in the case notes that this had any discernible positive effect on the outcome recorded. As we show below, this could have been down to a range of factors, from service user intransience to failures elsewhere in the wider multi-agency ecosystem. The remaining seven cases we analysed in depth did contain examples of good practice but did not stand out as especially innovative and it was not clear in the case notes that Drive had a substantive impact on risk reduction or behaviour change. Thus, there were then a total of 10 cases out of the 18 where risk reduction or behaviour change was not clearly attributable to Drive.

That Drive did not have a discernible impact on this proportion of cases raises the question of appropriate referral/selection guidance for a Drive case.

Since the end of the pilot, in cases where there appears to be a low likelihood of making contact with the service user or conducting meaningful disruption and/or risk-management activity, Drive have had the option to close the case 'early' – that is, prior to the allocated 10 months. In the examples and analysis that follows, we assessed whether the case would have been selected if the current selection guidance had been in force and/or whether the case would have qualified for early closure.

Of the ten cases where risk reduction and/or behaviour change could not be clearly attributed to Drive, we assessed seven as unlikely to have passed current case selection guidance and five as qualifying for early closure if this had been an option at the time. Of the eight cases where risk reduction or behaviour change was clearly attributable to Drive, we assessed that four would have passed current case selection guidance, two may have (ie it was unclear whether they would have or not) and two would not have passed the guidance criteria. These findings suggest that current guidance criteria are on the right track²⁸, and indicate that positive impact may be more likely with cases that would have passed the guidance criteria.

²⁸ Even if the guidance were 'perfect' we would not expect to find 100% conformity (between a case passing inclusion and Drive achieving impact). The fact that a case meets the guidance criteria will

GROUP 1:***Exemplary casework where reductions in risk and/or positive behaviour change are clearly attributable to Drive. N=8/18***

The eight cases in which Drive had a clear positive impact on risk reduction shared the common factor of a high degree of IDVA-case manager communication, information sharing and collaborative working. All had some statutory involvement, with six using statutory involvement to compel the service user to engage - either as Rehabilitation Activity Requirements (RAR) days, to comply with a child protection plan or via the National Probation Service (NPS) probation officer while the service user was in prison. In those six cases where some statutory compulsion was deployed, the service user did engage. In the two exemplary cases where engagement did not occur, risk reduction was achieved through a combination of IDVA work and/or disruption, multi-agency working and institutional advocacy to heighten agency awareness of risk and prompt action. By our assessment, four out of eight of these cases would have passed the guidance criteria currently in use. In two cases it was unclear whether they would have passed the selection criteria and two would be very unlikely to have passed due to the low likelihood of engagement or possible avenues for disruption. The two cases that were less likely to have passed would have qualified for early closure if this had been available as an option at the time. We further divided the 8 cases in this group along the lines of whether risk reduction was achieved *primarily* via work with the service user (n=5) or *primarily* via work with the victim-survivor (n=3).

Example from Group 1 – Drive-attributable risk reduction primarily via work with the service user: *Child Protection Process as an Effective Lever for Engagement*

Motivation to engage: parenting/fatherhood

Lever: CSS CP process

Needs: material low, emotional high

MA work: IDVA, CSS.

CJ Measures: Injunction and RO

Selection Criteria: Pass

Candidate for early closure: No

The service user in this case had been physically violent and controlling towards his partner, the mother of their two children. Social services were involved from the outset and provided useful and relevant information to the Drive case manager to inform contact and engagement – notably that the service user reported that he ‘will do whatever it takes to keep his family

never guarantee Drive-attributable impact at the level of that individual case – it simply means that Drive-attributable impact is more likely on that case than it would be on a case that did not meet the guidance criteria. Likewise, a case not passing guidance criteria does not mean a positive is impossible – just that it is less likely than on a case that passed.

together.’ These were identified as the levers to engagement. The service user’s motivation to engage was around wanting to be a good parent.

The case manager worked jointly with the social worker and service user to enable him to understand and contribute to the child protection process in a more productive way than he had previously. Alongside this, the case manager began engaging one to one with the service user in bespoke behaviour-change sessions to challenge his high levels of minimisation, denial, and blame. The case notes detailed that the case manager worked to ensure the service user could identify and understand his controlling behaviour, encouraging him to think about ways in which to manage his actions and how they were impacting the victim and their children. The victim-survivor initially engaged, and then had sporadic engagement throughout the case, but was reporting positive changes. Progress was noted and the children were also taken off the child protection plan, as the social worker had assessed that the risk to the children had significantly reduced.

At case closure, the service user was referred to a 26-week domestic violence perpetrator programme (DVPP) but did not wish to attend – after fifteen months, the case manager had received a call from the social worker reporting that there had been a deterioration in the service user’s behaviour. Drive acted quickly to re-refer the service user to the DVPP, which he attended, and no further incidents have been reported at the time of writing.

I have been involved in a case with [case manager] that was being monitored under Child Protection. Today the children’s names were removed from the register following a 9-month period. Whilst there have been a number of agencies involved with the family, I am of the view that [case manager]’s involvement has been pivotal in the positive changes made with the family. I have observed [case manager] directly work with [service user] within his positive contribution at core group meetings. He developed a positive relationship with [service user] and as such the plan of work had developed. Having had direct discussions with [service user] he values the support that was provided to him and is now able to recognise when his emotions are becoming heightened and has learnt new strategies to diffuse a situation. There have been no reported incidents since the offence last year and therefore the level of risk significantly reduced. It is a shame the project is still within the pilot stage as this service would benefit so many families.

Many thanks [Social Worker] Social Worker Family Support Team

Although the service user did not have complex needs, the child protection process was able to be used as an effective lever for engagement with the Drive case manager. This led to a substantial amount of positive work being undertaken, and improvements – however, it is noted that ten months is not necessarily long enough for a change in entrenched behaviours and that there needs to be the flexibility and support available post-initial Drive support.

GROUP 2: Reductions in risk and/or positive behaviour change are not clearly attributable to Drive but exemplary casework is present. N=3/16.

The three cases we analysed in this section were recorded as having reduced risk and/or evidenced positive behaviour change in the corresponding Drive assessments (the Drive DASH and/or ABI respectively). Qualitative analysis of these cases suggests that these

positive changes are not clearly attributable to Drive activity, despite the case evidencing some detailed and/or skilful casework. All three cases involved extremely high risk, high harm perpetrators, two of whom engaged with their case manager in what appears in the notes to be exemplary one-to-one work but which met high levels of resistance and continued minimisation, denial and blame by the service users themselves. The third was a non-contact case while the service user was in prison – this case demonstrated some outstanding attempts at disruption and institutional advocacy but that ultimately failed, it appears, due to a lack of prioritisation from the police and prison officers involved. At least two of the three had extensive DA and non-DA offending histories, all had current restraining orders in place and were either out on licence or in prison. Two of the three would have been unlikely to have been included under the current selection criteria – one due to existing high-level multi-agency supervision (WISDOM AND MAPPA) and one due to the length of custodial sentence. One of the three would likely have qualified for early closure.

Example from Group 2 – Reductions in risk and/or positive behaviour change are not clearly attributable to Drive but exemplary casework is present: *skilled and persistent attempts at behaviour change without a breakthrough*

Motivation to engage: Unknown

Levers: RAR Days, CP process

Needs: Possible mental health

MA work: Social Services, Police, IDVA

CJ Measures: Probation

Selection Criteria: This case would be likely to be included in Drive

Candidate for early closure: No

The service user in this case was making death threats and using high levels of physical violence against his ex-/partner who at intake was stating (to the IDVA) that she wanted to end the relationship but was remaining in it out of fear. The Drive case manager showed some exemplary, innovative attempts at trying to engage the Drive service user who was presenting as very resistant to change with high levels of denial in behaviour-change interventions and the case manager does record some minimised admission of his behaviour by the service user and subsequently some changes in the way he spoke about women. These actions may be a very small sign of change. There were also examples of good practice in multi-agency work between the Drive case manager and offender manager and Drive case manager and IDVA. Ultimately, it appears that in this case risk reduced primarily due to the restraining order, which he did respect, and the self-agency given to the victim-survivor as a result of this order and support by the IDVA in separating from the service user, resulting in feelings of increased safety. This likely would have happened without Drive. The key IDVA work was carried out in months 1–3 – ie standard provision. It is possible that further risk reduction was achieved by there being heightened multi-agency awareness of the service user's activities but there is no clear evidence of this. Behaviour change seems to have been largely unsuccessful – with a

longer duration or higher intensity it may have been more effective, however, he declined the offer of ongoing behaviour-change support through a DVPP. There seems to be a very low likelihood that any positive change will occur post-Drive. The key question then, post-Drive, is how agencies will monitor this individual to better manage risk.

GROUP 3: Reductions in risk and/or positive behaviour are not clearly attributable to Drive where case work is standard. N=7/16.

As with the previous cases, these cases showed reductions in risk or behaviour change in Drive assessments. In our analysis of the case notes, it is not clear that the reported reductions in risk or positive changes in behaviour in these cases are due to Drive. The casework here was by our analysis, of a good standard, meaning that it was safe, collaborative and entirely defensible – it simply did not stand out as exemplary to the degree that the cases listed above did. In these cases, we see lower levels of criminal justice involvement with only some of the cases having some criminal justice measures imposed. Contact was also much more challenging in these cases, with one-to-one work occurring in three of the seven and in those cases often inconsistently and/or ending before case closure. Crucially, by our analysis, only two of these cases would have passed the current selection criteria for a Drive Case, while five would have qualified for early closure due to the lack of options for meaningful impact on behaviour or risk reduction.

3.1 Challenging and patchy engagement despite Rehabilitation Activity Requirement (RAR) days on Drive

Motivation to engage: Unknown

Levers: RAR Days, Access to substance misuse service

Needs: Substance Use

MA work: CRC, IDVA

CJ Measures: RO, RAR days, suspended sentence

Selection Criteria: It seems likely this case would be selected given the level of offending and short/suspended sentencing and substance use both providing possible levers to engage.

Candidate for early closure: Possible due to service user disengagement.

At Drive intake, this service user was serving an 8-week suspended sentence with RAR days for burglary of his parents' home. He was also on licence for DV-related offences and was using crack cocaine. CRC agreed to include Drive in the sentence plan allowing Drive one-to-one work to be conducted as part of the service user's RAR days. Upon meeting him it was agreed that additional support in relation to his substance misuse was required and it also became an additional lever for engagement. The case manager worked with a local substance-misuse agency to support him in engaging and to ensure the service user could get help with his substance misuse. This was also a practical way to engage the service user in one-to-one work, as the Drive case manager would meet with the service user after his

appointments at the substance-misuse service. In these appointments, the service user evidenced high levels of minimisation, denial and blame and a reluctance to acknowledge a need to make any changes to his behaviour, making any attempt at behaviour-change interventions very hard. The service user also blamed the victim-survivor for his level of substance misuse. Five months past the point of referral, the service user completely disengaged with the case manager. The victim-survivor periodically engaged with the IDVA, and IDVA work was carried out post-three months. There was good work carried out on this case and there were reported reductions in risk during the time it was open, however there is not sufficient evidence in the case notes to class it either as exemplary or as having had a significant impact on risk reduction.

HOW DOES THE MODEL GENERATE OR REQUIRE AGENCY OR SYSTEMS CHANGE?

As the previous chapters have demonstrated, Drive is having a positive impact on increasing victim-survivor safety and space for action, as well as facilitating service user behaviour change, especially for those with a variety of needs, severe DVA and who may be serial perpetrators. It is a multifaceted and complex intervention. Moreover, Drive is most effective when embedded in well-functioning multi-agency ecosystems and relies on case managers and IDVAs who are highly skilled. In this concluding chapter, we take up the wider thematic issues from the evaluation, regarding processes both within and around Drive.

The chapter combines our findings from the three years of the evaluation. Our findings were fed back to the Drive Project at regular intervals, and it should be noted that as a consequence, some of the areas we highlight in this chapter have already been implemented and/or tried beyond the pilot period, for instance, access to police data systems, guidance on referral and closure of cases, and a disruption toolkit detailing best practice cases. However, apart from the guidance criteria – which we consider in the chapter on case note analysis – we are unable to comment further as these changes were outside our remit and/or timeframe.

The following sections are divided into a) *the Drive casework process*, referring to the work carried out by and within the Drive team and b) *the wider multi-agency ecosystem*, referring to the web of agencies and relationships within which the respective Drive teams are situated.

The points listed below emerge from analysis of practitioner, service user and victim-survivor interviews.

Systems Change: The Drive Casework Process

- ***Caseloads***

Case managers find it increasingly challenging to do the very in-depth and reflective practice they were able to do when Drive started, due to increased caseloads. There is a risk that the bespoke, innovative, and unique character of Drive casework, which service users seem to be responding well to, may not be possible with caseloads above 25. There is also a concern that teams may lose skilled practitioners and their knowledge due to increased staff turnover. To help mitigate differences in the workload carried by each case (some are very time-intensive, others require much less input), a case workload assessment tool would be helpful to enable a fair allocation of cases within Drive teams. Ultimately, however, the question is one of cost and the value placed on the kind of changes that can be achieved with more in-depth work.

- ***Access to Police Data Systems***

Access to police data systems would save a great deal of Drive practitioner time when researching service user backgrounds.

- ***Service Users with Very High Mental Health Needs or High Levels of Other Criminality***

As discussed above, while mental health need seemed to be a benefit to engagement for some, practitioners also expressed concern that above a certain threshold of mental health need, it is almost impossible to engage service users in behaviour-change work, although other support and/or disrupt interventions were possible. For those with very high levels of other criminality engagement, behaviour-change work was also rarely possible. In some cases, indirect work on disruption and risk management was also less urgent if service users were under the purview of other agencies, like Integrated Offender Management (IOM).

- ***Stalking Cases***

Stalking cases were identified by case managers as the most challenging for both direct and indirect work. These were cases where service user denial and minimisation was often very high, where service users often lacked convictions to enable straightforward contact approaches, and where disruption activity could involve costly surveillance. One proposal was that stalking cases could be outsourced to a more specialist service, but this relies on such a service existing in the locality.

- ***Direct Work in the Absence of Another Agency Contact***

An ongoing challenge for direct work has been making initial contact in the absence of other agency connections to the service user. This was especially the case when the service user had very few identified material needs. The effect of this is that service users with higher financial security, due to income or existing wealth, may be both less visible and less accessible to Drive.

- ***IDVA Provision***

Year 1 indicated that a dedicated Drive IDVA, as opposed to an IDVA team with each IDVA having responsibility for some Drive and some non-Drive cases, was the optimal arrangement for Drive IDVA provision. Year 2 has highlighted that this can result in bottlenecks where dedicated IDVA provision relies on a single individual.

Two of the Drive sites saw continual change to the IDVA provision over the course of Year 2. One common challenge to these sites was the lack of clarity for IDVAs working on Drive cases around what differentiates working on a Drive case and on the lines of management and accountability. IDVA provision such that the Drive IDVA(s) is/are managed or co-supervised by the Drive service manager would help to alleviate this issue, and that has been even more apparent in Year 3.

- ***Sharing Best Practice on Disruption Activity***

Drive disruption activity is an innovative area of multi-agency practice with a huge variety of interventions taking place across the three sites. More information, skill sharing, and documentation of disruption activity would be useful. A disruption toolkit detailing case studies and offering possible courses of action for various scenarios could be a helpful resource. More training around disruption would be useful for wider agencies, especially police and probation.

- ***Drive Training***

There was feedback from newer Drive workers that more practical aspects to the Drive training would be useful, especially around challenging service users' talk in one-on-one settings. This could take the form of new case managers shadowing their more experienced colleagues and/or a greater emphasis on these skills in the training.

- ***More Effective Measurement/Assessment Tools***

The Drive cohort differ in significant ways from the typical participant of a structured group-work Domestic Violence Perpetrator Programme (DVPP). As we outlined in the opening sections, this is in part in terms of their levels and complexity of need, but also, and importantly, in terms of the degree to which they openly recognise their behaviour as problematic, take responsibility, and are committed to change.

Case managers felt that this difference in 'readiness to change,' paired with the precarity of engagement of service users with complex needs, meant that existing outcome measurement tools with an evidence base, such as the Impact Toolkit and URICA, which are completed by the service user, were difficult for Drive case managers to use consistently and posed a high risk of disengagement. For these reasons, Drive case managers were reluctant to use them. An additional issue was the Impact Toolkit 3-month timeframe set out in the behaviour questions. For example, these questions asked 'how many times in the last three months have you...' Three months was felt to be too small a window as for many Drive service users, the time window between a Drive-triggering incident or offence and initial contact was more than three months. This meant that service users who had been convicted of very serious DVA but had, for example, been in prison prior to engagement, would appear to start the intervention as relatively low risk.

- ***Case Referral and Early Closure Criteria***

The desire for referral criteria – or simply to be able to select Drive cases rather than have them randomly allocated – was mentioned by every practitioner interviewed²⁹. However, there was little consensus on whether Drive should aim for early intervention and behaviour change or risk management and disruption, or some combination of the two. Proposals for referral criteria included:

- Recency Frequency Gravity (RFG) of abuse – the idea that within certain thresholds of RFG, a case could be considered as eligible for Drive. Where these thresholds sit remains to be established.
- Severity of mental health need – it has been suggested that the severity of diagnosis for some service users is so high that it is rendering them 'incapable of empathy'

²⁹ As could be seen in the chapter on case note analysis, guidance has been developed and is in place in new sites who are testing the replication of Drive. The model being used draws from learning in practice and learning from our evaluation (eg referral guidance, perpetrator panels, early case closure, Drive Fellow in place, ie a senior police sponsor and local champion/leader for Drive).

and/or behaviour change. For this reason, some argue for a threshold above which service users are considered unsuitable for Drive's behavioural-change element. The severity of mental health need of some service users interviewed (who were high engagers) suggests that if such a threshold were to be implemented, it would need to be very specific.

- Levels of other offending – service users with very high levels of other offending are often eligible for other interventions, like Integrated Offender Management. These service users can be difficult to achieve behaviour change with and for some there is disruption in place via other agencies. As such, they may not be suitable for Drive.
- Out-of-area referrals – it is very challenging to conduct either non-contact or contact work when the Drive service user does not reside in the Drive area. Service users residing out of the Drive area would be an exclusion criterion.

- ***Clarity on the Step-down Process for Local Agencies***

After 10 months on Drive, step-down support for service users is being managed by the three sites in different ways and it is too early to tell which model is most effective. A key theme that has been highlighted by multi-agency practitioner interviews is the need for local agencies to have greater clarity around what process is in place in their area and the corresponding requirements for continued information sharing and multi-agency working. For one site, more time could usefully be allocated to the step-down handover process to allow the case managers, IDVA and step-down worker to more effectively manage the handover.

- ***Better Monitoring of What Happens after Drive***

Questions remain around the sustainability of change for Drive service users, and more importantly, around who will continue to manage risk from the service users for whom behaviour change was not possible. The case studies presented in this report show Drive to be 'stepping in' where other agencies were unaware of the risk or unable, sometimes due to capacity, to act on it. When Drive is removed from those situations, it is unclear whether the wider multi-agency ecosystems are sufficiently equipped to monitor and support these high-risk individuals.

The case note analysis indicated in almost every 'good' case we assessed that questions remain as to what will happen after Drive to that service user. While a 6-month 'step-down' period during which the case remains open is a helpful addition to the model in this regard, a key learning from Drive is the very simple one that change with this type of service user takes a long time and is not always a linear process. This, in turn, highlights the importance of a functioning multi-agency ecosystem around Drive that service users can be referred out to and, in relation to statutory services, within which the service users' visibility has been heightened such that if future incidents do occur, they can be acted upon swiftly.

Systems Change: The Wider Multi-Agency Ecosystem

- ***Police and the Criminal Justice System***

Stakeholders interviewed felt that the police could make better use of tools available to them, for example, by using civil injunctions – including leading on the application for civil injunctions. A Community Rehabilitation Company offender manager we interviewed argued for a change

in Crown Prosecution Service (CPS) guidelines to allow use of a conditional caution as a disposal option for DVA perpetrators to facilitate engagement in a DVPP without the need for a court ruling.³⁰

In some cases, Drive case managers felt that the quality and utility of information provided by the police to Drive teams was variable, in part due to a lack of clarity on the part of the police on what constitutes Drive-relevant information. Training for police on what is applicable information for sharing with Drive could help with this.

The case note analysis indicated that staffing changes for the CRC offender manager without appropriate handover or notification was also a barrier in some cases. We would anticipate that this should improve with longevity of the project – nonetheless, additional training may help to embed Drive handover procedure into standard practice. Moreover, issues became apparent regarding the prison service, for instance that practitioners were not always aware that Drive could begin (or continue) while the service user was in prison.

- ***Multi-Agency Risk Assessment Conference (MARAC)***

Stakeholders interviewed identified significant and challenging issues with MARAC processes. For example, MARAC leadership and the effectiveness of the process varies between areas and meetings and is reliant on the resourcing capacity, experience, skills and DVA awareness of individuals and agencies supporting the MARAC process. Challenges included: inconsistent attendance by some agencies; some agencies attending only to hear ‘their’ cases rather than contribute to the whole process; variable perceptions of the strength of MARAC decisions; variable follow-up and accountability around agreed actions; variable utility as an information-sharing and practice-discussion space. Stakeholders interviewed felt that greater oversight and commitment to local MARACs is needed for them to function more effectively. Relatedly, there are variable approaches to the degree of information sharing between MARACs despite already existing protocols for MARAC-to-MARAC information sharing.

- ***Multi-Agency Perpetrator Forums***

Across the three years we saw considerable changes in this area, with development of perpetrator forums in all sites. Challenges were identified with set-up and resourcing, attendance and accountability. Agency buy-in and resourcing are critical here, especially from the police. A dedicated Drive worker to facilitate and promote the perpetrator forum is a key asset to ensuring this process is efficient and effective.³¹

- ***Economic Austerity and a Functioning Multi-Agency Ecosystem***

Drive relies on a healthy and functioning multi-agency ecosystem as it cannot fill all the gaps. Therefore, adequate funding of the services that Drive caseworkers refer to and draw on in their everyday work is crucial. Stakeholders interviewed identified multi-agency resource/capacity as a challenge in relation to work with:

- Police – in some areas there was a lack of capacity to consistently prioritise information sharing around Drive background research;

³⁰ This is now being piloted by the CPS.

³¹ This is now being implemented in the form of a Drive champion or Drive Fellow.

- Mental health – extremely long waiting lists, high thresholds for action, and low intensity of interventions;
- Housing – general lack of housing provision to refer service users to;
- Social services – some excellent multi-agency working enabled engagement of service users to take place because of the intensity of the Drive intervention. According to social workers involved, this level of multi-agency work and service user engagement would have been highly unlikely without Drive. If social services cannot reach the cohort of service users without Drive, it is essential to consider which agencies will be managing risk after Drive's involvement in a case ends.

- ***Mental Health Treatment Orders (MHTO)***

Case managers report that that in one area, MHTOs were made without the local provision to deliver them. This gap in services was then met by Drive case managers. This was partly a resource problem, but also suggests failings in communication between courts, probation and mental health services.

- ***Lack of Drive Recognition in Different Areas***

While the profile of Drive became increasingly recognisable and understood, gaps in knowledge for relevant agencies and individuals who may not know any information about Drive and what it does continued to emerge. This highlights the need for rolling outreach and training about Drive in each area – especially as multi-agency work is critical to the Drive model.

- ***Information Sharing***

While generally positive, challenges remain in certain areas about ease of information sharing with different agencies. To illustrate this, there have been challenges with housing agencies due to the lack of a single identifiable point of contact among multiple providers. Additionally, the police have struggled with information sharing because of a lack of resources and prioritisation. Social services and local authorities have also proved challenging – mainly due to local management priorities and pressures.

The case note analysis found that some Drive case manager actions could be achieved through better multi-agency relationships, for example, case manager requests for information sharing from CRC, NPS and police on behalf of the IDVA. In one case, which was also a MAPPA case and subject to a different local offender management initiative (WISDOM), the police used the case manager as a conduit to pass on information to the IDVA. While there are conceivable scenarios in which this could be an effective use of resources, in this particular case it did not appear to benefit the perpetrator side of the work. Better relationships between police and the IDVA team such that police go direct where appropriate would be a better use of resources. To enable this, training may be needed for offender managers (OMs) and police, demonstrating how they can and when they should collaborate and/or actively pass information on to IDVAs as opposed to placing the onus on the IDVA to make the request. Similarly, requesting police watch on a service user could be done by an IDVA – this was usually done by the case manager. Again, police training may be needed to enhance the profile (and perceived authority) of IDVAs in the eyes of police. IDVAs would also need to be adequately funded to be able to take on any actions that widened the scope of the role.

To help mitigate the challenge of high staff turnover and reliance on practitioners' personal connections for information gathering, there needs to be an establishment of a central point of contact for each agency, with Drive collaboration as a designated aspect of their role.

- ***Working Across Local Borders***

While there has been some excellent work by case managers facilitating cross-border information sharing, this has often been difficult to establish. Challenges involving capacity for Drive teams, who may not have sufficient tools to contest a refusal of information sharing from an out-of-area MARAC, are hurdles to successful cross-border work. Cross-border information sharing within probation (CRC) is particularly challenging due to the privatised nature of provision, lack of knowledge about Drive, and unfamiliarity with information-sharing protocols.

- ***Drive as the 'Best Available Mental Health' Intervention***

As mentioned earlier, the highly-engaging service users selected as interview participants had a variety of mental health needs. The desire for help focused on their mental health need formed part of the reason for the strong engagement of these service users.

Depending on severity, extremely high levels of mental health needs potentially posed a challenge to engagement for some service users – hence the desire among some Drive case managers to screen out service users with very challenging diagnoses.

However, even for those with challenging mental health conditions who did not engage, critical risk management was possible through indirect working. This was conducted against a backdrop of local mental health provision that was overstretched and under-resourced with long waiting lists, extremely high treatment thresholds, and a lack of frequent and dedicated high-intensity one-on-one casework.

Given these challenges within local mental health provision, it seems highly unlikely that either the one-on-one casework or non-contact indirect risk management activities would have occurred without Drive. While this is not the explicit focus of Drive work, the Drive model seems to be effective at responding to needs that are otherwise not being met. The question then becomes – what is the risk of not doing this work, and if that risk is considered to be too high, who should pay for it?

- ***The Role of Social Services***

As evidenced in the case studies and the interviews with case managers and social workers, the level of multi-agency working with social services has been particularly noteworthy.

As with the mental health work, Drive case managers have been 'filling in' where the social workers involved in the case do not have time and/or capacity to extensively research the case or conduct the same frequency of visits to the service user.

Unlike the mental health work, there has been much closer joint working between social workers and case managers. The following quote from a social worker demonstrates that this close partnership working resulted in a 'deep' institutional advocacy, to the extent that it

changed the perspective of the social worker's understanding of the dynamics of abuse in the case:

R So the actual contents of the session really were [Drive worker] talking to mum about what's acceptable and what's not in terms of domestic violence and behaviour from the son, and me doing it to [service user] to the son ... but also swapping that role round, so I'd be talking to mum, [case manager] be talking to [service user], just to get that kind of extra opinion and influence into a situation.

I And did that change the way that you saw the situation?

R It did, yes it did. I think for me as an individual worker... I can't speak for the other people in my service, but certainly as an individual worker, you kind of get used to blurring the boundaries and trying to engage with families whose behaviour may not be the norm shall we say. So, to have somebody say, 'well actually, you know this is abuse, this isn't correct,' you know you shouldn't be... and whilst I know that and I'm sure my colleagues know that, it's so difficult to engage with some people that you're making allowances, aren't you? So, having somebody from the project kind of spelling it out... especially to [service user], [service user]'s mum – spelling out that this behaviour isn't acceptable, and she shouldn't be living her life with this kind of constant anxiety around [service user]'s behaviour and his outbursts (social work practitioner).

The case manager's role in this case was changing the practices and perceptions of other professionals through collaborative working.

Case managers have also facilitated better engagement by service users with the child protection system. For example, working with service users to explain requirements, address issues around the impact of abuse on children, and provide skills for impulse control has enabled service users to be present during the core group meetings where previously this was not possible. The extent to which subtler or 'deep' institutional advocacy work cultivates attention to abuse that was previously unseen or offers additional mechanisms for holding perpetrators to account is promising.

It is not, however, entirely unproblematic – the way this kind of co-working has been reported by social workers has occasionally revealed a gendered character to who is authorised to speak the truth about victims-survivors. One social worker described hearing from the Drive case manager as being more 'valid' than hearing from the IDVA or, it is implied, from the victim-survivor. This was justified with the claim that the case manager is in direct contact with the service user, which is true, but suggests direct contact with the victim-survivor, which is where the IDVA's perspective is drawn from, is somehow less believable or valid.

Prioritising men's knowledge either directly, as in this case – the case manager is a man – or indirectly when hearing from a male service user, and the suspicion of victim-survivor testimony is something that evidently remains an issue in the field.

- **Using Pro-social Terminology**

We found that 'Fail to attend' was a common term in the case notes from case managers, offender managers and police. This seems an unnecessarily morally loaded use of language, suggesting a failure of the person rather than simply describing what occurred – eg 'the service user did not attend'. It also places the responsibility for non-attendance entirely with the individual, disallowing for the possibility that the actions of services/practitioners played a part

in non-attendance. This is particularly problematic when used to describe the non-attendance of victims-survivors whose non-attendance may have been intimately tied up with the abuse they were experiencing.

There is a parallel here to the use of the phrase service user/victim-survivor is 'difficult to engage' which ascribes the person a negative quality and shields the practitioner/service from any perceived failing – again a more accurate and pro-social description (to the extent that it models the taking of responsibility) would be 'we struggled to engage the service user/ victim-survivor' or 'we had difficulties engaging the service user/victim-survivor'.

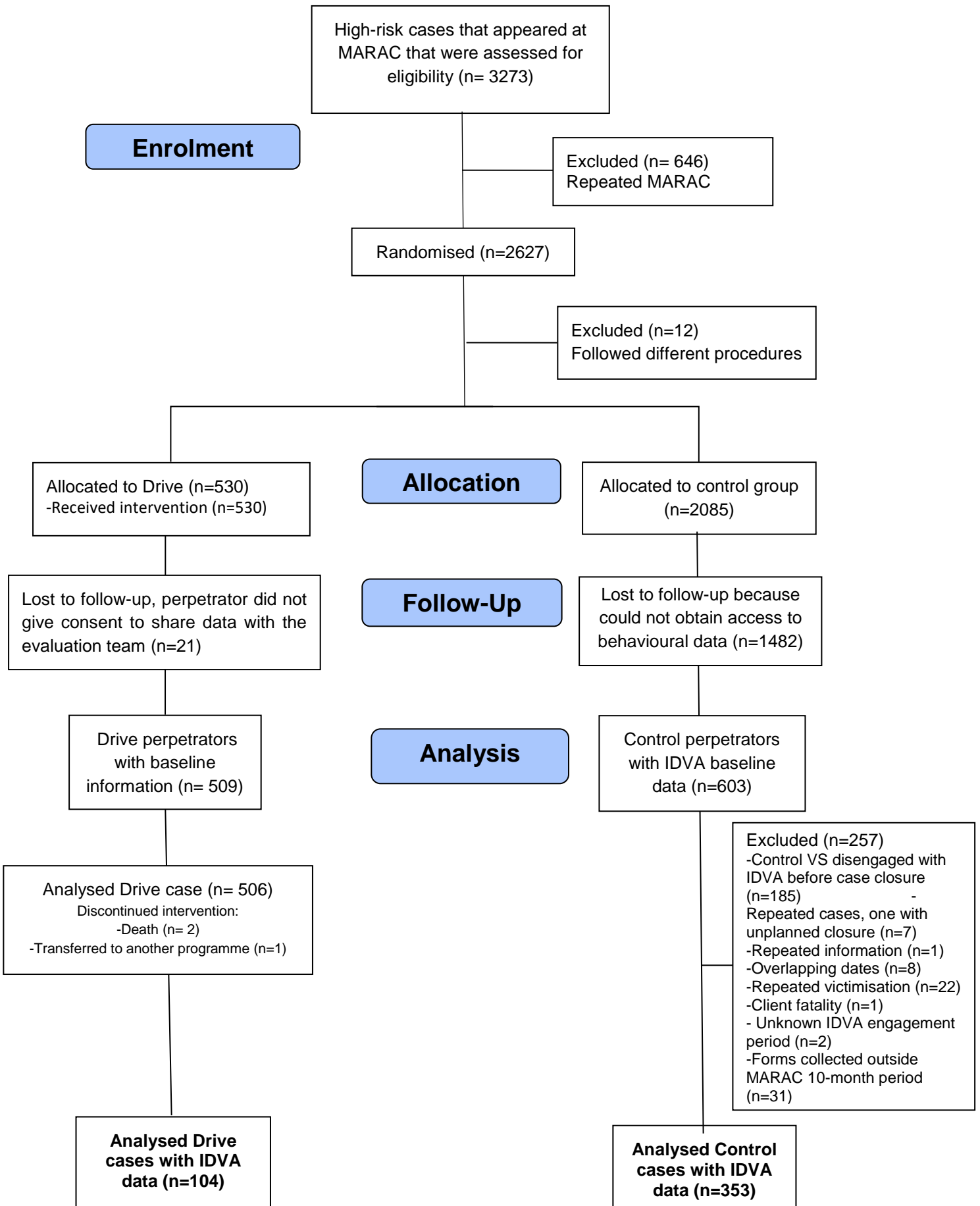
We therefore suggest that language used by practitioners needs to be revised to fit with the ethos of Drive.

REFERENCES

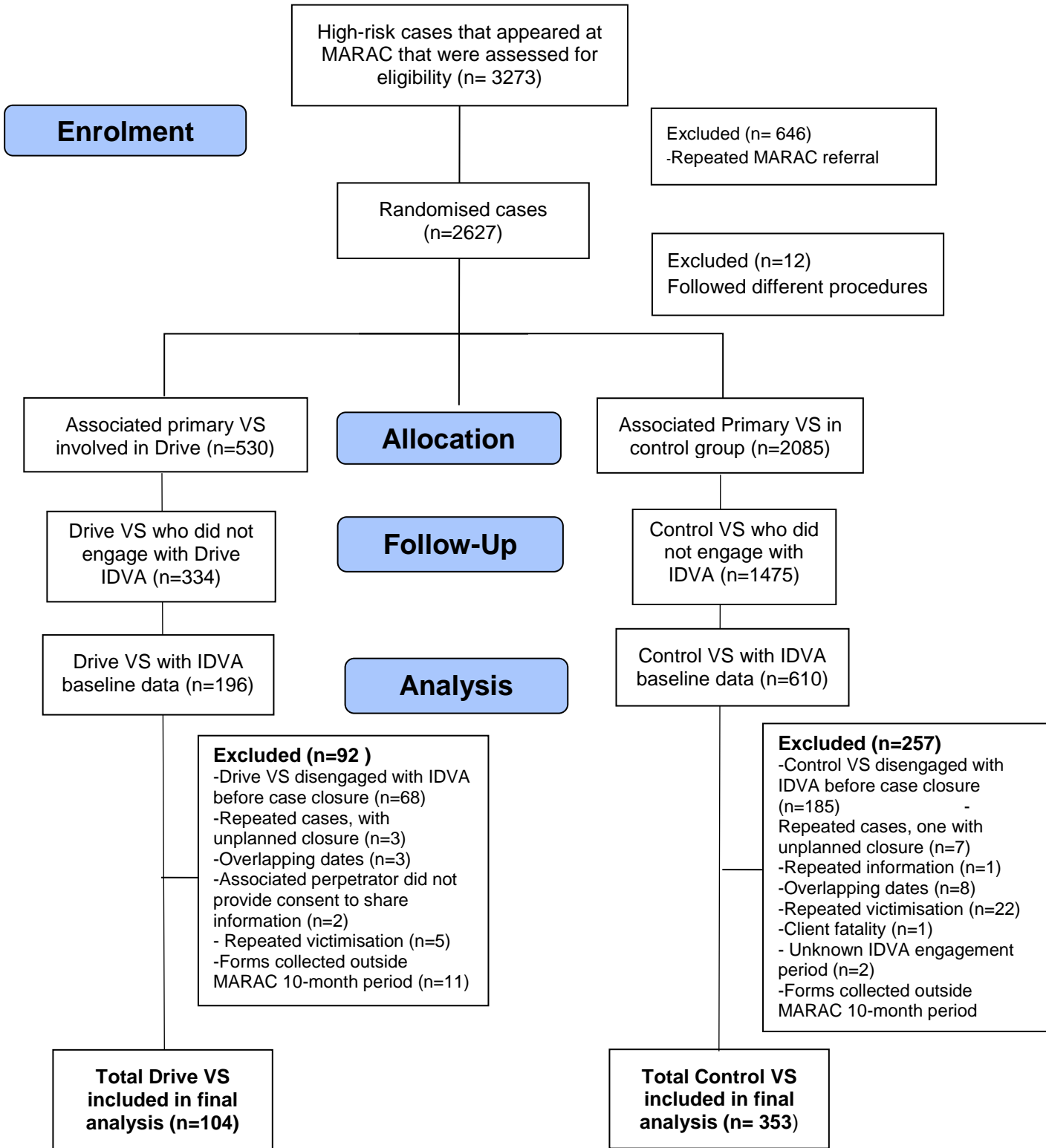
- Hester, M., Westmarland, N., Gangoli, G., Wilkinson, M., O’Kelly, C., Kent, A. & Diamond, A. (2006) *Domestic Violence Perpetrators: Identifying Needs to Inform Early Intervention*, Bristol: University of Bristol in association with the Northern Rock Foundation and the Home Office.
- Hester, M., Eisenstadt, N., Jones, C., & Morgan, K. (2017) *Evaluation of the Drive Project - Year 1 Feasibility Study*, Bristol: University of Bristol in association with the Drive Project.
- Howarth, E., Stimpson, L., Barran, D., and Robinson, A. (2009) *Safety in Numbers: A Multi-site Evaluation of Independent Domestic Violence Advisor Services*. London, The Hestia Fund and The Henry Smith Charity.
- Kelly, L. and Westmarland, N. (2015) *Domestic Violence Perpetrator Programmes: Steps Towards Change. Project Mirabal Final Report*. London and Durham: London Metropolitan University and Durham University.
- 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*, 1–17. DOI: 10.1177/0306624X16673853
- Ofsted, Care Quality Commission (CQC), HMI Constabulary and Fire & Rescue Services (HMICFRS), and HMI Probation (HMIP) (2017) *The multi-agency response to children living with domestic abuse*, No. 170036.
- ONS (2018) *Sexual Offences in England and Wales*.
<https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/>
- Radford, L. and Hester, M. (2006) *Mothering through domestic violence*. London: Jessica Kingsley Publishers.
- Robinson, A. (2016): Serial Domestic Abuse in Wales: An Exploratory Study Into its Definition, Prevalence, Correlates, and Management, *Victims & Offenders*, DOI: 10.1080/15564886.2016.1187691
- SafeLives (2019) *Insights Idva England and Wales Dataset 2018-19: Adult Independent Domestic Advisor (Idva) Services*. Bristol: SafeLives.
- Steel, N., Blakeborough, L. and Nicholas, S. (2011) *Supporting high-risk victims of domestic violence: a review of Multi-Agency Risk Assessment Conferences (MARACs)*. London: Home Office
- Wistow, R., Kelly, L. & Westmarland, N. (2017) ‘Time out’ a strategy for reducing men’s violence against women in relationships? *Violence Against Women* 23(6): 730–748

Appendix 1: Study Flow Diagrams

Flow Diagram for Perpetrators



Flow Diagram for Primary Victim-survivor



Appendix 2: Service user needs additional information

Table A2.1 Distribution of needs across intake, mid-point and case closure

Variable	Intake (n=468)		Mid-point (n=487)		Closure (n=497)	
	N	% of yes	N	% of yes	N	% of yes
Housing need	456	22	472	27	483	24
Employment difficulties	435	19	461	27	469	31
Alcohol misuse	447	18	467	28	477	29
Relationship issues with children	452	17	472	18	484	15
Parenting capacity	436	16	459	18	468	17
Mental health difficulties	447	15	469	23	480	23
Drugs misuse	448	14	467	17	477	16
Relationship issues with family members	433	14	463	18	478	16
Financial difficulties	437	6	463	16	477	17
Social and community ties	435	7	464	14	474	12
Poor physical health	435	5	465	11	477	12
Other addictions	460	1	485	2	495	2

Appendix 3: Statistical methods

This section describes the statistical methods used throughout the Drive evaluation.

Section 1: Latent Class Analysis

Latent class analysis (LCA) is a model-based approach used to cluster individuals into distinctive groups also known as latent classes (Wang & Wang, 2012). The main objective of LCA is to identify subgroups of similar individuals. It identifies subgroups based on posterior membership probability, which allows for formal statistical procedures for determining the number of groups (Wang & Wang, 2012).

Measures

In order to be able to cluster service users into groups or classes, it is necessary to have a set of observed variables that help classify individuals based on their responses (Vermunt & Magidson, 2002). In the case of Drive evaluation, we were interested in classifying individuals based on the presence or absence of certain needs. We used data collected by case managers via the 'needs assessment form' in the case management system. The needs assessment form was divided into eight general sections namely: 1) housing; 2) physical health; 3) work training and education; 4) substance abuse and other addictions; 5) finance and debts; 6) children, families and parenting; 7) social and community support; and 8) mental health and psychological wellbeing. We identified 12 needs that would be useful to classify service users and therefore were considered appropriate latent class indicators:

1. Housing need
2. Employment difficulties
3. Alcohol misuse
4. Relationship issues with children
5. Parenting capacity
6. Mental health difficulties
7. Drugs misuse
8. Relationship issues with family members
9. Financial difficulties
10. Social and community ties
11. Poor physical health
12. Other addictions

Covariates

We were interested in assessing whether the latent classes predicted DVA behaviours. This type of LCA is known as conditional LCA and the DVA behaviour variables are known as distal outcomes. DVA behaviours (physical, sexual, harassment and stalking, and jealousy and control) were measured by case managers using a 'risk assessment form' where changes in severity of DVA behaviours were recorded at three different time points: intake, midpoint and case closure. These are time-variant ordinal variables with four severity categories 1) none;

2) standard; 3) moderate; and 4) high. However, in order to include them as distal outcomes these variables were dichotomised as yes and no.

Statistical analysis

To estimate the LCA model several steps were followed. First, we determined the optimal number of latent classes. To do this, model fit statistics and indices were used to determine how many classes/groups were in the sample. We ran a series of LCA models with an increasing number of latent classes. Because descriptive statistics showed 37% of service users reported not having any of the needs mentioned above, we knew beforehand that there was a subgroup of service users with no identified needs. In order not to reduce the sample size, we specified a zero-class as a priori. This class was formed by those service users who answered “no” to all 12 needs questions. In this way the model focused only on classifying those service users who had one more need to a specific group.

A total of six models were run and the model fit statistics of each of the models were compared: Table A3.1. To select the optimal number of classes, we reviewed the information criterion indices, namely Akaike’s Information Criterion (AIC), the Bayesian Information Criterion (BIC), and the Sample Adjusted Bayesian Information Criterion (SABIC) and identified which model had the lowest number (Nylund, Asparouhov, & Muthén, 2007)

Table A3.1 Model fit statistics for

	AIC	BIC	SABIC	Entropy
2-class model	4679.3	4733.7	4692.5	0.90
3-class model	4450.2	4559.1	4476.6	0.73
4-class model	4313.0	4476.3	4352.5	0.80
5-class model	4281.2	4499.0	4333.9	0.79
6-class model	4262.9	4535.1	4328.8	0.78

The second step was to examine the latent class classification. A criterion often used to assess the quality latent class classification (how good a model is at classifying individuals) is entropy (see Table A3.1). Good classification is when entropy values are closer to 1.0. The third step consisted in defining and labelling the latent classes. Once the optimal model is selected it is important to check that each latent class is meaningful and interpretable. The label of each of the classes is based on the item-response probabilities in that class, that is, the indicators (needs) composition for each class, specifically those needs that have higher item-response probability.

LCA analysis models were run using the statistical software Mplus version 8 (Muthen and Muthen, 2017).

Inclusion of covariates

There are a number of approaches to include covariates in LCA models, however, the 1-step approach and 3-step approach are the most common. For the purpose of this evaluation the 3-step approach was used. The 3-step approach involves performing the enumeration of classes first, followed by creating the most likely class variable using the latent class posterior

distribution (obtained during the first step), and then regressing the most likely class on the distal outcome (Asparouhov and Muthen, 2013).

Section 2: Pooled ordered logistic regression for behaviour change and possible predictors

Considering the longitudinal nature of the data it was important to incorporate the relation between time and the longitudinal measures available in models. Therefore, within longitudinal multivariate analysis, pooled logistic regression was used to evaluate the relationship the changes in DVA behaviours over time and different variables, including age, living arrangements, victim/perpetrator relationship status, direct contact with case managers and statutory involvement variables.

Measures

Dependent variables

DVA behaviours (physical, sexual, harassment and stalking, and jealousy and control) were measured by case managers using a 'risk assessment form' where changes in severity of DVA behaviours were recorded at three different time points: intake, midpoint and case closure. These are time-variant ordinal variables with four severity categories 1) none; 2) standard; 3) moderate: and 4) high.

Explanatory variables

Among the explanatory variables (or predictors) there were a mix of continuous and categorical variables. The only continuous variable included in the model was the age of service user at intake (in years). Among the categorical variables were: 'living arrangements with the victim-survivor' with three categories: 1) Not living together; 2) Living together; and 3) Living together intermittently; and 'victim/perpetrator relationship status' with five categories: 1) Current intimate partner; 2) Ex-intimate partner; 3) Intermittent intimate partner; 4) Family member; and 5) Other person. Among the binary variables included were: 'direct contact with case manager' (yes/no), 'DV charges' (yes/no), 'victim-survivor involvement with an IDVA' (yes/no) and statutory involvement variables such as Children and Young People's Services (CYPS) involvement (yes/no), criminal and civil justice (CCJ) involvement (yes/no).

Statistical analysis

In total, four pooled ordered logistic regression models were run, one per DVA behaviour. Predictors were the same for all four models. Pooled logistic models permitted pooling of the repeated measures of DVA over the years to assess whether their changes were attributable to predictor variables mentioned above.

Model coefficients were obtained in odd ratios. However, to facilitate the interpretation of findings marginal effects were used. Marginal effects are an alternative metric that can be used to describe how the outcome variable (in this case DVA behaviours) changes when an explanatory variable changes while holding all other variables constant in the model. The marginal effect provides the predicted probabilities for cases in one category relative to the reference category. In the main text, marginal effects for each model are presented in graphs so the reader can easily observe the trends of DVA behaviours in relation to changes in explanatory variables in the model. Marginal effects were only calculated when the association between the DVA and predictor was statistically significant.

Section 3: Random effect Poisson regression to assess changes in risk scores

To assess how the risk score changes over time, accounting for other variables such as site, we conducted a random effect Poisson regression. By using this method, we assume that the unobserved within-subject variation is uncorrelated or independent of the explanatory variables in all time periods (Wooldridge, 2013).

Measures

Dependent variables

The dependent variable for this model is the risk score obtained from the Drive-DASH. This score is a count variable which is a form of discrete variable that consists of non-negative integers.

Explanatory variables

Only one explanatory variable was included, which was site, a categorical variable with three categories 1) Site 1; 2) Site 2; and 3) Site 3.

Table A3.2 Results from Random effect Poisson regression assess changes in risk score over time

Drive-DASH score			IRR	Std. Err.	P-value	[95% Conf. interval]	
Time point	(ref.)						
Intake							
<i>Middle</i>			0.91	0.02	0.00	0.86	0.95
<i>Case closure</i>			0.82	0.02	0.00	0.78	0.87
Site (ref. Site 1)							
<i>Site 2</i>			0.95	0.05	0.27	0.86	1.04
<i>Site 3</i>			1.07	0.05	0.17	0.97	1.18

References for statistical methods

- Asparouhov, T., & Muthen, B. (2013). Auxiliary Variables in Mixture Modeling : 3-Step Approaches Using Mplus. *Mplus Web Notes: No. 15, 8(15)*, 1–48. <https://doi.org/http://dx.doi.org/10.1080/10705511.2014.915181>
- Nylund, K. L., Asparouhov, T., & Muthén, B. O. (2007). Deciding on the number of classes in latent class analysis and growth mixture modeling: A Monte Carlo simulation study. *Structural Equation Modeling, 14(4)*, 535–569. <https://doi.org/10.1080/10705510701575396>
- Wang, J., & Wang, X. (2012). *Structural Equation Modeling: Applications Using Mplus* (1st edition). John Wiley & Sons, Ltd.
- Wooldridge, J. M. (2013). *Introductory Econometrics: A modern approach* (5th edition). South-Western CENGAGE learning.
- Vermunt, J. K., & Magidson, J. (2002). Latent class cluster analysis. In J. A. Hagenaars & A. L. McCutcheon (Eds.), *Applied Latent Class Analysis* (1st edition, pp. 89–106). Cambridge University Press. <https://doi.org/10.1017/CBO9780511499531.004>

Appendix 4: Other statistical results

Figure A4.1 Changes in sexual abuse and factor resulted from the pooled order logistic regression

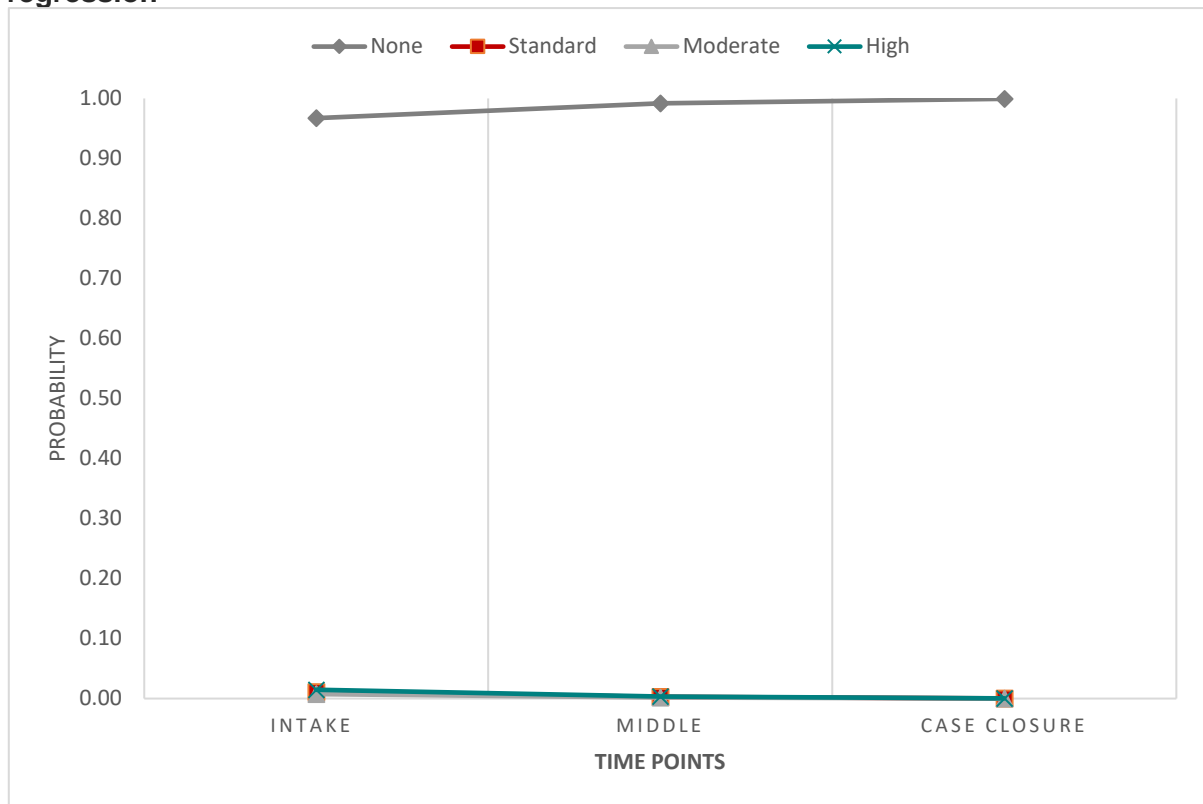
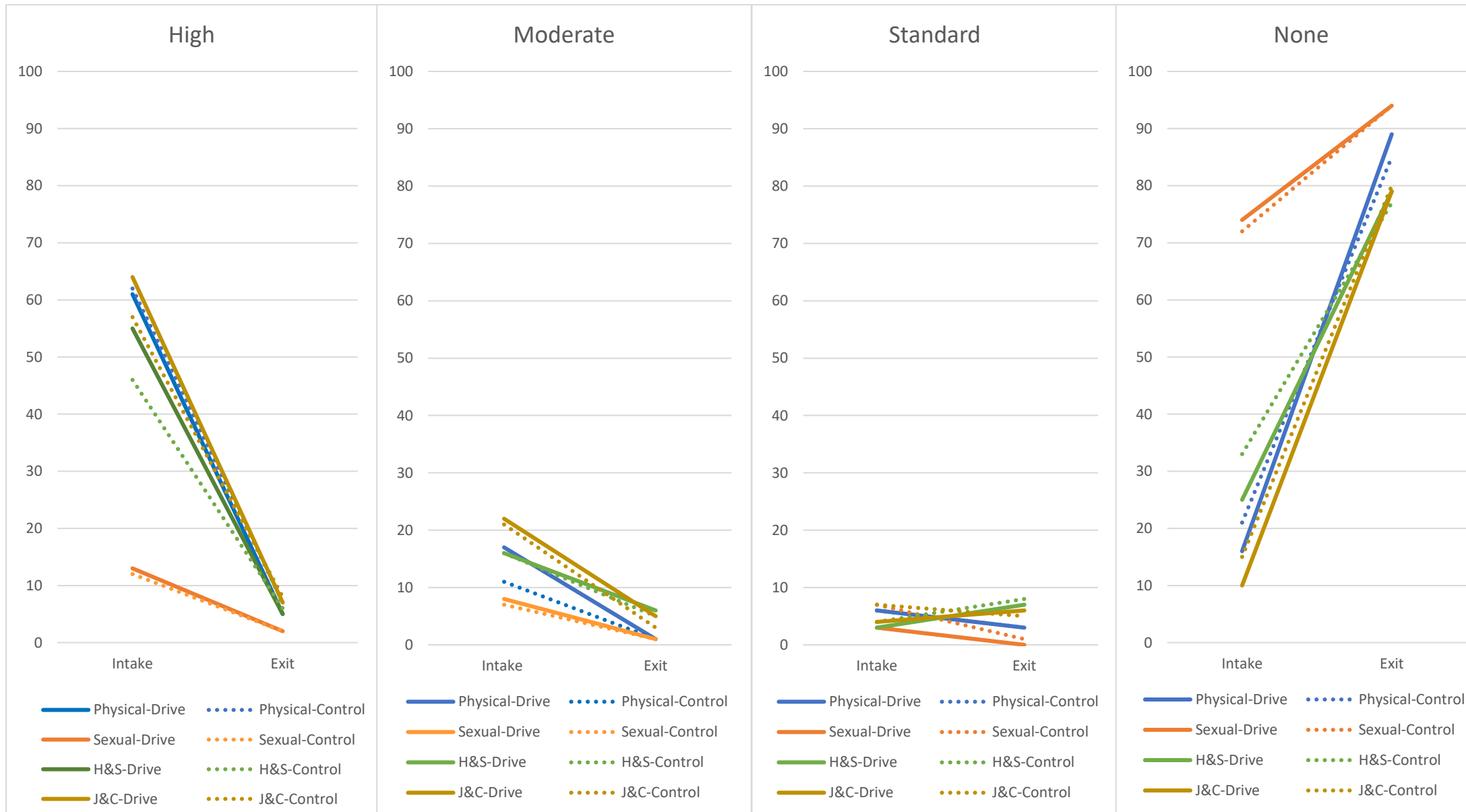


Figure A4.2 IDVA perception of changes in severity of DVA behaviours for Drive and control victims-survivors



Section 1: Difference in Difference regression results

Table A4.1 Physical abuse

	OR	Std. Err.	P value	95% Conf. Interval	
Time#allocation	0.69	0.34	0.45	0.26	1.81
Time (ref. intake)	0.03	0.01	0.00	0.02	0.05
Allocation (ref. control group)	1.14	0.27	0.57	0.72	1.82
Living situation (ref. Not living together)					
<i>Living together</i>	1.23	0.34	0.47	0.71	2.12
<i>Living together intermittently</i>	0.81	0.36	0.64	0.34	1.93
Current relationship (ref. Current intimate partner)					
<i>Ex-intimate partner</i>	0.69	0.15	0.10	0.44	1.07
<i>Intermittent intimate partner</i>	2.24	1.30	0.17	0.72	6.98
<i>Family member</i>	0.65	0.25	0.27	0.31	1.39
<i>Other person</i>	0.53	0.60	0.57	0.06	4.92
Criminal record for DV (ref. No)	0.98	0.21	0.92	0.65	1.48
CYPS involvement (ref. Yes)	0.85	0.15	0.38	0.60	1.22

Table A4.2 Sexual abuse

	Odds Ratio	Std. Err.	P Value	95% Conf. Interval	
Time#allocation	0.68	0.56	0.64	0.13	3.44
Time (ref. intake)	0.10	0.03	0.00	0.05	0.20
Allocation (ref. control group)	0.98	0.28	0.93	0.56	1.70
Living situation (ref. Not living together)					
<i>Living together</i>	1.46	0.47	0.24	0.78	2.75
<i>Living together intermittently</i>	0.80	0.44	0.69	0.28	2.33
Current relationship (ref. Current intimate partner)					
<i>Ex-intimate partner</i>	0.76	0.21	0.33	0.45	1.31
<i>Intermittent intimate partner</i>	2.24	1.28	0.16	0.73	6.89
<i>Family member</i>	0.28	0.18	0.05	0.08	0.99
<i>Other person</i>	0.00	0.00	0.98	0.00	.
Criminal record for DV (ref. No)	0.87	0.23	0.59	0.51	1.47
CYPS involvement (ref. Yes)	1.15	0.26	0.54	0.74	1.79

Table A4.3 Harassment and Stalking Behaviours

	Odds Ratio	Std. Err.	P value	95% Conf. Interval	
Time#allocation	0.56	0.22	0.15	0.26	1.22
Time (ref. intake)	0.08	0.01	0.00	0.05	0.11
Allocation (ref. control group)	1.35	0.32	0.20	0.85	2.15
Living situation (ref. Not living together)					
<i>Living together</i>	0.49	0.13	0.01	0.29	0.83
<i>Living together intermittently</i>	0.58	0.25	0.20	0.25	1.33
Current relationship (ref. Current intimate partner)					
<i>Ex-intimate partner</i>	1.19	0.24	0.39	0.80	1.76
<i>Intermittent intimate partner</i>	1.16	0.62	0.78	0.41	3.29
<i>Family member</i>	1.47	0.51	0.27	0.75	2.89
<i>Other person</i>	0.21	0.25	0.20	0.02	2.28
Criminal record for DV (ref. No)	1.30	0.25	0.17	0.89	1.89
CYPS involvement (ref. Yes)	1.71	0.28	0.00	1.23	2.36

Table A4.4 Jealous and Controlling Behaviours

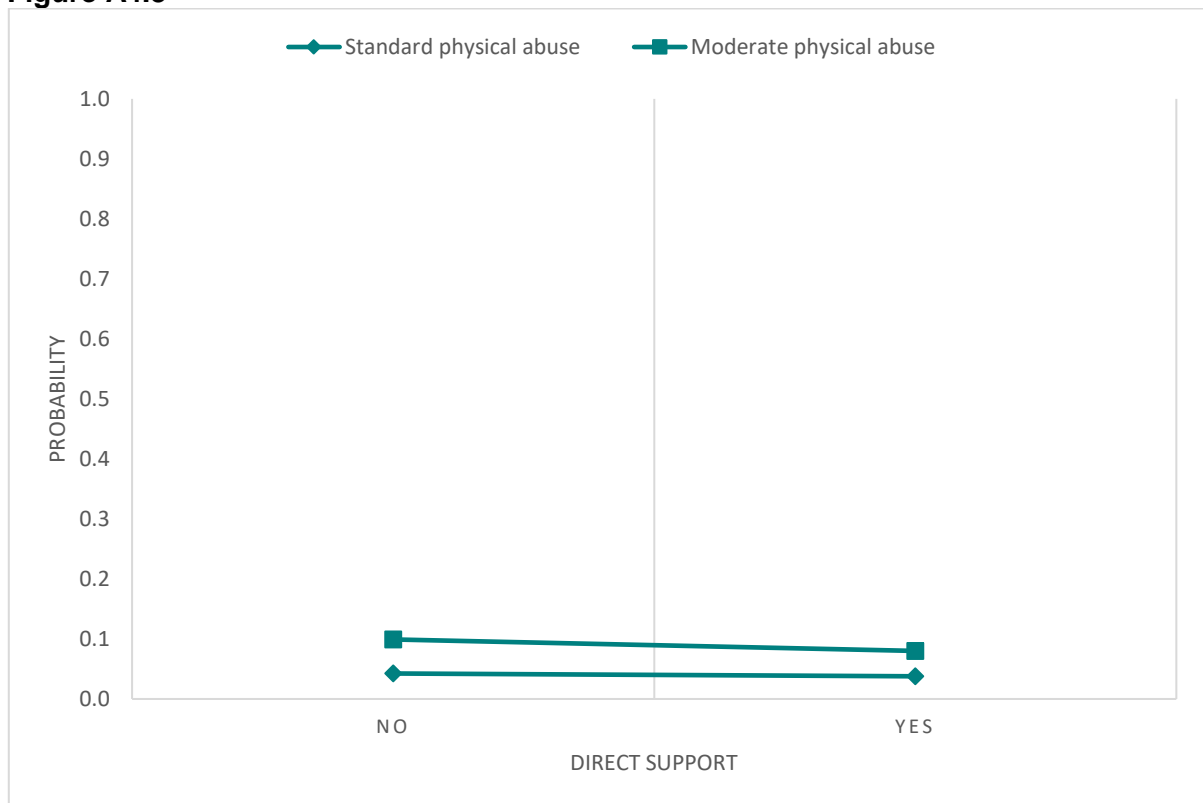
	Odds Ratio	Std. Err.	P value	95% Conf. Interval	
Time#allocation	0.67	0.27	0.33	0.30	1.49
Time (ref. intake)	0.03	0.01	0.00	0.02	0.05
Allocation (ref. control group)	1.27	0.31	0.33	0.79	2.04
Living situation (ref. Not living together)					
<i>Living together</i>	0.83	0.22	0.48	0.49	1.39
<i>Living together intermittently</i>	0.62	0.27	0.27	0.27	1.45
Current relationship (ref. Current intimate partner)					
<i>Ex-intimate partner</i>	1.09	0.23	0.67	0.73	1.64
<i>Intermittent intimate partner</i>	0.65	0.34	0.41	0.24	1.81
<i>Family member</i>	0.25	0.10	0.00	0.11	0.55
<i>Other person</i>	2.22	2.47	0.47	0.25	19.61
Criminal record for DV (ref. No)	1.42	0.28	0.07	0.97	2.09
CYPS involvement (ref. Yes)	1.05	0.18	0.78	0.76	1.46

Section 2: Results from the pooled logistic regression between direct work action and DVA behaviours

1. Direct support for standard and moderated DVA behaviours (unadjusted model)

Although the effects are very small (and very difficult to see in the graph), the unadjusted model indicates that those who received direct support from case managers reduced their standard and moderate physical abuse more than those who didn't received direct support from case managers. The other DVA behaviours were not affected by the presence or absence of direct support.

Figure A4.3



2. Behaviour change for standard and moderate DVA behaviours (unadjusted models)

Results suggested that behaviour-change sessions by case managers were consistently associated with a reduction in all four DVA behaviours. As shown in the figure below, those service users who received one or more behaviour-change sessions were more likely to reduce standard and moderate severity of DVA behaviours than those service users who did not receive such sessions. If the figures below are compared to Figure 24 in the main text, it is possible to observe the effect of behaviour-change work, which has a smaller effect on standard severity of DVA and then increases slightly for moderate severity, but the biggest effect of this type of work is for high severity of DVA aligning with the objectives of Drive.

Figure A4.4

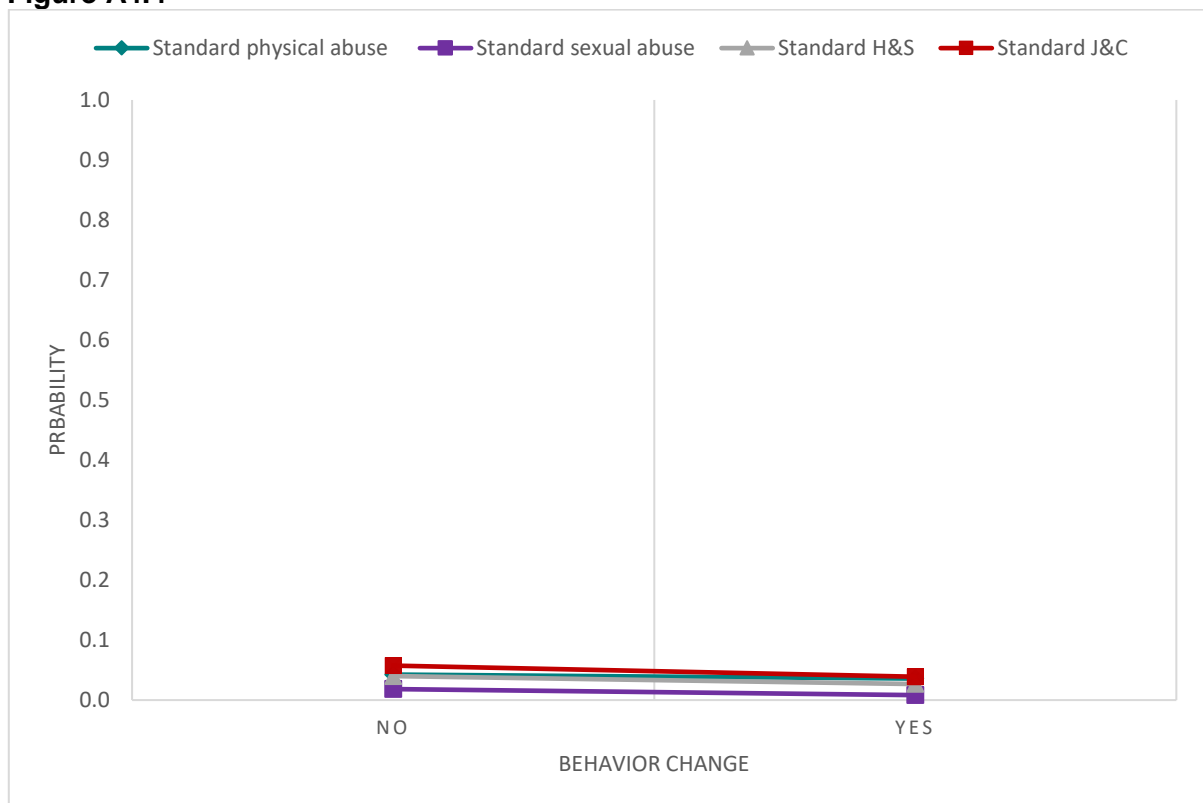
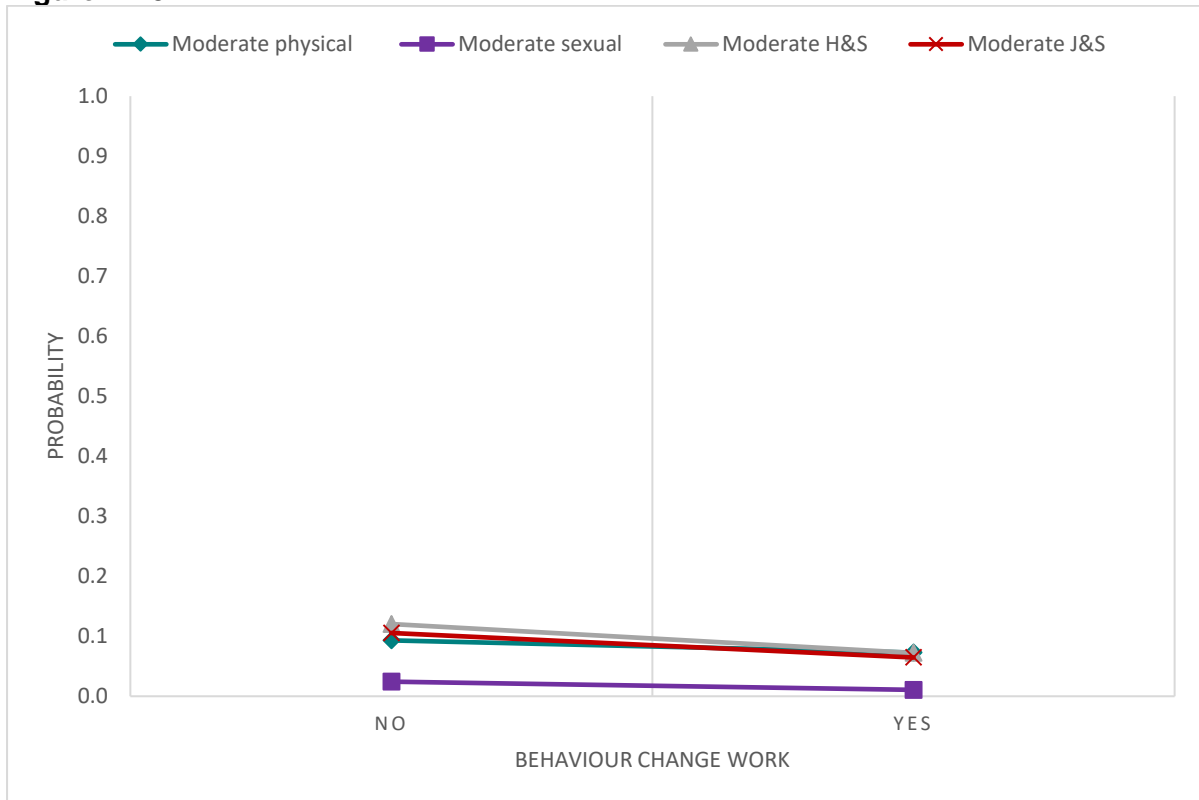


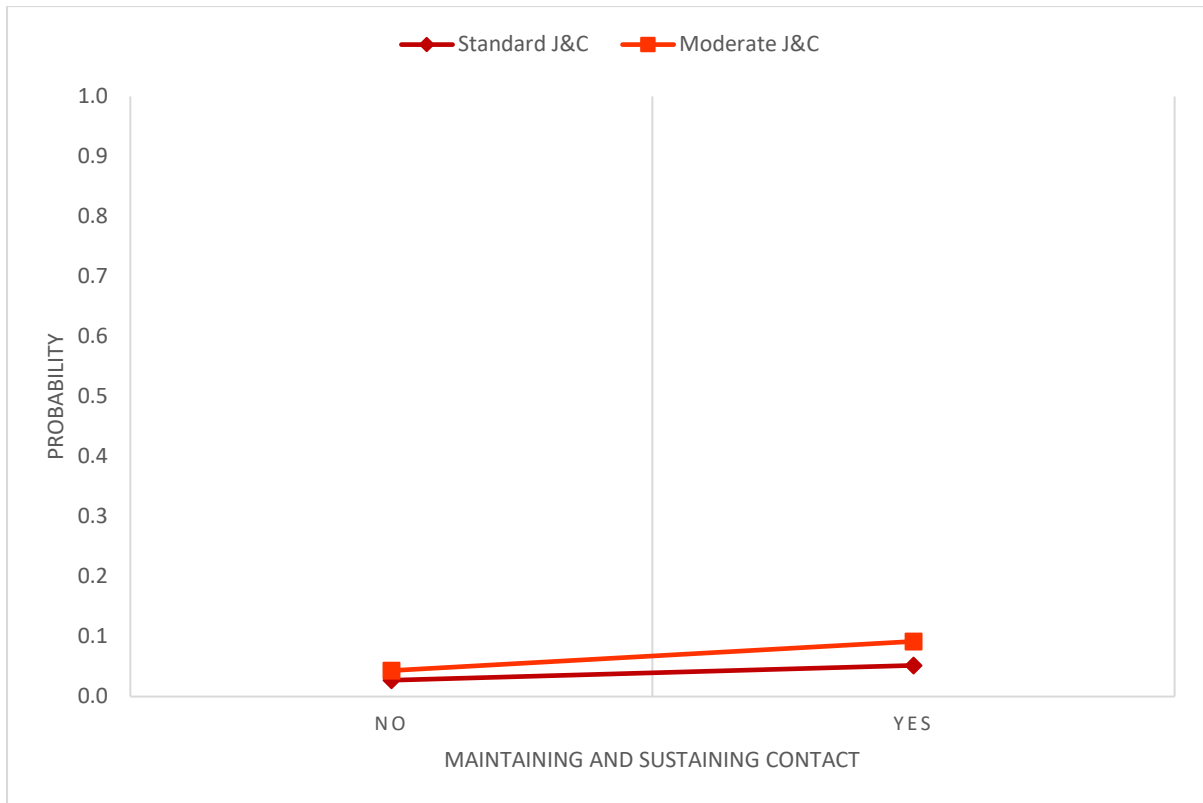
Figure A4.5



3. Maintaining and sustaining contact: standard and moderate DVA behaviours (unadjusted models)

The unadjusted model indicates that those who received 'maintaining and sustaining contact' from their managers were more likely to increase standard and moderate J&C than those who did not receive this type of work from case managers. The other DVA behaviours were not affected by the presence or absence of 'maintaining and sustaining contact'. This is similar to what was observed for high J&C and physical violence (see main text).

Figure A4.6



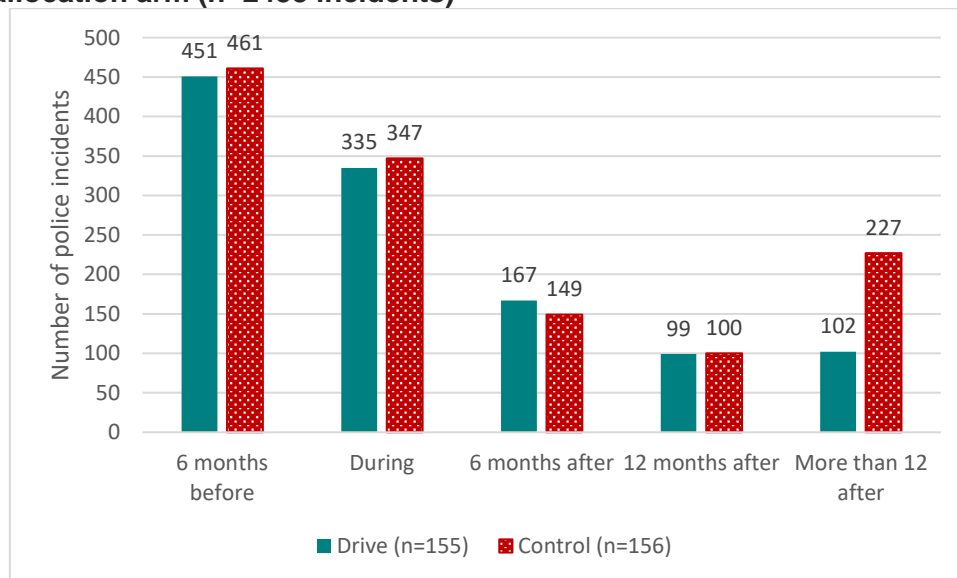
Appendix 5: Police data analysis for site 1

We obtained police data for Site 1, but this was not included in the main report as we did not have MARAC data for this site. In what follows we outline the findings from the analysis of the police data for Site 1. It should be noted that the trends are similar to those for Site 2 (Analysis of police and MARAC data for Site 2 are included in the main report in the section on sustaining behaviour change).

A total of 2983 incidents were recorded by police forces from Site 1 between October 2015 and September 2019. From this total of incidents, 18% (n=545) of the incidents happened outside the Drive evaluation period and therefore were excluded, leaving a total sample of 2438 incidents.

Out of the 169 service users from Site 1, 155 service users (92%) had police information of at least one police incident in a period of 4 years. From the randomly selected control group for Site 1 (n=169 control perpetrators) 156 cases (92%) had police data. When looking at all types of incidents together (DV and non-DV), the number of police incidents for Drive service users in Site 1 ranged from 1 to 54 in a four-year period (mean=17.1, SD=13.2), whereas for the control group the number of incidents ranged from 1 to 72 (mean=21.5, SD= 18.5). When looking at the total number of incidents distributed by period (before, during and after Drive intervention³²) it is possible to observe a reduction in the number of incidents during and after the Drive intervention for both groups. This reduction was very similar throughout the time periods (see Figure A5.1) up until 'more than 12 months post-Drive' when Drive service users sustained a similar number of incidents but control perpetrators doubled their number of incidents.

Figure A5.1 Number of police incidents by different time periods before and after Drive and by allocation arm (n=2438 incidents)

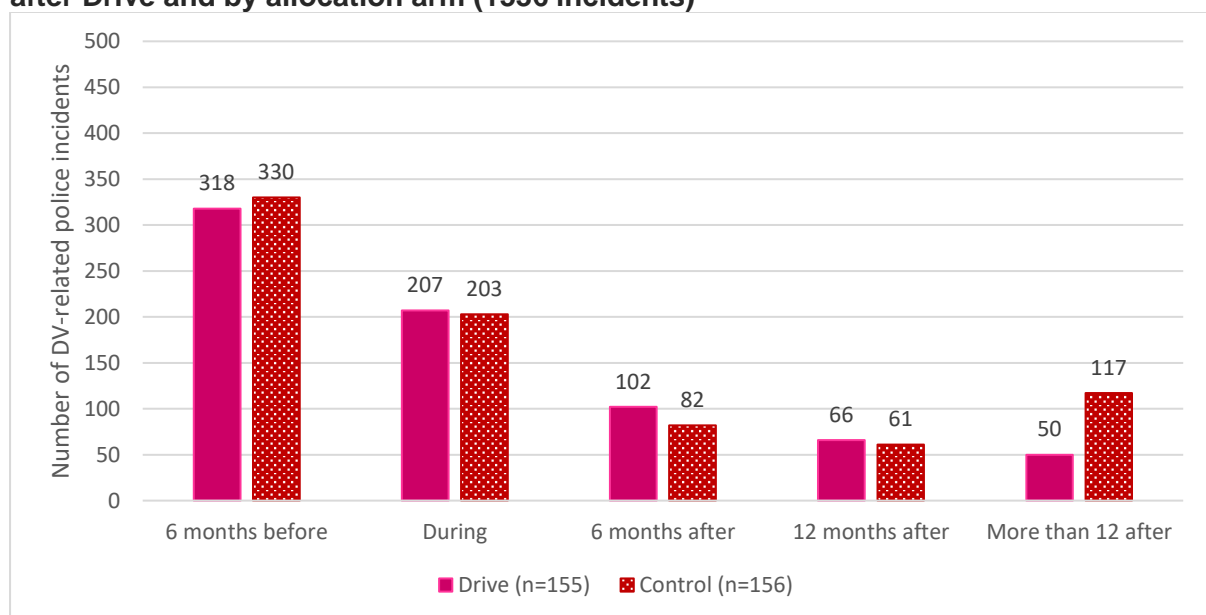


³² It is important to note that police data for 12 months after case closure was available for 27% of cases (n=85) and police data for more than 12 months after case closure was available for 26.6% of cases (n=83).

Domestic-violence-related incidents

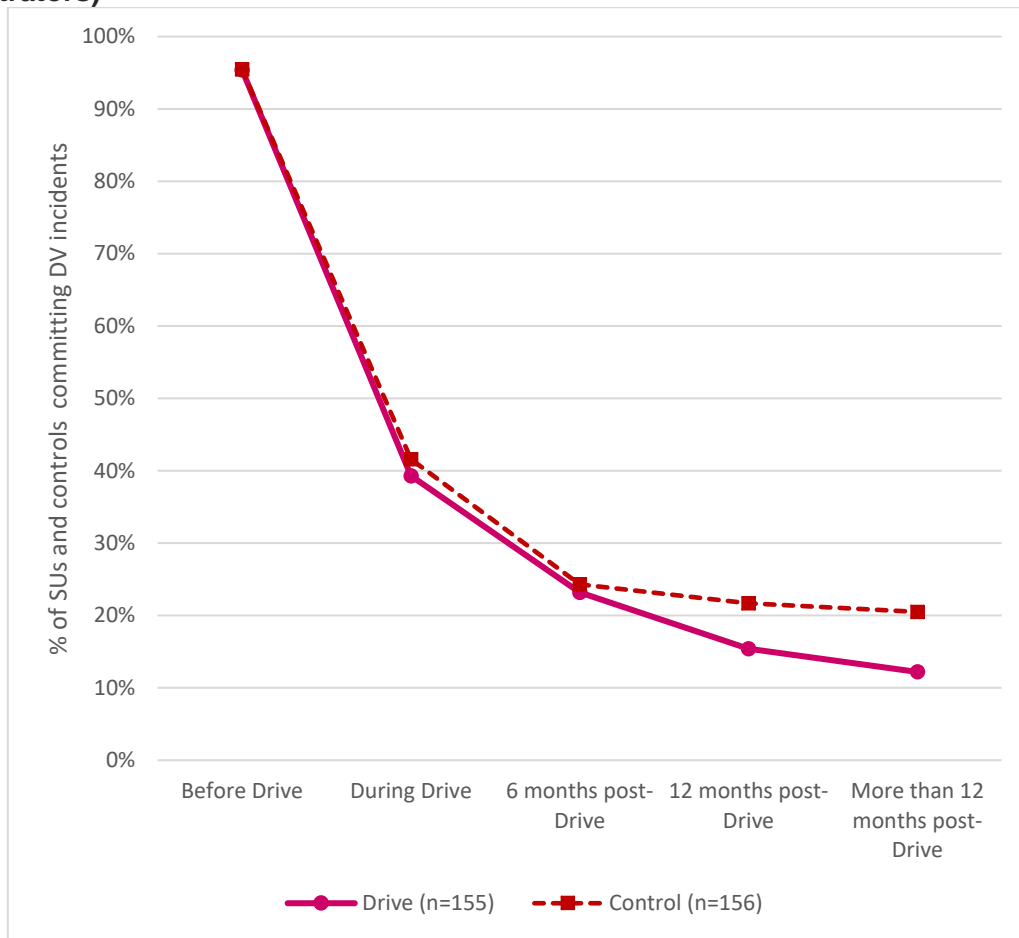
From the total of incidents, 63% were related to domestic violence (n=1536). The number of police incidents per Drive service user ranged from 0 to 34 in a four-year period (mean=10.5, SD=8.4), whereas for the control group the number of incidents ranged from 0 to 39 (mean=12.2, SD= 11.8). When looking at the total number of DV incidents distributed by periods it is possible to observe a reduction in the number of DV incidents during and after for both groups, but again a similar reduction is observed between groups up until more than 12 months post-intervention when those service users with data for this period kept reducing their number of incidents, whereas control cases doubled their number of incidents (see Figure A5.2).

Figure A5.2 Number of DV related police incidents in different time periods before and after Drive and by allocation arm (1536 incidents)



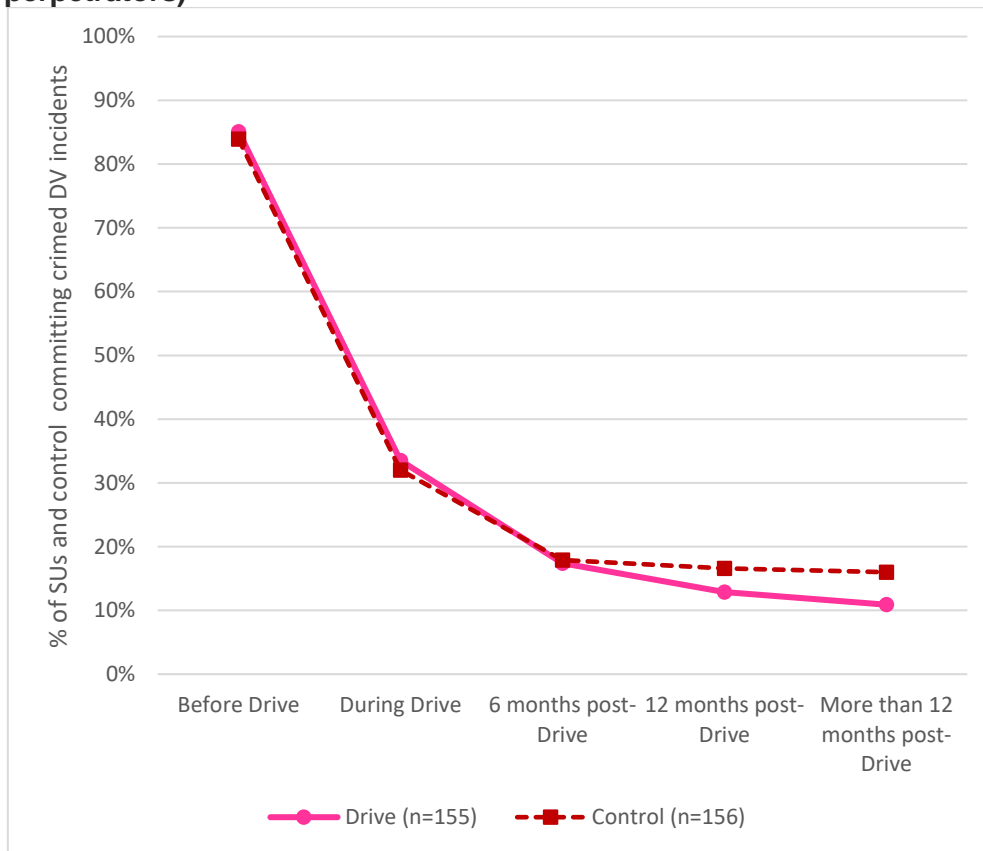
We were also interested in assessing the percentage of perpetrators (both Drive and controls) who committed a DV-related police incident. Figure A5.3 shows a difference in the percentages of Drive and control cases with DV incidents throughout the evaluation period. It was until 12 months post-Drive, when a significant difference is observed between the two groups, and a reduction in incidents involving Drive service users is observed in comparison with control perpetrators and then sustained for more than 12 months post-intervention (13-32 months).

Figure A5.3 Percentage of Drive and control cases that committed DV related police incidents in different time periods before and after Drive and by allocation arm (n=311 perpetrators)



Not all DV police incidents were crimed, thus, from those DV incidents recorded more than half of the DV incidents were crimed during the evaluation period (54%, n=984 DV incidents). A reduction in the percentage of perpetrators who committed crimed DV incidents is also observed (Figure A10); this reduction was higher for those in the Drive arm only in the post-intervention period. The trend is similar to the trend of all DV incidents presented in Figure A5.4 where Drive service users continued to reduce the number of crimed DV-related incidents more than 12 months post-intervention while for those in the control group incidents started to increase.

Figure A5.4 Percentage of Drive and control cases that committed crimed DV related police incidents in different time periods before and after Drive and by allocation arm (n=322 perpetrators)



Non-domestic-violence police incidents

Among the total police incidents there was a higher number of DV incidents than non-DV-related incidents (n=1536 vs. n=902 respectively). The number of police non-DV incidents per Drive service user ranged from 0 to 29 in a four-year period (mean=6.5, SD=6.8), whereas for the control group the number of incidents ranged from 0 to 33 (mean=9.5, SD= 10.0). When looking at the total number of non-DV incidents distributed by period it is possible to observe an overall reduction in the number of DV incidents during and after for both groups, but no significant effect was observed for those who received the Drive intervention until more than 12 months post-intervention (see Figure A5.5). Figure A5.6 shows a small decrease in the percentages of Drive and control cases that committed non-DV incidents throughout the evaluation period.

Figure A5.5 Number of non-DV related police incidents by time periods and by allocation arm (902 incidents)

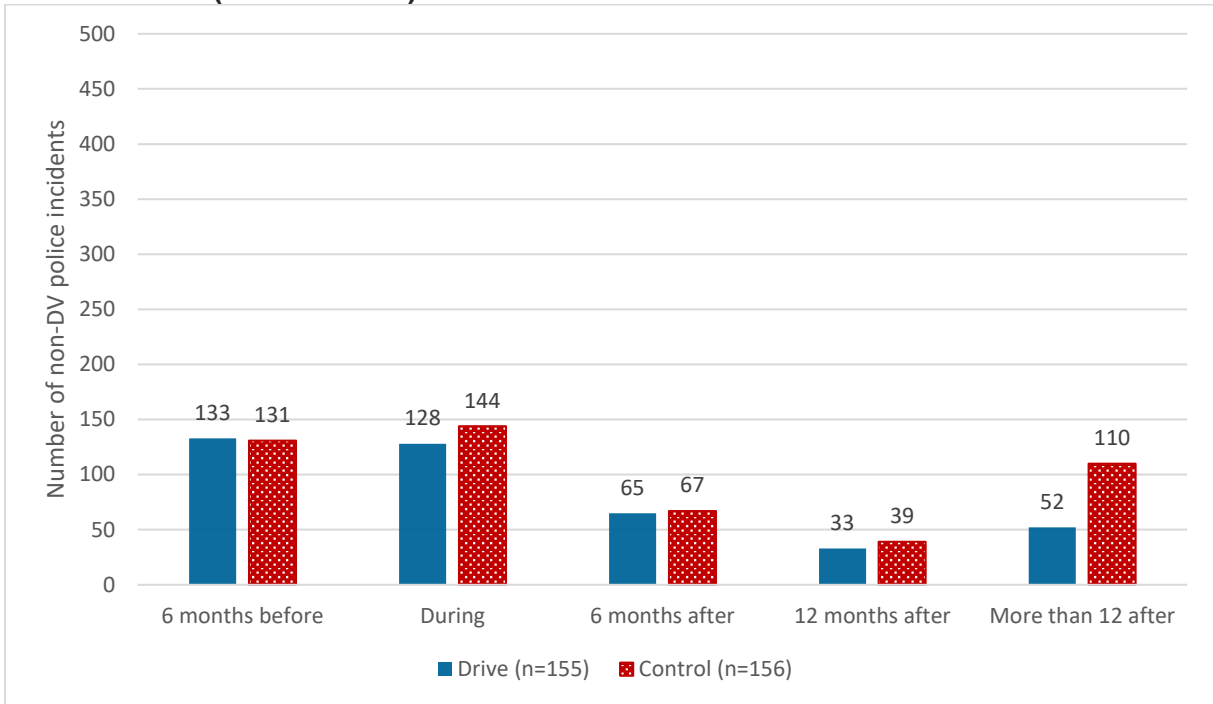
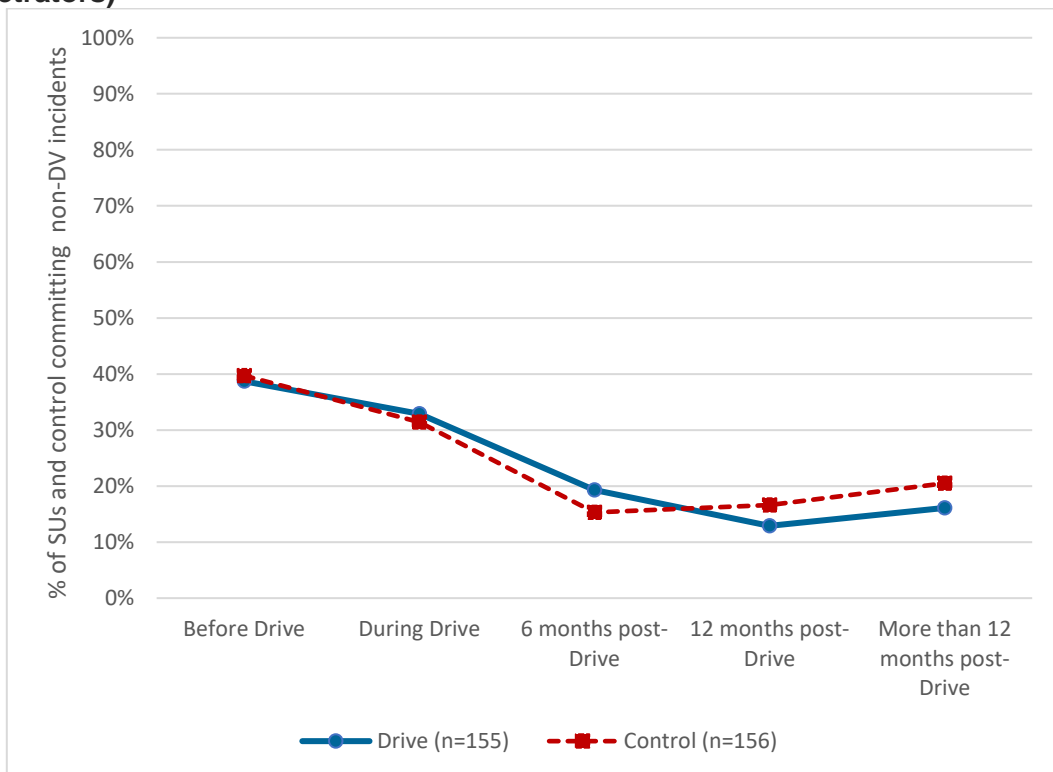
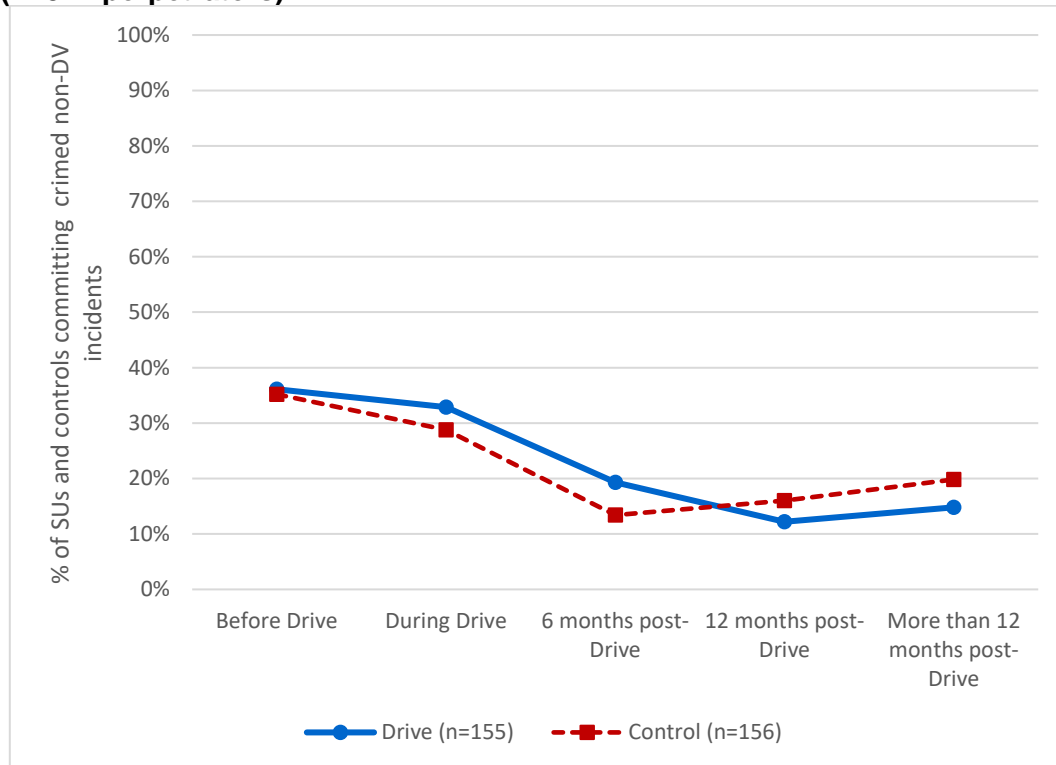


Figure A5.6 Percentage of Drive and control cases that committed non-DV related police incidents in different time periods before and after Drive by allocation arm (n=311 perpetrators)



From those non-DV incidents recorded (n=902), the majority (93%) were crimed during the evaluation period (n= 840 incidents). There was a significant reduction in control perpetrators committing non-DV crimed incidents during and 6-months post-Drive but then this started to increase again, while the Drive service users kept reducing until 12 months post-Drive and then increased slightly during “more than 12 months post-Drive”.

Figure A5.7 Percentage of Drive and control cases that committed crimed non-DV related police incidents in different time periods before and after Drive and by allocation arm (n=311 perpetrators)



Police data on repeat perpetrators for Site 1

We were interested in assessing police incidents by repeated perpetrators. This was possible by identifying who committed two or more DV-related incidents during the evaluation period. Out of the 311 total cases, 260 cases were identified as repeat perpetrators (83%). The mean number of DV incidents per repeat perpetrator was 13.7 (SD 28.5). For Drive repeat perpetrators the number of incidents ranged from 2 to 34 incidents per case (mean 11.7, SD=8.5), whereas for control repeat cases the number of incidents ranged from 2 to 39 incidents (mean 14.0, SD=11.9). Figure A5.8 shows the number of DV incidents committed by repeat perpetrators across different time periods, showing that repeat control perpetrators had a slightly greater reduction in number of DV incidents up to 12 months post-intervention, then Drive service users kept reducing their number of incidents while those in the control group slightly increased their number of incidents.

Figure A5.8 Number of DV related police incidents committed by repeat perpetrators in different time periods before and after Drive by allocation arm (n= 1454 incidents)

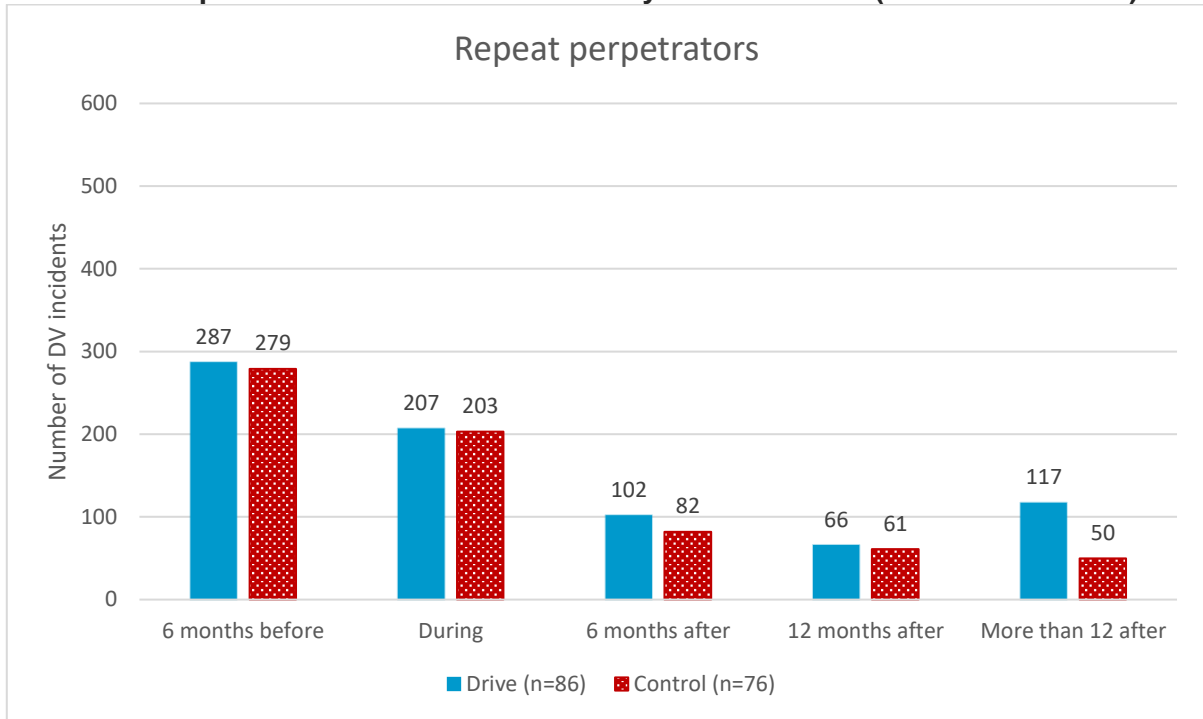


Figure A5.9 Percentage of Drive and control repeat perpetrators that committed DV related police incidents in different time periods and by allocation arm (n=218 perpetrators)

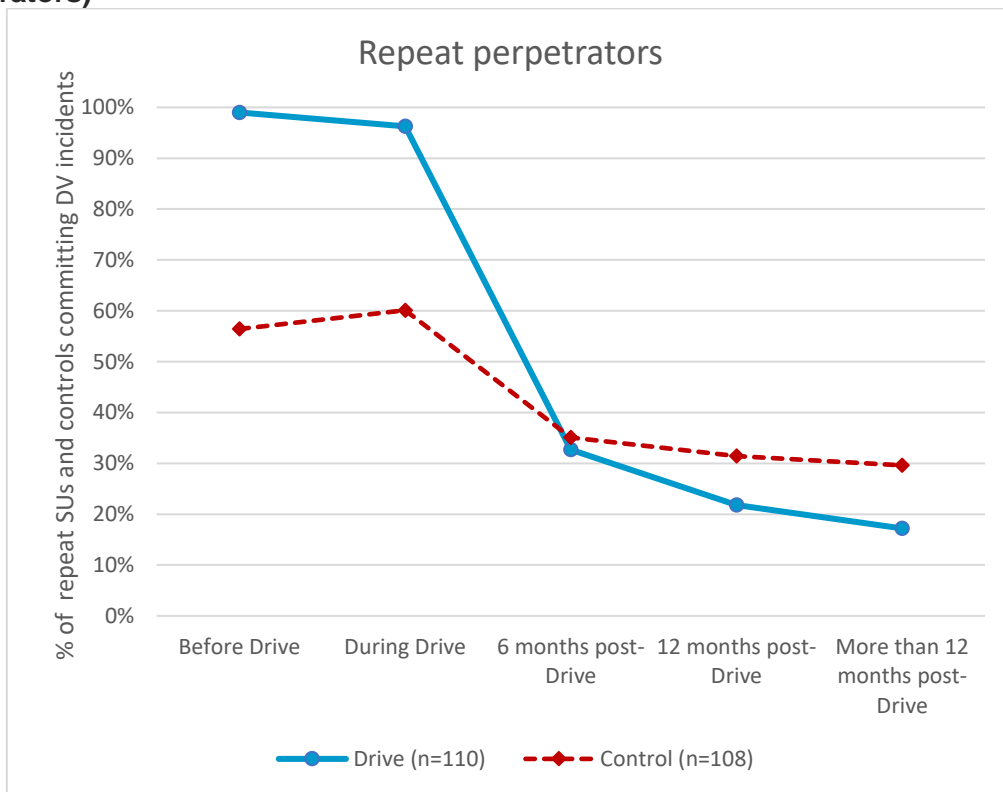


Figure A5.9 shows the reduction in cases committing DV incidents across the different time points only among repeat perpetrators³³. An important reduction in repeated Drive service users committing DV-related incidents is observed up until the end of the evaluation period. However, for control repeat perpetrators this is less consistent with a slight increase in perpetrators committing DV-related incidents during Drive, then reducing post-drive and sustaining this level for the remaining period.

³³ Please note that these percentages are not calculated over the whole sample of perpetrators, which is 311, but are instead calculated for the total number of repeat perpetrators (N=218).

Appendix 6: Case studies

1. Institutional Advocacy with Children's Social Services and the Child Protection Process as a Lever for Service User Engagement

Keywords: social services, child protection, indirect leading to direct, institutional advocacy

Background information

The service user had an extensive history of domestic abuse incidents against his partner with a child present in the home. Referrals were being made to social services. Social services were then contacting the mother (victim-survivor), who would inform them that the relationship was over. This would result in the case being closed with no initial risk assessment taking place. Drive was allocated the case while the service user was on probation. The service user breached probation before Drive made contact with him.

Multi-agency disruption

When the service user was in court for a breach of probation, the magistrates refused to accept the address he provided as his own – because it was the same as the victim-survivor's home address – but did not notify the agencies involved in the case. The case manager noticed this when reviewing notes and notified the respective agencies immediately.

The case manager then submitted a child protection referral, citing previous domestic abuse history, lack of initial risk assessments, and the fact that the service user claimed to reside at the victim-survivor's address. As a result, the child was put on the child protection register.

The case manager liaised with the social worker, shared information about the case background, and requested that a home visit be carried out to assess risk. When social services carried out the visit, the service user was found at the victim-survivor's house.

The case manager then liaised with the service user's offender manager and organised for Drive engagement to be written into the service user's probation requirements and the child protection plan. The child protection plan also required that the service user did not attend the victim-survivor's property.

Engagement

The service user subsequently engaged with Drive, enabling the case manager to conduct behaviour-change work on the effects of children witnessing domestic abuse. The case manager also worked with the service user on improving his interaction, communication and engagement with the child protection plan and system.

Salient questions & learning:

Disruption and engagement should not be seen as an either/or – they can work together. This case study also highlights the importance of child protection as a lever of engagement and the critical role social services play in terms of institutional advocacy.

A key question remains – what happens after Drive?

2. High Risk of Child Sexual Abuse

Key words: child abuse, social services, MAPPAs, disruption, high-level learning difficulties, child protection

Background information

The service user has learning difficulties that are recognised as very high, but no formal assessment was available. The service user was referred to Drive because of domestic abuse against a partner who was pregnant at the time by the service user. His partner also has learning difficulties, although information on the severity of these was not available.

The service user was known to have previously disclosed that he intended to get a partner pregnant solely for the purposes of abusing the child. The service user was open about his desire to abuse children and had previously been prevented from attempting to enter a children's ward at a local hospital.

The service user was not supervised by probation or any adult social services, meaning Drive was the only sustained intervention that he was receiving.

Drive Actions

Information sharing

The Drive referral and information sharing highlighted the situation to social services, who opened a case to respond to the victim-survivor's needs. Prior to Drive involvement, social services were unaware of the disclosure by the father about the intention to abuse the unborn child. This information was also promptly shared with the police.

Risk assessment and escalation

After extensive assessment by the case manager, it was determined that behaviour-change work was highly unlikely to be impactful because of the service user's learning difficulties. A referral was made to Multi-Agency Public Protection Arrangements (MAPPAs) and a decision was made to escalate risk management activity.

Research and disruption work

Drive research revealed a new address where the service user was residing and the location where he was begging on the street. This information was immediately shared with police in relation to the risk of harm to children. There was also a marker placed on the name and identity of the service user at the local hospital, enabling the hospital to respond and manage risk in line with their procedures.

Drive also put in a request to the police for more intelligence and surveillance of the service user. As a result of the MAPPAs referral, a civil Sexual Harm Prevention Order (SHPO) was requested to be put in place, which would apply the same conditions to the service user as a convicted child sex offender in the community. At the time of writing, work on this was ongoing.

Due to risk posed in this case, the child of the victim-survivor was taken into care shortly after birth. During the course of Drive's involvement with this case, the service user disengaged from contact with Drive and separated from the victim-survivor. However, the Drive case manager continued to gather information and found out about a new relationship the service

user had begun with a potentially vulnerable young woman who had significant contact with children due to family and friends. Drive submitted a log to the police detailing this intelligence.

Salient questions & learnings

While behaviour change may not have been possible in this case, the indirect work seems to have been extremely useful in terms of risk reduction. The intensive research that the case manager maintained in the case proactively and consistently kept police and relevant social services alert and aware of the ongoing risk the service user was posing.

Questions:

- Is Drive the most appropriate intervention for this kind of individual?
- What if Drive did not exist? Why were the police or adult social services not more involved?
- What will happen to this service user after Drive?

3. Cross-Border Multi-Agency Working – Disruption while in Prison

Keywords: cross-county/cross-border multi-agency work, prison, disruption breach, engagement

Background information

The service user had been convicted of coercive control for abuse of the victim-survivor and had a restraining order in place. The service user and victim-survivor were accessing services across two counties and providing different information to the various agencies involved. While the Drive case manager was working with the service user, the victim-survivor was being supported by two IDVAs across counties in differing capacities.

The service user was obsessed with the victim-survivor, with whom he was in an intermittent and coercively controlling relationship. He had breached his bail conditions by attending her place of work. He had also breached his restraining order conditions on multiple occasions in a short period of time.

The victim-survivor disclosed to the IDVA that she felt unsafe and trapped in the relationship. Within the context of understanding the dynamics of coercive control and the impact that this has on a victim-survivor's space for action, Drive pursued actions around disrupting the service user's ability to use coercively controlling behaviours and contact the victim-survivor. The Drive case manager worked closely with the IDVAs to conduct a dynamic risk assessment to reduce the risk posed by the service user.

Cross-border multi-agency working

The Drive case manager initially started an email group of agencies involved in the case to share information, but as the case escalated and developed quickly, professionals were beginning to miss crucial information, either by being missed off the information-sharing group, or through information shared bilaterally in conversation.

To remedy this, the case manager called a cross-county multi-agency meeting to bring the involved professionals together and ensure the risks were noted by all agencies involved. This revealed inconsistencies in what was thought to be known by different professionals, provided insight into the victim-survivor's thoughts and feelings, and helped develop an understanding of the dynamics of the relationship. Led by the advocacy of the Drive case manager, this meeting also provided additional information about the service user, which further elevated the risk level. This was a fundamental turning point in the case, as all agencies involved fully understood the risks involved after the meeting. The Drive case manager and the IDVAs acted as a crucial advocate on behalf of the victim-survivor due to their understanding of the intensity of coercive control being perpetuated by the service user.

Information sharing and disruption

For example, a critical piece of information that was shared early on was that the service user had been sending letters to his mother's house when in prison. These letters were addressed to the victim-survivor's children, sometimes using their known nicknames, but they were for the victim-survivor.

As a result, the prison was requested to put a hold on all the service user's letters and to check that they were not intended for the victim-survivor.

Drive continued to engage with the service user while in prison but were unable to elicit any acceptance of responsibility for the abuse from the service user.

Upon release, the service user continued to engage with the Drive case manager and the victim-survivor continued to engage with IDVAs. From the information disclosed by both parties, it was suspected that they were arranging to meet.

As noted above, within the context of understanding the dynamics and risk associated with coercive control, disruption actions were taken to reduce the service user's risk to the victim-survivor by sharing this information with the police. As a result, the police found the service user in contact with the victim-survivor, in breach of his restraining order, and he was returned to prison.

During his time in prison, the victim-survivor applied for the restraining order to be lifted. Aware of this application through the information sharing in place, probation, Drive and the IDVA services across the two counties wrote to the court urging the judge to reject the application due to safety concerns for the victim-survivor. At the time of writing, the service user remains in prison and is engaging with his Drive case manager. Safety planning for the victim-survivor was also being undertaken.

Salient questions & learning

This case is an excellent example of effective and efficient multi-agency collaboration and risk management. Relevant and proportionate information sharing was essential for the quick responses to the rapid developments in the case. The multi-agency working also provided a holistic approach to the work, enabling a thorough understanding of the case from all possible angles.

A key question remains – what happens after Drive?

4. Case Manager, Social Worker and IDVA Collaborative Working

Keywords: deep institutional advocacy, what can be done when service users don't change, the value of collaboration.

Background information

This family's case was open to social services due to the risk posed by the father (the Drive service user) to the mother (the victim-survivor) and the children, who were on a child protection plan. The victim-survivor was engaging with the IDVA, and the service user was engaging with the Drive case manager, but was, according to the social worker, 'not in a place where he wanted to change any of his behaviours' (T1.15 social worker).

Information sharing and multi-agency working:

The Drive case manager attended and provided written reports to the core group formed at the child protection meetings. The case manager acted as a bridge between children's social services and the service user – as a check and balance on the service user and what he was saying about his own improvement/change, and as an advocate for the victim-survivor by highlighting the patterns of abuse and control that other professionals were not aware of or did not previously understand as abuse (this was reported by a social worker present T1.15).

This provided a venue and communication channel for information sharing between the Drive case manager, social worker, and the IDVA. In the words of the social worker, the Drive case manager would 'liaise with me, keep me updated about what the service user (the dad) was doing, any police involvement, how their sessions are going, engagement – things like that' (T1.15. social worker). For the social worker, hearing about the service user's behaviour from someone working directly with the service user was reported as being particularly 'valid' and impactful.

The case manager shared information with the social worker and IDVA, who communicated with the victim-survivor. The case manager fed back his assessment that the service user was engaging with Drive as a 'box-ticking exercise' without real commitment to change. As the social worker reports:

And I suppose just like really highlighting with me and the [IDVA], the patterns of control within the relationship. I think... so when I was first working the case, mum was very hopeful that he would change and that actually things were going to be different now that they had had a baby, and dad would be very much obviously saying those things to her, and she would say 'Oh well, he is meeting with [the case manager], like he's trying to change, he's working with Drive' – but actually just meeting with [the case manager], he's not trying to change, it's almost just ticking the box. And [the case manager] was really... yeah, he was really clear about that – actually [the service user] the dad has not really done very much at all in terms of being able to reflect even anything that he would want to change within his behaviour or take any responsibility. So... yeah, that was helpful for her to hear as well.

For the social worker, of particular importance to this case was having someone to work specifically with the father and the extent to which this offered insight into his behaviour and accountability in relation to his claims to have changed:

... like [the IDVA], she would work really closely with the woman and would keep me updated and support her... but when Drive's not involved it feels like there's a kind of gap. Often the dad's... well the dad in this case, he wouldn't be wanting to really engage with me because I'm the social worker and I have to kind of... yeah, my focus is on the children's safety, and I didn't really feel it was safe for him to see the children... but yeah, it just meant that he had someone working specifically with him.

[...]

It hasn't necessarily led to positive outcomes in that if dad is particularly difficult to engage... so I think [the case manager] has struggled with that [...] but it has helped in terms of me knowing more about what's going on I suppose, and [the case manager]'s been really helpful in that respect. And I think it's helped because somebody is... [the case manager]'s been trying to build a relationship with him, with the dad, so we have got some insights that I wouldn't have got necessarily had there not been a professional involved specifically working with dad around his patterns of behaviour within relationships and that kind of thing. And also it meant that... so... there being a consistent working with dad throughout the time that the [children's cases] have been open has meant that when dad's tried to tell me one story, and then I speak to [the case manager], we can kind of piece together where he's trying to... not play us off against each other, but he's trying to portray things in one way to me when actually [the case manager] knows differently. (T1.15. social worker)

The information shared by the case manager was thought by the social worker to have directly influenced their child protection decisions. The mother and children were subsequently moved to a refuge out of the area.

Social workers are closely monitoring the service user's requests for and actions in relation to contact with the children, recognising that this may be used to continue perpetration against the victim-survivor. Their focus is on what the service user is or is not demonstrating in terms of evidence of behaviour change, including addressing substance misuse issues. Crucially, the focus is on the service user's behaviour, not that of the victim-survivor.

Salient questions & learning:

This case demonstrates the utility of information sharing and collaborative working even in the absence of behaviour change – as a tool both to understand the whole picture and proactively exercise a continuous assessment of the case. Drive was impactful here in two key aspects – first, in providing information to allow the other professionals to better assess and manage risk, and second, in helping to change the focus of professionals away from the conduct of the victim-survivor to that of the service user, who is wholly responsible for the abuse.

5. Victim-Survivor Rent Arrears Paid Off to Enable Priority Re-Housing

Keywords: housing, local authority, multi-agency work, IDVA

Background information

While the victim-survivor and service user were separated, the victim-survivor remained under surveillance from the service user and his family and friends, who would report back to him on her whereabouts.

For this reason, the victim-survivor wanted to move but was given very low priority by the council due to rent arrears (of approximately £200–300). To be prioritised, the victim-survivor would have to make ten consecutive monthly payments or pay the arrears in full. Paying in full was not an option at her income level and a ten-month delay before getting on the priority list exposed her to significant risk.

Disruption work with the IDVA

Working closely with the IDVA, the Drive team identified, facilitated, and enabled the housing officer to access a ring-fenced fund within the local authority that was specifically designated for assisting victims of domestic abuse. This was used to pay the arrears and get the victim-survivor on the priority housing list, so she could relocate.

Appendix 7: Cost of high-risk, high-harm domestic abuse

Differences between how the needs information was used in analysis for the main report and for the costing analysis report

The same data set was used for both the main report and the cost-benefit report, however, there are differences in how needs variables were dichotomised to calculate the prevalence of selected needs as well as the denominators used to calculate the percentages. It is important to note that for the cost-benefit analysis not all needs were included. Table A7.1 shows how each variable was classified for the purposes of each report. For instance, for the cost-benefit analysis the prevalence of each of the four needs used is presented only for those who presented a high level of needs (this being excessive and high), whereas the current evaluation incorporates all levels of needs. Also the denominators used were different in each report – for instance, if we take, as an example, drugs use, the main report included the response ‘Don’t know’ in the total number of cases so the denominator is 467, while the cost-benefit analysis excluded ‘don’t know’ responses and the denominator is therefore 176.

Table A7.1 Differences in classification and denominators for the group of needs used in the current evaluation and in the cost benefit evaluation

Need	Original classification	Frequencies	Current report (n=varies)	Costs report (n=varies)
Drug use	Excessive	14	Yes 17% (n=467)	Yes 28% (n=176)
	High	35		
	Moderate	17		
	Low	15	No 82.6%	
	None	95		
	Don't know	291		
Housing	Homeless	20	Yes 27% (n=472)	Yes 40% (n=268)
	Transitory (sofa-surfing)	18		
	Unstable	36		
	Temporary	53	No 73%	
	Stable	141		
	Don't know	204		
Mental health	Poor	61	Yes 23% (n=469)	Yes 62% (n=172)
	Fair	46		
	Good	46	No 77%	
	Very good	14		
	Excellent	5		
	Don't know	295		
Alcohol	Excessive	19	Yes 28% (n=467)	Yes 34% (n=169)
	High	39		
	Moderate	26		
	Low	45		

	None	40	No 72%	
	Don't know	298		

Appendix 8: Estimating the cost of domestic abuse³⁴

Summary

Drive, SafeLives Insights and MARAC data reflect the human cost of domestic abuse and outcomes for victims accessing support, but commissioners and policy makers need to know the fiscal cost of domestic abuse in order to assess the business case for investment in interventions.

This analysis estimates the predominantly state funded costs associated with perpetrators identified as high-risk via the MARAC referral pathway and randomly allocated to Drive and control groups to be £63000 per case, (Table A8.1). In this analysis the costs for loss of quality of life and economic output, though real, have not been included³⁵.

The analysis uses data from Drive in year two to determine the costs relating to victims (and their children) associated with perpetrators assigned to either Drive or control groups, (Appendix 8.1), and the perpetrators themselves, (Appendix 8.2). The resulting costs per case are shown in Table A8.1.

Table A8.1 Summary of costs per case

	Cost Per case: Victims & children	Cost Per case: Perpetrators	Total Cost per case
Police		£17,800	
Other CJS		£14,200	
Total CJS			£32,000
Physical Health ³⁶	£3,240		
Mental Health	£3,345	£2,050	
Substance use disorders	£1,375	£3,400	
Total Health			£13410
Children's Services	£14,390		£14390
Housing (including refuge)	£2,215	£1,385	£3,600
Total cost	£24565	£38,835	£63,400

³⁴ **Disclaimer:** The use and costs are based on the best available estimates only and are routinely rounded in order to avoid the appearance of spurious accuracy. Caveats noted within the document apply.

³⁵ HORR107: Oliver et al, 2019: The economic and social cost of domestic abuse 2019 calculated the costs attributable to 1.9m victims of all risk levels at £34,015 per victim of which £31,545 per victim was due to a loss of quality of life (£24,300), and loss of economic output (£7,245).

³⁶ Immediate physical costs associated with assaults only.

There were 76,000³⁷ cases heard at MARAC in England and Wales in the year to December 2018. Applying the £63,000 cost per case to all cases heard at MARAC represents an estimate of the cost to the state of domestic abuse of £4.8bn. (See Table A8.2).

³⁷ SafeLives MARAC Data 12 months to 31/12/2018: 97,600 cases net of 28% repeats.

Table A8.2 Summary of total costs for all MARAC cases

	Victims- survivors & children	Perpetrators	Total
Police		£1,350m	
Other CJS		£1,080m	
Total CJS			£2,430m
Physical Health ³⁸	£250m		
Mental Health	£250m	£160m	
Substance use disorders	£100m	£260m	
Total Health			£1,020m
Children's Services	£1090m		£1,090m
Housing (including refuge)	£170m	£110m	£280m
Total cost	£1,860m	£2,960m	£4,820m

The Drive intervention targets high risk perpetrators within the MARAC process with the aim of interrupting this cycle of high risk, high harm abuse to increase the safety of victims-survivors, reduce the number of repeat and serial perpetrators and associated cost to the state. The cost of delivering Drive, at the time of this analysis, is £2,400 perpetrator with an estimated £9m per annum being the total cost required to deliver Drive in all PCC and police force areas across England and Wales.

Limitations

The cost of domestic abuse is calculated using estimates of the expected 'use' of various largely state-funded services multiplied by the unit cost of service delivery. The costs and use of services are based on the best available estimates and are average costs applicable to cases relating to perpetrators allocated to Drive or control groups.

This simple formula does not reflect the complexity of either the cost or the 'use' of state services as a result of domestic abuse. The reality is that costs are not incurred uniformly and neither do victims-survivors' needs for services fit neatly into a time frame of one year. The following caveats apply:

- For some costs only one year of costs has been estimated, when in reality many cases will incur costs for multiple years both before and often after an intervention.
- In some cases, the use of the services may be latent, eg post-traumatic stress disorder (PTSD) can emerge at any time after a traumatic incident. Where costs are latent, the cost of the service 'use' is included, regardless of when those costs might materialise.
- Some state costs are initiated as a result of the intervention and could be viewed as a cost of the intervention (eg the cost of rehousing, or costs triggered as a result of a referral to children's social care), however, for the purposes of these estimates, costs triggered at the point of intervention are treated as costs as a result of the domestic abuse.

³⁸ Immediate physical costs associated with assaults only.

- Some costs relating to the perpetrator that were identified during the Drive intervention are not 'as a result of domestic abuse' but are included here as the costs of perpetrators' needs. These include mental health, substance misuse and housing costs as well as the CJS costs.
- Other latent costs, such as those due to long-term damage to physical health or loss of economic output have not been included. It may be possible to estimate these costs using the methodology applied in "The economic and social cost of domestic abuse 2019; HERR107", but this is out of the scope of this document. Including this analysis would increase the estimated cost per MARAC/perpetrator case.
- Where costs are potentially due to multiple disadvantage rather than domestic abuse alone, no attempt has been made to estimate a proportion attributable to domestic abuse, for example, costs of substance misuse, health service use or children's services use.
- Where Drive data has been used either in respect of victims-survivors of perpetrators assigned to either Drive or control or perpetrators themselves, the data is from Year 2 of the Drive project.
- The Drive service users (or control group) are allocated via the MARAC referral pathway so the unit costs per case are based on data related to MARAC-threshold cases and are therefore only appropriate for use in analyses of interventions where cases meet MARAC risk thresholds. These unit costs per victim-survivor are not applicable to medium- or all-risk cases.
- To estimate the total cost for all MARAC cases (around 76,000 cases), the cost per case for relatively small samples relating to Drive (or control) perpetrators and their victims-survivors has been applied to the whole MARAC caseload.
- This analysis does not address any potential savings that might be achieved as a result of any intervention.

Criminal Justice System

The cost to the criminal justice system (CJS) per perpetrator is the extent of police and other subsequent criminal justice events multiplied by estimates of the unit costs of these activities.

The average police cost of £17,800 per perpetrator per year and the average of other criminal justice system costs of £14,200 per perpetrator per year are calculated by applying unit costs per incident to the average number of incidents (annualised) by severity.

Table A8.3 shows the cost to the criminal justice system is estimated at £32,000³⁹ per perpetrator per year.

³⁹ **Caveat:** The unit cost per perpetrator is based on usage rates derived from Drive (or control) case data and is therefore only applicable to interventions aimed at high-risk perpetrators such as MARAC

Table A8.3 CJS costs per perpetrator

	Incidents per perpetrator (6 months) ⁴⁰	Unit costs of police	Unit costs of other CJS activities	Cost per average perpetrator (annualised)
GBH: grievous bodily harm ⁴¹	0.05	£1,950	£33,616	£3,414
ABH actual bodily harm	0.89	£1,950	£2,953	£8,679
Threats to kill	0.02	£1,180	£3,614	£230
Stalking and Harassment	0.57	£1,180	£1,749	£3,339
Common assault and battery	0.39	£1,180	£762	£1,531
Sexual Offences: Rape	0.10	£16,290	£5,891	£4,569
Sexual Offences: Other	0.04	£9,300	£6,194	£1,116
Criminal Damage and Arson	0.21	£1,350	£895	£952
Other (non DV) related crimes ⁴²	0.73	£3,620	£660	£6,274
Callouts non-crime incidents	2.21	£440		£1,947
Totals / average costs	5.22			£32,000

Assumptions used in the calculations:**1. Rates of Criminal Justice System use by perpetrators**

- 1.1 Criminal justice system 'use' includes police activities, subsequent court events, custody and probation.
- 1.2 The 'use' of the criminal justice system is based on police activity data in the six months prior to a referral to MARAC in respect of perpetrators (n=165) allocated to either the Drive intervention or control group. Table A8.3 shows that on average there are around 5.2 police incidents per perpetrator in the 6 months prior to a referral to MARAC and subsequent allocation to Drive (or control). The number of incidents in the six-month period prior to MARAC has been annualised to estimate the cost per perpetrator per year.

2. Unit costs of police activity

- 2.1 The unit costs of police incidents are taken from Home Office Research Report 107 Study (Horr107), The Economic and Social Costs of Domestic Abuse, Jan 2019. Where a unit cost for a specific crime type is not provided in Horr107, unit costs for crimes of similar severity are assigned as a proxy (see Appendix 8.3).

or Drive. These unit costs per perpetrator should **not** be applied to medium or all-risk cases as incidents are less likely to be reported, and the frequency and severity will be much lower than for high-risk cases.

⁴⁰ The number of incidents in the six months prior to allocation to Drive (or control) have been annualised in the calculations.

⁴¹ Police data on violence with injury from South Wales was not separated into ABH and GBH. The relative proportions of GBH to ABH were applied to the South Wales data; 5% of the SW incidents of violence with injury were deemed to be GBH.

⁴² Includes theft, drug offences, some of which are flagged as related to a DV incident

3. Unit costs of other criminal justice system costs

- 3.1 Criminal justice system costs other than police activity costs may include court costs, legal aid, probation service, custody costs, and criminal-injuries compensation payments.
- 3.2 The unit costs of court events are derived from information in the Home Office Research Report 107 Study, *The Economic and Social Costs of Domestic Abuse*, Jan 2019⁴³. Using data for CPS, court hearing costs, legal aid, etc, the average cost of a Crown Court event is estimated at £9,400, and a magistrates' court event at £300. It is assumed that the crimes of GBH, ABH and rape, accounting for around 10% of prosecutions, are tried in the Crown Court⁴⁴ and the remaining prosecutions in the magistrates' court.
- 3.3 The cost of custody per offender is based on the direct costs per (male) prison place per month in 2017 to 2018 at £2,140⁴⁵ per month, multiplied by the average custody length in months by offence derived from CJS outcome statistics 2016 and 2017.
- 3.4 The unit cost of probation per offender and probation costs associated with community and suspended sentences are calculated using total expenditure for the National Probation Service 2017 divided by the number of offenders supervised in 2017⁴⁶ at £3,910 pa.
- 3.5 All of the above costs are converted to a per-incident basis by applying estimates of the charging, prosecution, conviction and sentencing outcome rates. See Table A8.4.
- 3.5.1 The analysis includes police outcomes where an incident has resulted in a charge or summons, and this data is used to estimate the likelihood of subsequent court, custody and probation costs. Note that not all recorded crimes are referred to the Crown Prosecution Service (CPS) for charging and not all charged crimes result in a prosecution.
- 3.5.2 The weighted average rate of charged to recorded crimes in the police activity data for (n=165) Drive (or control) perpetrators in the six months prior to referral to MARAC is 40%. This is almost double the rate of charged to recorded crimes for all domestic abuse flagged offences in 2018, which was 18%⁴⁷.

⁴³ Excluding the cost of private representation and the court cost of homicides.

⁴⁴ HERR107: Oliver et al, 2019: *The economic and social cost of domestic abuse 2019*: In 2018 around 9% of domestic abuse flagged prosecutions were heard in the crown court.

⁴⁵ Her Majesty's Prison and Probation Service Annual Report and Accounts 2017-18; Costs per prison place and cost per prisoner by individual prison establishment 2017 to 2018 table 1.

⁴⁶ Number CDP 2018/0162, 29 June 2018 Page 10 [House of Commons Library].

⁴⁷ In the year ending 31 March 2018, there were 599,549 domestic abuse-related crimes recorded by the police in England and Wales and a further 598,545 incidents not subsequently recorded as crimes (Office for National Statistics, 2018b). In the year to 31 March 2018, 18% (110,562) of domestic abuse-related crimes were referred from the police to the CPS, (Crown Prosecution Service VAWG Report 2017-2018).

- 3.5.3 There is a time lag between police referral to the CPS for charging, prosecution, conviction and sentencing. As a result, the data on referrals, prosecutions and convictions do not directly follow on from one another.
- 3.5.4 Violence Against Women and Girls (VAWG) data from 2018 indicates that the overall prosecution rate for domestic abuse flagged charged crimes in 2018 was 80.6%¹. With the exception of rape, 75%, the data is not available by crime category, so 80.6%⁴⁸ has been applied to all charged crimes.
- 3.5.5 VAWG data from 2018 indicates that the overall conviction rate for domestic abuse flagged charged crimes in 2018 was 76.1%. Conviction rates, where available in the VAWG report 2017/8, have been applied to prosecuted crimes.
- 3.5.6 The custody rates and average custody lengths (ACL) per crime are based on a four-year average for all crimes by a matched offence group to Dec 2016. (CJS outcomes by offence tool 2016). These data are not available for domestic abuse flagged crimes but are used as proxies.
- 3.6 In this analysis the following prosecution to charged crime and conviction rates have been used to calculate the court/custody/probation costs per incident.

Table A8.4 Prosecution conviction/custody rates

	VAWG 2017/8	Charge/ incident	Prosecution / charged offence	Conviction rate	Custody rate	ACL months
GBH: grievous bodily harm	DA	75%	80.6%	76.4%	62.0%	42.72
ABH actual bodily harm	DA	50%	80.6%	76.4%	37.0%	13.10
Threats to kill	H&S	25%	80.6%	79.0%	48.0%	18.35
Stalking and harassment	H&S	40%	80.6%	79.0%	35.0%	4.65
Common assault	DA	32%	80.6%	76.4%	13.0%	2.95
Sexual offences: rape	Rape	6%	75.1%	58.3%	96.0%	101.54
Sexual offences: other	SO	33%	80.6%	80.4%	41.0%	28.20
Criminal damage / arson	DA	46%	80.6%	80.0%	5.6%	9.63

- 3.7 Table A8.5 shows the estimates of the unit costs of other CJS activities, limited to direct costs of court events, custody and probation only. The costs reflect the charging, prosecution, conviction and custody rates by offence.

- 3.7.1 ABH, for example, has a low custody rate because incidents recorded as ABH are often downgraded and prosecuted as common assault.

⁴⁸ Crown Prosecution Service VAWG Report 2017-2018: The volume of DA-flagged prosecutions completed fell to 89,091 (80.6% of 110,562).

3.7.2 The costs for violent incidents (without injury), and property crimes are low because these incidents rarely proceed to costly court cases and custody.

Table A8.5 Unit cost of court, custody and probation by offence

	Court event	Custody	Probation	Total
GBH: grievous bodily harm	£5,681	£26,183	£1,752	£33,616
ABH actual bodily harm	£1,057	£1,004	£892	£2,953
Threats to kill	£60	£3,000	£554	£3,614
Stalking and harassment	£98	£896	£755	£1,749
Common assault	£78	£163	£521	£762
Sexual offences: rape	£415	£5,378	£98	£5,891
Sexual offences: other	£81	£5,344	£769	£6,194
Criminal damage / arson	£111	£340	£445	£895
Other crimes (non-DV)	£81	£251	£328	£660

Physical health

The physical health costs in this analysis are limited to the immediate medical costs of A&E attendance, hospital admission and follow-up appointments with a GP on discharge for injuries to the victim as a result of domestic abuse incidents (likely to cause injuries; GBH and ABH). Where physical health costs are incurred due to mental ill health, such as for intentional self-harm, these are included in the section relating to mental health.

The average physical health costs per case per year are calculated by applying unit costs per incident to the average number of incidents (annualised and adjusted for under-reporting) by severity.

Table A8.6 shows the cost of medical intervention for injuries to the victim is estimated at £3,240 per case.

Table A8.6 Cost of medical intervention for injuries to the victim per case

	Number of incidents per average perpetrator (6 months) ⁴⁹	Estimated Attendances at A&E (annualised and adjusted for under reporting)	Unit cost per incident	Cost per case
GBH – serious injury	0.05	0.09	£7105	£663

⁴⁹ The number of incidents in the six months prior to allocation to Drive (or control) have been annualised in the calculations.

ABH – less serious injury	0.89	2.97	£867	£2,576
A&E attendances per victim	0.93	3.06	£1,057⁵⁰	£3,240

Assumptions used in the calculations:

4. Serious injuries as a result of GBH

- 4.1 The frequency of serious assaults likely to cause injury has been derived from analysis of the police activity data in the six months prior to referral to MARAC in respect of perpetrators (n=165) allocated to either the Drive or control group. The number of incidents per perpetrator in the six months prior to the MARAC referral has been annualised.
- 4.2 Due to the serious nature of GBH, all such incidents are assumed to result in a hospital admission for serious injury. GBH includes serious harm such as:
- Injury resulting in permanent disability or permanent loss of sensory function;
 - Injury that results in more than minor, permanent, visible disfigurement; broken or displaced limbs or bones, including fractured skull;
 - Compound fractures, broken cheekbone, jaw, ribs, etc;
 - Injuries that cause substantial loss of blood, usually necessitating a transfusion;
 - Injuries resulting in lengthy treatment or incapacity.
- 4.3 It is assumed that due to the seriousness of the assault, all GBH incidents are reported to the police; therefore, no adjustment has been made for under-reporting. On average there are around 0.05 incidents per perpetrator of GBH in the 6 months prior to MARAC per case (0.09 annualised).
- 4.4 The hospital cost of serious injuries due to GBH is estimated using a weighted average of spell⁵¹ costs for multiple trauma diagnoses and some maxillofacial procedures, (£6,470)⁵², plus the cost of an ambulance attendance (£252)⁵³, an A&E attendance (£247)⁵⁴, and two follow up appointments with a GP including prescription costs (£68 each)⁵⁵. (See Table A8.7).

⁵⁰ HORR107: Oliver et al, 2019: The economic and social cost of domestic abuse 2019, Table 9: The unit cost of violence with injury is £1900. The healthcare costs relied on CSEW data for crime as a whole, rather than domestic abuse-specific medical assistance needs.

⁵¹ A hospital spell cost is defined as the period of admission to discharge or death for the same patient at the same provider.

⁵² National Schedule of Reference Costs 2017-18 for NHS trusts and NHS foundation trusts: Weighted average cost of treating various levels of multiple trauma or maxillofacial procedures; (Excludes the most serious diagnoses and treatments which are proxies for serious road traffic incidents).

⁵³ NHS reference costs 2017-18: NHS Ambulance attendance for attendance & convey

⁵⁴ NHS reference costs 2017-18: NHS A&E attendance for admitted attendances excluding minors or walk-ins.

⁵⁵ Curtis and Burns 2018: Unit Costs of Health & Social Care 2018 Table 10.3b

5. Less serious injuries as a result of ABH

- 5.1 On average there are around 0.89 incidents of ABH in the 6 months prior to MARAC per case per year (1.77 annualised). The number of ABH incidents per case in the police data has been up-rated to 2.97 to reflect under-reporting of violence to the police. Generally, only 60%⁵⁶ of violent crime incidents are reported to police. Reporting of domestic violence is likely to be lower still.
- 5.2 Overall the estimated number of A&E attendances per case for injuries as a result of both GBH and ABH is around 3.06 per case per year.
- 5.3 For a charge of ABH to be brought, the hurt need not be permanent, but must be more than transient and trifling. Relevant factors may include significant medical intervention such as cases where there is the need for a number of stitches or a hospital procedure under anaesthetic. It is assumed that ABH incidents will result in attendance at A&E for injuries requiring medical intervention, but that only a quarter of patients will arrive in an ambulance and subsequently be admitted⁵⁷.
- 5.4 The cost of an admitted spell for less serious injuries (£2,350)⁵⁸ is calculated using multiple trauma costs in the lowest diagnostic score range. Ambulance and A&E costs plus one follow-up appointment with a GP are also included. (See Table A8.7).

Table A8.7 Cost per incident for serious injuries

	Serious injury (GBH)		Less serious injury (ABH)	
A&E attendance (weighted avg.)	100%	£247	100%	£160
Ambulance (% conveyed)	100%	£252	25%	£62
Admitted spell costs (multiple trauma injuries)	£6,470 x 100%	£6,470	£2,350 x 25%	£577
GP Follow up	2 appts	136	1 appt	£68
Total cost per incident	£7,105		£867	

- 5.5 Injuries due to common assault are not included in this analysis, even though in some cases the victim may visit the GP for medical attention.

⁵⁶ CSEW 2018 (Crime Survey for England and Wales), Table D8: Proportion of violent crime incidents reported to the police, year ending March 2018. Adults aged 16 and over: Five year average = 60%. Data on reporting to police of wounding due to domestic violence is not available.

⁵⁷ NHS Hospital Episode Statistics - Admissions External Cause 2017/18: 25% of patients who have been assaulted are admitted. It is assumed the same proportion is brought in by ambulance.

⁵⁸ National Schedule of Reference Costs 2017-18 for NHS trusts and NHS foundation trusts: Weighted average cost of treating less serious incidents of multiple trauma.

Mental Health

Victims of domestic violence are more likely to suffer from a common mental health disorder (CMD) such as depression, anxiety, or post-traumatic stress disorder (PTSD). Not all those meeting diagnostic criteria or disclosing mental health problems will have contact with health services in relation to mental and emotional problems. It is unclear as to when victims will seek the estimated psychological support needed. Despite this, the cost of treatment, whether accessed or not, is included in this analysis.

Table A8.8 shows the cost of victims-survivors' mental health service use, which is estimated at £3,345 per case.

Table A8.8 Cost of victims-survivors' mental health service use per case

	Prevalence	Unit cost	Cost per victim
Common mental health disorder	51%	£2,385	£1,216
PTSD/ anxiety /panic	52%	£2,947	£1,535
Self-harm or intentional poisoning	22%	£2,698	594
Total Mental Health cost per victim			£3,345

Assumptions used in the calculations:

6. Rates of Mental Health services use: common mental disorder (CMD)

- 6.1 Hidden Hurt⁵⁹ analysed Adult Psychiatric Morbidity Survey data (APMS 2007) on abuse and violence which provided evidence of the degree to which women who experience the most extensive abuse and violence are more likely to face other adverse circumstances. The groups presented in Table A8.25, Appendix 8.4 are women with little or no experience of violence, women with experience of extensive physical violence or coercion from a partner, and women with experience of extensive physical and sexual violence⁶⁰.
- 6.2 Very high-risk victims are likely to have experienced a high degree of trauma and harm, similar to that experienced by women in the extensive physical and sexual violence cohort, where 54% meet the diagnostic criteria for at least one common mental disorder (CMD)⁶¹.
- 6.3 Themis data supports this; 57% of victims disclose mental health problems when accessing support in a hospital setting. This figure is higher than for victims accessing

⁵⁹ Scott and McManus (2016) Hidden Hurt. Violence, abuse and disadvantage in the lives of women.

⁶⁰ As an adult and a child

⁶¹ Scott and McManus (2016) Hidden Hurt. Violence, abuse and disadvantage in the lives of women.

support in community settings, reflecting a greater propensity to disclose in a health setting.

- 6.4 In the latest Crime Survey for England and Wales (CSEW); 96% of victims reported that they were emotionally impacted by a violent incident⁶² (with or without injury); 52% reported depression and 35% anxiety/ panic attacks⁶³.
- 6.5 51% of victims of perpetrators assigned to Drive (or control) disclosed mental ill health at the point of intake. (See Appendix 8.1). This data is used to estimate the likelihood of suffering a CMD such as depression or anxiety.

7. Post-traumatic stress disorder (PTSD)

- 7.1 PTSD is a disabling condition that includes flashbacks, nightmares, avoidance, numbing, and hypervigilance. Delayed presentation is a common feature of PTSD; it usually starts three months after the traumatic event⁶⁴ and may persist for months or even years. Not all trauma will result in PTSD and not everyone with PTSD will be diagnosed and access services⁶⁵.
- 7.2 Rather than occurring as a single traumatic event, domestic violence and emotional abuse tend to be chronic and repeated over time. Chronic exposure to the trauma of domestic abuse can lead to chronic (often years-long) PTSD. Individuals referred to MARAC are likely to have experienced multiple traumatic incidents.
- 7.3 For women with little or no experience of violence 1% screened positive (in the past week) for PTSD, compared to 16% for women with experience of extensive physical and sexual abuse⁶⁶. These data are based on a snapshot of one week and underestimate the lifetime prevalence of suffering PTSD. Previous studies documenting the rate of PTSD in abused women across diverse samples give rates ranging from 31% to 84%, with a modal range of between 45% and 60%⁶⁷.

⁶² CSEW 2018 (Crime Survey for England and Wales), Nature of Crime Table 6 Domestic violence: 96% of domestic violence victims were emotionally impacted by a violent incident, 45% very much and a further 31% 'quite a lot'.

⁶³ CSEW Table 6: Emotional impact of violent incidents, year ending March 2008 to year ending March 2018. The 2017 figures were used in HORR107: "The economic and social costs of domestic abuse 2019" to estimate the likelihood of suffering emotional harm.

⁶⁴ The term traumatic event can be described as 'Any experience that put you or someone close to you at risk of serious harm or death'

⁶⁵ Adult psychiatric morbidity Survey (APMS) in England, 2014: Table 4.11. In the general population of people who screen positive for PTSD only 12.8% will have been diagnosed with PTSD (ever) and 60.5% will access a health care service for an inpatient stay or outpatient visit in past quarter, or will have spoken with GP in past year for a mental or emotional reason.

⁶⁶ Scott and McManus (2016) Hidden Hurt. Violence, abuse and disadvantage in the lives of women. Table 50: 78% had experienced a life threatening trauma and 16% screened positive for PTSD

⁶⁷ Cascardi, Daniel O'Leary, and Karin A. Schlee Michele. Journal of Family Violence (1999): Co-occurrence and Correlates of Posttraumatic Stress Disorder and Major Depression in Physically Abused Women: Figure 1.

- 7.4 In this analysis the latest CSEW data is used to estimate the prevalence of anxiety/panic (52%) whether or not there is a diagnosis of PTSD. The assumed number of treatment sessions for PTSD is the same as for an anxiety/panic disorder.
- 7.5 In HRR107, no adjustment was made for victims suffering both depression (53%) and anxiety (51%), and both conditions were deemed as being treated separately. In the Drive (or control) victim cohort due to the very high rates of trauma, there is a high probability of a life time episode of anxiety and/or panic disorders (including PTSD), so it is reasonable to assume an additional block of counselling even if there is some overlap or comorbidity.

8. Cost of mental health service use

- 8.1 The unit costs of counselling for depression and anxiety in “The economic and social costs of domestic abuse 2019: HRR107”, were based on the assumed number of hours required to treat the condition⁶⁸ in Heeks et al at 20 hours for depression and 25 for anxiety/panic disorder⁶⁹.
- 8.2 The unit cost of mental health treatment equals the assumed number of hours required to treat the condition; 20 hours for a CMD and 25 hours for an anxiety/panic disorder⁷⁰ multiplied by the hourly cost of a mental health practitioner, plus follow-up visits to a GP.
- 8.3 The cost (£112 per hour) in this analysis is for a high intensity Improving Access to Psychological Therapies (IAPT) practitioner using the latest available National Reference Costs (2017/18)⁷¹, adjusted for the number of patient contact hours per week (20 hours) recommended for an IAPT intensive support team. Further costs have been assumed for two GP appointments including prescription costs. The resulting episode costs are £2,385 for depression and £2497 for anxiety or panic disorders. (See Table A8.9).

Table A8.9 Cost of CBT/counselling

	Hours of treatment	Cost CBT/ counselling	GP visits / prescription	Unit cost
Cost CBT/counselling		£112/hr	£68/hr	

⁶⁸ HRR107: The economic and social costs of domestic abuse 2019, Table AP5: Average number of medical requirements following an injury (emotional or physical).

⁶⁹ These estimates are reproduced in Appendix 8.5, Table A8.26; caveats apply.

⁷⁰ National Clinical Practice Guideline NG116: The management of PTSD in adults and children in primary and secondary care. Trauma-focused CBT interventions for adults with PTSD which should typically be provided over 8 to 12 sessions, but more if clinically indicated, for example if they have experienced multiple traumas.

⁷¹ Curtis and Burns 2018, Unit costs of health and social care 2018: Behavioural activation.

Common mental health disorder (cost for depression)	20	£2,248	137	£2,385
PTSD/anxiety (cost for Anxiety /panic disorders)	25	£2,810	137	£2,947

8.4 By way of comparison, in 2008 The King's Fund⁷² estimated the average cost for those with depression and in contact with services was £2,085 in 2007 uprated to £2,593⁷³ in 2018.

9. Self-harm and suicide attempts

9.1 There are costs associated with self-harm and suicide attempts not least because some individuals who survive suicide attempts and self-harm make further attempts. The rate of suicide in the self-harm patient population is up to 100 times higher than that of the general population and approximately half of all people who die by suicide have previously self-harmed⁷⁴.

9.2 Data from A Cry for Health⁷⁵ suggests high rates of attendance at A&E for intentional self-poisoning or other self-harm. CSEW data indicate that 8.4% of victims tried to kill themselves in the last year as a result of partner abuse⁷⁶. This is likely to be a conservative estimate for victims meeting MARAC thresholds because rates of self-harm or suicidality increase with the severity of violence⁷⁷, and some people make multiple attempts. The victim data indicates 22% of self-harmed and 20% had planned or attempted suicide. (See Appendix 8.1) In this analysis we have assumed 22% of victims attended A&E as a result of self-harm or suicide attempts.

9.3 There were around 112,000⁷⁸ A&E attendances for deliberate self-harm in 2018. An estimated 61,000 women attended for intentional self-poisoning and a further 9,000 for self-harm by other means⁷⁹. Most incidents are brought in by ambulance and most are admitted.

⁷² King's Fund, McCrone et al. (2008) Paying the Price: The cost of mental health care in England.

⁷³ GDP deflator to uprate to 2018 prices.

⁷⁴ R Carroll (2014): Hospital Presenting Self-Harm and Risk of Fatal and Non-Fatal Repetition: Systematic Review and Meta-Analysis

⁷⁵ A Cry for Health 2016 SafeLives: One in six (16%) hospital Inpatient patients had been to A&E for an overdose in the last six months.

⁷⁶ CSEW 2018, Table 14: Other effects felt as a result of the partner abuse experienced in the last year, year ending March 2018.

⁷⁷ Scott and McManus (2016) Hidden Hurt. Violence, abuse and disadvantage in the lives of women. Table 50: 22% of women with experience of extensive sexual and physical abuse had self-harmed with suicidal intent compared to 5% overall. Suicidal thoughts and attempts also increase with increasing severity.

⁷⁸ NHS Hospital Episode Statistics - Admissions External Cause 2017/18

⁷⁹ NHS Hospital Episode Statistics - Admissions External Causes 2017/18. Admissions for intentional self-poisoning and intentional self-harm by other means.

- 9.4 NHS data does not distinguish between self-harm and attempted suicide. An incident of self-harm resulting in an admission indicates a degree of serious intent.
- 9.5 The cost of attendances for intentional self-harm includes hospital costs, and a course of counselling post discharge. The weighted average hospital costs of intentional self-harm by poisoning or other means is £805⁸⁰. The cost for ambulance, A&E attendance, GP follow up, and a course of counselling with a high intensity IAPT practitioner are added to the hospital costs to give a total cost per incident of intentional self-harm of £2,698. (See Table A8.10).

Table A8.10 Cost per incident of self-harm

	Self-harm
Ambulance attendance	£252
A&E attendance	£160
Admitted spells (multiple trauma injuries/ poisoning)	£805
GP Follow up	£141
High intensity IAPT counselling 12 sessions	£1,344
Total cost per incident	£2,698

- 9.6 The majority of costs are incurred for follow-up psychiatric care. There may be overlap with people suffering PTSD, or other common mental disorders among those who attempt suicide, but these potentially additional therapeutic costs are included here to reflect the need for more intense and complex treatment following an episode of self-harm.

10. Perpetrators' use of mental health services

- 10.1 Mental health issues are prevalent in perpetrators of domestic abuse. 62% of perpetrators assigned to Drive (n=162) were identified as having an excessive or high degree of mental health problems at the Drive mid-point. 21% had planned or attempted suicide. These proportions are calculated using data for Drive service users and exclude missing or don't-know answers.
- 10.2 The unit costs of treatment are assumed to be the same as for victims-survivors' use of services. The hospital and costs of follow-up mental health interventions following suicide attempts are assumed to be the same as for victims-survivors' use of services.

⁸⁰ Tsiachristas et al (2017): General hospital costs in England of medical and psychiatric care for patients who self-harm: a retrospective analysis; Costs were mainly associated with the type of health-care service contact such as inpatient stay, intensive care, and psychosocial assessment. Further primary care costs were not included.

10.3 Table A8.11 shows the cost of mental health services use by perpetrators is estimated at £2,050 per perpetrator.

Table A8.11 Unit costs of mental health for Drive perpetrators

	Prevalence	Unit cost	Cost per perpetrator
Common mental health disorder	62%	£2,385	£1,484
Self-harm (including hospital costs)	21%	£2,698	£564
Total Mental Health cost per perpetrator			£2,050

Other health services Costs

11. Health services costs due to multiple disadvantages

11.1 Physical and sexual abuse is consistently associated with a broad array of negative health outcomes such as gynaecological disorders, adverse pregnancy outcome, irritable bowel syndrome, gastrointestinal disorders and various chronic-pain syndromes⁸¹. Individuals who are victims of domestic abuse are more likely to experience disadvantage in many other areas of their lives, including disability, ill health and substance dependence.

11.2 Disadvantage has many contributing factors and may not be directly attributable to the experience of violence and abuse alone. The health costs associated with multiple disadvantages and additional health risks for individuals with experience of extensive violence and/or sexual assault are many and often long term.

11.3 Quantifying and attributing the costs of multiple disadvantage over the long term is complex. The economic and social costs of domestic abuse 2019 HORR107, used the QALY method to quantify these costs⁸². This approach uses the percentage by which the victims' health-related quality of life is estimated to be reduced (the QALY loss) by

⁸¹ Ellsbery et al. (2008) Intimate partner violence and women's physical and mental health in the WHO multi-country study on women's health and domestic violence: an observational study. *Lancet* 371: 1165-72.

⁸² The physical and emotional harm to the victims is calculated as the likelihood of sustaining physical and emotional injuries (LIKE), multiplied by the percentage reduction in health-related quality of life (REDUCEQL), multiplied by the duration of the recovery period (including the length of abuse where appropriate) as a fraction of a total year (DUR). This is then multiplied by the value of a year of life at full health (VOLY) to give an estimate of the average cost. The formula is as follows: LIKE * REDUCEQL * DUR * VOLY = average physical and emotional cost.

suffering particular injuries and psychological harms. The unit cost per average victim is estimated at £24,000 due to QALY loss, and a further £7,245 due to lost output. These unit costs are averages for 1.9m victims of all risks and would not reflect the much higher cost of QALY loss associated with the very high-risk cases in the Drive (or control) cohort which were identified as high-risk via the MARAC referral pathway.

11.4 This analysis is a conservative estimate of the total costs attributable to the cases associated with Drive (or control) perpetrators because these very real human and fiscal costs have not been included.

Substance use disorders

Exposure to traumatic experiences has been linked to substance use disorders (SUDs), including abuse and dependence. SUDs are also highly comorbid with post-traumatic stress disorder (PTSD).

In Hidden Hurt, about a third (31%) of women in the extensive physical and sexual violence group had an alcohol problem, nearly half smoked (47%) and 8% showed signs of drug dependency. These rates are much higher than for women with little experience of violence and abuse: they are about twice as likely to have an alcohol problem, three times more likely to smoke, and eight times more likely to be drug dependent⁸³.

Substance use disorders are associated with a wide array of health service, criminal justice, social and economic costs, but this analysis is limited to the health costs associated with hazardous use or dependency, and the cost of treatment. Not all those disclosing substance use disorders will engage with drug and alcohol services, but the costs of treatment whether accessed or not are latent and therefore included in the calculation.

Table A8.12 shows the health costs associated with victims' substance use disorders are estimated at £1,375 per case.

Table A8.12 Cost of victims-survivors' substance use disorders per case

	Prevalence	Unit cost	Cost per victim
Cost to NHS (primary and acute care)			
Alcohol use disorder	14%	£4,330	£606
Drug use disorder	11%	£2,060	£227
Treatment cost⁸⁴, (PHE)⁸⁵			
Alcohol use disorder	14%		
Drug use disorder	11%		

⁸³ Scott and McManus (2016) Hidden Hurt. Violence, abuse and disadvantage in the lives of women.

⁸⁴ There may be some overlap between these groups

⁸⁵ Drug misuse treatment oversight and commissioning moved to public health structures in England in 2013.

	25%	£2,160	£540
Total substance use cost per victim			£1,375

Assumptions used in the calculations:

12. Alcohol and drug health services use

12.1 Table A8.13 shows the prevalence of alcohol and drug use disorders in the general population⁸⁶ and the Hidden Hurt extensive violence cohort.

Table A8.13 Substance use disorders

	Hazardous alcohol use	Drug dependence / misuse
APMS 2014 (All women aged 16-74)	15%	2.4%
Hidden Hurt (extensive violence group)	31%	8%
Drive victims at intake (misuse)	14%	11%
Themis Hospital cohort (misuse)	18%	11%

12.2 15% of women are hazardous drinkers⁸⁷, which doubles for women with experience of extensive violence 31%⁸⁸. Drive (or control) victim data indicates rates of alcohol misuse of 14%. (See Appendix 8.1). Rates of alcohol misuse in the data are not calculated on the same basis as APMS data and do not differentiate between hazardous and dependent drinking. In this analysis it is assumed that misuse indicates problem use with a need for some intervention whether accessed or latent.

12.3 The rate of drug misuse disclosed in the same victim cohort as above of 11% is somewhat higher than the rate of dependence of 8% in the extensive violence group, and similar to the 11% of disclosures in the Themis Hospital cohort. In this analysis it is assumed that drug misuse indicates problem use with a need for some intervention whether accessed or latent.

⁸⁶ Alcohol Use Disorders Identification Test (AUDIT) scores of 0-7 indicates no or low risk; 8-15, hazardous drinking; 16-19, harmful drinking or mild dependence; 20+, probable dependence. An AUDIT score of 8-15 suggests probable need of brief alcohol intervention (e.g. in primary care); those scoring 16-19 may warrant an 'extended brief intervention' and referral to specialist treatment for those who don't respond to the initial intervention (stepped care); 20+ indicates a need for referral to specialist services for further assessment and treatment. Surveys tend to under-estimate the 20+ population due to sampling and participation issues.

⁸⁷ APMS survey (2014): 14.7% had an AUDIT score of 8 or above.

⁸⁸ Scott and McManus (2016) Hidden Hurt. Violence, abuse and disadvantage in the lives of women. From an analysis of similar data from the 2007 APMS survey – Women with an AUDIT score of 8 or above.

13. Cost to the NHS due to alcohol and drug misuse

Table A8.14 Unit cost to NHS due to problem alcohol use

	DOH 2007	2014 NICE guidelines	Updated 2018/9 Prices
NHS Health spend problem alcohol use	£2.7bn	£3.5bn	£4.2bn
Individuals hazardous drinkers	£2.65m		
Of which dependent drinkers	£0.65m		
Relapse cost per dependent drinker		£1,800	£2,160
Total NHS cost per dependent drinker			£4,330

13.1 In 2007 there were 2.6m problem drinkers⁸⁹ which cost the NHS £2.7bn per year. The annual cost of alcohol misuse to the NHS in England was estimated at £2.7bn by the Department of Health (DOH) 2007⁹⁰. Cost components included hospital inpatient and day visits, outpatient visits, A&E, ambulance and primary care consultations and prescriptions. This cost was later updated to £3.5bn in 2009/10 to take into account increases in unit costs as well as more recent and accurate data on alcohol consumption.

13.2 The National Institute for Health and Care Excellence (NICE) guidelines for alcohol use disorders 2014⁹¹ used the updated figures to estimate the proportion of the £3.5bn cost attributable to people who relapse to dependency at £1,800 per dependent drinker.

13.3 In this analysis the £3.5bn has been further adjusted for inflation to £4.2bn, and the whole cost of dependency (rather than just the cost of relapse⁹²), has been estimated at £4,330 per dependent drinker.

⁸⁹ Statistical bulletin Adult drinking habits in Great Britain 2014. Individuals who had drunk more than 14 units in their most heavy drinking day in the previous week; the equivalent of drinking more than the low risk guidelines recommend for regular drinking in a week, in one day. Previous estimates using different criteria indicate a similar number of dependent or excessive drinkers at 2.6m.

⁹⁰ An update to the Cabinet Office (2003) study July 2008 Health Improvement Analytical Team Department of Health (2010): The cost of alcohol harm to the NHS in England.

⁹¹ NICE Clinical Practice Guidance 115: Alcohol Use Disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence, p.408

⁹² Based on a based on a ratio of service use of 2:1 for dependent to hazardous drinkers; i.e. one third of the £3.5bn cost is due to relapse; (two thirds for the total cost).

Table A8.15 Unit cost to NHS due to problem drug use

	Estimate 2003/4	Updated to 2018/9 Prices
NHS Health spend problem drug use	£0.5bn	
Individuals problem drug users (2007)	£0.33m	
Cost per Problem drug user	£1,490	£2,064

13.4 In 2003/4 there were 327,466 dependent drug users costing the NHS £488m⁹³, or £2,060 per problem user updated to 2018/9 prices.

14. Cost of alcohol and drug treatment services

Table A8.16 Unit cost of Cost of Drug and Alcohol treatment services

	2017/18
Public Health spend Drug and Alcohol services 2017/18	£0.6bn
Individuals in structured treatment 2017/18	£0.3m
Cost per person in treatment	£2,160

14.1 Public Health spending on adult substance misuse treatment services in 2017/18 was £579m⁹⁴. During 2017/18 the National Drug Treatment Monitoring System (NDTMS) reported a total of 268,390⁹⁵ individuals aged 18 and over in contact with structured treatment. This total includes all individuals in treatment for either problematic drug use, alcohol use or both. The cost is £2,160 per individual in treatment.

15. Perpetrators use of drugs and alcohol

15.1 Substance use disorders are prevalent in perpetrators of domestic abuse. 34% and 28% of perpetrators assigned to Drive were identified as having excessive or high degree of alcohol and/or drug misuse respectively. These proportions are calculated using data for Drive service users⁹⁶ and exclude missing or don't know answers.

15.2 In the general population for males the rate of hazardous alcohol misuse is 28% and drug dependence is 5%⁹⁷.

⁹³ Singleton Murray, Tinsley (2006) Economic and social costs of class A drug use (2003/4). Measuring different aspects of problem drug use: methodological development.

⁹⁴ Revenue Outturn (RO3) data for England 2017-18 Social Care and Public Health

⁹⁵ National Drug Treatment Monitoring System (NDTMS) 2017/2018: Adult substance misuse statistics

⁹⁶ The Drive mid-point data was used, because it was assumed that services users were more likely to disclose substance misuse at the mid-point than the point of intake.

⁹⁷ APMS 2014 survey: had an AUDIT score of 8 or above:

- 15.3 Data relating to high-risk victims supported by an Idva showed that when the victim was asked the question 54% and 39% of perpetrators were identified as having problem alcohol and/or drug use respectively at the point of intake⁹⁸, so the Drive data is likely to be an under-estimate.
- 15.4 The unit costs to the NHS and treatment for problem use are assumed to be the same as for victims' use of services. Substance misuse is assumed to be problem use with a need for intervention, and these costs are included whether or not treatment is accessed. No adjustments have been made to account for any overlap between drug and alcohol misuse or multiple relapses.
- 15.5 Table A8.17 shows the health costs associated with perpetrators' substance use disorders is estimated at £3,400 per perpetrator.

Table A8.17 Unit costs of perpetrators' substance use disorders

	Prevalence	Unit cost	Cost per perpetrator
Cost to NHS			
Alcohol use disorder	34%	£4,330	£1,486
Drug use disorder	28%	£2,060	£574
Treatment cost⁹⁹			
Alcohol and/or drug use disorder	62%	£2,160	£1,343
Total substance use cost per perpetrator			£3,400

Children's Services

In this analysis Children's Services costs are included¹⁰⁰ despite the possible co-occurrence of mental ill health and/or substance misuse in families experiencing domestic abuse. This is because domestic violence was the most commonly identified factor in over half (51%) of all assessments by children's services in 2017-8¹⁰¹. SafeLives' data shows that almost two thirds (62%) of children exposed to domestic abuse are also directly harmed¹⁰². No attempt has been made to attribute costs to the individual factors leading to Children's Services involvement in the family.

⁹⁸ Howarth et al, 2009: Safety in numbers: Table E1.

⁹⁹ There is very likely to be overlap between these groups, but the additional complexity will likely mean additional costs.

¹⁰⁰ HERR107: Oliver et al, 2019: The economic and social cost of domestic abuse 2019: Costs of children's services were excluded from the overall cost because "There is a high degree of co-occurrence between domestic abuse and child abuse within abusive families. So, while the initial safeguarding referral has been assumed to be a direct cost as a result of domestic abuse, the subsequent actions made by the safeguarding authority cannot be directly linked for domestic abuse and therefore have been excluded".

¹⁰¹ 2017-8 Characteristics of Children in Need Table C3

¹⁰² Insights data "In Plain sight 2014"

Table A8.18 shows the cost of Children's Services involvement is estimated at £14,390 per case.

Table A8.18 Cost of Children's services involvement per case

Children's Services use (actual and potential)	Known to CS Victim data (n=650)	Not known to CS but assumed post referral	Estimated total Prevalence	Unit cost	Cost per case
- S 31 Care orders	3.5%	1.7%	5.3%	£59,360	£6,255
- S47 or S17 Children in need	18.0%	19.0%	37.0%	£10,950	£8,135
Total CS cost per MARAC victim					£14,390

Assumptions used in the calculations:

16. Rates of Children's Services use (See Appendix 8.1)

16.1 Nearly two thirds (61%) of victims have children. The average number of children per family is 2.0.

16.2 The children Act 1989 gives local areas a statutory responsibility to safeguard children who are in need, including a duty to investigate if a child is suffering or likely to suffer 'significant harm'. Children of victims reaching MARAC thresholds are likely to be at high risk themselves and MARAC guidance indicates that "when a referral is made to MARAC and there are children and young people in the family, another referral should automatically be made to children's social care."

16.3 Almost half of victims' families with children are already known to Children's Services. The level of involvement is shown in Table A8.19. The rate of involvement is higher than in the general population and yet there is likely to be a high degree of unmet need within families not known to children's Services. Assuming these families are referred to Children's Services; some children will be assessed as a Child in Need (CIN) and a small number may reach thresholds to become Looked After children (LAC).

16.4 Where children are not known to Children's Services at intake, the level and likelihood of Children's Services involvement post MARAC is estimated by applying the national average rate of CIN starts to CIN referrals to referrals initiated as a result of the

MARAC. The 5-year average rate of CIN starts to referrals¹⁰³ is 68%, of which around 8% meet thresholds for LAC¹⁰⁴.

- 16.5 Where children Service's involvement results in a Section 31 (S31) care order, the Drive (or control) victim data (n=651) indicates high rates of intervention. Analysis of the children data associated with the Drive service users (n=506) indicates similarly high rates of S31 care orders. The victim data applies to both the intervention and control cohorts so the data is not necessarily from the same families.
- 16.6 Where the involvement results in either a Section 47 (S47) child protection or a Section 17 (S17) child in need intervention, the data in the Drive (or control) victim cohort indicates higher rates than that in the Drive service user data. (See Table A8.19). Victims with children at risk may be more likely to engage with an Idva provided in the Drive programme resulting in higher levels of Children's services support.

Table A8.19 Use of Children's Services

	Children's Services Victim data (n=651)	Children's Services Drive SU data (n= 506)
- S 31 Care orders (LAC)	3.5%	3.0%
- S47 or S17 Children in need	18%	6.3%

17. Children's Services costs

- 17.1 Previous DFE studies¹⁰⁵ estimating the cost of Children's Services involvement utilised a 'bottom-up' approach to calculate unit costs to reflect the range of difficulties experienced by families and the various ways in which children with different needs and circumstances are supported by children's social care over time.
- 17.2 As it is not feasible to identify specific levels of need within the families associated with the Drive (or control) cohorts, a 'top-down' approach is used to provide an average unit cost imputed from routinely published data on the costs of children's social care services and the numbers of Looked After children (LAC)¹⁰⁶ and Children in Need (CIN)¹⁰⁷. These are outlined in Table A8.20.
- 17.3 The analysis includes the costs of Children's Social Services in respect of:
- S31 care orders (Looked After Children)
 - S47 Children at risk of harm

¹⁰³ The number of children starting an episode of need as % of number of children referred (5 year average).

¹⁰⁴ Children who started to be looked after during the year as a % of CIN starts (5 year average rate).

¹⁰⁵ Homes, McDermid Padley, Soper 2010 DFE-RB056: Extension of the cost calculator to include cost calculations for all children in need.

¹⁰⁶ DFE National Tables: Children Looked After in England 2018

¹⁰⁷ DFE Characteristics of Children in Need 2017 to 2018

- S17 Children in need

To avoid double counting, the analysis doesn't account separately for costs associated with sub threshold outcomes or additional services. All of the Children's services costs are included in the total cost per head for LAC or CIN.

Table A8.20 Unit costs of Children's Services

Unit Costs of Children's services		
Cost of Looked after children		
Cost of LAC ¹⁰⁸ :	£4,476,595	
Number of LAC as at 31 March 2018 ¹⁰⁹	75,420	
Cost per LAC		£59,360
Cost of Children in Need		
Total Safeguarding Children and Young People's Services Costs ¹¹⁰	£4,430,121	
Children in Need as at 31 March 2018 ¹¹¹	404,710	
Cost per CIN		£10,950

17.4 The information available in the public domain does not allow to establish whether 'snapshot numbers', such as all children in need or looked after as at 31 March, or 'throughput numbers', such as all children supported throughout the year, provide a better denominator to obtain spend per head estimates. In the Albaba report¹¹², it was decided that 'snapshot numbers' provide a better denominator, which results in a reliable indication of the spending that goes to a profile of need that may be reasonably supported within a year.

Housing

The housing needs of victims can include refuge, rehousing in temporary accommodation or a new secure tenancy, sanctuary schemes, housing advice and/or eviction of the perpetrator. The costs of providing a safe house or other housing support are usually incurred when victims seek support from specialist services, so although they are associated with a package of support, in this analysis refuge and housing costs triggered at the point of intervention are

¹⁰⁸ S251 Outturn England LAC 2018: Children Looked After, Item 3.1.11

¹⁰⁹ DFE National Tables: Children Looked After in England 2018

¹¹⁰ S251 Outturn England LAC 2015: Safeguarding Children and Young Peoples Services, Item 3.3.4 /3.2.1/3.4.6/3.5.2/3.0.5).

¹¹¹ DFE National Tables: Characteristics of Children in Need 2017-2018

¹¹² Albaba 2017: Children's services: spending, 2010-11 to 2015-16.

treated as being latent costs as a result of domestic abuse, rather than a cost of the intervention.

Table A8.21 shows the cost of housing and accommodation needs of victims is estimated at £2,215 per case.

Table A8.21 Cost of victims' housing and accommodation needs per case

Housing costs	Estimated % MARAC victims	Average cost per victim	Average Cost per victim
Cost of refuge	10%	£5,630	£569
Homelessness	9%	£16,000	£1,406
Housing need (homeless prevention)	50%	£480	£239
Total housing cost per victim			£2,215

Assumptions used in the calculations:

18. Refuge

18.1 Around 15,000¹¹³ victims in England and Wales are accommodated in refuge per year. Access to refuge is needs rather than risk based so not all of those accommodated in refuge meet MARAC thresholds and fewer still have their cases heard at MARAC. Many victims do not stay in refuge long enough to be referred, others will already have had their cases heard prior to intake, and some may be deemed safe whilst in refuge.

18.2 There is likely to be some overlap between the victims referred from MARAC¹¹⁴ to refuge via an Idva and those accommodated within refuge whose cases subsequently are heard at MARAC. The data on victims associated with Drive (or control) perpetrators relates only to the former. To avoid either under-estimating or double counting, the analysis uses the proportion of refuge victims meeting MARAC thresholds on intake to refuge. Insights data¹¹⁵ on a sample of over 1000 refuge victims indicate that at the point of intake around half (52%) of victims in refuge meet MARAC thresholds, equivalent to around 10% of MARAC victims.

¹¹³ WA survey 2017(Survival and Beyond) estimates there are 4094 units accommodating 13,400 victims in England. Including an estimate for Wales, there are approximately 4,390 bed spaces of refuge in England and Wales accommodating around 15,000 victims per annum.

¹¹⁴ SafeLives Insights data on victims meeting MARAC thresholds indicate that 6% access refuge with the support of an Idva (~3000 victims).

¹¹⁵ SafeLives Insights Refuge England & Wales dataset 2015-2018: Exit data for over 1000 cases of victims accommodated in refuge indicate that 52% met MARAC thresholds (~7600 victims).

18.3 The average cost per refuge unit per week is £390 reflecting £200 to £300¹¹⁶ of rent funded through housing benefit¹¹⁷ plus another £150¹¹⁸ for support and administrative costs. The average stay in refuge per victim is about 14.5 weeks giving an average cost per accommodated victim of around £5,630.

19. Homelessness and Homelessness prevention

19.1 In 2018 around 8,000 households were accepted as homeless due to violent breakdown of relationship with partner. “ ‘violent breakdown of relationship’ does not include other forms of domestic abuse that occur which may also force people to leave their homes and only includes people for whom the main reason for homelessness is domestic abuse, so it does not represent those for whom domestic abuse is cited as a secondary contributing factor”¹¹⁹.

19.2 Insights data at the point of exit on victims associated with Drive (or control) perpetrators provided data on housing need. ‘Victims rehoused in the area’ has been used as a proxy for ‘homelessness’. Around 7% of Drive (or control) victims and 19% of victims in refuge which together amount to 9% of all MARAC victims are rehoused in the area. The result is very close to the official number of households accepted as homeless due to violent breakdown of relationship with partner¹²⁰.

19.3 The average cost of homelessness is £16000 per individual accepted as homeless calculated using official statistics for the numbers and costs of homelessness¹²¹. (See Table A8.22).

19.4 Other housing needs include advice, sanctuary, perpetrator eviction, and rehousing elsewhere. In this analysis any housing need is a proxy for homeless prevention service use.

¹¹⁶ In this analysis the average rent is assumed to be £240 per week, based on 2017 financial accounts for Refuge; Social housing costs of £3.7m for 300 units.

¹¹⁷ The rent element of the cost of refuge is paid by housing benefit and is an incremental cost even where a victim has an existing tenancy funded by housing benefit as it may be paid for both the existing tenancy and refuge place for up to a year.

¹¹⁸ Based on 2017 financial accounts for Refuge; Social housing costs of £3.7m for 300 units.

¹¹⁹ HORR107: Oliver et al, 2019: The economic and social cost of domestic abuse 2019.

¹²⁰ 9% of MARAC victims (~7000). In 2018 there were 6810 in England a further 1218 in Wales accepted as homeless due to (violent) breakdown of relationship with partner.

¹²¹ Local Authority Revenue Outturn (R04) Housing Services, 2017/8: Total cost of homelessness in England £1.3bn. HCLG Statutory Homelessness Statistics – “Table 774: Households accepted by local authorities as owed a main homelessness duty England, 2005 to 2018: 56,600 accepted homeless in priority need. (1242 in Wales).

- 19.5 Around 43% of Drive (or control) victims and 70% of victims in refuge have other housing related needs which together amount to 50% of all MARAC victims. The imputed number of cases equates to around 17% of all homelessness prevention cases¹²².
- 19.6 The average cost of homelessness prevention is £480¹²³ calculated using official statistics for the numbers and costs of homelessness prevention cases¹²⁴. (See Table A8.22).

Table A8.22 Unit costs of homelessness

Unit Costs of homelessness	
Cost of temporary housing (£'000)	£986,187
Other costs including administration and support (£'000)	£305,787
Total cost of homelessness (£'000)	£1,291,973
Households accommodated by the authority on 31 March 2018	80,720
Unit cost of homelessness	£16,000
Homelessness: Prevention cost (£'000)	£102,391
Total homeless prevention cases 2018	215,532
Unit cost of homelessness prevention	£480

20. Perpetrators use of Housing services

- 20.1 Perpetrators of domestic abuse very often have housing needs. 7% and 40% of perpetrators assigned to the Drive intervention (n=268) were identified as being homeless or having housing needs respectively at the Drive mid-point. These proportions are calculated using data for Drive service users and exclude missing or don't know answers. (See Appendix 8.2)
- 20.2 In this analysis perpetrators whose housing need was transitory, unstable or temporary were assumed to be eligible for homeless prevention services. The costs associated with homelessness or homelessness prevention are assumed to be the same as for victims.
- 20.3 Table A8.23 shows the cost of perpetrators' housing and accommodation needs is estimated at £1,385 per case.

¹²² HCLG Statutory Homelessness Statistics – "Table 792: Homeless prevention cases, England, 2005 to 2018: 215,532 in 2017-8 plus another 10674 in Wales, Welsh Government statistics.

¹²³ Local Authority Revenue Outturn (R04) Housing Services, 2017/8: cost of for homelessness prevention £100m.

¹²⁴ HCLG Statutory Homelessness Statistics – "Table 792: Homeless prevention cases, England, 2005 to 2018: 215,532 in 2017-8 plus another 10674 in Wales, Welsh Government statistics.

Table A8.23 Cost of perpetrators' housing needs per case

Housing costs	Estimated % MARAC victims	Average cost per victim	Average Cost per MARAC victim
Homelessness	7%	£16,000	£1,195
Housing need (homeless prevention)	40%	£480	£192
Total housing cost per perpetrator			£1,385

Appendix 8.1 Victim data

The following data is from a cohort of victims-survivors who engaged with an IDVA following allocation of an associated perpetrator to Drive or control groups. The data is from Year 2 of the Drive project.

Victims-survivors at Intake (n=651)	Frequency	%
Drugs misuse		
Yes	68	11%
No	562	
Don't know	12	
	642	
Alcohol misuse		
Yes	92	14%
No	537	
Don't know	10	
	639	
Mental health		
Yes	325	51%
No	312	
Don't know	4	
	641	
Planned/attempted suicide		
Yes	130	20%
No	481	
Don't know	34	
	645	
Self-harm		
Yes	140	22%
No	438	

Don't know	56
	634

Victims-survivors at Intake (n=651)	Frequency	%
Children in household		
Yes	399	61%
No	251	
Don't know	1	
	651	
Average number of children living in household = 2		
CYPS Involvement		
Yes	194	33%
No	389	
	583	
Type of CYPS involvement		
S17-Child in need	38	20%
S47-Child protection	77	40%
S31-Care or supervision order	23	12%
CAF	29	15%
Other	27	14%
	194	

Victims-survivors at Exit (n=440)	Frequency	%
Types of interventions and outcomes (exit analysis)		
Housing	188	43%
Of which		
Sanctuary scheme	46	10%
Client re-housed in area	30	7%
Client moved out of area	32	7%
Perpetrator evicted	9	2%
Refuge	19	4%
Other	106	24%

Appendix 8.2 Drive service user (perpetrator) data

The following data is from the mid-point of the Drive intervention for Drive service users in Year 2 of the Drive project (n=488). The proportions are calculated excluding missing or don't-know answers.

Drive service user data (n=488)	Frequency	%	Used in analysis
Drugs			
Excessive	14	8%	
High	35	20%	28%
Moderate	17		
Low	15		
None	95		
	176		
Alcohol			
Excessive	19	11%	
High	39	23%	34%
Moderate	26		
Low	45		
None	40		
	169		
Mental health			
Excessive	61	35%	
High	46	27%	62%
Moderate	46		
Low	14		
None	5		
	172		
Planned or attempted suicide			
Yes	23	21%	21%
No	21		
Don't know	66		
	110		
Housing			
Homeless	20	7%	7%
Transitory (eg sofa-surfing)	18	7%	
Unstable	36	13%	
Temporary	53	20%	40%
Stable	141		
	268		

The following data is from the Drive service users in Year 2 of the Drive project (n=506).

Drive service user data (n=506)	Frequency	% of CYPS involvement	% of service users
Children in household			
Yes			
No			
Don't know			
Average number of children living in household			
CYPS Involvement			
Yes	106		21%
No			
Type of CYPS involvement			
S17-Child in need	32	30%	7%
S47-Child protection			
S31-Care or supervision order	15	14%	3%
CAF			
Other			

Appendix 8.3 Police unit costs

The cost of police activities have been based on figures on the Economic and Social Costs of Domestic Abuse Horr107, 2019 Table 15: Police unit costs, volume and total costs for domestic abuse flagged police recorded crime in 2016/17. The unit costs have been applied to the crime categories as follows:

Table A8.24 Police costs applied to recorded crimes by offence

Police Costs	Oliver et al (HOrr107)	Unit cost applied
GBH: grievous bodily harm	Violence with injury	£1,950
ABH: assault occasioning actual bodily harm	Violence with injury	£1,950
Threats to kill	Violence without injury	£1,180
Stalking and Harassment	Violence without injury	£1,180
Common assault and battery	Violence without injury	£1,180
Sexual Offences: Rape	Rape	£16,290
Sexual Offences: Other	Other sexual offences	£9,300
Criminal Damage and Arson	Criminal damage	£1,350
Other non DV related crimes	Other police recorded crime	£3,620
Callouts non crime incidents	Not costed	£440

Appendix 8.4 Scott and McManus 2016, Hidden Hurt

Table A8.25 Hidden Hurt: Mental health/other health risks among women in the violence and abuse groups

Victim-survivor group women with experience of:	Little or no violence	Extensive physical violence/ coercion (as a partner)	Extensive physical and sexual violence (as a child / adult)
Mental ill health			
Common mental disorder ¹²⁵	13%	36%	54%
Self-harmed (ever)	2%	11%	22%
Suicidal ideation (ever)	9%	33%	47%
Suicide attempt (ever)	2%	18%	36%
Experienced life-threatening trauma	32%	64%	78%
Screened positive for PTSD (past week)	1%	11%	16%
Other Health risks			
Describing general health as poor	5%	10%	16%
Smokes cigarettes (>7/day)	17%	45%	47%
Alcohol problem	13%	16%	31%
Drug use (Last year)	4%	11%	18%
Drug dependence	1%	6%	8%

¹²⁵ Met diagnostic criteria for a common mental health disorder

Appendix 8.5 Counselling costs

As the cost for emotional harms used in this analysis has to some extent been based on costs in HORR107: The economic and social costs of domestic abuse, Oliver et al 2019, the following caveats in HORR107 apply here:

- The emotional harms are associated with counselling costs. The average number of hours of counselling required is based on Dubourg *et al.* (2005). Average unit costs of medical requirements following abuse can then be estimated. The hourly cost of counselling is based on Curtis and Burns (2016). These hourly costs are multiplied by the number of counselling hours required to give an average health cost for emotional harms.
- To estimate the health costs associated with the other harms, the unit cost of the procedure is multiplied by the proportion of victims-survivors who require that procedure (from Table AP5). Average unit costs of injuries following abuse are shown in Table AP6.
- A single course of treatment has been assumed for all medical emotional requirements; if greater treatment is needed, the estimated emotional health services costs will likely be an underestimate. Where different types of domestic abuse overlap, the emotional harm with the greater likelihood has been used.
- It is unclear as to when victims-survivors will seek the estimated psychological support needed.
- It should be noted that the estimated total healthcare costs included within this analysis rely on CSEW data for crime as a whole, rather than domestic abuse-specific medical assistance needs.

Table A8.26 Cost of CBT/counselling HORR107, (compared to cost update used in this analysis)

HORR107 (Updated for this analysis)	AP5 HORR 107	HORR107 Unit Cost CBT/ counselling	Updated Cost CBT/ counselling	GP visits / prescription	Unit cost this analysis
Cost CBT/counselling per hour		£51	£112	£68	
Depression (Common mental health disorder)	20	£1,020	£2,248	£137	£2,385
Anxiety / panic (Anxiety/panic disorders incl. PTSD)	25	£1,275	£2,810	£137	£2,947

Appendix 8.6 The economic and social cost of domestic abuse 2019; HARR107

The average cost for 1.9m victims-survivors of any risk level was estimated in “The economic and social cost of domestic abuse 2019; HARR107” at £34,015 per victim¹²⁶.

£31,545 per victim-survivor was due to a loss of quality of life (QALY) of £24,300, and a loss of economic output of £7,245. In this analysis the costs for loss of quality of life and economic output, though real, have not been estimated.

The predominantly state-funded element in HARR107 amounted to £2385 per victim-survivor: health services (£1,200 per victim-survivor), victim services (£370 per victim-survivor), police (£645 per victim-survivor), and criminal legal costs (£170 per victim-survivor).

The level of costs per case in this analysis is much higher than in HARR107 due to the following:

- The average cost for 1.9m victims-survivors of all risk levels masks the much higher cost associated with the very high-risk cases in the DRIVE (or control) cohort, which were identified as high-risk via the MARAC referral pathway.
- Low- or medium-risk victims-survivors are less likely to report to state agencies. Fewer report the abuse to police and low-level incidents do not often result in costly court or custody outcomes. Victims-survivors with injuries due to GBH or ABH requiring hospital admission are unlikely to be classified as low or medium risk.
- Costs not included in HARR107, but included in this analysis:
 - Children’s services costs
 - Police and other CJS costs for incidents that were not flagged as domestic abuse incidents.
 - Custody and probation following convictions
 - Perpetrator costs for mental health and substance use

¹²⁶ HARR107: Oliver et al, 2019: The economic and social cost of domestic abuse 2019, calculated the cost attributable to 1.9m victims of domestic abuse of any risk level at £34,015 per victim.

Appendix 8.7 Summary cost per case at MARAC by agency

Table A8.27 Summary of costs per case by agency

	Cost Per case Victims-survivors & children (£)	Cost Per case Perpetrators (£)	Total Cost per case (£)
Police		£17,800	£17,800
Other CJS		£14,200	£14,200
Physical Health ¹²⁷ (Acute care)	£3,240		£3,240
Mental Health (primary/ community)	£3,345	£2,050	£5,395
Substance use disorders (PHE)	£1,375	£3,400	£4,775
Children's Services	£14,390		£14,390
Housing (including refuge)	£2,215	£1,385	£3,600
Total cost	£24,565	£38,835	£63,400

There were 76,000 MARAC cases¹²⁸ in England and Wales in the year to December 2018. Applying the £63,000 cost per case to all cases heard at MARAC represents an estimate of the cost to the state of domestic abuse of £4.8bn (see Table A8.28).

Table A8.28 Cost by agency for all MARAC cases

	Cost All MARAC Victims-survivors & children (£m)	Cost all MARAC Perpetrators (£m)	Total Cost all MARAC cases (£m)
Police		£1,350m	£1,350m
Other CJS		£1,080m	£1,080m
Total CJS		£2,430m	£2,430m
Physical Health ¹²⁹ (Acute care)	£250m		£250m
Mental Health (primary/ community)	£250m	£160m	£410m
Substance use disorders (PHE)	£100m	£260m	£360m
Total health	£600m	£420m	£1,020m
Children's Services	£1,090m		£1,090m
Housing (including refuge)	£170m	£110m	£270m
Total cost	£1,860m	£2,960m	£4,810m

¹²⁷ Immediate physical costs associated with assaults only.

¹²⁸ SafeLives MARAC Data 12 months to 31/12/2018: 97,600 cases net of 28% repeats.

¹²⁹ Immediate physical costs associated with assaults only.