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Islands in the stream:

An evaluation of four London independent domestic violence advocacy schemes

Final report

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Contents

Glossary

A&E	Accident & Emergency
BCS	British Crime Survey
CAADA	Co-ordinated Action Against Domestic Abuse
CDRP	Crime and Disorder Reduction Partnership
CPS	Crown Prosecution Service
DV	Domestic Violence
DVSS	Domestic Violence Support Services
CCR	Co-ordinated Community Response
GLDVP	Greater London Domestic Violence Project (now known as the AVA project)
FJC	Family Justice Centre
IDVA	Independent Domestic Violence Advisor
IPV	Intimate Partner Violence
LAA	Local Area Agreement
LSP	Local Strategic Partnership
MARAC	Multi-Agency Risk Assessment Conference
NAADV	Newham Action Against Domestic Violence
NI	National Indicator
NRPF	No Recourse to Public Funds
PSA	Public Service Agreement
SDVC	Specialist Domestic Violence Court
UN	United Nations
VAW	Violence Against Women

Introduction

This report presents the results of an evaluation of four Independent Domestic Violence Advocacy (IDVA) schemes in London, which are based in different settings: in a police station; hospital A&E department; a community based domestic violence project; and a women-only violence against women (VAW) organisation. The evaluation was commissioned by the Trust for London (formerly known as City Parochial Foundation) and the Henry Smith Charity to run alongside their joint special initiative on IDVAs, under which grants totalling £900,000 over three years, increased to £1.6 million with statutory funding, were made to the four schemes with the aim of strengthening the impact of this recent innovation in service provision.

The current national definition of IDVA devised by Co-ordinated Action Against Domestic Abuse (CAADA)[1] is:

> The main purpose of an IDVA is to address the safety of high risk domestic abuse victims and their children. Serving as a victim's primary point of contact, IDVAs normally work with their clients from the point of crisis to assess the level of risk, discuss the range of suitable options and develop co-ordinated safety plans.
>
> IDVAs are pro-active in implementing the safety plans, which include practical steps to protect victims and their children, as well as longer-term solutions. These plans will include actions from the Multi-Agency Risk Assessment Conference (MARAC) as well as sanctions and remedies available through the criminal and civil courts, housing options and services available through other organisations. IDVAs offer independent support and work over the short- to medium-term to put victims on the path to long-term safety (CAADA, n.d.)[2]

The practice principles for IDVAs combine practical and emotional support based on a 'care pathway' developed by CAADA (2006)[3] and subsequent Westminster[4] government guidance (Home Office, 2008) define the key elements of IDVA schemes as:

- independent, professional and trained;
- aware of all safety options;
- able to offer crisis intervention and risk assessment;
- work in partnership;
- delivery of measurable outcomes (e.g. reduced repeat victimisation, fewer withdrawals and increased reporting of children at risk from harm).

It is with these criteria in mind, that this evaluation of the four schemes – DVSS (Barnet), REACH (Lambeth/Southwark), and IDVA posts at the nia project (Hackney) and NAADV (Newham) has been undertaken.

Domestic Violence in London

Metropolitan Police data indicates that there were 52,276 *recorded* domestic violence crimes in London during the 12 months from February 2009 to March 2010 (MPS, 2010). Since not all reports translate into recorded crimes, there will have been many more calls to the police about incidents of domestic violence. In the four boroughs where the IDVA schemes are based, the number of reports varied between 1,417 in Barnet, 1,896 in Lambeth, 1,947 in Hackney and 2,319 in Newham (MPS, 2010). Regional analysis of the 2007/8 British Crime Survey (BCS) reveals that almost a quarter (22.8%) of women in London have experienced violence from intimate partners since the age of 16, and 4.5 per cent within the last year[5]. These figures are almost certainly underestimates since the majority of incidents are not reported to the police, and the BCS excludes women not living in households (those in prisons, temporary accommodation, refuges and hospitals for example). Nevertheless they demonstrate that each year many thousands of women in London experience domestic violence.

[1] CAADA was established in 2004 and is a national charity that promotes multi-agency responses to domestic violence, focussed on saving lives and public money through protecting the highest risk victims and their children. See www.caada.org.uk for details of services provided.

[2] www.caada.org.uk/News/FAQs.htm#whatisanIDVA

[3] CAADA (2006) Advocacy Training Course material

[4] We use this term as the policy framework for Scotland and Northern Ireland differs from that for England and Wales. Details of policy approaches to domestic violence and violence against women in the UK jurisdictions can be found in Coy et al (2009).

[5] Weighted percentage drawn from regional analysis of the 2007/8 British Crime Survey by CWASU.

National policy context

IDVAs were introduced in the 2005 Domestic Violence National Action Plan as a key area for service expansion (Home Office, 2005), with a national commitment to IDVA posts in all Specialist Domestic Violence Courts and over £14 million in funding invested since 2006 from Westminster government sources for IDVA posts and accompanying training (Home Office, 2009). The 2008 Tackling Violent Crime plan identifies domestic violence (DV) as a priority area with IDVAs and Multi-Agency Risk Assessment Conferences (MARACs) core strategies in reducing DV and improving the criminal justice response (Home Office, 2008). This framework marks an approach to domestic violence through a crime lens, with a shift to focussing on serious violence and high risk victim-survivors[6]. The recent Westminster government strategy on violence against women reiterates support for IDVAs and MARACs as a priority and pledges £5 million in 2010/11 for the delivery of national coverage of MARACs and IDVAs to support them (Home Office, 2009). Thus IDVAs are now central to the twin planks of SDVCs and MARACs in Westminster government policies on DV.

At a local government level, the 2008-2011 Public Service Agreement (PSA) 23 – Safer and Stronger Communities – does not specify targets in relation to DV, but requires that priorities for response and service provision are set according to local needs. The PSA also notes that voluntary sector interventions, supported by Crime and Disorder Reduction Partnerships (CDRPs), are vital to reduce risk. From June 2008, Local Area Agreements set delivery targets for local authorities, with each required to choose 35 stretch targets from a portfolio of 198 benchmarks. Just two National Indicators now explicitly refer to domestic violence – 32 (reduce repeat victimisation) and 34 (reduce domestic homicides) – replacing the previous performance indicator (BVPI 225) on domestic violence service provision, which was more wide ranging in content[7]. Implementation of indicator 32 was delayed until 2009/10, and indicator 34 is likely to be discontinued. While there are at least 50 further NIs where addressing DV would enable targets to be met, many strategic partnerships fail to recognise this. Thus where authorities are funding provision, they are typically doing so under the Safer and Stronger Communities stream of the LAA targets, resulting in domestic violence being addressed primarily through a criminal justice lens (Select Committee on Home Affairs, 2008).

Developing and strengthening independent domestic violence advocacy services with a minimum of three advocates in every borough was a key aim of the second London Domestic Violence Strategy (LDVS2), in place at the inception of the schemes. This strategy had a wider vision than central Westminster government policy, promoting empowerment, flexible co-ordinated services and a reduction of risk and dangerousness. Project Umbra, a domestic violence initiative for London's criminal justice agencies, now integrated into LDVS2, had improving advocacy services (not solely IDVA schemes) as one of six strands of work. Trust for London and the Henry Smith Charity received a special award from the Mayor in 2006 in recognition of the contribution their special initiative made to the LDVS2. In 2007, the Government Office for London (GOL) and the London Criminal Justice Board (LCJB) received £600,000 from the Home Office towards establishing IDVA services and MARACs in every London borough over the next two years (GLA, 2007). The four schemes evaluated offer insights for future developments.

While IDVAs, with their emphasis on criminal justice outcomes and risk assessment when supporting victim-survivors, are a potentially crucial resource for meeting LAA targets, concerns have been raised that the IDVA model is diverting resources from community-based work with victim-survivors not designated high risk, and may inadvertently contribute to escalation of violence due to a reduction in early interventions (Select Committee on Home Affairs, 2008). This debate on the directions of policy and practice, and the reduction in statutory responsibilities, shapes the context in which the four IDVA schemes established themselves.

Aims of the Evaluation

The specific aims of the evaluation were set out by funders as:

- assess the outcomes and impact of the work;
- assess the merits of each IDVA model and suggest improvements as appropriate;

[6] We use this term to recognise both the victimisation that women have experienced and their agency in seeking to end violence, seek redress and/or deal with its impacts and consequences.

[7] Best Value Performance Indicator 225 required local authorities to benchmark provision against 11 measures: a directory of services; a minimum of one refuge bed per 10,000 of population; funding for a domestic violence co-ordinator; a multi-agency strategy; a multi-agency forum; an information sharing protocol; a sanctuary scheme; a reduction in the percentage of homeless due to domestic violence cases re-housed in the previous two years; a clause in tenancy agreements stating that perpetrating domestic violence was grounds for eviction; an education pack devised for schools; and delivery of multi-agency training.

- contribute to an evidence-base on IDVAs;
- identify the lessons learnt from the implementation of these projects;
- provide feedback to the sector, service providers and other interested parties on the programmes' achievements and challenges;
- identify best practices for wider dissemination.

The professionalisation of domestic violence support work and advocacy has raised evaluation of interventions to higher priority (Bennett et al, 2004). Our focus has been not only on outcome measures but also: to identify and analyse if and how the projects were implemented as intended (Shepherd, 1999); if not why not; and how their position in local multi-agency responses affected their development trajectories and advocacy practices. Variations in local contexts can affect outcomes, such that may be a reflection of agency understanding, responses and relationships as much as an IDVA scheme itself (Parmar & Sampson, 2007).

We draw on models of process evaluation, described by Spinola et al (1998) as a technique that 'documents what occurs, [and] can help to inform the intervention by describing what actually takes place and by identifying stakeholder responses during implementation' (op cit: 92). Outcomes for individual service users are measured using data collected from the schemes about their cases, alongside data from service users themselves. Multi-site evaluations are beset with complex challenges, especially where projects are embarking on initial processes and still determining their own outcomes. This evaluation is, therefore, different in crucial respects to the recently published Hestia evaluation (Howarth et al, 2009), which focuses on outcome data drawing on seven well-established schemes. Tracing the foundation and development of new projects necessitates paying attention to process outcomes, including establishing a local presence, referral pathways and their positioning in multi-agency networks. That all schemes are based in London also lends specificity since aspects of IDVA practice are shaped by the diverse populations and tests of the capital city.

Locating IDVAs in the Co-ordinated Community Response

The CCR model of responses to domestic violence was pioneered in Duluth, Minnesota, with aim of ensuring safety for victim-survivors, and holds at the core: identifying domestic violence as a pattern of control rather than isolated incidents; gendered power relations; criminal justice redress; co-ordinating agency responses; victim perception of danger; and risk assessment (Pence & McMahon, 1997). Adapted by the Home Office in 2006, its parameters were defined as: increasing safety of victims and children; holding perpetrators accountable; enhancing responsibility of service providers and the wider community; and prevention. At the core of the CCR is integrated partnership work between agencies while each maintains independence, and recognition that criminal justice responses are only part of the picture – local agencies including health, education, children's services, support services and community networks (friends/family) are all regarded as essential to the model.[8]

The core of this evaluation is an exploration of the contribution IDVA schemes make to the Co-ordinated Community Response (CCR) that has been at the heart of Westminster government policy for four years. It builds on recent work by Amanda Robinson (2009) who also explores IDVAs' contribution to CCR since 'an evaluation of IDVA services cannot be truly understood apart from these other recent, and now widespread, initiatives' (p11). Assessing the development of the projects is not a linear process since the IDVA model is so deeply embedded in multi-agency relationships. For evaluation purposes, therefore, it was important to pay attention not just to the schemes but also to the development of MARACs within the local authorities in which the IDVA schemes were based, and where present the Specialist Domestic Violence Courts (SDVCs), which frequently took place alongside the schemes.

Recent evaluations of domestic violence advocacy projects note that there are gaps in evidence with respect to interventions that are embedded in multi-agency partnerships and the impact of differing agendas, the specific settings in which the advocacy schemes are located, local communities and national policy contexts (Bacchus et al, 2007; Howarth et al, 2009). Successes in IDVA work are 'likely to reflect the strength of their local multi-agency partnerships' (Howarth et

[8] www.ccrm.org.uk

al, 2009: 99). Advocacy in practice, which we explore in detail in this report, has its foundations in identifying rights under law and policy and working to ensure that individuals receive their entitlements, as Kelly and Humphreys (2001) note:

> It is the emphasis on rights, in a context of fighting to secure justice and redressing abuses of power, which marks one key difference between advocacy approaches and those that use the concepts of support and/or empowerment. The latter focuses on the individual, whereas the former locates individuals within a social context in which they are understood to be connected to various agencies, organisations and systems, and from which in turn they have entitlements (p243).

The four schemes under evaluation were all based in the voluntary sector, established in 2007, with two (DVSS, in a police station, and REACH, in a hospital A&E department) stand-alone, and two (NAADV, in a community centre and nia, in a women's organisation) new arms of existing services. The three year grants from Trust for London and the Henry Smith Charity for the schemes were conditional on match funding from statutory agencies. Difficulties with guarantees of match funding, and delays in decision making, were a recurrent theme, despite the Westminster government investment in IDVAs. Often match funding was only provided on a quarterly basis, affecting ability to plan strategically, and scheme managers spent considerable time and energy chasing decisions and patchworking monies for salaries from a range of local statutory sources. Trust for London and Henry Smith have released another tranche of funding for each of the four schemes, securing them to March 2012.

The title of this report – Islands in the Stream – refers to two interlinked themes that emerged from the evaluation; as a 'one stop person', IDVAs were described as providing a lifeline for victim-survivors; and the ways schemes had to negotiate the sometimes turbulent tides of local multi-agency responses. The report itself is constructed around a set of core themes across the four schemes, rather than examining each in turn. We use a constant comparative method from grounded theory (Glaser & Strauss, 1967) to reveal commonalities and differences simultaneously. Chapter One describes the evaluation methodology. Chapter Two details the initial development, growing pains and development journeys of the four schemes. Chapter Three reflects on the processes and experiences of becoming and being an IDVA, while Chapter Four presents analysis of the data on service user profiles and outcomes. Chapter Five presents feedback from service users about their perceptions and experiences of IDVAs and provides valuable information about outcomes in terms of safety and empowerment. Chapter Six explores multi-agency working and the positioning of the IDVAs in the Co-ordinated Community Response, and Chapter Seven focuses on MARACs. In Chapter Eight conclusions are drawn, including recommendations to inform future service planning and practice.

Chapter 1:

Methodology

Introduction

A prospective multi-methodological approach was developed to ensure that both quantitative and more in-depth qualitative data were collected from diverse perspectives. There were four core layers of data collection, devised to address the evaluation aims: quantitative data on cases using a bespoke database; feedback from service users via questionnaires and interviews; two sets of interviews with IDVAs and scheme managers; and a series of phased interviews with stakeholders, drawn from MARAC membership in each borough. Observation field notes from visits to IDVA schemes and MARAC meetings supplement all these strands, and in places we draw on schemes' own monitoring data to draw out lessons. The evaluation also had an action research element. Interim reports were completed in December 2007 and September 2008, highlighting gaps in data, which in turn enabled adaptations in methodology in consultation with schemes and funders. The reports also identified emerging implementation issues for debate and discussion across the schemes; risk assessment tools being one of the most significant here.

Database

The foundation for outcome measures required building a common prospective case tracking relational database, to document cases over a two year period (1st April 2007- 31st March 2009). Two projects – nia and REACH – did not begin accepting service users until August 2007, and the timeframe was altered for these schemes to 1st August 2007- 31st July 2009.

The intention was for the database to be both an evaluation tool and a monitoring/tracking tool for use by the schemes during and beyond the evaluation phase. The database was constructed drawing on each scheme's paperwork to devise standardised fields for gathering basic data on service user and perpetrator demographics, referral processes, risk assessment, criminal justice and wider case progress. There were numerous challenges to developing the database, ensuring that case file data was kept up to date and cleaning the data for analysis purposes, which are discussed in detail in Appendix 1. By the end of the data collection period, not all fields in the databases were completed and it is not clear whether this reflects data input or record keeping omissions, or a combination of both. That practitioners often perceive data collection for externally mandated evaluations a frustrating burden that reduces capacity for support work is a consistent theme in the literature (Bennett et al, 2004; Hester & Westmarland, 2005; Howarth et al, 2009). This is particularly so for IDVAs who were negotiating the tension of crisis intervention with high risk cases and data collection requirements.

There are important lessons here for evaluation of multi and single site support projects; first, that the development of common databases presents considerable challenges in multi-site evaluations where the projects are in the process of establishing their own recording systems. This is further complicated when the schemes alter paper recording systems, requiring amendments to the electronic databases that in turn necessitate new layers of analysis. Keeping databases up to date in order to track case outcomes is essential but posed problems for IDVAs for whom new cases are more of a priority than completing data entry for those that have been closed. The most complete databases were those where case file information was entered only when the cases were closed. Whilst this appears to be the most fruitful method to enhance case tracking data, it required dual data systems – paper case files for ongoing casework, electronic records for outcome/evaluation measurements. This data is drawn on in Chapter Four.

Service User Perspectives

Obtaining feedback from service users was also a lengthy process, with a combination of self-complete questionnaires and interviews used. Full details of the strategies developed to gather feedback from service users are discussed in Appendix 1.

In total, 73 completed questionnaires were received and nine interviews were completed. All interviews were tape recorded (with permission), and transcribed. The transcripts were analysed using Nvivo 7, a software package for qualitative data. This enables each transcript to be systematically coded according to emergent themes, and themes to be hierarchically organised. Data is drawn on in Chapter Five.

IDVA interviews

All IDVAs and scheme managers were interviewed for the first time in mid/late 2007 and the second time in early/mid 2009. Staff changes at REACH, NAADV and nia necessitated additional interviews in April and July 2008. One IDVA worked at two of the schemes during the evaluation. A total of 27 interviews were carried out and quotes are coded in this report as 'R1' or 'R2' to indicate whether they are drawn from the first or second round of interviews.

The first round of interviews explored definitions and understandings of domestic violence, the role of IDVAs, advocacy, risk assessment and safety planning. The second round focussed on developments in the scheme and multi-agency relationships, caseloads and referral pathways, the MARAC model and process, changes to risk assessment and CAADA training. Further questions probed issues that arose from observation visits, including the emotional work involved in supporting victim-survivors in high risk situations, attention to sexual violence and ratios of short/long term casework. These transcripts were also analysed thematically using Nvivo 7.

Observation visits

The evaluation team visited each scheme on at least four occasions throughout the evaluation period, in order to observe the everyday practice in schemes. On some occasions, observation was combined with interviewing new members of staff. Although originally planned for whole days, the cramped space at most schemes meant that this was scaled back and each visit lasted around three hours. Evaluators also visited the SDVC at Stratford magistrates' court with IDVAs from NAADV on one occasion (the second was cancelled when the trial was adjourned). Additional observations were undertaken when the evaluators visited the schemes to interview IDVAs and managers or discuss the database. This ethnographic engagement enabled the evaluators to gauge the pace of IDVA work, types of contact with service users, interaction with other agencies and time requirements of various tasks, alongside having 'real time' evidence of how IDVAs work alongside service users and put 'empowerment through knowledge' into practice. Field notes and reflections on observation visits were transcribed and analysed thematically using Nvivo 7.

Observation of MARACs

The evaluation team attended four MARAC meetings, one in each borough where the schemes are located, from January to December 2009. Although IDVAs from the REACH scheme attend both Lambeth and Southwark MARACs, the chair at Southwark refused permission for evaluators to observe a meeting. At each MARAC the evaluation team signed confidentiality agreements and took anonymised notes in order to gain a picture of cases referred to MARACs, as well as the operation of the meeting, attendance, the roles and voices of the IDVAs and contributions from other agencies. Particular attention was paid to power relations between the statutory and voluntary sector, which agencies engaged with the development of safety and support plans, and what added value the MARAC process brought to each case. In total, 81 cases were discussed

across the four meetings. A proforma was developed to systematically record anonymised data for each case, covering: numbers of new/existing cases; referrers; risk assessment details; interventions with victim-survivors and perpetrators; if case stayed open and who kept it; and criteria for closing cases. Informal interviews with IDVAs took place after each MARAC to explore if the meeting was typical. Whilst observation material may not be representative of all meetings, nor case lists representative, each meeting was considered by the IDVAs present to be standard local practice, with no 'out of the ordinary' events.

Stakeholder Interviews

Two rounds of interviews with stakeholders were undertaken, the first completed by April 2008 with stakeholders from all four schemes' local MARACs, and the second from July-December 2009. Contacting stakeholders, all busy professionals, proved to be time consuming and frustrating, with many not responding to email and telephone requests for interviews. As a result not all MARAC members were interviewed in either round. Notable gaps include the probation service. It is also of interest that the most common engagement was with other domestic violence services and the police. This may reveal which agencies, in the MARAC model, regard domestic violence as core business. There is also a visible difference in engagement from Social Services' Children Family teams, who in round one responded from all four boroughs, but none at all responded in round two to repeated efforts to specific individuals named on MARAC member lists. Table 1 in Appendix 1 gives details of the 44 interviewees across the four schemes.

Following the positive endorsement from A&E at the launch of the REACH project in February 2008, they emerged as key stakeholders for this project. The example of how complex it was to interview them gives some idea of the challenges involved in reaching and engaging stakeholders in evaluations – discussed in detail in Appendix 1. A total of five staff (four nurses and one doctor) and two senior staff with strategic remits on domestic violence were interviewed.

National Experts

In order to provide a wider context on IDVAs, MARACs and the CCR, an additional layer of interviews canvassed the views of practitioners, policymakers and academics with a national remit, or level of expertise on domestic violence and the MARAC model. Four were completed, with three digitally recorded, and transcripts and/or notes were analysed using Nvivo 7.

Financial costs analysis

The cost of providing support to each victim-survivor was calculated using the formula developed by Howarth et al (2009:16) in their multi-site evaluation of IDVA schemes: division of an IDVA salary plus on costs by annual caseload. While Howarth et al used an estimated average caseload of 100 cases, we base our figures on the annual caseload per IDVA as derived from the number of cases on the database, divided by number of IDVAs at each scheme. Hence for DVSS, nia and REACH the scheme caseload was halved, while at nia it was divided by 3.6 to reflect the two full time posts and the two 0.8 WTE posts. Results are presented in Chapter Two and in more detail in Appendix 2.

Chapter 2:

The Four IDVA Schemes

Introduction

The development journeys of the four schemes were affected by their contexts in a number of ways: challenges of setting up a new model of provision; liaising with existing service providers; negotiating local priorities and targets around domestic violence; recruiting and retaining staff with appropriate skills and experience. Nationally, many IDVAs are not linked to domestic violence projects but are single workers in statutory settings, and some have part time locations in police stations and/or health settings (Robinson, 2009). The IDVA schemes evaluated here were intended as more strategic interventions, with at least two staff in each and scheme managers. They were also selected through an open application process, with a decision made to explore different locations and target groups. In this process evaluation chapter we note the specific benefits and challenges of each context. It is worth noting here that while the terms 'advocate' and 'advisor' are both used to describe IDVAs, in this study the IDVAs referred to themselves as advocates and conceptualised their role as advocacy. This is a debate which we return to in Chapter Three.

This chapter addresses each IDVA scheme using a set of core themes: setting; establishing the IDVA scheme; growing pains; developments; advantages and disadvantages of the location as reported by IDVAs, stakeholders and service users. Table 2.1 summarises these advantages and disadvantages.

Table 2.1: Advantages and Disadvantages of each IDVA setting

IDVA setting	Advantages	Disadvantages
Police station (DVSS)	Access to police information systems useful for comprehensive risk assessments	Location may be a potential barrier for women who are uncertain about contact with police.
	Daily contact with police officers and prosecutors built strong relationships and changed practice	
	Association with the police enhanced credibility and responses from other agencies, including at local MARAC	
Community based organisation, linked to SDVC (NAADV)	Seamless transition to other services within organisation	Less status/recognition in multi-agency networks

(continued)

IDVA setting	Advantages	Disadvantages
	Existing relationships with agencies and the strong local reputation Support for IDVAs	
Community based women's organisation specialising in BME communities (nia project)	Seamless transition to other services within organisation	Less status/recognition in multi-agency networks
	Specialised women's organisation valued by stakeholders and IDVAs and vital to the continued development of responses to domestic violence	
	Offers routes into support for some of the most marginalised women from small communities, including self-referrals Support for IDVAs	
A&E department (REACH)	Supported routine enquiry in A&E	Self-referral discouraged /difficult
	Immediacy of access highly valued by service users	
	Clinical Decision Unit, a ward to A&E, enabled short term admission, and space to think over options	
	Link with a statutory service conferred credibility by association	

DVSS: Police station

Domestic Violence Support Service (DVSS), Barnet, is a non-profit-making, limited company, formed in 2003, that aims to reduce repeat victimisation and assure the short and long term safety of domestic violence survivors and their children. An evaluation of a similar model found that the project enabled new access to services for victim-survivors of domestic violence and that law enforcement approaches to domestic violence, which have developed considerably in recent years, required appropriate support (Kelly, 1999). This previous project was managed by the DVSS scheme manager, who was therefore experienced in the specific demands and opportunities of working in a police station. DVSS were awarded £180,000 by Trust for London and the Henry Smith Charity to develop their existing skeletal IDVA service in a police station.

Establishing the IDVA scheme

DVSS were funded to employ an Independent Domestic Violence Advisor and a contribution towards the core costs of the organisation. Funding from the Safer & Stronger Communities Fund covers another post and Barnet police provide core running costs in the form of office space and facilities. Two full time IDVAs work from DVSS, and the initial designation was for one 'Sanctuary' worker and one 'MARAC' worker, although the work was combined across both posts until early 2009 when specialisation was considered to bring consistency and efficiency.

Two original IDVAs were in post by April 2007, but failed to complete probationary period. The two current IDVAs were recruited in July and August 2007, and both have considerable experience of supporting victim/survivors of domestic violence. The stability in the staff team is regarded as one of the successes of the scheme, enhancing peer support and consistency of practice. The scheme accepts referrals from a range of local agencies, although self-referrals are discouraged, and cases are allocated to IDVAs by the scheme manager.

Growing Pains

The scheme began accepting referrals in April 2007, with two relatively inexperienced IDVAs in post, and a scant infrastructure in terms of policy, protocol and documentation. Implementing such systems while delivering front line support work required considerable energy, and in October 2008 a part time policy officer was recruited who assisted with standardisation of various systems including data monitoring. The lack of profile given to domestic violence in Barnet by statutory agencies was highlighted by DVSS as a significant barrier to delivering effective services for victim-survivors. For instance, the absence of a DV Co-ordinator for several months resulted in the DVSS manager co-ordinating the MARAC from January-March 2008, an additional demand on her time[9].

Developments

Tensions have emerged between DVSS and another domestic violence organisation in the borough that primarily provides casework support for low/medium risk, but latterly have taken on high risk cases and begun to refer to themselves as IDVAs. These tensions have been resolved at a practitioner level by individuals, but overlaps in their work appear to create confusion among stakeholders and lead to territorial disputes over cases that play out in multi-agency settings.

DVSS have also moved physical location since the inception of the project. Initially the team were based at High Barnet police station, located at the very northern tip of the borough, in a tiny office that housed both IDVAs and the scheme manager. This move meant the IDVAS no longer had daily contact with CPS staff and the Witness Care Unit, and increased the workload of the scheme in maintaining these relationships. In November 2008, DVSS moved to Colindale police station, a large modern building that sits mid-west in the borough, into a much larger office with space partitioned off to provide more privacy for face to face contact with victim-survivors. However, the physical layout of Colindale police station was raised as a possibly uncomfortable access point to DVSS. When arriving at the station, visitors are required to inform reception who they are there to see. There is no private space available to do this and sometimes the officer at reception is not familiar with DVSS, and thus cannot establish who to contact. One stakeholder observed a woman having to say in front of several other people that she was there to see someone because of domestic violence, and suggested that an alternative means of access was introduced. This noted, the location has a number of strategic advantages for IDVAs, being the operational police hub for the borough, with CPS, custody officers, the Witness Care Unit and Immigration Officers all in close proximity. This makes some of the basic tasks of an IDVA easier since they can make personal contact with the appropriate person without having to make multiple phone calls.

Lobbying by DVSS has led to domestic violence being more prominent on the local policy agenda, but this in turn has had the unintended consequence of the local authority introducing more onerous data monitoring requirements. A considerable amount of time and effort has been invested by DVSS in negotiating the relevance and practical implications of requests for data, particularly since they were incorporated into a recent funding agreement as conditional clauses.

[9] Amanda Robinson (2004) in the evaluation of the first MARACs in South Wales recommends that the administrative burden of MARACs should not be borne by front line support services.

DVSS has been accepted onto CAADA's Leading Lights programme, a quality assurance and accreditation scheme, and the scheme manager began the training in November 2009.

Advantages and disadvantages of the location

A base in the police station facilitates access to information systems such as the Metropolitan police databases Crime Report Information System (CRIS) and MERLIN (information related to children) and the national CRIMINT database that records crime intelligence. DVSS IDVAs consider this essential to gather data for comprehensive risk assessments, particularly as they are 'part of the extended police family' which can seem impenetrable to outside agencies. One stakeholder, based in the local authority housing department, identified DVSS' access to police information as invaluable, particularly for risk assessments. This is explored in more detail in Chapter Three.

The daily contact with police officers has also enabled strong relationships to be forged, and provides opportunities to influence responses to domestic violence, and thus change practice (see Chapter Three for a more detailed discussion). However, several stakeholders noted that being located in a police station may be a potential barrier for some women, for two main reasons: distrust of the police and a fear that engaging with a support service based in a police station might mean automatic criminalisation of perpetrators, with repercussions for victim-survivors safety:

> They must wonder slightly are you all part of the same thing, and if I tell you that he's done this, are you going to go and report him and then is he going to get arrested then I'm going to get beaten up again *(Stakeholder, Barnet, R2).*

DVSS IDVAs are careful to point out their independence to service users for precisely this reason:

> You use it to your advantage and disadvantage, because sometimes you have to be very very clear, although I'm based in a police station, I'm not actually related to the police *(IDVA, DVSS, R1).*

Most DVSS service users were aware of the independence of the IDVAs, and consequently thought that proximity to the police was 'imperative – I have found in the past that police can misjudge or misinterpret information and the situation' (SU 3, DVSS). A few acknowledged an initial fear that was assuaged when the IDVAs explained their role, with one noting:

> It's not a problem for me [to be in a police station] but to some women it could be *(SU 17, DVSS).*

Service users welcomed the immediate referral to support from statutory services facilitated by location in a police station. For IDVAs, being associated with the police, particularly using email and postal addresses, was felt to enhance credibility and increase the likelihood of prompt, appropriate responses from other agencies (see Chapter Three for a more detailed discussion).

NAADV: Community based organisation

NAADV was formed in 1990 and is a registered charity, providing advocacy and support to anyone experiencing domestic violence from a gender-neutral perspective, offering a range of services including support for children and young people and training. NAADV were awarded £158,000 from Trust for London and the Henry Smith Charity to develop the IDVA service.

Establishing the IDVA scheme

NAADV were funded to employ one full-time IDVA and a contribution towards the core costs of the organisation. Further funding was received from Newham Crime and Disorder Reduction Partnership that enabled the recruitment of a further IDVA. Both IDVAs are based at NAADV's offices in a community centre and at least one IDVA attends the SDVC at Stratford Magistrates Court two days a week, to support current service users and initiate contact with those who have not yet accessed services.

The IDVAs were appointed in December 2006 and June 2007, having previously been employed as volunteers with NAADV. Original staff left NAADV in December 2008 and May 2009, and although replaced in January and June 2009 respectively, there was at least one unfilled post for some weeks. In addition, the new IDVAs had not received the CAADA training and thus did not have the same level of knowledge and confidence; re-training for new recruits was noted by all schemes as an issue with staff turnover.

Growing Pains

Initial referral processes from the police in Newham were highlighted by stakeholders and IDVAs as problematic, resulting in very small numbers, and some referrals contained such minimal information that it was difficult to decide whether or not the case fulfilled the IDVA remit. This had repercussions for workloads as IDVAs had to spend time chasing referrers, and contacting the victims/survivors, to gather information. These gaps in the process were resolved through negotiation and referral pathways are now operating smoothly.

Developments

The borough context in Newham has shaped the development of the IDVA scheme at NAADV. All specialist agencies in Newham meet the previous Mayor's minimum standards of provision and a range of voluntary and statutory workers, including all health/PCT staff, have had training on domestic violence. Newham also opened a Family Justice Centre (FJC) in July 2009, aiming to address all issues of violence against women. The FJC currently have eight support workers, four of whom have completed CAADA training and are also designated IDVAs. At the first round of interviews, police hoped the NAADV IDVAs would be part of the planned Family Justice Centre, but to NAADV's surprise and disappointment, they were not integrated and there are no plans for them to be. This has led to tensions over referrals and anxiety within NAADV about local commitment to their IDVA scheme.

The SDVC in Stratford that the IDVAs attend two days a week was accredited in March 2009 and NAADV received funding from the Ministry of Justice (MOJ) to part cover an IDVA post from April 2009-March 2010. There is no guarantee for further funding from the MOJ. This leaves the future of the IDVA scheme fragile, and signals that the borough investment has now moved to a mainstreaming agenda within the statutory sector.

Advantages and disadvantages of the location

Both stakeholders and IDVAs identify the infrastructure and depth of experience in a specialised voluntary sector organisation as the main strength of hosting IDVAs at NAADV, referred to by one stakeholder as 'the maturity of the project'. This includes benefits for both service users and workers: the former being the range of other services that NAADV can offer to IDVA service users (counselling, casework, services for children and young people). IDVAs reported that proximity to other practitioners acts as a vital support network for them, where they can share knowledge. The profile of NAADV in the community was also highlighted as an advantage, with the scheme benefitting from existing relationships with agencies and the strong reputation of the organisation locally. Service users reported that the location of the IDVAs with other forms of support was valuable.

The two original IDVAs suggested that it would have been valuable for them to be based at least part of the time at a police station in the borough in order to gather information and receive referrals earlier. Local police officers concurred, but lack of space precluded this. By June 2009, the two new IDVAs were visiting Plaistow police station for this purpose, as well as delivering short presentations twice a month for community safety unit officers about the IDVA scheme and referral processes. Police are also keen for NAADV IDVAs to be part of the Violent and Priority Crime Evidence Retrieval Car (VIPER) that responds to incidents of violence in the borough between 2pm and midnight (MPA, 2008).

Nia: Community based women's organisation

The nia Project, formerly Hackney Women's Aid, was founded in 1975. The organisation provides holistic services for survivors of gender-based violence and has four main service areas: housing; family support; legal and advice and training; and group-work. Nia received £230,000 from Trust for London and Henry Smith Charity to establish the IDVA service.

Establishing the IDVA scheme

Nia received funding for three IDVAs, with a focus on supporting women from black and minority ethnic and refugee (BMER) communities. The community and language specific roles are Turkish and Kurdish-speaking, Somalian/East African women and two part-time workers to support Eastern European and Vietnamese communities, reflecting the current diversity in Hackney and gaps in local provision. A number of longstanding specialised services for women from BME backgrounds began with a community-based advocacy model (Coy et al, 2007). Such services often incur higher costs, not least because they require interpreting services and resource/time-intensive community outreach work (Rai & Thiara, 1999). However, research demonstrates that BME support services ensure that women's additional and specific needs are addressed (Gill & Rehman, 2004), particularly 'intense advocacy' (Thiara, 2005:7). The Home Affairs Select Committee (2008, para 241) affirmed the *'necessity of linguistic- and culturally-specific services for black and minority ethnic women'.* The experiences of the specialist community IDVAs are discussed in Chapter Three.

Growing Pains

Development of the IDVA scheme at nia was hindered by initial reluctance from the local authority to confirm match funding. Once this was resolved, recruitment difficulties mirrored those at the other IDVA schemes, but were compounded by the challenges of such specialised posts. The already small pool of practitioners with experience and skills necessary for IDVA work is further diminished by language requirements and knowledge of community contexts, and some IDVAs have required intensive training and supervision. The Turkish speaking IDVA was appointed in August 2007, having worked at nia for three years across several roles. An IDVA to work with Eastern European communities began in post in February 2008, and the Somalian/East African IDVA was recruited in July 2008, but failed to meet the probationary standards and left the organisation in March 2009. A further round of recruitment failed to attract any suitable candidates, and the post was re-advertised in September 2009 as 'working with women from Black African Communities' to increase the pool of potential applicants.

An initial overlap between the IDVAs and the local authority Domestic Violence and Hate Crime (DVHC) team led to territorial disputes and a blockage in referrals to nia which meant the scheme was not operating at capacity for several months. However, nia negotiated a protocol with the DVHC team to establish remits for each service with nia IDVAs taking on all high risk cases and the local authority team standard and low risk. This arrangement alleviated tensions over referrals and duplication of support, as well as creating seamless provision for victim-survivors in the borough.

Developments

The IDVA working hours were reconfigured in 2009 so that the half time Eastern European post and the full time Somali/East African post are now both four days a week. Nia also identified the need for a Senior IDVA with a reduced caseload to provide supervision of the team. The Turkish speaking IDVA was appointed to this position in September 2009.

Nia have also received funding from the Ministry of Justice for a part-time IDVA post for the Specialist SDVC launched in October 2009 covering Hackney and Tower Hamlets. It is anticipated that all nia IDVAs will take on court responsibilities and attend the SDVC with service users.

From August 2009, the information and referral line that nia run offered a weekly Eastern European language service, covered by the Eastern European IDVA who speaks Russian and Romanian.

The intention here is to raise the profile of nia in these communities, and increase referrals to the IDVA service. Workshops with organisations in London working with Eastern European communities have also been given, and nia plans to place notices about the scheme in Russian language newspapers (discussed in more detail in Chapter Three).

Nia were also successful for their application onto the CAADA Leading Lights programme and as with DVSS, the manager began training in November 2009.

Advantages and disadvantages of the location

As with NAADV, the advantages of situating IDVAs in a well established project centred on the organisational infrastructure, the range of linked services offered within the organisation and the local positioning of nia as respected specialists.

> One of the advantages is the knowledge base that we've got within the organisation, so for instance, I wasn't sure about something this morning, so I asked somebody who would know… we've got a referral line, we've got refuge workers, we've got drug and alcohol workers… we have had a solicitor in the past, so there's always somebody to ask and there's always somebody who has a bit of knowledge *(IDVA, nia, R1).*

> The staff within nia are appropriately trained to respond to domestic violence, but they also are more aware of recent developments and training initiatives… I do think that one of the more positive things is that the nia project offers family support services and IDVAs would be aware of all the resources that are available to support a family within the nia project and any other organisation *(Stakeholder, Hackney, R2).*

Service users also identified the expertise of the nia project as significant for the IDVA service, a 'perfect placement' in the words of one.

> I think it's a good decision [to be based in a DV organisation] because the IDVA is helping a lot of people and they know how to deal with those cases *(SU 12, nia).*

One stakeholder suggested a possible drawback might be that women who do not define their experiences as violence will not approach specialised services for support, and may not come into contact with any referral points such as police or social services. Whilst this is undoubtedly true it affects all other locations of IDVA services since they all rely on either self-referral, or referral from another agency where domestic violence has been identified.

Finally, that nia is a women's organisation was identified as a strength by both stakeholders and IDVAs.

> I think a huge advantage is that they're based in women-only services and a specialist agency that is going to come into contact with women who are experiencing domestic violence, I think that's fantastic *(Stakeholder, Hackney, R2).*

REACH: A&E department

REACH is an IDVA scheme at the Accident and Emergency Department of St Thomas's Hospital, also covering the Minor Injuries Unit at Guy's Hospital. The scheme is a partnership project between Guys and St Thomas' NHS Foundation Trust and Victim Support Lambeth (VSL), a local branch of the national charity. REACH received £210,000 from Trust for London and Henry Smith Charity to establish the IDVA service, and covers both Lambeth and Southwark.

Establishing the IDVA scheme

The scheme is located in the A&E department, supervised by an on-site project manager who is employed by the hospital Trust and managed by Victim Support. The scheme is known as the Reach Domestic Abuse Project, and began accepting cases in August 2007, with an official launch on 14th February 2008.

Studies suggest that the prevalence of domestic violence among women attending A&E departments is between a fifth and a third (Bacchus et al, 2007). Victim-survivors who have experienced a greater number of attacks and more severe injuries are more likely to seek medical assistance, with A&E the second most common source of support after GPs (Walby & Allen, 2004). Only just over a third (36%) of those who disclose to health professionals that their injuries are domestic violence related are referred to another service (ibid). Another advantage of locating specialised services in health settings is their availability to female staff, since the NHS is a major employer of women (Barnett, 2005) and REACH have received staff referrals. Installing specialised domestic violence support services in hospital emergency departments is a relatively new form of provision in the UK, but one evaluation suggested that it reduces repeat visits to A&E because of domestic violence injuries (Regan, 2004). In the U.S., a growing body of research has tracked the development of DV interventions in emergency departments (see Witting et al, 2006; Watt et al, 2008), but the majority are predicated on training clinical staff to offer support and advice. REACH differs in that the support work is undertaken by IDVAs who are based in A&E and receive referrals from clinical staff where injuries are suspected or confirmed as due to domestic violence (as with the EIP project in Portsmouth). Thus all REACH referrals are intended to be from hospital departments, although for a short period in 2008 the scheme accepted overflow cases from the Gaia Centre in Lambeth where the centre was overloaded with victim-survivors who were too high risk to wait for support. IDVAs at REACH are available from 8am to 6pm, and while one nurse we interviewed suggested that 24 hour availability would be useful, there are substantial funding and staffing implications here.

Growing Pains

Staffing difficulties hindered the early development and delivery of the project. The two original IDVAs, recruited in June 2007 left the project in April and May 2008, and another IDVA employed by Victim Support moved across to the REACH scheme to fill one post. Recruitment for the second post was unsuccessful in July 2008, and in the interim the scheme manager undertook casework for approximately twenty five per cent of her time, assisted by temporary agency staff. A second round of recruitment in September 2008 was successful, and an experienced IDVA who had previously worked at NAADV was employed in April 2009. However she left the post in July and again the scheme manager was required to cover support work. By October 2009, the project had not operated for an entire month at capacity (two full time IDVAs). A second IDVA began in post the same month. The difficulty of recruiting experienced IDVAs, particularly in an A&E setting, is one of the challenges in developing new provision; identifying domestic violence practitioners that have all the necessary skills has proved to be challenging for most of the schemes, and the CAADA training for IDVA qualification is oversubscribed, with long waiting lists.

Negotiating a ‘culture clash’ between the NHS and the voluntary sector was also a frequently expressed difficulty in the early stages of the project. IDVAs perceived that their independence was compromised by the need to adhere to Trust policies, exacerbated by a complicated management structure where the IDVAs are line managed by Victim Support and the scheme manager by the hospital Trust. This has created some complex accountability issues. Multiple and complex layers of management have also been noted in evaluations of hospital based Sexual Assault Referral Centres (Regan, 2004). Some bureaucratic barriers – installation of computers and Trust email addresses for IDVAs not being available for nine weeks – were obstacles to establishing the service. REACH IDVAs also referred to a more general lack of fit between the aims of clinicians to treat injuries as efficiently as possible, exacerbated by pressures of four hour waiting targets, and their own to support victim-survivors to make decisions that take more time and input. This is also apparent in the reflections of nurses that IDVAs are able to offer more ‘sympathy’.

Developments

The physical locations of REACH have changed since the inception of the scheme. Initially the manager had an office in A&E and the IDVAs were based in an office in an adjacent building. The scheme noted that this meant they were less familiar to A&E staff and further away from service users. In July 2008 the locations were swapped and subsequently the referral rate has increased, suggesting that the visibility and immediacy of access to the IDVA enables prompt referral by A&E

staff. REACH's integration into A&E services has also been consolidated since the move. The IDVA office was requisitioned for consultations and the IDVAs compelled to move to a smaller office within A&E, and the scheme manager lost her office in the adjacent building. This means there are only two computers available for three members of staff, with the scheme manager required to 'hotdesk' with nurses. Moreover the cramped physical space makes sensitive telephone calls difficult. The office is not able to maintain privacy and confidentiality as the electrical cupboard is located in it, and engineers require regular access. Despite regular dialogue between the scheme and senior hospital management over this situation, there appears to be no imminent alternative due to the lack of space in the A&E department. Similar problems with location, space constraints and the lack of confidential spaces in which to meet victim-survivors have been raised in previous evaluations of hospital based domestic violence projects (Bacchus et al, 2007; Regan, 2004). IDVAs noted that the scheme was now considered an integral part of A&E by clinical staff yet had appeared to have little support from middle management. One manifestation of this was IDVAs having to transfer computers themselves when they moved location (see also Bacchus et al, 2007). For health settings to truly embrace specialised intervention and support, appropriate office space and infrastructure must become essential and basic prerequisites. There are issues here for design of new hospitals and any capital projects to upgrade existing ones. In particular, office and consultation space for these services should be planned from the outset in A&E and maternity sites at minimum.

REACH attend a number of weekly hospital inter-departmental fora, including the Paediatric Psychosocial meeting and the Safeguarding Team meeting. The scheme's involvement in these fora reflects recognition of the relevance of their work to a range of hospital services. In 2008, REACH were nominated for the Thomas Guy Award for excellent service as the 'best team' and made it to the final three projects.

REACH have also been accepted onto the CAADA Leading Lights programme, and by the end of 2009 were at the second stage of accreditation.

Advantages and disadvantages of the location

Routine enquiry about domestic violence in health settings is recommended by Westminster government guidance (Department of Health, 2006), but evidence on effectiveness and weighing benefits against possible harmful outcomes is mixed (Bacchus et al, 2007; Ramsay et al, 2002). While the practice enables women to name and disclose violence, reduces stigma and opens referral pathways to support services (Taket, 2004), such support needs to be in place and able to meet victim-survivors' needs. Additionally, Taket et al (2004) suggest that because of the presence of partners/perpetrators in A&E, selective rather than routine enquiry may be more appropriate. On the other hand routine enquiry has become standard practice in a number of other countries (WHO, 2002).

Both stakeholders and IDVAs identified the main advantage of locating a scheme in A&E as the opportunity to provide immediate crisis intervention, and identification of those who may not seek help from other sources:

> They've obviously got quicker access to people... with REACH it's immediate so somebody comes into hospital they can immediately get some support whereas if somebody reporting to police it may be a historical report or it may be even just 24 hour, 48 hours later or something… whereas with Reach it's immediate which I think is fantastic *(Stakeholder, Lambeth, R2).*

REACH service users also valued the immediacy of access (see also Bacchus et al, 2007), and suggested that IDVAs should be more widely available in emergency departments.

> I feel it is great they are in a hospital, you get to see them straightaway, all hospitals should have them *(SU 11, REACH).*

> Very convenient for me to access, if injured, I can access support when coming in for treatment *(SU 13, REACH).*

> I think it is the best place to be based as when you come into hospital you do need someone who understands and talks about it with you. Nursing staff do not have time to do this, they are doing their own job *(SU 10, REACH).*

U.S. research has shown that whilst nurses in emergency departments consider practical information the most useful, victim-survivors value emotional support (Watt et al, 2008). In this study, women suggested that nurses needed more insight into the complex processes of disclosure and help seeking, but to some degree locating a specialised domestic violence service in A&E relieves medical staff of this role. IDVAs here are able to provide long term support and safety planning that is more effective in addressing needs than simply giving out contact details for support services to victim-survivors in A&E (Kendall et al, 2009). For instance, none of the medics we interviewed had any familiarity with risk assessment procedures or safety planning – one nurse referred to a vague awareness of risk and danger, described as 'you just go on gut instinct'. Referrals to REACH increased significantly in the second year, which they attribute to the scheme becoming embedded in A&E and part of the care provided to victim-survivors presenting with DV related injuries.

The hospital location also has the benefit of the possibility of using the Clinical Decision Unit, a ward close to A&E to admit victim-survivors, offering a safe space to recover from injuries, consider options and enable IDVAs to secure additional support, e.g. a refuge place. Finally, the link with the hospital seems to confer on the IDVA scheme credibility by association, as explored in Chapter Three. This enhanced credibility through association with statutory settings was also noted by DVSS, based in a police station.

Reflections and Conclusions

A significant difference between the four schemes is that they do not share a definition of domestic violence. While all identify a range of abusive behaviours including physical, sexual, emotional and economic violence, understandings were framed differently. Two base their work on the Westminster government gender-neutral definition which extends the category of domestic violence to *'any threatening behaviour, violence or abuse between adults who are or have been in a relationship, or between family members' (Home Office, 2005).* This understanding of 'abuse in a family context' was perceived as an advantage by one scheme as few other local services are available to both women and men. Two schemes focus on a gendered analysis of intimate partner violence (IPV), with one providing a women-only service, but both also supported victim-survivors subject to violence from family members. These differing definitions influence not only overall perspectives but also caseloads and profile of cases (Kelly et al, 2008). However, these differences do not undermine the foundation of the advocacy work that we report on here; where the framing of domestic violence is relevant to casework we note it in the text.

The financial analysis of the schemes reveals that cost per victim-survivor varied between: £363.94 at DVSS; £415.84 at REACH; £690.28 at nia; and £711.36 at NAADV. Across the four schemes, the average cost per service user is £501, slightly higher than the 'less than £500' per victim-survivor in the Hestia multi-site evaluation (Howarth et al, 2009:16): however, the majority of the schemes in that study were well-established, and thus able to maximise caseloads. The two schemes in this evaluation that had the most streamlined referral processes fall into this bracket, whereas the two that focused on minority women and SDVC cases respectively had higher costs. Thus schemes that have a specific remit have higher overall costs per victim-survivor than those that are able to take referrals from a wider network. Full details can be found in Appendix 2.

Delays and difficulties with recruitment and retention were common across all schemes, resulting in reduced caseload capacity (see Chapter Four) and pressures on managers to take on casework. The newness of the IDVA model means the pool of experienced and skilled candidates is currently small, particularly when seeking to recruit from specific communities, as at nia. Wider issues related to current policy frameworks, especially mainstreaming, also resonated, raising issues of 'turf' and competition for referrals. Negotiating location in context was inflected by the positioning of the IDVA scheme within the CCRs in each borough and what other forms of provision existed/emerged over the evaluation time frame. The limited co-ordination of how local provision was enlarged led to preventable overlaps and duplication that schemes had to negotiate.

The following chapter explores the processes of becoming and being an IDVA, focussing particularly on how they advocate for their service users.

Chapter 3:

Becoming and being an IDVA: Advocacy in Practice

Summary

A key theme explored in this chapter is how empowering women through knowledge and risk assessment may be in tension, rather than mutually reinforcing. At the same time proactivity provides a route for workers to 'keep tabs' on those women they have grave concerns about. The obvious hope and intent of IDVA practice is to empower women to the extent that they prioritise their own safety and that of their children. Empowerment through knowledge often required a first step naming violence to enable women to recognise abusive dynamics and links to risk.

While all IDVAs are clear about individual advocacy and demonstrate genuine commitment to enhancing women's safety and wellbeing, institutional advocacy seems to have less prominence, limited to engagement with individual professionals. Research from the US on advocates in rape crisis centres indicates that there is limited potential in contexts where advocates have considerably less status and security than larger, long-standing statutory services (Ullman & Townsend, 2007). There are potentials for IDVAs to report concerns to local Domestic Violence Co-ordinators who can then take up the institutional advocacy. However, in one of the boroughs here there was no DVC in post throughout the evaluation period, and there are reports of LAs diverting funds from co-ordinators to IDVA schemes.

Key points

- There was a tension between empowerment to enhance safety and respecting women's choices that might include a decision to stay in abusive relationships (Peled et al, 2000). As IDVAs work primarily with high risk victim-survivors this dilemma is particularly acute.
- The ability of IDVAs to deliver advocacy in practice is constrained by responses from other agencies where these are slow, inadequate or simply not forthcoming – housing departments, police and Social Services departments were all identified as, at times, failing to deliver on their responsibilities.
- The independence of IDVAs has been regarded as essential to their effectiveness, reflected in the 'I' of IDVA. The emergence of IDVA schemes and posts in some boroughs within statutory services raises serious questions about how the required independence can be maintained.
- IDVAs and stakeholders voiced concerns about the limitations of short term crisis intervention for those women most diminished by domestic violence. Some schemes kept cases open for longer than the recommended timeframe, a manifestation of the tensions between the IDVA model, advocacy in practice and the needs of individuals.

Introduction

> What we looked at was not about a worker providing an advocacy service for an individual, but coordination – providing a premium multi-agency response by coordinating those agencies, and ensuring that those agencies prioritised their response

to domestic abuse, as opposed to it being in the "too difficult" box *(National Expert Informant).*

The IDVA model comprises a number of key elements: working with high risk victims-survivors in short/medium term interventions, often from the point of crisis; closing cases when risk is reduced, with a concomitant high throughput; and delivering advocacy through multi-agency partnerships (GLDVP[10], n.d). Exploring how IDVAs understand and implement their role is key to assessing how they operate in their capacity to support and advise women and also in the wider Westminster government agenda of a co-ordinated community response to domestic violence. The IDVAs were asked in both rounds of interviews to define their role, and through analysis and coding it emerged that while there are overlaps with how they define advocacy as a practice and role of an IDVA, they do not simply map onto each other.

Key themes, addressed in detail in this section, are:

- aims of the scheme;
- advocacy in practice;
- difference from other services including specialised DV projects;
- risk assessment;
- proactivity;
- independence;
- caseloads and how time is spent;
- empowering women through giving knowledge of rights and options;
- safety planning;
- crisis intervention vs long term casework;
- emotional impacts;
- specialist community IDVAs;
- CAADA training.

Stakeholders external to the schemes tend to give more prominence to the criminal justice aspect, while IDVAs themselves focus more on the holistic nature of the role and range of support required. In this chapter we draw primarily on the interviews with IDVAs and scheme managers and observation visits, to provide a picture of their day-to-day practice. The multi-agency context is discussed later in the report.

Aims of the schemes

The aims of the four schemes evinced considerable consensus, all include:

- enabling victim-survivors to recognise dynamics of domestic violence;
- empowering victim-survivors to make choices;
- enhancing victim-survivors safety;
- reducing violence and repeat victimisation;
- reducing risk;
- providing holistic support.

Both REACH and NAADV have two additional aims, articulated by IDVAs and scheme managers:

- acting as a bridge between the criminal justice system and service users;
- encouraging perpetrator accountability.

A key aspect of evaluation is the extent to which projects meet their aims and objectives. This chapter explores this through accounts of being an IDVA and it is followed by one which looks at case work and case outcomes. Here readers are asked to be mindful of how the scheme aims are threaded through IDVAs' accounts of 'doing advocacy'.

[10] The Greater London Domestic Violence Project (GLDVP) is now known as The AVA Project.

Advocacy in practice

> For me, being an advocate is about working side by side with women *(IDVA, nia, R1).*

Advocacy is a relatively new concept, but not a new practice, in domestic violence services; aspects of it have been integral to women's services since their inception. There are, however, some important differences of emphasis: advocacy is founded in ensuring rights and entitlements and has proactive engagement as a core component (Kelly & Humphreys 2001). The former has, to some extent, been part of existing provision, the latter marks a departure from the principle of self-determination which left the initiative of making contact with services to the service user. International research on domestic violence advocates describes them as 'stewards of this infrastructure as they direct, guide and support battered women while confronting and challenging obstacles to their safety' (Shepard, 1999: 115). Previous studies demonstrate that specialised advocacy leads to enhanced access to community resources and social support for victim-survivors and reductions in violence (Sullivan & Bybee, 1999; Kelly, 1999; Robinson, 2003; Howarth et al, 2009). The processes of advocacy constitute several core actions: initiating contact with women; liaising with agencies; being a 'one stop person' with respect to information about the case; speaking on behalf of women where they feel unable to do so; ensuring rights and entitlements are realised.

Having a 'one stop person' has been noted in previous evaluations of domestic violence advocacy projects to be highly valued by victim-survivors (Hester & Westmarland, 2005), and in this project was widely reported by IDVAs and stakeholders alike as crucial. Benefits included 'cutting through bureaucracy' and jargon for service users as well as 'knowing the system'. Acting as a buffer between victim-survivors and local agencies requires that IDVAs know and understand not only their own roles and responsibilities, but also that of other agencies within local CCRs. This ensures that they can not only advise about possible options but also challenge any poor practices. This entails an accumulation of knowledge, 'inventiveness', experience and negotiation skills, as well as persistence in pursuing routes that can be time and conflict intensive. Observation of IDVAs with service users revealed their depth of knowledge, highly developed listening skills and abilities to undertake sensitive casework over the phone.

> You really do need to be a chameleon, you need to be multilingual, you need to understand where those agencies and individual practitioners are coming from, what their constraints are, what their strengths and weaknesses are… so it's not just understanding your own job, you've really got to be conversant with theirs *(IDVA manager, R1).*

> It's a bit like being the eyes, the ears and the voice for our clients, but also negotiating with other professionals... say for example it's a situation with housing or Social Services and I'm aware that their response is wrong. Then what I will do is get in touch and explain to them – this is what your duty is and negotiate: 'this is what the client needs, this is actually what you should be doing'... And then if you don't get the appropriate response then you look at what the other options are. So that would be legal options, because often when we're turned down by Social Services I would get a solicitor to challenge them under judicial review. So it's about knowing that you can do that, and explaining that to the woman *(IDVA, REACH, R1).*

> I'm trying to do the best job I can but I'm battling other professionals for information *(IDVA, NAADV, R2).*

Ensuring that rights and entitlements were recognised and acted upon was frequently referred to as one of the most demanding aspects of IDVA work. One example offered involved a housing officer refusing an application for a management transfer on the basis that domestic violence did not constitute eligible grounds. The IDVA asked to see the departmental policy and showed the housing officer the relevant sections proving that the woman was entitled to a transfer. While this ended in a successful outcome, the IDVA pointed out that housing officers are supposed to have received training about domestic violence, and should at least be familiar with their own policies. Without intervention from the IDVA, this woman would have been refused the assistance to which she was legally entitled, denying her the opportunity to escape the perpetrator.

In the first round of interviews, few IDVAs made explicit reference to rights. By the second round of interviews the language of rights was more prominent, possibly reflecting the struggles that IDVAs had undergone to secure entitlements for victim-survivors in the face of often unsympathetic and intransigent responses from statutory services.

> We are pressure agencies, apart from empowering the women, which I think is really really crucial, but also because the woman is tired, or there's a language barrier, she doesn't know her rights, so I'm her voice, and it works *(IDVA, nia, R2).*

That the 'A' in IDVA stands for adviser, rather than advocate, raises the question of whether this naming has dulled the original emphasis on rights and working alongside individuals in ways that seek to help them regain the power that violence has compromised. There is some suggestion that this is the case in Howarth et al (2009) statement that: 'the role of the IDVA has evolved from that of the advocate to a more risk focussed approach to intervention' (p39). Whilst this may be a policy position linking the Westminster government and CAADA, IDVAs in this study referred to themselves as advocates, defining their role through their everyday practices: one was clear that 'just by the job title, an advocate, you're putting a different concept on the service... defining yourself in a different role than a support worker' (IDVA, nia, R1).

> Being an advocate... I'm essentially working for the woman, speaking on her behalf when she feels not able to, and very often women deal with so many agencies, that to put you between them and the agencies gives them a space to breathe slightly... very often when they deal with statutory agencies, there's a feeling that nobody really listens to them, and that maybe by having an advocate there's a sense of security and safety and the fact that you've got somebody who is not necessarily on your side, but is working for your benefit rather than against you *(IDVA, nia, R1).*

The IDVAs interviewed for this project not only valued, but embraced, the role of advocate: 'being an advocate' for victim-survivors was the core of their work, with – as we shall show later – risk playing an important but less central role than suggested by Howarth et al (2009).

Difference from other DV services

One of the aspects of the IDVA model we explore is what it adds to the well-established sector of domestic violence support provision. The added value IDVAs make has been described as: focussing on risk; central to multi-agency responses; a standardised definition of the service; and pro-activity (Howarth et al, 2009). IDVAs and stakeholders were asked if, and how, they felt the schemes differed from existing domestic violence services and identified all these points, with the most straightforward distinction being the focus on high risk cases (see also Robinson, 2009).

> We're dealing with the high risk end, if someone's got to be made safe then we have to make sure that they're made safe *(IDVA, DVSS, R1).*

Close partnerships and accountability, particularly with the criminal justice system, were also described by stakeholders as distinguishing IDVAs from existing services, both statutory and voluntary.

> I would say the only new dimension it brings is that it is being multi agency. I feel I am accountable to other bodies, other than the client, [before] it was only client and [the] organisation I work for *(IDVA, nia, R1).*

> Many other organisations in the borough provide similar support services, so it is important that IDVAs provide the CJS focus. They [IDVAs] provide something new in that they have better access to CJS agencies than other DV organisations *(Stakeholder, Newham, R1).*

One IDVA with previous experience of working in a community based domestic violence service suggested that the main distinction is the point of intervention.

> It's different because we deal with women at more crisis points, that's important, they come at a point of crisis and it's about that… Most of the time the women I was working with before were already well through the cycle… quite a few of the women that come

> via the MARAC and the police they're all at crisis… So I see a massive difference in the approach that you have to work with the women *(IDVA, DVSS, R1).*

This was particularly relevant at REACH, where because of the A&E setting, IDVAs reported that the difference from other DV work was that it was 'crisis, crisis, crisis' all the time: specialised services rarely have contact with victim-survivors so immediately after a serious assault. This in turn increases the intensity of the IDVA work as they are attempting to reduce risk and enhance safety in a short window before victim-survivors are discharged (discussed in more detail later in this chapter).

The focus on high-risk cases is the subject of some debate in the domestic violence sector with concerns about reductions in resources for victim-survivors who do not reach the high-risk threshold with some arguing that severity of incident misunderstands the core dynamics of domestic violence, and leads to inappropriate 'rationing' of interventions (Stark, 2009). One stakeholder expressed concern that this would leave the majority of domestic violence cases in the borough, currently at low/medium risk, with less support.

> If there was sufficient funding for early intervention prevention work for agencies, then cases wouldn't escalate to a high risk level. Of course some cases would, but in terms of a long term strategy, what we're doing is we're taking core funding away from the early intervention… it would be much more costly on the health services, on education services and all the other statutory services that are available, because cases have been now escalated to a higher risk level because there is a gap in support and provision *(Stakeholder, Newham, R1).*

This stakeholder reflects wider concern that domestic violence support provision in this borough has shifted, with funding for the many specialised voluntary sector services withdrawn and invested in the statutory sector. The local authority domestic violence support team, based in the new Family Justice Centre, is being developed as the lead DV support agency and support workers trained as IDVAs.

> I've got eight DV advisers, four of whom I call the IDVAs who have done the [CAADA] training and four that haven't but they will be trained as IDVAs *(Stakeholder, Newham, R2).*

Similarly in Hackney, the diversion of funding streams has led to the nia project casework team being replaced by IDVAs. Nia have negotiated that the local authority domestic violence service focuses on low/medium risk while the nia IDVAs take up high risk cases, but their concerns about escalation mirror those of the Newham stakeholder.

> Funding for advice workers, no one's interested in funding for that really. All the money's in high risk. Which is kind of counter-productive… We'll wait for them to get high risk and then we can work with you *(IDVA manager, R1).*

Some national experts also expressed concern that this shift in emphasis will diminish specialised support provision. It is arguably counterproductive if one of the indicators of success is a reduction in domestic violence homicides. Two UK studies concur that in at least a third of cases there were very few previous incidents of assault, and hardly any contact with agencies (Dobash et al, 2007; Regan et al, 2007). What characterised these cases were high levels of coercive control[11] and jealous surveillance. Whilst this has been added to the DASH risk assessment instrument, adopted by 41 police forces in 2009/10, it alone would not constitute high risk.

Three of four boroughs had an overall strategic lead on domestic violence during the evaluation period who was interviewed at least once. Two of the three (and a number of other stakeholders and IDVAs) considered IDVAs a vital element of specialised support provision that can only function effectively when complemented within co-ordinated community approaches by other agencies to pick up low/medium risk cases.

> IDVAs are part of wider wraparound provision... *(Stakeholder, Barnet, R2).*

> IDVAs can spend more time dealing with high risk victims. But that can really only help in a framework where you have other caseworkers to deal with non high risk victims *(Stakeholder, Lambeth, R2).*

[11] Stark (2007) provides a detailed breakdown of the behaviours that comprise 'coercive control': violence (including sexual coercion and jealously); intimidation (including threats, surveillance, stalking, degradation and shaming); isolation (including from family, friends and the world outside the home) and control (including control of family resources and 'micromanagement' of everyday life).

> Ideally, we'd have caseworkers as well, so IDVAs could do the crisis work and caseworkers can take over with empowerment *(IDVA, nia, R2).*

A national evaluation of IDVA schemes recommended 'aftercare' options in 'a model of continuing safety' for victim-survivors as short term interventions are unlikely to meet all needs given the complexity of domestic violence (Howarth et al, 2009: 93). We would add that no single service has ever claimed to resolve domestic violence at the first intervention. There is an implicit presumption in the CAADA IDVA model that once risk has been reduced, cases should be referred onto services dealing with low/medium risk. However, there may be locations where no such services are available; central (Westminster) government and policy and local commissioning has prioritised high risk provision, often at the expense of other services. There is a real and present danger that instead of a Co-ordinated Community Response, provision is increasingly skewed to high risk, and IDVAs have decreasing resources to refer women onto. Here we see a clear advantage to locating IDVAs within existing community based provision, which not only ensures independence, but also seamless support as individuals can access those services appropriate to their situation. If central government funding, and messages to local commissioners, continues to channel decision making towards high risk, we may face unbalanced provision, and even undermine the contribution of IDVAs, as they simply will not have resources to refer women to. Reducing risk through short term interventions is not the same as either stopping violence or empowering women to the extent that they are able to take more control over their lives and safety.

Even where victim-survivors end the relationship, for many the violence continues post-separation (Humphreys & Thiara, 2003; Kelly, 1999), sometimes changing form to harassment and sometimes becoming more dangerous. This underscores that IDVA schemes require refuges to refer certain cases to, as for some the protection of safe housing is needed to reduce risk and enhance safety. One scheme decided in April 2009 to apply for funding to broaden their remit to longer term casework, in recognition of the need for consistency and continuity of provision for longer term safety. We return to this point later in this chapter, but here we reiterate the importance of service provision being rooted in the expertise of specialised domestic violence organisations.

Risk assessment

Whilst the high risk parameter was shared across schemes, in practice risk thresholds varied by setting. For instance, at NAADV, the support that IDVAs provide at the SDVC inflects the nature of their work; victim-survivors receiving simply advocacy while at court did not always require a risk assessment, since the court case was the only (known) outstanding issue with respect to safety, and gauging whether all these cases would be classified as high risk was not possible. At REACH, the scheme manager defines all IDVA service users as medium/high risk since they present A&E with injuries from physical or sexual violence. In this section we explore how IDVAs and stakeholders view risk assessment tools, practices and outcomes. Data on the risk indicators and levels of risk across the four schemes are presented in Chapter Four.

Risk assessment has emerged at a time where there is a perceived need to focus resources on the most serious cases, linked to research evidence identifying factors associated with lethality (Robinson 2003; Humphreys et al 2005). Risk assessment instruments developed out of 'checklists' used in the 1990's, primarily in the USA, but have evolved so that current risk assessment instruments are often lengthy and increasingly detailed, incorporate a scoring system, which weights factors deemed the most predictive of further harm.

Interviews with IDVAs probed the value of a structured risk assessment. Most viewed it as useful 'information gathering tool' that prompted questions that might not otherwise be linked to risk, but did not, and should not, replace professional judgement. Many spoke of adding in information from victim-survivors not asked in risk assessments in order to draw conclusions about levels of danger (Cattaneo, 2007). Some endorsed risk assessment as enabling inexperienced workers to extract information and in doing so, build their learning about factors that constitute high risk.

> You do get a real sense of what the risk is. You really do, it's tick boxing and then you add it up, so even if you're not hugely experienced at it, as long as you get the woman's story, you get the information *(IDVA manager, R2).*

In contrast, another suggested that experience was a vital component even with a structured tool.

> Something can change that appears quite small, and that's the importance of being quite experienced at it really. Something you might not think is really apparent actually could be potentially dangerous *(IDVA, DVSS, R1).*

Amanda Robinson (2007) also comments that risk assessment processes require more than completing a form, rather they rely on:

> The good judgement and experience of trained advocates rather than a simple matrix that can be completed by anyone with access to victims of domestic abuse. The 'science' of risk assessment is still in its infancy, and complex lives and dangerous situations cannot simply be reduced to a tick box form. It is important that a sophisticated understanding of domestic abuse and knowledge of risk is combined with an environment (both physical and human) that is supportive of victims, and helps them to feel comfortable disclosing features of their personal lives, in order to produce a process of risk assessment and classification that can help to identify those victims who are most vulnerable and at risk of further harm *(p4).*

Echoing this, several IDVAs reported that they constantly supplement risk assessment tools with their own expertise, including development of rapport and trust with victim-survivors.

> For me it's not really much about sitting there like 'OK, go through the questions', it's about being able to build that relationship… I think you improvise as you go along *(IDVA, REACH, R1).*

> When I've been going through it, I add other questions... how it works if you've got so many yeses then it's [high risk] but sometimes I find that I get something that's high risk that I don't actually think is high risk... I work from the whole case, there's all those indications but I look at their resources as well *(IDVA, DVSS, R1).*

The definition of risk within risk assessment remains one that prioritises criminal behaviour, specifically physical assault. One case illustrates this: here risk of physical violence had been decreased, but the perpetrator continued to undertake a war of attrition using legal and social systems to exercise coercive control by making false reports about the woman's use of violence against him and the children to both the police and Children's Services. This woman's fragile belief in her right to justice was undermined, and her mental and physical health slowly deteriorated to the extent that the IDVAs scheme supporting her thought she was heading for a breakdown. They saw this potential outcome as providing the perpetrator with grounds to argue for and gain custody of the children. There were no appropriate services to refer this woman into in the borough. Within current risk assessment processes this case would be categorized as 'low risk', yet the potential for serious harm to the victim and her children were evident. This scheme faced the dilemma of working within 'the model' and closing the case since 'risk' had been reduced, or continuing to support an extremely vulnerable woman and her children. It is also worth mentioning here that using a conventional outcome and cost benefit analysis, that there were no further crime incidents would count as success,that she became a mental health patient and lost custody of her children would be invisible. Many IDVAs talked poignantly about their ambivalence of following rules against which they were assessed versus their own perceptions of what women needed to regain control over their lives. We have already noted the necessity of appropriate services for IDVA to signpost service users onto, and another key lesson here is that IDVA experience and skills in using risk assessment tools was underpinned by depth understanding and awareness of the dynamics of domestic violence and its consequences.

Concern was also expressed across the schemes about risk assessment undertaken by the police, with respect to the questions asked, police levels of knowledge/skill in eliciting answers, and their ability to interpret any other information that may not be captured on the risk assessment form. Research has highlighted that the six weighted factors of SPECSS+ do not adequately address high-risk (Humphreys et al, 2005; Regan et al, 2007). IDVAs from NAADV suggested that police are scoring women as lower risk than IDVAs. One police officer, interviewed as a

stakeholder in Lambeth, argued the opposite way, claiming that police assessments were more accurate.

> Obviously the risk assessment that IDVAs are able to do may differ from what we're able to do, because we have access to different information, and I think to some degree they're probably reliant, you know, to a large degree on what they're told. And whilst the fact that the majority of victims of domestic violence are honest and tell the truth and so on, if that's solely what you rely on, then it makes it difficult, because some victims do make malicious allegations from time to time, and if their risk assessment is solely based on the victim's account, then I see that as being probably less accurate than our risk assessment process *(Stakeholder, Lambeth, R1).*

This account has two worrying aspects: first, an emphasis on false allegations, described as a 'culture of scepticism' in relation to rape and sexual assault (Kelly et al, 2005: 83). Secondly, the lack of respect for the perceptions of victim-survivors, which some researchers have argued can be the most accurate assessment of risk. In contrast another police officer expressed the view that IDVAs were more likely to obtain detailed information about danger.

> When an IDVA has spoken to a victim and done their checklist they're coming out extremely high risk; when we've spoken to them prior to the IDVA, they've not come out high risk… so I guess it does change a little bit the way that it's assessed from our point of view, because we wouldn't have known about those cases had the IDVAs not informed us *(Stakeholder, Lambeth, R1).*

Some schemes reported that local agencies were frequently identifying cases as high risk when IDVAs did not reach the same conclusion. This in turn has implications for those deemed eligible for support and cases being referred to MARAC (see Chapter Seven). IDVAs highlighted two explanations for this difference: firstly, that other agencies were not undertaking risk assessments or lacked the skills to complete them accurately; secondly, inadequate understandings of domestic violence influenced how other agencies conceptualised risk. IDVAs thus carried out important functions in raising awareness of what constitutes risk and drawing out victim-survivors' experiences, underpinned by their expertise and skills.

> When an IDVA's spoken to a victim and done their CAADA checklist they're coming out extremely high risk; when we've spoken to them prior to the IDVA, they've not come out high risk *(Stakeholder, Lambeth, R2).*

Finally, another issue raised about the efficacy and comprehensiveness of risk assessment was the proportion of missing data when other agencies had forms as part of referral processes. IDVAs and stakeholders alike valued the fact that DVSS have access to police databases where they can draw information for risk assessments, but unlike the stakeholder above, saw this not as about verifying/disproving victim-survivors' accounts but to fill in vital gaps about perpetrators. At NAADV, developing links with the police CSU was prioritised in order to add to risk assessment information. There are two messages here: for projects aiming to address risk through criminal justice outcomes, close links and information sharing with police must be integral to the work. Secondly, the evidence base of risk with respect to domestic violence is linked to the lens of criminality, as IDVAs perceive that they can only fully risk assess with knowledge of prior criminal justice involvement. At the same time, their accounts also demonstrate that advocacy in practice is wider than engagement with CJS.

IDVAs describe risk assessment as an ongoing process with each service user, with change possible with each new contact.

> Every time you have contact with that client, you're basically carrying out a risk assessment, because something can change that appears small, and I think that's the importance of being quite experienced at it really *(IDVA, DVSS, R1).*

Here gathering of information takes place in the context of accumulated knowledge and skills of specialised services. Although experienced workers acknowledge that they are able to do this, there is also an explicit endorsement of a specific tool that guarantees a systematic approach. There was a tension here, however, for the evaluation, since the intuitive approach used by many IDVAs is less amenable to accurate recording on a database and is hard to track across cases. In fact the formal assessment tool becomes an aide memoire for experienced workers, who are able

to carry out the assessment without ticking lists. This is undoubtedly good practice with respect to service users, who feel their story is being listened to and engaged with, rather than being merely used to complete a form. There are however, implications for evaluation and outcome measures, as not all cases will have contemporaneous risk data entered onto either forms or databases. This, as a national stakeholder highlighted, reinforces the need for regular contact between IDVA and service users given that 'low risk can move very quickly to high risk'. The type of proactive contact that IDVAs are engaged in enables them to monitor such shifts. This begs the question, however, of what happens to the low risk cases which become high risk that IDVAs do not check on and raises questions about the presumption that IDVA work is short term.

IDVAs at one scheme expressed discomfort that risk assessment had superseded the holistic support which they perceived as key to enabling women to leave abusive relationships and rebuild their lives.

> I would try and do [the risk assessment] at the first appointment, but it's around what's going on with the client, because if your client is in crisis, the first appointment is spent with her crying the whole time. Do you then bombard them with the paperwork of the risk assessment? *(IDVA, nia, R1)*.

Some IDVAs were also uneasy with the principle of the IDVA model that those who did not score highly enough on risk assessments would be refused a service (see also Select Committee on Home Affairs, 2008).

> I don't like the idea of saying 'Well, we're not going to work with you because you're standard risk'. I hope the risk assessment doesn't do that within other agencies… By doing risk assessments I don't think you should lose the purpose of what we're meant to be doing, which is supporting women and empowering her and giving her options, still giving her choices, rather than just going 'Right, I'm assessing your risk' *(IDVA manager, R1).*

This sense of discomfort with the prescribed IDVA model links to concerns about: IDVAs eclipsing other forms of provision, such as those that work low/medium risk; and the efficacy of short term intervention to enable victim-survivors to rebuild their lives and live free from violence. We return to both of these points later in the chapter.

While for IDVAs assessing risk had become a practice that had become routinely embedded in their work, Appendix 4 reveals significant proportions of uncompleted formal risk assessments. Some of this may be due to incomplete data entry, but not all. Changes to the risk assessment tools also seem to have affected completion rates. At NAADV the completion rate dropped from an average of four-fifths to around a third with the new form. Conversely at nia, the rate increased from two thirds completed to almost all, with the new format.

One explanation for the proportions of uncompleted risk assessment is that the 'one size fits all' approach may not work for all victim-survivors. Some IDVAs noted that it was not always possible to complete a risk assessment on the first appointment. By the first/second/third intervention or contact, the immediate danger may have been resolved. Making the process of IDVA work victim-centred must factor in these variations in circumstances, but this does not sit comfortably with requirements for systematic outcome measures. Here it appears that practice makes for imperfect record-keeping but more nuanced interventions with victim-survivors.

Influences on local understandings of risk

All IDVAs and stakeholders were asked in both rounds if local risk assessment practices, and understandings of risk, had changed since the establishment of the IDVA scheme. The introduction and, for some, standardisation of risk assessment tools was perceived to have increased the numbers of cases classified as high risk and enhanced understandings of factors that increase the likelihood of re-assault.

Most IDVAs and stakeholders believed that cases were being identified as high risk earlier, as a result of more consistent understandings of danger among MARAC members. This had the added benefit of agencies 'speaking the same language' and responding to requests for entitlements, but relied on IDVAs investing time and effort in education.

> People understand now that there is a grading of risk... I talked a lot to all the different agencies about risk and just raised the different risk indicators and people are becoming more aware *(IDVA manager, R1).*

Conversely, some commented that the police in particular were marking cases as low risk when IDVAs considered them high risk, relying on weapons and alcohol and less on victim-survivor perception (see Chapter Four).

A minority of stakeholders did not think that awareness and understanding of risk had changed since the inception of the IDVA schemes, as they were already carrying out risk assessments, albeit less routinely. Even here however, there was acknowledgement that how risk assessments were conducted affected the amount of information that victim-survivors felt comfortable volunteering, and that IDVAs were eliciting more information and thus building a more complete picture.

From Reactive to Proactive

In the initial stages of the evaluation, the proactive aspect of IDVA work was given limited prominence by interviewees. Although reference was made to the importance of initiating contact with victims/survivors, one IDVA noted that at times this could feel uncomfortable. However the observation visits and interviews with IDVAs who began in post later into project development demonstrated that pro-activity was increasingly regarded as essential. Initiating contact with women who have not sought help from support services but from statutory agencies such as police or health is the first stage for some IDVAs, particularly REACH, in part reflecting a shift in mainstream services identifying domestic violence as an issue requiring specialised support (Shepard, 1999). During observation visits we witnessed IDVAs making this contact, explaining to potential service users the purpose of the call, what the scheme could offer, options for help and arranging to meet.

IDVAs also carry out another proactive role - making regular (in some cases daily) phone calls to service users to check on their welfare and safety (see also Parmar & Sampson, 2007). Maintaining this contact 'regardless of whether [women] are routinely accessing the service or not' is identified as good practice in IDVA work, more likely to result in a positive view of the service and for progress in cases (Parmar et al, 2005: 2). The provision of practical advice alongside emotional 'reaching out' reduces isolation (ibid). During observation visits we noted IDVAs making 'check-in' calls offering a combination of both emotional reassurance and practical suggestions, and commend this as a marker of good practice. One IDVA identified the proactive approach as a strand in empowering service users.

> I think you have to judge that [pro-activity] in terms of your client. For instance, this morning it's been left that I'll contact her once a week and see how she's getting on, but in the meantime if she needs to contact me, she can, so it's kind of a two-way thing. But then with some clients I would ring them almost on a daily basis… I tend to ask clients… "Do you want me to ring you tomorrow? *(IDVA, nia, R1).*

For this IDVA, proactive contact is a means to regularly gauge the temperature of risk.

In order to assess service users' views of proactive contact, the questionnaire asked who usually makes contact first and what they prefer (discussed in detail in Chapter Five). This data demonstrates the necessity of pro-activity for agencies. Fears of 'bothering' women are largely unfounded; proactive contact is certainly not resented and more likely to be valued. This confirms findings on proactive contact in the aftermath of rape (Lovett et al, 2004) and domestic violence (Kelly, 1999). A study of how women access information on domestic violence also found that reassurance and support from repeated proactive contact is immensely important to many victim-survivors (Regan et al, 2003).

Independence

The national domestic violence delivery plan specifically identifies that IDVAs must 'be independent of any single organisation' in order to be effective (Home Office, 2005: 10). Guidance from the Greater London Domestic Violence Project further elaborates, noting the importance of independence 'from both the justice system and local government, in order to focus on safety and not other targets which statutory agencies must bear in mind when providing a service. Victims need support from someone who can give impartial advice on their safety options' (GLDVP, n.d.:1). This was also emphasised by IDVAs and stakeholders as core to the development of services for victim-survivors at high risk, for whom relevant agencies needed to act quickly and effectively (see also Kelly & Humphreys, 2001; Robinson, 2009).

> It's important for the IDVAs to be independent ... to provide women with an independent service going through the MARAC process... we aren't coming from a statutory point of view, we're coming from the point of view of empowering women and supporting her, being able to feed back what decisions have been made at MARAC but also being able to challenge statutory organisations within MARAC... that's the benefit for the service user *(IDVA manager, R1).*

> I think their independence is invaluable, because then they are not restricted by contracts of employment or whatever in terms of the options and services they can get *(Stakeholder, Newham, R2).*

In Newham, the shift in funding for domestic violence support provision to the local authority IDVAs has evoked concern about the implications for the sustainability of the specialised voluntary sector locally and the independence and flexibility of services. That the FJC IDVAs are based in the statutory sector raised questions about the independent aspect of the role, but the local authority was confident that this would not be a conflict.

> I don't see any difference between them and my team, being IDVAs, because my team are clear that their role is as advocates, and they are at arm's length from the court or the police, and it's their job to work across all those boundaries for the client, which is what NAADV would do. So I think from the beginning, I was very clear about the role of IDVAs being in the voluntary sector and at arm's length, but now I've changed my view… Being in the council we have quite a tremendous advantage maybe over some of the other voluntary sector services because I can lever in funding, I've got political support *(Stakeholder, Newham, R2).*

Interestingly this stakeholder located the role of IDVAs as fulfilling local government targets of reducing domestic violence and DV homicides, and reported that this is reflected in the IDVA appraisals. This is a distinct contrast to the descriptions and conceptualisations of the role offered by IDVAs and scheme managers, who emphasised the safety and empowerment of victim-survivors and securing their entitlements. Whilst the stakeholder saw no tension, at the same there is clear evidence that locating IDVAs in statutory services led to a focus on performance targets, with local government agendas driving IDVA practice. Maintaining the independence of IDVAs has been a consistent recommendation in recent evaluations (Howarth et al, 2009; Robinson 2009). The latter concludes that independence for IDVAs is 'essential to effectively co-ordinate the community response, to provide institutional advocacy to their multi-agency partners and to their ability to engage with and provide appropriate advice to victims' (p20). We can but concur, it is the independence of IDVAs which 'adds value' to the CCR; not belonging to any of the agencies with statutory responsibilities to deliver entitlements is precisely what enables IDVAs to advocate on behalf of victim-survivors. As the 'one stop person' they are in a position to co-ordinate local support in ways that increase both safety and empowerment.

Caseloads and how time is spent

IDVAs were asked about their current caseloads and the degree to which these were manageable. Guidance from CAADA recommends that schemes have clear policies on manageable caseloads and protocols to prevent sudden increases (CAADA, 2007). In practice, schemes found that

surges in caseloads were very difficult to avoid where they were the only projects working with high risk victim-survivors in a borough.

> We don't really have capacity, because there's no other service to refer on to, as we're the only service providing support for high risk clients and we can't say 'can you go on our waiting list? *(IDVA manager, R2).*

Large numbers of referrals within short spaces of time often occurred, and where victim-survivors were in acute danger/crisis, affected all open cases.

> The referrals were coming in every day, sometimes we'd get one that needs us to act immediately, and one case can take us three days, and with that we don't get a chance to speak to or check in with other clients *(IDVA, NAADV, R2).*

> You deal with the point of crisis, but out of that just comes so much other work, and it's not fixed in a day, and there's a lot of liaising with other services to help move something forward – a really heavy case [can] take up a whole week's worth of your time, so the rest of your cases sit on a back burner, and then that one slows down, and then you've got four new ones come through the door so that one goes and joins them *(IDVA, DVSS, R2).*

For IDVAs at REACH, the majority of victim-survivors they work are in crisis, and they found their days virtually impossible to plan since they had to be flexible and responsive to immediate referrals.

On average IDVAs perceived that between 15-25 cases at any one time was manageable, although for some this had reached 40 at peak points.

We also explored in the second round of interviews if the nature of the work had changed over time, as from observation visits it appeared that the bulk of advocacy was completed by telephone (also noted by Robinson, 2009). IDVAs confirmed that this was a shift over the trajectory of the scheme, partly because the intensive nature of caseloads required methods that were as time efficient as possible (ibid). Some IDVAs noted that telephone contact decreased their ability to build rapport and trust with victim-survivors and therefore assess risk accurately.

Tensions between empowerment and safety

The concept of 'empowerment' is widely if not ubiquitously used with respect to responses to domestic violence, but few agencies or models define what they mean by it (Hague 2001; Kasturirangan, 2008). Hence, uses and understandings of empowerment are shaped by practitioners, 'often defined in terms of giving choice back to victims whose choice has been taken away [by perpetrators]' (McDermott & Garofalo, 2004:1248). This is a narrower definition than some, especially those used by many women's organisations in developing countries, where empowerment is firmly located within a human rights framework. Here empowerment means more than being enabled and equipped to make choices: it could be described as extending women's space for action, in part through understanding oneself as a 'rights holder' (Merry, 2006). Elizabeth Rocha (1997) distinguishes five types of empowerment, three of which are relevant here: 'personal coping ability', typically bolstered by support services; 'mediated', based on the transfer of knowledge and information; and 'socio-political', involving raising awareness of structural inequality. In the following section we explore all three, especially 'empowerment through knowledge', akin to mediated empowerment, as a key theme of IDVA work, based on giving service users knowledge of their rights. Accounts from IDVAs highlighted that enhancing service users' capacity to cope was core to their role, a prerequisite for victim-survivors to feel sufficiently confident to claim rights, but few explicitly linked empowerment to gendered inequality.

One definition of empowerment underscores both the needs and rights dimensions, suggesting 'a person is empowered to the extent to which his or her needs are translated into rights' (Peled et al, 2000:10). This in turn reinforces the sense that one is worth more than abuse, and such changed perceptions of self expand capacities for change/independence. Zweig & Burt (2007) found that where women perceive their sense of control to be respected by agencies, they were more likely to report positive advocacy outcomes including enhanced safety.

As a practice, advocacy itself also extends models of support beyond notions of emotional empowerment to a focus on rights and acknowledgement of social contexts (Kelly & Humphreys, 2001). Throughout both rounds of interviews with IDVAs, we explored these various ways of conceptualising and operationalising empowerment, including whether these were ever in tension with women's safety.

All IDVAs categorically affirmed that there are tensions between empowerment and keeping women safe, with friction at times between their assessments of risk and the choices women make. Here women were often perceived as making 'bad choices', (Dunn & Powell Williams, 2007), 'not thinking about safety' as one IDVA phrased it, and for some, actively choosing to decline routes that the worker's believed would make them safer.

> We just have to keep saying to them that, "Look, that may not be a good idea, and maybe you need to think about this" *(IDVA, NAADV, R1).*

> They don't all want to do what we say is the safety option *(IDVA, DVSS, R1).*

This raises another issue which risk assessment and short term interventions are not necessarily best able to address: for some women there are a multitude of risks they are juggling, only one of which is their safety. Interventions which are designed not to take a holistic approach to the context in which she is weighing options and making decisions will not work for this group. Here longer term case work and counselling are needed, again highlighting the necessity of a range of services being available that can meet the diverse needs of women living with domestic violence.

The process of respecting women's autonomy yet prioritising their safety reflects debates in feminist approaches to domestic violence between enabling women's self-advocacy and the need for advocacy by others (Kelly & Humphreys, 2001). For IDVAs, the aim is for their input to facilitate self-advocacy, but they work with perceptions that this is compromised by the high levels of violence that their service users are experiencing, and the possibility that women might decide to stay in abusive relationships.

> The best way of getting her to make changes in her life is to let her to be able to feel in control of that, I think it's about giving the power and the control back to her, at the same time as being mindful of her safety… it's empowerment but within restraints of reality *(IDVA, DVSS, R1).*

Discussions of empowerment with respect to domestic violence focus heavily on developing support and safety plans that place victim-survivors' goals and wishes at the centre (Kasturirangan, 2008; Allen et al, 2004; Postmus et al, 2005; Hague, 2005). Similarly, for IDVAs, the importance of respecting victim-survivors choices is particularly significant since the coercive control inherent in domestic violence typically compromise ability to make autonomous choices and self-determination (Stark, 2009).

> [It's about] ensuring that the women understand what their choices are, so we're not telling them what to do, it's about telling them what their choices are and that they decide. I think that's important because they've been controlled, so it's not for us to then take that [control] *(IDVA,DVSS, R1).*

At issue here is the tension between victimisation and agency in domestic violence. While recognising that ongoing abuse constrains women's space for action, advocates frame their entrapment as based on a lack of knowledge of their options; once these are revealed to them, the language of agency emerges (Dunn & Powell-Williams, 2007).

> I always try to look at it like, "I've given you this information, and how you choose to use that information is then your choice" *(IDVA, REACH, R1).*

One IDVA summarised this balance of providing knowledge that attempts to guide decision making without controlling choices.

> By empowering women do you make the choices for women, do you give them advice, do you give them guiding advice? I've heard it described as "guiding choices". So you're guiding women to make those choices when – when they might not choose to… You're going to give someone the skills to empower them, but actually the choices they make might not be choices that you agree with, and you have to respect them… And I would tell a client "I think that's your choice as a woman, but actually I have to tell you,

> for this reason and that reason, for your safety, that I actually don't think that's the right decision" *(IDVA, nia, R2).*

This illustrates one of the dilemmas for IDVAs – accepting women's decision to stay in abusive relationships (Peled et al, 2000). For IDVAs, only working with victim-survivors at high risk of revictimisation and/or murder renders this dilemma particularly acute. Discussions of risk become the discursive mode through which this is articulated. The impression of the majority of IDVAs is that women underestimate levels of risk (see also, Campbell, 2004). At the same time, the research literature emphasises the importance of paying attention to women's perception of risk (Weisz et al, 2000, Robinson, 2007; Bell et al, 2008; Heckert & Gondolf, 2004). Yet the coping strategy of minimising danger, combined with the coercive control that women are subject to, means some may not see abuse as indicating potential lethality (Bell et al, 2008). In this context, respecting victim-survivors' choices is beset with ambiguities, as it raises the possibility that women will remain at risk, carrying an emotional weight for IDVAs, and not producing the required outcomes for schemes.

> It can be very difficult for advocates to be working with a woman who then chooses to reconcile with her partner, for example… sitting back and going "Oh well at least we've given her the choice!" You know "We've empowered her so next time if something does happen at least we know that she knows how to contact us." It's very difficult *(IDVA manager, R2).*

The role of the advocate here is 'pointing out the gap between their decision and the reality of the risk' (IDVA manager, R1). One manager described IDVA practice as '[for] some of the highest risk ones, they do say "You don't have to do this, but if you don't, this could be a consequence" ' (IDVA manager, R1). So information on potential consequences of living with ongoing violence, drawn from a now extensive knowledge base, can be seen as a step to enabling women to continue self-advocacy (Allen et al, 2004). This is what we term 'empowerment through knowledge'; providing information and options in order that women can make evidence based decisions.

Empowerment through knowledge

Research from the US with DV advocates finds similar accounts to those of the IDVAs who are the focus of this study in their practice of empowerment through knowledge, with advocates describing themselves as 'option givers', seeking to enhance victim-survivors decision-making processes on the basis of increasing the information available to them (Dunn & Powell-Williams, 2007). The type of information that IDVAs provide has several layers: recognition of the abusive dynamics of DV (especially if the perpetrators' behaviour is not understood as such); explaining rights under the law and social welfare systems; outlining possible options in terms of safety, criminal justice redress and child custody; and finally, possible consequences of decisions. We focus here on the first layer of this work, and define 'empowerment through knowledge' in this sense as more than revealing material/practical options. Sometimes empowerment through knowledge was rights-based and IDVAs offered examples of equipping women with how to ask questions in court or informing them that they could make police reports without pursuing charges as empowering practices. However, before this, came a process of reframing perpetrators behaviour and providing information about domestic violence.

This approach 'explicitly presumes that there is a version of reality that advocates have access to but to which victims are unaware' and that the practices of advocacy open doors to this perception (Dunn & Powell-Williams, 2007:989). IDVAs explicitly endorsed this approach, often drawing on the emotional and psychological disruption of living with violence, including deliberate strategies by perpetrators to minimise abusive behaviours, in order to explain why empowerment through knowledge was so central to their work. Accounts from two different IDVAs at the same scheme illustrate this.

> It's identifying the patterns so for the women themselves, just 'cause they're living in it doesn't mean to say they understand what's going on… sometimes they're not even aware that they're suffering domestic violence… they don't recognise that there's a

> pattern in this behaviour, and that this is the likely outcome, because this is potentially what always happens *(IDVA, DVSS, R1).*

> I see it very differently to how she sees it... So at the moment I'm trying my best to support her where she is, at the same time trying to empower her to recognise that she needs to make something change, to actually get out of this, because it's not going to change where she is *(IDVA, DVSS, R1).*

IDVAs frequently used the Duluth Power and Control wheel, in seeking to offer alternative perspectives on perpetrators' actions.

> I do a lot of work with power and control, it's like "Well I don't think it's domestic violence because he didn't slap me" – so getting them to identify abusive behaviour *(IDVA, DVSS, R1).*

> She might think next time when his behaviour starts to change "actually now I know about the power and control wheel from my worker, which she gave me, actually these are starting to trigger", there are triggers there and again she might have a better awareness *(IDVA manager, R1).*

The evaluation team observed this practice when a woman admitted to A&E for injuries as a result of domestic violence was given a copy of the wheel while the REACH IDVA made phone calls to locate safe accommodation for her. When the IDVA returned the woman expressed surprise at how much of her relationship she recognised and was then able to understand as damaging and controlling.

Another key aspect of enabling women to name violence relates to sexual violence. Initially, some IDVAs reported that they avoided asking victim-survivors about sexual violence for fear of distressing them. As the IDVAs confidence increased however, they recognised the need for this information as it both enabled victim-survivors to name their experiences and meant that IDVAs built a more complete picture (Mburia-Mwalili et al, 2010).

> I think it's an interesting question to ask because it alerts women, like where you say "Has your partner ever done anything of a sexual nature to hurt you, or cause you distress or upset?", then they'll say "No no, he's never done nothing, just generally he goes on about sex and then I just give in." And I'll say "Well do you recognise that that is actually taking advantage?" Or they will say "Oh, he talks – he calls me a fat, ugly slag, or I'm shit at sex" and I will then bring her back to "You answered no to that question. Do you think that that fits in with that?" and then trying to get them to recognise that is sexual abuse *(IDVA, DVSS, R2).*

> They will tell us things that they don't believe amounts to domestic violence, they'll say "Oh, maybe he does this, he doesn't do that," but what they will say to us that he does, then we go ahead to explain that that actually amounts to DV *(IDVA, NAADV, R2).*

Two different approaches emerged here: asking directly or rewording the question 'putting it in the right way'. Both were viewed as reliant on having built a rapport with victim-survivors, with some IDVAs noting that it was easier to ask when meeting face to face than over the telephone. IDVAs also found innovative ways to ask, including an example of when a woman was with her father so the IDVA pointed to the questions on the risk assessment form so she could read them and say yes or no. This IDVA also commented that the short length of time on first meeting often meant that service users were not yet ready to disclose. These accounts tell us much about the climate of shame and secrecy surrounding sexual violence that may inhibit workers from asking and women from telling.

This has specific resonance for enabling women to name violence, since one IDVA reported women 'becoming more empowered, [when] they recognise it as abuse rather than something they have to just accept' (IDVA, DVSS, R1). Whilst the emphasis is on women's rights to live free from violence, but this depends crucially on them recognising the extent of abuse, and its impacts on themselves and their children. The emphasis on 'high risk' contains within it an implicit assumption that the level of danger is such that practitioners and victim-survivors alike will easily recognise this. This assumption is belied by the experience of and practice of IDVAs which confirms the extent to which much domestic violence can be normalised (Lundgren, 2004). What IDVAs are doing is challenging the processes of normalisation.

'Empowerment through knowledge' was also recognised by service users as essential in enabling them to name violence (see Chapter Five).

This process of challenging normalisation by identifying and naming violence is an essential precursor to developing safety plans synergising practitioners' awareness of risk with women's experiential knowledge of the relationship (Kelly & Humphreys, 2001; Campbell, 2004). Enabling women to safety plan represents a vital shift towards self-advocacy (Kelly & Humphreys, 2001). We identify this as the foundation of IDVA work, best captured by one scheme manager.

> It is an empowerment, there is a transference of skills and knowledge in an appropriate manner, so that they can start thinking about safety issues themselves *(IDVA manager, R1).*

For some women, however, the safety of being in a relationship, of not losing home, possessions and social networks may remain their priority. It is an open question whether the knowledge that she could access support to leave, and facilitation of rights, enhances safety where women decide to stay in the relationship, and this can only be assessed through a more longitudinal research design, that follows victim-survivors after they have accessed support services.

Safety Planning

Safety planning is a tool used to explore danger and produce an action map to enhance safety. All the IDVA schemes carried out safety planning with service users, but none had a specific model or way of doing it. They appear to devise plans that are based on core actions but also tailored to individual circumstances. Of interest is that DVSS and nia, organisations grounded in a gendered analysis of domestic violence, viewed safety planning as an automatic part of the work, 'ingrained in the basics' (IDVA, nia, R1), resulting on it being integrated fluidly into their casework. This may reflect the roots of safety planning in feminist responses, whereas the risk assessment focus has emerged from the statutory sector (Radford & Gill, 2006). MARAC members that were interviewed were less familiar with safety planning processes, but recognised it as valuable. Some police officers explicitly identified the MARAC model as the most effective form of safety planning. However, a collaborative approach between advisors and service users is regarded in research literature and Association of Chief Police Officers guidance as essential, if safety planning is to be realistic for individuals (Kelly & Humphreys, 2001; ACPO, 2008).

> Safety planning is best conducted as an active partnership between a woman who is abused and an advocate or other service provider trained in domestic violence *(Campbell, 2004: 1466).*

The process and outcomes of safety planning give both IDVAs and service users structure and 'peace of mind'. In terms of structure, IDVAs and stakeholders talked about the value of clear actions and a 'task-oriented approach' (IDVA, NAADV, R1), particularly helpful where women are distressed or panicking. Some IDVAs also described safety planning as enabling service users to recognise their own strengths and abilities, even regain control of their circumstances.

> It's an empowerment that there is a way out of that situation, even if we're not available at that time, then they can do something themselves and they know what to do, so I think it's reassuring for them *(IDVA, Reach, R1).*

> [Living with domestic violence is] quite chaotic, and sometimes you go from one incident to the next incident and you don't really think about what's going in between… it gives them a space to think about their own safety, and also a space to give them a bit of security. It secures them in the fact they have a plan *(IDVA, nia, R1).*

This opens up 'space for action' for service users (Lundgren, 1998) – in situations that previously seemed overwhelming, options offer possible safe resolution, made more realisable by support from specialised services. Similarly IDVAs can feel some peace of mind in devising a strategy tailored to each individual's circumstances. Rather than viewing this as 'minimising risk', we suggest it might be recast as 'maximising safety', with actions that women can direct, and that IDVAs can follow up to check if it is effective, and if necessary re-work with women, as their situation evolves.

One of the national experts commented that a flaw in safety planning has been an understanding of its purpose as solely a 'safe exit plan', focussed on ending the relationship – rather than a strategy to enhance safety, including whilst still living with the perpetrator. We note, with encouragement, that REACH and nia IDVAs specifically identified working with women still living with their abusers to develop 'protective mechanisms' as part of their work. These included: establishing codes for speaking to friends and family that indicated emergency help is needed; codes with similar meanings for responding to calls from the IDVA; and flagging addresses with local police stations for immediate responses to 999 calls. This not only gives victim-survivors potential routes out of imminent danger, but also builds trust, as illustrated in one case from REACH.

> She's just not ready to leave. Her safety planning is when she can contact us, we have a safety code with her...the way that we've worked with her is it's ok, we support you whether you're in the relationship or you're not in the relationship, you can still access the support... now she's linking in with the police officer. She's got a safety plan as well, which is better than before. And every time she comes she discloses more *(IDVA, REACH, R1).*

Given that almost half of the perpetrators in the sample of service users from the four schemes were ex partners/spouses, developing safety plans that are focused solely on leaving abusive relationships fails to address the realities of women's lives, the extent and dangerousness of post-separation violence. Women and NGOs have long known that ending a violent relationship does not necessarily increase safety – this has always been on the raison d'être for refuges. IDVA practice by necessity engages with this complexity, albeit that many of their colleagues in other agencies are yet to catch up with this basic reality.

Crisis intervention vs longer term support

As the IDVA schemes became more established in their local contexts, the basis of their work shifted towards shorter interventions aimed at resolving immediate crises, attributed to external pressures to increase throughput of cases in line with the CAADA model. Thus 'cut off points' for closing cases were shaped by external forces.

> We're under intense pressure to keep taking on new cases once we have finished doing the right work with current ones… Our ideal would be to cut it off when she is safe and strong enough to go it alone *(IDVA manager, R2).*

All IDVAs reported that the majority of their cases were short term, but again practice in determining cut off points varied by setting. At DVSS, the IDVA with responsibility for referring victim-survivors to the Sanctuary scheme reported that the majority – around 70–80 per cent – of her cases were short term as they required risk assessment and completion of the Sanctuary application, with most cases already having support from other agencies. REACH have no specified length of time for support work, and if there are criminal justice proceedings, keep cases open on an inactive basis (since other needs had been met) until the court case. IDVAs here suggested that whilst six months was ideal, cases involving the CJS often stretched this. Similarly at NAADV, the marker for closing cases was the resolution of criminal proceedings, where risk has been reduced, on the basis that:

> If I've been doing my job properly everything else will be in place by the time they get to court *(IDVA, NAADV, R2).*

Here IDVAs noted that maintaining short term interventions crucially relied on caseworkers within their organisation being able to pick up support once risk had been reduced.

At nia, three months is loosely defined as the length of time for cases to remain open, but IDVAs here were most explicit about the tension between crisis intervention work and the ethos of the organisation to empower women.

> There's a bit of conflict with the IDVA model and our organisation. As an organisation, the way that we've worked in the past, you see the woman through her journey: she comes to you in crisis and then you work with her on a practical and emotional level

> and then you end up closing the case because everything's done. It doesn't always work like that, but she is the one to say that she no longer needs the support. The IDVA model doesn't allow for that – we need to be referring the woman on as soon as the risk is reduced, and that's quite difficult for everybody in the organisation to work with, because we're not doing our kind of holistic work that we're so used to doing. It feels like a lot of the time just trying to manage that crisis and then refer her on *(IDVA manager, R2).*

Further insights from IDVAs who had previous experience of working in the domestic violence field are particularly revealing here. Some felt that while the term holistic was widely used in relation to IDVA work, the nature of the role and pressure to accept large numbers of cases precluded a truly holistic focus and compromised their aim to enable women to live free from violence. They described the shift to short term crisis intervention work as laced with tension and doubt over whether they were equipping victim-survivors with sufficient skills to cope with the ongoing threat and reality of violence. While putting 'victims on the path to long term safety' is described as core to the IDVA model (Howarth et al, 2009:24), IDVAs in this study questioned whether this was possible to achieve through short term intervention. Thus the focus is on safety 'rather than being able to address all aspects of a victim's situation' (ibid: 33). For the IDVAs in the four London schemes, this did not fit with their aim of enabling service users to recognise and achieve what Kabeer (1994) describes as 'transformatory potential' – a capacity for sustainable change, freedom from violence.

> If you're true to the CAADA model, you do the crisis stuff and move on… there's not so much pastoral care… sometimes I'm not comfortable because it feels like working with women and empowering them, there's less chance to develop that because we do the crisis work then if the risk is minimised you should be closing the case… If you're concentrating on the crisis, then I'm not sure how much empowerment you're doing… it feels like you're giving them an incomplete service *(IDVA, nia, R2).*

> It feels like you're just dealing with a crisis, a particular crisis, and then you move it on. Whereas with domestic violence sometimes it takes a long time to actually get to that point so therefore it's going to take a lot longer to unravel it, and apart from the physical violence or the initial crisis point, there is lots of other facets to it and as a service we're not funded to actually go in depth… I feel like I almost have to work in a situation where I lose the element of care *(IDVA, DVSS, R2).*

Research from the U.S. on women's perceptions of specialised provision found that where services were liaising intensively with other agencies and under pressure to work with larger caseloads, women were less likely to receive emotional support (Zweig & Burt, 2007). Working with victim-survivors who have no recourse to public funds also affected the length of support required.

> [If you have] five clients that you're working with who have no recourse, it's a lot of work. And it means that we're working with women for a lot longer than maybe the CAADA model might suggest, but it's quite difficult to reduce that risk to that client as quickly as we're meant to be. We might be going back to MARAC and reviewing that case for quite a long time without necessarily much happening, because issues around her immigration need to be sorted out, she might be a single woman so really has not a lot of chance of getting alternative accommodation, it's very time-consuming *(IDVA manager, R2).*

Some IDVAs spoke of resisting the pressure for short term intervention, with one suggesting that 'people don't have sell-by dates'. Others described how they crafted an intermediate path that combined effective crisis intervention with wider empowerment work.

> We are trying not to do on-the-spot work... so when we finish the practical work like finding solicitor, going to court, getting injunction, moving her, she doesn't fall back to the same cycle again, so it was more holistic work we were doing. The IDVA [model] and quick work, do the necessary stuff, and let her go, it [raised] a question in our minds as a service. But I think there is a middle way now... we establish a good relationship with the woman, so we don't send her away, but we don't linger much *(IDVA, nia, R2).*

Although research indicates that women prefer longer-term support from an advocate rather than short-term crisis intervention (Hester & Westmarland, 2005), IDVAs have to negotiate the pressure of a model which dictates the opposite, described by one as 'quantity instead of quality'. Some IDVAs noted that the model limited the amount of time they could spend listening to women, which they perceived as the crux of empowerment and advocacy.

Emotion work

There is currently minimal literature on how domestic violence advocacy work affects the emotional and psychological welfare of advocates (Slattery & Goodman, 2009). Yet the impact on IDVAs of providing support to women living in dangerous and volatile situations emerged as a significant theme early in the evaluation. IDVAs referred to the intensity of the work causing stress and anxiety, compounded by the fact that they act as single reference point for service users.

> It is difficult when a woman looks up to you, she doesn't call the police, she doesn't call anybody else, but calls you, and you think 'if something happens to her'... it gives you sleepless nights *(IDVA, nia, R2).*

Accounts from IDVAs reveal that they undertake considerable 'emotion work' (Hochschild, 1983): managing their own feelings and responses to the experiences of violence and damage that they deal with. Emotion work refers to the requirements in many roles that feelings have to be controlled in order that behaviour is consistent with organisational or occupational 'display rules', which may be at odds with internal feelings. Arlie Hochchild's ground breaking study focused on how flight attendants manage their own fear or irritation in order to ensure the safety and/or comfort of passengers; but that this aspect of their work was under-valued and unrecognised. Subsequent research has addressed how these processes are core elements of nursing and care work, but similarly invisible (Miller at al, 2008). For IDVAs, providing support to victim-survivors, they have, on occasion, to suppress feelings of anger at perpetrators, distress at the treatment of women, or frustration with victim-survivors if they are to maintain respectful communication with service users and enable them to explore options.

For IDVAs at REACH, the daily interaction with victim-survivors with injuries was particularly distressing, and management had arranged for clinical supervision to be available when needed.

> Seeing severe injuries... I just had to tell myself it came with the job. It came with the job and it's something to manage because at that point I'm there for the clients and I can't let my emotions overcome me or show because then I won't be of benefit to the clients, so I coped *(IDVA, REACH, R2).*

The ability of IDVAs to undertake emotion work and cope rested heavily on peer and team support, and thus required trusting relationships between themselves. Most IDVAs reported supportive working relationships within the team from which they drew sustenance, but some reflected that lack of time occasionally meant supervision did not happen.

Regular case supervision for domestic violence advocates also provides an opportunity to develop practice and maintain consistency as well as support for practitioners (Bacchus et al, 2007). As service users need empowerment through knowledge, so do the workers supporting them. IDVAs at one scheme attended a workshop on 'vicarious trauma' run by the Greater London Domestic Violence Project (GLDVP) and also garnered support from meetings of the London IDVA network. However, all scheme managers reported a need for clinical supervision for IDVAs, and managers, which is currently precluded by a lack of financial resources.

> Ideally we would like clinical supervision, this is something that was raised by everybody within the organisation and especially IDVAs on a regular basis and it's something that certainly [higher managers] and I would love to happen. We don't have funding, unfortunately, to pay for that *(IDVA manager, R2).*

> I think it's something that I would recommend should be put in all funding applications *(IDVA manager, R2).*

Robinson (2009) makes the salient point that the costs of providing clinical supervision for both IDVAs and managers should be offset against the potential costs of staff burnout and turnover.

US research found that 'supportive professional relationships' with colleagues reduced emotional burdens, as did regular clinical supervision (Slattery & Goodman, 2009¬1369). The experiences of IDVAs here demonstrate that the former was mostly present and also perceived as essential, but that the latter is rendered impossible by insufficient funding. There are lessons here for funders, commissioners and those establishing schemes. The intense nature of IDVA work requires budget lines that enable support mechanisms and processes for workers, alongside recognition that workloads may need to be adjusted by context. Consistency of supervision is also recommended in other evaluations of domestic violence intervention projects (Bacchus et al, 2007; Regan, 2004), but to date little attention has been given to discussion of both the demands of emotion work, but also the insights that reflecting on it can reveal (Whittier, 2001). For instance, Rebecca Campbell, in her (2002) study of the impact of researching rape, concluded that emotional engagement with victim-survivors enhances understanding. If IDVAs are to benefit from this emotion work, regular support to do so is required.

Specialist Community IDVAs

The community specific IDVAs at nia offer IDVA support to women from Turkish-speaking, Eastern European, Somali and Vietnamese communities in Hackney. Links with the Turkish-speaking communities are fairly well-established, as nia has been offering a Turkish speaking service for several years. This IDVA works on the referral line one session a week for women who speak Turkish. Work with women from Somali and Eastern European communities was slow to develop due to the blocks in the referral pathways to the nia project. Outreach work with the Eastern European community was initially limited to one workshop per quarter, and the Somali/East African IDVA targeted organisations to raise awareness of domestic violence and the support available from the scheme.

> I think my community [Somali] is a bit of a difficult community, they are isolated basically, a bit isolated, and they would need a lot of effort. I'm working on doing some leaflets at the moment, and I'm going to make a lot of visits… I'm going to do some workshops… Community centres, women's bases. And I was just thinking about the schools as well, where they have a lot of Somali children *(IDVA, nia, R1).*

Since the reconfiguration of the IDVA working hours, the Eastern European IDVA now runs a weekly Russian speaking referral line and has undertaken extensive networking within relevant societies and organisations in order to raise awareness of the service. As noted in Chapter Two, recruitment was unsuccessful for the Vietnamese IDVA and the remit here was changed to a generic post with responsibility for outreach within the Vietnamese community. The IDVA has attended various events within the community to advertise the nia project, and in the process has discovered only one Vietnamese speaking domestic violence worker and no Vietnamese counsellors in the UK. Two Vietnamese women have been referred to the nia IDVA, both from the police. The progress of developing awareness and referral pathways within the communities has been slow. While hindered by recruitment difficulties and the challenges of implementation of a new model of provision, there have also been missed opportunities here during the recruitment process to open channels of communication within the specific communities.

Some stakeholders in other boroughs highlighted the need for local specialist community IDVAs. Here developments at the nia project could serve as a model for future development. For instance, stakeholders in Newham also identified a need for IDVAs from BME communities to deliver specialised services in the borough. An IDVA in post here from June 2009[12] speaks Punjabi, Hindu, Urdu and aimed to develop a specific role here, as she estimated a quarter of her cases were from Asian communities. NAADV also made an unsuccessful application for funding for an Eastern European IDVA post and hoped to find alternative funding in the future.

CAADA training

As advocacy becomes more recognised, the model has been institutionalised in other countries (McDermott & Garofalo, 2004), often through the provision of training seeking to professionalise

[12] This IDVA left the organisation on January 2010.

standards (Shepard, 1999). The accredited training developed by CAADA has become a central element of IDVA provision. By mid 2009, over 700 individuals had attended (Home Office, 2009). The expansion of IDVA services at a local level, has not, however, been matched by training availability; made impossible for some of the four schemes to manage given that there is only a single provider. By the halfway point of the evaluation, the majority of IDVAs had not completed the training and some still did not have allocated places. CAADA subsequently guaranteed priority places following a meeting with Trust for London and the Henry Smith Charity. By the end of the evaluation period, IDVAs at DVSS, nia and REACH have completed the training, as had the two original IDVAs at NAADV, although change in staffing means that the training cycle has to be begun again. The fact that some IDVAs were in post for over a year before training was described as very frustrating.

The DVSS manager completed the training in 2007, and managers at nia, NAADV and REACH would like to attend the training, conscious that they are supervising workers accredited to deliver the role in a CAADA framework. Funding limitations preclude this. Financial costs are compounded by the time away from the scheme, as attendance is typically based on three days per month with an additional two days to complete assignments – a total of five days a month out of the office for the duration of the course. All IDVAs who have completed the course drew attention to the inadequacy of two days per month to complete the coursework, with some struggling to balance this with their work and personal responsibilities and having to make requests for extensions. Some noted how this also encroaches into precious leisure time where they attempt to wind down from the emotional demands of the job. Managers also had to juggle the capacity of the schemes while IDVA were attending the training.

> I think everyone finds it difficult to carry caseloads, we allowed for study leave, but it was an extremely busy period and I think it had a huge impact on their caseload… we weren't able to refer their cases on to anyone else *(IDVA manager, R2).*

There are current concerns that IDVA training is so time and resource intensive, with consequences not only for small organisations with limited staff capacity, but also for individual IDVAs (also highlighted by Robinson, 2009).

Feedback from those that have completed the training was positive, with all noting that it increased their confidence in their abilities as well as enhancing their knowledge base. One IDVA felt that initially the course created insecurity about gaps in her knowledge, while others were reassured that they were aware of much of the content and therefore were 'doing it right'.

> It gave me the negotiation tools and the confidence really that because you are trained by CAADA, that it is a recognised certificate and you are the professional, so you can challenge, especially when it comes to MARAC. Before I had CAADA training, my experience is that the IDVA's voice is not really heard at MARAC. But the CAADA training gives you the confidence and the tools to say "Well actually this is how it's supposed to be, this is my professional opinion,"… It's given me more confidence to challenge, to negotiate, and to actually state at a MARAC if I'm not particularly happy with an action or if I'm not particularly happy with what they're saying, or if I'm being dismissed *(IDVA, REACH, R1).*

This statement is revealing on a number of levels, not least that the knowledge and experience of specialised domestic violence workers is often ignored at multi-agency meetings. That a CAADA qualification empowers IDVAs to be more assertive is to be commended, but it raises concerns noted in research on advocacy in the US for victims of rape; that those with the deepest understanding of cases and the issue are often accorded low status by professionals from established institutions (Ullman & Townsend, 2007).

Another IDVA described how the training had redefined the parameters of her role, moving it on from casework to criminal justice liaison with a high-risk focus. This reflects the prioritisation of CJS work in the CAADA framework, which we have already noted attracted some ambivalence. Both London schemes and national stakeholders raised doubts over the rigidity of the CAADA model and its applicability in London. For instance, some aspects of both case and institutional advocacy that are promoted on the course as best practice and have been shown to work successfully in Cardiff, are significantly restricted in London. One scheme offered details of two such situations, both related to housing. One London borough routinely refuses homelessness

applications, requiring IDVAs to engage solicitors and threaten legal action in order to achieve a successful outcome. This is at odds with CAADA measures of success. Secondly, there is an ongoing issue of perpetrators being released from prison without addresses given the lack of accommodation available in London, adversely affecting women's safety and opportunities to serve and/or enforce injunctions. Mobility across London borough boundaries also enables perpetrators to avoid monitoring with similar outcomes. IDVAs perceived that some CAADA trainers, unused to London variations, responded with disbelief, rather than practical strategies, and in doing so failed to acknowledge the complex and difficult contexts in which London-based IDVAs work. These gaps in the training created some anxiety that IDVAs were failing to meet the CAADA standards and this might undermine perceptions of the efficacy of the scheme.

By the second round of interviews with MARAC members, several stakeholders began to refer to the CAADA training as a benchmark for IDVAs, referring to professionalism and consistency of response as valuable benefits. In Barnet and Newham strategic leads aimed for all IDVAs to be CAADA trained, and one housing officer had also requested a place. We have already noted that in Newham, CAADA training for four of the eight of the local authority domestic violence team has been one strand in a policy decision, and the aim in this borough is to shift all specialised support work from the voluntary to the statutory sector. There are questions here about the ethical implications of training being provided to agencies and individuals who will be in competition with existing CAADA trained schemes and IDVAs, which fulfil the independence criteria, for funding and cases. One stakeholder also suggested that the predominance of CAADA training, almost a sole benchmark for skills, obscured the value of prior experience.

> There are lots of very experienced domestic violence specialist staff who have not had CAADA training but are equally professional, and are working with very difficult cases around things like honour, who have been doing that in maybe a refuge setting or a specialist service. [They] are not termed IDVAs, but they're equally proficient *(Stakeholder, Barnet, R2).*

A recent study from New Zealand refers to this as 'knowledge based practice' which recognises the skill of practitioners and the experiences of service users (Mossman et al, 2009: pxi). In current policy approaches in England and Wales, this framing is given little emphasis, eclipsed by what Mossman et al (2009) refer to as practice driven by 'trends'.

The following chapter presents analysis of the service user profiles from each scheme.

Chapter 4:

Profiles of Service Users

Summary

This chapter presents service user profiles from the four schemes, which confirm research literature: a gendered asymmetry between victim-survivors and perpetrators; a majority aged under 40; and multiple routes into services. Data also demonstrates that IDVAs are providing support to women who are vulnerable in terms of having no recourse to public funds, health/psychosocial needs, unemployment, emotional/psychological legacies of violence, and that service users from BME communities are over-represented when compared to London populations. Some aspects of the work are particularly acute for services working in the capital, including work with women who have insecure immigration status and/or NRPF.

In terms of risk assessment, there is some variation across schemes. REACH, not unexpectedly given their location in A&E, appear to be dealing with the most serious physical violence across measures such as injuries, use of weapons, sexual violence, strangulation/choking attempts, escalation of violence, fear of being killed and highest levels of suicidal thoughts among victims. Perpetrators at REACH and nia are less likely to have a criminal record than at the two other schemes, possibly suggesting different populations. At NAADV, on both risk assessments perpetrators were more likely to have a criminal record for violence to the current victim-survivor. This reflects their position in the SDVC, where they are supporting victim-survivors through prosecutions against perpetrators. High levels of fear (at two thirds to four fifths) and isolation (one in six to over a half) are apparent across the schemes, with both highest at REACH and lowest at nia. Stalking/harassment, recorded by three schemes at an average of just under a third, can add to isolation, as victim-survivors 'restrict their activities and movement in order to avoid contact with the abuser, his family and friends' (Bacchus et al, 2007: 233). Proportions of service users reporting current/imminent separation varied significantly from three quarters at REACH and DVSS to a quarter at nia and half at NAADV.

Recorded levels of repeat victimisation following accessing all four schemes were very low, with half of cases closed because all needs had been met or service users were referred on, demonstrating that IDVAs are successful in achieving targets devised with women and implementing actions that decrease re-assault.

Key points

- The vast majority of service users were women, and almost all perpetrators male, reinforcing the importance of a gender perspective in domestic violence interventions.
- Reflecting the particularities of London a high proportion of service users were from BME communities, including significant numbers of women with no recourse to public funds.
- Scheme caseloads were lower than those set by CAADA, due to a combination of: difficulties in recruitment and retention of IDVAs; the London context, particularly working with women with no recourse to public funds; housing shortages; and lack of services to refer on to.
- Key risk indicators including fear and jealous/controlling behaviour featured in over two thirds of cases, with sexual violence, strangulation, conflict over child contact and isolation present in a third.
- Levels of repeat cases and further incidents of violence recorded in IDVA records were very low across all four schemes.

Introduction

This section presents data on the 748 cases that received support from the IDVAs over the two year period. Three schemes also recorded on their databases referrals that did not become an 'IDVA case', all of which involve either time spent attempting to make contact or gathering information to determine if the case meets the risk threshold. Two IDVAs described victim-survivors who did not engage with the service as the most demanding cases, particularly where there are acute concerns about risk and danger. Whilst this is a component of IDVA work, cases that did not receive support are not included in analysis here as there is no advocacy on which to report.

Caseloads of schemes

The number of service users was broadly similar across three of the schemes, with a slightly smaller proportion at NAADV, as shown in table 4.1

Table 4.1: Number of cases per IDVA scheme

IDVA scheme	N	%	Number of full-time IDVAs
DVSS	238	31.8	2
Nia	201	26.9	2 + 2 @ 0.8
NAADV	127	17.0	2
REACH	182	24.3	2
Total	748	100	9.6

Numbers of cases per IDVA are fewer than the annual 80-100 recommended by CAADA, and smaller than those of the schemes in Howarth et al's (2009) national evaluation and Robinson's (2003) study of the Women's Safety Unit in Cardiff. This reflects factors inherent to the development of new services and for some is specific to setting – the process of establishing the schemes locally was not straightforward, with blockages in referrals, already outlined in Chapter Two. Delays in recruitment and staff turnover also reduced capacity at all schemes, as noted earlier. At three of the schemes the number of IDVAs was not constant during the two year period, and vacant posts at REACH meant they did not operate at full capacity throughout the entire evaluation period. At some schemes, this required managers to undertake case advocacy in addition to the IDVAs, on occasion for up to 50 per cent of their time. The smaller number of cases at NAADV reflects the additional dimension to their role, attending the SDVC for two days a week, where considerable time is spent waiting either for cases to be heard or to make contact with victim-survivors who are not engaged with any support service. IDVAs also reported that domestic violence cases were frequently timetabled on days outside of the SDVC operation, requiring their presence at court almost every day, and thus greatly diminishing their support capacity. This raises questions about whether spending so much time at court is the most effective use of IDVA time. While their specialised advocacy skills and experience are invaluable,

and research demonstrates IDVA support is key to the success of SDVCs (Cook et al, 2004), this time involved affects their capacity to carry caseloads of the size set by CAADA.

At REACH, referrals are based on two criteria – A&E patients who disclose domestic violence and consent to details being given to the IDVAs. Half (49.9%) of all total referrals to the scheme (n=365) accepted support from IDVAs. Reasons for not engaging with the scheme included: being unable to make contact; victim-survivors declining support; referral onto more appropriate services; existing involvement with a specialised support organisation; being identified as the perpetrator not victim. Proportions of referrals translating into service users were less than 50 per cent at other schemes.

The following sections present the service user profiles across the IDVA schemes by: gender of victim and perpetrator; relationship of perpetrator and victim; length of relationship and violence; age; ethnicity; languages; employment and housing details; immigration status; service users with no recourse to public funds; referral sources; children; pregnancy. The chapter concludes focussing on risk assessment outcomes and closing cases.

Gender of victims and perpetrators

Across the four schemes, 97.9 per cent (n=733) of service users were women, with men constituting 1.9 per cent (n=14) and transgender victim-survivors 0.2 per cent (n=2). This confirms the wealth of international research evidence that the vast majority of domestic violence victims, who seek support, are female, and that domestic violence victimisation disproportionately affects women[13]. Even in the three schemes that accepted male service users, they comprise less than four per cent.

Table 4.2: Gender breakdown of service users

Gender	DVSS		nia		NAADV		REACH		Total	
	N	%	N	%	N	%	N	%	N	%
Female	236	99.2	199	99.0	122	96.1	175	96.2	732	97.9
Male	2	0.8	0	0	5	3.9	7	3.8	14	1.9
Transgender	0	0	2	1.0	0	0	0	0	2	0.2
Total	238	100	201	100	127	100	182	100	748	100

Whilst 6.8 per cent of referrals to REACH were male (n=25), data from REACH's own monitoring reports revealed that half of the men presenting as victims were in fact perpetrators. Table 4.3 presents the gender of perpetrators by IDVA scheme.

[13] In recognition of this, we use the term 'women' throughout the report to reflect that majority of victim-survivors were female.

Table 4.3: Gender breakdown of perpetrators

Gender	DVSS		nia		NAADV		REACH		Total	
	N	%	N	%	N	%	N	%	N	%
Male	234	98.3	178	88.6	110	86.6	160	87.9	682	91.1
Female	4	1.7	3	1.5	6	4.7	9	4.9	22	2.9
Unknown	0	0	20	9.9	11	8.7	13	7.1	44	5.9
Total	238	100	201	100	127	100	182	100	748	100

Again table 4.3 confirms the international knowledge base, with female perpetrators representing just 3.1 per cent where gender is known. Analysis of relationships between victim-survivors and perpetrators including by gender is detailed below in table 4.4[14].

Table 4.4: Relationship of perpetrator to victim

Relationship	DVSS		Nia		NAADV		REACH		Total	
	N	%	N	%	N	%	N	%	N	%
Ex partner/spouse	57	23.9	77	38.3	36	28.3	41	22.5	211	28.2
Current partner/ spouse	25	10.5	60	29.9	42	33.1	72	39.6	199	26.6
Other relative	6	2.5	7	3.5	7	5.5	13	7.1	33	4.4
Son	3	1.3	0	0	0	0	0	0	3	0.4
Father	2	0.8	0	0	1	0.8	0	0	3	0.4
Daughter	3	1.3	0	0	0	0	0	0	3	0.4
Mother	0	0	0	0	0	0	1	0.5	1	0.1
Other	3	1.3	0	0	4	3.1	2	1.1	9	1.2
Missing	139	58.4	57	28.4	37	29.1	53	29.1	286	38.2
Total	238	100	201	100	127	100	182	100	748	100

Despite considerable missing data here, some patterns emerge. Where the perpetrator/victim relationship is recorded, almost half (45.7%, n=211) are reported as an ex partner/ spouse at the point of referral, confirming research evidence that separation does not necessarily end violence (Humphreys & Thiara, 2003a; Kelly, 1999; Robinson, 2004; Howarth et al, 2009). Current partners/spouses comprise a slightly smaller proportion at 43.1 per cent (n=199), and range from a quarter (25.3%) at DVSS to over half (55.8%) at REACH. This variation in service user populations suggests that A&E departments, where the primary aim of those attending is medical treatment, act as an important route into support services for victim-survivors still in abusive relationships.

[14] Data here refers to the primary perpetrator – some schemes also recorded the number of family members who were perpetrators and relationship to the victim. This data is not presented here as it was not collected across all four schemes.

Definitions of domestic violence that IDVAs base their work on also seem to correlate with service user profiles, with almost all the nia scheme service users experiencing violence from intimate partners and the largest proportion of family member perpetrators at REACH and NAADV. However, family members comprise only one in ten perpetrators (9.3%, n=43) when percentages are adjusted for missing data.

Analysis of victim and perpetrator by gender reveal that: at DVSS, 232 cases (97.5%) were male perpetrators and female victims; two male perpetrators and male victims (in both cases the perpetrator was a family member); in four cases both victim and perpetrator were female (again all family members), with no male victims/female perpetrator combinations. At NAADV, 108 cases (85.0%) were male perpetrators/female victims, two male perpetrators and male victims (one family member perpetrator and one recorded as 'other'); three cases where both victim and perpetrator were female (one perpetrator here was an ex partner, one a current partner and one unrecorded) and three cases of female perpetrators/male victims (all current spouses/partners). At REACH, 158 cases (86.8%) were female victims/male perpetrators; five cases of male victims/female perpetrators (four current partners/spouses and one ex partner) two cases where victim and perpetrator were both male (one relative and one unknown relationship), and four cases where victim and perpetrator were both female (two relatives, one other and one unknown) [15]. At nia, 177 cases (88.9%) were male perpetrators/female victims. The two transgender service users were both experiencing violence from their current male partners, and of the three female perpetrators/female victim cases, two were ex partners and one a family member. The vast majority of cases were, therefore, cases of intimate partner violence, with heterosexual partnerships by far the greatest category. In only eight cases, less than one per cent, was a woman being violent towards a male partner/spouse.

Length of relationship and abuse

Average lengths of relationship and periods in which victim-survivors have been subject to violence are calculated for those cases where data was available, as presented in table 1 in Appendix 3. The proportion of missing data was highest at NAADV, again possibly due to the fact that many of their cases are court support work where they may not have these details. It is, however, not possible to draw meaningful conclusions from this data. Some observations can be made on data from the three schemes with usable data. All have supported service users who are in very new relationships, for whom violence is recent, suggesting that in some cases this is early intervention. Equally they are also working with victim-survivors who have been subject to violence for decades. It also appears that REACH service users are identified sooner in terms of both relationship and violence, confirming that locating specialised services in A&E has the potential to deliver early interventions.

Age

There is some commonality in the age range of service users. Across the four projects, where age is recorded, two fifths (38.8%) are aged between 21-30, and over two thirds (68.1%) between 21-40, with similar proportions across the schemes. This reflects data from other evaluations of IDVAs projects (Robinson, 2003; Howarth et al, 2009). In total only 3.1 per cent are outside the 16-60 age range (see table 2, Appendix 3).

Cases of family violence were present in all age categories, with the largest proportions in the over 70 age group (five out of nine cases), and in the under 16 category (three out of four cases). That cases of intimate partner violence were also present among over 70s supports recent research that found domestic violence to be a common form of elder abuse (O'Keeffe et al, 2007). Whilst all four projects received referrals for victim-survivors aged over 70 years, DVSS and REACH have notably higher proportions of cases of service users aged 16-20. The only age category with significantly higher proportions that did not engage with the schemes was the 51-60 category at REACH.

[15] The fifteen cases where gender of the perpetrator is unknown were all female victim.

Ethnicity

Numbers of women from BME backgrounds are significant across all schemes, comprising just over half where ethnicity is recorded (45.3%, n=292). The proportions are similar at three schemes, at around two thirds at nia (n=114. 63.0%), NAADV (n=57, 62.0%) and REACH (n=100, 61.0%) and significantly smaller at DVSS (n=72, 34.6%)[16] (see table 3, Appendix 3). Comparable data for the boroughs in which the project is based shows that half of women over 16 in Hackney (51.4%) are from BME communities, compared to 44.5 per cent in Lambeth, 43.7 per cent in Barnet and 65.2 per cent in Newham (ONS, 2009). Thus at nia, whilst the proportion of service users from BME backgrounds is larger than the borough population, this is unsurprising given the focus of the IDVAs on Turkish, Eastern European, East African and Vietnamese communities. For REACH the proportion is also higher, while at DVSS and NAADV, BME service users are slightly under-represented. However, all schemes worked with women from outside of their local authority areas, and thus a direct comparison with borough rates may not map directly onto service user profiles. Data for the London population demonstrates that just under a third of women[17] are from BME backgrounds (ONS, 2009). Howarth et al (2009), in a recent national evaluation of IDVA schemes also found higher proportions of BME service users compared to local populations, perhaps confirming Purna Sen's (1999) recommendation over a decade ago that advocacy services had the potential to meet the needs of BME women.

Languages

Across the four projects, service users spoke 17 different languages for which interpreters were required. At DVSS and NAADV, eight languages were identified, seven at nia, with Turkish and Russian comprising the largest proportions, and four languages at REACH. One in eight (n=27, 13.4%) service users at the nia project required language support, including 11 Turkish speaking women, five Russian, four women of African origin with French as first language, and three Somali speaking service users. The specialist community IDVAs at nia speak Turkish, Russian and Romanian, and viewed language as important for building trust and rapport.

> It opens an avenue for the woman. And knowing the culture. Even if the client speaks English, my Turkish client, speaks English, (half) of them do, after a while they switch to Turkish with me and I think it's a good sign for them, because at the beginning they speak English and then they turn to Turkish *(IDVA, nia, R2).*

> I'm sure women would rather speak to me than someone who will call an interpreter *(IDVA, nia, R2).*

A lack of language skills can have an impact on service users, particularly where interpreters are likely to be drawn from small pools.

> We use Language Line interpreters, and we use police interpreters as well, but I've got a Vietnamese client who doesn't want to use an interpreter because of the community *(IDVA, nia, R2).*

Further discussion of the role of specialist community IDVAs can be found in Chapter Three.

Employment and housing status

Just under a fifth (21.1%, n=157) of all service users were in employment (see table 4, Appendix 3), a significantly lower proportion than the four in ten of in Robinson's (2003) study. REACH had the highest proportion of service users that were employed full time. Basing specialised workers in A&E has the potential to open up routes to support for women in employment, who may not access other sources of assistance.

Compared to the rates for female employment in London (ONS, 2010), female service users were significantly under-employed[18]. A slightly smaller proportion of men were unemployed (n=10, 71.4%), with four in employment. Both transgender service users at nia were unemployed. The IDVA schemes are providing support to women with limited socio-economic resources.

[16] All percentages here are adjusted for missing data.

[17] Comparative data here is for the female population of London as the sample of service users is 97.9 per cent female.

[18] These rates of unemployment may also reflect the profiles of service users from marginalised communities, as the London Poverty profile indicates that women from Bangladesh, Pakistan and Turkey are more likely to be unemployed than women born in other countries (MacInnes & Kenway, 2009: 66).

Employment has specific resonance for victim-survivors of domestic violence as it offers access to social support outside of the house as well as crucial financial resources (Macy et al, 2005).

More than half (53.3%) of service users were in either local authority or housing association properties, and almost one fifth (18.6%) homeless, if not roofless, in temporary accommodation or living with friends or relatives (see table 5, Appendix 3).

Immigration status

Information on victim-survivors' immigration status was available in 343 cases. Where known, the most significant findings are that almost two thirds (n=216, 63.0%) were British citizens, a minority had Leave To Remain (n=20, 5.8%) or were overstayers (n=21, 6.1%), on marriage/student/visitor visas (n=13, 3.8%), or asylum seekers (n=4, 1.2%). Raj and Silverman (2002) conclude that migrant women are at increased risk of domestic violence, as insecure immigration status can be used to control the woman, as well as acting as a barrier to seeking and receiving help. Building on this, Regan et al (2007) advocate an approach which views irregular immigration status and migration as 'conducive contexts' for domestic violence for two reasons:

> Being a woman dependent on a male partner for status and livelihood increases the potential for coercive control. Secondly, migration is a context in which gender relations are in flux, with movement from one gender order to another. This may result in an expectation/desire for greater equality from the woman, alongside a perceived need to assert traditional entitlements by the male (p26).

The following section turns to the issue of 'no recourse to public funds', the most acute manifestation of insecure immigration status that featured strongly in the IDVA scheme caseloads.

No Recourse to Public Funds

Across the four schemes, 8.2 per cent (n=61) of victim-survivors, all female, had no recourse to public funds (NRPF), with insecure immigration status restricting access to welfare benefits and public housing. Typically, women without recourse are either recently married to men living in the UK, are 'overstayers' or illegal entrants: they thus have no entitlements in their own right, and have 'a 'stark' choice between living with life-threatening ongoing violence or facing destitution' (Anitha, 2008: 3). NGOs argue this represents an unambiguous breach of human rights obligations, as the lack of 'access to safe, secure and appropriate accommodation and support means that [women's] right to life, liberty and security of person is constantly under threat' (Amnesty International & Southall Black Sisters, 2008: 20). IDVAs cited frequent examples of women having no option but to remain living with the perpetrator, even though this caused anxiety and severe distress, as the case study below illustrates.

Case Study:
Attempting to keep women with no recourse to public funds safe

An IDVA worked with a woman who had no recourse, and not knowing anyone in the UK, was forced to carry on living with the perpetrator despite being regarded at high risk of further assault and extremely afraid.

> I see her on a weekly basis to make sure she's safe. At the end of every appointment she cries because she has to go back.

The IDVA referred the woman to a solicitor in order that she could claim Leave To Remain, but until this was resolved the woman had no entitlements to support. Eventually, when she was assaulted again, the service user called the police and the perpetrator was arrested for assault. Bail conditions prevented him from returning to the address. This finally enabled the woman to live safely, but as the IDVA noted wryly:

> It took that for her to be safe... she had to be assaulted again before she was safe.

The proportion of women with NRPF varied between 4.6 per cent at DVSS (n=11), 3.1 per cent at NAADV (n=4), 10.4 per cent at nia (n=21) and 13.7 per cent at REACH (n=25). In terms of ethnic origin, over a third (36.1, n=22) were from black African communities and a further seven (11.5%) were black Caribbean. A small number (6.6%, n=4) were from South Asian communities, with 11 (18.0%) from white backgrounds, including Turkish and Eastern European women.

Supporting with women with no recourse to public funds was the most demanding and time intensive aspect of IDVA work, invariably involving longer-term support work. This has implications for caseloads and scheme capacity, and was noted by all schemes and some national experts as particularly relevant in London, with implications for CAADA guidelines.

> The clients who have no recourse are going to be at high risk of repeat, because of the vulnerability with regards to no recourse... it does have a huge impact on the individual IDVAs' caseload who are working with, say, five clients who have no recourse, it's a lot of work. And it means that we're working with women for a lot longer than maybe the CAADA model might suggest, but it's quite difficult to reduce that risk to that client as maybe as quickly as we're meant to be *(IDVA manager, R2).*

REACH reported that their location in A&E enabled them to offer support.

> We do seem to pick up a lot of no recourse… but a lot of women that are British citizens already either don't want to take us up on the help because they know what's available, or are already working with a support agency, whereas the women that have no recourse obviously are frightened to go to the police... Because they come to the hospital with injuries, and if they're suddenly enlightened by the fact that there's someone that can help them and isn't going to try and deport them, so that's quite a big thing *(IDVA, Reach, R1).*

However, all schemes indicated that the lack of options for women with NRPF on occasion meant that cases had to be closed without enhancing safety, also noted in previous research (Amnesty International and Southall Black Sisters, 2008).

A 2007 Scottish Women's Aid survey found that one per cent of all enquiries to member groups concerned women with NRPF and a similar project in Wales revealed that two per cent of women in Welsh Women's Aid refuges had no recourse (Amnesty International & Southall Black Sisters, 2008). The latest Women's Aid Federation of England census found the annual figure for women in refuges was just under three per cent (WAFE, 2009). No similar data was available for non-refuge services offered by Women's Aid across the nations. The four IDVA schemes reported on here are supporting approximately double the proportion of women of NRPF than refuges. This is undoubtedly in part due to refuges being often unable to accept women with NRPF as they do not have the financial resources to subsidise rent and living expenses. IDVA schemes, like outreach/floating support and other specialised community based services are therefore a valuable provision for women with NRPF. Although recently monies for six weeks' accommodation has been available from the Westminster government through a women's NGO, IDVAs reported that many refuges were still unable to accept women with such short term funding, and consequently this had not, for the most part, widened possible safety and support options. All IDVAs from the schemes attended a training course on NRPF[19] in recognition of the prominence of such cases in their caseloads, but despite enhanced knowledge still encountered blockages in securing safety for vulnerable women.

> If they have no recourse, we want to empower them to keep them safe but then we hit a brick wall which is no recourse to public funds, so therefore you're not really empowering them at all *(IDVA manager, R2).*

> With no recourse to public funds it's extremely difficult, it's extremely unmanageable in terms of finding them a refuge or any accommodation, no one wants them, accepts, it's quite a huge gap I think from the government. At some point we can't just help them… I had quite a few clients with no recourse, they can't stay with the perpetrators, so I'm asking them to leave and go and stay with their friends, but some of them they don't have anyone and it's quite difficult… it's challenging, extremely challenging *(IDVA, nia, R2).*

[19] Delivered by Rights of Women and funded by Trust for London/ Henry Smith Charity.

At one of the MARAC meetings that the evaluation team observed, IDVAs had, for three weeks, sought with some desperation accommodation for a woman with NRPF. IDVAs had pinned their hopes on the representative from the No Recourse team at the local authority, due to attend the MARAC specifically for this case. They did not turn up, and subsequently the woman reluctantly returned to the perpetrator, having run out of options.

Referral sources

Tracking referral sources of cases for each scheme enables an overview of how victims-survivors reach specialised services. Given that IDVA schemes are a new development, it is especially critical to analyse pathways by which service users access the scheme. Many victim-survivors present at a range of agencies for support before reaching specialised domestic violence services (Macy et al, 2005), it is thus important for IDVA schemes to identify gaps in referral pathways from local agencies. This is especially topical given that a primary objective for 2007/8 in policy terms was 'to increase the early identification of – and intervention with – victims of domestic violence by utilising all points of contact with front-line professionals' (Home Office 2007: 19).

In the first interim report we noted that referral processes to IDVAs were complex and required ongoing negotiation, regardless of whether the scheme was newly established or a new arm of an existing service. Across the schemes, relationships have evolved so that referral pathways are smoother, partly due to increased profile through multi-agency working including presence at fora such as the MARAC, and partly due to concerted efforts by schemes to resolve territorial disputes with agreed protocols for cross-referrals.

Details of referral sources by each scheme as recorded on the databases are presented in table 6, Appendix 3.

Across all four schemes, almost three quarters of referrals (72.3%) are from statutory agencies especially health, police, social services and housing. This indicates that IDVAs are a valuable resource for these agencies, particularly as the interagency focus of MARACs means that domestic violence is becoming mainstreamed into their work. Interestingly, one stakeholder in Hackney (R1) reflected that 'my understanding is that it's mainly for the non-specialist agencies to refer high risk cases directly to the IDVAs'. Yet there are also significant gaps here from agencies that might be expected to be coming into contact with victim-survivors of domestic violence. The most notable are Social Services, who comprise the referrer for less than one in ten (7.9%) cases, and probation at only 2.1 per cent.

IDVAs at nia have the largest range of referral agencies, reflecting awareness of the project locally, developed community links and the outreach that is a feature of this scheme. That one in eight referrals (12.4%) is from GPs is most likely a result of a pilot project run by nia that educates local GPs about domestic violence and the need to refer women to specialised services. Research undertaken with women attending GP surgeries in London found that almost two fifths (41%) had experienced domestic violence within their lifetimes and 17 per cent within the last year (Richardson et al, 2002). Developing referral pathways from GP surgeries to specialised support services thus has the potential to reach large numbers of women experiencing violence. The nia IDVA scheme also has the largest number of self-referrals, indicating that it is possibly the most directly accessible to women. As it is based in a project that has developed a high profile based on independence from the statutory sector, this demonstrates success in enabling women to seek support.

For DVSS, only a quarter of referrals (23.5%) are from different teams within the police. This was an unexpected finding given their location in a police station. It perhaps signals that while victim-survivors will access support through reporting to the police, limiting the scope of IDVAs to criminal justice liaison excludes significant numbers of victim-survivors who are also at high risk of further violence yet access support from a range of agencies. For instance, the largest proportion of referrals from Social Services was to DVSS (16.8%). A fifth of DVSS referrals (20.1%) were from housing departments, which in all likelihood is linked to the fact that the scheme has an IDVA funded to work with the Sanctuary scheme, further supported by the fact that the other schemes had minimal referrals from housing. Halfway through the evaluation we suggested that there was

scope here for closer links to be forged with housing departments, but subsequent tensions between the IDVA schemes and local authority DV teams in both Newham and Hackney limited this potential.

At NAADV the proportion of referrals from the police is almost three quarters (69.3%), which may reflect the positioning of the scheme as central to the local Specialist Domestic Violence Court and thus embedded in criminal justice responses, and the development of referral pathways with the local CSU.

Referrals to REACH are commensurate with their protocols, with three quarters (75.3%) from A&E, and a further eight per cent from other hospital departments. A minority are self-referrals (5.5%) or from Victim Support and DV organisations, including one located within another hospital department and a specialised support service in Lambeth.

The lack of referrals from drug/alcohol, mental health and general health services reflects concerns from IDVAs and stakeholders about limited recognition of the relevance of domestic violence to their work.

Health and Psychosocial Needs

Two fifths of all service users (40.9%, n=306) had additional health or psychosocial need, as shown in table 7, Appendix 3. Physical health was the most common, but three quarters of these (73.2%) are REACH cases who have attended A&E for medical treatment for injuries. Across the three other schemes, 4.9 per cent had physical health issues, including lupus, diabetes, heart conditions, multiple sclerosis, epilepsy and mobility difficulties. Excluding the immediate injuries at REACH mental health issues are the most common, affecting one in six (16.3%, n=122) of all 748 service users. Although detailed information is not available for all cases, there are indications that at least some of these are related to living with violence. Across all four schemes, 75 service users (10.0%) report depression and a further 16 (2.1%) anxiety/self-harm/suicide attempts/eating disorders. All are female service users, with schizophrenia the only mental health issue reported amongst male service users.

Research indicates that rates of depression amongst women experiencing domestic violence are approximately twice that of the general female population, with higher proportions of suicide attempts (Humphreys & Thiara, 2003b). While women often trace a 'direct causal connection between their mental health and the violence and abuse', symptoms of emotional distress are rarely linked in this way by mental health professionals (ibid: 213). Studies also consistently find that having support significantly reduces rates of depression among women experiencing domestic violence (Mburia-Mwalili et al, 2010)[20].

The numbers of service users reporting problematic alcohol use and/or drug misuse, as well as the combinations of both of these and or mental/physical issues/disability, demonstrates that IDVAs need to be skilled and knowledgeable about appropriate support responses and alert to how these might affect safety and levels of danger. In addition, any one of these often poses a barrier to accessing services and might therefore reduce IDVAs' ability to secure entitlements.

Whilst only 2.7 per cent of service users report a disability, a stakeholder noted that she had made referral to one scheme that had been unable to see the woman because their offices were not accessible, and also highlighted a gap in local provision for victim-survivors with learning disabilities.

Children

Following the paring down of the database fields, the only information captured with respect to children was the number aged under 18 and details about Social Services involvement. Table 4.5 shows this data by IDVA scheme.

[20] Research from the U.S. found victim-survivors diagnosed with PTSD were more likely to fear further re-assault, whereas practitioners did not retain PTSD as a risk factor (Cattaneo, 2007). The researcher concludes that this requires further investigation as it is not clear whether is that victim-survivors are hyper-alert to cues with the possibility of exaggeration, or base their vigilance on their knowledge of the relationship which indicates extreme danger.

Table 4.5: Numbers of children and Social Services involvement

IDVA scheme	Service users with children		N children[21]	Social Services involvement
	N	%		N
DVSS	180	75.6	316	61
Nia	138	68.7	271	70
NAADV	65	51.2	110	16
REACH	84	46.2	138	54
Total	467	62.6	848	201

While there should be some caution in viewing these figures as definitive because of missing data[21], they nevertheless indicate minimum numbers of children. Interestingly NAADV and REACH appear to be dealing with larger numbers of cases where there are no dependent children. Almost half of service users (those with children) had Social Services involvement, with notes on the database indicating that in at least a small number of cases this was related to domestic violence, adding a layer of complexity for both victim-survivors' needs and for IDVAs in advocating for their rights and entitlements.

Pregnancy

A total of 47 service users (6.3%) were pregnant at the time of contact with the IDVA schemes. The largest proportion was at REACH, (9.3%, n=17), with 13 at nia (6.5%) and DVSS (5.5%) and four (3.1%) at NAADV. An additional 13 pregnant women were referred by REACH to another domestic violence service based in the maternity department of the hospital. In total then 8.5 per cent of referrals (n=31) to REACH were pregnant. Research evidence shows that women presenting at A&E departments with injuries incurred through violence from a partner are more likely to be pregnant than those with accidental injuries (Mezey & Bewley, 1997). Cases of women miscarrying after physical assaults and being forced to have terminations were also present on the databases, also found in US research (Sullivan & Bybee, 1999).

Most recent incidents

The database recorded details of whether or not the most recent incident prior to contact with the IDVA scheme had been reported to police, if the perpetrator had been charged and there had been a conviction, as shown in table 4.6.

[21] On some databases there were cases where data on children was missing (implying no children), yet it was recorded that Social Services Children and Young People's Service were involved with the family or risk indicators related to children had responses of 'yes'. These cases were all assigned a value of one child (or two where references were made to 'children'), but this almost certainly underestimates the actual number of children.

Table 4.6: Criminal justice details of most recent incidents

Most recent incident	DVSS		nia		NAADV		REACH		Total	
	N	%	N	%	N	%	N	%	N	%
Reported	141	67.5	81	49.1	67	72.0	113	66.5	402	63.1
Charge	56	26.8	17	10.3	56	60.2	40	23.5	169	26.5
Conviction	22	10.5	3	1.8	18	19.4	14	8.2	57	8.9

There is a high level of CJS involvement across the IDVA schemes, with almost two thirds resulting in a police report: NAADV have the highest level at 72%, undoubtedly linked to their role at the SDVC, with nia the least, but still just under a half. Levels of charging are much more varied ranging from 60 percent at NAADV to 10% at nia. Whilst the variations are partly a function of reporting rates, they are worthy of note, especially the low charging and conviction rates in Hackney. Charging ranges from the vast majority at NAADV, through 1 in 3 at DVSS and REACH to 1 in 5 at nia; conviction (as a proportion of reports) ranges from 1 in 3.5 at NAADV to a low of 1 in 27 at nia (rates at DVSS were 1 in 6.5, at REACH 1 in 8).

Risk Assessment

At the inception of the schemes, DVSS and REACH used a risk assessment based on the then CAADA template; nia used a 'needs/risk assessment' that had evolved in their work providing refuge and which we characterised as a 'danger checklist' rather than risk assessment tool; and NAADV used a borough wide assessment used by all members of the MARAC. At the halfway point of the evaluation we highlighted the limitations of risk assessment tools used by each project and the variations in indicators, with the only one indicator common across all: victim-survivors perceptions. Particular concern was noted that only DVSS and REACH were recording controlling behaviours given that research has indicated this is highly significant in determining the potential for domestic homicide (Dobash & Dobash, 2001, 2004, 2007; Regan et al, 2007; Richards & Baker, 2003). Further gaps identified at NAADV and nia included factors known to be linked to further assault and domestic homicide: sexual violence; pregnancy; strangulation/choking attempts; whether children had witnessed the violence. Many factors that nia originally recorded such as financial responsibility, proof of identity, food and clothes and whether or not service users have a GP/solicitor, were safety planning measures rather than risk assessment. NAADV and nia changed their risk assessments radically during the evaluation, with nia adopting a CAADA template in May 2009, and the instrument in Newham expanded in July 2008 from 20 to 45 items, again to be more in line with CAADA guidance (see Appendix 4 for risk assessment tools).

Analysis of the risk indicators across the six risk assessments used by the four schemes during the data collection period is presented below, with table 8 in Appendix 3 showing factors.

Comparison of risk indicators reported by female and male victims by Robinson & Rowlands (2009) found that significantly more women experienced jealous surveillance, isolation, fear of being killed and children being harmed, and overall being very frightened. The small number of men in our sample (n=14) precludes undertaking similar analysis.

The most common risk indicators are victim-survivors' fear and fear of further violence, found in almost three quarters of all cases. Research evidence highlights this as promising practice (Gondolf, 2002; Radford & Gill, 2006), suggesting that it is the most accurate predictor of further violence (Weisz et al, 2000; Heckert & Gondolf, 2004). As noted earlier, this is complex, given the tendency for some women to minimise the danger, the coercive control that women are subject to, and not to see some forms of abuse as indicating potential lethality. Campbell (2004) suggests

a two pronged approach is necessary – where women perceive they are high risk, this should be weighted as the most important factor, but where they report low risk, a thorough risk assessment should be undertaken. Only REACH and DVSS currently ask if women fear being killed. Although the other two schemes do ask if victim-survivors fear further violence, fear of being killed was on the original risk assessment at nia but is no longer. Of the 542 service users asked if they feared being killed, 41.4 per cent did, with a similar proportion of missing responses (39.9%). We discuss service users' perceptions of risk in more depth in Chapter Five.

Other key risk indicators such as jealous and controlling behaviour, featured in over two thirds of cases, but varied in proportion from over four fifths at DVSS and REACH to one in six for the 79 service users asked this at nia (see table 8, Appendix 3). Examples included accusations of infidelity; being unable to go out alone; telling victim-survivors what to wear; constantly checking on whereabouts; forbidding contact with friends; and withholding money. This behaviour, termed 'jealous surveillance' by Regan et al (2007), is a strong predictor for future violence (Bennett et al, 2000) and homicide (Kelly et al, forthcoming), and is also linked to escalation of violence and suicidal ideation by victims (Robinson, 2004). Crucially, studies show that jealous surveillance is present in cases where women are killed after serious violence and where there was no/minimal physical violence (Kelly et al, forthcoming; Regan et al, 2007). Thus where IDVAs are aiming to ensure safety and pay attention to victim-survivors' emotional welfare, asking about jealous surveillance is key. Evan Stark (2007) comments 'not only is coercive control the most common context in which women are abused, it is also the most dangerous' (p276).

Questions about separation were configured slightly differently across the schemes, with NAADV asking whether there had been repeated separation and reconciliation attempts. Separation is consistently found to be a risk factor for homicide (Aldridge et al, 2003; Dobash et al, 2004; Kelly et al, forthcoming). Again this was present in almost two thirds of cases, with almost half of perpetrators in this sample former partners/spouses.

In over half of cases, the most recent incident caused injuries, with the highest proportion at REACH (88.9%). Nia's new risk assessment also asks if this is the first time that violence has resulted in injuries, with only seven out of 76 service users (9.2 per cent) responding yes, indicating that the majority have experienced severe physical violence on at least two occasions. Strangulation/choking attempts were reported in nearly two fifths of cases, with the highest proportion at REACH and lowest at nia (see table 8, Appendix 4).

All four also ask about mental health problems for perpetrators, considered by some as a reliable predictor of future violence and homicide (Aldridge & Browne 2003) and related to less positive outcomes overall for victim-survivors (Howarth et al, 2009). There is a potential gap here, though, as other studies suggest that it is depression specifically that is the key factor here (Gilchrist et al, 2003; Hester et al, 2006; Regan et al, 2007), and depression is not always considered a mental health condition. Details were not available on the risk assessments for what the mental health issue was for the perpetrators in our sample. Where risk assessments ask if mental health problems are a significant concern, we recommend that depression is included specifically. Financial problems have been found in reviews of domestic homicide cases (Regan et al, 2007; Kelly et al, forthcoming) and were apparent in two fifths of the cases here where this question was asked. The Newham risk assessment also asks if perpetrators are homeless, insecurely employed and recently bereaved, with almost two fifths unemployed or insecurely employed and tiny numbers homeless or bereaved (see Appendix 4).

While a third of service users had experienced sexual violence, this proportion varied from a quarter at DVSS to almost half at REACH (see table 8, Appendix 3). In terms of gender, 107 victims of sexual violence were female/male perpetrators, with one male victim/male perpetrator (relationship unknown) and one female/female relationship (a familial relationship where the sexual harm comprised insults and accusations of infidelity). It is of concern that although sexual violence is regarded as a strong risk predictor of further assault (Robinson, 2004), linked to serious injuries (Richards & Baker, 2003), and homicide (Dobash et al, 2007), data is missing for this indicator in over a third of cases. However, at nia, the proportion of missing data is just 3.9 per cent.

Risk assessments at DVSS, nia and REACH and the original tool at NAADV ask about criminal records, but on the new NAADV tool this has been narrowed to a criminal record for offences relating to domestic violence. Where known, 40.5 per cent of perpetrators had a criminal record,

although there is a large amount of missing data (see Appendix 4), indicating that information about perpetrators may be the most difficult to elicit. Metropolitan police data revealed that at least 70 per cent of perpetrators of serious domestic violence had criminal histories including for offences committed outside the home, some involving rape and sexual assault (Richards, 2004).

It is also notable that questions about children have the lowest proportion of missing data, with recorded responses at three quarters of all cases where service users had children (see Appendix 4). This perhaps suggests that IDVAs prioritise asking about harm to children and/or that service users volunteer this information as an indication of seriousness. In almost one in six cases across the schemes, perpetrators had abused children, in addition to instances where children had attempted to intervene or witnessed violence, or were frightened of the perpetrator. In over a third of cases (37.0%) there was conflict over child contact, in line with previous research highlighting this as a common experience for women at high risk of further violence and homicide (Robinson, 2003; Kelly et al, forthcoming). Threats to kill children had been made in one in eight cases (11.2%). This is not only an indication of possible danger to children, but also of manipulation and controlling behaviour.

With respect to pregnancy, present as a risk factor in one in ten cases, it is worth noting that NAADV, nia and REACH extend this question to whether victim-survivors have been pregnant recently/within the last 12/18 months. This is a more comprehensive question than whether the victim is currently pregnant, and reflects evidence that the post-partum period can be more dangerous than pregnancy (Bowen et al, 2005).

Table 8 (see Appendix 3) also shows that in half of cases, perpetrators made threats to kill victim-survivors, with similar proportions across the three that record it. All four schemes do ask about threats to kill, but at NAADV this is not differentiated by whether it refers to victim/self/children. Hence in addition to the numbers detailed above, 13 perpetrators here had made threats to at least one of victim/self/children. Similarly, NAADV ask about alcohol and drugs as one category, so in addition to the numbers above, a further 13 also had drugs/alcohol problems. Recent analysis of domestic homicides in Ireland found that threats to kill were present in the majority of cases (Kelly et al, forthcoming). That this data is missing in a third of cases is of concern; it should be basic good practice to ask victim-survivors if the perpetrator has ever threatened to kill them. In one case where REACH made a third party report to the police this was due to the perpetrator describing in gruesome detail how he was going to kill the woman.

It is encouraging to see that violence to previous partners including threats is included on three risk assessments, as this was recommended by Regan et al (2007) and is also on the *Spousal Assault* Risk Assessment *Guide (SARA) (Kropp et al, 1995) and the new CAADA-DASH risk identification checklist (CAADA, 2009a)*. That it was present in just 3.3 per cent of cases here should not be read as a true indication of prevalence, since victim-survivors may well not know about previous violence and even the scheme with access to police databases can only rely on this having been reported to the Metropolitan police and correctly flagged as domestic violence.

A third of perpetrators are reported as having alcohol or drugs problems, with an additional 41 cases from NAADV and nia where these two are combined. Recent research found substance abuse among perpetrators to be a significant risk factor for domestic homicide (Kelly et al, forthcoming). Yet a U.S. study concluded that while advocates identified substance abuse as significant, victim-survivors focussed on behaviours outside of the relationship such as general violence as indicators of dangerousness (Cattaneo, 2007).

That almost a quarter of perpetrators have access to weapons including guns and hunting knives is a strong indicator of levels of dangerousness, and almost certainly an underestimate since this relies on victim-survivors' knowledge or police intelligence, both of which may lack full information. There is a slight variation across schemes from almost a fifth at DVSS to a third at nia. Two schemes also record if the most recent incident involved weapons, with the proportion where this was the case comprising a quarter at DVSS and over a third at REACH.

All four schemes ask about the escalation of violence, but in different ways, with DVSS and REACH[22] combining both severity and frequency (occurring in exactly half of cases at the former and 90 per cent at the latter), and NAADV and nia specifying them separately. At NAADV, violence was escalating in severity in almost half of cases (47.8%) and in frequency in over half (56.5%), while at nia these were considerably lower at 18.4 per cent and 19.7 per cent respectively.

[22] REACH have now changed the risk assessment to the CAADA-DASH instrument which does include asking about both severity and frequency as separate questions.

Reflections on the risk assessment instruments

The lack of consensus on risk assessment tools and on which indicators should be included is reflected across the four schemes. In terms of the current knowledge base important gaps include:

- NAADV and nia do not ask if victim-survivors fear being killed although they do ask if they fear further violence;
- NAADV do not ask if victim-survivors have suicidal thoughts or whether or not there is conflict over child contact;
- DVSS did not record stalking/harassment but have subsequently changed their risk assessment to CAADA-DASH, which does include this;
- nia do not record if there is history of violence to others.

Adaptations of risk assessment instruments reflected either increased awareness of the current knowledge base or the underlying explanatory frameworks schemes drew on. For example, while some factors added to the new risk assessment used in Newham are evidenced by research as predictors for homicide (presence of step-children (Campbell, 2003), unemployment (Campbell et al, 2003), power imbalance between victim and perpetrator including age (Aldridge & Brown, 2003) others are explicitly based on the cycle of abuse theory (whether or not the perpetrator and victim were abused as a child and whether the victim lived with domestic violence as a child). There are implications here for how service users understand the risk assessment process, and what messages they take from it.

At DVSS, reviews of cases were introduced some time into the evaluation period, and monitoring data from the scheme shows that their intervention reduced risk in the majority of cases, but that risk fluctuated – for instance when perpetrators were released from prison. Howarth et al (2009) recommend that cases are reviewed at set intervals. While this was introduced by two schemes, it was part of their development trajectory rather than procedures from the outset, meaning it is not possible to present valid data on this.

The most complete dataset on risk assessment specifically was from DVSS with data missing in just under a third of cases. At REACH the proportion of missing data varies by indicator, at between a third and two fifths. The proportion of missing data was considerably smaller at nia following introduction of the new risk assessment, at just 3.9 per cent. There are suggestions here that when IDVAs have bedded into their role and are more accustomed to the practice of risk assessment, the more complete assessments are. However, the opposite took place at NAADV, where the proportion of missing data increased from around a fifth to three fifths following the introduction of the new risk assessment tool. It is of concern that the schemes failed to record such significant proportions of data on key risk factors such as fear, jealous surveillance, pregnancy, isolation and sexual violence[23].

Repeat victimisation

There are two measures of repeat victimisation recorded on the databases that we present here: further incidents of violence and closed cases that had to be re-opened. It is worth noting though that this data is subject to caveats: victim-survivors may not disclose further incidents to IDVAs, may decide not to access specialised support again, data may not have been fully entered onto the database, and data was only available for a two year timeframe, a limited period for assessing this. Nevertheless, we present the data here as minimum indications of the complexity of enabling victim-survivors to escape violence and abuse.

Further incidents

Across the four schemes, 72 service users (71 women and one man) disclosed further incidents of violence to IDVAs. Of these, 54 women and one man experienced one further incident, 12 women two further incidents, two women three further incidents, one women four incidents and two women five further incidents. The nature of the incidents comprised; 30 harassment; 22

[23] Some schemes recorded this information in text on files or in sections for 'worker perception' on the risk assessment instruments, but it was not entered on to the evaluation database.

physical violence; 16 threats and/or threats to kill; four breaches of bail conditions or injunctions; three sexual violence including a rape at knifepoint; three ongoing control and emotional abuse and three cases of threats or assault on children. The majority of further incidents that were recorded were physical or sexual violence, thus potentially failing to capture the extent to which victim-survivors continued to experience intimidation and coercive control (Stark, 2007, 2009). As Kelly et al (2008: 55) point out, 'safety is more than the absence of assault, it is a state of mind which replaces a guarded and anxiety laden daily life with a life context in which it is possible to flourish'. It is significant then, that only nia and DVSS record ongoing emotional abuse under further incidents.

Repeat cases

For evaluation purposes, repeat cases were defined as those were a service user was referred (by self-referral or agency) back to the IDVA scheme once the case had been closed, leading to another file being opened on the same service user. At DVSS, nine women (3.8% of total cases) were recorded as repeat cases, with one of these returning for support twice. REACH recorded eight women as repeats and one man (4.9% of total cases)[24]. Here there were also an additional five cases who did not engage with IDVAs on the second visit to A&E for domestic violence injuries, another four who had not engaged on the first visit but did on the second, and four victim-survivors that did not engage at all despite repeat visits to A&E (one woman had five visits within the two year data collection period). All but two of these were female victim-survivors, tentatively confirming research evidence that women are more likely to experience injuries for which they need medical treatment (Walby & Allen, 2004). One of the most obvious points to make here is that victim-survivors who go to A&E are not necessarily seeking support around domestic violence and may therefore not be willing to accept interventions. Proportions of repeats were slightly lower at NAADV (2.4%, n=3) and nia (3.5%, n=7), and again all female. Again we reiterate that an absence of repeat visits does not indicate an absence of ongoing violence (Bacchus et al, 2007).

Closing cases

Across all four schemes, three quarters (76.%) were closed by the end of the two year data collection period, although proportions varied from one in ten cases at DVSS to over a third at nia (see table 4.7). This variation is again inflected by context; NAADV and REACH keep cases open until the resolution of criminal justice proceedings. Nia experienced an extremely busy period at the end of the data collection stage which they highlighted as having delayed the closure of inactive cases. The process of closing cases was described by all IDVAs as time and administration intensive.

[24] In five cases there had been no further assaults but the service users required support around legacies of domestic violence.

Table 4.7: Cases closed

Closed	5		nia		NAADV		Reach		Total	
	N	%	N	%	N	%	N	%	N	%
Yes	215	90.3	129	64.4	90	70.9	140	76.9	574	76.7
No	23	9.7	72	35.6	37	29.1	42	23.1	174	23.3
Total	238	100	201	100	127	100	182	100	748	100

The most common reason for closing cases across all four schemes was having met all the victim survivors' needs (n=200, 34.8%), followed by referral on to another service (n=90, 15.7%). In just under a fifth of cases, (n=108, 18.8%), the IDVA scheme lost contact with the service user and in a minority of cases (n=52, 9.1%) the service user declined further support. 'All needs met' referred to reduced risk through a range of routes: criminal justice processes resulted in a custodial sentence and/or civil protection order; victim-survivors were moved to a safe location; or were enabled to leave the relationship with support to the extent that there was no further violence. At NAADV half 'all needs met' cases referred to the conclusion of the criminal case, with some here ended by charges being dropped rather than a prosecution.

Referrals on to other services included to refuges, mental health teams, drug/alcohol services and signposting to domestic violence organisations working with low/medium risk. A minimum of 27 women were referred to refuges both in and out of London, demonstrating that IDVA support alone is not always sufficient to secure women's safety.

A small number of those service users who declined further support stated that they had reconciled with the perpetrator, and one scheme reported examples of perpetrators suggesting to victim-survivors that the IDVAs were trying to 'split them up', causing women to disengage from the scheme.

Some important conclusions can be drawn from this data. First, IDVAs are successful in achieving targets devised with women and implementing actions that decrease danger of re-assault. This is tempered by accounts discussed in the next chapter that many IDVAs are uneasy with pressure to close cases after short-term interventions. Secondly, the proportion of service users declining further support is very low, suggesting that IDVAs are also developing trust with victim-survivors that encourages ongoing relationships.

The next chapter turns to feedback from service users.

Chapter 5:

The views and experiences of service users

Summary

The service users who gave feedback for the evaluation were overwhelmingly positive about the IDVA projects at all stages – first impressions, casework and outcomes. One service user summed this up by describing DVSS as 'a life line of friendly, helpful, supportive people'. Service users clearly value the support from the schemes and their responses demonstrate that some of the key aims, including enabling women to cut though jargon and to act as 'option givers' (Dunn & Powell-Williams, 2007) are being achieved. That women felt safer, were safer, and more likely to contact organisations for support if there was recurrence are all positive outcomes. Echoing previous research, almost all service users report that IDVAs have enabled them to live more safely (Kelly, 1999, Robinson 2003, 2006). Those who continued to fear for their safety and were frustrated at a lack of helpful outcomes, attributed this not to IDVAs but to inadequate responses and provision from other agencies. That fewer than half of service users did not know whether their case had been referred to MARAC is an indication of gaps in communication, and compromises aims to empower victim-survivors.

There are also interesting reflections showing that for victim-survivors access to support was not linked to level of risk, but the form and content of responses. Advocacy, practical and emotional support, empowerment through knowledge, had enabled them to make changes and/or be safer; and some regretted not having been able to do this sooner, and wanted that option for others. The majority made reference to the need for increased awareness of IDVA schemes among local agencies and publicity materials to enable self-referrals. This raises questions about how CCRs can maximise advocacy across a range of services, rather than viewing it as residing only in IDVA schemes, many of which are already working to capacity.

Key points

- Ten per cent of service users (n=73) took part in the evaluation. They reported both feeling and being safer, with two-thirds reporting no further violence since contact with the scheme.
- Service users were more confident about their knowledge of services, dealing with the criminal justice system and legal rights: evidence of advocacy in practice, empowerment through knowledge and securing entitlements that contribute to enhanced safety.
- Service users regarded IDVAs as more helpful, supportive, non-judgemental and specialised than other services from which they had sought help. What was most valued were core components of the IDVA model: pro-activity; being enabled to recognise and name violence; listening; safety planning; being given information about rights and options; and liaison with other agencies.

Introduction

> Our biggest achievement lies in what our client says *(IDVA, nia, R2).*

> Since I spoke out and sought help from DVSS I have felt very protected. I have become a stronger woman and mother *(SU 26, DVSS).*

While the expansion of specialised domestic violence services necessitates feedback from service users about their perceptions and experiences, voices of victim-survivors are often absent in service development (Hague & Mullender, 2006). Gathering the experiences of service users from the four IDVA schemes was a core part of the evaluation in order to assess a range of outcomes including enhanced safety.

The methodological approach and how it was adapted during the evaluation is described in Chapter One and Appendix 1. Despite setting a target of 25 respondents per scheme, only 73 questionnaires were completed, representing 10 per cent of the total sample (see table 5.1). Nine service users from three of the schemes (DVSS, nia and NAADV) also participated in more in-depth telephone interviews. This proportion of service users from whom feedback was gathered is considerably larger than in the recent national evaluation (see Howarth et al, 2009) but smaller than Robinson's (2005) project from Cardiff. While the views and experiences of these service users may not be representative of the caseloads across the schemes, they nevertheless offer valuable insights from a diverse range of victim-survivors.

Table 5.1: Service user questionnaire completion by IDVA scheme

IDVA scheme	N	% of service users
DVSS	26	10.9
Nia	16	8.0
NAADV	18	14.2
REACH	13	7.1
Total	73	9.8

This chapter presents findings from service users, covering: profile; experiences of violence; impact of living with violence; referral routes; help seeking patterns; first impressions of IDVAs; understandings of the IDVA role; contact with IDVAs; risk assessment; knowledge of MARAC process and outcomes; helpful and important IDVA actions; enhanced safety; IDVA interpersonal skills; experiences of the criminal justice system; areas for improvement and hopes for the future.

Profile

All bar one of the service users who returned questionnaires were women, with ages ranging from 15-57 years (mean = 33 years). Equal proportions were employed (n=26, 13 full-time and 13 part time) as unemployed (n=24), with 16 having caring responsibilities that precluded paid employment and five being students. This is a larger proportion in employment than that of the total sample (see Chapter Four).

This sample is disproportionately BME, compared to the overall profile (see Chapter Four), with a quarter white British and two thirds (65.4%, n=48) from BME communities.

Table 5.2: Ethnicity of service users who completed questionnaires

Ethnicity	N	%
White British	20	27.4
White Other	12	16.4
Black African	10	13.7
Asian British	5	6.8
Mixed	4	5.5
Black British	3	4.1
White Irish	3	4.1
Asian Indian	3	4.1
Asian Pakistani	2	2.7
Asian Other	2	2.7
Black Caribbean	1	1.4
Black Other	1	1.4
Asian Bangladeshi	1	1.4
Other	5	6.8
Missing	1	1.4
Total	73	100

Almost all (n=69, 97.1%)[25] perpetrators were men, relationships varying from husband (n=28, 39.4%); ex partner (n=24, 33.8%); partner (n=20, 28.2%) and two family members (son and father of husband). Both female perpetrators were current/ex partners of female victim-survivors.

Experiences of violence

The length of violence varied widely (see Table 5.3), but the most common time spans were one to three years and four to ten years. However, for over a quarter (n=21, 28.8%), the violence had lasted less than a year, suggesting there is early intervention taking place through IDVA schemes, and that some are seeking/accepting help at earlier points than recorded in previous research (Hanmer, 1995). Responses here reflect those from the total sample (see Chapter Four).

[25] Two missing responses.

Table 5.3: How Long Violence Occurring

Length of time	N
Less than 6 months	6
6 months to a year	15
1-3 years	21
4-10 years	21
More than 10 years	9
Missing	1
Total	73

Service users were asked to identify the forms of violence they experienced (physical, mental/ emotional, sexual) and with what frequency (often, sometimes, never). Table 5.4 summarises the data.

Table 5.4: Frequency of Forms of Violence

Frequency	Physical	Mental/ emotional	Sexual
Often	32	56	12
Sometimes	31	14	17
Never	3	0	22
Missing	7	3	22

* N=70 who completed this question

Emotional abuse affected all 70 service users who completed this question with three saying they had never experienced physical violence. This chimes with research demonstrating the significance of patterns of coercive control in domestic violence (Stark, 2007), and suggestions that constructing domestic violence as a duality of physical and psychological abuse is problematic since the latter is always present (Radford, 2003). It also raises the issue of limitations of some risk assessment tools which emphasise physical assault, and shows the inadequacy of police assessments that privilege the use of weapons when determining risk.

It is of interest that only a third report no sexual violence, albeit that this also has the highest rate of missing data. As we noted in Chapter Three, there is a climate of shame surrounding sexual violence that inhibits disclosure. One service user here described rape as 'one of the worst' impacts of violence.

As part of exploring points of intervention that may inform IDVA models, service users were asked how many incidents of physical/sexual violence they experienced before contact with IDVAs (see table 5.5).

Table 5.5: Number of incidents before help sought

Number of incidents	N
None	1
Less than five	15
6-10	7
10-20	7
21-30	7
31-40	1
More than 40	1
Too many to count	13
Missing	21
Total	73

While some experienced more incidents than they could count, others had sought/accepted help at an early stage. It is worth noting here that over half of those answering this question (n=30, 57.8%) had experienced less than 20 incidents. This is considerably less than the widely cited 35 incidents that is regularly incorporated into policy documents, despite being two decades old.

For two thirds of service users (n=48, 67.6%)[26], the violence had become more serious and had increased in frequency (n=44, 64.7%) in the month before they had contact with IDVAs[27].

Living with violence

Service users were asked how the violence had affected them. All 73 responded to this question, and only two stated that it had not affected them at all. For the majority the impacts of living with violence were reported as a range of emotional legacies, including: depression; a lack of confidence and self-esteem; mistrust of others; fear; shame; sleeplessness; weight loss; feeling unsafe and isolation.

> I felt bad about myself all of the time, felt it was my fault and I was to blame, I have sleepless nights and am scared a lot *(SU 12, REACH).*

> It has affected me emotionally and physically. It has made me lose confidence in my selfhood and instilled fear into me *(SU 2, NAADV).*

> It has made me a very insecure person. I suffer from a lot of anxiety attacks. I get frightened and stressed quickly *(SU 14, NAADV).*

> I am unable to sleep, had to move away to a refuge, family disowned me as I left my husband and brought shame to them *(SU 8, REACH).*

> Shattered my confidence in people, I do not trust anyone anymore, it has affected my relationship with my children *(SU 10, REACH).*

> I'm completely withdrawn and half the person I used to be *(SU 16, DVSS).*

> I was like a prisoner in the house, I can't communicate with society. I don't know how to use transport or go anywhere *(SU 4, nia).*

[26] Two missing responses.

[27] Five missing responses.

> No confidence, forgot how the world is like, forgot how to socialise with people *(SU 15, NAADV).*
>
> [When I go outside] sometimes I'm checking my body and I'm scared because I was thinking that my husband knows which place I go and which road I am using. Sometimes I am scared and I don't know what to do *(SU 22, DVSS).*

These were, for many, compounded by material consequences, including: injuries; infertility; losing their home and support networks; being unable to work; impacts on relationships with their children; Social Services involvements. These accounts will not surprise those who understand the ways in which domestic violence undermines selfhood. It is the debilitating effects of routine demeaning, often in front of children (Mullender et al, 2002) that undermines women's capacity to act, diminishing what has been termed 'space for action' (Lundgren, 1998). Recognising that women's abilities to parent, take assertive actions such as seeking support, applying for protection orders or supporting a prosecution, are progressively reduced within the process of domestic violence is critical for professionals. Yet as Chapter Seven on MARACs demonstrates this was rarely in evidence outside of the specialised DV support services, including the IDVA schemes. Failure to understand this basic issue can result in unreasonable expectations being placed on women to take actions which they have neither the strength nor confidence to do. Empowerment, in this context, involved providing support and information that extends women's space for action.

Routes into support

Service users were asked to identify how they heard about IDVA schemes (see table 5.6). The majority (n=41) were told about the IDVA schemes by the police, with other sources including a range of community based professionals such as GPs, Social Services, solicitor, housing officers and health visitors. Parallels are evident here with the referral sources presented in Chapter Four, including the connections with the locations of the four schemes.

Table 5.6: How service users heard about IDVA schemes

Referral route*	DVSS	nia	NAADV	REACH	TOTAL
Police	18	7	15	1	41
Victim Support	3	6	4	1	14
A&E	1	0	0	9	10
Social Services	6	0	0	1	7
GP	0	4	0	0	4
DV organisation	1	0	0	1	2
Friend	1	1	0	0	2
Housing officer	1	1	0	0	2
Solicitor	1	1	0	0	2
Children's Centre	0	0	1	0	1
Contact from IDVAs	1	0	0	0	1

Referral route*	DVSS	nia	NAADV	REACH	TOTAL
Health Visitor	1	0	0	0	1
MARAC	1	0	0	0	1
Total	35	20	20	13	88

* Multiple responses possible

The diversity in referral pathways is further evidence of the need for information about specialised support to be widely available in community settings, (Regan et al, 2003) and for local professionals to be aware of such services.

Help seeking patterns

One of the issues that we hoped to explore through the evaluation was patterns of help seeking, especially the extent to which scheme service users reflect patterns previously reported in literature. That women typically initially approach a friend or family member, often female, for help rather than a formal agency is well documented in research (McGibbon et al, 1989; Mooney 1994: Kelly 1999; Bagshaw et al 2000; Wilcox, 2000). Reactions from friends and family affect victim-survivors' further actions (Goodkind et al, 2003). However a limited understanding of the dynamics of intimate partner violence (Bagshaw et al, 2000), and a lack of knowledge of rights (Kelly, 1996) can limit effectiveness, particularly since responses from informal sources can influence decisions to access formal agencies (Regan et al, 2007). A recent exploratory study of domestic homicides found that while informal networks knew more about the violence than agencies 'they lacked the knowledge and resources to interpret this and they were thus prevented from enhancing protection… There is strong evidence of the need to deepen public understanding of the dynamics of coercive control' (Regan et al, 2007: 7). However the current policy construction of 'communities' in the CCR means that work with informal networks has been neglected.

Service users were asked if they had told anyone about the violence, who this was, if they had approached organisations, and how helpful sources of support had been. The majority had told someone prior to seeking support from the IDVAs. Over half (n=40, 55.6%) had told several people, almost a quarter (n=17, 23.6%) told one person, with a fifth (n=15, 20.8%) not having told anyone (one did not answer this question). Friends and family were the most common source of help, both singly (n=42, 73.7% of all that responded) and in combination with colleagues and other professionals (n=8, 14.0%). The most common responses from family and friends were offers of support, advice to leave or seek help from the police and shock/anger. Smaller numbers of service users also reported reactions of helplessness/impotence; worry and concern; disbelief; blame for provoking. Very few reported interventions with the perpetrator.

Over half (52.1%, n=38) had not approached an organisation for help before contact with the IDVA scheme. This suggests that the high risk model needs to be tempered with recognition that IDVAs are also offering a first port of entry into formal support services. Risk assessments may, therefore, be a second step with service users who are for the first time naming, recognising and understanding domestic violence.

Of the 35 respondents who had approached an organisation for help, almost half (n=15) had contacted one, a quarter (n=9) two to three services and four had contacted four or more services. Exploring experiences of agency responses is crucial to contextualise service users' assessments of the IDVA scheme, as disclosing to professionals renders victim-survivors vulnerable to their judgements (Bacchus et al, 2007). Unhelpful responses are likely to delay or prevent subsequent help seeking attempts (ibid), not to mention result in mistrust and defensiveness as experiences of unhelpfulness multiply.

Service users were asked to rate the helpfulness of responses from agencies they had contacted, and table 9 in Appendix 3 shows the responses. Police and Social Services are reported as equally helpful and unhelpful, but GPs were more commonly regarded as helpful. More consistency was experienced from voluntary organisations, with a local Asian women's association and a homelessness organisation not helpful, but health-based agencies and Victim Support regarded as largely helpful. Interestingly, specialised domestic violence organisations were only slightly more likely to be regarded as helpful than unhelpful, although only eight had had any contact.

Overall, these victim-survivors have been poorly served by local professionals, including by organisations that might be expected to respond more knowledgably. This makes IDVA work in seeking to secure entitlements for victim-survivors from agencies even more acute.

How IDVAs differ from previous support

In Chapter Three we discussed that IDVAs and stakeholders saw IDVAs as distinctive because of the focus on high risk, point of intervention and multi-agency accountability.

With service users we sought to explore if they perceived IDVAs to be different from previous help. As only a minority had received support from specialised domestic violence services before contact with the IDVA schemes, most of these responses refer to other local agencies. The most common finding was that IDVAs were more helpful (n=12), in the following specific ways: more supportive (n=9); had a specialised understanding of domestic violence (n=5); proactive (n=2); and non-judgemental (n=2).

> I feel safe and supported, not judged *(SU 11, REACH).*

> They are always there for people and they contact you first and really do care *(SU 2, NAADV).*

> What is said by worker gets done *(SU 13, REACH).*

One respondent compared support from IDVAs to that from a Social Services department.

> They focussed not just on children but also on me, Social Services focussed just on the children. DVSS helped me and the children to have a better life *(SU 24, DVSS).*

This service user further illustrates the failure of Social Services to recognise that protecting women can protect children (Kelly, 1996), an approach that IDVAs across the four schemes reported was almost entirely lacking (see Chapter Six).

First impressions

Given the newness of the IDVA model and the schemes in their local contexts, we asked about first impressions of the service. The overwhelming majority were positive.

> Very knowledgeable and informative, kind and understanding *(SU 10, nia).*

> Extremely good, friendly, welcoming, they made me feel at ease. They did not blame me *(SU 10, NAADV).*

> I felt good there was help and support available. Such kind and understanding help who were there for me through the whole ordeal *(SU 14, NAADV).*

> There for me whatever I decided to do, very very helpful *(SU 24, DVSS).*

> That you had support and they would help in all they could – most of all they CARED *(SU 12, nia, original emphasis).*

> They could offer me exactly what I needed, because I wanted protection going to the court… they were taking it very seriously *(SU 11, NAADV).*

> It was really welcoming, I mean I was still covered in bruises and everything and no one was looking at me *(SU 13, NAADV)*

Common themes here were openness, feeling they were not being judged, availability and working with women on their needs.

Several were unaware that such support was available and reported that had they known, they would have reached out much earlier, confirming the need for IDVAs to have a strong local profile.

> If I knew organisations like this before, I would not suffer like I did *(SU 6, NAADV).*

> If I had known I would have got this much help I would have felt I could contact someone before *(SU 8, REACH).*

> They were brilliant and I didn't realise help was around. It helps you realise you're not on your own because that is how you feel *(SU 9, DVSS).*

> I was surprised, I was surprised that they could do so much. And it was dramatic, they saw it as a valuable case, not – you know, not something that's like "Oh we can't help you 'cause it's no big deal"… I didn't think that I was entitled to it, because it more mental violence than physical *(SU 7, DVSS).*

> I was pleasantly surprised by help, was pleased she called after the incident and helped as in the past I had to find my own help *(SU 19, DVSS).*

Here we see the welcoming of pro-activity and the importance of in-depth understandings of the forms domestic violence takes. However, some had had ambivalent initial impressions, based on fear and distrust.

> I was upset and scared and didn't know what to say *(SU 2, REACH).*

> My first impression was that I wasn't going to like it. She kept telling me I was in danger and that I needed to get away from him *(SU 2, DVSS).*

> I thought I would compromise myself if I ever trust any other people *(SU 5, NAADV).*

One service user reported an initially favourable first impression that was tempered later by a lack of local resources and effective responses from the criminal justice system.

> First impressions were very positive. I learnt afterwards that their service as well as the police are very weak and cannot really help *(SU 25, DVSS).*

This example crystallises one of the key aims of our evaluation – to track how the multi-agency foundation of the Co-ordinated Community Response (CCR) enables IDVAs to secure appropriate resources for service users. For this service user, advocacy in practice failed to deliver – demonstrating that effective and successful interventions are indeed 'a direct reflection of the strength of their local multi-agency partnerships' (Howarth et al, 2009: 99).

Understanding the IDVA role

A majority (n=67, 91.8%) reported that the IDVA explained their role and what was understood included: independence; specialised support on domestic violence; listening; advice; confidentiality; referral to other organisations and ensuring safety. A minority also referred to support through the criminal justice system process/court cases and explaining options under the law.

> Someone who would try and support me with any problems and try and solve them *(SU 3, nia).*

> She is there to offer support when I feel scared and feel that I need help and refers me to the right organisations *(SU 3, REACH).*

> She gave me help, didn't judge, listened and let me cry the hurt out *(SU 16, nia).*

These responses indicate that IDVAs emphasise emotional support when describing their role to service users, and also demonstrated the 'empowerment through knowledge' theme.

> To help me and make me understand about people who are violent *(SU 1, DVSS).*

> To help victims of domestic violence not to suffer in silence. To support them in overcoming their problems *(SU 2, NAADV).*

> Explaining my choices *(SU 21, DVSS).*

In contrast, one respondent said that the police 'didn't explain the role very well, they made it sound like a counselling service' *(SU 14, DVSS).*

Contact with IDVAs

Service users were asked how many times they had had contact with the IDVAs, and responses were coded into categories as shown in table 5.7.

Table 5.7: Amount of contact with IDVAs

Number of contacts	N
1-5	15
6-10	10
11-20	6
Over 20	8
More than can count	3
A lot	17
A few	4

This data indicates that IDVA interventions are often intensive, involving multiple contacts, a finding echoed by a recent national evaluation (Howarth et al, 2009). Intensity of support is also linked to better outcomes for service users in terms of safety (ibid), reinforcing accounts from IDVAs in Chapter Three that there are no 'quick fixes'. The intensity of IDVA work includes liaison with other agencies and attending meetings (Bacchus et al, 2007).

Almost half of service users reported contact being mainly over the phone (n=32, 45.1%) or equal between telephone contact and face to face (n=33, 46.5%), with only a minority (n=6) having mainly contact with IDVAs in person. Given the prominence afforded to pro-activity, we also explored who made contact first and service users' preferences. In over half of responses (n=40, 56.2%), IDVAs made contact first, with about a third equal (n=26, 35.6%) and only four respondents reporting that they usually initiated contact. Two fifths (n=29, 39.7%) preferred IDVAs making contact, while over half (n=40, 55.6%) did not have a preference. This confirms previous research that victim-survivors welcome proactive contact in the aftermath of violence (Kelly et al, 2005; Kelly, 1999).

> They kept calling. When you're very down you don't feel like reaching out to anyone *(SU 24, DVSS).*

> When you're in that sort of situation, you don't think straight, and to have somebody say "Right, well I can arrange this for you, I can do this and I can help you with that" is like, great, fine. I was in a relationship for fifteen years with the father of my two children, he never so much as raised his voice to me. And then all of a sudden I was with this person who was extremely domineering and violent and so I've not experienced

> needing help. And to have that help there – it's what you need. Definitely *(SU 9, NAADV).*

The support options that service users reported on initial contact with the schemes illustrates again the blend of emotional and practical support that characterises advocacy: the most common being 'discussing options' and 'just talking' (see table 5.8). The 'something else' option was chosen to refer to emotional support – knowing that they could talk at any time and feeling comfortable talking.

Table 5.8: Actions at first contact

Actions	N*
Discussed options	53
Just talked	52
Arranged to meet again	46
Safety plan	35
Given contacts for other organisations	30
Arranged for IDVA to accompany to an appointment	20
Found a refuge place	10

* Multiple responses possible

Some also referred to IDVAs contacting organisations on their behalf, arranging to visit court together, and dialogue about domestic violence using the 'power and control' wheel.

> She was thinking clearly what to do, gave me support, advised me, helped me find and contact the necessary organisations. She wrote me letters to the organisations *(SU 13, DVSS).*

> She went through my situation and she explained the [Power and Control] wheel to me and pointed to the different things she felt I was experiencing *(SU 2, DVSS).*

> She made me realise how I took the relationship and showed me how it should be different and not every relationship is like this *(SU 9, DVSS).*

Again these accounts are evidence of the advocacy in practice and 'empowerment through knowledge' themes. It is apparent that a proportion of victim-survivors valued someone else naming violence (Kelly, 1999).

While referrals to other agencies are not 'outcomes' in that we do not know if any action resulted from referrals or if this was useful to victim-survivors, they offer indications of how IDVAs draw on multi-agency working as part of advocating for service users. Table 5.9 presents data on referrals that women reported.

Table 5.9: Referrals to other agencies

Referral	N*
Solicitor	32
Counselling	22
Other domestic violence service	14
Medical appointments including mental health	13
Refuge	12
Police	12
Social Services with respect to children	8
Social Services for victim-survivor needs	7
Sanctuary scheme	6
Drugs and alcohol service	7
Housing	3
MARAC	2
Amnesty International	1
Pet fostering	1

* Multiple responses possible

The most common referral was to solicitors, perhaps reflecting that legal advice/representation is not a service that IDVAs provide. Similarly the referrals to the police represent IDVAs encouraging/enabling victim-survivors to make official reports. There is also potential ambiguity here over how service users understand the term referral, as an action they are encouraged to take or a formal signposting to another service. While not possible to determine if the referrals are based on recommendations from IDVAs or requests from service users, the emphasis placed by IDVAs on victim-survivor centred approaches (see Chapter Three) strongly suggests the latter is more likely. A wide range of services are thus deployed in response to service user need, encompassing emotional and practical support. These include referrals to counselling, medical appointments and drug and alcohol services as well as other specialised domestic violence services. The smaller numbers of referrals to housing departments reflects the fact that IDVAs undertake the bulk of such liaison directly as part of their advocacy. In only a minority of cases was it necessary for IDVAs to make referrals to Social Services with respect to the welfare of children. A larger number were referred to refuges, reinforcing the continuing need for a range of provision.

Risk assessment

Service users were also asked if IDVAs talked about safety and risk. We are aware that this can take place as part of wider rapport building and therefore may be introduced unobtrusively.

Nevertheless given the prominence of addressing risk in IDVA work and the aim of schemes to empower victim-survivors, frank discussions of safety and risk should be taking place.

Almost all (n=67) service users indicated that the IDVA had talked about safety and/or risk, with two thirds (n=45) indicating this happened at the first meeting, and four at the second meeting. For six service users, discussions about risk had occurred 'throughout', and in one case a risk assessment was undertaken after the woman was physically attacked in court by the perpetrator. This confirms the accounts from IDVAs that risk assessment is a dynamic process.

Research on victim-survivors' perceptions of risk (compared to that of professionals) emphasises the need for their views to be prioritised (Weisz et al, 2000), but this is not without debate given that coercive control by perpetrators can affect ability to identify danger (Campbell, 2004). Recent studies suggest that victims are as likely to underestimate as overestimate risk and danger (Bell et al, 2008). We explored the congruence between victim-survivor and IDVA views here to develop a picture of how victim-survivors assessed danger and how the process of risk assessment influences their perceptions. For many, this was an essential first step to enabling them to end abusive relationships and take protective actions.

Almost two thirds of service users (n=36, 59.0%)[28] knew that they had been assessed as high risk, six (9.8%) as medium risk, another six not knowing and 13 (21.3%) unsure. It is not possible to know if the missing responses and those that did not know/were unsure are service users that did not have a risk assessment carried out (see Chapter Four) or were not informed of risk assessment outcomes. Of those that responded to the question whether the IDVA risk assessment was the same as their own[29], two thirds (n=36, 64.3%) reported that it was, and a third (n=20, 35.7%) that it differed. Here over three quarters (n=14, 77.8%) thought they were at lower risk.

Service users perceptions focussed on an absence of physical violence and becoming desensitised to threats and danger.

> I was exposed to emotional and physical abuse for a long time. There was a point I could not see my ex partner's behaviour being abnormal, only later I realised I was putting up with too much *(SU 13, DVSS).*

For some the dialogue about risk was initially shocking but then led to reflection.

> I was shocked when I found out the IDVA had me as high risk, I did not realise and it made me think about my situation *(SU 11, REACH).*

> It was a shock to know I was high risk, just living with my husband and not knowing the danger. I was very sorry to find out the real risks but it helped me too *(SU 12, REACH).*

> I've always underestimated it, but it's good because it does make you realise – you don't look at it from anyone else's point of view, you think people are always going to underestimate it, but doing anything like that, it highlights how bad it is really *(SU 17, DVSS).*

Some that reported knowing they were at high risk drew on their knowledge of perpetrators' behaviour in making their assessments (see also Cattaneo, 2007).

> I knew what he was capable of *(SU 3, NAADV).*

> I knew I was at high risk after being assaulted to the head and strangled *(SU 13, REACH).*

As a result of conversations about safety and risk, 59 service users specified actions that had been suggested by IDVAs (see table 5.10).

[28] Twelve missing responses.

[29] Seventeen missing responses.

Table 5.10: Actions suggested by IDVAs in response to safety and risk

Actions	N*
Referral to other agencies	13
Sanctuary scheme	13
Move house	12
Safety planning/measures	11
Apply for civil protection orders	10
Criminal justice	3
Addressing child contact	2
Support around existing actions	2

*Multiple responses possible.

Of the referrals to other agencies, four specified refuge, three solicitors and one each to Social Services, the local authority no recourse team and MARAC. Safety planning/measures included flagging addresses with police, changes to routine and developing escape plans. Overall actions suggested here reflect advocacy in practice, with referrals to other agencies the most common and issues of safety addressed both in safety planning and Sanctuary schemes (the prominence of the latter is probably due to the proportion of respondents from DVSS, who have an IDVA focussed on liaison with the local Sanctuary scheme). It is of note that civil protection remedies considerably outnumber actions related to seeking criminal justice redress. Findings with respect to moving house and enhancing security at victim-survivors' homes through the Sanctuary scheme echo recent research which also found changes in housing situations to be the most common outcome of IDVA work reported by service users (Howarth et al, 2009). That IDVAs consistently identified housing departments as one of the most difficult agencies with which to secure victim-survivors' entitlements (see Chapter Three), these outcomes were almost certainly the result of intensive negotiation.

Only three service users reported that actions were not helpful, with three not sure and 57 finding them helpful. When probed about what was helpful, key themes were: advice and information; knowing that support was available alleviating a sense of isolation; space to think and name violence. Some also identified the ability of IDVAs to secure their entitlements from other agencies.

> Before I twice asked for help from Social Services but I was refused. This time I had protection from nia. Social services immediately responded to the request from IDVA and helped me *(SU 6, nia).*

Knowledge of MARACs

Keeping service users informed about the MARAC process was referred to by IDVAs as one of the ways in which they advocate for their service users. However, of the 73 questionnaires completed, only 30 women knew that their case had been referred to the MARAC, with 33 unsure and eight not knowing (two missing responses here). Only 16 responded that they knew the outcome, and one stated that they had 'no idea'. This suggests gaps in communication about the MARAC process that not only contravenes the good practice model promoted by CAADA, but it also sits uneasily with the goal of empowering women. The celebrated notion that IDVAs are

respectful of women's capacity to make decisions and enable her to be in charge of her future, is potentially compromised here. Focus within the MARAC on safety and risk reduction, rather than empowerment, is possibly in tension with the approach of IDVA schemes. While attendance may be inappropriate due to the volume of cases and speed with which they are dealt with, claims to place women's voices at the centre of statutory processes ring hollow if women are uninformed about them. Some of this may reflect the account from an IDVA that when they contact victim-survivors after a MARAC meeting for the first time, 'nine of ten cases I ring won't know that their case has been referred' (IDVA, DVSS, R2).

Details of outcomes following MARAC offered by respondents included: house move (n=4); liaison with children's schools (n=3); referral to refuge (n=2); recognition of high risk (n=2); address flagged with police (n=2); ongoing IDVA support (n=1); reduction in risk (n=1); information sharing (n=1); linked to other services (n=1)[30]. It is debatable whether any of these outcomes require a MARAC for them to be actioned.

Service users were also asked how they felt about their case being discussed at MARAC when they are not present. Twenty-nine responded that they did not mind, for two this was explicitly based on trust in IDVAs to protect their best interests.

> Because I have confidence in the IDVA, my presence would not have made any difference in hearing my case being discussed *(SU 18, NAADV).*

> Did not bother me, I trusted my support worker *(SU 9, REACH).*

This underscores the role of IDVAs in representing victim-survivors at the MARAC. However, as IDVAs reported and our observations confirmed a lack of an 'inclusive climate' (Allen, 2005) and recognition of their expertise and representative position, the process of MARACs does not always facilitate this role.

Three were not sure, and some expressed ambivalence even when they said they were 'fine' about it, pondering what had been said and wanting to know the outcome. Five (all women) were not happy about their experiences and personal information being discussed among agencies at the MARAC.

> It makes me feel very bad *(SU 5, DVSS).*

> I'd like to have been there to hear for myself *(SU 10, nia).*

> I understand why I was not present, would have liked to be there, but I know it would be difficult to hear the information at the meeting *(SU 13, REACH).*

> I would have liked to be present at the meeting as I feel that if the person who experienced the violence attended it would have more of an impact *(SU 10, REACH).*

There are important questions raised here about privacy and sharing of personal information that underscore the importance of addressing consent, as discussed in Chapter Seven. While objections are in the minority, they nevertheless indicate that at least some women find the MARAC process intrusive and excluding.

Helpful and important actions

In order to assess outcomes of the IDVA model, service users were asked what they found helpful (see table 5.11).

Table 5.11: Helpful actions from IDVAs

Helpful actions	N*
Believing me/being there/non-judgemental listening	14
Everything	12

[30] Multiple responses possible.

Helpful actions	N*
Advice/information	11
Referrals to other agencies	6
Giving options	4
Attending meetings/appointments	3
Help to move house	3
Keeping safe	2
Following up actions/proactive contact	2

* Multiple responses possible

The most helpful was simply 'being there', encompassing a non-judgemental attitude, listening and believing victim-survivors' accounts, which made women feel that they were in control of their own decision-making.

> Whenever I call she was there for me whenever I need her. She was there on my behalf, she never pushed me to do anything *(SU 23, DVSS).*

Equipping victim-survivors with sufficient knowledge and options to live free from violence – empowerment through knowledge – was a common theme.

> Not to feel guilty about reporting to the police the husband. What to expect in court and from the defendants solicitors, court accompaniment *(SU 2, NAADV).*

> Advised of what my orders meant in normal non legal jargon talk and what I could do in relation to access for my son and stopping it *(SU 7, DVSS).*

> I didn't really know what to ask for and she asked me, what do you want, what are you aiming for, and I didn't know what I was aiming for really. All I knew is like I'd tell them the story and they'd give me options, sit down with me and explain to me things that meant things, and words that I didn't understand. She taught me loads of them. It was always about important things like that *(SU 14, nia).*

Again, having accurate information put women back at the centre of their lives. Many service users simply described 'everything' as helpful.

> All the information was helpful as I was in fear at the time and knew I had help and support *(SU 8, NAADV).*

> Everything has been helpful, if it wasn't for REACH I'd still be in the same situation *(SU 9, REACH).*

The importance of proactive contact and following through on actions has also been highlighted by previous evaluations of domestic violence advocacy projects (Kelly, 1999; Bacchus et al, 2007).

Four fifths (n=58, 79.5%) respondents said that it mattered that the IDVA was female, citing trust and the importance of feeling comfortable and that a woman would not judge. Many noted that this was particularly important after being subjected to violence by a man and some were explicit that they would have not spoken to a male IDVA.

> [It is] easier to talk to [a woman] after experiencing DV from a male *(SU 3, DVSS).*

> Because of what my ex partner did to me I prefer to speak to a female *(SU 2, REACH).*

> I've never really been nervous of men but when you are being abused by a man and you flee, you're scared and an emotional wreck and petrified of men, so you feel safe dealing with women until you begin to heal *(SU 12, nia).*

Only four service users reported actions that had were not helpful. For one this was related to not being contacted by the IDVAs for over a week following a visit to A&E, which heightened her sense of isolation, and being given a copy of the Power and Control wheel further into her support journey with the IDVA, when she thought it would have been helpful to have this earlier. Another referred to the constraints on IDVAs' ability to meet her needs because of a lack of refuge space, and a third to a referral to Social Services for support with childcare that she perceived as unhelpful out of fear that she would be suspected of harming her children. The fourth felt under pressure to take particular actions.

> She was very in panic for me to leave. Today I can understand why. She was just helping me to be ok *(SU 4, REACH).*

This suggests that discussions of risk and safety can make some victim-survivors feel less safe and influence their perception of support services. Table 10 in Appendix 3 details responses to a question that set out the key roles of IDVAs and asked which had been the most important. The core practices of advocacy were the most valued: listening, information about options, safety planning and keeping victim-survivors up to date on progress.

The questionnaire also sought to explore whether support from IDVAs had enhanced knowledge of rights and confidence in liaising with other agencies: the 'empowerment through knowledge' nexus. The majority (n=54, of 61) reported increased confidence in liaising with other agencies, and slightly smaller proportions with respect to the police (n=51 of 61), courts (n=45 of 56), and prosecutors (n=36 of 50). Three quarters (41 of 52) were more confident in their knowledge of protection orders and 49 of 61 about rights under the law. This is robust evidence that IDVA aims of empowerment through knowledge were realised and is a positive outcome of IDVA schemes.

Enhanced safety

How to measure victim safety is a contested issue for evaluations of domestic violence interventions that are seeking to identify the impact of a specific model (Shepard, 1999), and the evidence base on the impact of advocacy on safety is in its infancy (Howarth et al, 2009). We used two measures: if service users feel safer and if there had been further incidents of domestic violence since they had begun contact with the scheme.

Significantly, the majority stated (n=60, 64.3%) that they did feel at least a little safer as a result of support from IDVAs (see Table 5.12).

Table 5.12: Feeling safer as a result of support of IDVA support

	N	%
Yes	45	64.8
A little	15	21.1
No difference	6	8.5
Less safe	2	2.8
Not sure	2	2.8
Total	70	100

Two thirds (n=47, 65.3%) had also not experienced any further violence since they began contact with the IDVA scheme (see table 5.13).

Almost all of the 25 who had suffered further incidents (n=23, 92.0%) had informed IDVAs, with a further service user thinking about them. Responses from IDVAs to disclosures of further incidents comprised: practical help that included referrals to other agencies, MARAC and attempts to find safe accommodation (n=9); advice, particularly about criminal and civil justice options (n=7); talking/listening (n=4).

Table 5.13: Incidents of violence since contact with the scheme

	N	%
No	47	65.3
Yes, one	7	9.6
Yes, a few	13	17.8
Yes, several	5	6.8
Total	72	100

This highlights a critical but complex issue in evaluating interventions like IDVAs, between 'being' and 'feeling' safer. The absence of violence suggests that two thirds of service users had been safe for the period of time they were tracked for the evaluation. But, as we noted earlier, the work of IDVAs in moving women from minimising violence and danger to taking it seriously, and even designating some as 'high risk' may – at least in the short term – heighten a sense of *unsafety*. Alternatively, advocacy work that makes someone aware that they have options may result in 'feeling' safer despite the recurrence of violence. A larger sample than is available here is needed in order to explore these complex correlations.

Interpersonal skills

Some service users pointed out the importance of the interpersonal skills of the IDVA that made them comfortable and thus able to seek and accept support.

> I found her very, very approachable very friendly, 'cause I was a bit hard at the beginning, like not wanting to talk with anybody. But then I explained to her why, it was nothing personal to her… I'm not a very easy person to speak out, but she managed to somehow, to relax me *(SU 5, NAADV).*

> At first I didn't want to talk but once I spoke to the IDVA, I felt relaxed and able to share my experience *(SU 11, DVSS).*

Interpersonal skills and supportive attitudes have particular significance given that almost all service users identified emotional impacts of the violence that had diminished their confidence and made contact with others difficult and anxiety provoking. For those where this was early in the process of violence, naming what was happening carried additional weight.

One prominent theme of this in accounts from service users centred on a sense of shame. A recent study from Sweden conceptualises this as 'gendered shame', complicated by social expectations on women to keep families together but also to extricate themselves from violence (Enander, 2010). Shame is therefore attributed to 'staying or allowing' violence, being fooled into believing it would not happen again, 'giving in' to perpetrators and being judged by others (ibid). In this context, being able to put victim-survivors at ease and shift self-blame are vital skills, as 'women [who have experienced violence and] who conceptualize themselves or their actions as

stupid are still plagued by negative feelings that may affect their self-esteem and sense of well-being' (Enander, 2010: 7). One service user described this succinctly:

> It made me feel ashamed, embarrassed, which led me to have no self confidence *(SU 10, NAADV).*

To be respectful and knowledgeable about these impacts is in itself empowering, and is what specialised services bring to their engagements with victim-survivors.

> They listened and they spoke to me, not at me. They didn't look down their nose at me, they didn't blame me for staying for as long as I did *(SU 13, NAADV).*

> I just feel stupid now but she has helped me understand this is not unusual *(SU 7, nia).*

Finally, service users were asked to rate the IDVAs attitude and behaviour using a scale of 1-5 on the following: respectful; practical; supportive; non-judgmental. The vast majority found the IDVAs very respectful (n=68)[31], very practical (n=64)[32], non-judgmental (n=63)[33] and supportive (n=66)[34]. The remaining responses were still positive, at points 2 or 3 on the scale, with only one service user describing the IDVA as disrespectful and not practical, and two as not supportive and judgemental. This is very strong endorsement of IDVA practice; encompassing a culture of belief, enabling women to name violence and prioritise their own safety, and 'standing alongside' them to support an exploration of options to decrease risk. Research from the U.S. found that where service users perceived the attitude of staff at specialised support services to be positive and felt listened to, they were more likely to contact them again if needed (Zweig & Burt, 2007).

Experiences of the criminal justice system

At the inception of the four schemes, the IDVA model was firmly embedded in the criminal justice system, although as we noted in Chapter Three, this diminished in importance over the evaluation period as the schemes developed a more holistic approach to advocacy. However, that two of the schemes have formal links with law enforcement – NAADV through their support role at the SDVC and DVSS as they are based in a police station – the questionnaire explored service users' perceptions and experiences of the criminal justice system prior to and throughout their contact with IDVAs.

Over three quarters (n=52, 78.8%) stated that they had reported the incident that happened just before contact with IDVAs to the police, with another one reported by someone else (see table 11, Appendix 3). Over three quarters of service users (77.8%) had attempted to seek help by calling the police on at least one occasion, with half (51.4%) contacting them a few or several times. In over two thirds of cases (69.4%), the perpetrator was arrested at least once although convicted in only a third (34.7%).

> I think if the police were more willing to help, if they'd looked like and felt like and acted like they wanted to help, I would've known what the hell was going on… I'd just been practically stabbed and it was me running around to get help *(SU 17, NAADV).*

Half had made a statement to the police and subsequently withdrawn it (see table 11, Appendix 3). While withdrawal of statements is often regarded as a failure of the criminal justice system, this depends on knowing what the justice goals are at the time (Kelly et al, 2008). Hence a further question explored why statements were withdrawn, and service users offered the following responses: fear (n=11); believing it would not happen again (n=5); not understanding/confused about process (n=2); pressured to do so (n=2, one by in-laws and one by perpetrator); not wanting to send the children's father to prison (n=2); isolation (n=1) and reconciliation (n=1). Some service users gave multiple reasons, demonstrating the complexity of factors that influence women's decision making, alongside gendered shame (Enander, 2010).

> My partner would swear not to hit me again, I did not want to break up the family, I did not want to live in shame in the eyes of my community *(SU 14, NAADV).*

That fear was the most common reason for withdrawing statements is significant here, particularly as in another question about whether or not IDVAs could do anything to make a difference, two specified that IDVA support had enabled them to continue with prosecutions.

[31] Two missing responses.

[32] Three missing responses.

[33] Four missing responses.

[34] Three missing responses.

Almost half of service users (n=31, 44.9%) reported that cases against perpetrators had gone to court (four did not complete this question). In 14 cases the perpetrator was convicted, with four fines; seven custodial sentences; three suspended sentences; one mandated to attend a perpetrator programme and two conditional discharges (multiple responses were possible); in twelve cases perpetrators pled guilty. Three were acquitted, eight cases adjourned and five service users were not sure of the outcome. Fifteen service users reported that they had to give evidence. We also explored sources of support available to them whilst they were in court. Nineteen had someone with them every time, and four sometimes and all described this as helpful, with five not having any support. Of these, 11 had IDVAs with them, six family/friends, two their solicitor and two a worker from Victim Support.

Twenty-four service users indicated that they had been granted a protection order by the court, with 22 feeling safer as a result. Tellingly, three were not sure if they had been granted protection orders, suggesting gaps in communication between criminal justice agencies and victim-survivors. Table 5.14 shows the types of orders according to whether they were granted or rejected.

Table 5.14: Protection orders: granted and rejected

Type of order*	Granted	Rejected
Non-molestation	18	0
Occupation	4	3
Harassment	4	0
Contact/residency	2	4
Prohibitive steps	5	0

* Multiple responses possible

Some caution should be exercised here as service users may not have indicated that orders had been rejected, and not all specified which orders had been granted, but nevertheless it is notable that there are no instances reported of non-molestation or harassment orders being rejected.

Two fifths of respondents (n=12, 42.9%) reported that going to court had made them feel safer, but four felt less safe and five perceived no difference. Similarly, Amanda Robinson (2007) found that only a quarter of women attributed increased safety to criminal justice interventions, supporting Robyn Holder's (1999) statement that the criminal justice system is a 'resource not a solution'. For those that did not feel safer, this centred on lack of faith in the criminal justice system to provide effective protection.

> I feel that as he was found not guilty it makes him believe he can get away with it *(SU 9, DVSS).*
>
> He still comes back even though there is an order so I don't feel any safer because he is just so unpredictable *(SU 7, REACH).*
>
> Well, the problem is that even if he gets a guilty verdict not very much happens. Just 'cause although he is breaking the law, with the breach, the law hasn't caught up all round. I mean he could just get a suspended sentence or he could just get a rap on the knuckles *(SU 12, nia).*
>
> I feel less safe because of fear or reprisals from his family, however this will not stop me giving evidence *(SU 10, REACH).*

Lack of support from other points of the CCR undermined confidence in the ability of the CJS to deliver safety.

> The support and reliability of the police and the system in general is very poor. I prefer to walk away than waste my time going any further *(SU 25, DVSS).*

One service user's negative experience underscores the importance of having specialised support workers in court, and the necessity of training magistrates and judges on how domestic violence affects victim-survivors and appropriate ways to deal with this.

> The court were not prepared or trained on domestic violence, I felt violated by them and DEVASTATED *(SU 15 nia, original emphasis).*

For those that did report feeling safer, the process and outcomes of prosecutions were important, both for their own sense of being believed and supported, as well as making perpetrators aware of consequences.

> My husband knows now that if he hits me he will be arrested *(SU 14, nia).*

> The police and NAADV are aware of my problem and I no longer suffer alone. I have people who care for me *(SU 2, NAADV).*

We also asked service users if they were intending to continue with the criminal case, and just under half of those that responded confirmed that they were (n=26), with a quarter (n=12) not sure. Motivations for not continuing included: having moved on; reconciliation with perpetrator or in jail; lack of funding; hoping that perpetrators seek different support. Thus for those that decided not to continue, their reasons demonstrate clearly that alternative resources were in play.

Areas for improvement

Almost all service users (n=66 out of 69 that answered this question) said that they would recommend the IDVA scheme to others (with three not sure). When asked to identify any ways in which the service could be improved, encouragingly, 18 (36.7%) responded that the service did not need any improvements. A fifth (n=10, 20.4%) suggested that the scheme needed more capacity and/or should be more widely available.

> For the people to be full time or have evening support by phone *(SU 12, nia).*

> More staff as I think there are only a few of them, be available in other hospitals *(SU 11, REACH).*

> More of them available and to be stationed at local police stations *(SU 7, DVSS).*

Similarly, two suggested that more accompaniment to appointments would be helpful, something that for all schemes was limited by lack of time. Five service users, and most of those interviewed, highlighted that more publicity was necessary in order to make victim-survivors aware of sources of specialised support.

> I think every woman should be given notice about [IDVAs], because I think the service is good, but we don't know about it until we're actually in that situation, and we're not told about it... So it would be good basically just to know something's there. But when you're in it, and you think "I'm going through this every day," people just want to help, and they don't know of the people that can help. That's the only thing, I think women should really know that there is that help *(SU 17, NAADV).*

> Advertising in women's magazines or schools or nurseries *(SU 4, NAADV)*

> It might have been good if other services had recommended DVSS to me earlier as I might have got help sooner *(SU 16, DVSS).*

We asked service users if they not taken up support from the IDVAs, why. The most common response was because they had enough support (n=17); followed by referred to another organisation (n=5); perpetrator being in prison/mental health unit (n=3); fear that their partners would find out (n=2) and not finding them helpful (n=2). Again in only a minority of cases are there concerns here about high risk women refusing interventions.

Hopes for the future

Finally, service users were asked how they would deal with violence if they experienced it again. Of the 61 responses, almost half (n=27) that they would report it to the police, a quarter (n=16) said they would contact the IDVAs, one in six (n=11) that they would leave, with four stating that they would have not have another relationship, and four not sure. Again, we see some evidence that the role of IDVAs supports engagement with the criminal justice system.

Hopes for the future centred on continued safety and building strength that for many was explicitly bolstered by support from IDVAs, with some speaking hopefully of new opportunities for employment and education.

> [I am] aware of the psychological damage but have become a stronger person and hope to be safe and happy with my children *(SU 11, DVSS).*

> I feel in control now that I know I have the help *(SU 6, DVSS).*

> To rebuild confidence, not allow him to hold me back and find the old me and a new revised me, knowing what I want and will not accept *(SU 10, REACH).*

The following chapter turns to multi-agency work and how IDVAs contribute to the Co-ordinated Community Response to domestic violence.

Chapter 6:

Locating IDVAs in the Co-ordinated Community Response

Summary

In this chapter we explore the place of IDVAs within the CCR. IDVAs are accorded a specified place within the Westminster government domestic violence delivery plan. They are, through this, located as legitimate and necessary members of multi-agency responses, especially SDVCs and MARACs. The IDVAs and schemes reported that this conferred on them credibility, particularly with statutory agencies, which in turn appeared to have tangible benefits in responses to, and increased levels of support for, women they were working with. This is the foundation of advocacy – ensuring that rights and entitlements are forthcoming. At the same time, establishing and maintaining multi-agency relationships absorbed time and energy across all schemes, and ongoing difficulties with housing departments and social services were common.

This credibility did not, however, stretch to having the security to undertake institutional advocacy through routes that would be perceived as publicly exposing. The vulnerability of voluntary sector, short term funded projects is a major issue here. It may be that the bottom up approach of case based advocacy is not only the preferred route for change for IDVAs, but also the one that is most sustainable. Ellen Pence, who arguably founded the CCR, always argued for creating change through building relationships, identifying barriers in routine everyday practices (Pence, 1999) [35]. Ullman and Townsend (2007), in their study of advocates in rape crisis centres, identify a number of barriers to institutional advocacy, as we previously noted, including attitudes to violence against women held by practitioners, inadequate resources and status differentials. They also note that professionalisation of advocacy moves the focus to individual casework, which has the unintended effect of marginalising institutional advocacy.

Key points

- Examples of internationally acknowledged integrated CCRs tend to be in small cities, with shared agency boundaries, low staff turnover and key players in post for extended periods. London shares none of these characteristics and faces additional challenges.
- Whilst the four IDVA schemes undoubtedly made significant contributions to emerging CCRs in their boroughs, there were limits on what new, small projects can achieve. The loss of London-wide co-ordination of DV responses during the evaluation period undoubtedly reduced the potential for creating consistency of perspective and responses.
- IDVAs are only one part of a CCR, without the other components – especially the voluntary women's sector and including safe shelter – the range of needs among victim-survivors' cannot be addressed and changes in risk may not be picked up.

Introduction

The location of projects within the local multi-agency relationships is crucial to the IDVA model, which has been described as 'founded on the bedrock of multi-agency intervention' (Howarth et

[35] However, an adaptation in the German-speaking countries (Germany, Austria, Switzerland) comprises 'intervention projects', which operate primarily at the level of overarching policy and protocols (Seith, 2005)

al, 2009: 99). Each is establishing services in a local context, and negotiating the complexities of place and relationships, producing multiple challenges that can be in tension and/or raise complex dilemmas to which there are no immediate solutions. All schemes identified a similar range of services that effective multi-agency working necessitates: Social Services (primarily Children and Families Departments and Domestic Violence Teams but in some cases Vulnerable Adults Teams); Police, particularly Community Safety Units; local authority housing departments including Sanctuary schemes; and local hospitals. Thus one of the major challenges for IDVAs is negotiating the priorities of different local services, particularly understandings of domestic violence and agency responsibilities. This 'plurality of discourses' where domestic violence is viewed variously by police as crime, by health within the medical model and by Social Services in a family welfare framework, resonates profoundly at a local multi-agency level (Harne & Radford, 2008: 179). For IDVAs, securing entitlements for their service users is dependent on their knowledge of agency responsibilities and building positive relationships and referral pathways. In seeking to explore what contribution IDVAs make to the Co-ordinated Community Response model (see also Robinson, 2009), we focus on how IDVAs 'help survivors of domestic violence navigate the systems involved in the community response' (Allen et al, 2004: 1017).

A number of evaluations of CCRs in other countries have noted that specialised DV organisations, particularly women's services, are marginalised (Allen, 2005; Malik et al, 2008). Gill Hague and Sue Bridge (2008) comment that if specialised services are not central to the CCR, they become eclipsed by statutory responses 'which do not understand the gendered dynamics of intimate abuse, and under-resourced women's services are likely to become marginalised as powerful agencies take over' (p188).

In one example of safety conferencing, a form of co-ordinated response to DV from the US, a key stage in the model development was the recognition that collaborative approaches required the participation of victim-survivors and support networks, as well as services, as a way of maximising resources and educating the community in the fullest sense of the word (Pennell & Francis, 2005). In a similar vein, Regan et al's (2007) study of domestic homicide conclude that 'a truly co-ordinated community response' must equip citizens with 'the knowledge, confidence and information to recognise and name coercive control and act on it' (p43). However in current policy frameworks the 'community' appears to be comprised entirely of professionals and agencies, with little, if any, recognition of informal support networks. In Chapter Five, we explored in more detail the importance of responses from informal support networks from the perspective of victim-survivors.

This chapter addresses six themes in multi-agency working: developing relationships; publicising the schemes; credibility; local tensions; working in the criminal justice system; institutional advocacy. The multi-agency practice of MARACs is explored in the following chapter.

Developing multi-agency relationships

Some research suggests that victim-survivors perceive services to be more helpful where they are working in collaboration (Zweig & Burt, 2007). Acting as a one stop person also leads to recurring contacts with local agencies that have the potential to enhance understandings of domestic violence and actions (Kelly, 1999). IDVAs in this evaluation noted that this was a reciprocal process, with their own knowledge expanding through the advocacy process.

> I am liaising with other bodies, so it is opening up new horizons for me. I get better understanding how other bodies are working, and it gives me more confidence and knowledge *(IDVA, nia, R2).*

At the inception of the schemes, stakeholders reported confusion over what IDVAs were and/or the parameters of their role, with some attributing this to oversight at the strategic level where the introduction of IDVAs into local provision had not been adequately publicised. All IDVAs reported that relationships with other local agencies had improved considerably over the last two years, with police singled out as the most constructive in terms of working relations. For DVSS and REACH, their presence in police and A&E settings had facilitated the development of positive relationships. Some IDVAs noted with frustration that relationships continued to depend on

personal contacts and the expertise and goodwill of individuals, albeit that this was a consistent finding in multi-agency initiatives.

There was however still some lack of clarity reported by IDVAs and stakeholders, particularly evident where services provided by the local authority or another organisation in the borough appeared to be 'competing' for cases.

> The information has to be cascaded down through the various teams about what their remit, what the difference between the IDVAs and what the council [DV] service is *(Stakeholder, Hackney, R2).*

> There are a lot of agencies and practitioners who won't know the difference essentially, except they know we belong to different organisations, but they won't know the difference in the work that we do *(IDVA manager, R2).*

Stakeholders were asked where they perceived the IDVAs sat in terms of multi-agency responses to domestic violence. Interestingly some responses, mainly from those new to working on domestic violence through their involvement in the MARAC, located them at the centre in terms of significance and expertise.

> I would say that they are probably the leaders! It seems to be a really important role because there isn't anyone else really offering that kind of level of intervention for that particular client group *(Stakeholder, Barnet, R2).*

This alone is testimony to the abilities of IDVAs to advocate, and their expertise as specialists in domestic violence. Police officers were particularly likely to perceive IDVAs as vital and offering a fuller service than existing services. This undoubtedly reflects poor understanding of the range of services offered by many community based projects, whilst also revealing the potentials of linking police interventions to more holistic forms of support.

Other stakeholders with experience of working on domestic violence identified them as 'part of a chain', albeit valuable partners.

> There's a whole range of different people involved in community safety and domestic violence, and that's just an arm of the strategy around DV *(Stakeholder, Lambeth, R1).*

> I would not say any service is more important than any others… we have lots of services… they don't have the status of being called an IDVA service *(Stakeholder, Barnet, R2).*

In sum, the IDVA schemes worked tirelessly to promote multi-agency working, and both they and stakeholders saw the MARAC model as facilitating this. There are serious questions here about the ramifications for specialised DV agencies that are not viewed as so core to MARAC, as they are not afforded the same strategic value in multi-agency responses.

Publicising Services

Raising the profile of the service is two fold: first ensuring other services, and secondly potential service users, are aware of IDVA schemes. Both IDVAs and service users referred to this as an essential aspect of provision. Services must make their existence known in order to develop links and relationships that feed into co-ordinated responses to domestic violence. Although linked to institutional advocacy and awareness raising, for new projects it is vital that they are able to build a local profile.

> It's really, really good to do a lot of socialising and networking and getting your name out there. So that they're aware that there are these services, because sometimes it's through lack of knowledge that women fall through nets because they've got nowhere to direct them to *(IDVA, DVSS, R1).*

A stakeholder from Social Services in Hackney suggested that training workshops would be a useful way to establish links with statutory agencies, with the additional function of facilitating institutional advocacy.

> If we could have a way of just informing us, educating us every so often, every quarter or something like that, so we can at least have some info of what's actually going on, what's developing, how convenient and how suitable are they to the families that we're working with *(Stakeholder, Hackney, R1).*

Schemes had invested different human and financial resources in 'marketing'. Simple measures include leafletting local settings 'so that people can see actually who we are and how we can help', with one scheme producing two versions, one for service users and one for local practitioners. Minimum standards of the London Domestic Violence Strategy 2 (LDVS2) required any organisation to display posters and information on domestic violence in all public areas of the service (in at least three community languages or alternative formats). This has particular relevance to REACH based at A&E. Evaluators observed little material in the hospital that alerts victim-survivors to the presence of REACH. Yet the key issue here is not just that a service is 'there', but also to encourage victim-survivors to disclose to medical professionals. At the interim evaluation stage, we recommended the development of publicity materials that act as an 'invitation to tell', informing victim-survivors that they can safely tell A&E staff and access specialised support. Leaflets are now available in the female and male toilets in the A&E department. More innovatively, REACH has had lip balm sticks produced with a bar code and the IDVA phone number discreetly printed underneath, given out to those who are referred to the project at A&E.[36]

It is crucial for schemes to have accessibility strategies, since enabling contact was a key theme of interviews with service users. However, the recommendation at the halfway point of the evaluation for schemes to enhance publicity material was met with concern about resulting increases in referrals and a lack of capacity (also noted by Howarth et al, 2009). To not do so, however, limits women's self determination, meaning that agencies become gatekeepers/openers into IDVA schemes.

Credibility

The ways IDVA schemes achieve credibility with other agencies emerged as a strong theme from all project workers, connected to participation in MARACs, location of the project, and the relationships between voluntary and statutory agencies. Expertise on domestic violence was also mentioned, as the prominent role of the IDVAs within local responses raises the profile, and therefore the perceived value of, specialist services. Multi-agency networks have potential to cast IDVA schemes as equal partners and mitigate their less powerful position as voluntary sector agencies. The fact that many of the IDVAs had previously worked in/for other domestic violence services makes these reflections especially revealing.

> People still have this attitude that if you work for a voluntary organisation it's voluntary and amateur, and I think people still believe that, and I think the only reason certain people attend [MARACs] from Social Services and housing is because they actually have to do it. I think that's why the IDVAs get the co-operation that they perhaps get *(Stakeholder, Newham, R2).*

Physical location within statutory settings – REACH based at St Thomas' hospital Accident and Emergency department and DVSS at Barnet police station – seems to confer credibility by association.

> I feel, especially in multi agency settings, at meetings, that I've got a bit more credibility, because as soon as you say that you are at the hospital, I think people are a lot more open to sharing information with you… So I think that's one really good thing that's come out of being based in a hospital *(IDVA, Reach, R1).*

Addresses – email and postal – associated with statutory settings were also felt to enhance credibility and increase the likelihood of prompt, appropriate responses from other agencies.

Credibility was also acquired because the IDVA role, in some settings, was thought to blur the boundaries between voluntary and statutory agencies on two levels. Firstly, the IDVA scheme is afforded vicarious credibility through close working with statutory agencies. Secondly, that on

[36] This is also in place in Newham where the lip balm features the emergency domestic violence helpline number (GLA, 2007).

occasion, some agencies believe the scheme to be a statutory service. This suggests that the IDVAs are perceived as occupying an intermediate role, 'in between' voluntary and statutory.

> I think we sit quite independent of statutory agencies but I think we're within sight, if that makes sense? *(IDVA, DVSS, R1).*

> I think sometimes people think that we possibly are a statutory agency, so you'll get not as many barriers *(IDVA, REACH, R1).*

> If they don't consider me as a plain worker from some voluntary organisation when we are sitting around the table and I'm questioning them, it is more powerful *(IDVA, nia, R1).*

The limited power accorded to refuges and other community based services in inter-agency fora has been noted in previous research (Hague et al, 1995). This potentially opens space for creative approaches to service delivery, but may also create tensions and territorial discord. For instance in Hackney, the IDVA scheme is negotiating a position of credibility with statutory agencies, as nia define themselves as a feminist organisation, offering an independent service.

> It's important for the IDVAs to be independent, to provide women independent service going through the MARAC process… It's good that we as a voluntary organisation are a part of that, so that we're saying, it isn't just down to statutory organisations to make decisions about women, we're actually there as well, and this is what we're about and we're coming from a feminist perspective *(IDVA manager, R1).*

We explore the manifestations of this contested power at MARACs in the next chapter.

Overall, enhanced credibility for IDVAs schemes leads to increased responsiveness from agencies – requests for information are often acted upon promptly, and action relating to the case is more likely to be taken. This was most commonly reported in relation to housing departments or Social Services. To the extent that effective and appropriate support for women is forthcoming, here we have advocacy that realises their rights under law and policy, and is undoubtedly one of the most positive outcomes of IDVA schemes.

Local tensions

Here we explore those tensions that are perceived by schemes as arising out of an inadequate knowledge base, and/or clashes in agency culture. These are not 'teething problems' inherent in all new projects but represent more fundamental fault lines. For instance, NAADV report initial tensions with the Witness Service at Stratford Magistrates Court, who feared that the IDVAs were encroaching on their role; conversely, NAADV thought that the Witness Service did not understand the dynamics of domestic violence that necessitate support from specialised services. These tensions appear to have been resolved through meetings at a senior level about the remit of each service.

The core tension is a perception by schemes that IDVAs represent the interests of service users, whereas other agencies are at worst believed to be acting for the priorities of their agency, or at best failing to recognise the needs of service users. One stakeholder revealingly suggested:

> IDVAs have it very much from the victim's point of view and you always need that, sometimes you can lose sight of that a bit from an agency point of view *(Stakeholder, Lambeth, R2).*

Housing Departments, Social Services and the police were identified as agencies where IDVAs had on occasion been obliged to challenge decision-making in order to advocate for service users.

> The [problematic] dynamics are usually with Social Services and Housing. Social Services are usually very reluctant….they still tend to view any issue that the child comes first so therefore we'll put the child into care, rather than look at a more holistic approach. With Housing it's actually getting people to accept that they [victim-survivors] need to be rehoused in an emergency…They are certainly the two areas that every agency in [the borough] comes up against *(IDVA manager, R1).*

This need for and potentials of institutional advocacy are explored in more detail later in this chapter.

Working within the criminal justice system

The criminal justice basis of the IDVA model in policy framings was initially described by most IDVAs as new and unfamiliar to them, yet central to their work. Over the course of the evaluation this assumed less prominence, with a more holistic approach developing. This is consistent with research demonstrating that ensuring safety requires a greater range of support options than criminal justice routes (Shepherd, 1999; Allen et al, 2004; Parmar & Sampson, 2007) In fact, 'meeting women's basic needs may be a necessary precursor to fostering an effective criminal justice response' (Allen et al, 2004: 1031). While some stakeholders perceived the IDVA role as mainly about securing criminal justice redress, others expressed concern about this eclipsing other vital aspects of the work.

> The partnership approach is always welcome, but it has to be conceptualised within a very comprehensive strategy for dealing with domestic violence, and the MARAC, the IDVAs and the specialist courts are just one component… other DV work isn't being adequately picked up… I don't think in the long term there is going to be a positive impact, a wholly positive impact, of just focusing on things like the IDVAs and the MARACs and the specialist courts, without also ensuring that there is sustainable funding for the work that the women's sector does *(Stakeholder, Newham, R1).*

> Supporting the criminal justice response is one of the key benefits, because I can see that strategically people can see why they need to have IDVAs, what I think is a bit of a shame really is that there's not as much understanding of the fact that IDVAs are not just about the criminal justice response… I do think that closer links to the criminal justice arena sometimes give people a false understanding of what the other types of work an IDVA service might be doing, and the other types of things that make people at risk *(Stakeholder, Barnet, R2).*

This stakeholder suggested that a system where every charge and caution for domestic violence is referred to IDVAs, as is the case at some well established IDVA schemes, would provide consistency for victim-survivors and ensure that wider needs were met. There are however 'potentially untenable resource implications of automatic referrals' (Robinson, 2009: 24). IDVAs at DVSS have already had to decline providing support at the embryonic SDVC in the borough because of a lack of capacity. In Hackney the same issue emerged when nia were asked to provide IDVA support at the SDVC at Thames Magistrates Court, but no funding was offered for this extension of the service. Nia later secured funding from the Ministry of Justice for a part time post at the SDVC.

IDVAs at DVSS are embedded in the criminal justice system because of their base in a police station, and although they receive referrals from a wide range of local agencies (see Chapter Two), IDVAs perceive their location as crucial to their practices. The scheme has access to police databases (CRIS, CRIMINT and MERLIN) for information gathering, and the opportunity for daily interaction with police officers, probation staff, and CPS prosecutors, helping to build relationships and improve knowledge. Through these links, IDVAs were also able to contribute to pre-sentencing reports and influence bail conditions for perpetrators.

> Working at the police station, I've no doubt we're enhancing the response the police give *(IDVA manager, R1).*

The flag on police databases that denotes cases as domestic violence enables IDVAs to check whether victim-survivors are receiving any support, but the scheme often finds cases not flagged as DV despite details demonstrating clear evidence of it[37].

The criminal justice focus that NAADV provide through their role at the local SDVC was initially felt to be limited by a lack of relationship with the local police, which IDVAs sought to rectify by developing contacts and visiting the Community Safety Unit twice a week to collect referrals and

[37] The DV flag on the Metropolitan police database (CRIS) has been reported as 80-90% accurate (Kelly et al, 2008).

liaise with officers about cases. Having to overcome negative perceptions of specialist voluntary sector agencies was however noted.

> I think initially they were thinking 'Voluntary sector, are they going to be up to the job?' But the IDVAs have been down there to talk to them about DV, when to refer… and they formed some really good relationships *(IDVA manager, R2).*

Nia have also actively created links with the local CSU in order to develop referral pathways and establish ways of joint working that ensure women's perspectives are respected. All new CSU officers now visit nia as part of their induction.

> There's a new DI in post, and we made sure that we invited him up here, sat him round the table, and said "This is how we work, and it would be really good if you could do this, this and this". He was really receptive to all of our suggestions, and saying that we might be working from different angles, CSU might want to prosecute and we [said] we're coming from a woman's perspective and it might not always be her choice or the safest option to go down that route, so there might be conflicts with the way that we're working but we really want to work together *(IDVA manager, R2).*

The referral protocol with the CSU was agreed at the same time as that with the local authority to cross refer high and standard risk cases, and nia's own monitoring data reveals that this led to a 50 per cent increase in referrals. More importantly, IDVAs feel that the dialogue with the police enables them to protect women's interests and enable police to understand that 'for some victims, in some contexts, pursuing a prosecution might make them feel, and be, less safe' (Kelly et al, 2008: 54).

At REACH, IDVAs also negotiate victim-survivor priorities with respect to criminal justice as a key element of their work. They have developed strong links with the police officer affiliated to the hospital, who will take statements from victim-survivors while they are in A&E.

> I always encourage women to report incidents to the police, but what I say to them, if they're not happy to report the incident and follow it up, I will encourage them to report it but to let the police know they don't want to take any further action at the moment… then if they change their mind further down the line, they've got the option to do that, and then if they need to take out a non-molestation order then they've got the crime reference numbers… it's a kind of revelation for them… for me it's as if as an IDVA you're breaking down the barrier between the police and the client *(IDVA, REACH, R1).*

If IDVAs are required to reduce risk, it cannot always be presumed that CJS interventions will deliver this careful assessment of whether women's reluctance is due to intimidation and divided loyalty or an assessment, based on previous experience, that it would exacerbate danger.

IDVAs at REACH were the only scheme to have reported incidents to the police on a third party basis, on approximately three occasions. Decisions to do this were based on levels of danger, often involving concern for the welfare of children and including a case where the perpetrator had threatened to kill the victim-survivor in intricate detail. Consideration was given to the possibility of losing victim-survivors trust, resulting in a protocol of 'always with their knowledge, even if not with their consent'. In two of the three cases, the service users appeared to appreciate the level of concern underpinning the decision and continued to engage with the scheme.

Institutional advocacy

> Institutional advocacy is the sum total of those activities designed to change an institutional practice (i.e. policy, procedure or protocol) that works against the interests and needs of battered women as a group *(Pence & Shepard, 1999: 10).*

While institutional advocacy was referred to by all IDVAs as an ongoing aspect of their work, it was given less emphasis than advocating for individual service users. Home Office evaluations demonstrate that case advocacy was more effective when supplemented by local strategies to raise awareness of the issue of domestic violence (Parmar & Sampson, 2004). Institutional advocacy is described by IDVAs as part of everyday interaction with other agencies, in which they educate professionals about the dynamics of domestic violence and where necessary challenge

decisions. For IDVAs, the constant liaison required to secure victim-survivors' entitlements was a form of institutional advocacy, albeit less explicit than creating formal policy changes. In fact policies were often in place but inconsistently implemented.

> [It's] ironing out the creases so the service works better and everyone is doing what they're supposed to be doing *(IDVA, NAADV, R2).*

Some targeted work has also been undertaken – for instance, NAADV have trained the clerks at the SDVC and DVSS have trained local housing workers. The manager at REACH has also trained over 3,000 practitioners including A&E staff, midwives and medical students and voluntary sector agencies on domestic violence, child protection, intersections between domestic violence and substance misuse, and routine enquiry, and assists in the Vulnerable Adults Awareness training at the hospital. Training is acknowledged as an effective means to equip agencies with an accurate knowledge base, but is often constrained by local targets and priorities.

> We're trying to roll out training to counter some of this, you can give them a bit of DV awareness but you can't change the targets that they're being forced to meet *(IDVA manager, R1).*

Schemes also provided such training for free to other agencies and while they acknowledge the importance of this for enhancing response to victim-survivors, noted that remuneration would be a vital source of income.

Data below has been analysed for the agencies that featured in IDVA accounts. Where evidence is presented from only one or two schemes, this should not be read as suggesting that practice in other boroughs was unproblematic.

Social Services

All Schemes had concerns about their local Social Services, Children and Family (SSCF) teams: as they were universally identified as lacking an understanding of the dynamics of domestic violence, women's decision making processes and the impact of physical, emotional and psychological abuse. Schemes routinely encountered an emphasis on children's safety that showed minimal recognition of the principle, in cases of domestic violence, that protecting women can be the most effective form of child protection (Kelly, 1996). This has been termed a 'culture of blame' (Hester, 2005; Radford and Hester, 2008), within which the failure of abused women to leave/go to a refuge, or take other kinds of assertive action, is interpreted as a 'failure to protect' their children. Here limited ability of women to control the behaviour of abusive partners – as evidenced by the fact that they are seeking help to end violence – is disregarded. Whilst such practices may protect Social Services, they do next to nothing to protect women and children; and an argument could even be made that they are counter-productive. Placing vulnerable women in positions where they feel under surveillance cannot be said to be empowering, and is likely to undermine the efforts of others – especially IDVAs – in the intervention chain. Furthermore, all schemes reported that SSCF teams and other professionals across the four boroughs continued to make a conceptual distinction between being a 'violent partner' and a 'good father'; as if living with domestic violence and witnessing the diminishment of their mother had no negative impacts on, or meanings for, children (see also Eriksson, 2009 for similar approaches in Sweden). There is considerable disparity here between the risk assessments of social workers and those of IDVAs. These conflicts between woman and child protection have been well documented in the literature (Eriksson et al, 2005; Hester 2005; Humphreys, 2008), and were at play in all four boroughs.

Ultimately IDVAs felt that there was a gap in knowledge amongst most statutory agencies about violence against women, particularly how gendered inequalities, power imbalances and patterns of control affected women's ability to live free from violence: perhaps an outcome of gender neutral framings of domestic violence within multi-agency frameworks (as also noted by Hague, 1998; James-Hanman, 2000; Radford, 2003; Harne & Radford, 2008). Part of their regular engagement with Social Services departments involved explaining gendered power dynamics.

> There's an awful lot of practitioners who don't understand domestic violence and yes, she is still taking him back, and perhaps you don't understand the debilitating effects that 14 years of being knocked from pillar to post will have, and the fear... so you have to work with that, explaining... those cumulative effects, and that you've got to put more

> in place in terms of support structures for her... so in a way it's actually training all the time *(IDVA manager, R1).*

> There's this round table and we voice the dynamics of domestic violence, how a woman feels, because sometimes police or Social Services say "Why do they go on in a violent relationship?" and then we have chance to broaden other non DV organisations knowledge. They come to learn about it just by our learning *(IDVA, nia, R1).*

Whilst still case advocacy, there is potential here to the extent that understandings are deepening and changing practices more generally.

Police

DVSS in particular have encountered several examples of poor police practice that they sought to address through institutional advocacy (and the advantages of their location) including: cases not being flagged as DV on the computer (and therefore not referred to DVSS); police not responding to callouts for six hours; lack of awareness that breaches of non-molestation orders are now criminal offences; documents representing victim-survivors views missing from files prepared for the CPS.

Three schemes also encountered women being arrested under 'dual arrest' policies where perpetrators made cross allegations and police seemed unable to determine who the primary aggressor was, although the schemes were clear that it was the male partner. This practice, a result of pro-arrest policies, demonstrates a lack of gendered understanding of domestic violence, since where women use violence in self-defence or retaliation it does not carry the same 'cultural meaning of powerfulness, nor does it likely accomplish the same outcome of control' (McMahon & Pence, 2003: 51). In Duluth, where the CCR model was developed, advocates devised a number of actions in conjunction with police to address this, including a requirement to determine who was acting in self defence (ibid). This resulted in a significant reduction in numbers of women arrested for domestic violence offences. REACH also reported that in both of the boroughs their scheme straddles, police do not accept dual arrests and officers are instructed to gather evidence about who the primary aggressor is, including contacting REACH to determine if victim/perpetrator have domestic violence related A&E attendances.

The examples of institutional advocacy offered by schemes include raising awareness of domestic violence dynamics with individual officers and the Community Safety Unit.

Housing

Housing and homelessness departments were also frequently perceived as failing to respond appropriately to women, who under the Housing Act 1996 and the Homelessness Act 2002 are entitled to assistance to escape domestic violence. Although the 2006 Homelessness Code of Guidance specifies that DV is not limited to physical violence and proof is not required before local authorities provide assistance, most of the IDVAs cited practices that ignored this. Other examples included housing departments attempting to refuse assistance on the grounds that women had reconciled with partners/perpetrators after expensive Sanctuary scheme security measures had been fitted to their homes.

> Housing – negotiating around unsuitable offers, and moving people around, [they say] "Oh well they've moved once already, we're just moving them again, and we'll move the problem" *(IDVA, DVSS, R1).*

> Problems with housing – even if they are top priority, women don't always want to go to refuge or HPU, so it's part of advocacy explaining that to housing, that they've got children in schools in that area *(IDVA, NAADV, R1).*

For IDVAs women and children should be entitled to be safe in their existing homes and neighbourhoods if they wish this.

Finally, Gill Hague (1998: 445) points out that 'setting up co-ordinating initiatives is of limited value if the systems being co-ordinated are inadequate'. However by the second round of interviews,

one scheme was encountering resistance and hostility when they challenged inadequate responses by a range of agencies (also noted by Hague, 1998).

> There's always a tension between your working relationships with people and saying what's best for the woman... so you have to assess the gains of interjecting *(IDVA manager, R2).*

This had led to a shift in approach, with the IDVAs retreating from institutional advocacy and the scheme manager taking over this aspect of the work, enabling IDVAs to maintain positive relationships with agencies. While reports have been made to the Domestic Violence Co-ordinator and MARAC, the scheme fears that making a formal complaint will jeopardise the future funding of the scheme locally. Similar negotiations over criticising poor practice as part of advocating for victim-survivors have been previously noted in UK and U.S. research (Kelly & Humphreys, 2001; Malik et al, 2008).

In short, most of the schemes were imprecise about how to actualise institutional advocacy and had given it less emphasis than individual advocacy for service users. Examples of institutional advocacy offered by IDVAs were in fact case advocacy – highlighting poor practice and decisions. Less directly, IDVAs also perceive that institutional advocacy is enacted through securing women's entitlements where these have been either refused (thus appealing decisions) or simply not offered (using their knowledge of victim-survivors' rights to request they are fulfilled). Whilst there are possibilities here for wider policy changes, this falls short of developing new policies and protocols that would apply to *all* cases, not just those who have an IDVA advocating for them.

The following chapter explores the schemes' engagement with and experiences of MARACs.

Chapter 7:

Multi-Agency Risk Assessment Conferences (MARACs)

Summary

This chapter reports on findings from observing MARACs, interviews with MARAC members and IDVAs. Just over a quarter of IDVA cases were referred into MARACs, revealing that the majority of their work takes place outside the MARAC framework. On occasion IDVAs referred to MARAC in order to secure leverage for entitlements, but it is disappointing that this level of accountability is required before agencies are willing to meet their responsibilities. Some IDVAs perceived that agencies were participating in MARACs as a way of ticking boxes on domestic violence without real commitment to outcomes (Hague, 1998). The multi-agency basis of the MARAC model was welcomed in principle, albeit that all IDVAs and many stakeholders expressed concerns about increased throughput, inappropriate risk thresholds and premature closing of cases. The absence of some key agencies, especially health, reflects a bigger national picture of gaps in representation at MARACs (Howarth et al, 2009). A key finding was the limited knowledge base that MARACs are working from – with trade-offs clearly being made between having members who have the power to make decisions and those who have a depth of understanding of domestic violence. Poor understandings of the gendered dynamics of domestic violence were reported by all schemes and witnessed by the evaluation team. In such contexts what IDVAs bring to the table is expertise and an evidence base, which they draw on for all cases – not only those they are directly involved with. The good practice in MARACs, therefore, relies heavily on IDVAs, both their framework of understanding, and all too often they also carry the weight of actions to be implemented after the meeting (see also Robinson, 2009).

Finally, a critical concern across all IDVA schemes was the disregard of victim-survivor consent and respect for their privacy rights, with some reporting most women they contacted post-meeting being unaware of the MARAC referral (see Chapter Five for evidence of this from service users' perspectives). In representing victim-survivors' voices, IDVAs prioritised victim-survivors' wishes to avoid inappropriate sharing of personal information and had an acute sense of the risks of breaches of confidentiality.

Key points

- Serious concerns were raised about the functioning and contribution of local MARACs specifically: disregard for victim-survivors consent; patchy attendance; limited understanding of domestic violence.
- IDVA participation in MARACs protected the rights and interests of all victim-survivors, not just those they were directly involved with, by: respecting the right to privacy and consent; challenging victim-blame; acting as advocates through voicing the needs and concerns of victim-survivors.
- IDVAs made the most contribution to reducing risk, before and after meetings, and in fact only a quarter of scheme cases were referred to MARAC. This was not because cases were low risk, but that IDVAs had coordinated necessary responses already, making a MARAC referral redundant.

- Observation of MARACs revealed little evidence of the 'inclusive climate' necessary for effective multi-agency working (Allen, 2005), with IDVAs frequently marginalised.

Introduction

> The MARAC is designed to take responsibility for addressing these high risk cases of domestic violence from one or two agencies and share it between all relevant agencies *(CAADA, 2009b: 1).*

> Multi-Agency Risk Assessment Conference (MARACs) have become the cornerstone of our approach to identified high risk victims of domestic violence as indicated through the use of risk assessment tools *(Home Office, 2008:38).*

Multi-Agency Risk Assessment Conferencing (MARAC), was developed in South Wales in 2003 and emerged onto the policy agenda for England and Wales in 2006 as part of the Co-ordinated Community Response (CCR) to domestic violence. The key elements are a focus on high risk victim-survivors and the management of perpetrators through sharing information among local agencies (Robinson, 2004) with IDVAs described as 'intrinsic' (Home Office, 2006). In early 2007, the Westminster government announced a £1.85 million investment in MARACs, alongside the expansion of Specialist Domestic Violence Courts (SDVCs) and IDVAs, conceptualised in policy terms as a 'trinity of developments… to transform the delivery of domestic violence services at the local level' (Home Office, 2007: 11). Both MARACs and IDVAs are core components of SDVCs and are credited with expanding the CCR model beyond a criminal justice focus (Home Office 2007, 2008). Evaluation of the original MARAC model in South Wales found reductions and cessations in violence, recorded by both police callouts and interviews with victim-survivors (Robinson, 2004).

In 2007, at the inception of the four IDVA schemes, few London boroughs had operational MARACs (Doyle, 2007), although all boroughs bar the City now do. There are currently 225 MARACs in England and Wales, with a planned national roll out complete by 2011 (Home Office, 2009), and it is estimated that 150,000 cases per year will be discussed at MARACs when there is national coverage[38], although the Home Office estimate is a third of this at 50,000 (Home Office, 2009). In our sample, 210 cases (28.1%) of the total caseload (n=748) were discussed at MARACs, a slightly smaller proportion than the 34 per cent noted by Howarth et al (2009) in a recent evaluation of seven IDVA schemes.

All four IDVA schemes are members of the local MARACs, and the REACH project, due to their location on borough borders, attend MARACs in both Southwark and Lambeth. Whilst there is recognition by projects that they are part of new developments and subject to 'teething' problems, considerable variation in process and practice was reported, and some ambivalence about the MARAC model. This chapter draws on IDVA and stakeholders' views and experiences of four MARACs, and observations from the evaluation team at MARAC meetings.

Multi-agency networking and accountability

All IDVAs and stakeholders valued the multi-agency basis of the MARAC model in terms of the ability to share information and devise action plans and 'solutions' (also noted by Robinson, 2004). Key to this is the possibility of the MARAC forum. MARACs provide a mechanism to hold parties accountable for their responses (also noted in an evaluation of MARACs in Wales, see Robinson & Tregidga, 2005). However some interesting trajectories emerged over the course of the evaluation. Initially all IDVAs embraced the MARAC model as a means to raise awareness of specialised voluntary sector support agencies and engage statutory agencies who had previously been reticent about addressing domestic violence.

> It's useful because it gives a place where you can bring high risk cases and you can actually have the input of all the different services who are actually there *(IDVA, DVSS, R1).*

[38] Presentation by Jan Pickles to the Women's National Commission VAW Working Group, 2 April 2008.

> I suppose for me it's understanding the support you can get from other agencies, whether it's probation, whether it's health, the CSU, and also hearing how they're dealing with other cases *(IDVA, Reach, R1).*

By the second round of interviews, some IDVAs remained positive about the potentials of MARACs to encourage statutory services to take responsibility for meeting victim-survivors needs'.

> Previously we were having trouble to explain the case, the urgency, to let's say Housing, but with the MARAC it's general pressure… I think these other parties feel more accountable *(IDVA, nia, R2).*

> I do like the MARAC idea, the whole principle of the one stop shop that you refer everything in there and it gets dealt with *(IDVA, DVSS, R2).*

Others had become sceptical about the actualisation of actions through the MARAC process, captured succinctly by one stakeholder.

> We're not totally sure that people have got confidence in the process of MARAC, and I think this is not around the concept of MARAC, it's around the fact that sometimes people don't carry out their actions, so therefore that weakens the support plan *(Stakeholder, Barnet, R2).*

Accounts from IDVAs indicate that networking alone is not sufficient to ensure women's safety (Hague, 1998), as it requires integration of domestic violence into their routine practice. Again accountability was perceived to be critical here. Clearly just sitting together, sharing information and even establishing an action plan are not, in themselves, sufficient to make changes even in individual cases. In some instances MARAC made little difference to the work of IDVAs, who had to continue to advocate with agencies.

Development of the MARACs

Over the course of the evaluation period, the MARAC model has been shaped by both local contexts and national guidance. For one scheme the developmental trajectory of the MARAC has been a useful opportunity to influence local practice.

> Our MARAC, like any other, is evolving and developing, and I go to every single one because I like to shape it *(IDVA manager, R1).*

Across all MARACs, monitoring visits from CAADA representatives led to significant shifts in operation, with pressure to increase throughput and numbers of cases discussed at each meeting. Reports from CAADA recommended that fewer cases were carried over to the next meeting for review, and all four MARACs were advised that they were 'holding onto cases' for too long. Parallel to this, enhanced attendance and participation from local agencies universally led to a rise in referrals. Thus a common development was an increase in throughput.

> '[It used to be] 'Ok, we'll review – we'll do every action, we'll review this next month, see whether we've done the actions. I did appreciate that [in] the CAADA model, if you don't have the review then you can deal with things quicker…but I think you need to review… if I had my way, I would like to see more cases reviewed [at the next meeting], but it does slow the process down, it does reduce the number of cases you can deal with *(Stakeholder, Newham, R2).*

One national expert interviewed for the evaluation described MARACs in interview as a 'high volume' model. One of the criteria by which to assess local implementation of MARACs is that 10 or more cases are processed at each meeting.

> This is a high-volume model, it's a high volume of cases coming through… we now have data from over a hundred MARACs that are working effectively, that is they're doing more than ten cases, they're meeting at least monthly, and their BME and disability figures are reflecting what there is in their community.

This optimism was not shared by all interviewees in London.

> I think in principle it's a very useful forum, but it is not possible to deal properly with the number of cases that… people are being advised they could deal with. I think they're expected to deal with up to eleven, and it isn't possible in one meeting to do that properly *(Stakeholder, Lambeth, R1).*

MARAC members were divided on shorter time slots for each case, with some perceiving that it enhanced efficiency, while others reflected that:

> There's a loss in that as well because there's a kind of usefulness to having a lengthier discussion about complex cases *(Stakeholder, Barnet, R2).*

Protocols and procedures across all MARACs had been refined and systematized (including referral processes and thresholds, documentation and the dissemination of case details before meetings) which most IDVAs attributed to the recruitment of skilled MARAC co-ordinators. Part of the honing of MARAC operations by co-ordinators included efforts to ensure comprehensive and consistent attendance from relevant local agencies.

Representation and attendance

Three of the IDVA schemes and the majority of stakeholders identified poor attendance by some agencies. In the one borough where representation was generally perceived as good, this was attributed to a committed MARAC co-ordinator who had tirelessly developed the membership. The IDVA manager here observed that 'attendance has actually stabilised and it's good, and people do take away their actions'.

In the other three boroughs, whilst representation and attendance had been enhanced, gaps remained. Mental health teams, drug and alcohol services, midwifery and A&E were all identified as absent (see also Howarth et al, 2009). However, alongside membership, inadequate attendance by agencies was consistently highlighted as hampering the effectiveness of the multi-agency work. Similarly some attendees were unable to participate fully, either due to insufficient decision making power or lack of familiarity with cases. This was summarised by one IDVA manager.

> There are difficulties with the MARAC, with loads of agencies unfortunately around the table, because people aren't attending, people who are attending are not in the position to be making decisions; different people are turning up from an agency and not knowing what MARAC is, not knowing how the processes are; people not coming with updates, so it has and does feel an awful lot of the time like the MARAC is just between the IDVA service and maybe the CSU, and [other DV organisation], but no one else is really contributing, no one else is bringing anything, and then that very much questions the purpose of the MARAC *(IDVA manager, R2).*

Seniority was perceived as particularly important in this context, in order that decisions can be made immediately and necessary changes in policy and practice cascaded through organisations (Hague, 1998; James-Hanman, 2000; Allen, 2005). Yet there is also a balance needed between those who have strategic oversight and those who are familiar with details of the case.

> What's really helpful is having the person from the social services there who coordinates all the child protection conferences. She attends, and she's been invaluable *(Stakeholder, Newham, R2).*

Statutory agencies are most commonly named as non-engagers, specifically housing and Children and Families (Social Services) teams. This has a negative impact on the ability of the forum to devise a comprehensive action plan, and on the ability of IDVAs to deliver women's entitlements, the core of their work.

> Sometimes we need some advice from them... Sometimes we don't have always enough time to go to agencies who are on that case. And this is why MARAC is there for us, to have a kind of sharing participation *(IDVA, nia, R2).*

The following section addresses the neglected area of consent thresholds for referring into MARACs.

Consent

> Disclosures to MARAC are made under the Data Protection Act and the Human Rights Act. Information can be shared when it is necessary to prevent a crime, protect the health and/or safety of the victim and/or the rights and freedoms of those who are victims of violence and/or their children. It must be proportionate to the level of risk of harm to a named individual or known household... The principle that underpins MARAC is that the threshold of risk is so high that consent is not legally necessary from the victim to share info (CAADA, 2009c: 2, emphasis added).

> Sometimes the victims clearly say they don't consent, they say they don't want the cases to go anywhere, they don't want anybody to bother them… but it overrides their consent if the risk is very high, I mean we're not going to say "Oh because you've said you don't consent, then it won't come to the MARAC" *(Stakeholder, Barnet, R2).*

Ten of the 17 stakeholders interviewed in round two had made referrals to MARAC and therefore felt able to answer questions about obtaining consent from victim-survivors and whether they would still take cases where service users had refused consent. All referred to 'good practice' or a 'preference' to seek consent, but two approaches emerged: disregarding consent where cases met thresholds of risk but informing victim-survivors of the referral, and taking cases without consent or knowledge. The former was more common, with some organisations perceiving it important for trusting relationships that victim-survivors were aware of the reasons why referrers were overriding their wishes. One organisation reported working to the latter approach, on the basis that women might take actions that endangered her safety if she was aware of the MARAC referral, but was unable to be more specific about what these actions might be.

Guidance from CAADA on the 'Information sharing without consent' form refers to eleven legal grounds (as well as local protocols) on which to base decisions to refer without victim-survivor consent. These include: prevention/detection of crime; prevention/detection of crime and/or apprehension of or prosecution of offenders[39]; protection of vital interests of the data subject/ serious harm or matter of life or death[40]; administration of justice[41]; the exercise of functions conferred on any person by or under any enactment (police/Social Services)[42]; in accordance with a court order; overriding public interest; child protection; public interest in safeguarding the welfare of a child overrides confidentiality[43]; right to life[44]; and right to be free from torture or inhuman or degrading treatment[45] (CAADA, 2006).

At the observations of MARACs, consent was only explicitly mentioned in two of 81 cases. A range of reasons were offered by stakeholders in interviews to justify disregarding consent. These included those suggested by CAADA, the Crime and Disorder Act[46] enabling information to be shared to preserve safety, the Data Protection Act, the Human Rights Act, and the 1989 Children's Act.

> No we don't have consent for all victims to be discussed, obviously we would hope to have consent, but their right to safety and their right to their life is more important under the Human Rights Act than their consent *(Stakeholder, Barnet, R2).*

Some stakeholders reported taking cases to MARAC without consent for the purposes of sharing or obtaining information:

> Often the service users kind of say "No I don't want it to go any further than this," but I've advised the clinician to take them even just for an information exchange, and also potentially to find out if there's other information that's being held in other agencies… I suppose sometimes just for information perhaps that the police could find out a bit more information around the perpetrator *(Stakeholder, Barnet, R2).*

> Unfortunately even if the victim doesn't agree to be a MARAC case, the benefit for the victim is that every agency should know about that case, and then continue to give them a premium service, so even if they came back in a year, the agencies would

[39] Data Protection Act, section 29.

[40] Data Protection Act, schedules 2 and 3

[41] Data Protection Act, schedules 2 and 3

[42] Data Protection Act, schedules 2 and 3

[43] Data Protection Act, schedules 2 and 3

[44] Human Rights Act, articles 2 and 3

[45] Human Rights Act, articles 2 and 3

[46] Section 115 of the Crime and Disorder Act 1998 gave partners (the responsible authorities and probation committees) the power to share information for the purposes of reducing crime and disorder. This is however not a legal duty. Schedule 9(5) of the Police and Justice Act (2006) introduces a new duty on the same agencies, but this requires agencies to share depersonalised data, that is already held in a depersonalised format, for the purposes of reducing crime and disorder. Information discussed at MARACs is not depersonalised, and it is not possible for it to be given that agencies are required to check names and details against their own records.

> have that information that there was this person's got a very difficult domestic violence background, and therefore should respond appropriately. If the agencies don't know about the case, it doesn't sort of help the victim in the future *(Stakeholder, Barnet, R2).*

In this borough, information sharing is one of the criteria for referring cases to the MARAC. Sharing personal and sensitive information between agencies has increased in importance following the Safety and Justice overview (Douglas et al, 2004) and National Domestic Violence Delivery Plan (Home Office, 2005) where it is described as key to protecting victim-survivors, and the core of the current MARAC model. The intention is to enable agencies to have 'a better picture of victims' situations and so develop responses that are tailored to the needs and goals of individual victims and their children' as well as to better manage perpetrators (Home Office, 2007:8). This should lead to agencies responding to cumulative patterns of domestic violence rather than isolated incidents (Hurst, 2009). Douglas et al (2004) highlight benefits of information sharing that include enhanced risk assessments, tailored advice and support and a cohesive response from agencies. However they also note that inappropriate sharing of information, particularly where victims do not give consent, can place women at risk. Although the MARAC model has been approved by the Information Commissioner (Home Office, 2008[47]) and the first evaluation of MARACs found that the main output was perceived to be information sharing (Robinson, 2004), IDVAs were sceptical of and concerned about the practice of referring cases to MARAC on this basis because of the implications for rights to privacy. Following the CAADA recommendation to increase throughput, IDVAs found that the majority of victim-survivors that they contacted following a MARAC meeting did not know that their cases had been referred to MARAC. Kelly (2009) raises the question of whether MARACs are sufficiently mindful of the position of women from minority communities, for whom absolute confidentiality has been a pre-requisite for seeking help and staying engaged with services.

> If you're looking to MARAC because you want it to alert other services, sometimes that's not necessary, and a person may not choose – may not want other people to know, and I think they have a right to that, just because they're victims of domestic abuse doesn't necessarily mean that everybody in a MARAC meeting are party to all their personal details and information *(IDVA, DVSS, R2).*

This account reveals the crux of trepidation about sharing personal and sensitive information – that where it is done for 'alert' purposes, this is mistaken for protective action. As Kelly et al (2008) note:

> Information sharing is a tool, not an intervention. Outcomes in cases where information was not shared would be precisely the same unless the additional information was used in ways that changed the course of events. If enhanced information sharing is to have any impact on safety it has to be linked to improved practice at the individual and agency level (p7).

One scheme's reticence about referring to MARACs centred on concerns about consent and the professionalism of agencies at the meeting: they cited an example where a representative from an agency shared their personal knowledge of a woman's life drawn from a friendship with her. The following case study illustrates how IDVAs negotiate the discrepancies between women's self determination and agency practices.

[47] Under the "crime and taxation' exemption', enabling data to be processed for the prevention or detection of crime and/or the apprehension or prosecution of offenders. However the Information Commissioner has also identified that there must be a substantial chance that the detection or prevention of crime would be damaged without information sharing. The requirement to comply with Schedules 2 and 3 of the Data Protection Act still apply. Finally, exemptions should be considered on a 'case by case' basis (Home Office, 2008).

Case Study:
Self determination versus MARAC referral

A case was referred to MARAC by a statutory agency, against the wishes of the victim-survivor, as the referrer perceived it was sufficiently high risk to over-ride consent. The IDVA scheme was aware that the victim-survivor had refused consent. Before the meeting, the IDVAs questioned the appropriateness of discussing the case with the referrer as in their view it did not meet the MARAC threshold, but the referral proceeded. At the MARAC, the IDVAs were surprised to see the case on the list, and repeated their concerns – described by a stakeholder as:

> They're very client focused. If for instance it comes out that actually it hasn't met the threshold, they say "Actually we don't have the right to be discussing this case", because the threshold's not high enough.

In this instance, the Chair refused to hear the case at the MARAC. When interviewed for the evaluation, the DV Co-ordinator in the borough was very critical of the IDVAs for challenging the statutory agency, suggesting that they had undermined the purpose of the MARAC:

> We have people who [are] constantly being challenged about breaching client confidentiality by putting cases into MARAC if they don't want to be in MARAC, and this is often coming from [the IDVA scheme] unfortunately, so therefore it's very vocalised. It's people [being challenged] who are not totally sure, so it makes them less confident of dealing with domestic violence, because the MARAC in actual fact is a safety valve in a way for practitioners, because it takes the responsibility off them, doesn't it. It makes it the responsibility of that MARAC to put in a safety plan around that victim… where the client is actually with an IDVA service and the client is saying they don't want to be in MARAC, then the IDVA service hasn't brought the case but maybe the police have or the health visitor or housing. The IDVA, should really still be providing information to the MARAC… I can understand why victims don't want to because really who would want everyone in the whole borough to know this, because it's your private personal experience. But when you're positioning yourself as an IDVA service then good practice would be to work [together] and not gatekeep.

Practice in the borough was affected by this case with the statutory agency no longer referring any cases without consent from victim-survivors; where this is refused a note is made in their file that the agency has ongoing concerns about risk and danger. This action was decided as part of an ongoing dialogue with the IDVA scheme. At the same time, the IDVA scheme was subsequently reprimanded by the local authority and the victim consent box on the MARAC form was removed without discussion with or notice to any stakeholders.

In contrast, IDVAs across all schemes were much clearer about not only obtaining consent but what they told service users about the MARAC. One scheme stated that they would not refer without victim-survivor consent, on the basis that their intervention reduced risk to the level that a MARAC referral was not necessary, and they would seek alternative safety options. Occasionally this had meant that possible benefits of MARAC (for instance, the probation service being aware that the case had been discussed at MARAC) were not available, but this was, for IDVAs, the consequence of respecting women's autonomy. IDVAs at all schemes were particularly careful about explaining to service users that MARACs involve the sharing of intimate, sensitive information to and from a wide range of local agencies, regardless of whether they know the woman or her children, and that the IDVA role was to be her representative.

> I say "This is that, it is called multi agency because of the participants and because they are accountable and responsible, and don't panic because I mentioned social services or the police, we are independent from them, I am your representative at MARAC, [and] I will always give feedback to you. It only helps to discuss your case more directly with other agencies." And it works. Immediately after the MARAC meeting I phone the client and I said "People said this." *(IDVA, nia, R2).*

> I'm very, very detailed about what MARAC is, what agencies sit on MARAC, what I'm hoping to achieve from that referral, what I hope to get out of it, and then get their consent that they're happy for that to go ahead. Then I'll always feed back to them what happened and what was discussed... I will put it to her that way and make sure we look after her in the MARAC because we're in control of her information *(IDVA, DVSS, R2).*

IDVAs were far less likely than other agencies to have victim-survivors refuse consent for a MARAC referral and they attributed this to reassuring service users that they would act as their voice at the meeting. Statutory agencies in one borough were aware of this and asked IDVAs to persuade women to consent to MARAC referrals. IDVAs also reported speaking to women following a MARAC who had simply been asked 'Is it ok if your case goes to MARAC' with no idea of what the process involved, or had been blandly informed that it was a multi-agency meeting aiming to devise a support and safety plan. For IDVAs this description failed to convey the extent to which intimate lives and decision making processes were being discussed and questioned by strangers. For IDVAs a frank discussion about what a MARAC involves was a core part of seeking consent. In one borough, a leaflet had been produced explaining what the MARAC is and all agencies are asked to give these to service users. The local IDVA scheme also uses these leaflets for victim-survivors; all boroughs should consider developing similar information leaflets.

For the other three schemes, consent was always sought but all had, on very rare occasions, taken cases to MARAC without agreement from service users. These decisions were based on thresholds of risk and/or child protection obligations. At one scheme, the threshold for MARAC referrals was based on a risk assessment score, but professional judgement could tip the decision.

> We've had people below the score but we've made the referral – and it's usually because we believe there's more going on than what we're being told at the time, or there's certain things that trigger our concern, so then we will refer anyway *(IDVA manager, R2).*

At this scheme, IDVAs informed victim-survivors of the possibility of a referral to MARAC and implications for confidentiality before they began the risk assessment.

> I will explain to them that if they meet a certain threshold with this risk assessment that they could identify as a MARAC, and I'll explain what a MARAC is, and what I'll say to them is that if they reach the threshold for a MARAC, then I would have to breach confidentiality because then I would have to share the information with the MARAC conference, and I'd advise them who's sat around the table. I think it's important to tell the clients beforehand, rather than do the risk assessment and go "Oh by the way, I just told you that it remains confidential between us but I actually now have to share this" *(IDVA, REACH, R2).*

IDVAs were also less likely than stakeholders to perceive that referrals to MARACs enhanced their ability to support victim-survivors, as much of their multi-agency liaison took place as part of routine casework, by telephone or email, in time scales that were more acute than MARAC scheduling. All the schemes had developed protocols and practices which paid due regard to the right to privacy, and in what circumstances these could (and should not) be over-ridden. Given their emphasis on empowerment through knowledge (see Chapter Three), IDVAs were far more committed than the stakeholders interviewed to explaining what MARACs were and seeking consent. Observation of MARACs confirmed that their concerns had some foundation, where considerable detail, and even judgements, about women's past and current lives were shared with up to 30 individuals. Whilst all MARAC members sign confidentiality agreements, these cannot ensure that information heard will not affect responses in ways that only do not enhance safety, or mitigate the potential for stereotypes to influence responses. It is therefore essential that consent is a prerequisite for referral to MARAC.

Referrals into MARACs

CAADA guidance recommends three criteria for MARAC referrals: professional judgement, visible high risk (based on risk assessment) and potential escalation (based on number of domestic violence callouts to police in the last 12 months) (CAADA, 2006). In Lambeth these are the three grounds for referral, with potential escalation defined as three recorded crimes or five incidents, and any reported rapes. In the other three boroughs, the referral threshold for MARAC was based on risk assessment scores, although all schemes noted that cases of low/medium risk were discussed (see page 94 for details)[48]. Of the 81 cases that we observed across the four MARACs, police were the most common referrer (n=31 cases), followed by domestic violence services (n=21). Referrals from IDVAs comprised just 14 cases, although the proportion varied from one to nine across the boroughs. This confirms evidence from the interviews that IDVAs schemes rarely refer into MARACs:

> Even if the ticks come to MARAC referral, if between the time that we met the client until the time of MARAC, we're able to reduce the risk, and place the client in a secure environment, we don't really refer, because we've done everything that has to be done *(IDVA, NAADV, R2).*

Tracking referrals in and out of MARACs to and from IDVAs is complex since some referrals are simultaneously made to both, and some are cases already known to IDVA schemes that are referred from other agencies. IDVAs appear to be providing advocacy and support to most of their cases without recourse to the MARAC forum. One stakeholder provided a possible explanation for this.

> We were sending referrals that were high risk, and the IDVAs were so efficient in what they were doing that they were bringing them down to medium, so they weren't getting to the MARAC *(Stakeholder, Hackney, R1).*

That said, on occasion the MARAC acts as useful leverage for IDVAs to secure support for victim-survivors (discussed in more detail below).

> Sometimes she comes to me and I do everything possible before any MARAC meeting, so there is no need to involve MARAC. Although it is a high risk case, [because] I did everything it is not necessary for me to refer to MARAC, only if it crucial to her domestic violence matters [for instance, immigration related] then I make the referral. Just to give it some officiality *(IDVA, nia, R2).*

Revealingly, IDVAs seldom found it necessary to refer to MARAC for information sharing purposes, as their practice and crisis response function required that they undertake this routinely and urgently.

Role of IDVAs at MARAC

> I was actually quite amazed at what they do *(Stakeholder, Barnet, R2).*

In national policy, IDVAs are described as 'intrinsic' (Home Office, 2006) and 'pivotal' (Home Office, 2007) to the MARAC process. The evaluation of MARACs in South Wales concluded that 'it is difficult to imagine how the MARACs could succeed let alone function without the existence [of IDVAs] (Robinson & Tredidga, 2005: 23). Stakeholders described the role of the IDVAs at MARAC to 'act as the voice of the victim' and 'a central point of contact'. Yet IDVAs here experienced a paradoxical situation where they were expected to 'speak up for victims' but at the same time, found their voices as specialists drowned by those of statutory agencies (see also Harne & Radford, 2008). This contradiction was particularly evident in the earlier case study, where the scheme was criticised publicly and privately for raising that the victim-survivor has refused consent for a MARAC referral. Stakeholders made clear that they saw the primary allegiance of IDVAs to the multi-agency group, even where it compromised aims to build trust with victim-survivors who did not consent.

> Where the client is actually with an IDVA service and the client is saying they don't want to be in MARAC, and the IDVA service hasn't brought the case but maybe the police

[48] At one MARAC observed, where cases were recognised as inappropriate due to low risk, the chair commented that they did not know why the cases had been referred, a comment greeted by laughter around the table.

> have, or the health visitor, or housing, the IDVA should really still be providing information to the MARAC, because if they're joint working they need to communicate what the victim's objections to being in MARAC were... There's enough specialism on MARAC to understand that victims don't necessarily want to be in MARAC, they're there because it is public protection and about how are we as a group going to work to reduce [risk to] that victim and to build trust in that victim... I mean this is still part of being an IDVA *(Stakeholder, Barnet, R2).*

These experiences reflect more fundamental power imbalances between statutory and voluntary sector agencies, particularly women's organisations. Both the model of community co-ordinating councils in the U.S. and the original MARACs in Cardiff were based on mainly statutory agencies with one or two specialised DV services present (McMahon & Pence, 2003; Robinson, 2004). In Wales the protocol stated that DV agencies were to be invited *if* they had had contact with the victim (Robinson, 2004). The evolution of MARACs since locates IDVAs as key to the process, as previously noted, but nevertheless IDVA experience and our observations indicated continuing power inequalities. Specialised services (especially IDVAs) were marginalised by statutory agencies in terms of both numbers and voice. At the MARAC where there was particularly strong leadership from the police and active participation from probation services, the benefits in terms of information and action about perpetrators were tempered by the fact that support for women (rather than her safety) was the final issue to be discussed and women's organisations had little input. In an investigation of 43 co-ordinated community councils in U.S, Nicole Allen (2005) found that different power bases were not explicitly addressed by co-ordinating members. She concludes that the most effective councils displayed an 'inclusive climate' where the voices and experiences of all participating members were invited and respected. Amanda Robinson (2006: 784) concluded that MARACs 'were not part of a co-ordinated community response, they are a co-ordinated community response'. A response, and a 'community', that currently excludes the individuals who are to be discussed and any recognition of conventionally understood 'communities' – neighbours, friends, kin and community associations.

At a more practical level, the 'Ten Golden Rules' of MARACs issued by CAADA state that the IDVA should attempt to contact victims-survivors before the meeting and feedback actions to them (CAADA, 2007). This was referred to frequently by stakeholders, framed as giving updates on victim-survivors in order for the MARAC to review available support options and 'researching' cases. For police, the role of IDVAs was to elaborate on aspects of support beyond the criminal proceedings and report back on the outcomes of the meeting in a sensitive and empathetic way. That, in many cases, the IDVAs were the only practitioners in contact with victim-survivors lent this specific resonance. The extensive knowledge bases of IDVAs with respect to domestic violence and legal and welfare entitlements were also highly valued, although one stakeholder noted that IDVAs new in post at one scheme lacked the necessary knowledge required. From observation at the MARACs, IDVAs from the four schemes demonstrated expertise in the complexity of domestic violence and contributed vital suggestions from their extensive knowledge of possible options (as did other specialised DV organisations).

In the first round of interviews, IDVAs expressed concern that they continued to shoulder most of the work (also noted by Robinson, 2004).

> I always believed a case would be presented, an action plan would be put in place, and people are coming forward and saying "Actually I'm going to do this for this woman". Whereas it just feels like the IDVA is still doing phoning round housing, trying to sort out her transfer or temporary accommodation, chasing, chasing, chasing, chasing *(IDVA manager, R1).*

By the second round of interviews, IDVAs were more positive about responses from statutory agencies at MARAC, but acknowledged that this was due to their own sustained lobbying. It also reflects how IDVAs had established their service and role and felt more comfortable addressing inadequate responses, drawing on their expertise within the specialised voluntary sector.

> [We're now] able to challenge statutory organisations, saying actually we would prefer it to be like this. Having thought about it from the woman's perspective this way [is better]. We are the specialists in working with women, we're the experts *(IDVA manager, R2).*

One tension that arose during the later period of the evaluation was over representation from IDVA schemes at the MARAC. At one scheme, the guidance that senior managers should attend had been misinterpreted as applying to IDVA projects, so both IDVAs and the manager were attending, with serious time implications. In the main scheme managers only attended when IDVAs were unavailable, in recognition that they were most familiar with the details of the case and best placed to request action from MARAC members. Where managers were regularly attending MARACs in place of IDVAs, stakeholders were critical of the lack of detailed feedback, which reinforces how central IDVAs are to the MARAC process.

Finally, from the MARAC observations, it was evident that IDVAs introduce respect and empathy for victim-survivors into the deliberations. On occasion members questioned whether women were lying about the violence. Flippant jokes were made at all four MARACs; other potentially problematic responses included groans when the names of women who were repeat victims came up, disbelief at 'why women stay', a comment about one woman that she was 'a bit daft' (producing much laughter). For the most part, IDVAs interjected, but their marginalisation precluded this on occasion. While this trivialisation and casual manner may be a coping strategy, it nonetheless created an implicit atmosphere of victim-blame. Frequent references were made to women's 'choices', as if they were entirely free to make them, and interventions by Social Services carried the clear message that children would be removed if women returned to the perpetrator. Interestingly, in the evaluation of MARACs in Cardiff, it was also noted that members 'placed the responsibility squarely with the victim' (Robinson, 2004: 19), albeit with sympathy. Enhancing women's safety, decreasing risk, must surely require a focus on the source of danger: perpetrators. Only at a MARAC where the probation service was present and proactive did attention focus on interventions with perpetrators.

Risk assessment

Across the four schemes, IDVAs and stakeholders reported that risk assessments were rarely presented at MARACs. Of the 81 cases observed by the evaluation team, for only seven were formal risk assessments discussed. At each MARAC, a risk assessment should be completed by the referring agency, forming the threshold for referral and distributed with the case details. There was however, concern among IDVAs that agencies were neither skilled nor trained in risk assessment processes and therefore the risk checklists were inadequately and/or incompetently completed.

> When another agency makes a referral, fills in the MARAC form, risk assessment, there is sometimes missing information, wrong information… it is difficult, because when they make a referral to MARAC, that means it's a high risk case by their standard, and it comes to me as an IDVA, and I don't feel necessarily it is high risk *(IDVA, DVSS, R2).*

There are critical issues raised here about whether or not MARACs are focusing, as they are supposed to, on high risk cases when risk assessments that are used to determine thresholds are incomplete, inaccurate or entirely missing. It is the high risk designation which underpins the justification that potentially violates the right to privacy. In the original Home Office exploration of the legal framework under which information sharing can be legitimised it was the risk to personal/public safety that 'trumped' the privacy rights of individuals within the Human Rights Act (Douglas et al, 2004). Using MARACs as either a 'sounding board' or a way for agencies to 'watch their back' risks challenge, since the legal basis for sharing information, especially where consent of the victim-survivor has not been obtained, is absent.

Both stakeholders and IDVAs perceived that most MARAC cases were high risk, but they estimated that on average between 10-20 per cent were not. This was viewed as a consequence of increased referrals and lack of local understanding about domestic violence and MARACs.

> Some of those levels of risk I would say are not actually always as high as CAADA are saying, and that's about some of the practitioners' understanding of what is high risk and what isn't. So there is an element of referring the wrong cases and because you haven't identified properly… some of those cases will end up as information sharing

> cases rather than being truly a MARAC case for a support plan *(Stakeholder, Barnet, R2).*

For IDVAs, low/medium risk also raised issues about potential breaches of confidentiality and the suitability of the MARAC process – they should instead be referred to specialised domestic violence support services. Stakeholders, however, endorsed these cases being discussed at MARAC.

> I don't mind because it's your perception, and the value added by other professionals is important anyway *(Stakeholder, Barnet, R2).*

> I'm encouraging my team to take some medium risk cases, where you know there's a risk of it escalating. I'm wanting more forced marriage cases to go to the MARAC, just so we have a good idea of what risk the violence is in some of the cases *(Stakeholder, Newham, R2).*

These responses speak volumes about the skill gap in statutory agencies, alongside unwillingness to take responsibility for initial case work. This is in sharp contrast to the practice of IDVAs who endeavoured to do their job so that cases did not need to go to MARACs. The original Cardiff MARAC emerged out of a perceived need to find new ways to work with 'chronic' violence; cases where interventions had failed to create safety for women and re-victimisation was extremely likely. MARAC members in the four London boroughs were using them in very different ways; for some it was a 'fishing exercise', for others it seemed more like an opportunity to learn something from others. Neither is the purpose of MARACs.

Outcomes

> In terms of outcomes, I don't think the outcomes are particularly tangible in any case… I have often felt that if there weren't tangible outcomes from referring clients, it was more about [the borough] saying "Look we're spreading out our worry. It might result in putting a tag on the house". Well I could do that without going to the MARAC *(Stakeholder, Newham, R2).*

This interviewee, similarly to some of the IDVAs, felt that specialised DV organisations would already be carrying out all the necessary actions to support victim-survivors and that a referral to MARAC was often superfluous. This was not shared across the schemes, however, although what MARACs achieved was still not what they were intended to.

> I think the process is useful, most definitely. I don't think usually it changes at all the way we work with the clients, we don't usually go to a MARAC and somebody says "Oh that's a good idea, you should do this," I think actually we're on the ball and doing it but it probably helps more with other agencies… because Probation are there, they get maybe more about the perpetrator which helps our risk assessment. I suppose from my point of view that's what I find is the most useful about going *(IDVA manager, R2).*

> I see the MARAC now as a sharing of information exercise more than anything else…. Initially in the beginning when you took a no recourse case to a MARAC, they got things done. Now it's like "Oh well it's not really a MARAC issue, it's not really a DV issue, it's immigration."… And they just swerve it to the side *(IDVA, REACH, R2).*

At the MARACS observed by the evaluation team, the tangible outcomes comprised: letters to immigration supporting victim-survivors' applications for leave to remain; addresses flagged on police computers; referrals to Social Services; housing situations fast-tracked; police escorts arranged. The most potentially productive outcomes involved probation services, who were able to contribute vital information about perpetrators and proactive in adding information to pre-sentencing reports or arranging for perpetrators with outstanding warrants to be arrested at their next meeting with probation officers. However, while some of these (such as letters to immigration) carry the weight of the MARAC process, it is arguable that many could have been arranged outside of the MARAC forum by liaison between agencies, and in the majority of cases it was clear that such inter-agency case advocacy was already taking place via IDVAs.

Closing Cases

The conventional management of MARAC success is that cases are closed, since this is, according to protocols only to take place when risk has been reduced. All stakeholders and IDVAs/managers were asked about the protocol for closing cases. A consensus emerged that the Chair was responsible for the decision to close a case with agreement from those present, although not all MARAC members who were interviewed were clear about the basis of this decision making. In Lambeth, the criterion for being officially removed from the case list is a period of twelve months without any further incidents of violence, but cases are not discussed at meetings beyond the initial MARAC unless there has been a repeat incident. In contrast, in another borough the process of closing cases was more akin to 'bidding' between agencies to keep the case open.

The corollary of increasing throughput is that existing cases are closed in order to make way for new ones, resulting in some MARACs aiming to discuss and close cases in one meeting.

> We're working to CAADA guidance, which is that, basically a case comes to MARAC once, is dealt with, plans put in, and then it should not come back to MARAC unless there is a repeat incident. We've stopped this practice of just keeping every case held over… before there was a sort of tendency to keep them on for a very long time, we now sometimes might hold it on if it's very complicated *(Stakeholder, Barnet, R2).*

This was justified in another borough on the basis that the MARAC does not actually hold responsibility for cases.

> It's not so much as you're closing a case because you're not actively managing a case… you could say that a case is closed after it's been to the MARAC, insofar as the MARAC are concerned, the MARAC process, unless it's re-referred back in *(Stakeholder, Lambeth, R2).*

However, IDVAs and some stakeholders were uncomfortable with the process of this high volume model:

> They close cases too quickly... once the case has been referred to a particular organisation that's it. When MARAC first started, that you would have updates. There would be points of action, and then when you [went] back to the MARAC [the chair] would make sure everybody had done these action points. But that's not happening anymore... they refer and then they close the case. So they aren't following up and saying have you done this, have the police done that, they're not following up at all *(IDVA manager, R2).*

At the root of this anxiety is a lack of confidence in other agencies' appropriate responses to domestic violence, especially high risk cases. As one IDVA noted, the practice of closing cases without follow up 'is based on an assumption that everyone is doing what they are supposed to be doing' (IDVA, NAADV, R2). Reviewing cases in order to hold agencies accountable and ensure victim-survivors were actually safer was a key recommendation of the first evaluation of MARACs (Robinson, 2004). That this is now considered unnecessary for most cases is a cause for concern. The fact that IDVAs have to advocate for their service users with agencies represented at the MARAC shows that they are yet to deliver effective responses that prioritise safety.

Similarly, dealing with such high numbers of cases in each meeting was viewed as problematic since not all agencies round the table were skilled and experienced. One IDVA manager suggested that it would be possible for cases to be effectively dealt with in the time frame if all practitioners were sufficiently engaged and knowledgeable, but currently the levels of knowledge and skills in the borough precluded this.

IDVAs also expressed unease that MARAC cases were regularly closed on the basis that no contact had been made with victim-survivors. The very fact that agencies had been unable to establish contact was, for IDVAs, evidence that levels of risk were unknown and efforts should be redoubled. However, one stakeholder raised similar concerns about an IDVA scheme reporting back at MARACs that they had closed cases where they had not been able to make contact with victim-survivors.

Chapter 8:

Conclusions

Introduction

In this final chapter we present core research findings organised around the evaluation aims, highlighting similarities and differences across the four schemes alongside broader issues relevant to all IDVAs. Some areas, such as risk assessment processes and outcomes, and multi-agency relationships (including MARACs) are relevant to several of the evaluation aims. The requirement that the study 'provide feedback to the sector, service providers and other interested parties on the programmes' achievements and challenges' underpins the whole research report and informs the recommendations which conclude this chapter. The findings show that IDVAs are islands of consistent and ethical practice, in a stream of turbulent and often inadequate responses from other agencies.

Assess the outcomes and impact of the work

As we noted in the introduction to this report, the outcomes and impacts of IDVA schemes included establishing a local presence, referral pathways and their positioning in multi-agency networks. All schemes demonstrated considerable success in developing a local profile, borne out by accounts from MARAC members, although a minority of stakeholders continue to be confused about the remit of the IDVAs and other domestic violence support organisations. Developing referral pathways, particularly cross referral protocols with statutory agencies, has required much energy and finely-tuned negotiation skills. The results are clearer remits of specialised support services in some boroughs, a strong positive outcome. However, this was not universal, and some schemes continued to feel intimidated and/or marginalised by more powerful statutory agencies, leading to confusion for potential referrers and ongoing territorial disputes.

The vast majority of service users were women, and almost all perpetrators male, reinforcing the importance of a gender perspective in IPV interventions. Minority communities were over-represented compared to the London population, and all schemes worked with significant numbers of women with no recourse to public funds. Despite the variance in risk assessment instruments, key indicators documented in the literature such as fear and jealous/controlling behaviour featured in over two thirds of cases, with other factors such as sexual violence, strangulation attempts, conflict over child contact and isolation present in a third. Levels of repeat cases and further incidents of violence were very low across all four schemes, although these are minimal measures through which to judge safety. Half of cases were closed because all needs were met or service users were referred on. These findings demonstrate that IDVAs are successful in achieving targets devised with women and implementing actions that decrease re-assault.

Ten per cent of service users (n=73) took part in the evaluation. They reported both feeling and being safer, with two-thirds reporting no further violence since contact with the scheme. Service users were more confident about their knowledge of services, dealing with the criminal justice system and their legal rights: evidence of advocacy in practice, empowerment through knowledge and securing entitlements that contribute to enhanced safety. Service users also regarded IDVAs as more helpful, supportive, non-judgemental and specialised than other services from which they had sought help. What was most valued were core components of the IDVA model: pro-activity; being enabled to recognise and name violence; listening; safety planning; being given information about rights and options; and liaison with other agencies.

That caseloads here were smaller than those recommended by CAADA was due to two factors: difficulties in recruitment, thus reducing capacity; and the London context, particularly working

with women with no recourse to public funds and housing shortages that require more intensive input. However, in exploring the congruence between IDVA practices and the CAADA model, another significant issue emerged: the limitations of short term crisis intervention in undoing the emotional and psycho-social legacies of being controlled, intimidated and assaulted. IDVAs and stakeholders voiced concerns about the limitations of the IDVA model for those women most diminished by domestic violence. Some schemes kept particular cases open for longer than the recommended timeframe, a manifestation of the tension between the IDVA model and advocacy in practice, and of more differentiated perceptions of risk.

Key messages

- New schemes need time to invest in developing their local profile and multi-agency relationships, including referral pathways and protocols.
- That most service-users are female, and a high proportion from BME communities reinforces the need for a gender perspective which simultaneously recognises the additional needs of minority women.
- IDVA schemes in London face challenges specific to the capital, including high numbers of women with no recourse to public funds where options to reduce risk and enhance safety are constricted.
- Identifying and understanding coercive control emerged as a crucial element in enabling victim-survivors to name violence, address its impact and enabling other agencies to understand the complexities of domestic violence.
- Service users valued the combination of informed advocacy, practical and emotional support that IDVAs provided.
- Whilst IDVA interventions were effective in reducing risk in the short term, sustaining this and re-building lives required ongoing support, which was not always available locally.
- IDVAs in the four schemes adhered to traditional understandings of advocacy – empowerment, securing rights and entitlements – and this was endorsed by service users.

Assess the merits of each IDVA model and suggest improvements as appropriate

The four locations all offer specific merits, especially with respect to access to specialised support.

REACH, based at A&E, was able to do immediate follow up of routine enquiry, which in turn increased identification of victim-survivors by medical staff. Service users here had experienced violence for a shorter period than at other schemes, whilst suffering the most serious recent assaults. A&E presence must, therefore, be understood as early intervention in cases where the risk of physical injury is substantial. Other differences worth noting are that more REACH service users were: in employment; had no recourse to public funds; and fewer perpetrators had criminal records.

For DVSS the police station location made specialised support promptly available to those who make a formal report. The scheme also received referrals from a wide range of agencies, reflecting the dearth of local provision. Strong relationships with police officers expanded their understandings of domestic violence, and willingness to intervene positively, and crucially, the location also enhanced risk assessment processes, as the IDVAs had access to police records.

Both A&E and the police station locations enabled IDVAs to trade on credibility associated with statutory settings, which they believed enhanced responses from other agencies. Further support for this was that the two community based agencies reported more resistance from statutory agencies, including limited acknowledgment of their expertise.

Community based locations offered different benefits, especially seamless transition to ongoing support within the organisation itself. Self-referrals were most evident here, demonstrating the importance of confidentiality for some women, and of women-only provision for others. IDVAs

themselves were also able to draw on decades of expertise within the organisations, access peer support and share knowledge.

At nia, posts were developed to provide services for women in specific local minority communities which had been identified as less likely to access support. The NAADV scheme was designed to provide advocacy for victims whose case came to the local SDVC: time spent at court diminished their caseload capacity, compounded by inefficiencies in court scheduling. There was a higher likelihood of picking up cases that may not be high risk and the setting precluded detailed risk assessment, since the focus was on the court hearing.

Finally, the two schemes that worked from an explicit gendered analysis of domestic violence recorded ongoing coercive control as 'further incidents'. For the two schemes working with male victim-survivors this did not preclude a gender perspective, rather it was essential to make subtle assessments of whether male service users were victims or perpetrators.

Key messages

- The four locations offered varied opportunities and benefits, reaching discrete populations at varying points in dealing with domestic violence.
- As IDVA schemes diversify into a range of settings the 'one size fits all' model will need to be adjusted.
- Whilst schemes in statutory agencies benefited from recognition by association, those in community settings were more able to provide integrated wraparound responses.
- The recent Westminster government VAW strategy which locates domestic violence within a gender equality and human rights framing provides an opportunity for IDVA schemes to reflect on how a gender perspective might enhance their work.
- Several schemes were mindful of the link between coercive control and inequality, following Evan Stark's (2009) recommendation that advocacy should enhance both freedom and safety.

Contribute to an evidence-base on IDVAs

One original contribution of this evaluation is the exploration of how IDVA practice shapes and is shaped by the Co-ordinated Community Response (CCR). Advocacy requires, by definition, working with other agencies, and both SDVCs and MARACs rely for their effectiveness on IDVAs. The ability of IDVAs to deliver advocacy in practice is constrained by responses from other agencies where these are slow, inadequate or simply not forthcoming – housing departments, police and Social Services departments were all identified as, at times, failing to deliver on their responsibilities. Examples of internationally acknowledged integrated CCRs tend to be in small cities, with shared agency boundaries, low staff turnover and key players in post for extended periods. London shares none of these characteristics and faces additional challenges. Whilst the four IDVA schemes undoubtedly made significant contributions to emerging CCRs in their boroughs, there were limits on what new, small projects can achieve. The loss of London-wide co-ordination of DV responses during the evaluation period, undoubtedly reduced the potential for creating consistency of perspective and responses.

Serious concerns were raised about the functioning and contribution of the local MARACs specifically: disregard for victim-survivors consent; patchy attendance; simplistic perspectives on domestic violence. IDVAs made the most contribution to reducing risk, before and after meetings, and in fact only a quarter of scheme cases were referred to MARAC. This was not because cases were low risk, but rather IDVAs had coordinated necessary responses already, making a MARAC referral redundant. Observation of MARACs revealed little evidence of the 'inclusive climate' necessary for effective multi-agency working (Allen, 2005), with IDVAs frequently marginalised.

The independence of IDVAs has been regarded as essential to their effectiveness, reflected in the 'I' of IDVA. The emergence of IDVA schemes and posts in some boroughs within statutory services raises serious questions about how the required independence can be maintained.

In terms of caseloads, the fact that in a quarter of cases violence has been present for less than a year, and over half of service users who participated in the evaluation had experienced less than 20 incidents both confirms that help is sought/offered at an earliest point than research found in the 1990s and reinforced that enabling victim-survivors to recognise and name violence, especially coercive control, was often a necessary first step, even before risk assessment.

For IDVAs, regular supervision is essential to manage the emotional impact of the work, develop skills and confidence and to secure retention of trained staff. It is unreasonable to expect recently established IDVA schemes with fragile status and insecure funding to undertake extensive institutional advocacy.

Key messages

- The ability of IDVAs to secure rights and entitlements is compromised by slow and inadequate responses from other agencies within the CCR.
- Independence should be a core minimum standard for IDVA schemes.
- IDVA interventions, rather than MARACs, appear to have the most impact in reducing risk.
- Whilst institutional advocacy is necessary to challenge stereotypes of domestic violence and poor agency practice, it is fraught with tension for insecurely funded IDVA schemes.

Identify the lessons learnt from the implementation of these projects

In the establishment of new IDVA schemes, time and resources should be allocated to develop an infrastructure of procedures, referral pathways, policies and data monitoring systems. The monopoly of a single provider for IDVA training caused problems for schemes and means the pool of qualified individuals remains small. Retention of trained staff is therefore critical to effectiveness. Funders and commissioners should be mindful of this and make timely decisions about forward funding.

All schemes found that aspects of the CAADA model, on which their effectiveness was assessed, failed to take account of the particulars of London, the specificities of their locations, and the needs of some of their service users.

The expertise of IDVAs and scheme managers was a combination of their training and the knowledge based practice that many brought with them from the women's voluntary sector. Preserving and building on this is vital to the continued development of responses to domestic violence.

Key messages

- Three months should be allocated for establishing the infrastructure for new schemes.
- The 'one size fits all' model for IDVAs needs to be revisited to take account of local contexts, different settings and women who have been most diminished by domestic violence.
- Short term funding regimes undermine the capacity of IDVA schemes to retain trained staff and compromise their effectiveness.

Identify best practices for wider dissemination

We use the concept of 'promising' rather than 'best' practices to highlight that practice continues to evolve, and contexts vary, so that what is 'best' at one point in time or a specific place may not be over time or in other contexts.

Whilst few IDVAs used the language of rights, their focus on knowing and securing entitlements both reduced risk and empowered service users. This frequently required persistence with

reluctant agencies, even reminding them of their legal responsibilities. Building alliances with other specialised agencies created more space for the perspectives of victim-survivors to be heeded in multi-agency forums. IDVA participation in MARACs protected the rights and interests of all victim-survivors, not just those they were directly involved with, by: respecting the right to privacy and consent; challenging victim-blame; acting as an advocate through voicing the needs and concerns of victim-survivors.

The fact that many service users were contacted relatively early meant IDVA practice also had to be a form of early intervention, naming violence and re-framing actions of perpetrators. As already noted, two schemes recorded further coercive control as incidents of violence, a practice we commend as promising. IDVAs frequently had to negotiate a tension between respecting women's choices and enhancing safety, and used 'empowerment through knowledge' as way to do this. Maintaining pro-active contact not only enabled monitoring of changes in risk but also provided opportunities to reinforce the message that women not only had the possibility of lives free of violence, but also that they had legal and other entitlements to enable them to achieve this.

Key messages

- IDVAs need a thorough knowledge of victim-survivors' entitlements and the ability to skilfully negotiate their realisation.
- IDVAs bring the voice and interests of victim-survivors to MARACs.
- Identifying coercive control as violence and an indicator of dangerousness is a promising practice.
- Two aspects of pro-activity – initial contact and ongoing 'checking in' – opened doors to support and enabled monitoring of risk.

Potentials for development

The most significant potential for development is the creation of local 'wraparound' provision, since the effectiveness of IDVA schemes is dependent upon the availability of other specialised services to refer on to. However, there is a danger that the policy focus on IDVAs will eclipse other essential specialised services, particularly those offering longer term support and/or safe shelter. IDVAs are only one part of a CCR, without the other components – especially the voluntary women's sector – the range of needs among victim-survivors' cannot be addressed and changes in risk may not be picked up.

The most commonly desired development from service users and stakeholders was increasing availability and capacity of IDVA schemes through: extending hours to evenings and weekends; expanding numbers of IDVAs; establishing satellite services in local agencies. IDVAs also have a unique potential to reach out into communities where women have limited access to support – those in minority communities and secure environments, such as prisons, inpatient mental health provisions and detention centres. All, however, have resource implications.

Finally, IDVA schemes hold both indepth knowledge of domestic violence and information about local provision and systems; this could be a rich resource in local training.

Key messages

- Wraparound provision is essential to meet the short, medium and long term needs of victim-survivors.
- IDVAs support those currently on the margins of existing provision.
- Provision of training by IDVAs has the potential to enhance local CCRs.

Recommendations

We conclude with a number of recommendations drawn from the research findings.

Practitioners

- Coercive control (jealous and controlling behaviour) should be regarded as a critical risk factor, including for homicide, and where it continues, should be recorded as ongoing domestic violence.

Policymakers

- Given the experiences of these four schemes, the role of MARACs in safety planning needs to be re-examined.
- Operational issues about MARACs need to be addressed:
    - All victim-survivors referred to MARACs should be provided with full information about the purpose and process of these bodies.
    - Procedures for MARACs should be developed that require victim-survivor consent for information sharing.
    - All cases should be reviewed before they are closed.
- IDVAs should be regarded as 'critical allies'; part of their role is to challenge poor practice, through institutional advocacy, without fear of negative implications for their funding.
- The CCR model should recognise the significance of informal networks in supporting victim-survivors; local and national awareness campaigns should enhance knowledge of controlling behaviour as violence.

Commissioners

- IDVAs are only one part of a Co-ordinated Community Response, and to be effective need other specialised services to refer onto. Provision for victim-survivors of domestic violence needs to be comprehensive, available for those at low, medium and high risk, including refuges for those who need enhanced safety measures.
- A broader set of indicators of success should be developed for IDVA schemes that include their impact on CCRs. This outcome is not measurable as a standard output, but nonetheless is essential recognition of their role enhancing agency understandings of domestic violence and appropriate responses to victim-survivors.
- IDVAs should be regarded as 'critical allies'; part of their role is to challenge poor practice, through institutional advocacy, without fear of negative implications for their funding.
- Each of the locations of the four schemes had distinct benefits, suggesting that IDVAs should be based in a range of settings in order to create multiple access routes into specialised support and reach different populations. Basing IDVAs in A&E appears to offer early intervention, and should thus be regarded as an effective use of resources that reduces costs to the public purse. IDVAs in police stations can directly influence responses and undertake comprehensive risk assessments. IDVAs in community based organisations enable self-referrals, reach minority communities and provide holistic responses through seamless access to other services within the organisation.
    - For IDVAs who work with minority communities, necessary investment in developing outreach and referral routes should be funded according to local contexts.
- Since independence is integral to the IDVA model, they should remain at arm's length from the statutory sector. Even IDVAs located in statutory settings such as police stations and hospitals need to be positioned as independent in order to effectively advocate for service users.

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Appendix 1:

Methodological Challenges

Database

Dovetailing the different ways that schemes record information was an extremely time consuming process, as there were significant variations not only in the ways that information was recorded, but also in the types of information routinely collected. After several attempts to create a design that met all the needs of each scheme, a decision was made to base the design on Barnet DVSS. As they only provide IDVA services it was simpler to work from them outwards, with additional fields incorporated for the other schemes with more layered provision. Sections on risk assessment were bespoke to each IDVA scheme, as each began using a different risk assessment tool. This enabled comparative analysis of how each scheme's caseload varies in terms of proportions identified with specific risk indicators, and whether there were differences in the types of risk reported by service user populations at each scheme. Some fields were also specific to projects – for example, DVSS records whether or not service users are local authority care leavers. Cases of family violence are retained in analysis in this report because two of the schemes base their work on the Westminster government definition and thus consider these cases integral to their work.

However, installation of the database was hampered by software availability and alterations to scheme paperwork that were not communicated to the evaluators. Consequently the database was not installed at all four schemes until April 2008, when schemes had been operating for several months. None of the schemes used the databases for their own monitoring purposes: two developed a simpler version containing only the fields they required to report on outcomes to funders, and the two schemes based in larger organisations were required to use management systems. The evaluation data collection led to all schemes reflecting on what data they collected and for what purposes. Some were subject to particularly onerous reporting requirements from external funders that they did not perceive had relevance to their performance. A target driven culture has privileged assessments of success based on quantitative measures, designated longer term ambitions as less measurable and marginalised the perspectives of service users (Kelly et al, 2008). This was at odds with a priority in some schemes to locate success on empowerment and enhanced safety for service users, which are less easy to capture in purely statistical data.

Time constraints and the limited administrative support in schemes (only available in NAADV) meant that the inputting of already completed case data was beyond the capacity of IDVAs, although at one scheme, one of the IDVAs took on inputting the first year of cases as overtime. In April 2008 the research team commissioned the consultant who built the databases to spend time at each project inputting the backlog of cases. A copy of each database was then used to undertake interim analysis using the Statistical Package for the Social Sciences (SPSS, version 14.0). This stage revealed significant gaps across many fields. The inputting for the second year of case files (April 2008-2009) again presented a time and capacity challenge, and two schemes employed someone else from within their organisation to input data. Resource implications for extensive data inputting were also noted in a recent national multi-site evaluation of IDVA schemes (Howarth et al, 2009), and raises serious questions about funding levels where interventions are expected to report regularly on complex outcome measures.

The shift from paper to electronic recording represented a very different mode of working for most IDVAs (see also Howarth et al, 2009). This was compounded by the fact that initially not all schemes had systematic case file documentation or standardised recording methods. While levels

of record keeping and the organisation across case files varied across the projects, it nonetheless presented a challenge to locate information. Unsystematic recording affects our ability to report on outcomes, and combined with the lack of priority given to keeping the database up to date, meant that the intended case tracking function of the databases was severely limited. In March 2009, a decision was made to pare down the database fields to those essential for evaluation purposes. While this involves some compromises in terms of the information on which we are able to report, it reduced the pressure on schemes to input large amounts of data that detracted from front line support work.

Data was cleaned by the evaluators in order to ensure that all cases met the criteria for inclusion. Duplicate cases were removed from three databases, although where it was unclear whether they were duplicates or repeats details were checked with IDVAs. A small number of cases outside of the specified data collection period were also removed. The evaluation team also visited NAADV and manually extracted data on risk assessments from case files when it emerged that the evaluators had not been informed or the database amended following a substantial change to the risk assessment instrument in July 2008.

Service User Perspectives

Each project was issued with 100 questionnaires, a protocol for distribution and pre-paid return envelopes addressed to CWASU in January 2008. Questionnaires were distributed by the IDVA schemes with self-addressed envelopes to be returned to the evaluation team, and included a consent form that allowed service users to indicate that they would prefer to be interviewed by telephone. This route aimed to enable victim-survivors without English as a first language to participate via this route, although some added at the end of the returned postal questionnaire that they had struggled with English and completed them to the best of their ability. Projects were also asked to record the distribution on pro-formas and send these back to the evaluation team on a monthly basis so that we could compare distribution and return rates, but the forms were rarely returned. Without questionnaire returns the evaluation team had no means to contact service users to conduct more in depth interviews.

Through discussion with the schemes and funders, new strategies were introduced to contact service users and garner their experiences. The first was for the evaluation team to interview them during observation visits at the schemes. This was dependent on service users attending and consenting to participate during the period of the observation visit when in fact much IDVA work is undertaken by telephone. The fact that most of the contact with service users was by telephone posed an unanticipated challenge for the evaluation team since on only one occasion was an interview conducted during an observation visit. This strategy was also impractical for REACH, as service users present at the IDVA site were almost always those who had just been admitted to hospital, with little or no experience of the scheme and typically seriously injured and/or distressed. Telephone contact emerged as a more fruitful route, so schemes were asked to seek permission for evaluation team to make direct contact. However, this process was also not straightforward, as the majority of calls were unanswered and many numbers were unobtainable. This illustrates the particular challenges of research with women who are in the process of attempting to end violence in their lives. The necessities of moving, changing telephone numbers and screening calls linked with the often complex negotiations with multiple agencies combine to make this a 'hard to reach' group. We see this not as a challenge which methodological innovation could overcome, but a reflection of the demanding material reality that dealing with domestic violence creates. Whilst creating new and flexible routes for inclusion in research is the responsibility of researchers, it also behoves us to respect that participation cannot be a priority for people whose lives are at risk and/or in turmoil.

By September 2008 only 20 of a possible 400 questionnaires had been returned, and a decision was taken to set a target of 25 for each scheme (total 100). This sample was sufficient for meaningful conclusions to be drawn. The majority of service users who completed questionnaires also agreed to an in depth interview with the research team. However, difficulties in reaching service users by telephone meant not all of those volunteering were interviewed. In a small

number of cases, interviews were conducted at the same time as completion of the questionnaire by telephone.

Stakeholder Interviews

Table 1 shows the affiliation of the stakeholders (MARAC members) that were interviewed as part of the evaluation.

Table 1: Stakeholder interviews rounds 1 and 2

Stakeholder affiliation	DVSS		NAADV		nia		REACH		Total
	2007/8	2009	2007/8	2009	2007/8	2009	2007/8	2009	
DV – specialised voluntary sector	1		1	1			2		5
DV – strategic role	1	1		1			1	3	7
Health (A&E staff)								5	5
Social Services C&F	1		1		2		1		5
Police (MARAC chair and CSU)			1	1			2	1	5
Housing Officer	2	1			1				4
DV – statutory			1		1	1			3
MARAC co-ordinator		1			1				2
Social Services – adults	1		1						2
Drugs and Alcohol						1			1
Education Welfare		1							1
Health (Safeguarding Children Nurse Advisor)		1							1
Housing Options Officer/DV		1							1
Mental Health		1							1
Victim Support				1					1
Total	**13**		**9**		**7**		**13**		**44**

*Includes DV Centre Co-ordinator, DV Co-ordinator, Co-ordinator of domestic violence court, local authority Domestic Violence and Hate Crime Manager and MARAC Coordinator

In order to interview A&E staff about REACH, the scheme manager supplied the name, designation and contact details of five staff. It was impossible to reach them by telephone and several rounds of emails went unanswered. In July 2008, we liaised with the nurse responsible for liaison with REACH to arrange a date on which we would be available all day in the hospital. However the nurse liaison failed to turn up and despite assistance from another nurse, we were unable to find any other of the specified members of staff. In November 2008 the REACH manager and the new nurse liaison arranged for members of clinical staff to be available for interview during breaks or quiet times in shifts on a nominated day. The evaluation team spent the day at A&E and interviewed five staff (four nurses and one doctor). Two senior staff with a remit to strategically steer domestic violence services within the hospital were subsequently interviewed by telephone in early 2010.

Appendix 2:

Financial analysis

The cost of providing support to each victim-survivor was calculated using the formula developed by Howarth et al (2009:16) in their multi-site evaluation of IDVA schemes: division of an IDVA salary plus on costs by annual caseload. While Howarth et al used an estimated average caseload of 100 cases, we base our figures on the annual caseload per IDVA as derived from the number of cases on the database, divided by number of IDVAs at each scheme. Hence for DVSS, nia and REACH the scheme caseload was halved, while at nia it was divided by 3.6 to reflect the two full time posts and the two 0.8 WTE posts. However, there are some important caveats:

- Salary levels varied by scheme, as did monies allocated to expenses (travel, stationery, telephone).
- As we note in the main report, capacity was diminished by delays in staff recruitment and turnover, and schemes required time to establish themselves and referral pathways. Thus the caseload recorded in the two year evaluation period reflects the *development journey* of the schemes rather than their *established capacity*. Costs would *fall* where schemes are able to support higher numbers of victim-survivors than in their first two years. Similarly, start up costs would not appear in subsequent years calculations.
- Scheme managers often spent time on casework because of vacant posts. A proportion of this is reflected in the managerial on costs, but no means all. As managers' salaries are generally higher than those of IDVAs, the actual cost of support provision to the schemes will have been somewhat higher than the calculations suggest.
- Where the Co-ordinated Community Response (CCR) is not functioning effectively, IDVAs are required to provide more intensive input per victim-survivors in order to secure entitlements, which, in turn, increases costs per case.

Table 1 shows the figures for each scheme. Across the four schemes, the average cost per service user is £501, slightly higher than the 'less than £500' per victim-survivor in the Hestia multi-site evaluation (Howarth et al, 2009:16): however, the majority of the schemes in that study were well-established, and thus able to maximise caseloads. The two schemes in this evaluation which had the most streamlined referral processes fall into this bracket, whereas the two which focused on minority women and SDVC cases respectively had higher costs.

Table 1: Cost of IDVA support per victim-survivor

IDVA scheme	IDVA annual salary + oncosts	Number of full-time IDVAs	Average annual caseload	Cost per victim-survivor
DVSS	£43,303.78	2	119	£363.94
REACH	£37841	2	91	£415.84
Nia	£38,655.77	2 + 2 @ 0.8	56*	£690.28
NAADV	£45,526.86	2	64**	£711.36
Total	£165327.41	8 + 2 @ 0.8	330	£500.99 (average)

* rounded up from 55.83
** rounded up from 63.5

With the above caveats in mind, and drawing on wider evidence from the evaluation, the following observations can be drawn.

- Schemes that have a specific remit have higher overall costs per victim-survivor than those that are able to take referrals from a wider network.
    - Both DVSS and REACH had larger caseloads per IDVA, which in turn reduced the overall cost of support to each victim-survivor.
    - Schemes based in statutory settings also had fewer overheads such as rent, ICT equipment, as these costs were underwritten by the police (DVSS) and NHS (REACH). These costs are therefore not visible in the above figures. If full economic costings were calculated the amount per case would increase.
    - Time spent by NAADV IDVAs at the Specialist Domestic Violence Court (SDVC) reduced their advocacy/support capacity.
    - nia had to devote more time to recruitment than other schemes and to outreach, in order to deliver services to minority communities.

Reflections

Jarvinen et al (2008) calculated the cost of domestic violence to be £20bn per year in 2006/2007 terms, with an additional £18.8bn for sexual violence (at 2003/2004 costs) perpetrated by intimate partners (p118-120). This figure comprises: human and emotional costs; lost economic output; civil legal costs; housing costs; Social Services and children; mental and physical health; and criminal justice (p118). They also cite costs developed by CAADA 'of an average 'high risk' victim to statutory agencies' of over £10,000 per year, comprised of six police call outs and six visits to A&E, eight GP appointments and anti-depressant medication, 12 nights in a refuge and a prosecution (p30). The 'average' victim-survivor in these calculations, however, has no children and no lost employment days, nor are voluntary sector resources included. The case file data from the four IDVA schemes demonstrates that between half and three quarters of scheme service users had children, and a significant proportion had social services involvement, which would add to the costs.

Against this, the average cost of £500 per victim-survivor supported by IDVAs, even the higher cost of £700 for the community based schemes, represents considerable savings. To put the figure in context with other costs:

- One police call out costs £1,027[49].
- The Social Services assessment process per child costs an average £2,300[50].
- The estimated cost to the state of investigating one rape is £73,487[51] (Dubourg et al, 2005).

Findings from the evaluation demonstrate that advocacy and support from IDVAs enabled women to feel and be safer and increased their knowledge of available options. Over a third (34.8, n=200) of all cases were closed because IDVAs had met all the service users' needs and in a further 15.7 per cent (n=90), risk was reduced to the point that a referral was made onto a more appropriate support organisation. For two thirds (65.3%, n=47) of service users who participated in the evaluation, there had been no further violence since contact with IDVAs.

To the extent that IDVA support/advocacy enables women to live free from violence, the cost per service user of between £363-£711 is undoubtedly a worthwhile investment.

[49] Source: Government Office for London (cited in Coy, M, Kelly, L & Foord, J (2007) Map of Gaps: The Postcode Lottery of Violence Against Women Support Services London: EVAW p45.)

[50] Source: RSE consulting (2007) based on figures for three London boroughs. (Cited in Coy et al, 2007: 45.)

[51] Dubourg, R, Hamed, J & Thorns, J (2005) The economic and social costs of crime against individuals and households 2003/04 London: Home Office

Appendix 3:

Data tables

Table 1: Length of relationship and violence

Scheme	DVSS (n=238)	Nia (n=201)	NAADV (n=127)	REACH (n=182)
Relationship mean	7.75 years	7.75 years	9.25 years	5.5 years
Minimum	1 month	1 month	3 months	2 months
Maximum	29 years	36 years	38 years	38 years
Missing cases	73 (30.1%)	60 (29.9%)	89 (70.0%)	76 (41.8%)
Violence mean	6.17 years	5.5 years	7 years	3.75 years
Minimum	3 months	1 month	2 months	1 month
Maximum	26 years	26 years	25 years	29.5 years
Missing cases	108 (45.3%)	48 (23.9%)	117 (92.1%)	81 (44.5%)

Table 2: Age range of service users

Age bracket	DVSS		Nia		NAADV		REACH		Total	
	N	%	N	%	N	%	N	%	N	%
Under 16	2	0.8	0	0	1	0.8	1	0.5	4	0.5
16-20	25	10.5	8	4.0	6	4.7	20	11.1	59	7.9
21-30	80	33.6	76	37.8	49	38.6	60	33.0	265	35.4
31-40	60	25.2	61	30.3	30	23.6	49	26.9	200	26.7
41-50	26	10.9	33	16.4	18	14.2	35	19.2	112	15.0
51-60	5	2.1	3	1.5	7	5.5	10	5.5	25	3.3
61-70	2	0.8	3	1.5	1	0.8	1	0.5	7	0.9
Over 70	2	0.8	2	1.0	3	2.4	3	1.5	10	1.3
Missing	36	15.1	15	7.5	12	9.4	3	1.6	66	8.8
Total	238	100	201	100	127	100	182	100	748	100

Table 3: Ethnicity of Service users

Ethnicity	DVSS		Nia		NAADV		REACH		Total	
	N	%	N	%	N	%	N	%	N	%
White British	94	39.5	35	17.4	28	22.0	50	27.5	207	27.8
White Other	42	17.6	32	15.9	7	5.5	14	7.7	95	12.7
Black African	11	4.6	33	16.4	12	9.4	18	9.9	74	9.9
Black Other	12	5.0	5	2.5	6	4.7	29	15.9	52	6.9
Other	1	0.4	14	7.0	10	7.9	26	14.3	51	6.8
Black Caribbean	8	3.4	26	12.9	8	6.3	6	3.3	48	6.4
Mixed Any	6	2.5	8	4.0	2	1.6	12	6.6	28	3.7
Asian Other	13	5.5	4	2.0	1	0.8	3	1.6	21	2.8
Asian Indian	6	2.5	4	2.0	8	6.3	3	1.6	21	2.8
White Irish	6	2.5	6	3.0	1	0.8	1	0.5	14	1.9
Asian Pakistani	6	2.5	4	2.0	4	3.1	0	0	14	1.9
Black British	0	0	8	4.0	0	0	0	0	8	1.1
Asian Bangladeshi	1	0.4	1	0.5	5	3.9	0	0	7	0.9
Asian Chinese	2	0.8	1	0.5	0	0	1	0.5	4	0.5
Mixed Asian	0	0	0	0	0	0	1	0.5	1	0.1
Missing	30	12.6	20	10.0	35	27.6	18	9.8	103	13.7
Total	238	100	201	100	127	100	182	100	748	100

Table 4: Service user employment status

Employment status	DVSS		nia		NAADV		REACH		Total	
	N	%	N	%	N	%	N	%	N	%
Unemployed	189	79.4	159	79.1	117	92.1	126	69.2	591	79.0
Employed (full time)	16	6.7	19	9.5	5	3.9	37	20.3	77	10.3
Employed (part time)	12	5.0	16	8.0	4	3.1	19	10.4	51	6.8
Employed (unspecified)	21	8.8	7	3.5	1	0.8	0	0	29	3.9
Total	238	100	201	100	127	100	182	100	748	100

Table 5: Service user housing status

Type of housing	N	%*
Local authority	204	37.2
Private sector rental	99	18.1
Housing association	78	14.2
Owner occupied	65	11.9
Temporary accommodation including hostels	54	9.9
Staying with friends/relatives	43	7.8
Refuge	5	0.9

* Percentages here are adjusted for missing data and where the category 'other' did not have any more details.

Table 6: Referral sources as recorded on IDVA scheme databases

Referral source	DVSS		nia		NAADV		Reach		Total	
	N	%	N	%	N	%	N	%	N	%
Self	14	5.9	38	18.9	3	2.4	10	5.5	65	8.7
Health (all)	11	4.6	46	22.9	1	0.8	152	83.5	210	28.1
A&E department	0	0	17	8.5	0	0	137	75.3	154	20.6
Clinical Decision Unit	0	0	0	0.0	0	0	5	2.7	5	0.7
Minor Injuries Unit	0	0	0	0.0	0	0	5	2.7	5	0.7
Paediatric department	0	0	0	0.0	0	0	2	1.1	2	0.3
Hospital**	5	2.1	0	0.0	1	0.8	3	1.5	9	1.2
GP	0	0	25	12.4	0	0	0	0	25	3.3
Health Visitor	5	2.1	2	1.0	0	0	0	0	7	0.9
Mental health	0	0	1	0.5	0	0	0	0	1	0.1
Drugs/alcohol service	1	0.4	0	0.0	0	0	0	0	1	0.1
Police (all)	56	23.5	36	17.9	88	69.3	1	0.5	181	24.2
Police CSU	39	16.4	28	13.9	78	61.4	0	0	145	19.4
Police (unspecified)	13	5.5	8	4.0	0	0	1	0.5	22	2.9
Police Safer Neighbourhood	2	0.8	0	0.0	0	0	0	0	2	0.3
Police Sapphire	2	0.8	0	0.0	0	0	0	0	2	0.3
Police CJU[52]	0	0	0	0.0	1	0.8	0	0	1	0.1
Witness Care Unit	0	0	0	0.0	9	7.1	0	0	9	1.2
Other statutory (all)	124	52.1	25	12.4	8	6.3	0	0	157	21.0
Social Services (children/ families)	40	16.8	4	2.0	0	0	0	0	44	5.9
Social Services (adults)	1	0.4	0	0.0	0	0	0	0	1	0.1
Social Services (unspecified)	0	0	10	5.0	4	3.1	0	0	14	1.9

Referral source	DVSS		nia		NAADV		Reach		Total	
	N	%	N	%	N	%	N	%	N	%
MARAC	21	8.8	0	0.0	2	1.6	0	0	23	3.1
Probation	14	5.9	2	1.0	0	0	0	0	16	2.1
Housing	48	20.1	7	3.5	0	0	0	0	55	7.4
Education	0	0	2	1.0	0	0	0	0	2	0.3
Specialist Domestic Violence Court	0	0	0	0.0	2	1.6	0	0	2	0.3
Support organisations (all)	30	12.6	40	19.9	12	9.4	13	7.0	95	12.7
DV organisation***	25	10.5	28	13.9	9	7.1	7	3.8	68	9.1
Victim Support	0	0	2	1.0	3	2.4	6	3.2	11	1.5
Turkish women's organisation	0	0	2	1.0	0	0	0	0	2	0.3
Somali women's organisation	0	0	1	0.5	0	0	0	0	1	0.1
Children's centre	0	0	3	1.5	0	0	0	0	3	0.4
Young people's service	5	2.1	1	0.5	0	0	0	0	6	0.8
National DV helpline	0	0	4	2.0	0	0	0	0	4	0.6
Missing	1	0.4	9	4.5	15	11.8	6	3.2	32	4.3
Other	2	0.8	7	3.5	0	0	0	0	9	1.2
Total	238	100	201	100.0	127	100	182	100	749	100

** includes hospital social work teams and other hospital departments
*** includes DV Co-ordinators and other DV teams within organisations/setting

[52] The Criminal Justice Unit (CJU) links police officers and the Crown Prosecution Service (CPS), and is responsible for administration, preparation and processing of prosecution files and care of victims who become witnesses in the criminal justice process.

Table 7: Health and Psychosocial needs of services users

Health need	DVSS (n=238)		Nia (n=201)		NAADV (n=127)		Reach (n=182)		Total	
	N	%	N	%	N	%	N	%	N	%
Physical health issues	10	4.2	21	10.4	6	4.7	101	55.5	138	45.1
Mental health issues	20	8.4	33	16.4	2	1.6	9	4.9	64	20.9
Physical and mental health issues	3	1.3	17	8.5	3	2.4	3	1.6	26	8.5
Drugs	6	2.5	2	1.0	0	0	3	1.6	11	3.6
Alcohol	5	2.1	2	1.0	1	0.8	1	0.5	9	2.9
Alcohol, drugs and mental health issues	1	0.4	1	0.5	1	0.8	3	1.6	6	2.0
Alcohol and disability	1	0.4	0	0	0	0	0	0	1	0.3
Alcohol, disability, drugs and physical health issues	1	0.4	0	0	0	0	0	0	1	0.3
Alcohol, disability, drugs, mental and physical health issues	0	0	3	1.5	0	0	0	0	3	1.0
Alcohol and drugs	9	3.8	1	0.5	0	0	0	0	10	3.3
Alcohol, drugs and physical health issues	1	0.4	0	0	0	0	2	1.1	3	1.0
Alcohol and mental health	5	2.1	2	1.0	1	0.8	4	2.2	12	3.9
Alcohol, mental health and physical health issues	1	0.4	0	0	0	0	0	0	1	0.3
Alcohol, drugs, mental health and physical health issues	0	0	0	0	0	0	2	1.1	2	0.7
Alcohol and physical health	0	0	1	0.5	0	0	0	0	1	0.3
Disability	2	0.8	3	1.5	0	0	0	0	5	1.6
Disability, mental health and physical health	1	0.4	1	0.5	0	0	1	0.5	3	1.0
Disability and physical health	0	0	2	1.0	0	0	1	0.5	3	1.0
Disability and mental health	1	0.4	1	0.5	0	0	0	0	2	0.7

Health need	DVSS (n=238)		Nia (n=201)		NAADV (n=127)		Reach (n=182)		Total	
	N	%	N	%	N	%	N	%	N	%
Disability, drugs, and physical health issues	1	0.4	0	0	0	0	0	0	1	0.3
Drugs and mental health	0	0	1	0.5	0	0	0	0	1	0.3
Drugs, mental and physical health issues	0	0	2	1.0	0	0	1	0.5	3	1.0
Total	68	28.6	93	46.3	14	11.0	131	62.0	306	100

There are three sets of figures shown in table 8: the first column refers to the cases where risk indicators applied, as not all were present on all risk assessments, and percentages are calculated against the total sample (n=748). The second contains data on cases where data is recorded, as in around a third of cases risk assessment data was missing on the database. The final column shows cases where the risk indicator was present, and percentages are calculated against the number where the indicator applied. It is possible that the missing data mean that these responses are not representative of the whole caseload of each scheme. For indicators relating to children, the first column refers to the number of service users with children, with percentages in this column calculated against the number of cases where this risk indicator applied.

All four risk assessment instruments were weighted in different ways, with some using a simple addition system and others weighting indicators, an analytic approach recommended by Regan et al (2007) to prioritise high risk factors. However, the fields on scoring/weighting were poorly recorded on the database, making it impossible to report on the scoring outcomes here.

Table 8: Risk indicators

Risk indicator	Base N1: Cases where this indicator was in use		Base N2: Cases where risk assessment was completed		Cases where risk indicator was present	
	N	%	N	%	N	%
Victim is frightened[53]	626	83.7	423	67.6	310	73.3
Victim fears further violence	748	100	441	59.0	310	70.3
Jealous/controlling behaviour[54]	553	73.9	360	65.1	248	68.9
Has been/going to be separation/repeated separation and reconciliation[54]	553	73.9	366	66.2	237	64.8
Most recent incident caused injuries[54]	553	73.9	377	68.2	209	55.4
Perpetrator has financial problems[54]	553	73.9	357	64.6	144	40.3
Strangulation/choking attempts[54]	553	73.9	363	65.6	143	39.4

Risk indicator	Base N1: Cases where this indicator was in use		Base N2: Cases where risk assessment was completed		Cases where risk indicator was present	
	N	%	N	%	N	%
Victim is isolated[55]	675	90.2	424	62.8	151	35.6
Sexual violence[54]*	553	73.9	352	63.7	109	31.0
Criminal record for offences relating to domestic violence[56]	675	90.2	393	58.2	94	23.9
Perpetrator has mental health problems[54]	553	73.9	355	64.2	68	19.2
Perpetrator has harmed children[54]**	388	62.0	279	71.9	39	14.0
Victim is pregnant/has given birth in last 12 months [54]	553	73.9	358	64.7	37	10.3
Threats to kill animals/abused animals[54]	553	73.9	356	64.4	17	4.8
Threats to kill victim[57]	499	66.7	341	68.3	170	49.9
Conflict over child contact[57]**	323	64.7	238	73.7	88	37.0
Perpetrator has drugs problems[57]	499	66.7	332	66.5	99	29.8
Perpetrator has alcohol problems[57]	499	66.7	331	66.3	114	34.4
Stalking/harassment[58]	388	51.9	261	67.3	77	29.5
Perpetrator has access to weapons[57]	371	49.6	261	70.4	60	23.0
Victim has suicidal thoughts[60]	621	83.0	422	68.0	75	17.8
Threats to kill self[57]	499	66.7	333	66.7	56	16.8
Threats to kill children[57]	323	64.7	242	74.9	27	11.2
Threats to kill others[57]	499	66.7	341	68.3	31	9.1
Threats to kill/harmed previous partner[57]	499	66.7	341	68.3	11	3.2

*Includes the indicator 'forced to have sex' from nia's new risk assessment, in addition to 'sexual harm'.
** These numbers are based on those service users with children and where the risk indicator was in use (see Appendix 4).

[53]On all four current risk assessments but not the original at nia.

[54] Not on the original risk assessment at nia and NAADV.

[55] On all four current risk assessments and the original at NAADV.

[56] On all four current risk assessments and the original at nia.

[57]Not on the original risk assessment at nia or on either at NAADV.

[58]Not on the original risk assessment at nia and the current at DVSS.

[59]Not on the original risk assessment at nia and NAADV, or at REACH, although the latter ask if the most recent injuries involved weapons.

[60] Not on the original or current risk assessments at NAADV.

Table 9: Helpfulness of agencies

Agency	Helpful	Quite helpful	Not helpful
Police	7	7	12
GP/health centre	6	2	4
Social Services	2	3	5
Domestic violence organisation	4	1	3
Voluntary organisation	3	-	2
Victim Support	2	-	1
IDVA	2	-	-
Church	-	1	-
Local authority	-	1	-
Housing	1	-	-
Counselling/therapist	1	-	1
Family	-	-	1

Table 10: Important issues for service users

Issue	Very important	Quite important	Neither important nor unimportant
Support/listening	64	5	1
Safety planning	54	9	5
Keeping informed about legal case	53	4	7
Information about options	52	14	2
Contacting other services on their behalf	50	9	7
Referrals to other services	42	12	10
Court accompaniment	36	4	12
Accompaniment to other services	26	11	15
Attending Children and Family Meetings	23	6	16

Table 11: CJS experiences before contact with the IDVA scheme

Frequency	Called police		Perpetrator arrested		Perpetrator convicted		Made statement and withdrawn	
	N	%	N	%	N	%	N	%
Once	19	26.4	28	38.9	20	28.2	19	27.1
A few times	19	26.4	18	25	4	5.6	9	12.9
Several times	18	25	4	5.6	1	1.4	6	8.6
No	16	22.2	22	30.1	46	64.8	36	51.4
Total	72	100	72	100	71	100	70	100

Appendix 4:

Risk Assessments

Risk Indicators	DVSS (n=238)			NAADV Original RA (n=73)				NAADV new RA (n=54)				Nia new RA (n=79)			REACH (n=182)			
	N	%[61]	Missing N (%)	N	%	Unsure N	Missing N (%)	N	%	Unsure N	Missing N (%)	N	%	Missing N (%)	N	%	Unsure N	Missing N (%)
Pattern of domestic violence																		
Most recent incident caused injuries	77	47.5	76 (31.9)					10	45.5	0	32 (59.2)	18	23.7	3 (3.9)	104	88.9		65 (35.7)
First injuries												7	9.2	3 (3.9)				
Previous incidents caused injuries															95	83.3		64 (35.2)
Injuries are a significant concern	19	11.7	76 (31.9)												51	43.2		64 (35.2)
Victim incapacitated by perpetrator															12	12.4	1	85 (46.7)
Incapacitation a significant concern															5	5.8		86 (47.3)
Recent incident involved weapons	42	25.9	76 (31.9)												42	36.2		66 (36.3)
Weapons are a significant concern	15	9.3	76 (31.9)															

Risk Indicators	DVSS (n=238)			NAADV Original RA (n=73)				NAADV new RA (n=54)				Nia new RA (n=79)			REACH (n=182)			
	N	%[61]	Missing N (%)	N	%	Unsure N	Missing N (%)	N	%	Unsure N	Missing N (%)	N	%	Missing N (%)	N	%	Unsure N	Missing N (%)
Victim prevented from reporting				8	14.0	13	16 (21.9)	4	16.7	3	30 (55.6)							
Perpetrator threatened to kill self	29	17.9	76 (31.9)									7	9.2	3 (3.9)	20	21.1	1	87 (47.8)
Perpetrator suicide threats a significant concern														3 (3.9)	2	2.1		86 (47.3)
Perpetrator threatened to kill victim/self/children								13	59.1	2	32 (59.2)	41	53.9	3 (3.9)	63	60		77 (42.3)
Perpetrator threatened to kill victim	81	50	76 (31.9)									36	47.4	3 (3.9)	53	51.5	1	79 (43.4)
Perpetrator threatened to kill/ abused animals	2	1.2	76 (31.9)					3	14.3	2	33 (61.1)	1	1.3	3 (3.9)	11	11.3	28	85 (46.7)
Perpetrator threatened to kill/ harmed other partner	5	3.1	76 (31.9)									3	3.9	3 (3.9)	3	2.9	1	79 (43.4)
Perpetrator threatened to kill others	12	7.4	76 (31.9)									7	9.2	3 (3.9)	12	11.7	1	79 (43.4)
Threats to kill are a significant concern	22	13.6	76 (31.9)											3 (3.9)				
Threats from others												11	14.5	3 (3.9)				
Perpetrator abused others												20	26.3	3 (3.9)				
Perpetrator abused other family members								13	65	2	34 (63.0)	3	3.9	3 (3.9)				

Risk Indicators	DVSS (n=238)			NAADV Original RA (n=73)				NAADV new RA (n=54)				Nia new RA (n=79)			REACH (n=182)			
	N	%[61]	Missing N (%)	N	%	Unsure N	Missing N (%)	N	%	Unsure N	Missing N (%)	N	%	Missing N (%)	N	%	Unsure N	Missing N (%)
Strangulation/choking attempts	64	39.5	76 (31.9)					10	41.7	1	30 (55.6)	13	17.1	3 (3.9)	56	55.4	3	81 (55.4)
Strangulation/choking attempts a significant concern														3 (3.9)				
Jealous/controlling behaviour	132	81.5	76 (31.9)					15	65.2	3	31 (57.4)	12	15.8	3 (3.9)	89	89.9	2	83 (45.6)
Jealous/controlling behaviour a significant concern															68	66.7		80 (44.0)
Power imbalance between victim/perpetrator (i.e. age)								8	36.4	4	32 (59.3)							
Perpetrator blames victim for violence								16	69.6	4	31 (57.4)							
Stalking/harassment				9	15.3	49	14 (19.2)	6	26.1	6	31 (57.4)	17	22.4	3 (3.9)	45	43.7	3	79 (43.4)
Abuse escalating in severity or frequency	81	50	76 (31.9)											3 (3.9)	104	90.4		67 (36.8)
Abuse escalating in severity								11	47.8	3	31 (57.4)	14	18.4	3 (3.9)				
Abuse escalating in frequency								13	56.5	2	31 (57.4)	15	19.7	3 (3.9)				
Sexual violence	41	25.3	76 (31.9)					3	14.3	2	33 (61.1)	6	7.9	3 (3.9)	44	45.8	2	86 (47.3)

Risk Indicators	DVSS (n=238)			NAADV Original RA (n=73)				NAADV new RA (n=54)				Nia new RA (n=79)			REACH (n=182)			
	N	%[61]	Missing N (%)	N	%	Unsure N	Missing N (%)	N	%	Unsure N	Missing N (%)	N	%	Missing N (%)	N	%	Unsure N	Missing N (%)
Forced victim to have sex												15	19.5	3 (3.9)				
Forced victim to take drugs												2	2.6	3 (3.9)				
History suggests repeat incidents likely				33	56.9	16	15 (20.5)								57	58.8	22	85 (46.7)
History of violence a significant concern															20	20.6		85 (46.7)
Threats of violence likely to continue or escalate				31	52.5	23	14 (19.2)											
Has been/going to be a relationship separation/ repeated separation/ reconciliation attempts	128	79	76 (31.9)					11	47.8	3	31 (57.4)	20	26.3	3 (3.9)	78	74.3	9	77 (42.3)
Separation a significant concern															24	22.6		76 (41.8)
Recent change in relationship				26	44.8	8	15 (20.5)											
Forced marriage including threats of/pressure to marry												1	1.3	3 (3.9)	6	6.2		85 (46.7)
Breach of protective order												3	3.9	3 (3.9)				
Breach bail conditions												-	-	79 (100)				

Risk Indicators	DVSS (n=238)			NAADV Original RA (n=73)				NAADV new RA (n=54)				Nia new RA (n=79)			REACH (n=182)			
	N	%[61]	Missing N (%)	N	%	Unsure N	Missing N (%)	N	%	Unsure N	Missing N (%)	N	%	Missing N (%)	N	%	Unsure N	Missing N (%)
Breach Non-Molestation Order												3	3.9	3 (3.9)				
Breach Forced Marriage Protection Order												-	-	79 (100)				
Perpetrator																		
Access to weapons	30	18.5	76 (31.9)					5	21.7	4	31 (57.4)	25	32.9	3 (3.9)				
Abused as a child								5	21.7	9	31 (57.4)							
Unemployed/insecurely employed								9	39.1	9	31 (57.4)							
Homeless								1	4.3	3	31 (57.4)							
Recently bereaved								2	8.7	7	31 (57.4)							
Financial problems	82	50.6	76 (31.9)					4	17.4	11	31 (57.4)	15	19.7	3 (3.9)	43	44.8	9	86 (47.3)
Financial problems a significant concern															14	14.6		86 (47.3)
Alcohol problems	67	41.4	76 (31.9)									14	18.4	3 (3.9)	33	35.5	6	89 (48.9)

Risk Indicators	DVSS (n=238)			NAADV Original RA (n=73)				NAADV new RA (n=54)				Nia new RA (n=79)			REACH (n=182)			
	N	%[61]	Missing N (%)	N	%	Unsure N	Missing N (%)	N	%	Unsure N	Missing N (%)	N	%	Missing N (%)	N	%	Unsure N	Missing N (%)
Alcohol problems a significant concern															11	11.8		89 (48.9)
Mental health problems	35	21.6	76 (31.9)					10	43.5	9	31 (57.4)	2	2.6	3 (3.9)	21	22.3	19	88 (48.4)
Mental health problems a significant concern															7	7.2		85 (46.7)
Drug problems	54	33.3	76 (31.9)									14	18.4	3 (3.9)	31	33.0	10	88 (48.4)
Drug problems a significant concern															15	15.8		87 (47.8)
Alcohol/drugs problems								13	56.5	3	31 (57.4)	28	36.8	3 (3.9)				
Any of alcohol/drugs/mental health issues				36	64.3	1	17 (23.3)											
Criminal record	88	54.3	76 (31.9)	6	54.5	3	62 (84.9)					16	21.1	3 (3.9)	33	31.7	21	78 (42.9)
Domestic violence related criminal record (at nia to current victim)	28	17.3	76 (31.9)					10	43.5	4	31 (57.4)	8	10.5	3 (3.9)	11	23.9	5	136 (74.7)
Sexual violence related criminal record												-	-	79 (100)				
Criminal record for violence to others												6	7.9	3 (3.9)				

Risk Indicators	DVSS (n=238)			NAADV Original RA (n=73)				NAADV new RA (n=54)				Nia new RA (n=79)			REACH (n=182)			
	N	%[61]	Missing N (%)	N	%	Unsure N	Missing N (%)	N	%	Unsure N	Missing N (%)	N	%	Missing N (%)	N	%	Unsure N	Missing N (%)
History of violence to others	25	15.4	76 (31.9)												57	59.3	22	86 (47.0)
Recognises abuse and will maintain preventative actions				3	5.2	42	15 (20.5)											
Supported in abusive behaviour by others				9	15.3	21	16 (21.9)	10	43.5	3	31 (57.4)							
Intoxicated when violent				3	30	1	63 (86.3)											
Knows where victim lives								18	75.0	2	30 (55.6)							
Victim																		
Under 25 years								4	17.4	1	31 (57.4)							
Abused as a child								1	4.5	2	32 (59.3)							
Parents/carers abusive to each other								2	8.7	4	31 (57.4)							
Has a disability								3	14.3	0	31 (57.4)							
Has appropriate safety measures				20	33.9	14	14 (19.2)											

Risk Indicators	DVSS (n=238)			NAADV Original RA (n=73)				NAADV new RA (n=54)				Nia new RA (n=79)			REACH (n=182)			
	N	%[61]	Missing N (%)	N	%	Unsure N	Missing N (%)	N	%	Unsure N	Missing N (%)	N	%	Missing N (%)	N	%	Unsure N	Missing N (%)
Has Non-molestation/ Occupation order in place								9	45.0	2	34 (63.0)							
Frightened	119	73.5	76 (31.9)	40	67.8	10	14 (19.2)	18	78.3	1	31 (57.4)	50	65.7	3 (3.9)	83	80.6	2	79 (43.4)
Fear a significant concern															49	47.6		79 (43.4)
Has suicidal thoughts	22	13.6	76 (31.9)									4	5.3	3 (3.9)	33	33.7	1	84 (46.2)
Suicidal thoughts a significant concern															17	17.2		83 (45.6)
Has mental health problems								4	18.2	3	32 (59.3)							
Uses drugs/alcohol								1	4.5	2	32 (59.3)							
Is involved in prostitution								0	0	2	32 (59.3)							
Feels isolated	49	30.2	76 (31.9)					5	22.7	1	32 (59.3)	12	15.8	3 (3.9)	60	58.8	1	82 (45.1)
Is financially dependent on perpetrator								4	17.4	1	31 (57.4)							
Fears further violence	115	71.0	76 (31.9)	6	66.7	2	64 (87.7)	15	65.2	4	31 (57.4)	41	53.9	3 (3.9)	81	78.6	5	79 (43.4)

Risk Indicators	DVSS (n=238)			NAADV Original RA (n=73)				NAADV new RA (n=54)				Nia new RA (n=79)			REACH (n=182)			
	N	%[61]	Missing N (%)	N	%	Unsure N	Missing N (%)	N	%	Unsure N	Missing N (%)	N	%	Missing N (%)	N	%	Unsure N	Missing N (%)
Fears further violence a significant concern															36	34.9		79 (43.4)
Fears being killed	65	40.1	76 (31.9)												45	45.9	11	84 (46.2)
Currently pregnant/ pregnancy or birth within the last 12 months	13	8.0	75 (31.5)					1	4.5	1	32 (59.3)	16	1.1	3 (3.9)	7	7.2	1	85 (46.7)
Miscarriage/termination result of DV															14	14.9	2	88 (48.4)
Children	**DVSS (n=180 with children)**			**NAADV Original RA (n=39 with children)**				**NAADV New RA (n=26 with children)**				**Nia New RA (n=59 with children)**			**REACH (n=84 with children)**			
Under five years								6	23.1	1	9 (34.6)							
Step children in household								4	15.4	1	9 (34.6)							
Have contact with perpetrator																		
Victim fears children may be hurt	57	31.7	45 (25.0)												15	17.9	3	35 (41.7)
Perpetrator threatened to kill children	20	11.1	45 (25.0)									5	8.5	1 (1.7)	2	2.4	1	35 (41.7)
Perpetrator has harmed children	13	7.2	45 (25.0)	1	2.6	2	24 (61.5)	4	15.4	1	10 (38.5)	13	22.0	1 (1.7)	8	9.5		29 (34.5)

Risk Indicators	DVSS (n=238)			NAADV Original RA (n=73)				NAADV new RA (n=54)				Nia new RA (n=79)			REACH (n=182)			
	N	%[61]	Missing N (%)	N	%	Unsure N	Missing N (%)	N	%	Unsure N	Missing N (%)	N	%	Missing N (%)	N	%	Unsure N	Missing N (%)
Children witnessed violence	69	38.3	45 (25.0)												46	54.8	1	25 (29.8)
Children directly involved in violence	15	8.3	45 (25.0)															
History of abuse to children				0	0	2	21 (55.3)											
Attempted to intervene in violence				4	10.3	6	24 (61.5)	4	15.4	4	10 (38.5)				13	17.6	1	32 (38.1)
Frightened of perpetrator				1	2.6	8	24 (61.5)	9	34.6	2	10 (38.5)							
Displaying behavioural problems related to domestic violence				1	2.6	1	24 (61.5)	5	12.8	2	9 (34.6)							
Live with perpetrator								3	11.5		9 (34.6)							
Threats to remove children/ victim worried will remove children												8	13.6	1 (1.7)				
Conflict over child contact	60		45 (25.0)									8	13.6	1 (1.7)	20	23.8	6	39 (46.4)
Breach child contact orders												0	0	1 (1.7)				
On Child Protection register																		

Risk Indicators	DVSS (n=238)			NAADV Original RA (n=73)				NAADV new RA (n=54)				Nia new RA (n=79)			REACH (n=182)			
	N	%[61]	Missing N (%)	N	%	Unsure N	Missing N (%)	N	%	Unsure N	Missing N (%)	N	%	Missing N (%)	N	%	Unsure N	Missing N (%)
Victim's ability to parent reduced by DV				2	5.1	5	24 (61.5)											
Ability to parent reduced by DV				3	7.7	4	24 (61.5)											

[61] Percentages are calculated against the baseline number of definite responses, with missing data excluded.

Original Risk Assessment at nia (n=122)

Risk Indicators	N	%	Unsure (N)	Missing N (%)
Pattern of domestic violence				
Victim ever had injunction	12	14.0		36 (29.5)
Perpetrator				
Domestic violence related criminal record to current victim	37	43.0		36 (29.5)
Criminal record for violence	39	45.3		36 (29.5)
Criminal record for violence to others	6	7		36 (29.5)
VICTIM				
Feel safe at home	60	69.8		36 (29.5)

Risk Indicators	N	%	Unsure (N)	Missing N (%)
Outstanding issues where victim lives	24	27.9		36 (29.5)
Visits places perpetrator may find them	42	48.8		36 (29.5)
Responsible for paying rent	40	46.5		36 (29.5)
Has proof of identity	61	70.9		36 (29.5)
Has enough food and clothes	54	62.8		36 (29.5)
Has debts	17	19.8		36 (29.5)
Has difficulty managing money	15	17.4		36 (29.5)
Has solicitor	21	24.4		36 (29.5)
Has GP	73	84.9		36 (29.5)
Ever had contact with police	56	65.1		36 (29.5)
Knows how to contact police	61	70.9		36 (29.5)
Outstanding immigration issues	22	25.9		36 (29.5)
Will feel safer after support	23	26.7		36 (29.5)
Has suicidal thoughts	16	18.6		36 (29.5)
Health problems	31	36.0		36 (29.5)
Takes medication	22	25.6		36 (29.5)
Uses drugs	3	3.5		36 (29.5)
Uses alcohol	7	8.1		36 (29.5)

Risk Indicators	N	%	Unsure (N)	Missing N (%)
Feels isolated	25	39.1	7	58 (47.5)
Fears further violence	52	76.5	8	54 (44.3)
Fears being killed	24	36.4	23	56 (45.9)
Feels unable to cope with violence	54	80.6	5	55 (45.1)
Wants to end relationship	58	86.6	6	55 (45.1)
Has tried to end relationship	53	80.3	4	66 (53.3)
Has told others about DV	63	94.0	1	55 (45.1)
Has sought help	64	92.8		53 (43.4)
Feel protective of perpetrator	20	30.3	10	56 (45.9)
Children	**Nia original RA (n= 79 with children)**			
Have contact with perpetrator	21	26.6		20 (25.3)
Victim fears children may be hurt	17	21.5	7	36 (45.6)
Threats to remove children/victim worried will remove children	12	15.2		20 (25.3)
On Child Protection register	5	6.3		20 (25.3)