Domestic violence advocacy and support in a changing climate - findings from three recent evaluations

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Introduction

This article draws together findings from three evaluation studies of twelve domestic violence projects providing advocacy and support to mainly female victims/survivors of domestic violence in Cumbria and Gateshead (Donovan et al. 2010), across England and Wales (Howarth et al. 2009), and in London (Coy & Kelly 2011). The studies used a mixture of outcome and process evaluation, following the impacts of the project interventions from four months to four years. The studies provide an important insight into the advocacy approaches currently used in domestic violence interventions in the UK, highlighting positive practice within the constraints of an evolving policy context.

Context

The evaluations were carried out during a period when government policy on domestic violence in England was becoming increasingly focused on criminal justice approaches and intervention with high risk adult victims (at risk of serious harm and homicide), albeit within a wider Co-ordinated Community Response (CCR – see Home Office 2006). Together, Specialist Domestic Violence Courts (SDVCs), Independent Domestic Violence Advisors (IDVAs) and Multi-Agency Risk Assessment Conferences (MARACs) became the central plank of the Labour Government's policy, combined with what may be deemed a 'professionalisation' of the interventions via national training, systems and templates (www.caada.org.uk).

The projects and interventions in the three evaluation studies discussed in this article reflect these changes in policy. The two projects evaluated from 2004 (*Gateshead/Cumbria study*) were initially aimed at providing early intervention with victim/survivors using a holistic approach, although later became focused on high risk; while those evaluated from 2007 (in the *England/Wales* and *London studies*) focused specifically on high risk adult victim/survivors.

The projects and interventions

The Gateshead/Cumbria study evaluated two innovative and experimental domestic violence projects in urban Gateshead and rural Cumbria. The projects built on research showing that early intervention in domestic violence cases increases the chances of improving the outcomes for victim/survivors and their children (Hanmer, Griffiths & Jerwood 1999); and that the criminal justice system is unable to deal effectively with chronic and entrenched cases without multi-agency involvement, and (perhaps paradoxically) is better able to deal with lower risk cases (Hester 2006). The projects were initially set up to provide early intervention, within 24 hours of referral and with any level risk, with referrals primarily from the police. A holistic service was offered with one-to-one support to victim/survivors, one-to-one and group work for children and voluntary perpetrator programmes. The projects were situated within multi-agency partnerships to provide continuity of service to victim/survivors and their children through a case-worker approach. The model thus initially aimed to encourage early intervention, multi-agency working and ensuring that all family members got the support they needed, when they needed it.

After the Gateshead/Cumbria study had begun, the government introduced the national Coordinated Community Response (CCR) for domestic violence. As a consequence, both project areas introduced the MARAC model, leading to a reconfiguration of multi-agency working (especially in the area where multi-agency work had been difficult), and a re-focus on adult victim/survivors at

highest risk rather than early intervention. Workers in both projects undertook IDVA training. Continuing, and building on, their previous roles within the projects, the newly termed IDVAs undertook a risk assessment and a common (CAADA-DASH) risk assessment tool was introduced.

By comparison with Gateshead/Cumbria, the evaluations in London and England/Wales were focused more narrowly, looking specifically at IDVA intervention with victim/survivors. However, it is not possible to consider IDVAs without taking into account the wider multi-agency context within which they need to work: successes in IDVA work are "likely to reflect the strength of their local multi-agency partnerships" (Howarth et al. 2009: 99; and Coy & Kelly 2011: 9). Key elements of IDVA work are that they are independent, professional and trained, and aware of all safety options for high risk victim/survivors. The practice principles for IDVAs are based on a 'care pathway', intervening from the point of crisis, and time limited, with an anticipated throughput of 80-100 cases per IDVA per annum (www.caada.org.uk).

The 11 projects across the London and England/Wales evaluations were funded to develop services along the lines of the IDVA practice principles, within a variety of settings: women's organisation, police station, A&E, and a community domestic violence project supporting women going through the courts. Given the large proportion of minority ethnic groups in London one of the projects was targeted at Black and Minority Ethnic (BME) populations, with staff from different minority groups and with a range of languages. Such staff proved especially difficult to recruit and maintain.

The seven projects evaluated in the England/Wales study were generally more well-established, had been funded for longer prior to the evaluations, and included varied models of delivery as well as settings. Settings ranged from stand-alone services to those attached to existing domestic violence projects, and one project was in a health setting.

Findings

Across all the projects it was mainly women who had left violent partners who accessed the projects. Some projects were only available to women. It was apparent that the national IDVA model of risk assessment and time limited intervention from the point of crisis (as outlined earlier), did appear to reduce risk, but in practice did not fit the needs of all service users to the same extent. All three studies found in some way that individuals with further 'vulnerabilities', such as alcohol or drug dependency, or who were not 'classic' female domestic violence victim/survivors often had greater needs for support.

The England/Wales and London studies highlighted some important differences related to the location of the IDVAs, and thus to service user group. As may be expected, the Accident and Emergency (A&E) based projects recorded higher levels of physical abuse/ injury, fear and isolation. It also appeared that a greater proportion of the A&E service users were still in a relationship with the abusive partner (although there was much missing data), and the London research team point out that A&E may consequently be "an important route into support services for victim-survivors still in abusive relationships" (Coy & Kelly: 49). However, service users in the A&E project were also less likely to engage with the IDVAs than in the other London projects.

While general victimisation data in the UK does not indicate that ethnicity is a factor increasing abuse (Smith et al. 2010), both the London and England/Wales IDVA projects were accessed by disproportionately high numbers of BME women given the demographics of the local populations. In the London projects this included many women with insecure immigration status and those with no recourse to public funds, which increased both the complexity of their needs, the time required for

the intervention and the cost per service user[1] (Coy & Kelly 2011). At the same time, the specific London project for BME women recorded the lowest levels of severe violence, seemingly because these women had a wider range of needs but few services to turn to. Generally, the findings indicate that BME women have to use domestic violence services to a disproportionate degree due to an especial lack of other resources and alternative means of support, and highlight the particular requirement of services for these women.

All three studies indicated that, at least during the period of the interventions, victim/survivors experienced reduction in violence and abuse from partners and, to a lesser extent, from ex-partners. There was also evidence from the England/Wales study that the work of IDVAs with mothers had a positive impact on the safety of their children, and from the Gateshead/Cumbria study that mothers valued the work with children.

The Gateshead/Cumbria study showed that early intervention had some positive effect, as measured by prevention of further incidents during the intervention (which was 8-months on average for one of the projects), decrease in re-referrals, increased perception of safety by staff and service users, reduced risk, trust in the project and greater confidence in seeking help (Donovan et al. 2010). Engagement with the projects by victim/survivors was more likely where they were assessed at lower and medium risk, thus also indicating the importance of earlier intervention. Emotional support was the most cited form of support received by victim/survivors in the Gateshead/Cumbria study and was also identified by the small number of service users interviewed as the most important type of support received (Donovan et al.: 7). Victim/survivors had greater difficulty engaging with services or to leave an abusive relationship in rural areas. Outreach to access service

[1] In the London BME IDVA project the cost of working with women was £690 per service user, compared to £364 for the police based service users and £416 for the A&E based service users. However the cost for the court-based service users was highest at £711.

users was developed in the more isolated parts of the rural region, however this aspect of the work decreased when the project expanded into a high risk focused service in 2007 (Donovan et al. 2010).

The England/Wales projects found a reduction in domestic violence across the period of the IDVA interventions, especially in physical abuse, with a smaller reduction in other abuse such as stalking and harassment (Howarth et al. 2009). Monitoring data showed a clear relationship between intensity of intervention and reduction in domestic violence, with 67% of the victim/survivors receiving intensive support achieving an overall cessation in abuse compared to 44% of those victim/survivors receiving limited support.

In the London projects, levels of repeat victimisation were also low, with only 72 out of 394 service users (71 women and one man) disclosing between one and five further incidents of violence to IDVAs, and only 27 cases were re-opened following further violence. Coy and Kelly (2011) suggest that the projects were especially effective via their approach of providing 'empowerment through knowledge', that is giving information and options in order that women can make evidence-based decisions. They conclude that IDVAs became very skilled at moving women through these processes relatively swiftly: empowerment required expanding their "space for action" (Coy and Kelly 2011: 68).

A related aspect concerned multi-agency working and links with MARACs. All three studies found that IDVA links with other agencies were important in decreasing victims/survivors' risk of violence. In the Gateshead/Cumbria study, victims/survivors in the urban project were provided with support from three to five partner agencies, and such multi-agency working was found to be "positively correlated with both those victim survivors at the highest risk and with risk reduction" (Donovan et al. 2010: 9). The England/Wales study found similarly that "… the odds of feeling safer and of abuse ceasing were doubled when 2-5 interventions were offered and increased by four times where there

were more than 6 different interventions." (Howarth et al.: 14). Coy and Kelly (2011) talk about the links made to other local services as "wraparound", and that specialised NGO domestic violence provision, including refuges/shelter, is an essential part of this "since the effectiveness of IDVA schemes is dependent upon the availability of other specialised services to refer on to" (ibid.: 109). However, some of the agencies in London, especially within the state sector, appeared to display a lack of understanding about the impact of the domestic violence dynamics of coercive control and women's consequent decision-making processes. IDVAs therefore had to educate agencies in order to enhance their grasp of such complexities. The London research team point out that doing such 'institutional advocacy', while necessary, was also fraught with tension for IDVAs who are insecurely funded.

The studies also provide useful information regarding perpetrators. Based on the information provided by victim/survivors, the England/Wales study provided profiles of the perpetrators: "Of the perpetrators, 50% had criminal records; half of which were for domestic abuse related crimes. Perpetrators' substance misuse problems and mental health issues were also prevalent" (Howarth et al. 2009: 46). Moreover, in 62% of cases the perpetrators had made threats to kill against the victim, 21% of perpetrators had threatened to kill others and 9% had threatened to kill a previous partner. As Howarth et al. point out "These findings ...remind us that the perpetrator's own characteristics and behaviour are the strongest predictors of re-victimisation and serious harm of victims" (ibid.:8).

In both the Gateshead and Cumbria projects multi-agency partnerships struggled "to engage with perpetrators to the extent they had originally intended..." (Donovan et al. 2010: 2). There were a number of reasons for this, including suspicion from criminal justice agencies that perpetrator programmes were a 'soft' option and that contact with programmes would undermine cases proceeding through the courts; and interpretation by some agencies of 'family work' as meaning work with women and children.

Conclusion

The evaluations show that both early intervention and work with high risk adult victim/survivors may reduce re-victimisation. Targeted and empowering individual advocacy is the most positive approach to enhancing victim/survivor wellbeing and safety, and involves tailored support with differential degrees and types of intervention intensity, and access to relevant services at the right time. Such an approach requires effective multi-agency links and relationships, which can be difficult to achieve and may rely on advocates creating and maintaining the links. The studies highlight the importance of work with children, although such services were scarce, and the need for co-ordination between services working with victim/survivors and those working with male perpetrators.

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