Improving the safety and well-being of domestic abuse survivors – the role of a specialist organisation in supporting the work of Independent Domestic Violence Advisors

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Abstract

Over the last 15 years, successive UK Governments have promoted the role of Independent Domestic Violence Advisors (IDVAs) in addressing the safety of (primarily) women affected by domestic abuse. Limited evaluations of IDVA services exist, with evidence suggesting women report improved safety and wellbeing as a result of specialist support. To date, however, little attention has been paid to the organisations in which IDVA services are based, despite recommendations that specialist domestic abuse organisations are the most appropriate home for IDVAs. This article draws on findings from the evaluation of an IDVA service in England to explore firstly, the outcomes achieved by the service and secondly, the extent to which the organisation facilitated IDVA support through its values, principles, policies and procedures. Finally, the article reflects on what these findings mean for the effective delivery of domestic abuse services.

Key words

Domestic abuse, advocacy, IDVAs, third-sector organisations

Background

Independent Domestic Violence Advisors

In the UK, the concept of Independent Domestic Violence Advisors (IDVAs) was first formally introduced by the Labour Government in their 2005 National Action Plan (Home Office, 2005). IDVAs were originally defined according to seven key principles: independence (from statutory services); professionalism achieved through intensive training; a focus on safety options; crisis intervention; supporting victims assessed as high risk; working in partnership with other voluntary and statutory services; and working to measurable outcomes in terms of reducing rates of victim withdrawal (Home Office, 2005, p.10). Around the same time as the IDVA role was established, two related initiatives were also developed, Multi-Agency Risk Assessment Conferences (MARACs) and Specialist Domestic Violence Courts (SDVCs). MARACs developed out of a pilot in Cardiff where key agencies, including police, probation, health, housing and specialist domestic abuse services discussed those at most risk and devised plans to keep victims safe (Home Office, 2006). SDVCs were intended to improve the victim journey through the Criminal Justice System as rates of victim withdrawal were especially high in cases of domestic abuse (Home Office, 2005). The IDVA had an integral role in both. In the former, their role was to act as a point of contact for victims, to ensure their views were represented and follow through the actions of the meeting, while in the latter, they were to provide support throughout the court process with a key focus on safety.

Over a decade on, there have been a small number of evaluations and studies investigating the contribution of IDVA services to victim safety (Robinson, 2009, Howarth et al, 2009, Coy and Kelly, 2010, Granville and Bridge, 2010, Madoc-Jones and Roscoe, 2011, Taylor-Dunn, 2015). In addition, the organisation SafeLives, who were the first to provide nationally accredited training for IDVAs (Women's Aid Federation England (WAFE) also provide accredited IDVA

training) regularly publish data regarding the nature and impact of IDVA support in England and Wales (SafeLives 2017, 2018, 2019).

Increased safety

All of the studies that have assessed the impact of IDVAs on victim/survivor safety have reported a positive relationship (Coy and Kelly, 2010, Granville and Bridge 2010, Howarth et al, 2009, Howarth and Robinson, 2016, Madoc-Jones and Roscoe, 2011, Robinson, 2009, Safe Lives, 2017). For example, Howarth et al (2009) reported that 57% of victim/survivors experienced complete or near cessation of abuse following 3-4 months of IDVA support, while Granville and Bridge (2010) suggested that 92% of victim/survivors felt safer and less alone following IDVA support. In the most recent report published by Safe Lives, 84% of victim/survivors accessing IDVA services across England and Wales reported increased safety (Safe Lives, 2019). While these studies do not use control groups (due to the ethicality of denying a service to vulnerable victims) the figures still suggest a link between IDVA support and victim safety. Given this apparent link, the question arises as to what it is about IDVAs that leads to this outcome. There are three common themes in the existing literature – independence, multi-agency working and frequency and intensity of support:

Independence

IDVAs can be located in any type of organisation, including statutory services (police, health, social care), third sector organisations (charities) and private organisations (housing providers, social enterprises). It is also the case that IDVAs can be co-located between services, possibly being managed by a charity, while delivering some of the service within a police station (SafeLives, 2018). Yet research suggests the independence of IDVAs is critical to their success (Robinson, 2009, Coy and Kelly, 2010, Taylor-Dunn, 2015). In the first ever evaluation of IDVA services, Robinson (2009) concluded that the 'independence' of IDVAs was key to their

efficacy. Similarly, Coy and Kelly (2010) evaluated IDVA services across a range of settings and found that IDVAs located in statutory services (the police and A & E) were seen as creating barriers for women, whereas the IDVAs based in a women's organisation supporting BME communities, reached some of the most marginalised women and received self-referrals as a result. Having said this, the IDVAs based in statutory settings received more credibility in a multi-agency environment than those in community based organisations (Coy and Kelly, 2010).

Multi-agency approach

The second theme to emerge from existing IDVA research concerns the importance of a coordinated multi-agency approach where IDVAs can support victim/survivors to navigate a range of statutory processes (such as the Criminal Justice System) and act as a point of contact (Howarth and Robinson, 2016, Howarth et al, 2009, Coy and Kelly, 2010, Taylor-Dunn, 2015). Some of the research suggests that safety is increased when victim/survivors are able to access multiple services in a relatively short time (Howarth and Robinson, 2016, Howarth et al, 2009). The role of IDVAs within the MARAC process is key to this, with research suggesting that violence is more likely to cease as a result of multi-agency intervention (Robinson, 2006, Robinson and Tregidga, 2007, McCoy et al, 2016).

Frequency, and intensity of support

The final theme to emerge from existing research into the success of the IDVA role concerns the frequency and intensity of contact. Studies suggest that victims who receive frequent contact are the most likely to report increased safety – Howarth and Robinson (2016) refer to this as a 'dose-relationship' whereby - 'Frequency of contact with an IDVA and the number of community resources accessed were positively associated with the odds of achieving safety.' (p.55).

The role of specialist domestic abuse organisations

Most IDVAs receive accredited training to undertake their role (either through SafeLives or WAFE), but they operate in a variety of organisations, with their own values and principles. Specialist domestic abuse organisations are those that deal specifically with the issue of domestic abuse and they come in a variety of guises, with varying histories, structures and values. Specialist domestic abuse services originated in the form of refuges in the 1970s and 1980s (Robinson, 2009). Refuges emerged in response to the second wave feminist movement which placed the issues of domestic and sexual violence on the political agenda and what started as illegal squats eventually became funded third sector charities (Dobash and Dobash, 1979). During the late 1990s and early 2000s, domestic abuse charities began to offer community based services such as 'outreach' and by the late 2000s, Independent Domestic Violence Advisors were well established in these specialist organisations. While many specialist organisations consider themselves to be feminist, this is not the case for all, and many services that started as feminist have moved to a more gender inclusive approach in recent years (Hamel, 2006). In addition, while some specialist services provide accommodation in addition to outreach and IDVA support, others only provide community-based services (such as IDVA support) (SafeLives, 2019).

In a 2019 survey of IDVA services in England and Wales, SafeLives report that 60% are based solely in specialist domestic abuse services, with the remainder based in agencies such as the police, courts, health and housing associations (SafeLives, 2019). In the first evaluation of IDVA services, Robinson (2009) commented on the challenges associated with IDVAs being based in statutory services and recommended that IDVAs were best managed by specialist domestic abuse organisations. Similarly, Coy and Kelly (2011) suggest that IDVAs are best placed in specialist organisations for reasons of independence and fewer barriers to vulnerable groups. Despite this, there is yet to be sufficient consideration in the research literature as to

what makes an effective specialist domestic abuse service. In 2016, a set of shared standards for the Violence Against Women and Girls (VAWG) sector were developed by Women's Aid Federation England, Rape Crisis, Respect, Imkaan and SafeLives, in conjunction with London Metropolitan University (WAFE, 2016). These standards were designed to enable joint commissioning across specialist services in the VAWG sector (p.4) and are considered to be the core minimum which are common to all five organisations. They include, among others; an understanding that VAWG is gender-based, an emphasis on diversity and equality, the importance of safety (both for service users and staff), dignity and respect, user and participant engagement and governance and leadership (WAFE, 2016). However, these standards only apply to the organisations that developed them and so do not cover all organisations in which IDVAs are based. Furthermore there has been no published research evaluating the impact of these standards on the delivery of services.

In addition, SafeLives who offer accredited training for IDVAs (and contributed to the service standards), run an accreditation programme for domestic abuse services called Leading Lights. This programme sets out four key areas with a number of standards that service providers need to consider and then evidence in order to be accredited. These areas include standards for service provision, multi-agency working, human resources and governance. Yet this accreditation process is not mandatory and there are currently only 50 services in England and Wales who have successfully gone through the programme (SafeLives, 2019). Moreover, the rationale behind the standards is not articulated and there is no published research exploring the extent to which these standards translate into practice. As such, this is the first published research to explore the role of a specialist domestic abuse service in facilitating the support offered by IDVAs. The article considers the outcomes achieved by an IDVA service based in one specialist domestic abuse organisation in England, but more importantly, it explores what role the organisation had in supporting IDVAs to achieve these outcomes. The focus of the

research concerns the values and principles of the organisation, how these translated into policies and procedures and finally, the extent to which they were translated into practice.

Methodology

The IDVA service

This article draws on research conducted as part of the evaluation of an IDVA service in England. The evaluation was commissioned by the CEO of the organisation in 2018 and concluded in 2019. The organisation in which the IDVA service is based is an independent charity with over 40 years of experience in delivering services to adults and children affected by domestic abuse. The organisation started by providing refuge services in the 1970s, over the next three decades they expanded to meet the needs of women and children in the area by providing community based services and expanding refuge provision. In 2010, the organisation re-branded and restructured in order to meet the challenges posed by widespread public sector austerity (Jones, Meegan and Kennett, 2015). The organisation now provides refuge accommodation, a helpline, outreach support, an IDVA service and several community groups.

Sample

The data used in this evaluation relates to referrals received by the IDVA service during 2017 (January to December). At this time, the organisation employed 23.5 (full-time equivalent) IDVAs and received 2252 referrals. There were four types of data collection which included; 12 months of IDVA service data for 2017 taken from monthly monitoring reports and a case-management system; the organisation's policies and procedures, which were relevant to the operation of the IDVA service, including: Co-ordinated Community Response policy; Client Feedback and Participation policy; Complaints policy; Clinical Supervision policy; Referral

policy; Safeguarding Adults policy; Safeguarding Children and Young People policy; Service Review policy; Community Services Operational Standards of Practice and the Operations Manual which included all policies and procedures related to staff and employment (such as sickness absence, home working and annual leave); a random sample of 20 cases (provided by the organisation) where victims were supported by an IDVA; and finally, an online survey with IDVAs and key stakeholders. These differing forms of data collection were chosen to help explore what IDVAs did, how they did it, and the organisational and external factors that contributed to their work.

In the initial design of the research, we had created an online survey for victim/survivors, following consultation with the IDVA service that this would be an appropriate form of data collection for their service users (and could be distributed safely as part of existing support groups within the organisation). Only one service user completed the survey, and their feedback was included in the final evaluation report but has not formed part of this analysis. The case-files were selected at random by the organisation. There is of course the potential for bias in the selection of these files, firstly in terms of the organisation selecting files that reflect their service positively, and secondly, in recognising that these files represent service users who actively engaged in the service. In addressing the first issue, given the sensitive nature of the organisation's work, it was not possible for the research team to select cases directly. We could have identified a random set of case-file numbers from the IDVA referral spreadsheet, however, given the time and effort taken to copy and redact all of the case-files that were sent to us, we were keen not to add to the burden of an already time-pressured service and so left it with them to identify a random sample of cases. In addressing the second issue, the question may be asked as to why we focussed on cases of those who engaged with the IDVA service. This is because there would only be a case-file for those who engaged to some extent beyond the initial referral, however, there were varying levels of

engagement in the case-files and service users remain with the service for as long as they feel is necessary as opposed to completing a pre-defined program of support.

Measures

Descriptive statistical analysis of 12 months of IDVA data was undertaken to determine the nature of the client group, safety and well-being outcomes to identify any changes in assessment outcome for those engaged with the service. For each of the assessments, where the data is available, there is an analysis of the number of clients completing one or more of each measurement tool, and where an assessment measure has been repeated, the number of clients who have an improved score is analysed. The outcomes achieved by this service are compared to national data (where available).

Procedures

The organisation provided their policies and procedures via email to the lead researcher. The IDVA service data were provided via a secure portal requiring a password. The documents were then saved to an encrypted USB and stored securely. The case-files were anonymised by the organisation and sent via a secure courier service. The information in the files was transferred to excel spreadsheets by the lead researcher and the hard copies were shredded on completion of the evaluation. The organisation provided a sample of 20 cases, one of which did not contain sufficient information to be analysed and so 19 files were used. The survey was created on the JISC online survey platform and the link was distributed by the IDVA service manager to both IDVAs and stakeholders. Response rates to the online surveys varied, with nine IDVAs (40% of those employed by the organisation) and six stakeholders. The stakeholders represented the police (3), children's services (1), education (1) and a multi-agency position between the local authority, police and health (1).

Ethics

This research was approved by the University of Worcester Ethics Committee. There were particular ethical issues associated with this project. For the online surveys with staff and stakeholders we needed to ensure voluntary participation. We did this by providing information to potential participants which explained that it was entirely their choice to complete the survey (or not) and that they could withdraw from the study up to 7 days after completion (by quoting the reference number they receive at the end of the survey). To ensure informed consent, participants were provided with information about the study prior to completing the survey and could contact the research team to ask questions. Before starting the survey, participants were asked to confirm that they consented to take part and understood their rights – including withdrawing from the study. In order to ensure confidentiality, participants were not asked to provide their name or other identifying details – instead, participants received an identification number which could be printed or recorded elsewhere and could be used to withdraw from the study (up to 7 days after completion). The data captured in the online surveys was downloaded and stored on a password protected PC located on the University of Worcester server, with a copy being stored on an encrypted USB and kept in a locked cabinet in a locked office.

Analytic strategy

The organisation's policies and procedures, case-file data and qualitative survey questions were all analysed using the framework of Thematic Analysis (Braun et al, 2015). In respect of the organisation's policies and procedures, this analysis identified four key principles that were intended (from the organisation's perspective) to ensure the safe and effective delivery of the IDVA service. We then looked for evidence of these principles being translated into practice in the case-file analysis and online surveys. The case-file data involved a qualitative analysis of the individual support plan, risk and needs assessment in order to understand the context of

the referral and the type of support offered. Following thematic analysis of the organisation's policies and procedures, this was synthesised with the case-file analysis and online survey data to evidence the extent to which each policy area was implemented in practice.

Results

The below data are compared to national data published by SafeLives who host a database for IDVA services called Insights. While not all IDVA services in England and Wales report their data to SafeLives, this is still the best approximation of national demographic and outcome data for IDVA services in England and Wales.

Table 1 here

Most service-users were female (94.4%) (Table 1), and 5.2% were male, compared to 4% nationally between 2017/18 (SafeLives, 2018). The majority who responded indicated that they were heterosexual (99%), although data was missing for 15% (n=336) of all clients. According to SafeLives, in 2017/18, 3% of service users identified as lesbian, gay or bisexual (SafeLives, 2018) suggesting a slightly lower percentage for this IDVA service. However, the low numbers may reflect the fact that most IDVA service referrals (both in this service and nationally) come from the police, but research suggests gay, lesbian and bisexual victims of domestic abuse are less likely to report their abuse (Donovan et al, 2006) – therefore limiting access to services such as those provided by this organisation.

Disability data was missing in the majority of cases, with over three-quarters of the records not recording a response for this (this is potentially explained by no response meaning no disability). However, 17% (n=380) of all clients recorded that they had a disability, the majority of whom were female (n=376), with 92 (4%) disclosing a physical disability. The majority (92.6%) of clients were White British or other white background – reflecting the demographic make-up of the area in which the IDVA service is based. Asian clients made up 2.3% of the total, while Black African and Caribbean clients made up a further 3.3%.

It is important to note here that of the 2252 referrals received by the IDVA service in 2017, not all were successfully contacted or engaged with the service. When analysing the data, we measured engagement with the service as all cases where a service user had engaged with at least one assessment (n=1093). Moreover, the data reported in Tables 2 and 4 refer to the percentage of outcomes for cases closed during 2017 (n=447).

The focus of this article is the role of the specialist organisation in facilitating the support provided by IDVAs. It is therefore important to consider the outcomes achieved by the IDVA service with regard to survivor safety and well-being.

Risk, Safety and Recovery Outcomes

Victims report feeling safer

The IDVA service capture data on a range of outcomes relating to safety. This data is captured in a number of ways, including written and/or verbal feedback provided by survivors in addition to IDVA assessments based on conversations with the service user. In 2017, of the cases closed during this year (n=447) where the victim had engaged with the service, 344 (77%) reported a cessation in all types of abuse, 395 (83%) reported significant or moderate reductions in risk and 393 (79%) reported feeling much safer or somewhat safer. Interestingly, 77% of service users experienced a cessation in all forms of abuse, compared to 54% nationally in 2017/18 and 83% reported a reduction in risk in the study compared to 73% nationally (SafeLives, 2018). However, a lower proportion of victims reported feeling safer than reported nationally (79% compared to 88% (SafeLives, 2018)).

Recovery and Resilience Outcomes

The IDVA monitoring data suggest increases in quality of life and confidence in accessing support for closed cases during 2017 (n=447). For example, 344 (77%) reported their quality

of life had improved a lot, 339 (76%) reported being confident or very confident in accessing support, and 254 (57%) reported accessing health & wellbeing advice and support. These figures are lower than those reported nationally in 2017 for quality of life (83% nationally, compared to 77%) and reported confidence in accessing support (89% nationally compared to 76%). Importantly however, the IDVA service captures additional data to that available nationally including self-esteem and depression measures.

Domestic Abuse Stalking and Honour-Based Violence (DASH) Checklist

In addition to the above outcomes for closed cases, we were able to analyse data from the case management system for all open cases during 2017. The DASH risk assessment is a tool used by those working with domestic abuse to help build a picture of the risks posed to a victim/survivor by a perpetrator (SafeLives, 2014). The data suggests that the DASH risk assessment was completed for 1068 clients - just under 98% of the 1093 clients who actively engaged with the service in 2017. Table 2 shows the number of clients completing DASH risk assessments. The DASH risk assessment was repeated for 525 clients during their time in the service, and for almost half of these (n=249) clients, the case management data indicates this was repeated on multiple occasions. Of those providing repeated DASH measures, 380 clients demonstrated a reduction in the DASH score, representing 72.4% of those who did multiple DASH assessments. In n=20 cases, the DASH score was reduced to 0.

Rosenberg Self-esteem Scale

Using the 12-month IDVA case management data, we identified that the Rosenberg Self-esteem Scale (RSE) (Rosenberg, 1965) was completed by n=207 clients (18.8% of the total number of clients engaged). Of those who completed the RSE more than once, around one third (32.9%) indicated there was an increase in self-esteem (**Error! Reference source not found.**2).

Beck Depression Inventory

The Beck Depression Inventory is a self-report tool that measures the characteristic attitudes and symptoms of depression (Beck et al, 1996). During 2017, 210 clients completed the Beck Depression scale as part of their interaction with the IDVA services, representing 19.1% of the client group who engaged. Of those who completed the tool more than once (n=84), three-quarters (75%) of the clients indicated that there was a reduction in depression (Table 2).

Summary

As the above analysis has shown, the data available from the IDVA service suggests that service users who engaged experienced a reduction in risk and increase in feelings of safety – with 77% reporting a cessation in all forms of abuse. The data highlighted a number positive outcomes in terms of well-being, self-esteem and mental health and while some figures for this IDVA service were slightly lower than those reported nationally, additional measures were available; with 70% (of those completing the Beck Depression Inventory more than once) reporting a reduction in symptoms of depression. These findings align broadly with IDVA services nationally who use the SafeLives Insights database and reflect the positive impact of this IDVA service on the safety and wellbeing of domestic abuse victims.

Values, Principles, Policy and Procedures

The focus of this article now turns to the role of the specialist organisation in which the IDVA service is based and the extent to which this organisation facilitated the support provided to survivors. At this point, it is helpful to outline how the organisation approaches the development and implementation of policy. Any staff member or service user can suggest the need for a new policy, this will then be considered by the Senior Management Team (SMT) who will discuss whether a new policy is required or if existing policies are sufficient. Typical situations that may require a new policy include; changes to legislation, emerging best practice

or a specific incident that highlights a gap in existing policy. If a new policy is required, SMT will review best practice and research what is working well in other sectors as a basis to their policy development. Policies and procedures are then communication to staff on an ongoing basis- starting with a comprehensive induction programme when staff join – and continuing with away-days and team meetings.

The starting point involved a review of the organisation's policies and procedures to help build a picture of what the organisation was trying to achieve. Using the framework of Thematic Analysis (Braun et al, 2015), we identified a number of themes that were interwoven throughout their policies and procedures (aimed at facilitating the support provided by IDVAs). The principles were: a culture of support and investment in staff; a commitment to community-based, multi-agency working; effective governance and management; and flexible, victim-led, meaningful support. The remainder of this article will explore the extent to which these principles, which are intended to support IDVAs in providing a safe and effective service to survivors, were operationalised based on case-file analysis and online surveys with IDVAs and stakeholders.

Culture of support and Investment in staff

It was clear when reviewing the organisation's policies and procedures that they had given considerable thought to the wellbeing of their employees. Employment policy topics included: compassionate leave, emergency leave, parental leave, cancer, domestic abuse and the workplace, bullying, stress, clinical supervision and flexible working. There was recognition throughout these policies of the demands of working in this field, as the Clinical Supervision policy explained:

> *(The organisation) is committed to delivering safe and effective practice, to ensuring our clients are safeguarded and that our staff are supported to manage the personal and professional demands of the work.*

Similarly, in the Stress Policy, it was noted:

> *The primary aim of the policy is to ensure that its employees are kept safe and healthy at work and are not subjected to excessive workloads, onerous working practices or a detrimental working environment which might, if unchecked, cause the employee stress.*

To address these issues, the organisation was signed up to an Employee Assistance scheme where staff could access practical and emotional support with personal issues. Similarly, in the Clinical Supervision policy, staff were advised that if personal issues were impacting on their work could be provided with financial support to access counselling from the organisation.

In addition to support for staff, the organisation's policies and procedures articulated a clear commitment to investing in their staff by supporting them to access training and development opportunities. As the training policy explained:

> *It is the policy of (the organisation) to be committed to helping their employees to develop through training and believe that their staff are their greatest asset.*

The policy advises that the organisation will consider supporting them to access further and higher education to assist their personal and professional development.

Evidence in practice

In order to determine the extent to which the culture of support for staff translated into practice, we asked IDVAs to rate their responses to a series of statements. As Table 7 shows, all IDVAs enjoyed their role, 8 (89%) felt supported by the organisation and 6 (67%) thought their role

was valued. It is important to note that we asked IDVAs how long they had worked for the organisation with responses ranging from 5 months to 9 years (with an average of 2 years 7 months) and so IDVAs newer to the service may not yet have had sufficient experience in relation to each statement.

Table 3 here

Interestingly, when asked how they felt about working for the organisation, the comments below suggested IDVAs were proud of their role and the wider organisation, which does suggest a culture of support and investment in staff:

> *'I think the IDVA service is a brilliant service and really does make a difference in the lives of victims'.*
>
> *'They do not discriminate and help clients of all backgrounds'.*
>
> *'I am very proud to be part of and deliver the IDVA service at (the organisation)'.*
>
> *'I have found my time here extremely enjoyable; it plays to my strengths and prior experience, communication can be an issue at time with teams being so spread across the county but on the whole it works very well'.*

In seeking to assess the extent to which there was a culture of investment in staff, we asked IDVAs about the training they had received while working for the organisation. The responses were; legal training (2), stalking training (2), Child Sexual Exploitation training (1), Vocational Qualification Assessment Services training (2), Older Persons Violence Advisor training (1), Diploma in Domestic Violence (1), sexual violence training (1), Domestic Abuse Stalking and Honour-based Violence (DASH) training (1), and Safeguarding training (1). Some of these were short one-day training events, but others (such as the Diploma in Domestic Violence) were long-term higher education qualifications funded by the organisation. The above responses suggest that for those who took part in this research, they enjoyed their role, felt

supported and were provided with opportunities for development – thereby evidencing that the principle of a 'culture of support and investment in staff' has been translated into practice.

Commitment to community-based, multi-agency working

The organisation recognises that effective partnerships are vital to the success of their work, stating: *We will work collaboratively with individuals, families and partner agencies to reduce risk of harm* (Annual Report, 2015/16).

As discussed earlier, the IDVA role is an integral part of Multi-agency Risk Assessment Conferences where statutory and voluntary agencies work together to safeguard the most at-risk victims. However, multi-agency working is not confined to MARAC – most survivors of abuse will require the assistance of more than one organisation to address their needs. In recognition of this, the organisation has a Coordinated Community Response Policy:

> *Partnerships are key to successful organisations; and most often, the needs of our clients cannot be adequately met within the remit and capability on one organisation alone. We recognise that in order reduce domestic abuse, multiple agencies from both the statutory and third sector are required to work collaboratively in order to effectively manage the risk to the client and meet individual client need. We are dedicated to working within the community to increase our reach to hidden victims and the safety of our clients and client's families, holding perpetrators to account for their abuse, effective prevention strategies and ensuring service provision is accessible to all on an equitable basis of client, risk, need and choice. (Coordinated Community Response Policy)*

Evidence in Practice

We found evidence from a number of sources to corroborate that IDVAs were providing community based services with multi-agency partners. Firstly, when analysing 19 case-files it

was clear that IDVAs were working with a range of organisations to help meet the needs of their service-users. For example:

- Liaising with Solicitors regarding civil orders (4)
- Liaising with Housing – writing supporting letters for housing applications, following up repairs/requests to change locks (9)
- Liaising with court/police/Witness Care Unit to chase bail conditions, request special measures, request conditions for Restraining Orders (10)
- Safeguarding referrals (adult and child) (3)
- Referring victim/survivors to other agencies (4)

The fact that IDVAs were working with these agencies and were able to secure what they needed for their service-users, suggests that at the local level, effective partnerships exist. Moreover, findings from the stakeholder survey suggests that other organisations have a positive view of how the IDVA service works – again suggesting effective relationships. As Table 4 shows, stakeholders largely report very positively when considering the work of IDVAs.

Table 4 here

We also asked stakeholders to rate how effective they felt IDVAs were at delivering key aspects of their role, as depicted in Table 4. The unanimous agreement amongst stakeholders regarding the efficacy of IDVAs suggests the organisation is successful in establishing and maintaining multi-agency partnerships (at least for those who responded to the survey). In addition, we asked stakeholders what they thought made the IDVA service effective at achieving outcomes for victims. It was clear from their comments that involvement in MARAC was seen as vital:

> *'The IDVA at MARAC is dedicated to ensuring support is provided to every victim'*
>
> *'Co-located with MARAC. Good links and relations with Police colleagues'*

'Representing the victims at MARAC and court'

These comments suggest that the commitment of the organisation to work with their partners in order to address the safety of service users has translated into practice for the stakeholders who took part in this research.

Effective governance and management

Given the level of risk IDVAs are dealing with in their day-to-day work, the management of IDVAs is crucial. We found a clear theme regarding effective governance and management while reviewing the organisation's policies and procedures. For example:

> *Our case-management review process (tasking and coordinating) as well as our service audit process means that all cases are constantly reviewed and "drift" is minimised. Any barriers to progress due to difficulties in timely access are swiftly identified and acted upon* (Annual Report, 2015/16).

Similarly, in recognition of the level of risk IDVAs are managing in their caseloads, the organisation's supervision policy states:

> *Supervision must take place on a regular basis … and safeguarding must always be discussed*.

Moreover, policies regarding the recruitment and induction of new members of staff stressed the importance of clear expectations and a thorough induction programme – with the aim of ensuring IDVAs are operating in a safe way, recognising the risk to their service users and their children:

> *The induction of all newly appointed staff should include, an introduction to the organisation's safeguarding policies and procedures …this should include being made*

> *aware of the identity … of those staff with designated safeguarding responsibilities and location of all policies including the organisation's Safeguarding policies and procedures. (Safe Recruitment Policy)*

Evidence in practice

In assessing the extent to which the principle of effective governance and management translated into practice, we found evidence of this in both the case-file analysis and online survey with IDVAs. We analysed data recorded in the case-files to ascertain the time taken between each stage of the referral and allocation process. Of the 16 files where the dates were recorded, 14 (88%) were allocated within 24 hours and 12 (78%) had an attempt at contact within 48 hours. Where there were delays of more than 48 hours this related to a weekend or a bank holiday. Finally, 11 (69%) were successfully contacted with 24 hours. While this analysis is based on a small sample, it does evidence the commitment of the IDVA service to managing the referrals process in a timely manner, resulting in early engagement with service-users.

In addition, we also looked at the length of service and how this was managed as part of the case-file analysis, identifying that two thirds of the cases (12) were concluded within 5 months. There were a number of cases that went on longer than this, with two cases open for 8 months, however, for both of these there were further incidents during IDVA support which required the file to be open longer. The fact that cases were not left to 'drift', but at the same time showing sufficient flexibility to remain open where needed, suggests the IDVA service had a good balance of managing risk with operational requirements.

Yet there are other measures of this principle translating into practice. In the survey, IDVAs rated their response to different statements regarding how they were managed within the organisation (Table 3).

It is important to note that the organisation has a commitment to ensuring that IDVAs are managed by qualified and experienced IDVAs. This is with the intention that the quality of advice and support they can offer will be more effective than if managed by someone with no experience of providing the service. The data from case-files and the online survey with IDVAs suggests that the principle of effective governance and management has translated into practice (albeit for a small sample of cases and proportion of IDVAs).

Flexible, person-centred, meaningful support

In some existing evaluations of IDVA services, specialist domestic abuse services are described as feminist women-only services (Robinson, 2009, Coy and Kelly, 2011). The organisation in this research does not identify as feminist, instead promoting equality of access. Yet there are fundamental values at the heart of the organisation that inform the type of service they wish to deliver- many of which correspond to feminist values of empowerment and choice (Ullman and Townsend, 2008).

> *It is the policy of (the organisation) that at the outset all clients must be made aware of their options regarding the services we can offer and that it is for them to choose the services they wish to access and how they want their support to be delivered (Referral Policy)*

In addition, the organisation's policies place the survivor at the heart of the support:

> *All interactions with clients must remain trauma informed and be meaningful to both parties; if a conversation is only of meaningful value to the service provider then it is a method of data collection rather than an intervention. (Risk and Needs Assessment Scoring Matrix)*

Evidence in practice

In seeking to understand the extent to which these principles were reflected in practice, we explored both the case-files and the views IDVAs shared in the online survey. It was clear in the case-files that IDVAs were flexible to the needs of their clients. Some victim/survivors' lives were extremely challenging as they were balancing a number of issues in addition to the abuse. This made regular engagement with the IDVA difficult, but the files suggested IDVAs understood their circumstances and did their best to be flexible, while still following their organisation's policies.

The IDVAs were also non-judgemental in their approach. There were several cases where the victim wanted to withdraw their support for the prosecution – in each case, the files suggested that IDVAs explained the process for doing so and explained the possible implications, but they were clear that they respected their client's decision and that support would continue. In addition to the case-files, we found evidence of these principles in the IDVA online survey responses. Regarding their focus on victims and a non-judgemental approach, some commented:

> *'I listen to what the victim wants unlike some statutory agencies who tell them what they should do. IDVA's give advice and offer options to a victim so they can make their own decisions, and at the same time supporting them throughout the process'.*

> *'An empathic non-judgmental diverse approach with an ability to adapt the service to meet the needs of all and be inclusive'.*

Others commented on the importance of independence:

> *'The fact we are independent from other agencies and are a SPOC (single point of contact) for victims means we build a better rapport with victims then most agencies, we know more about the situation so can provide better advice and risk assessments'.*

'Sometimes it may feel like there is no one on client's side, and having an IDVA would ensure she feels she has someone on her side and someone to go to for any help she may require'.

Finally, the issue of advocating for survivors clearly emerged as a central aspect of their role:

'Someone who is prepared to push agencies to gain positive outcomes for their client'.

'Being thorough and leaving no stone unturned when it comes to safety of our clients'.

'Understanding of the process, knowing that they have an advocate that will go the extra mile for them'.

The responses of IDVAs who took part in this research suggest a clear commitment to person-centred meaningful support with the aim of achieving positive outcomes for survivors. The flexibility demonstrated in the case-files similarly suggests the organisation has been successful at translating the principle of flexible, person-centred, meaningful support into practice.

The relevance of funding and resources

During the evaluation, it became evident that financial constraints and the instability of funding were potentially impacting on the ability of the organisation to deliver an effective service. If contracts are not adequately funded, they may not be safe for service users. When we asked stakeholders if they thought the IDVA service was adequately funded, their response was telling – only 33% agreed that the IDVA service had sufficient resources.

Furthermore, while most IDVAs who took part in the survey enjoyed their role and felt supported by the organisation, there were also some who reported less positively for management support and feeling valued. A possible explanation for this is suggested in the below comments –which relate to staff-turnover and the instability of funding.

'I enjoy working for (the organisation), we have some amazing staff who are dedicated, the only negative is the high turn-over of staff which leaves us under a lot of pressure to do the job and train new staff'.

'There are not enough staff when people leave, it's difficult because funding for the services seems to reduce each year'.

Limitations

There are a number of limitations to this research that must be acknowledged. The main limitation is that there is no comparison with other organisations who employ IDVAs. A comparison would have helped to shed light on the different principles upon which specialist services structure their policies and procedures and the extent to which this facilitates support to victim/survivors. In addition, the extent of missing referral data, the small number of respondents to the online survey and small sample of case-files does limit the findings of this research. Interviews with IDVAs and their managers would have produced more nuanced detail regarding their experience of the organisation and it would have been preferable to include the opinions and experiences of victim/survivors (unfortunately we struggled to recruit participants during the evaluation). It is also important to consider that the outcome data and case-file analysis presented in this article reflect cases where service users engaged with the IDVA service. There are a considerable number of service users who are referred to the service but do not wish to access support. While understanding the reasons for non-engagement with domestic abuse services is important, it was beyond the scope of this study. Moreover, it was not possible to compare outcomes for those who did and did not engage as outcome data is only captured when there has been some level of support provided. However, despite these limitations, this study is the first to consider the role of an organisation's policies and procedures in facilitating IDVA support and can therefore act as a starting point for future studies.

Conclusion

This research sought to understand the role of a specialist domestic abuse organisation in supporting the work of an IDVA service. Despite recommendations that IDVAs are best placed in specialist services (Robinson, 2009, Coy and Kelly, 2010), little is known about how such organisations support IDVAs to address the safety of domestic abuse survivors. Furthermore, there are no national guidelines for these organisations to follow and while SafeLives run an accreditation scheme for providers, (called Leading Lights) the rationale behind the standards is not clear and there is no published research exploring the extent to which these standards are translated into practice. As such, this is the first study to explore the role of a specialist domestic abuse service in facilitating the support offered by IDVAs.

The research began with an analysis of the outcomes achieved by the IDVA service to determine the extent to which they had helped to improve the safety and well-being of survivors. As the analysis identified, those supported by the service reported a cessation of all forms of abuse in 78% of cases with other measures broadly aligning with IDVA services nationally. The second stage of the research involved a thematic analysis (Braun, et al, 2015) of the organisation's policies and procedures to determine the key values principles upon which the service intended to support the work of IDVAs. We then looked for evidence of these principles being translated into practice through a review of case-files and online surveys with IDVAs and stakeholders.

We found evidence that the values and principles of the organisation (as set out in their policies and procedures) had largely been operationalised. There was a culture of support for staff, there were effective multi-agency partnerships, the service was managed effectively, and IDVAs were committed to a flexible, non-judgemental, person-centred service. These findings, albeit limited to data for those who actively engaged with the service, shed light on

the vital role of the organisation in facilitating the support provided by IDVAs. If we want to ensure domestic abuse survivors can access safe and effective services, we need to ensure IDVAs are supported, managed effectively, and have good working relationships with partners – especially given the level of risk they are managing on a daily basis. Yet the role of the organisation, in particular specialist domestic abuse services, is far from understood. The nature of specialist services can vary dramatically – some may be based in feminist Third sector organisations that have been providing support since the 1970s, while others may be based in relatively new gender-neutral social enterprises. It is surprising that the role of the organisation in facilitating effective domestic abuse services has yet to be considered in the literature, particularly when specialist services are deemed to be the most appropriate home for IDVAs. It is therefore vital that researchers, commissioners and providers begin to more formally consider the important role of the organisation in facilitating support. This article is a starting point, and has highlighted that the principles upon which this one organisation has based its policies and procedures have indeed translated into practice (for those cases where service users engaged, and based on the responses of IDVAs and stakeholders). However, these principles are not necessarily shared by other specialist services, and while SafeLives promote a set of standards as part of Leading Lights, research is yet to ascertain the extent to which they are translated into practice. More broadly, however, there is yet to be a discussion as to whether the standards issued by Leading Lights, or indeed the principles articulated by the organisation in this research, are the most appropriate. Further research is therefore needed to understand the different types of organisations in which IDVA services are based and the extent to which their policies and procedures are safe, supportive and translate into practice. Moreover, the pressures placed on specialist services as a result of insecure and inadequate funding must be addressed by commissioners to prevent the safety of services being compromised.

Reference List

Beck, A., Steer, R., & Brown, G. (1996). *BDI-II: Beck Depression Inventory Manual* (2nd ed.). Boston: Harcourt, Brace.

Braun V., Clarke V., Terry G. (2015) Thematic Analysis. In: Rohleder, P. and Lyons, A. (eds) *Qualitative Research in Clinical and Health Psychology*. Basingstoke: Palgrave MacMillan, pp 95-113.

Coy, M. and Kelly, L. (2010) *Islands in the Stream: An Evaluation of Four London Independent Domestic Violence Advocacy Schemes*. The Henry Smith Charity, Trust for London and London Metropolitan University: London. [Online] Available from: https://www.trustforlondon.org.uk/publications/islands-stream-evaluation-independent-domestic-violence-advocacy-scheme/

Dobash, R. and Dobash, R. (1979) *Violence Against Wives: A case against the Patriarchy.* London: Open Books

Donovan, C., Hester, M., Holmes, J., and McCarry, M. (2006) *Comparing Domestic Abuse in Same Sex and Heterosexual Relationships.* ESRC. [Online] Available from: http://www.equation.org.uk/wp-content/uploads/2012/12/Comparing-Domestic-Abuse-in-Same-Sex-and-Heterosexual-relationships.pdf

Granville, G. & Bridge, S. (2010). *Pathway Project: An Independent Domestic Violence Advisory Service at St Mary's Maternity Hospital*. [Online] Available from: http://www.endthefear.co.uk/wp-content/uploads/2010/10/PATHway-Project-Summary1.pdf

Hamel, J. (2006) Gender-Inclusive Family Interventions in Domestic Violence – An Overview. In Hamel, J. and Nicholls, N. (eds) *Family Interventions in Domestic Violence: A Handbook of Gender-Inclusive Theory and Treatment*. London: Springer

Home Office (2005) *Domestic Violence: A National Report*. London: Home Office

Home Office (2006) *National Domestic Violence Delivery Plan: Progress Report 2005/6*. London: Home Office

Howarth, E., Stimpson, L., Barran, D. et al (2009) *Safety in Numbers: A Multi-Site Evaluation of Independent Domestic Violence Advisor Services*. London: The Hestia Fund and The Henry Smith Charity

Howarth, E. and Robinson, A. (2016) Responding Effectively to Women Experiencing Severe Abuse: Identifying Key Components Of A British Advocacy Intervention. *Violence Against Women*. Vol. 22, No. 1, pp 44-63

Jones G., Meegan R., and Kennett P, Croft J. (2016) The Uneven Impact of Austerity on the Voluntary and Community Sector: A Tale of Two Cities. *Urban Studies***.** Vol. 53, No. 10, pp 2064-2080. doi:10.1177/0042098015587240

Madoc-Jones, I. & Roscoe, K. (2011). Independent Domestic Violence Advocates: Perceptions of Service Users. *Diversity in Health and Care*. Vol. 8, No. 1, pp 9-17

McCoy, E., Butler, N., Quigg, Z. (2016) *Evaluation of the Liverpool Multi-Agency Risk Assessment Conference (MARAC).* [Online] Available from: http://www.cph.org.uk/wp-content/uploads/2016/06/Evaluation-of-the-Liverpool-MARAC.pdf.

Robinson, A. (2006) Reducing Repeat Victimization among High-Risk Victims of Domestic Violence. The Benefits of a Coordinated Community Response in Cardiff, Wales. *Violence Against Women.* Vol. 12, No. 8, pp 761-788.

Robinson, A. (2009) *Independent Domestic Violence Advisers: A Multisite Process Evaluation*. London: Home Office

Robinson, A. and Tregidga, J. (2007) The Perceptions of High-Risk Victims of Domestic Violence to a Coordinated Community Response in Cardiff, Wales. *Violence Against Women.* Vol. 13, No. 11, pp 1130 -1148

Rosenberg, M. (1965). *Society and the Adolescent Self-Image*. Princeton, NJ: Princeton University Press.

SafeLives (2014) *Safelives Dash Risk Checklist – Quick Start Guidance*. [Online] Available from: https://safelives.org.uk/sites/default/files/resources/Dash%20risk%20checklist%20quick%20start%20guidance%20FINAL.pdf

SafeLives (2017) *Safe Lives 2017 Survey of Domestic Abuse Practitioners.* [Online] Available from: http://www.safelives.org.uk/news-views/practitioner-survey-2017.

SafeLives (2018) *Insights Idva England and Wales Data Set 2017-18.* [Online] Available from: http://www.safelives.org.uk/sites/default/files/resources/Insights%20Idva%20national%20dataset%2012%20months%20to%20April%202018.pdf

SafeLives (2019) *Insights Idva England and Wales Dataset 2018-19.* [Online] Available from: https://safelives.org.uk/sites/default/files/resources/Idva%20NDS%20201819.pdf

Taylor-Dunn, H. (2015) The impact on victim advocacy on the prosecution of domestic violence offences – lessons from a Realistic Evaluation. *Criminology and Criminal Justice.* Vol. 16, No. 1, pp 21-39

Ullman, S. and Townsend, S. (2008) What is an empowerment approach to working with sexual assault survivors? *Journal of Community Psychology*. Vol. 36, pp 299-312. doi:10.1002/jcop.20198

WAFE (2016) *Sector Sustainability Shared Standards.* [Online] Available from: https://safelives.org.uk/sites/default/files/resources/Shared%20Standards%20Whole%20Document%20FINAL.pdf

Table 1 Characteristics of clients referred to the IDVA service in 2017

Client characteristics - referred to the service		**N**	**%**
Gender	Female	2127	94.4
	Male	116	5.2
	Transgender Man	1	0
	Transgender Woman	1	0
	Missing Data	*7*	*0.3*
Sexual Orientation	Heterosexual	1896	84.2
	Homosexual	10	0.4
	Bisexual	4	0.2
	Other	2	0.1
	Prefer Not To Say	4	0.2
	Missing Data	*336*	*14.9*
Disability	No	131	5.8
	Yes	380	16.9
	Missing DATA	*1741*	*77.3*
Ethnic origin	White/White British	2008	89.2
	Asian/Asian British	48	2.1
	Black/Black British	73	3.2
	Mixed ethnic origin	25	1.1
	Other	21	0.9
	Missing data	*77*	*3.4*
Total		2252	100%

Table 2 - Clients completing; DASH risk assessments, Rosenberg self-esteem scale scores and the Beck depression inventory in 2017

Number of DASH risk assessments completed			**Decrease in DASH score**		**Number of self-esteem tools completed**			**Increase in self-esteem**		**Number of depression indicators**	**Number of clients**		**Number of clients with a reduction in depression**	
	n	**%**	**n**	**%**		**n**	**%**	**n**	**%**		**n**	**%**	**n**	**%**
1	543	50.8	-	-	**1**	124	59.9	-	-	1	124	59.9	-	-
2	276	25.8	195	70.7	**2**	41	19.8	29	70.7	2	41	19.8	30	71.4
3	129	12.1	93	72.1	**3**	13	6.3	13	100.0	3	13	6.3	10	76.9
4	52	4.9	38	73.1	**4**	19	9.2	17	89.5	4	19	9.2	8	80.0
5	41	3.8	34	82.9	**5**	4	1.9	4	100.0	5	4	1.9	11	84.6
6	13	1.2	10	76.9	**6**	2	1.0	2	100.0	6	2	1.0	1	50.0
7	10	0.9	8	80.0	**7**	4	1.9	3	75.0	7	4	1.9	3	75.0
8	1	0.1	0	0	**Total**	**207**	**100.0**	**68**	**32.9**	**Total**	**207**	**100.0**	**63**	**30.0**
9	1	0.1	1	100										
10	1	0.1	1	100										
14	1	0.1	0	0										
Total	**1068**	**100.0**	**380**	**35.6**										

Table 3 –IDVA online survey statements

Statement	**% Agree or strongly agree N=9**
I enjoy my role	100%
My role is valued in the organisation	67%
I feel supported by the organisation	89%
I have regular opportunities for development	66%
I have good management support	78%
I have regular access to supervision	100%
I am clear what is expected of me as an IDVA	100%

Table 4 – Stakeholder online survey statements

Statement	**% Strongly or mostly agree**
I can contact the IDVA service easily	100%
I receive a timely response to requests for information	83%
I understand the role of the IDVA	100%
I see the value of the IDVA service	100%
How effective are IDVAs at Risk Assessment?	100%

How effective are IDVAs at Safety Planning?	100%
How effective are IDVAs at liaising with other organisations?	100%
How effective are IDVAs at representing victims' views at MARAC?	100%
How effective are IDVAs at helping victims to access accommodation or other resources?	100%
How effective are IDVAs at supporting victims at court?	100%
How effective are IDVAs at advocating for victim/survivors?	100%