



**Integrating the Independent Domestic Violence  
Advisor and Flying Start:  
A Process and Outcome Evaluation**

**Final Report**

Trudy Lowe MSc

Universities' Police Science Institute

Cardiff University

**November 2009**

***“Goodness, don't take it away!  
That's a danger, isn't it, with pilots,  
it just gets taken away”  
(017)***

## Contents

<b>Key Messages and Recommendations for Practitioners and Decision Makers.....</b>	<b>4</b>
<b>Executive Summary.....</b>	<b>5</b>
<b>1. Introduction.....</b>	<b>8</b>
<b>2. Background Context.....</b>	<b>9</b>
<b>3. Findings: The Process Evaluation.....</b>	<b>12</b>
3.1. ‘Right Place, Right Time’ – The Importance of Accessibility.....	13
3.2. ‘One of Us’ – The Importance of Trust and Confidence.....	20
3.3. ‘Direct Line to Knowledge’ – The Importance of Expertise.....	27
3.4. ‘Providing the Glue’ – The Importance of Integrated Multi – Agency Working.....	31
<b>4. Findings: The Outcome Evaluation.....</b>	<b>36</b>
4.1. Overall Risk and Concern.....	37
4.2. Experience Indicators.....	38
4.3. Concern Indicators.....	41
4.4. MARAC Referrals.....	45
<b>5. Summary and Conclusions.....</b>	<b>46</b>
<b>6. References.....</b>	<b>49</b>
<b>Appendix 1: Research Design and Timetable.....</b>	<b>50</b>
<b>Appendix 2: Research Methodology – Process Evaluation.....</b>	<b>52</b>
<b>Appendix 3: Research Methodology – Outcome Evaluation.....</b>	<b>53</b>

## **Key Messages and Recommendations for Practitioners and Decision Makers**

- Integrating a dedicated Independent Domestic Violence Advisor (IDVA) into a Flying Start team provides a flexible, accessible, victim-focussed service to families at risk from domestic abuse within the most vulnerable of communities. A service in the 'Right Place, at the Right Time'
- A dedicated IDVA provides a familiar, simplified and timely referral route for health and education practitioners when domestic abuse is disclosed or suspected in families with whom they interact. It is highly valued by them as a 'Direct Line' to the specialist knowledge and services.
- Improved specialist knowledge and experience among practitioners for whom the management of domestic abuse is not a core function can increase the early detection of and intervention with families at risk.
- The multi-faceted, independent nature of the IDVA role allows for a more co-ordinated and synergistic approach to data sharing across agencies, including criminal justice, circumventing some existing failures and enabling a more informed intervention and a less daunting process for families. It provides the 'Glue' for multi-agency working.
- Optimal integration of the role into a multi-functional team is achieved when all partners are fully informed of its function and aims at the outset. Trust and confidence must be given time to build based on experience and enhanced understanding of the role. This is considerably expedited by co-location of the IDVA with local Flying Start teams, enabling the IDVA to be quickly seen as 'One of Us'.
- On the basis of the evidence collected to date, it is recommended that funding for similar, dedicated practitioners in the remaining Flying Start areas be explored. Each position need not be full time, allowing for either several IDVAs to 'cover' an area each as part of their full time workload or all areas being covered by one or two specialist practitioners. However, whilst the idea of such a peripatetic practitioner might seem attractive, consideration should be given to the importance of co-location with local teams, at least for part of the working week.
- The success of this or similar future provision should be more rigorously evaluated in terms of objective outcomes for service users over a longer timescale.

## **Executive Summary**

### **Context**

The objective of this research was to evaluate the innovative pilot provision of an Independent Domestic Violence Advisor (IDVA) working as part of a Flying Start team located within a defined school catchment area in Cardiff. The aim of this initiative is to explore how integrated multi-agency working can improve the quality of a victim-focussed service delivered in complex cases of children and adults at risk of violence in the home.

### **Approach**

A qualitative approach was used for the process evaluation element of the research, drawing on data obtained from in depth interviews conducted with key practitioners whose work impacts upon the pilot programme: the IDVA herself; Flying Start management and Health Visitors; staff at the school for whose catchment area the Flying Start team are dedicated; police officers at the Cardiff Domestic Abuse Unit (DAU); and females who used the services of the dedicated IDVA during the evaluation period. A total sample of fourteen practitioners and three families were interviewed at the beginning and end of the six month pilot period.

For the outcome evaluation, a quantitative approach compared the data collected by the Cardiff Women's' Safety Unit (WSU) on a sample of service users during the evaluation period and a sample of matched cases from prior to the initiative.

### **Main Findings**

Findings from the qualitative data collected suggest that four key aspects of this role were important in determining its successful implementation and potential for impact upon the rate and seriousness of domestic abuse within families in the area.

#### **1. Accessibility - 'Right Place, Right Time'**

The most significant finding is the importance of the enhanced accessibility afforded to a dedicated IDVA. For the victims of domestic abuse in particular, the ability to see an IDVA at the local school emerges as pivotal. The school is seen as a safe, familiar and convenient location in which individuals can discuss their problems in confidence at a time that is easiest for them. This flexibility of access to this victim-focussed service at the right place and time for them is seen as particularly important

when victims are limited in their movement as a result of controlling behaviour on the part of the perpetrator of domestic abuse. Referral to the service via a health visitor also emerges as an important aspect of the role for service users. Providing details of a named individual and reassurance of the ensuing process appears to improve the rate of take up of this voluntary provision by families compared with just providing information about a 'faceless' organisation.

## **2. Expertise – 'Direct Line to Knowledge'**

The dedicated IDVA provided an important and direct source of specialist advice and knowledge for other practitioners more indirectly involved in the management of domestic abuse. The direct line provided by a dedicated and familiar practitioner has helped to improve the knowledge and skills required for the early identification of violence in the home and has also aided timely intervention where violence is either disclosed to or suspected by them. The pilot highlights further opportunities for enhancing the specialist expertise of generalist practitioners in vulnerable locations, particularly in schools where the incidence of domestic violence in local families is high and impacting upon the safety and development of children in their care.

## **3. Trust and Confidence – 'One of Us'**

For the health visiting staff, having regular face-to-face contact with an IDVA whom they could get to know and incorporate into their team had a significant impact upon their ability to identify and manage domestic abuse within their family caseload. The data showed clearly that co-location is pivotal to the development of trust and confidence in the IDVA and that this relationship is essential for the provision to function at an optimal level. The physical presence of the IDVA within the team, albeit on a part time basis, went a long way to assuaging initial concerns about conflict between data sharing and patient confidentiality. Positive experience with specific cases during the pilot compounded this development of trust and a greater appreciation of what the service could offer such that, by the end of the pilot period the IDVA was seen by the Flying Start team as very much 'one of us'.

## **4. Integrated Multi-Agency Working – 'Providing the Glue'**

The other significant finding to emerge from the evaluation is the pivotal role played by the dedicated IDVA for access to and the co-ordination of multi-agency partners and the information they hold. Despite data sharing protocols, the qualitative data illustrate clearly that access to full information is not always an easy process for some partners. The criminal justice – orientated role evaluated here was able to co-ordinate the collection of information from a variety of agencies in a synergistic fashion, providing the 'glue' required to bring it all together and inform successful, victim-centred, multi-agency intervention

The evaluation highlighted some potential shortcomings in the current role of the police DAU. With the exception of their role in the MARAC, there was little indication from the interviews conducted of any proactive, problem-oriented policing methods designed to manage the incidence of domestic abuse in the city. In the initial stages they had little knowledge of the pilot placement and as such appeared very much on the edges of the multi - agency team in this regard.

Whilst the process evaluation interviews yielded a rich dataset on the success of the implementation of this pilot programme, data for the outcome evaluation was minimal over the relatively short timescale of the project. What data there was would seem to indicate the beginnings of a pattern for a decreasing risk in some families engaged with the dedicated IDVA. The innovative approach would therefore now benefit from a more extensive evaluation of outcomes over a longer period of time.

## **Conclusions**

Overall this evaluation has shown the pilot provision to have been successfully implemented, with early signs of benefit for the identification and ongoing management of domestic abuse in homes where the city's most vulnerable children are at risk from exposure to this all too often hidden crime. As such the pilot has met its aim and provides empirical evidence to support a wider roll out of a dedicated, victim-focussed IDVA provision in other Flying Start areas of the city. A longer term evaluation of such a project would enable a more objective measure of success and the exploration of the potential and capacity of this approach to operate at scale.

## **1. Introduction**

The objective of this research was to evaluate the innovative pilot provision of an Independent Domestic Violence Advisor (IDVA) working as part of a Flying Start team located within a defined school catchment area in Cardiff. The aim of this initiative is to explore how integrated multi-agency working can improve the quality of a victim-focussed service delivered in cases of children and adults at risk of violence in the home.

The evaluation aims to:

- provide an assessment of whether such modes of integrated multi-agency working can improve the effectiveness of identifying children and young people at risk in situations where domestic violence is occurring;
- establish whether such early identifications may contribute to the capacity of Flying Start to deliver its wider objectives.

In so doing, the project will address a current limitation of the Flying Start programme in recognising the extent to which criminal justice agencies may have a role to play in helping it to achieve its aim to give children a better start in life. It will also build upon and enhance the nationally recognised innovations established in Cardiff through the initial Multi-Agency Risk Assessment Conferences (MARAC).

A qualitative approach was used for the process evaluation element of the research. In depth interviews were conducted at the beginning and the end of a six-month evaluation period, with key practitioners whose work impacts upon the pilot programme: the IDVA herself; Flying Start management and Health Visitors; staff at the school for whose catchment area the Flying Start team are dedicated; and police officers at the Cardiff Domestic Abuse Unit (DAU). In addition, interviews were conducted with females who used the services of the dedicated IDVA during the evaluation period. A total sample of fourteen practitioners and three families were interviewed; a small, but diverse sample giving an all round assessment of the implementation of the initiative.

For the outcome evaluation, a quantitative approach compared the data collected by the Cardiff Women's Safety Unit (WSU) on a sample of service users during the evaluation period and a sample of matched cases from prior to the initiative.

This report begins by detailing the background context of the initiative, before going on to discuss the findings from the process and outcome evaluations in turn. It concludes by turning to the implications for policy and practice in the management of domestic abuse. Further details of the research design and methodology used can be found in Appendices 1 to 3 at the end of the report.



## **2. Background Context**

### **National Domestic Violence Strategy**

Over the past thirty years there has been a steadily increasing recognition of the prevalence of violence and abuse within a domestic setting and its significant impact, not only on direct victims themselves, but upon families and communities in general. Governmental action to tackle the issue of domestic abuse has moved on apace in recent years, culminating in the publication of the first National Report and National Delivery Plan for Domestic Violence<sup>1</sup> in 2005, swiftly followed by the All Wales National Domestic Abuse Strategy.<sup>2</sup>

Both the National and All Wales strategies recognise that whilst domestic abuse is first and foremost a crime, it is very often a hidden one with victims “suffering in silence, afraid for themselves and their children”<sup>2</sup>. In order to effectively address the impact of domestic abuse on society, in both human and financial terms, the plans recognised the need to first understand the full extent of the problem by establishing a system which encourages more victims to come forward to report their victimisation and that then supports them through the process of making themselves safe.

Central to the National Delivery Plan was the recognition of the need to develop a Co-ordinated Community Response (CCR) model, involving and encouraging partnership working between the community and all service agencies on whose work domestic abuse might impact, both within and outwith the Criminal Justice System. The model “recognises and makes explicit that no one agency can deal effectively and safely with the effects of domestic violence<sup>3</sup>” and calls for an integrated network of support to which a victim can turn. At the core of the model are the creation of Specialised Domestic Violence Courts (SDVC) and the Multi Agency Risk Assessment Conference (MARAC). The latter, first established in Cardiff in 2003<sup>4,5</sup>, is a regular, structured multi-agency forum allowing for the sharing of information on potentially high-risk victims and their children and the co-ordination of interventions to reduce further harm.

### **The Role of the Independent Domestic Violence Advisor**

Alongside this more structured process of information sharing between agencies, there is recognition of the need for victims to have access to a dedicated, independent source of advice and assistance to help them recognise that they are at risk, make decisions about their future and to access the range of services they may need. The role of the Independent Domestic Violence Advisor (IDVA) has become established as that integral part of a successful response to

domestic abuse, serving as the victim's primary point of contact. The nationally accepted definition of the role is that it:

*".. address the safety of victims at high risk of harm from intimate partners, ex-partners or family members to secure their safety and the safety of 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 safety plans. They are pro-active in implementing the plans, which address immediate safety, including practical steps to protect victims and their children, as well as longer-term solutions. These plans will include actions from the MARAC as well as sanctions and remedies available through the criminal and civil courts, housing options and services available through other organisations. IDVAs support and work over the short- to medium-term to put them on the path to long-term safety."*<sup>6</sup>

Working with and on behalf of victims the IDVA provides direct practical help aimed at improving safety as well as support within the multi-agency setting to ensure their voices are heard. Recent advances in accredited training programmes<sup>7</sup> are further professionalising this important catalyst to a successful, victim-focussed management of domestic abuse and IDVA services are now located in a variety of settings around the country.

In Cardiff, the IDVA service is based at the Cardiff Women's Safety Unit (WSU), a Home Office funded multi-agency initiative working with a wide range of statutory and voluntary organisations including the police, CPS, Offender Management and Social Services. Via its team of IDVAs, the WSU offers a comprehensive range of services to female victims of domestic abuse, at one referral point.<sup>8</sup>

### **The Flying Start Programme**

Inseparable from the risk domestic violence presents to women is the impact of such abuse on the children of victims. The All Wales Strategy notes that "domestic abuse is a grave crime and that witnessing it or being the subject of it can have a serious adverse effect on a child/young person's well being and development<sup>2</sup>".

Building upon the success of the UK – wide Sure Start programme, the Welsh Assembly Government's Flying Start programme aims to make a decisive difference to the life chances of children aged 0 to 3 years in targeted deprived areas based on school catchments. All families in these areas can access enhanced services including quality part-time childcare for 2 and 3 year olds, parenting and basic skills programmes. Central to the Flying Start entitlement is a dedicated and well resourced health visiting service that works within a multi disciplinary team to refer children to the services they require within the provision. Whilst funding is not available to provide specialist services to those children

identified as having higher needs, the partnership approach is designed to encourage and enable referral to the relevant agencies as required<sup>8</sup>.

In Cardiff Flying Start currently has a significant staffing drawn from different backgrounds including education, health visiting and dietetics. Such intensive support to young families under the Flying Start banner thus results in health and education professionals being well placed to identify the early indicators of abuse within the home. In theory, via the partnership approach, vulnerable families can be referred to a specialist domestic abuse service, but in practice referral is little more than the provision of information and advice to seek help and there is little evidence to suggest that such referrals are regularly taken up by mothers. With no Flying Start staff experienced or skilled in the criminal justice arena it is possible that an opportunity for early intervention to address and prevent domestic abuse is not being realised to its full potential.

Data collected by the WSU would appear to support this view. During the year 2007-2008, 597 children were discussed at Cardiff MARACs, of whom, nearly 25% attended schools within the Flying Start catchment areas. However, no direct referrals to MARAC were made by Flying Start, suggesting either that early indicators of domestic abuse are not being recognised by its practitioners or that the referral process is not functioning successfully.

In an attempt to explore and improve the processes available to Flying Start for the identification of domestic abuse, the Cardiff WSU has obtained funding to provide a dedicated IDVA to work with potential victims with children from one of the Flying Start school catchment areas. The role will also involve working with the Flying Start team to help identify and refer other potential cases in order to provide and disseminate the skills required for early identification of children at risk. This research aims to evaluate the implementation and outcome of this placement and to establish the potential of such an intervention to develop an integrative model combining existing criminal justice services with Flying Start provision.

## **The Setting**

For the pilot placement the IDVA was dedicated to a selected Flying Start catchment area in Cardiff for approximately half of her working week. The Flying Start health visitor team for the area is physically based in a separate building within the school grounds although initially the IDVA worked from the Cardiff Flying Start offices in another part of the city. During the course of the pilot period the IDVA moved to be based with the local team at their offices in the school grounds for 2 full days per week. Three months into the pilot period, a separate building providing Flying Start nursery provision was also opened within the grounds.

### **3. Findings: The Process Evaluation**

The first round of qualitative interviews with key stakeholders were undertaken approximately six to eight weeks after the dedicated IDVA began her placement within the Flying Start team. As such they do not represent a true baseline as the role had already begun to have some impact, at least on some of the respondents interviewed. Nevertheless, data was obtained relatively early in the process of the pilot when the full breadth of the IDVAs anticipated role appeared not to have become fully established. The second round of interviews took place some 6 months later, and included four new respondents whose roles were likely to have interacted with that of the IDVA during that time.

Using this complete dataset it was possible to explore: the existing processes in place within different agencies regarding the identification and management of domestic abuse in this area of Cardiff; initial reactions from different agency practitioners and service users to the pilot provision and its immediate impact; and the development of the role over the first nine months and its implications within a multi-agency framework for the management of domestic abuse.

During the pilot period, a number of themes emerged within the views of practitioners that had a direct impact upon the successful implementation of the initiative. These can be aggregated into four key areas as follows:

- Accessibility - 'Right Place, Right Time'
- Trust and Confidence – 'One of Us'
- Expertise – 'Direct Line to Knowledge'
- Integrated Multi-Agency Working – 'Providing the Glue'

In order to evaluate the impact of the pilot processes, this section of the report will discuss each of these themes in turn, using direct quotations from practitioner and service user interviews to illustrate findings from the qualitative analysis.

### **3.1. 'Right Place, Right Time' – The Importance of Accessibility**

Accessibility emerges as one of the key factors impacting upon the success or otherwise of the service provided by IDVAs, both to service users and to other professionals.

#### **Ease of Referral**

For the Flying Start Health Visitors, having a dedicated IDVA to whom they could refer families from their caseload was seen as a positive step from the outset. Having a known, named individual made the referral process easier and therefore more likely to be considered at an early stage. A timely response and detailed feedback were also valued highly and personal contact with an individual built trust and confidence in a service previously only accessible through a faceless and potentially time consuming referral process;

*“Access to somebody without having to make lots of phone calls is invaluable because ringing, ringing and ringing people is quite time consuming as you know and I think having somebody here we know ... is really useful.... I just think it's really helpful having somebody on site dedicated to this team and I know we're very lucky, and that I think is invaluable really”*  
(016)

For families themselves, access to the IDVA service via their Health Visitor was welcomed. With little previous knowledge of the existence of the WSU, referral via a health practitioner they could trust was an important step in accessing the help they needed;

*“So if it wasn't for [Health Visitor] I wouldn't have ever gone to anybody like [IDVA], it would never have happened and then obviously I wouldn't have felt safe in the home ... I think its brill that the health visitor can ask you if you want to go further... you don't have to accept it, you know, [Health Visitor] didn't force it on me, I think it's down to the individual really”*  
(013)

The data suggest that this ease of access for families experiencing or at risk of violence in the home provides a gentle, victim-centred approach to encouraging more women to come forward and seek help to manage their own safety at an early stage, before serious abuse leads to crisis;

*"I wish I knew about it sooner rather than let it get to the explosion before [IDVA] got involved. I wish it was like, dealt with beforehand, if I knew"*  
(010)

Staff at the school strongly valued the ease of access to the expertise provided by a dedicated IDVA, both for themselves and for local families. Whilst already following prescribed referral processes in child protection cases, they clearly recognised the value of access to a specialist resource, particularly in low level and/or as yet un-evidenced cases of domestic abuse that are not at the level of social service intervention. Whilst they were universally aware of the WSU and acknowledged having literature available in the school, a direct, formal referral was rare prior to the introduction of the dedicated IDVA. Experience of having direct and easy access during the pilot period has to some extent changed the way in which teachers now think about managing disclosure from parents in some of these low level cases;

*"Before [IDVA] has started, [talking to the WSU] hasn't been an avenue... normally I just would leave at social services. But not now, I do it completely different now...I'm only a teacher and when mums come in and say the things they do say to you...you are their first port of contact, they just want to tell you everything. Sometimes you think, "oh no, don't say anymore please!" But now I would say you know we've got a women's counsellor on site. I would never say domestic violence, I would say we've got somebody on site who can sort this out for you and that is immense, the personal contact is great".*  
(017)

### **The Importance of Location - Families**

One of the strongest themes to emerge from the data is the importance attached to the IDVAs services being accessible to potential users. An early successful negotiation for the use of a room at the school for consultations proved particularly important. Both Health Visitors and teaching staff reported that women seem more amenable to referral locally and women themselves readily admit that they might not otherwise have availed themselves of the IDVAs services. Going to the school was seen as non-threatening, anonymous and convenient, particularly considering the distance involved in travelling to the WSU;

*"I would never have gone to see [IDVA], never, if she wasn't round the corner, or she couldn't come to me like. She said "oh I'll come to you if you need me to, you know if you can't [get] there", but obviously with school just up the road.... I think it's like, I don't know, it's like accepting you've got more of a problem if you go to them somewhere - does that make sense? But it was over the school, I know the area, and it was just kind of chit chat, it wasn't, there was no atmosphere, there was no, you know I wasn't scared to go and see her, because it was in my own environment"*  
(013)

*"I just think it is away from the house isn't it, sort of thing, so nobody knows what you are going there for. It's not as if you are going where there is a big sign outside...you could just be going there with the baby couldn't you? ...because you don't want the stigma attached sort of thing, do you? That's the problem".*  
(011)

Whilst none of the service users interviewed had seen the IDVA at a time when an abuser was still resident with them, they all recognised the value of the school as a meeting place had that been the case. The ability to more easily get away to a non-suspicious location was also influential in cases recalled by practitioners during the pilot, suggesting this is one of the key advantages for victims;

*"one mum in particular is coming to drop her child off at [the nursery], she can come in here without having to make an excuse to leave the family home, and I think that's the beauty of [IDVA] being on site. Because it's safe for mums to come here. They can say they're coming to see the health visitor when actually they're not and that's fine".*  
(016)

The level of support that can be given was also perceived to be more intense than that provided by the standard WSU service, because of its convenient location. In one particular case during the pilot period that required focused co-ordination between Flying Start, the school and the IDVA, the physical co-location of all three was pivotal to success to moving a woman and her child to a place of safety, when previous attempts had failed;

*"although I had tried before with the WSU, once we got [IDVA] involved it did bit by bit happen... I don't think it would have happened without her... I don't think WSU does offer that sort of support. I'm sure it does, but this woman certainly would not have been able to accept that level of intensity of support had [IDVA] not physically been here and that's fact"*  
(004)

The importance of such a victim-focussed service cannot be understated, particularly as the very nature of domestic abuse leads to significant denial and under-reporting on behalf of those experiencing it. The flexibility afforded to the dedicated IDVA to see clients in the right place and at the right time for them is significant in the success of such a role.

### **The Importance of Location - Practitioners**

As well as providing a far easier and more effective referral process, the physical presence of a dedicated IDVA within the school complex was also important to both to the local Flying Start Health Visitors and the school staff.

In the first part of the pilot period, the IDVA was located at the Cardiff Flying Start offices in another part of the city. Whilst she was dedicated to work with families within the school catchment area, and interacted with them there, this day-to-day physical separation from the local Flying Start team appeared to somewhat delay the development of trust and confidence and consequently, the full realisation of her service offering;

*"I thought it was going to be somebody, sort of, sitting in our office that I could actually literally talk to when, and, and ask, um, ideas and, um... So, in, in a way, um, I know [IDVA] is based in our headquarters so I first thought that she was actually going to be part of our team. It doesn't, you know, feel like she's part of our team"*  
(006)

Three months into the pilot, the decision was made to physically move the IDVA to work alongside the Health Visitors in their offices in the school grounds for two full days per week. Despite a minor, but strongly felt logistical problem relating to desk space, the data showed a significant development in the team work and respect between professional groups and an increase in the utilisation of the IDVA service;

*"I do think the face to face contact, being part of the team you know, just generates referrals, and the sooner she can get in the better"*  
(001)

*"...one of the advantages of her being in the office really, that we saw her as another health visitor, you know, she was just one of the people in the office".*  
(004)



Anecdotal discussion and advice, significant in its impact on this development of trust, was only one aspect of the dedicated service to be enhanced by physically co-locating Flying Start staff and the IDVA. The speed at which information could be obtained and actions put into place was also valued by the health visiting staff;

*"I think it's um smoother obviously, because she is on site, we can discuss things and she picks up more information. She can give appointments quite sort of soon if not that day, and she has also got the added information on the database, if sometime we are not sure about something. She has got information, we can say "do you have knowledge of this particular person?" and she can say "oh yeah I do".*

(006)

*"All the leaflets which I've got to the right of me and I can quickly give them rather than, I'm in a different town or location in Cardiff and I'm having to send them. By the time they land on their desk they're actually trying to remember which case they wanted them for. So it can all be dealt with much quicker"*

(002)

For the school staff themselves, location within their grounds was less important than having a dedicated individual to whom they could put a face and a name. Recognising that a full time, co-located resource may not be justifiable in relation to their direct need, they valued most the personal contact with someone they knew – a 'direct line' to services as and when they required them. Nevertheless, being part of the school community was seen by teaching staff to be key to take up by families who would see the service in a non-threatening way;

*"I think the fact that staff feel comfortable and safe with her and can see how , parents then can see how relaxed we are with her it's not like, oh my goodness here's an outside person. It's somebody who is all part and parcel of the normal care and welfare of the school almost and it seems less threatening when it's somebody who is already on site"*

(007)

## **Awareness**

Once in touch with the IDVA, service users commented on how little they knew about the services provided by the WSU prior to their referral and how a more rigorous awareness campaign may have encouraged them to seek help earlier;

*“I just don’t think anybody knows about [the WSU], you don’t see it advertised anywhere, phone this number. Like I saw a woman’s aid leaflet but you never see anything about, we’re here to help, here’s a number. If it weren’t for [the Health Visitor] had said about it, I wouldn’t have known about it”*

*(011)*

There is no way of knowing whether this would have actually have been the case of course, and highlights the importance of awareness raising at an early stage via existing provisions such as health visiting, which this pilot placement explores. Health Visitors tended to agree with services users that awareness should be raised via themselves and other health practitioners, most notably midwives and General Practitioners;

*“Doctors....Because obviously when, um, you know, you get so far....you go to a doctor’s, and talk to your doctor, regarding like your health issues, if you have a like, anxiety or anything like that. Then the doctor should be able to say, right, you know, there is this company called Women’s Safety Unit, you know, and they will be able to help you, talk through your problems and try and resolve stuff. So I would have expected the doctors to come out with that, but they never...”*

*(010)*

Whilst school staff saw enormous value in closer working with a dedicated IDVA , there was a reticence to become more directly involved in generally raising awareness of the service, preferring to access it reactively on a case by case basis and preferably via the Flying Start provision where this was appropriate. There was, understandably, concern to maintain the trust of parents and not to risk alienating them;

*“what’s happened in the little nursery that we’ve just opened... we’ve had 7 referrals in 3 months for physical abuse, and they’re saying “oh this is just a watching zone then is it? Get them in, check them for bruises top to toe so, well we’re not going to get them in”... so really difficult, we have to be very careful. I think the service is something that we should deal with [at] senior leadership and the mums who need it being accessed through the Flying Start provision not the school, because the school still has to maintain it’s...we have to be one step away”*

*(017)*

Overall, the data show very clearly that easy access to an IDVA at the right place and time has had a significant impact upon its success in the eyes of both service users and other agency practitioners. Bringing this specialist service directly to victims and those practitioners who interact with them on a regular basis has created opportunities for timely intervention hitherto unexplored.

### 3.2. **'One of Us' – The Importance of Trust and Confidence**

#### **Early Understanding and 'Buy-in'**

Within the Flying Start team itself, there was initially good knowledge and partial understanding of the aims of the pilot, although there appeared to be some initial uncertainty as to how it is envisaged that those aims would be achieved and the precise role of the IDVA herself. The early data suggested that this uncertainty was due in part to the gradual introduction of the role and its potential benefits in order to gain commitment from a relatively new team working within an emerging structure;

*"I wondered, with Flying Start so many new things came along at once, how it would fit with our role and the information sharing part of it as well. And I suppose the link between the WSU and how it was all going to work really. Particularly because we knew she was supposed to be based with this team that at the start of it she was in [Flying Start central offices] and I didn't really get that"*  
(016)

But there were also concerns amongst Health Visitors regarding aspects of confidentiality. Working on the frontline within targeted areas, they have a good recognition of the need to share information about families considered to be at risk, particularly where there is direct and evidenced child protection concerns. Nevertheless, there is an underlying worry about the potential impact such information sharing can have on rapport and the building of trust with families they visit and being unsure of the precise role the dedicated IDVA was going to play added somewhat to these concerns;

*"I was worried about the, the women being contacted without me knowing because, um, one, that they would not understand how their information was passed on, and two, that, you know, as health visitors we've got a very privileged position in working with people in their homes and, and them telling us what's going on....."*  
(006)

There was also some resistance regarding the extent to which there can be proactive intervention with families where risk from domestic abuse is less clear cut, the data suggesting the potential for working with an IDVA to identify such cases was not initially fully understood or accepted;

*"I have to work on fact and, and not opinion or perception.*

***Is there any point where you would....say, my whim [that there is domestic abuse] is strong enough that I think...?***

*I can't. Unless there's any evidence of the child being at risk, you know, that's stepping outside of my role"*

*(006)*

As time progressed, however, trust and confidence in the role built dramatically and the experience of working with a dedicated IDVA on specific cases has assuaged these initial fears. Initially, many of these cases were already known families with entrenched problems going back some time. Positive progression with some of these families has been evident since the IDVA became involved, leading to a marked development of trust and respect between the practitioners;

*"I have learned a lesson from that definitely, that it's worth chipping away. I mean I hope I would never have just discounted people but always continued to give the opportunity, the push. But in health visiting and especially in an area like this, you do so much work and the families just don't pick it up"*

*(004)*

A more detailed understanding of the skills and experience of the IDVA has also enabled initially concerned practitioners to develop respect for both the individual and the role, such that they quickly became assimilated into the team as 'one of us';

*"...we saw her as another health visitor, you know, she was just one of the people in the office. And I know now that she's a qualified social worker so she's well aware of the importance of confidentiality as anybody. I think I became more aware of her training and experience while she was with us so maybe I probably ended up valuing her a bit more by the end of the three months".*

*(004)*

This assimilation and respect has improved recognition among Health Visitors that a more pro-active approach to identifying potential domestic violence in the home is possible without risking families' confidentiality and trust in them. As understanding of the parameters of the IDVA role has grown, more advice has been sought regarding subjective 'whims' and ultimately more referrals made to the IDVA;

*“Yes, that's another thing hopefully, that more have been identified because we know there's a bit more help out there I suppose”  
(004)*

The development of understanding, trust and confidence in the IDVA role among other practitioners in this innovative model was mixed. Within the school at which the Flying Start team are based, teachers and other staff naturally already had a detailed understanding of the Flying Start Programme, what it aims to achieve and the benefits to the school and the local community. There was consequently an excellent working relationship between the school and both the strategic management and frontline team of Flying Start. The introduction of an IDVA to the already multi-disciplinary team was well known about at the school leadership level at least, and universally welcomed. There was a good understanding of how it was envisaged the role would integrate with the rest of the team and a commitment to making it work;

***“When you first heard about [IDVA] starting this position, what were your first thoughts?”***

*“Yippee! Really. Because as I said, what goes on with the Women's Safety Unit and all of that, I think it's brilliant, I can't fault it. But it's away. It's not here. And I think, when they said, we're going to have an advocate who's here for the mums... I was just so thrilled because I know that there are still, I think half a dozen parents here who I know are victims. I know in my heart are victims, I haven't always got the proof, but at least I think if I've got something to go on, I can say, look we've got somebody here who you can talk to”  
(008)*

There was, however, a suggestion in the data that maybe understanding of the role and its aims was not as comprehensive among those teachers and staff at a more junior level or those without specific responsibilities within the child protection arena;

*“There is a lot to be said about everybody knowing what's going on... what there is to offer. Sort of everybody being involved, the things we've done that have been successful, have TAs involved as well for example, so the more people that are involved. Being more aware of either what we need to know through that person who's a specialist or that person being accessible to...Raising their profile. .. actually saying I need this inset with your whole school, I need an inset with your staff, I need an hour or whatever it is. Everyone knows, not just one or two people being aware of it”  
(009)*

Those in leadership roles acknowledged that, whilst the IDVA had 'blended in' at the school, she had not fully integrated to the team which, with hindsight, might have been a useful aim from the beginning. That said, confidence and trust in the individual and the role was generally high at the outset although, the role was seen by some as one of reactive service provision rather than a pro-active role to help in the management of specific cases. This continued to build steadily over the course of the pilot period as the role developed and specific case studies allowed teaching staff to experience first-hand the level of pro-active input an IDVA can contribute to managing difficult situations;

*"I knew she was coming in and doing it, I wasn't aware that she was going to be so much support to us. Now I'm still not clear if that was the role, [that] she was going to be so hands on with the children. I thought it was going to be quite distinctive, the mums having support, we will get advice. But so pro-active!"*  
(017)

Overall, the data suggest that the pilot provision was not only accepted but welcomed by the school staff as a positive development. As experience led to a further understanding of what the role could bring, trust and confidence grew to level where the role was considered a vital part of the schools efforts to protect its children from the potential harm caused by experiencing domestic abuse in the home.

Conversely, from a policing perspective, there was evidence that there was little knowledge of the pilot schemes existence or indeed, of the Flying Start programme itself, as the following quotations attest;

*"I knew of IDVAs... but, I certainly didn't know there was any in place in Cardiff within a school, I didn't know that"*  
(013)

*"I don't know exactly what she's doing, I know about it....Just that she's attached to Flying Start, but I don't know what this Flying Start really is, and I don't know what her role is"*  
(003)

This lack of initial knowledge did improve with time, although understanding of the pilot's aims and their translation into a practical role for an IDVA working alongside Flying Start staff remained limited. Whilst there was an improved understanding that the IDVA was working more closely with Health Visitors, there appeared to be a lack of distinction between the IDVA role generally, which was well understood and the specific advantages of a practitioner dedicated in this way, particularly in relation to pro-activity outside of the WSU environment;

*“That basically she's involved with health, the NHS, and she sort of speaks to young mothers, maybe giving like parenting advice or skills really? I don't know, to help and advise and obviously if they've got concerns or anything is disclosed to them, then she takes it forward. I don't know if that's it?  
(015)*

*“I don't know exactly what they do; I don't know how busy they are. Surely there's no point in having something if one person a week drops in. I don't know how successful it is at the moment”  
(003)*

Whilst this might be understandable among generic police officers working on response duties, it is of concern that those officers dedicated to the police Domestic Violence Unit were not better informed, given that one of the aims of the pilot is to achieve a better integration of criminal justice agencies into the management of domestic violence victims. Indeed, this lack of detailed knowledge had created some worrying misunderstanding with regards to information sharing, as this following exchange illustrates;

*“Initially I was, I'm not sure I can give you information because it's that different area isn't it?... I'm thinking I know I can normally give you this information...she's still in IDVA, I appreciate that, but she's then been seconded to do something else and they might not be part of the information sharing process....are they signed up to the information sharing process, Flying Start? They don't come to MARAC – no-one from Flying Start ever comes to MARAC”.*

***“Well they might do, because a lot of the health visitors are employed by Flying Start”***

*“... or are they employed by the NHS trust? We can give information to the NHS”*

***“They are employed by the NHS but they'd come under – well all Flying Start is, is an umbrella to bring health and education together”***

*“Which are all under the information sharing Act. But initially I'm like, ooh..”  
(014)*

Nevertheless, the police recognised that there is a role for a practitioner with a criminal justice focus to work alongside health professionals in the management of domestic abuse, a view in no small part influenced by their role in the MARAC. That this should become a more hands-on, proactive involvement was seen as a positive step to help mitigate what they see as some of the current limitations of the health service in this regard;



*"I think NHS people are seen to be a bit hung-up on whistle-blowing, don't they, a little bit, to be perfectly honest. I don't think its whistle-blowing; it's being honest and saying I've got a concern. And they are seeing people in their natural environments"*

(014)

Overall, whilst the data clearly illustrate that understanding of the pilot placement was limited within the police, this is not to say that they were not instrumental in its execution, at least in terms of a reactive response to requests for information under the multi-agency framework. A proactive, problem solving contribution was less obvious, however, and it may be that the timeframe was insufficient for the organisation to fully comprehend how a more involved approach might influence outcomes.

### **Personality**

Similarly, the personality of the individual in a role such as this has a direct impact on how quickly they are able to gain the trust and confidence of a multi-agency team. The ability of the IDVA in this project to integrate her specialist skills and expertise into an already complex, multi-faceted environment required a commitment to team work and a great deal of flexibility. Some practitioners clearly recognised the importance of this commitment and valued it highly;

*"I wonder how much of it is, is it the service that's good or is it [IDVA] that's good? Because I've got to say that when I said right have my mobile number, and it was instantly, this is my work you can ring me anytime, and it was often....that's what [IDVA] gives but I'm not sure if that's outlined in the definition of the job description or whether she is just conscientious"*

(017)

Given the previously noted importance of successful outcomes in gaining the trust and confidence of other practitioners, high levels of patience and tenacity would also appear to be crucial personal traits for an individual in this type of role. Whilst this is likely to be true for any IDVA position, in any setting, the pilot investigated a different way of working that amplifies this need, a point not lost on the IDVA herself;

*"This role terrified some of the other IDVAs because... the way they work is all they've known. They've been here for years, so the fact that they'd be travelling around and seeing people, kind of was completely foreign to them. But I think because I come from a social work background and I worked in child protection as well, when we were doing health visits where there was likely to be a perpetrator and you never knew who was going to be there, you can't risk assess that before you get in to it"*  
(002)

The data across all three practitioner groups suggest the integration of an IDVA within a setting such as this is unlikely to be a quick process and that personality, time and positive experience will be required for trust and confidence in the role to become truly established. It is important for the future of such placements to recognise that individual practitioners may feel somewhat disheartened by this and may require additional support from committed management to maintain the level of pro-activity required while the position 'beds down' and its true impact can be realised. Indeed, the following quotation makes clear that Flying Start management recognised up front the potential for the dedicated IDVA role to lead to a different way of working which may take some time to be understood;

*"So I said to [IDVA], "let's take it slowly, it'll happen slowly because they need to get trust in you and understand what you're doing".....I think [she] thought she was going to be inundated in week one, I knew she wouldn't be. I know it's out there, but it doesn't work like that, it's gradually talking to people and gradually have some people thinking what can [IDVA] bring us that we can't do....And it's really beginning to open up now and I think that the more [IDVA] does, the more that she will show what she's been able to provide"*  
(001)

Before understanding and trust can develop a basic knowledge to the scope of the role is clearly important and during this pilot has been instrumental in gaining initial support from the Flying Start team and senior school staff. That the police and wider school staff were not 'bought in' or directly impacted by the role will have been due in part to their lack of knowledge at the outset. Whether this is because they weren't provided with the relevant information or have simply not assimilated it is not clear. But in any event the data contain a strong message that the more information provided to all potentially effected practitioners, the better and quicker the role will become established and the IDVA considered 'one of us'.

### 3.3 **'Direct Line to Knowledge' – The Importance of Expertise**

#### **Specialism vs. Generalism**

Much of the IDVAs initial casework was reactive to issues in families who were already known by various agencies to be affected by domestic abuse, some seriously so. Flying Start staff initially brought such cases to the IDVAs attention primarily in order to receive advice themselves on appropriate action. Key to these early referrals was the IDVAs perceived specialist expertise in an area considered peripheral to Flying Start staff's core function and focus. Such expertise proved itself to be a valuable resource, particularly in cases where concerns were as yet unsubstantiated and where specialist knowledge was deemed to be necessary;

*"Her expertise in domestic violence is obviously more than mine and it's, it's yeah, like you say, if you do have a nagging doubt where you think, well it's not enough to speak to that person, but perhaps you could speak to [IDVA] and, yeah definitely"*  
(005)

As the pilot period progressed, the importance of the IDVA function as a direct line to knowledge became increasingly apparent. For the Flying Start Team, specialist expertise has been drawn upon by self-acknowledged generalist Health Visitors to update and improve their understanding of the signs of domestic abuse, their assessment and potential implications;

*"I sat with [IDVA] doing a risk assessment and I had seen the data somewhere before in a conference, but to actually see it being used brought back really significant questions, and those things that were on the risk assessment that [IDVA] does with the woman... markers, flags. Say for example one of the questions might say "did the perpetrator of violence every try and strangle you?" And that figures quite highly in those relationships which could go onto be homicides".*

***"In what way has it helped you?"***

*"I wouldn't have asked those questions, I wouldn't have known to ask those questions".*

(006)

*"...[IDVA] is very valuable because there wouldn't have been anyone else really...one of them really needed somebody who could give her the facts about her position, which I couldn't..."*

(004)

Staff at the school was similarly appreciative to the expertise the IDVA represented to both them and local families. Whilst very detailed procedures are in place to record and manage children's behavioural changes via a 'Care Book' and 'opt out' system, there was a limited understanding how best to advise parents where low level abuse in the home is suspected or disclosed to them and the input of social service is not yet prescribed. Experience of accessing reactive advice from the dedicated IDVA has highlighted that proactive training in the area of domestic abuse would be beneficial, particularly in light of the of the nursery provision now on-site via Flying Start;

*"..specific training for nursery, Flying Start nursery, and our nursery reception. How to deal with year 1 and 2 children who just blurb, say what it is, no consequences, and then 3 and up. I think it could be packages delivered in that particular area, don't know if there's anything available but I think that is a definite way that she could be utilised"*  
(017)

### **'Bouncing' Ideas**

As well as formal training sessions the IDVA engaged in a considerable amount of anecdotal discussion with the Health Visitors in particular, who acknowledged and valued the ability to 'bounce' thoughts and ideas with a specialist. Such 'water cooler talk' undoubtedly improved the knowledge and skill base of the team in a softer, non- patronising manner and allowed them access to a resource they might not otherwise have had the time or the inclination to seek through the WSU. Just as importantly, the IDVA's knowledge of potential referral routes and resources available for victims of domestic abuse was heavily utilised by Health Visitors, allowing them to work with families who where maybe not yet ready to use the IDVA service directly;

*"Her expertise, you know, she has given me advice on the Women's Safety Unit and also on projects that they are running for a few months. She found out about a project for a young mum which may be implemented when she finishes on different things that are going on. So no, her knowledge is very good, and her experience".*  
(005)

Such anecdotal advice is significantly important when one considers some of the early concerns of the health visiting team with regards to taking action in cases where there are no hard facts and potential implications on the confidentiality and trust of families. Informal access to a specialist with whom they can discuss

relatively minor concerns or un-evidenced 'gut feels' about a family adds significantly to the opportunity to identify potentially abusive situations at an early stage.

### **Making Things Happen**

Reaction to the IDVA service from women referred by the Flying Start team has been overwhelmingly positive. The expert knowledge and skills provided were, in many cases, considered pivotal in enabling them to understand their situation and take steps to make themselves and their children safe. Service users universally found the help they received to increase their confidence, helping them to recognise that they were not to blame for the abuse they had experienced;

*"For me, it's probably the best thing I have done. Although it was only a few short meetings - well long meetings, we would always talk for over an hour - it was a big step for me because it made me see that I was a better person than they said I was and that's why I'm single now. I don't think I would be if it wasn't for [IDVA]"*

(013)

One of the most important aspects of the IDVA's service for those who used it was the help it gave them in co-ordinating and understanding the activities of other agencies involved in managing their situation. Direct access to a professional who was easily able to obtain information about their case and progress it was highly valued by women baffled by processes and procedure. That advice was delivered in an honest and realistic fashion was also important;

*"I was having trouble with the solicitor, you know she weren't writing her letters out to him to stop him from coming to my house.... She weren't doing her thing, so when I got in touch then with [IDVA}, she could like eh, kicked her up the backside and basically said, do your job!"*

(010)

*"I suppose [the refuge] have got to do their job haven't they, but I suppose that with [IDVA] it's an outsider looking in so she has got a different perspective....' they won't do this and they won't do that and he won't get contact and this won't happen', but then it does. They say he will never get contact, I was like ok, then you see a solicitor and they say he is going to get contact you know, if he sorts himself out...but [IDVA] said he will get contact with him, unless there is really really GBH sort of thing...you think why didn't you tell me straight at the beginning?"*

(011)

Overall the data show the importance of an expert resource to both service users and the professionals trying to manage domestic abuse. Of course, this expertise already was, and continues to be available from the WSU, but placing the expert in a position where they provide a personalised, direct line to knowledge appears to improve the take up and consequent value of this important resource.

### 3.4. **'Providing the Glue' – The Importance of Integrated Multi-Agency Working**

The management of domestic abuse relies on input from practitioners from a number of agencies and its success is often inherent upon how well these agencies share information and co-ordinate their activities. Indeed, the aim of this pilot project was to explore how integrated multi-agency working can improve the quality of services delivered in complex cases.

All the practitioners interviewed recognised the importance of a multi-agency approach to managing cases of domestic abuse and during the course of the pilot, became to recognise the dedicated IDVA as an important resource to access and co-ordinate their activities. For the Health Visitors, used to working closely with social workers with more serious cases, the IDVA provided an accessible source of information and a different view-point with which to confer, as previously described. As a specialist with focus on the multiple impacts of violence in the home, the IDVA was able to access other specialists from various agencies, bringing them together to share information and manage their own role within a multi-agency strategy;

*"[IDVA] was the pivot, the core worker, the key worker that, co-ordinating the social worker, the health visitor, the victim, the abuser, she was able to link in with the school because there was school aged children... to say look, this is what's going on. And that was down to one practitioner... that wouldn't have happened prior to [IDVA], we just never had that facility before"*  
(001)

Being a link between agencies with regard to information sharing emerged as a significant aspect of the role, most notably when it came to the relationship between health and the police. Whilst the MARAC provides a system for very high risk cases, the system that exists for information sharing in relation to other incidents appears to be less robust. All reported cases of domestic abuse are detailed in a specific format on what is termed a PPD1 form. Whilst in theory these are circulated by the police to other agencies under an information sharing protocol, the data reveal that practical problems are preventing this system is not always working as well as it might;

*"Unfortunately we're a victim of not being able to get the internal post directly to here at the moment. It goes to the Ely and Caerau Children's Centre and then comes here, so it might mean that we get a PPD1 form a couple of days late"*  
(016)

*“...with NHS it's not so good because they haven't a secure e-mail so we can't send them the PPD1s or either fax it over to the. So they collect them every 2 weeks when they come to a MARAC which I think is a bit... if it was really urgent, and then basically they have got a fax, we're not meant to fax over but under those circumstances we would fax or e-mail them over but then we're basically getting written warnings for e-mailing them over because it's not a secure address”*  
(015)

This breakdown in information sharing appears to have had an impact upon the problem-solving relationship between Health Visitors and police and other criminal justice agencies in as much as the former have not felt in full possession of all the facts in relation to some of the families they work with. Having the dedicated IDVA on site provided access to criminal justice information that helped to understand better the circumstances behind situations they are observing;

*“It's mainly perpetrators of violence who are either in prison, been to prison or things, that we can find out, that we never had access to before. If a child is born this year, [IDVA] could say actually over the last 6 years going back to 2000/2002, there have been 1,2,3,4,5...because until a child is living in the house, we wouldn't have that information from the police, so we wouldn't know”*  
(006)

Another particularly useful role played by the IDVA involved her access to the probation service. Obtaining accurate information regarding the movement and status of perpetrators of domestic abuse already involved with the service, both in and out of custody, allowed for a more detailed assessment of victims' risk and overall management of their cases;

*“I give you an example where a mother who had experienced a lot of domestic violence had told me that that the boyfriend was in prison and everything was safe and the release date, and there was some ambiguity about that. Now [IDVA] could contact the person, now I don't even know who it was, in the probation. Is that person still in prison? Have they got a release date? Are the family safe until then? And I would never have known who to ask, who to ring. I would of started with the police which would have been the wrong place. And she could actually tell me that a certain probation officer had visited this man last week, he wasn't due for release. So it is definitely information sharing”*  
(006)]



School staff also recognised the importance of a single point of contact; a known, dedicated resource with detailed knowledge of a case, to 'own' and co-ordinate multiple agency inputs. The ability of the IDVA to understand how different agencies work and access them quickly was particularly valued by practitioners for whom this is not a core function;

*"The social worker was on holiday and every day I rang in it was a new duty social worker picking it up. It was a complete disaster and without [IDVA], I just dread to think how that child would've turned out"*

(017)

The current information sharing protocol between the school and other agencies is naturally more restricted and school staff were keen to remain somewhat removed from problems within families where there is no direct impact upon the children or the school. However, whilst they recognised this necessary need for confidentiality, they also expressed a desire to work more closely with other agencies when trying to manage the problems faced by some of their pupils and the impact upon the school community. The co-location of the Flying Start team and, in particular, the nursery provision has provided a unique opportunity to work closely with health professionals and both agencies agreed that this relationship is developing well. Partnership working with the police, however, appeared to have diminished and is not as useful as has been in the past;

*"Well in fact we used to have a really good relationship with the police. The officers used to come down weekly to share information or just to, you know, we've got concerns about this you know, but it's been stopped because of data protection... the neighbourhood officers won't say anything, they really, you know, even to the point some of my children have been involved in crimes that it would really help us to know about... In the old days the bobby on the beat used to come in here and say "I'll have a word with him, and sort it out", there was really good communication but they're running scared now they really are, they will not discuss information, anything like, and it used to be so beneficial"*

(017)

Similarly, there were some concerns that they weren't always in receipt of information from criminal justice and other agencies which might aid their management of children who are experiencing violence in the home. Whilst the MARAC is valued as a process, the data suggest that school staff would find earlier notification of cases referred useful, together with information on the very high risk cases via police PPD1 forms;

*"Weeks after the abuse took place the MARAC phoned me and said "are you aware of domestic violence?" And I said "you're too late". Now had they phoned when it was even put on the list for MARAC...the children wouldn't have gone to the house that night...I know we've got a lady who does ring up and say ... but it's not enough. We need, as soon as they're in the top 20% of domestic violence incidents, you know the PPD1s that go to the health visitors? We need those in school"*  
(017)

During the pilot, the IDVA provided a strong link between the school and other agencies on specific cases, suggesting such a role is useful to ensure they were provided with the level of information they need, without crossing the confidentiality line they are keen to maintain.

That there was little knowledge of the pilot and the dedicated nature of the IDVAs position was significant in evaluating its implementation from a policing perspective. The generic role of an IDVA at the WSU was well understood and recognised by them as a valuable part of the criminal management of domestic abuse. But whilst there was some awareness that cases had been referred to the MARAC from Flying Start, the police at the Cardiff DAU had little understanding of the IDVAs role in these referrals and the proactive nature of her involvement. They knew the individual in the pilot position and had contact with her throughout the pilot period, but drew very little distinction between their interaction with her before and during those three months;

*"...because [IDVA] knows me, she would ring through and ask for an update or, do I know who's dealing, so I would pass her on to the relevant person. And maybe she might ring to check if incidents have been reported to see whether we've got any PPD1 forms, and if she's spoken to somebody and stuff hasn't been reported, maybe might want a welfare check conducted so advise and speak to her on that sort of knowledge but ... I haven't had loads of contact with her"*  
(015)

It is unfortunate that the police DAU did not get involved in the pilot project in any substantial way, but it is maybe not surprising given the apparently administrative nature of the officers' roles in the unit. The data suggest that the unit sees the WSU and the IDVA role very much as a victim support function and are unaware of projects such as these aimed at systematically reducing the impact of domestic abuse via the early detection of lower risk incidents before they escalate to a level where police intervention is required.

Overall the data clearly indicate that the IDVA provided an all-important 'glue' that is needed to weld together the activities of various agencies in a synergistic fashion to the ultimate benefit of the victim. In this regard particularly, the pilot achieved its aim of improving information sharing via a more integrated approach to the management of domestic abuse and its impact upon children. The IDVA herself was able to see the benefits of this way of working, as the following case study attests;

*"...[I had] a bit of information that I was unsure about that I really wanted to run by [the Health Visitor] and it's kind of putting blocks together really and we were able to establish a bigger picture....because I had a bit of information, she had another bit and she knew someone else who had another bit so it was like piecing it together and then realising that this is bigger than perhaps the original bits. So that's a good example of me being down there because I don't know whether that would have happened without it, because...this particular case of very low level abuse, it hasn't even hit the police's attention so therefore it needed a health visitor to pick up on those things. And maybe with the training I've been putting in, and maybe with my being at [the school] now, in the office it may be that, yes, they are more tuned in....that's immediately coming to their mind whereas perhaps it might not have been before. And I remember the female saying to me I'm so glad this health visitor did refer me to you, she recognised the signs... and on the back of it we are making child protection referrals"*  
(002)

#### **4. Findings: Outcome Evaluation**

The outcome evaluation component of this research was designed to provide a measure of the benefits that have been delivered to service users via the introduction of the dedicated IDVA role. The evaluation is structured around the following outcome measures for cases occurring during the project period:

- Changes in assessments of safety and security from the Hestia/HSC Risk Evaluation method<sup>9</sup>, both in terms of the victim's 'Experience' and IDVA's 'Concern';
- Number of referrals to the MARAC

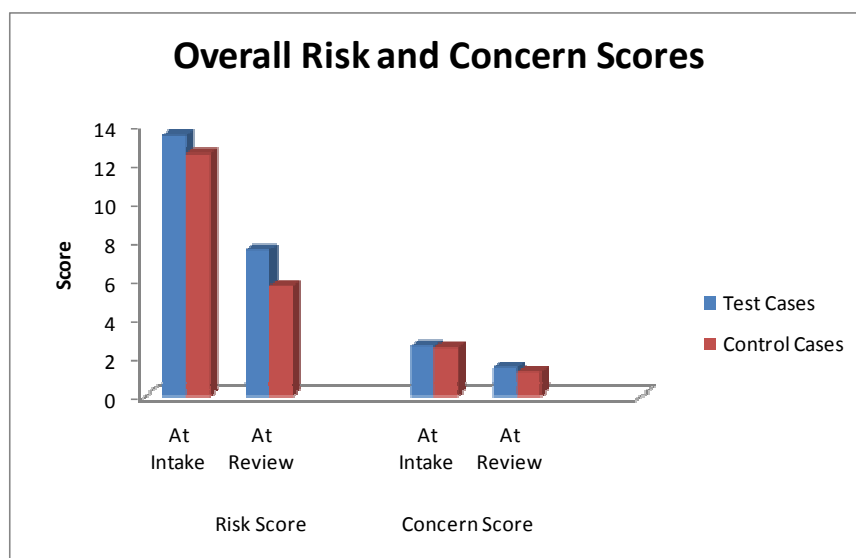
Data for measuring these outcomes was derived from that already collected by the Cardiff WSU. A 'test' sample of cases with which the IDVA was involved as a direct consequence of her placement was compared with a 'control' sample of matched cases from the WSU's database. By comparing these samples we aimed to ascertain the success of the intervention. Full details of the samples, the methodology used to derive them and to analyse the data are given in Appendix 3.

It should be noted that, as a result of the short timescale over which this evaluation was conducted, data available for the test sample were minimal, with less than half the cases (n=4) having a recorded Hestia review. As such, the qualitative analysis presented in this section is not statistically justified and should be viewed as indicative of potential patterns only.

## 4.1. Overall Risk and Concern

Mean overall Hestia 'Risk Score' at the service users' first meetings with an IDVA ('intake') were similar for the test sample and the control sample. In both samples, by the time of the first review the score fell significantly to below the threshold for referral to MARAC (RA Score = 10) and by a similar amount (Figure 1). A similar pattern was observed with mean overall 'Concern Score'.

These data illustrate the success of the service provided by the WSU and the IDVAs working within it in improving the safety and security of victims of domestic abuse. That there is no difference in the benefit as measured by this raw assessment when it is provided by an IDVA dedicated to the Flying Start team is perhaps not surprising as the service delivered amounts to much the same thing. The aim of the pilot was not to necessarily improve upon the help and support already provided by an IDVA based at the WSU, but more to impact upon the number of referrals to and accessibility of the service via a more dedicated provision.



**Figure 1: Overall recorded 'Risk' and 'Concern' Scores**

To further evaluate outcomes of the dedicated IDVA service, users and IDVAs responses to specific questions in the Hestia questionnaires were explored. Those involving the service users' objective responses to questions about the impact of the abuse they experienced are collectively referred to here as 'Experience Indicators'. Those questions which rely upon an assessment of risk by the practitioner conducting the questionnaire are termed 'Concern Indicators'. Data comprising each set are discussed in turn below.

## 4.2. Experience Indicators

In both the test and control samples, the number of cases answering 'yes' to each of the six 'Experience Indicator' questions fell between initial Hestia intake assessment and first review.

In the test sample (Figure 2 overleaf), the most significant change was in the percentage of victims who were 'Afraid of being Killed', which fell from 78% at intake to zero at first review. Other significant falls were observed in the number feeling 'Isolated from Family/Friends' (78% to 25%) and those 'Suspicious of being Stalked' (67% to 25%).

In contrast, for cases comprising the control sample (Figure 3 overleaf), the most significant drops were in the numbers who were 'Afraid of Further Violence' (85% to 25%), 'Afraid of being Killed' (63% to 13%) and 'Very Frightened' (74% to 31%).

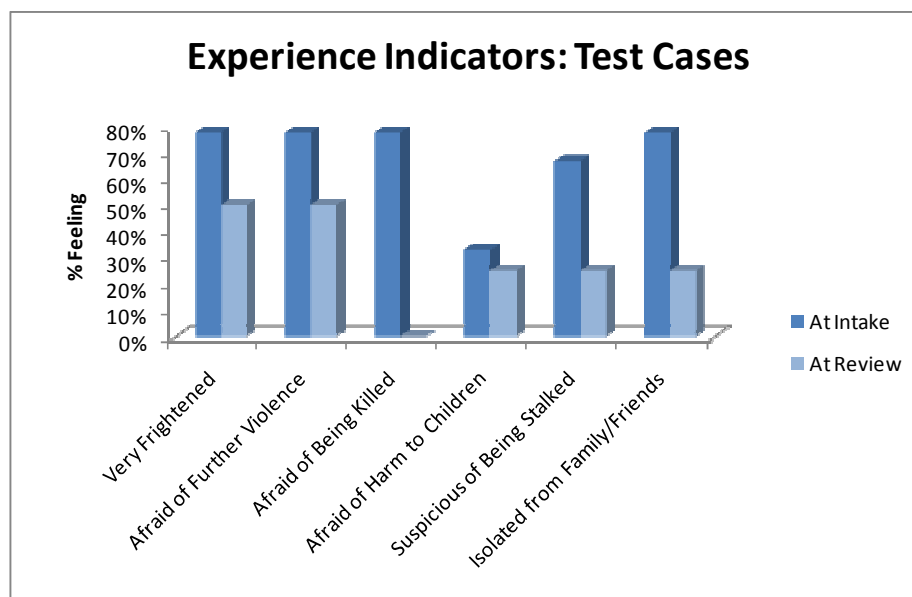
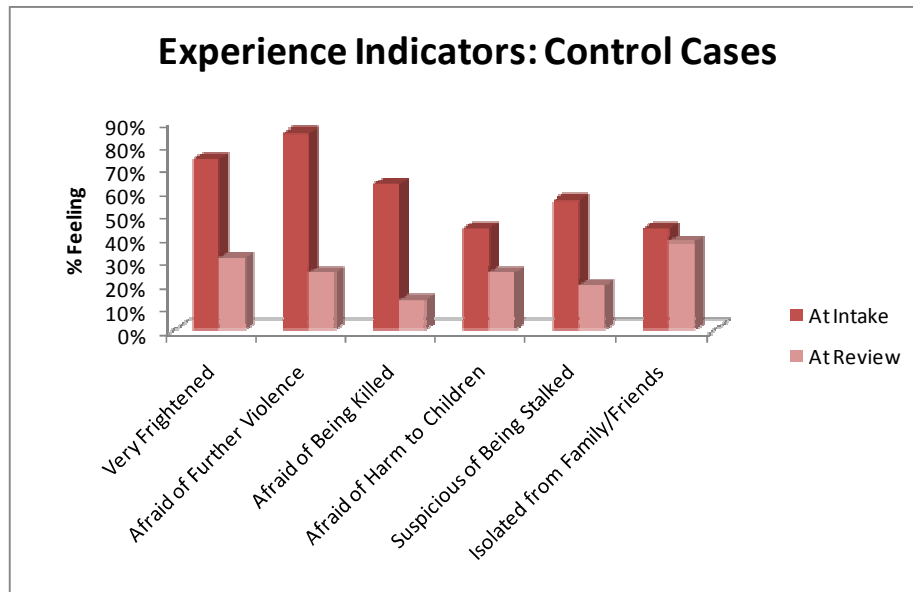
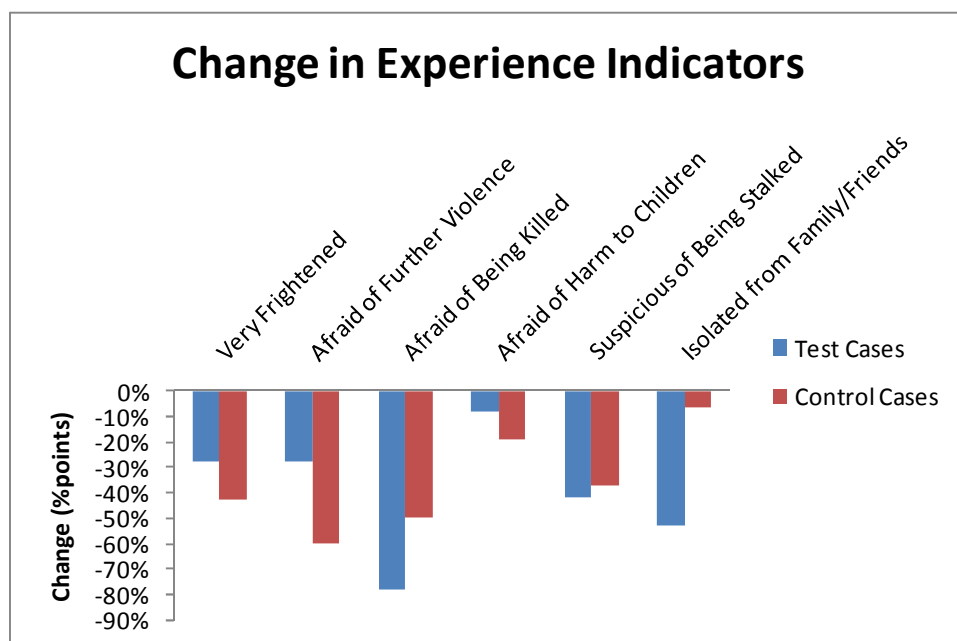


Figure 2: Experience Indicators: Test Cases



**Figure 3: Experience Indicators: Control Cases**

The comparative changes in severity of ‘Experience Indicators’ is more clearly illustrated in Figure 4 below. For the test sample, service users were more likely than those in the control sample to feel less afraid of fatal violence and less isolated from friends and family. Test cases, on the other hand, were more likely to be less afraid of further violent abuse and less frightened overall than those in the test sample.



**Figure 4: Change in Experience Indicators**

This data profile may suggest that for cases referred to the dedicated IDVA, isolation from other forms of support in friends and family may be of particular importance. That many were referred for the first time via a Health Visitor suggests that these victims were not receiving or proactively seeking support and advice from any source before referral to the IDVA. Indeed, the qualitative data show that there was little knowledge of the support available via the WSU before a Health Visitor referral and that a destruction of confidence prevented these women from even recognising that they are entitled to help in any event;

*"I remember the female saying to me I'm so glad this health visitor did refer me to you, she recognised the signs"*  
(002)

*"I wish I knew about it sooner rather than let it get to the explosion before [IDVA] got involved. I wish it was like, dealt with beforehand, if I knew"*  
(010)

It is unsurprising that isolated women, with no obvious source of support, would feel in fear of their lives in a violent home. Both the administrative and qualitative data support the notion that, once the support and security measures offered by an IDVA are introduced, there is a relatively quick boost in women's confidence and a corresponding reduction in feelings of isolation;

*"...I blamed myself, you know? Everything was my fault because I should've done this or shouldn't have done that, and [IDVA] kind of made me see that everything wasn't my fault and it shouldn't have been like that. So she kind of made me a bit more relaxed and be myself a bit more...helped me find who I was before, so I'm not so much in my shell now"*  
(010)

It is also interesting to note that the reduction in the number saying they were 'Afraid of Harm to their Children' is less pronounced in the test sample than among control cases. This is possibly illustrative of the fact that referral came via a professional they deem to be looking after their child/children's best interest and that this particular concern is more entrenched, taking longer to assuage.



### 4.3. Concern Indicators

An IDVAs subjective assessment of the risk faced by victims is based on the presenting severity of abuse and whether that severity is escalating in terms of its nature or frequency. In order to determine whether these indicators of a specialist practitioners concern differed within the test and control samples, responses to these three assessments at Hestia review were compared with intake severity in three different types of abuse: physical abuse; harassment and controlling behaviour. There was insufficient data to review the concern indicator for sexual abuse.

In relation to physical abuse (Figure 5 overleaf), the severity assessment at Hestia intake (B/L) was similar in both samples. At Hestia review (F/U) the percentage of women in the test sample assessed as experiencing 'Extreme' abuse fell, as did the percentage of those assessed as experiencing 'Moderate' abuse. There was a corresponding increase in the percentage of women assessed as experiencing a 'High' level of abuse. A similar pattern was observed in the control group although the drop in 'Moderate' and increase in 'High' assessments were less significant. Although there was generally a reduction in the severity and frequency of physical abuse in the control group, no particular pattern is emerging in the, as yet, limited test sample data.

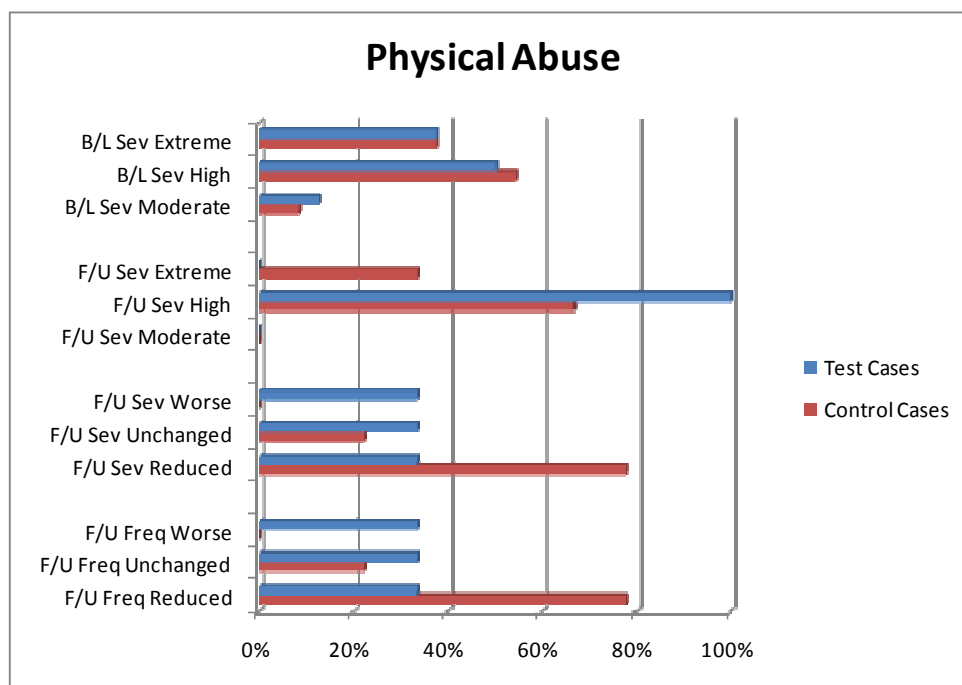
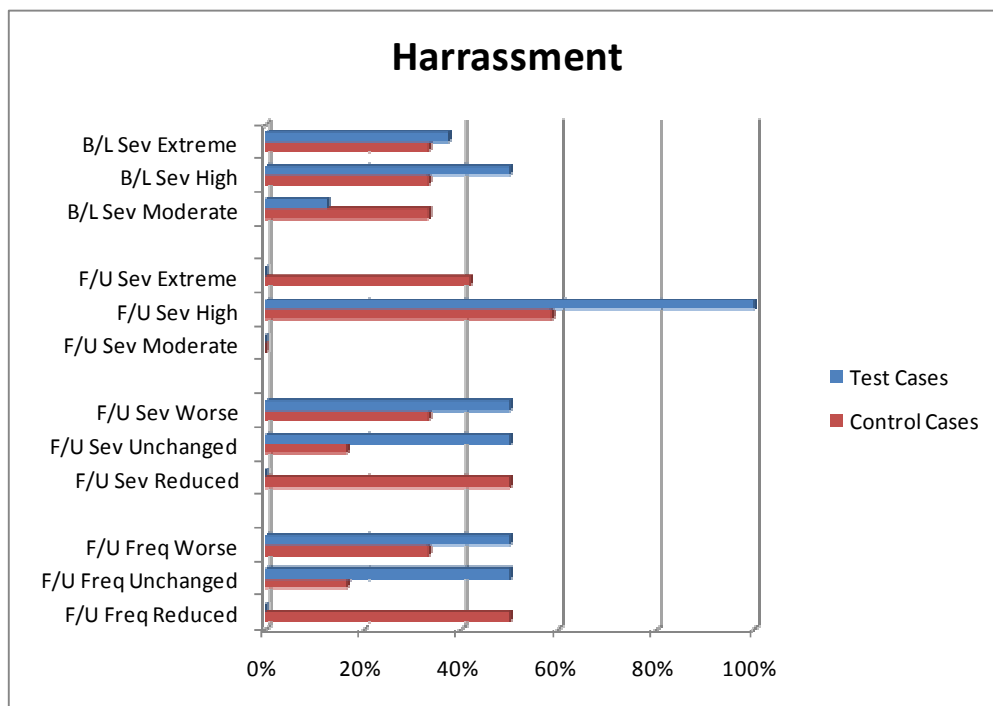


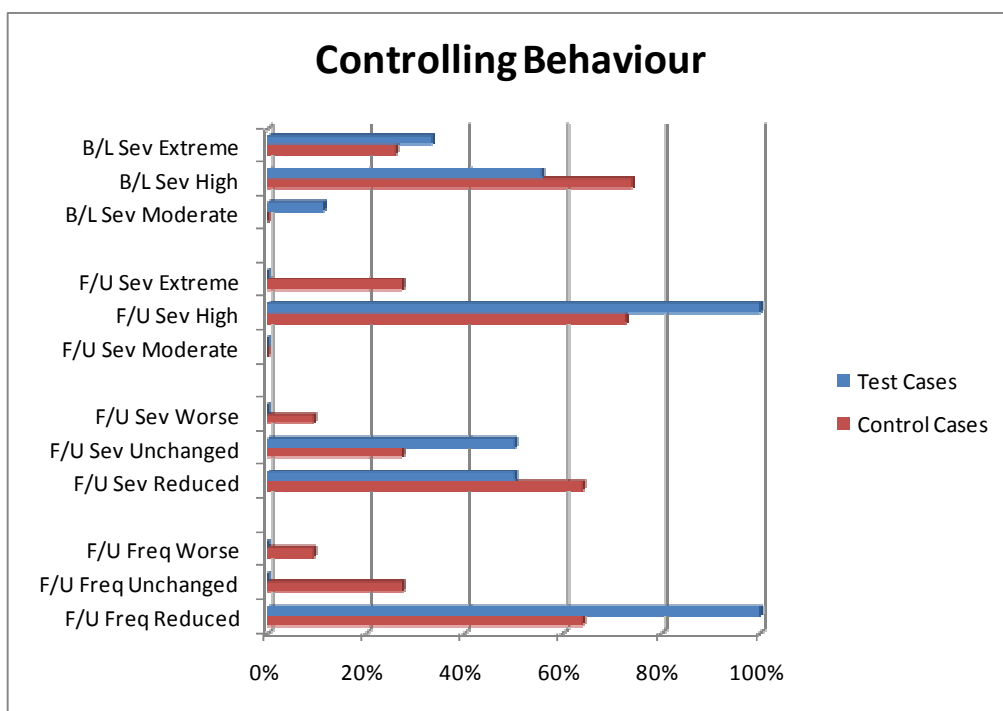
Figure 5: Concern Indicators - Physical Abuse

IDVA concern about levels of harassment (Figure 6 overleaf) was generally slightly higher in the test sample at intake assessment compared with the control group. At first review, the number of cases assessed as experiencing both ‘Extreme’ and ‘Moderate’ harassment fell, with an overall increase in the ‘High’ rating. Severity and frequency of this type of abuse remained the same or worsened over this timescale. This compares with the control sample where, although severity assessment at review tended to be worse and changes in frequency and severity generally were more mixed, there was a reduction in 50% of cases.

Service users’ experience of controlling and jealous behaviour (Figure 7 overleaf) from the perpetrator was generally assessed as significant in both groups and although there were more ‘Extreme’ cases in the test sample, there were also more ‘Moderate’ ones too. Both these two assessment ratings had fallen at first review, compared with the control sample which had remained more consistent. Severity over the period between intake and review was assessed as either unchanged or reduced and frequency has having reduced in all cases. This compares with a more mixed assessment in the control sample where abuse of this type was perceived as having worsened in both severity and frequency in 9% of cases.



**Figure 6: Concern Indicators - Harassment**



**Figure 7: Concern Indicators - Controlling Behaviour**

Viewing the concern indicator data overall, no clear patterns emerge regarding changes in the pilot IDVA's professional, subjective assessment of concern about level of abuse experienced by service user. This is largely a result of the small test sample and the paucity of available Hestia Assessment data collected over the relatively short period of the evaluation and therefore these analyses are difficult to accurately interpret.

With this significant limitation in mind however, there is an early indication that cases referred to the dedicated IDVA may be less likely to have experienced a reduction in harassment at first review compared with those referred directly to the WSU. This suggests this may be a particularly entrenched form of abuse in these cases and may indicate that of the types of cases identified and referred by health visitors are at an earlier stage than those referred to the WSU by other sources, before behavioural-type abuse has moved on to more violent incidents and victims more urgently seek help themselves.

Such notions are supported by the qualitative data. It is clear that as confidence in the IDVA grew, Health Visitors were identifying potential cases for referral who might not otherwise have sought advice directly.

*“The mother has not reported any domestic violence but because the child is on the child protection register, he is not allowed to see the baby, and he was turning up. So we just thought that if he did get violent, you know, that there were tips that [IDVA] could offer, which she did. It was prevention”.*  
(005)

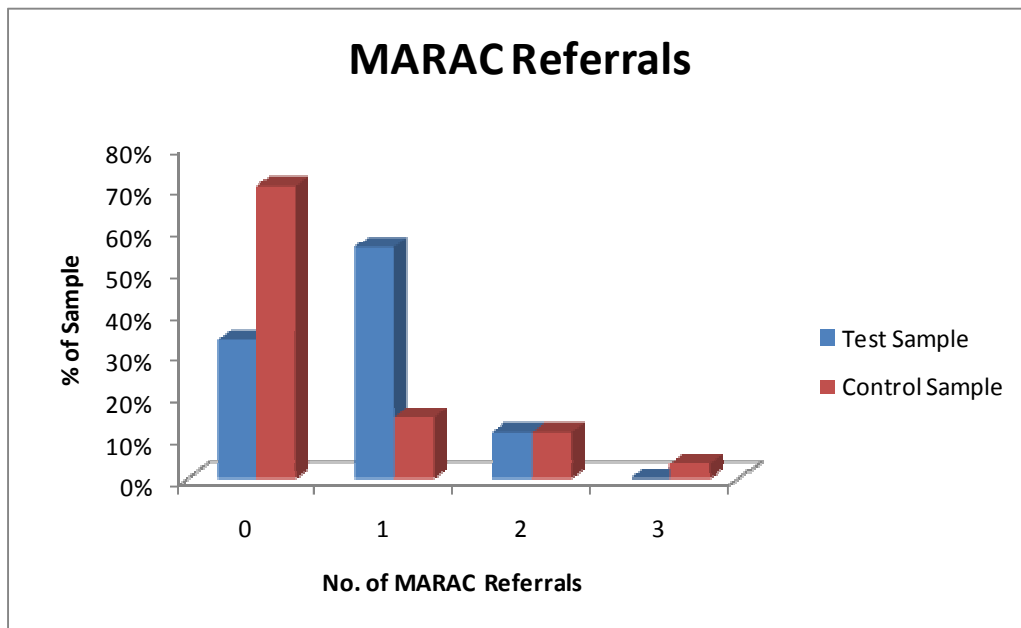
*“Some of the families ...have just had an outcome, have just decided that, yes, I'm ready to make this change and it's taken that long. But she built up trust with [IDVA], she knew [IDVA] was here, she knew there were health visitors there ... and that trust, for her to say “I'm ready”, was needed so that was tremendous.... She wouldn't have got to the WSU, had she had to go into town or down to the Bay, she couldn't have achieved that with the children”*  
(001)

Similarly, there is a suggestion that the severity and frequency of controlling behaviour experienced by the test cases is less likely to have worsened at review than that experienced by the control sample. This finding may be indicative of the importance of support and advice given women via an easily accessible provision in increasing their confidence to minimise the impact of such behaviour. The qualitative data obtained from women in the test sample show a unanimous sense of confidence to stand up to controlling behaviour following the intervention of the IDVA;

*“..by seeing [IDVA] it helps me to think that I don't actually need a man and the men I'm attracting now are wrong for me because I'm not at my right state of mind and I'm not where I should be in life, do you know what I mean? So now that I'm single I think I am finding myself. I sounds very clichéd don't it, but it's true, unless you find yourself then you are going to get all the rogues like I did... they can see that we are a bit of a walkover and obviously that's what they preyed on, was the fact that I would do anything just to keep them happy even though I wasn't happy. But now I'm single, which I'm loving! I'm loving it, it's wicked, I'm my own person”*  
(013)

#### 4.4. MARAC Referrals

The majority of cases in the control sample (n=19) had no recorded referral to MARAC despite many of these cases having a high Hestia Risk score (10 or over) at intake. In contrast, 6 of the 8 test cases have been referred the MARAC at least once (Figure 8).



**Figure 8: MARAC Referrals**

Unfortunately, the data were not clear precisely when MARAC referrals had taken place and as some of the test cases were re-referrals to the dedicated IDVA, it is not possible to ascertain whether the MARAC had taken place during or prior to the pilot period.

## 5. Summary and Conclusions

The pilot commenced in mid-October 2008 with the placement of a dedicated IDVA within the Flying Start Programme in one intervention site in Cardiff. Findings from the qualitative data collected suggest that four key aspects of this role were important in determining its successful implementation and potential for impact upon the rate and seriousness of domestic abuse within families in the area:

- Accessibility - “Right Place, Right Time”
- Trust and Confidence – “One of Us”
- Expertise – “Direct Line to Knowledge”
- Integrated Multi-Agency Working - “Providing the Glue”

The most significant finding is the importance of the enhanced accessibility a dedicated IDVA. For the victims of domestic abuse in particular, the ability to see an IDVA at the local school emerges as pivotal in the decision to engage with the service. The school is seen as a safe and familiar environment in which individuals can discuss their problems in confidence at a time that is easiest for them. This flexibility of access to the service at the right place and time for them is particularly important when one considers the nature of domestic abuse and the limitations of movement that some victims endure; a visit to the local school involves little, if any, travel time or cost and arouses less suspicion in controlling perpetrators of abuse. Referral via a health visitor is also crucial in this regard. Providing details of a named individual and reassurance of the ensuing process appears to improve the rate of take up of this voluntary provision by families compared with just providing information about a ‘faceless’ organisation.

Accessibility also emerges as important to practitioners in other partner agencies. For staff at the school, a direct line to a specialist knowledge of issues relating domestic abuse has helped in the timely management of cases where violence in the home is disclosed to or suspected by them and is impacting upon the behaviour and development of children in their care. Whilst cognisant of the need to remain one step removed from problems within families where a child is not considered to be in immediate danger, teachers could see a huge potential in being able to advise mothers of a confidential service provided within the safe environment of the school. They also saw an opportunity for enhancing the expertise within the staff of a school where the incidence of domestic violence in local families is high. Particularly with the opening of the Flying Start nursery provision within the school grounds, there is potential for a dedicated IDVA to work more closely with school staff in helping them

to recognise the early signs of domestic abuse in homes of the younger children in their care.

For the Flying Start health visitors themselves, having regular face-to-face contact with IDVA whom they could get to know and incorporate into their team had a significant impact upon their ability to identify and manage domestic abuse within their family caseload. The process evaluation showed clearly however, that co-location is pivotal to the development of trust and confidence in the IDVA and that this relationship is essential for the provision to function at an optimal level. Concerns about how the referral process would work and what precisely was involved in the IDVA service provision were apparent in the early stages of the pilot period and maybe illustrate a natural conflict between data sharing and patient confidentiality among those in the health sector. The physical presence of the IDVA within the team, albeit on a part time basis, went a long way to assuaging these concerns, often because of the ad-hoc 'water cooler talk' engaged in by co-located workers. Positive experience with specific cases during the pilot compounded this development of trust and a greater appreciation of what the service could offer such that, by the end of the pilot period the IDVA was seen by the Flying Start team as very much 'one of us'.

That accessibility in terms of co-location and flexibility for both service users and other practitioners impacted so significantly upon the success of the pilot placement does, however, highlights a concern when considering the longer term development of a dedicated IDVA role. If such a provision were to be considered in other Flying Start catchment areas, the physical location of individuals fulfilling the role must be carefully considered. Whilst one or two peripatetic practitioners covering a number of sites would be able to fulfil many of the desired aspects of the role highlighted in this report, such as familiarity and accessibility for service users, the building of trust and confidence with other practitioners may be slower than if physically based with the teams, at least for part of the working week.

The other significant finding to emerge from the evaluation is the pivotal role played by the dedicated IDVA for access to and the co-ordination of multi-agency partners and the information they hold. Despite data sharing protocols, the qualitative data illustrate clearly that access to full information is not always an easy process for some partners, often simply because they do not know where to go for the information they need. In a victim-centred, criminal justice – orientated role the IDVA knew how to access agencies such as police and the probation service far better than health and education staff. Obtaining information from these and other agencies she was able to co-ordinate the piecing together of families' stories and the management of risk therein by 'gluing' together the various interventions in a synergistic way. Whilst this function is not new and is already performed by IDVAs in other settings, the dedicated nature of the pilot role made it even more valuable to a small core, multi-functional team working together in a defined area.

Interviews with staff from the Cardiff police Domestic Abuse Unit painted a disappointing picture about the unit's role in the management of domestic abuse. Trained police officers working in the unit appear to be in predominately reactive and administrative roles, recording and managing data from reported incidents and preparing for cases going to MARAC, which is chaired by them. The role of victim support appears to have been effectively 'sub-contracted' to the WSU and there was no indication of any proactive, problem-orientated policing methods designed to manage the incidence of domestic abuse in the city. They had little knowledge or indeed interest in the pilot placement and as such appeared very much on the edges of the multi - agency team in this regard. Logistical failures were also highlighted, particularly the difficulties in sharing information when no quick and secure method of communicating with health and education staff seems to exist. The role of the IDVA very much circumvented this failure by directly obtaining the information and support needed from the police in cases identified within the Flying Start team.

Whilst the process evaluation interviews yielded a rich dataset on the success of the implementation of this pilot programme, data for the outcome evaluation was disappointing. Over the relatively short timescale of the project, very few cases managed by the IDVA had a Hestia review assessment undertaken and therefore a valid objective measure of its success was not possible. Nevertheless, what data there was would seem to indicate the beginnings of a pattern for a decreasing risk in some families engaged with the IDVA, probably in part a result of the ease of accessibility making engagement more likely. Indeed the qualitative data illustrate that there were significant success stories during the pilot and families themselves commented that they wish they had been aware of the service at an earlier stage.

Overall this evaluation has shown the pilot provision to have been successfully implemented, with early signs of benefit for the identification and ongoing management of domestic abuse in homes where the city's most vulnerable children are at risk from exposure to this all too often hidden crime. As such the pilot has met its aim and provides empirical evidence to support a wider roll out of a dedicated, victim-focussed IDVA provision in other Flying Start areas of the city. A longer term evaluation of outcomes for service users in such a project would enable a more objective measure its success.



## 6. References

1. Domestic Violence: A National Report (2005). Home Office: London.
2. Tackling Domestic Abuse: The All Wales National Strategy (2005). The Welsh Assembly Government: Cardiff.
3. <http://www.crimereduction.homeoffice.gov.uk/dv/dv014.htm>
4. [www.communitycare.co.uk/Articles/2007/04/19/104205/risk-assessment-and-domestic-violence-the-multi-agency-marac-model-of.html](http://www.communitycare.co.uk/Articles/2007/04/19/104205/risk-assessment-and-domestic-violence-the-multi-agency-marac-model-of.html)
5. Robinson, A. L. (2004). Domestic Violence MARACS for Very High –Risk Victims in Cardiff, Wales: A Process and Outcome evaluation. Cardiff University: School of Social Sciences.
6. [www.caada.org.uk/library\\_resources/Nationally%20Accepted%20Definition%20of%20IDVA%20work.pdf](http://www.caada.org.uk/library_resources/Nationally%20Accepted%20Definition%20of%20IDVA%20work.pdf)
7. [www.caada.org.uk/cat\\_training.htm](http://www.caada.org.uk/cat_training.htm)
8. [www.wales.gov.uk/topics/educationandskills/policy\\_strategy\\_and\\_planning/104009-wag/flyingstart/?lang=en](http://www.wales.gov.uk/topics/educationandskills/policy_strategy_and_planning/104009-wag/flyingstart/?lang=en)
9. [http://www.caada.org.uk/practitioner\\_resources/riskresources.htm](http://www.caada.org.uk/practitioner_resources/riskresources.htm)

## **Appendix 1: Research Design and Timetable**

In order to evaluate the success of the dedicated Flying Start IDVA provision in fulfilling its stated aims, this research was designed to robustly and rigorously evaluate its effectiveness by:

- Assessing whether such an intervention enables a more systematic management of domestic abuse cases from the area and leads to better identification of the early indicators of domestic violence;
- Investigating and informing the potential development an integrative model combining existing criminal justice services with Flying Start provision in order to enhance service provision and the safety of children at risk.

The evaluation was organised around two components: a process evaluation; and an outcome evaluation.

### **Project Timetable**

The dedicated IDVA commenced her placement within the Flying Start programme on 13<sup>th</sup> October 2008. Initial stakeholder interviews were unfortunately delayed pending confirmation of research funding awards from two match funders but commenced during late November 2008 and were completed by early January. These interviews form the baseline data for the process evaluation. In order to ensure the evaluation was conducted over an adequate time frame, second round interviews were conducted in June - July 2009. Administrative data was also collected in July 2009. Both sets of data were analysed during August - September 2009.

October 2008:	Dedicated IDVA takes up placement within the Flying Start Team
	Notification of New Ideas Research Fund Award received
November 2008:	Notification of Cymorth Research Grants Award received
November 2008 – January 2009:	First round qualitative interviews conducted

January 2009:	Outcome Evaluation baseline and control case data identified. Qualitative interview recordings transcribed
February 2009:	Analysis of first round interview data commenced
March 2009:	Interim Report issued
June - July 2009:	Second Round qualitative interviews conducted Outcome Evaluation data obtained
August - October 2009:	Qualitative interview recordings transcribed Final analysis of process and outcome data
November 2009:	Final Report issued

## **Appendix 2: Research Methodology - Process Evaluation**

The process evaluation component aimed to provide an assessment of the quantity and quality of work being performed. This includes establishing an understanding of what activities the IDVA engages in, what blockers and inhibitors have been encountered and how these have been overcome. Of particular consequence to this part of this research was an effort to document what aspects of introducing this role seem to make a difference to the various partner agencies involved in the programme overall. As such, the interviews sought to identify what specific changes the IDVA has been able to negotiate, and also the skills required to perform this function. Alongside this independent assessment of implementation quality, the data collected as part of the process evaluation aimed to identify 'promising' areas of development that might inform the ongoing development of this role in the future.

The process evaluation utilised semi-structured qualitative interviews with key participants and stakeholders engaged in both the Flying Start programme and other agencies as detailed below:

- The individual fulfilling the dedicated IDVA role;
- One (1) member of Flying Start managerial staff;
- Four (4) front line Flying Start Health Visiting staff;
- Three (3) domestic violence victims who have utilised the dedicated IDVA provision;
- Four (4) members of staff at the school whose catchment area is the focus of the intervention;
- Four (4) representatives from South Wales Police Domestic Violence Unit.

The majority of respondents in each group were interviewed on two occasions - once towards the start of the project and then again towards the end of it. In both the school and police groups, one respondent was unable to be re-interviewed and were therefore replaced with an alternative respondent. One additional respondent in each of the police and health visiting groups were interviewed in the second round. Analysis of these qualitative data was performed using the specialist qualitative data analysis software N-Vivo 8.0.

## **Appendix 3: Research Methodology - Outcome Evaluation**

Data for measuring outcomes was derived from that already collected by the Cardiff WSU. A 'test' sample of cases with which the IDVA was involved as a direct consequence of her placement was compared with a sample of matched cases from the WSU's database.

### **The Samples**

For the test sample a total of 10 cases were identified as women who had been seen by the IDVA during her placement with Flying Start. For one of these cases, baseline data had yet to be recorded by the WSU and therefore this case was removed from the test sample. Of the remaining 9 cases, 6 were cases new to the WSU and had been referred to the IDVA by Flying Start Health Visitors. A further 2 had used the WSUs services previously but were re-referred to the dedicated IDVA by Health Visitors during the pilot period. The remaining case had been referred to the WSU by another source but was seen by the IDVA at the school where the Flying Start team were based.

As a 'control' sample, 27 cases were selected from the WSUs database. Three (3) cases were matched to each of the test cases using the following criteria:

- Resident in the same postcode area of Cardiff
- One or more children resident in the home
- Drugs and/or alcohol misuse involved in violent incidents
- Date of initial referral within six months

### **The Data**

On initial intake at the WSU, service users undergo a risk evaluation using the Hestia/HSC Risk Evaluation Method (Hestia).<sup>9</sup> Risk is monitored whilst the individual remains in contact with an IDVA, with Hestia Updates conducted at unspecified intervals, usually around 4 monthly or after significant events in the case (such as court proceedings etc).

The Hestia/HSC instruments consist of a series of questions designed to assess the nature and impact of the abuse experienced to date and the risk of further abuse occurring. The questionnaire is completed by the IDVA in discussion with the victim and a scoring system applied to their answers to assess future risk objectively, based on history and subjectively, based on the IDVAs concern. This gives rise to an overall 'Risk Score' and a 'Concern Score'.

For the purposes of this evaluation, specific questions within the instrument were selected as being particularly indicative of the impact of abuse experienced to date and the probability of further violence as perceived by the victim. These questions together were termed the 'Experience Indicators' and were:

- "Is the survivor afraid of further injury or Violence?"
- "Is the survivor very frightened?"
- "Is the survivor afraid that the accused will kill her/him?"
- "Is the survivor afraid that the accused will harm her/his children?"
- "Does the survivor suspect she/he is being stalked?"
- "Does the survivor feel isolated from family/friends?"

In addition, a series of IDVA made assessments on the type and severity of abuse experienced were also analysed. These assessments together were termed the 'Concern Indicators' and were:

- Current Severity of Abuse (Extreme/High/Standard)
- Change in the Severity of Abuse over last 3 months (Worsened/Unchanged/Reduced)
- Change in the Frequency of Abuse over last 3 months (Worsened/Unchanged/Reduced)

Each of these assessments was made for each of 4 categories of abuse, if they are present:

- Physical Abuse
- Sexual Abuse
- Harassment/Stalking
- Jealousy/Controlling Behaviour

Analysis of these data was conducted using the Microsoft Excel 2007.



Universities' Police Science Institute  
Sefydliad y Prifysgolion ar Wyddorau'r Heddlu



**© Universities' Police Science Institute,  
Cardiff University**