Safety in Numbers

A Multi-site Evaluation of Independent Domestic Violence Advisor Services

November 2009

Dr Emma Howarth
Louise Stimpson MRes
Diana Barran BA
Dr Amanda Robinson

The Hestia Fund The Sigrid Rausing Trust The Henry Smith Charity

Foreword

It is a real pleasure to commend this thorough and important research report on the work of Independent Domestic Violence Advisors. Both the researchers and the funders deserve credit for describing and evaluating so thoroughly the activities and outcomes of these very specialist staff.

Domestic violence is a blight. It has a lasting impact on the lives of children, the adults in their lives and on the wider community. More than that is the clear evidence that unless this behaviour is remedied, it is likely to pass from one generation to another.

The work of Independent Domestic Violence Advisors is relatively new to this country so this report is most timely. It sets out clearly the scale and range of the issues to be tackled and ways to make the greatest impact for good. The report creates a solid foundation on which to shape and build future services. This is especially so when, as the report clearly shows, these staff are dealing with victims that are in danger of death or serious harm. Most of the victims were experiencing multiple forms of abuse that was both emotionally distressing and physically dangerous. Living in such explosive circumstances must be horrific.

The research shows that domestic violence often begins early in a relationship and then persists. Some 65% of the victims were in a relationship of less than five years. The most chilling fact to emerge was that 69% of cases involved children mainly of primary school age or younger. The frequency of the abuse and the accompanying risks are set out most graphically. So much so that, perhaps not surprising, in 65% of cases victims required the very focused support of an IDVA and 87% of the victims needed help from a range of services.

But the good news, if there be any in this aspect of human behaviour, is that the actions of these specialist workers resulted in either a complete or near ending of the abuse previously experienced by the majority of the victims.

At the beginning of my career in 1961, amongst my court duties was working in Domestic Courts. I had thought that through better education and greater equality, the use of force or domination in relationships would by now have been largely replaced by mutual respect and conflicts resolved through discussion. This research demonstrates all too clearly that these problems now need to be addressed with greater urgency. That being so, I hope this report will be widely used in tackling more successfully the blight of domestic violence.

Lord Laming

November 2009

Acknowledgements

Acknowledgements from the Authors

Any report like this does not get written without the hard work and cooperation of many different people. This report is no exception.

The authors would like to thank, first and foremost, the IDVA services who participated in this evaluation: Advance, HALT, The Haven, Let Go, North Devon Women's Aid, The Women's Safety Unit and Worth Services. They worked with us at every stage and each, without exception, went beyond the call of duty to ensure the collection of good quality data. Their desire to 'get it right' has been truly admirable and is testament to their commitment to keeping victims of domestic abuse and their children safer.

The authors would also like to extend their thanks to the Expert Panel that served to provide advice, guidance and challenge throughout the evaluation process. Dr Amanda Robinson has been invaluable in bringing clarity to the structure of this report and has contributed significantly to the editing process. Her insightful and experienced feedback has brought important perspective to this work. Professor Gordon Harold has also contributed greatly to all aspects of this evaluation. In particular, we would like to thank him for his guidance around the methodology and analysis and the time he took in helping us to make sense of the numbers. We would also like to thank Laura Richards for her advice in relation to risk and Alana Diamond for her comments on an earlier version of this report.

In addition, Juliet Dearden was particularly significant in overseeing this work and the production of this report would not have been possible without her.

Most importantly, the authors would like to thank the literally thousands of victims who consented to the use of their information for the purposes of this study. We hope that this work will contribute to their and their children's safety.

Emma Howarth and Louise Stimpson

November 2009

Acknowledgements from the Trustees

As Trustees of the Hestia Fund we would like to echo the thanks of the authors to all who have contributed to this research; it has been a great example of many different parties working together and much has been learnt by all of us along the way.

In addition, our thanks must go to the Trustees of the Sigrid Rausing Trust who supported us in 2004 to embark on creating a grant programme that funded the work of Independent Domestic Violence Advisor (IDVA) services. Given the changes that have taken place in the sector since then, it should be remembered that at that time the term IDVA did not even exist! This was genuinely a far sighted move. Our thanks also go to the Trustees of the Henry Smith Charity who, as long time funders in this field of work, had the foresight to join the Sigrid Rausing Trust in funding this programme. The field of domestic abuse is well recognised as being under-funded and their commitment to this report and the grant making programme that underpinned it is rare and much needed.

The main authors of the report, Emma Howarth and Louise Stimpson, have worked tirelessly and rigorously to create an honest and robust analysis of the work of the services that were evaluated. None of us saw quite how big a project this would be at the outset, but their intellectual curiosity and commitment to furthering our understanding of this work has been undaunted by the scale of the project.

We would also like to thank Lord Laming for writing the foreword to this report. There can be few people in this country that have the knowledge of this subject matter combined with a wider perspective on other aspects of abuse and we are honoured to have his support.

As Trustees of the Hestia Fund, it has been a privilege to be involved with this project. Our aims, set out initially in our applications to the Sigrid Rausing Trust in 2004 and 2005, were as follows: *'The objectives of the Hestia Fund are to sustain and develop the work of independent advocacy charities in the field of domestic violence (DV), to disburse grants on behalf of donors at a minimal cost and to monitor the progress and outcomes of the grants with the aim of helping to effect real change in the sector. Hence it will take the advice offered to donors a step further than has traditionally been the case both through its active participation with grantees and in its sophisticated outcome analysis which should in turn drive grant-making strategy.'* Five years later, we feel that we were true to these objectives and that this report represents one important aspect of this.

Safety in Numbers highlights the importance of numbers in many ways. It reminds us of the number of victims, mainly women, who suffer domestic abuse. It gives us numbers in terms of hard evidence of abuse suffered. It highlights the number of contacts and number of choices offered and acted on when it comes to providing much needed intensive support. It points to the number of pounds that can be saved through proper implementation of the report's recommendations. Lastly, it gives concrete evidence for the number of people we could protect, especially children, if proper IDVA coverage was a reality. In the words of one victim of domestic abuse who was supported by an IDVA *'You gave me back my future'*. If this report helps to give back the future to the thousands of victims and children currently suffering abuse, our efforts will have been repaid many times over.

Diana Barran, Miko Giedroyc and Elizabeth Jack

Trustees of the Hestia Fund

November 2009

Glossary

BM&E	Black and Minority Ethnic
CAADA	Coordinated Action Against Domestic Abuse
CPS	Crown Prosecution Service
Hestia Fund	A grant making trust funded by the Sigrid Rausing Trust and The Henry Smith Charity
H&S	Harassment and stalking
IDVA	Independent Domestic Violence Advisor
J&C	Jealous and controlling behaviour
MARAC	Multi Agency Risk Assessment Conference
RIC	Risk Indicator Checklist
SDVC	Specialist Domestic Violence Court
Time 1	Time at which intake data was collected
Time 2	Time at which review data was collected, either after 4 months of support from an IDVA or at case closure if sooner

Executive Summary

This report presents the findings from a significant programme of research that was undertaken to examine the provision and impact of IDVA (Independent Domestic Violence Advisor) services for female victims of domestic abuse deemed to be at high risk of harm or homicide. Commissioned by the Hestia Fund and funded by the Sigrid Rausing Trust and The Henry Smith Charity, this study, conducted between 1 January 2007 and 31 March 2009 and involving seven services operating in England and Wales, represents the first, large scale, multi-site evaluation of IDVA services ever undertaken in the United Kingdom.

Importantly, this national-level research helps us to understand both the process of delivering IDVA services and the outcomes that may be achieved for victims. Specifically, this evaluation set out to examine:

1. The profile of victims accessing IDVA services, particularly with respect to the extent and nature of the abuse they were experiencing along with their socio-demographic characteristics;
2. The specific types of interventions and resources mobilised on behalf of victims by IDVAs, as well as the intensity with which this support was offered and the potential for IDVAs to tailor their approach to the particular needs of individual victims;
3. The effectiveness of these interventions in increasing victims' safety and well-being, and the factors that increased or decreased the likelihood of achieving these positive outcomes. In addition, the research examined the extent to which these outcomes were sustained over time.

This evaluation represents the result of almost 5 years of work and could not have been possible without the input of far sighted funders, the commitment of the Independent Domestic Violence Advisors themselves to gather and submit data, and the critical eye of a distinguished Expert Panel. The result of this work is a set of recommendations that, if implemented, will change the lives and futures of thousands of victims and their children and save hundreds of millions of pounds to public services. At a time when the vulnerability of our society in general and our young people in particular, appears so clear, the need to follow these recommendations is all the more pressing.

The background to the evaluation

This evaluation forms part of a wider grant programme which was started in 2004 with funding from the Sigrid Rausing Trust. This programme was built on a report by New Philanthropy Capital (1) which identified the fragmented response to victims of domestic abuse, the need for specialist support for victims and the need for more capacity in this field. The wider grant making programme had three elements.

The first was to help expand capacity in the sector by making a series of grants to charities already active in the field to employ specialist case workers, or Independent Domestic Violence Advisors. This was doubled in size in 2006 when the Henry Smith Charity decided to establish a major grant programme in this area and to match fund the grants made by the Sigrid Rausing Trust. In total, grants of £775,630 were made to 19 charities operating in all 4 parts of the UK, with an average grant size of £20,000.

The second element was the establishment of the CAADA IDVA training course in early 2005, with the aim of giving practitioners in this field a recognised qualification and a common framework for their practice and the development of service standards for IDVAs[1].

The third element was an evaluation of outcomes, namely this document, which aimed to measure the impact of the IDVA services funded as part of the grant programme. In order for any approach to be adopted on a national scale, there needs to be a firm evidence base about its impact. Given the costs associated with any major social problem such as domestic abuse, evidence of effectiveness is crucial to policy makers and commissioners.

[1] Funded with grants of £22,000 and £40,000, respectively.

The three elements of the grants were always conceived of as a whole, with an aim to build and sustain capacity in this sector.

What is an IDVA and what is unique about the service that they provide?

Independent Domestic Violence Advisors or IDVAs are specialist case workers who focus on working predominantly with high risk victims, those most at risk of homicide or serious harm. They work from the point of crisis and have a well defined role underpinned by an accredited training programme. They offer intensive short to medium term support. They also mobilise multiple resources on behalf of victims by coordinating the response of a wide range of agencies who might be involved with a case, including those working with perpetrators and children. Thus, they work in partnership with a range of statutory and voluntary agencies but are independent of any single agency. In common with other specialist domestic abuse services, their goal is safety.

Why was an evaluation needed?

There were several reasons that meant a large scale evaluation of IDVA services was timely. First, the UK evidence base addressing 'what works' in improving the safety of victims of domestic abuse is generally underdeveloped. That the work of IDVAs is relatively new means that there is even less research that specifically examines this model of working. The few studies that have been undertaken in the UK mostly represent in-depth and rigorous evaluation of individual services. Single site evaluations will naturally be influenced by local operating conditions and by the individuals involved, which may potentially limit the extent to which the conclusions derived from these studies are applicable to IDVA services more widely. Finally, much of the evaluation undertaken to date in a UK context has focused on the process of service delivery rather than on the efficacy of this approach in enhancing the safety of victims and their children.

Given the gaps in our knowledge with respect to the effectiveness of the IDVA model , there was pressing need to undertake more extensive research about how IDVA services are delivered, and their impact on the safety and well-being of high risk victims and their children. As a step towards addressing this knowledge gap, this multi-site study was commissioned.

The services that were evaluated

Seven IDVA services participated in this evaluation. The services evaluated are based both in urban, suburban and rural locations. They range in size from 1 full time IDVA as part of a wider community based domestic abuse service, up to 12 IDVAs. Some are part of a dedicated IDVA service; others include wider services such as community outreach and refuge. Some were relatively newly established, with others having been in operation for over 30 years. Finally, some work in communities with high Black and Minority Ethnic populations and others in areas where these groups are under-represented.

How was the evaluation conducted?

The evaluation was carried out over a period of 27 months. In order to address the areas of enquiry, IDVAs gathered data (n 2567) at the point of referral to a service (Time 1) relating to victim demographics and the type and extent of abuse experienced during the prior three months[2]. Where possible, data (n 1247) were gathered on a second occasion (Time 2); either at the closure of a case or after 4 months of engagement with the service as an interim marker of case progress (whichever came first). Information collected at this time point related to the interventions and types of support provided by IDVAs and, importantly, documented levels of victim safety and well-being. IDVAs also conducted short interviews with victims (n 411) on their exit from the service in order to garner their perspectives as to the factors that had impacted on their safety during the period of intervention. Finally, a small group (n 34) of victims were re-contacted 6 months after the closure of their case in order to examine the sustainability of any changes made with respect to safety and well-being.

The data included in the study pertained only to female victims. Some of the services participating in the evaluation offer direct support to male victims of abuse. As a result, 44 records were found to relate to males. A further 95 records related to abuse perpetrated by someone other than an intimate partner such as by another family member. While it is increasingly recognised that both homosexual and heterosexual males can suffer abuse and that abuse can be inflicted by another family member, less is known about both of these areas. These cases may be marked by a different pattern of risk and it is feasible that different intervention strategies are required to address these issues. For this reason, and in recognition that there is a marked asymmetry in the extent to which males and females experience severe levels of abuse, it was decided to exclude these cases from the study sample.

Finding 1: IDVAs work with complex, high risk cases

The reality of high risk domestic abuse

Using the term 'high risk' to describe a person experiencing particularly severe domestic abuse is a relatively recent phenomenon. It is derived from a process of risk assessment where a high risk of serious harm and homicide has been identified. Whilst the types of abuse that characterise a high risk case may be intuitively understood by those working within the area, this may not be so for those outside it, therefore descriptive data that can detail what 'high risk' really looks like makes an extremely important contribution to the knowledge base with respect to this issue. This research articulates specifically that the abuse experienced by victims accessing IDVA services was both multi-faceted and extremely serious. The large majority of victims (76%) were experiencing at least one type of severe abuse at a level considered to be 'severe'. Examples of severe abuse includes violent behaviour causing injuries, strangulation, rape and other sexual abuse, stalking (H&S) and extreme controlling behaviour (J&C) such as threats to harm children. In addition, most victims (86%) were experiencing multiple forms of abuse, underscoring that domestic abuse is best understood as a pattern of behaviour rather than a single abusive incident per se.

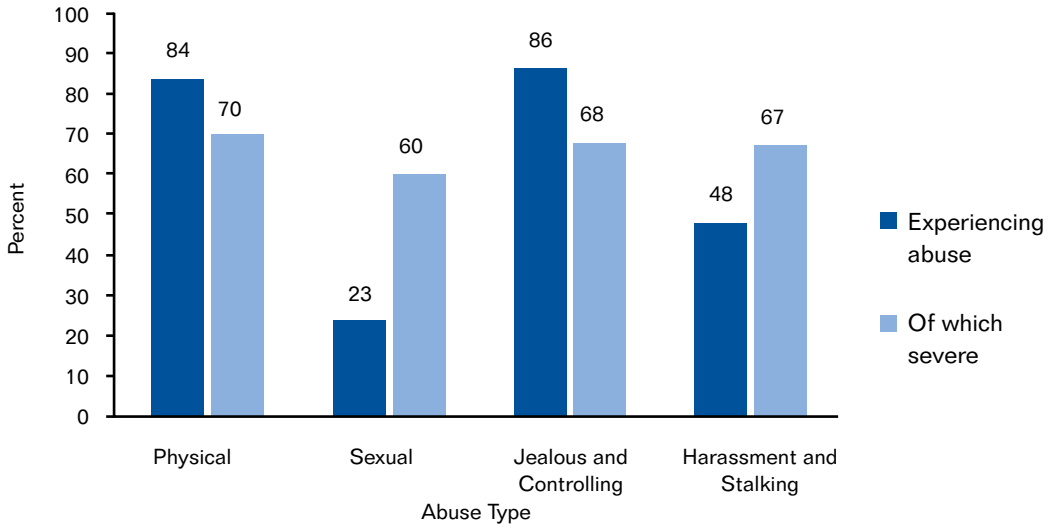


Figure E1: Types of abuse at Time 1

The majority of victims (66%) were separated from their partners, confirming once again that domestic abuse frequently continues once a relationship has ended. Indeed, in line with other work in the field, this research highlighted the additional risk faced by those

[2] Much of this information was already being gathered and recorded in case notes as part of everyday practice, although for the purposes of this evaluation, IDVAs were provided with an electronic case management system. This included several data collection modules that helped structure and standardise the information that was gathered.

victims who had separated or were attempting to do so, with these victims experiencing relatively more serious abuse than those who remained in relationships with their abuser.

As shown in **Figure E2**, the research highlighted the length of time that victims had been in an abusive relationship. This averaged just over 5.5 years, but ranged from less than one year to over 10 years.

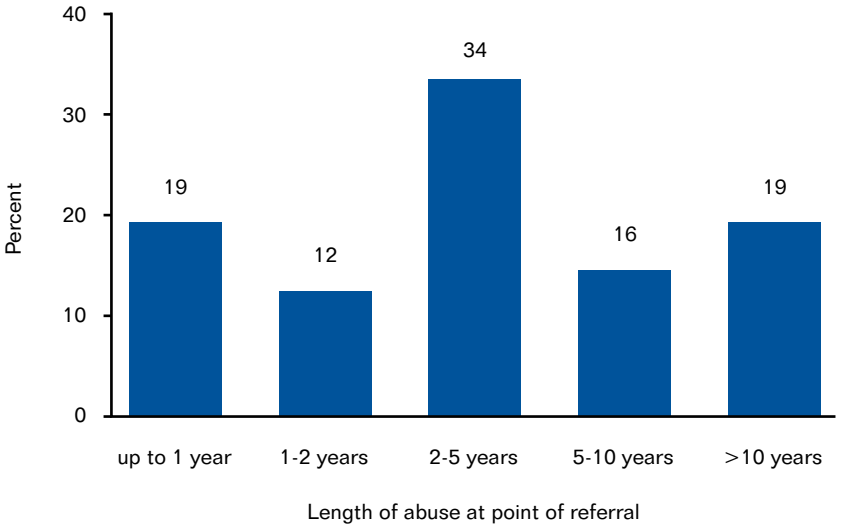


Figure E2: Length of abusive relationship at Time 1

The very serious and chronic nature of the abuse experienced by victims in this sample, along with the high prevalence of factors linked with increased risk of serious harm and homicide confirms that the work of the IDVA services participating in this study was well targeted and much needed.

The perpetrators of serious domestic abuse

This research also gave us some information about the profile of the perpetrators included in the study. This showed that a substantial number of those committing severe levels of abuse were chronically aggressive and antisocial. **Table E1** highlights some of these risk factors and their prevalence in the study based on the information provided by victims.

Table E1: Perpetrators' criminogenic behaviour and aggravating problems

Risk Factors	Frequency	Percent (N=2567)
Perpetrators' alcohol abuse	1374	54%
Perpetrators' criminal record	1296	50%
Perpetrators' financial problems	1151	45%
Perpetrators' drug abuse	989	39%
Perpetrators' threats of suicide	904	35%
Perpetrators' mental health issues	713	28%
Perpetrators' DV related criminal record	669	26%

Findings showed that where there was evidence of perpetrators' criminal and antisocial history at the point of referral, victims were experiencing relatively more severe abuse as well as each type of abuse more frequently.

The socio-demographic profile of 'high risk' victims

The socio-demographic profile of victims revealed both the profile of the 'average victim' and also the diversity in this 'high risk' sample.

The average age of the victims accessing these services was 33 years old, although the

range was from 15 to 83 years. Over two-thirds (69%) of victims accessing IDVA services had children, the large proportion of whom were of Primary school age or younger. The presence of children was related to the higher prevalence of each of the 4 types of abuse surveyed as part of this study, as well as the more frequent occurrence of more severe levels of abuse.

Nearly half of victims accessing IDVA services may have had potentially limited access to their own economic resources given that they were not currently employed at the time of intake. Rates of drug and alcohol use were calculated as 6% and 12%, respectively,. Of the sample, 11% were registered as disabled because of some form of physical, sensory or learning disability. In addition, a small group of victims were noted as having insecure immigration status (3%). Each of these factors represents an additional source of vulnerability which may magnify the effects of domestic abuse. Indeed, this research found that abuse was more frequent and severe for victims reporting some form of additional adversity in their lives.

One key concern with a new area of work such as the IDVA is the accessibility of the service to groups of victims who in the past have faced significant difficulty in seeking help from formal service providers in the context of domestic abuse. Perhaps surprisingly, almost a quarter (23%) of victims were from B&ME communities, a higher than expected representation based on the communities from which this sample was drawn. Research does not typically find ethnicity to be a factor increasing the likelihood of abuse in and of itself. Therefore, this is an encouraging finding if it means that B&ME victims are able to access these services relatively easily given the barriers to getting help for these communities.

The nature of risks facing the children of high risk victims

In total, around 3,600 children are represented by this sample of victims, highlighting the potentially huge number of children across the UK living in family environments marked by serious levels of abuse.

The Table below highlights the direct risks to children's safety and wellbeing that were noted in this sample.

Table E2: Child related risks

	Frequency	Percentage of those with children (N=1774)
Conflict around child contact	725	41%
Victim is afraid of harm to children	476	27%
Perpetrators' threats to kill children	199	11%

The very serious nature of the abuse experienced by this sample and the finding that those victims with children experienced comparatively more severe abuse (compared to those without children) suggests that many of the children with whom IDVAs come into contact may be at significant risk of physical and psychological harm. Many more children may experience problems that, whilst not meeting the threshold of clinical concern, are nevertheless disruptive to children's healthy development.

These figures highlight the extreme nature of the abuse suffered by the victims in this sample, the antisocial nature of a large number of those who perpetrate abuse at this level and the direct risks to children living in these very violent households. Together, these findings articulate the need for specialist practitioners, such as IDVAs, to address these complex cases.

The key features of an IDVA's work

The key principles that underpin the work of the IDVA have been defined as including a short to medium –term service that is delivered to high risk victims of domestic abuse, from the point of crisis, in partnership with other agencies and with safety as its goal.

1: Victims' engagement with IDVA services

Almost 60% of victims referred to the services in the research remained 'engaged' with IDVA services. Clearly, victims cannot be obliged to accept help and not all will feel that it is safe to do so and thus this is an impressive retention rate given the level of abuse suffered. This is likely to reflect both the specific skills that IDVAs have relating to engaging with victims and the range of services offered in general.

Most of the victims in this research received a service lasting around 3 months, although it was clear that IDVAs worked with victims over longer periods of time where this was necessary.

2: Types of interventions provided by IDVAs

As part of the research, the IDVAs were asked to identify the different actions that they took to help support victims and address their safety. As can be seen from the table below, there were a broad range of actions that were taken, reflecting in part the range of issues that victims face. These findings make clear that victims want and need an extensive set of options when working with an IDVA to address their own safety.

Table E3: Frequency of support options mobilised

Interventions mobilised (n=1247)	Frequency	Percent
Safety planning undertaken	1005	81%
Support in relation to a criminal court case	534	43%
Support with civil justice remedies	315	25%
Subject to MARAC	426	34%
Support with housing issues	615	49%
Access to target hardening†	375	30%
Access to sanctuary scheme	168	13%
Support to access refuge accommodation*	160	13%
Support in relation to child contact††	443	51%
Support with Social Services*††	232	27%
Support with children's schools*††	63	7%
Support with benefits*	202	16%
Support with immigration issues*	30	2%
Support to access a GP*	95	8%
Support to access mental health services*	84	7%
Support with alcohol and drugs issues*	72	6%
Support to access counselling*	400	32%
Completed pattern changing course	125	10%

*Possible ambiguity around the meaning of 'support', † Target hardening and the Sanctuary schemes are terms often used interchangeably by the IDVA, however they appear separately in this table as they were included as discrete options as part of this study, †† Percentages are based on those with children (n=873).

It was not in the scope of this research to find out what gaps exist in service provision, but certain areas of need appeared to be less well addressed. For example, whilst safety planning was the most frequently undertaken activity, it was surprising to find that it had not occurred in almost 20% of cases, although this might reflect the fact that safety planning was being undertaken elsewhere, or on an informal basis. Equally, the extent to which some options were utilised was likely to be limited by capacity, for example MARAC,

where it might have been expected that all cases would have met the referral thresholds. Options and resources addressing areas of vulnerability in victims' lives also seemed to be made use of less frequently, including benefits advice and support with health issues such as mental health and substance misuse.

3: Multiplicity of interventions and intensive support

It is not just the range of options that typifies the work of the IDVA, but also the number of options that can be offered to meet a victim's specific set of needs, in conjunction with very focused levels of support. In 87% of cases, victims were helped to access multiple services, with the average being 4. In 65% of cases, victims received intensive support, having more than 5 contacts during the course of their case.

4: The provision of tailored support

Crucially, IDVAs were found to provide intervention that was tailored around the nature of the abuse being experienced by victims, as well as their individual circumstances. Thus, victims experiencing comparatively more severe abuse received more intensive support and more frequent access to many services (eg court, housing, target-hardening). Equally, victims with specific support needs (eg children, substance misuse) received more frequent access to relevant services and agencies.

However, in addition to demonstrating that IDVAs effectively tailored the support they delivered, these results also indicate that IDVAs were having to prioritise access to specific interventions and concentrated support within an already 'high risk' case load, suggesting that there may be a lack of capacity to work at the highest level with all high risk victims.

Finding 2: The impact of the IDVA service on safety

Considering first the impact on victims' safety, after the intervention of the IDVA, 57% of all victims experienced a cessation in the abuse they were suffering. This ranged between 67% for those receiving intensive support and 44% for those receiving limited support.

In general, research shows that severe levels of abuse are more difficult to address. **Figure E3** shows that over the course of the intervention there were very impressive reductions in the proportion of victims experiencing severe abuse. Similarly, the figure shows large reductions in the proportion of victims experiencing more than one form of abuse, indicating that IDVAs were successful in addressing the broader pattern of abuse, which this research shows is a reality for most victims.

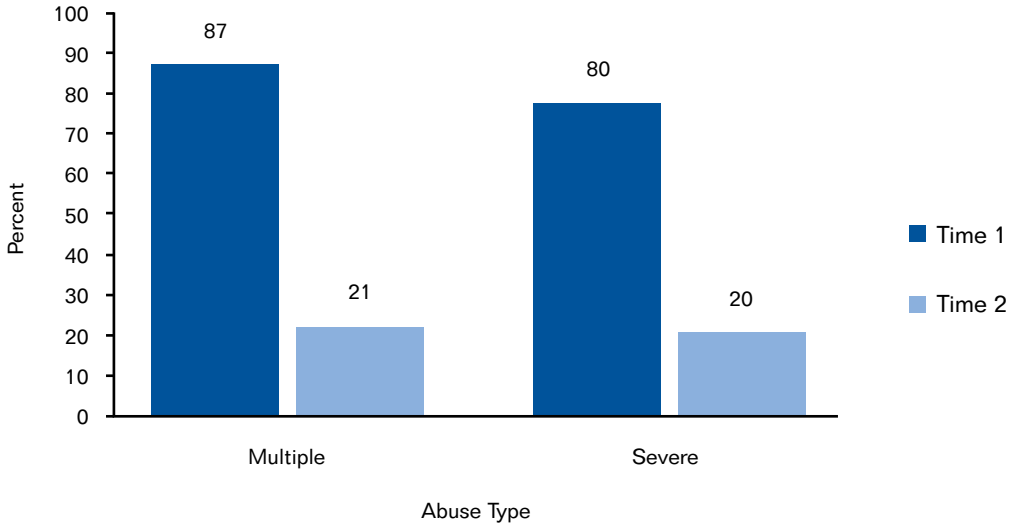


Figure E3: Attributes of abuse at Time 1 vs. Time 2

Looking in more detail at the changes in different types of abuse, from **Figure E4**, it can be seen that the most significant changes were in relation to physical abuse, with stalking and harassment showing a smaller relative decline.

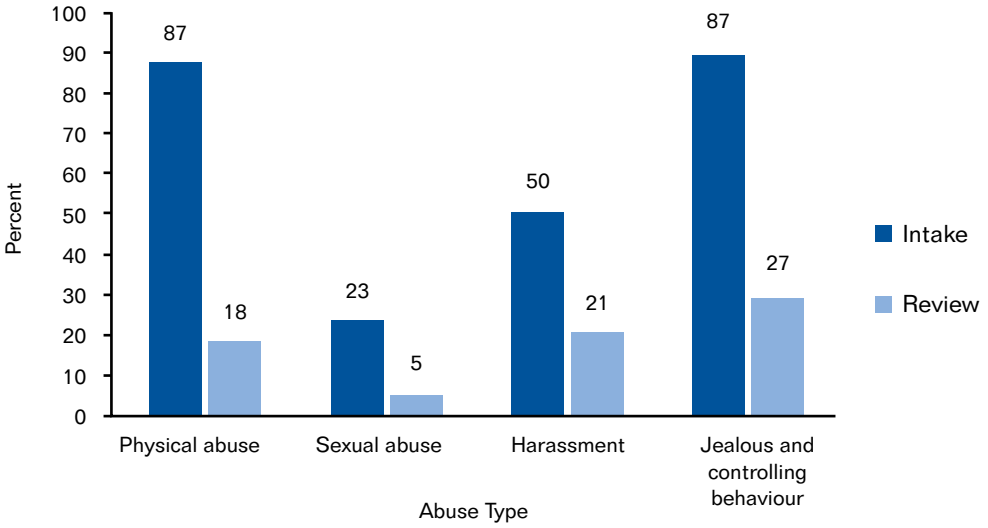


Figure E4: Frequency of abuse (all levels) Time 1 vs. Time 2

Finally, there were also important reductions in the levels of severe abuse across each individual abuse type. The relative reductions in abuse ranged from over 75% in relation to physical, sexual abuse and jealous and controlling behaviour, to around 66% for severe cases of stalking.

Results relating to reductions in abuse were corroborated by the finding that 76% of victims reported improved feelings of safety, confirmed in turn by IDVAs reporting reduced risk in 79% of cases. Importantly, less than 1% of victims who were asked about their feelings of safety reported that they felt less safe following support from an IDVA.

This research indicated a reduction in the level of direct risk to children, suggesting that by addressing the risk to the non-abusing parent, the intervention that IDVAs offer may have an associated impact on children's safety and wellbeing.

Table E4: Child related risks at Time 1 vs. Time 2

Risk factor	Intake (T1) Percentage of victims with children (n=699)	Review (T2) Percentage of victims with children (n=699)	Percentage Change
Threats to kill children	11% (80)	6% (45)	-44%
Conflict around child contact	42% (292)	23% (160)	-45%
Victim is afraid of harm to children	30% (207)	7% (49)	-76%

However, as was expected, results demonstrated that the impact of this intervention was of course limited with respect to the risks posed by the perpetrators' antisocial and criminal behaviour. This finding underscores the need for a more integrated approach to intervention between IDVAs and those services that have direct contact with the perpetrators of abuse.

Table E5: Perpetrators' criminogenic behaviour and aggravating problems Time 1 vs. Time 2

Risk factors associated with perpetrators'	Intake (T1) Percentage of victims (n=966)	Review (T2) Percentage of victims (n=966)	Percentage Change
Perpetrators' alcohol abuse	53% (516)	48% (459)	-11%
Perpetrators' criminal record	53% (516)	53% (516)	0%
Perpetrators' financial problems	43% (416)	25% (242)	-42%
Perpetrators' drug abuse	40% (388)	33% (316)	-19%
Perpetrators' threats of suicide	34% (331)	10% (101)	-69%
Perpetrators' DV related criminal record	27% (261)	35% (338)	30%
Perpetrators'mental health issues	26% (254)	24% (234)	-8%

Collectively, these findings offer a clear indication that the intervention offered by IDVAs has a measureable impact on the safety of victims and, to some extent, their children. The convergence of findings across multiple measures of safety means that this study offers sound robust evidence of the effectiveness of this model of intervention in ameliorating all types and levels of abuse.

2. The impact of IDVA services on victims' well-being:

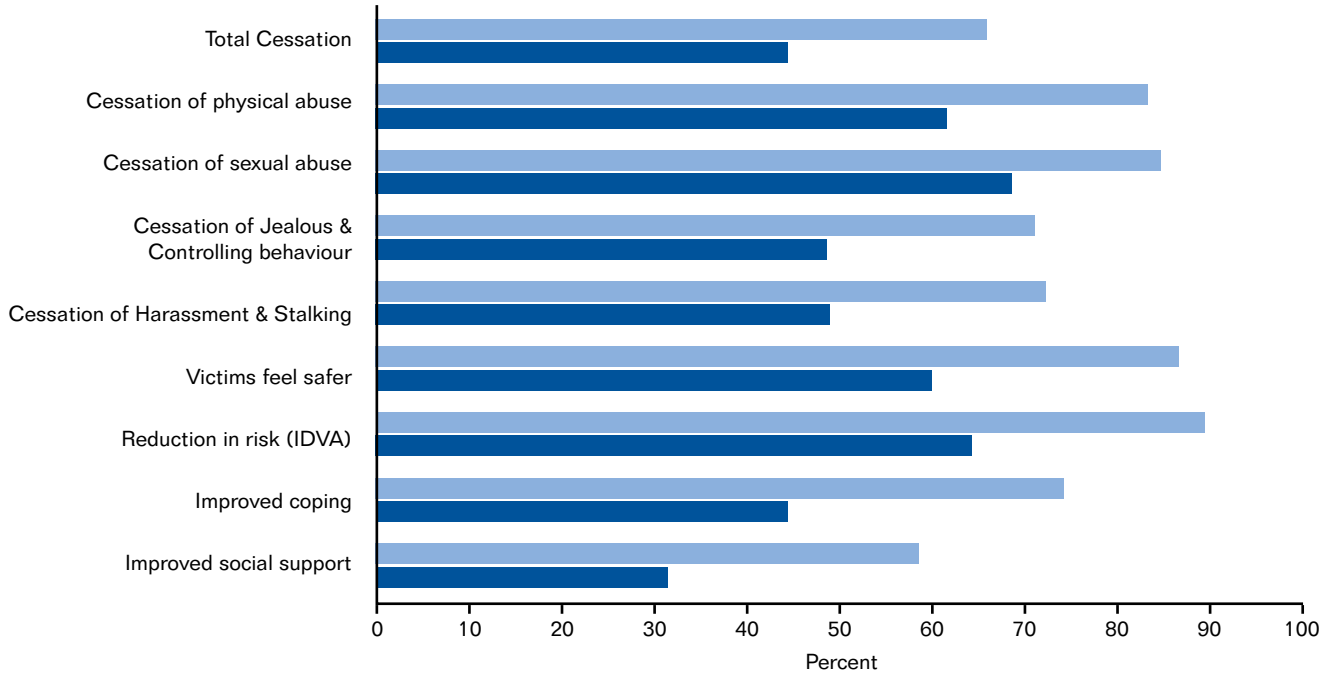
It is important to gauge the efficacy of this type of intervention not just by a reduction in abuse and specific risk factors, as evidenced above, but also in terms of its impact on victims' well-being. This is especially relevant given evidence that improved functioning in this domain may help to protect victims from re-abuse in the longer term.

IDVAs reported that there had been significant improvements in victims' social networks in 47% of cases and significant improvements in victims' coping abilities in 63% of cases. These results show that in addition to the impact on safety, the intervention that IDVAs offer facilitates associated benefits in terms of victims' well-being.

Finding 3: Victims are much safer when they receive intensive support

The way in which IDVAs worked with victims had a direct bearing on the chances of achieving improved safety and well-being. Victims receiving more intensive support were more likely to do better than those receiving limited support; and victims who received multiple forms of intervention fared better than those receiving none, or a single form of intervention. These findings suggest that the intervention that IDVAs provide is causal in bringing about positive changes for victims.

Specifically, victims who received intensive support were roughly twice as likely to experience a cessation in abuse compared to those victims receiving less intensive intervention. In concrete terms, 67% of victims receiving intensive support achieved an overall cessation in abuse, compared to 44% of those victims receiving limited support. **Figure E5** provides illustration of the relative changes in victims' safety and well-being as a function of the intensity of support offered.

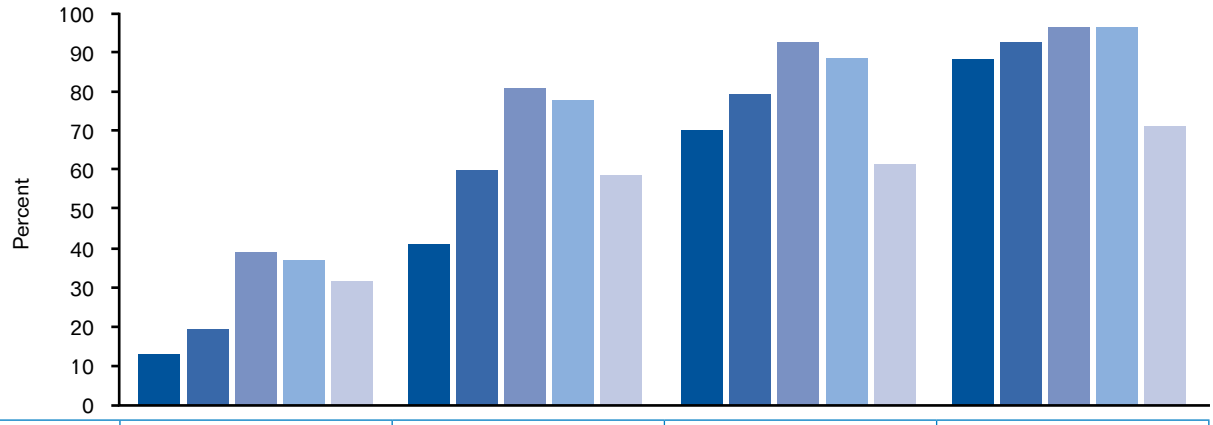


	Improved social support	Improved coping	Reduction in risk (IDVA)	Victims feel safer	Cessation of H&S	Cessation of J&C behaviour	Cessation of sexual abuse	Cessation of physical abuse	Total Cessation
More intensive support	57	75	90	87	73	72	84	73	67
Less intensive support	32	44	65	60	50	50	68	64	44

Figure E5: Impact of intensity of support on safety and well-being

Finding 4: Victims were much safer when multiple services were offered

The receipt of multiple forms of support (compared to the mobilisation of none or only a single type of intervention) also increased the chances of positive changes in victims' safety and well-being. Furthermore, the likelihood of a positive outcome increased progressively with the number of interventions received. For example, the odds of feeling safer and of abuse ceasing were doubled when 2-5 interventions were offered and increased by four times where there were more than 6 different interventions. In absolute terms, 37% of victims felt safer on access to 0-1 forms of support in comparison to 77% of those receiving access to 2-5 forms and 88% of those helped to access 6-10 forms.



Number of interventions	0-1	2-5	6-10	11+
Improved social support	14	43	69	88
Improved coping	20	63	81	94
Reduction in risk (IDVA)	39	81	93	97
Victim feels safer	37	77	88	97
Total Cessation	31	58	66	73

Figure E6: Impact of number of interventions on safety and well-being

Whilst by and large, the chances of achieving improved safety and well-being did not differ according to victims' demographic profiles, several factors were identified that seemed to diminish the likelihood of achieving positive change for victims, even after taking into account the type of intervention that victims received. Victims who were experiencing relatively more severe abuse, who had been referred to a service on a previous occasion and who were separated or separating from their partners had a decreased chance of achieving a positive outcome. This was also true for those victims who reported the presence of perpetrators' antisocial and criminal behaviour.

Sustainability of positive changes over time

In 39% of cases where abuse had stopped altogether, IDVAs believed that the cessation was sustainable into the longer term.

Results derived from a small number (n=34) of follow up interviews conducted at 6 months after the closure of a case showed that a majority of victims surveyed (82%) reported that they had experienced no further abuse since the closure of their case,. However, these results are far from conclusive given the small number of victims who were re-contacted and the fact that this sample was not representative of the larger sample of victims referred to IDVA services.

In commenting on the factors that helped and hindered their safety, it was clear that victims perceived the work undertaken by IDVAs on their behalf as pivotal in helping them to achieve these positive changes. These results provide some suggestion that the short term intervention offered by IDVAs, and the links it creates with other services, may facilitate longer term changes in the safety and well-being of at least some of those victims who draw on their services.

Finding 5: The impact of the evaluation on IDVAs practice

In order to facilitate this evaluation, IDVAs were required to gather standardised data at stipulated time points, at the point of referral (Time 1) and again after 4 months of work with victims or at the closure of a case, whichever came first (Time 2). This in effect provided a formal case review process which IDVAs reported allowed them to manage their cases in a more structured way and aided them in their decision making as to the next steps to be taken on any given victim's behalf. They also reported that this process reduced some of the stress associated with their work, and allowed them to prioritise cases in a more rational way.

Implementation of follow up interviews with former clients 6 months after case closure revealed that whilst most of those contacted continued to live safely, several victims reported that abuse had resumed, but at much lower levels. By recontacting the victim in this way, the IDVA was able to offer continued support or other options. We understand that as a result of this, two of the participating services introduced this sort of follow up contact as a standard procedure.

Following on from these findings, we have four key recommendations to make to commissioners, policy makers and practitioners.

Recommendation 1: More IDVAs are needed

The research showed clearly that there were incredibly positive changes in victims' safety and well-being over the course of the intervention delivered by IDVAs, and further highlighted that the chances of achieving positive changes varied systematically as a function of the intensity of support provided and the number of resources mobilised on behalf of victims. These results give the empirical basis for expanding IDVA coverage nationally. It is estimated that there are currently less than half the number of trained IDVAs that would be needed to give adequate coverage for all the high risk victims in the UK. Without an expansion of capacity in IDVA provision many thousands of victims will not receive the support that they need.

Recommendation 2: IDVA services must be commissioned to a common framework that keeps safety central

First and foremost, IDVA services need to be commissioned. Only two of the services in this study had funding which could be described as 'mainstreamed'. The others, in common with most of the rest of the domestic abuse sector, had very fragmented short-term funding, with all of the well understood impact that this has on the quality of the service that can be provided. The marginal cost of providing the support of an IDVA is less than £500 per victim supported[2b], which is a fraction of the costs associated with the provision of public services [(2)], and thus the case for commissioning properly focused and structured services is clear.

Second, it means that IDVA services need to have the capacity to offer an 'intensive' level of support. Based on the evidence derived from this report, this means 6 or more significant contacts with a victim. If IDVAs do not have the time to offer intensive support, the outcomes that they are able to facilitate for victims and their children will suffer.

Third, it means that IDVA services must be structurally part of a multi-agency response. The IDVA often acts as a catalyst to mobilizing multiple resources from other agencies, saving the victim the stressful and often unproductive work of trying to do this on her

[2b]The figure of less than £500 is based on the IDVA salary plus on costs divided by an estimated annual caseload of 100 cases.

own. The early work of advocacy focused principally on the criminal justice system. This research shows that while this is an important element in addressing the safety of victims of domestic abuse, it is just that: an element and rarely the total solution. IDVAs offer the victims with whom they work a full range of choices and support covering the broad range of issues that they face. Thus, IDVAs need to be commissioned as an independent service, working closely in partnership with voluntary and statutory sector agencies both within and outside the Multi-Agency Risk Assessment Conference (MARAC).

Recommendation 3: Urgent links need to be made with the risks to children

Almost 70% of the victims in this sample had children which amounted to an estimated 3,600 children in total – a huge number. Of note is that a third of children were aged between 0-4 years. Combined with what we now know about the average abusive relationship continuing for 5.5 years, it is reasonable to conclude that a significant proportion of these children had been living with abuse their entire lives. In around 40% of cases, there was conflict over child contact, in a quarter, the victim was concerned that the child would be directly harmed and in 11%, there were direct threats to kill the child.

Furthermore, in over half of cases perpetrators had substance misuse issues and in almost 40% of cases they had mental health problems. The co-existence of domestic abuse, substance misuse and mental health issues was highlighted in Lord Laming's Review following the report into the death of Baby Peter. Indeed a key recommendation from this report was that: *'The National Safeguarding Delivery Unit should urgently develop guidance on referral and assessment systems for children affected by domestic violence, adult mental health problems, and drugs and alcohol misuse using current best practice. This should be shared with local authorities, health and police with an expectation that the assessment of risk and level of support given to such children will improve quickly and significantly in every Children's Trust'* [(3)].

Given the prevalence of all of these risk factors in the families that were studied in this evaluation, along with the direct threat to children's physical safety evidenced here and what is known of the impact of abuse on children's psychological development, these findings underline the urgency of addressing the specific risks faced by children living in households blighted by abuse. The findings showed clear reductions in the direct threats to children's safety, suggesting that this type of intervention may be somewhat effective towards this end, and thus careful consideration must be given to incorporating the IDVA model as part of the safeguarding response for children.

It is not the role of the IDVA to work directly with children, but rather to help their non-abusing parent to access safety, if at all possible in their own home. However, the impact of the work of the IDVA in helping end the abuse that victims are suffering has clear implications for the safety of children also. Work needs to happen without delay to examine how links can be made between those whose work it is to safeguard children and those who are working with this high risk group of victims.

Recommendation 4: Stronger links need to be made to health services and those who work with perpetrators

The results presented throughout this report also identify areas where there is room for more effective partnership working in order to maximise safety for those who do engage with IDVAs and to support those who did not engage more effectively. For example, they indicate that many perpetrators of the very severe abuse described here were more broadly aggressive and antisocial, having criminal convictions for other crimes, a high level of drug and alcohol use and a history of domestic abuse against other partners. The presence

of these factors was found to be associated with increased levels of abuse in the first instance, disengagement from services and for those who did remain engaged, diminished chances of achieving enhanced safety and well-being. These were also the types of risks that were the most enduring over the course of a case, which is to be expected: the IDVA works with the victim and needs support from other agencies in order to impact on the perpetrator's behaviour. Whereas the IDVA can work *directly* with the family and criminal courts (for example to address the perpetrator's behaviour), they are dependent on other services whose remit it is to work directly with the perpetrator to make this work effective and to address wider issues.

If IDVAs are to be as effective as possible, closer links need to be made with these services and referral pathways for these high risk cases should be clear and prioritised. This relates both to work within the criminal justice system, the MARAC (where, for example, mental health and substance misuse services are often under-represented) and more widely in relation to the links made with IDVA services in general.

Similarly, research shows that victims have a greatly elevated risk of experiencing all kinds of physical and mental health problems, that only a fraction of women access the health services they require [4] [5] [6] and that victims perceive themselves as having unmet health needs. Moreover, whilst many victims choose not to contact the Police [6] they may have contact with a health practitioner [7], with studies showing victims may feel comfortable in disclosing abuse in this setting [8]. Nevertheless, without an immediate service to refer on to, such disclosures have little impact in terms of additional support, and an opportunity for intervention is lost [9].

This evaluation highlighted the relatively limited extent to which information was gathered by the IDVAs regarding health issues of victims. This study also indicated lower rates of referral to health services than might be expected based on other research which documents the prevalence of physical and mental ill health in this population. Together, these results suggest that in particular there is a need to review the identification of health related issues and the referral pathways to and from health related services.

These findings point to the need for concerted efforts to be made to strengthen links with generic and specialist health services, especially since recent studies have shown that the delivery of integrated services to address domestic abuse in tandem with health related issues (mental health, substance misuse) facilitates improved outcomes for victims [10] [11]. Work needs to be undertaken to explore how best to improve on these links and, in particular, the viability of directly commissioning community based domestic abuse services by Primary Care Trusts, which should, in principle, assure accessibility for all groups of victims and the potential for better long term care to address some of the health impacts of domestic abuse.

Looking forward

This evaluation highlights the reality of living with high risk domestic abuse and the impact of IDVA services on victim safety. It is hoped that the results derived from this evaluation have the potential to significantly advance our understanding of 'what works' in improving the safety of victims of domestic abuse and their children, and that this research will be drawn upon to shape the delivery of effective services in the future.

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Chapter 1: Setting the Scene

1. Introduction

This report presents the findings from a significant programme of research that was undertaken to examine the provision and impact of IDVA (Independent Domestic Violence Advisor) services for female victims of domestic abuse deemed to be at high risk of harm or homicide. Commissioned by the Hestia Fund and funded by the Sigrid Rausing Trust and The Henry Smith Charity[3], this study, conducted between 1 January 2007 and 31 March 2009 and involving seven services operating in England and Wales, represents the first, large scale, multi-site evaluation of IDVA services ever undertaken in the United Kingdom.

Importantly, this national-level research helps us to understand both the process of delivering IDVA services and the outcomes that may be achieved for victims. Throughout this report we draw upon both quantitative and qualitative data (gathered across different points in time) to offer a range of findings and we discuss their implications for policy and practice.

2. Background to the research

Domestic abuse is a major problem for society that is associated with serious, sometimes fatal, consequences for victims and their children. Mounting research that attests to the short and long term consequences of domestic abuse, coupled with the growing recognition of the heavy financial costs borne by victims and their families, employers and wider statutory services[4], has brought into sharp focus the social and economic need for an effective response to victims of domestic abuse.

However, domestic abuse has remained a difficult area to address for policy makers, the scale and often the complexity of the problem renders it inherently challenging to resolve. Notwithstanding this, there has been some significant progress in recent years with regard to Government policy in the field.

In 2003, *Safety and Justice: The Government's Proposals on Domestic Violence*(12) was published, setting out the Government's strategy for tackling domestic abuse, underpinned by the core elements of prevention, protection, justice and support. This was closely followed by the passing of the *Domestic Violence Crime & Victims Act (2004)*(13) which was seen by some as the first significant overhaul of legislation in relation to adult victims of domestic violence in 30 years. Since 2005, the Home Office has presented an annual national report on its work in relation to domestic abuse. The first such report(14) indicated 15 different Government commitments to achieve the core elements set out in 2003 (prevention, support, protection and justice), within which were outlined a number of different initiatives, some of which have gained real momentum in the past few years. One such initiative related to the provision of independent support and advice targeted specifically at victims of domestic abuse deemed to be at high risk of serious harm or homicide at the hands of a violent partner or ex-partner. This led to the concept of an Independent Domestic Violence Advisor (IDVA)[5]. This approach to tackling domestic abuse emerged at a time of increasing recognition of the benefits of multi-agency working (both within the court system and outside it) towards providing a more effective response to the victims of domestic abuse, as well as

[3]This research was made possible by a three year grant from the Sigrid Rausing Trust , with joint funding from The Henry Smith Charity in its last two years. The programme was managed by the Hestia Fund[3]. Together, the two trusts have distributed £775,630 to support and develop the work of IDVAs. The express intention of this grant making programme was to fund direct service delivery, capacity building and evaluation of process and outcomes. See Appendix 1 for a list of grantees who were awarded funding as a result of this programme.

[4]The UK Department of Trade and Industry estimated in 2004 that domestic abuse costs England and Wales £3.1 billion a year through costs to the criminal justice system, the health service and other public services such as housing and social services (Walby, 2004). However, these figures are acknowledged to be short of the true costs based on an underestimate of the prevalence of domestic abuse and the omission of costs to particular services, including the cost of support provided by the voluntary sector, as well as costs of lost economic output and costs of human suffering, estimated at £2.7bn and £17bn respectively.

[5]There was also a focus in the Plan on the provision of services for children, a commitment to expanding the number of Specialist Domestic Violence Courts, the potential development of the first integrated family and criminal domestic violence court, and improving access to justice for victims. In addition, plans for implementing the various provisions of the *Domestic Violence Crime & Victims Act 2004* were included.

the need to prioritise the allocation of limited resources in relation to the level of risk faced by victims. In particular, the evaluation of the new Specialist Domestic Violence Courts (SDVCs), highlighted the crucial contribution that advocates made in terms of creating and strengthening the multi-agency partnerships underpinning their effective operation.

Currently, the provision of IDVA services in the context of wider multi-agency initiatives forms a central part of the Government's strategy to tackle domestic abuse, with early indications pointing towards this as an effective model for addressing serious levels of domestic abuse, both from a human and a financial perspective.

The nationally recognised definition of an IDVA service states: *'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 themselves and their children, as well as longer-term solutions. These plans will include actions from the MARAC [6] 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. They receive specialist accredited training and hold a nationally recognised qualification.' (95)[7]

Core aspects of this approach to intervention include:

- Safety as the overriding goal, independent of any other outcome such as those achieved in the criminal justice system;
- Intervention targeted at victims of domestic abuse at high risk of harm or homicide as a result of domestic abuse;
- Intervention from the point of crisis;
- A risk based approach to intervention;
- The proactive provision of practical help to address the immediate risks to victims' safety and help put victims on the path to long term safety.

The type of intervention offered by IDVAs in part builds on the advocacy model developed initially in North America[8], which grew out of the desire to offer victims of domestic abuse viable alternatives to refuge as the only means of escaping abuse. Advocacy services largely focus on helping victims to access the many community resources and interventions that can be drawn upon to keep them safe in their own homes.

The efficacy of this model has been empirically documented. Studies have shown that women are able to access services more effectively for themselves, adopt more safety promoting behaviours, and experience less physical violence in the medium term and a higher quality of life in the longer term, relative to those who do not receive advocacy(16) (17). Studies of British advocacy services have corroborated these positive findings (18) (19) (20).

Given the 'newness' of the IDVA role, it is not surprising to find that there is far less research evidence relating specifically to the efficacy of IDVA services. Although the IDVA model of intervention overlaps with that provided by advocacy services[9] in a number of ways, there is still a need to understand the strengths and limitations of this relatively new, specialised role on victims' safety and well-being. However, it is helpful to draw upon the wider research on providing advocacy to victims of domestic abuse, as the approach taken

[6]The MARAC model was first developed in Cardiff in response to the lack of systematic risk assessment amongst agencies responding to domestic abuse and a formal process by which local agencies could share information about victims experiencing extremely serious levels of abuse. The role of the MARAC is to provide a forum for effective information sharing and partnership working amongst a diverse range of adult and child focussed services in order to enhance the safety of high risk victims and their children.

[7]CAADA is a national charity which supports the multi-agency response to victims of domestic abuse through the provision of practical tools, accredited IDVA training and support to IDVA services. The core elements of CAADA's definition of an IDVA service were reproduced in the national SDVC resource manual and CAADA's definition is now widely recognised and accepted (p.31, 1st Ed. March, 2006, www.crimereduction.homeoffice.gov.uk/domesticviolence/domesticviolence059a.pdf)

by IDVAs is consistent with the 'advocacy' tradition in a number of ways:

- Both aim to provide independent advice to victims with no special interest in advocating for the use of one particular type of response or intervention;
- Both approaches largely focus on providing victims of domestic abuse with practical advice and services that will help to enhance their safety, which research suggests may be most valued by victims and most effective in reducing the negative impact of domestic abuse;
- Both models strongly emphasise the need for the involvement of a range of services in order to meet the extensive needs that victims of domestic abuse are likely to have;
- Both are often part of wider community efforts to provide a co-ordinated response to victims, although it should be noted that this tradition is newer in the UK compared with North America.

In fact, it is worth stating that IDVA services often have evolved from existing advocacy projects, and that there are a number of models of practice across the UK, depending on the location and history of the service.[10]

Nevertheless, the IDVA role offers something new and thus can be distinguished from advocacy services in the following ways:

2.1 A focus on risk

The core difference is that the intervention provided by IDVAs is guided by assessment of the specific risks in a victim's life, and an in-depth understanding of how to manage risk effectively, gained from an accredited training programme and resulting qualification. In particular, the systematic use of a formal risk identification tool represents a new development in practice that distinguishes the two models. Furthermore, IDVA services are specifically targeted at individuals who are experiencing very serious current levels of abuse, in recognition that these victims are most in need of a rapid and highly specialised response to avert serious and potentially fatal harm[11]. Whilst it may be that many victims accessing advocacy services in the past have been experiencing very serious levels of abuse (see chapter 2), there has not been an explicit effort to target this form of intervention in the same way. Consequently, advocacy services may potentially work with a broader range of victims, at all levels of risk.

2.2 A structural part of the multi-agency response

Through their role at MARAC and the SDVC, in particular, IDVAs are now recognised as a formal part of the multi-agency response to high risk domestic abuse victims. This means that the IDVA's part in trying to address safety is recognised by partner agencies. Equally,

[8] The starting point of advocacy as a model of working with victims was the realisation that they were all too often presented with extremely limited options to address the abuse they were experiencing. In many instances this came down to a choice between remaining with a violent partner or leaving their homes, possessions, friends and family as well as uprooting their children in order to enter a refuge. Victims looking for alternatives were often unsure of where to go for the range of help they needed. Those who did seek formal assistance were often confronted by a bewildering array of institutions (and their procedures), many of which were not well versed in the difficulties surrounding domestic abuse, and as a result many women abandoned their help seeking efforts. The sense of social injustice created by the fact that victims and children, and not the perpetrators of the abuse were often the ones to leave their homes spurred those in the field to seek new ways of keeping victims safe. The focus of these efforts was on increasing victims' access to community resources that could enhance the safety of victims and their children and to help them move on with their lives.

[9] For the purposes of this research, 'advocacy services' refers to agencies where the primary remit is to provide help and advice to victims, in contrast to those services who may informally advocate on behalf of victims as a part of their wider role.

[10] In 2007, the Home Office commissioned a multi-site process evaluation of IDVA services which demonstrated the complexity and variability of existing models of practice (see Robinson, forthcoming). IDVAs may be located in dedicated domestic violence advocacy projects, or as stand-alone workers embedded in statutory services, or in some combination of these two arrangements. The current research pertains specifically to the first type of model as data were collected from IDVAs working in 7 services that were either standalone or attached to other domestic abuse services. Although this might be the recommended model of IDVA service provision, it must be remembered that it is not the only model, and thus different conclusion might be reached for other types of IDVA services.

[11] These victims are also more likely to access formal services more regularly, meaning that they account for a disproportionate amount of money spent in responding to domestic abuse, thus warranting a more focussed intervention (Gordon, 2000).

IDVAs can be well placed to mobilise these wider resources.

2.3 A more tightly defined service

While there is still some variation in the range of services that IDVAs offer, there is an agreement around a common definition (cited above) as to what this model of working should entail. Historically, advocacy services have not had such a definition to work to, with services being very varied in terms of their multi-agency links and focus. This is underpinned by a formal accredited qualification[12] for IDVAs.

2.4 Proactive intervention

Finally, the 'high risk' group of victims with whom IDVAs work necessitates proactive crisis style intervention, usually offered at the point at which victims have come into contact with other formal services, due to the abuse they are experiencing. In contrast, advocacy services are not uniformly invoked at the point of crisis, and some victims may be using their services some time after the crisis has dissipated.

These points of difference potentially limit the extent to which the conclusions derived from existing evaluations of advocacy services are applicable to IDVA services. Given these critical gaps in our knowledge, along with the wide scale roll out of IDVA services across the UK, there is pressing need to undertake more extensive research about how IDVA services are delivered, and their impact on the safety and well-being of high risk victims and their children.

3. The current study

This research was funded to evaluate the delivery and impact of IDVA services for individuals experiencing domestic abuse and who are at high risk of experiencing serious harm or death at the hands of an abusive partner or ex-partner. Specifically, this evaluation set out to examine:

1. The profile of victims accessing IDVA services, particularly with respect to the extent and nature of the abuse they were experiencing along with their socio-demographic characteristics;
2. The specific types of interventions and resources mobilised on behalf of victims by IDVAs, as well as the intensity with which this support was offered and the potential for IDVAs to tailor their approach to the particular needs of individual victims;
3. The effectiveness of these interventions in increasing victims' safety and well-being, and the factors that increased or decreased the likelihood of achieving these positive outcomes. In addition, the research examined the extent to which these outcomes were sustained over time.

4. Methodological approach

The data included in the study pertained only to female victims. Three of the services in the evaluation offer direct support to male victims of abuse. As a result 44 records were found to relate to males. A further 95 records related to abuse perpetrated by someone other than an intimate partner such as abuse by another family member. While it is increasingly recognised that both homosexual and heterosexual males can suffer abuse and that abuse can be inflicted by another family member, less is known about both of these areas. These cases may be marked by a different pattern of risk and it is feasible that different intervention strategies are required to address these issues. For this reason, and in recognition that there is a marked asymmetry in the extent to which males and females experience severe levels of abuse, it was decided to exclude these cases from the study sample.

In order to address the areas of enquiry outlined above, IDVAs gathered data at the point of referral to a service (Time 1), around information relating to victim demographics and the type

[12]See CAADA IDVA Training (www.caada.org.uk)

and extent of abuse experienced during the prior three months[13]. Where possible, data were gathered on a second occasion (Time 2), either at the closure of a case or after 4 months of engagement with the service as an interim marker of case progress (whichever came first). Information collected at this time point related to the interventions and types of support provided by IDVAs and, importantly, documented levels of victim safety and well-being. IDVAs also conducted short interviews with victims on their exit from the service in order to garner their perspectives as to the factors that had impacted on their safety during the period of intervention. Finally, a small group of victims were re-contacted 6 months after the closure of their case in order to examine the sustainability of any changes made with respect to safety and well-being (see Appendix 2 for full methodology). Several attributes of this study design are of particular note because of the implications they have for the quality of the findings yielded by this study:

A multi-site design: Multi-site studies are advantageous in considering service provision at a national level as they yield findings that are neither specific to one group of victims residing in a particular geographic location or to an individual service[21] [22] [23]. A further advantage of multi-site studies is that they often generate larger sample sizes that are necessary for more powerful statistical analyses; for example, those that can take into consideration factors, aside from the intervention itself, that could also have an impact on the outcomes achieved (eg, different levels of abuse at the point of referral, or factors differentiating groups of victims such as drug/alcohol abuse).

Assessment of safety outcomes: Given that enhancing the safety of victims is the core aim of an IDVA's work, it is surprising how little research evidence exists in this regard, with much of the research to date documenting the *processes* by which IDVA services are provided. Although process evaluation is extremely important, it can at most offer only a limited insight into the impact that services might have on victims' safety. The key aim of this study was to provide evidence about the impact of IDVA services on outcomes such as victims' safety and well-being.

Measurement of multiple outcomes using multiple measures: Importantly, this study investigated the impact of IDVA services on multiple outcomes (victim safety and well-being), each of which was measured in more than one way (using various assessment tools and questions) by multiple raters (as information was gathered from many IDVAs working in more than one location and also from victims). This methodological process is likely to yield more valid and reliable data and thus more accurate and informative conclusions relating to the impact of IDVA services.

Measurement of change over time: This study gathered information about the level and nature of abuse, as experienced by victims on multiple occasions. This allowed for the comparison of abuse before and after intervention, which is a more robust way of assessing an intervention's impact. In addition, looking at the change over time in four different types of abuse (physical abuse, sexual abuse, jealous and controlling behaviour, harassment and stalking) provided insight as to whether particular types and/or levels of abuse responded differently to intervention. This can help to build both a more nuanced picture of the abuse experienced by victims and, importantly, of whether and how this abuse was ameliorated by IDVA services.

Linking process to outcome: The collection of standardised information relating to both the process of IDVA service delivery and the impact on victims' safety and well-being, afforded the opportunity to examine whether particular ways of working were linked to better outcomes for victims. Specifically, this study examined the link between safety and well-being and the intensity with which IDVAs worked with victims and the amount of resources that IDVAs

[13]Much of this information was already being gathered and recorded in case notes as part of everyday practice, although for the purposes of this evaluation, IDVAs were provided with an electronic case management system. This included several data collection modules that helped structure and standardise the information that was gathered.

mobilised on their behalf. Understanding the specific elements of an intervention that produces positive changes for victims provides a sound basis for developing specific recommendations for enhancing 'best practice' within IDVA services.

The unique features of this study offer a degree of methodological strength that is unmatched by any previous UK evaluation of IDVA or advocacy services undertaken to date. However, as with any research, there are inevitably some issues that should be given due consideration when interpreting the findings of this work. Many of these stem from the fact that this study represents an evaluation of fully operational services, where IDVAs themselves, rather than trained researchers, carried out the data collection as part of their everyday work (see Chapter 6 for a consideration of participating services' views of the evaluation process). Limitations to the research caused by incomplete data, the use of a simple practice–friendly data collection tool instead of more rigorous but impractical measures, and the lack of a control group must be borne in mind and are considered in greater detail in Appendix 3.

Notwithstanding this, it is hoped that the results derived from this evaluation have the potential to significantly advance our understanding of 'what works' in improving the safety of victims of domestic abuse and their children, and that this research will be drawn upon to shape the delivery of effective services in the future.

5. Structure of the report

The structure of the report is organised as follows:

Chapter 2 – Review of the Relevant Literature

Chapter 3 – Findings: With Whom do IDVAs Work?

Chapter 4 – Findings: Key Features of an IDVA's Work

Chapter 5 – Findings: The Impact of IDVA Services on Victims' Safety and Well-being

Chapter 6 – Impact of the Evaluation Process

Chapter 7 – Discussion of Main Findings and Recommendations

Chapter 2 provides a review of relevant literature structured around the three primary questions addressed by this evaluation: (1) with whom do IDVAs work; (2) what are the key features of an IDVA's work; and (3) what is the impact of this intervention on victims' safety and well-being?

Chapter 3 goes on to describe the profile of victims accessing the participating services, both in terms of the abuse they were experiencing and their socio-demographic characteristics.

This is followed in Chapter 4 by consideration of services' success in keeping engaged their high risk clients so as to be able to provide support, and the type and amount of interventions and resources mobilised for victims. The Chapter ends with an exploration of the way in which IDVAs may tailor the interventions they provide to victims, according to the types and level of abuse victims experience and other factors present in their lives.

Chapter 5 describes the changes in victims' safety and well-being following a period of intervention by IDVAs. It then moves on to consider the association between the intensity of support and the multiplicity of interventions and victims' outcomes, in an attempt to locate specific components of this intervention that are important in determining helping victims to move towards safety. Also considered are those factors that hinder the chances of successful outcomes. The Chapter ends by examining the sustainability of any positive outcomes achieved for victims beyond the period of intervention.

Chapter 6 considers the impact of the evaluation process on the participating services, reflecting on some of the factors that helped and hindered progress and the benefits to IDVA practice that were unexpectedly observed as a direct result of participation in this project.

Finally, Chapter 7 serves to summarise and discuss the findings of this report and offers recommendations for policy and practice in this area, as well directions for future research.

Chapter 2: Review of Relevant Literature

Chapter 1 outlined the significant gaps in our knowledge with respect to how IDVA services operate and, importantly, their impact on victim safety. By way of contrast, the evidence relating to the efficacy of advocacy interventions (upon which IDVA services are based) is much better developed. This chapter draws on this related research evidence to give a sense of who might seek the assistance of IDVA services, what IDVAs do in order to enhance a victim's safety and the degree of success that this approach might facilitate. This chapter is presented in 3 sections:

1) Characteristics of victims accessing advocacy services
2) Core elements of advocacy work, such as that now undertaken by IDVAs
3) Empirically documented impacts of advocacy on safety and well-being

The content of each of these sections broadly corresponds to the three main questions addressed by this research: with whom do IDVAs work, what are the key features of an IDVA's work and what is the impact of this intervention on safety and well-being. This literature review is not exhaustive but touches on just some of the principle issues faced by victims, the many services, systems and organisations which may play a critical role in helping them to live safely, and the impact of this type of intervention across key outcomes.

1. Characteristics of victims accessing advocacy services

1:1 The nature of the abuse disclosed to advocates

In general, victims seeking formal assistance to help them deal with domestic abuse are found to experience very significant levels of chronic abuse[24][25], with victims referred to advocacy services (both here and abroad) showing little exception to this rule. The great majority of victims utilising advocacy services are currently experiencing, or have recently experienced, severe physical abuse[14], which in many instances has rapidly worsened[7][19][26]. In a study of one of the first advocacy projects to be set up in the UK (where referrals were made primarily by police), beating was reported by 63% of women experiencing more than one episode of abuse, strangulation by 53% and 39% of victims had been assaulted with a weapon[18]. Studies of advocacy services in the US offer a similar picture of abuse. Sullivan and her colleagues[17][27][28] found that most women referred to a community advocacy project were deemed to have experienced severe abuse (as classified by a standardised measure) and had suffered a range of significant injury as a result: 19% had experienced broken bones, 10% dislocations and 11% miscarriage or pregnancy complications as a direct result of abuse. Many more women live in fear that this will be the case. By way of illustration, Robinson (2003)[19] found that 70% of the victims referred to a single service believed that they would be injured or killed at the hands of their abusive partner or ex-partner. Evidence presented later in this chapter emphasises the importance of victims' perceptions in predicting the likelihood of further harm.

Other forms of abuse are also common place amongst victims accessing advocacy services and many, if not most, victims are abused in a number of ways[7][19][26]. Robinson (2003)[19] reported that 25% of victims were experiencing forced sexual activity, with a third indicating that this happened on at least a weekly basis. A second study found that nearly half of all victims experienced forced sex[18]. A report by the Metropolitan Police Service[29] noted that domestic sexual assault tends to result in more serious injury than any other domestic incidents and research shows that it is a key risk factor for severe and lethal violence perpetrated against an intimate or ex-intimate partner[30][31][32][33][34].

Emotional abuse is found to be extremely prevalent amongst victims in contact with advocacy services, with one study finding that this type of abuse was reported by 98% of

[14]Physical abuse can involve any kind of hitting, slapping, pushing, kicking, the use of weapons or objects as weapons, burning, scalding, choking, hair pulling, misuse of medication, undue restraint or inappropriate sanctions. (Bacchus, 2006).

victims, which for many occurred on a constant basis[19]. In particular, controlling behaviour and a high level of jealousy may comprise part of the emotional abuse to which victims are subjected. A study of an advocacy programme providing support to victims progressing through the Scottish court system documented perpetrators' jealous and controlling behaviour[15] in around 60% of cases[26]. Several reviews of intimate partner homicides identify intense jealousy and high levels of control as a significant feature in the majority of cases[30][35][29]. It is also found to be a key precursor to repeat victimisation as well as extremely serious levels of subsequent violence[36][26][37]. Additionally, women reporting their spouses or partners to be more controlling are found to be more likely to report multiple forms of abuse, as opposed to a single type[38].

Harassment and stalking may also feature as part of the pattern of non-physical abuse that victims experience, with ex-partners most likely to engage in this form of abusive behaviour[39][40][41][42][6]. Around 25% of women experiencing physical violence also reported being stalked by a partner or ex-partner[38], and also when coupled with physical abuse (or previous violence), is significantly associated with murder or attempted murder[29].

Prior to contact with formal services, victims have typically experienced abuse on a great many occasions, over a number of years[18][19] although, contrary to popular opinion, many victims have attempted to seek help elsewhere before their referral to an advocacy service. Most have spoken to someone about the abuse in the past[18][19] and in a number of cases, victims have had some involvement with formal services such as the police or emergency medical services[7]. Victims may also attempt to put a stop to abuse by separating from the perpetrator, although much research has shown how the abuse may continue even after the relationship has ended. Separated victims are found to comprise between a third and a half of all cases with which advocates work[18][7][19][26][28][43], although this figure is much higher when those looking to separate are included in this estimate; one study finding this to be as high as 85%[19]. Actual or imminent separation is an extremely risky time for victims, illustrated by the fact that separated women (or women in the process of leaving a violent relationship) are estimated to comprise 65-75% of all domestic violence homicides[44].

There is increasing recognition that children living in abusive families are as much victims of domestic abuse as their non-abusing parent. Most studies show that the majority of victims accessing advocacy services have children[7][29][26][28]. Moreover, in line with studies showing that the risk of domestic abuse is highest amongst younger women[45][46][47], the great majority of victims are aged below 40 and by virtue of this tend to have young children[19].

Exposure to domestic abuse is linked to a wide range of negative outcomes for children, both in the short and longer term, and children growing up in families marked by abuse are more likely than children from non-abusive families to be maltreated in all kinds of ways[48][49][50]. Direct threats to children's well-being are noted in several studies of victims receiving advocacy interventions. For example, in the Scottish sample mentioned above, 12% of victims reported that the perpetrator had threatened to harm the children and in 3% of all cases surveyed, threats against children's lives had been made[26]. A second study revealed that in 6% of cases, children had been directly harmed by the perpetrators of abuse[19] and a third revealed that in over half the cases where there were children, children had intervened to protect their mothers[18].

[15]Intense jealousy often centres around accusations of infidelity or separation (Fluery, Sullivan & Bybee, 2000; Serren & Firestone, 2002; Wilson & Daly, 1993, 1998), but can also include isolation from friends, family and other support networks, limited access to money, surveillance of everyday tasks such as grocery shopping, intercepting mail, phone calls and text messages. Threats to harm or kill children are also noted as tactics used to control victims (McCloskey, 1996; 2001; Sullivan & Bybee, 2007).

[16]Harassment and stalking may be characterised by various behaviours including unwanted communication (phone calls, text messages or emails), being followed on the street, contacted at home or at work, unwelcome visits or gifts, threats, damage to property, violence, and falsely gaining information about the victim (Kamphuis & Emmelkamp, 2001; Abrams and Robinson, 2002).

In addition to threats of or actual harm to children, child-related topics of conflict are noted frequently amongst victims accessing advocacy services. Robinson's (2003)[19] study showed that 22% of all victims reported that the perpetrator had threatened to 'take the children away' and problems and conflict around child contact have been noted in around half of cases where the victim and perpetrator have children together[26]. Child-related topics of conflict have been found to have a particularly detrimental impact on children's emotional and behavioural health[51][52], the effects of which may be magnified when children perceive themselves in some way responsible for violence against a parent; either in causing it or by failing to stop it from happening[53][54]. Moreover, these types of child related issues are cited as a common precipitating factor in the murder of women and children in the context of domestic abuse[29][55].

This snapshot of the experiences of victims and their children accessing advocacy services highlights chronic levels of severe abuse and the very significant risk that it poses to the safety of both adult victims and their children.

Whilst none of the studies reviewed here relates explicitly to victims accessing IDVA services, these results suggest that those accessing advocacy services represent a similar group of victims to whom IDVA services are targeted – those at high risk of harm or homicide.

1:2 Additional areas of vulnerability

For some victims domestic abuse occurs in the context of wider adversity (which may or may not be directly related to abuse), which may serve to compound the effects of abuse or which, if left unaddressed, may place significant obstacles in the way of achieving safety. For example, nearly half of the sample surveyed by Robinson (2003)[19] was unemployed and in over 80% of cases victims were receiving some form of welfare benefits. Similar rates are also noted in the US[27]. Economic dependence presents a key instrumental barrier to leaving a violent relationship[56][57][58][59]. It is also cited as a primary reason for women's decisions to return to abusive relationships[60], which in turn is made more likely because escaping a violent relationship often leads to poverty[61]. In line with these findings, Robinson (2003)[19] reported that amongst advocacy clients, lack of access to their own money was linked with victims' increased risk of more severe physical and emotional abuse and poorer mental health outcomes. Similar results are yielded by population based studies; Walby & Allen (2004)[6] found that those women who thought it difficult to find money at short notice were much more likely to experience domestic abuse that those who reported that this would not cause a problem.

Substance misuse may also have a bearing on victims' safety, increasing the likelihood of 'service failure, future injury and relapse'[10]. Surveys of victims accessing specialist domestic abuse services indicate that the prevalence of substance misuse may be anywhere between 25-50%[62][63], although some estimates are even higher[63]. Whilst there is little evidence to suggest that victims' substance misuse is a causal factor that directly leads to victimisation, it is often cited as a consequence of abuse. In other words, victims use drugs and/or alcohol to 'self medicate' or numb the psychological pain stemming from the abuse[64][65][66]. Victims' substance misuse can also provide an additional opportunity for violent partners to exert control, with perpetrators introducing victims to drug use, and subsequently using access to substances or treatment programs as a means of controlling the victim[67]. Substance abuse also brings with it a number of other social problems. For example, it may inhibit the chances that a victim is able to gain employment as a step towards reducing financial dependency on her abuser.

Physical and mental health problems are documented with a greater degree of frequency amongst victims of domestic abuse compared to those who are not abused[36][68][69][70].

Robinson (2003)[19] reported the prevalence amongst victims accessing a community-based advocacy project to be 15% and 12%, respectively. Regan (2004)[7] noted even higher need amongst those accessing advocacy services in a health-based setting, with almost a quarter of victims disclosing physical and mental health needs. The presence of either issue is found to be linked with increased levels of physical and emotional abuse as well as higher levels of injury, although it is difficult to determine the direction of relationship between abuse and health. Ill health may be directly caused by abuse[71][69], but it may also render individuals more susceptible to experiencing abuse in the first place or to experiencing more severe abuse.

Additionally, disabled women are found to experience abuse at a higher rate than non-disabled women[72] and also experience more severe consequences from the abuse[73]. Disability can create additional needs and complexities in a case[72][74] that serve to heighten the vulnerability of victims; for example, this group of victims may encounter significant barriers to help seeking, including practical difficulty in contacting and accessing specialist services, reliance on a perpetrator for the provision of care, and fear of having to leave specially adapted accommodation[75][73][76]. Furthermore, when victims do attempt to access support, provision may be inadequate to meet their needs[77][78], making it more likely that they will return to an abusive partner.

Ethnicity may also be linked to increased levels of vulnerability to the negative effects of abuse, not because it increases the risk of abuse per se, but because black and minority ethnic (B&ME) victims may encounter significant barriers in accessing particular types of interventions and resources[79][80], thus increasing the time that victims are exposed to abuse. Lack of familiarity and understanding of available services, language barriers and issues around culture and religion are commonly cited difficulties that victims may meet when seeking help[81]. A further barrier to service utilisation amongst some B&ME women is insecure immigration status. Current UK immigration laws mean that women who have entered the country on a spousal visa are unable to access public funds until they are able to apply for the 'right to remain' in the UK, which they are eligible to do only after two years of marriage. Having no recourse to public funds dramatically limits the assistance that women are able to access, and thus presents a key barrier to leaving an abusive relationship[82]. B&ME victims may also experience abuse at the hands of other family members (so called 'honour' crime) which again makes it extremely difficult for women to seek help[83][81]. Furthermore, some forms of intervention may be in general more or less acceptable to particular ethnic groups or cultures, with different patterns and preferences of help seeking noted amongst minority ethnic groups[84][85][86][87].

Each of the issues discussed here represents a wider context of risk in which domestic abuse may take place and which for some victims may have a bearing on the type and level of abuse they experience and the ease with which they are able to seek and accept help.

Overall, this section draws attention to the complex array of needs that victims referred to advocacy services may have, all of which IDVAs must take into account in order to deliver an effective intervention. To this end, the flexible and individualised response offered by IDVA services may serve as a key mechanism to achieving safety, both in the immediate and longer term. The core components of advocacy work, such as that undertaken by IDVAs working with high risk victims, are discussed next.

[17]Relatively recent changes to government policy mean that a person may be exempt from this requirement if they can prove that they have experienced domestic abuse (Domestic Violence Rule p.298 A of the Immigration Rules), although this can be a lengthy process during which victims are still not able to access public funds (Fellas & Wilkins, 2008). Immigrant women are also likely to be more isolated than indigenous women, having left their families and social networks to move to a new country (Mehrotra, 1999) and so they have fewer avenues for support during the time during which they attempt to secure their immigration status in the UK.

2. Core elements of advocacy work

2.1 Intervention from the point of crisis

IDVAs typically work with victims from the point of crisis[18]. Referral to a service often follows an emergency call to the Police or treatment in A&E for injuries sustained in an assault (although referrals may be made by a range of agencies)[19] and, as such, IDVAs provide a type of crisis intervention. Crisis intervention[(88)] at a general level is aimed at those in extremely dangerous situations or following exposure to extreme trauma (eg a car accident, natural disaster) and looks to reduce the likelihood of long term impacts, including psychological harm. Parallels are drawn with emergency medicine (which is invoked at the point of a physical crisis) in that it aims to deal only with the most urgent problems before referring an individual onto the next level of service or treatment[(89)]; thus, crisis intervention is viewed as but one point along a continuum of care[(89)]. It is normally short term and looks to resolve the most pressing problems in around 1-12 weeks[(90)].

Utilising this approach has value for helping victims of domestic abuse for several reasons. First, victims are often in immediate danger at the point at which they reach crisis, and thus require a rapid, emergency-like response. Second, victims report that they require and value a fast response in the aftermath of an abusive incident or at the point at which they feel no longer able to cope[(18)(7)]. Third, individuals are more willing to seek and accept support during the early stages of a crisis[(91)] and so, paradoxically, a crisis may be a time of intense danger but also an opportunity for change[(18)(92)]. Related to this last point, it is suggested that reasonably simple measures applied during this time can have a relatively big impact on an individual's safety and well-being[(93)(94)]. The support that IDVAs provide is typically short to medium term and, rather than being able to address all aspects of a victim's situation during this time, it is anticipated that IDVAs will be able to address some of the immediate risks to victim safety. In line with the second aim of crisis intervention, it is also foreseen that IDVAs will have been able to initialise some of the longer term strategies to address the more entrenched problems impinging on victims' safety (e.g. referrals to substance misuse programs), as well as facilitate access to services providing longer term support (outreach programmes, support groups) where this is required.

2.2 A response focused around risk

In line with the notion of crisis work, an IDVA's primary goal is to address the most salient needs of a client in order to decrease the risk of further harm in the immediate and short term[(95)]. This often begins with a formal assessment of risk using a standardised tool such as the CAADA Risk Identification Checklist[20] (RIC). IDVAs tend to utilise simple tools[21] which include indicators that have been identified in academic and practice-based literature as associated with serious harm and/or homicide. These largely focus on factors associated with the perpetrator's previous behaviour (e.g. violence towards others as well as the client), characteristics of the current incident, and the victim's own appraisals of their risk of subsequent harm, as well as contextual factors (e.g. social isolation of the victim, imminent relationship separation) and assess both historical or static risks (eg perpetrator's criminal record), along with those that

[18]A crisis is defined as *'a subjective reaction to a stressful life experience, one so affecting the stability of the individual that the ability to cope or function may be seriously compromised'* (p.68, Roberts, 2005). A crisis can arise from a single traumatic event or a series of events which have a cumulative effect on the individual (Namoi & Golan, 1978). Victims of domestic abuse may reach crisis point for a number of reasons, perhaps following a particularly severe attack or following the rapid escalation in the frequency of abuse, failed attempts to seek help or those which result in abusive reprisals, the prospect of a perpetrator's release from prison, or when threats are made against children or other family members (Roberts, 2005; Young, 1995).

[19]A service may also receive self referrals from women in crisis, especially as it becomes better known in the community (Kelly, 1999).

[20]Following an extensive period of coordinated development and piloting of a common risk assessment tool with ACPO during 2008-9, this tool is now known as the CAADA/DASH risk indicator checklist (www.caada.org.uk). It is the recommended tool for use by Police and multi-agency partners (primarily IDVAs).

[21]It is important to note is that these tools often do not constitute a full risk assessment, which differentially weight factors based on the statistical association with a given outcome.

may change over time-dynamic risks (e.g. relationship status)[22]. The number of indicators present in a particular case gives a basic indication of the level of risk to a victim's safety.

'She stated that the risk assessment was extremely helpful to her because it challenged her mind and allowed her to admit the fact that the perpetrator was a danger to her'

The use of a standardised tool provides a structure around which IDVAs are able to gather extensive information about a victim's case and aids in the prioritisation of caseloads, helping IDVAs to identify those victims in grave danger and who will require their immediate attention[(26)(96)23]. The completion of a risk focused checklist may also have direct benefits for victims, helping them to make a realistic appraisal of the likelihood of subsequent abuse, especially if they initially appraise their risk as low[(97)(35)].

It is recommended that this approach to risk identification is used in tandem with, rather than instead of, an IDVA's professional or clinical judgement, as research has shown that using both actuarial and clinical methods of risk assessment together represents the most accurate and reliable means of gauging the likelihood of further harm[(98)(99)]. With specific reference to domestic abuse, evidence also suggests that careful attention should be paid to the victim's perception of risk as research indicates can be a very accurate predictor of further victimisation and harm[(97)(26)(99)(96)(100)]. In practice, this may mean deeming a victim who is fearful as high risk, even in the absence of other indicators.

Identification of specific risks in a victim's life provides the foundation on which to build *a safety plan*[(101)]. Safety planning focuses on addressing the immediate and short term risks in a victim's life, and may include simple and practical measures that victims themselves can take to enhance their own and their children's safety, such as changing a phone number, planning what to do if the perpetrator tries to gain entry to the house, or changing the route taken to a child's school. Safety planning has been shown to be successful in increasing the number of safety measures that victimised women use, and in reducing physical and emotional abuse in the medium term[(102)(103)].

2.3 The provision of a co-ordinated multi-agency response to victims

IDVAs may also help victims to explore a range of suitable options that may be mobilised to form part of a wider safety strategy, both in addressing the immediate risk that victims face and which may help to put victims on the path to long term safety. For example, they may aid victims in accessing the criminal justice system by encouraging them to report abuse to the Police or supporting them through a criminal court case, increasing the chances that perpetrators will be successfully convicted[(101)(19)(20)]. They may also help victims to navigate the complex civil justice system in order, for example, to gain protection for themselves and their children, seek or respond to child contact orders or to obtain a divorce. Furthermore, negotiation of housing issues, access to welfare benefits and other financial entitlements and health related services are all areas in which victims referred to advocacy services commonly require support[(16)], although the potential range of services and remedies that might be mobilised on behalf of any one victim is extremely broad.

'She stated that MARAC was a life line for her. She was surprised at how all the agencies suddenly "came out of the woodwork" for her and did their bit to keep her safe'

[22]It is argued that there is considerable interplay between static and dynamic risk factors with a change in dynamic risk factors having a differential impact on risk given the level of static risk (Mills, 2005).

[23]In the context of a multi-agency framework, a common tool used by a number of agencies can help to create a shared language of risk between agencies who are working together.

An effective multi-agency response in which IDVAs play the central role rests on being able to provide victims with co-ordinated access to a wide range of appropriate options that are suitable given an individual's specific needs. In each case, IDVAs *actively* promote multi-agency collaboration and co-ordination to ensure that all key agencies are involved, are working effectively without duplication, and that relevant information is shared amongst those who need to know[104]. They also play a key role in holding individual agencies to account[105], ensuring that clients are able to access the services to which they are entitled.

Independent evaluations undertaken in the UK evidence the role that advocates play in mobilising a multi-agency response in order to facilitate victims' safety. For example, Robinson (2003)[19] reported that the majority of clients accessing an IDVA service received referrals to other community agencies (78%) and Regan's (2004)[7] evaluation of a health-based advocacy service showed that victims received multiple referrals to community agencies, with the average being 5. IDVAs are anticipated to be most effective when they are operating in the context of wider efforts to promote a co-ordinated community approach to tackling domestic abuse.

The MARAC (Multi-agency Risk Assessment Conference) epitomises the multi-agency response to domestic abuse, providing a tangible forum at which to bring together the many statutory and voluntary services that have a role in managing the risks to victims' safety. In particular, this resource is targeted at the most serious of cases of domestic abuse. During a MARAC meeting, the circumstances of victims are discussed and each agency offers the information they hold on a case – in practice this often reveals discrepancies in what is known across agencies and Robinson (2006)[20] argues that it is only in a multi-agency context such as this that these gaps in knowledge can be identified and closed. Once the details and specific risks involved in a case have been established, comprehensive safety plans can be mapped out[24]. The presence of all relevant agencies in one room means that these plans can be developed quickly and with relative ease, with all involved informed of the wider efforts being undertaken to keep victims and their children safe. The IDVA plays a critical role in the MARAC process in a number of ways: (1) they refer victims' cases to MARAC offering an extra layer of multi-agency intervention[25]; (2) they liaise directly with the victim, wherever possible engaging the victim in the process, ensuring that their views are heeded with respect to the strategies that they believe will be most effective in keeping them safe; and (3) they also work to keep the victim informed as to the outcomes of the meeting and the course of action that may have been set in action[106][106][107].

Relatively recent evaluation of this risk reduction strategy finds that around 40% of victims remain free from abuse one year after the MARAC, which is extremely significant given the extremely serious nature of the abuse typically experienced by victims involved in the MARAC process[107][108]. Victims themselves are found to report the MARAC as contributing to their safety once they were ready to change their situations[107] and individual agencies view the process as improving the response to victims of domestic abuse through enhanced information sharing, awareness raising and the strengthening of links between key agencies[109][107][110].

2.4 Provision of a flexible response to victims tailored around risk and other support needs

As Section 1 of this Chapter explores, when victims arrive at the doors of an IDVA service they are likely experiencing a number of different forms of abuse, they may have children

[24]As with other co-ordinated community approaches the MARAC also serves an awareness raising function – not just of domestic abuse in general but also of the array of often creative strategies that can be employed by individual agencies in order to enhance victims' safety. MARACs also provide a mechanism by which to hold agencies to account in instances where they fail to respond effectively to keep victims safe.

[25]In reality this is a reciprocal process and referrals may be made from the MARAC to the IDVA where the IDVA was not directly working with a victim prior to the meeting.

who are traumatised and in direct danger and they may have a number of other problems that are impacting on their own and their children's' safety. An important skill that IDVAs bring to their work is the ability to tailor the multiple interventions they provide around factors such as these.

In the first instance, different forms of abuse may warrant different types of intervention and what may be effective in ameliorating sexual abuse for example, might be quite different to the interventions successful in addressing stalking behaviour[111][112][38]. Furthermore, each form of abuse may bring with it a specific set of problems again which may require targeted intervention.

Whether or not a victim has children is also important in determining which options are presented to victims and in what order. Victims with children may require intervention strategies that incorporate their children's needs and victims may be unwilling to address their own safety until they know that of their children is being attended to[113][16][114]. The presence of children may also bring the need to liaise directly with safeguarding agencies which can add an additional layer of complexity in working with a victim, especially where they do not support this involvement[115].

Relationship status is also a key variable to be borne in mind by IDVAs. Safety strategies such as target hardening, where efforts are made to shore up and secure a victims' home to prevent the perpetrator gaining access, are for obvious reasons less appropriate if the victim and abuser continue to live under the same roof[116]. Instead, in these instances, the IDVA may explore a victim's emotional attachment with the abuser with a view to helping her consider living independently in the future[8][18][117]. Conversely, where victims separate in the time during which they are supported by an IDVA then intervention may need to accommodate a perpetrator's change in tactics whereby harassment might become a more salient feature of the abuse[101][118].

2.5 The provision of intensive and focused support

Of course, the provision of a multi-agency response tailored around risk and need is only part of what is anticipated to make this an effective approach towards enhancing victims' safety. The level of intensity with which this intervention is delivered is thought to be of equal importance in achieving positive outcomes for victims. The high risk status of victims accessing IDVA services, the often complex nature of their cases and the short term nature of this work means that IDVAs often have a great deal of contact with their clients.

The provision of intensive support is likely to forge a trusting and emotionally supportive relationship with victims which may be beneficial for a number of reasons. First, victims may be more receptive to ideas and options which are put forward by an IDVA with whom they have a good bond, making it more likely that they will engage with a greater number of safety strategies[119][116]. Second, a good relationship may facilitate the transfer of help seeking skills from advocate to client, ensuring that victims know where to access support in the future, thus decreasing the likelihood of revictimisation[116].

This short review highlights the many facets of the highly individualised and often complex intervention that IDVAs aim to provide to high risk victims of domestic abuse and it is anticipated that intervention delivered in line with the model outlined here will be the most efficacious in facilitating positive outcomes for victims and their children. The next Section offers a short review of the impact of advocacy interventions across key outcomes for victims, specifically their safety and well-being.

3. Empirically documented impacts of advocacy on a range of outcomes[26]

3.1 Impact of advocacy on victim safety

Sullivan and colleagues[27][17][28][120][121] examined the impact of a 10 week advocacy programme delivered to severely abused women on leaving refuge accommodation. Women worked with an advocate on average twice a week for about 6 hours (each week) in order to obtain access to much needed community resources and social support. In order to examine the effectiveness of the programme, comparisons were made with a group of similar women (the control group) who did not receive the assistance of an advocate across key outcomes, immediately after the intervention and at 6, 12, 18, 24 and 36 months post intervention. The results derived from this seminal series of studies demonstrated an immediate impact of advocacy on both the occurrence and severity of abuse. Those in the advocacy group were found to be experiencing less severe abuse that the comparison group and significantly more women reported that abuse had stopped altogether (58%) as compared to the controls (45%). Importantly, further study showed that the benefits of advocacy were maintained in the longer term with a significantly higher proportion of victims remaining abuse free two years post intervention (24%) as compared to those who had received no additional service on their exit from refuge (11%), suggesting that advocacy interventions have long lasting effects on victims' safety. However, it should be noted that the positive effects of advocacy were no longer observed at three years post intervention where safety outcomes looked much the same across the two groups of victims, although those who had worked with an advocate continued to report higher levels of well-being relative to those who did not.

Supporting these positive findings, Bell and Goodman (2001)[122] undertook a small evaluation of advocacy services offered to women seeking the support of student advocates in order to help them navigate the civil court process. Whilst advocates primarily provided support around women's pursuit of civil protection orders, they also worked in a wider way to help women safety plan, obtain other community resources, and to provide emotional support. The findings of this study showed that there were group differences in the level of emotional and physical revictimisation and the degree to which women reported dominance and isolation by their partners or ex-partners, with those working with an advocate showing more positive outcomes. Other studies examining the efficacy of programmes situated in a legal setting have also documented some success[123][124].

Results yielded from evaluation of UK services mirror those of the larger and more advanced international evidence base. For example, Bacchus et al. (2007)[118] documented significant decreases in levels of violence and controlling behaviour relative to baseline measures amongst a small sample of women accessing a health based advocacy project. Furthermore, a study undertaken by Robinson (2006)[26] reported positive outcomes for victims immediately post intervention, with a cessation in abuse reported in 70% of cases. Several studies examining the level of repeat victimisation reported to the Police are also suggestive of the positive effects that advocacy may have in tackling domestic abuse, with falling repeat rates observed following the establishment of advocacy services[101][19]. One study also recorded a lower repeat visit rate to A& E as a consequence of domestic violence related injuries amongst women who had initially accessed the advocacy service via this route, although there were no baseline figures with which to compare this finding

[26]This review does not describe the important impact that advocacy services may have at an institutional level. As part of an extensive evaluation of the implementation and impact of a crisis model of advocacy, Kelly et al (1999) surveyed the perception of local community agencies with respect to the role and value of the advocacy service. Interviews with 24 voluntary and statutory agencies working with a police based advocacy service, revealed that two thirds of the agencies reported that the existence of the advocacy service had made a positive change to the way they addressed domestic abuse, with particular importance being attributed to the services ability to advocate for women, and the linking and co-ordinating role they played. It was noted that relationships became more reciprocal over time as the service became more trusted and known, meaning that these agencies referred into the advocate project as well as receiving referrals from advocates, providing evidence of the role of advocacy in promoting co-ordinated multi-agency working (Kelly et al, 1999).

(to show what this repeat rate would have been without intervention[7]). Moreover, women experiencing repeat victimisation may have been seeking help via other routes or simply not seeking help at all – a criticism that befalls all studies that report revictimisation rates as a measure of success. Importantly, victims' reports also corroborate these findings. Studies undertaken by Kelly et al. (1999)[18] and Robinson (2003)[19] revealed that over 75% of clients reported that the receipt of advocacy services had made a positive impact on their situations and that nearly all felt that the receipt of advocacy had been highly effective in helping them to achieve a safe outcome.

In general, there has been little work undertaken to examine the components of advocacy interventions that are most effective in bringing about positive changes in victims' safety[125][17], although there is some suggestion that the intensity of support may impact on the outcomes achieved. The intensity with which an intervention is delivered is linked to more positive treatment outcomes across wide ranging types of intervention, delivered to many different groups of people[126][127][128]. In line with this, several recent reviews have concluded intensive support from an advocate may be more efficacious in facilitating reductions in the severity and occurrence of physical abuse compared to less intensively delivered interventions[129][125][27] with those programmes providing over 10 hours of contact thought to be most impactful[129].

Similarly, safety planning, which forms a key part of the work that IDVAs undertake, is seemingly linked to victim outcomes. For example, an intervention comprised of three 20-minute sessions, focusing on the dynamics of domestic abuse, safety planning and awareness raising with respect to the availability of relevant community agencies has shown some positive effects[102]. The intervention delivered by nurses to pregnant women over the course of the antenatal period was found to facilitate an increase in safety behaviours, with positive changes observed after just one session. Compared with those who did not receive the intervention, women working with an advocate reported significant reductions in violence, threats of violence and non physical types of abuse at 1 year post intervention[103]. Although, in contrast, a second, similar intervention did not appear to facilitate any decreases in abuse at 18 months[130].

3.2 Impact of advocacy on victims' well-being

In addition to the impact on victim safety, evidence also suggests that there are clear benefits of this approach to intervention in terms of victims' well being. The studies undertaken by Sullivan found that victims receiving the support of an advocate reported lower levels of depression and higher quality of life and social support directly after the intervention, as compared to victims in the control condition. These results are corroborated by Robinson (2006)[26] who found that just over 50% of victims reported that their quality of life was improved as a result of receiving advocacy. Importantly, long term follow up studies demonstrate that these effects may be maintained in the longer term as evidenced by the fact that victims receiving intervention reported high levels of social support and quality of life than the control group, three years after working with an advocate[121][17]. There is also some evidence to suggest that this type of intervention may impact positively on post natal depression, anxiety and psychological distress and symptoms of depression, although evidence is equivocal (see Ramsay et al, 2009[125] for a review).

In building on these results, Bybee and Sullivan (2005)[121] examined the mechanism through which advocacy might facilitate both short and long term impacts on victims' safety. This type of study moves from asking *if* advocacy is effective, to exploring *how*

[27]There is simply not enough evidence to draw any conclusion with respect to other forms of abuse and associated outcomes eg depression, as opposed to this type of intervention being ineffective in tackling other types of abuse (Ramsay et al, 2009).

[28]Understanding the process by which advocacy impacts on victim outcomes potentially allows for the refinement of intervention, either by maximising the components that turn out to be important in achieving outcomes, or for locating the breaks in the causal chain that mean that intervention has little or a negative impact (Holder, Saltz, Treno, Grube, & Voas, 1997; Parmar & Sampson, 2007; Weiss, 1997).

advocacy facilitates positive effects in terms of victims' safety and well-being. Bybee and Sullivan (2002)[120] found that greater access to resources and improvements in victims' social networks in the short term improved victims' quality of life in the medium term. Improved quality of life, in turn, protected against revictimisation two years after working with an advocate, with those reporting a higher quality of life less likely to be re-victimised. These results show how short term intervention provided by an advocate may be able to facilitate long term change in victims' safety. Thus not only does positive change in victims' well-being represent a key outcome in and of itself, it may also represent the mechanism through which longer term safety might be achieved.

Collectively, this body of evidence suggests that advocacy is an effective intervention that improves the safety and quality of victims' lives over the immediate and longer term. Nevertheless, the evidence base is by no means complete and there has been a recent call for more work to be undertaken in order to develop the evidence base with respect to the impact of advocacy on safety and well-being, in order that stronger conclusions can be drawn[125]. In particular, there is a need to develop the UK evidence base.

Much of what we think we know about 'what works' for victims of domestic violence is derived from studies lacking methodological rigour, from research conducted in different countries or from research investigating similar, but not the same, interventions[131]. There are significant differences between the United States and Britain in the 'nature and effect of the criminal justice system, welfare system, patterns of social exclusion and gender relations' (pg 3[132]) which may have a bearing on the delivery and effectiveness of this type of intervention. Furthermore, as pointed out in Chapter 1, the role of the IDVA has evolved from that of the advocate to a more risk focussed approach to intervention, with the intervention offerred targeted primarily at victims experiencing very significant levels of abuse. The implication of this is that studies conducted in the US (and even some of the earlier evaluations of UK services) may not fully reflect the most current way of working with high risk victims in Britain.

The paucity of research undertaken to evaluate the efficacy of IDVA services brings into sharp focus the need for systematic research that looks at the process by which this type of intervention is delivered, and the benefits it affords to victims and children in terms of improved safety and well-being. This report represents a first step towards this end with the ensuing three empirical chapters looking to give insight into; with whom IDVAs work, how they work, and importantly the outcomes that are facilitated for high risk victims and their children.

Chapter 3: With Whom do IDVAs Work?

This Chapter examines the profile of over 2,500 victims accessing IDVA services, helping us to understand in more detail the risks and other issues that feature in these victims' lives. This, in turn, will be helpful in identifying the spectrum of service provision and expertise that is required from agencies dealing with these serious cases. The key points from this analysis highlight that:

1. The severity of abuse suffered by this group of victims was striking.
   - 76% of victims reported experiencing abuse that was considered to be at a 'high level', in other words the most extreme manifestations of physical, emotional, and sexual abuse. For example, over 60% had been choked or strangled and 62% had received threats to kill.
   - 86% of victims suffered multiple forms, rather than just a single type, of abuse.
   - 57% of victims reported that the abuse was escalating in either severity or frequency at the point of referral to the IDVA service.
   - Victims in this sample had experienced, on average, 5½ years of abuse. For many victims (66%), the abuse continued despite being separated from their partners.
2. Information gathered about perpetrators revealed high proportions exhibiting a range of criminogenic behaviours.
   - 50% had a previous criminal record,
   - 54% were reported by the victim to have abused alcohol and 39% to have abused drugs.
3. There were commonalities but also differences in victims' socio-demographic and background characteristics.
   - Most victims were young (average age 33 years) and 69% of victims had children.
   - B&ME victims accounted for 23% of the total sample - a higher representation that would be expected based on the local populations of participating services.
   - Some victims were experiencing additional adversity which was found to increase the risk of harm posed to victims.
4. There were over 3,600 children living with abuse in this sample.
   - In 41% of cases involving children, there was conflict over child contact.
   - In 27% of cases involving children, victims were afraid that children would be harmed.
   - In 11% of cases involving children, there had been direct threats to kill the children.

A detailed, comprehensive analysis of the types of people *with whom* IDVAs are working, and the types of abuse that they suffer, is crucial for informing and shaping service provision at a national level. To date, there has been little attempt to gather, in any consistent way or on any large-scale, basic data relating to the profiles of victims deemed to be at high risk of harm or homicide and who are accessing formal services. We hope that this chapter goes some way to addressing the lack of key information in relation to:

(1) the types and levels of abuse experienced by victims referred to IDVA services, their relationship status with perpetrators and the average length of these relationships;

(2) the profile of perpetrators, in terms of their criminogenic behavioural characteristics;

(3) the socio-demographic profile of victims, including sources of vulnerability such as disability and insecure immigration status; and

(4) the nature of the risks facing the children of these victims.

What does severe abuse look like?

As part of this research, IDVAs were asked to categorise the types of abuse and the attributes of each type of abuse being experienced (severity, escalation) using an 'abuse grid' (see Appendix 4). IDVAs were provided with guidance around how to categorise the severity of abuse in a consistent way. Examples of 'High level' abuse were as follows:

Physical abuse: Beating up, broken bones, burns, strangulation, holding underwater, internal injury, loss of consciousness.

Sexual abuse: Use of threats to obtain sex, forced sex, deliberate inflicting of pain during sex, enforced prostitution.

Harassment and stalking: Constant calls/texts, uninvited visits, pursuit of victim, damage to property, threats.

Jealous and controlling behaviour: Control of daily activities, extreme jealousy ('if I can't have you no one will'), locking up, threats to take or harm children.

1. The types and level of abuse experienced by victims referred to IDVA services[29]

Figure 1 depicts the frequency with which victims' experienced specific forms of abuse. 84% of victims were subjected to physical abuse and even more (86%) were suffering from the perpetrators' jealous and controlling behaviour. Nearly half (48%) of victims reported experiencing some form of stalking or harassment, and a substantial number (23%) of victims were experiencing some level of sexual abuse.

Figure 1 also shows that where a particular type of abuse was reported, the majority of victims were experiencing severe abuse (see section in blue above for examples of behaviours used to define severe abuse for the purposes of this study). 70% of all those experiencing physical abuse were experiencing severe abuse. 60% of those experiencing sexual abuse, 68% of those experiencing the perpetrators' jealous and controlling behaviour and 67% experiencing harassment or stalking were experiencing extremely significant levels of abuse. Considered across all forms of abuse, three-quarters (76%) of the sample reported at least one form of abuse that was described as severe in nature (**Figure 2**).

The severity of abuse is a key indicator of the likelihood that victims will be seriously harmed or killed in the future without some form of intervention, and it is to this subgroup of 'high risk' victims that IDVA services are particularly targeted.

[29]These figures are derived from the severity of abuse grid (see Appendix 4).

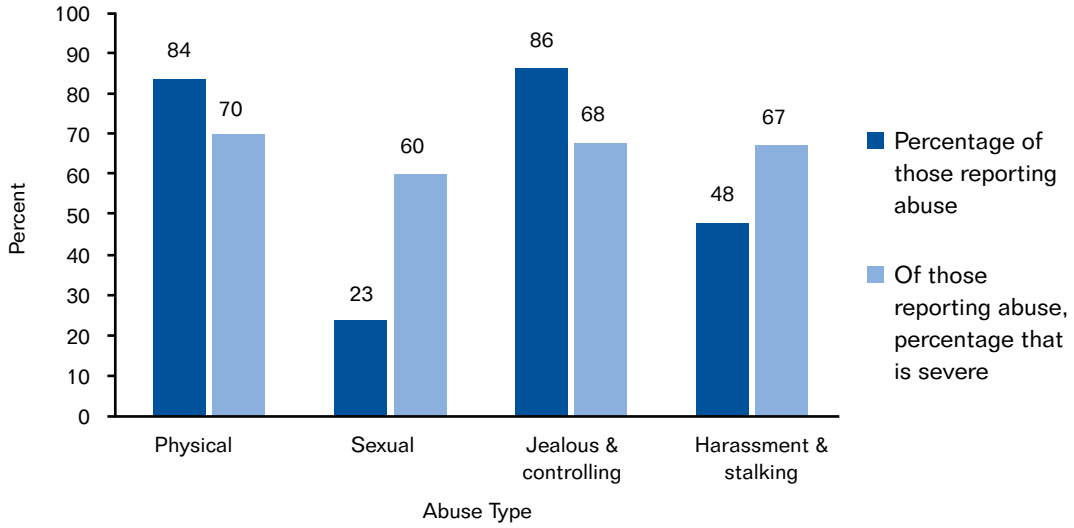


Figure 1: Breakdown of Abuse at Time 1

Figure 3 indicates that 57% of victims reported that at least one form of abuse was escalating in terms of the frequency of its occurrence and/or its severity. Escalating abuse is cited as a factor precipitating the serious harm or murder of victims[30][29]. Present or past intimate relationships that are (or which have been) marked by a high degree of controlling, coercive behaviour are, in particular, known to be characterised by escalating abuse[36][133].

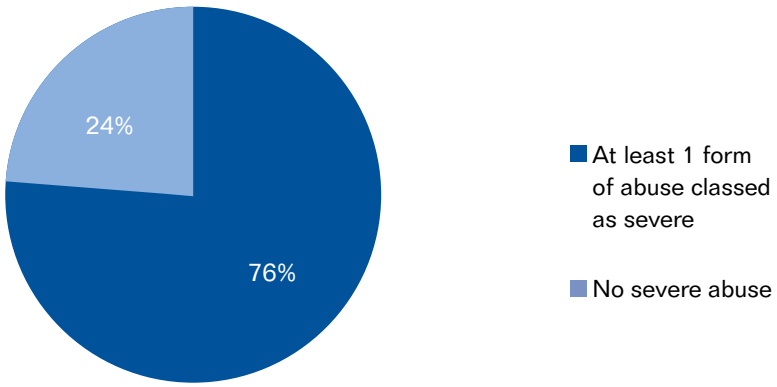


Figure 2: Proportion of the sample experiencing at least one form of severe abuse

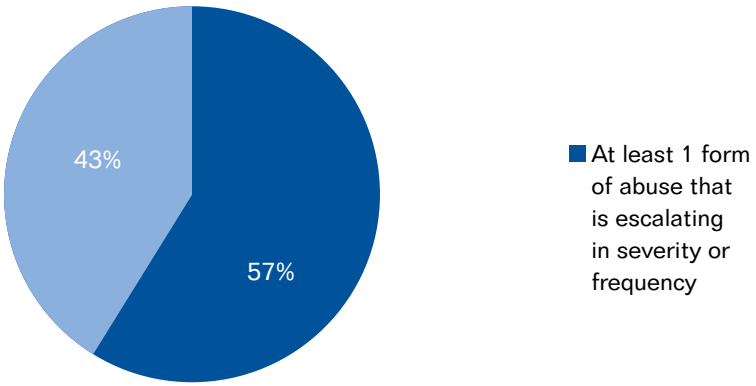


Figure 3: Proportion of the sample experiencing at least one form of abuse that is escalating in severity or frequency

Supporting other analyses of victims accessing advocacy services[7][19], **Figure 4** shows that most victims in this sample (86%) were experiencing multiple forms of abuse at the point of referral to an IDVA service. This clearly illustrates that more often than not, domestic abuse comprises a range of behaviours and acts that may be used in isolation or, more commonly, together in an attempt to harm or exert control over a victim.

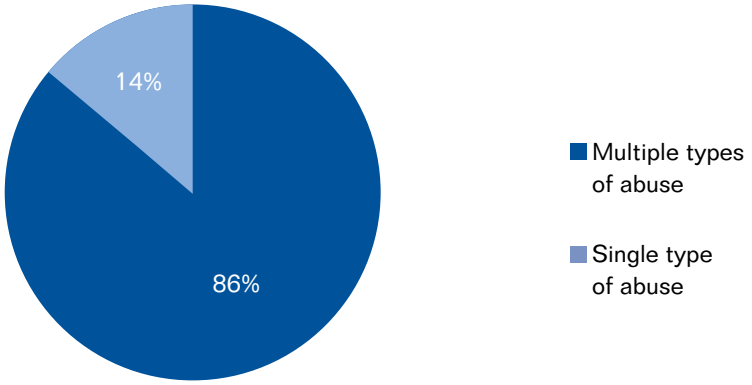


Figure 4: Proportion of the sample experiencing multiple types of abuse

Tables 1 to 4 display the frequency with which some of the indicators surveyed as part of the Risk Indicator Checklist (RIC, see Appendix 5)[30] were noted amongst this sample. Each of the 20 indicators comprising the checklist is known to be associated with the increased risk of future serious harm.

Table 1 details specific aspects of abusive behaviour known to be linked to an increased risk of harm or homicide. It can be seen that 51% of victims had experienced injuries as a result of the last incident of abuse and in 61% of cases, victims had been strangled or choked by their partner or ex-partner. In 62% of cases, threats to kill had been made against the victims, highlighting the extremely serious nature of abuse experienced by individuals with whom IDVAs are working.

Table 1: Specific features of abuse

Risk Factors	Frequency	Percent (N=2567)
Jealous and controlling behaviour	2333	91%
Escalation of abuse	1874	73%
Perpetrators' threats to kill victim	1582	62%
Victim has been strangled/choked	1559	61%
Current incident resulted in injuries	1309	51%
Stalking	790	31%
Sexual abuse that makes victim feel bad	729	28%
Use of weapons	567	22%
Perpetrators' threats to kill others	536	21%
Perpetrators' threats to kill other intimate partner	241	9%

[30]The Risk Indicator Checklist (RIC) used by the services in this research was initially developed in Cardiff for the use of Police officers in attendance at incidents of domestic abuse. The factors comprising the RIC were located following a review of 47 domestic violence homicides, relevant practice and academic literature and communications with community and criminal justice agencies (Robinson, 2004). The 20 indicators included in the checklist can largely be organised into broad factors relating to the perpetrators' aggravating problems (mental health issues, suicidal ideation or attempts) and criminal behaviour, current and recent abusive behaviour, and victims' feelings of fear and perceptions of future risk of serious harm and homicide. The checklist is often completed following an initial conversation with the victim, rather than in a survey style, where victims are asked to provide their answers in a serial fashion. The number of positively endorsed indicators is totalled in order to give a basic indication of the risk of significant harm that further abuse poses to victims.

Research on the assessment of risk in cases of domestic abuse emphasises the significance of victims' feelings of fear as a measure of how likely victims are to experience further abuse and injury[97][100][26][99].

Table 2 indicates that the vast majority of victims were fearful, both of sustaining further injury and of being killed, again confirming the high risk status of this group.

Table 2: Victims' appraisals of threat

Risk Factors	Frequency	Percent (N=2567)
Victim is afraid of further injury	2136	83%
Victim is frightened	2070	81%
Victim is afraid of being killed	1122	44%

Together, these findings point towards the extensive information about the possible range and levels of abusive behaviours experienced by victims that must be gathered, in order to build a comprehensive picture of the risk that each victim faces. This can then be used to direct the types of intervention strategies that might be mobilised on an individual victim's behalf. Importantly, different types of support and intervention strategies may be required depending on the types of abuse that a victim is experiencing[111][134][38].

In the majority of cases (73%), victims were not living[33] with their abuser at the point at which they were referred to an IDVA service **(Figure 5)**, and in 66% of cases, victims reported experiencing abuse at the hands of an ex-partner rather than a current partner **(Figure 6)**[34]. This is in line with other evidence which underscores first, that abuse does not inevitably cease with the termination of a relationship and second, that separation may represent a particularly risky time for victims when abuse may escalate in frequency and severity[135][136][137]. These factors, in particular, may shape the types of safety strategies that IDVAs may help victims to access; for example, target hardening[35] is less appropriate where the victim and perpetrator live under the same roof.

Relationship status was significantly associated with abuse type, where, as many other studies have shown, harassment and stalking were more frequent amongst those reporting the abuser to be an ex-partner or those who were looking to separate[39][40][41][42][6]. This was also the case for perpetrators' jealous and controlling behaviour. In addition, separated/separating victims also experienced more serious levels of abuse which is consistent with other studies that locate the time at which victims leave a violent relationship as extremely risky[136][44] (see Appendix 7 for full set of results). Conversely, those reporting the perpetrator to be a current, rather than ex-partner experienced physical abuse more frequently[36].

[31]It is noticeable that some of the figures derived from the RIC do not marry up exactly with those derived from the abuse grid and which are presented above. For example, stalking was experienced by 30% of victims (according to the RIC), although the figure relating to stalking and harassment derived the abuse grid was nearly 20% higher. This is likely because the abuse grid prompts IDVAs to think about all levels of harassment and stalking, whereas the RIC focuses only on more serious behaviour (stalking). Although the severe abuse that a victim may be experiencing may warrant primary attention, lower level abuse may be important to factor into safety plans. It is important that IDVAs are able to gather a picture of abuse that is as complete as possible in order to put together effective intervention strategies. The use of multiple information gathering tools, as were used here, may help to achieve this.

[32]It is known however, that a proportion of victims may fail to recognise the level of risk they face (Campbell, 2004) and thus the absence of fear should not be taken to indicate lower risk. Indeed, this may be where the completion of a risk assessment could be helpful for the victim, to bring the seriousness of their situation into focus (Campbell, 2004).

[33]Previously lived together and not living together.

[34]These figures are based on adjusted percentages to account for the large amounts of missing data (see appendix 3)

[35]Target hardening involves the provision of additional physical protection to a victim in their home. It may include the provision of alarms, panic buttons and new locks.

[36]A risk factor in this context is a characteristic that is linked with being subject to a particular type of abuse or to particularly serious levels of abuse. Whilst a risk factor may indicate groups of victims who are most likely to experience abuse, it does not necessarily represent the cause of abuse (Walby & Allen, 2004).

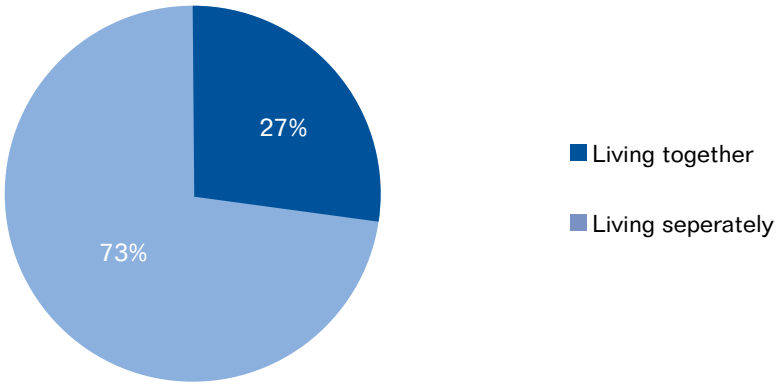


Figure 5: Living arrangements between the victim and perpetrator

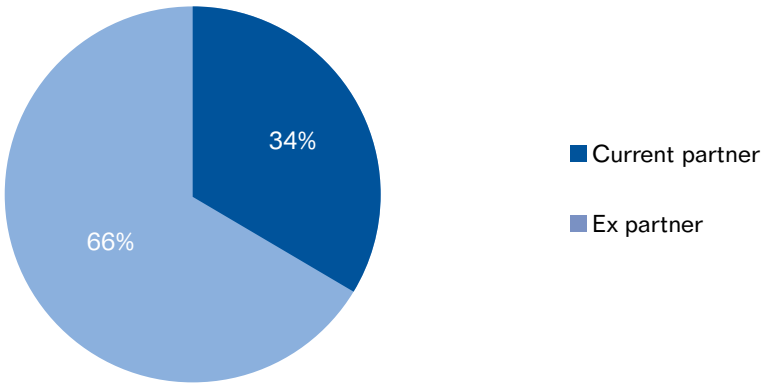


Figure 6: Victims' relationship to the perpetrator

These data showed that 25% of victims had accessed the IDVA service on at least one previous occasion. **Figure 7** further illustrates the chronic nature of the abuse to which most of the victims accessing IDVA services have been subjected. Nearly two-thirds of victims reported having endured domestic abuse for over 2 years, with the average length of time being around 5.5 years. Significantly, 20% of victims reported experiencing abuse over a period of 10 years or more.

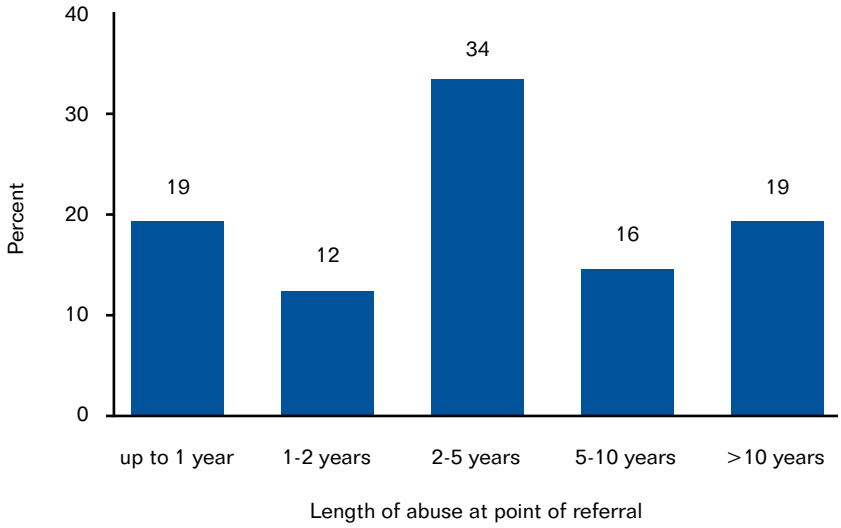


Figure 7: Length of abuse at the point of referral

The results presented thus far indicate that victims referred to IDVA services are typically experiencing chronic levels of extremely serious abuse, which is often getting worse at the point of referral, and which for many continues despite separating from their partners. Further, most were victimised in a number of ways, underscoring abuse as a pattern of behaviour which extends beyond physical abuse. Taken together, these findings suggest that IDVA services are indeed working with a group likely to be harmed or killed by an abusive partner or ex-partner, which in turn indicates that this intervention is reaching those for whom it was intended to help.

2. The profile of perpetrators

Table 3 contains information relating specifically to the behaviour and social problems of perpetrators associated with this sample. Although not the focus of this study *per se*, data gathered here as part of the survey of risk indicators provides important information about those responsible for the abuse.

Of the perpetrators, 50% had criminal records; half of which were for domestic abuse-related crimes. Perpetrators' substance misuse problems and mental health issues were also prevalent. Moreover, **Table 1** shows that in addition to the high proportion of cases in which threats to kill had been made against the victim, 21% of perpetrators had threatened to kill others and 9% had threatened to kill a previous partner[37].

Table 3: Perpetrators' criminogenic behaviour and aggravating problems

Risk Factors	Frequency	Percent (N=2567)
Perpetrators' alcohol abuse	1374	54%
Perpetrators' criminal record	1296	50%
Perpetrators' financial problems	1151	45%
Perpetrators' drug abuse	989	39%
Perpetrators' threats of suicide	904	35%
Perpetrators' mental health issues	713	28%
Perpetrators' DV related criminal record	669	26%

These findings, along with those from previous research, remind us that the perpetrator's own characteristics and behaviour are the strongest predictors of re-victimisation and serious harm of victims[24][19][17][138][139]. This last point is confirmed by the finding that perpetrator-related factors (eg, having a criminal record, substance abuse problems, etc) were found to be related to the higher prevalence of each type of abuse and the more frequent occurrence of relatively more serious levels of abuse (see Appendix 7).

Conferring with studies profiling perpetrators of serious abuse[194] [195], these figures paint a picture of a large proportion of perpetrators who are chronically aggressive and antisocial and, correspondingly, a group of victims who are particularly likely to be re-victimised.

[37]It is likely that these figures represent an underestimation given these figures reflect only those threats of which victims, IDVAs or other agencies were aware.

3. The socio-demographic profile of victims accessing IDVA services

The findings presented up until this point leave us with little doubt that victims accessing IDVA services are a high risk group who require immediate intervention to ensure their safety. However, victims are defined by much more than just the level of abuse they experience and, in fact, their lives may be marked by considerable diversity. This may apply in terms of their individual experiences of abuse, the broader context of risk which may be present for some, their existing strengths and resources, and their wishes and intentions relating to the abuse itself and the type of intervention that is sought. This Section presents some key data with respect to victims' socio-demographic profile[38]. Developing a more detailed picture of victims' profiles is a step towards gaining a more comprehensive understanding of both the differences and sources of commonality in the lives of those who are referred to IDVA services. This, in turn, helps us to better understand how intervention may need to be shaped to address the individual circumstances of these high risk victims.

3.1 Age

Most victims represented in this sample were young, with the average age being 33 years. This supports other findings which show that abuse is more likely amongst younger women[(47)(6)]. Nearly half of the sample (45%) were aged 30 or younger, although victims' ages ranged between 15 and 83 years.

3.2 Victims' ethnicity

Nearly a quarter (23%) of victims in this sample were from Black and Minority Ethnic (B&ME) communities, a figure that is significantly higher than either the national statistic[39] (11.5%), or the average representation of B&ME women in the communities of the participating services (14.4%). Indeed, each individual IDVA service was found to have a higher B&ME intake than might be expected based on the makeup of their local population. Studies show that whilst rates of domestic abuse vary little by race or ethnicity[(6)(140)], B&ME victims may encounter significant barriers when seeking help, which may increase their vulnerability to the effects of abuse[(141)(142)(143)(131)]. Thus, it should be viewed as a positive finding that the proportion of B&ME victims accessing services was higher than expected, indicative of IDVA projects being accessible to local minority communities.

There was little variation in the type or severity of abuse across B&ME and white British victims, with the exception that B&ME victims reported higher rates of sexual abuse (28% versus 22%). This is surprising given discussion in the literature that B&ME groups may find it particularly difficult to disclose sexual abuse[(81)], although this finding replicates that of an earlier evaluation undertaken in Wales[(19)]. Further investigation found that this difference was not accounted for by relationship status (i.e. a higher level of current relationships amongst B&ME victims), and thus one possibility is that different cultural norms around sexual behaviour explain the more frequent reporting of sexual abuse, although without further investigation this rationalisation remains speculative.

3.3 Additional sources of vulnerability in victims' lives

These results show that nearly half of victims accessing IDVA services may have had potentially limited access to their own economic resources given that they were not currently employed at the time of intake[40]. Rates of drug and alcohol use were calculated as 6% and 12%, respectively[6], and 11% of the sample was registered as disabled because of some form of physical, sensory or learning disability. In addition, a small group of victims were noted as having insecure immigration status (3%)[6].

[38]Owing to a high degree of missing data, the figures reported in this section are adjusted for missing data. A full breakdown of unadjusted and adjusted figures can be found in Appendix 6.

[39]Figures are calculated using the 2001 Census and it is acknowledged that these may no longer be representative of the ethnic makeup of particular regions.

[40]This includes victims who were homemakers, students, retired and receiving benefits.

As described earlier in Chapter 2, each of these factors represents an additional source of vulnerability which may magnify the effects of domestic abuse. These figures highlight that for a number of victims, abuse occurs in combination with other sources of vulnerability that IDVAs will need to consider in order that the strategies that they implement have the maximum impact on victims' safety. This point is underscored by the finding that abuse was found to be more frequent and severe for victims reporting additional sources of vulnerability such as insecure immigration status, unemployment and other problems (substance misuse, disability, etc., see Appendix 7).

It is of note that, in general, the quality of data collection around these issues was poor. Although figures were adjusted to take account of missing data, it is likely that these statistics represent underestimates of the level of need characterising this sample. Moreover, poor data recording around the frequency of these issues may signal the need to raise awareness of the value of routine questioning with respect to particular areas of vulnerability.

This information helps us to understand more clearly who is referred to IDVA services. These results indicate that despite the common experience of severe levels of domestic abuse, the socio-demographic profiles of this group of victims is fairly heterogeneous. This is true in relation to age, ethnicity and employment status. In particular, these data illustrate the additional factors, besides those relating directly to abuse, that need to be taken into consideration when IDVAs are planning the most appropriate and effective package of support to keep victims safe. Having said that, low rates of recording around these issues highlight the difficulties of disclosure and perhaps suggest that IDVAs may require additional support to identify and respond to particular issues in victims' lives such as substance misuse, mental health issues and resources/benefits. Finally, these findings suggest that IDVA services are accessible to groups who historically, have been marginalised in terms of service provision, such as B&ME victims and those with substance misuse problems.

4. The nature of the risks facing the children of these victims

The majority of victims in this sample (69%) had children, and in total around 3600[41] children are represented by this sample of victims, highlighting the potentially huge number of children across the UK living in family environments marked by serious levels of abuse. Analyses undertaken to examine the link between victims' socio-demographic characteristics and the type and level of abuse experienced revealed that the presence of children was related to the higher prevalence of each of the 4 types of abuse surveyed as part of this study, as well as the more frequent occurrence of more severe levels of abuse (see Appendix 7). These findings highlight that IDVAs are supporting victims whose children are likely to have been exposed to the most extreme cross-section of abusive behaviours.[48][144][145][146][147][148][149][150].

Table 4 highlights the direct risks to children's safety and wellbeing that were noted in this sample. Over a quarter of victims (27%) with children were fearful that they would be directly harmed and in 11% of cases the perpetrator had actually made threats to kill children. When considered alongside the generally elevated risk of child maltreatment in the context of domestic abuse[48][148], and the prospect that children may be caught in the 'crossfire of violence' (both inadvertently and/or as they try to intervene)[151], these

[41]Detailed information on children (other than the presence of children and the number of children) was collected separately from victim information. It was therefore, not possible to match children's records with victims records and information and the figures presented here may include children of victims not included in the final sample used for detailed analysis. This information should be used as an indication only.

figures present a stark picture of the direct threat that domestic abuse poses to children's physical wellbeing.

Table 4: Child related risks

	Frequency	Percentage of those with children (N=1774)
Conflict around child contact	725	41%
Victim is afraid of harm to children	476	27%
Perpetrators' threats to kill children	199	11%

Even where the direct risk to children's physical wellbeing may not appear to be significant, many children may be at risk of psychological harm as a result of their exposure to domestic abuse[147][152][54][153]. Problems and conflict regarding child contact arrangements were prevalent in this sample and children may be particularly distressed when they perceive themselves as a cause of conflict, as is undoubtedly the case when they see their parents embroiled in battles over how and when to see them[154][155][54][153]. Prolonged child custody battles and contact visits may also represent an opportunity for perpetrators to maintain contact with and continue to abuse their partners or ex partners, further exposing children to risk [156] [157] [158] [159]. Child contact issues have also been noted as a precipitating factor in a number of domestic homicides [29].

Given that a high proportion of victims were aged 30 years or less, it was not surprising to find a high number of very young children reflected by this sample. Of note is that a third of children were aged between 0-4 years (**Figure 8**). *Combined with what we now know about the average abusive relationship continuing for 5.5 years, it is reasonable to conclude that a significant proportion of children have been living with abuse their entire lives.*

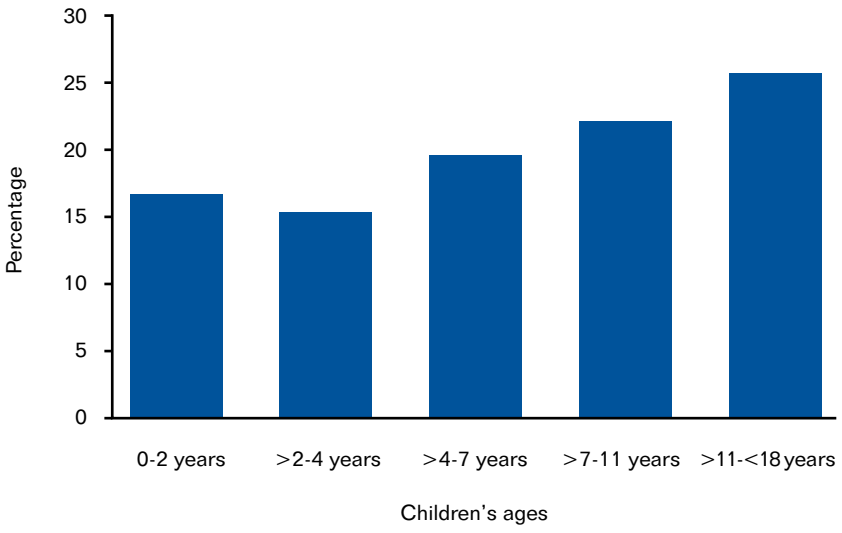


Figure 8: Age range of victims' children

Although domestic abuse is known to adversely affect children of all ages, exposure to traumatic experiences (such as exposure to domestic abuse) during these early years (0-4 years) can be extremely disruptive to children's emotional, behavioural and social development [145] [146] [147] [153] [149]. Furthermore, this is a critical stage during which children's brains undergo rapid growth and change, and exposure to stress during this time may lead to disruption and changes in children's neurobiological development. It is thought that changes in children's brains as a result of trauma may, in part, underpin the many

[42]The amended definition of significant harm (s.120 Adoption and Children Act 2002) now includes the 'seeing or hearing the ill treatment of another' as potential child protection issue.

emotional and behaviour problems that children may exhibit in the context of exposure to domestic abuse (behaviour problems, depression, anxiety; [160] [161]).

These results indicate that a large group of children are living in households where extremely serious levels of domestic abuse are being experienced by a parent (usually their mother). Most strikingly, over half of them will have been living with such abuse since birth. Consequently, it is likely that a substantial proportion of these children are at risk of significant harm – both physical and psychological. An even larger group of children (than those who meet the threshold of significant risk) are likely to experience problems that, whilst not reaching the level of clinical diagnosis, may make it more difficult to function in everyday life and which could potentially lead to longer term problems in adolescence and adulthood.

5. Summary of key points from Chapter 3

1. **The abuse experienced by victims accessing IDVA services was extremely serious.**
   - The large majority of victims (76%) were experiencing at least one form of severe abuse.
   - Most victims (86%) were experiencing multiple forms of abuse, underscoring domestic abuse as a pattern of behaviour rather than physical violence per se.
   - Actual or intended separation was found to increase the potential risk faced by victims.

➢ **The very serious nature of abuse experienced by victims in this sample along with the high prevalence of factors linked with increased risk of serious harm and homicide indicates that the intervention offered by services participating in this study were well targeted.**

2. **The limited information gathered with respect to perpetrators indicates that a substantial number of those committing severe levels of abuse are chronically aggressive and antisocial.**
   - 50% had a previous criminal record.
   - 54% abused alcohol and 39% abused drugs.
   - 28% had mental health issues.
   - Where these factors were noted, victims were more likely to experience extremely serious levels of abuse.

➢ **Effective co-ordination between victim- and perpetrator-focused service providers is required in order to enhance the efficacy of victim-focused services.**

3. **There were commonalties but also differences in victims' socio-demographic and background characteristics.**
   - Most victims were young, but victims' ages ranged from 15 – 83 years.
   - The majority of victims had children (69%).
   - 23% of victims were from B&ME communities, a higher than expected representation based on the communities from which this sample was drawn.
   - Some victims reported additional sources of vulnerability which, in turn, increased the risk of the harm they faced.

➢ **Services were accessible to groups of victims who are known to encounter barriers to their help-seeking efforts, for example B&ME victims and those experiencing additional sources of vulnerability (eg disability).**

➢ **The breadth of victims' needs must be comprehensively addressed by IDVAs in order to optimise the impact of intervention on safety.**

4. **The majority of victims accessing IDVA services had children, the large proportion of whom were of Primary school age or younger.**
   - The presence of children was associated with an increased risk of harm to victims.
   - In a worrying number of cases, direct threats to children's safety and wellbeing were noted:
     - In 41% of cases involving children, there was conflict over child contact,
     - In 27% of cases involving children, victims were afraid that children would be harmed,
     - In 11% of cases involving children, there had been direct threats to kill the children.

➢ **Given the very serious nature of the abuse experienced by this sample (and that those with children experienced comparatively more severe abuse than those without children), it is likely that many of these children are at risk of physical and psychological harm. Many more children may experience significant problems that do not meet the threshold of clinical concern, but which nevertheless are disruptive to children's healthy development.**

6. Implications for practice and policy

1. **The diversity in victims' profiles (abuse and demographic), the risks to children and the profile of those perpetrating the severe level of abuse described here clearly documents the need for a comprehensive, co-ordinated multi-agency response to domestic abuse that addresses the safety of the adult victim and the risks posed to children. In order to maximise the impact of the intervention that IDVAs provide on victims' safety, it is crucial that IDVA services:**
   - Are skilful in engaging with victims who may find it difficult to accept help given the severity of the problems that they are experiencing.
   - Build a comprehensive picture of the types and levels of abuse affecting victims, ensuring that all forms of abuse can be equally well addressed.
   - Have a clear understanding of effective ways of responding to different types of abuse and which agencies are able to deliver these. Some strategies and interventions will be more appropriate for one type of abuse compared to another (see Chapter 4 for evidence that IDVAs tailor intervention around abuse type).
   - Be well equipped to deal with specific cultural issues relating to particular minority ethnic groups.
   - Have a clear understanding of the additional risks present in victims' lives that may compound the effects of abuse and that, if not addressed or factored into safety plans, may stand in the way of safety.
   - Have adequate training to properly identify these issues and, in turn, strong links with specialist services that may be best placed to address specific problems.
2. **The impact that IDVAs can have on victim safety and wellbeing may be enhanced by co-ordinating their practice with services working directly with perpetrators. It is essential that these services address factors that are known antecedents of abuse along with issues such as substance misuse. In order to achieve this IDVA services will need to:**
   - Work in close partnership with generic agencies such as Police and Probation, as well as specialists in relation to substance misuse and perpetrator programmes in

order to ensure that they provide an integrated and comprehensive response to victims of domestic abuse.

- Utilise existing processes such as Multi Agency Risk Assessment Conferences (MARACs) that provide the opportunity for more integrated working with these agencies.

3. **Under the remit of their existing role, IDVAs have a pivotal part to play in ensuring the safety and wellbeing of the children of high risk victims by:**
   - Working to end the violence against the non-abusing parent (usually the mother).
   - Ensuring that all children of high risk victims are flagged to the appropriate statutory bodies which are involved in the safeguarding of children, in order that risks to children can be fully assessed.
   - Working with the non-abusing parent to help them understand the impact of domestic abuse on their children and what they can do to protect them.
   - Working in close partnership with services to support children.
   - Helping victims to respond to applications for contact made by the perpetrator, collating and articulating evidence of abuse, and implementing safety measures and plans around contact visits.

Putting it into context:

Linda is a 31 year old white British woman, with 2 children, a boy of 9 and a girl of 17 months. She had been with her partner for 5 years and had recently separated from him because of the extreme abuse he had subjected her to during their relationship. During the most recent incident, her ex-partner (and father of her youngest child) subjected her to a severe attack where he used a cricket bat to beat her; he also raped her. This incident was witnessed by the children, the eldest of whom called 999. The Police referred her case to the IDVA service, which began working with her in January 2007.

(This case study is an illustrative example based on the details of an actual case included in the study sample)

Chapter 4: Key Features of IDVAs' Work

This Chapter draws on data collected from 1,249 victims on a second occasion (Time 2)[43], following a period of engagement with IDVA services and seeks to explore the nature of the work which IDVAs undertake with high risk victims. The data from this Chapter showed that:

1. IDVAs offered short to medium term intervention to the majority of high risk victims referred to their services.
   - A majority of victims (57%) remained engaged with IDVA services for at least 4 months or until the closure of their case. On average IDVAs worked with victims for 3 months.
   - In general, victims engaged with IDVA services largely irrespective of the nature of the abuse they suffered or other issues present in their lives, however, there were some factors that increased the chances that victims would disengage from services (e.g. escalating abuse, fear of being killed, and perpetrators' criminogenic behaviour).
2. IDVAs helped victims' to access a wide range of interventions to increase their safety, some of which addressed victims' wider support needs and areas of vulnerability.
3. IDVAs were delivering a response to victims that was informed by providing multiple services in combination with intensive support.
   - In 87% of cases, victims were helped to access multiple services, with the average being 4.
   - In 65% of cases, victims received concentrated support from an IDVA.
4. IDVAs provided intervention that was tailored around the nature of the abuse being experienced by victims, as well as their individual circumstances.

As was shown in the previous Chapter, victims in this sample were experiencing very severe levels of abuse, but that as a group they had potentially diverse needs. Chapter 3 also highlighted a range of risk factors relating to the perpetrator's behaviour as well as the added complexity of addressing safety for those victims with children. These findings suggest that any effective service will need to offer a comprehensive range of interventions, involving the co-ordinated efforts of many agencies and tailored support according to each victim's individual needs and circumstances. Additionally, the severity of the abuse experienced by these victims implies that the provision of focused and intensive support will be required in order to help victims move towards safety. With a view to understanding whether this is the type of service that is actually being delivered to victims, the aim of this Chapter is to describe the key features of IDVAs' working practices. Specifically, it examines: (1) the engagement of victims with IDVA services; (2) the type and amount of interventions mobilised for victims; (3) the utilisation of multiple interventions and the level of intensity with which IDVAs work with victims during the course of their case; and (4) the extent to which IDVAs deliver a flexible response to victims that is tailored around (a) their abuse profiles and (b) their socio-demographic characteristics.

1. Victims' engagement with IDVA services

It was found that the majority of victims (57%)[44] remained engaged with services for at least 4 months or until their case was closed (see Appendix 8 for more detailed discussion of sample retention). This is an important finding from a practice point of view given that very serious levels of abuse, high levels of fear and the presence of other support needs may make it difficult for victims to engage with any type of helping service in a consistent way, or for any length of time. Therefore these data give some indication that the intervention provided by IDVAs was well

[43]Quotes and statistics derived from exit interviews undertaken at the closure of a case are highlighted throughout the text. Further consideration is given to these data in the following Chapter and the full results table is located in Appendix 10.

[44]This figure is derived from the first 21 months of data to give a more accurate reflection of retention rates, given that some of the cases opened in the latter stages of the data collection period would have been too 'new' to warrant the collection of data on a second occasion.

received by victims (although this is only an indirect measure)[45].

A sizable group of victims (43%) did, however, disengage from services and it is useful to determine whether there were any systematic reasons accounting for this finding[46]. This knowledge might be usefully drawn on by IDVAs to determine where extra effort may be needed to prevent particular victims from dropping out of the service. Rates of disengagement did not differ according to victims' socio-demographic profile. For example, B&ME victims were no more likely to disengage than were White British victims (see Appendix 8 for a full set of results). This was also broadly the case with respect to the type and level of abuse that victims experienced. In other words, the cases with whom the IDVAs did work were no less serious than those that disengaged[47].

We did, however, identify a few specific factors that were associated with a higher chance that victims would disengage from services, and of which IDVAs should be mindful. In particular, special attention may need to be directed at keeping engaged those who report escalating abuse and who are fearful of being killed, to cases in which the perpetrator is known to have a prior history of criminogenic behaviour, and where the victim reports there have been threats to kill a previous intimate partner (or there is information gathered from other sources to suggest this is the case). This may require work with the agencies that specifically manage these aspects of perpetrator behaviour, again indicating the importance of coordinating services for victims and perpetrators.

On average[48], IDVAs worked with victims for around 3 months, with the largest number of cases closed after a period of between 1 and 4 months. This time frame is consistent with a crisis intervention approach, where it is proposed that the most pressing problems can be resolved in around 1-12 weeks [90]. This is not to suggest that victims are safe *per se* after this time, indeed, the first six months following both the termination of an abusive relationship and the receipt of intervention is a risky time for victims, especially for those who are making concerted and visible efforts to leave their violent partners [139] [17]. However, in a number of cases (22%) support extended beyond 6 months, suggesting that whilst on the whole IDVAs adhere to a crisis model, there is flexibility around the time frame for support where necessary (eg where an IDVA is supporting a victim through a lengthy criminal court case).

In summary, these results show that in line with recommended practice, IDVAs adhere to a crisis model of working, offering relatively short-term intervention in most cases. They also show that of the victims who were initially referred to services, most remained engaged for a significant period of time, despite the very high level of abuse they were experiencing. On the whole, it seems IDVAs were able to keep victims engaged with the service irrespective of the severity of abuse or the presence of other issues in victims' lives, providing an indication that all groups of victims were equally well served by this intervention. However, some specific factors relating to the behaviour and problems of perpetrators were found to increase the chances that victims disengaged from services. This knowledge may help IDVAs to focus on the need to work in partnership with other agencies and target resources more effectively towards those hard to reach victims.

[45]Other studies have sought to survey victims directly as to their satisfaction with advocacy services. Robinson (2003) found that 99.5% of victims were satisfied or very satisfied with the support they had received. Further research is required to understand victims satisfaction with IDVA services and the factors that may moderate satisfaction i.e. the extent to which service provision met with victims help seeking priorities.

[46]We are not able to determine how much intervention, if any, these victims received before disengaging.

[47]This is significant from a research point of view as it provides some confidence that findings relating to the impact of IDVA services on safety (discussed later) are not simply a function of outcome assessment undertaken on the least severe or least complex cases.

[48]The median was used as the measure of central tendency, given the very large spread in case length which may serve to distort the mean (average) value.

2. Types of interventions provided by IDVAs

The wide range of resources that IDVAs mobilised[49] on behalf of victims is evident from the results displayed in **Table 5**[50]. However, before turning to discuss the frequency with which victims were helped to access 1) safety planning, 2) short and longer term safety strategies, and 3) measures addressing wider support needs, it is pertinent to highlight several issues that are relevant to the interpretation of these data:

- IDVAs were asked to indicate the support they provided to victims although questions relating to support were not consistently phrased and little guidance was offered at the outset of this project pertaining to the exact definition of 'support'. Therefore, in some instances it was difficult to determine the extent to which an issue or intervention was discussed but not accessed, and the extent to which it was actually mobilised on a victim's behalf. Starred items in the Table denote where there is some ambiguity with respect to the support that was received.
- The numbers presented in **Table 5** relate to the frequency with which particular remedies or agencies were mobilised as a component part of the intervention that IDVAs provide. However, data were not systematically gathered with respect to the level of need around each issue (either from an IDVA's or victim's perspective). Presumably any single option was not viable or applicable in each and every case, and thus it is difficult to determine to what extent the figures in **Table 5** represent good IDVA practice (tailoring around need) or 'gaps' in service delivery. The demographic profile presented in Chapter 3 gives us some sense of the prevalence of particular issues and the extent to which one might expect to see these addressed, although this really only presents a proxy measure. Thus where assessments are made as to the extent to which particular options were utilised, this is based on previous research and experience but nevertheless remains speculative.

Table 5: Frequency of support

Interventions (n=1247)	Freq.	%
Safety planning undertaken	1005	81%
Support in relation to a criminal court case	534	43%
Support with civil justice remedies	315	25%
Subject to MARAC	426	34%
Support with housing issues	615	49%
Access to target hardening†	375	30%
Access to sanctuary scheme	168	13%
Support to access refuge accommodation*	160	13%
Support in relation to child contact††	443	51%
Support with Social Services*††	232	27%
Support with children's schools*††	63	7%
Support with benefits*	202	16%
Support with immigration issues*	30	2%
Support to access a GP*	95	8%
Support to access mental health services*	84	7%
Support with alcohol and drugs issues*	72	6%
Support to access counselling*	400	32%
Completed pattern changing course	125	10%

*Possible ambiguity around the meaning of 'support', † Target hardening and the Sanctuary schemes are terms often used interchangeably by the IDVA, however they appear separately in this table as they were included as discrete options as part of this study, †† Percentages are based on those with children (n=873).

[49]For the sake of consistency throughout this report, the action of addressing particular issues or mobilising particular services is attributed to the IDVA. However the support received by victims most probably reflects both the strategies suggested by IDVAs in response to particular risks and needs and also victims' express intentions with respect to the services they wish to access.

[50]The data collection module did not contain an exhaustive list of options that could have been pursued by IDVAs on the behalves of victims. Thus this table only represents a snap shot of the resources required, and accessed by victims and there are likely some gaps in the aspects of service that were surveyed.

2.1 Safety planning

The one exception to this rule, however, is safety planning, where it is reasonable to expect that a *formal* safety plan[51] is put together in 100% of cases where victims engage with a service, especially as there is evidence that victims adopt safety behaviours after as little as 20 minutes and that this measure alone may help to facilitate reductions in abuse over time [102] [103].

These results show that whilst safety planning was the most frequently delivered form of support, it was not undertaken in 19% of cases. Each of the victims included in this sample had engaged with a service until the closure of their case or for at least 4 months. Therefore, it should not have been the issue that there was little opportunity to undertake this activity. It is, of course, possible that this simply represents an omission in recording or that in these instances safety planning was addressed in an informal way (rather than not at all) throughout the course of the case as issues arose, and where this was the case it was not classed as a specific intervention that the IDVA had delivered.

Whilst it is prudent to return to a *formally developed* safety plan on a regular basis, in order to reflect changing risks in a victim's life, information and advice that is delivered in an ad-hoc and piecemeal way may reduce the chances that a victim is able to draw on it quickly at a time when information processing skills may be impeded by fear. It might also be argued that other remedies and interventions put in place for a victim (e.g. civil injunctions) constitute safety planning. However, whilst a critical part of the wider strategy to improve safety, none of these other interventions fulfil the specific function of addressing the practical actions that victims themselves can take in the immediate term or in an emergency to enhance their own, and their children's safety.

Victims interviewed on their exit from the services most commonly attributed their feeling of safety to changes in their housing situation.

2.2 Short and longer term safety strategies

43% of victims sought advice with respect to criminal court proceedings and 25% sought advice concerning civil justice remedies, such as injunctions. These figures indicate that although a substantial proportion of victims wish to seek (or are encouraged to seek) legal remedies or sanctions as a means of dealing with domestic abuse, many do not. This in turn signifies that exclusive focus on improving the criminal and civil justice response to domestic abuse, (as has been the emphasis in years gone by), cannot adequately provide the comprehensive response that victims require, although there is no doubt that these constitute important elements of this response [16]. Instead, partnerships between criminal justice agencies, civil law and other agencies such as health, housing and social services are required to provide a response that meets the breadth of victims' needs [131]. As has been discussed, IDVA services are seen as crucial in forging and maintaining these links [18] [19] [162].

The MARAC (Multi-agency Risk Assessment Conference) plays a principal role in creating and strengthening the multi-agency framework in which IDVAs may work most effectively. 34% of cases in this sample were reviewed at MARAC, which is reflective of the level of coverage for high risk victims observed nationally [163]. MARAC is specifically targeted at the most serious and complex cases. Given that all of the victims comprising this sample were deemed to be 'high risk' (and each of the areas had an operational MARAC, although in some areas it was not operational for the full period of the evaluation), then 100% of

[51] A formal safety plan reflects that which is developed in the company of the victim as an explicit course of action or set of measures to be taken in an emergency situation or to reduce immediate risks to safety. For example, it may include ensuring that a victim has a mobile phone with the relevant numbers programmed in, informing the neighbours to contact Police if the perpetrator is spotted, or a disturbance heard, or ensuring that a child's school is aware of designated adults who are allowed to collect their children.

cases could be expected to have met these criteria[52]. This result suggests that there are not the resources available to deliver this enhanced level of multi-agency intervention to all that need it, and this finding may focus attention on the need to capacity build in this area in order to ensure that this type of response is available to all victims assessed as being at risk of significant harm or homicide.

IDVAs supported nearly half of all victims (49%) with respect to general housing issues, although information was not gathered as to what this support entailed (direct work, referral etc). Target hardening[53] was also successfully applied to 30% of victims' homes and Sanctuary was applied in 13% of cases. Overall, some form of support was mobilised with respect to housing issues in 65%[54] of cases (not shown in table). It is difficult to comment on the extent to which the level of support offered met the extent of victims' needs. However, the frequency with which support was mobilised around housing-related issues (as opposed to refuge, 13%), suggests that this is a primary issue for victims to address and, where possible, victims desire to consider ways in which they may be able to stay safely in their own homes. Of course, for victims for whom this is not a possibility, refuge accommodation is an essential option.

Just under half (44%) of those victims with children were given assistance relating to child contact arrangements. Issues around children represent a primary concern for victims who have them [(16) (107) (26)], with fears for children's wellbeing often cited as the reason that victims sought help in the first instance. Importantly, the frequency with which support was offered around child contact mapped directly against the frequency with which this issue was noted as being a problem for victims at the outset of case (see Chapter 3)[55] showing, as far as is possible to say here, that this specific area of need was well addressed by IDVAs.

2.3 Victims' wider support needs

The previous Chapter showed that nearly half of the sample may have had potentially limited access to economic resources , yet the figures presented above indicate that only 16% of the engaged sample received support to access appropriate benefits. Given that victims' financial dependency on the abuser is cited as a primary reason for return to an abusive relationship, and that financial hardship may be a result of leaving [(60) (164) (165)], then a discussion of the welfare benefits available to victims, even for those who are employed or have their own money, may be prudent. It is likely that this requires specialist training and a greater awareness of where it is appropriate to refer victims for this type of advice and support.

It is also noteworthy that the degree to which victims were helped to address health issues or access health-related services was relatively low (GP: 8%; mental health issues: 7%; drug and alcohol issues: 6%), especially as it is highly unlikely that victims subjected to such extreme levels of abuse would not experience any physical or psychological health consequences as a result. We would have expected a higher degree of health-related referrals, but we cannot know for certain exactly how many of the victims in this sample

[52]It is possible that some of the victims with whom IDVAs were working had been referred directly from the MARAC itself and thus a slightly higher proportion of victims would have used for this service that was recorded here.

[53]Sanctuary and target hardening schemes were developed as a form of homelessness prevention, and are usually funded by central Government. Target hardening involves the provision of safety features such as locks, alarms and/or security lighting, whereas sanctuary schemes involve setting up a 'safe room' within the property with reinforced doors and locks, alarms and CCTV and is designed to be a safe place to wait for the police. These terms are sometimes used interchangeably to describe any physical safety measures that are applied to the home.

[54]Some victims received more than 1 form of support relating to housing (i.e. general advice and target hardening. Therefore this statistic does not represent the total of all three figures relating to housing interventions.

[55]This figure relates to the larger Time 1 sample. Reference to Table 8 in Chapter 5 shows that the proportional frequency with which this issue was noted did not differ substantively between the two samples described as part of this report.

[56]For example, victims who were unemployed, students, retired, or homemakers. This figure relates to the larger Time 1 sample. Reference to Appendix 6 shows that the proportional frequency with which this issue was noted did not differ substantively between the two samples (intake vs. reviewed samples) described as part of this report.

needed, but did not receive intervention around these issues. Furthermore, as noted below, over a third of victims received support in accessing counselling services which could be expected to address some of these issues and may reflect local availability of services.

'[She] is now in more control of her life since dealing with her addictions'

There are many possible ways to interpret this finding. First, it may be that addressing victims' health needs is seen as a 'second level' response, to be dealt with after risk has been reduced. Second, perhaps some victims are able to access health services without the help from an IDVA. It may also be (as discussed in Chapter 3), that these low numbers reflect limited screening around these issues or indeed difficulty for victims in disclosing information. Another possibility is that these findings indicate the lack of available local services to which to refer victims with particular issues (eg substance misuse). This finding reiterates the need for more focused attention on, recognition of and screening for health-related concerns, as well as the need to strengthen links with generic and specialist health services to ensure that IDVAs are able to make appropriate referrals.

'Victim feels safer now and is receiving support/counselling from university as a result of what's happened'

Finally, it can be seen that a number of victims in this sample received referrals to counselling (IDVAs were not required to specify the precise nature of the issue addressed by counselling) and 'pattern changing' interventions[57] (32% and 10%, respectively). IDVAs aim to provide a crisis like model of intervention, where the primary task is to attend to the physical safety of victims and their children. It is not recommended, therefore, that referral for counselling or similar forms of support takes precedence over other more immediate forms of intervention that explicitly address safety – especially where victims remain in abusive relationships or risk remains high [(129)]. However, it is not clear at which point these services were offered, and it may have been that referrals to these services were made towards the end of cases, *when risk had been sufficiently reduced,* which would be consistent with IDVAs facilitating access to the next level of care for victims, as is the secondary aim of a crisis response.

Overall, these results show that IDVAs help victims to access a wide array of intervention strategies, addressing both the abuse they are experiencing and, to some extent, those issues in victims' lives that are not always related directly to abuse but may attenuate the impact of intervention if left unaddressed. These results also raise the possibility of some gaps in service provision, although as has been reiterated throughout this chapter, it is extremely difficult to draw anything other than tentative conclusions given that there was a lack of direct measurement of victims' needs (at the outset of a case) undertaken as part of this study. Nevertheless, some of the potential issues identified here merit further discussion with commissioners, service managers, practitioners, partner agencies and those involved in setting the training agenda for IDVAs, if only to rule out the possibility of underutilisation.

[57]A 'Pattern changing' course usually refers to group work undertaken to explore the nature of domestic abuse, personal experience and feelings of empowerment. Feedback from IDVAs gathering these data suggest that this option may have been endorsed when victims attended any type of support group, course or family intervention to explore the impact of the abuse they had experienced.

3. Multiplicity of interventions and intensity of support

Whilst each of the individual elements of intervention discussed above may offer some degree of success in reducing the risk of harm to victims, there is a general acceptance that interventions founded on the provision of a multi-agency response represent the most efficacious way of enhancing the safety of victims experiencing severe domestic abuse [20] [17] [166]. The intensity with which advocacy is delivered is also known to be important, with intensive interventions significantly increasing the likelihood of victims achieving safety [101] [129] [125].

'The 'intake' and subsequent 'review' [forms] have helped to structure the paperwork necessary around working with clients' IDVA

Figure 9 indicates that in 87% of cases, victims were helped to access multiple services or forms of assistance. In most cases (57%), between 2 and 5 types of intervention or assistance were mobilised, with the average being 4[58]. These findings are consistent with other work detailing the volume of services that victims are helped to access and provide evidence that, for the large part, IDVAs facilitated a multi-agency response in order to meet the spectrum of victims' needs [7] [19].

There were, however, 13% of cases in which none or only single forms of additional intervention or advice were mobilised on top of the contact that victims had with IDVA services. There may be significant variation in victims' readiness to take action towards ending the abuse [118] [117] [167] and victims who are in the earlier stages of recognising and addressing their situations may be less willing to engage with other services in addition to the contact they have with an IDVA.

It could also be a possibility that, given the heavy case loads that IDVAs tend to carry, it is simply very difficult to ensure that all victims receive access to an extensive range of services. IDVAs themselves reported that as time progressed, the data they collected as part of this study allowed them to review with ease, and on a regular basis, the support that had been mobilised for victims, helping them to clearly identify what to do next. Thus, systematic case reviews undertaken at regular intervals may help overstretched IDVAs to identify those victims who have received access to a smaller number of interventions to date (see Chapter 6).

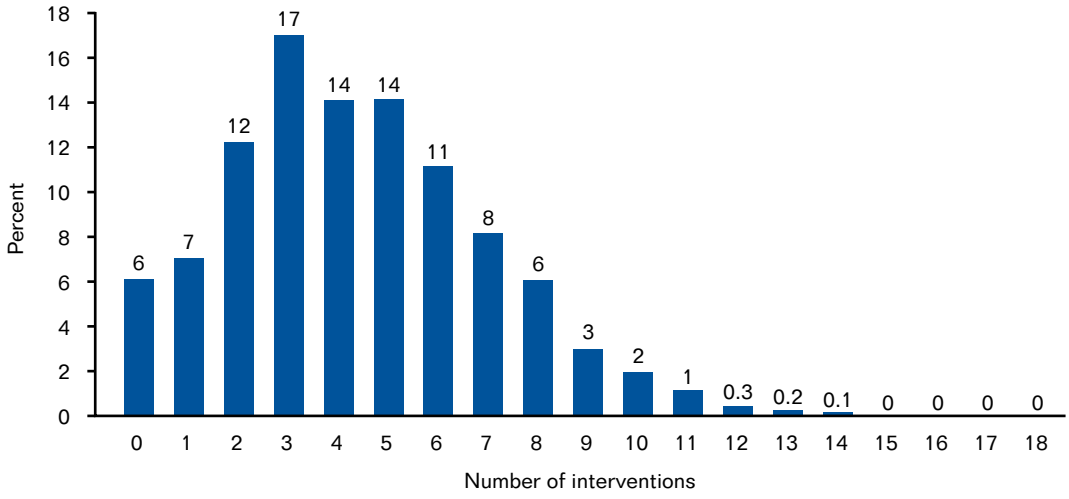


Figure 9: Number of interventions mobilised on behalf of a victim

[58]It is likely that this is an undercount because IDVAs were only able to indicate the types of support offered from a closed list of options. For example, this list did not include supportive services for children or referral to specialist B&ME services.

Figure 10 indicates the intensity of support provided to victims. IDVAs were asked to indicate the level of contact that they had with each victim with whom they worked. These results show that around two-thirds of the sample (65%) received quite a high level of support from an IDVA (>5 contacts or intensive support)[59]. The remaining third did not, receiving fewer than 5 contacts during the course of their case. Again, this may be an issue arising from victims' readiness to accept support towards ending the abuse they are experiencing, with those at an earlier stage finding it more difficult or are unwilling to engage on any intensive level [(16)]. It may also be the case that IDVAs simply do not have the capacity to work intensively with each of their clients and are thus forced to prioritise to whom they offer more support (see Chapter 4)[60].

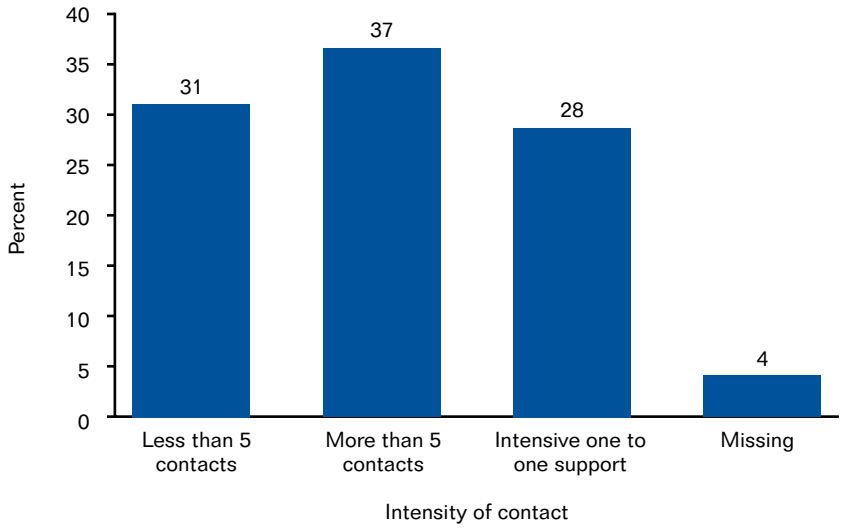


Figure 10: Intensity of support provided by IDVAs

In summary, the results presented here and in the preceding Section of this Chapter show that for the bulk of cases, IDVAs were working in the ways anticipated to be most successful in enhancing victims' safety: offering a wide range of solutions and providing multiple resources, and a concentrated level of support. Indeed, findings presented in Chapter 5 show that victims' safety and wellbeing was directly linked to these particular facets of the IDVA's work, with the receipt of multiple interventions and more intensive support increasing the chances of positive changes in victims' lives. The next Section illustrates the potential of these interventions to be tailored around each victim's unique personal circumstances.

[59]These categories are not mutually exclusive and thus interpretation of what differentiates more than 5 contacts from intensive support is ambiguous. For this reason these categories were collapsed for the purposes of analysis and discussion.

[61]These results are based on bivariate analyses that explore the association between 2 factors. Victims are of course defined by multiple characteristics, and thus it may be somewhat artificial to look at the relationship between one aspect of their profile and the intervention offered or received, without considering the many other factors that may also have a bearing on IDVAs' judgement of the most effective course of action and victims' help seeking priorities.

4. The provision of intervention tailored around victims' safety and support needs

Regardless of the positive findings discussed, it does not always follow that those simply getting more will always fare better in the end. Indeed, we have seen that IDVAs do not offer 100% of the available interventions to 100% of victims. Chapter 3 showed that although there is a degree of commonality between victims, there are also some differences both in terms of the particular pattern of abuse victims have experienced and in their personal and social circumstances. For each victim, therefore, slightly different packages of intervention will be required to achieve outcomes such as safety and wellbeing. With this in mind, it is hard to imagine, that the extent to which an IDVA is able to provide tailored solutions for a specific victim would *not* have a profound impact on her satisfaction and safety [16] [168]. Analyses were undertaken as part of this study to explore *if* and *how* the intervention provided to victims in this sample was tailored around victims' abuse and demographic profiles. A summary of results is presented here with the full Table detailing all significant associations located in Appendix 9.[61]

4.1 Tailoring interventions around victims' abuse profiles

Type of abuse

The frequency with which particular intervention strategies were used varied to some extent as a function of abuse type. For example, advice on going to court was given more frequently to those reporting physical abuse, whereas advice relating to the civil justice system was more common amongst those reporting harassment and jealous/controlling behaviour, suggesting that IDVAs are helping victims to put in place prospective protection against non physical forms of abuse. Interventions relating to housing and the security of the home were provided more frequently to those who were being harassed or stalked. Earlier results (see Chapter 3) showed that victims experiencing this form of abuse were more likely to be separated from the perpetrator and thus help to shore up the home is appropriate in these instances. In contrast, help in accessing a GP and mental health services was given more frequently for those reporting sexual abuse. This is in line with findings that injury and other complications (eg sexually transmitted infections) together with mental health issues may be particularly likely amongst those experiencing sexual abuse [169] [29] [170] [171] [172] [173], although it should be remembered that, in general, these services were not utilised with any great frequency.

Intensive support was given more frequently to those experiencing physical abuse relative to those who were not (of those experiencing physical abuse, 69% received intensive support versus 61% of those who did not report physical abuse). This difference was not maintained, however, when the *severity* of the abuse was taken into consideration. This finding suggests that IDVAs are more likely to take account of the level of abuse, rather than the presence of a particular type of abuse, when prioritising which victims require intensive support. *In other words, regardless of the particular features of a victim's abuse history, it is the severity of her current predicament that dictates whether IDVAs support her in a highly intensive fashion.*

Severity of abuse

In general, the service provided by IDVAs was found to be tailored around the seriousness of the abuse victims were experiencing, with victims reporting high level abuse, escalating abuse, and multiple forms of abuse receiving access to many of the types of interventions more frequently and at a more intensive level. Notably, options such as gaining access to the criminal legal system, refuge and MARAC were addressed more often with these victims. In particular, refuge accommodation and MARAC are forms of support that are limited by capacity and so directing these interventions towards those experiencing the most severe levels of abuse may be evidence that limited resources are being targeted most appropriately. Nevertheless, these findings (along with those relating to intensity)

suggest that IDVAs are at some level having to prioritise (albeit in the most appropriate way) an already high risk case load.

Interestingly, several interventions which address sources of vulnerability and contextual issues (benefits, counselling, and advice around children's schools) rather than the abuse in and of itself were offered *less frequently* to those victims reporting escalating abuse. Escalating abuse is strongly linked to re-victimisation, serious harm and homicide [30] [111] [29]; thus in cases where this is a feature, the primary concern may be to mobilise support which first address the immediate safety of victims, after which other issues like financial dependency may become more salient. Furthermore, as mentioned earlier, the provision of interventions like counselling services are seen as particularly inappropriate where the risk of harm to victims is high [129]. Thus, these findings are indicative of good practice in the context of very high risk cases.

Victims' appraisals of threat

Victims who felt fearful also received more interventions addressing immediate and longer term safety, such as access to the civil and criminal legal systems, housing and MARAC. Given evidence emphasising the importance of victims' perceptions [97] [26] [99], these results may reflect that IDVAs recognise the significance of a victim stating how frightened she is, while remaining alert to the fact that many victims will still minimise their situations.

Perpetrators' criminogenic behaviour

In addition to the level of abuse that perpetrators inflict on victims, factors such as the presence of a criminal record and aggravating problems such as substance misuse were associated with the frequency with which victims were provided with intensive support and particular types of interventions. This reflects the earlier finding that the severity of abuse may be correlated with the presence of perpetrators' chronic antisocial behaviour (recall Chapter 3) and thus resources are being appropriately targeted at these cases.

4.2 Tailoring interventions around victims' socio-demographic profiles

Separation

Actual or prospective separation was consistently related to receiving support around benefits, child contact and civil remedies, which is suggestive of the mobilisation of types of support which help to address some of the key factors (financial dependence and children) that victims report as presenting barriers to leaving an abusive relationship [56] [57] [58] [59]. A greater proportion of victims looking to separate were also referred to MARAC, which is indicative of the more serious abuse that this group were experiencing at the point of referral (see Chapter 3). In line with this finding, experiencing abuse from an ex-partner was associated with more intensive support from an IDVA, as well as support to access a Sanctuary scheme, which focuses on securing a victim's home. This may also signify the fact that victims who have separated from violent partners are further along in the process of addressing abuse, and therefore more willing to engage proactively with services [118] [117]. In contrast, victims in ongoing relationships received greater levels of intervention around immigration issues and substance misuse problems, which, as discussed in Chapter 2, may represent barriers to terminating an abusive relationship.

Children

The presence of children was consistently related to increased levels of support around a range of issues. Unsurprisingly, victims with children received higher rates of support to deal with child contact issues, schools and social services. Having children was also linked to higher rates of support around accessing the civil legal system, which may be a result of victims responding to or seeking contact orders and seeking other types of orders, which can also be applied to children (eg non-molestation orders)[62]. Victims with children also received housing support and accessed Sanctuary schemes more frequently than those without children. Whilst differences in rates of access did not remain significant at higher

levels of abuse, they were still evident at lower levels (remembering that this is relative and all of the victims here are deemed to be at high risk of harm). In addition, victims with children were also more likely to receive safety-planning advice and for their cases to have been taken to MARAC, with significant differences evident irrespective of the severity of abuse. Thus, the presence of children may be used by IDVAs to prioritise the delivery of some forms of intervention, particularly that relating to housing and especially where abuse is relatively less serious (again remembering that this is a high risk sample), although an alternative explanation is that victims with children may be more proactive in seeking particular types of support to increase the likelihood that they and their children can be safe.

Additional vulnerability

Victims who disclosed additional sources of vulnerability were more likely to receive interventions relating to mental health and drug and alcohol issues. Victims with complex needs were also more likely to need support to access social services, although this relationship was moderated by whether victims had children, meaning that complex needs were associated with more frequent access only when victims had children[63], although caution is required when interpreting these findings given the low rates of disclosure around these issues. Only 5% (n=44) of all those with children disclosed having complex needs.

Victims' ethnicity

Research suggests that different ethnic groups find particular types of interventions more acceptable than others [85] [87] and also that minority ethnic groups may have difficulty in accessing particular forms of support [174] [81] [175]. For this reason, the extent to which different types of intervention were utilised as a function of ethnicity was considered. Initial examination of the data revealed that victims from B&ME groups were more likely to receive or seek support in relation to immigration, benefits, housing and refuge, but less likely to receive support in relation to pursuing a criminal court case, addressing complex needs (mental health, substance misuse, employment), and interventions such as Sanctuary schemes and target-hardening. Their cases were also less likely to be heard at MARAC. Many of these differences might be accounted for by the fact that a higher proportion of B&ME victims, compared to White British victims (46% versus. 29%) were still in a permanent relationship with the perpetrator, making some intervention strategies more or less appropriate. Victims also may be reluctant to pursue the prosecution of the perpetrator when they anticipate remaining in these relationships, especially when there are cultural or family pressures against 'breaking up' the family. Further exploration with respect to MARAC showed that the inequity was largely accounted for by data contributed by two services, with access rates by B&ME relative to White British victims more even across the other five services. Therefore, further work is required at a local level to understand the reasons behind this finding.

These findings provide good evidence that IDVAs were tailoring the support they offered both around the type and level of abuse experienced by victims and also to some degree according to victims' socio-demographic profile (relationship status, children) and additional support needs, with some evidence of particular prioritisation for those with children.

[62]Whilst results presented in the previous Section revealed the presence of children was consistently and positively related to more severe abuse, those with children were still more likely to seek civil justice options after taking this into account.

[63]Factors like parental physical and mental ill-health, as well as substance misuse, are associated with more negative outcomes for children (Downey & Coyne, 1990; Conger, Elder, Melby, Simons & Conger, 1991; Cummings & Davies, 1994b; El-Sheikh & Cummings, 1997) and often-cited studies indicate that the risk posed to children by domestic abuse increases exponentially when multiple sources of adversity are present in children's lives (Sanson, Oberklaid, Pedlow, & Prior, 1991; Rutter, 1979; Sameroff, Seifer, Barocas, Zax, & Greenspan, 1987). Victims' complex needs are likely to compound the impact of children's exposure to domestic abuse, making them particularly vulnerable to harm and more likely to require the intervention of formal safeguarding agencies.

Furthermore, they provide evidence of the appropriate targeting of limited resources according to risk, as is recommended (e.g. those experiencing more severe abuse receive more intensive support and access to particular services more frequently). However, it should be borne in mind that each and every one of the victims represented in this sample was assessed as being extremely likely to experience further serious harm without intervention, and thus the requirement to prioritise the support offered to an already priority group of victims might be suggestive of inadequate capacity and resource across IDVA and other services (e.g. MARAC) to ensure that all high risk victims receive a premium service.

5. Summary of key points from Chapter 4

1. **IDVAs delivered relatively short-term intervention to the majority of victims referred to their services.**
   - A retention rate of nearly 60% was observed, which is particularly impressive given the severe abuse experienced by this group of victims.
   - Cases lasted on average for 3 months, although it was evident that IDVAs worked with victims over longer periods of time where this was necessary.
   - Some specific factors systematically increased the chances that victims would disengage from services.

➢ **IDVAs were able to engage with victims largely irrespective of who they were or the level of abuse they were experiencing.**

➢ **IDVAs may be able to use the information about the types of factors linked with disengagement to increase retention rates amongst some victims, although this will likely require co-ordination with other services – particularly those which come into contact and work directly with perpetrators of abuse.**

2. **IDVAs help victims to access a wide range of services to increase safety, some of which address additional sources of vulnerability and need.**
   - Safety planning was widely undertaken, although it was not offered in around 20% of cases.
   - Other resources commonly mobilised/provided by IDVAs included housing related interventions, advice around contact with children, legal remedies (criminal and civil) and MARAC.

➢ **Risk assessment and safety planning must be undertaken at the first point of contact with a victim as a basic level of service provision.**

➢ **The involvement of many agencies is needed to adequately address safety for victims living with chronic levels of severe abuse.**

➢ **Further exploration as to the extent to which service delivery meets need is required to identify any gaps in the provision of intervention.**

3. **IDVAs work intensively with victims, helping them to access multiple resources.**
   - In 87% of cases, victims were helped to access multiple services, with the average being 4.
   - In 65% of cases, victims received concentrated support from an IDVA.

➢ **More resources may be required to enable IDVAs to provide intensive support and access to multiple forms of intervention to all victims.**

4. **IDVAs provided intervention that was tailored around the nature of the abuse being experienced by victims, as well as their individual circumstances.**
   - Victims experiencing comparatively more severe abuse received more intensive support and more frequent access to many services (eg, court, housing, target-hardening).

- Victims with further types of support needs (eg, children, substance misuse) received more frequent access to relevant services and agencies.

➢ **IDVAs are prioritising interventions within an already 'high risk' case load, suggesting that there may be a lack of capacity to work at the highest level with all high risk victims.**

6. Implications for practice and policy

1. **IDVAs provide a response tailored around risk and other support needs, although they are, to some extent, required to prioritise service delivery to an already high risk group. Replication of this approach rests on:**
   - Services being commissioned in such a way as to facilitate this response. IDVA job descriptions and service locations should support this multi-faceted approach and not be restricted to just supporting victims through the criminal justice system, for example.
   - Funders and commissioners should ensure that services have sufficient capacity in order to work with all victims in the way anticipated to be the most effective.
   - Extensive assessment of victims' needs which must include an assessment of risk and the types of abuse experienced, as well as screening for other sources of vulnerability.
   - An understanding of the interventions which are most effective in tackling particular forms of abuse and other specific issues.
   - A structured case review process enabling IDVAs to ensure that the spectrum of victims needs have been, or are being met.
2. **IDVAs are largely working in the recommended way, to mobilise multiple interventions in an intensive manner, but this was not the case for 100% of victims.**
   - The systematic review of cases may help to identify those victims who have received access to a smaller number of interventions, ensuring that the full range of appropriate agencies or interventions are mobilised on behalf of all victims.
   - Funders and commissioners should ensure that services have sufficient capacity in order to work with all victims in the way anticipated to be most effective.
3. **These results highlight the range of services that may need to be drawn on in order to enhance the safety of victims and their children, and also highlights potential gaps in service delivery for consideration.**
   - IDVAs should ensure that wherever possible they undertake formal safety planning with all victims at the first point of contact, as a minimum level of service provision.
   - Regular review of the frequency with which resources are mobilised may help services identify any potential gaps in service provision.
   - Service managers and IDVAs should ensure that they have strong links with the wide array of services and intervention programmes that may be implicated in responding to domestic abuse. This should be underpinned by a strong understanding of their client group and local context.
   - Attention should be given by service managers and commissioners to building stronger relationship with local health related services to ensure that these links are made to all victims.
   - Those setting the training agenda for IDVAs may consider incorporating additional topics into their training course in order that IDVAs are fully equipped to respond to the range of victims' needs.

4. **These findings may help IDVAs to identify victims likely to disengage before the completion of intervention. In these cases, IDVAs may need to implement additional measures to ensure that continuing support reaches these victims. This may involve:**
   - Proactive efforts to keep victims engaged, wherever possible working intensively with victims.
   - Ensuring that victims who are likely to disengage are offered at the first point of contact essential information with respect to basic safety planning and future help seeking.
   - Co-ordination with specialist services addressing perpetrator behaviour and issues, including substance misuse and mental health services, Police and Probation.

Putting it into context:

Upon receipt of the referral for Linda, the case was assigned to Helen. Initially, Helen made contact with Linda by telephone and arranged a time when they could speak about the incident and start to talk about her options. They met for the first time on 12 January at the Police station. A risk assessment was completed which indicated that the availability of weapons, threats to kill both Linda and her children, and her ex-partner's mental health and substance misuse problems were particularly pressing issues impinging on the safety of the family. Helen helped Linda to devise a safety plan, including actions that she could take to minimise her risk. Since the break-up of the relationship, Linda's ex-partner had been stalking her when she walked her oldest child to school and had been bombarding her with abusive texts. They agreed that Linda would ask a friend if she could give her son a lift to school in the mornings and that she would change her mobile number. Helen also reassured Linda that she should call the Police if her partner turned up at the house, and advised that she should check in with her mum each day at the same time so that her family knew she was ok. Following their first meeting, Helen contacted a solicitor in order to begin the process of obtaining a civil injunction, she made calls to the local Housing Association to ensure that the tenancy agreement was in Linda's name and also arranged for the locks to be changed and a panic button installed at the property. On the third meeting, Helen helped Linda to make an appointment with the GP to talk about how low she was feeling. Helen also offered invaluable support to Linda through the prosecution of her ex-partner. She explained to her the importance of making a witness statement and the case resulted in her ex-partner pleading guilty to actual bodily harm and receiving a 6 week custodial sentence with an order to attend IDAP (Integrated Domestic Abuse Program). Linda found the case extremely harrowing and during the lowest times, she spoke to her IDVA every day by phone.

Chapter 5: The impact of IDVA services on victims' safety and well-being

So far this report has detailed the particular characteristics of those high risk victims with whom IDVAs work and the specific types of activities that IDVAs undertake, with the aim of increasing victims' safety and well-being. This Chapter examines whether, and to what extent, there are measurable improvements in victims' lives following the receipt of IDVA services,[64] and the ways of working that make positive changes more likely.

This Chapter draws on quantitative (n=1,247) and qualitative (n=412) data gathered at the closure of victims' cases. Follow-up data gathered from 34 victims 6 months after case closure are also presented. Results presented here describe: (1) the documented improvements in victims' safety; (2) improvements in their well-being; (3) the factors associated with a greater or lesser chance of achieving positive outcomes (which is necessary to help explain variation in victims' outcomes); and lastly (4) the sustainability of any positive changes over time.

The data from this Chapter demonstrate that:

1. There were significant positive changes in victims' safety following a period of work with an IDVA as evidenced by a cessation in abuse for the majority of victims, substantial reductions in all forms and levels of abuse and victims' enhanced feelings of safety in most cases.
   - 57% of victims experienced a cessation in all types of abuse.
   - Positive changes were observed for those victims experiencing the most severe levels of abuse, multiple forms of abuse and abuse that was escalating in severity or frequency.
   - The specific risks facing these victims at Time 1 were also significantly less likely at Time 2 (e.g. threats, fear, injuries, etc). This included substantial reductions in direct risks to children's safety and well-being.
   - In the majority of cases, victims (76%) and IDVAs (79%) reported enhanced feelings of safety and reductions in risk, respectively.
2. There were positive changes in victims' well-being following intervention as evidenced by victims' enhanced coping abilities and strengthened social networks.
   - IDVAs reported improvements in victims' coping abilities in 63% of cases and improved social networks in 47% of cases.
3. The receipt of multiple interventions and intensive support each doubled the chances of achieving positive changes in victims' safety and well-being.
   - Victims who were experiencing relatively more severe abuse at the point of referral, or going through a relationship separation, were less likely to achieve positive outcomes.
4. The positive changes achieved as a result of working with an IDVA may be sustainable in the longer term.
   - IDVAs felt that where positive changes had been made, they were sustainable in the longer term for 39% of victims.
   - The majority of victims surveyed (82%) reported that they had experienced no further abuse during the 6 months following the closure of their case.

[64]This study was limited in that it lacked a control group with which to compare the outcomes for victims receiving no intervention or a different type of intervention. This restricts the extent to which outcomes can be attributed to the intervention. Whilst randomised controlled trials represent the 'gold standard' approach to measuring the impact of any given intervention, they are difficult and expensive to set up and run. Furthermore, the assembly of a 'no treatment' group poses ethical questions for researchers and service providers, especially where the population of interest is at risk of serious harm in the absence of intervention, as was the case in this study.

1. The impact of IDVA services on victims' safety[65]

This section presents a synthesis of outcome data evidencing the impact of IDVA services on safety. This is not straight forward as there is no definitive measure of 'safety' and therefore, in an effort to develop a comprehensive and nuanced picture of impact, this study set out to measure changes in safety in three main ways: first, the proportion of victims experiencing a cessation in all forms of abuse; second the changes over time in the occurrence and severity of specific forms of abuse; and third, IDVA and victim perceptions of changes in safety.

Figure 11 shows that in 57% of cases,[66] abuse (irrespective of type or level) had ceased or mostly ceased after working with an IDVA, which is a success rate in line with other studies assessing the impact of advocacy interventions[67]. The fact that all forms of abuse had stopped in the majority of cases is a remarkable finding when one is reminded of the severe levels of abuse that characterised this sample (recall Chapter 3) and which past research has shown to be extremely difficult to ameliorate (129).

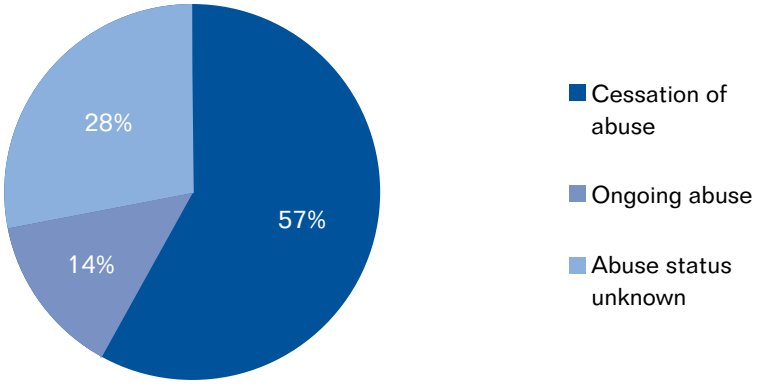


Figure 11: Experience of abuse at Time 2

Whilst these results are extremely positive, limiting judgments of success to whether there has been a complete halt in abuse fails to capture that the risk of serious harm or homicide may have been lowered substantially even where abuse continues to some extent. Furthermore, it is difficult to explore the possibility that an intervention such as this may have a differential impact across different types and levels of abuse when the measure of success is simply cessation. It was therefore important to consider if, and to what extent, different types of abuse were impacted by the work of IDVAs. In particular, this study looked to examine the change in frequency and seriousness of physical and sexual abuse, perpetrators' jealous and controlling behaviour and harassment and stalking.

Figure 12 shows that there were very substantial reductions[68] over time in the number of victims reporting the occurrence of each type of abuse (n=966[3]). Specifically:

- The proportion of victims reporting any level of physical abuse fell from 87% to 18%, a relative reduction[69] of 79%, meaning that 660 fewer victims were experiencing this form

[65]Information pertaining to this outcome measure was collected in a smaller number of cases (n=966) owing to it being situated in a different data collection module, thus IDVAs overlooked to provide this information in some instances.

[66]Data were missing in 28% of cases. We do not present a figure adjusted for missing responses as it is more likely that those with data missing with respect to this field were no longer in close contact with IDVAs (preventing IDVAs from answering this question) and that this was a result in some cases of victims experiencing ongoing abuse. It is unlikely that all of those victims were experiencing ongoing abuse and thus 57% may represent a conservative estimate of the cessation rate.

[67]Whilst the current study lacks a control group with which to draw comparisons, the randomised control trial undertaken by Sullivan et al (1992, 1999), revealed a significant difference in the cessation rates for victims who did and did not receive the assistance of an advocate (58% versus. 45%, respectively). Robinson (2006a) reported a cessation rate of 70% following the receipt of advocacy services.

[68]All reductions were significant at $p<.05$ employing the McNemar test of correlated proportions.

[69]The relative change is calculated by ((Time 1 value – Time 2 value)/Time 1) x 100. The advantage of looking at the relative change as opposed to the absolute change is that it allows comparison across the different types of abuse that were noted with varying frequency in this sample.

of abuse following intervention.

- The proportion of victims reporting any level of sexual abuse fell from 23% to 5%. This is a relative reduction over time of 77%, meaning that 176 fewer victims were experiencing this form of abuse following intervention.
- The proportion of victims reporting any level of jealous and controlling behaviour fell from 87% to 27%, a reduction over time of 69%, meaning that 580 fewer victims were experiencing this type of abuse following intervention.
- The proportion of victims reporting any level of harassment or stalking fell from 50% to 21%, a relative reduction over time of 58%. This represents a lower reduction relative to the other types of abuse, although this still equates to a cessation for over half of the victims who were experiencing this type of abuse at the point of referral, which in absolute terms is 282 fewer victims.

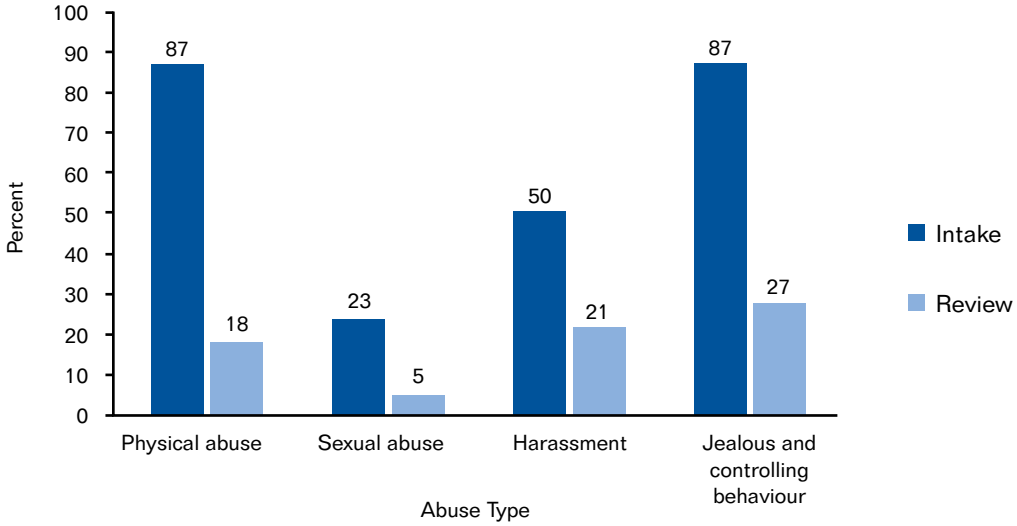


Figure 12: Frequency of abuse (all levels) at Time 1 vs. Time 2 by type

Given that severe abuse is very difficult to tackle, it was important to determine whether there were any reductions in the prevalence of severe abuse following work with an IDVA, otherwise this type of intervention might only be deemed effective for the less serious cases. **Figure 13** shows that the impressive reductions in each type of abuse displayed in **Figure 9** also extended to severe[70] forms of each type of abuse[71].

- The prevalence of severe physical abuse was reduced from 64% to 14% (a relative reduction of 79%), meaning that over 480 fewer victims were experiencing this kind of severe abuse which might include beating up, strangulation, dragging by the hair and simulated drowning.
- Severe sexual abuse was reduced from 16% to 4% (a relative reduction of 76%), meaning 115 fewer victims were experiencing this type of severe abuse, examples of which include rape, coerced sex and the deliberate infliction of pain during sex.

[70]Severe abuse represents where either 'high' or 'extreme' was endorsed on the severity of abuse grid.

[71]All reductions were significant at $p<.05$ employing the McNemar test of correlated proportions.

- Severe jealous and controlling behaviour fell from 62% to 15% (a relative reduction of 76%). Thus 454 fewer victims were experiencing behaviours such as monitoring of daily activities, being locked in the house and threats to remove or harm children.
- Severe harassment and stalking fell from 35% to 12% (a relative reduction of 65%). This equates to 222 fewer victims who were experiencing this kind of severe abuse which might include repeatedly following a victim, constant calls and text messages and uninvited visits and threats.

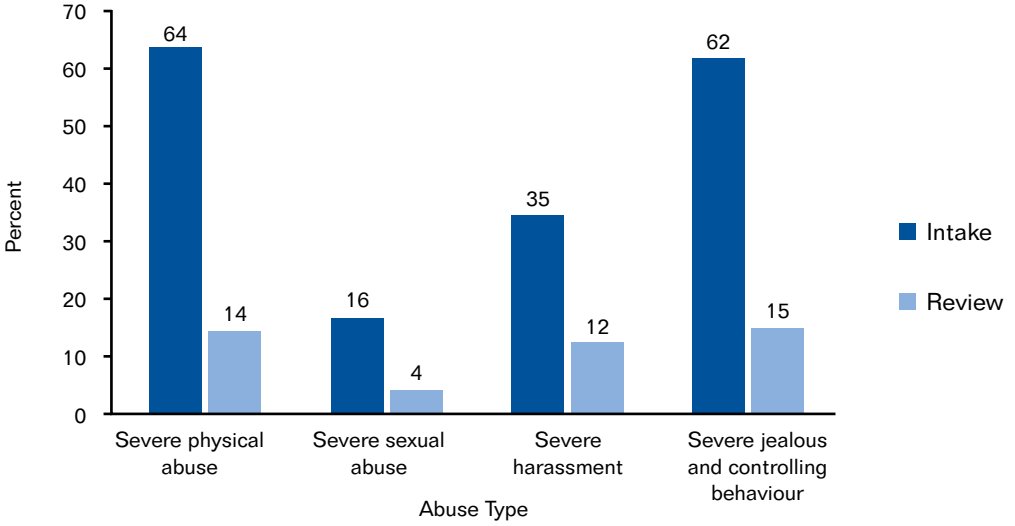


Figure 13: Frequency of severe abuse by type at Time 1 vs. Time 2

The number of victims who reported experiencing any type of severe abuse was reduced significantly following work with an IDVA: from 80% of the sample to 20% (**Figure 14**). Even greater reductions were observed amongst victims reporting that abuse was getting worse (escalating in frequency or severity), from 60% to only 5% at case closure[72], indicating that IDVAs are not only successful in preventing abuse from getting any worse, but also in decreasing the severity of abuse.

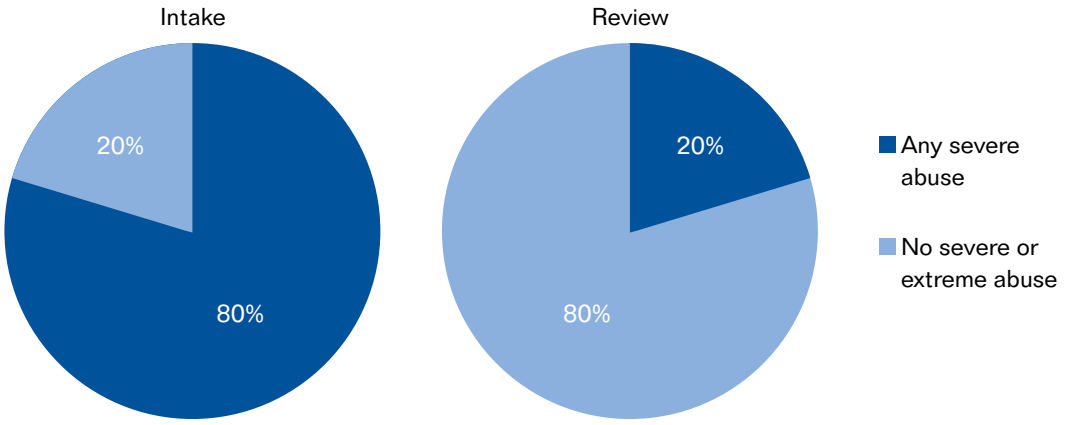


Figure 14: Proportion of sample reporting severe abuse at Time 1 vs. Time 2

Chapter 3 demonstrated that in the majority of cases victims were experiencing more than one form of abuse. **Figure 15** shows that the proportion of victims reporting multiple forms of abuse fell from 87% to 21%, meaning that IDVAs were successful in addressing the broader pattern of abuse, which we know is a reality for most victims (650, or more than two thirds of this sample).

[72]It is possible that the reductions noted here were in a small way inflated by slightly higher levels of missing data in relation to the escalation of abuse at Time 2.

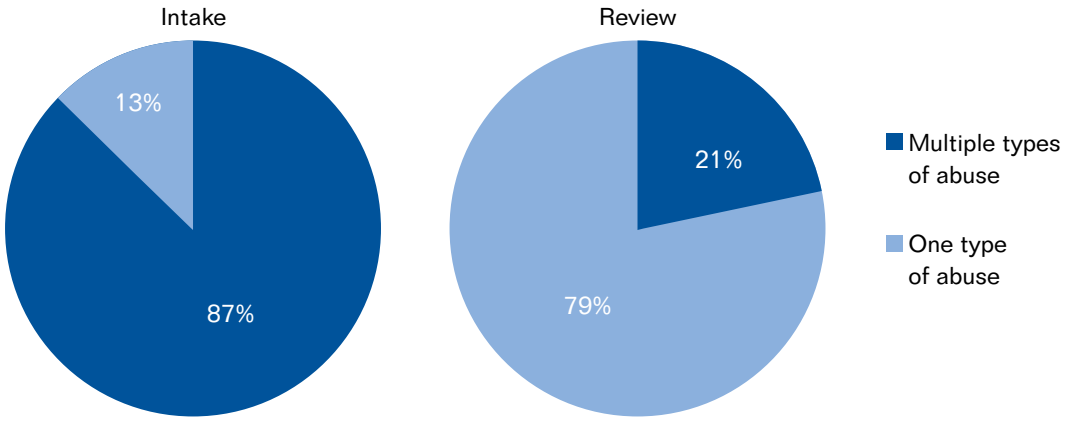


Figure 15: Proportion of sample reporting multiple types of abuse at Time 1 vs. Time 2

1.1 Reductions in specific types of risks[3]

The frequency with which specific indicators of risk were reported at each measurement point was examined to gives a sense of the overall reduction in risk and also of the specific types of risks that IDVA services are more likely to have success in ameliorating, and those which may require the additional input of other types of services, to ensure that victims and their children are made safe.

Comparison[73] of overall risk scores derived from the RIC showed that on average, victims were experiencing significantly fewer risks at Time 2 compared to those recorded at Time 1 (11.34 versus 4.87). Additionally, **Tables 6-9** shows that, in general, most types of risk were reduced over the period of intervention. First, there were marked relative reductions[6] in the extent to which victims perceived themselves to be at risk of harm, which is significant owing to the accuracy of victims' predictions (**Table 6**). For example, the frequency with which victims reported that they were generally fearful was reduced by 80%. The specific fear of being injured was reduced by 74% and the fear of being killed by 87%. These latter findings capture the express aim of IDVAs' work, which is to reduce the risk of significant harm or homicide that victims face. Nevertheless, it should be kept firmly in mind that victims are not always correct in their appraisals of risk [(176)] and the period following separation and intervention may be a particular risky time for victims [(30) (177) (139) (135) (17)].

Table 6: Victims' appraisals of threat at Time 1 versus Time 2

Risk factor	Intake (T1) Percentage of victims (n=966)	Review(T2) Percentage of victims (n=966)	Percentage Change
Victim is afraid of further injury	85% (818)	22% (213)	74%
Victim is frightened	83% (806)	17% (167)	80%
Victim is afraid of being killed	48% (465)	7% (63)	87%

Conferring with the findings relating to the type and severity of abuse discussed above, there were large decreases in the prevalence of risks relating to specific features of abusive incidents (**Table 7**), such as the use of weapons and injuries sustained, and also in the frequency with which particular types of abuse were noted (eg stalking and sexual abuse). There were less significant reductions in those questions which ask whether a risk had 'ever' happened, such as 'ever tried to strangle' a victim or where the perpetrator had ever made a threat to kill. The fact that there were perceived reductions at all, suggests that where victims were living in safety, their perception of the reality of the threats made historically may have altered.

[73]Paired samples t (964) =53.00, p<.001.

[74]These figures relate to those victims with children and time 2 risk data (n=699).

Table 7: Specific features of abuse at Time 1 vs. Time 2

Risk factor	Intake (T1) Percentage of victims (n=966)	Review(T2) Percentage of victims (n=966)	Percentage Change
Jealous and controlling behaviour	91% (879)	23% (223)	-75%
Escalation of abuse	72% (722)	7% (63)	-91%
Perpetrators' threats to kill victim	66% (636)	46% (442)	-31%
Victim has been strangled/choked	64% (619)	57% (555)	-10%
Current incident resulted in injuries	52% (501)	6% (58)	-88%
Stalking	33% (315)	7% (64)	-80%
Sexual abuse that makes victim feel bad	28% (273)	5% (44)	-84%
Use of weapons	22% (216)	3% (27)	-88%
Perpetrators' threats to kill others	22% (213)	13% (124)	-42%
Perpetrators' threats to kill other intimate partner	8 % (78)	4% (42)	-46%

Importantly, there were very positive reductions observed with respect to risks posed to children's immediate safety (**Table 8**)[74]. For example, there was a substantial drop in the number of cases where victims were afraid of harm to children (76%), indicating that as abuse desists, or at least decreases, victims on the whole perceive some reduction in the risk to their children. In addition, the number of cases in which conflict around contact issues was a feature was reduced by 45%, from 42% to 23%. There was a reduction of a similar magnitude with respect to threats to kill children, although it should be borne in mind that this risk was not reduced by 100% and threats of this nature may be especially concerning in the context of separation, or as victims make visible strides away from an abusive relationship. These results reveal that by addressing the risk to the non-abusing parent, the intervention that IDVAs offer can have an associated impact on the immediate risk to children's safety, although these effects are likely to be enhanced when work is supported by effective partnerships with child focused services. Furthermore, whilst this is an extremely positive finding, it should be acknowledged that these indicators relate largely to the immediate danger that children face and, like adult victims, children may require longer-term support to address the psychological effects associated with their exposure to very significant levels of abuse. As might have been expected, the prevalence of some risks relating directly to perpetrators remained largely unchanged over the course of the intervention (**Table 9**), although the proportion of cases where a criminal record was related to domestic abuse actually increased. This may reflect information gathering throughout a case, or the results of court cases that were pursued whilst IDVAs were working with victims. These findings highlight the very intuitive fact that services working with victims will have a limited impact on the behaviour of perpetrators (since they never come into direct contact), which again underscores the need for formal links and co-ordinated working between IDVAs and those services that interact directly with individuals who perpetrate domestic abuse. That said, there did appear to be large reductions in the frequency with which financial problems and threats of suicide were recorded, although it is possible that this might be accounted for by a lack of knowledge on the victim's part with respect to these issues owing to diminished levels of contact during the intervention period.

Table 8: Child related risks at Time 1 vs. Time 2

Risk factor	Intake (T1) Percentage of victims with children (n=699)	Review(T2) Percentage of victims with children (n=699)	Percentage Change
Conflict around child contact	42% (292)	23% (160)	-45%
Victim is afraid of harm to children	30% (207)	7% (49)	-76%
Perpetrators' threats to kill children	11% (80)	6% (45)	-44%

Table 9: Perpetrators' criminogenic behaviour and aggravating problems at Time 1 vs. Time 2

Risk factor	Intake (T1) Percentage of victims (n=966)	Review(T2) Percentage of victims (n=966)	Percentage Change
Perpetrators' alcohol abuse	53% (516)	48% (459)	-11%
Perpetrators' criminal record	53% (516)	53% (516)	0%
Perpetrators' financial problems	43% (416)	25% (242)	-42%
Perpetrators' drug abuse	40% (388)	33% (316)	-19%
Perpetrators' threats of suicide	34% (331)	10% (101)	-69%
Perpetrators' DV related criminal record	27% (261)	35% (338)	+30%
Perpetrators' mental health issues	26% (254)	24% (234)	-8%

1.2 Victims' and IDVA's perceptions about changes to safety

Consistent with the positive outcomes discussed thus far, **Figure 16** shows that in 47% of cases, IDVAs perceived *significant* reductions in the level of risk faced by victims. Importantly, victims themselves reported feeling *significantly* safer in 52% of cases. Some reduction in risk or increased feelings of safety was perceived by IDVAs and victims in 79% and 76% of cases, respectively.

IDVAs perceived there to be a limited reduction in risk in only 16% of cases and increased risk in less than 1% of cases. Similarly, a very small number of victims (4%) perceived little improvement in their situation or indeed felt less safe following work with an IDVA (<1%)[75].These latter findings give a sense that whilst things did not improve for a small group of victims, neither did they get worse. This is particularly significant when the reader recalls that abuse was escalating in either severity or frequency in nearly 60% of cases at the point of referral.

Importantly, in cases where both IDVAs and victims had provided information, a high level of consistency was found between IDVAs' and victims' perceptions about changes to safety. Although feelings of safety and perceptions of risk reduction are not constructs that are exactly synonymous, this finding provides confidence that IDVAs did not perceive large reductions in risk where victims were voicing that they felt unsafe or vice versa[76].

[75]Data relating to victims' feelings of safety were not collected in 20% of cases which IDVAs report was a result of being unable to formally close a case. When IDVA ratings were examined for those 259 cases in which victims' ratings were missing it was found that IDVAs perceived there to be a limited reduction in risk in 46% of cases, which is much higher than was observed in the general sample (an increase in risk was noted in just over 1% of cases, which is similar to that observed in the larger sample).

[76]The inter-rater reliability for the raters was found to be Kappa = 0.61 ($p < .01$), 95% CI (0.57, 0.65), indicating substantial agreement (Landis & Koch, 1977)

Collectively, the data described throughout this Section evidences extremely significant changes in the picture of abuse following intervention provided by IDVAs. Abuse was reported as having stopped in the majority of cases and there were very substantial reductions over time in the number of victims reporting each type of abuse irrespective of its severity. In addition, there were substantial reductions in victims' appraisals of threat and, in line with this, most victims reported feeling safer after receiving IDVA services. These results provide strong indication that the intervention provided by IDVAs is efficacious in ameliorating the range of abusive behaviours that victims may experience and, importantly, impacts on the very severe levels of abuse experienced by the high risk victims at whom this intervention is targeted. Crucially, these results also provide evidence that this type of intervention impacts on the risks posed to children in the context of severe domestic abuse, offering a clear indication that, by addressing the risk to the non-abusing parent, the intervention that IDVAs offer can have an associated impact on the immediate risk to children's safety.

2. The impact of IDVA services on victims' well-being

It is important to gauge the efficacy of this type of intervention not just by a reduction in abuse and specific risk factors, as evidenced above, but also in terms of its impact on victims' well-being, especially given evidence that improved functioning in this domain may help to protect victims from re-abuse in the longer term [121][77]. This section examines changes in victims' coping abilities and social networks as an indication of the impact that working with an IDVA might have on victims' well-being.

At the point of referral to IDVA services, victims may be overwhelmed by their situations or aware that their efforts to cope with abuse are no longer effective [18]. Research demonstrates that the way in which people cope represents a significant pathway through which domestic abuse may impact on victims' psychological functioning [178] [179]. In turn, psychological distress may compound the effects of abuse, inhibit the efforts of helping agencies and victims themselves to enhance safety, and increase the risk that victims will experience long lasting negative effects, even after abuse has stopped [180]. Thus, a positive change in coping represents a key indicator of the efficacy of this type of intervention.

Figure 16 shows that significantly improved coping strategies were documented for nearly two-thirds of the sample (63%)[78]. It should be made clear, however, that this does not directly represent any appraisal by victims of their own ability to cope, nor does it give us any indication as to the specific ways in which coping may have improved. Having said that, qualitative data (see Appendix 10) gathered from victims on their exit from a service suggested victims' feelings of being better able to cope may stem from knowing how, and from where, to seek help in the future.

[77]This study, described in Chapter 2, showed that increased access to community resources along with short-term improvements in safety lead to victims' increased social support and quality of life, which communicated the effects of advocacy intervention to victims' long term safety.

[78]Information was not gathered with respect to how coping had changed or improved. Coping, like many of the concepts discussed throughout this report, can be broken down into a number of facets, each of which are differentially related to outcomes for victims (Calvete et al, 2008; Compas, Connor-Smith, Saltzman, Thompsen & Wadsworth, 2001; Mitchell & Hodson, 1986) and the impact of this type of intervention on coping strategies warrants further attention.

[79]Research indicates that an individual's own appraisal of their ability to cope and the availability of informal social support is more important than the judgements of others (Lazarus & Folkman, 1984).

[80]Victims' responses were often paraphrased by IDVAs at the time of interview.

[81]Victims may become isolated for a number of reasons, Perpetrators of domestic abuse regularly isolate their victims from friends and family in an effort to maximize the level of control they have over victims and minimize the chances that victims will disclose abuse (Dobash & Dobash, 1998; Mitchell & Hodson, 1983; Walker, 1979). Victims themselves may also actively avoid contact with friends and families in order to keep the abuse secret or due to the onset, or worsening, of psychological symptoms like depression and anxiety.

Drawing on social support represents a specific way in which individuals may cope with a stressful situation and victims with better social networks are found to have lower rates of psychological symptoms. Also, crucially, improved social support is shown to reduce the risk of re-abuse over time indirectly, through the impact that it has on victims' perceptions of their quality of life [120] [121]. Many victims become extremely isolated as a result of the abuse they experience[81] and looking at ways to strengthen victims' social networks and decrease isolation forms an important part of the intervention that IDVAs provide.

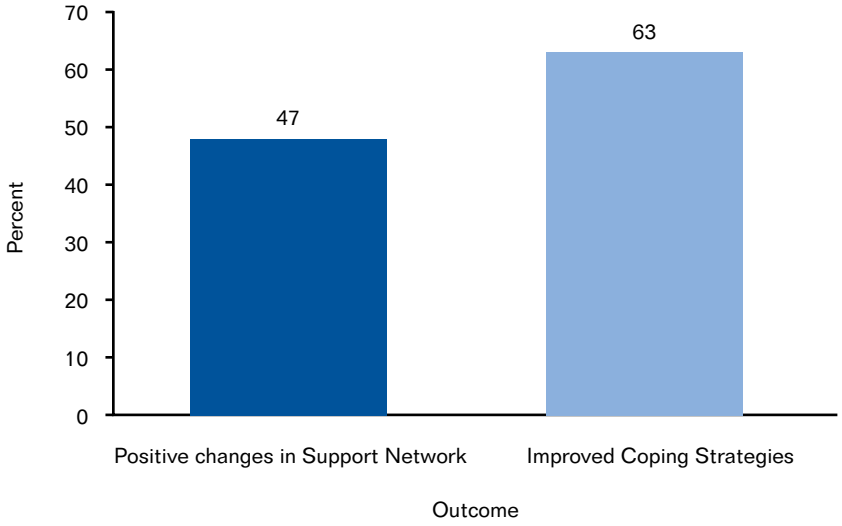


Figure 16: Positive changes in victims' support networks and coping strategies

Figure 16 indicates that even during the relatively short space of time in which victims worked with an IDVA, nearly half were able to make some significant improvement to their social networks. However, once again, the measure used to gauge changes with respect to this aspect of well-being was extremely simplistic and represented IDVAs', rather that the victims', views as to improvements that had been made. Nevertheless, qualitative data (see Appendix 10) again revealed that victims viewed social support as important to 'moving on'.

'[She] feels much safer and is glad she knows how to get help if she needs it' [IDVA]

'She has a good network of support and is hopeful for the future' [IDVA]

"Feel a bit safer because people are aware of the abuse that is going on" [victim]

In fact, victims who reported they felt safer at Time 2 frequently cited improved coping mechanisms and greater access to social support as playing an important role in facilitating this positive change, thus providing support for the notion that improved well-being represents a key mechanism through which IDVA services can effect long-term change in victims' safety.

These findings provide some indication that in addition to a clear and measureable impact on safety, the intervention that IDVAs offer impacts positively on victims' ability to cope and their access to social support. However, more in-depth investigation of the range of ways in which IDVA services may impact on well-being is required in order to understand more fully the possible benefits of this intervention and the processes by which longer-term safety might be facilitated.

On the whole, the results discussed in this Section suggest that IDVAs deliver an effective intervention that enhances the safety and well-being of victims experiencing extremely serious levels of abuse. However, given that at least 14% of victims were experiencing ongoing abuse at the time their case was reviewed, it is clear that this intervention did not work equally well for everybody, which is perhaps to be expected bearing in mind the nature of the abuse experienced by this sample[82]. Ongoing abuse was more often non-physical in nature (although it occurred in all forms); in particular, there were much smaller reductions in the level of harassment that victims were experiencing irrespective of severity[83]. Thus, it seems that non-physical forms of abuse may be especially difficult forms of abuse to address, with harassment across all levels of severity appearing to be extremely enduring.

'This has impacted his behaviour towards her and physical abuse has ceased. There is still some low level emotional abuse and jealous behaviour'

Chapter 3, along with many other studies [39] [40] [41] [42] [6], showed that harassment is more commonly perpetrated by ex-partners and therefore it seems that this form of abuse is particularly likely to escalate or ensue as victims make active efforts towards enhancing their safety [101]. There are many ways and opportunities that enable continued abuse in this form, and in particular, contact because of children presents an occasion for harassing and controlling behaviour [181] [182] [183] [184] [135] [185] [186] [85]. Supporting this, results presented in Chapter 3 found harassment to be more common amongst those with children (see Appendix 7), and victims' comments gathered at the end of a case, as well as six months after (see Appendix 10) suggest that issues around children render them vulnerable to continuing harassment and emotional abuse.

'She said she has always felt safe but was concerned about child contact as she felt he was using the child to get to her.'

'The situation is still up and down. Sometimes the perpetrator can be pleasant and calm and sensible in relation to child contact, but then other days he can fly off of the handle and scare our client.'

'Client has recently had a little girl and says that everything is fine at the moment in regards to physical abuse, but that he is 'torturing' her with mental abuse'.

The next Section of this Chapter draws on quantitative and qualitative data to examine in more detail the factors that might determine differences in the outcomes achieved for victims (eg whether abuse continues or stops following intervention). The factors considered include the type of intervention that victims receive and also those factors present in victims' lives that may have a bearing on safety and well-being.

[82]There was evidence of some positive changes for this group of victims (despite the ongoing abuse). There was some reduction in the occurrence of each type of abuse, and reductions in the number of victims reporting severe abuse. 71% of victims felt at least somewhat safer and 66% of IDVAs felt that there had at least been some reduction in risk. In addition, there were also some changes in victims' well-being, with 67% reporting positive changes to coping and 37% with respect to their social networks. These results suggest that even though the intervention provided by IDVAs does not stop the abuse in each and every case, it may still be successful in reducing the severity of abuse and thus the immediate risks to victims' physical safety.

[83]Any level of abuse: Harassment & stalking: 19% reduction; jealous & controlling: 43%; physical abuse: 59%; sexual abuse: 59%. Severe abuse: Harassment & stalking: 35%% reduction; jealous & controlling: 53%; physical abuse: 66%; sexual abuse: 50%.

[84]A recent paper explores the impact that technological developments have had on an abuser's ability to 'frighten, stalk, monitor and control their victims' (p. 843, Southworth, Finn, Dawson, Fraser & Tucker, 2007) and thus it may be possible for a perpetrator to continue to harass their victim via telephone, text message, email, social networking sites and other technological media, even when other forms of abuse have been curtailed by formal intervention.

[85]A recent study carried out in the United States found that in a sample of women who had experienced recent abuse and who had a least one child aged between 5 and 12 years, the majority reported that the perpetrator used the children as a means of maintaining contact, harassing them, or keeping track of their whereabouts. In particular, those fathers with court ordered visitation were most likely to implicate their children in the abuse in this way (Beeble et al, 2007).

3. Factors related to increases and decreases in the likelihood of achieving positive outcomes

3.1 Intensive support and the multiplicity of interventions: Impact on victims' safety and well-being

Understanding the ingredients of a successful intervention can enable those delivering it to maximise the activities that have the most impact, although to date there has been limited research to examine the component parts of the service that IDVAs deliver in an attempt to elucidate aspects of practice which are most strongly linked to positive changes in victims' lives [(16) (125) (187)]. Based on the fact that the provision of a multi-agency response and intensive support represent key principles underpinning the IDVA model, it might be expected that these elements, in particular, are linked to the likelihood of achieving outcomes such as safety and well-being. Multivariate logistic regression analyses were undertaken to examine the unique contribution of these aspects of intervention to victims' safety and well-being, whilst controlling for the impact of other potentially influential variables (e.g. separation, presence of children; see Appendix 11 for analysis plan and full set of results).

Results showed that these facets of intervention increased the likelihood of positive changes in victims' safety and well-being, even after taking into account many of the factors in victims' lives, which may have a bearing on outcomes (perpetrator related factors, the presence of children, victims' complex problems)[86]. Specifically, victims receiving more intensive support were more likely to do better than those receiving less intensive support; and victims who received multiple forms of intervention fared better than those receiving no, or single, forms of intervention. Furthermore, results showed that by and large the likelihood of positive outcomes increased as victims received more types of intervention; so the odds of enhanced safety and well being were greater when victims received 6-10 forms of intervention (compared to 0-1) than if they received 2-5 forms (compared to 0-1).

The impact of intensive support: Considering the role of intensive support in more detail, *the receipt of more intensive support was found to double the odds that abuse would cease . This means that those who received more intensive support were twice as likely to be free from abuse at case closure, compared to those who had received less intensive support[88].* In considering the cessation of individual types of abuse, the receipt of intensive support from an IDVA doubled the odds of achieving a cessation in physical abuse and jealous and controlling behaviour. There was also a better chance of experiencing a cessation of harassment/stalking and sexual abuse on receiving more intensive support, although these effects were less consistently observed. Victims receiving intensive support were nearly 4 times more likely to feel safer than those receiving less intensive support, concurring with this; IDVAs were nearly 3 times more likely to feel that there had been some reduction in the risk to victims' safety for those victims with whom they had worked intensively with.

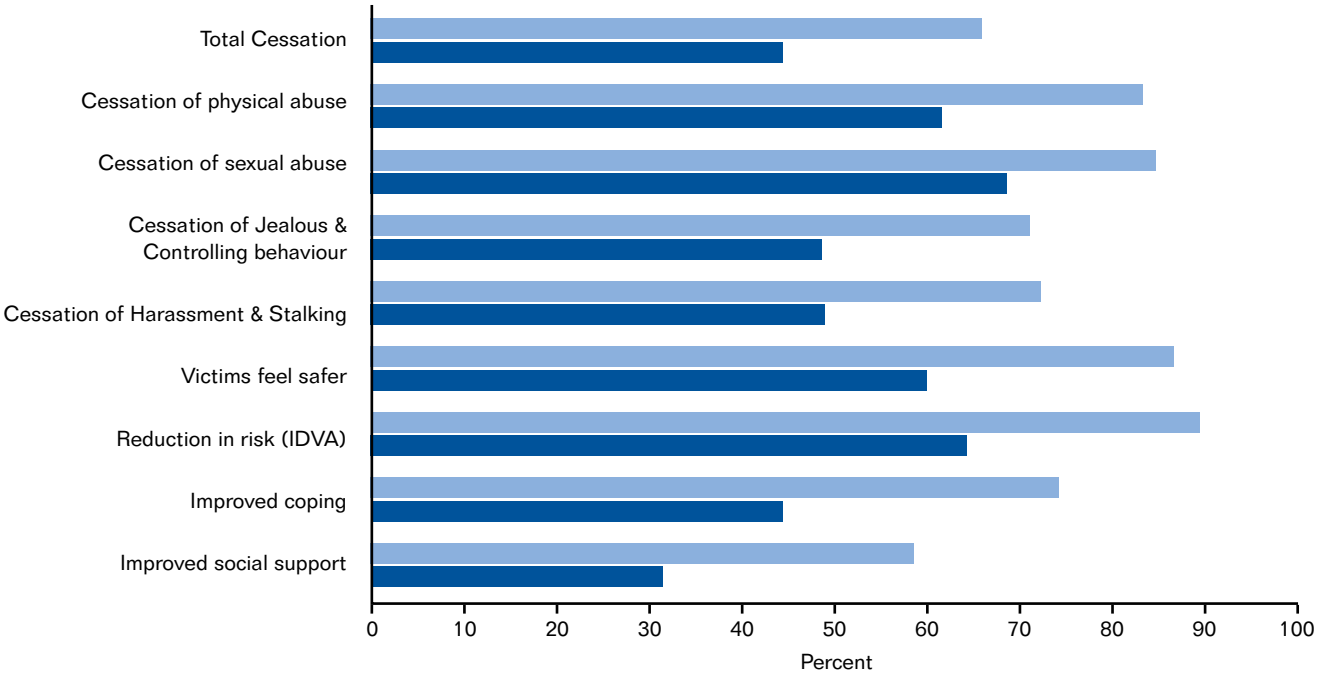
Intensity was also linked to victim well-being. There was a significant impact of this aspect of support on victims' coping mechanisms and support networks, with victims with whom IDVAs worked in a more focused way found to be twice as likely to have made significant positive changes to both their coping strategies and support networks (compared to those who received less intensive support).

[86]We were unable to take account of victims' readiness to address the abuse in their lives. Research suggests that this may have a significant bearing on victims' engagement with helping services (eg Feder et al, 2006b ; Zink et al, 2004), which may in turn have an effect on the degree of impact that an intervention may have. Several recent systematic reviews conclude that advocacy is most effective for those victims who have already begun to actively seek help, and the support they receive is intensive (Ramsay et al, 2009; Ramsay et al, 2005).

[87]These figures relate to the adjusted odds ratios which are calculated to show the likelihood that a positive outcome is achieved according to the presence of absence of an independent variable (eg intensity of support: intensive vs. less intensive) after taking into account the contribution of other variables that may have an influence on the outcome being considered (e.g. the presence of children).

[88]Given the fact that IDVAs work in partnership with other agencies, this effect is also likely to reflect more effective mobilisation of the resources of other agencies which will have had an impact on victim safety.

The concept of relative odds is somewhat abstract and difficult to understand and so **Figure 17** depicts how these results look like in concrete terms[89]. This figure illustrates clearly that the proportion of victims achieving successful outcomes was greater across each of the measures of safety and well-being that we considered when victims received intensive support compared to when the received less intensive support. By way of example, 67% of those receiving more concentrated support achieved a cessation in abuse, in comparison to 44% of those receiving less intensive support, and 87% of those receiving intensive support felt safer at Time 2, in comparison to 60% of those having less contact with an IDVA.



	Improved social support	Improved coping	Reduction in risk (IDVA)	Victims feel safer	Cessation of H&S	Cessation of J&C behaviour	Cessation of sexual abuse	Cessation of physical abuse	Total Cessation
More intensive support	57	75	90	87	73	72	84	73	67
Less intensive support	32	44	65	60	50	50	68	64	44

Figure 17: Percentage of victims achieving positive outcomes as a function of the intensity of support

The impact of access to multiple interventions: Turning to consider the impact of multiple interventions on victim outcomes, results showed that the receipt of multiple forms of support (compared to the mobilisation of none or only a single type of intervention) increased the chance that abuse would stop altogether. *The likelihood of a positive outcome increased progressively with the number of interventions received.* For example, receiving more than 10 types of intervention tripled the chances that abuse would stop altogether (compared to those receiving 0-1), whereas receiving 2-5 forms of intervention (compared to those receiving 0-1) still increased the odds of a cessation in abuse, but to a lesser extent. This can be more easily visualised by referring to **Figure 18** where the proportion of people achieving a positive outcome is seen to be incrementally higher as the number of interventions increased[90]. As illustration of this point, 31% of those accessing no or single services experienced a cessation in abuse,

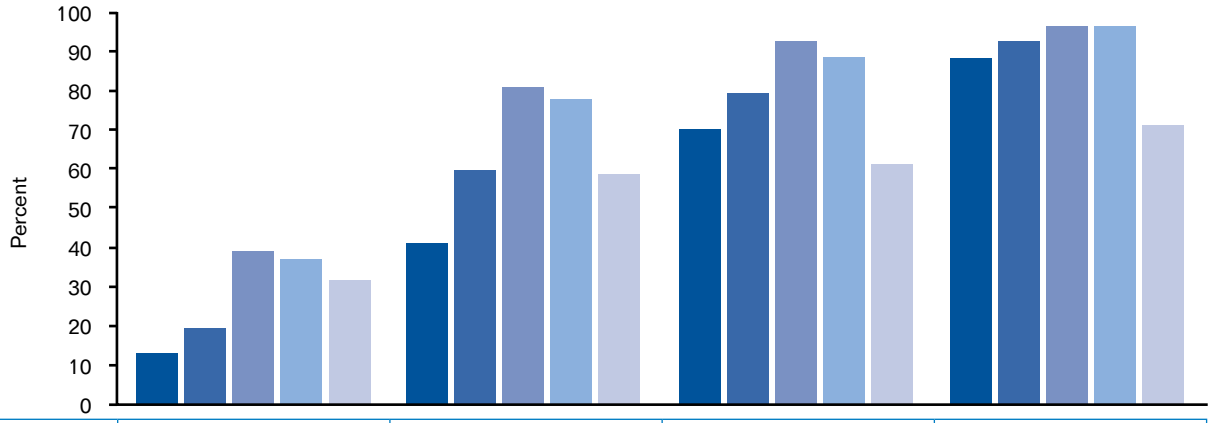
[89]The figures that can be read from this graph do not map back to the adjusted odds ratios discussed in the text.

[90]Again, the figures that can be taken from the graph do not directly map against the adjusted odds ratios presented in the text.

whereas this increased to 58% for those accessing 2-5 intervention, 66% for those accessing 6-10 interventions and 73% for victims helped to access over 10 services or resources.

Victims were twice as likely (relative to those receiving 0-1 interventions) to feel safe after being helped to access between 2-5 forms of intervention, and around 4 times more likely to feel safer when 6-10 interventions were mobilised. Conferring with this finding, some reduction in risk (as rated by IDVAs) was twice as likely on receiving 2-5 interventions and between 7-10 times more likely on receiving 6-10 types of support[91].

In addition to having some impact on safety, the multiplicity of interventions also impacted on victim well-being. Receipt of 2-5 interventions increased the chances of positive changes in coping strategies by three times and doubled the chances of improved social networks by 2.5 times. The receipt of 6-10 interventions increased the chances of improved coping and social support by 7 and 6 times, respectively. Finally, access to over 10 forms of specific intervention improved the odds of positive changes to coping by 20 times and support networks by a factor of 15[92].



Number of interventions	0-1	2-5	6-10	11+
Improved social support	14	43	69	88
Improved coping	20	63	81	94
Reduction in risk (IDVA)	39	81	93	97
Victim feels safer	37	77	88	97
Total Cessation	31	58	66	73

Figure 18: Percentage of victims achieving positive outcomes as a function of the number of resources mobilised.

In contrast to these findings, little consistent link was found between the multiplicity of interventions and the cessation of individual forms of abuse. However, it should be kept in mind that for the purposes of these analyses we considered the complete cessation of individual types of abuse and they tell us little about those cases where the severity of any particular type of abuse was reduced significantly, which the results discussed above (see **Figure 14**) show us as happening in a great many cases[93].

Again, victims' comments conferred with the conclusions derived from quantitative data,

[91]Irrespective of whether the outcome was measured from victims' or IDVAs point of view, the effect of receiving more than 10 interventions did not improve the chances of a positive outcome over those observed for victims receiving only 0-1 forms of help. This might have been because the mobilisation of so many different kinds of help might only characterise the very worst cases, or it may mean that contact with so many services may leave victims feeling confused and overwhelmed (even with the support of an IDVA) and thus the effectiveness of the multi-agency response is lost in these cases. Given that the group of victims receiving access to this very high number of interventions was small, caution is required in interpreting the results.

illustrating the role that access to wide ranging and multiple interventions played in determining their safety.

"[IDVA] helped make referral to Sanctuary and secured my property. She put me in touch with a solicitor to apply for an injunction and an order to keep my husband out of the property."

Additionally, victims' comments offered further insight into the specific components of the support delivered by IDVAs which were seen to have a positive impact on safety. Many victims made mention of the particular types of support or agencies that IDVAs were either able to offer directly or else were able to mobilise on their behalves. Victims most commonly cited changes in their housing situations and support though a criminal court case as facilitating their safety.

"I was getting nowhere with housing, but by taking my fears seriously you have managed to get others to take it seriously."

"I have an alarm and extra locks as this helped me stay strong and keep my ex-partner out of the house"

'[she is] safer because she has gone through the courts and given evidence against him so maybe he has listened and will leave her alone a bit more now.'

They also viewed assistance in obtaining civil injunctions and dealing with child-related issues as important as was MARAC and the improved response from and, as a result, confidence in the Police.

'Now has NMO [non molestation order] and occupation order and perpetrator has not breached the orders at all. Client feels much safer now she has these orders.'

'Is sticking to child contact arrangement.'

"Pleased Police aware of what is going on and feel as though it is taken seriously. Increased my confidence in Police because had joint meeting with IDVA and DAO who advised me of my rights and criminal offences."

Some victims also specifically mentioned the benefits of completing a risk assessment in helping them to make an accurate appraisal of the danger they were in.

'The survivor stated that the risk assessment was extremely helpful to her because it challenged her mind and allowed her to admit the fact that the perpetrator was a danger to her.'

Taken together, what do the results discussed throughout this Section tell us about the most effective way to promote positive changes in victims' safety and well-being?

First, these results show that the provision of intensive support and multiple interventions by IDVAs increased the likelihood of positive changes in victims' safety and well-being, with those receiving intensive support and multiple interventions being much safer compared to those receiving less intensive support and access to none, or only a single type of intervention. These findings are the first in the UK to explicitly draw a link between the way in which IDVAs work, the specific components of the intervention they offer and the outcomes that are achieved for victims. They confer with the results of previous studies that show that the provision of advocacy type interventions and other multi-agency solutions (eg MARAC) are effective in reducing abuse and enhancing safety and well-being (Robinson, 2006b; Sullivan & Bybee, 1999), and that those delivered with greater intensity are found to be more effective (Ramsay et al, 2009). Importantly, this study shows that these results can be extended to those victims experiencing very serious levels of abuse.

[92]This group of victims was extremely small and thus these results should be interpreted with caution.

[93]The sensitivity of the measure of abuse used here was not such as to allow us to examine the impact of these particular facets of intervention on the reduction in particular attributes of abuse (eg severity), and this remains an area that demands further enquiry.

Second, these results show that further work is required to understand what works in reducing the severity and bringing about a stop altogether in specific types of abuse. In particular, less consistent effects were found here with respect to non-physical forms of abuse (jealous and controlling behaviour and harassment and stalking). Further enquiry as to the specific intervention strategies and ways of working to address these forms of abuse would make a significant contribution to the evidence base.

3.2 Other risks that reduce the chances of positive changes in safety and well-being

A theme emergent throughout this report is that some factors present in victims lives may serve to compound or increase the risk that they will experience harm (see Chapters 3 and 4). Whilst by and large, the odds of improved safety and well-being did not differ according to victims' demographic profiles, several factors were identified as seeming to diminish the likelihood of achieving positive change for victims, even after taking into account the type of intervention that victims received (see Appendix 11 for results tables).

- It was consistently noted that where there was evidence of perpetrators' chronic antisocial behaviour, criminal history or mental ill health, then the chances of positive changes in victims' lives were reduced.
- Positive changes were also less likely for victims referred to an IDVA services on more than the first occasion (a repeat referral).
- Reduced odds of safety and well-being were found for victims who were experiencing at least one form of severe abuse at the point of referral to a service.
- The chances of safety and well-being were also progressively diminished as the number of risk factors in victims' lives increased (as surveyed by the RIC).
- Consistent with other research showing that the risk of harm is increased during the time that victims attempt to separate from an abusive partner, actual or impending separation was found to reduce the chances of positive changes to safety and well-being.

Not surprisingly, analysis of victims' comments identified continued contact with the perpetrator as the most salient threat to their safety, with some victims mentioning the continuing abuse they were experiencing, much of which involved harassment or emotional abuse, as opposed to physical or sexual abuse. This is consistent with the findings discussed throughout this Chapter which indicate that non-physical forms of abuse may be more difficult to curb than other forms and that harassment, in particular, may escalate or indeed begin as victims seek formal assistance and any physical abuse is curtailed.

'Feels like he could find her at any time and she feels she is always looking over her shoulder.'

'The physical abuse seems to have ceased but there is still emotional and mental. Perpetrator has broken telephone and laptop'

When considered alongside the results relating to the impact of intensity of support and multiplicity of intervention, these findings provide some account of the variation in victims' safety and well-being following the receipt of intervention. Receipt of less intensive support, limited access to additional services and remedies, the presence of particular risks in a victim's life and continued contact with the abuser may make it less likely that IDVAs are able to facilitate positive changes in a person's safety and well-being. In developing a more comprehensive understanding of factors that inhibit efforts to enhance victim safety and well-being, we can start to gain a better perspective as to where efforts must be focused in order to optimise the impact of intervention.

4. Sustainability of positive outcomes over time

So far, this Chapter has illustrated the many positive changes in safety and well-being that are achieved for the majority of victims, following a period of engagement with an IDVA service. Nevertheless, international studies demonstrate that initial success rates observed immediately post intervention tend to diminish over time, which is most likely a reflection of the complex and intractable nature of domestic abuse[94]. This section details IDVAs' perceptions as to the sustainability of positive changes in safety, immediately following intervention (n=1,247) and also draws on a small sample of data (n=34) to examine how victims were faring 6 months following the closure of their case.

When IDVAs were asked to predict (at the point that a case was reviewed) the period of time over which they expected victims to remain abuse free, 39% perceived the cessation in abuse to be sustainable over the longer term, whereas 44% felt that abuse had ceased for the medium or short term only. There was limited guidance offered to IDVAs as to the exact definition of long, medium and short term and as such responses to this question may have been fairly subjective (what one person considers as being medium term, another may consider being longer term). Nevertheless, these data provide some basic indication that in a significant number of cases, IDVAs anticipated that the positive changes achieved for victims would last well beyond the end of the intervention.

In order to gain a sense of the extent to which this was the case, a small group of victims (n=34) were re-contacted 6 months after the closure of their case[95]. The first finding to note from **Figure 19** is that the majority of victims (n=28) stated that they had not experienced abuse of any kind since their case had been closed. A small number (n=4) reported that they had experienced revictimisation, but on a lower level than before, and two victims indicated that abuse had mostly, although not completely, stopped. This ongoing abuse seemed to largely reflect harassment and stalking which as earlier results reveal, appears to be a relatively enduring form of abuse compared to physical abuse.

Importantly, the majority of victims reported feeling safe at this point in time (n=29). When asked to reflect on the reasons behind their improved feelings of safety, victims largely focused on the support they had received from an IDVA.

Victims also talked of improvement in their housing situation, better knowledge of how to access support in the future, and a cessation of contact with, or from, the perpetrator (often as a result of a non-molestation order), citing the IDVA as pivotal in helping them to access these services or to make changes in their lives.

"She said she could not have carried everything through without the constant support from [IDVA]"

"I feel safe, due to support from the IDVA in obtaining a non-molestation order"

"She now feels that thanks to the support of [IDVA] she has the tools to protect herself in future."

[94]Sullivan and Bybee (1999) documented that 58% of victims were free from abuse immediately following the receipt of advocacy services. This figure was reduced to 42% 6 months later and further reduced to 24% when victims were surveyed two years after receipt of advocacy (less than half of the original figure).

[95]All victims comprising this follow up sample had consented at case closure to be re-contacted after a period of six months.

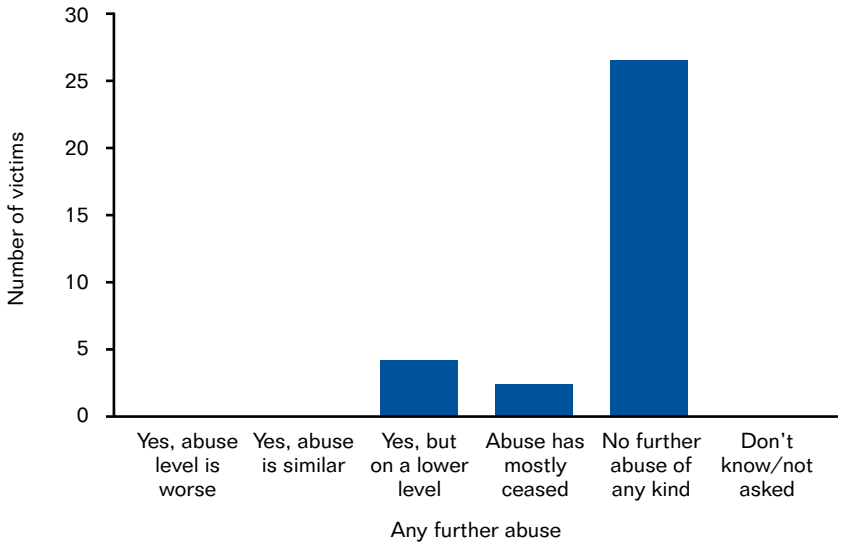


Figure 19: Number of victims experiencing abuse after 6 months

Whilst the results described here suggest the maintenance of positive changes in safety into the medium term (6 months), and victims themselves describe the IDVA and the specific forms of support that they mobilised as instrumental to their continuing safety and well-being, these findings should be interpreted with a good deal of caution due to the very small sample size[1].

Concerted research efforts (and funding) are needed to undertake larger scale follow up studies of victims accessing IDVA services in order to provide us with more robust evidence as to the potential longer-terms benefits afforded by this intervention. However, these results do give some sense that the benefits of working with an IDVA may extend beyond the immediate period of intervention.

5. Summary of key points from Chapter 5

1. **There was a dramatic improvement in victim safety following work with an IDVA.**
   - 57% of all victims experienced a complete or near cessation in the abuse they were experiencing.
   - The intervention that IDVAs offered produced significant reductions in all forms and levels of abuse, with the most marked reductions observed across physical forms of abuse.
   - Harassment and stalking of all levels showed reductions of smaller magnitude relative to other forms of abuse, although there were still significant positive changes over time with respect to the frequency with which this type of abuse occurred.
   - 76% of victims felt safer following the receipt of IDVA services. Similarly, IDVAs reported reduced risk in 79% of cases.
   - There were good reductions in specific child related risks following intervention.
   - Less than 1% of victims felt that they were less safe following support from the IDVA.

   ➢ **These results suggest that the intervention offered by IDVAs is effective in reducing the risk of serious harm faced by victims experiencing severe domestic abuse. The consistency of results, across multiple measures of safety, points to this as a robust finding.**

   ➢ **By virtue of its more covert nature harassment and stalking (along with other non physical forms of abuse), may be relatively more challenging to address, both for the IDVA and the victim themselves.**

   ➢ **IDVA services may enhance children's well-being, by bringing about a stop or a reduction in abuse, and also by helping to ameliorate specific risks to children's safety.**

2. **There were positive changes in victims' well-being following the receipt of IDVAs' service.**
   - IDVAs reported that there had been significant improvements in victims' social networks in 47% of cases.
   - IDVAs reported that there had been significant improvements in victims' coping abilities in 63% of cases.

   ➢ **These results show that in addition to the impact on safety, the intervention that IDVAs offer facilitates associated benefits in terms of victims' well-being, which evidence suggests may be the key to achieving longer-term safety.**

3. **The way in which IDVAs worked with victims had a direct bearing on the chance of achieving improved safety and well-being.**
   - Victims who received intensive support and multiple types of intervention were roughly twice as likely to experience a cessation in abuse compared to those victims receiving less intensive intervention, or only a single type of intervention.
   - Some factors present in victims' lives made it less likely that they would be able to achieve positive outcomes, including indicators of perpetrator antisocial behaviour (criminal record) and other aggravating problems (e.g. mental ill health), repeat victimisation, the presence of severe levels of abuse and separation.

   ➢ **These findings suggest that the intervention that IDVAs provide is causal in bringing about positive changes for victims.**

   ➢ **Intervention that includes intensive support and access to multiple resources represents the most effective way of working with high risk victims of domestic abuse who are likely to experience significant harm without subsequent intervention.**

➢ **IDVA services can have limited, if any, impact on specific risks relating to perpetrators' behaviour and other problems, underscoring the need for a more integrated approach to intervention, including those services that have direct contact with the perpetrators of abuse.**

4. Positive changes achieved as a result of working with an IDVA may be sustainable in the longer term

- In 39% of cases, IDVAs believed that a cessation in abuse was sustainable into the longer term.
- A majority of victims surveyed (82%) reported that they had experienced no further abuse during the 6 months following the closure of their case.
- Victims perceived the work undertaken by IDVAs on their behalf as pivotal in helping them to achieve these positive changes.

➢ **These results suggest that the short-term intervention offered by IDVAs (and the partnerships that this represents) may facilitate longer term changes in victims' safety and well-being.**

6. Implications for practice and policy

1. **IDVA services can effect positive change in victims' safety and well being over the short and medium term, although harassment may be relatively more difficult for IDVAs to address. Intervention that includes intensive support and access to multiple resources represents the most effective way of working with high risk victims of domestic abuse, although some factors present in victims' lives may diminish the impact of intervention.**
   - Wherever possible, IDVAs should offer intensive support and help victims to access multiple resources.
   - Service managers should ensure that IDVAs are adequately supported in order that they can work in the ways shown in this report to be most effective: intensive support coupled with a multi-agency response.
   - Funders and commissioners should ensure that services are structured in such a way and with sufficient capacity in order to work with all victims in the way shown to promote the best outcomes for this high risk group.
   - Greater awareness of the factors that inhibit efforts to enhance safety and well-being may help IDVAs as far as possible to mobilise interventions and services that directly address these risks.
   - IDVAs must ensure that they have strong links with specialist services addressing perpetrator behaviour and issues including substance misuse and mental health services, Police and Probation and co-ordinate with these services wherever possible.
2. **The intervention that IDVAs provide to the adult victims of domestic abuse has a positive impact on the risks to children, through reducing levels of abuse and addressing some direct risks to children's safety. There are a number of actions that services may be able to take in order to maximise the benefits for children:**
   - IDVA services must work in close partnership with services which work directly with children exposed to domestic abuse creating a care pathway that protects the safety of the child while supporting the non-abusing parent.
   - All children of high risk victims should be flagged to the appropriate statutory bodies which are involved in the safeguarding of children. This will ensure that risks to children can be fully assessed and the appropriate course of action determined.
   - Explicit risks to children's safety should be communicated as a priority to all services working with the children of high risk victims.

- Effective links between MARACs and local safeguarding boards need to be established.
- Those involved in safeguarding children should be made aware of how an IDVA service should work to be most effective and the impact that this can have on the safety of the child.
- IDVAs should receive basic training with respect to the risk that domestic abuse of all levels poses to children's physical and psychological well-being. This will enable IDVAs to work with the non-abusing parent in order that they understand the impact of domestic abuse on their children and what they can do to protect them.

3. **The use of intervention strategies to specifically address non-physical forms of abuse, particularly harassment and stalking, needs to be considered. This may include:**
   - Working with victims to better recognise, acknowledge and document all levels of harassing and stalking behaviour in order that it can be shown to be a persistent 'course of conduct' and reported as such.
   - More effective use of existing criminal and civil remedies and systematic reporting of breaches of non-harassment orders.
   - Implementation of safety measures around child contact arrangements in order to minimise the opportunity for ongoing abuse of this nature.
   - This must be supported by increased awareness amongst all other agencies, particularly the Police, as to the potential risk that continuing stalking and harassment poses to victims' safety and well-being.

Putting it into context:

Helen worked with Linda for another week following the end of the court case. Linda indicated that she felt much safer and Helen agreed that she was in a much better situation now compared to when they first started working together. Despite feeling much safer, Helen's ex-partner only received a short custodial sentence and she indicated that she was worried about what would happen when he 'got out'. She was particularly concerned that he would try and resume contact in order to see their daughter. Helen reassured her that the civil order she had previously received would be in place for the remainder of the year and that if he wished to see their daughter he would need to apply through the courts. Linda also felt that whilst she had been able to get out a bit more, she was still feeling that she didn't know many people in the area. Helen and Linda talked about Linda seeing her mum and her sister on a more regular basis and Helen also suggested that Linda might want to think about joining a local survivors group – both to talk about her experiences and to meet some new people. Linda's case was closed after 10 weeks on 28th March 2007.

Chapter 6: Service Level Perspectives[96]

In drawing together the many different findings yielded by this evaluation, we felt it important to reflect on the impact that the evaluation process itself has had on IDVAs and on their practice. This is an often overlooked, yet crucial aspect of any evaluation, particularly as evaluation and monitoring is now being seen by funders as desirable, or even essential, in today's climate of increased accountability and limited funding. In this short Chapter, we highlight some of the problems that hampered progress in the beginning and the learning and impact on practice that became apparent as the process became embedded in everyday routines. We hope that consideration of what helped and what hindered the evaluation process may be useful to others who look to embark on a similar type of project and perhaps also to services who wish to be evaluated or, indeed, to evaluate their own progress. Furthermore, we hope that IDVA services more widely will integrate these routines into their case management procedures.

At the outset of this project, services were keenly aware of the need for an outcome focused evaluation of the IDVA model. Although some of them had previously commissioned either internal or external evaluations of their work, none had embedded comprehensive data collection in their normal everyday practice. None of the projects were routinely gathering sufficient data that could be used to evidence their impact on the safety and well-being of the victims with whom they worked, yet, without exception, all were looking to secure sustainable funding for their services and were being required by funders to provide evidence of their effectiveness to make a strong case. Against this backdrop, participation in an evaluation did not need to be 'sold' to services, with one service manager commenting that the reason for her project's involvement was:

'to support the sustainability and future funding of the service, to demonstrate not only effectiveness but also that we are part of a large network of services'

The foresight of service managers, IDVAs and project administrators - those who deliver the IDVA model of intervention - as to what this research could mean for the sector as a whole, as well at their own local levels, created a unique blend of commitment and openness to ideas that has been a key to the success of this project. As one project administrator said:

'We need to keep at the forefront of developments [in the sector] and all evaluation and data is important for the future of the project'

Despite this, the evaluation process did not prove to be easy to implement. Those services who did not already have a computerised case management system were asked to use one, from which data for this evaluation were extracted. It was hoped that electronic case files would aid services in accessing and storing their records, which, in turn, would help them to keep better track of case progress and ensure continuity if a case had to be handed over. However, moving from paper to screen presented significant challenges for services in the early stages, as they were slowed by having to learn how to use a new system. For many, this did not represent the natural way of working with clients and required that information was still recorded using paper notes which were later transferred on to the computerised system, creating an additional task for IDVAs and/or administrative staff.

As expected, one of the primary difficulties was the pressure created by juggling data collection requirements with the core business of working with victims of domestic abuse and their children. Some of the words that services commonly used to describe the process were 'time consuming', 'distracting' and 'frustrating', although tempering this services also saw it as 'necessary' and 'worthwhile'. Whilst some information required for the evaluation was collected by IDVAs as a matter of course, a significant amount was not. At first, collection of this extra information felt like a significant demand on an IDVA's precious time. Moreover, the evaluation team agreed with the projects that some supplementary data would need to be collected a year into the evaluation, which compounded the workload issue.

[96]This chapter is based on an earlier article published in Safe Magazine Howarth, E. (2009), Evaluation of advocacy services for domestic abuse survivors, safe, 28, p. 14-16.

'It was a time consuming process in relation to the questions and ongoing forms that need to be completed with clients and then put into the electronic Hestia forms on the database' [Service Manager]

The need for data that was as complete as possible meant not only were projects wrestling with the demands of data collection, but also, to some extent, with the issues surrounding the management of data. Issues at this level often seemed far removed from the overarching goal of improving safety and time spent checking data appeared at times difficult to justify. One manager commented that they were:

'constantly hassling IDVAs regarding the completion of forms and in missing data...and really was quite a culture shift for the teams'

'I felt at times they did not understand the amount of extra work we were being asked to do' [IDVA]

Nevertheless, as the collection of data has become embedded into everyday practice, these matters became more manageable for projects and for the individuals involved. Embedding the process was often, although not exclusively, lead by project administrators. It was noticeable to us that those services who found the evaluation more manageable were those which took time to look at how the collection of information relating to victims and children could be built into their everyday operations, although by the end of the process every service had managed this to an extent.

'I soon changed the way that the IDVAs collected data and then the evaluation just became a routine task' [project administrator]

'Once I had a system in place and some organisation, the evaluation became part of my life. Yes there was a bit more work but I had the back up of a good team' [Service Manager]

Over time, projects became noticeably more adept at collecting and handling data and there was a clear shift in individuals' understanding and knowledge of what was required in order to gather valid, meaningful information that could be usefully employed to evidence impact. Indeed, several projects intend to continue with data collection using the evaluation tools, in order that they may be able to monitor the impacts of their individual services 'in-house'. We feel that equipping projects with the 'know how' to assess the impact of their individual services is an extremely positive outcome of this evaluation.

'We are now as a matter of course collecting more valid information than before' [Service Manager].

A critical part of this evaluation's success was the collaborative nature with which it was undertaken. From the outset, it was clear that success would hinge on the commitment of the IDVA services serving as data collection sites, and therefore it was fundamental that this work was undertaken as a partnership between those commissioning the work, those collecting the data and those co-ordinating the evaluation. Maintaining good levels of contact was important in keeping everyone's eye on the shared goal of this work. Throughout the course of the evaluation period, we held regular feedback meetings with the services, which gave everyone involved an opportunity to voice the high points and the low points that arose as a result of their involvement in this major research endeavour.

In particular, the presentation of preliminary results served as an injection of morale for both those individual IDVAs involved in co-ordinating data collection and for the projects as a whole. It marked an important point in reaffirming some of the benefits of evaluative work. The projects involved reported that they rarely had the chance to 'step back' and review the impact that their work had on victims experiencing serious levels of abuse and, for this very reason, it could be difficult to get a sense of how effective they were. Time spent examining and discussing outcome data provided the much-needed opportunity to reflect on the work that they do, and also helped in the interpretation of difficult findings. Importantly, owing to the collaborative nature of this project, there was a sense amongst

projects that they owned the findings we presented, adding to what one IDVA called the 'combined sense of achievement' felt at each one of these feedback sessions.

'The elements of the service highlighted by the Hestia evaluation were precisely those which promote the safety of the client and, therefore, it was time and effort doubly repaid' [Service Manager]

The potential of the evaluation process to impact in these ways is documented elsewhere[19] [188] and was, to some extent, expected, or at least hoped for. However, there were also some unexpected benefits that emerged over the two years, which have provided important insights into the process by which services can operate most effectively. Service managers and IDVAs reported that the collection of data at multiple time-points throughout a case helped them to 'tighten up' the way in which the progress of a case is reviewed, resulting in a more timely and systematic case closure procedure.

'the 'intake' and subsequent 'reviews' have helped to structure the paperwork necessary around working with the clients and the evaluation has given the team goals and targets which has been positive [Service Manager]

As we have seen, victims come through the doors of an IDVA service with many needs, meaning these complex cases are difficult to manage and even more difficult to close, especially when risk is never fully diminished. Whilst caution around the closure of cases is understandable, it may result in IDVAs shouldering a far heavier caseload than is in the best interests of either victims or IDVAs themselves. The regular review of cases using standardised assessment measures has enabled IDVAs to document changes in victims' situations over time, helping them to identify what still needs to be done, as well as prompting the timely closure and perhaps the referral onwards of those cases where there has been a significant decrease in risk. As illustration of this, one IDVA commented that

'some cases never close completely, but this has helped us tighten up the way we manage our cases, helping us to make the decision to move some cases off the active case list' [IDVA]

Another service commented that the data collection tools gave structure to the decision making process around closing a case. In essence, it became apparent to us that the provision of practical tools which formalised the gathering of information around service outputs (what has been done) and outcomes (safety and well-being) had a profound effect on the efficiency with which some services were able to operate.

This was not the only process level benefit. Part way through the evaluation process, and on the advice of the advisory panel overseeing this work, we asked services to gather follow-up data from victims who prospectively gave their consent to be re-contacted. At first there was a fair level of resistance to re-contacting victims six months after exiting a service, both because of concerns for safety and because of the additional workload this represented. This is perhaps reflected in the fairly small sample that we were able to assemble. As one service manager described the follow-up:

'This always felt quite difficult as the individual has often moved on and if it is not a service user that has ongoing involvement with the service, they may not want to go over the incident'

However, those who did take on the challenge reported that rather than causing the problems that they initially anticipated, victims were often pleased to hear from service staff. Where victims remained free from abuse, women wanted to share the extent to which they had moved on.

'Certainly, of all of the women we have managed to get through to, not one has refused to do the follow-up, in fact, all have been really pleased to hear from us (not to mention thrilled to receive a voucher)'.

In the less successful instances, where there had been repeat abuse, then the follow-up call represented a way of re-engaging victims who were reluctant to return to the service. One IDVA reported that a client felt too 'ashamed' to re-contact the service, feeling that she had 'let her IDVA down' after the support she had been given in the first instance. As a result of this, two of the seven projects have taken the decision to incorporate this proactive contact as part of their practice.

'...so we have made a policy decision to try to contact women after 6 months in all cases where we can, as an added part of our service, to ensure safety, as we think it works well' [Service Manager]

'...I am planning to continue with 6 month follow-up calls as I feel we will be able to encourage clients to re-engage if risk has increased again/abuse started again' [Service Manager]

So what did we learn from this experience that may be useful to others? The success of this project underscores the importance of undertaking evaluation in a collaborative fashion between those being evaluated and those undertaking it. In particular close and regular contact between evaluators and data collection sites is critical in helping to ensure that the quality of data collected is adequate for evaluation purposes, and for obvious reasons these relationships are important to establish at the outset of the evaluation. For us this was aided by the interim reporting of findings, which was particularly powerful given the paucity of research undertaken in this area. Further more our experience shows that whilst the introduction of new processes (such as formal case reviews and follow-up interviews) to support an evaluation can be incredibly difficult at the outset, this has the potential to lead to longer term benefits for services in terms of increased efficiency and more evidence based decision making.

Chapter 7: Discussion of Main Findings and Recommendations

1. Introduction

In today's Britain, there can be little doubt that domestic abuse remains a serious social problem accounting for a minimum 16% of violent crime and approximately 40% of female homicides [(189)]. Recent years have seen increasing recognition both by Government and the range of agencies involved in responding to abuse that victims deserve to be offered a professional and effective service. IDVAs represent the outcome of accumulated efforts that have dramatically altered the landscape of service provision for victims of domestic abuse in recent years. The proliferation of IDVAs in England and Wales indicates a new risk-based approach to tackle the most chronic and severe of these cases, recognizing the inevitable shortage of resources to address the problem and the concomitant need to prioritise the response.

In common with other areas of intervention in this field, this expansion in IDVA provision is not rooted in an extensive, reliable, nor directly relevant evidence base but rather on 'expert opinion, anecdotal evidence, personal experience and logic' (p. 18 Ramsay et al, 2005). Thus to date, little is known about the methods used by IDVAs to help high risk victims and the extent to which these methods are successful either in the short or long-term in enhancing safety. This study was conducted as an initial step towards addressing this significant knowledge gap and represents the first, large scale multi-site evaluation of this type of specialist advocacy provision. The unique features of this study design mean that this evaluation is able to yield robust evidence about both the process of IDVA service delivery and the impact of these services across a range of outcomes.

The central aim of this research was to consider the effectiveness of IDVA services in enhancing both the safety and the well-being of victims considered to be at high risk of serious harm or homicide as a result of domestic abuse. In order to achieve this, the study set out to examine: (1) the nature of the abuse experienced by the victims with whom IDVAs work, and a description of the children and perpetrators involved in these cases; (2) the key features of the service that IDVAs provide to victims, and the extent to which they can tailor what they offer to meet the specific needs of individual victims; and finally (3) the extent to which abuse was reduced after working with an IDVA.

In terms of one woman's story, this research illustrated how Linda, a young mother of two children who experienced life-threatening abuse from her ex-partner, was given the advice and support necessary to improve her situation significantly. Her example is typical of literally hundreds of women in this study who received specialist support from IDVAs to help them deal with extremely serious, multi-faceted, and often terrifying levels of abuse. As an additional consequence of receiving support from IDVAs, many thousands of children living with these victims will have had a better chance of being safe.

The extensive information provided by seven IDVA projects over the course of 27 months, has produced a wealth of insights that have significantly advanced our understanding of 'what works' to improve the safety and well-being of these high risk victims. Furthermore, this study has shone a torch on those areas of practice that could be improved, with the view of making this an even more effective way of enhancing the safety of victims of domestic abuse and their children. Aside from making a valuable contribution to the evidence base, we hope this research is used to further improve policy and practice for the many adults and children whose lives are blighted by domestic abuse.

This final chapter presents a synthesis of the main findings and conclusions drawn from each of the empirical chapters in order to first address what this research tells us about the efficacy of this model of intervention and how these findings can be drawn upon to inform policy and practice., We also consider those areas of service delivery which these findings suggest might be improved upon, in order to ensure that each and every victim accessing an IDVA service receives a premium service, maximising their chances of living safety in the future. Lastly, we briefly discuss some of the limitations of this study before ending with some thoughts on future directions for policy, practice and research.

2. Key findings and conclusions

Chapter 3 of this report showed that victims referred to IDVA services were typically experiencing extremely serious levels of abuse that had been occurring over a number of years. In addition there were often additional sources of adversity or vulnerability in their lives that served to increase the risk of harm to victims, no doubt adding an additional layer of complexity to the work IDVAs were undertaking in these victims' cases. Finally, this Chapter documented that many perpetrators exhibited chronic levels of antisocial, criminal, and violent behaviour and a large number of children were also exposed to abuse, which in many cases posed a *direct* threat to their physical safety.

Chapter 4 showed the majority of victims referred to services chose to remain engaged over a significant period of time regardless of their socio-demographic characteristics, suggesting that IDVA services were well received and valued by victims. Most victims received intensive support and were provided with access to a wide range of advice and services. The support IDVAs provided was also clearly tailored according to the individual characteristics of victims, including the type and levels of abuse they were experiencing and their personal and social circumstances.

The very substantial improvements in victims' safety and well-being over time were detailed in Chapter 5, showing that even in these very serious cases, a complete cessation of all forms of abuse was reported by a majority of victims. This was supported by evidence showing that there were significant reductions in the type and seriousness of abuse and, crucially, by the fact that victims *felt safer* following a period of engagement with an IDVA. Importantly, this Chapter provided very significant insight into the most effective ways of working with victims, showing that those victims receiving access to multiple resources and more focused support from an IDVA fared significantly better than other victims.

What are the key messages to take from these findings?

2.1 The efficacy of IDVA services.

2.1.1 An effective approach to tackling very serious domestic abuse.

Above all, these results indicate that the intervention offered by IDVAs has a clear and measureable impact on the safety and well-being of victims experiencing extremely serious levels of life threatening domestic abuse. Moreover, the results of this study show (as we would intuitively expect but have not been able to document before now), that by reducing the risk of harm faced by the non-abusing parent, this type of intervention goes some way to reduce the risks to children who are growing up in homes marked by abuse.

In essence, the results described here suggest that short to medium term intervention provided by IDVAs from the point of crisis offers one very practical, effective and evidence-based policy option for responding to high risk victims and their children. In the UK and elsewhere, there has never been such clear cut evidence of the immediate benefits that are possible from providing a multi-agency response to domestic abuse, and thus this type of work must be protected, supported, and properly resourced. The overall implication of this research, given the evidence that we now have, should be to further develop and professionalise these very valuable newcomers to multi-agency partnership work on domestic abuse.

2.1.2 The efficacy of this approach rests on having sufficient capacity.

Additionally, this study gives important insight into the ways in which IDVAs can work with victims in order to give the best chances possible of enhancing safety and well-being, namely by providing intensive support and access to multiple solutions. This is the first time that a study has been able to draw an explicit link between the way in which IDVAs work and the outcomes achieved for victims, meaning that we are now in a position to make some clear and simple recommendations for practice that are rooted firmly in evidence.

Nevertheless, this study showed that IDVAs did not work in the most concentrated way with all victims and, furthermore, not all victims were aided in accessing multiple resources. This may have been for a number of reasons, one obvious one being that victims themselves were not always ready to engage with services in order to tackle the abuse they were experiencing. However, IDVAs were prioritising the intervention they provided according to risk (which is of course the most effective use of resources). When one considers that this is an already high risk sample to begin with, then it is difficult not to question whether this might be explained in part by inadequate capacity both in terms of the IDVA services themselves and the external agencies with whom they need to work.

Anecdotal evidence from the sector as a whole and from the services participating in this study suggests that in many instances IDVAs are often shouldering case loads that sometimes seem unmanageable. This will only become a more commonplace state of affairs if capacity is not increased as the value of this approach to intervention becomes more widely recognised and referral pathways from all directions become stronger. If this should be the case, then there is a danger that the benefits of this approach to working will be significantly attenuated. With this in mind, there is an urgent need to review the capacity of IDVA services to ensure that their caseload is both manageable and sustainable. This will ensure that wherever possible IDVAs have the capability to work in the most effective way possible with all victims with whom they come into contact.

Capacity building must be supported by the embedding of adequate case management procedures that ensure the best use of the available resources and which, importantly, prevent victims from 'slipping through the net' in terms of service provision. As the previous Chapter detailed, the requirement to gather data at multiple time-points throughout a case for the purposes of this research helped participating services to 'tighten up' the way in which the progress of a case was reviewed, providing an easier way of examining what had already been done and a more systematic and defensible case closure procedure based on an evident reduction in risk. The regular review of cases using standardised assessment measures enabled IDVAs to document changes in a victim's situations over time, prompting the closure and perhaps the referral onwards of those cases once there had been a reduction in immediate risk [(190)].

2.1.3 IDVAs are but one point along a continuum of care.

IDVAs offer a rapid emergency response for a relatively short period of time in order to reduce the immediate risks to victims' safety, and it would be unreasonable to presume this type of approach will be all that is required when most victims have been subjected to abuse over a number of years, have myriad needs and often face additional sources of adversity in their lives. A model of 'continuing safety' provides the best chance of building upon, and fortifying the helpful solutions given by IDVAs into a lasting and stable situation. A wide range of other organisations facilitate longer-term care during the time at which victims are resettling, including a number of health-related services and some longer-term community based services (both those focussing on domestic abuse and other issues such as substance misuse). Thus, local partnerships need to ensure there are both appropriate 'after care' options for victims following work with an IDVA and that there are clear referral pathways for these services. Given that repeat referrals (victims accessing IDVA services more than once) had a reduced likelihood of successful outcomes, it is imperative that local partnerships work to support victims to live in longer term safety.

What are the policy implications of these findings?

This study shows that IDVA services were effective in helping to end abuse in two thirds of cases where intensive support was delivered and a range of safety options reviewed. First and foremost, this finding provides the grounding that should allow IDVA services to move from pilot funding that most services currently receive, to being commissioned. Only two of the services in this study had funding which could be described as 'mainstreamed'. The others, in common with most of the rest of the domestic abuse sector, had very fragmented short term funding, with all of the well understood impact that this has on the quality of the service that can be provided. The marginal cost of providing the support of an IDVA is less than £500 per victim supported [1], and thus the case for commissioning properly focused and structured services is clear.

Second, it means that IDVA services need to have the capacity to offer 'intensive' support. Based on the evidence derived from this report, this means over five significant contacts with a victim. If IDVAs do not have the time to offer intensive support, the outcomes for victims and their children will suffer.

Third, it means that IDVA services must be structurally part of a multi-agency response. The IDVA often acts as a catalyst to mobilizing multiple resources from other agencies, saving the victim the stressful and often unproductive work of trying to do this on their own. The early work of advocacy focused principally on the criminal justice system. This research shows that while this is an important element in addressing the safety of victims of domestic abuse, it is just that: an element and rarely the total solution. IDVAs offer the victims with whom they work a full range of choices and support across the broad range of issues that they face. Thus, IDVAs need to be commissioned as an independent service, working closely in partnership with both voluntary and statutory sector agencies both within and outside the Multi Agency Risk Assessment Conference (MARAC).

2.1.4 The IDVAs' role in children's safety.

Almost 70% of the victims in this sample had children, which amounted to an estimated 3,600 children in total – a huge number. Of note is that a third of children were aged between 0-4 years. Combined with what we now know about the average abusive relationship continuing for 5.5 years, it is reasonable to conclude that a significant proportion of these children had been living with abuse their entire lives. In around 40% of cases there was conflict over child contact, in a quarter the victim was concerned that the child would be directly harmed and in 11% there were direct threats to kill the child. Furthermore, in over half of cases perpetrators had substance misuse issues and in almost 40% of cases they had mental health problems. The co-existence of domestic abuse, substance misuse and mental health issues was highlighted in Lord Laming's Review following the report into the death of Baby Peter. Indeed, a key recommendation from this report was that: *'The National Safeguarding Delivery Unit should urgently develop guidance on referral and assessment systems for children affected by domestic violence, adult mental health problems, and drugs and alcohol misuse using current best practice. This should be shared with local authorities, health and police with an expectation that the assessment of risk and level of support given to such children will improve quickly and significantly in every Children's Trust'* [3].

Given the prevalence of all the risk factors in the families that were studied in this evaluation, the direct risks to children's physical safety evidenced in this report as well as what we know about the impact of abuse on children's psychological development, these findings underline the urgency of addressing the specific risks faced by children living in households marked by abuse. Contact with an IDVA service represents a crucial

point at which children at risk of harm - physical or psychological - can be identified and flagged to the appropriate safe guarding agencies. However, this must be accompanied by recognition of the difficulties and tensions that this may pose for IDVAs when working with parents who are fearful that the disclosure of the severe levels of domestic abuse they are experiencing will result in their children being removed from their care [115].

Presently, it is not standard practice for IDVAs to refer all children with whom they come into contact to Children's Services and, as a result, they are left to make difficult decisions on a daily basis about the identification of the specific risks to children's safety and well-being. In order to manage these risks effectively, there is a need to map out, in partnership with children's services, a clear definition of the remit of IDVAs' work as it affects children, along with referral policies and procedures which should be agreed and communicated nationally. This must be supported by the continued delivery of training for IDVAs, focusing on the impact of abuse on children in order that they are able to communicate clearly to the non-abusing parent, the risk that domestic abuse poses to their children's physical and psychological well-being.

What are the policy implications of these findings?

It is not the role of the IDVA to work directly with children, but rather to help their non-abusing parent to access safety, if at all possible in their own home. However, the impact of the work of the IDVA in helping end the abuse that victims are suffering also has clear implications for the safety of children. The findings that show a clear reduction in direct threats to children's safety suggest that careful consideration must be given to incorporating the IDVA model as part of the safeguarding response for children. Work needs to happen without delay to examine how links can be made between those whose work it is to safeguard children and those who are working with this high risk group of victims.

2.1.5 The need for strong partnerships with perpetrator focused services.

This work indicates that many of the perpetrators of very severe levels of abuse are more broadly aggressive and antisocial, having criminal offences for other types of crime, a high level of drug and alcohol use and a history of domestic abuse against other partners. The presence of these factors was found to increase the risk to victims, increase the likelihood of disengagement with services, and diminish the chances that victims were able to make positive strides towards safety. Together, this collection of findings point strongly to the need to expend greater efforts improving links with services that have direct contact with the perpetrators of domestic abuse. One place where this is already progressing is via the MARAC, although national data suggest that services such as substance misuse and mental health are often underrepresented at these meetings, thus contributing to the under utilisation of the resources that they can provide[97]. Without this level of co-ordination, the impact of victim focused services may be to some degree limited, particularly where a perpetrator is intent on continuing their abusive behaviour.

What are the policy implications of these findings?

If IDVAs are to be as effective as possible, closer links need to be made with perpetrator related services and referral pathways for these high risk cases should be clear and prioritised. This relates both to work within the criminal justice system, the MARAC (where, for example, mental health and substance misuse services are often under-represented) and more widely in relation to the links made with IDVA services in general.

[97]CAADA 2009

2.2 Improving service delivery to high risk victims of domestic abuse

The function of this evaluation is not just to focus on the good news or the parts of an intervention that are working well, but also to uncover areas where there is room for development. This is a crucial requirement if we are to support the continued and even improved effectiveness of the 'IDVA approach' of working with high risk victims. This report details a number of very significant achievements that can be attributed to the specific ways in which IDVAs work with victims. However, it was also clear that the 'IDVA approach' did not work equally well for all victims.

2.2.1 Potential gaps in service provision

This research highlighted some potential gaps in service provision. The first of these was in relation to the nearly 250 victims where safety planning was not recorded as being undertaken as a specific activity. By 'safety planning', we mean a review of safety carried out with the victim that includes strategies that they can follow themselves (for example, changing their phone number, altering a route to work, etc) as opposed to a multi-agency 'safety plan' (such as that produced at a MARAC). This gap may simply reflect an omission in terms of recording, or the fact that safety planning has taken place elsewhere or on a more informal basis. However, given that IDVAs systematically carry out an initial risk assessment with victims, we feel that it is appropriate to recommend that basic safety planning should be undertaken with all victims, as it represents a fundamental building block that comprises the IDVA approach. Furthermore, it may offer some benefits to victims even in the absence of any other service provision. Victims are often actively attempting to deal with their situation and safety planning, in particular, may equip victims with something they can do for themselves to stay safe. Not only is this likely to enhance feelings of self efficacy, but this will also ensure that should a victim disengage from a service they have at least some, albeit, very basic level of protection.

These findings also underscore the need for more focused attention on, recognition of and indeed screening for additional sources of vulnerability especially victims' health-related concerns or problems. Many IDVAs are no doubt implicitly aware of how these issues impact on victims' safety, but the low rates with which particular issues were documented and the high levels of missing data we observed suggest that we need to formalise what we know about these additional sources of risk and integrate the identification of these issues into the wider risk assessment process. This must be supported by clear referral pathways for IDVAs and training for all multi agency partners about how to best respond to particular problems once they are identified.

Increased efforts to identify additional sources of adversity or vulnerability in victims' lives must, of course, be underpinned by strong links to the range of specialist services which are implicated in responding to particular issues. The results of this study suggest that, in particular, there is a need to review the referral pathways to and from health-related services. In addition to the missed opportunities to identify health-related issues, once they were identified, then rates of referrals to appropriate agencies were lower than expected. Research shows that victims have a greatly elevated risk of experiencing all kinds of physical and mental health problems, that only a fraction of women access the health services they require and that victims perceive themselves as having unmet health needs [4] [5] [6].

What are the policy implications of these findings?

These findings point to the necessity for concerted efforts to strengthen links with generic and specialist health services, especially since very recent studies have shown that the delivery of integrated services to address domestic abuse in tandem with health-related issues (mental health, substance misuse) facilitates improved outcomes for victims [191] [11].

2.2.2 Harassment

These results showed that although there was a significant reduction in the levels of severe harassment and stalking experienced by victims, there was less impact for lower levels of harassment. Continued harassment, in the context of very recent physical and/or sexual abuse, may represent a significant threat for victims as they attempt to move forwards with their lives - even if it does appear 'low level'.

Thus, this issue warrants some careful thought as to what can be done to specifically target this type of behaviour. Harassment and stalking behaviours have come to be widely seen as criminal actions only relatively recently, especially when they are perpetrated by a current or former intimate partner. Compared to violence, which is much easier to identify and assess in terms of its seriousness, these nonphysical forms of abuse require more interpretation as to severity and potential for harm. In other words, what is seen as an apparently benign act to an outsider may clearly symbolise a threat of harm to a victim. Given that IDVAs provide a crisis response and this type of behaviour may ensue after the immediate risk has dissipated, then there is a need for a co-ordinated approach across all agencies supporting women along the road to safety, in order to effectively address harassment. Furthermore, there must be increased focus on the specific factors and contexts that may help to maintain this type of behaviour. In particular, there is need to focus on contact around children as an opportunity for ongoing abuse, which likely requires better integration of services and more contact centres to reduce the occasions and issues on and around which perpetrators are able to continue contact with victims.

Some of the challenges discussed here are inherent in the nature of IDVA work itself, and will be difficult to remedy. However, it is our belief that most of these issues can be addressed by focused and steady commitment by IDVAs alongside their multi-agency partners. The incredible achievements that have been made thus far offer a platform for continued success.

2.3 Issues to consider when interpreting these findings

Despite the promising results yielded by this evaluation, there are, of course, limitations that should be borne in mind when interpreting these findings (see Appendix 3). Perhaps most obvious is that this study lacked a control group with which to compare the outcomes for victims receiving no treatment or a different type of intervention. Whilst randomised controlled trials represent the 'gold standard' approach to measuring the impact of any given intervention, they are difficult and expensive to set up and run. Furthermore, the assembly of a 'no treatment' group poses ethical questions for researchers and service providers, especially where the population of interest is at risk of serious harm in the absence of intervention and the evaluation is of fully operational services, as was the case in this study. Whilst technically, this absence of a control group restricts the extent to which outcomes can be attributed to the intervention, the finding of a dose response relationship between the intervention provided and the outcomes achieved (those victims receiving more focused intervention and access to a greater number of services fared better) offers indication that the intervention was indeed the mechanism of change, however, there remains the possibility that this association might be accounted for by an unmeasured third variable.

It is also important to note that the tools used to collect this information were not perfect and did not yield information comparable in validity or sensitivity to that derived from lengthy standardised measures of abuse, such as those used in clinical trials. On the other hand, their simplicity meant that IDVAs used them in a systematic fashion, which in turn has enabled us to assemble an extremely large body of information with respect to what it means to be a 'high risk' victim of domestic abuse. Nevertheless, it was impossible to have complete details, across several points in time, for every one of the hundreds of cases analyzed for this research. Therefore, we are aware that more information of this type

would have given us an even richer understanding of the issues considered here.

A key methodological issue that related to Chapter 4 was that information with respect to the types of support that IDVAs provided or helped victims to access was not consistently articulated and little guidance was offered at the outset of this project pertaining to the exact definition of 'support'. It was therefore not possible to differentiate the extent to which a type of service was discussed with a victim versus knowing this service was actually used as part of the intervention. Simply raising a particular option with a victim is unlikely to be as effective as actually facilitating access and ensuring a tangible result and thus it would have been helpful to be able to reliably make this distinction. This would be an important issue to resolve in future research. However, the association between improved safety and more interventions offered suggests that offering more choices may result in victims choosing more services to support them.

Furthermore, although we were able to gather some of the information used in this report directly from victims, it would have been preferable to access their views to an even greater extent. For example, we acknowledge that concepts such as 'coping ability' and 'social support' may be most reliably and usefully measured from the point of view of the victim, although we made a pragmatic decision to gather this information from IDVAs. Going forwards, there is a need for quantitative research such as this to measure outcomes of interest from victims' perspectives. There is a growing body of qualitative research that considers this in depth and which could be used to guide researchers as to outcomes that are of relevance to victims themselves [192]. We also need to gather more in-depth and nuanced information with respect to victims' satisfaction with IDVAs, what worked for them in particular and what could be improved, and to use this to assess the likelihood they would draw upon these services in the future should they be required. Lastly, as already mentioned, Chapter 5 provided some indication of the sustainability of these outcomes, but, in common with other domestic abuse interventions, further work is needed to know that the 'IDVA approach' can indeed achieve lasting results.

3. Implications for future research

This project represents a major undertaking in terms of the resources committed to collecting and managing such a large volume of data. The successful assembly of a data set that is both detailed and comprehensive is impressive in its own right, given the known difficulties of collecting consistent information about sensitive topics like domestic abuse. This effort was shouldered primarily by the seven participating projects – a large and committed group of IDVAs, administrators and service managers. Throughout the duration of this project, we received clear feedback from services about what they needed and wanted from the research. Regardless, there was understandably some tension at times as everybody attempted to juggle data collection requirements with the core business of working with high risk victims of domestic abuse and their children.

Although some of the participating services continue to gather data (using the monitoring tools developed for this study) in an effort to document their own effectiveness, this evaluation attests to the considerable resource implications of establishing data monitoring systems that hold up-to-date, accurate and reliable data. We feel strongly, as do other researchers in the field [101] [193], that designated resources should be available within services to ensure that they are adequately able to gather standardised data by which to monitor and evaluate their own performance against the benchmarks set by this study. This will help develop the continued transparency and accountability of the sector.

Despite the methodological challenges noted above, we hope this study will represent the beginning rather than the end of systematic attempts to identify the types of interventions and approaches that significantly reduce domestic abuse in an ethical, effective and efficient way. In order to achieve this, substantial funding and capacity building will be required to

carry out similar work in the future. Importantly, concerted efforts are necessary to ensure that future research is also relevant to 'frontline' workers, so that practice continues to develop and improve.

This study was successful in isolating some of the effective components of this complex and multifaceted intervention that are linked with better outcomes for victims. The next step is to specify the mechanisms that explain *why* these aspects of intervention are particularly important. Earlier work has shown that enhanced well-being may help to translate the effects of short-term intervention into long-term safety [121]. Therefore, the positive changes in victims' coping capacities and social networks noted as part of this report may represent key factors that help to put victims on the path to living their lives free from abuse. Locating the mechanisms of change underpinning the positive impacts of an intervention means that professionals can try to maximise positive outcomes by focusing on activities which address the putative mechanisms of change. Moreover, understanding the process by which an intervention works is especially important when attempting to replicate a successful programme at other sites. This is particularly relevant when one considers the commissioning of new IDVA services in a range of different locations.

Finally, whilst there is increasing standardisation in the way that services operate and the quality of intervention that is offered, there is some variation in the context and setting in which services are delivered (as noted in Chapter 1). Naturally, in undertaking this study, we observed variation in practice as a function of setting and it is important to gain a sense of if and how these factors influence outcomes. Furthermore, any successes that IDVAs may have in particular cases will likely be a direct reflection of the strength of their local multi-agency partnerships. Further research is thus required to conduct multi-level studies that can take into account community and service-level characteristics in order to give us a better understanding of how to maximise the benefits of intervention for victims.

In producing an evaluation that is both useful and transparent, it is necessary to highlight findings that point towards areas of service development, the limitations inherent to any study and also what we need to do next. However, in thinking about these issues it is important not to lose sight of the key message that can be taken from this study, namely:

The IDVA approach founded on the bedrock of multi-agency intervention and concentrated support is an effective way of improving the safety and well-being of victims and children living with the everyday realities of very serious levels of domestic abuse.

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Appendix 1

Services receiving grants as the part of the Hestia grant making programme

Advance, Hammersmith*
SSIST, Glasgow
Belfast & Lisburn Women's Aid
Blackburn with Darwen District Women's Aid
Women's Safety Unit, Cardiff*
East Berkshire Women's Aid
Gloucestershire Domestic Violence Support and Advocacy Project (GDVSAP)
Grimsby and Scunthorpe Rape Crisis
HALT, Leeds*
The Haven Wolverhampton*
Latin American Women's Aid (LAWA)
Let Go Project, Carlisle*
North Devon Women's Aid*
Nottingham Women's Aid
Olive Tree, Norfolk
Plymouth Women's Aid
Redcar and Cleveland Women's Aid
Refuge
Worth Services, West Sussex*

*denotes those who contributed the multi-site study

1. Overview

As part of the capacity building strand of the grant making programme managed by the Hestia Fund, some services were awarded grants with which to implement an electronic case management system that would allow instant and easy access to current and archived case files. Some projects were also awarded funding for the additional administrative support needed to smooth the transition from working with paper files to working electronically. The implementation of this system in turn allowed for the collection of standardised data across multiple services, providing the foundation for this evaluation.

2. Participating services

Seven IDVA services participated in this evaluation. The services evaluated are based both in urban, suburban and rural locations. They range in size from 1 full time IDVA as part of a wider community based domestic abuse service, up to 12 IDVAs. Some are part of a dedicated IDVA service; others include wider services such as community outreach and refuge. Some were relatively newly established, with others having been in operation for over 30 years. Finally, some work in communities with high Black and Minority Ethnic populations and others in areas where these groups are under-represented.

A period of consultation preceding the evaluation period was undertaken with service managers, IDVAs, funders and evaluators in order to develop an evaluation protocol and to gain service's views with respect to the type and amount of data that it would be acceptable to collect as a routine part of everyday work, in order to supplement the basic data that was already part of the system. Following this period of consultation, regular feedback meetings were held with services throughout the course of the data collection period. This provided opportunity to address data collection and management issues, from both the perspective or services and the evaluation team, and also a forum for the presentation of interim findings.

3. Evaluation period

Data were collected from victims of domestic abuse accessing seven IDVA services across the country, over a 27 month period (January 1st, 2007 - March 31st, 2009). Anonymised data were extracted from the case management system and exported to the evaluation team on a three monthly basis.

4. Criteria for data collection

There were some specific inclusion criteria set for the purposes of this study that determined from whom IDVAs should gather data in the first instance.

Engaged victims: IDVAs collected data from individuals who explicitly engaged with services. Data were not gathered where victims did not wish to receive the services of an IDVA.

Victims giving consent: Each participating service had a unique consent procedure that victims were taken through as standard as part of the initial contact with an IDVA. As part of this process, IDVAs were required to ask victims consented for their anonymised data to be used for external monitoring purposes. IDVAs were able to indicate non consent using an 'opt out' check box which prevented a victims' data being included in the dataset available for analysis

High risk victims: For the purposes of this evaluation IDVAs were only required to gather data from victims deemed to be high risk[98]. IDVAs utilised the 20 point CAADA Risk indicator Checklist in combination with their professional judgement in order to gauge the level of risk posed to a victim. For the purposes of this research, a victim was deemed to

be at high risk of serious harm or homicide if:

- Victims endorsed 10[99] of the 20 indicators on the checklist;
- 3 of 5 particular questions on the risk indicator checklist were appraised by the IDVA as causing significant concern[100];
- The IDVA perceived the level of risk to be high (and marked it as being so), irrespective of the score obtained on the RIC. This allowed IDVAs to exercise their professional judgement, which in combination with actuarial assessment is thought to be the most accurate way of assessing risk[(98) (99)].

5. Data collection procedure

An electronic case file was created at the first contact (face to face or over the telephone, Time 1) with for each client. Each case was assigned a unique identifier to enable the data to be anonymised and matched with other information gathered during the life of a case.

IDVAs collected demographic information and information pertaining to the nature and severity of abuse and also the presence of specific risks in a victim's life (e.g. suicidal ideation, separation, issues around child contact).

Data were gathered on a second occasion (Time 2); either at the closure of a case or at the end of criminal court proceedings (this tended to be proximal to case closure), or after 4 months of engagement with the service, as an interim marker of case progress. Where both interim and case closure data were gathered, interim data were replaced with that pertaining to the more recent case closure, to give a better picture of the outcomes achieved for the victim. Data gathered at Time 2 related to the interventions or types of support offered to victims during the course of their case and a second assessment of abuse and specific risk factors associated with serious harm and homicide. IDVAs also gave the status of abuse at Time 2 (whether abuse had ceased or was ongoing), the sustainability of any positive change in abuse and their perceptions of the level of risk reduction achieved for the victim. Victims were also asked to indicate their feelings of safety following the period of intervention wherever possible.

Data were not gathered on a second occasion where IDVAs had lost contact with a victim i.e. victims had disengaged from the service and the IDVA had no recent contact. Where victims were re-referred to the service following the previous closure of their case, a second set of data were gathered, replacing the existing information in the data set (even where Time 2 data were not available for the more recent data). IDVAs marked such cases as 'repeats', enabling them to be denoted in the database.

Nine months into the project, IDVAs were asked to conduct short interviews with victims on their exit from the service. As part of the original evaluation protocol, victims were asked about their feelings of safety. On giving their answer victims were asked to cite the reasons for their changed (either positive or negative) or unchanged feelings of safety. Where victims did not offer comment spontaneously, IDVAs prompted victims to think about the particular aspects of their case and the intervention they had received. IDVAs recorded victims' responses on the case management system, which limited the amount of information that IDVAs could gather. In many instances, victims' words were paraphrased by IDVAs rather than recorded verbatim. Each victim was offered a £10 high street voucher as a token of appreciation for giving their time to complete the interview.

In order to gather data relating to the longer term outcomes for victims, at the point of case closure (from 9 months into the evaluation period) IDVAs began to ask victims for their consent to be followed up by phone 6 months later. Those victims who could be re-contacted were asked, using the severity of abuse grid as a guide, if they had experienced any abuse since the time their case had been closed, how safe they felt at the present time and how they perceived their quality of life. Victims were again offered a £10 high street

voucher in thanks for their participation.

6. Measures used as part of this study

a) Socio-demographic and referral information

Information was gathered at the point of referral (Time 1) relating to gender, ethnicity, immigration status, children, the presence of substance misuse issues & disability employment. Information was also gathered with respect to victims' relationship with the perpetrator of abuse and whether they lived with the perpetrator.

b) Assessment of abuse and risks known to be related to serious harm and homicide

Risk indicator checklist (see Appendix 5):

The Risk Indicator Checklist (RIC) was completed at the point of referral to a service (Time 1) and again at Time 2, either after a period of 4 months engagement or at the point of case closure (whichever came first).

The RIC was initially developed in Cardiff for the use of Police officers in attendance at incidents of domestic abuse. The factors comprising the RIC were located following a review of 47 domestic violence homicides, relevant practice and academic literature and communications with community and criminal justice agencies (Robinson, 2004). The 20 indicators included in the checklist can largely be organised into broad factors relating to the perpetrators' aggravating problems (mental health issues, suicidal ideation or attempts) and criminal behaviour, current and recent abusive behaviour, and victims' feelings of fear and perceptions of future risk of serious harm and homicide. The checklist is often completed following an initial conversation with the victim, rather than in a survey style, where victims are asked to provide their answers in a serial fashion. The number of positively endorsed indicators is totalled in order to give a basic indication of the risk of significant harm that further abuse poses to victims. The total number of indicators positively endorsed by victims is used to provide an indication of the risk of serious harm or homicide to a victim.

The severity of abuse grid (see Appendix 4):

IDVAs were required to complete the severity of abuse grid at Time 1, and where victims where victims remained engaged with services, again at Time 2. This measure was developed for the purposes of this project in order to provide IDVAs with a simple tool with which to gather standardised data relating to the type, severity and frequency of four types of abuse (physical abuse, sexual abuse, perpetrators' jealous and controlling behaviour, and harassment and stalking). The design of this tool was based on Mederos, Gamache and Pence's severity of violence matrix (www.mineava.umn.edu). IDVAs were required to indicate the presence of each of four types of abuse: physical, sexual, jealous and controlling behaviour and harassment and stalking. On endorsement of any type of abuse, IDVAs were required to indicate the severity of abuse on an ordinal scale ranging from standard through to extreme. Each level of severity was illustrated by detailed examples of behaviour, specific to each form of abuse that were based on the measure developed by Gamache et al. IDVAs also indicated the extent to which abuse was escalating in severity and frequency along a 3 point scale (reduced, unchanged, worse). Responses at Time 1 were framed in terms of abuse occurring during the previous three months, whereas at Time 2, IDVAs completed the grid to reflect the level of abuse experienced

[98]Whilst IDVA services work primarily with high risk victims, in reality some services were also working with some lower risk victims.

[99]At the outset of this study this threshold was set at 6 but was raised to 10 in line with recommendations issued by CAADA. Only data meeting the new inclusion criteria were included in the study sample.

[100]A criminal record that was domestic abuse related; current incident has resulted in injuries and causes concern; incident involved weapons and causes concern, perpetrator displays jealous and controlling behaviour and causes concern; perpetrator has made threats to kill and causes concern

during the period of intervention, or in the last three months if the period of intervention was lengthy.

Other measures relating to safety:

In addition to data relating to the level of risk and abuse assessed at review, several other measures of harm reduction or safety were completed at case review. IDVAs were required to indicate whether abuse has ceased or remained ongoing. In those cases where there has been cessation of abuse the IDVA was required to judge whether this was a permanent cessation or whether cessation was judged to be short term. Further, IDVAs were required to indicate the level of risk reduction that they perceived at Time 2. Wherever possible, IDVAs were requested to ask victims directly about their feelings of safety at Time 2, relative to Time 1.

c) Victims' well-being at Time 2

IDVAs were asked at Time 2 to endorse whether victims had made any significant changes with respect to their coping mechanisms and access to social networks. IDVAs simply checked a box to indicate whether any changes had been made. An unchecked box was taken to mean that no significant changes had been made.

d) Support and intervention provided or mobilised by IDVAs.

IDVAs were required to complete 20 questions at the point of review (Time 2) relating to the specific aspects of intervention which the victim received during the course of their case. Questions related both to the intensity of the intervention and specific areas where support was delivered (e.g. housing). The IDVA was also required to indicate discrete strategies which were mobilised or put in place, for example, whether the survivor was helped to access the criminal and/or civil justice systems, and what the outcomes were and whether the survivor was subject to a Multi Agency Risk Assessment conference (MARAC). The list of options was not exhaustive and many of the types of support that might be mobilised on victims' behalves were not included in this list (e.g. supportive services for children).

7. Exclusions from the data set

Overall data pertaining to 3266 cases were gathered by services and exported to the evaluation team. Data were carefully screened in order to ensure that first; all cases met the inclusion criteria set out above. This process also allowed us to identify cases to be removed from the data set based on a number of reasons

- Cases that did not meet the criteria for high risk, as set out for the purposes of this study were excluded. The threshold above which cases were assessed as being high risk was amended (raised) during the study period in line with nationally recommended practice. Therefore, a sizable portion of data was excluded based on this criterion.
- Cases with predominantly missing data at Time 1 were removed from the data set. Where cases with complete data at Time 1 had predominately missing data at Time 2, then only Time 1 data were retained, based on the assumption that IDVAs were not in close contact with victims at the Time of data collection and therefore could not comment with any accuracy on the outcome measures of interest.
- 339 cases were found to be duplicate cases, where information pertaining to an individual had been entered on a previous occasion. Where this was apparent, the most recent information was retained and the previous case information removed to ensure that each individual was represented only once in the dataset. Where two records had been created on the same date, the record with the most information was retained.
- Forty four records were found to relate to males and in 95 cases it was recorded that abuse was perpetrated by someone other than an intimate partner. Less is known about the dynamics of abuse where victims are male or where the perpetrators of abuse are

other family members or acquaintances. It is feasible that these cases are marked by a different pattern of risk and that different intervention strategies are required in order to ameliorate abuse. For this reason, the decision was taken to exclude data belonging to these individuals, although it is our intention to undertake further analysis of these cases at a later date.

In total, 2567 cases were eligible for inclusion in the study sample. Of these, 49% had available data gathered on a second occasion (see appendix 6 for attributes of both samples and appendix 8 for an analysis of sample retention). There was a reasonably consistent contribution of data to the sample across each of the participating services.

In 72% of cases with T2 data, data were collected at the closure of a case, 5% at the end of criminal case proceedings[101], and 15% at an interim point during the life of a case (without further data contributed at case closure). In 5% of cases, the reason for the collection of Time 2 data was listed as 'other', with a small number of cases having missing data with respect to this field.

Sample size and contribution of data across services.

Service	% contribution to T1 sample		% contribution to T2 sample	
	Freq.	%	Freq.	%
1	398	15.5%	224	17.96%
2	276	10.8%	188	15.08%
3	365	14.2%	180	14.43%
4	271	10.6%	124	9.94%
5	284	11.1%	133	10.67%
6	571	22.2%	218	17.48%
7	402	15.7%	180	14.43%
Total	**2567**		**1247**	

8. Victims attributions for safety at Time 2 (exit interviews)

In order to garner victims' views on the types of intervention and support that impacted on their feelings of safety, short semi structured interviews were undertaken at Time 2 (on the closure of a case). Qualitative data were gathered from 412 victims, representing 33% of the sample with T2 data. Comparisons were undertaken to determine the extent to which this subgroup of victims were representative of the larger sample with Time 2 data, with respect to both victims' intake profile[102] and outcomes achieved at the end of the case. There was no statistical difference in the frequency of physical abuse, sexual abuse or jealous behaviour at Time 1 between those who were and were not interviewed, although a higher proportion of those who completed exit interviews were experiencing harassment χ^2 (1, n=1247) = 7.67, p<.01, and severe abuse χ^2 (1, n=1247) = 7.08, p<.01 at the point of referral. There were more consistent differences with respect to outcomes recorded at Time 2, where in general a higher proportion of those who were interviewed reported positive outcomes at Time 2.[103] Thus it can be concluded that this sample was not particularly representative of the larger Time 2 and that qualitative data reflects a positive bias, where victims offering comments were generally in a betterposition than others at case closure.

9. Follow up data

10% of all victims with Time 2 data consented to being re-contacted (remembering that IDVAs did not begin to seek consent until 9 months into the evaluation process). IDVAs were able to contact 34 victims, approximately 27% of all those providing consent in the first instance. Comparisons were made in order to locate any differences in either the intake profile and/or the outcomes achieved at the end of the case for those with and without and follow up data. There were no differences in the proportion of victims reporting sexual abuse, harassment or jealous behaviour at Time 1; although a lower proportion of those providing follow up data were experiencing physical abuse (χ^2 (1, n=1247) = 7.88, p<.01), and escalation in abuse (χ^2 (1, n=1247) = 6.83, p<. There were also consistent differences with respect to outcomes, where in general a higher proportion of those with follow up data reported a more positive outcome[104]. Thus again, it can be concluded that this small sample is not representative of the larger sample and extreme caution is required in drawing conclusions as to the sustainability of positive changes based on analyses undertaken employing these data.

That this sample was not representative likely reflects the careful decisions that IDVAs made with respect to who could be contacted safely, rather than an attempt to portray longer term outcomes as more favourable. Undoubtedly, IDVAs would have felt more confident in contacting those victims for whom positive outcome at T2 were recorded. Entire articles and book chapters are dedicated to the discussion of the logistical and ethical difficulties posed by attempting to re-contact victims of domestic abuse for research purposes and this issue more than any other provides illustration of the tension that exists between research endeavor and the more important task of ensuring victim safety(196) (197) (107).

[101]In many instances closure of a case follows shortly after the end of criminal proceedings, although a period of 'after care' is provided in some cases.

[102]Comparisons were made for physical abuse, sexual abuse, harassment, jealous and controlling behaviour, multiple abuse, severe abuse, escalation in abuse, and repeat victimization at intake. At review, comparisons were made across the IDVAs and Victims perceptions of risk and safety (respectively), physical abuse, sexual abuse, harassment, jealous and controlling behaviour, changes in coping strategies and support networks.

[103]The proportion of victims experiencing each type of abuse at Time 2 was lower for those contributing interview data relative to those who did not (physical: χ^2(1, n=1247) = 57.7, p<.001; sexual abuse χ^2(1, n=1247) = 50.57, p<.001; harassment χ^2(1, n=1247) = 31.27, p<.001; and jealous and controlling behaviour χ^2(1, n=1247) = 17.71, p<.001). There was also a higher proportion of victims making positive changes to their support networks and coping strategies in the exit interview group (support: χ^2(1, n=1247) = 54.07, p<.001; coping: χ^2(1, n=1247) = 64.11, p<.001). A higher proportion of those who were interviewed were perceived to have achieved positive changes in the level of risk as rated by IDVAs (χ^2(1, n=1247) = 28.66, p<.001) and accordingly a greater proportion of victims perceived positive changes to their safety (χ^2(1, n=1247) = 51.01, p<.001).

[104]IDVAs perception of risk reduction was significantly higher for this group χ^2(1, n=1247) = 5.01, p<.05, as was victims perception of safety χ^2(1, n=1247) = 6.47, p<.05. The proportion of victims experiencing physical abuse χ^2(1, n=1247) = 8.5, p<.01 and sexual abuse χ^2(1, n=1247) = 5.92, p<.05 at Time 2 was lower for those with follow up data than for those without. There was also a higher percentage of victims achieving positive changes to their support networks and coping abilities in the follow up group χ^2(1, n=1247) = 10.39, p=.001, χ^2(1, n=1247) = 10.4, p=.001 respectively.

As with any research there are inevitably some limitations inherent to this work that should be given due consideration when interpreting the findings that it yielded. Considered here are (1) issues relating to the overall design of this evaluation, (2) the quality and representativeness of the data that were gathered, and (3) unmeasured factors that could potentially account for the results described throughout this report.

1) Issues relating to the evaluation design:

- Perhaps most obvious is that this study lacked a control group with which to compare the outcomes for victims receiving no, or a different type of intervention. Whilst randomised controlled trials represent the 'gold standard' approach to measuring the impact of any given intervention, they are difficult and expensive to set up and run. Further, the assembly of a 'no treatment' group poses ethical questions for researchers and service providers, especially where the population of interest is at risk of serious harm in the absence of intervention, and the evaluation is of fully operational services, as was the case in this study. Whilst technically, this absence of a comparison group restricts the extent to which outcomes can be attributed to the intervention, other studies using a randomised control design have showed significant differences in outcomes for those in receipt of advocacy services in the immediate and longer term, compared to those victims who did not work with an advocate[17]. Further more, the finding of a dose response relationship between the intervention provided and the outcomes achieved (those victims receiving more focused intervention and access to a greater number of services fared better) offers a degree of confidence that the intervention was indeed the mechanism of change, although there remains the possibility that this association might be accounted for by an unmeasured third variable.
- It is further important to note that the type and amount of data gathered for the purposes of this evaluation was constrained by what was practical for IDVAs to undertake as part of their everyday work. Consequently, the tools used to gather data for this study were not perfect and did not yield information comparable in validly or sensitivity to that derived from lengthy standardised measures of abuse, such as those used in clinical trials. On the other hand, their simplicity meant that IDVAs used them in a systematic fashion, which in turn has enabled us to assemble an extremely large body of information with respect what it means to be a 'high risk' victim of domestic abuse.
- The amount of data gathered from victims themselves was limited for ethical and pragmatic reasons. As many of the victims were in crisis at the point of referral it was not possible or appropriate to ask them to complete long questionnaires in relation to their experiences of abuse. This meant that IDVAs reported on most of the variables of interest, although we acknowledge that concepts such as 'coping ability' and 'social support' may be most reliably and usefully measured from the point of view of the victim, given that research indicates that an individual's own appraisal of their ability to cope and the availability of informal social support more reliably determines their impact on individuals' psychological functioning[(198)]. Further, information was not gathered with respect to how coping had changed or improved. Coping, like many of the concepts discussed throughout this report can be broken down into a number of facets, each of which are differentially related to outcomes for victims[(179) (15) (178)] and the impact of this type of intervention on coping strategies warrants further attention.
- IDVAs were asked to indicate the support they provided to victims however, questions relating to support were not consistently phrased and little guidance was offered at the outset of this project pertaining to the exact definition of 'support'. Therefore, in some instances it was difficult to determine the extent to which an issue or intervention was discussed but not accessed, and the extent to which it was actually mobilised on a victims' behalf. Simply raising a particular option with a victim is unlikely to be as effective as actually facilitating access and ensuring a tangible result and thus it would

have been helpful to be able to reliably make this distinction. This would be an important issue to resolve in future research. Further, a limited range of intervention options were surveyed. IDVAs were asked to indicate the options addressed or mobilised on victims' behalves from a closed list. This list was not exhaustive and for this reason it is likely that the findings presented as part of this report give only a snapshot of the range and number of resources that IDVAs mobilise in an attempt to enhance the safety of victims and their children.

- For the purposes of this study we took the number of contacts with a victim as a proxy for the intensity of support that victims received. The frequency and intensity of intervention delivery are not exactly synonymous constructs and it is of course possible that a victim could receive very intensive support during a smaller number of contacts. Future work might more reliably make this distinction in order to determine whether the frequency and intensity of support have differential effects on outcomes achieved for victims.

2) The quality and representativeness of data gathered for the purposes of this study

- IDVAs were given clear guidelines as to when data relating to a case should be gathered. It was stipulated that information should be gathered as soon as a victim engaged with a service and then again after 4 months of contact or at the closure of a case, whichever came first. However, the reality was that data collection had to be fitted around IDVAs' every day duties and it is very possible that where IDVAs fell behind with data collection, details relating to cases were gathered sometime after intake or closure and IDVAs relied on a degree of retrospective recall as to the picture of abuse or the interventions offered. This may have lead to some inaccuracies in the information with which we were supplied.
- The assumption was made that where data were missing at a case level, this was either because victims had disengaged from a service before it was appropriate to gather data on a second occasion or that the case was too 'new' to be reviewed at the point at which the data collection period was terminated. It is of course possible that missing cases simply represented those instances where IDVAs overlooked to gather data or where data were gathered in paper form and were subsequently never entered onto the system. If this were to be the case then the findings we present with respect to attrition are likely to be a poor reflection of the factors that are associated with victims' disengagement from a service
- Whilst missing data at the item level are inevitable to some extent, some data points surveyed as part of this study were characterised by a substantive proportion of non responses or instances in which the IDVA did not ask the question or did not obtain a response from the victim. The concern here is that the pattern of missing data may not be random[(1)], and for this reason may bias results. Data may have been missing for a number of reasons:
  - Some questions may have been deemed by IDVAs as difficult to ask. For example, broaching the issue of sexual abuse may be difficult in some instances. It may have also been the case that some questions were, in the light of significant time pressure, deemed less important to ask than others. This may be particularly so of information that does not relate directly to abusive experiences (e.g. substance misuse, disability, employment).
  - Some questions may have typically resulted in high rates of refusal to answer amongst victims. This may have been particularly so with respect to questions relating to victims' complex needs including substance misuse, where those with additional needs may have been less willing to provide an answer and thus more likely to be characterised by missing data. This presents the possibility that the

pattern of missing data is not completely random, which as stated above has the potential to bias results[1].

- Some demographic fields were dispersed throughout different modules in the case management system, which may have elicited lower response rates given that IDVAs were required to seek them out. Further, in some cases response options may not have adequately captured victim's situations and thus where this was the case, response rates may have been lower as IDVAs found it difficult to fit a victim's answer to the pre-determined list of options.
- Analyses revealed that the subsamples of victims interviewed at both case closure and at the six month follow up stage were not representative of the larger sample, where in both instances more positive outcomes were recorded at Time 2 for those from whom additional data were collected. This limits the extent to which findings relating to victims' views of what was important in determining safety or the sustainability of outcomes are reflective more broadly of victims referred to IDVA services.

3) Unmeasured factors that may confound results

- In examining the relationship between intervention and outcome, variables relating to victims' socio-demographic and abuse profile, as well as factors relating to the perpetrator were entered into multivariate logistic regression models by way of controlling for their impact on the outcomes of interest. Taking account of or controlling for the influence of factors such as these in the estimation of statistical models helps to disentangle the unique effects of advocacy on safety, ruling out competing explanations that might account for positive outcomes rather than the intervention itself. This layer of analysis gives greater confidence that any association observed between indicators of the intervention provided (intensity and access to multiple resources) and outcomes was a function of treatment effects, rather than of other factors. Nevertheless, the range of factors taken into consideration was not exhaustive meaning that the association between intervention and outcome could potentially be accounted for by an unmeasured third variable. In particular, we were unable to control for the readiness of victims to change their situations which may be influential in determining engagement with services and the likelihood of achieving positive outcomes [129] [117].
- Whilst inter-agency differences were not discussed as part of this report, attempt was made to control for variation across site (agency) in multivariate models. Whilst it was possible to partial out to some degree variance in outcomes arising as a function of agency, this was only a crude control. Further, results showed that outcomes differed significantly across agencies and thus there is need to understand the attributes of services that may account for these differences. The results derived from this study reflect the 'average' picture and further work will be required to determine whether they are replicated across different models of IDVA service delivery and across specific groups of victims. Further this work does not take account of the wider community in which services were embedded. Given that the strength of multi-agency partnerships are key to the success of this intervention, there is an need to understand how these factors influence victims outcomes and whether once taken into consideration, the actions of the IDVA continues to exert a unique effect on the odds of achieving safety and well-being for victims.

Appendix 4: Abuse Grid

Type of abuse	Is abuse occurring	Severity of abuse	Escalation in severity	Escalation in frequency
Physical	Yes No Don't know Not answered	Extreme High Standard/moderate	Worse Unchanged Reduced	Worse Unchanged Reduced
Sexual	Yes No Don't know Not answered	Extreme High Standard/moderate	Worse Unchanged Reduced	Worse Unchanged Reduced
Jealous & controlling behaviour	Yes No Don't know Not answered	Extreme High Standard/moderate	Worse Unchanged Reduced	Worse Unchanged Reduced
Harassment & stalking	Yes No Don't know Not answered	Extreme High Standard/moderate	Worse Unchanged Reduced	Worse Unchanged Reduced

Guidance given for completion of the abuse grid

Physical abuse			
No	Standard/ moderate	High	Extreme
Never, or not currently	Slapping, pushing; no injuries and/or lasting pain or mild, shallow bruising or cuts	Beating up, severe contusions, burns, broken bones, miscarriage, threats to kills (imprecise) Noticeable bruising, lacerations, pain	Threats to kill partner, children, relatives or pets with specific risks such as access to weapons. Strangulation, holding under water or threat to use or use of weapons; loss of consciousness, head injury, internal injury, permanent injury, miscarriage.
Sexual abuse			
No	Standard/ moderate	High	Extreme
Never, or not currently	Uses pressure or threats to obtain sex	Uses force to obtain sex, threatens to sexually abuse children	Forced sex or sexual acts on partner, violent sexual practices, deliberately inflicts pain during sex, combines sex and violence, sexually abuses children and forces spouse to watch, enforced prostitution
Harassment & stalking			
No	Standard/ moderate	High	Extreme
Never, or not currently	Frequent phone calls, texts, emails, drops in occasionally	Constant phone calls, texts or emails. Uninvited visits.	Calls obsessively, pursues victim after separation, stalking, threats of suicide/ homicide to you and other family members, threats of sexual violence
Jealous & controlling behaviour			
No	Standard/ moderate	High	Extreme
Never, or not currently	Makes you account for your time, isolates you from family and friends, intercepting mail or phone calls, controls your access to money	Controls most or all of your daily activities? (e.g. tells you with whom you can be friends, when you can see your family, how much money you can use, or when you can take the car?	Extreme dominance, e.g. Believes absolutely entitled to partner, partner's services, obedience, loyalty no matter what. Extreme jealousy, (e.g. 'If I can't have you, no-one can) with belief that abuser will act on this. Locking you up or severely restricting your movements Threats to take the children Suicide/homicide threats Extreme sexual fantasies

Appendix 5: Risk Indicator Checklist

Indicators of Risk	Response
Does partner / ex-partner have criminal record for violence of drugs?	Yes, No, Don't Know, Not Asked
If yes, is record domestic abuse related?	Yes, No, Don't Know, Not Asked
Give details	Written Response
Has current incident resulted in injuries?	Yes, No, Don't Know, Not Asked
If yes, do injuries cause significant concern?	Yes, No, Don't Know, Not Asked
Give details	Written Response
Has the incident involved the use of weapons?	Yes, No, Don't Know, Not Asked
If yes, does this cause significant concern?	Yes, No, Don't Know, Not Asked
Is your partner / ex-partner experiencing / recently experienced financial problems?	Yes, No, Don't Know, Not Asked
Does the partner / ex-partner have / had and aggravating problems with the following:	Yes, No, Don't Know, Not Asked
Alcohol?	Yes, No, Don't Know, Not Asked
Mental health?	Yes, No, Don't Know, Not Asked
Drugs?	Yes, No, Don't Know, Not Asked
Is the survivor pregnant?	Yes, No, Don't Know, Not Asked
Has the accused expressed / behaved in a jealous and controlling ways?	Yes, No, Don't Know, Not Asked
If yes, does this cause significant concern?	Yes, No, Don't Know, Not Asked
Give details	Written Response
Has there been / going to be a relationship separation between the survivor and the partner / ex-partner?	Yes, No, Don't Know, Not Asked
Is there any conflict with the partner / ex-partner over child contact?	Yes, No, Don't Know, Not Asked
Give details	Written Response
Has the partner / ex-partner ever threatened to kill anybody? (indicate all that apply)	Yes, No, Don't Know, Not Asked
Survivor	Yes, No, Don't Know, Not Asked
Children	Yes, No, Don't Know, Not Asked
Other intimate partner	Yes, No, Don't Know, Not Asked
Others	Yes, No, Don't Know, Not Asked
If yes, does this cause significant concern?	Yes, No, Don't Know, Not Asked
Give details	Written Response
Has the partner / ex-partner ever attempted to strangle / choke / smother past or current partner?	Yes, No, Don't Know, Not Asked
Is abuse becoming worse and/or happening more often?	Yes, No, Don't Know, Not Asked
Has the survivor or partner ever threatened/ attempted suicide? (indicate which)	Yes, No, Don't Know, Not Asked
Survivor	Yes, No, Don't Know, Not Asked

Partner/ex-partner	Yes, No, Don't Know, Not Asked
Has the accused said or done things of a sexual nature that makes survivor feel bad or that physically hurt the victim?	Yes, No, Don't Know, Not Asked
Give details	Written Response
Is the survivor very frightened	Yes, No, Don't Know, Not Asked
Give details	Written Response
Is the survivor afraid of further injury or violence?	Yes, No, Don't Know, Not Asked
Is the survivor afraid that the accused will kill her/him?	Yes, No, Don't Know, Not Asked
Is the survivor afraid that the accused will harm her/his children?	Yes, No, Don't Know, Not Asked
Does the survivor suspect she/he is being stalked?	Yes, No, Don't Know, Not Asked
Does the survivor feel isolated from friends / family?	Yes, No, Don't Know, Not Asked
Give details	Written Response
IDVA's perception (please complete this section with your observations about the clients risk especially where there is a lower number of 'yes' responses):	Written Response
Do you feel the survivor is at high risk of experiencing further domestic abuse?	Yes, No, Don't Know, Not Asked

Appendix 6: Socio-Demographic and Abuse Profile of study samples at Time 1

Variable	Total sample 2567			With review data 1247		
	Frequency	Percent	Adjusted Percentage	Frequency	Percent	Adjusted Percentage
Ethnicity						
Asian	206	8	9	124	10	11
Black	173	7	7	89	7	8
Other	194	8	8	84	7	7
White/British/Irish	1722	67	74	828	66	72
Unknown/Not asked	231	9		97	8	
Immigration						
British/EU/perm residents	2190	85	97	1084	87	97
Prov residents/refugee/visitor	64	2	3	33	3	3
Unknown	313	12		130	10	
Relationship						
Current Partner	387	15	32	196	16	33
Ex Partner	746	29	62	393	3	67
Unknown/Not asked	1370	53		658	53	
Children						
Has Children	1774	69	78	873	70	79
No children	502	20	22	233	18	21
Unknown/Missing/Not asked	291	11		141	12	
Living Arrangements						
Living together	295	11	27	137	11	24
Previously lived together	322	13	29	192	15	33
Not living together	492	19	44	252	20	43
Unknown/Not asked	1458	57		666	53	
Employment						
Employed	672	26	51	356	29	50
Homemaker	79	3	6	28	2	4
Benefits	66	3	5	38	3	5
Retired	13	1	1	7	1	1
Training/student	47	2	4	23	2	3
Unemployed	443	17	33	232	19	33
Other	7	0	1	2	0	0
Unknown/Not asked	1240	48		540	43	
Age (range 15-83, mean 33)						
-20	213	8	8	103	8	8
21-30	924	36	37	446	36	36
31-40	787	31	31	402	32	33
41-50	444	17	18	217	17	18
51+	161	6	6	67	5	5
Missing	42	2		12	1	
Substance Misuse						
Drugs						
Yes	106	4	6	51	4	5
No	1770	69	94	896	72	95
Unknown/Not asked	561	22		245	20	
Missing	130	5		55	4	
Alcohol						
Yes	216	8	12	100	8	11
No	1660	65	88	850	68	90
Unknown/Not asked	564	22		243	19	
Missing	127	5		54	4	
Disability						
Any disability indicated	295	11		147	12	

Level of Abuse at Time 1	Total sample			With review data		
	Frequency	Percent (N=2567)		Frequency	Percent (N=1247)	
Type of abuse						
Physical abuse						
Yes	2152	84		1066	86	
No	277	11		124	10	
Missing	138	5		57	5	
Sexual abuse						
Yes	599	23		291	23	
No	1544	60		767	62	
Missing	424	17		189	15	
Harassment & stalking						
Yes	1230	48		599	48	
No	1039	40		514	41	
Missing	298	12		134	11	
Jealous & controlling behaviours						
Yes	2214	86		1083	87	
No	183	7		94	8	
Missing	170	7		70	6	
Severe level of abuse at intake (of total sample and of sample experiencing that abuse)		Of Total	Of Sample		Of Total	Of Sample
Physical abuse	1514	59	70	778	62	73
Sexual abuse	357	14	60	193	16	66
Harassment & stalking	820	32	67	421	34	70
Jealous & controlling behaviours	1512	59	68	771	62	71
Other descriptions of abuse at intake (of total sample)						
Multiple types of abuse	2206	86		1083	87	
At least one form of abuse that is severe	1945	76		987	79	
Any escalation in severity of abuse	1433	56		708	57	
Any escalation in frequency of abuse	1377	54		678	54	
Any escalation of abuse (frequency or severity)	1472	57		722	58	

Risk factors endorsed at Time 1 for both study samples (full sample & those with T2 data)

Risk Factors	Total sample (T1) Frequency of clients (n=2567)	Total sample (T1) Percentage of clients (n=2567)	With review data (T2) Frequency of clients (n=966)	With review data (T2) Percentage of clients (n=966)
Current incident resulted in injuries	1309	51	501	52
Use of weapons	567	22	216	22
Jealous and controlling behavior	2333	91	879	91
Stalking	790	31	315	33
Sexual abuse that makes victim feel bad	729	28	273	28
Victim has been strangled/ choked	1559	61	619	64
Escalation of abuse	1874	73	722	75
Perpetrators' threats to kill victim	1582	62	636	66
Perpetrators' threats to kill other intimate partner	241	9	78	8
Perpetrators' threats to kill others	536	21	213	22
Victim is frightened	2070	81	806	83
Victim is afraid of further injury	2136	83	818	85
Victim is afraid of being killed	1122	44	465	48
Perpetrators' criminal record	1296	50	516	53
Perpetrators' DV related criminal record	669	26	261	27
Perpetrators' financial problems	1151	45	416	43
Perpetrators' alcohol abuse	1374	54	516	53
Perpetrators' mental health issues	713	28	254	26
Perpetrators' drug abuse	989	39	388	40
Perpetrators' threats of suicide	904	35	331	34
Victim is isolated	1166	45	439	45
Victim and perpetrator have separated	2137	83	809	84
Victim is pregnant	158	6	63	7
Victims' threats of suicide	589	23	216	22
With Children	Victims with children (n=1774)	Victims with children (n=1774)	Victims with children (n=699)	Victims with children (n=699)
Conflict around child contact	725	41	292	42
Perpetrators' threats to kill children	199	11	80	11
Victim is afraid of harm to children	476	27	207	30

Appendix 7: Association between Victims' Profile Factors and Type of Abuse at Time 1

Victim Demographic Factors	Severity	Escalation	Physical	Sexual	Harassment	Jealous	Multiple
Ethnicity (n=2335)							
White (British/Irish)	75.8	58.1	83.6	21.8	47.4	86.2	85.9
BME	76.8	56.6	85.8	27.7	48.5	85.6	86
Total	76.1	57.7	84.2	23.3	47.7	86	85.9
Chi-Square	.27	.4	1.7	**8.96****	.18	.11	.00
Immigration (n=2254)							
British/EU/Permanent	75.5	58	84.2	23.2	47.8	86.5	86.3
Temporary/Othera	93.8	70.3	92.2	42.2	48.4	90.6	92.2
Total	76	58.4	84.5	23.7	47.8	86.6	86.4
Chi-Square	**11.38****	**3.86***	3	**12.47****	.01	.9	1.87
Relationship (n=1133)							
Ex Partner	79.6	67.2	86.3	21.6	58.2	88.6	89.8
Current Partner	80.9	64.3	91.5	26.1	41.6	91.5	91.5
Total	80.1	66.2	88.1	23.1	52.5	89.6	90.4
Chi-Square	.25	.9	**6.43***	2.92	**28.07****	2.25	.81
Separation (n=2567)							
Not Separated	67.7	59.8	82.6	20.5	36.7	79.1	77
Separated	77.7	56.9	84.1	23.9	50.2	87.7	87.7
Total	75.8	57.3	83.8	23.3	47.9	86.2	85.9
Chi-Square	**18.44****	1.24	.62	2.38	**25.83****	**22.44****	**34.31****
Employment (n=1327)							
Not Employed	79.8	64	87.5	27.3	53	88.2	89.2
Employed	75.7	59.5	84.4	19.2	49.4	89.3	88.8
Total	77.8	61.7	85.9	23.2	51.2	88.8	89
Chi-Square	3.23	2.78	2.64	**12.31****	1.69	.36	.04
Children (n=2567)							
No Children	73.2	54.3	80.7	22.6	44.9	81.7	82
Has Children	77.1	58.9	85.5	23.7	49.5	88.6	88
Total	75.8	57.3	83.8	23.3	47.9	86.6	85.9
Chi-Square	**4.99***	**5.17***	**9.93****	.36	**4.75***	**23.49****	**19.93****
Aggravating Problems (n=2567)							
No Problems	75.1	56.2	83.4	22.2	48.4	87	86.4
Has Problems	78.4	62.1	85.6	28.1	45.9	83.2	84.2
Total	75.8	57.3	83.8	23.3	47.9	86.2	85.9
Chi-Square	2.42	**5.7***	1.48	**8.05****	1.01	**4.77***	1.5
Repeat (n=2567)							
Not a Repeat	74.8	58	83.1	24.6	46.3	85.9	85.4
Repeat	78.7	55.2	86	19.4	52.8	87.4	87.6
Total	75.8	57.3	83.8	23.3	47.9	86.21	85.9
Chi-Square	**3.89***	1.61	2.91	**7.23****	**7.91****		1.91
Perpetrator Criminal Record (n=2567)							
No Record	71.8	56.3	78.8	23.5	44.9	84	82.7
Record	79.7	58.4	88.8	23.1	50.8	88.4	89.1
Total	75.8	57.3	83.8	23.3	47.9	86.2	85.9
Chi-Square	**11.10****	1.22	**47.87****	.05	**9.02****	**10.46****	**21.95****
Perpetrator Aggravating Problems (n=2567)							
No problems	73.1	52.6	80.1	22.4	44.3	84	82.6
Problems	77.3	60.1	86	23.9	50.1	87.6	87.9
Total	75.8	57.3	83.8	23.3	47.9	86.2	85.9
Chi-Square	**5.72***	**13.96****	**15.61****	.67	**8.08****	**6.52***	**13.76****

Emboldened figures represent factors significantly associated with attrition p<.05

Appendix 8: Sample attrition

Studies show that attrition (or 'drop-out') from an intervention programme is not always random and that it is marginalised groups or individuals with the most difficult cases who tend to start, but not finish, treatment. Parametric tests were undertaken in order to ascertain whether the rate of attrition differed according to victims' profiles. Analyses were undertaken for the total sample (n=2567) and also using data collected during the 1st 21 months in order to take account of that fact that some cases would have been missing data due to the the case being too new to warrant a review. Many comparisons were undertaken, although only those significant associations are shown here. Emboldened figures in the table denote that the rates of attrition differed significantly across the different levels of a profile indicator (e.g. children vs. no children).

Profile indicator	Attrition rate (%)	
	All data (n=2567a)	21 months (n=1877b)
Perp. Aggravating problems		
No Problems	47.3	41.7
Problems	53.7	43.4
Total	51.3	42.7
Chi-Square	**9.79****	.59
Strangulation/Choking		
No strangulation occurring	53.8	44.2
Strangulation occurring	49.8	41.7
Total	51.3	42.7
Chi-Square	**3.91***	1.2
Separation		
Not Separated	54.9	46.8
Separated	50.6	41.8
Total	51.3	42.7
Chi-Square	2.59	**2.88†**
Sur. Frightened		
Not Frightened	57.9	51.9
Frightened	49.8	40.3
Total	51.3	42.7
Chi-Square	**10.76****	**17.03****
Threats to kill Victim		
No Threats	54.3	45.7
Threats	49.5	40.7
Total	51.3	42.7
Chi-Square	**4.65***	**4.51***
Threats to kill another intimate partner		
No Threats	50.8	42.2
Threats	56.8	48.4
Total	51.3	42.7
Chi-Square	**3.22†**	2.3
Ethnicity		
White (British/Irish)	52	44.1
B&ME	46.8	37.1
Total	50.7	42.2
Chi-Square	**4.92***	**6.78****

Profile indicator	Attrition rate (%)	
	All data (n=2567a)	21 months (n=1877b)
Afraid of further injury		
Not afraid	56.8	47.6
Afraid	50.2	41.7
Total	51.3	42.7
Chi-Square	**6.27***	**3.84***
Afraid of being killed		
Not afraid	53.4	45.7
Afraid	48.8	38.6
Total	51.3	42.7
Chi-Square	**5.36***	**9.47****
Afraid of harm to children		
Not afraid	52.6	43.9
Afraid	47	38.3
Total	51.3	42.7
Chi-Square	**5.49***	**4.22***
Afraid of harm to children (with child)		
Not afraid	50.8	42.7
Afraid	45.9	36.4
Total	49.4	41
Chi-Square	**3.24†**	**4.2***
Children		
No Children	55.1	46
Has Children	49.4	41
Total	51.3	42.7
Chi-Square	**7.4****	**4.42***
Severe		
No severe	58.4	50.1
Severe abuse	49.1	40.3
Total	51.3	42.3
Chi-Square	**16.18****	**13.73****
Escalation		
No Escalation	51.4	43
Escalation	51.3	42.4
Total	51.3	42.7
Chi-Square	.004	.06
Physical		
No physical abuse	56.6	47.8
Physical abuse	50.3	41.7
Total	51.3	42.7
Chi-Square	**5.53***	**3.81†**
Risk Score[c]		
Mean Score With Review	11.35	11.37
Mean Score No Review	10.64	10.7
t	**4.86****	**3.6****

† p<.06, *p<.05, **p<.01

Appendix 8: Sample attrition

Indicators found to be significantly associated with attrition were entered into a multivariate logistic regression in order to examine the unique contribution of each profile indictor to the likelihood of attrition, after controlling for the effect of other potentially influential factors. Boldface type denotes a profile factor linked with increased or decreased odds of attrition. An exp(b) value of >1 is found to increase the odds of attrition; where values are <1 the factor is found to decrease the odds of attrition.

Logistic regression model predicting attrition

	27 months (full sample)			21 months		
	B	S.E.	Exp(B)	B	S.E.	Exp(B)
Victim has children	-0.17	0.09	0.84	-0.12	0.11	0.89
Victim is from B&ME group	-0.14	0.11	0.87	-0.21	0.13	0.81
Physical abuse at T1	-0.04	0.13	0.96	0.04	0.16	1.04
Severe abuse at T1	-0.19	0.11	0.83	-0.17	0.13	0.84
Escalating abuse at T1	**0.29**	**0.10**	**1.34**	**0.33**	**0.12**	**1.39**
RIC score	**-0.10**	**0.02**	**0.91**	**-0.08**	**0.02**	**0.92**
Perpetrator aggravating problems	**0.34**	**0.09**	**1.41**	0.18	0.11	1.19
Relationship seperation	0.02	0.12	1.02	-0.14	0.15	0.87
Threats to kill victim	0.03	0.10	1.03	0.05	0.12	1.05
Threats to kill other partner	**0.34**	**0.15**	**1.41**	**0.36**	**0.19**	**1.43†**
Attempts to strangle/choke victim	0.07	0.10	1.07	0.11	0.12	1.12
Victim is frightened	-0.21	0.13	0.81	-0.28	0.15	0.75†
Victim is afraid of injury	0.10	0.14	1.11	0.12	0.17	1.12
Victim is afraid perpetrator will kill her	**0.21**	**0.10**	**1.23**	0.10	0.13	1.11
Victim is afraid perpetrator will harm children	0.03	0.11	1.03	0.00	0.14	1.00
Constant	0.62	0.22	1.85	0.10	0.27	1.11
	Model statistics			*Model statistics*		
	Percent classified correctly		60.0	Percent classified correctly		62.0
	Model chi-square significance		0.43	Model chi-square significance		0.00
	-2 Log Likelihood		3073.61	-2 Log Likelihood		2139.61
	Nagelkerke R-square		0.09	Nagelkerke R-square		0.13
	n=2335			n=1703		

All emboldened values $p<.05$. †$p<.06$

[105]These variables included: ethnicity (White British or Irish vs. other ethnic group); immigration status (British national/ EU citizen, permanent resident vs. Visitor, refugee, provisional resident); relationship status (current partner vs. ex partner); employment status (employed vs. not employed); the presence of any aggravating problems (physical disability, learning disability, victim's substance misuse present vs. none recorded), the number of aggravating problems recorded; the presence of children (has children vs. none recorded); score on the risk indicator checklist; the recorded presence of each form of abuse experience of multiple forms of abuse (more than one form vs. one form or none recorded), one or more forms of abuse recorded as being severe, one or more forms of abuse recorded as escalating in either severity or frequency, victims repeat status at the service (repeat visit vs. not repeat visit not recorded) and all of the 20 risk factors surveyed in the initial assessment. Given the large number of comparisons, only significant differences are reported here, although a full set of analyses is available from the first author on request.

Appendix 9: Tailoring of Interventions according to Victim Demographic and Abuse Profile

Factor	Variable	More frequent support (Respective percentages)	Less frequent support (Respective percentages)
Demographic factors	B&ME vs. White British	Housing (56.8 vs. 47.1)** Benefits (21.7 vs. 14.3)** Immigration (8.1 vs. 0.2)** Refuge (15.8 vs. 11.5)*	MARAC (22.4 vs. 39.7)** Court advice (31.7 vs. 49.8)** Pattern changing (6.5 vs. 11.7)** Mental health advice (2.5 vs. 8.5)** Target Hardening (19.9 vs. 34.2)** Sanctuary (11.2 vs. 15.9)* Drug and alcohol (3.5 vs. 7)*
	Current partner vs. ex partner	Drug and alcohol (7.3 vs. 3.4)** Immigration (5.1 vs. 1.3)*	Sanctuary (11.2 vs. 23.9)** Intensity (67 vs. 75.3)*
	Insecure immigration status vs. secure	Immigration advice (33.3 vs. 0.7)**	Court advice (27.3 vs. 44.9)*
	Unemployed vs. employed	Pattern changing (15.2 vs. 9.3)*	Court advice (46.4 vs. 54.5)* Sanctuary (18.2 vs. 24.4)*
	Children vs. no children recorded	Child Advice (45.5 vs. 14.3)** Civil Advice (28 vs. 19.3)** Housing (52.2 vs. 43.2)** Recent MARAC (37.8 vs. 27.9)** Safety Planning (83 vs. 75.4)** Sanctuary (15.2 vs. 9.8)** Schools (6.5 vs. 2)** Social Services (22.5 vs. 10.3)**	
	Complex needs vs. no complex needs/none recorded (victim)	Alcohol and Drug (13.2 vs. 4.2)** Mental Health (15.5 vs. 4.6)** Target Hardening (39.6 vs. 27.7)** Recent MARAC (40.4 vs. 33.2)* Social Services (23.7 vs. 17.4)*	
Abuse characteristics	Physical abuse vs. not/not recorded	Court Advice (44.6 vs. 32.6)** Housing (50.8 vs. 40.3)** Intensity (68.9 vs. 61.3)* Refuge (13.6 vs. 8.3)* Mental Health (7.3 vs. 3.3)*	
	Sexual abuse vs. not/not recorded	Mental Health (12.4 vs. 5)** Immigration (4.2 vs. 1.7)** Drug and Alcohol (9.5 vs. 4.9)** Safety Planning (84.9 vs. 79.3)* Target Hardening (36.1 vs. 28.2)* GP (10.3 vs. 6.8)*	Sanctuary (7.6 vs. 15.3)**
	Harassment vs. not/not recorded	Civil (28.5 vs. 22.2)** Housing (54.3 vs. 44.8)** Sanctuary (16.4 vs. 10.8)** Target Hardening (34.7 vs. 25.8)** Pattern Changing (12 vs. 8.2)* Counselling (35.2 vs. 29.2)*	
	Jealous and controlling vs. not/not recorded	Civil (26.5 vs. 17.1)** Safety Planning (81.8 vs. 72.6)** Target Hardening (31.1 vs. 23.2)* Schools (5.5 vs. 1.8)* Mental Health (7.4 vs. 2.4)*	

Factor	Variable	More frequent support (Respective percentages)	Less frequent support (Respective percentages)
Abuse characteristics	Severe vs. not/not recorded	Counselling (34.7 vs. 22.3)** Court advice (45.1 vs. 34.2)** Housing (51.9 vs. 39.6)** Pattern changing (11.3 vs. 5)** Refuge (14.4 vs. 6.9)** Sanctuary (15.3 vs. 6.5)** Target hardening (32.8 vs. 19.6)** Intensity (69.5 vs. 61.4)* Mental Health (7.5 vs. 3.8)*	
	Multiple types vs. one type of abuse	Target Hardening (31.5 vs. 20.7)** Safety planning (81.8 vs. 72.6)** Recent MARAC (36 vs. 25.6)** Refuge (13.7 vs. 7.3)* Social Services (19.5 vs. 12.8)* Housing (50.4 vs. 42.1)* Intensity (68.9 vs. 60.8)*	
	Escalation in abuse vs. not	Court Advice (46.8 vs. 37.3)** Intensity (71.5 vs. 62.8)** Recent MARAC (37.5 vs. 30.7)* Refuge (14.5 vs. 10.5)* Mental Health (8 vs. 5)*	Counselling (28.8 vs. 36.6)** Schools (3.6 vs. 7)** Benefits (14 vs. 19.2)*
	Has used Weapon vs. not/not reported	Counselling (38.8 vs. 30)** Court Advice (50.2 vs. 40.6)** Pattern Changing (16.8 vs. 7.9)** Mental Health (9.3 vs. 6)*	Civil Advice (19.6 vs. 27)*
	Current Injuries vs. none/none reported	Counselling (35.7 vs. 28.1)** Court Advice (51.2 vs. 33.8)** Pattern Changing (12.2 vs. 7.7)** Target Hardening (34.7 vs. 25.1)** Recent MARAC (37.9 vs. 31.1)*	
Perpetrator Factors	Threats to Kill Victim vs. none/none recorded	Court Advice (46.7 vs. 36)** Housing (52.9 vs. 42.9)** Intensity (70.6 vs. 62.9)** Recent MARAC (40.2 vs. 24.9)** Sanctuary (16.7 vs. 7.8)** Schools (6.5 vs. 2.4)** Child Advice (37.9 vs. 31.3)* Safety Planning (82.3 vs. 77.6)* Target Hardening (32 vs. 26.7)*	
	Perp has criminal record vs. not/not recorded	Court Advice (48.5 vs. 36.7)** Recent MARAC (44.7 vs. 23.8)** Sanctuary (16.7 vs. 10)** Target Hardening (33.8 vs. 26)** Intensity (70.5 vs. 64.9)* Social Services (21 vs. 16)* Mental Health (8.3 vs. 5)*	Immigration (0.6 vs. 4.3)**
	Threats to Kill Child vs. none/none recorded	Recent MARAC (45.7 vs. 33.4)** Court Advice (52.8 vs. 41.7)* Drug and Alcohol (10.5 vs. 5.4)* Mental Health (11 vs. 6.3)*	

Factor	Variable	More frequent support (Respective percentages)	Less frequent support (Respective percentages)
Victim Factors	Victim Frightened vs. not/not recorded	Benefits (17.4 vs. 10.1)* Civil Advice (26.9 vs. 17.3)** Court Advice (44.6 vs. 34.1)** Housing (51.5 vs. 38.5)** Intensity (70.3 vs. 55.2)** Recent MARAC (37.1 vs. 22.6)** Refuge (14.1 vs. 6.3)** Safety Planning (82 vs. 73.6)** Sanctuary (14.6 vs. 7.7)** Schools (5.7 vs. 1.9)* Target Hardening (32.1 vs. 19.7)**	
	Repeat Victim vs. not/ not recorded	Court Advice (55.1 vs. 38.7)** Intensity (74.3 vs. 65.6)** Recent MARAC (43.7 vs. 31.6)** Sanctuary (22.5 vs. 10.4)** Mental Health (10.1 vs. 5.6)** Housing (54.7 vs. 47.5)*	Immigration (0.3 vs. 3.1)** Schools (2.2 vs. 6)**
	Has Separated vs. not/ not recorded	Benefits (17.1 vs. 11.5)* Child Advice (37.2 vs. 27)** Civil Advice (26.5 vs. 19)* Recent MARAC (36.1 vs. 27)*	

*p<.05, **p<.01

The table below illustrates the major themes that emerged from the qualitative data gathered from victims with respect to the factors that accounted for their changed or unchanged safety. Figures relate to the proportion of victims mentioning each theme. In some instances, victims' comments pertained to more than one theme, thus the figures do not add up to 100%. Each major theme was comprised of minor themes, the content of which are detailed below.

Major themes emerging from victims comments with respect to safety

Theme	Total n=412	
	Safer	Still Concerned
IDVA's support	30%	/
General agency support	13%	/
Housing issues	30%	0.5%
Criminal justice system	14%	1%
Police contact	9%	0.2%
Civil remedies	12%	1%
Children	8%	3%
MARAC	10%	1.5%
Risk assessment and safety planning	9%	0.5%
Safety Measures	9%	/
Mental and Physical Health	6%	0.2%
Coping and Support	24%	0.2%
Relationship and perpetrator related factors	29%	10%

Appendix 10: Exit Interviews

Breakdown of major themes and explanation of each minor concept

Theme	Key Concepts	Explanation
IDVA	IDVA	The victim is thankful to the IDVA, believes their help, advice and/or support was crucial in their improved safety.
General Agency Support	General Agency Support	Victim is grateful for support from people, or agencies involved in her case (non specific)
Housing	Perpetrator made to move out	The perpetrator has been forced to move out of the house (whether by court order or the victim)
	Refuge	Victim is currently living in refuge or hostel
	Housing Services	Client was supported in accessing housing services, has been re-housed
	Victim changed housing situation	The victim has actively moved house/ out of area
	Perpetrator changed housing situation	The perpetrator has moved out of the property
	In process of moving	Victim is in the process of moving out, or is applying for housing (and this is enough to make them feel positive for her safety)
Criminal Justice System	Court	The victim is in a court case, has pressed criminal charges
	Legal Advice	Victim is receiving/seeking legal advice
	Support	Victim was supported through the trial
Police	Police	Victim has been supported by the police, they have given the perpetrator a caution, their involvement has improved the situation; victim feels like she can call the police if she needs to
Civil	Orders/restraints	Victim has an injunction/court order
	Support	Victim is seeking/has received advice regarding an injunction/order
Children	Social Services	Victim has been visited by social services
	Contact arrangements	Contact issues have been arranged; contact issues may remain
	Intervention	Victim has received support from services working with children
MARAC	MARAC	Victims' case has gone to MARAC
Risk Assessment /Safety Plan	Risk Assessment	Risk assessment carried out
	Safety Plan	Safety plan put into place
Safety Measures	Safety measures	Safety measures have been installed at victims home
Mental/Physical Health	Alcohol/Drug	Victim and/or perpetrator is/has received drug or alcohol support
	MHS	Victim is accessing/receiving support from mental health services
	Counselling	Victim has received counselling
	Health general	Victim has accessed health services
Coping and Support	Emotional Support	Victim received/is receiving emotional support
	Confidence	Victim is more confident, stronger, more in control, is getting on with her life
	Knowledge and Rights	Victim knows what services are available, how to get help, knows about where she stands legally, knows how and who to contact, and is aware of her rights
	Support Networks	Victim now has a support network (friends, family, agencies etc)
	Coping Strategies	Victim has developed better coping strategies

Theme	Key Concepts	Explanation
Relationship/ perpetrator related factors	No Contact	Victim and perpetrator have not been in contact; the victim no longer wants contact; the perpetrator does not know the whereabouts of the victim.
	Relationship Ended	Victim and perpetrator have separated; ended their relationship.
	Divorce/Annulment	Are now divorced, in the process of divorce or have had marriage annulled.
	Victim/Perpetrator in new relationship	Either the victim or the perpetrator is in a new relationship and therefore circumstances have changed (they have moved on).
	Still/Back together	The victim has not left the perpetrator or has returned to the perpetrator.
	In Prison/On Bail	The perpetrator is in prison, on bail, on a tag, in remand/custody.
	Future contact	There are concerns of future contact from the perpetrator (when they get out of prison/back from abroad/will find victim), there has already been contact/sightings in area.
	Continued Abuse	Perpetrator continues to abuse (any kind) the victim, whether separated or not
	No problem at present time	There have been no recent problems with the perpetrator; things are ok between the victim and the perpetrator.
	Has Changed	Victim believes that the perpetrator has changed.
	Perpetrators' Family	Issues around the perpetrator's family.

Appendix 11: Analytic strategy, coding convention and results for multivariate analyses

Multivariate logistic regression analyses were undertaken to examine the unique contribution of the IDVAs intervention to victims' safety and well-being, whilst controlling for the impact of other potentially influential variables (e.g. separation, presence of children).

There were a large number of variables, other than those relating to the intervention itself that may have been important in determining the odds of achieving safety and well-being. In order to retain adequate statistical power, analyses were undertaken in a series of six steps.

- Step 1: modelled the odds of achieving a positive outcome as a function of the intervention received after controlling for a core set of variables reflecting victims' demographic characteristics and indicators of abuse at the time of referral.
- Step 2: modelled the odds of achieving a positive outcome as a function of the intervention received after controlling for factors that might represent agency level differences.
- Step 3: modelled the odds of achieving a positive outcome as a function of the intervention received after controlling for factors relating to perpetrators' criminal and antisocial behaviour.
- Step 4: modelled the odds of achieving a positive outcome as a function of the intervention received after controlling for victims' demographic characteristics.
- Step 5: modelled the odds of achieving a positive outcome as a function of the intervention received after controlling for factors relating to the profile of abuse at Time 1.
- Step 6: modelled the odds of achieving a positive outcome as a function of the intervention received after controlling for all factors that were correlated with a given outcome.
- At each stage separate models were estimated for each of the nine outcomes of interest. Results are discussed in terms of adjusted odds ratios which indicate a victim's odds of achieving a positive outcome (coded as 1) given the receipt of a particular aspect of intervention, relative to victims who did not receive this aspect of intervention.

Appendix 11: Analytic strategy, coding convention and results for multivariate analyses

Variable	Coding convention
Intensity	1=intensive support (>5 contacts) 0= less intensive support or non recorded
Interventions	0-1 - comparison category
Agency	** significant interagency differences in adjusted odds
Case length	Continuous variable (days)
Ethnicity	B&ME=1, White British or Irish = 0
Victim has children	1= child 0 = else
Victim age	Continuous variable (years)
Severe abuse	1=severe, 0=else
Escalating abuse	1= escalating, 0=else
RIC score	Score ranges 0-20
Repeat referral	1= repeat, 0=else
Perpetrator's Criminal record	1=endorsed
Incident resulted in injuries	1=endorsed
Perpetrator's aggravating problems (inc. alcohol and drug misuse and mental health issues)	1=endorsed
Separation	1=endorsed
Threats to kill (towards any person)	1=endorsed
Victim has aggravating problems (disability, substance misuse)	1=endorsed
Victim is frightened	1=endorsed
Severe abuse at T1	1= severe abuse, 0=else
Escalating abuse at T1	1= escalating abuse, 0=else
Multiple types of abuse at T1	1= multiple forms of abuse, 0=else
Physical abuse	1=endorsed, 0=else
Sexual abuse	1=endorsed, 0=else
Harassment & stalking (H&S)	1=endorsed, 0=else
Jealous and controlling behaviour (J&C)	1=endorsed, 0=else
Cessation of abuse	1=cessation or near cessation, 0 =else
Cessation of physical abuse (for all those reporting at T1)	1=cessation, 0 =else
Cessation of sexual abuse (for all those reporting at T1)	1=cessation, 0 =else
Cessation of jealous and controlling behaviour (J&C) (for all those reporting at T1)	1=cessation, 0 =else
Cessation of harassment and stalking (H&S) (for all those reporting at T1)	1=cessation, 0 =else
IDVA's perception of reduced risk	1= reduced, 0=else
Victim's feelings of safety	1= felt safer, 0=else
Positive changes to coping	1= positive change endorsed, 0=else
Positive changes to social networks	1= positive change endorsed, 0=else

Step 1

Logistic regression models examining the association between intervention and outcomes after controlling for core demographic and abuse variables

	Cessation of abuse			Cessation of physical abuse			Cessation of sexual abuse		
	B	S.E.	Exp(B)	B	S.E.	Exp(B)	B	S.E.	Exp(B)
Agency			**			**			**
Case length	**0.00**	**0.00**	**1.00**	0.00	0.00	1.00	0.00	0.00	1.00
Ethnicity	-0.01	0.17	0.99	**0.76**	**0.25**	**2.14**	0.25	0.49	1.28
Victims has children	-0.04	0.15	0.96	0.12	0.23	1.13	-0.10	0.48	0.91
Victim age	0.01	0.01	1.01	0.01	0.01	1.01	**0.05**	**0.02**	**1.05**
Severe abuse at T1	-0.22	0.18	0.80	**-0.68**	**0.29**	**0.51**	-2.00	1.15	0.14
Escalating abuse at T1	-0.06	0.15	0.94	0.09	0.22	1.10	-0.70	0.47	0.50
RIC score	**0.05**	**0.02**	**1.05**	-0.01	0.03	0.99	**0.14**	**0.07**	**1.15**
Intensive support	**0.74**	**0.17**	**2.09**	**0.45**	**0.24**	**1.56**	-0.19	0.50	0.83
2-5 interventions	**0.56**	**0.25**	**1.75**	-0.29	0.37	0.75	0.49	0.88	1.63
6-10 interventions	**0.83**	**0.28**	**2.29**	-0.03	0.41	0.97	0.07	0.95	1.07
10+ interventions	**1.12**	**0.52**	**3.07**	2.40	1.32	11.05	21.42		
Constant	-0.28	0.44	0.76	1.32	0.68	3.73	1.38	1.70	3.96
	Model statistics			*Model statistics*			*Model statistics*		
	Percent classified correctly		65.1	Percent classified correctly		78.9	Percent classified correctly		82.9
	Model chi-square significance		0.63	Model chi-square significance		0.99	Model chi-square significance		0.19
	-2 Log Likelihood		1312.47	-2 Log Likelihood		646.86	-2 Log Likelihood		157.07
	Nagelkerke R-square		0.15	Nagelkerke R-square		0.4	Nagelkerke R-square		0.46
	n=1066			n=1066			n=1066		

**denotes significant variation in the adjusted odds of achieving any given outcome as a function of agency

Emboldened text represents a factor significantly linked with increased or decreased odds of achieving a positive outcome $p<.05$

Sample sizes across estimated models relating to the same outcome variable vary slightly owing to different degrees of missing data

Financial dependence and relationship status were not included in the models owing to a high degree of missing data

	Cessation of J & C behaviour			Cessation of H&S			Victim felt safer		
	B	S.E.	Exp(B)	B	S.E.	Exp(B)	B	S.E.	Exp(B)
Agency			**			**			**
Case length	**0.00**	**0.00**	**1.00**	0.00	0.00	1.00	0.00	0.00	1.00
Ethnicity	0.21	0.22	1.24	-0.30	0.29	0.74	0.20	0.21	1.22
Victims has children	-0.05	0.21	0.95	0.11	0.28	1.12	-0.08	0.18	0.92
Victim age	0.01	0.01	1.01	**0.03**	**0.01**	**1.03**	0.01	0.01	1.01
Severe abuse at T1	-0.35	0.25	0.70	**-0.77**	**0.40**	**0.46**	-0.21	0.22	0.81
Escalating abuse at T1	-0.14	0.21	0.87	-0.18	0.28	0.84	-0.06	0.19	0.94
RIC score	0.04	0.03	1.04	0.02	0.04	1.02	0.01	0.03	1.01
Intensive support	**0.44**	**0.23**	**1.56**	0.39	0.32	1.48	**1.27**	**0.20**	**3.55**
2-5 interventions	0.02	0.34	1.02	-0.28	0.47	0.75	**0.85**	**0.26**	**2.34**
6-10 interventions	0.24	0.39	1.27	-0.31	0.53	0.73	**1.54**	**0.33**	**4.66**
10+ interventions	2.00	1.00	7.36	0.60	1.12	1.82	20.59		
Constant	0.39	0.61	1.48	0.82	0.84	2.27	-0.25	0.51	0.78
	Model statistics			*Model statistics*			*Model statistics*		
	Percent classified correctly		74.1	Percent classified correctly		75.4	Percent classified correctly		80.9
	Model chi-square significance		0.9	Model chi-square significance		0.54	Model chi-square significance		0.03
	-2 Log Likelihood		753.26	-2 Log Likelihood		418.74	-2 Log Likelihood		921.97
	Nagelkerke R-square		0.35	Nagelkerke R-square		0.4	Nagelkerke R-square		0.25
	n=715			n=418			n=1066		

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Sample sizes across estimated models relating to the same outcome variable vary slightly owing to different degrees of missing data

Financial dependence and relationship status were not included in the models owing to a high degree of missing data

	IDVA perceived reduction in risk			Improved coping ability			Improved support networks		
	B	S.E.	Exp(B)	B	S.E.	Exp(B)	B	S.E.	Exp(B)
Agency			**			**			**
Case length	0.00	0.00	1.00	0.00	0.00	1.00	0.00	0.00	1.00
Ethnicity	0.13	0.23	1.14	0.14	0.18	1.15	0.20	0.17	1.23
Victims has children	0.10	0.19	1.11	-0.14	0.16	0.87	-0.19	0.15	0.82
Victim age	0.00	0.01	1.00	0.00	0.01	1.00	-0.01	0.01	0.99
Severe abuse at T1	-0.30	0.23	0.74	0.09	0.19	1.09	-0.22	0.19	0.80
Escalating abuse at T1	-0.10	0.21	0.90	0.21	0.17	1.23	-0.16	0.16	0.86
RIC score	**0.07**	**0.03**	**1.07**	-0.01	0.02	0.99	0.01	0.02	1.01
Intensive support	**0.98**	**0.21**	**2.65**	**0.91**	**0.17**	**2.48**	**0.78**	**0.18**	**2.18**
2-5 interventions	**0.93**	**0.26**	**2.54**	**1.27**	**0.27**	**3.55**	**0.92**	**0.30**	**2.50**
6-10 interventions	**2.16**	**0.37**	**8.63**	**2.06**	**0.31**	**7.88**	**1.85**	**0.33**	**6.34**
10+ interventions	20.42			**3.06**	**0.80**	**21.32**	**2.66**	**0.64**	**14.32**
Constant	0.03	0.54	1.03	-1.53	0.48	0.22	**-2.31**	**0.49**	**0.10**
	Model statistics			*Model statistics*			*Model statistics*		
	Percent classified correctly		85.6	Percent classified correctly		72.9	Percent classified correctly		69.1
	Model chi-square significance		0.01	Model chi-square significance		0.4	Model chi-square significance		0.71
	-2 Log Likelihood		816.03	-2 Log Likelihood		1157.87	-2 Log Likelihood		1245.38
	Nagelkerke R-square		0.26	Nagelkerke R-square		0.26	Nagelkerke R-square		0.26
	n=1066			n=1066			n=1066		

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Sample sizes across estimated models relating to the same outcome variable vary slightly owing to different degrees of missing data

Financial dependence and relationship status were not included in the models owing to a high degree of missing data

Step 2

Logistic regression models examining the association between intervention and outcomes after controlling for agency related factors

	Cessation of abuse			Cessation of physical abuse			Cessation of sexual abuse		
	B	S.E.	Exp(B)	B	S.E.	Exp(B)	B	S.E.	Exp(B)
Agency			**			**			**
Repeat referral	-0.07	0.16	0.93	-0.28	0.23	0.76	-0.39	0.47	0.68
Case length	**0.00**	**0.00**	**1.00**	0.00	0.00	1.00	0.00	0.00	1.00
Intensive support	**0.78**	**0.17**	**2.19**	0.39	0.22	1.48	0.18	0.44	1.20
2-5 interventions (vs. 0-1)	**0.56**	**0.24**	**1.76**	-0.33	0.34	0.72	-0.21	0.80	0.81
6-10 interventions (vs. 0-1)	**0.82**	**0.28**	**2.27**	-0.04	0.38	0.97	-0.69	0.84	0.50
10+interventions (vs. 0-1)	**1.19**	**0.51**	**3.30**	2.20	1.23	9.05	20.07		
Constant	0.25	0.26	1.29	1.89	0.36	6.59	2.25	0.80	9.46
	Model statistics			*Model statistics*			*Model statistics*		
	Percent classified correctly		65.2	Percent classified correctly		79.2	Percent classified correctly		80.3
	Model chi-square significance		0.23	Model chi-square significance		0.24	Model chi-square significance		0.46
	-2 Log Likelihood		1320.30	-2 Log Likelihood		724.25	-2 Log Likelihood		.190.36
	Nagelkerke R-square		0.14	Nagelkerke R-square		0.38	Nagelkerke R-square		0.37
	n=1066			n=785			n=193		

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Emboldened text represents a factor significantly linked with increased or decreased odds of achieving a positive outcome $p<.05$

Sample sizes across estimated models relating to the same outcome variable vary slightly owing to different degrees of missing data

	Cessation of J & C behaviour			Cessation of H&S			Victim felt safer		
	B	S.E.	Exp(B)	B	S.E.	Exp(B)	B	S.E.	Exp(B)
Agency			**			**			**
Repeat referral	-0.11	0.21	0.89	-0.12	0.27	0.88	**-0.46**	**0.19**	**0.63**
Case length	0.00	0.00	1.00	0.00	0.00	1.00	0.00	0.00	1.00
Intensive support	**0.39**	**0.21**	**1.48**	0.19	0.29	1.21	**1.30**	**0.20**	**3.66**
2-5 interventions (vs. 0-1)	0.07	0.31	1.07	-0.11	0.41	0.89	**0.83**	**0.25**	**2.29**
6-10 interventions (vs. 0-1)	0.35	0.35	1.41	-0.13	0.46	0.88	**1.50**	**0.32**	**4.47**
10+interventions (vs. 0-1)	2.11	0.98	8.28	0.66	1.05	1.93	20.61		
Constant	0.68	0.31	1.97	0.86	0.43	2.37	0.06	0.28	1.06
	Model statistics			*Model statistics*			*Model statistics*		
	Percent classified correctly		73.1	Percent classified correctly		73.1	Percent classified correctly		82.0
	Model chi-square significance		0.26	Model chi-square significance		0.86	Model chi-square significance		0.14
	-2 Log Likelihood		830.38	-2 Log Likelihood		473.93	-2 Log Likelihood		919.68
	Nagelkerke R-square		0.35	Nagelkerke R-square		0.37	Nagelkerke R-square		0.25
	n=785			n=458			n=1066		

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Emboldened text represents a factor significantly linked with increased or decreased odds of achieving a positive outcome $p<.05$

Sample sizes across estimated models relating to the same outcome variable vary slightly owing to different degrees of missing data

	IDVA perceived reduction in risk			Improved coping ability			Improved support networks		
	B	S.E.	Exp(B)	B	S.E.	Exp(B)	B	S.E.	Exp(B)
Agency			**			**			**
Repeat referral	**-0.83**	**0.21**	**0.44**	-0.41	0.17	0.67	**-0.46**	**0.16**	**0.63**
Case length	0.00	0.00	1.00	0.00	0.00	1.00	0.00	0.00	1.00
Intensive support	**1.02**	**0.21**	**2.78**	**0.93**	**0.17**	**2.53**	**0.78**	**0.18**	**2.17**
2-5 interventions (vs. 0-1)	**1.03**	**0.26**	**2.81**	**1.25**	**0.27**	**3.49**	**0.91**	**0.29**	**2.48**
6-10 interventions (vs. 0-1)	**2.31**	**0.36**	**10.11**	**2.05**	**0.31**	**7.79**	**1.83**	**0.32**	**6.26**
10+interventions (vs. 0-1)	20.60			**3.09**	**0.80**	**22.00**	**2.68**	**0.63**	**14.53**
Constant	0.56	0.29	1.76	-1.23	0.28	0.29	**-2.51**	**0.33**	**0.08**
	Model statistics			*Model statistics*			*Model statistics*		
	Percent classified correctly		85.3	Percent classified correctly		72.1	Percent classified correctly		68.4
	Model chi-square significance		0.06	Model chi-square significance		0.1	Model chi-square significance		0.38
	-2 Log Likelihood		809.44	-2 Log Likelihood		1155.91	-2 Log Likelihood		1243.22
	Nagelkerke R-square		0.27	Nagelkerke R-square		0.26	Nagelkerke R-square		0.26
	n=1066			n=1066			n=1066		

**denotes significant variation in the adjusted odds of achieving any given outcome as a function of agency

Emboldened text represents a factor significantly linked with increased or decreased odds of achieving a positive outcome $p<.05$

Sample sizes across estimated models relating to the same outcome variable vary slightly owing to different degrees of missing data

Step 3

Logistic regression models examining the association between intervention and outcomes after controlling for indicators of perpetrator related risks

	Cessation of abuse			Cessation of physical abuse			Cessation of sexual abuse		
	B	S.E.	Exp(B)	B	S.E.	Exp(B)	B	S.E.	Exp(B)
Perpetrator's criminal record	-0.13	0.13	0.88	-0.42	0.17	0.66	-0.52	0.33	0.59
Incident resulted in injuries	0.12	0.13	1.13	-0.25	0.16	0.78	0.14	0.33	1.15
Perpetrator's aggravating problems	**-0.30**	**0.14**	**0.74**	**0.48**	0.17	1.62	0.34	0.34	1.41
Separation	0.32	0.18	1.38	-0.37	0.24	0.69	-1.62	0.78	0.20
Threats to kill	0.17	0.14	1.19	-0.21	0.18	0.81	-0.06	0.39	0.94
Intensive support	**0.71**	**0.15**	**2.04**	**1.18**	**0.18**	**3.24**	**0.97**	**0.34**	**2.65**
2-5 interventions (vs. 0-1)	0.43	0.24	1.53	-0.32	0.28	0.73	-0.19	0.62	0.82
6-10 interventions (vs. 0-1)	0.60	0.26	1.83	-0.33	0.32	0.72	-1.05	0.64	0.35
10+interventions (vs. 0-1)	0.82	0.49	2.27	1.83	1.07	6.22	19.94		
Constant	-0.71	0.27	0.49	0.82	0.34	2.28	2.15	0.92	8.61
	Model statistics			*Model statistics*			*Model statistics*		
	Percent classified correctly		64.3	Percent classified correctly		70.0	Percent classified correctly		73.1
	Model chi-square significance		0.1	Model chi-square significance		0.83	Model chi-square significance		0.09
	-2 Log Likelihood		1378.82	-2 Log Likelihood		918.80	-2 Log Likelihood		236.57
	Nagelkerke R-square		0.07	Nagelkerke R-square		0.13	Nagelkerke R-square		0.18
	n=1066			n=799			n=196		

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Sample sizes across estimated models relating to the same outcome variable vary slightly owing to different degrees of missing data

	Cessation of J & C behaviour			Cessation of H&S			Victim felt safer		
	B	S.E.	Exp(B)	B	S.E.	Exp(B)	B	S.E.	Exp(B)
Perpetrator's criminal record	-0.18	0.16	0.84	0.02	0.21	1.02	0.01	0.17	1.01
Incident resulted in injuries	**-0.06**	**0.15**	**0.94**	-0.13	0.20	0.88	**-0.16**	**0.16**	**0.86**
Perpetrator's aggravating problems	0.24	0.16	1.27	0.38	0.22	1.46	-0.34	0.17	0.71
Separation	-0.26	0.22	0.77	-0.70	0.31	0.50	0.17	0.22	1.19
Threats to kill	0.14	0.17	1.16	0.06	0.24	1.06	-0.18	0.18	0.83
Intensive support	**1.11**	**0.17**	**3.03**	**1.30**	**0.23**	**3.67**	**1.23**	**0.17**	**3.43**
2-5 interventions (vs. 0-1)	-0.17	0.28	0.85	-0.42	0.38	0.66	**0.81**	**0.24**	**2.25**
6-10 interventions (vs. 0-1)	-0.10	0.30	0.90	-0.58	0.41	0.56	**1.46**	**0.30**	**4.31**
10+interventions (vs. 0-1)	1.66	0.80	5.27	0.86	0.87	2.35	20.50		
Constant	-0.28	0.32	0.75	0.23	0.44	1.26	-0.07	0.29	0.93
	Model statistics			*Model statistics*			*Model statistics*		
	Percent classified correctly		64.3	Percent classified correctly		66.7	Percent classified correctly		78.4
	Model chi-square significance		64.3	Model chi-square significance		0.13	Model chi-square significance		0.45
	-2 Log Likelihood		1024.22	-2 Log Likelihood		582.26	-2 Log Likelihood		974.45
	Nagelkerke R-square		0.11	Nagelkerke R-square		0.14	Nagelkerke R-square		0.18
	n=799			n=465			n=1066		

Emboldened text represents a factor significantly linked with increased or decreased odds of achieving a positive outcome $p<.05$

Sample sizes across estimated models relating to the same outcome variable vary slightly owing to different degrees of missing data

	IDVA perceived reduction in risk			Improved coping ability			Improved support mechanisms		
	B	S.E.	Exp(B)	B	S.E.	Exp(B)	B	S.E.	Exp(B)
Perpetrator's criminal record	-0.06	0.18	0.94	0.01	0.15	1.01	-0.21	0.14	0.81
Incident resulted in injuries	-0.20	0.17	0.82	0.14	0.14	1.15	0.25	0.13	1.28
Perpetrator's aggravating problems	**-0.52**	**0.19**	**0.59**	-0.15	0.15	0.86	0.19	0.14	1.21
Separation	0.27	0.23	1.31	0.25	0.19	1.28	0.12	0.18	1.13
Threats to kill	0.21	0.19	1.23	0.05	0.16	1.05	**-0.05**	**0.15**	**0.95**
Intensive support	**1.12**	**0.18**	**3.07**	**1.00**	**0.15**	**2.72**	**0.69**	**0.15**	**1.99**
2-5 interventions (vs. 0-1)	**0.90**	**0.25**	**2.45**	**1.16**	**0.26**	**3.19**	**0.87**	**0.29**	**2.38**
6-10 interventions (vs. 0-1)	**2.10**	**0.34**	**8.20**	**1.92**	**0.29**	**6.83**	**1.89**	**0.31**	**6.60**
10+interventions (vs. 0-1)	20.43			**2.95**	**0.78**	**19.15**	**2.79**	**0.61**	**16.34**
Constant	-0.08	0.30	0.92	-1.54	0.30	0.21	-1.87	0.32	0.15
	Model statistics			*Model statistics*			*Model statistics*		
	Percent classified correctly		82.9	Percent classified correctly		72.6	Percent classified correctly		64.9
	Model chi-square significance		0.62	Model chi-square significance		0.34	Model chi-square significance		0.68
	-2 Log Likelihood		854.08	-2 Log Likelihood		1216.41	-2 Log Likelihood		1322.21
	Nagelkerke R-square		0.21	Nagelkerke R-square		0.2	Nagelkerke R-square		0.18
	n=1066			n=1066			n=1066		

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Sample sizes across estimated models relating to the same outcome variable vary slightly owing to different degrees of missing data

Step 4

Logistic regression models examining the association between intervention and outcomes after controlling for victims' socio-demographic characteristics

	Cessation of abuse			Cessation of physical abuse			Cessation of sexual abuse		
	B	S.E.	Exp(B)	B	S.E.	Exp(B)	B	S.E.	Exp(B)
Victim's age	0.01	0.01	1.01	0.01	0.01	1.01	0.02	0.02	1.02
Victim's ethnicity (1=B&ME)	0.23	0.14	1.25	**0.70**	**0.20**	**2.02**	0.35	0.34	1.42
Victim has child	0.09	0.14	1.10	-0.04	0.19	0.96	-0.16	0.38	0.85
Victim has aggravating problems	-0.04	0.16	0.96	-0.13	0.21	0.88	-0.28	0.40	0.76
Intensive support	**0.69**	**0.15**	**1.99**	**1.18**	**0.19**	**3.26**	**0.84**	**0.36**	**2.31**
2-5 interventions (vs. 0-1)	0.45	0.23	1.56	-0.26	0.30	0.77	-0.12	0.62	0.89
6-10 interventions (vs. 0-1)	0.60	0.26	1.83	-0.20	0.34	0.82	-0.82	0.66	0.44
10+interventions (vs. 0-1)	0.81	0.48	2.24	1.81	1.07	6.09	19.93		
Constant	-0.83	0.32	0.44	-0.17	0.43	0.84	0.04	0.88	1.04
	Model statistics			*Model statistics*			*Model statistics*		
	Percent classified correctly		61.8	Percent classified correctly		72.2	Percent classified correctly		0.7
	Model chi-square significance		0.12	Model chi-square significance		0.47	Model chi-square significance		74.5
	-2 Log Likelihood		1386.60	-2 Log Likelihood		837.59	-2 Log Likelihood		219.70
	Nagelkerke R-square		0.06	Nagelkerke R-square		0.12	Nagelkerke R-square		0.13
	n=2335			n=730			n=196		

Emboldened text represents a factor significantly linked with increased or decreased odds of achieving a positive outcome $p<.05$

Sample sizes across estimated models relating to the same outcome variable vary slightly owing to different degrees of missing data

Financial dependence and relationship status were not included in the models owing to a high degree of missing data

	Cessation of J & C behaviour			Cessation of H&S			Victim felt safer		
	B	S.E.	Exp(B)	B	S.E.	Exp(B)	B	S.E.	Exp(B)
Victim's age	0.00	0.01	1.00	0.01	0.01	1.01	0.01	0.01	1.01
Victim's ethnicity (1=B&ME)	**0.35**	**0.17**	**1.42**	-0.08	0.23	0.92	**0.37**	**0.18**	**1.45**
Victim has child	-0.09	0.18	0.92	0.04	0.24	1.04	-0.02	0.17	0.98
Victim has aggravating problems	-0.15	0.21	0.86	-0.19	0.28	0.83	0.00	0.21	1.00
Intensive support	**1.13**	**0.18**	**3.11**	**1.41**	**0.25**	**4.10**	1.20	0.17	3.33
2-5 interventions (vs. 0-1)	-0.15	0.30	0.86	-0.61	0.40	0.54	0.82	0.24	2.27
6-10 interventions (vs. 0-1)	-0.05	0.33	0.95	-0.79	0.44	0.45	1.44	0.30	4.21
10+interventions (vs. 0-1)	1.67	0.80	5.33	0.53	0.87	1.70	20.38	7,400.38	
Constant	-0.40	0.41	0.67	-0.42	0.55	0.66	-0.65	0.37	0.52
	Model statistics			*Model statistics*			*Model statistics*		
	Percent classified correctly		64.7	Percent classified correctly		66.6	Percent classified correctly		79.9
	Model chi-square significance		0.78	Model chi-square significance		0.53	Model chi-square significance		0.89
	-2 Log Likelihood		928.45	-2 Log Likelihood		532.95	-2 Log Likelihood		976.26
	Nagelkerke R-square		0.11	Nagelkerke R-square		0.13	Nagelkerke R-square		0.18
	n=728			n=425			n=1066		

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Sample sizes across estimated models relating to the same outcome variable vary slightly owing to different degrees of missing data

Financial dependence and relationship status were not included in the models owing to a high degree of missing data

	IDVA perceived reduction in risk			Improved coping abilitiy			Improved support networks		
	B	S.E.	Exp(B)	B	S.E.	Exp(B)	B	S.E.	Exp(B)
Victim's age	**-0.01**	**0.01**	0.99	**0.00**	**0.01**	**1.00**	-0.01	0.01	0.99
Victim's ethnicity (1=B&ME)	0.37	0.20	1.44	0.16	0.16	1.17	-0.04	0.15	0.96
Victim has child	0.24	0.18	1.27	-0.06	0.15	0.94	-0.16	0.15	0.85
Victim has aggravating problems	**0.01**	**0.22**	1.01	-0.24	0.18	0.78	0.07	0.17	1.07
Intensive support	1.11	0.18	**3.03**	**0.99**	**0.15**	**2.69**	**0.69**	**0.15**	**2.00**
2-5 interventions (vs. 0-1)	0.86	0.24	**2.35**	**1.19**	**0.26**	**3.30**	**0.88**	**0.28**	**2.41**
6-10 interventions (vs. 0-1)	1.96	0.34	**7.11**	**1.98**	**0.29**	**7.27**	**1.92**	**0.31**	**6.81**
10+interventions (vs. 0-1)	20.26			**3.05**	**0.78**	**21.15**	**2.87**	**0.61**	**17.61**
Constant	-0.17	0.38	0.85	-1.33	0.36	0.26	-1.40	0.37	0.25
	Model statistics			*Model statistics*			*Model statistics*		
	Percent classified correctly		83.5	Percent classified correctly		71.6	Percent classified correctly		64.6
	Model chi-square significance		0.60	Model chi-square significance		0.89	Model chi-square significance		0.96
	-2 Log Likelihood		859.88	-2 Log Likelihood		1217.15	-2 Log Likelihood		1328.32
	Nagelkerke R-square		0.2	Nagelkerke R-square		0.2	Nagelkerke R-square		0.17
	n=1066			n=1066			n=1066		

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Sample sizes across estimated models relating to the same outcome variable vary slightly owing to different degrees of missing data

Financial dependence and relationship status were not included in the models owing to a high degree of missing data

Step 5

Logistic regression models examining the association between intervention and outcomes after controlling for indicators of abuse at Time 1

	Cessation of abuse			Cessation of physical abuse			Cessation of sexual abuse		
	B	S.E.	Exp(B)	B	S.E.	Exp(B)	B	S.E.	Exp(B)
Victim is frightened	0.12	0.19	1.12	**0.46**	**0.23**	**1.59**	1.24	0.51	3.45
Severe abuse	-0.18	0.18	0.84	**-0.68**	**0.25**	**0.51**	**-2.08**	**1.06**	**0.12**
Escalating abuse	0.09	0.14	1.10	**0.50**	**0.17**	**1.65**	0.05	0.33	1.05
Multiple types of abuse	0.60	0.36	1.82	0.23	0.63	1.26	22.41		
Physical abuse	0.17	0.23	1.19				-0.08	0.85	0.92
Sexual abuse	-0.19	0.16	0.83	0.11	0.19	1.12			
Harassment & stalking	0.02	0.14	1.02	-0.05	0.17	0.95	**-0.94**	**0.36**	**0.39**
Jealous & controlling behaviour	-0.49	0.31	0.61	-0.44	0.51	0.65	0.21	0.68	1.24
Score on RIC	0.01	0.02	1.01	**-0.09**	**0.03**	**0.91**	0.00	0.05	1.00
Intensive support	**0.68**	**0.15**	**1.98**	**1.16**	**0.18**	**3.18**	**1.16**	**0.36**	**3.18**
2-5 interventions (vs. 0-1)	0.44	0.24	1.55	-0.30	0.29	0.74	-0.62	0.67	0.54
6-10 interventions (vs. 0-1)	0.57	0.26	1.77	-0.18	0.32	0.84	-1.29	0.70	0.28
10+interventions (vs. 0-1)	0.81	0.48	2.26	2.03	1.07	7.59	19.64		
Constant	-0.80	0.32	0.45	1.35	0.49	3.85	-20.21		0.00
	Model statistics			*Model statistics*			*Model statistics*		
	Percent classified correctly		63.5	Percent classified correctly		72.2	Percent classified correctly		74.5
	Model chi-square significance		0.75	Model chi-square significance		0.91	Model chi-square significance		0.23
	-2 Log Likelihood		1381.54	-2 Log Likelihood		903.86	-2 Log Likelihood		225.31
	Nagelkerke R-square		0.07	Nagelkerke R-square		0.15	Nagelkerke R-square		0.24
	n=1066			n=799			n=216		

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Sample sizes across estimated models relating to the same outcome variable vary slightly owing to different degrees of missing data

	Cessation of J & C behaviour			Cessation of H&S			Victim felt safer		
	B	S.E.	Exp(B)	B	S.E.	Exp(B)	B	S.E.	Exp(B)
Victim is frightened	0.39	0.22	1.48	0.02	0.17	1.02	-0.11	0.23	0.90
Severe abuse	-0.45	0.22	0.64	-0.25	0.16	0.78	-0.09	0.22	0.92
Escalating abuse	0.28	0.16	1.33	**0.42**	**0.13**	**1.52**	-0.04	0.17	0.96
Multiple types of abuse	1.04	0.58	2.83	-0.02	0.32	0.98	0.38	0.43	1.47
Physical abuse	0.21	0.32	1.24	**0.63**	**0.21**	**1.88**	-0.13	0.29	0.88
Sexual abuse	0.08	0.18	1.08	0.05	0.15	1.05	0.00	0.20	1.00
Harassment & stalking	0.15	0.16	1.17				0.24	0.18	1.27
Jealous & controlling behaviour				-0.20	0.28	0.82	-0.21	0.37	0.81
Score on RIC	**-0.07**	**0.03**	**0.93**	**-0.06**	**0.02**	**0.94**	0.00	0.02	1.00
Intensive support	**1.08**	**0.17**	**2.95**	**0.73**	**0.14**	**2.07**	**1.22**	**0.17**	**3.39**
2-5 interventions (vs. 0-1)	-0.06	0.28	0.94	0.15	0.21	1.16	**0.76**	**0.24**	**2.15**
6-10 interventions (vs. 0-1)	0.06	0.31	1.06	0.31	0.24	1.37	**1.33**	**0.30**	**3.77**
10+interventions (vs. 0-1)	1.90	0.80	6.68	0.67	0.50	1.95	20.30		
Constant	-1.11	0.57	0.33	-0.43	0.29	0.65	-0.26	0.36	0.77
	Model statistics			*Model statistics*			*Model statistics*		
	Percent classified correctly		65.3	Percent classified correctly		66.9	Percent classified correctly		78.2
	Model chi-square significance		0.01	Model chi-square significance		0.41	Model chi-square significance		0.79
	-2 Log Likelihood		1007.74	-2 Log Likelihood		572.7	-2 Log Likelihood		977.17
	Nagelkerke R-square		0.14	Nagelkerke R-square		0.16	Nagelkerke R-square		0.18
	n=799			n=465			n=1066		

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Sample sizes across estimated models relating to the same outcome variable vary slightly owing to different degrees of missing data

	IDVA perceived reduction in risk			Improved coping ability			Improved support networks		
	B	S.E.	Exp(B)	B	S.E.	Exp(B)	B	S.E.	Exp(B)
Victim is frightened	0.27	0.23	1.31	0.08	0.20	1.08	0.25	0.20	1.29
Severe abuse	-0.17	0.23	0.84	0.26	0.19	1.30	-0.05	0.19	0.96
Escalating abuse	0.01	0.18	1.01	0.13	0.15	1.14	**-0.45**	**0.14**	**0.64**
Multiple types of abuse	-0.02	0.46	0.98	0.57	0.39	1.77	-0.12	0.37	0.89
Physical abuse	0.03	0.31	1.03	-0.06	0.25	0.94	0.27	0.24	1.31
Sexual abuse	0.26	0.23	1.29	-0.12	0.17	0.88	0.02	0.16	1.02
Harassment & stalking	0.14	0.19	1.15	0.19	0.15	1.21	0.06	0.15	1.07
Jealous & controlling behaviour	-0.11	0.40	0.89	-0.39	0.33	0.67	0.13	0.31	1.14
Score on RIC	0.02	0.03	1.02	-0.02	0.02	0.98	0.00	0.02	1.00
Intensive support	**1.08**	**0.18**	**2.94**	**0.97**	**0.15**	**2.64**	**0.73**	**0.16**	**2.07**
2-5 interventions (vs. 0-1)	**0.81**	**0.24**	**2.25**	**1.21**	**0.26**	**3.35**	**0.84**	**0.29**	**2.32**
6-10 interventions (vs. 0-1)	**1.90**	**0.34**	**6.67**	**1.95**	**0.29**	**7.00**	**1.86**	**0.31**	**6.41**
10+interventions (vs. 0-1)	20.16			**2.99**	**0.78**	**19.90**	**2.82**	**0.62**	**16.81**
Constant	-0.44	0.37	0.65	-1.59	0.36	0.20	-1.90	0.37	0.15
	Model statistics			*Model statistics*			*Model statistics*		
	Percent classified correctly		82.7	Percent classified correctly		71.8	Percent classified correctly		65.9
	Model chi-square significance		0.54	Model chi-square significance		0.16	Model chi-square significance		0.5
	-2 Log Likelihood		859.54	-2 Log Likelihood		1209.19	-2 Log Likelihood		1317.12
	Nagelkerke R-square		0.2	Nagelkerke R-square		0.21	Nagelkerke R-square		0.19
	n=1066			n=1066			n=1066		

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Sample sizes across estimated models relating to the same outcome variable vary slightly owing to different degrees of missing data

Step 6

Logistic regression models examining the association between intervention and outcomes after controlling for factors correlated with each outcome of interest

Cessation of abuse			
	B	S.E.	Exp(B)
Agency			**
Case length	**-0.004**	**0.001**	**0.996**
Actual/impending separation	**0.389**	**0.188**	**1.475**
Victim is frightened	0.153	0.190	1.165
Multiple forms of abuse at T1	0.016	0.237	1.016
Physical abuse at T1	0.205	0.229	1.228
Intensity of support	**0.752**	**0.168**	**2.121**
2-5 interventions	**0.525**	**0.245**	**1.691**
6-10 interventions	**0.778**	**0.279**	**2.176**
10+ interventions	**1.116**	**0.516**	**3.053**
Constant	-0.329	0.355	0.720
Model statistics			
Percent classified correctly	64.3		
Model chi-square significance	0.12		
-2 Log Likelihood	1313.62		
	0.14		
n=1066			

**denotes significant variation in the adjusted odds of achieving any given outcome as a function of agency

Emboldened text represents a factor significantly linked with increased or decreased odds of achieving a positive outcome $p<.05$

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Cessation of physical abuse			
	B	S.E.	Exp(B)
Agency			**
Case length	-0.002	0.001	0.998
Victim is member of B&ME community	**0.644**	**0.258**	**1.905**
Victim's aggravating problems	0.283	0.264	1.327
Perpetrator has a previous criminal record	**-0.428**	**0.228**	**0.652**
Perpetrator's aggravating problems	0.388	0.221	1.473
Actual/impending separation	-0.007	0.303	0.993
Severe abuse at T1	**-0.629**	**0.291**	**0.533**
Escalating abuse at T1	0.076	0.222	1.079
RIC score at T1	0.003	0.034	1.003
Intensity of support	**0.465**	**0.238**	**1.592**
2-5 interventions	-0.286	0.363	0.752
6-10 interventions	-0.067	0.411	0.935
10+ interventions	2.279	1.287	9.767
Constant	1.736	0.572	5.676
Model statistics			
Percent classified correctly	79.8		
Model chi-square significance	0.29		
-2 Log Likelihood	649.75		
Nagelkerke R-square	0.399		
n=723			

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Cessation of sexual abuse			
	B	S.E.	Exp(B)
Agency			**
Case length	0.001	0.002	1.001
Repeat referral	-0.363	0.508	0.695
Victim's aggravating problems	-0.633	0.491	0.531
Perpetrator has a previous criminal record	-0.799	0.454	0.450
Perpetrator's aggravating problems	0.222	0.452	1.248
Actual/impending separation	-0.990	0.903	0.372
Severe abuse at T1	**-2.660**	**1.177**	**0.070**
RIC score at T1	**0.165**	**0.072**	**1.179**
Intensity of support	0.146	0.467	1.157
2-5 interventions	-0.391	0.852	0.677
6-10 interventions	-0.935	0.888	0.393
10+ interventions	19.214		
Constant	4.215	1.634	67.672
Model statistics			
Percent classified correctly	83.1		
Model chi-square significance	0.2		
-2 Log Likelihood	175.88		
Nagelkerke R-square	0.46		
n=213			

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Cessation of jealous and controlling behaviour			
	B	S.E.	Exp(B)
Agency			**
Actual/impending separation	-0.046	0.252	0.955
Escalating abuse abuse at T1	-0.120	0.190	0.887
RIC score at T1	0.052	0.029	1.053
Intensity of support	0.299	0.210	1.349
2-5 interventions	0.082	0.301	1.085
6-10 interventions	0.301	0.346	1.351
10+ interventions	1.888	0.949	6.604
Constant	0.185	0.423	1.203
Model statistics			
Percent classified correctly	74.0		
Model chi-square significance	0.1		
-2 Log Likelihood	841.75		
Nagelkerke R-square	0.36		
n=799			

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Cessation of harassment and stalking			
	B	S.E.	Exp(B)
Agency			**
Case length	-0.001	0.001	0.999
Actual/impending separation	-0.267	0.355	0.766
Severe abuse at T1	**-0.709**	**0.364**	**0.492**
Escalating abuse at T1	-0.129	0.267	0.879
RIC score at T1	0.007	0.039	1.007
Intensity of support	0.238	0.299	1.269
2-5 interventions	-0.023	0.420	0.977
6-10 interventions	-0.033	0.469	0.967
10+ interventions	0.805	1.064	2.236
Constant	1.510	0.636	4.525
Model statistics			
Percent classified correctly	73.6		
Model chi-square significance	0.94		
-2 Log Likelihood	468.82		
Nagelkerke R-square	0.38		
n=458			

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IDVAs' perception of risk reduction			
	B	S.E.	Exp(B)
Agency			**
Repeat referral	-0.857	0.210	0.425
Victim has child	0.203	0.192	1.226
Threats to kill have been made	0.122	0.212	1.129
Victim is frightened	0.395	0.247	1.484
Sexual abuse at T1	0.112	0.234	1.118
Harassment & stalking at T1	-0.028	0.191	0.972
RIC score T1	0.036	0.031	1.036
Intensity of support	**0.938**	**0.209**	**2.554**
2-5 interventions	**0.935**	**0.262**	**2.547**
6-10 interventions	**2.144**	**0.368**	**8.538**
10+ interventions	20.335	7,289.019	
Constant	-0.299	0.396	0.742
Model statistics			
Percent classified correctly	84.9		
Model chi-square significance	0.13		
-2 Log Likelihood	880.98		
Nagelkerke R-square	0.28		
n=1066			

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Victims' feelings of increased safety			
	B	S.E.	Exp(B)
Agency			**
Case length	-0.001	0.001	0.999
Multiple forms of abuse at T1	-0.013	0.244	0.987
Harassment & stalking at T1	0.215	0.178	1.240
Intensity of support	1.273	0.197	3.570
2-5 interventions	0.818	0.251	2.267
6-10 interventions	1.469	0.318	4.347
10+ interventions	20.535	7,340.158	
Constant	-0.120	0.337	0.887
Model statistics			
Percent classified correctly	81.1		
Model chi-square significance	0.12		
-2 Log Likelihood	923.70		
Nagelkerke R-square	0.25		
n=1066			

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Victims' improved coping abilities			
	B	S.E.	Exp(B)
Agency			**
Case length	0.000	0.001	1.000
Perpetrator has a previous criminal record	-0.007	0.152	0.993
Current incident resulted in injuries	0.129	0.156	1.138
Threats to kill have been made	**0.032**	**0.166**	**1.033**
Actual/impending separation	**0.364**	**0.204**	**1.439**
Victim is frightened	0.165	0.207	1.180
Severe abuse at T1	0.053	0.199	1.054
Escalating abuse at T1	**0.217**	**0.168**	**1.242**
Multiple forms of abuse at T1	**0.714**	**0.397**	**2.042**
Physical abuse at T1	**-0.322**	**0.274**	**0.725**
Harassment & stalking at T1	**0.005**	**0.164**	**1.005**
Jealous & controlling behaviour at T1	**-0.574**	**0.344**	**0.563**
Intensity of support	**0.897**	**0.173**	**2.452**
2-5 interventions	**1.198**	**0.268**	**3.314**
6-10 interventions	**1.987**	**0.311**	**7.297**
10+ interventions	**2.955**	**0.803**	**19.208**
Constant	-1.853	0.410	0.157
Model statistics			
Percent classified correctly	72.7		
Model chi-square significance	0.13		
-2 Log Likelihood	1149.55		
Nagelkerke R-square	0.27		
n=1066			

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Victims' improved social networks				
	B	S.E.		Exp(B)
Agency			0.000	**
Case length	0.000	0.001	0.829	1.000
repeat referral	-0.487	0.165	0.244	0.614
Current incident resulted in injuries	0.172	0.149	0.211	1.187
Perpetrators' aggravating problems	0.178	0.153	0.422	1.195
Victim frightened	0.410	0.206	0.238	1.507
Escalating abuse at T1	-0.239	0.155	0.320	0.788
Physical abuse at T1	-0.074	0.219	0.548	0.928
RIC score	**-0.007**	**0.022**	**0.000**	**0.993**
Intensity of support	**0.768**	**0.177**	**0.000**	**2.155**
2-5 interventions	**0.859**	**0.296**	**0.000**	**2.361**
6-10 interventions	**1.770**	**0.324**	**0.000**	**5.870**
10+ interventions	**2.629**	**0.637**	**0.000**	**13.855**
Constant	-2.624	0.416		0.072
Model statistics				
Percent classified correctly	69.2			
Model chi-square significance	0.6			
-2 Log Likelihood	1234.22			
Nagelkerke R-square	0.27			
n=1066				

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For further information

For a copy of the full evaluation *Safety in Numbers* please contact:

The Henry Smith Charity
6th Floor
65 Leadenhall Street
London EC3A 2AD
Tel: 0207 264 4970

To download a copy of the full evaluation go to www.drop.io/safetyinnumbers

For questions about the evaluation or its recommendations please email info@safetyinnumbers.org.uk