

INDEPENDENT DOMESTIC VIOLENCE ADVISORS: a process evaluation

FINAL EVALUATION REPORT

24th November 2009

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with the assistance of
Policy Research Institute
Wolverhampton University



Funded by the Home Office



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(Both appendices are available as separate .pdf documents)

Acknowledgments

This study was funded by the Home Office (SRG/07/019). The views expressed here do not necessarily reflect Home Office policy.

The author would like to thank the staff at the participating projects for volunteering to be part of this study, and offering their time, assistance and cooperation with all aspects of the research process. Practitioners working in partner/referral agencies also deserve thanks, as do the victims who allowed their experiences to be included in this report.

Finally the author would like to thank Dr Angela Morgan at the University of Wolverhampton, Laura Blakeborough at the Home Office, and the anonymous reviewers for their helpful comments on earlier drafts of this report.

KEY IMPLICATIONS FOR DECISION MAKERS

Independent Domestic Violence Advisors (IDVAs) are trained support workers who provide assistance and advice to victims of domestic violence. They work closely with criminal justice and statutory partners, and may be based in many different settings. There has been considerable expansion of IDVA services in recent years, as they are linked to other government initiatives such as Specialist Domestic Violence Courts (SDVCs) and Multi-Agency Risk Assessment Conferences (MARACs). The government's *Action Plan for Tackling Violence, 2008-11* indicates that national implementation of SDVCs and MARACs is underway, and documents the continued need for IDVAs. Whilst there is widespread recognition of the value of IDVAs, there is currently not a consistent approach to their implementation.

- The key ingredients of effective IDVA services are independence, a focus on victims' safety, and the ability to coordinate a range of services across agencies on behalf of victims. Successful IDVA work depends on the local availability of other necessary support services (e.g., outreach / long-term support, specialist sexual violence services, etc.). IDVAs are crucial components of the Coordinated Community Response (CCR) model, yet they are only one part.
- The IDVA role offers a unique opportunity to provide independent, objective advice to victims about their options, and one that is not duplicated by any other worker. IDVAs navigate multiple systems and are crucial contributors to multi-agency initiatives, especially MARACs. Their specialist skills and ability to provide both individual and institutional advocacy are very highly valued.
- For a host of reasons, but primarily to maintain their independence, IDVAs should be managed by specialist domestic violence projects. This allows for better management of cases, collegial support and advice, supervision, and the opportunity for creating specialized IDVA positions, all of which enables better service provision for victims. Ideally IDVAs work as teams, rather than as lone attachments to agencies, and this is how they should be organized and supported in the future.
- IDVAs are inexorably linked to their partner agencies; therefore, referral protocols need to be consistent across both time and space. Statutory partners benefit from making referrals to IDVA services and should undertake strategic planning to ensure the long-term sustainability of their IDVA partners.

EXECUTIVE SUMMARY

Context

The overall aim of the work is to assess how Independent Domestic Violence Advisor (IDVA) services have been implemented in various settings and the perceived impact they have had with regard to providing support to victims of domestic violence. Assessing their contribution towards the CCR (Coordinated Community Response) model was also part of this research. This model promotes multi-agency participation, and requires the coordination of various components and interventions, in order to provide a more effective, holistic response to domestic violence.

Approach

This is a qualitative study drawing information from interviews and visits in four case study sites that provide an IDVA service. The fieldwork for this research took place over a 6-month period (Oct 2007-Mar 2008). Interviews were conducted with:

- Staff in domestic violence projects: IDVAs, supervisors, and management staff;
- Practitioners in referral/partner agencies: police, prosecutors, solicitors, court officials, those working in health or housing agencies, etc.; and,
- Victims/survivors of domestic violence: women accessing the sites for support and assistance.

In total, 87 interviews were conducted (21 with staff working in the sites, 35 with practitioners in referral/partner agencies, and 31 with victims).

Main findings

How to maintain the 'I' in IDVA

The independence of IDVAs was unanimously seen as the defining characteristic of their role, and the key way in which they were differentiated from other agencies coming into contact with victims of domestic violence. The independence of IDVAs was viewed as essential to effectively coordinate the community response, to provide institutional advocacy to their multi-agency partners, and to their ability to engage with and provide appropriate advice to victims. The two main factors that were perceived to potentially influence their independence were 1) sources of funding, and 2) location of IDVA services. There was concern that statutory funding could compromise the independence of IDVAs by changing the way they delivered advocacy, and to whom.

It was felt that performance targets associated with statutory funding needed to be consistent with the ethos and objectives of the domestic violence project; otherwise the independence of IDVAs would be diminished.

Regarding location, respondents believed that IDVAs should be embedded within domestic violence projects, as statutory settings could potentially compromise their (perceived or actual) independence. The two primary mechanisms by which their independence could be compromised included: a loss of identity (the 'IDVA' role being subsumed into the statutory role) and/or a change in practice (prioritizing the work of the statutory partner rather than the safety of victims). These problems were felt to be less likely when IDVAs were based in domestic violence projects within the voluntary sector.

The best locations for IDVAs

As stated above, an independent domestic violence project was viewed by the majority of respondents as the ideal location for IDVAs to carry out their day-to-day work; however, several sites had reached arrangements whereby IDVAs worked part-time in statutory settings (e.g., police, courts, health, housing). It was felt to be essential that 'co-located IDVAs' are managed by domestic violence projects to ensure that they maintain their commitment to the safety of victims and to reduce some of the pressure associated with being the 'outsider' based within a statutory agency. Importantly, they need to be able to access support and advice from other IDVAs on a regular basis. The key benefit of co-location (more effective partnership work) needs to be managed alongside the key benefit of IDVAs (providing independent advice and support).

The importance of consistent referral routes

Changing referral routes (especially with the police) created difficulties for small teams of IDVAs with little capacity to manage sudden variations in workload. For example, there were differences in police referral routes across the sites as well as changes to procedures within sites during the time of this research. These were fundamental changes to do with issues of victim consent, and whether this was to be explicitly obtained at the time of the incident by the responding officer, or whether there was a protocol in place to enable automatic or 'blanket' referrals to the IDVAs. Regarding the victim consent issue, on the whole respondents felt that victims should *not* be required to give explicit consent at the time of the incident. Instead, 'blanket' referrals were seen to be the preferred option to maximize the chances of a victim receiving timely support from an IDVA. Furthermore, any statutory partners that 'filter' victims in or out of the IDVA service should be specialists (e.g., Domestic Violence Officers), and ideally their practice would be regularly checked and informed by the needs and expectations of their IDVA partners.

Recognizing the IDVA contribution to a coordinated community response

IDVAs were viewed by the majority of respondents as vital contributors to the CCR model, as they are uniquely placed to coordinate the activities of a wide-range of agencies on behalf of victims, and in so doing, encourage multi-agency rather than single-agency responses to domestic violence. The importance of coordinating efforts

in order to provide a 'seamless response' to victims was often mentioned, by practitioners as well as by victims, as a key ingredient of a successful CCR. In addition, multi-agency risk assessment conferences (MARACs) received considerable commendation for either 'kick-starting' reluctant partners, or further embedding multi-agency work at an operational level. The contribution of IDVAs to MARACs was considered invaluable.

Challenges to partnership work mentioned by respondents included addressing gaps in service provision (e.g., children's services and those for black and minority ethnic victims), trying to share the workload equally amongst partners, coordinating responses from a large number of involved agencies, needing to have other relevant services available locally (e.g., outreach services, specialist sexual violence services) for IDVAs to refer victims to, and monitoring all of these various activities consistently and effectively. Despite these issues, the CCR model was universally praised by respondents as essential for delivering an improved, holistic response to victims of domestic violence.

Treating IDVAs like proper employees

It was clear that where IDVAs are located has profound consequences for the extent to which they are 'cared for' as employees. In this regard, domestic violence projects have noticeable benefits in terms of providing the ethos, philosophy, policies, day-to-day guidance and support that IDVAs need to work effectively. Both the practical advice and emotional support that are the hallmarks of IDVA work are delivered more successfully within teams than amongst solo IDVAs. For example, across the sites teamwork was hailed as enabling IDVAs (especially those new in post) to benefit from the experience and knowledge of their colleagues. Working in teams has the added advantage of enabling the provision of 'specialist' advocacy services, where individual IDVAs develop particular skills, focus on delivering certain aspects of the service, or target under-served communities. Taking the 'teamwork' concept further, regional networks (available in one of the four sites) were seen to add an additional layer of support and information for IDVAs to access, subsequently improving both their practice and morale.

Two deficiencies in 'taking care' of IDVAs were identified from the research. First, although regular performance reviews were undertaken, clinical supervision was lacking in all of the sites except one (largely due to financial reasons). Second, although effective IDVA work requires proficiency in a number of different skill sets, completion of a comprehensive and demanding training course, and a lengthy period of mentoring and supervision, all of the IDVAs were on short-term contracts. It was felt that these working arrangements did not honour the specialist know-how, expertise, and contribution of IDVAs. Respondents expressed concern that existing short-term and ad hoc funding arrangements were not compatible with the long-term vitality and sustainability of the 'IDVA workforce'.

The research has raised several issues to be considered in the future commissioning and implementation of IDVA services.

Recommendations

1. All IDVAs should be managed by independent domestic violence projects. Ideally they should, at least partially, carry out their day-to-day work from these types of projects too.
2. The merits of co-located IDVAs implies that further consideration of these types of joint posts, as well as co-located teams or 'one-stop-shops', is warranted. Alternative models of IDVA services to those studied here may be effective if they are able to preserve the independence of IDVA work, and should be studied.
3. Specialization within teams of IDVAs improves their working practice. Co-location in statutory settings and having specific remits (e.g., supporting Asian women or those referred to MARACs) are two mechanisms that foster specialization and should therefore be employed where possible. This further highlights the necessity of coordinating IDVAs services so that they are able to work as teams within domestic violence projects.
4. National guidance is warranted on the issue of 'victim consent' and police referral routes to IDVA services. It is recommended that automatic referral routes are adopted consistently across all areas, so that victims receive timely contact and support from IDVAs. Victims should not be required to give explicit consent for a referral to be made at the time of the incident.
5. IDVA services should receive the necessary funding in order to manage the increased caseloads associated with automatic referral routes effectively. As IDVA work produces benefits for statutory partners, they should undertake strategic planning to ensure the long-term sustainability of their IDVA partners.
6. Further work is necessary to address remaining gaps in service provision, especially the provision of direct services to children and appropriate/specialist services for black and minority ethnic victims.
7. CCRs must recognize that successful IDVA work depends on the local availability of other support services (e.g., outreach services, sexual violence services), and plan accordingly.
8. Monitoring the work of IDVAs (and therefore the CCR as a whole) is often a requirement of funding, yet more consideration needs to be given to how this responsibility is undertaken and resourced within CCRs. Consultation on the utility and feasibility of shared IT systems would be helpful.
9. IDVAs valued supervision and ideally their work should be reviewed by a supervisor on a monthly basis (in addition to routine day-to-day oversight). They should also receive individual clinical supervision. Regional networks of IDVAs could provide an informal avenue for exchanging collegial support and advice, and should be explored.

10. As this research was relatively small-scale and wholly qualitative, it is recommended that a comprehensive study of *all* IDVAs be commissioned in the future (there are currently more than 700). Such a study should attempt to gather quantitative information from every IDVA working in England and Wales (e.g., using a questionnaire), supplemented with more detailed qualitative information (e.g., interviews but also observation, documentary analysis, etc.) from a sub-sample of the total. Such a study could reveal whether the challenges identified in this research are widespread, how they might have been overcome with time, and likewise whether the observed benefits are sustainable. This should be linked to a similar national study of Independent Sexual Violence Advisors (ISVAs).

MAIN REPORT

INTRODUCTION

The overall aim of the work is to assess how Independent Domestic Violence Advisor (IDVA) services have been implemented in various settings and the perceived impact they have had with regard to providing support to victims of domestic violence. Assessing their contribution towards the CCR (Coordinated Community Response, see below) model was also part of this research. A qualitative approach was used, with interviews and visits conducted in four IDVA sites: two are 'stand-alone' advocacy projects and two are advocacy projects affiliated with refuge providers. This is a small sample that does not encompass all of the models of advocacy provision across the UK; however, these are the most frequently used models and those associated with best practice and effective delivery of IDVA services. Direct quotes from the interviews are denoted as "DVP", "RPA" or "VS", followed by the site number (e.g., RPA2). For more information about the methodology and the instruments used, see Appendix A.

Background to the Research

There is a body of research on providing advocacy to victims of domestic violence in the UK, which draws on work conducted in the USA pointing to the benefits of providing support and advice to women in community-based settings, as part of a 'Coordinated Community Response' (CCR) to domestic violence.¹ Accordingly, the Home Office definition is as follows:

"The CCR is a model way of operating a system which ensures multi-agency participation, and requires the coordination and consistency of various components and interventions."

The proliferation of advocacy in the UK is largely due to the expansion of Specialist Domestic Violence Courts (SDVCs) and Multi-Agency Risk Assessment Conferences (MARACs) for high risk victims in the last few years. These multi-agency interventions are the foundation of the government's approach to tackling domestic violence, and IDVAs are viewed as essential practitioners in their delivery.

The aim of this research was to study IDVAs working in diverse contexts, with different elements of a CCR in place. When the research was commissioned, sites varied according to whether they had both SDVCs and MARACs, compared to a SDVC only, or neither. It is noteworthy to report, however, that by the end of the fieldwork phase,

¹ For research documenting the effectiveness of providing support and advocacy to victims of domestic violence, see Cook et al., 2004; Parmar et al., 2005; Robinson, 2003, 2006; Sullivan, 1991; Sullivan and Bybee, 1999; Vallely et al., 2005. Readers should also note that a major outcome evaluation of IDVA services has also been very recently published (Howarth, Stimpson, Barran & Robinson, 2009).

all four IDVA areas had implemented both SDVCs and MARACs. Thus, differences in the type and style of CCR operating in the sites had diminished substantially over the course of the research, consistent with progress in this area nationally. Nevertheless, there was still much to be learned about how local features and characteristics of multi-agency partnerships impacted on the work of IDVAs.

IDVAs and SDVCs

SDVCs are specialized court settings that deal with cases involving domestic violence, the first was established in Leeds in 1999. They have emerged in different local contexts and so there are operational variations (e.g., full or part-time courts). Regardless, their guiding philosophy is that domestic violence is a crime that poses particular difficulties on both the victim and the criminal justice system, requiring a specialized method of dealing with these cases. Evaluations concluded that the support, information and advocacy provided by IDVAs to victims were found to be crucial in the success of SDVCs (Cook et al., 2004; Vallely et al., 2005). Consequently, the government's SDVC expansion programme (2005-07) created more opportunity for IDVA work and there was corresponding funding of new IDVA posts attached to these courts.

IDVAs and MARACs

In Cardiff, the implementation of Multi-Agency Risk Assessment Conferences (MARACs) for very high risk (VHR) victims took place in 2003 and evaluations showed the positive results from providing a multi-agency response to those victims suffering repeat, chronic abuse (Robinson, 2006; Robinson & Tregidga, 2007). This model of intervention follows a process of risk assessment in all reported cases of domestic abuse, in order to identify those at VHR so that a specialist multi-agency approach may be taken on their behalf. MARACs are inseparable from IDVA work nationally since both services are targeted toward VHR victims; IDVAs complete risk assessments, refer victims to MARACs, share information about individual cases, and represent the 'victim's voice' at these multi-agency meetings.

Thus, an evaluation of IDVA services cannot be truly understood apart from these other recent, and now widespread, initiatives. In large part this is due to the fact that IDVAs, SDVCs and MARACs are *all* multi-agency initiatives that must engage in partnership work to deliver their own, as well as CCR, outcomes.

Finally, it should be noted that providing support and advice to victims of domestic violence is not new, originating in refuges in the 1960s. In refuges, women willing to flee their homes were able to access support. The next stage was to offer services to women living in the community via 'outreach' or 'floating support' units within refuges. 'Advocacy' emerged in several areas in the 1990s to provide support and advice to *all* types of victims in the community, for example, even those still in relationships with the perpetrator. The workers who provide advocacy services to victims of domestic violence have come to be known, via government policies and funding arrangements, as 'IDVAs'. Thus, the label is newer than the type of work.

Methodology

This report is primarily a qualitative study drawing information from interviews and visits in four case study sites that provide an IDVA service. Please refer to Appendix A for detailed information regarding the methodology, the participants and the research instruments used in this study.

The four case study sites were selected to provide in depth information about how the IDVA role was established and delivered in different settings, and aimed to compare service provision in these settings. To that end, four sites were selected that had implemented the CCR model to different levels:

- Site 1 (SDVC in operation, MARACs initiated during fieldwork)
- Site 2 (SDVC and MARACs in operation)
- Site 3 (MARACs in operation, SDVC initiated following fieldwork)
- Site 4 (SDVC and MARACs in operation)

Although all four projects can be characterized as ‘domestic violence projects’, two are stand-alone advocacy projects (Sites 1 and 4), whereas in the other two projects, advocacy is one part of a larger domestic violence organization that also provides refuge accommodation (Sites 2 and 3). Furthermore, each site serves a geographical area with its own particular challenges, with demographic differences as well as variable histories and legacies of multi-agency partnership work. Appendix B contains brief descriptions of each of the projects participating in the research, in addition to tables containing comparative information for the four areas.

The fieldwork for this research took place over a 6-month period (Oct 2007-Mar 2008). During that time, interviews were conducted with:

- Staff in domestic violence projects: IDVAs, supervisors, and management staff;
- Practitioners in referral/partner agencies: police, prosecutors, solicitors, court officials, those working in health or housing agencies, etc.; and,
- Victims/survivors of domestic violence: women accessing the sites for support and assistance.

In total, 87 interviews were conducted (21 with staff working in the sites, 35 with practitioners in referral/partner agencies, and 31 with victims).

The names of the four sites that participated in the research will be kept anonymous. Direct quotes from the interviews are denoted as “DVP” (staff at the domestic violence projects, including managers, counsellors, and IDVAs), “RPA” (practitioners in referral or partner agencies) or “VS” (victim/survivors), followed by the site number (e.g. RPA2). Unless stated otherwise, direct quotes are indicative of broad sentiment expressed by a majority of respondents.

Research Questions

The aim of this evaluation was assess the process by which the IDVA operates in various settings and how she interacts with other organizations and systems, in order to identify their added value. Specific questions to be covered by this research included:

- Has the host organization supported the IDVA to do the job?

- Does the IDVA service add value to the organization and if so in what ways?
- Does the IDVA service complement or conflict with support services that are provided by the same organization or a different organization?
- How does the IDVA contribute to the CCR?
- How does the IDVA contribute to the MARAC?
- How does the IDVA contribute to the SDVC?
- What are the levers and barriers to providing an IDVA service?
- How does the IDVA contribute to the victim's welfare, satisfaction levels and safety?
- What are the challenges and issues faced by the IDVA?

Finally, readers should note that a similar multi-site process evaluation of Independent Sexual Violence Advisor (ISVA) services was commissioned by the Home Office and conducted during the same time as the IDVA evaluation. As they are linked pieces of research, the findings from that study will be relevant to readers interested in the issues discussed here.²

Structure of Report

The findings from this research are discussed in the following sections: Section 1 describes how the IDVA role has been conceptualized and developed, the main responsibilities of IDVA work and how they make contact with victims; Section 2 describes the IDVA services and discusses how these settings affect the work undertaken by IDVAs. Section 3 describes the contribution of IDVAs to multi-agency partnership work and the challenges within this, while Section 4 explains how host organizations 'take care' of IDVAs through supervision, support and training. A concluding discussion and recommendations arising from the research are provided in Section 5.

FINDINGS

1. ROLE OF THE IDVA

The nationally accepted definition of an IDVA service is provided here:

"... involves the professional provision of advice, information and support to survivors of intimate partner violence living in the community about the range, effectiveness and suitability of options to improve their safety and that of their children. This advice must be based on a thorough understanding and assessment of risk and its management, where possible as part of a multi-agency risk management strategy or MARAC process." (www.caada.org.uk)

² See Robinson (2009). *Independent Sexual Violence Advisors: A process evaluation*.
<http://www.cardiff.ac.uk/people/robinsona>

This section discusses the main responsibilities of an IDVA, how they are carried out, and the defining features of this relatively new specialist role.

Main responsibilities

Risk assessment

The work of an IDVA is inseparable from risk assessment and reducing risk amongst victims that have been identified at very high risk (VHR) of further harm and abuse. Referral routes and access to IDVA services are dictated – in large part, but not entirely – by risk assessment. All of the IDVA services studied here focussed their efforts on supporting VHR victims, some exclusively. The service provision afforded to those victims not meeting the VHR threshold depends on local arrangements. For example, they might receive a letter and leaflet from the police, or they might receive support from another unit within the domestic violence project (e.g., outreach workers). As this practitioner from a partner agency in Site 2 explained:

P39 (RPA2): Yes, I mean the high and the very high get everything and the standard and the medium although they get the letter and sometimes a phone call, that's all they get whereas I think they are looking at getting somebody to contact these people, then perhaps they can prevent them from becoming high risk....

Thus, identification of the risk category has large implications for victims of domestic violence, in that it dictates the level of service provision they receive. Whilst necessary to target limited resources to the most vulnerable victims, in practice this causes difficulties, not least because 'risk assessment' is not an exact science. Even amongst experienced IDVAs, it was felt that risk assessment was a highly skilled practice, in need of constant maintenance. Therefore it was seen as prudent to review practice and monitor the type and level of information that was being gained from the risk assessments. The following quote from a member of staff in Site 1 highlights particularly good practice in this regard:

P11 (DVP1): We sat down quite recently as a team to say how is everyone finding the risk assessment, this is an opportunity for you to say as a group where you stand with the risk assessment, are there questions that you just feel uncomfortable asking... I think it's about getting people used to asking questions they're not necessarily familiar with, and getting the advocates to think about learning techniques from each other about how to integrate questions into the dialogue rather than adding it on at the end of a conversation, making it relative to what the survivors telling us.

It was often noted that IDVAs were more successful at obtaining 'full disclosure', in that victims were willing to provide a more comprehensive account of the abuse, including sharing sensitive details (e.g., sexual abuse). This could be due to myriad reasons, such as the IDVAs' specialist training and experience, discussing experiences in a less-traumatic environment, some time after the initial offence, etc. Regardless of the reasons, and even though all of those interviewed (police, IDVAs and others) were aware of it, there are still profound implications of this for multi-agency working.

P10 (DVP1): Um ... the standard risk cases that the police send to us are just ... they work out for us to be a very different picture. Are the women withholding information, or are the questions just not being asked properly ... or, you know, lots of different reasons. So when we get them here thinking they're standard risk, we then soon realise that they're high risk, and then ... it becomes a case that we would case manage, and something that we would take very seriously, but the police would think of it as a lower level. It's kind of getting that to marry up, as well.

P51 (RPA4): ... sometimes we find that referrals from [site] come through and then when we look at them it appears from our involvement that they don't appear to be high-risk compared to what [information] we have got... so there is discrepancy over what is high-risk... but it is not a problem we just settle it out as to what we can do.

Crisis intervention and safety planning

It was agreed that the role of an IDVA is linked to short-term crisis intervention with high or VHR victims. As such, safety planning was viewed as the key piece of work that informed all of their other practices.

P11 (DVP1): So, it's basic safety planning from that point of initial call ... 'is it safe to talk right now?', 'do you need me to call you back?', 'if I call you back will you be able to speak?', 'where is the perpetrator? Where are the children?', 'is there anybody with you?', 'is there anywhere you can go?', 'if we get interrupted on this phone call, what shall we do?' ... And it's straight from the off, even before we know what the client's going to tell us, we're setting her up to say we're thinking about her safety.

The importance of the safety planning undertaken by IDVAs was recognized by partner agencies. This practitioner from Site 4 also noted the link between a woman's safety and that of her children, as well of the institutional 'ripple effect' of IDVAs' focus on safety.

P52 (RPA4): I think in particular the safety planning is a massive thing. The [IDVAs] do look at all the safety issues and are then able to incorporate and ensure that individual safety plans are made and also other agencies develop plans and procedures to ensure the clients – but it is not just the clients it's the children as well –if the clients aren't safe then that has massive implications to everyone else concerned... the IDVAs are ensuring that other agencies are prioritising safety awareness and that is a very positive thing.

Significantly, the role of an IDVA was perceived to be clearly differentiated from other types of workers providing support to victims of domestic violence (e.g., outreach workers). The role of an IDVA was generally not felt to be duplicated by any other position or agency (but see section on 'challenges of multi-agency work' for more on this issue). Risk assessment helped to distinguish the IDVA from other workers.

P10 (DVP1): I think that there's work to be done around what floating support and outreach services can do in terms of standard risk clients, trying to work in terms of risk, and what advocates [IDVAs] can do in terms of high and very high risk clients, and trying to separate the two, because I think that's where the two services should be defined. I think it's in relation to risk...

P30 (DVP2): We have a culture of long and slow support for women, a bit like slow cooking, whereas advocacy is a bit like fast frying you know to use that analogy... it requires you to have clear start and cut off times.

Supporting victims

Fundamentally, IDVAs help victims navigate their way through various systems; for example, the criminal justice system (CJS), the civil court system, and other systems such as housing, health, and education. Given recent history of much IDVA funding being associated with the government's SDVC expansion programme, as discussed earlier, it was not surprising that respondents held a view of the IDVA role being connected to the CJS, and in particular SDVCs. Supporting victims at court was highly valued by IDVAs, by partner agencies, as well as by victims.

P11 (DVP1): We all think very strongly that our presence at court is something that we must stick with, and however tight the pressures are, that service we offer to clients is so unique... that none of the advocates nor the management want to give [it] up.

P68 (VS2): To have that support, it just gives you the strength to go and give evidence. I could have backed out many times because I was afraid to stand up and go against my ex-husband but having [IDVA] there, she gave me the strength to go on with it. It is a hard thing to do, but having someone there to talk to you and listen to you, to reassure you everything will be ok, it did really help.

As a core component of their work, IDVAs must be able to provide information about the court process, explain what will be expected of victims in terms of giving evidence, how to make a victim personal statement, implications of making a withdrawal statement, and taking victims to visit the court. IDVAs even mentioned liaising with IDVAs from other areas to provide case progression information, indicating that the coordination of support in relation to criminal cases extended beyond the immediate locale. As this member of staff from Site 3 explained:

P23 (DVP3): So I'll explain to the woman about the court, and quite often people don't know anything at all about courts, so they want to know if they need a solicitor, and they want to know what they have to do, where they need to go, what they should wear, all the things you just don't think about until you have to go to court, I suppose.

Partner agencies were quick to comment on the importance of providing support to victims, as they were sympathetic to the stress involved in a court case. In fact, IDVA support was viewed as a necessary precursor to having successful court outcomes; for example, reducing retraction, giving better evidence, and obtaining convictions. Practitioners from partner agencies often mentioned the benefits of working with an IDVA service:

P55 (RPA4): I think the way that [site] and the domestic violence unit and ourselves work together – this encourages women to keep engaged with us... of course they are not always victims just the once, whilst the men are on programmes they can still be committing offences so you know you have got that contact being maintained throughout that sentence so it does encourage the women to remain engaged with the agencies and enable them to be more empowered.

P8 (RPA1): The ones who are being supported are generally ... they're still apprehensive, but they have information, so they're not as nervous as people who don't know what to expect at all. And sometimes when I'm talking to a person who's being supported, they will say 'my advocates already told me about this', 'I know what to expect in relation to that', so it helps when I'm talking to victims before the trial. It helps that I can concentrate on the most important things, in terms of preparing them to give evidence.

However, it was evident that this aspect of work varied across the sites in terms of whether it was viewed as central (e.g., for IDVAs attached to SDVCs) or just one of a multitude of ways in which support was provided to victims. For some IDVAs, the CJS aspect of their remit was *de facto* their sole remit. Other IDVAs were involved in the CJS primarily through the MARACs, rather than SDVCs. For others, their primary 'system' work was concentrated around civil remedies; for example, making applications for non-molestation orders. Therefore it is not accurate to equate IDVAs' work solely with SDVCs, as the information and support they provide to victims goes well beyond helping them through a criminal case.

Multi-agency working and institutional advocacy

Institutional advocacy refers to providing support and advice to institutions rather than to individuals. It is the process by which partners in multi-agency initiatives learn and improve their practice. IDVAs are uniquely placed to deliver institutional advocacy because they are the only ones with a truly multi-agency perspective, one gained from working within and across different agencies as they coordinate services on behalf of

victims. Importantly, their perspectives are informed by victim expectations and experiences. IDVA services recognized the importance of this function of their role:

P48 (DVP4): I suppose the thing that we do well is that we make other agencies aware that we are working with that woman and what our role is because I think it is very easy to work with a client and blinkingly think that no other agencies are involved. There are other agencies that have a different role that that client still needs so I think institutional advocacy is what we do really well.

In terms of delivering a CCR, practitioners from partner agencies often commented that IDVAs provided a vital blend of operational know-how, specialist knowledge, and policy advice.

P15 (RPA3): I think it's that real multi-agency cross-over, you know, being able to sit in the police ... within the police culture, as well as retaining those links with [site] and the outreach, and being well known by everybody who sits on that MARAC process, is just so helpful, because she really does have an overview of all the agencies involved.

Contact between IDVAs and victims

Making contact with victims of domestic violence to offer advice and support is the core business of an IDVA. Partner agencies recognized the value of offering the support of an IDVA to victims of domestic violence, and the commitment of IDVAs in making multiple attempts to offer their support.

P18 (RPA3): Well ... because I think a lot of people already feel like they're very alone dealing with it, and she keeps trying to contact people despite them not answering her calls, or ... she does give them every opportunity really to take up that support that she's offering, I think.

Across the sites, there were different models of how contact with victims was accomplished. In Sites 1 and 4, most of the contact with victims took place over the phone. One of these sites also had the on-site facilities for face-to-face contact with victims; the other did not (although face-to-face meetings took place in public places when necessary). Interviewees from both of these sites felt that they were highly effective working with women in this way.

P10 (DVP1): Most of our contact is by telephone and we're managing to be as effective as we are by telephone for the majority of clients... We have the facility here to see clients, and we use it when clients are ready for it, but it, there's no requirement that we have to see them face-to-face, the clients, it's what their needs are.

It was noted that face-to-face contact was the preferable method for engaging with certain clients (e.g., those who have English as their second language); however, the setting up of face-to-face appointments was time-intensive, and it was felt that if these appointments were mandatory, then this would put some women off (who might find disclosing sensitive information easier within the anonymous context of a telephone conversation). On the other end of the spectrum, some victims were happy to receive visits from IDVAs in their own homes. The quotes from these four victims illustrate a diverse range of experiences, all positively viewed:

P70 (VS1): ...I finally had somebody to actually speak to, they wasn't going to judge me and who didn't know me, and who wouldn't see me face-to-face.

P64 (VS2): I didn't have transport at the time when they got in contact with me, and I didn't know [city] at all, erm and she came to see me, rather than making me struggle, get through the city and try and find them. So I was really pleased about that. It meant a lot to me, that she came out to see me.

P84 (VS3): Well I could ring her whenever I wanted and she used to come and see me as well. I was contacted quite quickly actually, it happened and then I think it was the next day. I found it hard to start with, but then it got better when I started putting trust into her.

P59 (VS4): [IDVA], she gave me a lot of information. And everything that I asked she answered correctly and professionally, and she rang me. And she said that she was always at the end of the phone if I needed to ring her, which I did a time or two, and she was always there to talk to me if I was a bit upset or weepy or anything. She was very good with everything. So I did feel that I was quite safe, yeah.

In terms of contact, it was very much the case that victims commented on the timeliness of the contact ('I was more or less contacted straight away') and style of the IDVAs' approach ('non-pushy, not judgmental') rather than the method of contact (telephone or face-to-face). The best method of contact really depends on the needs and desires of the victims, and IDVAs were able to be flexible accordingly. Regardless of the method, however, contact is managed with clearly defined protocols adhered to by the IDVAs, as this quote shows:

P4 (DVP1): We have ... for every woman we have a case management flow chart that says, you know, if a woman comes in and she doesn't want to know, this is what you do, if she wants advice, these are the five things you must do, if she's high-risk then these are the things you need to do. So it guides workers in how much work they put into each woman, but also thinking about... even if the woman doesn't want to know, you still have to do these five things.

It was clear that how contact with victims was undertaken depended on many factors, such as the caseload or volume of work, the facilities available for appointments, and what best suited the victim.

Role development and independence of IDVAs

Across all of the sites, there was a very clear conception of the role and responsibilities of an IDVA. The independence of IDVAs was regarded by all respondents as the most important factor underpinning IDVA services. Independence meaning they had a separation of policy, practice and philosophy from their partners – one focussed exclusively on the safety of victims. Especially important was their perceived independence from the criminal justice system and local government. In fact, the independence of IDVAs could be seen as *the* defining characteristic of their role, and one of the ways in which they were differentiated from other agencies coming into contact with victims, as this practitioner explained:

P3 (RPA1): The officer in the case talking to the victim, or encouraging them or advising them... obviously they're not independent, because they are part of the case and part of the prosecution process. But the IDVAs are wholly independent, and so no axe to grind, nothing to benefit, nothing to lose.

The independence of IDVAs was viewed as essential to their ability to engage with and provide appropriate advice to victims.

P11 (DVP1): We know that by remaining independent a woman may engage with us, and we may be able to help her liaise with the more difficult agencies that she's having trouble with.

Independence also was linked to a better ability to provide 'institutional advocacy' in that IDVAs were seen, in a positive way, as whistle-blowers and enabling quality-assurance checks on the policy and practice of statutory agencies.

P53 (RPA4): I think it is important that they are an independent organization from the local authority and so it allows them to work neutrally and to challenge practice that might be going on in statutory organizations.

Independence from the victim's perspective most often reflected a separation of advice and information from that provided by their friends and family:

P64 (VS2):- Erm somebody to talk to really who wasn't biased, 'cos all my friends were biased, erm and I think they just gave me the cold hard facts really, instead of slagging my husband off.

They welcomed and trusted the advice provided by IDVAs; however, victims were clear that they had been supported to make their own choices. They felt informed by what the IDVAs told them, rather than commanded by it.

P63 (VS2): No. They didn't have any influence on my decision. They were very good, whichever route I wanted to take and that they said they would back me whichever one. You know [it was] my decision in whether I wanted to carry on or if I wanted to come back...

Thus, the 'I' in IDVA means they were able to provide a singular service to both their multi-agency partners and the victims they were supporting. It is noteworthy that the IDVA role fills these important gaps in two such different arenas.

Threats to IDVA independence

Given the value that independence was accorded, in terms of being absolutely central to the role and work of an IDVA, some of the perceived threats to the independence of IDVAs were also discussed in the interviews. The two main factors that were perceived to potentially influence their independence were 1) sources of funding, and 2) location of IDVA services.

In terms of funding, it was felt that statutory sources of funding could potentially compromise the independence of IDVAs. Funding was a bone of contention across all of the projects. In terms of how funding was related to the perceived independence of projects, they were consciously trying to maintain funding from sources that enabled them to have more flexibility and independence. It appeared that government funding, although both needed and welcomed, was viewed as a 'necessary evil' that had to be carefully managed, as it could not only compromise the independence of IDVA services, but also change the way they delivered advocacy, and to whom.

P30 (DVP2): Well, we have always cherished the independence erm yes... we have had various different methods of funding, but largely grants, and now they are contracts and that makes a difference to how independent you think you can be.

Regarding location, it was very much the view that IDVAs should be embedded within domestic violence projects, as statutory settings could potentially compromise their (perceived or actual) independence. The two primary mechanisms by which their independence could be compromised included: a loss of identity (the 'IDVA' role being subsumed into the statutory role) and/or a change in practice (prioritizing the work of the statutory partner rather than the safety of victims). These problems were felt to be less likely when IDVAs were based in domestic violence projects within the voluntary sector.

P 8 (RPA1): I think the beauty of the IDVA who is not attached to a statutory agency, like the local government or anything like that, is that their focus is really the safety of the woman... So I think they should never be attached to a statutory organization, I just don't think that is the place for them in terms of maintaining independence.... I think the voluntary sector is really the best

place, but properly funded, not as some sort of after thought.

Conclusion

The main responsibilities of an IDVA include: identifying victims at high risk of further harm and undertaking work to lessen the risks to victims, such as undertaking safety planning, supporting victims at court and coordinating other services on behalf of victims. IDVAs also contributed to multi-agency partnership work by providing institutional advocacy to partner agencies. The independence of IDVAs was unanimously seen as the defining characteristic of their role, and the key way in which they were differentiated from other agencies coming into contact with victims of domestic violence. The independence of IDVAs was viewed as essential to effectively coordinate the community response, to provide institutional advocacy to their multi-agency partners, and to their ability to engage with and provide appropriate advice to victims. There was concern that statutory funding could compromise the independence of IDVAs by changing the way they delivered advocacy, and to whom. It was felt that performance targets associated with statutory funding needed to be consistent with the ethos and objectives of the domestic violence project; otherwise the independence of IDVAs would be diminished.

2. LOCATION OF IDVA SERVICES

IDVAs in domestic violence projects

Given that one of the aims of the current research was to establish how the local context and setting affects the work of IDVAs, there was much discussion over the location of IDVA services. Different models of practice were apparent across the sites, each with its merits. Although all four projects can be characterized as 'domestic violence projects', two are stand-alone advocacy projects, whereas in the other two projects, advocacy is one part of a larger domestic violence organization that also provides refuge. Relatively speaking, all four sites are more similar than different precisely because they are domestic violence projects. This is a crucial distinction to make, because many IDVAs nationally are not based in, or managed by, domestic violence projects (e.g., single IDVAs sitting in statutory services). Even basic issues, such as managing IDVA caseloads, are much more difficult (if not impossible) to accomplish without the infrastructure afforded by domestic violence projects.

P 2 (DVP1): We'll always try to even them out as well, so it's not one person that's got 7 or 8 very high risk cases, because invariably there's more work in very high risk cases, so we try to make sure that they're evenly distributed.

P 6 (RPA1): But there are outfits out there who are bidding for advocates dotted around the place, and I'm afraid that the quality of um, of supervision and case management is not there ...

Furthermore, across the sites there was a conscientious and continuous desire to foster teamwork, which was seen to allow IDVAs (especially those new in post) to benefit from the experience and knowledge of their colleagues. This would not be possible to the same extent outside of a domestic violence project.

P11 (DVP1): I always induct members of staff to say we are a team here, and if you're not here, or you're in a meeting, the

other advocates will pick up emergencies that happen, they will deal with it, and you will do that for each other, and I think that's the best way of providing a consistent service to survivors.

P48 (DVP4): Working as a team, you never feel alone so whilst I gained a lot of confidence, it was reinforcement that I was doing everything right.

Working in teams has the added advantage of enabling the provision of 'specialist' advocacy services, targeted to particular communities. For example, Site 2 appointed two specialist BME advocates. This was widely viewed as a key strength of this particular IDVA service.

P30 (DVP2): Well, I think a good practice is the appointment of the two [specialist BME] workers in the advocacy service, which I think is critical because I am convinced that Asian women would not be accessing support from us if it wasn't for this service.

IDVAs affiliated with refuges

Firstly, it should be noted that there was no discernable difference in victim satisfaction with the IDVA services in the different locations, which was extremely high across the sites. Nor was it possible to identify better or worse multi-agency working as a result of whether IDVAs were based in 'stand-alone' advocacy projects compared to being affiliated with refuges. However, there was some discussion from respondents on the complex relationship between advocacy and refuge provision (with the former being seen as a recent off-shoot of the latter), reflecting the recent paradigm shift (from refuge being the only specialist service provision for victims of domestic violence to a host of different services being provided within a CCR model). One view that emerged was that advocacy benefits from being affiliated with a refuge provider, and having staff from refuge backgrounds.

P31 (DVP2): We are proud of the fact that our advocacy is delivered from a refuge perspective and this is something I keep coming back to... it is different because the staff are working and having that 'domestic violence head' if you like which doesn't demean others but they have grown up in the hostels and they have seen all of the scenarios that you can possibly see....

Importantly, organizations that are able to provide refuge in-house (rather than having to make a referral to a separate agency) can accommodate cases that a stand-alone advocacy project cannot:

P63 (VS2): Erm on the night that it happened, I did phone the police to have him taken away from the house but when they arrived they didn't do so because my husband was like changed to a nice person, and there was nothing that they could do at the time, so that's why I left the property with the children [and came into refuge].

Whilst refuge providers may have advantages associated with being larger and offering more types of services to victims, their ability to deliver 'advocacy' was felt to be limited if the organization was not willing to engage in multi-agency work (a criticism levied at refuges in the abstract rather than those in this research):

P21 (RPA3): So have an IDVA in an independent organization, if that independent organization is of the right culture and attitude to work in partnership with statutory agencies. It won't work if the independent organization is not prepared to work in partnership and hasn't got that reputation.

This reflects the concern that, although advocacy might have been born out of refuge provision, it has now 'grown up', so to speak. They were felt to be very different types of services; the necessity of participating in multi-agency work is a second skin for

advocates whereas more like a stiff new suit for some refuge providers. Consequently, the implication by some was that the two services are best kept separate. Both partner agencies and victims might not appreciate the difference between 'refuge' and 'advocacy' when they are under the same roof.

P10 (DVP1): So, we came out of the refuge, we started from the refuge in [site], and it became quite clear that we needed to be independent from the refuge, it was a very different kind of work...

Regardless of whether they are primarily advocacy or refuge providers, what is common across the sites is that they all have a woman-centred ethos. This helped projects clearly define their roles and remit, and provided a foundation for the philosophy which guided their day-to-day work. For example:

P10 (DVP1): You know, we're a feminist project, we have a very strong ethos in the project about what women should expect from services, and in the way that they're delivered...

Finally, it was notable, given the different histories and backgrounds of the participating projects, that IDVAs were fully integrated and highly valued by the organizations in which they were based. Having established that an independent domestic violence project was viewed as the ideal location for IDVAs, it was the case that several sites had reached arrangements whereby IDVAs would be 'co-located' in statutory settings (e.g., police, courts, health, housing), see below.

IDVAs in statutory settings

Some IDVAs carry out part of their working week based in agencies other than the domestic violence project; for example, they may spend time in a police station, SDVC, housing unit, or health setting. Regardless of how much of an IDVA's day-to-day work was undertaken within a statutory setting, it was strongly viewed that IDVAs should be managed by a domestic violence project.

P 7 (DVP1): I think if they're looking to work in partnership with a statutory agency... I think it is good practice to keep that advocate employed by the advocacy service, and to ensure that that advocate is very well supported, because the issue of split loyalties could really become a problem.

Thus, it is important to distinguish between co-located IDVAs (such as those participating in this research) and those that are wholly located in a statutory agency, bereft of support or management by a specialist domestic violence project (in other areas of the UK). The former was viewed as tenable by respondents, whereas the latter was not. As one IDVA (currently co-located with a SDVC) noted,

P34 (RPA2): So, I spend some time going around and explaining my role and really emphasising the independence bit which erm I mean, I don't know, could have been lost because my predecessor was based at the police station all of the time.

There was ample concern over whether co-location compromised the independence of IDVAs, in terms of their ability to deliver objective advice to victims without feeling the pressures of statutory agencies' different occupational cultures or performance targets. However, it was felt that these potential problems were minimized when the IDVA was managed by a domestic violence project. Furthermore, the difficulties were felt to be outweighed by the benefits of partnership work that took place when IDVAs

were co-located. By their very nature, these posts bridge two systems, enabling a more efficient response to be provided to victims.

P24 (DVP3): When I first started, I would have said no, I don't want to be up here at all, but having been here for a few months I'm sold. [But] I wouldn't want to be here full-time. I know that [other] IDVAs are based in their police station all the time, and they think that's the best thing to do, but I really like having one foot in outreach, so I know what's going on there, and one foot up here so I'm in touch with the police. I would choose to do what we're doing now.

As mentioned previously, Site 1 has two of its IDVAs co-located with other statutory settings (health and housing). This arrangement was seen to provide a degree of specialization and partnership work that would not have been possible otherwise. For example, from the perspective of her housing colleagues, the 'housing advocate' is a domestic violence advocate that is able to provide specialist support to women presenting to the housing authority for assistance as a result of domestic violence. From the perspective of other IDVAs, she has an 'insider' knowledge of the housing system, and she is their first point of contact should they have a client with housing needs.

P 9 (RPA1): I think it's an ideal kind of relationship or dynamic between a statutory service like ours and an advocate who has got that realism and that recognition of the pressure on budgets and accommodation etc but still comes from that place of informed sympathy, if you like, where the advocates sit, I think it's, you know, a very effective partnership.

Although she is based in the housing office full-time, she is employed and managed by Site 1 (although she also has a housing manager to oversee her work there, too). It was felt to be very important that the housing IDVA was embedded within a domestic violence project, in order to receive the support and advice from other IDVAs.

P10 (DVP1): We supervise the housing advocate very carefully about how she can integrate advocacy and the ethos of the advocacy project into her daily work, and how she can deliver on what the statutory service needs.

Although this is a fairly complex arrangement, there does not appear to be any confusion about her 'master status', which is IDVA. This was also recognized by the statutory partner:

P 9 (RPA1): I wouldn't describe it as she's fully integrated, because that might suggest that we've turned her into a housing advisor and she's not an advocate anymore, which she is, she's a domestic violence advocate.

Conclusion

An independent domestic violence project was viewed by the majority of respondents as the ideal location for IDVAs to carry out their day-to-day work. Respondents believed that IDVAs should be embedded within domestic violence projects, as statutory settings could potentially compromise their (perceived or actual) independence; however, several sites had reached arrangements whereby IDVAs worked part-time in statutory settings (e.g., police, courts, health, housing). The key benefit of co-location (more effective partnership work) needs to be managed alongside the key benefit of IDVAs (providing independent advice and support). Alternative models of IDVA services to those studied here may be effective if they are able to preserve the independence of IDVA work, and should be studied.

3. WORKING WITH IDVAs – MULTI-AGENCY PARTNERSHIPS

Referral partners and processes

IDVAs are inexorably linked with other statutory and voluntary agencies providing services to victims of domestic violence. Thus, maintaining effective referral processes and working relationships is not optional, but essential, for the delivery of IDVA services.

Police referrals

It is impossible to understand the working relationship between police and IDVAs, and how victims are identified and referred, without acknowledging how risk assessment is practiced and managed. MARACs are operational across the sites, and this also impacts on IDVA work. The issues of risk identification, assessment, management, and achieving MARAC risk-thresholds are complex. These are issues of concern both within the sites studied here as well as nationally: ACPO recently established a Risk Management Expert Panel to provide guidance on these topics.³ The timeliness of these issues, and attempts to resolve them within the evaluated sites and beyond, needs to be borne in mind.

Across all sites, police are the primary agency providing referrals to IDVA services (ranging from 49% to 100% of IDVA referrals). Thus, changes to police procedures or practices when dealing with victims can have a profound effect on their IDVA partners. Police may refer victims to IDVAs via phone, fax, or protected emails. Typically it is a short form containing the victim's contact details and brief facts of the offence. Once received, the IDVA makes contact as soon as possible to offer support.

Given the importance of this key relationship, it was surprising to discover that, what was expected to be a concrete referral route, was actually quite elastic. Not only were there differences in police referral routes across the sites, but there were also changes to procedures *within* sites during the time of this research. These were fundamental changes to do with issues of victim consent, and whether this was to be explicitly obtained at the time of the incident by the responding officer, or whether there was a protocol in place to enable automatic or 'blanket' referrals to the IDVAs. For example, in Site 4, an automatic referral route was changed back to one in which responding officers were required to obtain explicit consent from the victim at the time of the incident for a referral to be made. None of the interviewees spoke of this change in positive terms, although the potentially untenable resource implications of automatic referrals at the time (due to IDVA posts being unfilled) were recognized.

P45 (DVP4): All of these arguments have been won and lost, and I thought this had been sorted 4 years ago, but it tends to be changing personnel and the police don't tend to stay, they tend to move around into different roles... I am not sure whether I can overturn the consent issue but the main thing is that they don't always refer to us when I think they should.

³ The ACPO Risk Management Expert Panel (of which the author was a member) has agreed a recommended model of risk assessment and management for domestic violence cases. The CAADA-ACO Domestic Abuse, Stalking and Honour-Based Violence Risk Tool (short name DASH 2009) was delivered, along with accompanying guidance, to all forces and community partners earlier in 2009. Readers should note that this was well after the completion of the fieldwork for this research.

P49 (RPA4): I am very sad that the police cannot inform [site] about the victims without their consent. I am very sad about that because you are talking to people who are often not in a position to make that decision.

Requiring frontline officers to obtain explicit consent was viewed as problematic for a number of reasons, which is why Site 1 changed to automatic referrals, meaning that *'all victims will be referred, unless they categorically say that they don't want to be.'*

P12 (RPA1): We're talking about saving people's lives here, that's my view of, you know, someone's going to tell me off for releasing their details, well, bring it on. I'd say we've done everything to protect our victims in [site], and to stop people getting murdered, that's what we're trying to do, isn't it. If I get one out of ... how many allegations do I get in a year ... thousands ... one person ringing up grumpy with me, or cross with me, outraged with me, then fine, I'm quite happy to explain my actions and why we've done it.

In the two other sites, apparently stable referral systems were in place, taking the best from both models (the benefits of having victims consent to a referral, yet not relying on this to happen at the time of the incident). This can, at least in part, be explained by the presence of what seemed to be highly pro-active Domestic Violence Officers (DVOs) working in small, yet appropriately staffed Domestic Violence Units (DVUs). Therefore, although the frontline officers are still supposed to gain consent from victims, the DVOs provide a failsafe mechanism:

P28 (RPA3): They are asked at the time, because obviously that's the time when they're most vulnerable, and need more support. But they will be asked again, because domestic abuse officers speak to them, and they will ask that question again. Sometimes the officers out on the street don't really understand everything that [site] can offer.

It can be concluded that, whilst all of the different systems are in place for understandable reasons, if the objective is to maximize the chances of a victim of domestic violence receiving timely support from an IDVA, then an automatic/blanket referral route is the preferred option. Undoubtedly, this is why the police have put this in place with Victim Support. This option cuts out the 'middle-man' (of DVOs in DVUs), many of which deliver variable performance for all sorts of reasons (e.g., in Site 4 were several different DVUs each have their own *de facto* referral practices to one IDVA service!). On the other hand, good DVOs and DVUs take pressure off of the IDVA service by filtering out those incidents where IDVA support is not required. The question is whether this filtering is done in a way that is consistent and appropriate, from the perspective of the IDVA service. Regardless, any option has to be carefully managed to avoid 'flooding' IDVA services with referrals beyond their capacity.

Health referrals

Across the sites, these types of referral were relatively rare. Undoubtedly one main reason for the difficulty of engaging with health is the sheer enormity of the health system and the different types of workers, and points at which, a referral from 'health' could be made to an IDVA.

P19 (DVP3): We do find it really difficult to engage with GPs, in any kind of training that we offer, in any kind of conferences that we put on... and as we know, a lot of women, their first port of call is their GP, so that's the bit that we're kind of a little bit concerned about, because GPs don't refer to us, we've had very few referrals from GPs.

P30 (DVP2): Yes there is a huge gap in A&E... there should be a service up there, there are already in some hospitals established workers they might be IDVAs or they might be others who are domestic violence trained, who are on hand to identify cases that could be domestic violence or repeated domestic violence so that they can talk to them offer them support and I think that it is critical that they get it in here soon.

Site 1 was able to counteract this with their co-located 'health advocate' position, resulting in health being their 3rd largest type of referral (following police and housing). This co-located post fostered a more productive referral route and better working relationship between the statutory partner and the IDVA service.

P14 (RPA1): So, [site] really is a lifeline to us, and we would not be able to really bring up the subject of domestic violence with women unless we knew we had somewhere that we could then refer them on to. They're actually letting the nurses know, 'thanks very much for your referral, we now are kind of supporting this lady through the next few weeks, next few months, or whatever'.

Across the sites, MARACs provided the mechanism by which IDVAs and health professionals engaged in multi-agency partnership work. MARACs have the advantage of potentially enabling many different parts of the NHS to be involved in the CCR model.

P15 (RPA3): I work with [IDVA] at least on a monthly basis through the MARAC, and have an oversight of all the cases pertaining to health, so as the MARAC representative it means that I'm the sort of conduit of ... and attend the MARACs with all the information from health, about cases that are brought up, and, you know, and taking it back again, and that brings me into contact with [IDVA] on a regular basis, for information sharing, and such like.

Overall, it can be seen that the health-advocacy interface is being developed, albeit slowly. Across the sites, improving their engagement with health was seen to be a priority issue. Given the mental and physical health consequences associated with experiencing domestic violence, work with domestic violence victims was seen to be a responsibility of the health system, although perhaps not recognized as such by health professionals *writ large* as much as their IDVA counterparts.

Housing referrals

The need to address housing and safety issues for victims means that the referral route between IDVAs and housing providers is essential. In fact, assistance with housing and accommodation was often commented upon by victims themselves.

P66 (VS2): So they have helped me in so many ways, I mean I have had doors and glass that has been smashed and [site] have had security people come out and help me as well with that. I mean, to be honest, I was really scared and [IDVA] even said to me, 'don't run away from your house we are here to help and support you'... by now I would not have even come this far and I would have probably left the property to him. So they have helped quite a bit a way where they have helped me in my house and even go to the court with me and give me support.

P90 (VS1): [IDVA] got onto my actual housing officer and she got it done, and he gave permission, and I got an extra lock put on my door through her doing that. Yes she did, and I didn't have to chase her up, she was just so efficient.

Partners in housing also recognized the value added by having IDVAs available locally, with whom they could liaise over particular cases.

P27 (RPA3): It's so simple, I mean, literally, I could just ring up today, and say this is the lady, this is her contact telephone number, and that's it, that's all I need to do. And I know that they will contact that lady then, and make arrangements to work with her, supporting her, and I would try to resolve her situation from a housing point of view.

In conclusion, much research has documented victims' desires for practical advice to be provided alongside emotional support. Assistance with housing is an area where these two aspects of IDVA work are most integrated, as safety cannot truly be achieved in an unsecured home environment.

IDVAs and delivering a coordinated community response

Multi-agency working was viewed very positively, and there was much praise for attempting to provide a 'coordinated' response to victims of domestic violence. It was felt that key players were on board in all of the sites. In particular, the MARACs received considerable commendation for either 'kick-starting' reluctant partners, or further embedding multi-agency work at an operational level.

P 9 (RPA1): I think we work pretty effectively in partnership in this [area], but there's nothing like knowing you're going to be around the table with those other agencies to ensure that you can justify your course of action and that you keep the case at the forefront.

It was apparent that IDVAs were viewed as central actors in attempts to deliver the CCR model. This was due to the IDVA post enabling a true multi-agency perspective which is essential for the success of the CCR.

P27 (RPA3): Again it's just knowing that you've got one person that's got their finger on the pulse with the police, and everything else, that you've got contact that you can say, you can ring up [IDVA], and if she knows that anybody else is working with that client she can tell you. She's almost like the coordinator that pulls it all together, I suppose, that knows what else is happening, and people keep in touch.

Respondents felt that victims received a better service as a result of partner agencies working together (e.g., 'they don't see us as fragmented; they see us as working in partnership'). The importance of coordinating efforts in order to provide a 'seamless response' to victims was often mentioned, by practitioners as well as by victims.

P42 (RPA2): ...because it is a difficult process both technically and certainly emotionally. [IDVAs make it] easier than it would otherwise be [for victims] to access a number of different services. For me, I see the IDVA as the person in the middle who centralises all of that and coordinates it.

P74 (VS1): Well, it helps you remain strong and not to flounder. They've got, they know the right places, and if they don't know they find out for you, and you can get it all from one person rather, when you're so frightened and feel as you are, it's difficult to keep ringing up loads of different agencies, and it's nice to have just the one to deal with.

A partnership approach also was credited for achieving important targets, as indicated by the quote below:

P9 (RPA1): The number of women we've had to pick up as homeless due to domestic violence has gone down quite significantly, and I think that's because we've got this integrated service offering them proper alternatives before they have to make that choice.

Challenges of multi-agency work

Several challenges were identified with delivering the CCR. First, it was noted by a few participants that the response was not 'truly' multi-agency because the work was not shared equally amongst partners. Specifically, it was felt that most of the work associated with responding to domestic violence fell to police and IDVAs. Related to this was the feeling that, although IDVAs were viewed as key actors, they were only one type of actor amongst many that were needed to deliver a CCR. There was concern that this might be forgotten, perhaps because IDVAs currently enjoy a relatively high-profile, being the focus of government attention and central to local and national domestic violence strategies. Related to this was the worry that funding would

be focussed exclusively on IDVAs, perhaps at the expense of other necessary services.

P21 (RPA3): I think IDVAs on their own aren't enough, they have to be part of the whole infrastructure which looks at not just the risks and the very high risk clients, but also dovetails with support services for the other clients who are low to high risk.

Although key partners had strong working relationships across the sites, this did not mean that there was never any friction. One challenge with the CCR model is that changes in policy or practice in one agency can have a knock-on effect for partner agencies.

P11 (DVP1): We go through stages where we have pre-charge bail, and then it seems to get pulled, because the voices from above in the police say 'we shouldn't be doing it', and then 'we should be doing it' so it's quite difficult for us, because we don't feel we can give a consistent message to survivors about what they can expect from the police at that time.

In addition, there are now many different agencies involved in delivering services to victims of domestic violence. This obviously represents progress over the past, as many areas now have multiple service providers within one particular CCR. However this new reality indicates the necessity of full coordination of the work done across partner agencies and a clear understanding of each other's roles and boundaries. Whilst not 'problems' as such in the sites studied, it was plain that constant vigilance was necessary.

P 5 (RPA1): That's the bit that people want consultancy about, we find... is the turf wars between Victim Support, the advocates, the outreach services, how do they fit, how do you bring them together, Witness Support, the Witness Care Units. So we bring them together here in one network, and that's hard work, but you have to, otherwise you're just having poor old survivors being batted around.

P48 (DVP4): Erm there are obviously issues about boundaries and you know things like that which I know myself I haven't felt particularly comfortable when they have been overstepped and so I have had to put my point across that these are our roles and this is what I will be doing and this is how we should work ...because the last thing everyone wants is loads of agencies to be involved giving the same information or even conflicting information [to victims].

Finally, monitoring multi-agency work was seen to pose a significant challenge.

P38 (RPA2): That is a huge process, I have tried to do it at times and you know it is very difficult and that is why it is so, it's not sad but you know when the IDVAs, MARACs and the Specialist Courts are proliferating and everyone is confronted with the same challenge in that way you know that all of the work that we are doing requires monitoring the data within our agency but also outside of it. We have to have the partnerships in place but who actually analyses and manages the data... there do not seem to be any provisions for this.

Conclusion

IDVAs were viewed by the majority of respondents as vital contributors to the CCR model, as they are uniquely placed to coordinate the activities of a wide range of agencies on behalf of victims, and in so doing, encourage multi-agency rather than single-agency responses to domestic violence. The importance of coordinating efforts in order to provide a 'seamless response' to victims was often mentioned, by practitioners as well as by victims, as a key ingredient of a successful CCR. Changing referral routes (especially with the police) created difficulties for small teams of IDVAs with little capacity to manage sudden variations in workload. For example, there were differences in police referral routes across the sites as well as changes to procedures within sites during the time of this research. Other challenges to partnership work mentioned by respondents included addressing gaps in service provision (e.g., children's services and those for black and minority ethnic victims), trying to share the

workload equally amongst partners, coordinating responses from a large number of involved agencies, needing to have other relevant services available locally (e.g., outreach services, specialist sexual violence services) for IDVAs to refer victims to, and monitoring all of these various activities consistently and effectively. Despite these issues, the CCR model was universally praised by respondents as essential for delivering an improved, holistic response to victims of domestic violence.

4. TAKING CARE OF IDVAs

What it actually means to be doing the work of an IDVA is something that most of people will find difficult to envision, as their work involves such a high degree of commitment, empathy, specialist skills and knowledge. Yet, it is not clear that all IDVAs currently working in the UK have access to regular supervision, feedback on their performance, training opportunities, collegial support, or clinical supervision. This would be unacceptable for social workers, police officers, or other practitioners engaged in stressful, frontline work with vulnerable people. Luckily, these problems were not present in the four sites studied here (with the exception of clinical supervision, see below). This is entirely due to the fact that the IDVAs participating in this research were embedded in, and managed by, domestic violence projects. It is imperative to acknowledge that where IDVAs are located has profound consequences for the extent to which they are cared for (as people, and as employees).

Supervision and performance monitoring of IDVAs

In 3 of the 4 sites, monthly case reviews took place (in the other site it was bi-monthly). Supervision meetings involve the IDVA discussing each active case with a lead/senior advocate or manager. The reviews were used to agree the cases that could be closed and also provide an opportunity to discuss difficult cases. Across sites, supervision and performance monitoring of IDVAs was taken very seriously, as the following example indicates:

P 4 (DVP1): We have individual supervision where they go through their case files and case management, and it's about their own individual development as a worker with training and their cases and stuff. Then they have group supervision where we all have supervision together with a supervisor, and we talk about general issues, either among workers, or general issues that are coming up that effect our work, and then they have individual (clinical) supervision with an outside supervisor. Some people think that's a lot, but it's what keeps my advocates sound.

Supervision was very highly valued by both the IDVAs and their managers, to the extent that, in those sites where there was less, it was clear that the IDVAs would be happy to have more.

P46 (DVP4): I like supervision at work I like to know if I am doing things right... and if I am not doing anything right, I like to know that as well. I have never worked anywhere where I have had the support I have had here... the support we get as case workers from management is absolutely brilliant.

The cost implications of properly managing and supporting IDVAs within an independent project were also noted. However these up-front costs could be seen to reduce long-term costs associated with staff burnout and turnover. The benefits of properly managed IDVAs were positively commented on by partner agencies as well.

P44 (DVP4): I think one of the benefits of being an advocacy organization rather than an advocate attached to something else is that the philosophy of the whole organization is one of an advocacy service and support and so the staff have really intensive training and co-ordinated supervision on a monthly basis but then also weekly and daily support in directions on a case and I think that would be more difficult for someone who was just dumped on in a place without that support.

P11 (DVP1):... the number of workers that I've come across that get absolutely no support, internally, externally, I just, they do six months and get burnt out and leave, and actually what service are they really providing for women if they themselves feel burnt out.

P53 (RPA4): What is really remarkable is the level of professionalism... the way that they operate as practitioners and the way that they are managed and the commitment from the management and this has a cascading effect on the rest of the staff.

Clinical supervision

How to manage the emotional toil of IDVA work was an issue in all of the sites. It was recognized that IDVAs should have regular clinical supervision, to talk through any issues arising from their work with registered health professional. On the whole, clinical supervision was the area of discussion where the emotional 'costs' of doing IDVA work were most acutely illustrated. The stress associated with an IDVA's job was verified by partner agencies as well.

P23 (DVP3): I think the supervision would be nice, because that would take a great deal of worry off. There's some clients who you go home with on a Friday night and worry about all weekend until you speak to them on Monday, and I know that's not healthy. Then I probably could ring [manger], but it doesn't seem very fair somehow, to do that.

P33 (DVP2): Some of the cases, they do not disclose the sexual abuse they have had, and when they are disclosed to me they do not want me to tell anybody else and sometimes they going to a lot of detail and they come back all the time with more detail and there is nowhere I can take it apart from my line manager.

P4 (DVP1): There will always be women that rub you up the wrong way, or make you feel very sad. You need to go and explore that, and it's not about counselling, it's about making you a better worker, and being given the opportunity to explore it.

However the cost implications (both in terms of paying for the supervision and correspondingly the lost IDVA time) of providing regular clinical supervision for individual IDVAs mean that it was only offered in 1 of the 4 sites. Given the reality of IDVA work, providing clinical supervision indicates a commitment to addressing the stress and potential long-term health consequences associated with working as an IDVA. Those supervising IDVAs should not be presumed to be willing or able to provide this type of support in addition to their other responsibilities. Furthermore, we must not forget that some supervisors carry their own caseloads and cannot be reasonably expected to provide their own clinical supervision.

Training

CAADA training was viewed as very worthwhile, and spoken of very highly by those who had undertaken it (see www.caada.org.uk). Even for those who had worked with domestic violence victims for some years, or who had already achieved a relevant qualification or degree (e.g., in law or counselling), the CAADA training was considered to be essential for understanding and undertaking the work of an IDVA.

P32 (DVP2): As is with any training, it is a bit mind changing if you like. It made me so that I viewed things differently to what I did before working with survivors of domestic abuse... it made me centralise, if you like, on a woman's safety. Although, as I

say, I had experience from before which I took with me, it was a completely different way of working that [site] hadn't done before.

In addition, the CAADA training was one of the ways that IDVAs were differentiated from other practitioners working with domestic violence victims, in that they were viewed as the most highly trained.

P30 (DVP2): Advocates have that greater level of skill in terms of supporting people through court, and the difference is the CAADA training.

P21 (RPA3): We do think it's important to skill up all of our workers, [but] IDVAs have the CAADA training, [and] at the moment the distinction is that the IDVAs are higher trained.

Particularly for small organizations attempting to juggle the demands of multi-agency work whilst simultaneously providing services to a large volume of victims, the workload implications of sending someone on the CAADA course were pronounced. Although unfair, the choice seemed to present itself as – going on training versus taking care of victims.

P23 (DVP3): It took a lot of time up. When I did it I was working part-time, and it took an awful look of time up out of my week working face-to-face with women, but the actual content of it I found really really useful, and it was really nice to meet other workers as well, who do similar jobs, and I've since seen some of them around at meetings and suchlike.

P32 (DVP2): So I was travelling there every other week for 3/4 days at a time and then coming back and doing the coursework... as an example, a colleague of mine got my [CAADA] certificate framed and that is out there framed [whereas] my counselling diploma is at home in my drawer so you can see it did involve a lot of pressure.

Training was viewed as a crucial, necessary component of an effective IDVA, yet it was just one such component. It was strongly felt that training must be combined with the supervision, structure, policies, procedures, and day-to-day guidance from colleagues and managers that can be provided in domestic violence projects. The expressed view was that even fully trained and experienced IDVAs needed to be embedded into domestic violence projects for their work to remain effective, to say nothing of an IDVA new to the post. This is reflected in the fact that the sites *themselves* operated very comprehensive training and induction programmes for new members of staff.

P48 (DVP4): Even though I had done my LPC I was given 3 months training and it was on a one-to-one training with [manager] basically going through everything. I have a training pad going through flowcharts of how injunctions work, childcare issues, criminal court how to refer to, and we sat for everyday doing that so even although I knew the law anyway... We had to do role-plays before I could pick up the advice line to make sure I could deal with clients, so we do have a lot of training here.

On the whole, there were no significant gaps mentioned in terms of the CAADA content. The conclusion to be reached is that nationally-recognized and accredited training, such as that provided by CAADA, was viewed by IDVAs as invaluable. It is notable that such training was not felt to be redundant even to those very experienced workers who already achieved other relevant qualifications. However, a training course cannot take the place of the mentoring and collegial support provided by peers and managers within a project. Drawing on the benefits from facilitating 'teamwork', as discussed earlier, regional networks (available in one of the four sites) were seen to add an additional layer of support and information for IDVAs to access, subsequently improving both their practice and morale.

The role of an IDVA is multi-faceted and complex, and involves a number of different skill sets. Thus, the work of an IDVA can be considered a 'craft', in the same way as policing, and it is widely recognized that craft skills are imparted via a lengthy period of on-the-job experience and working closely as a team, under the direction of supervisors. These skills cannot be learned in the classroom alone.

Funding and resources

Funding arrangements provided a challenge in terms of maintaining a healthy workforce, in every sense of the phrase. Short-term funding meant that every IDVA in all four sites was on a short-term contract. Some would not know until a few weeks beforehand whether their post would be renewed.

P34 (DVP2): People have to pay rent and not knowing from one month to the next, it is a big stressor to be fair. I am a mum, you know, and I have my own responsibilities and financial [obligations] you know what I mean?

P31 (DVP2): There is nothing worse than having staff that you have to have the same conversation with every year about the funding and their post, it is awful. It is a poor way to be employing people.

It is only through their commitment to providing support to women that IDVAs continued in what can only be described as very difficult working conditions. Short-term funding arrangements compounded manager's efforts to maintain a full staff complement; for example, in Site 4 where posts had to be left unfilled for several months because they could not be advertised, appointed and trained before the funding came to an end. Even those from outside the projects could recognize the limitations of this state of affairs:

P43 (RPA2): I can't stress enough how difficult it is for somebody in their position where they are dealing with very stressful circumstances; for example, people who are very upset and they are dealing with too much work and they are dealing with it in an environment where they do not know whether they will have the job in two years' time. So, that level of insecurity is terrible when you are dealing with such circumstances. Personally, I know from the first IDVA we had that she left for those three factors: the insecurity, the level of work and the stress of the work.

P14 (RPA1): As far as I'm concerned, this is an important issue... and funding should be there, you shouldn't have to go out every year with your begging bowl trying to get money to continue your service. So I think that's something that really would make a difference, regular funding for the service.

It is difficult to envision how it will be possible to build and maintain a healthy IDVA workforce, anywhere in the UK, over the long-term, in the face of such insecure funding. Lack of long-term funding also has implications for the level of strategic direction and long-term planning that is necessary in the sites. Despite their best efforts, it was apparent that much of the work of IDVA managers was 'fire-fighting' and 'keeping heads above water'. Efforts had to be concentrated on keeping posts viable rather than engaging in any 'blue skies' thinking.

P6 (DVP1): [IDVA] was supporting... a survivor who had come off heroin during the course of the case going through, and, um, that's very intensive work... It's the kind of thing that's threatened, really, [when] there isn't enough staffing.

P31 (DVP2): There is other work we would like to pick up around providing advocacy within the hospital... but we just can't do it! There are so many things we would love to take part in but we just can't because there just aren't enough hours.

P19 (DVP3): I think awareness raising is something that needs to be developed. Awareness raising is one of the things that falls off the end when you haven't got enough money.

There were obvious advantages for the sites that had another agency to bear some of the burden in terms of applying for funding and undertaking strategic planning on their behalf. Two of the four sites had such support from outside agencies, in another it was from an internal unit, and the other was in the process of creating a new internal/external committee to assist in this regard.

Conclusion

Domestic violence projects appear to have noticeable benefits for the 'care' provided of IDVAs in that they are able to provide the ethos, philosophy, policies, day-to-day guidance and support that IDVAs need to work effectively. Both the practical advice and emotional support that are the hallmarks of IDVA work seem to be delivered more successfully within teams; for example, across the sites teamwork was hailed as enabling IDVAs (especially those new in post) to benefit from the experience and knowledge of their colleagues. Working in teams has the added advantage of enabling the provision of 'specialist' advocacy services, where individual IDVAs develop particular skills, focus on delivering certain aspects of the service, or target under-served communities. Two deficiencies in 'taking care' of IDVAs were identified from the research. First, although regular performance reviews were undertaken, clinical supervision was lacking in all of the sites except one. Second, although effective IDVA work requires proficiency in a number of different skill sets, completion of a comprehensive and demanding training course, and a lengthy period of mentoring and supervision, all of the IDVAs were on short-term contracts. It was felt that these working arrangements did not honour the specialist know-how, expertise, and contribution of IDVAs. Respondents expressed concern that existing short-term and ad hoc funding arrangements were not compatible with the long-term vitality and sustainability of the 'IDVA workforce'. As IDVA work produces benefits for statutory partners, there should be coordinated efforts to ensure the long-term sustainability of IDVA services.

5. CONCLUSION

This research documented many benefits from having IDVAs deliver services to victims of domestic violence. Their contribution to multi-agency partnership work, both operationally and strategically, cannot be overstated. Although most respondents felt that their area adhered to the CCR model, they hesitated to imply that they had a perfectly coordinated response to domestic violence. They considered the arrangements that were in place to be a multi-faceted process that could always benefit from tinkering and improvements to one part or another. For example, several notable gaps in service were mentioned, such as providing sufficient services for children exposed to domestic violence, and effectively addressing challenges around victims from diverse backgrounds (e.g., race/ethnicity, nationality, immigration status, and sexual orientation). There was concern that IDVAs, as the 'tip of the spear', would draw attention away from the importance of preventative work with children, young people, and adult victims. Consequently, it is imperative that communities continue their multi-agency partnership work so that even more positive gains may be made.

The research has raised several issues to be considered in the future commissioning and implementation of IDVA services.

Recommendations

11. All IDVAs should be managed by independent domestic violence projects. Ideally they should, at least partially, carry out their day-to-day work from these types of projects too.
12. The merits of co-located IDVAs implies that further consideration of these types of joint posts, as well as co-located teams or 'one-stop-shops', is warranted. Alternative models of IDVA services to those studied here may be effective if they are able to preserve the independence of IDVA work, and should be studied.
13. Specialization within teams of IDVAs improves their working practice. Co-location in statutory settings and having specific remits (e.g., supporting Asian women or those referred to MARACs) are two mechanisms that foster specialization and should therefore be employed where possible. This further highlights the necessity of coordinating IDVAs services so that they are able to work as teams within domestic violence projects.
14. National guidance is warranted on the issue of 'victim consent' and police referral routes to IDVA services. It is recommended that automatic referral routes are adopted consistently across all areas, so that victims receive timely contact and support from IDVAs. Victims should not be required to give explicit consent for a referral to be made at the time of the incident.
15. IDVA services should receive the necessary funding in order to manage the increased caseloads associated with automatic referral routes effectively. As IDVA work produces benefits for statutory partners, they should undertake strategic planning to ensure the long-term sustainability of their IDVA partners.
16. Further work is necessary to address remaining gaps in service provision, especially the provision of direct services to children and appropriate/specialist services for black and minority ethnic victims.
17. CCRs must recognize that successful IDVA work depends on the local availability of other support services (e.g., outreach services, sexual violence services), and plan accordingly.
18. Monitoring the work of IDVAs (and therefore the CCR as a whole) is often a requirement of funding, yet more consideration needs to be given to how this responsibility is undertaken and resourced within CCRs. Consultation on the utility and feasibility of shared IT systems would be helpful.
19. IDVAs valued supervision and ideally their work should be reviewed by a supervisor on a monthly basis (in addition to routine day-to-day oversight). They should also receive individual clinical supervision. Regional networks of

IDVAs could provide an informal avenue for exchanging collegial support and advice, and should be explored.

20. As this research was relatively small-scale and wholly qualitative, it is recommended that a comprehensive study of *all* IDVAs be commissioned in the future (there are currently more than 700). Such a study should attempt to gather quantitative information from every IDVA working in England and Wales (e.g., using a questionnaire), supplemented with more detailed qualitative information (e.g., interviews but also observation, documentary analysis, etc.) from a sub-sample of the total. Such a study could reveal whether the challenges identified in this research are widespread, how they might have been overcome with time, and likewise whether the observed benefits are sustainable. This should be linked to a similar national study of Independent Sexual Violence Advisors (ISVAs).

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