Manchester City Council
Report for Resolution

Report To: Citizenship and Inclusion Overview and Scrutiny Committee – 15 December 2010

Subject: Domestic Abuse update

Report of: Maureen Noble – Head of Crime and Disorder

Summary

To update the Committee in relation to actions to tackle domestic abuse.

Recommendations

- That scrutiny committee notes the contents of the Domestic Abuse Strategy 2010-2014 and support the implementation of the minimum standards and the delivery plan
- That scrutiny committee continue to support the work of the Domestic Abuse Management Group

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Wards Affected: all

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Appendixes:

Manchester Multi-agency Domestic Abuse Strategy 2010-2014 – appendix 1
DAMG Delivery Plan – appendix 2
PATHway Project: An Independent Domestic Violence Advisory Service at St Mary's Maternity Hospital, Manchester – appendix 3

1.0 Domestic Abuse in Manchester – Background

1.1 The number of reported incidents of domestic abuse to GMP for the city increased by almost 27 percent between 2006 and 2010 to 16,820 in the last year at 9223 locations.

1.2. This reflects a positive move in reporting incidents and confidence in accessing help but is also very high in comparison to other core cities.

1.3. Domestic abuse costs the city at least £40.6million each year in costs to the Criminal Justice System, Health Care, Social Services, Housing, Civil Legal and Public Services. If lost economic output, human and emotional costs are also included this rises to over 117 million. This still does not include costs to the Voluntary Sector, Community Nursing, Sure Start and other agencies.

Type of cost	**Cost**
Criminal Justice System	5,208,840
Of which police	*2,509,667*
Health care	7,149,991
Of which physical	*6,248,559*
Of which mental health	*901,432*
Social Services	1,167,764
Emergency housing	809,240
Civil legal	1,597,992
Public services	15,933,827
Economic output	13,685,370
Human and emotional	87,510,564
Total	**117,129,760**

(Costs estimated on Walby's research (2004) for the UK divided by the population size of Manchester).

1.3. We know that much of this spend is focused on costly crisis intervention rather than prevention. We also know that multi-agency work at a strategic and operational level must prioritise support for victims and their children as well as tackle the behaviour of perpetrators. The refreshed Manchester Multi-agency Domestic Abuse Strategy 2010-2014 aims to ensure that these key issues are addressed through earlier intervention and prevention (appendix 1).

1.4 Children suffer directly and indirectly if they live in households where there is domestic abuse and we are committed to listening to them. Children's Services are engaged with a number of these children - currently 57% of children subject to a child protection plan are listed due to neglect of which domestic violence is a key issue.

1.5 The Domestic Abuse Management Group (DAMG) and the Manchester Safeguarding Children's Board (MSCB) commissioned an independent review of services for children and young people (Hargreaves 2010). This will be the

basis for a separate strategy that specifically covers preventative work and practical and emotional support within a Think Family format. This work will be developed by colleagues in Children's Services, Manchester Women's Aid and Greater Manchester Police working together. Of particular importance will be the involvement of Education and Schools. The work will be overseen by the two multi agency boards.

2.0 Responding - Our New Strategy and Priorities

2.1 Manchester's 2nd Multi Agency Domestic Abuse Strategy was launched on November 29th 2010. This was an all day conference in partnership with NHS Manchester who also launched the successful findings of their PATHway report on the placement of an Independent Domestic Violence Advisor (IDVA) in St Mary's Hospital – see appendix 2. The strategy was based on survivor consultation completed over the last 12 months.

2,2. The Domestic Abuse Strategy for 2010-2014 aims:

- To ensure that domestic abuse is a strategic priority for all agencies
- To improve early identification and prevention of domestic abuse
- To reduce the prevalence of domestic abuse
- To ensure that victims of domestic abuse and their children are adequately protected and supported
- To hold perpetrators accountable through effective and early interventions

2.3. The Strategy also seeks to embed an approach to commissioning domestic abuse services that is informed, responsive and accountable, demonstrating positive outcomes in improving the lives of victims and their children.

2.4. The implementation of the Strategy is the responsibility of the DAMG who have developed a self-assessment tool and set out a series of minimum standards that all agencies, statutory and voluntary sector, are encouraged to sign up to.

2.5. Key multi-agency priorities will be updated annually and monitored through the Delivery Plan objectives attached at appendix 2

3.0 Key Issues and Gaps

3.1. During 2010 the DAMG commissioned an independent review of services by the Housing Quality Network (HQN). Their report identified a number of gaps in services

- Support for children and young people affected by domestic abuse
- Non statutory programmes for perpetrators of domestic abuse within a family intervention setting
- Improving communication strategies and prioritisation of domestic abuse within other key strategies
- Promotion of mandatory training on domestic abuse for key professionals

- Development of shared risk assessments and referral processes between domestic and sexual violence service and generic agencies
- Exploring the feasibility of a central point for domestic abuse referrals

4.0 Going Forward in Tackling Domestic Abuse

4.1. Following the report and the needs assessment, services are planned and will be commissioned to meet the four key objective areas of communication, prevention, provision and protection.

4.2. Survivor consultation and consultation with providers both statutory and voluntary has been crucial and key findings have shaped and supported the detail of the Delivery Plan objectives, which are

Communication

- Develop innovative publicity campaigns and further embed domestic abuse into multi-agency priorities.

Prevention

- Develop a children and young people's strategy based on a tiered model of intervention and referral pathway.
- Promotion of standardised multi-agency training for domestic abuse and forced marriage by the safeguarding boards.

Provision

- Develop and embed referral processes from all statutory and voluntary sector services to domestic abuse and sexual abuse services.
- Ensure services are available and accessible to everyone regardless of ability or immigration status.
- Consider the feasibility of a central referral point for adult survivors of domestic abuse.

Protection

- Evaluate and build upon the multi-agency criminal justice work of the Integrated Domestic Abuse Programme (IDAP), Multi-agency Risk Assessment Case Conference (MARAC), Multi-agency Public Protection Arrangements (MAPPA) and the Specialist Domestic Violence Courts.
- Ensure an appropriate process is in place to conduct Domestic Homicide Reviews in accordance with Part 9 of the Domestic Violence, Crime and Victims Act 2004 should a domestic homicide occur in the city and that lessons learned are embedded across all agencies.
- Develop the work of the Integrated Offender Management pilots to ensure domestic abuse offenders are targeted according to the risk they pose for victims.
- Develop early intervention work with perpetrators and a voluntary perpetrator programme which links into survivor and children's' support services.

5.0 Key Messages

5.1. Funding for services

5.1.1. On the 25th November 2010, the Home Secretary published a paper, Call to End Violence against Women and Girls, a cross-government plan in which there is a commitment to allocate more than £28 million for specialist services to tackle violence against women and girls until 2015.

5.1.2. Services which support victims of sexual and domestic violence will continue to receive central Home Office funding, including local domestic and sexual violence advisors, services for high-risk domestic violence victims, national helplines and work to prevent forced marriage.

5.1.3. However, Manchester has not previously been in receipt of significant funding from central government for domestic abuse services. As a result, domestic abuse services are funded from sources that are at significant risk for 2011/12 (eg Crime and Disorder Working Neighbourhoods Fund, Supporting People funds, GMP).

5.1.4. For this reason, it is crucial that support is given to the DAMG in reviewing commissioning arrangements to ensure value for money and evidence based interventions. It is also crucial to support the work of voluntary and third sector providers and work in partnership with community groups and volunteers to deliver high quality services.

5.2. Children and Young People

5.2.1. It is vital that the work being undertaken to improve services for children and young people is supported. The Strategy for Children and Young People Experiencing Domestic Abuse will contain a number of key recommendations that will improve outcomes for children.

5.2.2. Services will be developed that take a Think Family approach and seek to embed the learning from the National Centre for Social Research which demonstrates that families supported through Family Intervention Projects (FIPs) report reductions in domestic violence from 26% to 12%.

6.0 Members questions

Members asked for feedback on a number of key areas. Below are responses to these specific questions.

What are the levels of reporting, including differences in reporting levels by young people compared to the average and also reporting in BME communities?

GMP were called out to 16,820 incidents of domestic abuse last year at 9223 locations. We have data from 23 agencies/departments on domestic abuse however they all collect data based on adult reports. Specialist services providing therapeutic support for children and young people affected by domestic abuse are a gap in

Manchester and this is being addressed by MSAB (Manchester Safeguarding Children Board) and DAMG (Domestic Abuse Management Group). Those doing education work in schools encourage young people to report to 'a professional' but data on the number of domestic abuse related reports is currently unavailable. We do however have some idea of the numbers of children and young people affected by domestic abuse in Manchester. GMP sent 5978 notifications to NHS Manchester on children living in households where domestic abuse had been recorded. National research suggests that many victims do not report to the police so this will not be a full picture. Manchester Women's Domestic Abuse Helpline recorded 3986 children were living with the women who called their helpline and of the very high risk victims we know about who were referred to the Multi Agency Risk Assessment Conference (MARAC) 401 children were living in those households.

A key feature of the PATHway project (An IDVA placed in maternity services at St Mary's Hospital) was the significant number of referrals from pregnant women from BME backgrounds and particularly Pakistani backgrounds to the IDVA in comparison to those in the general community where routine enquiry about domestic abuse is not generally in place and referrals mainly come from non health professionals. During this project the PATHway IDVA saw 43% white British women, 23% Pakistani Women and 34% women from other BME communities. Inpatient data shows only 12.5% of women were of Pakistani origin so the figure for Pakistani women is particularly high. This is in comparison to the community IDVA service run through MCC Neighbourhood Services which last year saw 52.8% White British clients and 7.2% Pakistani clients. This is significant as it suggests that PATHway has been an effective method of reaching women from BME and Pakistani backgrounds in particular who may be more isolated and hard to reach than women of White British background.

The survivor consultation done in November showed that only 3 of the 23 women from BME backgrounds had heard of domestic abuse helpline numbers however all the women knew of 999 and were really grateful for the service they had received by ringing it. The Domestic Abuse Management Group is working with partners to promote the helpline numbers further through joined up publicity campaigns using media in community languages as well as English. This will aim to provide more early interventions rather than emergency call outs for this group of women.

What is the relationship between domestic abuse and alcohol and drug abuse, and how do public services take account of this?

The Domestic Abuse Strategy's 2010 Delivery Plan includes an action to establish a co-ordinated approach to tackling perpetrators who misuse drugs and alcohol. Of the 16,820 domestic abuse incidents reported to the police in Manchester last year 26% (4426) were flagged as involving or related to alcohol. This is likely to be under recorded with a true estimate at around 40-50%. The combined use of alcohol and illegal drugs is also becoming increasingly common, with use of powder cocaine and alcohol being particularly associated with increased violent behaviour.

GMP work jointly with the alcohol sector though the *Alcohol Arrest Referral scheme*. They identify individuals whose offending is related to alcohol use, and can make referrals to the Community Alcohol Team Criminal Justice Linkworkers who operate

across the city. Where attendance is required as a condition of court or police bail, there are very high levels of compliance.

Alcohol Treatment Requirements are available through the Probation Service, for dependent drinkers who receive community sentences for violent offences, and who are assessed as being suitable for an ATR. ATRs run for a minimum of 6 months, and usually involve access to community-based or inpatient detoxification treatment.

Drug Intervention Programme (DIP) Specific services are commissioned to identify, engage, case manage and refer drug users from within the Criminal Justice System – from arrest, through court, community sentence and prison sentence and release.

Although these interventions mainly impact on acquisitive crime offenders, there is an increasing interest in exploring substance misuse fuelled violent crime – especially in relation to the combination of powder cocaine and alcohol use.

There is no doubt that there are links between domestic abuse and alcohol/drug use but the exact nature of these links remains complex. Substance misuse cannot cause a person to be violent or abusive; the majority of domestic abuse is perpetrated in the absence of alcohol/drugs, and the majority of alcohol/drug users do not abuse their partners.

When a perpetrator enters treatment it can create a false sense of security for their partner who may expect the violence to stop or decrease because of the treatment. In fact this is often the most dangerous time for a partner, as abuse often continues and can escalate.

Substance misuse treatment alone cannot address the causes of domestic abuse. It should never be assumed that by working with a perpetrator's substance use the violent behaviour will also be reduced. However, any domestic abuse intervention with an abuser who has a substance misuse problem is more likely to be effective if the two issues are addressed simultaneously. It is therefore vital to include assessments of whether someone may be a perpetrator of domestic abuse in any assessments and interventions in relation to substance use and assessments of substance misuse must be built into perpetrator programmes. This already occurs for the statutory perpetrator programme IDAP (Integrated Domestic Abuse Programme) and will be included in the planned voluntary perpetrator programme.

Innovative practice in other areas focuses on building capacity within existing services to respond to the issues of domestic abuse and substance misuse, rather than establishing new services to meet a specific need. This can include building capacity to take a more "family focused" approach, rather than just addressing the presenting individual's substance misuse treatment needs. The Manchester alcohol strategy and Drug Treatment Plan are being refreshed and are linked into domestic abuse work.

The Community Alcohol Team attend the MARAC meetings sharing information and taking referrals. The perpetrator's substance misuse is included in the Risk Indicator Check list which is used to assess whether a victim is very high risk requiring referral to MARAC which ensures practitioners are aware of the links and are asking the

correct questions. Training has been provided for both sectors in each other's specialities and Manchester Women's Aid employ a substance misuse worker for victims of domestic abuse.

Our recent publicity campaigns have promoted a joint message to perpetrators in relation to alcohol consumption and stopping their violence.

What are the known causal factors for domestic abuse, including relationship with major sporting events?

The circumstances within which domestic abuse takes place and the motivation of perpetrators of domestic abuse cannot be attributed to a single 'cause'. Issues such as stress, debt, mental health and substance misuse may be implicated, however, clearly not everyone in these circumstances perpetrates domestic abuse.

Early exposure to violence in the home may be a factor, however, not everyone witnessing domestic abuse as a child will grow up to perpetrate violence and many will be more determined not to use abusive behaviour in their own relationships. A strong correlation is present however between children who have witnessed domestic abuse who then grow up to perpetrate it. This is possibly due to neuron pathways being laid down during the early years where violence and control are learned as ways to get what is wanted by the perpetrator. This is particularly damaging where there is a poor attachment to the victim who may be unable to meet the child's emotional needs due to the abuse they are experiencing. This shows the vital importance of therapeutic work for children and young people affected by domestic abuse and education work in schools in order to prevent future perpetration of abuse. Other key factors in the perpetration of abuse include society's view of women and men and the inequalities that exist in all countries of the world.

Alcohol whilst not a causal factor of domestic abuse does increase the level of violence for many perpetrators who misuse substances. Some perpetrators become less inhibited about their use of aggression and some become less concerned about the consequences of their violence. This is often shown at times of sporting events, Christmas and New Year when many perpetrators drink to excess.

During the last World Cup Greater Manchester Police recorded 353 incidents of domestic abuse on the day England went out of the World Cup after a 4-1 defeat by Germany. This is 15.7 per cent higher than the same day in June last year. Calls to the Greater Manchester Domestic Abuse Helpline rose by 187 during June, which included England's three-week World Cup campaign, compared to the number of calls received the previous month. The helpline received 448 calls in May, while in June, with England matches against USA, Algeria, Slovenia and Germany, 635 people contacted the helpline.

In order to prepare for these events Greater Manchester Police operate Domestic Violence Enforcement Campaigns at key periods of the year. They employ extra specialist domestic violence officers encourage uptake of alcohol and drug services and target known prolific offenders during these periods.

How are the voluntary and community sector organisations supporting victims of domestic abuse themselves supported?

The Domestic Abuse Management Group has a close relationship with the voluntary and community sector. Independent Choices (who run the Manchester Domestic Abuse Helpline) and Manchester Women's Aid both sit on DAMG and facilitate the transfer of information to and from other voluntary and community sector services. Both organisations are working with partners on the implementation of the DAMG annual delivery plan. Independent Choices led the Greater Manchester Domestic Abuse Campaign for the World Cup and the 16 days of activism (November 25th-December 10th). Manchester Women's Aid receive Supporting People funding for their refuge and outreach services. Independent Choices have been given WNF grant funding and we are waiting to see what this is replaced with by the current government. Small scale fund raising initiatives directed towards the helpline are in place such as selling White Ribbons at the strategy launch and ensuring non attendance charges for domestic abuse events are administered and collected by the Helpline. We are currently working with Independent Choices to explore the feasibility of facilitating contributions which businesses are encouraged to make by the Corporate Alliance Against Domestic Abuse to be given directly to the local rather than the national helpline. Other initiatives include:

- Service users of both Saheli Asian Women's Refuge and Manchester Women's Aid were consulted by the Domestic Abuse Coordinator which provided good evidence for the efficacy of these services.

- The NSPCC began a pilot project to support children of very high risk victims referred to the B division MARAC. This service is being funded by the NSPCC for 6 months and began in November 2010.

- Victim Support have a domestic abuse worker currently funded on WNF grant and also provide a service through their general staff.

- 'Women MATTA' who provide a service for women on the edge of offending or who have received a custodial sentence of less than 6 months have been given a grant of £1500 WNF funding by CDRP to set up a support group for young women affected by gang violence and exploitation. DAMG are also working with Women's Aid as well as statutory sector services on this issue.

- The Domestic Abuse Women's Employment Support Project recently announced its continuation of 3 years funding through the Esmee Fairbairn Foundation.

What is being done to encourage higher levels of reporting of domestic abuse?

National research shows that women approach 7-10 agencies before receiving the support that they need and this increases to 12-15 if they are from a BME background. The new strategy aims to tackle this and brings together a range of agencies and highlights the gaps in service which are linked to increasing reporting of domestic abuse.

Domestic Abuse training is offered in the City but is not mandatory for all key professionals. This is an issue which the Domestic Abuse Management Group in partnership with MSCB and MSAB seek to address. During the recent survivor consultation women requested to be asked routinely if they were suffering domestic abuse by key professionals (those who make holistic assessments as part of their service). They stipulated that the professionals must be adequately trained and able to signpost them to the support they required and routinely provide them with information on services regardless of whether they disclosed.

Survivors with immigration difficulties are at risk of not contacting services if they or professionals are unsure of what support they can access. There is a guide on endthefear.co.uk on how professionals can support such women in order to tackle this issue.

Publicity has been mentioned earlier and we are keen to continue a joined up approach with other Greater Manchester Boroughs to provide a consistent message to survivors and perpetrators that domestic abuse will not be tolerated and there are services available. Publicity is also aimed at increasing reports from friends, family and neighbours as national research shows many women are more likely to approach friends and family for help than professionals.

The PATHway project which was previously mentioned has shown increased reporting particularly from BME women through routine enquiry by midwives and referral to IDVA. The recommendation from the evaluation is for the project to continue however it is for the NHS to decide whether to continue this funding.

Domestic Violence Enforcement Campaigns were mentioned earlier and aim to increase the confidence of the public in making reports to the police as they see effective action taking place. One part of this will be the pilot of the Domestic Violence Protection Orders (Go Orders) which will bar perpetrators of domestic violence from their homes for up to a fortnight, giving their victims breathing space to consider their options. Currently, victims can only be protected immediately if the perpetrator is charged and bail conditions set, or if a civil injunction is sought by the victim. This means that in many cases, the only option for victims is to escape to temporary accommodation. The 'Go' orders will allow police to give evidence on the victim's behalf, removing the perpetrator from the home and preventing contact with the victim where they are concerned about the on-going risk of violence.

Manchester Multi Agency Domestic Abuse Strategy

2010-2014

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This strategy was produced in partnership with statutory, voluntary and private sector organisations working throughout Manchester and in consultation with service users.

Designed and produced by www.nectarcreative.com

Contents

Foreword by Councillor Suzanne Richards Lead Member for Women's Issues and member of The Domestic Abuse Management Group

'It is my privilege to introduce the refreshed Manchester Domestic Abuse Strategy on behalf of the multi agency partnership who work consistently to improve protection and support for survivors and their children experiencing domestic abuse.

Domestic abuse is a cross cutting issue and needs to be tackled through a broad response and on many levels.

It can have a devastating and long term effect on the lives of survivors and their children and the communities in which they live. Nationally, one in four women are affected by domestic abuse at some point in their lives (Council of Europe 2002) and two women are killed each week (Simmons and Dodd 2003).

This is a gender issue as it is mostly women who are seriously injured and murdered by men, however, it is also acknowledged that domestic abuse can take many forms and that we have male victims in Manchester who equally deserve a quality service response.

We also recognise the impact of domestic abuse in the Lesbian Gay, Bisexual and Transgender communities where additional forms of abuse, including using a person's sexual orientation, can be used to control or abuse them (Donovan, Hester, Holmes and McCarry 2006).

Since the last strategy it has been heartening to see the progress of services across Manchester. This has included the refurbishment of the Manchester Women's Aid refuge accommodation, gaining Specialist Domestic Violence Court status, development of the Manchester Multi Agency Risk Assessment Conferences (MARAC) and establishment of the Independent Domestic Violence Advice Service (IDVA) amongst many other achievements which are mentioned later.

Over these next few years the Domestic Abuse Management Group (DAMG) are committed to developing preventative and reactive provision. This strategy represents their dedication to early intervention through changing attitudes, provision of services so that survivors and their children can continue with their lives and protection through an effective criminal justice system.

I would like to thank all those agencies and partnerships which have driven and supported these developments and in particular the Domestic Abuse Management Group who hold the responsibility for leading the direction and embedding the strategy into every day work.

By working together in a positive and proactive way we can ensure that domestic abuse is not tolerated in Manchester and that safety and support for survivors and children whilst holding perpetrators accountable for their behaviour remains a priority.'

Suzanne Richards

Councillor Suzanne Richards

Aims of the strategy

- To ensure domestic abuse is a strategic priority for all
- To improve early identification and prevention of domestic abuse
- To reduce the prevalence of domestic abuse
- To ensure that victims of domestic abuse and their children are adequately protected and supported
- To hold perpetrators accountable through effective and early interventions

Introduction

"**(I found help and safety)...** really through the police. The police traced my phone call during an assault (the phones and keys had been forcibly removed by the offender). At least four officers arrived within 10 to 15 minutes… after the offender was arrested, two officers remained to take my statement and must have remained for at least a couple of hours.

The police must have contacted Victim Support who phoned the morning following the assault. I'm not sure if it was Victim Support or the Manchester IDVA Team (who also phoned) who organised to have the panic button/ police link installed. This was done in the afternoon (when I didn't know if the offender was going to be allowed back home)." **Survivor Consultation 2010**

The Manchester Crime and Disorder Partnership defines domestic abuse (also referred to as domestic violence) as any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between people who are, or have been, intimate partners or family members, regardless of gender.

This definition goes beyond abuse that occurs between intimate partners, thus allowing a wider range of issues, such as forced marriage, 'honour' based violence and female genital mutilation to be addressed within this context.

The numbers of reported incidents of domestic abuse to Greater Manchester Police for the city have increased by almost 27 per cent between 2006 and 2010 to 16,820 in the last year.

This reflects a positive move of residents knowing how to access help and contacting the police for support but also reveals a very high number of reported incidents in comparison to other core cities.

Domestic abuse threatens the health and safety of victims and their children, costs the city at least £40.6 million each year and is affecting the city's economic growth and regeneration plans (costs based on Walby 2004).

Much of this spend is on the costly crisis end of intervention rather than on prevention and it is the objective of this strategy to inform a joint commissioning process which remedies this.

Manchester must have a zero tolerance attitude to all forms of domestic abuse. Multi-agency work at a strategic and operational level has a duty to prioritise support for victims and their children as well as tackle the behaviour of perpetrators. The work we do is underpinned by a wealth of legislations which are outlined in Appendix 4.

Children may suffer both directly and indirectly if they live in households where there is domestic abuse. Domestic abuse is likely to have a damaging effect on the health and development of children, and it will often be appropriate for such children to be regarded as children in need or requiring protection (Hester, Pearson and Harwin (2007).

The needs of children and adults, whilst overlapping in terms of safety, are often very different and we are committed to listening to the voice of the child or young person and considering their every day experiences of living with domestic abuse.

There is also emerging research on the attitudes and needs of teenagers who use violence within intimate relationships including the overlap with gang and serious youth violence (**www.rota.org.uk**). In response to this, Manchester Safeguarding Children Board in partnership with the DAMG, commissioned 'A Review of Support for Children and Young People Affected by Domestic Abuse in Manchester (Hargreaves 2010).

This will form the basis of a separate strategy which links to this one to cover the specific needs of children and young people. The children and young people's strategy will include preventative work in schools, and, how we will provide support to deal with the impact including the emotional impact of domestic abuse upon children and young people within a Think Family format.

Marginalisation for victims can result from a history of antisocial behaviour or crime, having immigration issues, forced marriages, complex needs, disabilities or be due to their age. Domestic abuse can result in depression, anxiety, post traumatic stress disorder and research has indicated that a third of female suicide attempts in the UK can be attributed to past or present domestic abuse (Stark and Flitcraft 1996 and Mullender 1996). The difficulty of trying to retain employment or even rebuild one's self esteem in order to recover and attain self reliance is a challenging and often a long term process.

Women experiencing domestic abuse are more likely to have drug and alcohol issues due to the stress and fear they are experiencing.

They may be forced to use substances, or be controlled and not allowed to access information or treatment. Their substance misuse may be used against them by a perpetrator to depict them as an unfit parent and to take the focus off the domestic abuse. Partners using substances may use the victim's earnings for their habit, take their frustrations during detoxification out on the victim, or force their partner into the sex industry to pay for their habit.

They may also use their addictions as an excuse for perpetrating domestic abuse (Gilchrist, Johnson, Takriti, Weston, Beech and Kebbell 2003). The many needs which those affected by domestic abuse may present with, in addition to the domestic abuse itself, indicate the need for a cross cutting multi agency strategy such as this one.

'When the violence is happening it's very hard to pick up the phone to ring for help. When you're in it you've been silenced, you want it to stop – but when its over you want to get back to normal and to your routine. Then it looks like we put up with it and let him get away with it... but it's a way to survive.'
Survivor Consultation 2010

The Commissioning of Domestic Abuse Services

This strategy forms a part of the joint commissioning process for domestic abuse. It clarifies the needs assessments we have completed and the gaps in service that have been unveiled. The strategy states the commitment and intent of partners to prioritise those needs within their own strategic plans and to use our collective knowledge to shape service design and capacity and endeavours to move towards joint commissioning.

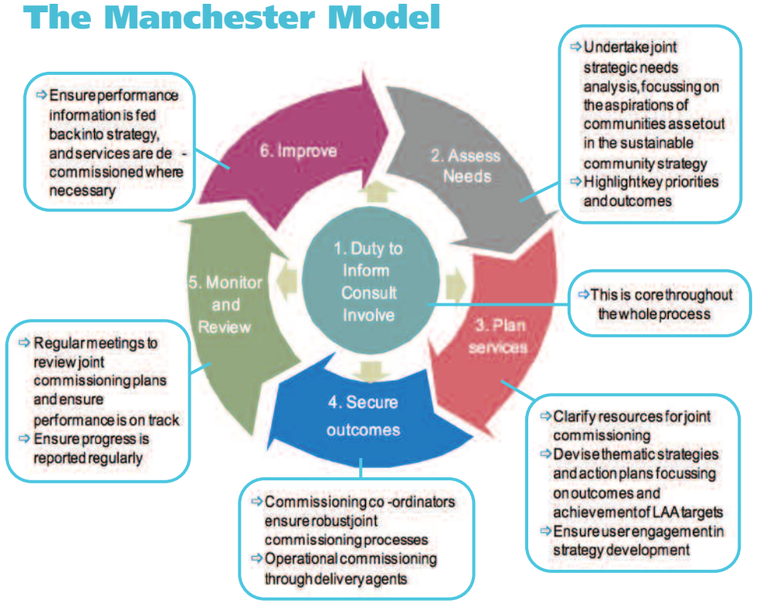
As partner agencies addressing this issue, we are aware that we can not achieve success alone, but can target resources efficiently and effectively when we work in a collective manner.

The DAMG is working to focus on preventative intervention rather than on the costly crisis end of the scale.

The following model is taken from 'Improving joint commissioning in Manchester: Introducing the Manchester Model and Guidance for implementation' (iMPOWER Consulting Ltd 2009).

The model is designed to introduce consistency to the commissioning process in Manchester and has been agreed by the Local Strategic Partnership.

The Manchester Model



1 Commissioning Cycle - Duty To Inform Consult and Involve

Taking a multi agency approach the Domestic Abuse Management Group endeavours to involve all relevant agencies within the centre of the commissioning process. Within our evaluation and performance management processes as well as our assessment stage, we embed the opinions and directives of survivors and their children to ensure that we are continually keeping our joint focus on meeting the real and current needs of those who live and work in Manchester.

Four survivor consultations have been completed recently. Three consultations were led by the domestic abuse coordinator with individual white British women and focus groups totalling twenty three women from BME communities who were accessing Manchester Women's Aid and Saheli/Hosla services. The fourth consultation was with a group of women from a range of different ethnic backgrounds, completed by Housing Quality Network (HQN) consultancy and is presented later as a collective statement. Their combined feedback will influence the formation and provision of future services.

Several themes came out of the first three consultations:

1. Only three of the BME women knew of the domestic abuse help lines. They all said that services needed to be better publicised. A white British survivor said that she had been given the number but the perpetrator controlled her access to the phone. This survivor found websites to be the most helpful way of accessing information when the relationship had ended.

2. Women wanted holistic support for their needs including ESOL (English for speakers of other languages) courses, financial aid, access to work courses and housing to enable them to function independently within society. The Saheli support group appeared to be meeting these needs and was well received by the 12 women attending.

The degree to which service response was holistic appeared to have had a large outcome on women considering returning to their partner, their mental health, their ability to access safety (especially if they had immigration issues) and their ability to keep their children.

They felt agencies needed to better understand and support them through the whole effects of domestic abuse, particularly its emotional consequences and how this affected their ability to engage with services and to safeguard their children. They also wanted support with arranging safe contact between the perpetrator(s) and their children.

3. At least twelve of the women had no recourse to public funds or state benefits which was a very hard situation for them to be in. They had the additional stress of trying to resolve their immigration status as well as having to frequently revisit the abuse to provide evidence for authorities and cope with living in temporary accommodation as well as the effects of the abuse itself.

They said 'all women should get help for domestic abuse regardless of immigration status'.

One woman said 'My partner used to threaten he'd ring immigration to get me deported and now others say we'll protect you but they also focus on my immigration.' The No Recourse to Public Funds team (MCC Adult Social Care) was mentioned frequently as a source of support.

4. 'Provide help to perpetrators through referrals and orders'. The women requested perpetrator programmes which were accessible from children's social care and the family courts and that tied into women's support services. 'Men need educating, undoing their whole culture is difficult but they really need this'. The women wanted to know when these programmes could start in Manchester.

5. A large amount of appreciation was voiced for Manchester's Specialist Domestic Abuse Services 'The (Women's Aid worker) is very good. I want more workers like (her) to work. (She) has helped me very much and raised my confidence. I was very helpless and (she) guided me all the way'. Women were also very pleased with the Saheli support group 'when I was with my husband I wasn't allowed to go out now I'm learning to go places…. every week we gain good information from the group.'

6. All the women felt there were benefits to being asked routinely about domestic abuse if they were alone with a professional and if that professional was well trained. They wanted to be given domestic abuse helpline numbers regardless of whether they had decided to disclose particularly if the number was given in a discrete way such as within a bar code label. They requested health visitors and 'well women' clinics in particular to ask about domestic abuse.

Bar code labels have the national helpline on them and are a discrete way for professionals to give information to survivors.

The fourth survivor consultation was done for an independent consultancy report commissioned by the DAMG in March 2010.

This led to the following statement being written by the Manchester Women's Aid Swings and Roundabouts Group (a support service):
"As survivors of domestic abuse, we invite the commissioners to think about the following to help keep future survivors and their children safe. That domestic abuse is more than just physical abuse and not just perpetrated by partners, so should be viewed in a wider family context.

There needs to be a far greater awareness around domestic abuse in general but the emotional and psychological effects in particular.

These can do the most damage and are often far reaching. Services should reflect this wider view and be more available. Counselling should be readily available and not just through the GP route where a mental health label is attached. Also, group work and personal development courses to help build up self esteem and confidence that has been eroded by the abuse.

Children are often the forgotten victims of domestic abuse. They should be our first priority but in fact they are our last and the lack of services for them reflects this. We need to have mainstream, well-funded and sustainable services for children. These could include counselling and other therapeutic services that counteract the negative effects of living with domestic abuse. Also services for children who are showing signs of abusing. Other services like the police, courts, immigration etc, need to be aware of how the abusers use 'the system' to further abuse.

That communication barriers and information sharing issues should be addressed. Also, to make sure the family is safe and that services are in place, particularly the police. All services should be widely publicised and non-domestic abuse agencies should be well informed as to what is available and be able to signpost to them.

There are services to try and stop people being killed through domestic abuse, but without proper long term prevention, the ability to achieve our potential, the recognition that we are not failures, resources to support our children, resources to overcome the negative coping strategies for example, alcohol or drug misuse, self harm, amongst others. "We may be alive, but we are not necessarily living" (Housing Quality Network 2010).

In summary, survivors would like to be asked about domestic abuse, to be given holistic support, especially for emotional and immigration difficulties and have expressed a great deal of appreciation for Manchester's specialist agencies.

They have also requested that services are better publicised, information shared appropriately, that children are provided with the support they need, and that perpetrators are given access to programmes to address their behaviour and are held accountable for their abuse by agencies.

Survivors were in agreement with the current year priorities the Domestic Abuse Management Group has set and will be consulted on future priorities. DAMG will take this information forwards through our strategic objectives and our annual delivery plans as discussed later in this strategy.

2 Commissioning Cycle - Assess Needs

During 2010 the DAMG requested an independent review of services by the Housing Quality Network (HQN), (Taylor Knox, Leyland, Wildsmith, Goldup, Knox and Leng).

The main gaps in service which the HQN report identified were:

- Support for children and young people affected by domestic abuse
- Non statutory programmes for perpetrators of domestic abuse within a family intervention service
- Improving communication strategies to promote zero tolerance of domestic abuse and prioritisation of domestic abuse within key strategies
- Promotion of mandatory training of domestic abuse for key professionals
- Development of shared risk assessments and referral processes between the domestic and sexual violence services and generic agencies
- Exploring the feasibility of a central point for domestic abuse referrals

Manchester Safeguarding Children's Board, in partnership with the DAMG, commissioned a review of both preventative and supportive services for children affected by domestic abuse (Hargreaves 2010). This report also outlined the need for increased support for children and young people and suggested how specialist support could be increased. This will be further explored within the future strategy for children and young people.

National research on domestic abuse confirms the local picture in Manchester of key areas where domestic abuse requires an integrated approach.

There is no research to suggest that the prevalence of domestic violence is higher in any socio-economic, ethnic or racial group. However, patterns of reporting indicate that some groups are more or less likely to report domestic violence to the police.

The Manchester Joint Strategic Needs Assessment (2008-2013), the Manchester Strategic Threat Assessment (2009) and the Greater Manchester Against Crime Strategic Assessment (2009) have also confirmed that there are groups who particularly experience barriers to seeking help or who have additional needs.

These groups include:

People with disabilities

The 1996 British Crime Survey revealed that 12 per cent of disabled women aged 16-29 had experienced domestic violence in 1995 compared with 8.2 per cent of non-disabled women (Mirlees-Black, Mayhew and Percy 1996).

Issues facing disabled women can include: disability discrimination, inaccessible information, agencies not using appropriate interpreters or communication aids, a focus on disability instead of violence, inaccessible resources and disbelief that disabled women experience violence or disabled men can perpetrate violence (Hague, Thiara and Mullender 2010).

BME persons and groups

There are additional issues facing black and minority ethnic survivors of domestic abuse.

These can include: institutional racism, inaccessible information, language barriers, immigration issues and lack of understanding of cultural issues.

Honour based violence, forced marriage, female genital mutilation and human trafficking disproportionately affect black and ethnic minority women and women from abroad.

These survivors are also likely to have a low level of awareness /knowledge about the existence of domestic abuse services and thus are likely to endure violence for longer periods (Sen 1997 and Gill 2004).

Victims of forced marriage

In 2009 the Forced Marriage Unit gave advice or support to 1682 cases. 86 per cent of these cases involved females and 14 per cent involved males.

There is a clear difference between a forced marriage and an arranged marriage. In arranged marriages, the families of both spouses take a leading role in arranging the marriage but the choice of whether or not to accept the arrangement remains with the couple. In forced marriages, one or both spouses do not (or, in the case of some vulnerable adults, cannot) consent to the marriage and duress is involved. Duress can include physical, psychological, financial, sexual and emotional pressure.

The government regards forced marriage as an abuse of human rights and a form of domestic abuse and, where it affects children and young people, child abuse. It can affect both men and women although most cases involve young women and girls aged between 13 and 30. (Statistics taken from the Forced Marriage Unit, for further information visit **www.fco.gov.uk**)

Victims of sexual violence

There are clear links between sexual violence and domestic violence. It is important to note that victims of sexual violence perpetrated by a current or former partner are likely to be victims of the most severe forms of domestic violence.

Approximately 51 per cent of serious sexual assaults and rapes are committed by current or former partners of the victim (British Crime Survey 2005). Domestic abuse is also linked with sexually transmitted diseases, teenage pregnancies and miscarriage (Martin, Matza, Kupper, Thomas, Daly and Cloutier 1999).

Persons who are homeless

Research on homelessness for Shelter has found that domestic violence is "the single most quoted reason for becoming homeless". This study found that 40 per cent of all homeless women stated domestic violence as contributor to their homelessness (Cramer and Carter, 2002).

People who misuse drugs and alcohol

National and local evidence suggests that alcohol and drugs feature in the experiences of both domestic violence perpetrators and victims.

Men who perpetrate violence against a female partner and misuse alcohol often inflict more serious assaults than perpetrators who are free of alcohol misuse. The nature and extent of alcohol as a factor will vary among individuals. For example, some men feel less inhibited about displaying aggressive behaviour whilst drinking; others feel less concerned about the consequences of their violence. Perpetrators often try to blame their behaviour on substance misuse however there is no excuse for violent and controlling behaviour. (Gortner, Gollan and Jacobson 2009).

Women's Aid Federation England have identified that women experiencing domestic violence are up to 15 times more likely to misuse alcohol than women generally. Many women misuse alcohol as a consequence of, and response to, abuse and therefore a significant number of women approaching services may present with multiple support needs. Some key issues for service providers include women who may not want to reduce or stop their alcohol misuse at the same time as they decide to end their abusive relationship (Baron 2004).

When a woman seeks treatment for her substance misuse, her partner may become even more abusive, or may actively encourage her to leave treatment. Women with problematic alcohol misuse experiencing domestic violence are likely to feel isolated and doubly stigmatised. They may find it harder than other women to report or even to name their experience as abuse (ibid).

People who identify themselves as Lesbian, Gay, Bisexual or Transgender

Lesbian, Gay Bisexual or Transgender persons can experience domestic violence and face a range of issues and barriers when seeking help. This can include disbelief, fears of losing their children, fears of being 'outed' to agencies/family and homophobic attitudes as well as indirect and direct exclusion (Townley 2002).

People with mental health problems

Women who have experienced domestic violence have higher rates of mental illness than other women: 64 per cent experience post-traumatic stress disorder, 48 per cent have depression, and 18 per cent attempt or commit suicide. There is also research to show that young South Asian women are three times more likely to commit suicide or self harm than young women of White British origin (Raleigh and Balarajan 1992). It is worth noting that mental health issues are more likely to result from domestic abuse than to cause it as this has been used as an excuse by perpetrators for their behaviour, particularly when the victim is also their carer.

Children and Young People

Violence involving people less than 18 years of age is classified as child abuse and is dealt with by specific policies and legislation. Nevertheless, children and young people are affected by domestic violence. Children are typically in the same room as the violence or are able to hear it.

And there is frequently direct abuse occurring with the domestic violence. Domestic abuse is not only traumatic in itself, but is also likely to adversely impact on a child's or young person's behaviour and performance at school.

Some of the ways domestic violence affects a child are: antisocial or disturbed behaviour, bullying or being bullied, personality changes such as becoming withdrawn or introverted, loss of concentration, running away from home, turning to drink or drugs to escape unpleasant home situations, reluctance to form or develop friendships, interrupted schooling and broken friendships.

For example, as a result of moving away from the home area with a parent escaping from an abusive partner (Hester, Pearson and Harwin 2007). Abuse can also continue or escalate after separation, often through contact issues with the perpetrator (Saunders and Barron 2004).

Men

It is widely recognised that some men experience violence and abuse in intimate relationships. Like women, men find it difficult to disclose or report incidents and may live with the abuse for many years. The impact for all victims experiencing violence can have long lasting, detrimental effects on their life.

This strategy promotes the principle that all good practice developed to respond to victims of domestic violence applies equally to men as it does to women.

While both men and women may experience incidents of inter-personal violence, women are considerably more likely to experience repeated and severe forms of violence (World Health Organisation 1997).

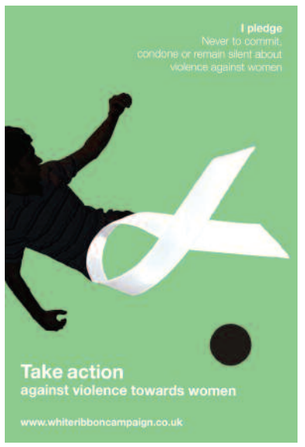
Women are also more likely to experience sexual violence, and the abuse they experience is also more likely to have a sustained psychological/emotional impact or result in injury or death (Coleman et al 2007).

Practitioners working with perpetrators should place the safety of victims and children at the heart of all interventions.

All agencies working with perpetrators should refer to the Respect Accreditation Standard. This is a comprehensive framework to assist agencies to develop minimum standards and good practice based on available evidence based research.

More information can be found at: **www.respect.uk.net**.

The Domestic Abuse Management Group also supports the White Ribbon Campaign which encourages all men to take responsibility for reducing the level of violence against women through prevention campaigns and supporting women's groups.



www.whiteribbon campaign.co.uk.

The different strands of the needs assessment outlined above in addition to survivor consultation have enabled the gap analysis and informed the strategic objectives of the Manchester Domestic Abuse Strategy.

3 Commissioning Cycle - Plan Services

Following the needs assessment services are planned in relation to our strategic objectives for 2010-2014, covering four key areas - communication, prevention, provision and protection.

Our survivor consultation has also been key within this stage and the findings have shaped and supported the detail of the Manchester objectives. The following is a summary of what has been achieved and what we aim to do within the timeframe of this strategy whilst further embracing joint commissioning.

Below is a snapshot of the endthefear.co.uk website which promotes a central point of information.

Objective 1
Communication

We will communicate to our service users Manchester's one message – Domestic Abuse will not be tolerated.

Key achievements:
- Implementing domestic abuse within other key strategies and business plans.
- Updating and developing the **endthefear.co.uk** website.
- Promoting helplines during the 2010 World Cup through joint Greater Manchester wide commissioning. This was implemented using posters which where shown on buses and major advertising sites and was coordinated by Independent Choices to promote joint working, one message and one contact point.

Future plans include:
- Developing innovative publicity campaigns and further embedding domestic abuse into multi agency priorities.

Publicity materials were displayed on the big screen in Manchester's Piccadilly Gardens during the 2010 World Cup.

Objective 2
Prevention

We will work with partner agencies to change attitudes, provide early intervention and prevent abuse.

Key achievements:
- A multi agency e learning package for domestic abuse.
- Manchester now has a domestic abuse education pack for Primary Schools as well as Secondary Schools materials. These are gradually being implemented within schools alongside staff training.
- The consultation by Hargreaves (2010) has provided a basis for a children's strategy which will include education work and how we will use our children's workers in the most effective way.

Future plans include:
- Development of the children and young people's strategy for children based on Hargreaves' (2010) recommendations. This strategy will reflect the children and young people's plan which integrates preventative work (education in schools and other settings) and supportive work (children's workers) within a Think Family format. The strategy is required to provide a tiered model of intervention and a referral pathway for children affected by domestic abuse and to build a Think Family approach into the plans for a voluntary perpetrator programme.
- Promotion of standardised multi agency training for domestic abuse and forced marriage by the safeguarding boards.

Objective 3
Provision

We will work collectively with other agencies to help those affected by domestic abuse to continue their lives.

Key achievements:
- A minimum standards and self assessment tool (see appendices 2 and 3) to promote quality of service delivery.
- The refurbishment of Manchester Women's Aid refuge accommodation, which now provides single units as well as shared refuge units as shown below. The quality of refuge accommodation in Manchester is excellent.

Future plans include:
- Developing and embedding referral processes from all statutory and voluntary sector services to domestic abuse and sexual violence services.
- Ensuring services are available for survivor's holistic needs and are accessible to everyone regardless of ability or immigration status.
- Considering the feasibility of a central referral point for adult survivors of domestic abuse.

Objective 4
Protection

We will support the criminal justice system to provide an effective response to domestic abuse.

Key achievements:
- Gaining Specialist Domestic Violence court status and seeing an increase in successful outcomes since this was granted.

Future plans include:
- Evaluating and building upon the multi agency criminal justice work of the Integrated Domestic Abuse Programme, Multi Agency Risk Assessment Conference, Multi Agency Public Protection Arrangements and the Specialist Domestic Violence Court.
- Using multi agency early intervention work with perpetrators which link into survivor and children's support services.

4 Commissioning Cycle - Secure Outcomes

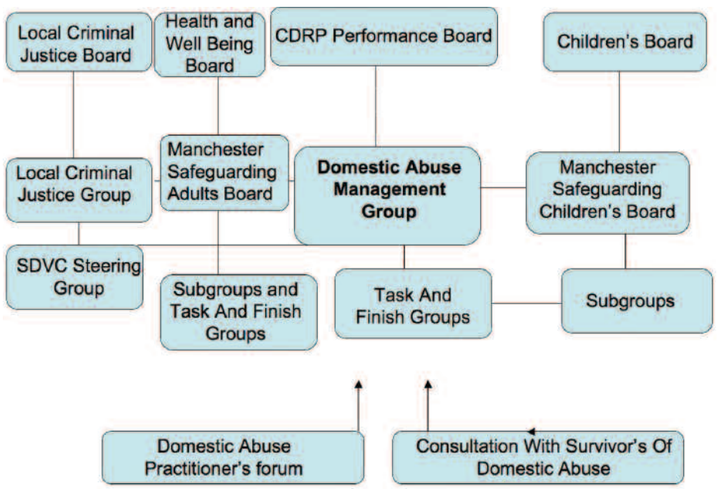
This stage identifies the way in which the outcomes of commissioning strategies will be achieved. At present providers are selected, funded and supported by individual agencies represented on DAMG to deliver the services which meet DAMG's intended outcomes (i.e. our objectives).

DAMG provides the information for needs assessments and service planning for those agencies and is working to facilitate joint commissioning where possible.

5 Commissioning Cycle - Monitor and Review

Within the structure of the Crime and Disorder Reduction Partnership, the DAMG is the multi-agency group that is responsible for strategically leading and performance managing the domestic abuse prevention agenda in Manchester. It has key accountability links to other quality assurance processes as is illustrated in the following diagram.

Through links to the practitioner's forum and survivor consultations the DAMG are held accountable for their work through a 360 degree approach which allows challenge and change within service commissioning and delivery. The DAMG's function in quality assurance is to ensure that obstacles are removed which would hinder the completion of the delivery plan and tighter performance management is enabled through the links with the performance board and Manchester Safeguarding Children and Adults Boards.



The Manchester Partnership employs a domestic abuse coordinator to develop, implement and manage Manchester's Multi Agency Strategy.

The remit of the Domestic Abuse Management Group is to:

1. Drive implementation of, and performance manage the Manchester Domestic Abuse Strategy through the annual delivery plan.

2. Monitor and review the Manchester Domestic Abuse Strategy which sets a clear strategic direction for domestic abuse prevention. Ensure that the strategy continues to be informed by, and influenced by, survivors of domestic abuse, the learning from serious case reviews, the national domestic abuse prevention agenda and the work of all other relevant thematic partnerships in Manchester.

3. Co-ordinate and identify resource requirements so that the Manchester Domestic Abuse Strategy can be delivered. Ensure domestic abuse priorities are fed into relevant commissioning groups. Maintain an overview of commissioning arrangements with a view to identifying any gaps in funding and bid opportunities.

4. Ensure that progress in delivering the Manchester Domestic Abuse Strategy is reported regularly to the relevant partnership Board.

5. Ensure that there is ownership of and commitment to domestic abuse prevention at all levels in the Manchester Partnership and that adequate communication channels are in place.

Task and Finish Groups of the Domestic Abuse Management Group assist in the development, implementation and monitoring of annual delivery plans to ensure the fulfilment of this strategy and to enable providers to give more effective and efficient services.

Manchester agencies have domestic abuse polices and procedures including employee policies which shape service design and delivery and are implemented through domestic abuse training.

In addition to this, the DAMG has agreed a set of minimum standards which partner agencies will honour and can be found in appendix 2.

Accompanying this in Appendix 3 is a self assessment chart which is designed so that member agencies of the DAMG can recognise what they must work towards to provide a premium service.

There are three levels in the chart, level one being the first level which gives a bronze standard of service and level three being that of a gold standard service. At the time of publication DAMG completed level one and many aspects of level two and some aspects of level three, so as a partnership we have achieved level one.

The yearly delivery plan enables partners to work together towards achieving the objectives in the chart as well as meeting wider identified gaps in service provision. We aim to have achieved a level three standard of provision by 2014 when this strategy is completed.

6 Commissioning Cycle - Improve

The 'improvement' phase occurs after reports and evaluations of services. Whilst this stage can and does occur at any time of the year, we specifically gather information at the end of the financial year to make detailed delivery plans for the following year and use innovation and reprioritisation to drive us forwards and ensure we are meeting the current needs of the population. These annual plans can be found on the **endthefear.co.uk** website.

During this part of the commissioning cycle we examine how we are performing in relation to our collective targets and commission or decommission services as appropriate. At this stage we would also refer to our minimum standards and self assessment chart to see how we are improving our services (see appendixes 2 and 3).

Manchester Provider Services Addressing Domestic Abuse

The following is a non exhaustive overview of the agencies in Manchester who provide specialist help and support for those affected by domestic abuse. Each service contributes to **Objective One** of our strategy - improving communication and promoting zero tolerance of domestic abuse as well as fulfilling the other objectives of the strategy as shown below.

Objective Two
Prevention

Children's Work

Working with children is key to changing the next generation's attitudes to and experiences of domestic abuse. Children's Services within Manchester City Council have a domestic abuse support service for children affected by domestic abuse.

In addition, Manchester Women's Aid (MWA) and Saheli Asian Women's Refuge employ children's workers to support children living in refuge and MWA has a youth worker who along with MCC Education staff is promoting the use of domestic abuse education materials in schools.

At the time of writing this strategy, the multi agency provision of services for children affected by domestic abuse is being developed along with a specific strategy for children and young people.

It is the aim of the Domestic Abuse Management Group that our work will take a 'Think Family' approach which will span the Safeguarding Children and Adults Boards. Further updates will be available on **endthefear.co.uk**.

Objective Three
Provision

Manchester Women's Aid (MWA)

Manchester Women's Aid provides emergency refuge accommodation to women and children escaping domestic abuse - they have five refuges across the city. Services can be accessed by calling directly or via a support worker, domestic violence help lines or any other statutory or voluntary agency.

They also have four houses in the community to provide accommodation for women with lower level support needs to move on to after they have stayed in the refuge. The outreach service is city wide and supports women and men who have experienced domestic abuse.

Staff undertake a risk and needs assessment to devise a safety and a support plan together with the individual or family. This ensures their needs are prioritised, and to work towards addressing their safety, health, and future life plans.

MWA also have community language workers who are able to speak Urdu, Punjabi and Hindi. They provide specialist support for women with no recourse to public funds and asylum seeking women fleeing domestic violence. There is a part time ESOL tutor for women who need to learn English and a part time youth worker to raise awareness of domestic violence, honour based violence and forced marriage to young people in schools and youth clubs.

Refuge staff work with residents to rebuild their lives focusing on the Every Child Matters Outcomes Framework. Group activities are also held on refuge sites with activities and trips arranged to promote emotional well being. Recent Survivor Consultation confirms the efficacy of this service:

'I was zero, I came new from Pakistan I didn't know how to get a bus here or understand anything. I am thankful to (the Women's Aid worker) for my whole life.'
Survivor consultation 2010

Independent Domestic Violence Advice Service (IDVA)

The Manchester City Council IDVA service provide advocacy, advice and support to survivors of domestic abuse who are at high risk of harm to address their safety needs and help manage the risk that they face.

All the IDVA's are trained to CAADA (Coordinated Action Against Domestic Abuse) standards. IDVAs provide short to medium term case work, focusing on risk management and safety planning to enable survivors to access a range of legal remedies available from the civil and criminal justice systems (CJS).

IDVAs have measurable outcomes which demonstrate impact and effectiveness, as well as value for money.

These include:
- Reduced repeat victimisation
- Prevention of homelessness
- Make survivors and children safer
- More survivors engaging with the CJS
- Reduced retraction rates

This service is provided both at the point of crisis and in relation to the client's long term safety and holistic support needs. A national multi site research study showed that abuse stopped in two thirds of cases where there was intensive support from an IDVA service including multiple interventions such as MARAC. (Howarth, Stimpson, Barran and Robinson 2009).

Forced Marriage Pilot

The IDVA service was funded by the Ministry of Justice to run a Forced Marriage Prevention Order (FMPO) pilot. An FMPO tells named persons to cease forced marriage related behaviours often until further notice. Previous to September 2009 there had been no FMPOs secured in Manchester, but by November 2010, 18 were secured.

The pilot raised the profile of forced marriage and domestic abuse services within children's and adult's services and has left a lasting awareness of specialist service pathways now that it is mainstreamed into the work of the IDVAs.

Sanctuary Scheme and Housing Options

IDVAs operate the Manchester Sanctuary Scheme which is the provision of professionally installed property security measures ranging from additional locks, window shock alarms, fireproof letterboxes to a fully secured room.

The scheme is designed to enable victims of domestic abuse to remain in their own home, where it is safe for them to do so, when it is their choice and where the perpetrator does not live in the home.

IDVA also provide a Housing Options advice service to support families who present as homeless due to domestic abuse. The family will be interviewed by an IDVA who discuss the range of options available to prevent homelessness where possible.

These options are also promoted by the Manchester Women's Domestic Abuse helpline, Manchester Women's Aid and the Local Authority Homelessness service.

Options include the provision of the Sanctuary scheme, accessing legal remedies, accessing the social and private rented sector accommodation through the Letwise scheme, accessing supported housing including refuges and respite accommodation and making a statutory homelessness application.

'The Sanctuary Scheme and the other services the IDVA referred me on to have been amazing... I am feeling much safer following the practical advice and information provided both on personal safety and security within the home. IDVA advocated on my behalf to external agencies when I needed the support the most. I was kept updated on progress and with any other relevant information to my case'.
A Survivor Using IDVA Service In 2010

Specific Homelessness Provision For Survivors and Children of Domestic Abuse

The Homelessness Division of Manchester City Council is working to ensure that everyone escaping domestic abuse is able to access a range of housing and advice services, including the provision of temporary accommodation and the full discharge of any duty owed under the Housing Act 1996 Pt VII.

They are working with partners to ensure that all those affected by domestic abuse are able to access consistent and comprehensive advice on housing and safety options from whichever agency they first approach and have an agreed protocol with Manchester Women's Aid, the IDVA service and the Manchester Women's Domestic Abuse Helpline.

The Homelessness Advice and Assessment service of Manchester City Council is the statutory assessment service for those who feel they are homeless or at risk of it. They will make an assessment of the duties owed under the homelessness legislation and ensure that duties are discharged in full. This may be through the offer of temporary accommodation for a reasonable period, the provision of advice and assistance or through a reasonable offer of more settled accommodation.

The Homelessness Division believes that those escaping abuse should receive comprehensive advice and support to enable them to choose the option that best meets their needs.

The PATHway Pilot

Almost every survivor of domestic abuse will use NHS services during their lifetime. A specific service which the NHS in Manchester has piloted is PATHway. Women and their unborn children are at increased risk during pregnancy and almost one third of cases of domestic abuse start or escalate during pregnancy (Lewis and Drife 2001).

The PATHway pilot project at St Mary's Hospital aims to improve the NHS's response to domestic abuse for these women. An Independent Domestic Violence Adviser (IDVA), based in maternity services, offers support and advice to women and their families affected by domestic abuse. The worker also undertakes awareness raising with staff, who are trained to ask women routinely about their experiences of abuse, whether or not they show any signs of abuse.

During the project, referrals to the IDVA have increased significantly and medical staff report that they feel more confident about discussing abuse with patients and making referrals. An independent evaluation of the project was commissioned and the report will help plan future services for this vulnerable group. In the first 12 months of the project (April 2009 to March 2010) there were 159 referrals to the IDVA service from St Mary's staff. This compares with 40 referrals to the main IDVA team from all health professionals across the area in the previous year (2008/9) (health professionals include staff working in the three acute hospitals, mental health and primary care services).

"I feel I have regained my self esteem and sense of belonging as a woman".
Granville (2010) Survivor Feedback PATHway Evaluation Report

Independent Choices

Independent Choices was founded in 1978 as the Women's Domestic Violence Helpline. Their services developed in the mid 1990's into a multi-project organisation. During 09-10 the helpline received 6193 calls, the majority of which were from Manchester residents. This included at least 74 calls in relation to forced marriage.

Independent Choices structures its services to work from a range of direct perspectives including promoting civil and criminal remedies, personal support/ advocacy and also societal attitudes and awareness. They provide a continuum of care across Greater Manchester that includes crisis support, post support, prevention work and early intervention and education.

Their vision is that all women and their dependents are made aware of their rights and offered choices so that they can live without the fear of domestic abuse. The focus of the work of the organisation includes direct service provision to women and agencies who support women.

They have provided services for many years to Manchester women through the Women's Domestic Abuse Helpline and the Women's Safety Service which offers support to the female partners/ex partners of men sentenced to the Integrated Domestic Abuse Programme (IDAP). Their Community Helpline Language Service provides a service to women of South Asian origin that recognises their cultural and language needs and they have recently set up an email support service and updated website facility.

Domestic Abuse Work and Employment Support (DAWES) Project

'Workplace then a haven, somewhere there is no pain, Until he thinks I enjoy it, then he ruins it yet again'
From Anger Is Just A Sentence Away by Caldwell 2010
www.dawesproject.org.uk

It is now largely accepted that domestic abuse is an issue for the workplace.

The abuse can impact on a person's employment in a number of ways, for example:

- Time off sick with injuries or mental health issues resulting from abuse
- Needing to attend appointments and having increased childcare responsibilities
- Health and safety issues within the workplace and isolation from colleagues
- Difficulties in concentrating resulting in lack of productivity

Many of these issues can ultimately lead to dismissal from work and therefore loss of financial independence and a healthy routine at a time when these things are crucial. Greater Manchester Pay and Employment Rights Advice Service (GMPERAS) provides an employment rights advice service and campaigns on behalf of vulnerable workers.

GMPERAS established the DAWES (Domestic Abuse: Women's Employment Support) project in response to a gap in service provision. The DAWES project works across Greater Manchester to support women experiencing domestic abuse to retain their employment.

The project can also provide training and consultation for employers, advice and support agencies and trade unions on any aspect of domestic abuse and employment.

In September 2010, the DAWES project launched a research report titled, "Work was an escape for me", which was conducted with women who had been supported by the project. Recommendations from the research echoed the survivor consultation and included:

- An employer having a domestic abuse policy for staff is not enough – it needs to be properly implemented with training and promotion, and should include flexible options depending on individual circumstances
- More work can be done to raise awareness with employers and trade unions are in a good position to do this
- Women experiencing domestic abuse want to be able to get advice and support on a number of different topics (e.g. employment, debts, housing) in one place, so joined up and innovative ways of working should be explored.

As with the previous survivor consultations the Domestic Abuse Management Group will take these recommendations forward through their annual delivery plans. The DAWES report can be found at: **www.dawesproject.org.uk**.

Saheli

Saheli (which means friend) is a free and confidential domestic abuse support service run by South Asian women for Asian Women and children. It is a Manchester based organisation that has been in operation since 1976. They provide refuge and support services to Asian women and their children who have been affected by domestic abuse, including forced marriage and honour based violence.

This peer support helps provide a trusted escape route from violent relationships that damage both physical and mental health.

Through the refuge and the services that are provided, vulnerable women are given an opportunity to take the first steps in rebuilding their confidence and ultimately the future of themselves and their children in an environment that meets their cultural needs.

Saheli helps women to come to a decision of their own - whether it is one of reconciliation or coming to terms with being a single parent and living independently. They are currently setting up groups and drop in surgeries in various locations across Manchester to help Asian women and are developing a training programme for professionals and youth centres on supporting young people being forced into marriage.

An outreach programme is provided called Hosla (which means support and empowerment) to help with access to support and advice for women living with domestic violence who are still considering their options.

Services are run for the children living in the refuge, this includes play sessions and talking therapies. Children's work focuses on developing the self esteem and confidence of the children in a safe space.

Saheli received recent recognition and appreciation for conducting pioneering research called **'Forgotten Women: Asian Women, Poverty and Destitution'** which was funded by the Oxfam UK Poverty Programme. The research looked at poverty and destitution being faced by women who have no recourse to public funds or state benefits and are fleeing domestic abuse.

As a result of the findings they have developed group work for women in these situations. Saheli has also conducted research into the mental health needs of Asian women.

'Saheli has helped me a lot, I have been to the refuge three times and three times they have been very helpful. They helped with (my) passport and if I need help in the middle of the night they help and with language it helps because I can't speak English properly…. The kids father wanted.. custody for (the) kids but Saheli got (a) good solicitor and now I have custody for the kids… Saheli is one of the best services in Manchester, they help(ed) me a lot because they speak our language and (are) good for people who don't speak English'.
Survivor Consultation 2010

The Sexual Assault Referral Centre (SARC)

The St Mary's Sexual Assault Referral Centre (SARC) is a collaborative venture between Central Manchester University Hospitals NHS Foundation Trust, Greater Manchester Police, Greater Manchester Police Authority and Manchester Primary Care Trusts.

SARC provides a comprehensive and co-ordinated forensic, medical aftercare, support and counselling service to children and adults in Greater Manchester who have experienced rape or sexual assault (whether recently or in the past). SARC services are designed to provide quality care to support and empower clients who have experienced sexual violence.

SARC Services include:

- Forensic medical examination including therapeutic medical services
- Assessment and documentation of injuries
- Independent Sexual Violence Advisor
- A counselling service
- Support through criminal justice process
- A 24 hour telephone help and information line

All services are available regardless of whether a report has been made to the police. Those who self refer are offered the opportunity to provide anonymous intelligence and ability to store forensic medical evidence offering the opportunity to make a report to the police at a later date.

Service provision also includes responding to clients who have survived or who are experiencing sexual assault in the context of domestic abuse.

This involves proactively assessing individual needs, responding to safeguarding issues and working closely with the domestic abuse services and other health and social care agencies to ensure ongoing quality care and support. The St Mary's centre is committed to interagency working and providing educational programmes to raise awareness and help develop skills in this field.

Manchester Rape Crisis

Manchester Rape Crisis (MRC) is a voluntary organisation run by women in Manchester. MRC provides information and support to women and girls who have experienced sexual violence. They provide a sign posting service for male survivors and information and support for friends and relatives who are themselves supporting survivors. Sexual violence within domestic abuse can be difficult to address and is vastly under reported.

MRC has a telephone helpline staffed by fully trained volunteers and provides free face to face counselling for women over 18. They also provide a support group for women which meets weekly and a counselling service for women in Styal prison on a weekly basis.

Twice a year MRC runs a self development course which looks at issues around self confidence and assertiveness which has been specially developed to address the needs of survivors.

MRC provides a service for all women in Manchester who define themselves as survivors and supports a large number of women who have been victims of sexual violence within an abusive relationship.

Victim Support

Victim Support is an independent national charity for people affected by crime. Their volunteers are trained to give information, practical help, and emotional support to survivors of domestic abuse and in Manchester they provide a specialist worker. Victims are usually put in touch with Victim Support by the police, or through their Witness Service at the criminal courts or they can be contacted directly, whether or not the victim wants to report the crime to the police. Victims can also be put into contact with other agencies that can help, for example, with housing, benefits and legal advice. For more information visit **www.victimsupport.org.uk**.

Witness Service

The Witness Service ensures that victims of domestic abuse are provided with maximum support in court. Support is tailored to suit individual needs including facilitating separate waiting rooms and entrances /exits so that the victim does not come into contact with the perpetrator.

The Witness Service staff liaise with Crown Prosecution Service (CPS), court staff, police and other agencies on the victim's behalf and endeavour to obtain the results of the trial, details of bail conditions and restraining orders upon request from the victim witness or one of the partner agencies.

The role of the Witness Service includes ensuring that any fears are addressed either prior to court or on the trial date. These may include needs for Special Measures. With consent, the Witness Service will contact the Witness Care Unit and CPS with any requests either before the trial or on the trial date.

Anyone with Special Measures will be accompanied to and from court by the Witness Service volunteer, who will either sit behind a screen with them or accompany them in the video link room. Victims and witnesses of domestic violence are offered pre court welfare and support together with a pre court familiarisation visit where court procedure and roles and responsibilities of court personnel are explained.

Before giving evidence:
"(I was) really daunted and worried before I came. I am totally relaxed now and confident. Everyone (is) friendly and down to earth. The explanation of procedures was really helpful. (I) have enjoyed watching television and am relaxed, it has helped me to chill. It does not feel like a court environment".

After giving evidence
" (I) felt confident. (The) procedures being explained really helped. (I'm) glad that there are such nice friendly people who are willing to help".
Witness Service User Feedback 2010

Safety4Sisters

Safety4Sisters is working towards securing greater protection, safety and support for women who have experienced gender violence and who have no recourse to public funds or state benefits. They meet on a voluntary basis to explore the services available, to identify need and to explore new ideas to improve and secure support and protection/safety.

Such women include trafficked women, asylum seekers, some women from eastern European countries, refugees and women with no recourse to public funding or state benefits due to their visa status.

For more information visit **www.endthefear.co.uk** and download the guide for practitioners on 'Securing Human Rights, Safety And Support For Women With Immigration Issues Who Experience Domestic Abuse'.

Objective Four
Protection

MARAC - Multi Agency Risk Assessment Conference

- is a meeting attended by statutory and voluntary sector agencies with the sole intention of safeguarding high-risk victims of domestic abuse. It hears cases referred by a range of agencies, which, without the intervention of the MARAC process, would be at high risk of death or serious injury.

The meetings are chaired by Detective Inspector's from Greater Manchester Police, and are attended by amongst others: IDVA's, Children's Services, Health, Probation, Homelessness Services, Drug & Alcohol Services, Registered Social Landlord's, Women's Aid and Victim Support.

Since October 2009 MARAC has increased from one meeting a month to three across the city.

As a result of this and increased awareness raising new referrals have increased over the last year from 15 to over 75 cases each month.

The MARAC co-ordinator is working to increase referrals from under-represented agencies, particularly those whom it is believed victims of domestic abuse are likely to disclose to, but who aren't yet part of the MARAC process.

With the intervention of MARAC, and the IDVA service, research has shown that victims remain abuse-free 12 months after the MARAC in 60 per cent of cases.

This represents a substantial reduction in further abuse, and apart from the benefits of this to victims and their children, also has significant financial benefits to agencies whether directly involved in the field of domestic abuse or not.

For every £1 spent on MARACs at least £6 of public money can be saved annually on direct costs to agencies such as the police and health services (CAADA 2010).

Greater Manchester Police - Public Protection Investigation Unit

The Public Protection Investigation Unit (PPIU) is a key service within crime operations on each division. The unit is divided into the investigation of child abuse, vulnerable adult abuse and domestic abuse.

The Domestic Abuse Unit forms part of the Public Protection Investigation Unit, ensuring that information regarding domestic abuse, child protection and mental health is not assessed in isolation.

The role of the domestic violence investigators is to:

- Take effective action against offenders of domestic violence so they can be held accountable through the criminal justice system.
- Adopt a proactive multi agency approach to prevent and reduce domestic violence.
- Advise and support victims of domestic violence and ensure force policy and procedures are followed by divisional officers dealing with such incidents.
- Offer support and guidance to divisional officers dealing with cases of domestic violence and harassment.
- Deliver multi agency awareness /training to divisional staff and professionals and vulnerable groups.
- Liaise with IDVA service, Manchester Women's Aid and Victim Support to ensure a victim focused approach.
- Attend, coordinate and manage divisional MARAC conferences.
- Provide a proactive preventative response to predicted spikes in domestic abuse (such as events which are linked to excessive alcohol consumption).
- Deal with prisoners who are or have been in an intimate relationship with a medium -high risk victim of domestic abuse, forced marriage or honour based violence.

There are three divisions within Manchester covering the north, centre and south of the city (A, B and C divisions). They each fulfil the role described above but also work independently to trial innovative ways of working within their local area and then share their findings and successes amongst the divisions and with multi agency partners.

Specialist Domestic Violence Court (SDVC)

In October 2008 Manchester City Magistrates Court was awarded SDVC status by the Home Office. The Specialist Domestic Violence Court represents a partnership approach to domestic abuse by police, prosecutors, court staff, probation services and domestic abuse support services (IDVA and Witness Service specifically). Magistrates sitting in these courts are fully aware of the approach and have received additional training in domestic abuse.

The specialist status represents a co-ordinated community response where agencies work together to identify, track, risk assess and support victims of domestic abuse and share information so that justice can be delivered.

It can be very hard for victims of domestic abuse to use the court systems when they fear reprisals from a perpetrator. Vulnerable and intimidated witnesses require special care and attention from the CPS, and this may require an application for special measures to enable them to give their evidence in the best way possible.

Special measures can include one or more of the following:

- Using screens in the courtroom so the witness can't see, or be seen by, the defendant
- Giving evidence by live video link from a separate room in the court building
- Using video evidence in cross examination
- Using an intermediary for questioning
- Communication aids

'Witness Service were nice, they phoned me and encouraged me to come to the court. They showed me around the court first as I'd never been inside a court before. They said I could have a screen, then he came and pled guilty and I didn't have to testify'.
Survivor Consultation 2010

Integrated Offender Management (IOM)

This is a multi agency approach to tackling known repeat offenders including those who perpetrate domestic abuse. The IOM structure being piloted in Manchester for domestic abuse assess all cases referred to MARAC or chronic repeat cases for offender targeting according to the risk they pose to victims.

Offender targeting uses adapted existing offender management systems to risk assess Domestic Abuse offenders. Where appropriate, Neighbourhood Police Teams are tasked to carry out interventions in relation to the offenders that live in their communities. This may include visits to the offender or victim, gathering intelligence about the offender for example what vehicle he or she is using or targeting them for other offences as a means of disruption.
It is early days but the feedback is positive and it is a structured way to manage the volume of offenders.

Probation services - Victim Liaison, MAPPA and IDAP

In all cases where an offender has been sentenced to 12 months prison or more for a sexual or violent offence, the victim(s) will be offered contact by the probation service victim liaison officer (VLO).

The **VLO** will keep the victim informed of any significant events in the sentence and help them ensure that their views are taken into account when planning for the offender's release. This might, for example, include additional conditions in the post-release licence to stop the offender contacting the victim or to exclude the offender from the area where the victim lives.

MAPPA stands for Multi-Agency Public Protection Arrangements. It is the process through which the Police, Probation and Prison Services work together with other agencies to manage the risks posed by violent and sexual offenders living in the community in order to protect the public.

There are three categories of violent and sexual offenders who are managed through MAPPA:
1. Registered sexual offenders are required to notify the police of their name, address and personal details, under the terms of the Sexual Offences Act 2003. The length of time an offender is required to register with police can be any period between 12 months to life, depending on the age of the offender, the age of the victim and the nature of the offence and sentence they received.
2. Violent offenders who have been sentenced to 12 months or more in custody or to detention in hospital and who are now living in the community subject to probation supervision. This Category also includes a small number of people who have been disqualified from working with children.
3. Other dangerous offenders, who have committed an offence in the past and who are considered to pose a risk of serious harm to the public.
All MAPPA offenders are assessed to establish the level of risk of harm they pose to the public. Risk management plans are then worked out for each offender to manage those risks. MAPPA allows agencies to assess and manage offenders on a multi-agency basis by working together, sharing information and meeting, as necessary, to ensure that effective plans are put in place.

The Integrated Domestic abuse Programme (IDAP) is a Probation intervention designed to reduce the risk posed by adult male domestic abuse perpetrators to their partners/ex partners and children. It is currently only available to those male offenders who have been convicted of a domestic abuse related offence and have been sentenced in a Criminal Court.

IDAP is an accredited programme, as are all of the programmes used by probation areas across England and Wales. In order to attain accreditation, a programme must be evidence based and proven to work. To this end, IDAP comprises of a number of key elements which research indicates is proven to reduce re-offending.

IDAP is a cognitive behavioural, community based programme involving an integrated approach. It includes a group work element of nine modules, each of which consists of three sessions, and entails detailed work on factors which are directly linked to the perpetration of domestic abuse.

Its aim is to provide a co-ordinated community based response to domestic abuse and a significant evaluation of domestic abuse programmes (Gondolf 2002) identified that the success of a programme appears to be related to the intervention system as a whole.

The integrated approach is therefore a crucial feature of IDAP. As part of the integrated approach, GMPT works in conjunction with other agencies including the Police, Local Authority Children's services and Women's Safety Services in order to protect victims and manage risk.

The overall aim of IDAP is to promote the safety of women and children and to reduce re-offending. Group programme outcomes are for offenders to:

- Take responsibility for their use of violent and abusive behaviour in their relationships.
- Identify the beliefs and intents which underpin their abusive and violent behaviour
- Acknowledge the effects of their use of abusive and violent behaviour on their partners /ex partners, children, others and themselves.
- Take specific positive steps to change their behaviour in relationships using non controlling behaviour strategies learned on the programme.

Research into the effectiveness of IDAP is ongoing, however Scottish Office research undertaken regarding the effectiveness of domestic abuse programmes like IDAP demonstrated that only 33 per cent of men who completed such a programme went on to commit another violent act during the 12 month follow up period.

This is in stark contrast to perpetrators who had been sentenced in other ways where 75 per cent went on to commit a further violent act in the same follow up period.

Partners of men in the programmes reported significant reductions in the coercive and controlling behaviours. Crucially, the biggest piece of research of such programmes; a long term comparative study of four programmes found that at the 48 month follow up period, 85 per cent of women felt safer.

In summary, the research indicates that for some men, participation in a programme such as IDAP does reduce the likelihood of perpetrating further abuse/violence and also reduces the severity and frequency of the abuse/violence.

Although not all men will end their abuse, perpetrator programmes can reduce risk.

For more information visit **www.probation.homeoffice.gov.uk**

Joint working

There are of course many other services in both the statutory and voluntary sector who provide an invaluable service to survivors, children and perpetrators of domestic abuse in Manchester.

Whilst this strategy does not name them all individually the ethos of this strategy is one of a coordinated community response which recognises the importance of working together as men and women to raise awareness and provide early intervention.

'The police, Saheli Refuge, (No Recourse to Public Funds Team/Women's Aid Worker) I am happy with them, they have helped me live again'.
Survivor Consultation 2010

Equalities and Diversity

The DAMG aims to ensure that equality and diversity are the principles running through every aspect of the work that we do. We currently collect equalities data and encourage agencies to gather further information to show a complete picture of need and service uptake.

We work closely with a number of specialist groups who support our diverse communities and ensure that service users are listened to within survivor consultations.

Every effort is made to ensure that service provision is monitored and assessed so that every community, group or individual is able to access and be positively impacted by services regardless of race, disability, gender, sexuality, age, religion or belief.

This is an important factor within each stage of the commissioning cycle.

Conclusion

The aims of this strategy are fundamental to ensuring a quality service is delivered in Manchester. The Domestic Abuse Management Group will ensure the annual delivery plans reflect our corporate aims and our progress will be reported to the Crime and Disorder Reduction Partnership Performance Board, Manchester Safeguarding Children and Adult Boards and the Local Criminal Justice Board.


Manchester Domestic Abuse Strategy
Newsletter
Issue: 11
Date: Dec 2010

Manchester launches its 2nd domestic abuse strategy during the 16 days of action against gender violence

On the 29th November 2010 a domestic abuse conference will be held at Manchester Town Hall to launch Manchester's domestic abuse strategy and focus on evidence for effective interventions in healthcare. The conference is now fully booked but further information will be posted on endthefear.co.uk to keep you updated. Presentations will include:

• The final evaluation of the PATHway domestic abuse project in maternity services at St Mary's, Central Manchester NHS Foundation Trust.

• Domestic Abuse Response in A& E (winner of Nursing Times Award 2010), Salford Royal NHS Foundation Trust Hospital

• IRIS (Identification and Referral to Improve Safety) Project evaluation of specialist domestic violence advocate educators working in GP Surgeries in Hackney and Bristol

• Manchester's new Strategy to prevent and respond to domestic abuse

Manchester Multi Agency Domestic Abuse Strategy
2010-2014

The new strategy examines the achievements which have been made since the last strategy was launched in 2007 and sets out what we hope to achieve in Manchester over the next few years. The objectives of the strategy are based on survivor consultation and the main themes, which came across. To read more about the strategy visit www.endthefear.co.uk.

December 2010 Newsletter

Our progress is regularly reported in our newsletters which can be found on the **endthefear.co.uk** website.

Manchester has made numerous achievements since the publication of the last strategy.

Using an established commissioning cycle we have identified where change most needs to happen and will dedicate our resource both monetary and personnel to justice, support and equity within our collective services.

Maureen Noble

Maureen Noble
Chair of the multi agency Domestic Abuse Management Group and Head of the Crime and Disorder Reduction Partnership.

Glossary

BME Black and Minority Ethnic Persons or Groups

CAADA Co-ordinated Action Against Domestic Abuse

CDRP Crime and Disorder Reduction Partnership

CPS Crown Prosecution Service

DAMG Domestic Abuse Management Group

DAWES Project Domestic Abuse: Women's Employment Support

ESOL English for Speakers of Other Languages

FMPO Forced Marriage Protection Order

GMAC Greater Manchester Against Crime

GMPERAS Greater Manchester Pay and Employment Rights Advice Service

GMP Greater Manchester Police

GMPT Greater Manchester Probation Trust

Hosla (Outreach Service) An Urdu word meaning to support or empower

IDVA Independent Domestic Violence Advisor

IDAP Integrated Domestic Abuse Programme

IOM Integrated Offender Management

LCJB Local Criminal Justice Board

LCJG Local Criminal Justice Group

MCC Manchester City Council

Manchester Partnership Manchester's Local Strategic Partnership

MRC Manchester Rape Crisis

MSCB Manchester Safeguarding Children Board

MSAB Manchester Safeguarding Adults Board

MWA Manchester Women's Aid

MAPPA Multi Agency Public Protection Arrangements

MARAC Multi Agency Risk Assessment Conference

PATHway Project Positive Action Through Health

PPIU Public Protection Investigation Unit

Saheli (Refuge) An Urdu word meaning Friend

SARC Sexual Assault Referral Centre

SDVC Specialist Domestic Violence Court

Appendix 1
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Appendix 2

Minimum standards for responding to domestic abuse

The following standards are the minimum requirement for any statutory or voluntary agency coming into contact with those affected by domestic abuse.

Objective 1
Communication

We will communicate to our service users Manchester's one message – Domestic Abuse will not be tolerated.

Standard 1
We will work with partner agencies in the statutory and voluntary sector to ensure that domestic abuse is tackled by Manchester's multi agency strategy.

Standard 2
Domestic abuse posters will be displayed in all public areas and materials will be available in community languages and accessible formats.

Standard 3
We will promote and utilise the media around positive messages of local support for domestic abuse when possible.

Standard 4
Our key strategies will recognise domestic abuse as a priority for Manchester.

Standard 5
We will nominate a specific person within our organisation (agency or directorate) with lead responsibility for domestic abuse.

Standard 6
We will communicate developments in the multi agency domestic abuse work to staff in our agency and have further information on domestic abuse on our website or links to **endthefear.co.uk**.

Objective 2
Prevention

We will work with partner agencies to change attitudes and prevent abuse

Standard 7
We will support awareness raising of domestic abuse in children and young people either through directly working in schools or through confirming our support to agencies for whom this is their responsibility.

Standard 8
We will ensure relevant staff receive appropriate domestic abuse training and guidance.

Standard 9
We will provide a specific personnel policy on domestic abuse in the work place for staff. This would encompass clear guidance both for staff experiencing domestic abuse and those who may be perpetrating domestic abuse.

Standard 10
We will collate and share data on domestic abuse, under agreed standardised criteria, with our partner agencies.

Standard 11
We will ensure information is treated confidentially whilst protecting those who are at risk of harm through appropriately sharing information with relevant agencies.

Standard 12
We will encourage third party reporting of domestic abuse to increase safety in the workplace and the community.

Objective 3
Provision

We will work collectively with other agencies to help those affected by domestic abuse to continue their lives

Standard 13
We will base our responses to domestic abuse on the guidance given in the MSCB and MSAB protocol.*

Standard 14
We will provide timely support and help for those affected by domestic abuse, having particular regard for those identified as high risk.

Standard 15
We will work to enable a coordinated response to public needs from prevention and education to crisis and support.

Objective 4
Protection

We will support the criminal justice system to provide an effective response to domestic abuse

Standard 13
Where relevant legislation or agreed policies are in place, we will share information as required to tackle and prevent further crime and disorder and to uphold human rights.

Standard 14
We will refer to Manchester's Multi Agency Risk Assessment Conference when we are working with very high risk cases of domestic abuse.

*Some partner agencies including GMP, CPS, Courts and Probation have policies and procedures for dealing with domestic abuse which support the principles of the MSCB and MSAB protocol but also support the responses of the criminal justice system in further detail.

Domestic Abuse Management Group Assessment Framework **LEVEL ONE**				Self Assessment
Level 1 Objective 1: Ensure Domestic Abuse Is Communicated As A Key Manchester Priority				
a.	A multi agency strategy to tackle domestic abuse has been developed in partnership with other agencies.			
b.	Local Authority supports and facilitates a local multi agency domestic violence forum which meets at least 4 times a year.			
c.	Evidence of service user/survivor consultation.			
d.	**Domestic violence included in at least five of the following:** ■ Local Area Agreement ■ Equality Action Plan ■ Homelessness Reduction Strategy ■ Education Development Plan ■ Anti-bullying Strategy ■ Crime and Disorder Reduction Strategy ■ Drug and Alcohol Strategy ■ Local Policing Plan ■ The Annual Drug Treatment Plan ■ Supporting People Commissioning and Strategy ■ Prostitution Strategy ■ Local Criminal Justice Plan	■ NHS Manchester Operating Plan ■ Think Family Strategy ■ Youth Crime Strategy ■ 1 Team Strategy ■ Strategic Threat Assessment ■ GMPT Business Probation Annual Delivery Plan ■ Manchester Attendance Strategy ■ Children and Young People's Plan ■ Primary Care Trust Local Development Plan ■ Child and Adolescent Mental Health Strategy ■ Teenage Pregnancy Strategy ■ The Healthy Schools Programme Plan ■ Sure Start Strategy	■ Neighbourhood Strategy ■ Manchester Safeguarding Adults Board Business Plan ■ Manchester Safeguarding Children Board Business Plan ■ Manchester Alcohol Strategy ■ Equality Standard for Local Government ■ Community Strategy ■ State of the City ■ NHS Commissioning Strategic Plan 09-14 ■ CDRP Communications Strategy ■ Independent Choices Business Plan ■ Anti Social Behaviour Strategy ■ Community Cohesion Strategy ■ Emotional Health and Well Being Strategy	
e.	A named individual with responsibility for domestic violence in at least 4 local statutory agencies/local authority directorates.			
f.	An elected local Councillor has specific responsibility for domestic violence.			
g.	Formal links existing between the Domestic Violence Forum, the Safeguarding Children Board and Safeguarding Adults Board.			
h.	A full time domestic abuse coordinator is employed for the City.			
i.	There is a commissioning strategy for domestic abuse services.			
j.	Publicity materials are displayed to promote sources of help and advice.			
Level 1 Objective 2: Prevention - Awareness, Safeguarding, Education, Early Intervention, Training				
a.	A directory of services is available for survivors of domestic abuse on endthefear.co.uk.			
b.	Domestic abuse training is available to all professionals in Manchester.			
c.	There is a domestic abuse education pack available for primary, secondary schools and other young people's settings.			
d.	Inter-agency data collection systems in place involving at least ten agencies.			
e.	Safe enquiry in place in maternity services.			
f.	The local refuge services provide children's workers.			
Level 1 Objective 3: Provision - Services, Advice, Support				
g.	Independent advocacy service in place (Independent Domestic Violence Advisors).			
h.	At least one refuge space available per 10,000 population.			
i.	A Sanctuary Scheme (offering extra security measures within properties) operates in the local area.			
j.	Local temporary accommodation hostels have a specific domestic violence policy in place.			
k.	Domestic abuse guidance is available for staff to follow.			
Level 1 Objective 4: Protection - Delivering An Effective Criminal Justice System, Victim Support, Perpetrator Programmes				
l.	GMP sanction detection rates (defined as charge, summons, (conditional) caution, reprimand, TIC, Penalty Notice for disorder etc) 45% with an agreed referral process for victims to domestic abuse support agencies.			
m.	A Multi Agency Risk Assessment Conference (MARAC) operates in each police division to coordinate the response of key agencies to very high risk victims of domestic abuse.			
w.	A Specialist Domestic Violence Court operates in the City.			
x.	Statutory Perpetrator Programme in place (IDAP) in place with a women's safety service.			
y.	Perpetrators with additional needs are referred into mental health & substance misuse services. The Respect Phone number is publicised.			

Assumes completion of level 1 in addition to the following: **LEVEL TWO**				Self Assessment
Level 2 Objective 1: Ensure Domestic Abuse Is Communicated As A Key Manchester Priority				
a.	Domestic Abuse is integrated into the commissioning strategies of DAMG agencies.			
b.	Evidence of survivor influence shaping local strategies and priorities.			
c.	**Domestic violence included in at the last seven of the following:** ■ Local Area Agreement ■ Equality Action Plan ■ Homelessness Reduction Strategy ■ Education Development Plan ■ Anti-bullying Strategy ■ Crime and Disorder Reduction Strategy ■ Drug and Alcohol Strategy ■ Local Policing Plan ■ The Annual Drug Treatment Plan ■ Supporting People Commissionin and Strategy ■ Prostitution Strategy ■ Local Criminal Justice Plan	■ NHS Manchester Operating Plan ■ Think Family Strategy ■ Youth Crime Strategy ■ 1 Team Strategy ■ Strategic Threat Assessment ■ GMPT Business Probation Annual Delivery Plan ■ Manchester Attendance Strategy ■ Children and Young People's Plan ■ Primary Care Trust Local Development Plan ■ Child and Adolescent Mental Health Strategy ■ Teenage Pregnancy Strategy ■ The Healthy Schools Programme Plan ■ Sure Start Strategy	■ Neighbourhood Strategy ■ Manchester Safeguarding Adults Board Business Plan ■ Manchester Safeguarding Children Board Business Plan ■ Manchester Alcohol Strategy ■ Equality Standard for Local Government ■ Community Strategy ■ State of the City ■ NHS Commissioning Strategic Plan 09-14 ■ CDRP Communications Strategy ■ Independent Choices Business Plan ■ Anti Social Behaviour Strategy ■ Community Cohesion Strategy ■ Emotional Health and Well Being Strategy	
d.	Evidence of a multi agency domestic abuse publicity campaign.			
e.	A named individual with responsibility for domestic violence in at least six local statutory agencies/local authority directorates.			
Level 2 Objective 2: Prevention - Awareness, Safeguarding, Education, Early Intervention, Training				
f.	Domestic abuse training is mandatory for all front line statutory services working with survivors of domestic abuse including Social Workers, Police, Health Visitors, Mental Health workers and Drug and Alcohol teams.			
g.	Domestic violence training has taken place in at least 50% of Manchester schools.			
h.	Interagency data collection involving at least 20 agencies.			
i.	Safe enquiry about domestic abuse is used by children's social work and health visiting services.			
j.	Community-based services for children exposed to domestic violence are available as part of a strategy agreed by MSCB and DAMG.			
Level 2 Objective 3: Provision – Services, Advice, Support				
k.	Independent advocacy service in place (IDVA) consisting of at least 9 IDVAs.			
l.	At least one refuge bed-space fully accessible to a woman with mobility or sensory impairment.			
m.	Sanctuary scheme operated by local authority and at least three registered social landlords.			
n.	A specific domestic violence policy in at least three local housing associations/housing support providers.			
o.	Evidence of cross-sector work between domestic violence and substance abuse services or domestic violence and mental health services with agreed protocols for joint working where appropriate.			
p.	Inter-agency information-sharing protocol in place.			
q.	A contact centre offering supervised handover.			
r.	Health, Housing and Police sign post women with immigration difficulties to the No Recourse to Public Funds Team, Law Centres and Domestic Abuse services.			
s.	Registered Social Landlord's tenancy agreements have a specific clause stating that perpetration of domestic abuse by a tenant can be considered grounds for eviction.			
Level 2 Objective 4: Protection – Delivering An Effective Criminal Justice System, Victim Support, Perpetrator Programmes				
t.	GMP sanction detection rates 50% with DVECs at key times of year when reported incidents increase (e.g sporting events and Christmas) and an agreed referral process for victims to domestic abuse support agencies.			
u.	A quality assured MARAC is in place.			
v.	SDVC ineffective trials are no more than 18% and unsuccessful outcomes are below 26%.			
w.	Referral is available to an accredited voluntary perpetrator scheme (or a scheme going through accreditation) for perpetrators who are not being managed by the CJS.			

Assumes completion of levels 1 and 2 in addition to the following: **LEVEL THREE**				Self Assessment
Level 3 Objective 1: Ensure Domestic Abuse Is Communicated As A Key Manchester Priority				
a.	Evidence of joint commissioning is in place for domestic abuse.			
b.	A sustainable, resourced and high profile publicity campaign strategy is developed.			
c.	Evidence of ongoing survivor involvement with the Domestic Abuse Management Group.			
d.	**Domestic violence included in at least nine of the following:** ■ Local Area Agreement ■ Equality Action Plan ■ Homelessness Reduction Strategy ■ Education Development Plan ■ Anti-bullying Strategy ■ Crime and Disorder Reduction Strategy ■ Drug and Alcohol Strategy ■ Local Policing Plan ■ The Annual Drug Treatment Plan ■ Supporting People Commissioning and Strategy ■ Prostitution Strategy ■ Local Criminal Justice Plan	■ NHS Manchester Operating Plan ■ Think Family Strategy ■ Youth Crime Strategy ■ 1 Team Strategy ■ Strategic Threat Assessment ■ GMPT Business Probation Annual Delivery Plan ■ Manchester Attendance Strategy ■ Children and Young People's Plan ■ Primary Care Trust Local Development Plan ■ Child and Adolescent Mental Health Strategy ■ Teenage Pregnancy Strategy ■ The Healthy Schools Programme Plan ■ Sure Start Strategy	■ Neighbourhood Strategy ■ Manchester Safeguarding Adults Board Business Plan ■ Manchester Safeguarding Children Board Business Plan ■ Manchester Alcohol Strategy ■ Equality Standard for Local Government ■ Community Strategy ■ State of the City ■ NHS Commissioning Strategic Plan 09-14 ■ CDRP Communications Strategy ■ Independent Choices Business Plan ■ Anti Social Behaviour Strategy ■ Community Cohesion Strategy ■ Emotional Health and Well Being Strategy	
e.	A named individual with responsibility for domestic violence in at least eight local statutory agencies/local authority directorates.			
Level 3 Objective 2: Prevention - Awareness, Safeguarding, Education, Early Intervention, Training				
f.	Domestic abuse is included within the course content of mandatory induction training and is mandatory training for all professionals in the statutory sector working with survivors of domestic abuse.			
g.	Domestic violence training has taken place in at least 90% of Manchester schools.			
h.	Inter agency data collection and reporting systems in place using a unique identifier system to further identify the scale of domestic abuse in Manchester.			
i.	Safe enquiry is established in all statutory agencies who complete holistic assessments on women.			
j.	Community-based services for children exposed to domestic violence with a maximum waiting list of 11 weeks.			
Level 3 Objective 3: Provision – Services, Advice, Support				
k.	Evidence that all domestic abuse services are accessible to women with learning or physical disabilities.			
l.	Sanctuary scheme operated by local authority and at least 6 registered social landlords.			
m.	All agencies represented on Domestic Abuse Management Group have a domestic violence personnel policy.			
n.	A contact centre offers high vigilance contact services.			
o.	A Snapshot Project operating in domestic abuse specialist agencies and all A&E Departments.			
p.	Evidence of cross-sector work between domestic violence and substance abuse services and domestic violence and mental health services.			
q.	Local one contact point system:- including a domestic abuse helpline (phone, email, multi -media) that can provide early intervention to crisis and specialist information to Manchester's public. One website for information and promotion of services and message- www.endthefear.co.uk.			
Level 3 Objective 4: Protection – Delivering An Effective Criminal Justice System, Victim Support, Perpetrator Programmes				
r.	Levels 1 and 2 with sanction detection rates at 55% and evidence of positive victim evaluation of GMP's service.			
s.	SDVC shows unsuccessful outcomes below 24%, ineffective trials are no more than 16.5% (or the LCJB standard) and positive evaluation from victims.			
t.	Formal referral routes in place for perpetrators to programmes meeting Respect minimum standards.			
u.	An agreed protocol is in place for domestic violence homicide reviews.			
v.	A regular system of quality assuring MARAC is in place including victim feedback, case review through audit and use of the Paloma system.			

Appendix 4

Legislation which underpins our strategy

The Human Rights Act 1998 This duty requires that the state has in place measures to secure to the individual:

- The right to life.
- The prohibition against inhuman and degrading treatment and torture.
- The right to security of the person.
- The right to private, family and home life.
- This includes a duty to have adequate laws in place to punish those who violate the right to life of others, or who inflict on others inhuman or degrading treatment.

The Crime And Disorder Act 1998

The Crime and Disorder Act 1998 promotes the practice of partnership working to reduce crime and disorder and places a statutory duty on police and local authorities to develop and implement a strategy to tackle problems in their area. In doing so, the responsible authorities are required to work in partnership with a range of other local public, private, community and voluntary groups and with the community itself. This is pertinent to this strategy as it gives a legal foundation for effective information sharing in order to protect and prosecute within domestic abuse.

Domestic Violence Crime and Victims Act 2004

This is an Act to amend Part 4 of the Family Law Act 1996, the Protection from Harassment Act 1997 and the Protection from Harassment (Northern Ireland) Order 1997.

The Act addresses proposals set out in Safety and Justice, the Government Consultation Paper on domestic violence and includes:

- Amendment to non molestation orders to include a criminal sanction for non-compliance which can carry a prison sentence of up to five years.
- Allows same-sex couples and cohabiting couples to apply for non-molestation orders.
- Introduces statutory multi-agency domestic homicide reviews when anyone over 16 years dies of violence, abuse or neglect from a relative, intimate partner or member of the same household. The aim is for services to learn from what happened and ascertain if the death could have been prevented and then review and improve services accordingly.

Allows courts to impose restraining orders on acquitted defendants.

- Expands the circumstances in which trials can be heard without a jury.
- Creates an offence of "causing or allowing the death of a child or vulnerable adult".

Children Act 1989

A major piece of legislation which consolidated all existing law relating to the safety, welfare and planning for children. The Act introduced the concept of parental responsibility. It established the legal framework for all applications that can be made by parents, family and others such as residence, special guardianship and contact orders and applications by local authorities including emergency protection orders, care and supervision orders. The Act contains the local authority's powers and duties in relation to children and young people regarding the provision of services and support and safeguarding.

It identifies significant harm as the threshold that justifies compulsory intervention in family life in the best interests of children, and gives local authorities a duty to make enquiries to decide whether they should take action to safeguard or promote the welfare of a child who is suffering, or likely to suffer significant harm. Significant harm may arise within domestic abuse due to neglect (the persistent failure to meet a child's basic physical and /or psychological needs), physical, emotional or sexual abuse.

Adoption and Children Act 2002

From 31 January 2005, Section 120 of the Adoption and Children Act 2002 came into force, which extends the legal definition of significant harm to include harm suffered by seeing or hearing ill treatment of others, especially in cases of domestic abuse.

The Children Act 2004

The Children Act 2004 provides the legal underpinning for Every Child Matters: Change for Children. It aims to ensure that every child can achieve the 5 key outcomes which are: Be Healthy, Stay Safe, Enjoy and Achieve, Make A Positive Contribution and Achieve Economic Well Being.

Section 11 of the 2004 Act puts a general duty on statutory partners to promote and safeguard the welfare of children and section 10 requires them to cooperate to improve the wellbeing of children.

Forced Marriage (civil protection) Act 2007

The Forced Marriage (Civil Protection) Act 2007 contains civil measures to enable a person (who may be an adult or a child) who is being forced into marriage or has been forced into marriage or a relevant third party to apply to the court for a Forced Marriage Protection Order.

The court can order the behaviour or conduct of those forcing another person into marriage to change or to stop, or impose particular requirements on them.

Appendix 5

Useful contacts

In an emergency phone 999

General police switchboard
0161 865 5050

Women's 24 hour domestic violence Helpline
0808 2000 247
www.womensaid.org.uk
(links to domestic abuse information in 12 languages).

Manchester Women's Domestic Abuse Helpline
t. 0161 636 7525
has a part time Community Helpline Language Service for Urdu & Punjab speakers.
Non urgent email advice service helpline@independentchoices.org.uk provides emotional and practical support, discussing options and safety planning, signposting to other agencies and referral to refuge accommodation. Offers advice and support to agencies around issues of domestic abuse.

MALE Men's Advice Line and Enquiries 0808 801 0327
www.mensadviceline.org.uk

For website information for both professionals and survivors of domestic abuse visit
www.endthefear.co.uk

Broken Rainbow
t. 0300 999 5428
For lesbian, gay, bisexual and transgender survivors of domestic abuse.
www.broken-rainbow.org.uk

Citizen's Advice Bureau
t. 08444 111 222
Offers free, confidential, impartial and independent advice and information on a wide range of subjects.
www.manchestercab.org

ChildLine
t. 0800 1111
Free helpline for children and young people providing counselling, advice and support.
www.childline.org.uk

Contact Centre for social care
t. 0161 255 8250
If you are concerned about the safety or the well being of a child or vulnerable adult.

42nd Street
t. 0161 832 0170
Young people age 14-25 under stress.
www.fortysecondstreet.org.uk

DAWES project
t. 0161 839 3236
Domestic Abuse Women's Employment Support.
www.dawesproject.org.uk
contact@dawesproject.org.uk

Dog's Trust
t. 0207 837 0066
Can help place dogs when survivor goes into a refuge.
www.dogstrust.org.uk

Greater Manchester Fire and Rescue Service
t. 0800 555 815
Offer free fire home safety check (smoke alarms and fire escape plans)
www.manchesterfire.gov.uk

Paws for Kids
t. 01204 394 842
Pet fostering service for women moving into northwest refuges.
www.pawsforkids.org.uk

Homeless Services
t. 0161 234 4847 (9am-4pm)
t. 0161 255 8250 (out of hours)
Emergency accommodation for families, single women and single men.

Hosla Asian Women's Outreach Project
t. 0161 636 7560/7500
Run by Asian Women for Asian women who have or are experiencing domestic abuse

Independent Domestic Violence Advisors (IDVAs)
t. 0161 234 5393
Provide domestic abuse support for high risk survivors.

Multikulti website
t. 020 7247 7226
Information on emergency housing and legal rights for survivors of domestic abuse in many languages.
www.multikulti.org.uk/en/housing/domestic-violence/

NSPCC
t. 0800 800500
Free confidential service for anyone concerned about children at risk.
www.nspcc.org.uk

Police PPIU
(also known as)
Domestic Violence Unit
t. 0161 856 3703 North
t. 0161 856 3541 Central
t. 0161 856 6187 South
www.gmp.police.uk

Rape Crisis
t. 0161 273 4500
Information and support for women and girls who have experienced sexual violence.
www.manchesterrapecrisis.co.uk

Respect
t. 0845 122 8609
Information for perpetrators or for those working with perpetrators in the UK.
www.respect.uk.net
info@respect.uk.net

Safety 4 Sisters Northwest
t. 0161 276 6515
Group working to improve services for women affected by abuse who have no access to public funds or state benefits.
safety4sisters@googlemail.com
St Mary's Sexual Assault Referral CentresOn-going treatment, advice, counselling and follow up specialist and forensically trained doctors and nurses. The service is for both women and men. They aim to provide a one-stop-shop service to survivors of rape.
Open 24 hours.
www.stmaryscentre.org

Saheli Asian Women's Refuge
t. 0161 945 4187

Sanctuary scheme
t. 0161 234 5393
If a survivor is no longer in a relationship with the perpetrator but feels unsafe in their home security measures can be provided for free where funding is available. Contact IDVA Team.

Samaritans
t. 08457 909090
24 hour confidential emotional support for people who are experiencing feelings of distress or despair, including those which may lead to suicide.
www.samaritans.org.uk
jo@samaritans.org

Survivors UK
t. 0845 1221201 (7-10pm)
Help men who have experienced any form of sexual violence.
info@survivorsuk.org.uk
www.survivorsuk.org

Victim Support
t. 0845 456 8800
Provides free and confidential support including information on police and court processes and information about compensation.
www.victimsupport.org.uk

Manchester Women's Aid
t. 0161 660 7999
Provide outreach worker support, refuge accommodation and advice.
www.womensaid.org.uk

Women's Domestic Abuse Helpline (Independant Choices)
t. 0161 636 7525
Telephone advice and support.
www.wdachoices.org.uk
Non-urgent Email for Domestic Abuse Advice:
helpline@independent choices.org.uk

MANCHESTER CRIME AND DISORDER REDUCTION PARTNERSHIP

DOMESTIC ABUSE MANAGEMENT GROUP

DELIVERY PLAN 2010-2011

MANCHESTER DAMG STATEMENT OF COMMITMENT AND INTENT

The Manchester Crime and Disorder Reduction Partnership defines domestic abuse as any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between people who are or have been intimate partners or family members, regardless of gender. This definition goes beyond abuse that occurs between intimate partners, thus allowing a wider range of issues, such as forced marriages, to be addressed within this context.

Domestic abuse threatens the health and safety of victims and their children, costs the city approximately £40.6 million each year and is affecting the city's economic growth and regeneration plans. Manchester has a zero tolerance attitude to all forms of domestic abuse. Multi-agency work at a strategic and operational level has a duty to prioritise support for victims and their children as well as tackle the behaviour of perpetrators.

The DAMG aims:

To ensure domestic abuse is a strategic priority for all.
To improve early identification and prevention of domestic abuse.
To reduce the prevalence of domestic abuse.
To ensure that victims of domestic abuse and their children are adequately protected and supported
To hold perpetrators of domestic abuse accountable and increase the rate of domestic abuse offences that are brought to justice.
To ensure that victims and perpetrators receive quality services which meet the needs of Manchester's diverse communities.

The following is the 2010/2011 delivery plan for Manchester's Domestic Abuse Strategy.

Objective 1:
To ensure domestic abuse is communicated as a key Manchester priority.

PRIORITY	ACTIONS	OUTCOME MEASURE	TIMESCALE	PERSON RESPONSIBLE	LINKS TO KEY STRATEGIES/BOARDS
1. Communicate Manchester's one message – Domestic Abuse will not be tolerated. (VAWG p.8 and HQN recommendation 1 and 59)	Map key partner action plans and key reporting boards and groups. Ensure domestic abuse delivery plan is on key partnership agendas for senior strategic prioritisation.	Domestic abuse is recognised as a priority at a senior and strategic level across all agencies. Key multi-agency strategic action plans reflecting the principles of Manchester's domestic abuse strategy	March 2011	Crime and Disorder Team MCC	Manchester's LAA NHS Manchester operating plan Community Strategy State of the city Performance Board NHS Commissioning Strategic Plan 09-14
	Work with other Greater Manchester leads to create a Greater Manchester Wide publicity campaign. Refresh Manchester's Domestic Abuse strategy.	12 Greater Manchester Boroughs working together and contributing towards a joined up publicity campaign. Increase of 5% in calls to Manchester Women's domestic abuse helpline. Event held to launch refreshed strategy. Launch event covered in Manchester's Media.	March 2011 with an interim report September 2010. September 2010	Independent Choices Domestic Abuse Coordinator	CDRP -Communications strategy Independent choices business plan CDRP – Comunications strategy.

Objective 2:
Prevention- changing attitudes and preventing abuse: Awareness raising campaigns, safeguarding and educating children and young people, early identification/intervention and training

PRIORITY	ACTIONS	OUTCOME MEASURE	TIMESCALE	PERSON RESPONSIBLE	LINKS TO KEY STRATEGIES/BOARDS
2.Development of a specific children's strategy for domestic abuse in reflection of the children and young people's plan which integrates preventative work (education in schools) and supportive work (children's workers) within a Think Family format. (VAWG p.26-28 and HQN recommendation 26, 28, 29, 30)	Task and finish group to: • Review the strategic government structure which oversees domestic abuse and children and young people • Draw up a comprehensive strategy for supporting children affected by domestic abuse in Manchester. Include: i) A tiered model of intervention for children affected by domestic abuse. ii) Priority 10 of this plan – voluntary perpetrator programmes. iii) The evidence base and referral pathway for specialised D.A. children's workers within the wider context of services for children and young people in Manchester.	Report circulated to DAMG and MSCB drawing on examples of national good practice and a range of options for service development. Report to Children's Board Rapid implementation of report findings	July 2010 August 2010 September 2010	Manchester Women's Aid Children's Services MCC MSCB Domestic Abuse Coordinator Greater Manchester Police	Manchester Safeguarding Children Board and Business Plan Think Family Strategy Youth Crime Strategy
	Increase number of high risk referrals to IDVA (Independent Domestic Violence Advisor)	Children's services (MCC) working in partnership with IDVAs as part of safeguarding process. Increase CS referrals to IDVA (Independent domestic violence advisor) by 25%.	March 2011	Children's Services MCC	
	Ensure front line practitioners employ an effective response to domestic abuse through the Common Assessment Framework (CAF) and 'Working together to	Review impact of CAF and the multi agency protocol through audit of multi agency files and outcomes of serious case reviews. Report to DAMG and MSCB.	December 2010	Children's Services MCC	

	safeguard children from Domestic Abuse' the multi agency MSCB protocol.				
	Task and finish group to ensure coordinated delivery of Domestic Abuse education materials to Manchester Schools.	Co-ordinator of domestic abuse education work nominated by Education. Teachers trained in Domestic Abuse and how to use the materials. Clear referral pathway in place. Report to DAMG which schools have delivered the DA pack and number of teachers trained. Domestic Abuse posters displayed in settings where there are children and young people.	June 2010 Sept 2010	Children's services MCC	
	Multi agency training on forced marriage to be arranged for key staff groups.	Those working with children including children missing from education team and school teachers trained in forced marriage and honour based violence. Report to DAMG on no. of staff trained and no. of referrals re forced marriage to IDVA (Independent Domestic Violence Advisor) and Women's Aid.	March 2011	Children's services MCC	
	Task and finish group to review serious case reviews and implement learning.	Action points from cases relating to domestic abuse and progress of implementation reported to DAMG and MSCB quarterly.	March 2011	Children's services MCC	

3. Promote domestic abuse training including mandatory training and safe (routine/selective) enquiry by key agencies/departments (VAWG consultation p.30 and 57 and HQN recommendation 6, 17, 55, 57, 58).	Ensure senior leads plan and resource training of frontline staff in domestic abuse. Work with senior leads with the view to prioritising domestic abuse as mandatory training within mandatory safeguarding training.	Key agencies in city to have domestic abuse training in place. Training included in self assessment chart of priority 4. Map of agencies offering mandatory and non mandatory safeguarding and domestic abuse training. Implementation of the multi-agency e-learning pack in 5 agencies/departments	September 2010 December 2010	Organisational Development MCC	Safeguarding adults board and multi agency business plan. MSCB business plan.
	Task and finish group to agree training standards across agencies.	Set of training standards agreed	December 2010	Organisational Development MCC	
	Task and finish group to consider pooling training budgets and resources	Opportunities and Challenges paper reported to DAMG	September 2010	Organisational Development MCC	
	Target 10 GPs in wards with highest numbers of domestic abuse call outs to GMP and offer training. Embed domestic abuse within GP registrar training.	10 G.P surgeries providing standard information for victims and engaged with domestic abuse support agencies and MARAC process. GP registrar course leaders identified and domestic abuse booked into training courses for 30 G.P registrars.	March 2011	NHS Manchester	
	Identify RSL training opportunities and promote to senior RSL leads.	50 RSL staff attending training in domestic abuse awareness.	September 2010	Crime and Disorder Team MCC	
4.Improve data recording by Manchester agencies (VAWG p.41 and HQN recommendation 7, 15, 24).	Agency data to be mapped and gaps in statistical knowledge identified. Data sharing protocol to be produced	Report to DAMG with recommendations for future development	September 2010	Domestic Abuse Coordinator GMP	1 Team Strategy Manchester Crime Reduction Strategy Strategic Threat Assessment

Objective 3: Provision- helping those affected by domestic abuse to continue their lives; Effective provision of services, advice and support, emergency and acute services, refuges and safe accommodation.

PRIORITY	ACTIONS	OUTCOME MEASURE	TIMESCALE	PERSON RESPONSIBLE	LINKS TO OTHER KEY STRATEGIES/BOARDS
5. Ensure a quality response and survivor focused service provision by Manchester agencies. (p.61-62 of VAWG strategy and HQN recommendation 5, 27)	All DAMG representatives to create a statement of minimum standards survivors of domestic abuse can expect from their agency.	All minimum standards circulated at DAMG meeting and placed on the endthefear website.	September 2010	Mental Health and Social Care Trust	ASB strategy Community cohesion strategy
	Task and finish group to create a self assessment chart for agencies to drive quality provision forwards.	Self assessment chart brought to DAMG and placed on the endthefear website.	December 2010	Mental Health and Social Care Trust	
	Develop multi agency domestic abuse principles	Adoption of the principles as part of the minimum standards. Principles endorsed to staff by multi agency leads. Copy of the principles available on endthefear website and individual agency websites.	December 2010	Mental Health and Social Care Trust Domestic Abuse Coordinator	Safeguarding adults board Safeguarding adults multi agency business plan
6. Ensure quality service provision is available to those at greater risk of being subjected to domestic abuse or at increased risk of serious injury and mortality(VAWG p.15 and HQN recommendation 23, 25,)	Develop pathway to increase referral from A&E to Domestic Abuse services and MARAC (link to priority 9).	Clear pathway between A&E, MARAC and Domestic Abuse services. 20 A&E referrals to domestic abuse agencies.	December 2010	Adult Social Care MCC Manchester Women's Aid NHS Manchester	

	Continue to monitor progress of PATHway project in St Mary's maternity hospital	Final evaluation report	December 2010	NHS Manchester	NHS commissioning strategic plan 09-14
	Establish a coordinated approach to supporting victims of domestic abuse who misuse drugs and alcohol.	Report presented to DAMG and Drug and Alcohol Action Board including information and recommendations about: Referral pathways. How public and professionals are informed about services. Training in both the domestic abuse and substance misuse sectors. Arrangements for routine enquiry within the substance misuse sector.	September 2010	Drug and Alcohol Strategy Team	Safeguarding Adults board and multi agency business plan The Alcohol strategy The annual drug treatment plan
	Quality assure and create a commissioning argument around mainstreaming IDVAs	IDVA service operating effectively in city	March 2011	Crime and Disorder Team MCC	
	Support survivor groups and report on specialist services for women with No Recourse to public funds or state benefits. Analysis of any gaps in service to be included in the report.	Women with No Recourse supported in City. Service information on End the Fear website	December 2010	Manchester Women's Aid Supporting People MCC	Supporting People commissioning and strategy 2010-2015
	Task and finish group to look at accessibility of services for older people and people with disabilities who experience domestic abuse	Report written outlining good practice points and areas for future improvement	March 2011	Mental Health and Social Care Trust Adult Social Care MCC Supporting People MCC	Safeguarding adults board and multi agency business plan Supporting People commissioning and strategy 2010-2015
7. Develop shared risk	Create a joint referral pathway for high	Proposal written outlining	December	Manchester	Independent Choices

assessments and a shared referral process within the DV and SV sector with a central referral point/24 hour service. (VAWG p.48 HQN recommendations 4, 21,33, 35, 39,51, 56)	risk cases to be referred to MARAC. Task and finish group (including Manchester Rape Crisis, Manchester Action on Street Health (MASH) and Victim Support representatives) to map the current referral pathways into support services and the work required to develop a central referral point/24 hour service.	costs, commitment and future options	2010	Women's Aid Adult Social Care MCC Independent Choices Sexual Assault Referral Centre Children's Services MCC Supporting People MCC Crime and Disorder Team MCC	Business Plan Prostitution strategy and Prostitution Forum Supporting People commissioning and strategy 2010-2015

Objective 4:
Protection-Delivering an effective criminal justice system: Investigation, prosecution ;victim support and protection; perpetrator programmes.

PRIORITY	ACTIONS	OUTCOME MEASURE	TIMESCALE	PERSON RESPONSIBLE	LINKS TO OTHER KEY STRATEGIES/ BOARDS
8. Monitor and improve the effectiveness of the criminal justice system including MAPPA, IDAP and the SDVC (HQN recommendation 10 and VAWG p.59-60)	Increase effectiveness of Specialist Domestic Violence Courts (SDVC) by increasing the cooperation and confidence of witnesses.	Increase % of special measures statements taken at first meeting with the victim by police officer. Report % increase in use of bail conditions to assure and protect victims Publicise SDVC to promote victim confidence in the process	September 2010	GMP HMCS	Local criminal justice plan and the LCJG delivery plan
	SDVC steering group to take action on any areas identified by the Domestic Abuse waterfall analysis where the SDVC is not performing well	SDVC data demonstrating improvements including % of discontinued domestic abuse trials post 1st hearing (currently 19% compared with 5.1% for all trials) reported to LCJG and DAMG. Report on improvements in domestic abuse offenders brought to justice to serious violent crime and serious sexual crime ratios.	September 2010	GMP HMCS	Local criminal justice plan and the LCJG delivery plan
	CPS to commission research into why witnesses fail to attend Court and develop an action plan with SDVC steering group and LCJG partners	Waterfall graph circulated to DAMG Action plan developed and implemented	September 2010	GMP CPS HMCS	Local criminal justice plan and the LCJG delivery plan

	Establish a project to increase the quality of photographic evidence of domestic abuse (Report to include both digital cameras and police body cameras).	10 Police & 10 Domestic Abuse Workers trained in collection of photographic evidence Cameras provided to trained staff Protocol agreed. Report to DAMG and LCJG	March 2011 September 2010	GMP CPS, Adult Social Care MCC, Manchester Women's Aid	Local criminal justice plan and the LCJG delivery plan
	Continue to operate police Domestic Violence Enforcement Campaign focusing on the 2010 world cup	Increase in number of police actions against perpetrators including increase in % of crimes detected & increase in number of victims spoken to by a specialist domestic violence officer.	September 2010 following World Cup and end of year March 2011.	GMP	The Policing Plan
	Outline the effectiveness of current statutory interventions with perpetrators including MAPPA, IDAP and prison based perpetrator programme – healthy lifestyles.	Report to DAMG covering: % of DV perpetrators who re offend whilst on MAPPA within a 1 year period. No of associated victims referred to IDVA/ Women's Aid/MARAC by the Probation victim unit. No of DV perpetrators assessed as unsuitable for IDAP and their sentencing outcomes. No of perpetrators successfully completing IDAP No of DV perpetrators not completing IDAP who are then sentenced to custody. No of prisoners who complete the healthy lifestyles programme.	December 2010	Greater Manchester Probation Trust.	GMPT Business Probation Annual Delivery Plan

	Explore the service needs of victims of domestic abuse who are partners/ex partners/family members of gang members who are monitored by MAPPA.	Report to DAMG including: % of MAPPA cases where there is ongoing domestic abuse by perpetrators. Current referral pathways of identified victims.	December 2010	Greater Manchester Probation Trust.	GMPT Business Probation Annual Delivery Plan
	Explore the effectiveness of interventions employed to manage DV perpetrators in the IOM cohort.	Report to DAMG including number of DV perpetrators within the IOM cohort and future recommendations.	March 2011	Greater Manchester Probation Trust.	GMPT Business Probation Annual Delivery Plan

9. Quality assure Manchester's MARAC (Multi Agency Risk Assessment Conference) (HQN recommendation 13 and VAWG p.9)	Manchester's MARAC to adopt the Paloma information technology system to ensure accountability of agencies and their actions.	Agencies to input action updates on paloma for audit by MARAC coordinator.	December 2010	MARAC Coordinator MCC	
	All 3 A&E departments to identify patients who have been referred to MARAC and share information.	Information received monthly from 3 A&Es and accessible on audit of paloma system.	March 2011	MARAC Coordinator MCC	
	Review MARAC to determine consistency of referral and procedure across the 3 divisions. Adapt the CAADA model to ensure that the volume of cases in Manchester are managed in the most effective way. Link MARAC into the Think Family Strategy.	Report on how the review will look Review finished and reported to DAMG	June 2010 March 2011	MARAC Coordinator MCC MARAC Coordinator MCC	Think Family Strategy

10. Develop a perpetrator programme including a child focused risk assessment service and a women's safety service (HQN recommendation 18 and 50, VAWG p.9,10,71 and 72)	Circulate to DAMG research evidence and previous feasibility study on VPPs Create final VPP proposal detailing: • The child focused risk assessment service • Which perpetrators we would target • Mechanisms of getting perpetrators onto a programme • What we would want from programme providers. • An overview of the service as a part of the coordinated community response model and integrated offender management.	Clear outline of programme and evidence base available for partners Perpetrator programme provider identified and programme created Funding committed.	June 2010 Service commissioned to provider October 2010.	Domestic Abuse Coordinator	Alcohol strategy Drug and alcohol strategy
	Establish a co-ordinated approach to tackling perpetrators who misuse drugs and alcohol.	Report to DAMG covering: An overview of the different services perpetrators who use drugs and alcohol may encounter. No of offenders with low alcohol/drug use being given a requirement by the SDVC to attend substance misuse agencies for brief advice. Gaps in services and future recommendations.	June 2010	Drug and Alcohol Strategy Team MCC	Alcohol strategy Drug and alcohol strategy
	Task and finish group set up to consider the feasibility of a young perpetrators programme	Research review completed. Map of Manchester services along with identification of gaps written into an options paper for DAMG.	September 2010	Manchester Women's Aid Children's Services, MCC Youth Offending Team	Youth Crime Strategy

"I felt as though I was carrying a heavy suitcase around which suddenly felt lighter and more manageable. The suitcase is feeling lighter already in a week".

(PATHway client)

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Acknowledgements

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The midwives at St Mary's who were frank in their views of the service and its impact on their practice. Their commitment and dedication to improving the lives of women who suffer domestic abuse was evident.

The evaluation management team, Val, Faye and Delia for your guidance and constructive comments during the process of this evaluation. It has been greatly appreciated.

And finally, but no means least, to June, the PATHway IDVA, for her patience with our continual questions and requests for information. She made our task easier and it was a pleasure to work with her. She has made a difference to women's lives.

Contents

Glossary

Co-Ordinated Action Against Domestic Abuse (CAADA) is a national charity supporting a strong multi-agency response to domestic abuse. The work focuses on saving lives and saving public money. CAADA provides practical tools, training, guidance, quality assurance, policy and data insight to support professionals and organisations working with domestic abuse victims. The aim is to protect the highest risk victims and their children – those at risk of murder or serious harm. http://www.caada.org.uk/

CAADA-DASH Risk Indicator Checklist (RIC) are used by Independent Domestic Violence Advisors and other non-police agencies for MARAC case identification when domestic abuse, 'honour'- based violence and/or stalking are disclosed

Independent Domestic Abuse Advisors (IDVAs) are specialist case-workers who focus on working pre-dominantly with high risk victims, those at risk of homicide or serious harm. They work from the point of crisis on a short to medium term basis and have a well- defined role underpinned by an accredited training programme. They offer intensive short to medium term support. They also mobilize multiple resources on behalf of victims by co-ordinating the response of a wide range of agencies who might be involved with a case. They work in partnership with a range of statutory and voluntary agencies but are independent of a single agency.

Multi-Agency Risk Assessment Conferences (MARAC): The MARAC model of intervention involves risk assessment in all reported cases of domestic abuse to identify those at highest risk so that a multi-agency approach may be taken. The goal of these conferences is to provide a forum for sharing information and taking action to reduce future harm to very high-risk victims of domestic abuse and their children. This model of intervention follows a process of risk assessment in all reported cases of domestic abuse to identify those at highest risk to enable a specialist multi-agency response.

SUMMARY

Outcomes from PATHway

- The safety of women and children attending St Mary's has been improved
- Early intervention with women experiencing abuse in pregnancy has occurred
- The number of South Asian women using the IDVA service in Manchester has increased
- Midwives response through routine enquiry has been enhanced
- Midwives have become more competent in recognising and responding to domestic abuse

Recommendations to key decision makers

Based on the evidence presented in this evaluation, we recommend that the IDVA service should continue at St Mary's maternity hospital and that it should be part of a joint commissioning, multi agency process across Manchester to safeguard women and children[1].

We recommend that consideration be given to the following points – learnt from the pilot – to further enhance the development and effectiveness of the service and its role in improving the safety of women in Manchester:

1. Another IDVA is trained to work with pregnant women so that there is full cover for the service. It would reduce the isolation of one worker in a health setting and build up further expertise to make the service sustainable. The population served by St Mary's, the high number of deliveries and significant ethnic minority population would warrant this

2. A specialist health team is developed in the IDVA service, including those working in midwifery, so that the service can be taken into other health settings

3. The IDVA service in St Mary's should continue to be managed in the main IDVA team and within the City's multi agency response to domestic abuse

4. The IDVA maintains her role in engaging with high risk and very high-risk women and quickly moving victims to other services. This is essential to maintain the particular expertise of the IDVA and not to dilute the effectiveness of the role through too large a case load

5. Further development and learning from engaging Pakistani women who disclose abuse should be shared with other domestic abuse services

6. When setting up this service elsewhere, time is spent inducting the IDVA into health settings, and there is a named, day to day, on site contact

7. Data systems, desk space, equipment and access to private meeting rooms need to be set up prior to the start of the service.

8. The data collection systems should be reviewed to capture more effectively the number of women seen who have no recourse to public funds and to more easily track women who move out of the area.

9. Patient pathways are developed to show clear referral routes from routine enquiry to domestic abuse services and to multi-agency pathways responding to domestic abuse and child and adult safeguarding procedures

10. Midwives are trained and supported to carry out the CAADA-DASH Risk Indicator Checklist with all women who

1. As the new structures for the NHS and local authority emerge, this should be part of the commissioning process in the proposed Health and Wellbeing boards formed to support joint working on health and wellbeing across the Greater Manchester area

disclose or where they suspect abuse. This will further enhance their professional role in safeguarding women and their unborn children. It supports the health services commitment to a multi agency response to high-risk women. Initially we only recommend this if the IDVA service continues while expertise is developed. The implementation will require attention to resources in an already busy and complex workplace.

11. Training of midwives in MARAC procedures, risk assessment, information sharing and operational protocols should be the responsibility of the Trust and is in line with the Trust's commitment to MARAC.

12. The role of the IDVA in increasing awareness and enhancing the professional response to domestic violence through institutional advocacy is recognised and mechanisms are maintained to transfer practice knowledge and wisdom in the health setting

13. Processes are put in place to enable other health professionals within St Mary's, such as doctors, to understand their role in response to domestic abuse and the contribution of the IDVA

14. In order to maintain the independence of the domestic abuse advisor, funding for the post (or posts) should be through joint commissioning in line with the multi agency response to domestic abuse

1. INTRODUCTION

The Manchester Domestic Abuse Strategy (2008-2011), which was launched in February 2007[2], sets out how the City aims to reduce domestic violence and support survivors through a multi-agency approach. One of the objectives of the strategy has been to increase the numbers of victims accessing core domestic abuse services and to ensure they receive that support as soon as possible.

In April 2009, in response to the Strategy's objectives, a two year pilot project funded by NHS Manchester 'Improving Health in Manchester' scheme, was set up at St Mary's maternity hospital (April 2009 - March 2011). The project secured the services of a trained full time Independent Domestic Abuse Advisor (IDVA), located in the antenatal department of the hospital. The rationale behind the pilot was that 30 per cent of domestic abuse begins in pregnancy and existing abuse escalates in pregnancy[3]. The referrals from health professionals to the main IDVA service, based in the City Council, were low compared to other services.

The pilot project aims to improve the physical and mental health outcomes for women and their children who are affected by domestic abuse and attending maternity and gynaecological services at St Mary's by providing advice and information on options to improve safety and advocacy[4].

The evaluation was commissioned in May 2009 with a brief to report by September 2010, six months before the end of the pilot. This was to enable future commissioning decisions to be based on evidence of what worked to improve the safety of women and their children. An interim report was produced in January 2010 and this final report covers data collected between April 2009 and June 2010 (15 months).

This report begins with a brief overview of the national and local context underpinning the project and an outline of the evaluation approach. The key findings are then reported:

- What has changed for women attending St Mary's?
- What has changed for NHS staff at St Mary's?
- What is the cost benefit/ savings of the project?

The report concludes with recommendations and key learning that has emerged and the implications of these for decision makers.

2. BACKGROUND

The government defines domestic violence as: "any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults, aged 18 and over, who are, or have been, intimate partners or family members, regardless of gender and sexuality"[5].

2.1 National Policy

Since the publication in March 2005 of the labour government's national action plan to tackle domestic violence[6] there has been an increasing national and local drive to reduce the prevalence of domestic violence, improve support for victims and bring more perpetrators to justice. The national plan recognised that domestic abuse was a cross cutting issue that straddles a broad number of ministries and this reflected the need for a concerted multi-agency approach at local level. As part of the implementation plan there was to be an increase in the understanding of the role of independent domestic abuse advisors in delivering effective services to increase the safety of high-risk victims of domestic abuse.

The Violent Crime Action Plan in 2008 gave a commitment to double the number of Specialist Domestic Violence Courts (SDVCs) by 2011 and to rollout nationally the Multi-Agency Risk Assessment Conferences (MARACs) by 2011. Other

2. A new strategy is being launched November 2010
3. McWilliams, M. and McKiernan, J. (1993) *Bringing it out into the open,* in DH 2005 'Responding to Domestic Abuse – a handbook for professionals'
4. PATHway Service Specification, Gateway reference 10804
5. NHS Choices August 2010
6. Home Office 2005: *Tackling Domestic Violence National Action Plan*

actions included a national rollout of Independent Domestic Violence Advisors (IDVAs) and the setting up of the forced marriages unit in recognition of the increase in cultural based abuses such as honour based violence.

In Spring 2009, a cross government consultation on 'Together We can End Violence towards Women and Girls' was led by the Home Office, and following this in September 2009, the Department of Health set up the 'Health Aspects of Violence Towards Women and Girls' task force, chaired by Sir George Alberti. The task force reported in March 2010[7] and argued that the health consequences of violence and abuse need to be taken more seriously. The NHS spends more time on dealing with the impact of violence against women and girls than almost any other agency; physical and sexual violence have direct health consequences on a wide range of long-term health problems, including mental health, alcohol misuse, trauma, including maternal and foetal death and unwanted pregnancy. For many women who experience violence and abuse, NHS settings often represent the one place where it is possible for a woman to talk to someone about her experiences without discovery or reprisal from the perpetrator.

Women who experience domestic abuse have twice the level of usage of general medical services and between three to eight times the usage of mental health services, yet their disclosure to medical professionals is low[8].

The taskforce made 23 recommendations including the need for clear outcome–focused commissioning guidance and commissioners, primary care trusts and their partners should ensure appropriately funded and staffed services are put in place along locally agreed pathways. Recommendation 15 said that NHS organisations should participate fully in multi-agency fora, such as Multi Agency Risk Assessment Conferences (MARAC) and that these should link to local structures in place for safeguarding children and vulnerable adults.

There are signs that the new government will continue this commitment to tackling domestic violence. Speaking at a Women's Aid conference in July 2010, Theresa May, the Home Secretary and Minister for Women and Equalities, said that stopping violence against women would be a priority for the government She added:

> "I believe I have a unique opportunity to bring about real change to the lives and the status of women in this country and my ambition is nothing less than ending violence against women and girls" (16th July 2010)

2.2 Domestic abuse and pregnancy

Evidence shows that up to 30 per cent of domestic abuse starts in pregnancy and that it escalates in situations where abuse already exists[9]. The impact of domestic abuse in pregnancy is extensive: a 2007 report showed that 24 per cent of maternal deaths occurred in women who had features of domestic abuse and of these women 19 were murdered[10]. The physical impact of abuse can result in miscarriage, low birth weight, ruptured uterus and pre-term labour. Mental health impacts include depression, anxiety and post traumatic stress disorder. A US study found a significant relationship between pregnancy, domestic abuse and suicide[11].

The Domestic abuse and Pregnancy Advisory group was set up by the Department of Health in 2005. Among its recommendations was that maternity units moved towards universal screening of pregnant women for domestic abuse. The Royal College of Midwives Position Statement (first published in 1997 and reviewed in 2009) supports routine enquiry into domestic abuse and recognises that every midwife has a responsibility to provide each woman in her care with support, information and referral to meet her needs.

The links between peri-natal mental health and domestic abuse were recognised in the response by the National Mental Health Development Unit's Gender Equality and Women's Mental Health programme to the National Institute for Health and Clinical Excellence (NICE) guidelines on Antenatal and Postnatal Mental Health (2007). It has established clinical networks for peri-natal mental health services in order to make connections with a wide group of stakeholders with responsibility for maternal mental health and aims to develop strategies for addressing the specific needs of women from black and minority ethnic groups.

7. Department of Health (2010) *Responding to violence against women and children – the role of the NHS,* March 2010
8. Women's National Commission (2010) *"A Bitter Pill to Swallow: report from the WNC focus groups to inform the Department of Health Taskforce on the Health Aspects of Violence Against Women and Girls",* WNC January 2010
9. McWilliams, M. and McKiernan, J. (1993) *Bringing it out into the open,* in DH 2005 'Responding to Domestic Abuse – a handbook for professionals'
10. Lewis, G The Confidential Enquiry into Maternal and Child Health (CEMACH) Perinatal Mortality: Saving women's Lives: reviewing maternal deaths to make motherhood safer women: 2003-2005. The Seventh Report on Confidential Enquiries into Maternal Deaths in the United Kingdom, CEMACH 2007 London
11. Stark E and Flitgraft A (1996) *Women at Risk* London Sage

NICE is due to publish guidelines[12] in September 2010 on supporting pregnant women who have complex social factors and there is a chapter devoted to pregnant women who experience domestic abuse. The guidelines are intended for those who work or use the National Health Service in England and Wales.

2.3 The local and regional context

The Greater Manchester area in the North West Region, has a total population of 3,921,819[13]. Manchester City has a population of 473,190[14] and is an area with high health inequalities and deprivation. It is ranked as the 4th most deprived local authority in England and has the 2nd lowest life expectancy for men and 4th lowest life expectancy for women compared with the 352 other local authorities[15]. Domestic abuse is recognized as a key factor in health inequalities. Local data shows reported domestic abuse is linked to deprivation[16] and attention to domestic abuse will contribute to reducing health inequalities in Manchester.

The City of Manchester Domestic Abuse Strategy in 2006 estimated that 40,045 women in the City will experience domestic abuse during their lives and at least 17,500 women will be experiencing domestic abuse each year. Currently, only 10 per cent are likely to disclose their abuse.

In November 2009, the Association of Greater Manchester Authorities (AGMA) Public Protection Commission[17], commissioned a Greater Manchester Strategic Assessment of Crime and Disorder and Community Safety. Tackling serious violent crime, with a focus on domestic violence is one of the four priority themes in the document and Recommendation Number 36 states:

> *"Relevant agencies to give support in identifying, developing and adopting the most appropriate policies, practice guidelines and training in order to facilitate early identification and a consistent response to domestic abuse across Manchester"*

Manchester has a well-established Multi-agency Risk Assessment Conference (MARAC) agreement to information sharing protocols in very high-risk cases of domestic abuse. The supportive and strategic context for tackling domestic abuse in Manchester was further demonstrated in 2007/8, by the reconfiguration of existing outreach services into the current IDVA service at Manchester Advice. This service now has 10 CAADA trained IDVAs and the IDVA at St Mary's has been seconded from that team,

St Mary's Maternity Hospital is part of Central Manchester University Hospitals NHS Foundation Trust and the new hospital building opened in June 2009. It is located in Central Manchester and also receives patients from Greater Manchester and surrounding areas in the North West. It carries out 6000 deliveries a year with a complex case mix of medical problems, deprivation, high South Asian population and a large proportion of women who do not speak English.

12. National Institute for Health and Clinical Excellence (NICE) draft guidelines, *Pregnant Women with complex social factors: a model for service provision'*.
13. 2001 census
14. Manchester Fact Sheet May 2010: 2008 mid year population estimate
15. Manchester Public Health Annual Report 2009: *The Importance of Early Years*
16. PATHway Service Specification: Gateway Reference 10804
17. http://www.gmac.org.uk/index3.php

3. EVALUATION APPROACH

The aim of the evaluation was to concentrate on the effectiveness of an IDVA service in the particular setting of a midwifery unit. A national study[18], reporting on the effectiveness of an IDVA service, looked at 2500 women who received the IDVA service and positive outcomes were identified; 2 out of 3 women receiving intensive support reported cessation of abuse and 9 out of 10 reported feeling safer. In PATHway, the main evaluation question was: Is the model of locating the IDVA in maternity services a good model?

The evaluation was to inform future commissioning decisions on the contribution of the NHS to the domestic abuse multi agency approach in Manchester. Effectiveness is measured against seven key outcomes agreed at the beginning of the pilot **(Appendix One)**. As this was a pilot project, an integrated style of evaluation was adopted in order to regularly feed evaluation findings back into the development of the service.

The evaluation process was designed to enable regular engagement with stakeholders. Three stakeholder events were held between July 2009 and September 2010 in order that interested practitioners and managers could be aware of the project, feed in their ideas and comment on the findings. This approach is known to enable evidence to more effectively inform future policy and practice[19]. A list of stakeholders can be found in **Appendix Two.**

A combination of quantitative and qualitative data collection methods has been used and drawn from a number of sources. The evaluator advised on the monitoring data that has been regularly collected by the IDVA as well as designing client questionnaires, setting up a number of stakeholder interviews and carrying out focus groups with NHS staff. A full list of data collection methods is recorded in Appendix Three. The data has been triangulated[20] and analysed against the expected outcomes.

We conducted 16 interviews with women who were victims of domestic abuse and had used the PATHway service. We had planned to interview 20 to 25 but this was difficult because of the issues many women faced. For many there were issues of safety, which rendered this unsafe. Some had chaotic lives and many of the women did not speak English or have English as a first language. We had originally planned to do face to face interviews at the hospital but it became clear that this was not possible.

Another key method used to capture data was a reflective diary (Appendix Four). The IDVA completed the diary electronically on a weekly basis and it was copied to her manager and the evaluators. The diaries served a number of purposes:

- To capture the development and process of the project
- To draw out themes and issues on an ongoing basis and feed back into the project
- To encourage reflective practice and learning by providing a structure for reflection
- To provide a simple means of communication and support

The IDVA has given her permission to use quotes from the diaries in the project findings.

18. Howarth E, Stimpson L, Barran D, Robinson A (2009) *Safety in Numbers*, Commissioned by The Hesta Trust. http://www.caada.org.uk/
19. Granville, G and Meyrick, J (2006) "How does Policy learn from Pilots", *British Journal of Health Care Management, 12, 61: 69-173*
20. Triangulation allows a meeting and meshing of different types of data for a given topic which enables questions to be posed in new ways, leading to fresh insights and understandings, Kellaher L, Pearce S and Willcocks, D (1990) *Triangulating data,* in Pearce, S (Ed) Researching Social Gerontology, London: Sage Publications

4 FINDINGS

4.1 The IDVA service at St Mary's

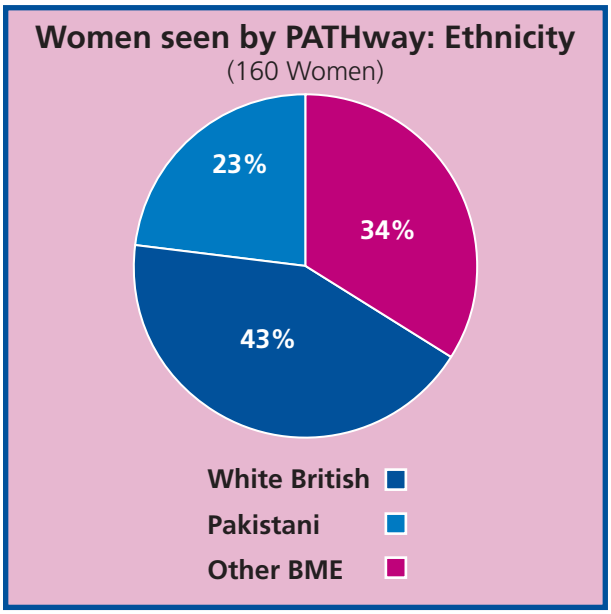
The Clients

The decision to have an IDVA working in the antenatal clinic has increased the number of women accessing the IDVA service from the NHS. In 15 months of the project (April 2009 to June 2010), the IDVA has received **196 referrals and seen 160 women.**

This compares with 40 referrals from all health professionals to the community IDVA team in the 12 months prior to PATHway (April 2008 to 2009). Health professionals include staff working in three acute hospitals, mental health and primary care services. In the first 12 months of PATHway (April 09 to March 10) there were 159 referrals, although not all of these would be high-risk victims. Between July 2009 and July 201021 (whilst PATHway has been operating) there have been a total of 28 referrals to the whole IDVA service from all health services. This excludes the 103 from midwifery services (in that time period), which were from PATHway.

The highest number of women seen by PATHway in one month was 19 and the lowest was 5. CAADA (Co-ordinated Action Against Domestic Abuse[22]) recommend 100 referrals a year for each IDVA allowing for a 70 per cent engagement rate. The St Mary's IDVA exceeds these levels.

A second feature of the service is the high number of women from black and minority ethnic groups, and in particular from South Asian Communities, that have been seen by the IDVA. The PATHway IDVA has seen 43 per cent (n69) white British women, 23 per cent (n36) Pakistani women and 34 per cent (n55) of women from other ethnic groups.



These figures reflect the ethnically diverse population that St Mary's serves with Pakistani women being the second highest ethnic group, but PATHway has seen a much higher proportion of Pakistani women than is reflected in the hospital population. For example, inpatient data (April 2009 to March 2010) shows women attending St Mary's are 42 per cent White British and 12.5 per cent are Pakistani.

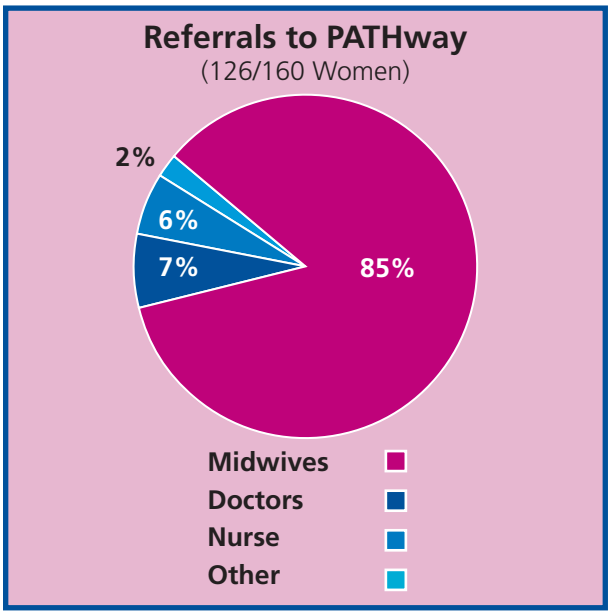
This is particularly significant for domestic abuse because of the increase risk to South Asian women of forced marriages and honour based violence and that they are often isolated and do not easily access domestic abuse services[23]. The Manchester community IDVA team saw 52.8 per cent White British clients and 7.2 per cent Pakistani clients. The IDVA service at St Mary's has shown it has been effective in reaching this vulnerable group.

14 of the women were under 20 years. One identified herself as from the lesbian, gay, bisexual, transgender community. 16 women reported attending Accident and Emergency Departments, which is a lower figure than anticipated by the project.

The vast majority of the women have been seen in the antenatal period and range from 12 to over 30 weeks pregnant. 17 women were seen in the post-natal period.

21. Different time frame due to change in IDVA monitoring system
22. http://www.caada.org.uk/
23. Richards, L , Letchford, S and Stratton, S (2008) *Policing Domestic Violence,* Blackstone's Practical Policing

Referrals to PATHway



Almost all the referrals that are made to the service at St Mary's are from midwives. These include community midwives based in St Mary's and covering parts of South Manchester, Central and part of North Manchester and hospital midwives working in the antenatal and postnatal wards.

Referrals have also come from the specialist midwifery team, midwives in the emergency gynaecological ward and the Whitworth clinic. Nine doctors working in the hospital unit made referrals, although these were all in the first eight months of the project. It is unclear why so few doctors make referrals, but there is a suggestion that it links to the midwives' role in asking the routine enquiry question[24] and enquiry is therefore perceived as the midwife's responsibility.

Currently all women who disclose domestic abuse at St Mary's are offered the opportunity to see the IDVA at the hospital. Significantly, since July 2010, the IDVA service is one of the options on the Hospital Trusts Inter Agency Child in Need Referral forms[25] alongside Children's Services, Health Visitors and Community Midwifes.

When the IDVA is on holiday, the midwives can refer the women to the main IDVA team based in the town hall but this has only happened once in 15 months and on this occasion the woman was already known to the hospital IDVA.

A unique feature of this IDVA service has been the speed at which women disclosing domestic abuse at routine enquiry have been seen. **82** of the women were seen and assessed within hours and **16** within minutes. No one waited more than a few days (which probably covered weekends and bank holidays). The main IDVA service seeks to contact all referrals within 24 hours, although these women will have already been risk assessed by the referring agency worker. As the IDVA at St Mary's assesses all the women, the speed in which she sees referrals is significant for the safety of the women and their children and for prevention of escalation of the abuse.

IDVA support

IDVAs are trained to work with women at high or very high risk of homicide or serious harm and who have been referred to MARAC or the Specialist Domestic Violence Courts. High-risk cases are identified by scoring 14 or over on the CAADA DASH Risk Indicator Check list (Appendix five).

The difference with the IDVA service at St Mary's is that the midwives do not complete the Risk Indicator Checklist to assess level of risk before referring to the IDVA. Referral is made to the IDVA after disclosure at routine enquiry and the IDVA then completes the assessment. In 15 months of the project **28** of the 160 women have been referred to MARAC, indicating the high level of risk being identified from a health setting that was not being identified previously.

IDVAs have a pivotal role in the multi agency response to domestic abuse and have particular knowledge and advocacy skills to connect women with a range of agencies. The women who see the IDVA are supported in a number of ways. The majority are seen in face-to-face interviews in the hospital. The IDVA often follows up with phone calls: from 160 women seen there were **533 telephone calls to clients.** The IDVA carries out actions on behalf of clients with a range of agencies and for the 160 women there were **697 actions taken on behalf of the women.** In December 2009 the IDVA was managing 38 on-going cases of which 4 were recorded as complex. Extracts from the reflective diary illustrate the breadth and depth of the work:

24. The evaluation planned to run a focus group in the hospital with doctors but in spite of a very flexible approach by the evaluators and support from a medical colleague it proved impossible to set this up because of the doctors' other commitments.
25. Green form: Ref J580 SF Taylor CM4599

"Being able to advocate for a young mum who is homeless. Having the knowledge to be able to speak to the correct team of people on her behalf that would be able to overturn a decision that a landlord had made. Giving her the option of returning to her B&B accommodation". **(IDVA diary August 2009)**

"I feel good this week, from the people I have seen this week I can see how my support has helped, they have all been at different stages and levels of abuse from the nightmare crisis point just starting, to coming to the end of the nightmare". **(IDVA diary May 2010)**

Referrals from PATHway

Midwives at St Mary's refer all women who disclose domestic abuse to Children's Services and to the specialist midwife for safeguarding children and adults. They also ask every woman who discloses if she would like to see the IDVA.

The IDVA does the Risk Indicator Checklist assessment and develops a safety plan with the woman. Approximately half of the women have then been signposted or referred to other services. Most of these are referred directly by the IDVA, however approximately a quarter of the women have asked for details and make contact themselves. This is from a diary extract:

"She was able to phone the solicitor and is now in the process of civil justice (Non Mol) I have spoken to her, she told me she felt confident at phoning the solicitor. I feel that as she had been given her options previously she was confident in accessing support from the correct agency". **(IDVA diary January 2010)**

Referrals[26] have included children's services (9) and solicitors (2). Only one referral was made to the community IDVA team. The referral to other domestic abuse services is low with only two women from PATHway recorded by Manchester Women's Aid. Seven women were referred from the IDVA to Women's Aid but these might have been recorded by the organisation as 'self referrals' or the women themselves may have decided to take no further action. Some women also moved outside Manchester as a result of the abuse although data on how many is not available. Only one woman has been referred to the alcohol services, which is extremely low. Five received alcohol advice from the IDVA.

It would be reasonable to assume that because of the high number of black and minority ethnic women referred to the project, some of those seen by the IDVA have 'no recourse to public funds'. The monitoring data has not recorded this separately although the women may be included in the referrals to the City Council Persons Without Access to Funding team or to Manchester Women's Aid refuge where there is a specialist worker.

The 28 referrals to MARAC means there have been multi-agency referrals so the use of other services is potentially wider than the data suggests.

4.2 What has changed for women attending St Mary's?

Improved safety for themselves and their children

The safety of women and their children who have been referred to the IDVA service at St Mary's has been improved. There is good evidence that because of an enhanced response from midwives to routine enquiry and the referral option to the IDVA, women experiencing abuse and attending St Mary's are identified earlier, offered access to support earlier and given the chance to consider their own and their children's safety. (This point is further developed in section 4.3 below: What has changed for midwives at St Mary's?)

26. Data provided by main IDVA service – incomplete at time of writing

In the client questionnaire, 116 women out of a total of 126 said they felt safer. Improved safety has been evidenced in a number of ways:

Prompt identification of high-risk victims
The IDVA carries out the CAADA-DASH risk assessment with all women referred to the service. From this assessment, high-risk women are identified and referred to MARAC[27]. Evidence from research on MARACs has shown that they are effective in making women safer and reducing the risk of murder.

On the spot support
Women are routinely asked about domestic abuse when they book with the midwife. Procedures are in place to alert professionals when it has not be possible for a number of reasons to ask the routine question at the first booking; reasons include the presence of the partner or family relative, or when English is not the first language, although interpreters are used widely at St Mary's. Midwives at St Mary's are very aware of the importance of asking women about domestic abuse and many ways are found within professional practice to speak to the woman alone.

If a woman does disclose it is probable that she will have almost immediate access to the IDVA without raising suspicion from her partner or endangering her safety because the IDVA is located on the hospital premises. The IDVA can make a first introduction and if necessary arrange for follow up meetings. The opportunity for women to be seen at the hospital, either at the time of disclosure or returning on a future occasions, suggests that she is more likely to take up the support. It is also likely to have been a factor in the high number of Black and Minority Ethnic women using the service:

> *"Face to face is better than a helpline".* **(PATHway client)**

> *"I was worried about the baby (in pregnancy), did not want to entertain the idea of going to the police or social services, but when the midwife offered me to talk to someone who could help me with the abuse, I was glad".* **(PATHway client)**

> *"Women come here (to the hospital) to see a midwife, it is expected, partners are not suspicious, they can talk freely, be counselled freely, they are not frightened, don't feel uneasy"* **(Midwife)**

> *"So many women leave the hospital quickly – their partners want the women home"* **(Midwife)**

> *"I spoke to a young women on the ward this week who had bruising on her arms from the assault of her partner but she doesn't want to do anything about her abusive relationship. I spoke to her for quite awhile and asked if she would take my number, she said she didn't need it, but in the afternoon when she was discharged she asked staff for my phone number, this makes me feel good I know I get through to people even if it doesn't seem that way at the time".* **(IDVA diary March 2010)**

Safety planning with an IDVA
IDVAs are specialist caseworkers that work predominantly with high-risk victims and carry out safety planning, including very practical advice. In addition, their training enables them to offer intensive support and, significantly, mobilise multiple resources on behalf of victims. They do this through co-ordinating the response of a wide range of agencies, working in partnership with a range of statutory and voluntary agencies[28]. Their role requires them to have up to date knowledge of all the services available to support a victim and a detailed understanding of complex legal, accommodation and immigration issues. Their role at MARAC is to support the victim. An extract from the IDVA diary reflects this:

27. A L Robinson 2004, *Domestic Violence MARACs for Very High-Risk Victims in Cardiff: A Process and Outcome Evaluation,* Cardiff University..
28. Howarth E, Stimpson L, Barran D, Robinson A (2009) *Safety in Numbers,* Commissioned by The Hesta Trust. http://www.caada.org.uk/

"Meeting a mum who was very high risk. Being able to put all my knowledge and resources together to get her the protection that she needs, to keep herself and new baby daughter safe". **(IDVA diary December 2009)**

The opportunity for women attending St Mary's to receive the services of an IDVA to plan for their own and their children's safety was significant. The women recognised the specialist knowledge and skills of the IDVA and this gave them confidence to make choices. One woman from a Black and Minority Ethnic background was particularly impressed with a service that demonstrated such an understanding of domestic abuse in the context of an ethnic minority community. The particular attributes required of an IDVA such as empathy and understanding were also demonstrated in the women's responses:

*"She (IDVA) was open, approachable, explained her job and what she could and could not do. Gave me choices***". (PATHway client)**

"She (IDVA) always had a box of tissues available...I felt I could show my emotions with (her)". **(PATHway client)**

"Being able to talk about a problem to someone who listened, understood and gave me options about how to cope to keep me and my baby safe". **(PATHway client)**

"She (IDVA) thought of everything". **(PATHway client)**

"She knew all the right things to ask". **(PATHway client**

"She (IDVA) does not tell you how to live your life". **(PATHway client)**

"When she comes and sees someone again on the ward, they (the women) are really happy to see her and talk to her". **(Midwife)**

Nearly all the women who completed the questionnaire (121/126) said they felt believed and less alone once they had met the IDVA. The women spoke of the importance of being listened to and taken seriously and this gave them confidence to consider their options. The women felt supported by a knowledgeable practitioner who understood the issues and gave them information that enabled them to look for solutions.

"I felt as though I was carrying a heavy suitcase around which suddenly felt lighter and more manageable. The suitcase is feeling lighter already in a week". **(PATHway client)**

"I can think things through now" **(PATHway client)**

"She's (IDVA) so much more understanding through the whole journey of my experience" **(PATHway client)**

"I can see a light at the end of the tunnel" **(PATHway client)**

Another example of a woman who since seeing the IDVA now had the information and facts to make choices about her future was recorded in the IDVA's weekly diary:

"I have said this before but it is very significant, I have a women coming to see me today who was very close to leaving her husband, she had her baby 2 weeks ago and now feels ready to leave. For her to contact me and ask for my help to leave makes me feel good I know we are doing a good job". **(IDVA diary April 2010)**

Improved safeguarding through early intervention

Easy access

The opportunity for early identification and intervention as soon as a woman discloses abuse increases the safety of the woman and her children. The abuse may have been at an early stage, or previously unrecognised by the victim, and specialist support sought before it escalates. If the abuse was high risk, immediate action can be taken to safe guard the woman and her child (or children). An example from the IDVA diary:

"Once again prompt action to get things moving when a mum wants to go down civil justice route, the relief on a mums face when she knows she has been believed, and she will have protection from the courts". **(IDVA diary November 2009)**

In the first 15 months of the project, 160 women have received that support at the hospital. Prior to the PATHway project there were no direct referrals to the IDVA service from St Mary's.

Take up of other domestic abuse services

There was some evidence that having had prompt access to a domestic abuse service soon after disclosure, the women were more willing to access other domestic abuse services directly themselves. Some women spoke of being signposted or referred[29] to domestic abuse services in the past but they had not taken the services up. Their experiences of early access to IDVA support was empowering and offered them choices that were previously unknown to them:

"I feel really good about talking to someone" **(PATHway client)**

"I feel I have regained my self esteem and sense of belonging as a woman". **(PATHway client)**

The positive experiences that women had when supported by the IDVA within the hospital setting led to some evidence that they would be more willing to take up other domestic abuse services in the future. This is a particularly important finding because some women move to other geographical areas and need to know there is support available for improving their safety and the safety of their children. This extract from the IDVA diary illustrates how the independent multi agency role of the IDVA can facilitate the process:

"A mum I spoke to on Monday had already left her husband and moved to Yorkshire I was able to send a MARAC referral to Yorkshire and set up support links for her with the IDVA near to where she is staying. The young mum told me about things she had kept to herself for 5yrs, she will need a lot of support, she left feeling very positive about herself, I feel because I had the time to sit and talk to her knowing she wouldn't be coming back as she was transferring her care to Yorkshire, we were able to resolve a lot of her issues and reassure her of the support she will receive in Yorkshire". **(IDVA diary February 2010)**

Many of the findings presented in this section are reinforced when we look at the evidence of what has changed for NHS staff. This is recorded in section below, 4.3.

29. The difference between 'signposting' and 'referral' was identified in the evaluation. The terms are sometimes used interchangeably but one involves the victim contacting the services and the other involves the professional initiating the contact.

4.3 What has changed for midwives at St Mary's?

Evidence from this project shows the vital role played by midwives in helping women and their children, who are victims of domestic abuse, to be safer.

Improved confidence in routine enquiry

Evidence from midwives working at St Mary's demonstrated professional commitment and a belief in the importance of their role for recognising and supporting women who suffer domestic abuse.

> *"Important part of our role…we are failing them if we don't ask the question".* **(Midwife)**

> *"Midwifery is women centred – women get a lot of attention at this time, encourages disclosure, women more open, tell".* **(Midwife)**

Routine enquiry has been in the process of rolling out among health professionals since 2006 and all midwives at St Mary's are trained to ask women about domestic abuse at initial booking. The midwives spoke of how at times it has been difficult to ask the question. They compared it with asking the question about HIV which initially had been difficult but was now routine. Over time their questioning of domestic abuse has improved because some women are expecting the question and for the midwives it has become part of the social assessment at booking:

> *"Used to worry about offending women but now I don't, I just ask"* **(Midwife)**

> *"At first it was really difficult, used to be awkward, one of the tick boxes"* **(Midwife)**

One student midwife said that she was happy with the question because she had only known that process and it was part of the whole raft of social questions.

There was good evidence that since the IDVA has been in place the midwives at St Mary's felt more confident at making the routine enquiry. This was partly due to the midwife knowing that, if a woman discloses, they have someone in the unit who can offer professional support to the woman. The midwives acknowledged that they now asked the question in a way that was more likely to lead to disclosure. Although the midwives are aware of their responsibilities to domestic abuse they admitted that in the past they were worried if a woman did disclose. Their concerns were that they felt they did not have the time, knowledge and experience to support women adequately in this complex, and in their view, specialist area:

> *"Before if you asked and then they disclosed- what do you do? You could give information, helpline etc but what did they do with it after they left the clinic? Now we can refer them to (the IDVA)".* **(Midwife)**

> *"We come across as more approachable because we have someone to refer to".* **(Midwife)**

> *"(In the past") we're hoping she does not disclose because you have not got the time to deal with it. Then she might pick up on that and not disclose, think you are not interested, just a tick box, but if you know you have that support behind you – more likely to be approachable".* **(Midwife)**

Midwives are clear of their responsibilities when a woman discloses and they do not see the presence of the IDVA as taking away their professional accountability. All women are referred to Social Services and to the specialist midwife for

safeguarding. Their concerns were about how to help the woman move forward and be safer after disclosure. A domestic abuse identification process is in all patients' notes and now also in staff hand over sheets. The IDVA has become one of the named referral routes along with the specialist midwives.

Cultural differences were raised as a potential barrier to routine enquiry. The midwives said that particularly in the South Asian community, the man or a female relative usually stayed with his wife. The midwives had developed strategies to ask the question of women who did not speak English by working with an independent interpreter and finding ways to see the woman alone. They now felt increased confident to do this with Black and Minority communities because if there was disclosure the woman could have an immediate appointment at the hospital with the IDVA.

Improved safety planning for women and children

There was considerable respect for the IDVA and the knowledge and expertise she brings to the role. Midwives spoke of the complexities of helping women once they disclosed and how special expertise was required around housing and legal issues, which they felt they did not have.

> *"(We say) 'we have identified a problem and we have someone in place. Would you like to talk to her'. A lot of women say 'yes' and because she is on the premises it is dealt with there and then".* **(Midwife)**

> *"And she (the woman) goes off with her shoulders much further down from her ears than when she came in".* **(Midwife)**

> *"IDVA takes women onto the next stage, its such a big thing to disclose, once they start they can't stop".* **(Midwife)**

> *"Unless they have met someone face to face, they will not come – too frightened".* **(Midwife)**

Prior to PATHway the midwives made some referrals or signposted women to other domestic abuse services by passing on helpline numbers or phone contacts. None of the midwives we spoke to knew or had referred directly to the community IDVA team.

Previously, some midwives had followed up referrals themselves and valued the support of the specialist midwife for safeguarding, particularly in high-risk cases going to MARAC. However, in perceived lower risk cases[30] action was often left with the woman herself and we can see from the evidence that women were not always able to follow this through. The midwives felt that prior to the IDVA being based in the hospital there had been an inadequate response in supporting victims to make safe choices for themselves and their children:

> *"If there wasn't anyone to refer to – make a 'bash' at getting her some help, (as well as referring to the specialist midwife for safeguarding), give out the helpline number".* **(Midwife)**

> *"I know for a fact that if I did not have (the IDVA) to refer to, I don't know what I would do, I would not know where to go (to give support)".* **(Midwife)**

> *"I cannot know all that is needed".* **(Midwife)**

30. The midwives do not carry out the Risk Indicator Checklist so would be using a degree of professional judgement about level of risk

"Being able to refer someone immediately and them to have face to face contact is easier". **(Midwife)**

"She (IDVA) knows exactly where to get help, where to refer (the women) to, we can't possibly have all that knowledge, can't all have it". **(Midwife)**

The specialist midwife for safeguarding has regular meetings with the IDVA to share information and to ensure that safeguarding processes are in place:

"I am also having a meeting each week with (the safeguarding midwife,) going over the actions I have set out for each referral. This has been set up so we both know what we have done, as we both get the referrals, this will benefit both of us as we will then be able to fill in the gaps". **(IDVA diary November 2009)**

Another example of the multi agency and interagency role of the IDVA in this project is that now she attends the monthly Maternity and Neonatal Child Protection Forum held in St Mary's where information is shared and care plans discussed for women referred from the specialist midwives.

The independence of the Independent Domestic Abuse Advisor (IDVA)

The midwives valued the independence of the IDVA from the NHS and the fact that she was managed by an agency that was outside the Trust. They believed that this helped her to maintain a dedicated focus on supporting victims and she was able to organise her own workload and decide her priorities. The fact that the IDVA was not a midwife was seen as an advantage because she could not be diverted into midwifery issues.

The midwives recognised the specialist nature of an IDVA working with pregnant women in a health setting and the particular and skills that were being developed by the IDVA in order to carry out that role effectively in the NHS:

"Is there a specialist IDVA at the town hall? Would the IDVA service cope with the extra health referrals?" **(Midwife)**

"Others don't get to see pregnant women, she has become a specialist – two clients in one go". **(Midwife)**

They expressed interest in how that expertise may be further developed in domestic abuse services and this point is picked up in section 5: key messages and learning.

Development of 'institutional advocacy' at St Mary's

The term 'institutional advocacy' is used in Amanda Robinson's evaluation of Independent Domestic Violence Advisors[31] and refers to providing support and advice to institutions rather than individuals. It is the process by which partners in multi-agency initiatives learn and improve their practice. She explains:

"IDVAs are uniquely placed to deliver institutional advocacy because they are the only ones with a true multi-agency perspective, one gained from working within and across different agencies as they co-ordinate services on behalf of victims" **(2009: 16)**

31. Robinson A (2009) *Independent Domestic Abuse Advisors: a process evaluation.* Cardiff University and funded by the Home Office

There is evidence from PATHway that institutional advocacy has been taking place in St Mary's through learning and improved practice. The presence of the IDVA in the midwifery unit has led to more midwives becoming more competent in recognising and responding to domestic abuse. This knowledge transfer has happened in different ways.

Snapshot training
168 midwives have attended the "snap shot training". These are 30-minute awareness-raising training sessions held in or near clinical areas and the staff released to attend. The domestic abuse sessions are run by the IDVA and her role is to enhance the knowledge and skills of the clinicians. The fact that she is already well known in the unit encouraged attendance and reference to domestic abuse case studies were seen as particularly useful.

> *"Jogs your memory, reminds you to be aware".* **(Midwife)**

> *"We know more than we did before (about domestic abuse)"* **(Midwife)**

Passing on knowledge and wisdom
The presence of the IDVA in the unit means that there are many opportunities to pass on knowledge and to support staff informally and the significance of this should not be under-estimated. Midwives spoke of how their professional judgement about domestic abuse disclosure had been enhanced through being able to explore and share concerns with an expert (the IDVA). This in turn increases the safety of women and their children:

> *"Sometimes I find that a woman who hasn't disclosed has lots of niggling things, they get sorted but you just get a feeling that they don't want to go home, get a feeling that something's not right here. We know we can just ring (IDVA) and say 'I have a lady here, would you come and talk to her'. She is just so easily accessible and immediate – they would have just gone home".* **(Midwife)**

Midwives valued the accessibility of the IDVA and her 'open door' approach to talking things through. The importance of being based in the unit is shown by the many opportunities there are for informal contacts:

> *"In the kitchen, brewing up together, she's (IDVA) there, so you'll just say what happened".* **(Midwife)**

> *"She's here, she's in the building".* **(Midwife)**

The community midwives office is situated next to the IDVA office and they spoke about "popping in" to see the IDVA if they were worried about a case and to get advice on whether they should refer even without disclosure.

There was other evidence of where institutional advocacy had developed the response of staff to domestic abuse. A recent example was an administrator in the unit who was aware of the IDVA's work and was concerned about a woman who rang for blood tests results and seemed particularly anxious. She spoke to the IDVA about it so it could be brought to professionals' attention. Other examples came from an interview with an obstetrician and this is developed further in the next section.

4.4 Engaging doctors

The section above on NHS staff focused on the improved response of midwives to domestic abuse. This is partly because the majority of the evidence came from midwives. It was difficult to engage doctors in the evaluation and seek their views, with only 3 doctors responding to the self-completion questionnaire and none taking part in a focus group organised by a doctor within the unit. A one to one interview with a consultant obstetrician did provide some useful insights into the

medical role in domestic abuse:

> *"I don't need to worry **as much** with women who disclose or we have concerns about – we phone (IDVA) or catch her in the corridor – '(IDVA) will sort it out'. That's how we see it".* **(consultant obstetrician)**

Many of the points raised by the midwives were similar to those raised by the obstetrician. These included the fact the IDVA was "on the spot" for making referrals or for informal knowledge sharing; that she had the expertise to support the women and that the complexity of the issues was recognised.

There was an assumption among some doctors that women had already been screened for domestic abuse at booking because of the midwives routine enquiry. This is not always the case and doctors may benefit from more awareness-raising on domestic abuse. There was a view that patient records and electronic note systems could be improved so that women did not get missed.

Although the responsibility of doctors towards domestic abuse is clear, clinical issues, workloads and lack of knowledge and specialist expertise on domestic abuse did not always allow the time to follow up women adequately:

> *"It gets so complicated, if you don't get the right person on your first couple of phone calls it then drops off, and another week goes by".* **(Consultant obstetrician)**

There was a high degree of trust by the doctor in the ability of the IDVA to offer the best advice and support to the women. This is an important finding for a project in an NHS setting working with non-NHS staff. Another important observation was the recognition of the value of the independence of the IDVA and the pivotal role in bringing different agencies together in a multi-agency response. The opportunity for the NHS to build relationships with non-NHS staff and agencies, "something we are not very good at", was seen very positively in the context of domestic abuse. This fits with other evidence[32] that highlights the limited links that the health service has had with IDVA services.

32. Howarth E, et al (2009) *"Safety in Numbers: A multi-site Evaluation of Independent Domestic Violence Advisors"*, commissioned by The Hestia Fund and can be found on http://www.caada.org.uk/Research/research.html

5 COST BENEFIT ANALYSIS

Domestic abuse has very high human costs but also gives rise to very high service costs. Developments in the last decade have shown that taking a more proactive, preventive approach not only saves lives but also saves public money. The improved understanding of the financial cost of domestic abuse is even more pressing in the current context of a reduction in public services. All initiatives have to show where their service can reduce costs to the public purse. It also provides an additional perspective for examining the devastating consequences of domestic violence on society as a whole as well as for victims[33].

A study by the Women and Equality Unit in 2004[34] based on the Home Office framework for costing crime found that the total cost of domestic violence to services amounted to £5.7 billion a year. The total cost of domestic violence to the state, employers and victims was estimated as £23 billion. The cost to the NHS for physical injuries was £1.2 billion with mental health care amounting to £176 million.

Another study in 2005 by the Cardiff's Women Safety Unit[35] estimated the cost of domestic violence to individuals and the state in one city in the UK was equivalent to each household in the city paying a tax of £125 a year.

A recent report published by CAADA (Co-ordinated Action Against Domestic Abuse)[36] in 2010 shows that domestic abuse costs the tax payer an estimated £3.9bn per year and high risk domestic abuse makes up nearly £2.4bn of this. The report estimates that every high-risk victim of domestic abuse currently costs the public sector £20,000 per annum and a conservative analysis shows that MARACs save on average at least £6100 per victim. One third of high-risk cases are identified by an IDVA.

Based on the data in Saving Lives, Saving Money[37] the 28 cases referred to MARACs in 15 months by PATHway resulted in an estimated **saving to the public sector of £170,800.** The costs to the health service in employing a full time IDVA at St Mary's in the same time period has been £50,591.

33. Walby S (2004) *The cost of Domestic Violence,* Women and Equality Unit
34. Walby S (2004) *The cost of Domestic Violence,* Women and Equality Unit
35. Robinson A (2005) *The Cardiff Women's Safety Unit: understanding the costs and consequences of domestic violence,* Cardiff University
36. CAADA (2010) *Saving lives, saving money: MARACs and high risk domestic abuse.*
37. CAADA (2010) *Saving lives, saving money: MARACs and high risk domestic abuse.*

6. KEY MESSAGES AND LEARNING FROM PATHway

6.1 Why an IDVA?

This evaluation presents compelling evidence that the presence of an IDVA in a midwifery unit improves the safety of women and their children. Women who disclosed at routine enquiry were referred to a specialist domestic abuse service (the IDVA) for risk assessment and safety planning. In addition, the presence of the IDVA in the unit has enhanced the knowledge and understanding of the midwives to recognise and refer women at risk of domestic abuse.

The commitment, knowledge, skills and attributes of the IDVA in this pilot project and her dedication to support victims has been well recognised by the women and staff. Independence from the health sector and the pivotal role of IDVAs to access, co-ordinate and refer to a range of agencies both locally and in other areas is at the core of the multi agency response required for domestic abuse and has been utilised here in the context of a maternity unit and NHS setting. Other research[38] has shown that where strong multi agency links exist outcomes are much improved for victims.

IDVAs are trained to work with high risk and very high-risk victims. This training means that they are able to assess risk and carry out crisis intervention. The IDVA, having assessed the level of risk, is able to move victims on to the appropriate support service, including MARAC for high-risk cases
The training and skills of assessment, multi agency co-ordination and appropriate allocation of cases according to the various levels of risk endorse the need for an IDVA to be in this role.

6.2 Why a midwifery unit?

The incidence of domestic abuse in pregnancy is now well known. There is a 30 per cent increase in pregnancy and where there has been abuse it escalates[39]. Therefore it can be argued that all pregnant women are a potentially high-risk group. This project has illustrated that a midwifery unit can provide the ideal environment to reach women who are abused or at risk of abuse; it is woman-centred and provides an enabling atmosphere for women to disclose and seek help. This has been evidenced by the high number of disclosures and referrals to MARAC as well as referrals from a group of women (South Asian) whom domestic abuse professionals find hard to reach.

There was some indication that when given this enabling environment, women who are pregnant and in abusive relationships may be more willing to disclose because of concerns about their unborn child. This would benefit from further research.

Midwives have a responsibility to enquire about domestic abuse. Evidence from PATHway has shown that through the presence of the IDVA, confidence and knowledge has been increased, enhancing the midwives' role and encouraging early identification and support.

The significance of the IDVA being based in the unit and able to see women quickly has been evident. There are legitimate reasons for women to attend the hospital to see the IDVA without raising the suspicions of the perpetrator and has been welcomed by the women. Many of the women in the project were able to see the IDVA as soon as they disclosed and before they left the hospital. This is an important finding as there were some indications that before the presence of the IDVA, women may have left the hospital with information from the midwives but did not contact domestic abuse services.

6.3 Reaching and engaging women from Black and Minority Ethnic Communities

PATHway has been successful in reaching a higher proportion of women from South Asian communities than is apparent in other domestic abuse services. A combination of factors appear to have come together to achieve this:

- The sensitivity of the midwives in carrying out the routine enquiry

38. Howarth E, et al (2009) *"Safety in Numbers: A multi-site Evaluation of Independent Domestic Violence Advisors",* commissioned by The Hestia Fund and can be found on http://www.caada.org.uk/Research/research.html
39. McWilliams, M. and McKiernan, J. (1993) *Bringing it out into the open,* in DH 2005 'Responding to Domestic Abuse – a handbook for professionals'

- The midwives enhanced confidence through the presence of the IDVA
- The enabling, women-centred environment
- The opportunity for women to have a legitimate referral route without raising suspicion
- Concern in pregnancy for their children's safety
- The knowledge, skills and attributes of the IDVA to be sensitive to cultural difference.

6.4 Engaging health services in domestic abuse

A report into the role of IDVAs[40] showed a need for health services to be more closely linked to IDVA services. In the 12 months prior to the PATHway project starting, the community IDVA team in Manchester only received 40 referrals from NHS organisations in Manchester. The PATHway project alone received **196 referrals** from Central Manchester Foundation Trust staff in its15 months of operation, increasing substantially the identification and referral of domestic abuse from the health sector.

A study is in progress[41] using a cluster random control trial to test the effectiveness and cost effectiveness of a training and support programme for domestic abuse in general practice teams (final report due in Autumn 2010). The intervention is a collaboration between primary health care services and third sector agencies specialising in domestic abuse. It was developed to meet the challenge of engaging health care services in identifying and supporting domestic abuse victims. The project is working with domestic abuse advocacy educators in General Practice settings[42]. Learning from the project will help to inform the future development of PATHway.

The recent report of the Taskforce on the Health Aspects of Violence against Women and Children, which explored the role of the NHS[43] in domestic violence recommends that all health service organisations should participate fully in multi agency responses to domestic abuse. It also recommends that every NHS organisation should have a single dedicated person to advise on appropriate services, care pathways and referrals for all victims of abuse providing urgent advice in cases of immediate and significant risk. St Mary's has a specialist midwife with responsibility for safeguarding and who is notified of all disclosures of domestic abuse. The presence of an IDVA in an NHS setting supports that safe guarding role and in addition supplies a direct referral route for women to an independent expert trained to reduce harm to women and their children.

6.5 Working in an NHS setting

Evidence from research[44] has highlighted the need to ensure IDVAs and other domestic abuse workers based in health settings receive the right support. Amanda Robinson's process evaluation of four IDVA projects highlights the challenges of working in health organisations whilst still preserving the independence of the IDVA. She recommends that all IDVAs should be managed by independent domestic violence projects and their work reviewed by a supervisor on a monthly basis. In addition there should be day-to-day oversight of the work and individual clinical supervision provided.

The WORTH service (Ways of Responding Through Health) has been developed and delivered by the West Sussex Crime and Disorder Partnership since 2004 and although originally based in Accident and Emergency Departments, it has now expanded to include other health settings. It is a multi agency funded service and has 20 IDVAs working in health organisations. Learning from WORTH[45] has enabled them to conclude that IDVAs working in hospital settings need to be fully integrated with a wider IDVA team.

In PATHway there has been considerable learning into how to facilitate this role in Manchester. A period of induction into the NHS setting and clarity of purpose of the role is essential, along with understanding lines of accountability and responsibility.

The PATHway IDVA works in the maternity unit and away from the central IDVA team. She has continued to be line managed by the manager of the community IDVA team based at the town hall and this has allowed professional supervision and case management to continue. Group supervision with other IDVA colleagues is in place and regular one-

40. Howarth E, et al (2009) *"Safety in Numbers: A multi-site Evaluation of Independent Domestic Violence Advisors"*, commissioned by The Hestia Fund and can be found on http://www.caada.org.uk/Research/research.html
41. Gregory A et al (2010) Primary Care *I*dentification and *R*eferral to *I*mprove the *S*afety of Women experiencing domestic violence (IRIS): protocol for a pragmatic cluster randomised controlled trial, *BMC Public Health 2010, 10:54*
42. Johnson M (2010) 'Herding Cats': the experiences of domestic violence advocates engaging with primary care providers, *The Domestic Abuse Quarterly Winter 2010: 14-17.*
43. Department of Health (2010) Responding to violence against women and children – the role of the NHS, March 2010
44. Robinson A (2009) *Independent Domestic Abuse Advisors: a process evaluation.* Cardiff University and funded by the Home Office
45. Trish Harrison, WORTH manager, January 2010

to-one clinical supervision is available with an external supervisor at the town hall. In addition, consideration needs to be given to who is best placed in the hospital setting to offer day-to-day support to the worker.
PATHway has demonstrated the need for the IDVA to adapt to working in an NHS environment alongside health colleagues where different policies and procedures and professional boundaries are in place. It is to the credit of the IDVA that this has been achieved in this project but if the role is to be replicated in other NHS settings, and independence is to be preserved, processes need to be in place to ensure there is a mutual understanding between all professional groups.

Learning from this project has shown that a number of processes need to be in place at the beginning. These include:

- Private room to see clients undisturbed
- Access to interpreters
- Dedicated desk space
- Computer and printer which is linked to the central IDVA data base
- Day-to-day contact with a named person on site

6.6 Is there a role for a specialist IDVA?

Through working in a health organisation and with a specific client group (pregnant women) the PATHway IDVA has learnt new knowledge and skills, which she brings to the IDVA role. It is important that this expertise is recognised and utilised effectively. For example, her caseload differs from her colleagues in a number of ways:

- She sees only pregnant women or those recently delivered
- The women are often in an acute phase of abuse with visible strangle marks or bruising
- Clients are referred following disclosure at a routine enquiry
- Clients have not been assessed for high risk or very high risk
- Clients are seen within minutes or hours of disclosure
- There is the extra responsibility and complexity of safe guarding the unborn child
- Victims are often still with the perpetrator and father of the child
- The IDVA is working in an NHS culture alongside health professionals who have different roles and responsibilities

During the evaluation some midwives asked if there was a health specialist IDVA at the town hall. It could be argued that the experience the IDVA has developed could be transferred to other health settings such as general practice or Accident and Emergency Departments.

It also suggests that there could be value in having a team of IDVAs who worked in a range of health settings. They would offer support to each other and share learning, reducing the isolation of a lone worker and building up a body of knowledge. Extra expertise would be built into a domestic abuse service and as demonstrated in this project, the response of health organisations to domestic abuse would be enhanced. It would allow cover to take place. When the PATHway IDVA is not at the hospital, either through leave or sickness, there have been no referrals to the community IDVAs[46]. We believe this demonstrates the value of having an IDVA presence within the health setting.

6.7 Should midwives at St Mary's complete the CAADA-DASH Risk Indicator Checklist?

The key intervention of the IDVA is normally with high risk or very high-risk victims. As discussed in the findings, the PATHway IDVA's role differs in that she carries out the risk assessment and addresses safety planning with all women who are referred. The circumstances evidenced in this report have also meant that the women have been more likely to engage with the IDVA after referral[47] (82 per cent). This has resulted in a high number of interventions for one IDVA and it is likely as the service matures and midwives identify more women with abuse this referral rate will increase and the service will be over loaded.

46. There was one recent referral (when the IDVA was on leave) to the central IDVA team from a midwife at St Mary's but the woman was already known to the PATHway IDVA.
47. CAADA recommends 100 referrals to each IDVA with a 70 per cent engagement

In order that the IDVA remains focused on very high or high-risk women, the midwives could carry out the CAADA-DASH Risk Indicator Checklist (RIC) with all women who disclose or who they believe may be at risk. This builds on their skills and is the next step on from routine enquiry. The women who score highly or they have particular professional concerns about are then referred to the IDVA. The women at lower risk are signposted or referred to other domestic abuse support services with the support of the safeguarding midwife.

If midwives take on the assessment, training will be required and become part of core training. The midwives interviewed for this evaluation had very patchy knowledge of MARAC, the Risk Indicator Checklist and domestic abuse support services. We do not see the training as a role for the IDVA, rather it is delivered by health professionals to health professionals. However we would only make the recommendation for midwives in St Mary's to carry out the RIC if, initially, there is back up support from an IDVA in the unit to take on safety planning and multi agency co-ordination. The complexity of St Mary's population and level of high-risk victims identified (28 MARACs in 15 months of PATHway and this would be likely to rise), make this essential.

If the NHS in Manchester is to take its full role in the multi agency response to domestic abuse in Manchester knowledge on these issues does need to be enhanced. There is also some evidence from the evaluation that through institutional advocacy midwives awareness of abuse was enhanced and they become better at detecting it. Manchester Community Health have produced staff guidelines for domestic abuse[48] and is recommending that all their staff who have a woman disclose abuse on selective enquiry do the Risk Indicator Checklist.

We recognise that there is considerable time pressures and other demands on professionals in the St Mary's unit. If the RIC assessment is carried out attention would need to be given to resources, processes and pathways.

6.8 Contributing to safeguarding pathways

The presence of the IDVA in St Mary's has improved the safety of women and children. If the service becomes part of mainstream provision an internal patient pathway needs to be developed which maps the pathway from routine enquiry to assessment, safeguarding processes, safety planning and multi agency referrals in the Trust. This will clarify lines of accountability and responsibility particularly when working with an external independent service.

The pathway needs to be in line with other agreed multi agency pathways and how these link with local children's and adult safeguarding pathways outside St Mary's.

Similarly, the PATHway service needs to be seen as a referral pathway for other agencies outside St Mary's. Multi agency pathways which link to other health services such as Accident and Emergency Departments, alcohol abuse and mental health services would be beneficial.

The forthcoming guidelines from the National Institute for Health and clinical Evidence (NICE) concerning pregnant women with complex social problems[49] includes domestic abuse and recommends that commissioners and providers should ensure that a local protocol is written which include: "Clear referral pathways that set out the information and care that should be offered to women" (2010: 116).

48. Manchester Community Health *Domestic Abuse Staff Guidelines July 2010 DRAFT Version 5*
49. *Pregnant Women with Complex Social Problems: a model for service provision,* National Collaborating Centre for Women's and Children's Health, commissioned by NICE, Draft for consultation February 2010. http://guidance.nice.org.uk/CG/Wave14/29

7. RECOMMENDATIONS TO KEY DECISION MAKERS

Based on the evidence presented in this evaluation, we recommend that the IDVA service should continue at St Mary's maternity hospital and that it should be part of a joint commissioning, multi agency process across Manchester to safeguard women and children[50].

We recommend that consideration be given to the following points – learnt from the pilot – to further enhance the development and effectiveness of the service and its role in improving the safety of women in Manchester:

1. Another IDVA is trained to work with pregnant women so that there is full cover for the service. It would reduce the isolation of one worker in a health setting and build up further expertise to make the service sustainable. The population served by St Mary's, the high number of deliveries and significant ethnic minority population would warrant this.

2. A specialist health team is developed in the IDVA service, including those working in midwifery, so that the service can be taken into other health settings

3. The IDVA service in St Mary's should continue to be managed in the main IDVA team and within the City's multi agency response to domestic abuse

4. The IDVA maintains her role in engaging with high risk and very high-risk women and quickly moving victims to other services. This is essential to maintain the particular expertise of the IDVA and not to dilute the effectiveness of the role through too large a case load

5. Further development and learning from engaging Pakistani women who disclose abuse should be shared with other domestic abuse services

6. When setting up this service elsewhere, time is spent inducting the IDVA into health settings, and there is a named, day to day, on site contact

7. Data systems need to be set up, desk space and equipment and the availability of private meeting rooms available prior to the start of the service

8. The data collection systems should be reviewed to capture more effectively the number of women seen who have no recourse to public funds and to more easily track women who move out of the area.

9. Patient pathways are developed to show clear referral routes from routine enquiry to domestic abuse services and to multi-agency pathways responding to domestic abuse and child and adult safeguarding procedures

10. Midwives are trained and supported to carry out the CAADA-DASH Risk Indicator Checklist with all women who disclose or where they suspect abuse. This will further enhance their professional role in safeguarding women and their unborn children. It supports the health services commitment to a multi agency response to high-risk women. Initially we only recommend this if the IDVA service continues while expertise is developed. The implementation will require attention to resources in an already busy and complex workplace.

11. Training of midwives in MARAC procedures, risk assessment, information sharing and operational protocols should be the responsibility of the Trust and is in line with the Trust's commitment to MARAC.

12. The role of the IDVA in increasing awareness and enhancing the professional response to domestic violence through institutional advocacy is recognised and mechanisms are maintained to transfer practice knowledge and wisdom in the health setting

50. As the new structures for the NHS and local authority emerge, this should be part of the commissioning process in the proposed Health and Wellbeing boards formed to support joint working on health and wellbeing across the Greater Manchester area

13. Processes are put in place to enable other health professionals within St Mary's, such as doctors, to understand their role in response to domestic abuse and the contribution of the IDVA

14. In order to maintain the independence of the domestic abuse advisor, funding for the post (or posts) should be through joint commissioning in line with the multi agency response to domestic abuse

Appendix One: PATHway Outcome indicator table

Outcomes: What change will result from your activities? What will success look like?	**Indicators:** what will be measured to know we have been successful?	**Data collection:** How can we measure it? What needs to be collected and when? **Document in progress**
1. The safety of women and their children who are referred will be improved	• Numbers of women willing to disclose to NHS staff raised • Numbers of cases referred to IDVA for initial contact will increase. • Number of women referred and engaged with IDVA on ongoing basis (2 or more contacts) will increase • Increased number of cases referred to other agencies from IDVA (agencies identified to reflect on sort of support needed/offered.) • Numbers of women given advice on alcohol use • Numbers of women referred to alcohol services • Increased numbers of cases identified as high risk and referred to MARAC • Increased number of cases where initial safety planning undertaken with woman by IDVA • Increased number of cases where more in depth safety planning undertaken • Number of cases referred for Target Hardening/ sanctuary type safety enhancement will increase.	Monitoring data: Increased number of referrals to IDVA at St. Mary's, compared with numbers of referrals previously to community IDVA service from St Mary's (baseline)
2. The service will reach a diverse range of people	• Increase nos of women from a ethnic minority backgrounds being referred to IDVA • Increase number of ethnic minority women being supported by IDVA • Increased number of ethnic minority women referred to other agencies.	Monitoring data and interviews
3. Repeat victimisation will be reduced	Number of REPEAT incidents to MARAC	MARAC co-ordinator
4. NHS staff will be more competent in recognising and responding to DA	• Midwives will be more confident about asking about DA • Increase in referrals from NHS staff to IDVA • NHS staff will understand the issue	Training evaluations Questionnaires Focus group
5. Data monitoring of prevalence of DA and the service response will improve, but without comprising the safety of women and their children.	• Reported incidences of DA are recorded • Actions/ referrals undertaken will be recorded	May need to ask if this is happening, procedures in place, etc if we do not have access to records
6. DA referral pathways for reproductive services will have been developed with staff at St Mary's and other NHS staff as appropriate	• Baseline data established from which to mark increase in referrals • By 2010 any wrinkles in referral process will have been ironed out • Clarity about pathways in context of the developing service will have been recognized and acted upon	
7. The project will become part of mainstream service provision	• Funding will be secured • Cost effectiveness of the project will have been demonstrated • Beneficial financially to NHS and partner agencies • Increased safety through support to women in pregnancy will be contributing to local targets	

Appendix Two: List of stakeholders and key informants

The following people contributed to the evaluation through attending stakeholder workshops, through one to one interviews and providing information:

Name	Title and Organisation
Val Armstrong	Public Health Manager, NHS Manchester and project commissioner
Maria Bartlett	Specialist midwife, Safeguarding, CMFT
Mary Bell	Assistant Director Maternity and Early Years NHS North West
Sam Bradbury	Commissioning manager, children's and maternity services, NHS Manchester
Hazel Chamberlain	Head of Safeguarding, Central Manchester University Hospitals NHS Foundation Trust
Julie Church-Taylor	Greater Manchester Police
Ishbel Cooke	Women's Aid
Cheryl Doyle	CMFT Accident and Emergency Department
Delia Edwards	Service Manager, Independent Domestic Violence Advice Service MCC
Colin Elliott	Head of Drug and Alcohol Strategy, MCC
Lydia Fleuty	Drug and Alcohol Strategy Team
Cathy Freese	National peri-natal mental health project lead, National Mental Health Development Unit
Barry Gillespie	Consultant in Public Health NHS Manchester
Anne-Marie Goodall	Modern Matron for Community CMFT
John Graves	Partnership Superintendent, GMP
Barbara Guest	Head of Service, Manchester Advice, MCC
Ruth Helen	MCC Supporting People
Alan Hinchcliff	DC Representing Detective Superintendent GMP
Dot Jennings	Senior Nurse – Safeguarding children, PCT/ MCH
Nita Jhanji-Garrod	Greater Manchester Police
Medina Johnson	IRIS (Identification & Referral to Improve Safety) IRIS Development Lead, Next Link
Gagandeep Kane	CMFT Accident and Emergency Department
Sarah Khalil	Domestic abuse co-ordinator, MCC
Rachel Lappin	MARAC co-ordinator for the Manchester Partnership
Faye Macrory	Consultant Midwife CMFT
Clare McCann	Public Health manager NHS Manchester
Phil Owen	Detective Superintendent GMP, Safeguarding Vulnerable Adults Unit
Helen Perry	Director, Manchester Women's Aid
Eleanor Roaf	Public Health Consultant, safeguarding children, NHS Manchester
Bernie Ryan	St Mary's Sexual Assault Referral Centre
Lisa Ryder	Project Manager/Specialist Trainer - Domestic Abuse, Manchester Community Health
Elaine Saunders	Information Officer, Central Central University Hospitals
Melissa Whitworth	Consultant Obstetrician St Mary's Hospital
Gabrielle Wilson	NHS Manchester Public Health Commissioner
Kathryn Wright	Solicitor for domestic abuse, Ayers Waters Solicitors

Appendix Three: Evaluation Data sources

Source	Details
Document and evidence review	National and local policies and research
Data sources April 09 to June 10	Including MARAC referrals Hospital ethnicity data IDVA monitoring data IDVA team data
126 Client structured questionnaires	Completed between IDVA and client
16 Client semi-structured telephone interviews	
33 IDVA Project diaries	Completed weekly electronically
70 NHS staff self completion questionnaires	Self completion in November 2009
3 focus groups with midwives (total14)	Community and hospital midwives in June 2010
1 Interview with consultant obstetrician	June 2010
3 stakeholder workshops	July 2009 (17), January 2010 (14) and September 2010 (20)
10 stakeholder interviews	National and local specialists and commissioners

Appendix Four: PATHway IDVA reflective diary

Suggestions for use:

- It is subjective so it is your experiences – there are no right or wrong answers
- Complete quickly, don't dwell for too long – about 5 minutes maximum
- Complete electronically on a weekly basis

Date:.....

What 3 things did I expect to happen this week?	
What 3 things did happen?	
What has been the most significant thing that happened this week?	
What have I learnt?	
How do I feel now?	

Appendix five: 09-06-09 CAADA-DASH Risk Identification Checklist (RIC)

Aim of the form:

- To help front line practitioners identify high risk cases of domestic abuse, stalking and 'honour'-based violence.
- To decide which cases should be referred to MARAC and what other support might be required. A completed form becomes an active record that can be referred to in future for case management.
- To offer a common tool to agencies that are part of the MARAC[51] process and provide a shared understanding of risk in relation to domestic abuse, stalking and 'honour'-based violence.
- To enable agencies to make defensible decisions based on the evidence from extensive research of cases, including domestic homicides and 'near misses', which underpins most recognised models of risk assessment.

How to use the form:

Before completing the form for the first time we recommend that you read the full practice guidance and Frequently Asked Questions and Answers[52]. These can be downloaded from www.caada.org.uk/marac.html
Risk is dynamic and can change very quickly. It is good practice to review the checklist after a new incident.

Recommended Referral Criteria to MARAC

1. **Professional judgement:** if a professional has serious concerns about a victim's situation, they should refer the case to MARAC. There will be occasions where the particular context of a case gives rise to serious concerns even if the victim has been unable to disclose the information that might highlight their risk more clearly. **This could reflect extreme levels of fear, cultural barriers to disclosure, immigration issues or language barriers particularly in cases of 'honour'-based violence.** This judgement would be based on the professional's experience and/or the victim's perception of their risk even if they do not meet criteria 2 and/or 3 below.

2. **'Visible High Risk':** the number of 'ticks' on this checklist. If you have ticked 14 or more 'yes' boxes the case would normally meet the MARAC referral criteria.

3. **Potential Escalation:** the number of police callouts to the victim as a result of domestic violence in the past 12 months. This criterion can be used to identify cases where there is not a positive identification of a majority of the risk factors on the list, but where abuse appears to be escalating and where it is appropriate to assess the situation more fully by sharing information at MARAC. It is common practice to start with 3 or more police callouts in a 12 month period but this will need to be reviewed depending on your local volume and your level of police reporting.

Please pay particular attention to a practitioner's professional judgement in all cases. The results from a checklist are not a definitive assessment of risk. They should provide you with a structure to inform your judgement and act as prompts to further questioning, analysis and risk management whether via a MARAC or in another way.

The responsibility for identifying your local referral threshold rests with your local MARAC.

What this form is not:

This form will provide valuable information about the risks that children are living with but it is not a full risk assessment for children. The presence of children increases the wider risks of domestic violence and step children are particularly at risk. If risk towards children is highlighted you should consider what referral you need to make to obtain a full assessment of the children's situation.

51. For further information about MARAC please refer to the CAADA MARAC Implementation Guide www.caada.org.uk.
52. For enquiries about training in the use of the form, please email training@caada.org.uk or call 0117 317 8750.

CAADA-DASH Risk Identification Checklist for use by IDVAs and other non-police agencies[53] for MARAC case identification when domestic abuse, 'honour'- based violence and/or stalking are disclosed

Please explain that the purpose of asking these questions is for the safety and protection of the individual concerned. Tick the box if the factor is present ☑. Please use the comment box at the end of the form to expand on any answer. It is assumed that your main source of information is the victim. If this is **not the case** please indicate in the right hand column	Yes (tick)	No	Don't Know	State source of info if not the victim e.g. police officer
1. Has the current incident resulted in injury? (Please state what and whether this is the first injury.)	☐	☐	☐	
2. Are you very frightened? **Comment:**	☐	☐	☐	
3. What are you afraid of? Is it further injury or violence? (Please give an indication of what you think (name of abuser(s)...) might do and to whom, including children). **Comment:**	☐	☐	☐	
4. Do you feel isolated from family/friends i.e. does (name of abuser(s)...) try to stop you from seeing friends/family/doctor or others? **Comment:**	☐	☐	☐	
5. Are you feeling depressed or having suicidal thoughts?	☐	☐	☐	
6. Have you separated or tried to separate from (name of abuser(s)….) within the past year?	☐	☐	☐	
7. Is there conflict over child contact?	☐	☐	☐	
8. Does (……) constantly text, call, contact, follow, stalk or harass you? (Please expand to identify what and whether you believe that this is done deliberately to intimidate you? Consider the context and behaviour of what is being done.)	☐	☐	☐	
9. Are you pregnant or have you recently had a baby (within the last 18 months)?	☐	☐	☐	
10. Is the abuse happening more often?	☐	☐	☐	
11. Is the abuse getting worse?	☐	☐	☐	
12. Does (……) try to control everything you do and/or are they excessively jealous? (In terms of relationships, who you see, being 'policed at home', telling you what to wear for example. Consider 'honour'-based violence and specify behaviour.)	☐	☐	☐	
13. Has (……..) ever used weapons or objects to hurt you?	☐	☐	☐	

53. Note: This checklist is consistent with the ACPO endorsed risk assessment model DASH 2009 for the police service.

Tick box if factor is present. Please use the comment box at the end of the form to expand on any answer.	Yes (tick)	No	Don't Know	State source of info if not the victim
14. Has (……..) ever threatened to kill you or someone else and you believed them? (If yes, tick who.) **You ☐ Children ☐ Other (please specify) ¨**	☐	☐	☐	
15. Has (…….) ever attempted to strangle/choke/suffocate/drown you?	☐	☐	☐	
16. Does (……..) do or say things of a sexual nature that make you feel bad or that physically hurt you or someone else? **(If someone else, specify who.)**	☐	☐	☐	
17. Is there any other person who has threatened you or who you are afraid of? **(If yes, please specify whom and why. Consider extended family if HBV.)**	☐	☐	☐	
18. Do you know if (……..) has hurt anyone else? (Please specify whom including the children, siblings or elderly relatives. Consider HBV.) **Children ☐ Another family member ☐ Someone from a previous relationship ☐ Other (please specify) ☐**	☐	☐	☐	
19. Has (…….) ever mistreated an animal or the family pet?	☐	☐	☐	
20. Are there any financial issues? For example, are you dependent on (…..) for money/have they recently lost their job/other financial issues?	☐	☐	☐	
21. Has (……..) had problems in the past year with drugs (prescription or other), alcohol or mental health leading to problems in leading a normal life? **(If yes, please specify which and give relevant details if known.) Drugs ☐ Alcohol ☐ Mental Health ☐**	☐	☐	☐	
22. Has (……) ever threatened or attempted suicide?	☐	☐	☐	
23. Has (…….) ever broken bail/an injunction and/or formal agreement for when they can see you and/or the children? (You may wish to consider this in relation to an ex-partner of the perpetrator if relevant.) **Bail conditions ☐ Non Molestation/Occupation Order ☐ Child Contact arrangements ☐ Forced Marriage Protection Order ☐ Other ☐**	☐	☐	☐	
24. Do you know if (……..) has ever been in trouble with the police or has a criminal history? (If yes, please specify.) **DV ☐ Sexual violence ☐ Other violence ☐ Other ☐**	☐	☐	☐	

Total 'yes' responses

For consideration by professional: Is there any other relevant information (from victim or professional) which may increase risk levels? Consider victim's situation in relation to disability, substance misuse, mental health issues, cultural/ language barriers, 'honour'- based systems and minimisation. Are they willing to engage with your service? Describe:

Consider abuser's occupation/interests - could this give them unique access to weapons? **Describe:**

What are the victim's greatest priorities to address their safety?

Do you believe that there are reasonable grounds for referring this case to MARAC? Yes / No
If yes, have you made a referral? **Yes/No**

Signed: **Date:**

Do you believe that there are risks facing the children in the family? Yes / No
If yes, please confirm if you have made a referral to safeguard the children: **Yes / No**
Date referral made .....

Signed: **Name:**	**Date:**

Practitioner's Notes

NHS Manchester

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