PATHway Project:
An Independent Domestic Violence Advisory service at St Mary's Maternity Hospital, Manchester

NHS Manchester

Independent Evaluation: Final Report

September 2010

"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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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

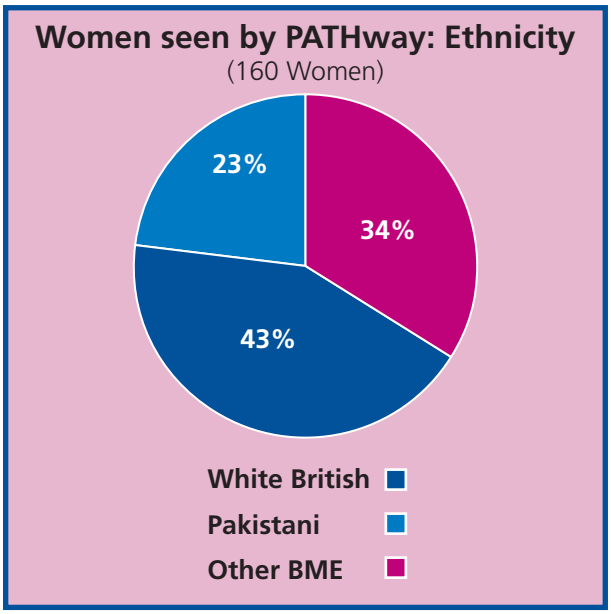
The Clients

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 2010[21] (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.

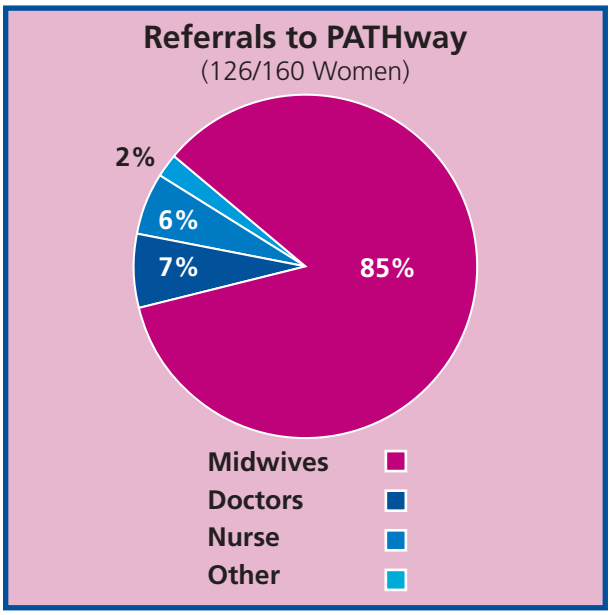
This is particularly significant for domestic abuse because of the increase risk to South Asian women of forced marriages and honour based violence and that they are often isolated and do not easily access domestic abuse services[23]. The Manchester community IDVA team saw 52.8 per cent White British 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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