Action for Change Final Evaluation Report

Findings from the United Kingdom
# Contents

1. Introduction .................................................................................................................. 3
2. Evaluation methodology ................................................................................................. 6  
   Desk based research and literature review .................................................................... 7
3. Context ......................................................................................................................... 9  
   National Statistics - Domestic Violence in the United Kingdom ................................. 9  
   Child protection in place in the United Kingdom ....................................................... 13  
   National statistics - children in care .......................................................................... 13  
   National statistics – multiple care proceedings ....................................................... 15  
   Cost of domestic violence and children being put into care in the UK ..................... 15  
   Mapping support – policy development .................................................................. 16  
   Mapping support – Domestic Violence .................................................................. 17  
   Mapping provision .................................................................................................. 20  
   Gaps in provision and policy .................................................................................... 23  
4. Findings ...................................................................................................................... 25  
   Policy drivers .......................................................................................................... 25  
   The Action for Change Model .................................................................................. 25  
   Research participants .............................................................................................. 26  
5. Tracking participants journey through the support .................................................. 27  
   Engaging clients ....................................................................................................... 28  
   Entry into support ..................................................................................................... 29  
   Delivery of support .................................................................................................. 30  
6. Outcomes from the support ....................................................................................... 34  
   Views of the support .................................................................................................. 37  
7. Recommendations and conclusions .......................................................................... 40  
   Recommendations .................................................................................................... 40  
   Bibliography ............................................................................................................. 44
1. Introduction

The Action for Change Project is funded by the Daphne Programme of the European Union and delivery officially started in January 2015. The project compromises six partners across four countries; the United Kingdom, Romania, Italy and Hungary. The Royal Borough of Kensington and Chelsea has managed and coordinated the overall project.

The overarching objective of the Action for Change programme is to advance knowledge and understanding of service models that most effectively address the needs of women who are victims of domestic violence and subject to removals of their children.

Where support has been piloted it has aimed to prevent any further siblings being taken into care or children coming into care through reducing risk and ending the cycle of violence; therefore, also improving the impact on siblings and future unborn children.

To do this the project has worked to empower women to make decisions and choices for themselves regarding factors including parenting, having further children and changing their lifestyle to keep any further children from being taken into care.

The project has targeted individuals who have lost, or are at risk of losing, a child to care as a result of domestic violence (DV) because, across all partners, they often are ineligible for service provision that would address their needs. Although they are vulnerable and may have a number of interrelated needs linked to domestic violence, such as substance misuse, mental health issues and/or learning difficulties, the focus for local authorities, once a child has been permanently removed has traditionally been to focus on the well-being of the child with its new carers and making any contact safe. Therefore, there is no intervention for the individual to address the cycle or pattern of behaviour driving the removal of a child, or support for them regarding loss of a child.

Women who separate from a violent partner are at particularly high risk: for 50 per cent of families who separate, the domestic violence continues beyond separation. Between 2009 and 2015, 936 women were killed by men in the United Kingdom; 64 per cent were killed by their current or former partners and 6 per cent of women killed by their ex-partner or ex-spouse were killed within the first year that followed their separation. Although often viewed as isolated incidents many of these cases followed similar patterns of violence and were premeditated.


In addition, poor maternal mental health increases the likelihood of harm for children exposed to domestic violence. In the United Kingdom, women experiencing domestic violence are fifteen times more likely to misuse alcohol; nine times more likely to misuse other drugs and five times more likely to attempt suicide than the general population.

Women are also more vulnerable to severe and lasting post-traumatic stress, especially those in on-going danger who experience multiple incidents, and through negative reactions from others. Women’s parenting is likely to be adversely affected by domestic violence, but there is evidence that it can recover.

To improve parenting and reduce the likelihood of a child going into care, the project has consequently not dealt with DV in isolation, but alongside the interlinking needs and risk factors. Services have been designed according to need so that the drivers and consequences of DV, particularly loss of a child, are addressed through assertive outreach.

**The project has had five main aims:**

1. To research/map services for women who have lost, or are at risk of losing, a child to care as a result of domestic violence, exchange best practice and identify gaps, resulting in the development of service options

2. To fill the gap in service provision by addressing the interlinking risks and needs of this group of women who typically ‘fall through the gap’, through assertive outreach and a multi-agency model that co-ordinates appropriate support

3. To facilitate participation of women from this group to establish their needs and views and furthermore to contribute to project developments and influence the outcomes

4. To pilot innovative multi-agency projects to support these women and evaluate the effectiveness of the support

5. To present recommendations for establishing service provision, raise awareness of the needs and risk factors and promote assertive outreach for vulnerable women to combat domestic violence.

As well as exploring what services work, we have also conducted research into those that are missing across the four countries.

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6 Stanley, *Children experiencing domestic violence…*
At the end of the project, partners intend to come together and share the learning to develop a toolkit for services in the UK and across Europe to support individuals who have experienced domestic violence and are either at risk of having their children removed or have had a child removed from their care.

Each country ran a pilot project simultaneously. The projects worked with individuals whose children have been removed, with domestic violence being a contributory factor. Alongside this evaluation and research was conducted in each country using a common framework. As well as leading the evaluation in the United Kingdom, the Learning and Work Institute (L&W) was the lead research partner on the project and was responsible for drawing together the Evaluation Framework.
1. Evaluation methodology

This evaluation has compromised five distinct elements:

- A desk research and a literature review;
- scoping interviews;
- longitudinal participant research;
- frontline provider interviews and;
- analysis of management information

These approaches sought to address specific research questions which included:

1. What are the risk factors that may trigger children being taken into care in household where inter-parental domestic violence has occurred?

2. How would the circumstances of a parent who has experienced domestic violence need to change to facilitate the return of a child or prevent a further child being taken into care?

3. What support is available to parents who have experienced domestic violence to help make the changes necessary to facilitate the return of a child/prevent a further child being taken into care (to explore form, function, effectiveness/outcome)?

4. How does support delivered through the Action for Change pilot add value to the existing delivery models?

5. To what extent does the support offered by Action for Change help to reduce risk factors associated with having a child placed into care?

The literature review and scoping interviews provided the necessary background and context to the evaluation, and informed the development of measures of success to be explored in the participant research, provider interviews and analysis on management information. These elements of the research intended to inform research questions 1,2 and 3.

The frontline provider interviews were also intended to inform what support is available to parents (question 3) and, alongside the longitudinal participant research, address questions 4 and 5 about the effectiveness of support.

Lastly analysis of management information was intended to provide evidence on the extent to which the support reduced the risk factors associated with having a child placed into care (question 5).
**Desk based research and literature review**

For the literature review, a common Literature Review Protocol, as outlined in the Action for Change Evaluation Framework, was followed. “Grey” literature and academic sources were analysed alongside official statistics on both the cost (in human and financial terms) and the number of domestic violence and child removal cases. Domestic violence and child protection policy documents were also reviewed and examples of provision for those affected by such issues were sought out.

The search strategy relied on online directories (i.e. Google scholar, Open Grey, etc), UK official statistics and bibliographic searches. In order to identify the most relevant publications searches were limited to reports published within the past 15 years and that had a specific focus on practice and policy within the United Kingdom.

**Longitudinal depth interviews**

Participant research has largely been in the form of longitudinal depth interviews. Although it was intended that during the programme, Acton for Change participants would be followed up on three occasions, due to difficulties in contacting participants in the United Kingdom, the second and third wave interviews were often merged.

The purpose of the interviews was to explore:

1. Participants’ pathways into and through multi-agency support, identifying barriers to access and how barriers were overcome, as well as how perceptions of the service evolve.

2. Understand the underlying and changing participant needs upon entry into and progress through support.

3. Outline how support is delivered and how it is adapted to changes in participant needs and circumstances.

4. Track changes in wellbeing, independence/confidence, household and economic situation, behaviour/decision making, progress away from destructive behaviour and distance travelled towards stable lifestyle.

5. Gain feedback on the support received at each point of the participant’s journey, highlighting strengths of the delivery model as well as areas where the service could be refined or improved.

6. Understand if and how support can build future resilience and preparedness to engage with support.

Evaluation teams had the discretion to implement the fieldwork in a way that is appropriate for their local context and to conduct the fieldwork in their desired mode (E.g. face to face, over the phone, using skype). However, across all partners,
participants were captured near the beginning of the programme and towards the end of their involvement in the programme.

Longitudinal interviews were conducted on a rolling basis, whereby participants were followed up at loosely defined points during their journey.

**Provider depth interviews**
Qualitative depth interviews with 4-5 frontline staff providing or managing support to participants were carried out towards the end of operational delivery of the support.

These interviews sought to provide an overview of the participants that engaged with the programme and their support needs; detail the support offered throughout pilot and the service delivery model; draw on provider’s experience of delivering support to understand how the pilot contrasts to existing provision and explore the effectiveness of model; outline outcomes achieved for participants as well as perceived benefits for funders and other stakeholders; and highlight strengths of the service, lessons learnt with regards to delivery and views as to how model could be refined.

**Analysis of management information**
Analysis of management information was provided by the Royal Borough of Kensington and Chelsea, and incorporated into this report:

1. Present total volumes of service use over the duration
2. Analysis of key performance measures captured during the course of participant involvement in the programme
3. Description of outcomes achieved for clients.
4. An assessment of cost effectiveness of the duration of the programme.

However, due to the intensity of the support, which therefore necessitates low case volumes the relatively small numbers of service users. As such, it is not possible to conduct a robust statistical analysis of data, though it is possible to identify overall trends.

**Outputs**
Each country has created a national evaluation report summarising the findings in the United Kingdom, Italy, Romania and Hungary respectively. The final report will summarise findings across each country.
2. Context

**National Statistics - Domestic Violence in the United Kingdom**

Domestic violence remains a largely hidden crime that is difficult to assess. Attempts to measure the true scale of the problem in the United Kingdom are hampered by both the reluctance of victims to report their experiences and the absence of a single criminal offence. For example, in 2012/3 only 21 per cent of victims of partner abuse reported it to the police.\(^7\)

In March 2013, following a consultation, the Home Office (the ministerial office in the U.K government responsible for crime policy) introduced a new official definition of domestic violence to be used across government. The definition was expanded to include young people aged 16 to 17 and coercive or controlling behaviour, as it was believed that without this, there may have be occasions where domestic violence and abuse could be regarded as an isolated incident. Consequently, victims may have been unsure about what counted as domestic violence and abuse and may not have reported it. Hence, the British Government’s definition of domestic violence and abuse, which is not a legal definition is currently:

> “Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality.”\(^8\)

This definition acknowledges that such behaviour can encompass, but is not limited to: psychological, physical, sexual, financial and emotional abuse.

Controlling behaviour is defined as:

> “A range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.”\(^9\)

Coercive behaviour is defined as:

> “An act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.” \(^10\)

Levels of domestic violence have been fairly stable in the United Kingdom since 2008/09. The most reliable estimates come from the Crime Survey of England and Wales (CSEW). The latest figures, estimate that in 2014/15, 8.2% of women and 4.0% of men reported experiencing any type of domestic abuse the equivalent to

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\(^7\) *The Crime Survey of England and Wales (2012-2013)*, The Office for National Statistics  
\(^8\) *Home Office (March 2013), Information for Local Areas on the change to the Definition of Domestic Violence and Abuse*  
\(^9\) Ibid.  
\(^10\) Ibid.
around 1.3 million female victims and 600,000 male victims.\textsuperscript{11} Although the level for males has remained at the same level since 2012/13, this represents a 1.2\% increase in incidents reported by females since 2012/13.\textsuperscript{12}

The survey also found that overall, 27.1\% of women and 13.2\% of men had experienced any domestic abuse since the age of 16, equivalent to an estimated 4.5 million female victims and 2.2 million male victims.\textsuperscript{13} Smith et al. estimate that at least 29.9 per cent of women and 17.0 per cent of men in England and Wales have experienced domestic violence or abuse at some point in their lives.\textsuperscript{14}

Partner abuse is the most prevalent form of domestic abuse in the UK. There were 6.5\% of women and 2.8\% of men who reported having experienced any type of partner abuse in the last year (2014/15)\textsuperscript{15} and at least 26.6 per cent of women and 14 per cent of men have, at some point, experienced this since they were 16;\textsuperscript{16} and this is more prevalent among people in healthcare settings.\textsuperscript{17} Furthermore, 8\% of CSEW respondents felt that it was mostly or sometimes acceptable to hit or slap their partner in response to their partner having an affair, and respondents in younger age groups were more likely to think this (13\% of individuals aged 16-19 and 20-24 respectively).\textsuperscript{18}

Households with at least one child under the age of 16, respondents are asked if any children in the household saw or heard what happened during the most recent partner abuse victimisation. In 46\% of cases of partner abuse there was at least one child under the age of 16 living in the household. Of those cases where children were present in the household, in 20\% of cases the children saw or heard what happened, in 62\% of cases the respondent stated that the children did not see or hear what happened, and in 18\% of cases the respondent didn’t know whether the children saw or heard what happened or did not wish to answer.\textsuperscript{19}

\textsuperscript{12} Office for National Statistics (February 2014), \textit{Chapter 4: Intimate personal violence and partner abuse}, National Crime Survey of England Wales 2012-2013
\textsuperscript{13} Ibid.
\textsuperscript{14} Smith et al. (July 2011), \textit{Analysis of the 2010/11 British Crime Survey intimate personal violence split sample experiment}, The Office for National Statistics
\textsuperscript{15} ONS (2016), \textit{Chapter 4: Intimate personal violence}.
\textsuperscript{17} Feder et al. (2009), \textit{How far does screening women for domestic (partner) violence in different health-care settings meet criteria for a screening programme? Systematic reviews of nine UK National Screening Committee criteria}, Health Technology Assessment, 2009; 13 (16)
\textsuperscript{18} ONS (2016), \textit{Chapter 4: Intimate personal violence}.
\textsuperscript{19} Ibid.
The Crown Prosecution Service (CPS) also provides statistics on the number of domestic violence cases referred to the CPS by the police, the number of prosecutions and the number of convictions. In 2014-15 the overall pattern of domestic violence prosecutions indicated, yet again, year on year improvements in prosecutions. The volume of domestic violence referrals from the police rose to the highest level ever of 122,898 in 2014-15 – a rise of 19,329 referrals (18.7%) from 2013-14. 84,711 (68.9% of these referrals) were charged. This reflects the highest volumes of cases recorded by the CPS and a rise of 11,806 charged defendants (16.2%) since 2013-14. All areas in the United Kingdom indicated a rise in the volume of both referrals and charging; but only four Areas increased the proportion charged: Eastern, East Midlands, London and South East. 20

Of the 92,779 defendants prosecuted, 85,687 defendants were men, 7,013 were women, 79 defendants had unrecorded gender. Of those with recorded gender 92.4% were men and 7.6% women. 21 However, such figures are widely understood to be underestimations as domestic violence and abuse is under-reported, both to the police and other services, but also within health and social research.

The likelihood of experiencing domestic violence or abuse in the United Kingdom increases if;

- the individual is female;
- aged between 16-24 (women) or 16-19 (men); 22
- has a long-term illness or disability, which is considered to almost double the risk; 23
- has a mental health problem; 24
- or is a woman who is separated. 25

Furthermore, there is evidence that there is a higher risk of abuse around the time of separation 26 and that the risk of domestic violence increases if the women is pregnant or has recently given birth (Harrykissoon et al. 2002); although one study showed that it appeared to offer protection for some women (Bowen et al. 2005). There is also a correlation between postnatal depression and domestic violence and abuse.

In December 2013, Women's Aid, a national domestic violence charity, declared a “state of crisis in domestic violence services” after their Annual Survey revealed large gaps in funding and provision for women experiencing domestic violence. The

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21 Ibid.
22 Ibid.
23 Ibid.
24 Trevillion et al. (2012), Experiences of Domestic Violence and Mental Disorders: A Systematic Review and Meta-Analysis, PLoS ONE 7(12)
26 Richards, L (2004), Getting away with it: a strategic overview of domestic violence sexual assault and 'serious' incident analysis, Metropolitan Police
charity warned that unless cuts to specialist gender-specific services were halted, an entire network of domestic violence providers in England was likely to collapse. They also emphasised that non-specialist providers were not a suitable alternative as they did not have the expertise or experience to support vulnerable women.\textsuperscript{27}

The Women’s Aid 2013 survey demonstrated that across the 150 responding organisations, 112 specialist posts were lost in the previous year, and the main reason for this was loss of funding. 48 percent of providers that responded were running some services with no Government funding, 30 per cent of services who rely on Local Authority funding experienced budget cuts in 2013 and 17 per cent did not know if they would be getting funds from the Local Authority in that financial year (even though the survey was conducted three months into the financial year).\textsuperscript{28}

As a result of such findings, Chief Executive of Women’s Aid, Polly Neate, said that as a result of cuts to domestic abuse support services "women [we]re more at risk of losing their children than would have been the case".\textsuperscript{29} However, Crime Prevention Minister Norman Baker stated that: "The Government is not cutting funding for domestic violence services. On the contrary, we have ring-fenced nearly £40 million to provide support for victims to escape abusive situations" in response to claims.\textsuperscript{30}

In the Women’s Aid 2015 Survey, the refuge services that responded reported 18,249 referrals to their services in 2014/15. Of these referrals 66.1% were declined and only 33.9% were accepted. We asked services to indicate why referrals were declined. Nearly a quarter (23.27%) of the referrals were declined due to the refuge’s lack of available bed space. Nearly 10% of referrals were declined because the service was unable to meet the woman’s mental health support needs, support needs around language, additional support needs around drug and alcohol issues, additional support needs due to a disability or additional support needs around a previous conviction.\textsuperscript{31}

44% (72 services) of responding services were running an area of work without dedicated funding during the previous financial year, and 19 refuge services in the sample were being run without dedicated funding, so are at risk of imminent closure. Overall, many domestic violence organisations are reducing the services they provide, or are running services using their reserves or voluntary contributions, which is not sustainable.\textsuperscript{32}

\textsuperscript{27} Women’s Aid (3 December 2013), Press release: Women’s Aid warns of crisis in domestic violence services,\textsuperscript{28} Ibid.\textsuperscript{29} Butler, P. (15 January 2015), Children of domestic abuse victims increasingly being taken into care, The Guardian\textsuperscript{30} Ibid.\textsuperscript{31} Women’s Aid (May 2016), Annual Survey 2015: the findings\textsuperscript{32} Ibid.
Child protection in place in the United Kingdom

No child can be taken into care in the United Kingdom without a court order or Section 20 Voluntary Care agreed by the parent(s). Court orders are usually issued by magistrates in the Family Proceedings Court, however, more complicated cases may be held in the county or high court. In legal terms, children in the United Kingdom become looked after through three main routes:

- **Care orders**: made by the courts under section 31 of the Children Act 1989. This allows a council to take a child into care and it gives them responsibility for important decisions such as where that child will live and be educated. A council can apply for a care order if it believes a child is suffering or at risk of suffering significant harm. Unless the court discharges the order; it will last either until the child is 18, or if parental responsibility is given to another person (such as through adoption).

- **Voluntary accommodation arrangements**: under section 20 of the Children Act 1989, which are made with the consent of parents, and often at their request. Under these arrangements, the local authority does not acquire overall parental responsibility, but undertakes day-to-day parental responsibilities.

- **Police protection or involvement with the youth justice system**: When it comes to collecting statistics, children are defined as ‘looked after’ by the local authority when they are subject to a care or placement order or when they are provided with local authority accommodation for more than 24 hours.

In 2005, the Children Act was amended to “make clear that harm includes any impairment of the child’s health or development as a result of witnessing the ill treatment of another person.”

Thereafter, children who witnessed domestic abuse were considered to be at risk, and it became more likely that domestic violence would be a factor in child protection cases.

National statistics - children in care

The number of looked after children has increased steadily over the past seven years and it is now higher than at any point since 1985. A total of 69,540 children were looked after by local authorities in England on 31st March 2015, a rate of 60 per 10,000 children under 18 years. The absolute number of children looked after has increased by 6% since 2011 (65,510).

On 31st March 2015, 55 per cent (38,530) of children looked after were boys and 45 per cent (31,010) were girls. Furthermore, the majority of children looked after (77 per cent) were from a White British background, with Mixed groups and Black or Black British children making up approximately 9% and 7% of the looked after population respectively. These minority ethnic groups appear to be overrepresented.

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in the looked after population (around 5 per cent of the child population of Great Britain is from Black or Black British and Mixed groups).\textsuperscript{35}

The largest age group, was 10 to 15 year olds, who made up 38 per cent of looked after children, whilst children under one were in the minority (5%).\textsuperscript{36}

In 2015, a total of 42,030 looked after children were subject to care orders (either interim of full), representing 60% of all legal statuses. 29 per cent (19,850 children) were being looked after on a voluntary basis, and 13% on some other basis (placement orders, freed for adoption). A small number of children were looked after under police protection or through involvement with the Youth Justice System.

The figures in recent years have also been affected by the implementation of the Legal Aid, Sentencing and Punishment of Offenders Act 2012. This law meant that all children who were remanded by the courts would become looked after by the local authority.

Most looked after children (75%) are in foster care placements. This has increased by 9% since 2010 (from 46,890 to 51,340). Over the same period there has been a 12% decrease in the number of looked after children placed with parents (3,990 in 2011 compared with 3,510 in 2015). Although the number of children placed for adoption increased by 22% between 2011 and 2015 - from 2,720 to 3,320 - this masks a fall of 15% since 2014 (3,910 adoption placements).

9% of children were living in secure units, children's homes and hostels. The domestic violence charity Refuge states that two thirds of the residents in their refuges are children, and that these young people “make up some of the most vulnerable children in our society.”\textsuperscript{37}

In 2015, the main reason why social services first engaged with looked after children was because of abuse or neglect (61%), with family-related issues making up the majority of the rest of cases. The reasons why children start to be looked after have remained relatively stable since 2011, but the percentage starting to be looked after due to family dysfunction has increased slightly (16% of children in 2015 compared with 14% in 2011).

In January 2014, the British press reported on research undertaken by the Family Rights Group, which warned that funding cuts to local domestic abuse services meant that children of domestic abuse victims were increasingly being put into care.\textsuperscript{38} The charity stated that the combination of the funding cuts to family and domestic abuse services and the recent welfare reforms had resulted in a lack of access to specialty support, which was putting families at risk of being split up. Their data

\textsuperscript{35} Ibid.
\textsuperscript{36} Ibid.
\textsuperscript{38} Butler P., Children of domestic abuse victims...
suggested that domestic violence was the most common underlying factor behind child protection intervention, and domestic violence was reported to be a factor in over a fifth of the child protection cases that the charity deals with. The charity, which promotes the rights of birth families, also said it had seen an 803 per cent rise in inquiries in which domestic violence was a factor between 2007-08 and 2012-13; and most were from families in poverty or on incomes below £15,000 per annum.

The Chief Executive of Family Rights Group, Cathy Ashley said abused women had reported that they were told by social workers to leave the family home with their children immediately or risk them being taken into care, often forcing them to move away from family and community support networks into insecure housing.39

**National statistics – multiple care proceedings**

Research by Broadhurst and Mason has established that “a sizeable population of birth mothers lose multiple infants and children to the care system in successive public law proceedings.”40 Likewise, public law profiling studies, such as that carried out by Masson et al. found that it was not unusual for care proceedings to involve children that have already been adopted or taken into care.41

Between 2012 and 2015, 40 women with an average age of 33 years were recorded as having been subject to multiple care proceedings within the Tri-borough and elsewhere. This cohort had a total of 125 children/ young people (CYP) who were subject to care proceedings, and their average age was six years old.

The borough of Hammersmith and Fulham had the highest number of multiple care proceedings with 21 cases, and over 70 per cent of cases involved parent(s) who had three or more CYP subject to care proceedings. Westminster had the second highest number of multiple care proceedings, with 11 cases; 50 per cent of which included parent(s) who had four or more CYP subject to care proceedings.

63 per cent of multiple care proceedings occurred to women during their thirties, and 82 per cent of women are between the ages of 36 to 45 years of age.

**Cost of domestic violence and children being put into care in the UK**

In the 2013/14 financial year, an estimated £2.5 billion (gross expenditure) was spent on the main looked after children’s services in England. The majority of expenditure (55 per cent) was on foster care services (around £1.4 billion) and children’s homes (36 per cent – at around £0.9 billion).42

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39 Ibid.
41 Masson et al. (2008), *Care Profiling Study*, Ministry of Justice.
In addition, the average annual cost to a local authority per care proceeding was approximately £30,000 in 2013. This is in respect to children who are subject to either a care or placement order. The average cost of each looked after child that same year was estimated to be £52,075.43

Research has shown that it is likely that a high proportion of women attending accident and emergency departments, primary care, family planning, reproductive and sexual health settings experienced domestic violence and abuse at some point.44 Furthermore, between 25 and 56 per cent of female psychiatric patient’s report experiencing domestic violence and abuse in their lifetime.45

Although the total cost of domestic violence in the UK has declined based on the fall in the estimated rate of prevalence between 2001/2-2008/9; Walby estimated that it was 15.7 billion in 2008. Broken down this included just over £9.9 billion in 'human and emotional' costs more than £3.8 billion for the criminal justice system, civil legal services, healthcare, social services, housing and refuges and more than £1.9 billion for the economy (based on time off work for injuries).46

Therefore, the National Institute for Clinical Excellence (NICE) has acknowledged that “the cost [of domestic violence and abuse], in both human and economic terms, is so significant that even marginally effective interventions are cost effective.”47

Mapping support – policy development

In June 2013, The Department for Health published professional guidance on domestic abuse and violence, in recognition that the subject is “a significant part of the midwife, health visitor or school nurse role.”48 It intended to increase knowledge and support through improved integration and partnership working between those who work to identify and assist those affected. Amongst the key principles and actions were ensuring that child safety is paramount and considering the rights of the child to live safely; ensuring the right to positive family life (which does not override safety); considering the rights of the child and young person and ensuring that every intervention is child focused whilst providing support to the whole family; and considering the rights of the family to remain a family (through restore d repair work).

The document also listed key components of effective practice. Highlighted was the need for staff to listen, assess, act and document every visit. Staff were encouraged to enquire sensitively, be familiar with relevant information and child protection

43 Audit Commission (2013)
44 See Alhabib et al. 2010; Feder et al. 2009
46 Walby, S.(2009), The Cost of Domestic Violence – Update, Lancaster University
47 The National Institute of Clinical Excellence (February 2014), Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively
48 Department for Health (June 2013), Health Visiting and School Nursing Programmes: supporting implementation of the new service model No.5: Domestic Violence and Abuse – Professional Guidance
procedures and share this information appropriately and informally; whilst focusing on safety. Effective practice in terms of support for professionals included providing training, local protocols, referral pathways and flow charts and promoting and encouraging role professionals in future commissioning of services. Furthermore, protective factors were outlined that staff could consider when deciding upon interventions. This included the victim having; insight into the risks that abuse posed to children and young people, positive support from family, friends and community and the ability and willingness to work with and access specialist services.\textsuperscript{49}

The National Institute of Clinical Excellence (NICE) has also published guidelines on how health and social services (and the organisations they work with) can respond effectively to domestic violence and abuse. The guidelines stated that working in a multi-agency partnership is the most effective way to approach the issue at both an operational and strategic level, and that training and support was necessary, both initially and throughout.\textsuperscript{50}

The recommendations included planning services based on an assessment of need and service mapping; developing and integrated commissioning strategy and care pathways that meet the health and social care needs of victims and CYP affected, addresses the perpetrators behaviour and health needs and the needs of local communities, whilst providing specialist support and advocacy for the victim; helping people who find it difficult to access support services, such as Black, Minority Ethnic (BME) communities, disabled people and older people; and identifying and referring children and young people affected by domestic violence and abuse.\textsuperscript{51}

**Mapping support – Domestic Violence**

As Guy, et al. outline, when thinking about domestic violence, there are three main preventive support offers; primary prevention from universal services (such as schools), who can embed an understanding of good relationships in childhood and adolescence and provide a gateway to more targeted support; secondary prevention in the form of early intervention to build social and emotional skills; and work to support victims, safeguard children and prevent reoccurrence.

However, there is limited evidence about what works in terms of the identification of domestic violence and abuse or referral to more specialist services.

In the 2015 Spending Review, the Department for Communities and Local Government announced that it will provide £40 million for services for victims of domestic abuse, tripling the dedicated funding provided compared to the previous four years.\textsuperscript{52} In addition to this, £3.5 million was awarded to 46 local authorities to

\textsuperscript{49} Ibid.
\textsuperscript{50} The National Institute of Clinical Excellence (February 2014), *Domestic violence and abuse*
\textsuperscript{51} Ibid.
\textsuperscript{52} HM Treasury (2015), *Spending Review and Autumn Statement 2015*
develop innovative services to support domestic violence victims: funding which meant that 710 new bed spaces were created in a range of safe accommodation.

Examples of the services being developed by local authorities who had successful bids include using the established foster care process to recruit local residents to provide short term, safe accommodation in their homes to victims fleeing domestic abuse in Barking and Dagenham, London; a domestic abuse refuge for young women aged 16 to 25 and especially young mothers in Birmingham; and specialist training for domestic abuse advisors to cater for the specific needs of Britain’s Black, Asian and Minority Ethnic communities in Oldham, Manchester.

Other services include The National Centre for Domestic Violence, which helps people get protection from their abuser through free legal support and police domestic violence units that have specially trained staff to help people experiencing domestic violence.

In addition, there is a 24-hour domestic violence Freephone helpline for women and family, friends, colleagues and others to call on their behalf. This is run in partnership between the national domestic violence charities – Women’s Aid and Refuge. There are also helplines available for men (Men’s Advice Line or ManKind), LGBT individuals (Broken Rainbow UK), forced marriage and “honour” crimes (Karma Nirvana or The Forced Marriage Unit) and perpetrators (Respect).

Women’s Aid have published The Survivor’s Handbook, it is available in 11 languages and audio, and provides a range of information including legal and housing advice, tips on how to create a safety plan and guidance on helping children caught up in situations of domestic violence. They also run The Hide Out, a website specifically for young people who may be living in a home affected by domestic violence, or who may be in a violent relationship themselves.

An example of good practice for raising awareness of domestic abuse in civil society can be seen in the Welsh Government’s national awareness campaign and training framework for public sector workers. It was acknowledged that public services had the potential to provide a gateway to support for victims, as well as opportunities for early intervention and prevention; but that this was only possible if staff could recognise indicators of abuse and consequently engage clients and provide appropriate support.

In attempt to strengthen the response to those experiencing gender-based violence, domestic abuse and sexual violence throughout Wales, a National Training Framework was introduced with the aim of changing attitudes and improving the nature and quality of the support provided to victims. As Figure 2 demonstrates, the framework proposed proportionately disseminated training for relevant authorities,
alignment of existing specialist training to further professionalise the specialist sector and core requirements of specialist service provision. As well as an alert and aware general workforce, it aimed to create a system which included skilled practitioners, in the right place, proactively identifying and offering support to victims (Level 2), key staff who are then able to support colleagues and their clients once victims are identified (Level 3), expert practitioners who can efficiently intervene once a referral is received (Level 4), capable, specialist managers who run effective services with good quality staff (Level 5) and finally service leaders who can help to create a culture in which domestic abuse is seen as a public service issue that requires an informed response (Level 6).

Figure 1: Proposed National Training Framework, Welsh Government

The Troubled Families Programme is another programme that looks to support complex families through a ‘whole family approach’ and much of the parenting support work seeks to prevent adoption or intervention by social services by intervening early and eliciting parents to consider the needs of the child in advance of their own. Furthermore, there is an increased focus on tackling domestic violence and abuse in the new expanded programme.

The Family Nurse Partnership (FNP) programme is a maternal and early years’ public health programme that uses a psycho-educational approach to provides ongoing, intensive support to first-time mothers under 19 years of age and their babies (and fathers/other family members, if mothers want them to take part). It was originally implemented in the United States and it is now licensed for use in England through the National Health Service (NHS). It involves structured home visits, which are delivered by highly trained nurses and start in early pregnancy: they then continue until the child’s second birthday. It aims to prevent risk factors like domestic violence through enabling young mothers and fathers to make the lifestyle choices
that will give their child the best possible start in life, build their self-efficacy and build positive relationships with others.

FNP is subject to well-designed Randomised Control Trials (RCTs) and the early results are very promising. For example, research has shown that in the U.S, participation resulted in the young mothers having more stable relationships with partners and with their child’s father.\textsuperscript{54} Early studies in England have also demonstrated positive impacts, such as increased confidence and aspirations for the future and positive views about their ability as parents.\textsuperscript{55}

Similarly, the \textbf{Strengthening Families parenting programme in Salford} aims to help vulnerable parents to care for and nurture their children and is based on the FNP as well as child development programmes. It provides intensive outreach support and an educational programme to help parents understand how babies and children develop and what they can do to support and promote this. It also addresses how current lifestyles and patterns of behaviour impact on the baby, both pre-and post-birth. The target groups are expectant mothers (up to 20 weeks) and those who are at significant risk such as domestic abuse or alcohol/drugs use and this is their first pregnancy, or parents who have had children removed by courts and are trying to avoid repeated incidents.

\textbf{Mapping provision}

The lack of central policy to address birth mothers’ post removal needs has resulted in a shortage of knowledge about the population of parents who experience successive removals of children from their care: and this issue had been compounded by the "child-centred discourse" in the United Kingdom.\textsuperscript{56}

Although health assessments that are commissioned following the care proceeding being issued may raise mental health issues, by this point mothers do not have enough time to engage with the necessary support services to reduce the risk of their child being removed.

The 2002 Adoption and Children Act specified the need for post-adoption services, and therefore highlighted the plight of birth parents and relatives; but in practice this is minimal and "certainly does not mandate agencies to address mother's rehabilitative needs."\textsuperscript{57}

Instead, once the courts permit an adoption, birth parents rights are severed and it is likely that the only contact with services will be in the form of letters. Furthermore, as Broadhurst and Mason explain - as there is no 'post proceedings protocol',

\textsuperscript{55} \url{http://fnp.nhs.uk/research-and-development/research-in-england}
\textsuperscript{56} Broadhurst and Mason, Maternal Outcasts
\textsuperscript{57} Broadhurst and Mason, Maternal Outcasts
committing services to respond to the parent’s need, it is unlikely that they will be able to access the help required, especially as to be eligible, users must meet specific criteria.

Therefore, it is of little surprise that Neil et al. found that those who could self-refer were more likely to use and benefit from post-adoption support services and that almost half the target population were not using these services at all.58

Such evidence, therefore points to a lack of improvement in post-adoption support following Masson et al.’s 1997 study that demonstrated that low-priority was given to those parents who had lost contact with their children in the care system.59

Lancashire County Council ran an “Early notification of pregnancy” initiative, which provided support at the early stage of pregnancy for vulnerable mothers to be, to enable them to access support at their local children's centre. Health and educational professionals delivered pre-and post-natal support with the intention of improving their parenting skills and increasing the likelihood of a safe and happy childhood for their baby. The support is targeted at women at high risk of stress or isolation, such as teenagers, lone parents, young people leaving care and victims of domestic violence.60

The early intervention begins after the midwife notifies the service of all local pregnancies, and the women will complete an early notification form giving her consent for the service to get in touch. Thereafter, the service gets in touch and encourages the mother to attend the centre for support and to meet other mothers. They can also get support from organisations such as Jobcentre Plus and housing services. The system has reported positive early results, for example women continued to engage with services following birth of child.61

The Positive Choices programme is run by a small team in Suffolk County Council’s Children’s Services. It offers family planning access (contraception support and sexual health checks) and compulsory specialist services (such as welfare support) on a one-to-one basis for recurrent mothers (and their partners where possible) who have had their children removed previously.

Between April 2011 and March 2012 around 70 per cent of women who were having their babies removed through court proceedings had previously had their children removed. Therefore, the programme was piloted with a group of women, to provide them advice and support to address the underlying issues behind their recurrent

58 Neil et al. (2010), Helping birth families: a study of service provision, cost and outcomes, University of East Anglia
61 Ibid.
pregnancies. Due to the pilot’s success, the council established the Positive Choices Team.\(^\text{62}\) The team is currently working with 45 women; 25 are receiving intensive support, and additional 16 women are being further supported in an outreach capacity.\(^\text{63}\)

**The Family Drug and Alcohol Court** (FDAC) was launched in 2008 by the vulnerable children’s charity Coram and Tavistock and Portman NHS Foundation Trust; a leading mental health care and education provider. The FDAC provides a pioneering way to address care proceedings that have been a result of parental substance misuse. Based on a model that is often used in the United States, which involves coordinating services to deal with the family’s needs and abilities and an underlying aim to keep families together by recognising that a stable family is the best outcome for the child. It is currently run at the Central Family Court in London and their services are available to families from five commissioning local authorities (including Hammersmith and Fulham and Westminster).\(^\text{64}\)

The FDAC is the first model of its kind in the UK, and it has been praised by academics and social work professionals alike. It differs from conventional care proceedings as families see the same judge throughout the proceeding; have regular reviews without legal representatives; getting support from a multi-disciplinary team that can provide fast access to services and help with issues such as domestic violence; and get additional support from volunteer parent mentors who have faced similar problems in the past.\(^\text{65}\)

An evaluation of the FDAC conducted between 2008 and 2013, found that there was a higher rate of family reunification and substance misuse cessation by FDAC families at the end of proceedings, that it offered more opportunities to access services and that it “more than paid for itself.”\(^\text{66}\)

**The Support for Change project**, began operation in three London boroughs from February 2014. It works with parents who have had one or more children removed from their care. A core function of the service is to provide intensive and assertive outreach on an individual basis to assist clients to make informed choices to effect positive change in their lives, with the overall aim to prevent un-planned pregnancies and future removals.

\(^{62}\)Suffolk County Council (26 June 2015), Programme to support Suffolk’s vulnerable recurrent mothers shows real success, See more at http://www.suffolk.gov.uk/council-and-democracy/council-news/show/programme-to-support-suffolks-vulnerable-recurrent-mothers-shows-real-success (Accessed 01/07/2015)

\(^{63}\)Ibid.


\(^{66}\)Harwin et al. (May 2014), Introducing the main findings from: Changing Lifestyles, Keeping Children Safe: an evaluation of the first Family Drug and Alcohol Court (FDAC) in care proceedings, Brunel University London and Nuffield Foundation
It was recognised that there was a cycle of repeat removals within the pilot area and that something had to be done differently to engage this isolated and vulnerable client group in a creative way. Therefore, the programme used networks and had a multi-disciplinary team involving social workers, outreach workers, domestic violence specialists and psychotherapists to work with the mothers on a one-to-one basis.

The expected outcomes of the project include a 75 per cent reduction in both repeat care proceedings and unplanned pregnancies over the next two to five years. Consequently, it is predicted that the project will save an estimated £240,000 after one year and an estimated £510,000 after two years.

The project has since been renamed as Action for Change to avoid confusion, with the European Commission funded element starting in June 2015, focusing on women who had been affected by domestic violence.

All the examples listed above have been recognised both nationally and in academic literature as examples of innovative practice. For example, Broadhurst et al. noted that common across such projects is;

“the allocation of a key worker, who works closely with mothers to devise an individually tailored plan of intervention, based on detailed assessment of mother’s history and presenting needs.”

The authors also recognised the importance of engaging and re-engaging mothers where they withdraw as a central component of an assertive outreach approach.67

Lastly, the charity Family Rights Group provides advice, information and advocacy to parents and families whose children are involved with Children’s Services due to welfare needs or concerns. They have comprehensive advice sheets on their website, that cover topics including contact with children in care and Care (and related) Proceedings. They also run a telephone advice line.

**Gaps in provision and policy**

A Citizens Advice Bureau (CAB) report, published in February 2015, found that more needed to be done to improve recognition and disclosure of domestic abuse. Following the research, CAB recommended that public education and practical definitions for police and prosecution needed to be introduced to ensure that financial and emotional abuse was better articulated, because victims remain unaware that their experiencing domestic abuse. Thus, they argued that the introduction of “coercive and controlling behaviour” as a criminal offence will be ineffective without such initiatives. In addition, they highlighted the need for a “sustained campaign to broaden societies understanding of abuse”, as well as public-facing guidelines for what to do if you suspect abuse, and enhanced engagement with community services to increase recognition of domestic abuse.

67 Broadhurst et al. (January 2015), Vulnerable birth mothers and repeat losses of infants to public care: is targeted reproductive health care ethically defensible?, *University of Manchester*
amongst civil society, which would in turn lead to greater referrals and thus more support for victims. As "without wider society playing a role, we risk failing to engage with the majority of victims in this country."\textsuperscript{68}

Despite some evidence of policy and laws that have attempted to address the issue of domestic violence, as Broadhurst and Mason state, the issue of vulnerable women being stuck in a negative cycle of having children removed has received "little attention in legislative and policy arena;"\textsuperscript{69} and they therefore label this group "hidden mothers,"\textsuperscript{70} whilst Scholfield et al. similarly refer this group as "welfare outcasts."\textsuperscript{71}

NICE’s Programme Development Group also recommended further research in the most appropriate ways to collect and manage data about domestic violence and abuse across the health, social care and criminal justice sectors; the effectiveness of programmes that aim to prevent domestic violence and abuse from ever happening in the first place; and what type of interventions (including training and referral pathways), in diverse health care settings that provide the most effective support for practitioners working with people who are experiencing, or have experienced, domestic violence and abuse.\textsuperscript{72}

Similarly, the Early Intervention Foundation, called for the improved measurement, evaluation and research of domestic violence and abuse with a focus on the impact of Early Intervention in preventing it and proven evidence based programmes and practices.

\textsuperscript{68} Parker, I (February 2015), “Victims of domestic abuse: struggling for support?”, Citizens Advice Bureau
\textsuperscript{70} Ibid.
\textsuperscript{72} Broadhurst and Mason, Maternal Outcasts.
3. Findings

Policy drivers
The apparent need for a fresh approach to supporting parents, and mothers specifically, was to redress the lack of understanding of the “dynamic of domestic abuse in child protection.” The pilots presented an opportunity to develop a collective strategy to address a “systematic weakness in how we support women who’ve been through an incredible trauma by having children removed”.

Ultimately, the objective was to develop a service for women who had experienced abuse and who were at risk of having a child removed who would have previously received little in the way of support.

“We don’t necessarily identify that domestic abuse as an influencing factor on their parenting. We take their children away for a good reason, and there will be, obviously, very good grounds for doing that, but then we drop them [the parent(s)]” (Stakeholder)

Consequently, for some the impact of having a child removed developed into a cyclical pattern whereby underlying issues which led to the removal of the first child are left unresolved. These individuals were therefore more vulnerable to a subsequent child being removed:

“[It’s] a very destructive pattern. Destructive for the children, because it’s traumatic to be removed. Hugely tragic and traumatic for the parents who find it terribly emotionally distressing…Very costly for the [public purse]; by the time you get to court it costs thousands of pounds” (Stakeholder)

Across the pilots, three dominant aims were apparent for the pilots:

1. To break the cycle of isolation women often found themselves in which could have devastating repercussions

2. An ethical and fiscal case to support the parent to change and improve their circumstances

3. To deliver better outcomes for the parent, their family and the wider community though more effective early and intensive intervention

The pilots were given flexibility around their implementation, with interventions being specifically developed in line with the local needs and processes.

The Action for Change Model
In the United Kingdom, the Action for Change programme operated within the Royal Borough of Kensington and Chelsea Families Forward Service within the tri-boroughs shared children’s services, which is a is a multi-disciplinary team that work
intensively using systemic practice with local families already known to frontline social work teams who have children between the ages of five to 18 years.

The programme was run in partnership with Advance, a charity based in West London that supports women, children and young people affected by domestic abuse and sexual violence. Therefore, the service involved domestic abuse expertise with the wrap around support of Family Services and part funded by the national Troubled Families Programme. A domestic violence specialist, employed by Advance, was co-located in the Families Forward Team to support Action for Change participants, and another Advance staff member ran the Women’s Shadow Board, the user-voice element of the project (explained in more detail on p.33).

As well as the Project Manager who oversaw delivery and programme operations, there were five full time practitioners supporting Action for Change participants, including the domestic violence specialist. Staff could also draw expertise from the wider Families Forward team, including from a substance misuse specialist and a family therapist.

There were three key elements to the Action for Change model, and these were vital to achieving outcomes and supporting participants effectively: therapeutic support, flexible support and bespoke support. Each will be elaborated on in the ‘delivery of support’ section.

The specific target group in the UK was 20 women who had their children removed from their care, with DV as a significant contributory factor, and who were at risk of having further children taken into care. In total, there have been 66 referrals to the service and 55 birth parents have engaged (though a proportion of these were engaged as part of the Action for Change predecessor programme, Support for Change).

**Research participants**

Participants were not a homogenous group; all individuals who took part in the research had a multitude of vulnerabilities and disadvantages, and these were not all at the extreme end of the spectrum.

In the first wave, we interviewed six females and two males, and two of the participants were a married couple. In the second wave, we interviewed four females and one male. Participants were broadly aged between 29-55. Everyone resided in West London and most lived alone. One interviewee did not have a permanent residency and was ‘sofa surfing’; this, they felt was preventing the return of their child to their care. The spread of participants’ ethnic origins reflected the diversity of West London. With regards to their economic status, one participant had found a part-time job since her child was removed, another had found a part-time job since being involved in the Action for Change support and one participant had previous employment experience and aimed to look for work in the future, while another had
been in employment throughout. Two interviewees were members of the Women’s Shadow Board (WSB).

Two of the interviewees had grown up children in addition to the children who had been removed, and overall interviewees had either one or two children that had been removed (a mixture of sons and daughters of varying ages). Only one interviewee had an infant child in their care. There were examples of children that had been adopted, children who were living a designated special guardian and children that were in foster care. The period of time which their child/children had been removed for also differed by individual, for some this had been the situation for several years, and for others this was a relatively new situation. In addition, there were examples of children who had been removed because of emotional and physical abuse occurring in the household.

Research participants spoke candidly about their previous offending history and substance misuse and/or dependency. Some also reported experiencing mental health issues; nearly all who reported any of these issues also reported taking steps to overcome these, for example, by engaging in offender rehabilitation programmes or drug or alcohol therapy. Furthermore, one interviewee had learning disabilities, although this was not acknowledged when they were interviewed.

Interviewees emotional support networks also varied. Some interviewees spoke of good relationships with their friends and families, and could draw on their support. In contrast, others appeared more isolated, particularly from family. In some instances, a participant’s child/children had been placed with family members as special guardians, which while preferable to other forms of care, sometimes led to different stresses and created tensions within the relationship. Regardless, it appeared that since being involved in Action for Change, their support worker had come to be regarded as their main support, and the person who they relied on if they had a problem or required guidance. Further, positive relationships had also emerged with peers in the programme.

Often, participants had engaged with numerous public and local services for support with issues including, of course, children and family services. Other types of support included health services, drug and alcohol therapy and housing support. Some had previously had a counsellor. Indeed, it was reported that support was still being received from a counsellor outside of Action for Change in some instances.

Although not explicit in the research conducted, a lot of Action for Change participants had been in care themselves and had experienced sexual abuse or childhood sexual exploitation, resulting in trauma. Domestic violence was the primary or secondary reason for removal in over 90% of cases.

5. Tracking participants journey through the support
Engaging clients

Participants interviewed either found out about the support through their child/children’s social worker or because of their involvement with Advance (who were a delivery partner) and their support programme; several had suggested becoming involved in Action for Change following their involvement in the Minerva Project which was run by Advance.

When asked about reasons influencing their decision to attend, participants often explained that they had a general desire for support when they found out about the service and thought that attendance would benefit them. It was interesting to note that very few of the interviewees referred to experience of domestic violence or the need to extricate violence or abuse from their life when discussing support needs; though this may in part reflect the point at which the research participants were at in their journey. However, the desire to improve their relationship with their partner and prevent arguments (amongst other things) was a support need raised in a few interviews. When asked about their motivation to get support, three core aims linked to where participants were in their journey were identified through the interviews:

- becoming more independent and resilient,
- becoming a better parent (“[I]t was more to do with increasing my ability to have more of an understanding for my child”); and
- (where possible), increasing the likelihood of their child returning to their care (“I suppose it is different as what I’m looking for now is how do I go forward, in the sense of my child to come back home…”).

Referrals to Action for Change were often made by social workers involved in the family. Some participants suggested that once being informed about the support the social worker provided them with details for Action for Change or Advance at that point, before making a referral on their behalf. Others reported being immediately unsure so were left to consider the option and were provided enough information to be able to self-refer. Among these latter interviewees, there was a strong sense of reluctance to engage with another social work service. In at least one case, this reluctance was overcome following the participants own online research about the service, which gave them the perception that the service was independent of the local authority.

In contrast, others told about the service by their child’s social worker explained that they trusted them and therefore were confident about acting upon the referral to. When participants expressed distrust of the social worker who referred them, it appeared that the timing of the intervention was key to their decision to attend; they wanted help, and were willing to be referred to support, regardless of who made that referral or delivered the service. An exception to this was when one participant felt as if they had no choice, but to agree to attend the support because they did not want to be viewed as uncooperative by social services.
“I felt like I did not really have a choice, if I don’t go it will seem like I did not really want to co-operate with social services” (Client)

Where participants were informed about the service by a staff member from Advance, whom they had a previous positive experience of working with and who they trusted, this was a factor that influenced their decision to attend. Further, where applicable it was clear that involvement in the WSB was a key driver for participation, with participants reporting that they were excited by the chance to work with their peers on a range of different activities, and have a voice in the delivery of the service. This also made the support option unique, with those involved in the WSB reporting that despite having used multiple services previously, the WSB gave them agency; they valued the ownership and responsibility they had through the group.

“It was a big deciding factor…It was going to empower me; I was going to be surrounded by likeminded women who would have interesting thoughts about domestic violence and social services” (Client)

There was a strong sentiment among participants that more information prior to the first session could have been provided. Participants who reported being told about Action for Change through a borough social worker explained that they did not understand what the support would involve and that more information would have put their minds at ease. Those who recalled receiving a leaflet felt that this could have been more detailed as they understood that the support was intended for people in their situation, but did not understand what taking part would mean and how much commitment it involved.

“More information on the leaflet [would have been helpful] to understand what the service is about, what they can help you with and how they can help you” (Client)

Some interviewees recalled meeting the Project Manager before they entered the support, which put their mind at ease about attending the induction and taking part. This was because they were told more about what the support would involve and were now clear that the support was separate from social services.

**Entry into support**

First contact with the service usually involved a one to one appointment with a designated support worker. In line with the delivery model, the location of this first appointment differed amongst the interviewees and included visiting people in their homes, council offices, public places (such as local cafes) and, for the WSB members, the Advance offices.

Those who reported receiving support within their own home, particularly during the first appointment were grateful for this as it reduced anxiety and provided a more relaxed and comfortable environment to discuss issues and receive support. In contrast, another participant who met her support worker for the first time in a local coffee shop explained that the setting made the encounter uncomfortable. The participant found talking about sensitive subjects in public difficult as she worried
about becoming emotional or distressed, and was acutely aware of other people nearby who might hear their conversation. Thus, she disclosed less at this point than she would have done in a more private location.

Similarly, on a couple of occasions, participant’s first interaction with the service involved attending a peer support group session, and staff explained that they increased instances of group sessions to overcome the growing waiting list and demand for the service. Although interviewees described the encounter as intimidating, they became more confident and open to contribute as the session went on and they could listen and observe others in the group. In such instances, there was agreement amongst staff and participants that one to one support would have been a more suitable way for individuals to be introduced to the service, as this would have been less daunting.

Interviewees explained that they were told a lot more about the service in this first appointment, so better understood the purpose of support and what involvement would mean better following on from it. They also explained that they were glad that they took part at this point as meeting the support worker, who they universally spoke highly about, reassured them that they had made the right decision.

**Delivery of support**

Physical and practical accessibility to the support (such as attendance at appointments) was delivered through a local outreach model. The support workers were considered extremely flexible in both the locations and timings of the sessions, fitting their availability around participants’ busy lives. Therefore, participants tended not to experience any practical barriers preventing them from accessing Action for Change support. The fact that it was delivered locally was seen as a benefit, as in several cases, participants could walk to the location where sessions were delivered.

In one instance, a participant struggled to find a time to meet her support worker as she was leading a chaotic life. However, they had regular text and telephone communication during this period, which she was grateful for, as she felt less isolated.

A staff member interviewed thought that this text and telephone contact in advance of the first face to face session was important to build up rapport with participants and to let them decide whether they want to engage.

Having less structured boundaries was also highlighted as important to successfully delivering support. For example, there was not a cut-off point at which they had to stop trying to engage with participants, and this was necessary as in some cases it took six months of occasional texts and phone calls before an individual felt ready to take part.

As noted, participants had often engaged with a range of other services, including counselling support. However, a distinction made with Action for Change was that it
was holistic and able to provide support on multiple issues rather than just a single issue. For example, in one instance a participant expressed dissatisfaction with peer support sessions for recovering alcoholics because other participants could not relate to her experience of domestic violence; something that the Action for Change was able accommodate.

**Crisis support**

One function of the Action for Change programme was to support participants in crisis through helping them to understand and cope with their current situation. This could include advice and guidance in relation to domestic violence and child removal as well as support with wider themes including financial, housing and drug and alcohol support.

There were examples of participants entering the service and not understanding why their child had been taken away, and of individuals who did not realise this situation was permanent. As well as helping these participants to make sense of what had happened, staff also supported them emotionally to deal with the loss of a child/their children.

Linked to this, in some cases participant’s children were subject to a care proceeding when they entered the support and therefore they could receive advice and guidance throughout this process. For example, one interviewee explained that her support worker attended the Child Protection Conference with her and then went through the Child Protection Plan. She appreciated having someone there to clarify the information being presented and who could support her to interact with Social Services, because she felt that her support worker understood the social care system so could advise her appropriately.

In addition, some clients presented financial needs that had to be addressed. This often included confusion around child benefits and what they were entitled to now that their child had been removed. Financial needs often interlinked with housing needs, as some participants were struggling to pay their rent and meet their housing costs.

**Trust building**

Although it was acknowledged that discussions often touched on emotionally raw subjects, interviewees found the support workers to be friendly, understanding of their situation and took them seriously as well as knowledgeable of their situation. Indeed, participants overall view of the service was deeply entwined with their perceptions of their main support worker:

“I like her. I feel like I can speak to her, and there are times that I feel she is on my side, and she is now trying to help me see my son more often which is great so I want to continue working with them” (Client)
As a result of the relationship that they had established with their support workers, participants reported that they were more willing to be referred to external services and interact with additional support. As well as trusting their support worker, another reason given for this was that they felt as if the support worker was trying to help them and not force them into anything against their will.

“Before when I was referred to the drug support I refused to go, but this time I feel like it's easier to talk with [support worker]...I feel like I am actually getting the help, not pressed to do something that I do not want to do” (Client)

Interviewees made comparisons with social services, who had advised them to get help with certain issues, but who they felt rarely advised them where to go, and how to do this. Therefore, interviewees were grateful that their Action for Change support worker could refer them to appropriate services and in some cases, make a warm handover.

In some cases, staff explained that participants were cautious about disclosing information to them because they were convinced that they would then inform social services of this information. Over time, when participants became to realise that their sessions were indeed confidential, they began to open up more.

Substantive support
Interviewees reported usually having face-to-face meetings with their support worker either once a week or once a fortnight usually on a one-to-one basis. Outside of this, participants felt confident to “give [the support worker] a call” whenever it was required. Indeed, it appeared common for support workers to conduct much of their work with participants over the telephone; for participants, this was well regarded as it was both flexible and convenient, and provided them with the reassurance that support was there where required. In some instances, using the telephone was a vehicle to monitor participants’ wellbeing and self-care; for example, one participant recalled how his support worker regularly phoned them to make sure they were eating and taking care of themselves.

The content of the support was tailored to the individual’s circumstances, and staff agreed this was key to effective support. It ranged from providing support on emotional concerns and wellbeing, legal proceedings and improving contact arrangements, to advice and guidance on issues including benefits, housing and immigration issues, including supporting referrals and signposting to appropriate support destinations.

Participants had control over what the focus of the sessions was and what they worked on, for some there was a preference for therapeutic meetings and emotional support, whilst others wanted to completed activities and worksheets. Regardless, staff reported that this organically would move onto why their child/children were removed.
An issue that became apparent throughout the research was the extent to which participants acknowledged the role that they had in the removal of their child/children. They felt let down (and often failed) by the Local Authority, wider support services and their families/partner, and understandably so, but rarely considered themselves as an agent in the situation. Staff explained that it was key to try and get participants to see things from multiple perspectives and to get participants to a point where they can accept criticism and be challenged.

Peer group sessions were a useful mechanism to encourage participants to be more open minded and think about their situations from other perspectives. For example, one interview explained that she learnt about other people’s experiences and realised that her own was “kind of mild” in comparison. Participants found commonality with others and felt less stigmatised about their situation as a result.

**Independent living**

Another aim of the Action for Change support was to empower participants to feel confident to make decisions and manage changes themselves, and to seek help when required as opposed to relying on support from the Action for Change service and other professionals in the long-term.

“I think the whole project is about sustainable change but sustainable change is something that leads to independence” (Practitioner)

One method of enabling this was by getting participants involved with other relevant services that would be able to support them once their Action for Change involvement ended. For example, one participant had started to attend sessions at Mind, a national mental health service, to help him with his trouble sleeping and to access their befriending service.

**Women’s Shadow Board**

While not overtly part of the support model, participants who were members of the WSB perceived it to be highly integrated within the overall delivery model. Membership of the WSB proved to be a very positive experience and important to those members. WSB members reported taking part in creative activities and had meetings about wellbeing and meditation. One interviewee who was a member, explained that the varied and interesting sessions motivated her to remain engaged in Action for Change.

One activity that WSB members reported was taking part in filming a short documentary about Action for Change with other service-users, where they could tell their stories and share their experiences. This was at times an upsetting experience for those interviewees who were involved as they recalled their own past and listened to others journey’s, but this was also found to be empowering: the participants were grateful of the chance to retell their experiences from their own point of view, to learn about the obstacles that others had overcome and to discover what they had achieved.
When asked about their expectations of the service, the two WSB members that were interviewed spoke about their hope that WSB would be able to influence positive change for domestic violence victims, through raising awareness. They also felt confident that taking part in the support more generally would give them hope and help them to feel empowered.

Since being interviewed as part of the research, the two WSB members interviewed have continued to provide a user-voice to services. One is a Survivor Representative at Advance Trustee Board meetings and the other is a Peer Facilitator for one of Advance’s support groups; which she thinks has helped her to “get her foot through the door and little bit more” in relation to her goal of working in the domestic violence sector in the future.

6. Outcomes from the support

Expectations
Expectations of Action for Change was determined by where participants individually were. Primary needs ranged from being becoming more self-reliant, understanding their circumstances, reassurance about parenting, reuniting or improving family circumstance, and housing circumstances. In terms of the expectations of the support presented in the first wave interviews was that the service would help increase contact arrangement, and potentially in the longer-term, enable them to return to their care. Interviewees felt that this could be possible because they were being supported to improve their situation and to become more confident in their parenting skills.

In the later interviews, a noticeable change was that a couple of participants had become unsure that the service could support them with their housing and financial needs. They acknowledged that their support worker had tried to help them with this, but felt like little progress had been made and remained uncertain about whether such concerns would be resolved. This is reflective of the fact that out of the seven participants who reported a risk of eviction upon referral, this remained the case for five participants at their last review. However, reports of housing benefit arrears had decreased considerably, from 28 to eight.

Otherwise, due to positive experiences of the support, participants remained confident that the support would improve their behaviour and situation.

Outcomes
In the initial stages the support from Action for Change helped those individuals whose child/children had been removed relatively recently, to understand their situation and look at it through another lens. They spoke about not understanding why their child/children had been removed, and so the support from Action for Change helped them recognise the reasons behind the child protection case, which they could then begin to address.
Linked to this, taking part in Action for Change had taught interviewees that they should be taking responsibility for their actions. The support seemed to emphasise that while there is support for them out there, a lot of that is dependent on them engaging and being receptive to advice. Therefore, the support led to individuals taking up advice and guidance where they had previously refused to do so. For example, one participant interviewed had attended support for her drinking issue for the first time, after having a warm handover with the counsellor and her Action for Change support worker.

Subsequently, interviewees also reported feeling better prepared to deal with different scenarios because they more aware of different services that could support them and activities that could benefit them.

“It made me more aware of how to deal with certain situations” (Client)

Participation also gave interviewees a clear objective for them to reach and steps for them to aim towards. By setting goals, interviewees reported feeling more motivated to take action that would improve their circumstances.

“Gave me the inspiration to do things and she is helping me…she gives me motivation” (Client)

Improved relationships with their partner, their children and their child/children’s carer was another important outcome of the Action for Change support. For example, one interviewee explained that her relationship with her partner, who was also on the project, was now “much stronger” as they were more aware of the consequences of their actions and because he listened to her more.

Similarly, a staff member described how one participant now had a better relationship with their daughter and their daughter’s carer, who they now have regular contact with. In the past, the participant could not understand why he was not able to see his daughter when he chose, but he now has a better understanding of the care order and his rights, and more respect for the carer as a result. He also had a better relationship with his daughter as his support worker gave him advice on activities that they can do together, which has led to him having a better understanding of her needs.

A better understanding of a healthy relationship was also seen as a significant outcome, and for one participant, realising that her ex-partner was “bad news” meant that she could focus on her daughter. Domestic abuse situations (past and present) decreased dramatically from the point of referral, with reported domestic violence falling from 50 cases to just five.

It was common for participants to report a lack of confidence when they entered the service, hence the support aimed to increase this through making them aware of their capabilities. This outcome was reported amongst interviewees who now had improved self-esteem because they were learning new skills, making progress in
their lives and no longer just saw themselves as victims of domestic violence. Linked to this, one interviewee explained that they felt much less angry because they had someone to express their frustrations to, who could support them accordingly.

As Figure 2 demonstrates, the project is also estimated to have prevented 24 births over three years based on the findings of research by x, which found that on average a new sibling is born in a first repeat care proceeding episode twenty-one months after his or her older sibling, and that in a second repeat care proceeding episode, a pregnancy interval of 13 months elapsed between the care proceedings episodes.

**Figure 2: Action for Change Birth Rate Data (2014-2017)**

Other outcomes reported by participants and staff included that individuals were now less judgemental towards others, more trusting and had improved their wellbeing – for reasons including that they were drinking less, leaving the house more and eating regular meals. This echoes overall programme data, as the number of participants reporting substance misuse at the last review dropped to 12, from 35 at referral. Similarly, the number of emotional and mental health issues reported at the last review had dropped to 20 from 53.

Furthermore, several participants had entered employment, training or educational opportunities. For example, upon entering the service 35 participants were classified as not in employment, education or training (NEET), yet at the last review this was only the case for 10 participants. One interviewee interviewed had found work with support from Advance, and they viewed this an important step in their aim to become independent.

Figure 3 also shows the progress a select number of participants made during their time on the Action for Change project. There were reductions in all categories
including participants who were not accessing mental health services and participants in housing arrears.

![Image]

**Figure 3: Action for Change Impact - Tracking 24 clients who were involved for between 3-18 months**

**Views of the support**

The most popular element of the support was the one-to-one advice and guidance; participants were grateful to have someone that they trusted to talk to regularly. They found it easy to contact and communicate with their support worker, who they found to be friendly and knowledgeable.

"You really do feel part of something that is about your wellbeing and moving forward and you really do feel supported" (Client)

"The fact that there is someone there that you can talk to that understands what is going on" (Client)

The only recommendation about this method of delivery concerned location. One interviewee explained that they did not like having to move rooms regularly when they went to the office where their practitioner was based, and as mentioned meeting in public was sometimes disliked due to the emotional and private nature of the issues being discussed.

In addition, as the support was holistic, participants liked that they could discuss and get help with a wide range of issues. However, as previously discussed, in the second wave it became apparent that although some participants expected support with their housing and benefit issues, Action for Change was not able to help them with this directly.

Involvement did not appear to be viewed as a major commitment for participants interviewed. They explained that their support worker would contact them to arrange
an appointment at a suitable time and that minimal activity was required outside of appointments. One interviewee completed a mood diary in her spare time, which she found beneficial as it allowed her to think about what made her stressed and upset, and why this was. When interviewees took part in additional activities such as the filming or being part of the Women’s Shadow Board, this was a choice and the involvement was important to them.

There did not seem to be any significant factors that participants did not like about the support. Interviewees understandably explained that it would have been beneficial for them if it had been in their lives sooner as it could have helped to prevent their child/children from being removed. One participant also explained that they would have benefited from some immediate support whilst they were waiting for their referral. The only other concern raised was that their stories would be edited too much in the filming, removing the message that they wanted to get across about their experience.

Comparisons with existing service provision
Staff and participants interviewed reflected that the service was more flexible than other provision due to the varying nature of the contact and availability of outreach support.

“A lot of agencies are not as flexible as we are, we will text them, we will meet them in an office, in the community, at home, at the jobcentre, we’ll meet them with their social worker and whilst it’s kind of nine to five we meet out of hours as well”

(Practitioner)

The lack of boundaries on efforts to engage participants was appreciated by staff and interviewees. One staff member highlighted that current community support would generally not support individuals who are not interested or motivated to engage, due to limited resources: whereas Action for Change practitioners could regularly attempt to contact and engage participants, even if they did not respond at first. The ability of the practitioners to use their discretion when trying to engage participants and the lack of time restrictions on this was acknowledged as important when working with the client group, who often lead chaotic lives and have interacted with multiple services in the past.

In addition, a couple of staff members felt that the support provided through Action for Change was more therapeutic and emotional rather than practical, which it would have been on other programmes. However, this appeared to be linked to the clients that they worked with, who could look after themselves, which contrasted to participants with higher needs who required practical support as well.

The most common thing that interviewees noted about differences with previous services was that they felt like Action for Change was more tailored towards their needs and more relevant for them. A reason for this was that the peer group support had allowed them to meet other people in similar situations, something that had not
previously happened through other services. Furthermore, as the service was holistic, participants could get support with multiple emotional and practical needs, rather than dealing with their concerns or issues in silos.
7. Recommendations and conclusions

Lessons learnt
Numerous lessons were learnt regarding the design and delivery of support for the client group, and these are outlined below.

Improvements that it was felt could be made, included having more upfront information about the service, particularly around what the support would involve, to reduce the likelihood of confusion about the project and apprehension about engaging, which was reported by some of the participants. Furthermore,

As discussed above, the service was seen as distinct because staff were able to be consistent in their efforts to engage potential participants, and this was seen to have been a successful element of the project. Staff appreciated this flexibility and participants acknowledged that it was nice to know that support was available and that somebody did want to help, even if they were not quite ready to engage when they were first contacted.

Staff also appreciated the flexibility that they had to deliver support which was most appropriate for the individual in question, rather than having to follow a rigid delivery structure. There was a range of evidenced tools, such as Cognitive Behavioural Therapy and Video Interaction Guidance, which practitioners could use to support clients when necessary: and clients recognised this flexible approach in that they appreciated that the support was tailored to meet their needs.

One bespoke intervention was not seen as enough due to the range of client characteristics and needs, and it was felt that you need an adequate length of time to engage with, and support such individuals. It took three months to engage a client on average, and long-term and intensive support was viewed as vital to achieving meaningful and sustainable outcomes; especially as the long-term effects of domestic violence and having a child removed require regular and long-standing support to overcome (e.g. lack of trust in professionals and depression). Practitioners were able to also consider clients’ long-term goals and support them in making progress in their lives, as well as addressing immediate concerns.

"We have to take them as individuals and, you know, appreciate that they are different and have this sort of longer period of time to… and maybe the flexibility to do that." (Practitioner)

In addition, it was recognised that participants experienced more comprehensive support as a result of the multidisciplinary team that worked on the project. Staff were grateful of the chance to learn from and work with colleagues who had expertise in a range of areas, to get the best possible outcome for participants: and some interviewees reported learning more about different techniques such as therapeutic approaches.
“You can’t do the work in isolation, you can’t do it in silos and so that, for me, is really important, that’s part and parcel of the work...I am not an expert in every field so I would draw on talking to [the domestic violence specialist], I will speak to the family therapist, I will speak to anyone to help me get the job done.” (Practitioner)

Staff explained that participant needs and the level of complexity of each case varied more than they anticipated. For example, some participants were in employment and were confident to address problems when they arose, hence one practitioner explained that the individual she supported was lower need than she expected; whilst others had a range of immediate needs, including financial and housing issues.

The UK pilot also highlighted the importance of working with the individual and their support network (professional or personal), which included working with the survivors and the perpetrators. This provided a fuller perspective as to how to support that individual appropriately, through looking at client’s other relationships, and helped to facilitate engagement as practitioners could learn from one another and the other party about what would work best.

Likewise, there was value in clients having simultaneous professional and peer support as they could get advice and guidance from qualified staff members, whilst meeting people who had been through similar experiences, which made them feel less alone in their situation. The activities completed in the Women’s Shadow Board and by those involved in the filming exercise also enabled members to gain work-related skills and experience.

Having a user-voice throughout the project, through the Women’s Shadow Board (WSB) was seen as key, and has led to thinking about how service users can be involved in the development of group and one to one support. Advance have also introduced some creative activities into their step-down support after seeing the benefits that this had for WSB members, because it increased skills and led to informal peer support.

**Recommendations**

Many lessons have been learned through this evaluation which should be observed when considering future support for individuals who experience domestic violence and have had, or are at risk of having their children removed in the United Kingdom. These lessons have been translated into recommendations around the development of the evidence base, delivery of support and implications for the pilots themselves.

**Developing the evidence base**

Regarding the evidence and monitoring of data around the issues of domestic violence and child protection it is recommended that:

- More evidence is collected and analysed on the relationship between domestic violence and child protection.
• There is consistent and more detailed monitoring of child protection trends, with a specific focus on domestic violence and its impact.

• Given the level and duration of support required by pilot participants, consideration should be given to running extended pilots to establish the longer-term outcomes that can be achieved for participants.

**Delivery of support**

Regarding the delivery of future support services covering this area it is recommended that:

• Future support is client led and voluntary, rather than mandatory as both aspects were critical to the success of the pilots.

• The appropriateness of group sessions, and particularly when they occur in the support journey, is carefully considered. It is recognised that peer support was an important element of the pilot, but it is necessary to ease people in, so that they feel prepared.

• Referral pathways are developed to improve the handover between the referral and delivery partner, and crucially, to increase participant trust in the support service.

• Future or ongoing support is holistic and intensive. Pilot participants often led chaotic lives and faced multiple issues that need to be addressed for them to make progress, making this essential to the delivery model.

• The delivery environment for the support should be considered, especially within outreach models. Having a safe-space where participants feel comfortable to discuss emotional subjects is vital.

• Staff working on such projects have a non-judgemental, value neutral approach. This was appreciated by Action for Change participants who contrasted the pilots favourably compared to other support they had previously experienced, which they described as value laden, and prejudiced against a parent who has had a child removed.

**Existing Action for Change pilots**

With regards to the pilot services themselves, it is recommended that:

• It would be beneficial if the Women’s Shadow Board was retained in some form, for the benefit of service delivery and members. The user-voice provided by the board was important to the pilots' success and proved influential throughout the pilots. It was also much valued by members themselves.
• The Best-Practice Toolkit is maintained and updated as required, to ensure that the most relevant and up to date information is available for key support workers to help those experiencing domestic violence.

• There should be continued efforts to raise profile of the Action for Change project, its impact and the challenge faced by parents effected by domestic violence and child removal more generally.
Bibliography

Broadhurst et al. (January 2015), Vulnerable birth mothers and repeat losses of infants to public care: is targeted reproductive health care ethically defensible? University of Manchester


Butler P (15 January 2015), Children of domestic abuse victims increasingly being taken into care, The Guardian


Department for Health (June 2013), Health Visiting and School Nursing Programmes: supporting implementation of the new service model No.5: Domestic Violence and Abuse – Professional Guidance

Feder et al. (2009), How far does screening women for domestic (partner) violence in different health-care settings meet criteria for a screening programme? Systematic reviews of nine UK National Screening Committee criteria, Health Technology Assessment, 13.16


Harwin et al. (May 2014), Introducing the main findings from: Changing Lifestyles, Keeping Children Safe: an evaluation of the first Family Drug and Alcohol Court (FDAC) in care proceedings, Brunel University London and Nuffield Foundation

HM Treasury (2015), Spending Review and Autumn Statement 2015

Home Office (March 2013), Information for Local Areas on the change to the Definition of Domestic Violence and Abuse
Masson et al. (1997), *Working with Children and ‘Lost’ Parents: Putting Partnership into Practice*, York Publishing Ltd.

Masson et al. (2008), *Care Profiling Study*, Ministry of Justice

Neil et al. (2010), *Helping birth families: a study of service provision, cost and outcomes*, University of East Anglia


Parker, I (February 2015), *Victims of domestic abuse: struggling for support?*, Citizens Advice Bureau


Richards, L (2004), *Getting away with it: a strategic overview of domestic violence sexual assault and ‘serious’ incident analysis*, Metropolitan Police


Smith et al. (July 2011), *Analysis of the 2010/11 British Crime Survey intimate personal violence split sample experiment*, The Office of National Statistics


The Centre for Excellence and Outcomes in Children and Young People’s Services, *Early Notification of Pregnancy*- Lancashire
The Crime Survey of England and Wales (2012-2013), The Office for National Statistics

The National Institute of Clinical Excellence (February 2014), Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively

Trevillion et al. (2012), Experiences of Domestic Violence and Mental Disorders: A Systematic Review and Meta-Analysis, PLoS ONE 7(12)


Walby, S.(2009), The Cost of Domestic Violence – Update, Lancaster University

Women’s Aid (3 December 2013), Press release: Women’s Aid warns of crisis in domestic violence services

Women’s Aid (May 2016), Annual Survey 2015: the findings