CROSSING PATHWAYS

CROSSING PATHWAYS KEY FINDINGS REPORT

March 2025

STANDING TOGETHER against domestic abuse

Project funded by the Home Office

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ACKNOWLEDGEMENTS

Standing Together Against Domestic Abuse (ST) would like to thank the survivors of domestic abuse who added their voices, insights and reflections to this project.

We would also like to extend our thanks to the Home Office for funding this vital work, to all the practitioners in the commissioned services, to the network partners and healthcare professionals across the health and social sectors, and to acknowledge the dedication of the internal Coordinated Health Team.

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ABOUT STANDING TOGETHER

Standing Together is a national charity bringing communities together to end domestic abuse. We exist to keep survivors and their families safe, hold abusers to account, and end domestic abuse by transforming the way organisations and individuals think about, prevent, and respond to this issue. We do this through an approach that we pioneered in the UK, and which we are known across the UK and internationally for, called the Coordinated Community Response (CCR).

COORDINATED COMMUNITY RESPONSE (CCR)

The Coordinated Community Response (CCR) is a 'whole community' collaborative approach to domestic abuse that prioritises the needs and safety of victim-survivors, attends to the welfare of children and holds those that cause harm to account. Its focus is on the complete life course, and journey of everyone affected by domestic abuse, encompassing prevention, early intervention, support and growth beyond abuse.

The cornerstone of the CCR model is that no single agency or individual can see the complete picture of the life of an individual or family. Still, all may have insights and can provide interventions crucial to their safety and well-being. Domestic Violence and Abuse (DVA) victim-survivors – adult or child, and those that cause harm requires all professionals to be able to identify, name, assist and coordinate community responses. Those professionals need to work collaboratively to build capacity for the effective meeting of needs and reductions in interpersonal trauma, which consequently makes everyone safer.

THE COORDINATED HEALTH PROJECT

Since the Pathfinder research project (2017-2020), Standing Together has developed a Coordinated Health Response (CHR): a programme of activities seeking to ensure that the CCR principles are embedded in the UK health sector. In 2022, Standing Together was commissioned by the Home Office to help drive the ongoing transformation of the health response to domestic abuse through the Crossing Pathways programme. The overall aim was to generate ongoing learning about the national landscape, to consider opportunities and barriers to sustainability, to evaluate the challenges on the ground, and to pilot new and adaptive interventions.

THE CROSSING PATHWAYS PROJECT

The Crossing Pathways Project was funded by the Home Office as a continuation of Pathfinder's work. Pathfinder sought to evidence the efficacy of providing specialist Domestic Violence and Abuse (DVA) interventions and training in healthcare settings.

Crossing Pathways took a multi-layered approach to the ongoing development of the health and DVA intersecting systems through:

- The integration of survivor voices.
- Provision mapping.
- Service commissioning.
- Network development activity.
- Pathway cost analyses.
- Themes and recommendations analysis.
- The production of a 'Pathways to Safety' health settings accreditation framework

With special thanks for supporting the development of the accreditation to:

Northumbria NHS Healthcare Trust
Nottinghamshire Healthcare Trust
Chelsea & Westminster NHS Foundation Trust

The Crossing Pathways project was funded by the Home Office.

PROJECT BACKGROUND

DVA as a form of Male Violence Against Women and Girls (MVAWG) is not lessening in UK society.

Increased reporting is starting to uncover the sheer scale of this issue (National Police Chiefs Council, 2025). Health settings have a unique position of trust and engagement with DVA victim-survivors (SafeLives, 2016).

This places health services at the heart of opportunities to safeguard families and individuals and to develop mechanisms and opportunities to hold those who cause harm accountable.

The benefits of developing DVA practice would also have a significant internal impact for the NHS as an employer of 1.5 million Healthcare professionals (HCPs) (Kings Funds, 2024) with some NHS practitioners up to three times more likely to experience the issue (Cavell Nurses Trust, 2016).

People experiencing or perpetrating DVA interact with health services across the breadth of their health needs irrespective of DVA, as well as victim-survivors seeking support for co-morbid health concerns, in the aftermath of their experiences.

HCPs are uniquely placed to intervene, enable safety, reduce harm and save public money.

- The costs of DVA to health services is estimated at **£2.3 billion a year.**
- **Nearly 500,000 victim-survivors** seek support in health care settings.
- Reference to the need for health service improvements through Domestic Homicide Reviews is continuous (Standing Together, 2016).

An essential component of undermining the insidious issue of DVA in our society is for health services to develop their responses with a focus on quality.

→ Facilitating cross-system approaches between HCPs and specialist DVA services is crucial to the success of practice development.

This has a range of impacts, including:

- Improving intersectional practice development.
- A person-centric practice that is culturally humble.
- Generating holistic thinking about the causes of some medical issues.
- Enhancing the understanding of the value of seeking disclosure across healthcare settings.
- Developing biopsychosocial understandings of poor mental health.

Doing so is critical in uncovering the problem, managing the risks and needs associated with it, safeguarding more effectively and reducing revolving doors that see victim-survivors return again and again to health services because of agency failures to work with context.

Increasing the connection between healthcare and specialist DVA services will ensure that currently (relatively) low referrals from health to specialist services are improved and more victim-survivors get the help they need at the right time.

It will also ensure the identification, accountability and potential support of those who cause harm more routinely. Providing strategic network opportunities both operationally and strategically enables the sharing of knowledge, insights and innovations and reduces practice development silos.

This Coordinated Health Response (CHR) is vital in addressing this issue, and integral to its success is the presence of specialist roles within health settings.

→ These roles can be intervention-focussed, providing direct support to victim-survivors and/or can be system-focussed.

The roles can ensure that there is an upskilling and development of practice across the system.

Where they are system-focussed only, they also provide a vital bridge to external specialist services. This is an essential capacity-builder where funding for internal practice-focused specialist roles is unstable and inconsistent.

I**n undertaking the Crossing Pathways programme an enormous amount of good and innovative practice was seen**, with many dedicated practitioners across both health and specialist services striving to identify, respond and reduce the debilitating impact of DVA on those living with this terrible issue.

> **I would have died. You saved my life, you were constantly checking on me and doing everything that needed to be done. I couldn't have done it without you.**
>
> **VICTIM-SURVIVOR**

PHASE ONE MAPPING

The first phase of Crossing Pathways was to map the provision of health and DVA services and processes throughout England.

Mapping was designed to identify gaps; however, it did not prove possible to map the entire system, as not all areas were able to respond due to time pressures.

It is also worth noting that there may have been an 'interest-based bias' in respondents, where areas with higher commitment to DVA practice may have responded more frequently.

The mapping exercise used roles from the Pathfinder Project. These roles were:

- IRIS Interventions - practice educators in primary care.
- Domestic Abuse Coordinator roles (DACs).
- Health IDVAs (HIDVAs).
- Mental Health IDVAs (MHIDVAs).

Along with an innovation checker:

- 'Any other health-based domestic abuse role' [1]

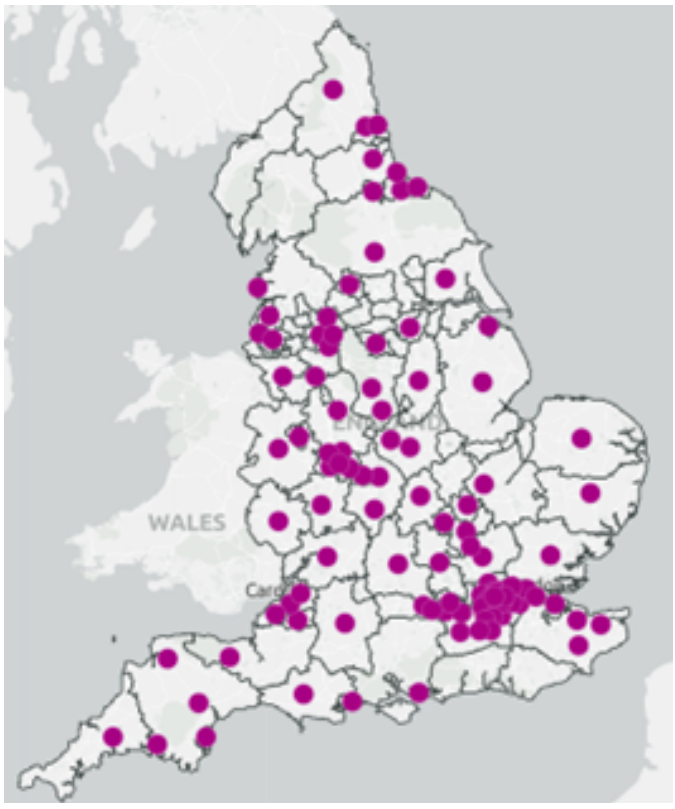
Findings

The number of areas mapped was 68% (n= 103/152) of England's County and Unitary authority areas. The responding areas were spread geographically across the nine English regions, namely North-West; North-East; Yorkshire and The Humber; West Midlands; East Midlands; East of England; London; South-West and South-East.

1 For this report, all roles will be called clinically based DVA specialists going forward unless there is the need to specify.

Key findings from participanting respondents found:

- **91.3% (n=94) have a health representative attend a DVA or VAWG steering or strategy group.**
- **79.6% (n=82) have a HIDVA service.**
- **33% (n=34) have IRISi or an alternative approach within GP surgeries.**
- **17.5% (n=18) have a DA Co-ordinator.**
- **13.6% (n=14) have Mental Health IDVA services.**



Other roles identified:

- Specialist IDVAs for: Maternity; Sexual Health; Acute; Primary Care, Complex Needs, Older Persons; Health and Communities; LGBTQ+ and female genital mutilation (FGM).
- Specialist DVA Nurses/ IPV (Intimate Partner Violence) Nurses.
- DVA specialist midwives.
- DA Health Advocate/ Workers.
- Sexual Violence Counsellors.
- DVA Liaison Worker/ Lead (similar to the DAC role).
- ISVA / IDSVA (Sexual Violence / DVA and Sexual Violence).
- Named nurse for DVA.
- Children's IDVA (CHIDVA).

The mapping also sought to understand the involvement of health organisations in DVA steering or strategy groups. Strategic engagement was expected to be high due to the requirements of the Domestic Abuse Act 2021.

Mapping themes

Gaps in partnership approaches

Respondents identified frequent issues with coordination between services, especially concerning service silos and health representatives being missing from multi-agency meetings, such as MARAC. Being present at such meetings is an essential component of the Coordinated Community Response (CCR) to DVA, but many areas struggled with the capacity to attend such meetings.

Limited coordinator roles co-located in acute trusts

Whilst some local authorities employed a DVA/VAWG lead to join up service provision, coordinate activities and generally develop and embed clear, consistent pathways, this strategic role was often absent. Other areas had piloted the role on a short-term basis, precluding the chance of embedding processes and seeing the longer-term benefits.

Limited DVA interventions in Primary Care

Pathfinder recommends that the IRIS programme be rolled out in all GP surgeries. IRISi provides a research-based gold standard model for ensuring that DVA knowledge and practice is developed and utilised with victim-survivors; however, local areas found it difficult to sustain or secure funding for this, some areas are developing their own model to help but coverage remains low despite the expectation that for each £1 invested a monetary return of £16.79 is expected(Dowrick, 2022).

Limited mental health interventions

Just 14% of mental health trusts in the mapping employed a MHIDVA despite a strong association between mental health and DVA. This is a stark gap given that women who experience DVA are three times more likely to have made a suicide attempt in the last year (Agenda Alliance, 2023) and, in 242 domestic abuse-related deaths recorded between April 2022 and March 2023, 38% (n=93) were suspected victim-survivor suicide following domestic abuse (National Domestic Homicide Project, 2024)

PHASE TWO
SURVIVOR VOICES, SERVICES AND NETWORKS

The second phase of the Crossing Pathways project aimed to increase the capacity for effective intervention for those experiencing DVA, using a three-pronged approach.

1 **Survivor Voices** was initiated ensuring that the whole project was informed and underpinned by the lived experience of victim-survivors.

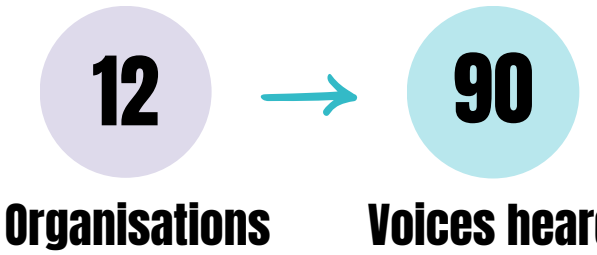
2 **Commissioning of 30 services.** This funding aimed to build national capacity, enable service piloting and inform the thematic analysis of the Coordinated Health Response.

3 **Leadership and partnership networks** were established across England.

Survivor voices

80 organisations were invited to collaborate – 12 took part, with 90 voices heard. Two reports were produced.

The voices represented DVA lived experience with intersecting experiences of rural communities, no recourse to public funding, FGM, So-called Honour-Based Abuse, Human trafficking, forced marriage, learning disabilities, young people.



Survivor voices themes

Better DVA and SVA knowledge across the health sector

Trauma-informed practice needs to be built in

Understand my intersecting needs, identity and background

Flexibility in policy development - allow HCPs to adjust to 'me'

Develop a multi-agency mindset that isn't just about MARAC

Record data helpfully

Be able to link me to external services

Survivor voices

> **For somebody to name it is massive... just to ask questions about me. How are you? Who are you? What do you want? What do you need? You're important too, not just the children, or not just your husband, or not just what this medical form says.**
>
> VICTIM-SURVIVOR

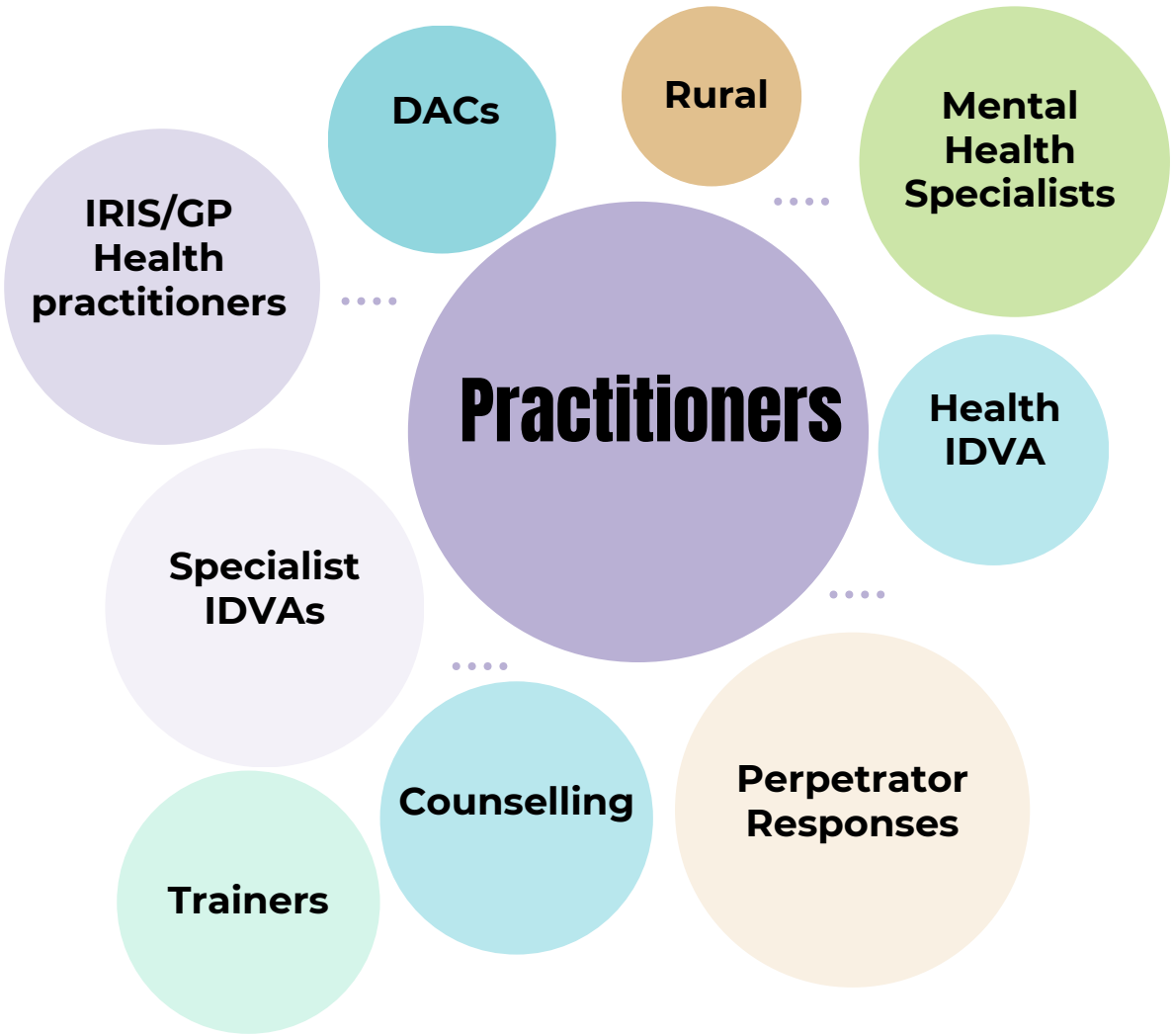
Thank you for...

- Being trauma-informed.
- Being timely.
- Communicating clearly and directly.
- Working with me not for me.
- Being thoughtful and compassionate.
- Respecting my culture.
- Recognising the risks and needs that I faced as a survivor.
- Understanding my gender needs.

Service commissioning

Thirty services were commissioned to provide a range of vital services. Seventeen were delivering direct support and training, four were service delivery only and nine were training only.

The purpose of the evaluation was to identify themes and issues. Pathfinder already evidenced the value and importance of providing these roles. Funding was only available for 12 months.



The service commissioning offered a vital opportunity to fund gaps and innovations in services with a significant commitment by the charities doing the work.

At the time of writing, some organisations were still delivering, but up to February 2025 the reach of the programme was extensive:

1152
Unique individuals supported

1407
Referrals received

12610
Professional Consultations

8960
Professionals trained

Service user outcomes

There were 149 outcomes surveys completed for those who received direct support:

96%
Felt safer

94%
Felt more empowered and confident

95%
Stated improved wellbeing

89%
Supported to engage with health / DA services

78%
Supported with additional needs

Training outcomes

There were 3523 evaluations completed for those who were trained. These showed:

- **98%** Improved understanding of the training issue
- **97%** Confident to recognise indicators of DVA
- **95%** Improved confidence for safe enquiry
- **95%** Confident to respond to disclosures
- **97%** Improved understanding of local pathways.

> **The programme went live on 8th January 2024. Over these 3 months, routine enquiries from clinicians have become standard practice.**
>
> NHS PRACTITIONER

> **I have successfully recruited 15 domestic abuse champions across different clinical areas within the NCA. Having this network will improve understanding, awareness and education around DVA. It will provide clinical teams with additional support in the context of domestic abuse and will create learning opportunities for the wider team to attend and enable a point of entry to embed learning around domestic abuse into each clinical area.**
>
> DOMESTIC ABUSE COORDINATOR

Recruitment & Sustainability

- **Mobilisation time reduces operational time in an already short timeframe.** Recruitment took between 6 and 24 weeks for providers with 98 weeks of delivery being lost across the services.
- **Fixed-term contracts of short length are undesirable for applicants.** Especially those with experience who may be in other roles. For co-location and training delivery this inhibits safe and effective practice.
- **Salary levels are inhibiting recruitment.** Largely due to the current cost of living, uplift stagnation and also where some local authorities are appointing domestic abuse specialists in-house on higher salaries.
- **A lack of suitably qualified and experienced staff.** Inhibits safe recruitment, especially in urban areas.
- **Some applicants expressed a preference for home-based, flexible working.** Especially in the context of adequate salary levels.
- **Public sector contracting is consistently moving to a 'more for less' mentality.** As the squeeze on the public purse continues to be felt nationally after many years of austerity agendas. This increases the demand in the social sector, causing higher levels of staff burnout and making the roles unattractive and difficult to maintain.

The demand on charities for fundraising for roles is extensive and is increased where role funding expires annually.

Responses to a sustainability survey showed that:

- Only six services had secured funding of more than six months towards the end of the project.
- Of 12 responding organisations, 484 hours had been spent on fundraising for the role at a cost of £15,004.
- On an extrapolated basis this could see the 30 organisations spend the cost of a whole post annually (£37,510) on fundraising activity for a single role, amounting to £1250 per organisation.

Service delivery themes

Knowledge development

To achieve a Coordinated Health Response there must be continuous practice development across the system. This enables a whole person approach that has the ability to prevent and reduce revolving doors in health settings.

Training

Training alone is not enough. Where training is provided it must be delivered flexibly and have continuous development opportunities that sit alongside. The best form of this is a Trust-based Domestic Abuse Coordinator who can work across the system to develop both strategic and operational practices and engage HCPs with external specialist providers.

Safeguarding

Improving the recognition of risks and vulnerabilities makes individuals and their families safer. It also reduces the risk of diagnostic overshadowing – the failure to see the context because the medical diagnosis overshadows it and is mistaken for root cause.

Intervention models

With the squeeze on public funding interventions are becoming more targeted and less trauma-informed. The Crossing Pathways programme did not place limits on how the model should be delivered enabling organisations to deliver in a client-led way. Domestic abuse interventions need to be relational, building trust and operating in a trauma-informed manner in order to elicit opportunities for change, the current landscape is increasingly target rather than outcomes driven.

Service delivery themes

Inclusion

The provision of specialist practitioners enables greater inclusion for those experiencing multiple barriers. A vast range of hopeful practice studies were submitted showing greater inclusion for those experiencing hidden harm.

Perpetrator accountability

Developing DVA awareness from both a victim and perpetrator perspective enables greater recognition of those who cause harm, and opportunities to disrupt for accountability.

Data and Process

With such a complex information governance system the NHS faces challenges in using data effectively to identify, respond and manage risks for those experiencing and enacting domestic abuse.

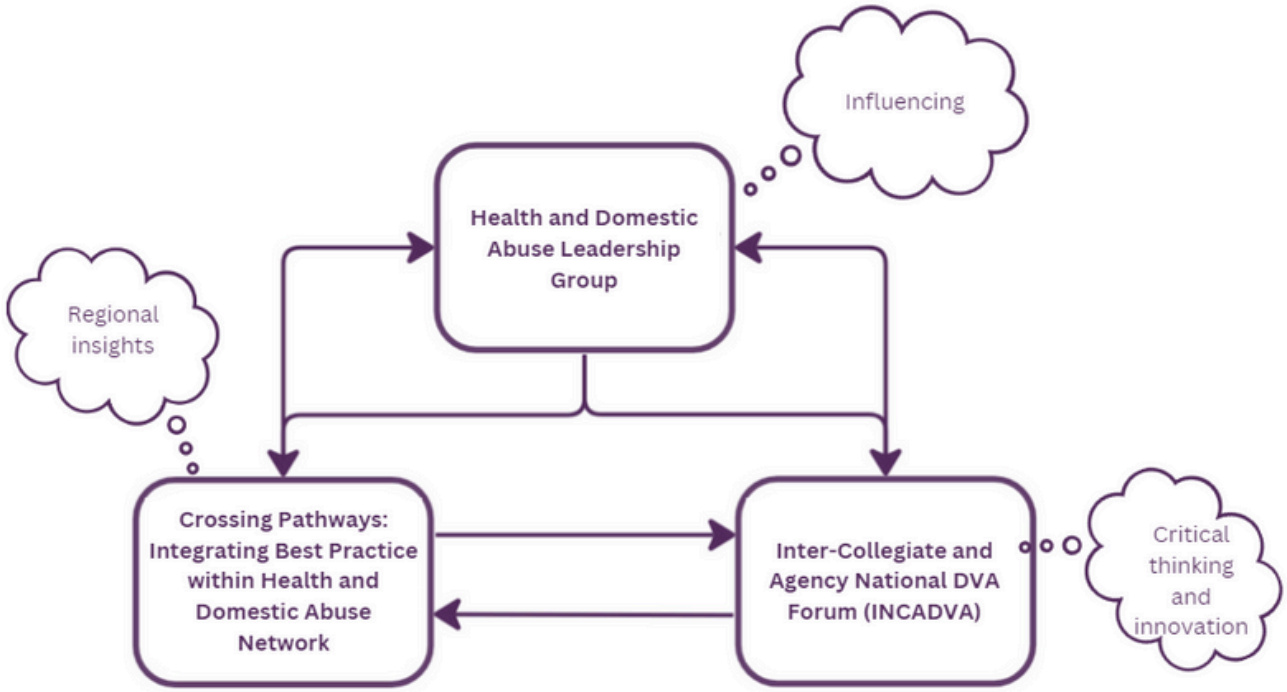
> **I saw a lovely male doctor, he just said all the right things, he listened, gave me lovely analogies and knew how I felt. He didn't tell me what to do – he supported me in my own choices and gave me a list of things I could do. I was feeling anti-male at the time, but he was fabulous. If someone asks the right question, it makes it an easier conversation.**
>
> VICTIM-SURVIVOR

Leadership & Networks

In keeping with the CCR model, bringing people together at both a local and national level to create networks of action and change was critical to a vision of a coordinated health landscape that is confident and proactive in tackling DVA.

The Health Team formed the central Crossing Pathways Network (CPN) meetings to enable cross-sector knowledge and learning dissemination. The team participated in and helped to coordinate the INCADVA Forum and finally developed a Health and Domestic Abuse Leadership (HADAL) group to drive strategic engagement.

- Crossing Pathways Netowork
- Inter-Collegiate and Agency Domestic Violence Abuse (INCADVA) forum
- Health and Domestic Abuse Leadership Group (HDALG)



Crossing Pathways Network

1100+ active members across the nine regions of England, with bimonthly meetings taking place.

Aims

To integrate best practices within health and DVA with the purpose of improving knowledge, pathways to support and responses for survivors of domestic abuse within healthcare settings.

Activities included:

- **Working together** and sharing ideas on how the health response to domestic abuse can be improved.
- **Disseminate learning** on domestic abuse within Health settings from training, case studies, DHRs and research.
- **Sharing knowledge** from the Survivor Voices co-production group.
- **Sharing resources** including expertise, knowledge and experience locally and across the region.
- **Creating equal space** for health staff across disciplines, domestic abuse organisations, system decision-makers and experts by experience to share their experience and ideas.
- **Sharing national developments** in domestic abuse and health practice to inform and influence the development of national policy and practice.
- **Learning from regional issues**, concerns, challenges and good practice.

Members said:

“It’s been really positive and has joined up approaches, resources and ensured there is a more coordinated response. Now we just need to do it with budgets!

“Thank you for this meaningful work on DVA within health. There is much to still achieve but it is really important that these spaces exist.

Inter-Collegiate and Agency Domestic Violence Abuse (INCADVA) forum

A pre-existing national critical thinking, innovation and policy forum

Aims

- To foster collaboration between medical, nursing and allied health professionals and national DVA agencies implementing national guidance on health, including mental health, response to DVA.
- To create evidence-based national, regional and local policy and innovation implemented in health care settings.

INCADVA has a rotating chair from each Royal College or Faculty and meets bi-annually online. Although not evaluated within this project, INCADVA proved an integral aspect of the project as shown in the diagram on page 21.

It was critical to connect these existing and new networks to ensure key learning was shared for the Coordinated Health Response.

Health and Domestic Abuse Leadership Group (HDALG)

Developed following feedback from the Crossing Pathways Network of the need to create a senior leadership space to support the strategic development of the Coordinated Health Response.

Aims

- To gather insights from CPNs and INCADVA alongside other health and DVA experts to inform decision-making, sector-wide innovation, policy, and collaboration to influence change. Membership consists of strategic roles, such as the Domestic Abuse Commissioner's officers, NHSE, Royal Colleges and social sector organisations working in the areas of domestic abuse, maternity and criminal justice.

PHASE THREE
ACCREDITATION, PATHWAYS AND THEMES

The final phase of the project aimed to:

1. Develop an accreditation framework to enable health settings to develop, gain recognition of and showcase best practice.
2. Undertake a pathway analysis evidencing the potential cost savings based on a predicted 'no intervention' pathway.
3. Draw learning together from across the project to generate key themes and a set of recommendations for the future of the Coordinated Health Response.

Accreditation - Pathways to Safety

Accreditation - Pathways to Safety

A draft accreditation framework was tested in relation to the learning across the project:

1. Respect reviewed the Pathfinder recommendations to inform this from a perpetrator perspective.

2.Three pilot Trusts were engaged to participate in a mock 'light touch' accreditation and semi-structured interview process enabling the research team to develop the framework in line with contemporary practice, challenges and thinking.

3.Each CPN was consulted on the framework areas to ensure a broad gathering of views on contemporary practice and policy landscapes

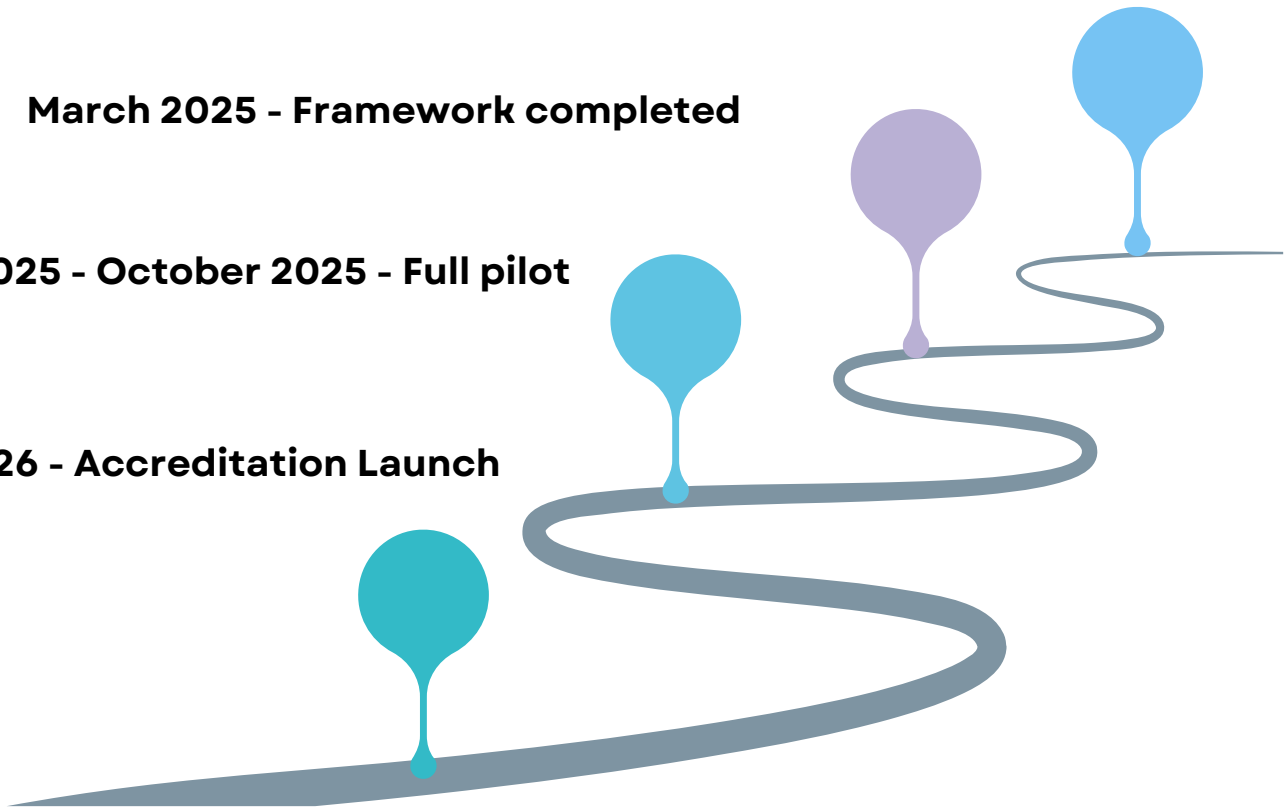
4. The accreditation framework 'Pathways to Safety' was completed for a full scale pilot in 2025-26.

September 2024 - Pilot Sites Accredited

March 2025 - Framework completed

June 2025 - October 2025 - Full pilot

April 2026 - Accreditation Launch



Pathway Analysis

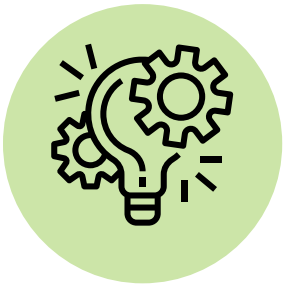
A Pathway Analysis was undertaken to consider the cost implications of five service-user journeys and how these may have looked without the assistance of a clinically-based DVA specialist.

This resulted in the Pathways to Safety and Savings: The Case for Clinically Based DVA Specialists in Health Settings [1] report, which presents compelling evidence for embedding these roles within healthcare settings.*

SUMMARY THEMES

£1.58m average cost savings versus intervention cost of £656

Enhanced Survivor Outcomes across health, safety and wellbeing



Health service reductions in demand and improved access to justice

> **It's been the most traumatic experience of my life, but I did it with you and that's amazing.**
>
> SURVIVOR

*Copies of the report will be available via the Standing Together website

SAMIRA (Not real name)

A British woman of South Asian heritage, in her early 30s, with two primary-aged children.

Health issues

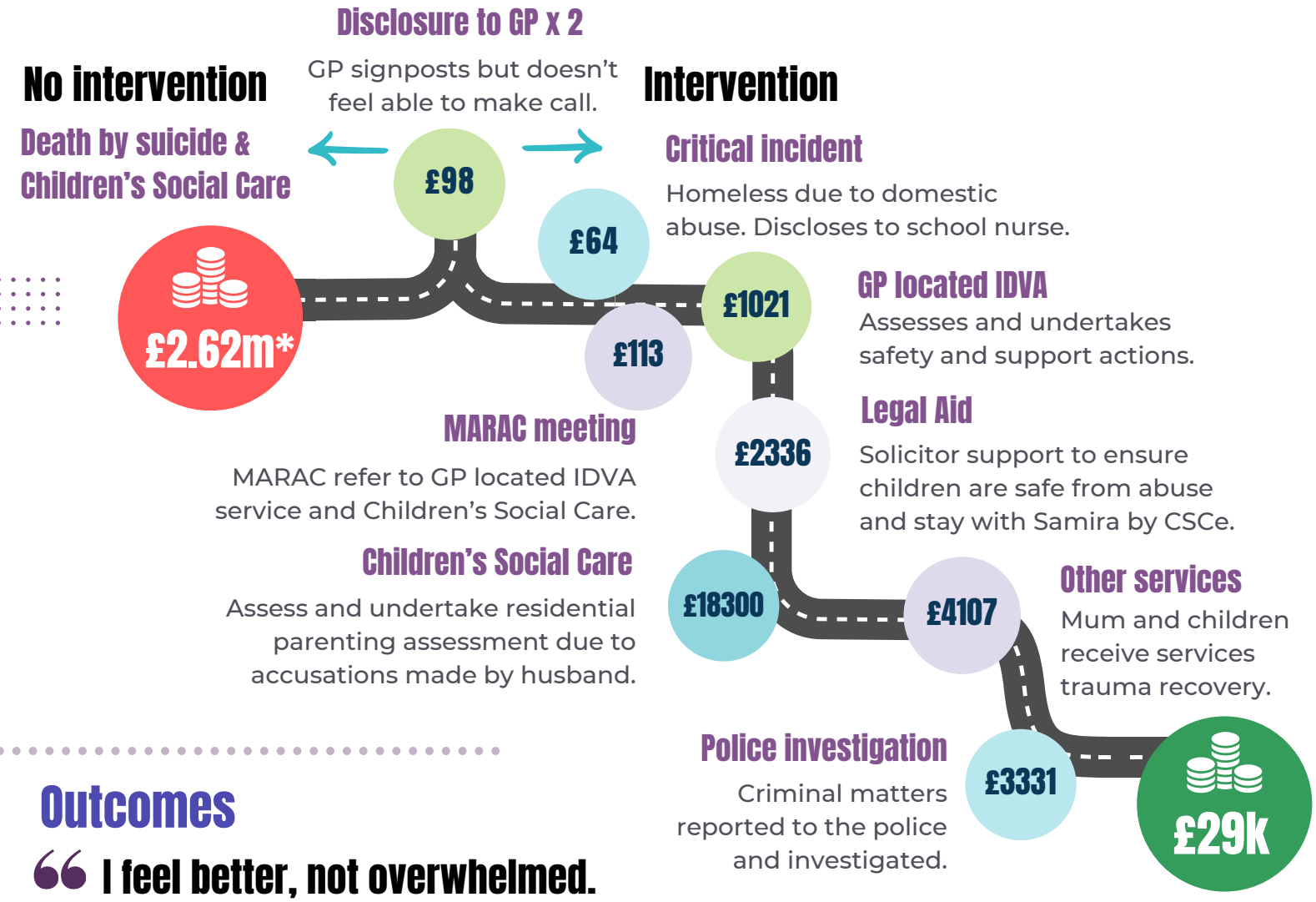
Weight loss, pregnancy complications, anxiety, depression, PTSD and suicidal Ideation, Isolation, children's HWB.

Forms of abuse

Physical, sexual, economic, legal, harmful cultural practices.

Duration of abuse

7 years.



Outcomes

> "I feel better, not overwhelmed.

Healthy weight, increased autonomy and physical activity, reduced suicidal ideation, enhanced self-esteem and motivation, focussed parenting, children's well-being improved, attends health check-ups routinely.

COST SAVING

£2,593,460

(excluding social and emotional consequences for two children)

*Figure updated from Oliver et al, 2019 using up-rating figures derived from GPD inflator figures and ASHE figures for lost output and health services.

TARA (Not real name)

A British-South Asian married woman in her early 40s, living with in-laws and three children under 18 years old.

Health issues

Multiple diagnoses, not necessarily resolving issues including chronic pain and fatigue, long COVID, possible fibromyalgia, depression, anxiety, PTSD, ADHD, and suicidal ideation. Socially isolated and describing significant parental stress.

Forms of abuse

Coercive control and psychological abuse from in-laws.

Duration of abuse

Childhood and from in-laws for over a decade.

Visits to GP x 25

Multiple treatments and diagnoses by GP.

No intervention

Multiple GP visits & hospitalisation

£7435

£1281

Intervention

Critical incident

Attends GP who now has access to DAV Counselling services and makes referral.

£49

DAV Counselling services

18 sessions of specialist counselling support over four months. No visits to GP are needed.

£475

£1805

Outcomes

> **I now have a space [counselling] where I can talk about things I have never shared before. I feel much calmer. I feel more mentally resilient.**

Recognising abusive behaviours, managing boundaries, confidence, improved self-awareness and management of behaviours that exacerbated pain, improved emotional regulation, and ability to manage interactions.

COST SAVING £5630

(excluding social and emotional consequences for three children)

KATE (Not real name)

A White British woman in her late 30s, regaining custody of three children due to alcohol misuse.

Health issues

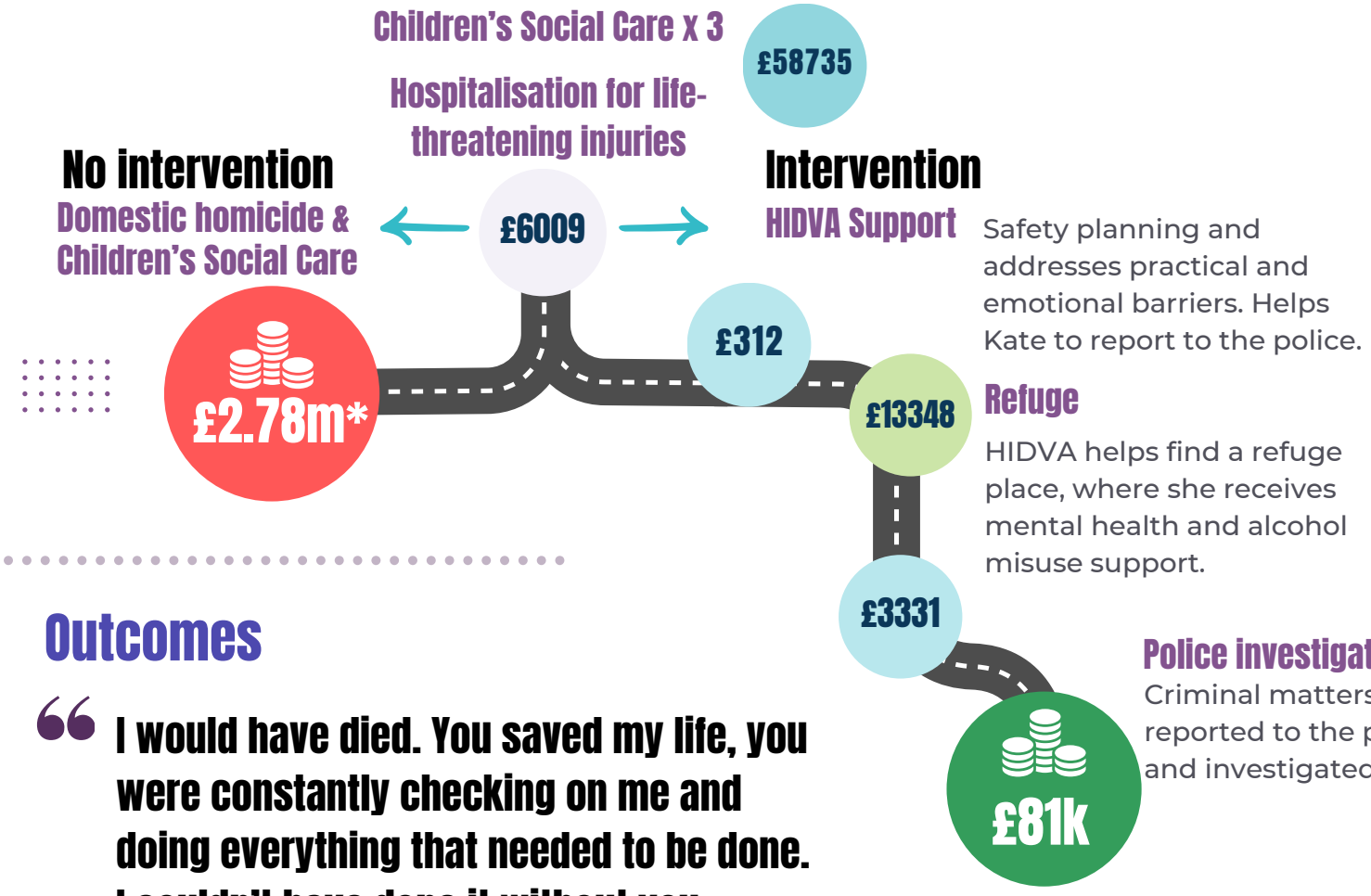
Registered disabled due to severe PTSD, depression and Emotionally Unstable Personality Disorder (EUPD). Life-threatening injuries. Active threats to livelihood from the perpetrator. Maintaining sobriety after a long history of drug and alcohol misuse.

Forms of abuse

Physical violence including whipping (HBV) and threats with knives, emotional and psychological abuse - forced self-harm and mutilation.

Duration of abuse

Prolonged over years. This case study: two months.



Outcomes

> **"I would have died. You saved my life, you were constantly checking on me and doing everything that needed to be done. I couldn't have done it without you."**

Immediate safety, improved mental health, ongoing sobriety, enabled to make informed decisions, increased stability leading to regaining custody of children.

COST SAVING £2.7m

(excluding ongoing social care costs for three children)

*Figure updated from Oliver et al, 2019 using up-rating figures derived from GPD inflator figures and ASHE figures for lost output and health services.

EMILY (Not real name)

A White British woman in her early 20s, a care-leaver with a toddler who identifies as lesbian and previously co-habited with a girlfriend.

Health issues

Depression, anxiety, eating disorder, bipolar disorder, flashbacks and stress-related seizures. History of missed community health care appointments, struggled to regularly take medications.

Forms of abuse

Experienced abuse from multiple perpetrators. This case study: historic incident of rape which resulted in her child and current partner abuse.

Duration of abuse

One year,
two months.

Visits Safe Haven to report historic incident

No intervention

Poor mental health.
Unsupported with abuse.
Local Authority foster care.

£927

Intervention

Mental Health IDVA

MHIDVA helps Emily report historic incident.

Hospitalisation

Treatment for drug overdose, walks out of hospital. MHIDVA locates child and files missing person report.

£2811

£5168

£91k

Critical incident

A concerned neighbour calls the police to Emily's home. Children's social care is also alerted. Emily later discloses abuse by current girlfriend.

Child Protection plan

Residential parenting assessment and MHIDVA support in engaging positively with child support services to keep child.

£840

Mental Health IDVA

Facilitates engagement with mental health services. Spots signs of abuse by new partner.

£1048

Police call out

Emily's child is not returned to her care by the father.

£13931

Refuge

Seeks refuge after abusive incident by new partner.

£16679

£41.4k

Outcomes

> **It's been the most traumatic experience of my life, but I did it with you and that's amazing.**

Significant reduction in risk of further harm, mental health stabilised, positive engagement with support services, ability to make informed decisions about her future.

COST SAVING
£49,731

MARY (Not real name)

A White British married woman in her early 70s, with two adult children who live far away. She lives in a rural area.

Health issues

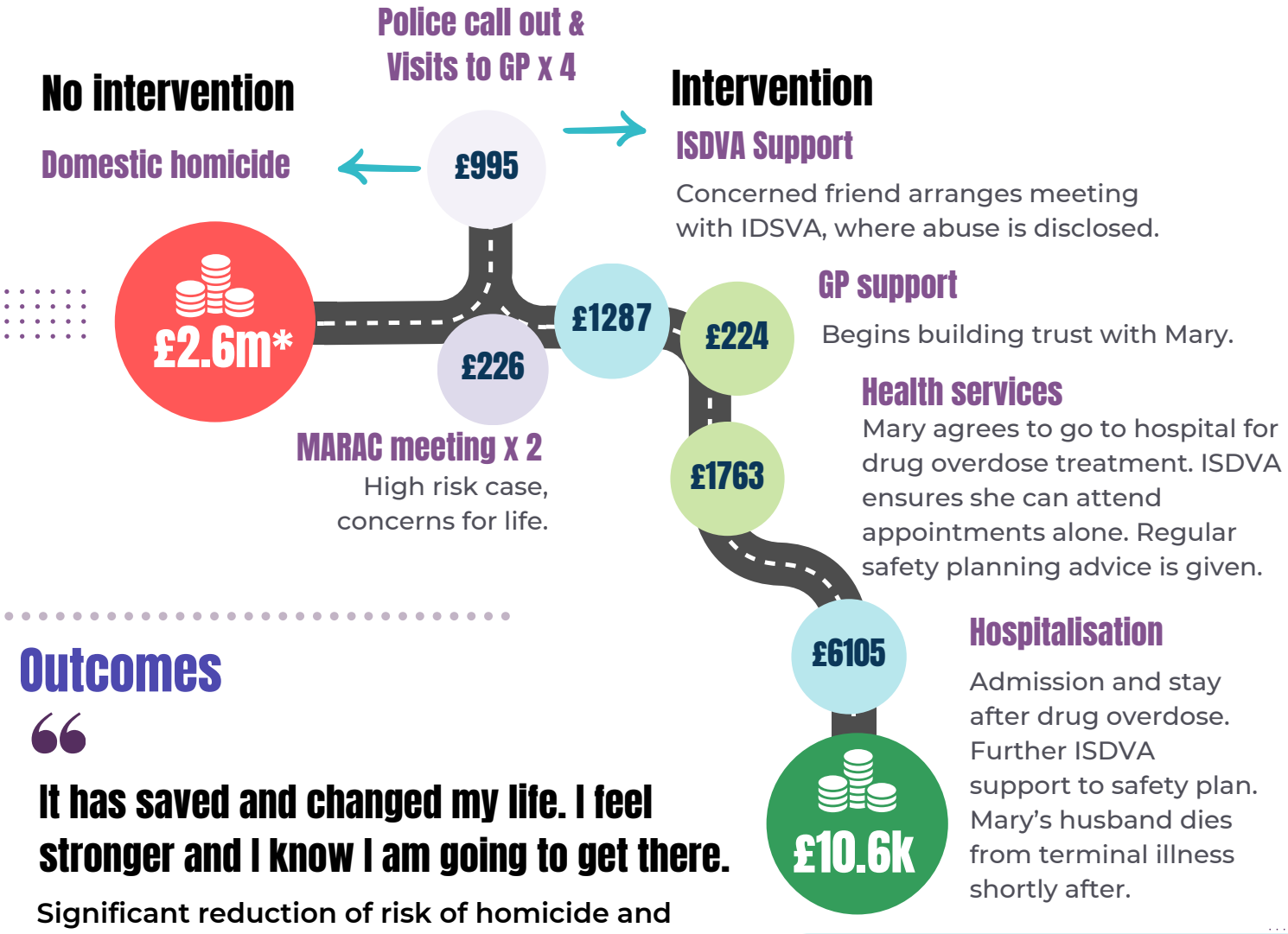
Depression, anxiety, PTSD, frequent suicidal ideation, high blood pressure, social isolation.

Forms of abuse

Physical, emotional, psychological, financial abuse, sexual assault, and coercive control.

Duration of abuse

50+ years perpetrated by husband - a wealthy and respected member of their close-knit rural community.



Outcomes

> **It has saved and changed my life. I feel stronger and I know I am going to get there.**

Significant reduction of risk of homicide and further self-harm, avoidance of possible escalation, recaognition of signs of abuse, improvements in physical health.

COST SAVING £2.59m

*Figure updated from Oliver et al, 2019 using up-rating figures derived from GPD inflator figures and ASHE figures for lost output and health services.

SUMMARY THEMES

Theme 1: Funding and Resourcing

Funding and resourcing were the primary themes throughout the project, creating significant concerns for the maintenance and development of a Coordinated Health Response (CHR).
Resolving the causes and consequences of DVA in the UK is a long-term issue and the intersecting issues that exacerbate this are not resolvable with patchwork and short-term project funding.

Charities and NHS services face significant budget pressure after many years of austerity funding and real-term budget cuts, despite this there are many committed and compassionate practitioners, ready to help

- **Charities have struggled to maintain salaries** that provide appropriate recompense for practitioners increasingly working with higher-risk, higher-volume practice loads as the impact of statutory services' rising thresholds creates a higher burden on Universal/ Level One services.
- **The patchwork funding of services creates inequity across the landscape** and inadequate/ unavailable funding levels are double-bound by short-term grants. This makes service provision unsustainable on multiple fronts.
- **The Autumn 2024 budget further exacerbated social sector budget issues** through National Insurance changes.
- **The NHS has ongoing and increasing strain** after many years of budget cuts alongside the systemic trauma and pressure on services during and following the COVID-19 pandemic.

Key issues: Sustainability

- **Complex system development requires adequate funding** that is considered strategically over the longer term for issues that NHS staff, who face multiple and competing pressures, cannot achieve alone. Strategies must be future-proofed ensuring that last-minute funding decisions are avoided.

- **A lack of sustainable funding for proven interventions impacts access to services for victim-survivors** who are confronted with changing service landscapes and may not know where to turn for help. In the context of a Coordinated Health Response (CHR), it is essential that funders appreciate the value of proven interventions and avoid the 'innovation' trap which causes service providers to try to provide new approaches when, in fact, the tried and tested approaches may work well.

- **Securing funding heavily depended on finding an internal champion within the Integrated Care System who understood the value of providing DVA support.** Organisations from different regions face varying responses to requests for continuation funding, indicating the need for a cohesive strategy.

- **Despite the recognition that DVA is a health issue, that demand is high and that a significant proportion of safeguarding within health settings is DVA-related, there remains a lack of commitment to effective funding.** The Victims Bill cites the need for funding strategy collaboration between health, policing and local authorities and the Royal College of Psychiatrists recently highlighted the need for "ring-fenced funding for independent domestic violence advocates to be placed in every mental health trust, in line with best practice." Community-based DVA support is not mandated within the Domestic Abuse Act 2021, which reinforces the inconsistent approach to its funding.

Key issues: Recruitment and Retention

The lack of adequate and sustainable funding across the domestic abuse sector has led to a recruitment and retention crisis.

78% of organisations struggled to recruit for roles at the salaries they could afford to pay.
Adequate salaries, especially for those expected to work in co-located settings must be available to ensure recruitment pressures are alleviated.[2]

Local and health authorities' budgetary pressures compounded recruitment and retention issues: the cost-of-living crisis, rapid inflation, and poor funding mechanisms.

The work is emotionally laborious requiring practitioners to manage the anxiety of risk management, and increasingly high practice loads, whilst trying to sustain a trauma-informed focus.

There is a significant impact on well-being, which results in practitioners leaving the social sector to seek higher salaries and better working conditions elsewhere.

Some organisations utilise internal secondments for short-term roles, creating an unhelpful burden on staff who are already struggling.

The roles require capable and competent practitioners, with adequate knowledge as well as practice skills to work in complex settings. DVA practitioner training, support and development are critical as well as receiving adequate recompense for the work itself.

2 www.womensaid.org.uk

Key issues: Demand versus capacity

A key issue is the practice loads of both HCPs and DVA practitioners:

- **Services often reported demand outstripping supply,** a lack of time to undertake key activities and the burden of risk of unsafe practice loads.
- **Reductions in funding also impact the ability to practice manage and supervise work effectively** causing greater risk possibility for survivors and potential burnout for practitioners.
- **DVA practice loads are often set at smaller levels for specialised roles** - for example, Rural IDVAs funded based on an intensive practice model. However, the impact of these services fails to be considered in the commissioning of services. These are largely focussed on outputs to the detriment of long-term change for victim-survivors and the inclusion of those with multiple barriers to support.

In committing to sustainable, centralised funding mechanisms a coordinated health system could achieve:

- → **Greater outcomes**
- → **Reduced costs**
- → **Maintaining and recruiting key personnel**
- → **Improved skills and knowledge**
- → **Reduction in health inequalities and costs**

The failure to prioritise comprehensive funding for a Coordinated Health Response (CHR), despite the proven opportunities for long-term cost reductions, impacts the commitment and capacity of the health settings to engage with these vital practices.

Theme 2: Culture and Buy-in

A Coordinated Health Response to domestic abuse requires the health system to develop a culture that: understands the issue for both patients and staff as survivors and perpetrators of DVA, is open to learning, is responsive to the needs of victim-survivors and can identify those that cause harm and understands what to do when they come across the issue.

Generating DVA-aware, trauma-responsive cultures in NHS settings enables victim-survivors to get help at the moment of need, rather than when they have reached a service-specified point of access.

Embedding such a culture requires the system to 'buy-in' to the value and importance of the provision of services with a specialist domestic abuse focus.

Development in this area is enhanced by the presence of dedicated roles, and continuous learning that drives knowledge, skill and practice development and enables engagement at critical moments.

Key issues: Service accessibility

Providing services at the point of crisis is a supportive factor for both HCPs and victim-survivors. Embedding specialist practitioners within hospital settings means overcoming multiple logistical and practice barriers. It was widely recognised throughout the project that colocation is key to the success of projects.

However, clinically based DVA specialists must overcome barriers to colocation that enable good practice and the engagement of the practitioners themselves.

- **Honorary contracting, a requirement for non-clinical staff working in these settings.** Securing such a contract can take several months, inhibiting the project's life, especially where funding is limited. One project utilised a licence to operate in the setting, this did create a swifter entrance to the hospital but reduced the practitioner's opportunity for credibility and information sharing.

- **The availability of private working spaces -** providing a dedicated working space, and one that can afford private, trauma-informed conversations is a challenge in hospital settings. Many services reported that no space was available to either work or spend time with victim-survivors which undermines the provision offer. There were two primary implications of this issue, the first is that NHS staff could be less likely to come forward, and the second is the impact on the engagement and feelings of being valued by domestic abuse practice staff themselves.

- **Service accessibility was seen to be affected by the independence of the practitioner.** Comments and questions arose regularly across the system about the concept of 'independence' for DVA practitioners. There are varying models being adopted across the landscape with three key issues needing consideration where commissioning decisions are made.

1. **Trust** - victim-survivors feel more trusting of an independent person and a dedicated role has greater scope to engage victim-survivors with a trauma-informed lens. This area was seen across the project as especially relevant for NHS survivors who may find it difficult to disclose if they are disclosing to their employing organisation.

2. **Specialism** - services specifically focussed on domestic abuse provision become specialised in their knowledge and continuous development and with the right supervisory principles these services do not allow co-located individuals to become 'institutionalised'. The loss of specialist focus was often referenced concerning 'in-housing' and/or functions being made adjunct to a pre-existing role.

3. **Intersectionality** - those facing multiple oppressions and barriers to help may find speaking with someone with a specialist and independent focus more helpful. Issues of trust are paramount in engaging those who currently fall out of scope due to so-called 'complexity'.

Key issues: Team engagement

Practitioners who were located within a team, usually safeguarding, had a greater sense of well-being and commitment to stay in role.

This is critical for the wellbeing of co-located staff, dealing as they are, with difficult issues in isolation from their organisational infrastructure.

- **Where staff are co-located in a health setting the employing organisation must have in place good structures for supporting remote staff,** as the emotional burden of the work itself cannot be underestimated and has direct causal effect on staff retention.

- **Collaborative partnerships** - discussions took place at all levels about the need to continuously improve the coordination of approach, sometimes in very simple ways, and at others more strategically. This crucial system coordination reflects the importance of creating the conditions for a Coordinated Health Response (CHR). The presence of DACs was widely evidenced to create these conditions.

Network members and services continually noted the need to have accessibility of services that are both strategic and operational. This requires sound partnerships between the NHS and the DVA sectors, and network members and services noted that this is a top-down requirement. Maintaining Crossing Pathways networks would be a valuable opportunity to continue to drive development.

Strategic leadership must drive the message that generating access to these services needs to be part of a shared vision for victim-survivors throughout the health system.

Theme 3: Practice Development

A primary driver of culture change is developing practitioners' knowledge, awareness and skills base to drive attitudinal and practice developments.

In health settings, the presence of domestic abuse specialist practitioners is known to improve the system response through three domains:

1. **Coordination of approach** (often in the form of a DAC role).
2. **Direct support** (clinically based DVA specialists) across all settings, especially mental health, but also primary and secondary care generally.
3. **Education** (training provision for NHS staff).

Good practice beyond specialist roles ensures that victim-survivors can access support at the point of needing help irrespective of their current circumstances. This enables:

- **Enhanced opportunities** for early intervention and the identification of the possible DVA-related context of health needs.
- **Opportunities to reduce the long-term impacts** of trauma and safeguard vulnerable families and individuals.
- **Reduced burden on agencies** of revolving door practice.
- **Ensuring that safeguarding is proactive.**

Key issues:

Early intervention / Identification of need

Safe/Routine Enquiry is a good practice model in identifying need, enabling disclosure, naming the problem and offering the opportunity to direct the victim-survivor or perpetrator of DVA for support.

- **Safe spaces are essential** for this along with the training of HCPs to develop their skills of recognition and safe enquiry.

- **Training and support from a DVA practitioner** can also reduce the risks associated with diagnostic overshadowing enabling HCPs to take a trauma-informed approach to understand the causal factors in someone's hospital admission from a specialised practitioner often bespoke learning opportunities.

Intersectionality

The development of HCPs DVA practice skills and the availability of DVA practitioners can strengthen the intersectional lenses.

Through which victim-survivors are viewed, enabling access to services for diverse populations. The presence of clinically based specialists offers the best opportunity for cultural sensitivity and subsequent identification of needs and risks.

Whole family

Holistic practice can enable better outcomes for wider family members via the identification of the perpetration or experience of abuse.

This improves safeguarding in a system that is a pressured working environment, and where holistic thinking can easily be lost.

Working with those who cause harm

There have been several challenges identified across the lifespan of the project in working with people who are causing harm.

Any health setting can come across perpetrators of DVA in varying scenarios with challenges in understanding the risks posed by them. The variability of presentation and identification poses huge challenges to policy development and practice. [3]

Information management

Recording DVA information is as important as any other information in health records, but inconsistency in guidance and practice exists across the system.

DVA should be recorded in a way that increases victim-survivor and children's safety and identifies the risks associated with those who cause harm. This is not a new subject with the Pathfinder project generating research and learning in this area. NHS policy and process should support not only the good recording of information, but also a clear understanding of appropriate information-sharing practices.

3 At the time of writing this report, the work commissioned from Respect, to analyse policy and practice in hospital Trust settings was ongoing. The findings from this work will be published separately but general themes have been incorporated throughout this report.

RECOMMENDATIONS

Following the evidence gathered from the Crossing Pathways report, Standing Together makes the following recommendations and commitments for improving the Coordinated Health Response (CHR).

1 **DHSC to develop a national strategy for the funding and provision of specialist clinically based DVA specialists and HCP practice development that recognises DVA as a public health issue and includes:**

- Profiling minimum practitioner levels in Integrated Care Systems.
- Prioritising of the Domestic Abuse Health Coordinator (DAHC) role.
- Co-location guidance that enables mobilisation and integration of DVA specialists in clinical settings.
- Protected time for HCPs to have standardised and role-appropriate, independently delivered training in DVA awareness delivered on a critical mass training basis, ensuring consistency of practice across the health system with nationally agreed learning outcomes.
- A commitment to the integration into existing medical training of the long-term physical and mental health impact of domestic abuse, including brain injury, post-traumatic stress disorder and cardiovascular conditions.
- Benchmarking of appropriate salary levels for clinically based DVA specialists.
- A commitment and approach to NHS staff who are victim-survivors or who are causing harm.
- A commitment to maintaining the Crossing Pathways networks.
- Guidance on best practices for intersectional and trauma-responsive practice in health settings.
- An update to the NICE Domestic Violence and Abuse Guidance, 2014.
- An update to the Domestic Abuse: A Resource for Health Professionals guidance, 2017.

2 DHSC to develop central commissioning guidance for clinically based DVA specialists which includes:

- Clarity regarding the responsibilities and approaches for consistent ring-fenced funding for DVA services in health settings.
- Funding and support for local health systems to take up their duty to collaborate in the commissioning of services.
- Formulating effective integrated commissioning practices that recognise the importance of DVA specialisms in health settings.
- A focus on impact over outputs to ensure that case volumes do not take precedence to the detriment of outcomes and safeguarding for survivors.
- Specifying minimum commissioning periods of three years.
- The strategy should include guidance on commissioning for intersectional and trauma-responsive practice in health settings.
- The strategy should include guidance on commissioning practices with local services, especially those delivering by-and-for services.

3 Standing Together will undertake the development of national role profiles and professional training programmes for clinically based DVA specialists:

- Recognising the specialised practice approaches in these roles.
- Acknowledging the need for role profiling consistency.
- Drawing together local innovations to inform national practice approaches.
- Development of a strategy-informed national training programme.

4 DHSC should develop a strategy and guidance for a consistent approach to DVA data recording:

- Ensuring the NHSE data improvement workstream is brought forward following disbandment.
- Piloting tests of medical record system function, and the development of system consistency, and investment in data systems and protocols that allow for improved analysis of domestic abuse.
- Collaborative approach with health, DVA and Perpetrator practice specialists in data sharing for safeguarding and practice development.
- Standardisation of data recording - establishing a national mechanism for collecting and reporting on data.

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