



## Supporting the development of safe and effective responses within drug and alcohol agencies

# Findings from Stage 1 of the MARAC Engagement Project Baseline research report

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## **Executive summary**

#### Context

Research consistently shows that whilst there is no causal link between drug and alcohol use and domestic violence (DV), survivors and perpetrators of DV are disproportionately affected by problematic substance use (PSU). A 2005 study by Humphreys & Regan<sup>1</sup> found that 63% of men attending DV perpetrator programmes self-reported their own PSU, and 44% of women accessing DV agencies self-reported their own PSU. Further, although there is no causal link between substance use and domestic violence, levels of alcohol use are related to the likelihood and severity of violence (Finney, 2004).

However, despite substance use being identified as a risk indicator in relation to DV, drug and alcohol agencies have, to date, had low participation rates at Multi-Agency Risk Assessment Conferences (MARACs). The role of the MARAC is to provide a forum for effective information sharing and partnership working among a diverse range of adult and child focused services in order to ensure the safety of victims and their children who are at high risk of serious injury or murder. AVA (Against Violence & Abuse) and Coordinated Action Against Domestic Abuse (CAADA) initiated the MARAC Engagement Project to understand and improve the drug and alcohol sector's participation in the MARAC process.

#### **Aims**

In partnership with CAADA, AVA's Stella Project aimed to establish through this baseline research:

- The current level of engagement of London drug and alcohol agencies with the MARAC process;
- The barriers these agencies face in engaging with MARACs;
- Examples of promising practice between the MARAC and the substance misuse sector.

This baseline research will be followed up by training and consultancy work in two London boroughs throughout 2011, informed by the research, to increase drug and alcohol agencies' engagement with the MARAC process.

#### Methodology

Between October 2010 and March 2011, AVA's Stella Project disseminated online questionnaires to MARAC Chairs and Managers of drug and alcohol agencies in all 32 London boroughs, and the City of London. Questionnaires were supplemented with telephone interviews with key respondents and data held by CAADA on selected MARACs who gave consent for their data to be shared with the Stella Project.

This report is based on responses from 69 individuals, including 52 London substance misuse sector professionals and 17 London MARAC Chairs. All respondents completed an online questionnaire, including 13 who were also interviewed by phone.

## **Key findings**

Amongst London drug and alcohol agencies surveyed, there is good level of general awareness around domestic violence, with 85% of agencies currently conducting routine questioning to identify survivors amongst their service users. Agencies were less likely to

<sup>&</sup>lt;sup>1</sup> Humphreys, C. & Regan, L., 2005. DV and Substance Use: Overlapping Issues in Separate Services. London: Greater London Domestic Violence Project.

conduct routine questioning to identify perpetrators (69%), or to report that their staff are mostly or always trained to identify high risk cases of domestic violence (65%).

Substance misuse sector respondents' knowledge and experience of the MARAC process was highly variable, from agencies that were very engaged and knowledgeable about the process to others that had not heard of MARAC prior to completing the questionnaire. Although all MARAC Chair respondents reported having a substance misuse sector representative on their MARAC, these representatives are disproportionately located in statutory sector agencies (71%) and nearly one third (31%) of the MARAC Chairs reported that the substance misuse representative attends only sometimes or rarely. Just over half (28 of 49=57%) of substance misuse sector respondents reported that their staff mostly or always know both the referral criteria to MARAC and the process they need to follow to refer to MARAC.

MARAC Chairs reported referral rates from the substance misuse sector that were comparable with those shown in data submitted to CAADA in 2010. However, within this questionnaire sample, the average referral rate was much higher than the referral rate across 28 boroughs as reported to CAADA (2.4% compared with 0.92%). In particular, Kingston upon Thames reported a referral rate of 16%, although even when Kingston is excluded from the analysis, the average referral rate is 1.2%. This suggests that MARAC Chairs who responded were likely to be based in boroughs with higher-than-average levels of engagement.

The strongest theme amongst respondents was the need for good communication between the MARAC and the substance misuse sector, including clear, well-publicised referral pathways to MARAC and systematic information-sharing processes. Where substance misuse sector respondents were currently engaged with the MARAC, they reported that good communication with the MARAC improved their ability to work effectively with their service users and that participation provided an opportunity for staff to share the responsibility for responding to domestic violence with other agencies. Nearly two-thirds (71%) of substance misuse sector respondents who mostly or always received clear information from the MARAC had made a referral in the past six months, whilst just 15% of those who rarely or never had clear information had made a referral. This finding suggests that sustaining and developing communication processes between the MARAC and the substance misuse sector is a relatively straight-forward and cost-effective way to dramatically improve engagement.

Many respondents mentioned the need for coordinated responses between agencies in the borough, both within the substance misuse sector and between different sectors, along with an understanding of drug and alcohol related domestic violence amongst MARAC agencies. MARAC Chairs, in particular, felt that better partnership-working between the substance misuse sector and other agencies in the borough was a benefit of the sector's engagement with their MARAC. Of substance misuse sector respondents who had referred to MARAC in the past six months, 67% reported that other agencies mostly/always offer useful support for their service users. Interviewees provided specific examples of how MARAC engagement had helped them secure additional support for their service users, above what they were able to offer themselves, resulting in increased safety for the survivor. However, many respondents felt that coordination between agencies in their borough could be improved. Specifically, respondents reported feeling frustrated at a lack of understanding of substance use within the context of domestic violence, as well as identifying issues around resources. such as the lack of refuge provision for women substance users, despite the high prevalence of substance use amongst survivors of domestic violence. The concerns raised by respondents in relation to coordinated responses were not specific to the MARAC process, but respondents tended to see MARAC as an opportunity to achieve a more coordinated response.

Another strong theme was the need for substance misuse sector staff to feel confident in working with survivors or perpetrators of domestic violence. Where substance misuse sector respondents were currently engaged with the MARAC, they reported that involvement with the MARAC had increased their knowledge and awareness around working with domestic violence, and their confidence in responding to survivors and perpetrators. None of the agencies who reported that staff are rarely or never trained to identify high risk cases of domestic violence had made a referral to MARAC in the past six months, however 50% of agencies where staff were sometimes trained had made a referral. This suggests that even training some staff to understand risk in relation to domestic violence can have an impact on the agency's engagement overall. Over half of the substance misuse sector respondents (54%) and 70% of MARAC Chair respondents reported that drug and alcohol staff need training in general domestic violence awareness and/or risk assessment. Around a third (38%) also wanted specific MARAC training for a substance misuse sector representative to the MARAC.

A small group of substance misuse sector respondents mentioned additional barriers to engagement with the MARAC, including: difficulties obtaining consent from service users who are involved in illegal activities; that the MARAC process is time-consuming; and that they believed the MARAC process excludes the voluntary sector.

#### Conclusion

Current levels of engagement between the substance misuse sector and the MARAC, although low across London, vary significantly from borough to borough. In general, substance misuse sector professionals are positive about the possibilities of the MARAC process and are interested in increasing or improving their engagement. Where there are existing good relationships between the MARAC and substance misuse agencies. professionals report that the MARAC process impacts positively on their work with both survivors and perpetrators of domestic violence.

Although barriers to increasing engagement vary between boroughs, the findings from this baseline research suggest that efforts to increase the substance misuse sector's engagement with the MARAC process will be most effective if targeted at: improving communication processes between the MARAC and drug and alcohol services in the borough, including publicising referral criteria and pathways; and providing training for at least some substance misuse sector staff in identifying and responding to high risk cases of domestic violence.

#### Recommendations

#### **Recommendations for MARAC Steering Groups**

- Monitor cases where substance use issues are identified for the survivor and/or perpetrator
- Make a case for the participation of the drug and alcohol sectors at MARAC
- Identify agencies providing drug and alcohol services in the borough, and what services these agencies offer
- Invite agencies to participate in the MARAC process, either as permanent attendees or on an ad hoc basis
- Where identified, support a Substance Use Lead at MARAC
- Provide clear information on MARAC referral pathways in the borough
- Provide training on risk identification and MARAC processes to staff providing drug and alcohol services.

#### Recommendations for the substance misuse sector

- Ensure at least one staff member in each drug and alcohol agency is trained in domestic violence (DV) awareness and risk assessment
- Ensure each agency has the capacity to routinely enquire for DV and/or use a common evidence based risk identification checklist (RIC)
- Drug & Alcohol Action Team (DAAT) managers should nominate a Substance Use Lead to the MARAC, and ensure that this staff member has appropriate training to fulfil the role
- DAAT managers should ensure that the Substance Use Lead on their MARAC communicates regularly with all agencies providing drug and alcohol services in their borough.

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## 1. Context

## 1.1. Project rationale

Research consistently shows that whilst there is no causal link between drug and alcohol use and domestic violence (DV), survivors and perpetrators of DV are disproportionately affected by problematic substance use (PSU). A 2005 study by Humphreys & Regan<sup>2</sup> found that 63% of men attending DV perpetrator programmes self-reported their own PSU, and 44% of women accessing DV agencies self-reported their own PSU. Further, although there is no causal link between substance use and domestic violence, levels of alcohol use are related to the likelihood and severity of violence (Finney, 2004).

Multi-Agency Risk Assessment Conferences (MARACs) were first piloted in Cardiff in 2003 and there are now 245 across the UK. The role of the MARAC is to provide a forum for effective information sharing and partnership working among a diverse range of adult and child focused services in order to ensure the safety of victims and their children at high risk of serious injury or murder. Early analysis suggests that following intervention by a MARAC and an Independent Domestic Violence Advocacy (IDVA) service, for up to 60% of domestic abuse victims the risk of physical violence is reduced. However, despite substance use being identified as a risk indicator in relation to DV, drug and alcohol agencies have, to date, had low participation rates at the MARAC.

In partnership with CAADA, AVA's Stella Project is seeking to establish the current level of engagement of London drug and alcohol agencies with the MARAC process and the barriers these agencies face in engaging with MARACs, and to increase this level of engagement where necessary. Through research and development work funded by Trust for London, the MARAC Engagement Project aims to increase the number of London drug and alcohol agencies engaging effectively with the MARAC process.

Between October 2010 and March 2011, AVA's Stella Project, supported by CAADA, disseminated online questionnaires to MARAC Chairs and Managers of drug and alcohol agencies in all the London boroughs. The aim was to establish baseline data about the level of engagement of drug and alcohol agencies with each MARAC, identify barriers to engagement and gather examples of promising practice. Questionnaires were supplemented with telephone interviews with key respondents and data on the local MARACs provided with their consent by CAADA.

This report presents the findings from this baseline research, and will provide the basis for our development work over the coming months.

## 1.2. AVA (Against Violence & Abuse) and the Stella Project

AVA was formed on 12 April 2010, replacing the Greater London Domestic Violence Project (GLDVP), which was formed in 1997. AVA is a national second tier service working to end all forms of violence against women and girls. AVA's Stella Project is the leading UK agency addressing drug and alcohol related domestic and sexual violence.

In 2002, discussions between the GLDVP and the Greater London Alcohol and Drug Alliance (GLADA) identified gaps in the current service provision for both survivors and perpetrators of DV who are problematic substance users. GLDVP and GLADA created the Stella Project in 2003 in order to find positive and creative ways to work towards more inclusive service

<sup>&</sup>lt;sup>2</sup> Humphreys, C. & Regan, L., 2005. DV and Substance Use: Overlapping Issues in Separate Services. London: Greater London Domestic Violence Project.

provision. Since 2010, the Stella Project has had a national remit and works around sexual violence, as well as domestic violence.

## 1.3. CAADA (Coordinated Action Against Domestic Abuse)

CAADA is a national charity supporting a strong multi-agency response to domestic abuse. CAADA's work focuses on saving lives and saving public money, providing practical tools such as training, quality assurance, data insight and policy guidance to support professionals and organisations working with domestic abuse victims. The aim is to protect the highest risk victims and their children – those that are at risk of murder or serious harm.

## 1.4. Definitions

1.4.1. AVA and CAADA use the UK government's definition of domestic violence:

Any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality.

This definition includes violence such as female genital mutilation (FGM), so-called 'honour' crimes and forced marriage.

However, AVA and CAADA also recognise that this definition is problematic and does not sufficiently reflect DV in its entirety.<sup>3</sup> DV is not restricted to an 'incident,' but is a pattern of abusive and controlling behaviour through which the abuser seeks power over their victim. Although DV occurs across all sections of society, regardless of age, race, sex, wealth and geography, it is most often perpetrated by men, against women.

Furthermore, although the above definition is restricted to adults, AVA and CAADA recognise that children and young people are also affected by DV, either by witnessing it between adults, or experiencing it in their own intimate relationships.

#### 1.4.2. AVA's Stella Project defines problematic substance use as:

The use of substances (such as illegal drugs, prescription medicines or alcohol) in such a way that results in harm to the individual user or to the wider community. The range of harms includes problems for physical health, psychological health, violence, financial problems, family problems or social problems.

#### 1.5. Methodology

This first stage of the MARAC Engagement Project involved online questionnaires and telephone interviews with commissioners and practitioners. As per National Research Ethics Service (NRES) guidance, this stage of the project fits the criteria of a clinical audit – "designed and conducted to produce information to inform delivery of best care" – and therefore formal ethics approval was not required. The Stella Project London Working Group provides ongoing advice and guidance on the project.

All online questionnaire participants were required to read information about the project and answer a question giving their consent to participate. Participants in telephone interviews were required to return a signed consent form before the interview commenced.

Two separate online questionnaires were developed to target London MARAC Chairs and London drug and alcohol service managers respectively, and were delivered online through

<sup>&</sup>lt;sup>3</sup> For a further discussion of this definition and its limitations, see: <a href="http://www.ccrm.org.uk/">http://www.ccrm.org.uk/</a>, Section 11.3 'Definitions and Debate'

Surveymonkey. Both questionnaires were open for responses from mid-December 2010 to mid-February 2011.

The questionnaire for London MARAC Chairs was distributed electronically to all 33 Chairs by the Metropolitan Police's Detective Inspector Lead for DV and by London borough DV Coordinators. The questionnaire for London drug and alcohol service managers was distributed electronically to London Drug and Alcohol Action Team (DAAT) managers, to the Stella Project mailing list of 1002 recipients, to members of the London Drug & Alcohol Network, and directly to 91 drug and alcohol services for whom email addresses were known.

In the online questionnaire, all respondents were asked whether they were willing to participate in a follow-up telephone interview. All those who responded in the affirmative were then contacted and asked to provide a convenient time to participate in a telephone interview. All interviewees who confirmed a time and returned a signed consent form were interviewed by telephone. Interviews lasted between 20 and 30 minutes, and the interviewer took handwritten notes. An audio recording was made of telephone interviews, from which the interviewer confirmed and added to handwritten notes. Full transcription of interviews was not done, due to time constraints.

Respondents to the MARAC Chairs questionnaire were also asked whether or not they consented to CAADA sharing data relating to their MARAC, either submitted as part of quarterly data returns or following their participation in the MARAC Quality Assurance process.<sup>4</sup> For the 11 respondents who consented to data sharing, CAADA provided the Stella Project with data collected between 1 January and 31 December 2010.

Finally, preliminary findings were presented at the Independent Domestic Violence Advocates (IDVA) Network Meeting on 17 March 2011 and at a Stella Project networking event on 21 March 2011. Additional feedback provided by substance misuse and DV practitioners at these meetings has been noted where relevant in the report.

All data was collected and analysed by the Stella Project London Coordinator. Anonymised data and a draft report was provided to CAADA and agreed with CAADA's Quality Assurance Manager. This final report has been reviewed by AVA and CAADA's Directors and by the Stella Project London Working Group.

#### 1.6. Respondents

This report is based on responses from a total of 69 individuals, all of whom completed (or partially completed) an online questionnaire. Of these 69 respondents, 13 also participated in individual telephone interviews. This data was analysed alongside supplementary data collected by CAADA in relation to 11 MARACs, who had consented to their information being shared, which included data collected from 7 drug and alcohol agencies through CAADA's MARAC Quality Assurance process.

Table 1.1

	Drug and alcohol services	MARACs
Online questionnaire	52	17
Telephone interview	12	1
CAADA Quality Assurance data	7	11

<sup>&</sup>lt;sup>4</sup> The MARAC Quality Assurance is the third stage of CAADA's MARAC Implementation Programme, funded by the Home Office, which is designed to support local areas establish, develop and sustain an effective MARAC.

Five additional responses to the drug and alcohol agency guestionnaire have been excluded from this analysis. Three of the five excluded responses were from agencies who only provide services to children and young people, as MARACs are used only in cases involving adult survivors of DV. Two of the five excluded responses were from the same person, who completed the questionnaire twice, giving different answers each time.

Three additional responses to the MARAC Chair survey have been excluded from this analysis. One excluded response was completed by the MARAC Coordinator, but a response was also received from that MARAC Chair. In the MARAC Chair's response, three answers requested that the MARAC Coordinator's response be referred to, and in these respects the Coordinator's responses were copied into the Chair's response and the rest of the Coordinator's response was excluded. Two further excluded responses were begun by MARAC Chairs who then aborted their responses when asked to provide quantitative data, and re-started and submitted a full response at a later date.

#### 1.6.1. Drug and alcohol service respondents

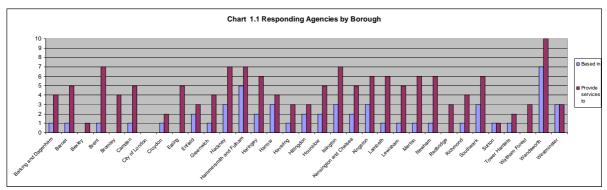
The National Treatment Agency (NTA) reports that there are currently around 400 agencies using the National Drug Treatment Monitoring System (NDTMS) in the London region each month. This suggests that the online questionnaire response rate to this survey was quite low (13%). However, all services that provide structured treatment for drug and/or alcohol users are asked to submit data to NDTMS, including hostels, youth offending services and young people's substance misuse services. The questionnaire was aimed specifically at adult services<sup>5</sup> which operate primarily as a drug and/or alcohol service. With this in mind, the NTA requested DAAT Managers to tell us the number of drug and alcohol services in their borough. Based on responses from eight boroughs, we have calculated an average of 6.5 drug and/or alcohol services per borough, for an estimated total of 215 agencies operating primarily as adult drug and/or alcohol services. This suggests a more reasonable response rate of 24%.

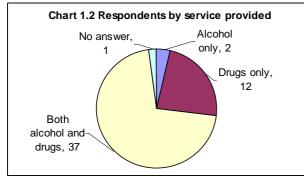
Of the 52 respondents, 42 agreed to be contacted for telephone interview but only 12 confirmed a time for interview. Thirty-eight respondents were the manager of the agency they were responding on behalf of, including five who also managed other agencies in the organisation. Although the questionnaire was targeted at managers, ten respondents were other frontline workers, including project workers and team leaders, and three respondents were Directors or Commissioners. One respondent was an administrative assistant.

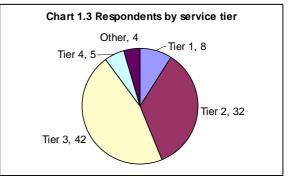
All respondents represented different agencies, including 41 (79%) voluntary agencies, ten (19%) statutory agencies and one voluntary/statutory consortium. Nine (17%) of these agencies provide national and/or pan-London services, and the remaining agencies collectively provide services in all London boroughs except the City of London. However, some agencies (excluding national and pan-London service providers) provide services in more than one borough. No responses were received from agencies actually located in Bexley, Bromley, City of London, Ealing, Redbridge or Waltham Forest.

the audit.

<sup>&</sup>lt;sup>5</sup> Only adults can be referred to the MARAC, so although the questionnaire asked whether the agency provided services to young people as well, it was not relevant to include young people's services in







The majority of respondents provide services in relation to both alcohol and drug dependence, although a significant minority (12=23%) provide drug-only services. Respondents were also asked what tier of services they provide in relation to substance use, in line with the Department of Health's (DH) tiered treatment system. Tier 1 services are nonspecific services which provide information and advice, such as GPs or probation services: Tier 2 is open access services, which provide advice and information, drop-in services and harm reduction; Tier 3 are community services, such as community drug teams, day treatment services and drug dependency units; and Tier 4 are specialist residential services, including inpatient and residential rehabilitation.

Most respondents provide services at more than one tier – most commonly Tier 2 and Tier 3 services together – although a significant minority (14=27%) provide services in just one tier, which was most commonly Tier 3. Two respondents who described their services as "other" and wrote open-ended answers were re-classified by the researcher as Tier 2 and Tier 3 respectively. 6 The four other respondents who provide "other" services include referral services to other tiers and family and parenting support for family members of problematic substance users.

#### 1.6.2. MARAC respondents

There are 33 MARACs in London (one in each borough and the City of London), so the 17 responses to the online questionnaire represents a good response rate of 52%. Twelve respondents agreed to be contacted for telephone interview, however only one returned a signed consent form allowing them to be interviewed.

The respondents were Chairs of 17 different MARACs across London. Table 1.2 illustrates which MARACs are represented in these results, and notes where respondents only partially completed the online questionnaire.

<sup>&</sup>lt;sup>6</sup> One respondent provided an open-ended response which stated "Tier 3", and the other wrote "Harm reduction advice and information and signposting", which would be classified as Tier 2 support by the DH.

Table 1.2

Borough MARACs included	Borough MARACs not included
Camden	Barking & Dagenham
City of London	Barnet
Croydon	Bexley
Greenwich	Brent
Hackney (partially completed)	Bromley
Hammersmith & Fulham	Ealing
Haringey	Enfield
Hillingdon (partially completed)	Harrow
Kensington & Chelsea	Havering
Kingston	Hounslow
Lewisham	Islington
Newham	Lambeth
Redbridge	Merton
Richmond	Southwark
Sutton	Wandsworth
Tower Hamlets	Westminster
Waltham Forest	

## 1.7. Gaps in the data

No responses were received from either the MARAC Chair or from drug or alcohol agencies based in Bexley, Bromley or Ealing. Furthermore, although some questionnaire respondents stated that they provide services in these boroughs, no respondents had referred a case to these MARACs in the past 6 months.

Although there was a good questionnaire response rate from MARAC Chairs, only one Chair returned a signed consent form to be interviewed, so it was not possible to conduct telephone interviews with a reasonable sample of MARAC Chairs. As such, the responses of MARAC Chairs were not probed in the same depth that those of substance misuse practitioners were.

## 2. Findings

## 2.1. DV awareness in the London drug and alcohol sector

## 2.1.1. Knowledge and understanding of DV

Of the 52 questionnaire respondents, 44 (85%) stated that their service conducts routine questioning to identify survivors of domestic violence (DV). Of these, 37 (71%) explained that this is done at the initial assessment stage, including 13 (25%) who reported that this is then also followed up in key work sessions and/or care planning throughout treatment. Although not as many services conduct routine questioning to identify perpetrators of DV, at 36 (69%) respondents, it is nevertheless a majority of services that do so.

Although most drug and alcohol agencies are asking routine questions about DV, it is not possible to determine the quality of routine questioning in agencies, as this was beyond the scope of this research. However, other questionnaire and interview responses suggest that the quality of this questioning is likely to vary between agencies. It is well established that the vast majority of DV survivors are women, and that providing women-only spaces is an important factor in creating a positive environment for survivors to disclose DV. However, although 85% of services conduct routine questioning to identify survivors, less than half of all respondents (21=40%) provide some form of women-only service. Women-only services that agencies reported they provide ranged from providing a female staff member for 1:1 sessions or confidential access to their building, to women-only group work, women-only drop-ins and whole days on which the service operates as women-only.

In telephone interviews, drug and alcohol respondents' knowledge and understanding of DV was probed further. Of this group of 12, 11 (92%) conduct routine questioning to identify survivors and ten (83%) conduct routine questioning to identify perpetrators. As they had an overall higher rate of routine questioning, it is possible that this group may have a slightly higher awareness around DV than the questionnaire group as a whole. When asked how they define DV, only one respondent failed to mention forms of abuse other than physical violence, with respondents variously mentioning emotional (8), sexual (6), mental/psychological (5) and financial (4) abuse. Two respondents reported that they use the MARAC definition – which they reported as being the same as the UK Government definition used in this report – but another two stated that they have no written definition for their agency. Three respondents provided examples of the ways DV specifically affects their client group, such as being controlled in prostitution or being criminalised through supporting a partner's drug use (e.g. being forced to buy drugs, being forced to take their partner's drugs into prison).

Thirty-two (65%) of 49 drug and alcohol questionnaire respondents reported that their staff are "mostly" or "always" trained to identify high risk cases of DV, whilst six (12%) respondents reported that staff are "never" or "rarely" trained and ten reported that staff were only "sometimes" trained. None of those whose staff were never/rarely trained had made a MARAC referral in the past 6 months.

## 2.1.2. Knowledge and understanding of the role of the MARAC

Twenty-nine (60%) of 48 drug and alcohol questionnaire respondents reported that their staff mostly/always understand the referral criteria to MARAC and 29 (59%) of 49 reported that staff mostly/always know the process they need to follow to refer. However, a significant minority reported that staff rarely/never understand the referral criteria (14 of 48=29%) and rarely/never understand the referral process (16 of 49=33%).

Interview respondents were asked what the role of the MARAC was in their borough. The most common understanding of the MARAC process was that it was a multi-agency

approach and a forum for information-sharing (6 of 12 respondents). Only 4 of 12 respondents mentioned that MARAC was for high risk cases, and only three of 12 mentioned the MARAC's role in reducing harm or promoting the safety of the victim. Two respondents did not know anything about the MARAC, including one who had not heard of the MARAC before taking part in the online questionnaire.

## 2.2. Current levels of MARAC engagement

All MARAC Chair respondents reported that their MARAC has a representative from the drug and alcohol sector, with an average of 1.4 representatives per MARAC for the 16 MARACs that answered this question. Drug and alcohol representatives on these MARACs were predominantly statutory services (71%), compared with respondents to the drug and alcohol questionnaire who were overwhelmingly based in the voluntary sector (79%). However, despite all 16 MARACs having at least one representative, five (31%) MARAC Chairs said that the representative attends only "sometimes" or "rarely," and another reported that they didn't know whether the representative has attended.

Just under half (25=48%) of the drug and alcohol questionnaire respondents reported that they had referred to MARAC in the past 6 months. Based on questionnaire responses, although drug and alcohol MARAC representatives are more likely to be statutory service providers, voluntary agencies are no less likely to refer to the MARAC. Twenty (38%) respondents provided information on how many referrals they made and to which MARACs. In the past 6 months, they made a total of 48 referrals to 16 different London MARACs, with the greatest number of referrals made to Enfield and Islington MARACs (7 each), followed by Wandsworth (6) and Kingston upon Thames (5).

Thirteen MARAC Chairs provided information on how many referrals they had received in the past 6 months, and what proportion of these were referred from the drug and alcohol sector. On average, just 2.4% of MARAC referrals came from the drug and alcohol sector, with five MARAC Chairs reporting no referrals from the drug and alcohol sector in the past 6 months. The major exception to this trend was Kingston, where 16% of referrals (8 of 50) came from the drug and alcohol sector; if Kingston is excluded from the analysis, the average referral rate from the drug and alcohol sector drops by 50% to 1.2%. It is possible that London MARACs where the Chair did not respond to the questionnaire do have higher referral rates from the drug and alcohol sector, particularly in Enfield, Islington and Wandsworth which showed high referral rates on the drug and alcohol sector questionnaire. In some areas, drug and alcohol agencies reported that they had made more referrals than the number reported by MARAC Chairs. It is beyond the scope of this research to identify the reason for this difference, which may reflect issues relating to the management of referrals at each MARAC. However, the most likely explanation for this is that drug and alcohol agencies may refer through their local Independent Domestic Violence Advocacy (IDVA) service, and so this will be recorded at MARAC as a referral from the IDVA service, not from the substance misuse sector.

Referral data collected in the questionnaires was consistent with data submitted to CAADA.<sup>7</sup> The 11 MARACs who consented to their data being shared with CAADA and provided referral data on the questionnaire, reported referral rates from the drug and alcohol sector of 1.3% (questionnaires) and 1.2% (CAADA data). Nationally, the referral rate from the drug and alcohol sector to MARAC is 0.62% (290)8, with London showing a slightly higher 0.92%

<sup>&</sup>lt;sup>7</sup> Data from these 11 MARACs was submitted using the MARAC data form, which records the number of referrals to the MARAC and the referring agency, in addition to other data such as the number of children and repeat referrals. The data covered the 12 months up to the end of December 2012. <sup>8</sup> 241 MARACs across England and Wales submitted data to CAADA for the 12 months up to the end of December 2010. In this period, over 46,000 adult cases and over 63,000 associated child cases were heard at these meetings.

(49)<sup>9</sup>. Overall, 58.1% of referrals to MARAC in London are from agencies other than the police, with the largest non-police referrer being IDVA services.

We would expect the largest referrers to MARACs to be the police and the DV sector. However, since we know that survivors of DV are disproportionately affected by problematic substance use (PSU), this would suggest that the identification and referral of high risk survivors affected by PSU may be quite low.

However, referral to MARAC is not the only way that the drug and alcohol sector engages with MARAC, and the fact that all MARACs in the sample had a least one representative from the drug and alcohol sector is encouraging. Nevertheless, this representation appears to be skewed towards the statutory sector and only around half of drug and alcohol questionnaire respondents (24 of 47=51%) reported that the MARAC Chair or Coordinator mostly or always provides clear and accessible information to them. Those who said that they rarely or never get clear information were slightly more likely to be voluntary sector agencies (85%, compared with overall voluntary sector participation of 79%).

## 2.3. Positive experiences of MARAC engagement

Of the drug and alcohol agencies that had referred to MARAC in the past 6 months, 15 (83%) reported that service users were mostly/always safer following the MARAC intervention. Overall, where agencies had established a working relationship with the MARAC, they were able to identify benefits to this engagement. However, all responses about the positive aspects of the MARAC were from a handful of respondents and therefore can only be interpreted as examples of individual positive experiences and cannot be generalised to the experience of agencies across London.

In general, drug and alcohol agencies found information-sharing with other agencies the more helpful aspect of MARAC. Although information-sharing is an important part of the MARAC process, drug and alcohol agencies tended not to mention risk. It is unclear as to whether this reflected any particular issues around the degree to which agencies understood risk and its management in the context of DV, or whether agencies had an implicit assumption that the sharing of information related to risk. Furthermore, it is unclear whether substance misuse professionals believe that increased information-sharing would be beneficial across all cases of DV, or whether this is a specific benefit in relation to high risk cases.

#### 2.3.1. Clear structure and referral pathways to some MARACs

Experiences of communication and referral pathways between the drug and alcohol sector and the MARAC were extremely varied amongst respondents, as noted above, with a significant minority of questionnaire respondents not being aware of referral pathways to their MARAC. However, amongst those who had referred to the MARAC in the past 6 months, 89% (16 of 18) reported that it was mostly/always easy to refer to MARAC and some interview respondents (4 of 12) mentioned clear referral pathways as something they found helpful about the MARAC process in their borough.

Examples of practice which promotes clear referral pathways given by drug and alcohol interview respondents were:

 Referral pathways are well known throughout the borough, including through the IDVA service and through the MARAC Substance Misuse representative (2);

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<sup>&</sup>lt;sup>9</sup> 28 MARACs in London submitted data to CAADA for the 12 months up to the end of December 2010. In this period, over 5,000 adult cases and over 6,000 associated child cases were heard at these meetings.

- Substance misuse staff understand their responsibilities in relation to the MARAC process and disclosure (2);
- A MARAC representative has come to the service to provide staff with MARAC information and/or training (2).

#### 2.3.2. Drug and alcohol sector confidence in identifying domestic violence

Amongst agencies which had referred in the past six months, all said their staff were at least sometimes trained to identify high risk cases of DV and 78% (14 of 18) reported that staff were mostly/always trained. Given that amongst all respondents only 65% reported that staff were mostly/always trained, training in identifying high risk cases appears to impact positively on referral rates.

Four of 12 drug and alcohol sector interview respondents reported that their staff were confident in identifying DV, and that this impacted positively on their engagement with MARAC. Factors that have impacted positively on staff confidence and skills included:

- Staff experience in responding to DV, with staff skills growing through dealing with more cases (2);
- Recent introduction of borough-wide assessment forms which require staff to ask specific questions around DV (1);
- Staff knowledge of local referral pathways for survivors and perpetrators of DV (1).

Engagement with the MARAC process was identified as increasing staff confidence in responding to DV.

## 2.3.3. Information-sharing and identification of survivors and perpetrators

Four drug and alcohol interview respondents mentioned information-sharing about service users discussed at MARAC as a helpful aspect of the MARAC process. Two respondents specifically noted that it is helpful when information shared at MARAC identifies survivors or perpetrators of DV amongst their service users.

It's helpful when something gets disclosed at MARAC that we didn't know about before, especially in relation to perpetrators - Commissioner.

I'm the MARAC lead and get the list every month, and there have been instances where we haven't been aware of either victimisation or that a client we were working was a perpetrator. It was a good idea for us to know about that - Tier 2 Statutory Service Manager.

Another two respondents highlighted how the information they provide is helpful to the MARAC:

Every month the MARAC sends us an email with the names of people involved with MARAC and we let them know if anyone is one of our clients - Tier 2/3 Voluntary Service Manager.

We send a representative to the MARAC meetings so are able to keep the MARAC informed of any cases that have substance misuse issues attached - Tier 3 Statutory Service Manager.

One substance misuse sector respondent provided a specific example of how informationsharing had impacted positively on the way their service worked with a client.

Tier 2 Statutory Service Manager: There was a case specifically that came out of prison, this was quite some time ago, who we weren't aware that he was a DV perpetrator and from the MARAC we were able to work with him in terms of encouraging him - we never told him he was identified, but we could work with him around his offending and work with him to acknowledge that he would need some kind of treatment around being a DV perpetrator. And from that he agreed to be referred to [the local perpetrator programme]. So I suppose in that respect, we knew of the offence relating to assault, but we didn't know that it was specifically a DV case, so in that respect, that was a positive outcome.

Interviewer: And do you think that referral to the perpetrator programme would have been made without that disclosure from the MARAC?

Manager: It might have taken a longer time. We develop a working relationship with the client...it probably eventually would have come, because the client was willing to do something about his offending behaviour. But I think it probably happened sooner, as we were aware of it and more able to focus our attention and work and questioning and specifically lead him to acknowledge his offending.

The MARAC Chair in this borough also mentioned this same case, as an example of a time when an Action Plan from their MARAC resulted in a drug or alcohol agency protecting a victim more effectively. This MARAC Chair was the only one to raise information-sharing as a benefit of increased drug and alcohol sector engagement, noting, "Joint sharing of information makes plans more realistic and achievable."

#### 2.3.4. Shared responsibility for DV and coordinated responses

In questionnaire responses, several MARAC Chairs identified coordinated responses (i.e. action planning) as a positive aspect of engagement with the drug and alcohol sector, including eight (47%) respondents stating that "better partnership working between drug and alcohol agencies and DV agencies" had been one of the benefits of drug and alcohol engagement to date.

Some drug and alcohol respondents also identified coordinated responses as a positive aspect of MARAC engagement, including three interviewees. Of those who had referred to MARAC, 12 (67%) questionnaire respondents reported that other agencies at the MARAC mostly/always offer useful support for their service users. Two respondents provided specific examples of how a coordinated response had increased a survivor's safety.

We had everything in place to protect the victim, or support the victim, but we referred to MARAC because it was quite high risk and that enabled all of the different agencies sitting on the MARAC to be aware of this case. So I suppose in that respect it was helpful, and then it got a coordinated response from everyone there - Tier 2 Statutory Service Manager.

A pregnant female client was referred by us to MARAC, and was enabled to access a hostel away from perpetrator within 24 hours, organising her script to be transferred in the same time period. She returned to him, but re-presented at our service. The MARAC referral helped her link up with the DV outreach worker and this has now enabled her to leave and secure alternative housing... Without MARAC she is likely to have been unable to leave the situation at all, sort out accommodation and address her drug use - Tier 2/3 Voluntary Service Manager.

A key aspect of the coordinated response is that agencies are able to work together. contributing their expertise to increase victim safety. One interviewee suggested that having a coordinated response with other agencies allows "the responsibility [of responding to DV] to be taken away from us," leaving the drug/alcohol agency to focus on substance misuse treatment.

#### 2.3.5. Promising practice

In both questionnaires, respondents were asked to provide specific examples of effective MARAC engagement which resulted in making survivors safer. Very few respondents provided further detail here, but those who did provide examples generally provided examples of improved partnership working.

A questionnaire and interview respondent who refers to Lewisham MARAC, but does not attend MARAC themselves, identified promising practices in relation to communication and information-sharing between the MARAC and the drug and alcohol sector in that borough. This was supported by another questionnaire respondent who had previously worked in Lewisham but had since moved to another borough:

Getting a link into MARAC has been a major administrative difficulty. However this is now sorted out and we can, hopefully, link into MARAC in the way that happened when I had previous experience of the system in Lewisham.

According to the respondent currently based in Lewisham, a lead from the substance misuse sector sits on the MARAC, the MARAC Coordinator is in direct contact with all drug and alcohol agencies in the borough, and cases listed at the MARAC are shared with all agencies. All drug and alcohol agencies are in contact with the Substance Misuse lead, and refer cases through this person who also attends and represents these agencies at MARAC. Drug and alcohol agencies in the borough always know if they are working with a survivor or perpetrator who has been discussed at MARAC, and if there are any further developments whilst they are working with a service user, the substance misuse worker contacts the delegate who referred the case to MARAC. This respondent noted:

It's a really good way of sharing information...To the credit of our MARAC Lead and DV Co-ordinator, they have come out to all agencies to make it clear about why this is important, to provide guidance around information sharing and stuff like that.

As only one respondent to the questionnaire was based in Lewisham, it is not possible to determine whether this experience is uniform across all drug and alcohol agencies in the borough. Further, Lewisham does not have significantly higher referral rates from the substance misuse sector than other boroughs. However, this respondent's experience provides a promising example of how communication and information-sharing with the drug and alcohol sector could be improved, and reveals that engagement cannot be measured simply by the number of referrals, but also by communication in the opposite direction which allows drug and alcohol agencies to work more effectively with survivors and perpetrators. It also provides a model of how the drug and alcohol sector can effectively engage in the MARAC process, while minimising the resource commitment from individual agencies.

#### 2.4. Opportunities for improved MARAC engagement

Five (29%) MARAC Chair respondents felt that there were no barriers to drug and alcohol sector engagement with the MARAC. Eight (15%) drug and alcohol questionnaire respondents similarly agreed. However, the vast majority of drug and alcohol agencies identified opportunities for improvement in their engagement with the MARAC process. The following table summarises questionnaire responses from the drug and alcohol sectors.

Table 2.1

Area for improvement	% of SMU respondents
Our staff don't know the process to follow to refer cases to MARAC	21%
Our staff don't feel confident in their understanding of the referral criteria for MARAC	17%
Our staff aren't confident in identifying high risk cases of DV	15%
We can more easily get the support offered through the MARAC by going to agencies directly	13%
Our staff don't know the MARAC exists	11%
Our service users rarely give consent for their information to be shared at the MARAC	8%
Other agencies at the MARAC do not understand substance misuse issues	6%

Area for improvement	% of SMU respondents
We don't have time to attend the MARAC to discuss the referrals they make	4%
Other agencies at the MARAC do not offer support which is useful for our service users	4%
The MARAC referral process is too time consuming	2%

Again, all responses regarding areas for improvement in the MARAC process were from a handful of respondents and therefore can only be interpreted as examples of individual experiences and cannot be generalised to the experience of agencies across London.

## 2.4.1. Improved communication between the MARAC and the drug and alcohol sector

Poor communication from the MARAC to their agency was the second most recurrent theme raised by drug and alcohol sector respondents, and there was a direct relationship between quality of communication and referral rates from the drug and alcohol sector. Questionnaire respondents to whom the MARAC Chair or Coordinator "always" or "mostly" provided clear and accessible information had disproportionately high MARAC referral rates in the past six months (71% had referred, compared with an overall referral rate of 48%). Just 3 (15%) of those who rarely or never had clear and accessible information from the MARAC made referrals in the past six months.

Eight of 12 interview respondents mentioned poor communication with the MARAC, including six respondents who reported that they did not know how to access the MARAC and/or believed they had been obstructed from accessing MARAC. Questionnaire respondents who were not subsequently interviewed also mentioned this in open-ended answers. Respondents' examples of poor communication included:

- Attempting to access information about the MARAC, but being refused or receiving no response (6);
- Not knowing how to make a referral to MARAC (5);
- Not receiving information back about what happens at MARAC (4);
- IDVA service not accepting referrals from their agency (1);
- Substance use lead at MARAC being from another substance misuse organisation. who fails to share information with their agency (1).

Six of 12 interview respondents mentioned that they wanted to be more engaged in the MARAC process, but had difficulty obtaining information about how to access the MARAC. Examples included:

We have very little involvement with it. We tried to get a place on the MARAC but can't. There's only one representative from the substance misuse sector, and they're from a different organisation... We don't know what happens at MARAC, it's not that well integrated... MARAC is a fairly separate entity. They are not good at information sharing and this results in 'silos', with certain groups holding lots of information. - Tier 2/3 Voluntary Service Manager.

We don't know the referral pathways to MARAC at all, and have had no information from them... I have asked a couple of times, but got nowhere. I've asked the statutory service and care managers, but I haven't been able to find anything out about it – [A different] Tier 2/3 Voluntary Service Manager.

Our service isn't really involved in the process, in the two years I've been here I've never been invited to a MARAC meeting or attended one, but I know that other drug agencies within the borough do go. So that's quite worrying... I've brought it up with my line manager and she's now emailed a manager from another service who she knows is

involved with them, to try and get me involved. I think it's important that I go as a women's worker, because we have some very high risk cases and yet we're not attending the meetings. And yet we may be the main agency the woman is working with... In one case I had, she was a self-harmer, there was increasing violence from her partner, she was showing all the indicators of DV - attending with injuries, always presenting in an agitated state, very chaotic drug use (literally changing on a week to week basis), depression, all the signs that it would be high risk. So that was guite a stressful case to work with... She may be discussed at the MARAC meetings, but I'm not there - Tier 3 Voluntary Service Practitioner.

Some MARAC Chairs also raised this issue, reporting that attendance at the MARAC from the substance misuse sector was poor. Although all MARACs had at least substance misuse representative, five (31%) MARAC Chair respondents said that the substance misuse representative only sometimes or rarely attended the MARAC. Two respondents suggested that insecure funding may be an issue for the substance misuse sector, including in one borough where funding for a women's worker in the local substance misuse agency had been lost and so regular substance misuse sector attendance was also lost.

#### 2.4.1.1. **Information sharing between MARACs**

Two drug and alcohol interviewees suggested that there was also a need for improved information-sharing between MARACs, to better protect survivors when they or the perpetrator move boroughs.

We had one case where the victim lived in our borough, but the perpetrator was being managed by probation [in another borough] and so we couldn't get a referral to MARAC. It was an extremely high risk case, he had thrown acid in her face - Tier 2/3 Voluntary Service Manager.

Many referrals we make are already known to MARACs in other boroughs. It would be good if there was more joined-up working between boroughs – Tier 2/3 Consortium Manager.

Recently, in response to a request from local authority domestic violence leads in London who identified a need for a consistent and safe approach to the transfer of cases, a MARAC to MARAC referral process<sup>10</sup> was developed. This was designed to ensure there is clear guidance on the transfer of cases between MARACs when high risk victims move from one area to another. The aim is to promote the safety of high-risk victims, regardless of where they live, and to ensure that all agencies at MARAC are clear about their roles and responsibilities at each stage of the transfer process.

## 2.4.2. Improved coordination between agencies in the borough

The most recurrent theme raised by substance misuse sector respondents was poor coordination between their agency and other agencies in the borough, mentioned by nine of 12 interview respondents. Respondents saw MARAC as an opportunity for a more coordinated approach, but either lacked access to the MARAC or felt that the MARAC wasn't fully achieving this.

Responses in relation to the need for improved coordination included:

- Desire to improve links between their service and local DV agencies (4);
- Service users are involved with a large number of agencies and support needs to be coordinated to ensure appropriate treatment (3):
- Desire for agencies for share information about their service users more often and/or in a more structured way (2);

 $<sup>^{10}</sup>$  For more information on the MARAC to MARAC referral process, see: http://www.caada.org.uk/Practitioner\_resources/MARACresources.htm.

Desire for shared expertise from MARAC and/or DV agencies (1).

Respondents also suggested other ways to achieve a more coordinated response for their service users who are survivors or perpetrators of DV.

There needs to be a more coordinated approach, like a dual diagnosis approach, so that things aren't dealt with separately but are dealt with together. This would require development of a joint programme, a joint effort between substance misuse and DV services. Services need to make sure we say it's not someone else's problem. Staff shouldn't say, 'Well we've referred to MARAC and that's it.' We need to be very much a part of this process - Tier 2 Statutory Service Manager.

There needs to be more disclosure between agencies. If someone's on probation and we are working with them, we need to be linked in, because the information that he's a perpetrator would help us to help the client move through treatment – Commissioner.

We don't get any guidance from [the MARAC and DV agencies], but they're the experts... There isn't a wraparound approach... Change needs to be monitored: one family can have 30 professionals involved, so we need to work together - Tier 2/3 Voluntary Service Manager.

We could advertise DV agencies more in our service, getting more leaflets, but I've found that quite hard. We tried to get advertising posters from DV agencies, but didn't get anything useful from them. I only got leaflets for people whose friends are experiencing DV – Tier 3 Voluntary Service Practitioner.

There needs to be better links between drug services and local refuges. We've tried to have link workers in our services and the local refuge, but it was hard work and never got off the ground – Tier 2/3 Voluntary Service Practitioner.

Responses from interviewees – either positive or negative – about information-sharing and coordination in their borough highlights again the perception in the substance misuse sector that this is the primary benefit of engagement with the MARAC. In questionnaire responses, just 7 (13%) of respondents said that they could more easily get the support offered through MARAC by going directly to other agencies and 29 (56%) felt that increasing their engagement would result in greater support for their service users who are survivors and better partnership working with specialist DV service; 24 (46%) felt that increasing their engagement would result in greater support for their service users who are perpetrators.

However, although MARAC is intended to be a vehicle for improved coordination in high risk cases of DV, responses from the substance misuse sector highlight a more general frustration with an uncoordinated approach around all cases of DV. This suggests that survivors of DV affected by substance use may benefit from wider work to improve coordinated approaches amongst agencies, alongside work that focuses on increasing engagement with the MARAC.

#### 2.4.3. Increased training opportunities for drug and alcohol staff

Many drug and alcohol agencies identified training for their own staff as an effective intervention to improve their engagement with the MARAC. Twenty-eight (54%) respondents reported that their staff needed DV awareness training and/or risk assessment training, and 20 (38%) would like MARAC training for a substance misuse representative. In interviews, several respondents also mentioned the need for training in working with perpetrators of DV.

In questionnaire responses, agencies that are not currently conducting routine questioning to identify survivors of DV were significantly less likely to have referred to MARAC in the past six months (25%, compared with an overall referral rate of 48%).

In agencies where staff are rarely or never trained to identify high risk cases of DV, no referrals to MARAC had been made in the past six months. However, in agencies where staff were only "sometimes" trained, the referral rate was 50%, with agencies where staff were mostly/always trained having a marginally higher referral rate of 56%. This suggests that even modest levels of training in DV awareness and risk assessment may have positive impacts on referral rates to MARAC.

Whilst 23 (44%) drug and alcohol questionnaire respondents believed their staff would benefit from DV awareness training, 12 (70%) MARAC Chair respondents believed the same thing. Nineteen (37%) drug and alcohol questionnaire respondents and seven (41%) MARAC Chairs believed staff would benefit from risk assessment training.

In interviews, eight drug and alcohol respondents mentioned staff training:

Practitioners are fearful of asking the question about DV, because they're worried about frightening the client off... it's about both a culture shift and a training need, to think about how we best meet the needs of vulnerable clients. People's needs don't get met because people are too frightened - Voluntary Family Service Manager.

We asked for MARAC training for our organisation, and for one of our staff members to be trained as a representative, but it was refused – Tier 2/3 Voluntary Service Manager.

We try to train our staff as much as possible, but it's expensive to train all 48 of our staff and volunteers. Sometimes you get training through the DAAT, but I want all our staff to be trained and only half of them have been trained in DV - Tier 2/3 Voluntary Service Director.

The skills set amongst our staff is fairly good, but there could be more training on what you can do to support survivors, what they're entitled to, so that we can advocate for them better - [A different] Tier 2/3 Voluntary Service Manager.

Preliminary findings from these surveys and interviews were presented to the London Independent Domestic Violence Advocates (IDVA) Network meeting in March 2011. IDVAs are trained specialists who provide a service to domestic violence victims who are at high risk of harm from intimate partners, ex-partners or family members, with the aim of securing their safety and the safety of their children; the London Network meetings are coordinated by AVA.

Following presentation of preliminary findings, several IDVAs noted that drug and alcohol agencies tend to refer through them, when actually IDVAs believe that the agencies are better placed to assess the risk themselves and make the referral directly to MARAC, as they have a working relationship with the service user. IDVAs suggested that drug and alcohol practitioners could speak with an IDVA for support in assessing risk, with one participant offering the example of Barnet's model, where the IDVA Manager meets monthly with substance misuse agencies to discuss cases they're referring to MARAC and share information. In Richmond upon Thames, the MARAC Coordinator provides risk assessment training to all substance misuse agencies, and IDVAs felt that this was a useful model as well.

A questionnaire respondent, who was also interviewed, provided further insight in this area:

Currently most of our emergency DV cases are directed to [the IDVA service], however in the future it is hoped that frontline staff would feel confident in approaching the appropriate DV service to support the client, but also make the MARAC referral themselves. This can only happen with staff understanding and appreciating the role in which the MARAC can provide. Currently our MARAC Coordinator doesn't have capacity as the role is stand alone with no administration support, which definitely puts a strain on the MARAC Coordinator's time available to provide training to all staff from all departments - Commissioner.

Finally, four drug and alcohol interviewees mentioned that they felt they were already doing enough, or that they didn't have the capacity and/or responsibility to prioritise DV. It is possible that a focus on the role of substance use in domestic violence, through tailored training aimed at the drug and alcohol sector, could challenge this perception.

With victims, we are pretty good. We have a women-only space and a nurse that comes in. With perpetrators, we do try to challenge beliefs, but really we're fire-fighting. It's outside our remit - Tier 2/3 Voluntary Service Manager.

We have limited time with people and we can't do everything - Tier 4 Voluntary Service Manager.

Our focus has to remain on substance use; DV is something linked to the work we do, we put resources into it, but it's not the main focus – Tier 2/3 Voluntary Service Director.

## 2.4.4. Improved understanding of substance misuse amongst MARAC agencies

In questionnaires, only 3 respondents overall identified other agencies not understanding substance misuse issues as a barrier to their engagement. However, of the 18 drug and alcohol agencies who provided information about their engagement with the MARAC in the past six months, nearly half (8=44%) reported that other agencies at the MARAC only sometimes or rarely understood substance misuse issues. In interviews, eight of 12 respondents raised this issue, with particular reference to housing and the lack of support available to survivors who use substances when they are fleeing DV:

- Some agencies refuse to work with service users experiencing problem substance use, specifically DV refuges (7);
- Other agencies lack an understanding of the role substance use plays in DV (3);
- In some cases, police believe the perpetrator rather than the survivor (1);
- When survivors are involved in prostitution, they are less likely to be believed (1);
- Attendance of police at drug and alcohol services alienates other service users (1);
- Social services focus on a survivor's substance use and ignore DV (1).

Respondents gave examples of situations where agencies' poor understanding of substance use had affected their work.

All that woman wants is for you to get a house for her to get away from that situation when she's decided that she's going to make that move... it can be guite frustrating and besides being supportive, you're not helping to take her away from that dangerous situation... There needs to be a change of attitude. Why don't all the services have places for women with drug problems? Because a lot - I guarantee you, the majority of the women who do access refuges, it will be discovered sooner or later that they have some sort of substance problem, whether it's alcohol or whether it's prescribed drugs or whether it's illicit drugs, because the women are going to be doing something to mask that pain. It's a very, very outdated approach – Tier 2/3 Voluntary Service Practitioner.

We need DV refuges to be available to people with substance misuse problems. This isn't a MARAC problem, it's a wider issue. We're reliant on our own housing service in the borough to assist with these cases, and that can't happen as quickly as a refuge would be able to... I acknowledge that our client base, victims and perpetrators, are very erratic or sporadic engagers, they're not the most reliable of clients and I can acknowledge the difficulty. However, it's been an ongoing thing ever since I've been working in this field, particularly with DV victims - Tier 2 Statutory Service Manager.

Other agencies need to understand the role substance misuse plays in DV and how you can work with that to raise awareness. This is a very complex problem and yet the responses feel very disjointed - Tier 2/3 Voluntary Service Manager.

Overall, examples provided of other agencies' poor understanding of substance misuse were not specific to the MARAC, but reflected wider problems around service provision for survivors experiencing the overlapping issues of DV and problem substance use. Nevertheless, this issue may impact negatively on drug and alcohol agencies' willingness to engage with the MARAC, if they do not believe the MARAC is able to offer the support their clients really need.

Three interviewees and one questionnaire respondent also mentioned that other agencies sometimes failed to understand the way DV is experienced by their service users who are affected by problem substance use.

Sometimes agencies rigidly stick to their remits and do not think more holistically about supporting a service user e.g. we had significant difficulties in supporting a female whom was being sexually abused and prostituted by her step father, but as the violence was not happening in a home all DV services in [our borough], London and nationally refused to help, stating that it did not fall in their remit – Tier 2/3 Voluntary Service Manager.

In relation to the priorities of the client compared to the identified risk reduction strategies the client often feels that the [MARAC Action] Plan is mostly about actions for them to do at extremely difficult times. Very few of the women are in a position to support prosecutions (extensive personal criminal records, involvement in prostitution, shoplifting etc) leading to them feeling like they are letting people down -Tier 1/2 Voluntary Service Practitioner.

We had a victim and a perpetrator in our service at the same time, and probation suggested to us that he was sweet as anything and that she was baiting him. So it's really down to individuals and people's own prejudices - Tier 2/3 Consortium Manager.

GPs should stop sending perpetrators to anger management – Tier 2/3/4 Voluntary Service Practitioner.

However, these responses also highlight problems of resourcing in the DV sector in particular. For example, in London there is currently only one specialist substance misuse refuge, which has six bed spaces. What is experienced by the drug and alcohol sector as the DV sector's poor understanding of PSU, may also sometimes reflect a lack of appropriately resourced refuge provision.

#### 2.4.5. Obtaining service user consent to refer to MARAC

Only four (8%) drug and alcohol questionnaire respondents reported that lack of service user consent was a barrier to their engagement with the MARAC. However, a further three respondents mentioned this when they were interviewed. Respondents provided the following explanations in relation to difficulties obtaining service user consent:

- Service users are involved in illegal behaviours and are fearful of statutory services
- Service users experiencing child to parent abuse want to protect their children (1);
- Service users change their mind about what they want and so don't accept the MARAC Action Plan (1);
- Women service users are fearful of social services (1).

#### 2.4.6. Challenging perceptions that MARAC is time-consuming

Only two drug and alcohol questionnaire respondents reported that they didn't have time to attend the MARAC, and one further respondent said that the MARAC process was too timeconsuming. Three interviewees also raised this concern. However, it was a small group of respondents that raised this issue, despite the fact that the question was explicitly asked of

them. One questionnaire respondent provided an insight into how misunderstandings of how the MARAC model should work can result in increased time burdens on staff.

Not all staff have accessed the free MARAC training available, and the number of serious DV cases requiring MARAC referrals makes it hard for all teams to prioritise focusing on this aspect... Also, the key worker needs to be able to attend the MARAC to present the case and staff can find this challenging. Some of our services only work with people for a short period, focusing on brief interventions and this may mean clients are no longer open cases with the service by the time they are presented - Tier 2/3 Voluntary Service

In this case, the service manager was under the impression that the key worker would be expected to attend the MARAC when in fact this is not recommended by CAADA. Another manager who was very positive about the MARAC highlighted that although the process is time-consuming, it is necessary and helpful, and the time spent on it is worthwhile.

It is very admin-heavy... I was the MARAC lead before I became manager, and without having other responsibilities I was able to focus on it and come up with a policy locally on how we were going to deal with MARAC cases and make sure the information was stored correctly according to the information-sharing protocol and all that... It's a very weak criticism, because it's a necessity... It's time consuming going through the list, but it's something that's a worthwhile use of the time - Tier 2 Statutory Service Manager.

#### 2.4.7. Challenging beliefs that MARACs exclude the voluntary sector

In this sample, the overwhelming majority (71%) of substance use agencies sitting as representatives on MARACs are from the statutory sector. In attempting to explain why they had had trouble accessing the MARAC, two interviewees suggested that being voluntary sector agencies was a barrier for them. As only two respondents mentioned this, it is not possible to draw any conclusions from it, other than to note the significant difference between the proportion of agencies who responded to our questionnaire who were from voluntary agencies (79%) and the proportion of substance use agencies represented at MARAC who are from voluntary agencies (29%).

#### 2.5. Conclusion

Current levels of engagement between the substance misuse sector and the MARAC, although low across London, vary significantly from borough to borough. In general, substance misuse sector professionals are positive about the possibilities of the MARAC process and are interested in increasing or improving their engagement. Where there are existing good relationships between the MARAC and substance misuse agencies, professionals report that the MARAC process impacts positively on their work with both survivors and perpetrators of domestic violence.

Although barriers to increasing engagement vary between boroughs, the findings from this baseline research suggest that efforts to increase the substance misuse sector's engagement with the MARAC process will be most effective if targeted at: improving communication processes between the MARAC and drug and alcohol services in the borough, including publicising referral criteria and pathways; and providing training for at least some substance misuse sector staff in identifying and responding to high risk cases of domestic violence.

## 3. Recommendations

## 3.1. Recommendations for MARAC Steering Groups

- 3.1.1. Monitor cases where substance use issues are identified for the survivor and/or perpetrator;
- 3.1.2. Make a case for the participation of the drug and alcohol sectors at MARAC;
- 3.1.3. Identify agencies providing drug and alcohol services in the borough, and what services these agencies offer;
- 3.1.4. Invite agencies to participate in the MARAC process, either as permanent attendees or on an ad hoc basis;
- 3.1.5. Where identified, support a Substance Use Lead at MARAC:
- 3.1.6. Provide clear information on MARAC referral pathways in the borough;
- 3.1.7. Provide training on risk identification and MARAC processes to staff providing drug and alcohol services.

#### 3.2. Recommendations for the substance misuse sector

- 3.2.1. Ensure at least one staff member in each drug and alcohol agency is trained in domestic violence (DV) awareness and risk assessment:
- 3.2.2. Ensure each agency has the capacity to routinely enquire for DV and/or use a common evidence based risk identification checklist (RIC);
- 3.2.3. Drug & Alcohol Action Team (DAAT) managers should nominate a Substance Use Lead to the MARAC, and ensure that this staff member has appropriate training to fulfil the role:
- 3.2.4. DAAT managers should ensure that the Substance Use Lead on their MARAC communicates regularly with all agencies providing drug and alcohol services in their borough.

## **Appendices**

#### Appendix 1: Drug and alcohol sector questionnaire



Stella Project D&A agencies questionnaire

1. Supporting the development of safe and effective responses within drug and alcohol agencies

14%

AVA (Against Violence & Abuse), formerly GLDVP, was formed on 12 April 2010 as a national second tier service working to end all forms of violence against women and girls. AVA's Stella Project is the leading agency addressing drug and alcohol related domestic and sexual violence. In partnership with Coordinated Action Against Domestic Abuse (CAADA), the Stella Project is leading an 18-month project aiming to improve the engagement of London drug and alcohol agencies with the Multi-Agency Risk Assessment Conference (MARAC) process.

MARACs are voluntary meetings where information is shared on the highest risk domestic violence cases between representatives from local police, health, child protection, housing practitioners, Independent Domestic Violence Advocates (IDVA) and other specialists from the statutory and voluntary sectors. A co-ordinated safety plan for each victim is then created, Early analysis shows that following intervention by a MARAC and an IDVA service, up to 60% of domestic abuse victims will be made safer. There is a MARAC in every London borough

Through our work with drug and alcohol agencies around domestic violence, the Stella Project has found anecdotal evidence that in many areas, the substance misuse sector is less engaged with the MARAC process than it could potentially be. This project aims to understand the reasons for this, and where appropriate, improve the substance misuse sector's engagement with the MARAC processes in London.

The first stage of this project (October 2010 - March 2011) involves conducting questionnaires and interviews with MARAC Chairs and drug and alcohol agencies in London to: (1) establish baseline data; (2) identify examples of current good practice; and (3) gather views on barriers to engagement. The findings of the baseline research will be published on the Stella website, to support MARAC Chairs and drug and alcohol agencies across London. The second stage of the research (April 2011 – February 2012) will involve free training and consultancy provided by the Stella Project Coordinator to agencies in two London boroughs, followed by dissemination of learning and case studies nationally.

This work is funded by Trust for London.

#### Stella Project D&A agencies questionnaire

2. Consent to participate

29%

The aim of this questionnaire is to provide the Stella Project with baseline data for its 18-month project to improve the engagement of London drug and alcohol agencies with the MARAC process. There are 31 questions, which ask you to provide information about any referrals you have made to the MARAC, your experience of the MARAC process, any barriers your agency faces in engaging with the MARAC, and your professional opinion about any current good practice in your area. If you have not made a referral to a MARAC in the past six months, you will only need to complete 21 questions.

Your answers to this questionnaire will be used solely to inform the Stella Project's policy, training and consultancy work to improve the engagement of substance misuse agencies with the MARAC process. All the information you provide will be stored securely, and the published results of this baseline research will be anonymised. The Stella Project may share non-anonymised data with CAADA, our partners on this project, however CAADA will not store any non-anonymised data or use non-anonymised data for any purpose outside this project.

In some cases, we may wish to highlight examples of good practice by identifying your agency, but we will contact you again for explicit consent. before doing so.

You may withdraw your consent to participate at any time by contacting shannon harvey@avaproject.org.uk. If you would like to discuss your participation further before completing this survey, please call Shannon Harvey on 1884 820 7785 3861 9

\*1.1 understand how the Stella Project will use and store my questionnaire responses, and I agree to participate.

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	43%	
survey should only be completed by managers of drug and alcohol agencies p	roviding support to service users	in London.
responses to this questionnaire will be anonymised before publication, however who has completed this questionnaire in order to: (1) interpret the responses tance misuse sector in your borough.	er it is important for the Stella Pro	ject London Coordi
Your name:		
Your job title:		
The name of your drug and/or alcohol agency:		
9		
The name of your organisation (if your agency is part of a larger organisation):		
Your email address:		
Your phone number:		
1		
Your position:		
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la Project D&A agencies questionnaire		
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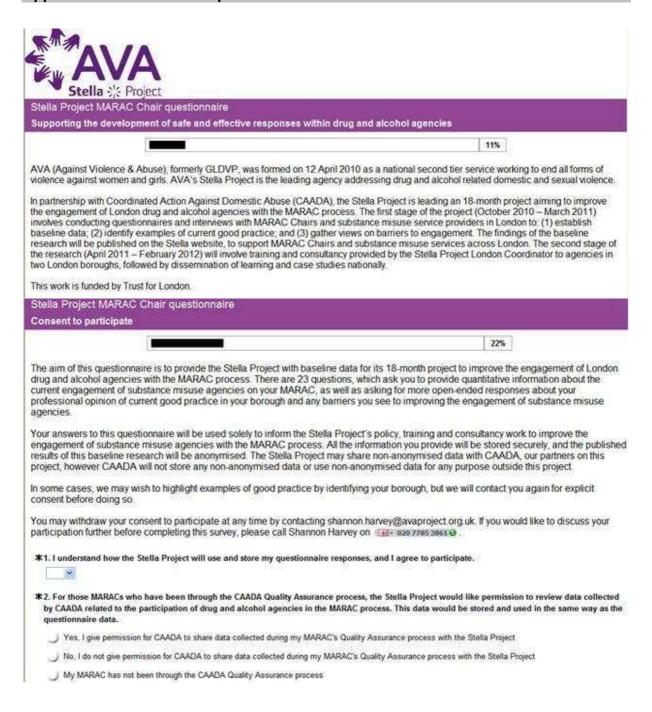
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If yes, please describe when and how	this happens? If r	io, why not?				
				(6)		
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9. Do you conduct routine questio	ning to identify i	f your clients are per	petrators of domestic	violence?		
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O Oleans describe ways assessed	niment anna asses	and with the MADAC	-222222210			
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Staff are trained to identify high			Surficulties	(6)	emays	
risk cases of domestic violence	0	O.	J	0	J	0
Staff understand the referral	. )	- J				
criteria to the MARAC Staff know the process they	2777A	(797)	1991	See C	(2000)	
need to follow to refer a case to	3	5	5)	5	5)	9
MARAC		1,867	0.000	2000	0.000	-20-2
The MARAC Chair or Coordinator	- W	100		SHOOM.	5.54	2,726
provides clear and accessible information to our agency	7	)	2	9	J	7
1. In the past six months, has you	r agency ever rel	erred a case to a MA	RAC?			
•						
2. In the past six months, which N	MARACs has your	agency referred cas	es to?			
•	•		Number o	cases		
Barking & Dagenham				v		
Barnet				v		
Bexley				~		
Brent				v		
Bromley				~		
Camden						
				v		
Croydon				-		
Ealing Enfield				v		
Greenwich						
Hackney				-		
Hammersmith & Fulham				· ·		
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n referring a	case to MARAC	allowed you to work	more effectively wi	th a victim of domest	ic violence
				aske about your experience of the MARAC process here	aske about your experience of the MARAC process here

larriers to drug and alcohol agencies' engagement with MARACs		
	86%	
RACs are voluntary meetings where information is shared on the highest risk domestic violence ca ce, health, child protection, housing practitioners, Independent Domestic Violence Advocates (IDV voluntary sectors. A co-ordinated safety plan for each victim is then created. Early analysis shows an IDVA service, up to 60% of domestic abuse victims will be made safer. There is a MARAC in	<ul> <li>A) and other speci that following inten</li> </ul>	alists from the statuto vention by a MARAC
<ol> <li>What barriers does your agency face to increasing your engagement with the MARAC process, in relationship.</li> </ol>	on to staff resources?	(please select all that
Our staff don't know that the MARAC exists		
Our staff aren't confident in identifying high risk cases of domestic violence		
Our staff don't feel confident in their understanding of the referral criteria for MARAC.		
Our staff don't know the process to follow to refer cases to MARAC		
The MARAC referral process is too time consuming		
We don't have time to attend the MARAC to discuss the referrals they make		
We don't face any barriers in relation to staff resources		
Other (please describe):		
<u> </u>		
W.		
27. What barriers does your agency face to increasing your engagement with the MARAC process, in relatiusers' needs? (please select all that apply)	on to its appropriates	ness to your service
MARACs are not relevant to us, because we do not ask our service users whether they are experiencing or per-	etrating domestic viole	ence
Our senice users rarely give consent for their information to be shared at the MARAC		
We are reluctant to share confidential information with other agencies at the MARAC		
Other agencies at the MARAC do not understand substance misuse issues		
Other agencies at the MARAC do not offer support which is useful for our service users		
Action Plans agreed at the MARAC do not make our service users safer		
We can more easily get the support offered through the MARAC by going to agencies directly		
We don't face any barriers in relation to its appropriateness to our service users' needs		
Other (please describe)		
0		
×.		
28. What do you feel would be the benefits of increasing your engagement with the MARAC process? (plea	en enlast all that any	NA.
Greater support available for our service users who are experiencing domestic violence	se select an that app	.,,,
Greater support available for our service users who are perpetrating domestic violence		
Increased safety for our service users who are experiencing domestic violence		
Gotter protespechia warding behavior our second and executive domestic vision.		
Better partnership working between our agency and specialist domestic violence services		
Reduced workload for staff in our agency		

29. What interventions do you believe would be effective in improving your agency's engagement with the MARAC process? (please select all that apply)
Domestic violence awareness training for staff in our agency
Risk assessment training for staff in our agency.
Drug and alcohol awareness training for domestic violence agencies
A representative from the substance misuse sector to be appointed to the MARAC
MARAC training for representatives from the substance misuse sector
An action plan for increased engagement agreed between the MARAC Chair and managers of drug and alcohol agencies in the borough
No intervention is needed
Other (please specify)
*30. The Stella Project would like to contact some questionnaire respondents to conduct a further telephone interview, to discuss responses in more depth. The telephone interview would take 15 to 20 minutes, and would be done at a time most convenient to you. Would you be willing to discuss you responses further in a telephone interview?  *31. The Stella Project will work with two selected London boroughs between April 2011 and February 2012, providing training and consultancy to improve the engagement of drug and alcohol agencies with the MARAC process. In principle, would your agency be interested in being involved in this work if your borough was selected?
Stella Project D&A agencies questionnaire
7. End of survey
100%
Thank you for completing this questionnaire. If you have any further questions about this project, or how your responses will be used, please call Shannon Harvey, Stella Project London Coordinator, on ♣ 020 77853851 ♥ or email shannon.harvey@avaproject.org.uk.

#### **Appendix 2: MARAC Chair questionnaire**



01 11 10 11 11 11 11 11 11 11 11	toron thousand	
Stella Project MARAC Chai	ir questionnaire	
About you		
	33%	
	nnaire will be anonymised before publication, however it is important for the Stella Project questionnaire in order to: (1) interpret the responses; and (2) provide ongoing support to y	
3. Your name:		
4. Your email address:		
5. Your phone number:		
<b>≭</b> 6. I am a Chair of a London MA	ARAC.	
Stella Project MARAC Chair About your MARAC	r questionnaire	
	44%	
<b>≭</b> 7. Which MARAC are you the Ch	hair of?	
v	VII	
## P		
×8. Does your MARAC currently h	have one or more representatives from the substance misuse sector?	
Stella Project MARAC Chair	r questionnaire	
About your MARAC (cont.)		
	56%	
9. How many representatives do	oes your MARAC have from the substance misuse sector?	
<b>v</b>	•	
10. Of the days and alsolul age	encies that are represented on your MARAC, how many are from the voluntary sector and how man	are from the statuten.
sector?	encies that are represented on your MP-KAC, now many are rom the voluntary sector and now mar	ny are from the statutory
	Number of agencies	
Voluntary sector	v	
Statutory sector	v	
Other	¥	
11. In the past six months, how i	many times has a representative from a drug or alcohol agency attended your MARAC?	
<b>▽</b>		
Stella Project MARAC Chair	ir questionnaire	
About your MARAC (cont.)	ii questionilaite	
About your maroto (conc)		
	67%	
12. In the past six months, how	w many cases have been referred to your MARAC overall?	
13. In the past six months, how	v many cases have been referred to your MARAC from a drug or alcohol agency?	
14. If you know them, please lis	ist all the drug and alcohol agencies that have referred to your MARAC in the past six months.	
1.		
2.		
3.		
4.		
5.		
6.		

la Pro	oject MARAC Chair questionnaire	
d pra	ctice in drug and alcohol agencies' engagement with MARACs	
		78%
5. Up u	ntil now, what have been the benefits of drug and alcohol agencies' engagement with your	MARAC? (Please select all that apply)
Mo	re holistic Action Plans for MARAC cases where the victim is affected by substance misuse (their ow	n, or that of the perpetrator)
Be	tter outcomes in MARAC cases where the victim has problematic substance use	
Be	tter outcomes in MARAC cases where the perpetrator has problematic substance use	
- Be	tter partnership working between drug and alcohol agencies and domestic violence agencies	
Inc	reased understanding of substance misuse issues by all agencies that attend MARAC	
Inc	reased understanding of domestic violence by drug and alcohol agencies	
The	ere have not been any benefits	
Oti	ner (please specify)	
		-4.
	levant, please provide an example of a time when an Action Plan from your MARAC has resu	Ited in a drug or alcohol agency protecting
netim n	nore effectively?	
	S.	
7 16		
	levant, please provide an example of a time when an Action Plan from your MARAC has resu stor more effectively, to protect a victim?	ited in a drug or alcohol agency working wi
18. If rel	evant, please provide an example of a time when an Action Plan from your MARAC has resu	Ited in a drug or alcohol agency working w
victim o	r perpetrator more effectively, to protect their child/ren?	
	<u>×</u>	
	in the second se	

tella Project MARAC Chair questionnaire	
arriers to drug and alcohol agencies' engagement with MARACs	
	89%
19. What barriers do you believe drug and alcohol agencies in your borough face to improving their engagem future? (Please select all that apply)	nent with the MARAC process in the
Drug and alcohol agencies don't routinely question their clients about domestic violence	
Drug and alcohol agencies aren't sufficiently trained to identify high risk domestic violence cases	
Drug and alcohol agencies aren't confident of how to refer to the MARAC	
Drug and alcohol agencies may be reluctant to share confidential information at the MARAC.	
Prug and alcohol agencies don't know that the MARAC exists	
There is a lack of strategic commitment to the MARAC from the substance misuse sector	
I don't believe there are any barriers	
Other (please specify)	
20. What interventions do you believe would be effective in improving the engagement of drug and alcohol a (please select all that apply)	gencies with your MARAC in the future?
Domestic violence awareness training for drug and alcohol agencies	
Risk assessment training for drug and alcohol agencies	
Drug and alcohol awareness training for domestic violence agencies	
MARAC training for drug and alcohol agency representatives	
A representative from the substance misuse sector to be appointed to the MARAC	
An action plan agreed between the MARAC Chair and managers of drug and alcohol agencies	
I don't believe any intervention is needed	
Other (please specify)	
<u>A</u>	

21, I	In the future, what do you feel would be the benefits of improved engagement of drug and alcohol agencies on your MARAC? (please select all that its)	
ř	More holistic Action Plans for MARAC cases where the victim is affected by substance misuse (their own, or that of the perpetrator)	
Г	Better outcomes in MARAC cases where the victim has problematic substance use	
Г	Better outcomes in MARAC cases where the perpetrator has problematic substance use	
-	Better partnership working between drug and alcohol agencies and domestic violence agencies	
Г	Increased understanding of substance misuse issues by all agencies that attend MARAC	
-	Increased understanding of domestic violence by drug and alcohol agencies	
Γ-	I don't feel that there would be any benefits	
	Other (please specify)	
dep resp *23.	The Stella Project would like to contact some questionnaire respondents to conduct a further telephone interview, to discuss responses in more th. The telephone interview would take 15 to 20 minutes, and would be done at a time most convenient to you. Would you be willing to discuss your persecution in a telephone interview?  The Stella Project will work with two selected London boroughs between April 2011 and February 2012, providing training and consultancy to prove the engagement of drug and alcohol agencies with the MARAC process. In principle, would your borough be interested in being involved in work?	
	× × × × × × × × × × × × × × × × × × ×	
Stella	Project MARAC Chair questionnaire	
End o	f survey	
	100%	

Thank you for completing this questionnaire. If you have any further questions about this project, or how your responses will be used, please call Shannon Harvey, Stella Project London Coordinator, on (1987-1920 7785 3861) or email shannon.harvey@avaproject.org.uk.

#### Appendix 3: Telephone interview consent form

Dear

#### MARAC Engagement Project: telephone interview letter of invitation and consent form

interview for AVA and CAADA's joint MARAC Engagement Project: supporting the development of safe and effective responses within drug and alcohol agencies. The telephone interview will take place on at . The Stella Project Coordinator, Shannon Harvey, will phone you on a number of your choice and the interview will last for approximately 30 minutes.

Thank you for completing the online survey and agreeing to take part in a telephone

During the interview, you will be asked about your understanding of any links between domestic violence and substance use. You will also be asked questions that explore further your responses to the online survey, about your experience of the Multi-Agency Risk Assessment Conference process and what you feel is needed in your borough to improve support for your service users who are survivors or perpetrators domestic violence. There are no right or wrong answers, we want to know your opinion and that of your organisation.

Your responses to the telephone interview will be used in a report to be produced by AVA and CAADA in March 2011, and published on our websites. All information that you provide will be fully anonymised. The report will provide the basis for AVA's training and consultancy work in London over the next two years, to improve multi-agency responses to service users affected by problematic substance use and domestic violence.

We need you to sign a consent form (see the following page) which will show that you understand what you are taking part in and what the information you provide will be used for. Please can you sign and post the form back to the Stella Project Coordinator (Shannon Harvey, AVA, 4th Floor, Development House, 56-64 Leonard Street, London, EC2A 4LT), or email a scanned form to <a href="mailto:shannon.harvey@avaproject.org.uk">shannon.harvey@avaproject.org.uk</a>. We will audio record all interviews, as a prompt to the interviewer to ensure that your answers are not missed. The interview will not be fully transcribed, but some sections may be. The consent form will also be your way of letting us know that you consent to us recording the interview.

If you have any questions before the telephone interview, please do not hesitate to contact me on 020 7549 0276.

Yours sincerely

Shannon Harvey James Rowlands Stella Project Coordinator

**Quality Assurance Manager** 

AVA (Against Violence & Abuse) CAADA (Coordinated Action Against Domestic Abuse)

### Telephone interview consent form

Before taking part in the telephone interview, you need to read the statements below very carefully and tick, sign and date next to the appropriate box to indicate you consent to take part.

- 1. I voluntarily agree to take part in a telephone interview for the AVA & CAADA joint MARAC Engagement Project.
- 2. I have read and understood the Letter of Invitation and Project Outline provided. I have been given a full explanation by the Stella Project Coordinator of the nature, purpose, location and likely duration of the study, and of what I will be expected to do. I have been advised of any discomfort and possible ill-effects on my health and wellbeing which may result. I have been given the opportunity to ask questions on all aspects of the stuffy and have understood the advice and information given as a result.
- 3. I understand the interview will be audio recorded.
- 4. I shall inform the researchers if I suffer any deterioration of any kind in my health or wellbeing, or experience any unexpected or unusual symptoms.
- 5. I understand that all personal data relating to volunteers is held and processed in the strictest confidence, and in accordance with the Data Protection Act (1998), I agree that I will not seek to restrict the use of the results of the study on the understanding that my anonymity is preserved.
- 6. I understand that I am free to withdraw from the study at any time without needing to justify my decision and without prejudice.
- 7. I confirm that my anonymised data can be used for the AVA & CAADA joint MARAC Engagement Project and any subsequent publications.
- 8. I confirm that I have read and understood the above and freely consent to participating in this study. I have been given adequate time to consider my participation and agree to comply with the instructions and restrictions of the study.

Please select the app	ropriate box:	
☐ Yes, I consent to t	ne above	
☐ No, I do not conse	nt to the above	
Name	Signed	Date

### Appendix 4: Drug and alcohol sector telephone interview schedule

# **AVA and CAADA MARAC Engagement Project** Telephone interviews with drug and alcohol agency managers

Thank you for completing the online survey and agreeing to be interviewed, I know that you're very busy. The purpose of this interview is to explore the answers you gave in the online survey, and to understand your agency's experience of the links between substance use and domestic violence, if there are any, and the Multi-Agency Risk Assessment Conference process. We are also interested in your views about what agencies in your borough could be doing better to support people experiencing domestic violence and problematic substance use.

Before we start the interview, I need thank you for returning the consent form, and remind you that you will be audio recorded and the interview will be transcribed. If you have any questions, please ask them now.

I'm going to start the recorder now.

inte	erview confirmed that they are c	e completed by the interviewer prior to interview, and at correct.
1.	Organisation:	
2.	Service:	
3.	Your role in organisation:	
4.	How long have you worked in the organisation?	
5.	How long have you worked in the sector?	
6.	How do you define domestic vi	olence?
7.	Do you think there are any link use?	s between domestic violence and problematic substance
8.	What is the role of the MARAC	in your borough?

Agency answered 'Yes' to Q21, "In the past six months, has your agency ever referred a case to a MARAC?" Answer questions 9-11, then skip to question 13.
☐ Agency answered 'No' to Q21, "In the past six months, has your agency ever referred a case to a MARAC?" Skip to question 12.
<ol> <li>Can I confirm that you've referred to the following MARACs in the past 6 months (interviewer to complete prior to interview):</li> </ol>
10. What has been helpful to your agency about the MARAC process?
Before interview, interviewer should note any relevant responses from Q22-25 to refer to with
follow up questions here:
Tollow up questions here.
11. What has been less helpful to your agency about the MARAC process?
Before interview, interviewer should note any relevant responses from Q23 to refer to with
follow up questions here.
<del></del>

12. In the survey, you said that your agency hasn't made a referral to your MARAC in the
past 6 months. Why is this?
Before interview, interviewer should note any relevant responses from Q20 to refer to with
follow up questions here.
tollow up questions here.
13. How do your staff feel about the MARAC process?
Before interview, interviewer should note any relevant responses from Q26 to refer to with
follow up questions here:
14. What could agencies in your borough do to better support your clients who are
experiencing dv2

experiencing dv?

15. What could agencies in your borough do to better support your clients who are
perpetrating dv?
16. What could your agency do to better support your clients who are experiencing dv?
17. What could your agency do to better support your clients who are perpetrating dv?
The state year agency as to sense support year enound who are perpending av.

Thank you very much for taking the time to be interviewed today. This information will contribute to a report we will release with CAADA in March, and our work over the 2 years to improve responses to people affected by domestic violence and substance misuse in London.

## Appendix 5: MARAC Chair telephone interview schedule

### **AVA and CAADA MARAC Engagement Project Telephone interviews with MARAC Chairs**

Thank you for completing the online survey and agreeing to be interviewed, I know that you're very busy. The purpose of this interview is to explore the answers you gave in the online survey, to understand your views about the links between substance use and domestic violence, if there are any, and drug and alcohol agencies' engagement with the MARAC process. We are also interested in your views about what agencies in your borough could be doing better to protect victims of domestic violence affected by drug or alcohol use.

Before we start the interview, I need to thank you for returning the consent form, and remind you that you will be audio recorded and the interview may be transcribed. If you have any questions, please ask them now.

The first question should be completed by the interviewer prior to interview, and at interview

I'm going to start the recorder now.

confirmed that they are correct.		
18. MARAC:		
19. How long have you been Chair of the MARAC?		
20. How long have you worked on domestic violence?		
21. Do you think there are any li use?	nks between domestic violence and problematic substance	
22. How does your MARAC prot their own use or someone e	tect victims who are affected by drug or alcohol use, either lse's use?	
Before interview, interviewer shoup questions here:	ould note any relevant responses from Q16 to refer to with follow	,

23. How does your MARAC respond to perpetrators experiencing problematic substance
use?
Before interview, interviewer should note any relevant responses from Q17 to refer to with follow
up questions here:
24. What could drug and alcohol agencies in your borough offer to better protect victims
affected by problematic substance use?
Before interview, interviewer should note any relevant responses from Q19 to refer to with follow
up questions here:

25. What could dv agencies in your borough offer to better protect victims affected by drug or alcohol use?
Before interview, interviewer should note any relevant responses from Q20 to refer to with follow up questions here:
26. What could the MARAC offer to better support victims affected by drug or alcohol use?
20. What could the MARAC oner to better support victims affected by drug of alcohol use:
Thank you very much for taking the time to be interviewed today. This information will

contribute to a report we will release with CAADA in March, and our work over the 2 years to improve responses to people affected by domestic violence and substance misuse in London.