Early Intervention & Accommodation Project:

Guidance pack for Social Care Practitioners.

Contents

Intervention background

Association of London Directors of Children's Services (ALDCS), London Council and Respect/SafeLives have secured funding from MOPAC to support the delivery of an early intervention programme for those who are at risk of perpetrating domestic abuse within families already in contact with social services.

COVID-19 and lockdown has put increasing strain on individuals and families, in many cases escalating the risk of domestic violence and abuse. Respect has seen an increase in the number of people who are calling their phonelines not because they are experiencing abuse, but are experiencing increased conflict in the home, which could descend into abuse and violence.

In response to this, Respect/SafeLives are proposing to deliver an emergency wrap around intervention to individuals who have been identified as being on the cusp of perpetrating abuse. This intervention will be designed to fully assess risk and potential for abuse alongside offering support and tools to help them manage their thoughts and behaviour in the longer term. Temporary alternative accommodation may also be offered to this individual, creating safe space to enable and appropriately respond to any further disclosure of abuse.

The aim of this intervention and accommodation pathway is to:

- provide a preventative intervention and potentially alternative accommodation for a temporary period until the added tensions of lockdown have eased
- reduce the risk of perpetration during lockdown and as restrictions ease
- increase safety of family members
- identify any additional previously unidentified risks or abuse and manage appropriately

The models which informed the development of this intervention are primarily concerned with increasing safety for victims/survivors and their children; facilitating the opportunity for meaningful behavioural change for the one using abusive behaviours; and aiding the systems and professionals that surround the family to become domestic abuse informed. By this we mean, and evidenced by the successes of the Drive project[1], intensively intervening with those who use abusive behaviours in a multi-agency coordinated approach, seeking to motivate towards (and engage in) behavioural change and paired with tactics to reduce opportunities to be abusive, are key tenets of this approach. However, not only evidenced in Drive, but also within the Make a Change[2] Safe & Together[3] and SafeLives One Front Door model[4], is the importance of culture shifts towards engaging and intervening with the person using abusive behaviours for better outcomes for children and the non-abusive parent.

This novel intervention project which will employ a critical and reflective stance synonymous with action research; thus, as part of this process, this guidance pack will be subject to change as learnings from the Early Intervention Project are gleaned and integrated into the model.

[1] http://driveproject.org.uk/wp-content/uploads/2020/03/DriveYear3_UoBEvaluationReport_Final.pdf
[2] https://hubble-live-assets.s3.amazonaws.com/respect/redactor2_assets/files/336/Make_a_Change_full_report_July_2020.pdf
[3] https://safeandtogetherinstitute.com/evidence-resources/reports/
[4] https://safelives.org.uk/sites/default/files/resources/Seeing%20the%20Whole%20Picture%20-%20An%20evaluation%20of%20SafeLives'%20One%20Front%20Door.pdf

A note regarding language…

This guidance pack has been authored, for the most part in a gender neutral manner; however in line with the widely regarded gendered nature of family abuse/violence[5] [6] [7] [8] [9], infrequent uses of 'he/his' has been used as the pronoun for the one using abusive behaviours and 'she/her' as the pronoun for the victim. However, domestic abuse does not discriminate; it can happen to anyone regardless of race, age, ethnicity, sexual orientation or socioeconomic status.

[5] Walby, S. and Allen, J. (2004) Domestic Violence, Sexual Assault and Stalking: Findings from the British Crime Survey. Home Office Research Study 276. London: Home Office

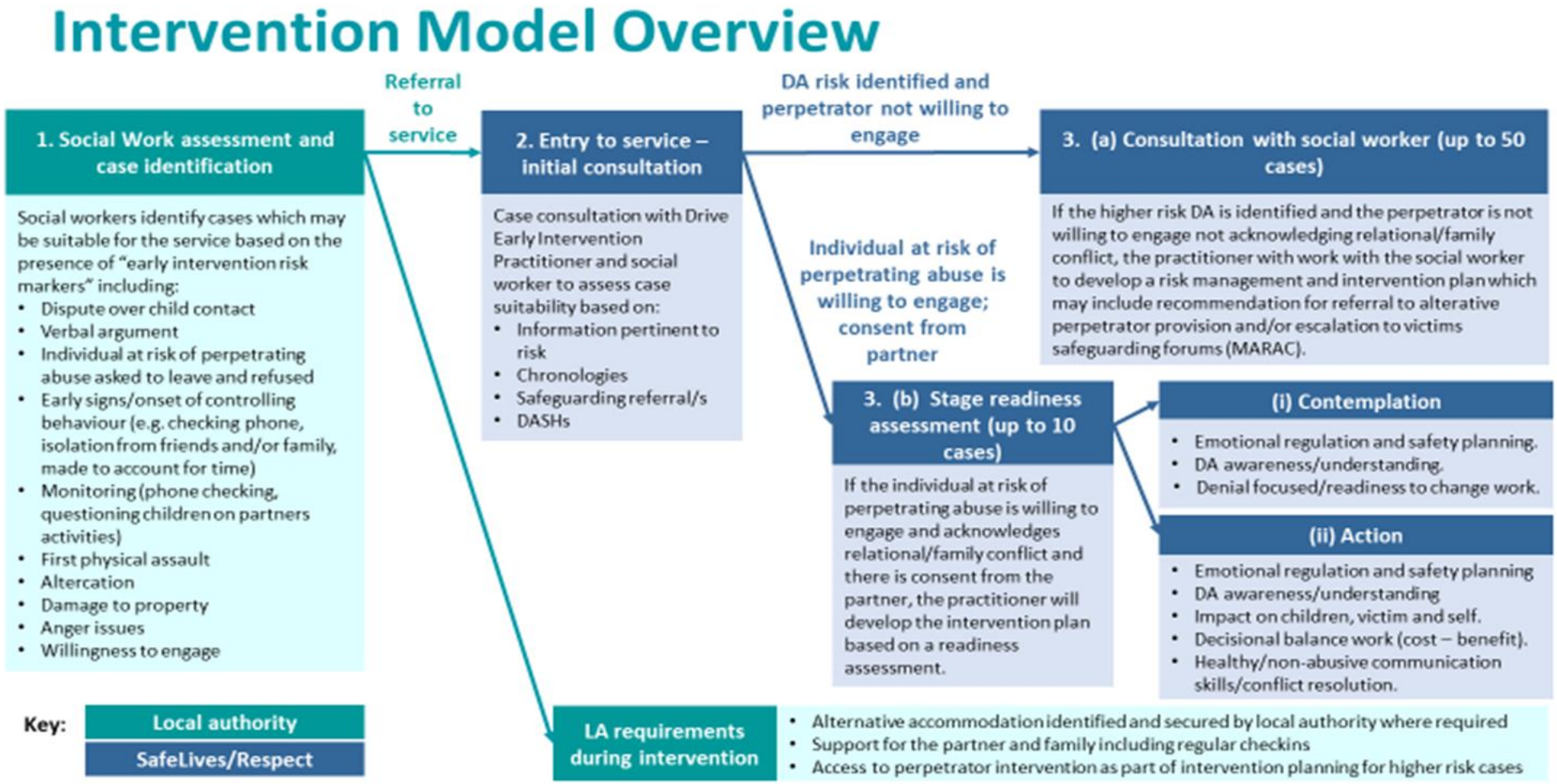
[6] Walby, S. and Towers, J. (May 2017) 'Measuring violence to end violence: mainstreaming gender', Journal of Gender-Based Violence, vol. 1, no.

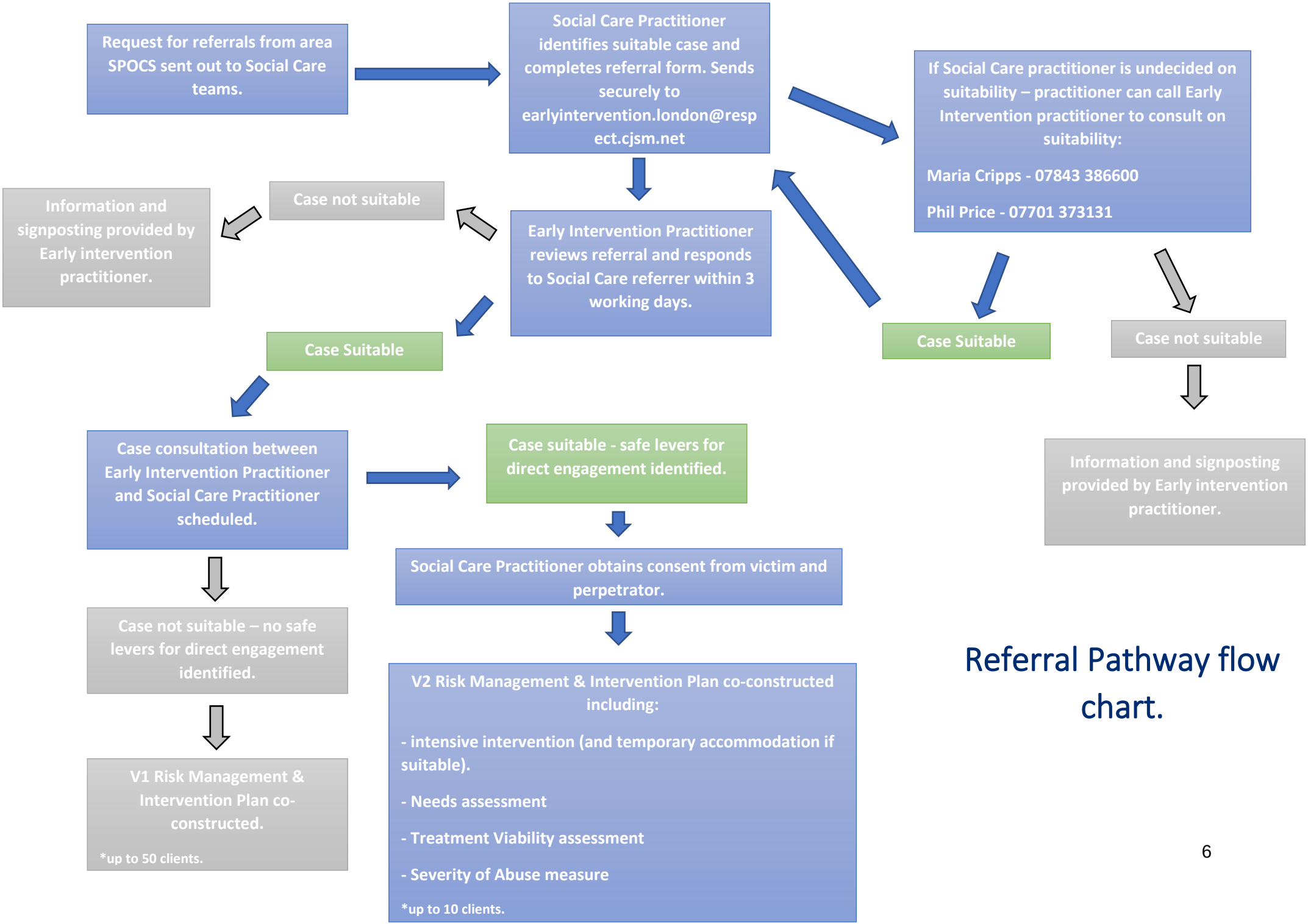
[7] Dobash, R.P. and Dobash, R.E. (2004) 'Women's violence to men in intimate relationships. Working on a Puzzle', British Journal of Criminology, 44(3), pp. 324–349

[8] Hester, M. (2013) 'Who Does What to Whom? Gender and Domestic Violence Perpetrators in English Police Records', European Journal of Criminology, 10: 623- 637

[9] Myhill, A. (2017) 'Measuring domestic violence: context is everything.' Journal of Gender-Based Violence, vol 1, no 1, 33–44

Service model overview





Referral Pathway flow chart.

The Role of the Child Protection Practitioner

It is imperative for safe and effective practice that the victim and children of the client who is undertaking the intensive behavioural change intervention are supported throughout the process.

The key underpinnings of this support is that the safety of those at risk is not compromised by the intervention. Synonymous with elements of the Respect standard[10] the Social Care Practitioner will act, in part, as the role of the integrated support worker.

The aim of this role is multifaceted. Below sets out the expected minimum requirements of the Social Care Practitioner within this model:

- The Social Care Practitioner to act as the source of contact and support for the victim and child, holding a minimum of one contact per week and remaining open to the case for the duration of the intervention.
- The Social Care Practitioner and the Early Intervention Practitioner (and any other pertinent professional) will liaise regularly (a minimum of once per week) in their collaboration to share information and facilitate the proficient risk management of the case.
- The Social Care Practitioner will offer a safe and appropriate space in which to meet with the victim and children.
- The Social Care Practitioner will proactively seek the voices of both the victim and the child, which will remain central to the work, informing the intervention.
- The Social Care Practitioner should communicate specific concerns about risk to the early intervention practitioner in a timely manner.
- The Social Care Practitioner will work collaboratively with the Early Intervention Practitioner to coordinate the interventions safely and effectively (e.g. consulting the victim on specific exercises/interventions like 'time out').
- Significant changes to a client's level of engagement with or attendance at the intervention will be communicated to the survivor within five working days, or sooner if there is heightened concern for safety.
- Where the suitability of a client is assessed before they are offered the intervention, the Social Care Practitioner, where safe to do so, will communicate the outcome to the victim. Where the client does not go on to access the intervention, the Social Care Practitioner, in consultation with the Early Intervention Practitioner, will explore the safety implications of this and link with other support services available to those at risk.
- The Social Care Practitioner works in partnership with other specialist domestic abuse services to ensure that the safety and support needs of survivors are met. Identified referral pathways need to be in place for survivors at all levels of risk.

In cases whereby the risk level exceeds that in which this intervention is designed to deal with, the need for established referral pathways to specialist support services becomes paramount. It is the expectation, if a client is identified at medium to high risk of abuse as per the SafeLives DASH[11], then Social Care as the lead agency will refer to the appropriate support service.

[10] https://hubble-live-assets.s3.amazonaws.com/respect/redactor2_assets/files/105/Respect_Standard_FINAL.pdf
[11] https://safelives.org.uk/sites/default/files/resources/Dash%20for%20IDVAs%20FINAL_0.pdf

Case Suitability Assessment

The intervention is designed to Intervene with abusive and harmful behaviours at an earlier stage before it becomes entrenched, thus facilitating enhanced safety for victims/survivors and their children before it reaches thresholds where intervention is mandated by courts or by child protection orders. Thus, suitable for referral to this intervention are those cases where the onset of abusive behaviours exist. In consultation with Social Care Practitioners a list of behaviours occurring within a family were highlighted as those synonymous with 'early intervention'.

Early intervention risk markers:

- Dispute over child contact.
- Verbal argument.
- Early signs/onset of controlling behaviours (e.g. phone checking, isolation from friends and/or family, made to account for time).
- Individual at risk of perpetrating abuse, asked to leave and refused.
- Monitoring (phone checking, questioning children on partners activities).
- First physical assault.
- Altercation.
- Damage to property.
- Anger issues.
- Willingness to engage.

*this is not an exhaustive list.

Referring into the Early Intervention

The Social Care practitioner, after identifying a case which fits the early identification risk markers, can refer The Early intervention Practitioner (referral form located in appendix A) with as much concise information around the case dynamic. Once completed the referral should be via secure email to the Early Intervention Practitioner, who, within 3 working days, will confirm receipt of the referral and advise on timelines for arrangement of the Case Consultation via telephone, or other suitable and secure video conferencing platform. Should you be unsure on the suitability of the case and require a discussion with the Early intervention Practitioners prior to completing the referral form, they can be reached on:

Phil Price: 07701 373131
Maria Cripps: 07843 386600

Case Consultation

In coming together with the Early Intervention practitioner, you will collaboratively formulate a domestic abuse informed Risk Management and Intervention Plan for the family. Below are the areas in which will be explored during the call:

- Presenting issues
- Risk
- Needs
- Goals – clients and victims
- Motivation for change
- Victim/survivor strengths

Collaboratively the Social Care Practitioner and Early Intervention Practitioner will formulate the bespoke Risk Management and Intervention Plan actions; which may consist of the perpetrator of abusive behaviours being taken onto intensive attitudinal and/or behavioural change programme. As part of this intervention, it may be deemed suitable (with the perpetrators and victims consent) that the perpetrator of abusive behaviour is placed in temporary accommodation for a period up to 4 weeks. The considerations for this will be outlaid below shortly. The expectations of the Social Care Practitioner during the intensive intervention are explicitly outlined in the section of this document named 'The Role of the Child Protection Practitioner'; during this call you may wish to clarify the nuances of this set of expectations and obtain advice regarding how to discuss the intervention with the victim.

Following the Case Consultation with the Early Intervention Practitioner, if the assessment is that the case is suitable for progression to the intensive behavioural change pathway, the Social Care Practitioner will need to explain the service to both parties, obtaining consent (see appendix B & C for associated forms). Please also forward these via secure email to the Early Intervention Practitioners.

Explaining the intervention

Professionals often can find it challenging to explain intervention which are concerned with addressing abusive behaviours to clients; with this in mind you may wish to lend upon the below, direct and transparent explanations:

1. The intervention works with people who experience difficulties in their relationships and want to get their lives back on track/work on that.
2. They offer support, time and a safe space to help you think about where you are in your life, how you want things to be and what options are open to you.
3. They can advise and support you on parenting issues and safety issues.
4. They can advise you about and help connect you to services you might need (parenting, housing, benefits etc).

Obtaining consent

Relevant personal information can be shared lawfully at the Case Consultation meeting (see referral pathway flow chart) as Domestic Abuse in the household is established and a child or individual is at risk as identified under Section 10 of the Children's Act[12]. However in order to provide a service to the families who are then identified as suitable for the intensive behavioural change intervention (which may include the temporary accommodation provision), and share personal information, consent will be required to be compliant for legitimate interest purposes under section 6 and 9 of GDPR regulations[13].

It's important the client understands the collaborative nature of the intensive behavioural change intervention, in that you will continue to offer support to their partner and children and that you will be liaising with other professionals (most specifically the Early Intervention Practitioner) in order to best cater to the needs of the family; which includes dealing with matters relating to potential harm and safeguarding.

You need to explain the reasons why their information might be shared, and how the service will treat the sensitive and personal data it is given. Explain that every case is individual but, in general, the

[12]https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/722307/Working_Together_to_Safeguard_Children_Statutory_framework.pdf

[13] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/711097/guide-to-the-general-data-protection-regulation-gdpr-1-0.pdf

service does not need consent to share information where the client, victim(s) or their children are at high risk or perpetrating behaviour assessed as causing significant harm.

The Confidentiality and Information Sharing Agreement (located in appendix B & C) details the important points of the agreement, to enable you to brief the client on the parameters of information sharing when you have limited time, or are in an emergency. The form also allows you to document where clients might want to limit the information shared with specific agencies or individuals.

In obtaining consent from the victim and explaining the intervention, the above framework can also be employed. However, the additional explanation regarding accountability and focus of the behavioural change work – in that the intervention is designed to tackle the abusive partners behaviour and work alongside the non-abusive parent. Within the role of The Child Protection Practitioner (found on page 6) you can find more information on the support that will be on offer to the victim and their children.

See here for further advice and guidance on information sharing.

Preparation for service user engagement:

Stance

Working with those who use abusive behaviours within intimate and familial relationships is challenging yet important work, in the attempt reduce risk and enhance safety and wellbeing for the whole family. Tactics and presentations of those who abuse have been well documented[14]; with minimisation, denial and partner blame being prevalent characteristics of a domestic abuser perpetrators disposition. A significant factor in achieving meaningful engagement will depend on your *stance*.

In particular there's a tension when working with those who we think have behaved abusively; a friction between colluding with them on the one hand and becoming accusatory on the other – often in an over-zealous attempt to avoid collusion. Somewhere between the collusive and the accusatory stance lies a more neutral zone which is generally more constructive. The table below might give you

Collusive Stance	**Earlier in ←--- Neutral Useful Stance. ---→ Later in cycle of change or hyper-aroused**		**cycle of change or hypo-aroused**	**Persecutory Stance**
You are like mates		You form an alliance with the side of them that wants to change		You are like enemies
There is little challenge or conflict	You work to get them ready for challenge	You make gentle but persistent invitations to them to challenge themselves	You can challenge them directly and effectively	There is a high level of challenge and judgement
You sit alongside them to look at others' wrong behaviour	You work on their behaviours that harm themself	You sit alongside them to look at their abusive behaviour	You work on their behaviours that harm others	You confront them with their wrongdoing
You empathise with them only as a victim of others	You empathise with them as victim sometimes for attunement and modelling	You empathise when they to feel things which could motivate them to stop their abuse	You use their victim experience to help them empathise with others	You don't empathise at all

[14] Bancrofy, L. (2003) Why Does He Do That?: Inside the Minds of Angry and Controlling Men

a better idea about how these different approaches feel and the client-worker relationships they foster.

It's important that you make professional judgements about your client's abusive behaviour – it is an essential part of your job to assess the harm that has been caused and that might be caused in the future. It's human that you'll make personal judgements and have emotional reactions about some of the things you hear. However, it's also important that you form an alliance with your client towards change.

To form such an alliance, you'll need to be able to tune into what the client brings to the meeting(s) with you. The client is likely to feel judged, ordered around and humiliated. Loss, or threats of loss – of relationships or children – are often in the foreground. From their perspective, everyone will seem to be worried about the children or their parter/ex and see them as a the monster. It is likely they feel professionals view their experiences and feelings as unimportant. They may expect to be challenged by you, judged, shamed and held to account; this is likely to inspire fierce defensiveness.

To aid movement from this defensive position, a first step can be simply acknowledging how they feel, particularly in relation to the consequences of their own behaviour.

- You've been referred to this support programme – has anyone thought about what that's like for you? What have you done with that?
- How has it left you that your partner is not with you?
- Has anybody been interested in how it's been for you being held to account?
- You've had children's services (and other agencies if relevant) come into your life, and now I come into your life, I'm wondering how that's been for you?

Later on in your work you can help your client link these consequences with their abusive behaviour. At first though, it's just a matter of tuning into his own experience in-the-moment.

It's all helped along by using language which feels natural to you and gets close to where your client is at. To some degree that means matching your language with that of the client. Useful phrases can be:

- When you and X fall-out with each other
- When your arguments get physical
- When you first laid a hand on her in anger
- How you get aggressive with her
- The ways you scare her
- When you feel out of control
- How you wind yourself up
- You felt really pissed off
- It really gets to you
- You pressured her to do something she wasn't into

While on the whole (there are always exceptions to these sorts of rules) the following are less useful:

- Your domestic abuse
- When you have been violent towards her
- The ways you sexually assaulted her
- You became dysregulated

- You are a perpetrator
- You have used coercive control.

In the meantime, useful ways to combat a feeling that you are linguistically slipping into collusion are:

- Keep being very straight about the violence – You've hit her and hurt her / you're feeling like your life is a train wreck and you need to get it back on track / you know the biggest problem in your life is you – sort that out and you'll be on your way!
- Call her by her name (the same with children – ask names, ages, size – bring them into the picture)
- Use a little humour when the relationship can stand it – "Wow, you are really expert at not answering my questions when you put your mind to it – it's impressive!"

Temporary accommodation provision

On a case by case basis - where safe to do so and where both the client and victim consent, the client will be offered the opportunity to utilise a temporary accommodation provision for up to a period of four weeks.

This provision is available for those cases whereby the creation of a space for action for the victim is deemed safe and to enable, and appropriately respond to, any further disclosure of abuse; thus facilitating the opportunity for a more effective assessment and management of risk. During the clients time at the temporary accommodation, the expectation is that they will be intensively engaging with the Early Intervention Practitioner whom will be providing bespoke support and the tools to help them manage their thoughts and behaviour in the longer term.

Whilst the level of support will depend on a number of variables like level of need, risk, employment, consent etc., it is expected that the client will meet face to face with the Early Intervention Practitioner a minimum of once per week and take part in other forms of communication (telephone calls – video calls) a minimum of twice per week. In summary: the client shall agree to a minimum of 3 contacts per week; one of which shall include structured behavioural/attitudinal change. Please see appendix E for the temporary accommodation behavioural contract/agreement and appendix I for the foreseen risks and their mitigations.

Risk Assessment

Factors that will make a service user less suitable for the accommodation element of the intervention:

- Evidence of stalking or monitoring behaviours.
- High risk client.
- Client with multiple needs which moving away from their local support services may destabilise the individuals needs.
- Either the victim or perpetrator doesn't consent.
- Where the victim will be negatively impacted (matter relating to child care, risk escalation etc.).

Risk Mitigation

There are a number of factors that require consideration in the endeavour to mitigate risk. The area of consideration are as follows.

Terms of the temporary accommodation offer:

- Consent from both parties
- Agreement to a minimum of one face to face meeting with the Early Intervention Practitioner per week and two further telephone/video conferencing contacts per week (3 contacts in total)
- Visitation
- Overnight visitation
- Use of accommodation for illegal activities
- Room service – board – other fee's etc.
- Damage to property
- To follow any other guidance/general terms & conditions of the hotel.
- The project reserving the right to end the agreement.
- Scenario planning with the perpetrator (not return to family home etc.).
- Safety planning with victim and children.
- End of service scenario planning with victim.

Children – points for consideration

- Where the children will remain resident?
- Access to children – specific times and dates?
- How and when handover of children will take place?
- What communication will happen between the non-resident parent and the children?
- How and when telephone communication with the children will take place?
- Will anyone else be involved in the above process (child minders, relatives etc.)?
- Any financial changes related to child maintenance?

Intensive behavioural/attitudinal change

The Early Intervention Practitioner and Social Care Practitioner may deem the case not suitable to progress onto intensive behavioural change/and/or the temporary accommodation provision. Whilst this list is not exhaustive, the following may present as some of the rationale for this: one party does not consent to the intervention, party causing harm denying behaviours, high risk client identified (requires high risk response), client presents with multiple and complex needs etc. Should this be the case, version 1 of the Risk Management and Intervention plan will be put in place, with the offer to review this plan at a relevant future point.

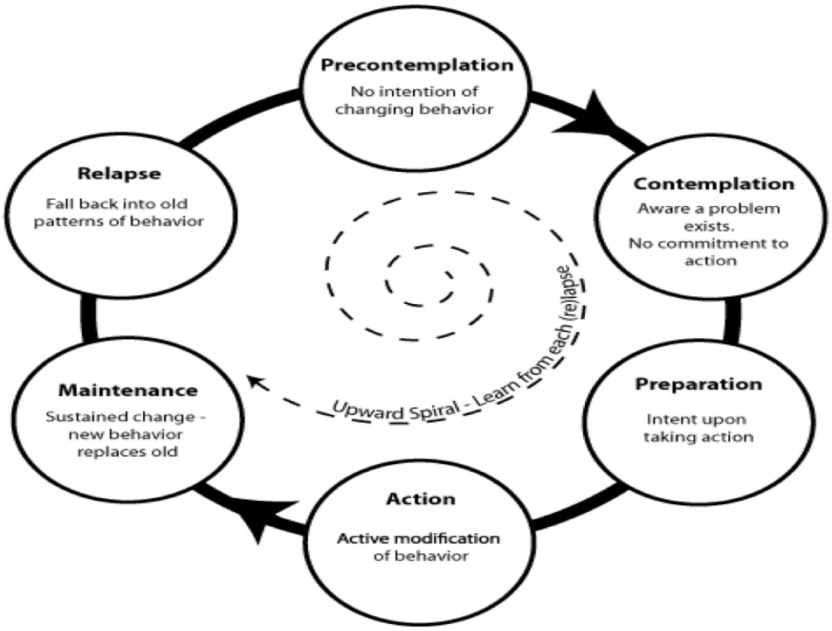
Those that are deemed suitable for direct engagement (both parties consent, not a high risk client, client in contemplation or action phase etc.) version 2 of the Risk Management and Intervention Plan will be employed and feature a plan/forecast of the attitudinal and behavioural change intervention as well as a host of other actions centred on engaging and intervening with the client using abusive behaviours.

Ongoing risk management

The Social Care Practitioner will be expected to work collaboratively on the case with the Early Intervention Practitioner in the pro-active management of risk for the duration of the intervention. The expectation is that the Early Intervention Practitioner and Social Care Practitioner will convene a professionals meeting a minimum of once per week to discuss updates, share information pertinent to risk, progress and intervention planning.

A key part of this meeting is the planning around the safety and wellbeing of the victim and children. It is pertinent to risk management to ensure that the Social Care Practitioner has an understanding of the planned intervention work, its key risks and is given guidance on how to discuss the planned intervention with the victim. We discuss this in more detail from page 16.

The Cycle of Change



Prochaska and DiClemente's (1983) Transtheoretical/cycle of change model has been used for decades as a framework for understanding motivation to desist from harmful behaviours. It is a useful and intuitively logical way of helping people to understand the change process.

Depending a client's acceptance of the need for change, very different stances, strategies, conversations and exercises will be appropriate. The further back they are in the cycle, the more you may have to edge to the left of centre in the *stance continuum* (see above). Indeed, research[15] [16] shows that being too directive with those who are ambivalent about change, or too neutral with those who are already committed to change each get in the way of effective client work.

Below the strategies, exercises and types of conversation are laid out in an order of their appropriateness to three of the key states of readiness change:

Precontemplation:

There is no intention of changing behaviour; the person may be unaware that a problem exists.

Precontemplation stage interventions – building the relationship and empowering the client to change (self-efficacy)

Contemplation:

The person becomes aware that there is a problem but has made no commitment to change.

Contemplation stage interventions – building motivation

Action:

The person is actively engaged in changing their behaviour

Action stage interventions – working directly on how to stop abuse and on alternatives

[15] Center for Substance Abuse Treatment. Enhancing Motivation for Change in Substance Abuse Treatment. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 1999. (Treatment Improvement Protocol (TIP) Series, No.
[16] Chapter 1-- Conceptualizing Motivation And Change. Available from: https://www.ncbi.nlm.nih.gov/books/NBK64972

Stages of change and appropriate interventions

Precontemplation

- Emotional regulation
- Grounding
- Externalising
- Risk Management & Intervention planning with Social Care Practitioner

Contemplation

- Emotional regulation
- DA awareness and impact
- Motivational consersations about abuse
- Denial focused work
- Decisional balance work

Action

- Emotional regulation
- Impact on children - parenting goals
- Healthy/non-abusive communication skills - conflict resolution
- CBT techniques -emotional intelligence - empathy

Direct work with the Adult Victim:

Social Care Practitioners will be very familiar with safety planning techniques they work with clients to instil (with both victims and children) when domestic abuse is a dynamic that they are subjected to; this imperative work which will be required to sit alongside explaining the interventions in which their partner/ex-partner is undergoing.

Bancroft[17], Stark[18] and others warn about the characteristics of those who use abusive behaviours; the Social Care Practitioner has a role in the planning and assessment of the behavioural change element of the intervention. Moreover, there are specific exercises in which the Social Care Practitioner will need not only to inform the victim around, but also obtain consent and consult on how the Early Intervention Practitioner can increase the safety and effectiveness of the specific intervention activity.

We should also be aware that any time a perpetrator of domestic abuse engages with professionals, he is likely to be talking to his partner about this and may misuse his contact with professionals to deceive or further abuse her. Here are some of the ways we have found that a man can use a behaviour change programme against (ex)-partner:

- Lying about his attendance/engagement
- Informing her that he doesn't need to attend any longer because he is 'cured'
- Using material from the intervention against her – to undermine her
- Lying about what the Early Intervention Practitioner is saying to him
- Using attendance on the programme to influence other professionals (social workers and family courts)
- Using attendance on the programme to influence his partner to stay with him when he hasn't made real change.
- Telling her that everyone thinks it's she who has the problem and she should stop nagging him/winding him up etc
- Using the material on the programme to criticise and control her behaviour
- Using jargon/concepts learnt on the programme to manipulate her

There is a growing body of evidence demonstrating that behaviour change Interventions with people who use harmful behaviours can be successful at reducing abuse for some people[1920]. However, these interventions can also increase the risks, as highlighted above.

Your role in supporting the adult victim will help mitigate the risks by supporting the victim to:

- develop realistic expectations about their partners' behaviour change
- monitor the degree to which their partner is engaging with the intervention and make decisions accordingly
- assess risk and safety plan
- understand domestic abuse and healthy relationships

It is important that you work closely with the Early Intervention Practitioner, and other professionals, to share information in order to increase safety

Explaining the intervention to victims

[17] Bancrofy, L. (2003) Why Does He Do That?: Inside the Minds of Angry and Controlling Men

[18] Stark, E. (2009) Coercive Control: How Men Entrap Women in Personal Life (Interpersonal Violence): The Entrapment of Women in Personal Life

[19] https://www.dur.ac.uk/resources/criva/ProjectMirabalfinalreport.pdf

[20] http://driveproject.org.uk/wp-content/uploads/2020/03/DriveYear3_UoBEvaluationReport_Final.pdf

There is a risk that work with the person causing harm can mean that the victim feels a sense of relief and reassurance that the abuse will stop. It is important that you provide realistic expectations about change and that you support the adult victim to continue assessing and planning for the safety of herself and her children.

Whilst you will be supported by the Early Intervention Practitioner on how to hold these conversations regarding the each specific intervention; the bellow example of a strategy within the Early Intervention Practitioner Behavioural Change Manual to avoid risk escalation is outlaid to give a insight:

Exercise: Time out

A time out should be used when the above warning signals present and the clients feels that they are building to a potentially abusive outcome, so they remove themselves. However, this exercise is a pre-agreed and collaborative one, in that the clients partner should also understand and agree to the implementation and use of this intervention.

A helpful structure to discuss the time out with the client (see below for client handout):

1. Recognise

As the client has completed the signs and signals exercise they are now more aware of the early sings of escalation of emotional states, this will aid them in intercepting potential escalation. It might be helpful to keep the signs and signals handout close by so you can look at feelings, thoughts, behaviours that are specific to that client.

2. Intervene

Take action and intervene – instigate a time out. We are responsible for our behaviours and actions. The client might feel that using the words 'time out' works adequately, however others may with the use other terminology that works better for them (as long as it's not a term that causes distress or insult).

3. Withdraw

Quite simply, this step is the removal of the client from the proximity of the partner. It could be that both client and their partner have pre-agreed places where they can retreat to. The length of time removed is recommended from 20 minutes up to one hour and thus serious consideration should be given to the space(s) that the client retreats to. Owed to the current COVID -19 restrictions, additional consideration should be given to how separation for this allocated time can be successfully achieved within a single household (separate room, garden, shed space etc).

4. Regulate & Reflect

The practitioner should discuss the options available to the client which would aid the clients relaxation. Use of substances may come up here and the practitioner should acknowledge the

potential draw for the client, but balance this with discussions around how substances lower inhibitions and impact decision making…a cocktail for escalation. Step one is to find a way to relax once you have left the conflict situation. Thus exercise, listening to music, engaging in exercise or activity that requires dexterity or is mentally challenging for 10-15 minutes can be useful.

Once the clients then feels calmer, they can reflect on what just occurred:

- What was it that I wanted as the outcome – what did I want to happen?
- How could I have behaved differently?
- Did I do or say anything to hurt, upset, scorn? How did this make my partner feel?
- Is there another way I can get my view across which doesn't have negative consequences?
- How can I return and be different?

5. Return

The client may have decided to revisit the discussion employing the reflection framework above, but the client may also have decided to move on and not mention. Either way, the client should expect to be respectful, collaborative and compromising should their partner choose a different method of resolution to theirs.

Time out handout

WHEN SHOULD I USE A TIME-OUT?

The time-out procedure is based on one simple fact: if you're not near the person you're annoyed with, you can't hurt them physically. Use it every time you recognise that:

- **You want to have an argument -** Typical examples include conflicts over, money, going out, jealousy, who is right, and any other time you recognise that you don't want to let go of the fight.
- **Bodily signals -** You start to feel tension in the stomach /shoulders/ jaw/ neck, raising your voice or shouting, pacing, swearing etc.
- **Emotional signals -** Feeling trapped, angry, confused, persecuted, resentful, jealous etc.
- **Mental signals -** winding yourself up: you tell yourself the other person is controlling you; you use degrading names such as 'bitch', or you're thinking to yourself 'Here we go again!' and are wanting to shut them up. You start seeing them as the enemy - you despise them.

As soon as you recognise any of these signs in yourself (don't wait until you get worse), tell the other person 'I need to take a time-out', **and leave.**

WHAT IS A TIME-OUT?

Taking a time-out means that you *calmly* leave the argument wherever you may be for an agreed time – 30 minutes is a good amount of time. There are two important reasons why you need to stick to the agreed time:

- The other person is more likely to trust you if you stick to a standard format.
- For most people, half an hour is a realistic length of time in which to calm down. If you start to shorten this to, say 10 minutes, you increase the risk of returning and escalating again.

During that period, do the following:

- Calm yourself down
- Don't drink alcohol, drive or take drugs.

- During this first part of the half hour *(about 15 minutes),* regulate/soothe yourself by working off adrenalin – walk fast, do sit-ups, run etc. or relax by listening to music, engaging in an activity that requires dexterity or is mentally challenging.
- Examine your behaviour.

During the second part of the half hour *(about 15 minutes)*

- Think about what was going on for the other person – why would ***they*** say they were acting like that? How they were ***they*** feeling?
- Think about ***your*** behaviour and figure out in what ways you may have already been abusive. What might you have to apologise for?
- If you're going to be non-abusive, you will need to be able to return to the situation and ***be*** different rather than try to make the other person different. Think about what you're going to do or say when you go back that's honest but that won't escalate the situation.

Return - If the other person doesn't want to talk when you return, propose a better time when you could both do so.

INFORMING OTHERS ABOUT THE TIME-OUT

It's very important to talk about time-outs with relevant other people well ahead of when you will need to use one. Do this at a time when you're calm. Show them this handout and give them time to read it. They may not want to talk about it with you. If this is the case, leave this handout with them to look at.

You can use the template below to help you manage your time out:

1. Recognise - what sings and signals are cues that you're getting angry?

- my bodily signals:

- my feelings:

- my thoughts:

2. Intervene – the word/phrase I will use to call a time out.

- my code word/phrase:

3. Withdraw – where I will go and for how long?

4. Regulate & Reflect – how I will calm myself and think over what happened.

I will calm myself down/relax by:

- What was it that I wanted as the outcome – what did I want to happen?
- How could I have behaved differently?
- Did I do or say anything to hurt, upset, scorn? How did this make my partner feel?
- Is there another way I can get my view across which doesn't have negative consequences? How can I return and be different?

6. Return – what I will do when I return.

Remember, return at the pre-agreed time, be respectful, collaborative and compromising.

Summary

After reading the above exercise, which is only employed as a last resort intervention to stop an abusive incident occurring, you can foresee how such an activity could be used incorrectly: calling a time out to avoid co-parenting responsibilities, to avoid chores, telling another person they need a time out etc. This therefore only further demonstrates the importance of the collaboration with the victim regarding the planning, implementation and reviewing. This aforementioned is the role of the Social Care Practitioner, who will receive bespoke support on how to do this with their respective client.

Assess Risk & Safety Plan

Initial risk indicators will be assessed by completion of the SafeLives Dash risk checklist. To respond to client feedback about repetitive questioning within a short space of time: where a full Dash has been completed at the start of the intervention, the Social Care Practitioner will go through the questions the victim answered 'no' or 'don't know' to ascertain if anything has changed since the time of the initial assessment, or to offer the opportunity for the victim to disclose any further information about the abuse. During the intervention period the Social Care Practitioner will get to know the victim's situation to understand the nuances of the risks, what might cause an increase to risk, and what safety measures or planning can be put in place to manage the risks.

If during the intervention (or at any time thereafter) a victim is identified as being at high risk of harm, a referral should be made to the high risk IDVA team as soon as possible, and to MARAC if the client reaches the MARAC threshold.

Domestic abuse informed practice

Trauma

Trauma is be defined as exposure to death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence; thus trauma is caused by an experience of extreme threat to physical or psychological safety that overwhelms normal coping mechanisms. It is evident by this description that family victims and children subjected to domestic abuse experience trauma.
Someone might also be considered to have been exposed to trauma if they experienced one of these incidents indirectly, such as learning that they happened to someone very close to them.
When a person is in a threatening situation, a part of the brain called the amygdala becomes activated. The amygdala is associated with ensuring physical survival. When the amygdala becomes activated, it overrides a person's executive functioning (rationalising, planning etc) and triggers them

to rapidly pursue the course of action deemed most likely to result in survival[21]. These automated and largely uncontrollable reactions, instigated by the amygdala, can be broken down into 5 possible response categories:

Fight: Physically or verbally 'fighting back' against the threat. For example, attempting to overpower the threat physically or shouting "no!"

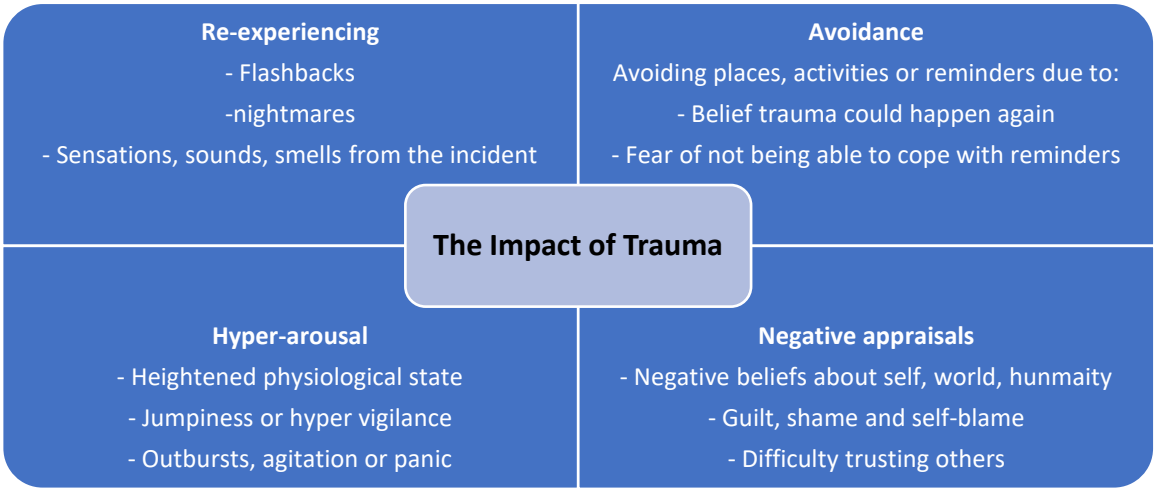
Flight: Running away or using other means to create distance between yourself and the threat

Friend: Utilising one's social engagement skills to seek safety. This manifests in two main ways:
1) Attempting to engage others who may be able to assist, such as calling "help me!"
2) Engaging directly with the person who is posing the threat, to persuade them not to cause further harm. This might involve being apologetic, kind, pleading, trying to reason, displaying empathy or promising to be compliant. Passive Responses.

Freeze: People may describe feeling 'frozen with fear'. This behaviour is also observed in the animal kingdom, where animals appear to remain very still to avoid a predator detecting them.

Flop: This is a state of submission when the body feels entirely floppy and does not offer any resistance to what is happening. The brain may perceive that this is likely to lessen the extent of physical injury. During a 'flop' state the mind may also feel disconnected from the full reality of the traumatic events.

The amygdala is highly focused on ensuring physical survival in the current situation. It is less able to factor in ongoing psychological wellbeing and longer-term planning. This means it will trigger victims to act in the way that seems most likely to ensure their physical survival in the immediate moment, even if this is contrary to how the person expected themselves to act. Once a victim has responded in a certain way to a threatening situation they are more likely to act in the same way in future dangerous situations. The parts of the brain associated with responding to danger will encourage the person to replicate behaviours that have previously proved successful in maintaining physical survival.



[21] Lodrick, Z (2007). *Psychological Trauma – What Every Trauma Worker Should Know*. The British Journal of Psychotherapy Integration. Vol. 4(2)

Trauma Informed Care

Trauma-Informed Care understands and considers the widespread nature of trauma and promotes environments of healing and recovery rather than practices and services that may inadvertently re-traumatize[22].

Safety: Ensuring physical and emotional safety
Principles in Practice - Common areas are welcoming and privacy is respected.

Choice: Individual has choice and control
Principles in Practice - Individuals are provided a clear and appropriate message about their rights and responsibilities.

Collaboration: Making decisions with the individual and sharing power
Principles in Practice - Individuals are provided a significant role in planning and evaluating services.

Trustworthiness: Task clarity, consistency, and Interpersonal Boundaries
Principles in Practice - Respectful and professional boundaries are maintained.

Empowerment: Prioritizing empowerment and skill building
Principles in Practice - Providing an atmosphere that allows individuals to feel validated and affirmed with each and every contact at the agency.

Impact on parenting

One well researched explanation of why domestic abuse affects children is through the impact that it might have on parenting[23]. There are a number of ways in which domestic abuse and even hostile but nonviolent conflict may negatively affect the quality of parenting.

Parents setting examples (modelling) of aggression
Parents involved in a relationship marked by conflict and violence show their children that negative and aggressive behaviour is an acceptable means of exchange and problem solving.

Hostility
Parents experiencing domestic abuse may be more hostile towards their children; using harsher forms of parenting, in extreme cases this may constitute maltreatment of the child.

Withdrawal
Parents may become withdrawn from and less warm towards their children, as they try to cope with the abuse and relationship problems that they are experiencing. This may also be the case when a parent is coping with depression.

Inconsistency
Parents may become inconsistent in what they expect from children and how they discipline them. There may be little co-operation in parenting between caregivers where domestic abuse is an issue. There is some suggestion that perpetrators of domestic abuse may wilfully contradict the non-abusive parent as a means of undermining their parenting skills.

Blame

[22] http://socialwork.buffalo.edu/social-research/institutes-centers/institute-on-trauma-and-trauma-informed-care/what-is-trauma-informed-care.html
[23] https://www.parentingacrossscotland.org/publications/essays-about-parenting/parenting-under-pressure/parenting-in-the-context-of-domestic-abuse/

Parents may blame their children for the occurrence of conflict and violence, particularly if abuse arose out of a child related issue, such as a child's difficult behaviour. This may increase the likelihood of parents directing negative behaviour towards their children.

Boundaries

Boundaries between parents and children may become blurred, where one parent badmouths the other to the child or alternatively leans on a child for emotional or practical support. This may be overwhelming for a child, leading to anxiety and depression, or alternatively, it may evoke feelings of resentment towards a parent who expects the child to play a role in supporting them. This might lead to a child's aggressive behaviour.

Strength based working: practice principles

Strengths-based practice is a philosophy and a way of viewing clients as resourceful and resilient in the face of adversity. It is also considered a method of practice, which by and large has the fundamental assumptions: the practitioner's relationship with the client is one of collaboration; that people are resourceful; and are capable of solving their own problems. The dominant approach, prior to strengths-based practices, the dominant philosophy involved viewing individuals in terms of their pathologies, weaknesses, limitations, and problems. In strengths-based models, in contrast, the practitioner, in collaboration with the client, identifies and amplifies existing client capacities to resolve problems and enhance quality of life. Strengths-based approaches can be viewed as respectful toward and empowering of people who are experts in their own lives.

Project evaluation & client feedback

This is currently under consultation with the Research and Evaluations team at the Social Care Institute for Excellence.

Appendix A: Referral form

Early Intervention Referral form

Completed Early Intervention referral form, and accompanying DASH RIC (if available) should be sent by secure email to the Early Intervention practitioner:
earlyintervention.london@respect.cjsm.net

Referring agency

Referrer name		**Referring Social Care Team**	
Telephone & email		**Date of referral**	
Referrers working hours (for Case Consultation)			

Referral detail

Victim Name		**Victim D.O.B**	
Address		**Ethnicity** **Disabled** **Sexual orientation** **Gender**	
Telephone no.		**Alternate contact no.**	
Safe contact information			

Perpetrators name		**Perpetrator D.O.B**	
Address		**Relationship to victim**	
Telephone no.		**Alternative contact no.**	
Ethnicity **Disabled** **Sexual orientation** **Gender**			
Perpetrator(s) occupation			

Relationship status (separated/co-habiting etc.)	

Children	DOB	Relationship to victim	Relationship to perpetrator	Address
Is the victim pregnant?		**Due date**		

Reason for referral

Outline risk factors, relevant background and reason for referral.	
Detail actions/behaviours the Perpetrator has used towards the victim and/or children (e.g. the father takes the mothers money, isolates her from family/friends).	
Detail the impact of the perpetrators listed actions/behaviours to victim and child.	
Detail the victims strength and their efforts made to	

support or provide safety and wellbeing of the children.			
Detail fathers willingness and motivation to engage			
Is the victim aware of this referral?		**Has the victim given consent to this referral?**	
If the victim is not aware or not given consent, why not?			
Is the perpetrator aware of this referral?		**Has the perpetrator given consent to this referral?**	
If the perpetrator is not aware or not given consent, why not?			
Has the victim identified any priorities to increase their safety or meet their needs?			
Has the victim been referred to MARAC previously? If so when are where?			
Has the perpetrator been heard at MARAC or MAPPA previously? If so when and where?			

Confidentiality and Information Sharing Agreement

Notes to practitioner:
If you are having this conversation over the telephone, read through the agreement below and sign in the box over the page to say you have explained it to the client. On the first opportunity you get to see your client face to face, go through this agreement again and ask the client to sign the reverse.

In an emergency please follow the guidance in the box below.

Our aim:

- To offer an intervention/support in whatever choices you make.
- Inform you of choices that are available to you.
- To create a safe environment for you to disclose sensitive and personal information.
- To respect your decisions.

The information below outlines how we will treat the information that you give us about yourself, your family, others and your circumstances.

It is important for you to read this information sheet, and for it to be explained to you by your Early Intervention Practitioner. If you have any additional needs to enable you to fully understand what you are signing e.g. language, or literacy, or, do not understand the terms, you can ask for additional support. When you have read and understood the agreement, sign and date it on the next page. If the agreement is discussed over the phone the Early Invention Practitioner will ask for your verbal consent.

In an emergency

The basic principles of confidentiality and information sharing are:

The information you provide is confidential unless:

a. You consent to information being shared **OR**
b. You or any adults/children connected to you are likely to be at risk of harm to 'self' or others
c. You or anyone connected to you are likely to commit an offence of terrorism which may harm the general public

We will always inform you when information is being shared, unless it is not safe for us or others to do so, as it may put you or others at risk of harm.

- If we have to share information in this situation, we will only share relevant information that will improve you and / or others' (including children's) safety.
- If we do not have your consent to share information, we will talk this situation through with the Project Manager, where they are not available prior to the decision, an information without consent form will be completed outlining the rationale and legislation used to base our decision on. The decision taken by the

Early Intervention Practitioner will be reviewed within 48 hours and the without consent form will be attached onto your case file, detailing what we have shared, why and who with.

You have a right to access your file under a Subject Access Request (excluding 3rd party information), please contact the service which will advise you of the process.

How will we treat any information that you give us?

We will use information you give us to help keep you, others and any children safe. We will also use this information to improve the service we offer you and others.

Generally, the information that you share with us about yourself, your family and others and your situation will be treated as confidential by the Early Intervention Project. This means that only authorised people at the Early Intervention Project will have access to this information unless you say otherwise.

There may be times when it is useful for someone from the Early Intervention Project to share information about you with other agencies, this as an example maybe as a case study to illustrate the work the project is engaged in. Unless the situation is 'high risk' your Early Intervention Practitioner must ask for your permission to share this information, and you will be able to say yes or no.

Improving the service we offer you:

- So that we can try to improve the service we offer, we might need to make your details and information you give us anonymous so that we can share it with agencies and researchers outside our service. This helps us to monitor our performance, understand more about domestic abuse and the best ways to improve the lives of people who experience it.
- When we share information in this way the identities of our clients and significant others will never be revealed.

You can choose if you are happy for your information to be made available for these reasons. If you decide to say no, this will in no way affect the service that you receive.

So that we know you have read and understood this agreement, please answer yes or no to each statement by placing a cross in the box. It is important that you answer yes or no to each statement.

	Yes	No
The confidentiality and information agreement has been explained to me.	☐	☐
I give permission for anonymised information about me to be used by other agencies and researchers for the purpose of monitoring and research.	☐	☐
I understand that information about me will be held confidentially unless I give my permission for it to be shared with others.	☐	☐
I understand that there are exceptions to this and in the event that I, others and/or my children are assessed to be at high risk of harm, information about me can be shared without my permission.	☐	☐

Please sign and date the agreement

Signature _____ Date _____

_____

Print name

Early Intervention Practitioner's

signature

_____

If agreement was explained and consented to over the telephone:

Early Intervention Practitioners

signature Date:

_____ _____

Agency name	Agency contact	Information shared	Permission to share information	Date	Date of review
			Y / N		
			Y / N		
			Y / N		
			Y / N		

Confidentiality and Information sharing agreement

Notes to practitioner

If you are having this conversation over the telephone, read through the agreement below and sign in the box over the page to say you have explained it to the client. On the first opportunity you get to see your client face to face, go through this agreement again and ask the client to sign the reverse.

Our aim

- To support you in whatever choices you make
- Inform you of choices that are available to you
- To create a safe environment for you to disclose sensitive and personal information
- To respect your decisions

The information below outlines how we will treat the information that you give us about yourself, your family and others and your circumstances.

It is important for you to read this information sheet and for it to be explained to you by your case worker. When you have read and understood the agreement sign and date it on the next page.

In an emergency

The basic principles of confidentiality and information sharing are

1. The information you provide is confidential unless:

a. You consent to information being shared OR

b. You or any adults/children connected to you are likely to be at risk of harm to 'self' or others

c. You or anyone connected to you are likely to commit an offence of terrorism which may harm the general public.

2. We will always try and tell you when information is being shared unless it is not safe for you or your children or if we can't contact you.

3. If we have to share information in this situation, we will only share relevant information that will improve you and/or your child[ren's] safety.

4. If we do not have your consent to share information, we will talk this situation through with a senior member of the team (where they are not available prior to the decision, the decision taken will be reviewed within 48 hours) and will be written on your case file what has been shared, why and with who.

5. We store your information in the following way on a secure case management system and only those employed by the Early Intervention Project that only are authorised to have access to this information.

6. You have a right to access your file under a Subject Access Request (excluding 3rd party information), please contact the service which will advise you of the process.

How will we treat any information that you give us?

- We will use information you give us to help keep you and any children safe. We will also use this information to improve the service we offer you and others.
- We are here to support and advise you. We offer you a safe space to share your worries, concerns and experiences. You can tell us anything and we will treat what you tell us with sensitivity and respect. It is important that you understand from the beginning that some of the information you share with us will need to be shared with other agencies if we think that sharing that information will help us and those other agencies make you and or your children safer. We can do this legally under the Children's Act section 10 to safeguard children and under the Crime and disorder Act Section 115 to prevent and detect crime. This means that we believe there is a legitimate interest in sharing information.
- We will only share enough information that is necessary to increase your safety or the safety of others we believe to be at risk.
- We would like to tell you what, when, how & to whom we will share information and will endeavour to do so at all times.
- When deciding when to share any information we will always balance the consideration to share any information with the risks of not sharing. We want to assure you that we will not share anything that is unnecessary or not relevant for the purpose of making you or anyone else safer.
- It is very important to us that we maintain the trust you are putting in us to help you. If you are happy that you have understood this please sign and date here:

…….. Date:

Service user

…… Date:

Signature of practitioner

If there is any information that we think is necessary to share with an agency or agencies; and we believe we need your consent to do so we will be clear about this and ask.

Request for consent:

We need your consent to share the following piece of information [detail info which should be proportionate & relevant to the purpose]

With [name agency]

For the following purpose: [detail purpose]

I [service user name] consent to the information detailed here being shared with the relevant agency(ies) for the agreed purpose.

…….

Service user Date:

……..

Practitioner Date:

Was this consent obtained over the telephone? Yes/No

If Yes please ensure that the service user signs a written consent when possible.

Improving the service we offer you

We always try to improve our services. To do this we need to monitor our performance, understand more about domestic abuse and learn from those, like yourself, who is living or has lived with domestic abuse. This means we would like to use your anonymous information to share with those who fund our services, some agencies and researchers. Any information that could identify you or your family will be removed and you will remain anonymous.

You can choose if you are happy for your information to be made available for these reasons. If you decide to say no, this will in no way affect the service that you receive.

I agree for my anonymised information to be used in this way:

……. Date

Service user

We store your information in the following way (insert here more detailed explanation of how information is stored and retained this must be GDPR compliant & you should justify the length of time you intend to store data)

If you are happy that you understand how your data will be stored please sign here:

…… Date:

If agreement explained and consented to over the telephone:

Case worker's signature _____ Date _____

GDPR Statement: EIP are committed to ensuring the security and protection of the personal information that we process, and to provide a compliant and consistent approach to data protection.

Appendix D: Information Sharing Without Consent Form

Information Sharing Without Consent Form

What is this form for?

Sharing information without consent can feel like a very difficult and complex area for all practitioners.

Routinely briefing Service Users at intake on the service's confidentiality policy allows the Service User to make informed choices about the disclosure of information, and enables them to understand the consequences of that disclosure. Every decision to share information should be made on a case by case basis. The Information Sharing without Consent form will help you walk through each decision to share information when you do not have your Service User's consent.

How should I use it?

1. Create the right expectations for your Service User by making sure they have already signed up to and understand the confidentiality agreement.

2. Establish whether it is safe to discuss with your Service User that you are sharing information with/without their consent.
    a. If it is safe, be clear what your decision is before you enter into the conversation. Your aim is to bring your Service User along in the information sharing process, and gain their consent and cooperation by the end of your call.
    b. If it is not safe discuss and develop a strategy and agreement in relation to sharing any information about your service user without consent. Ensure all your defensible decision making is recorded in full on the electronic case management system.

3. Make sure you cover the following points with your Service User:
    a. Who you are concerned about.
    b. Who they are at risk from/to.
    c. What your concerns are. Who you want to share information with.
    d. What information you want to share.
    e. Reassure your Service User that this does not mean you will share all the information she/he has given you with all agencies.

4. Document the outcome of the conversation in your case notes and note:
    a. What information you have shared.
    b. Which agencies/individuals you shared it with.
    c. Whether your Service User knows or why they do not know.
    d. Where your Service User has refused consent, complete the form, embed it into your case file and reference it in your case notes.

The form will help you create a robust and defensible decision around each situation to disclose. Ensure you discuss each situation with your Project Manager, or a senior member of the team, who will need to sign off the decision and establish when a review needs to take place.

If your Service User does not know information is being shared you could use the 'Significant concerns flag' on the Intake form to notify your colleagues.

What else do I need to consider?

Be familiar with your agency's information sharing policies and procedures, the Multi-Agency Risk Assessment Conference (MARAC) protocols and any other local policies.

Information Sharing Without Consent Form

Name:		Sent to:		Date:	

Service User name:		DOB:	
Address & contacts			
Children:		DOB(s)	
Address & contacts (if different to above)			
Victim(s) name:		DOB:	
Address & contacts: (if different to above)			

Concerns and risk information:

Who are you concerned about?		Who are they at risk from?		What are your concerns? Flag immediate risk – separate professional judgement and professional opinion
Child[ren]	☐	Perpetrator (Service User)	☐	
Victim(s)	☐	Victim(s)	☐	
Perpetrator (Service User)	☐	Self-harm	☐	
		Family member	☐	
Other (state who)		Other (state who):		
Have you completed a Risk Assessment?		Y / N		
RIC classification & number of ticks				

Attach SafeLives RIC	

Information Sharing Process:

I am sharing information based on the legal authority of (tick one or more):		What are your concerns? Flag immediate risk – separate professional judgement and professional opinion
Child Protection Act 1989		
Data Protection Act 1998		
Human Rights Act 1998		
Crime and Disorder Act 1998		
Common Law		
I have balanced the following considerations:		
I have discussed this internally with:		
Date:		
The action we have taken is:		

Service User notification:

Has the Service User been notified?	Y / N	If Service User not notified, why not?	
Date/time			

Appendix E: Accommodation Agreement

Early Intervention Temporary Housing Agreement

Note that this agreement is a not a legal document but forms part of the terms of the Early Intervention project. The Service user is staying at the accommodation as a guest of those premises and expected to abide by the legal terms of that arrangement.

Service User Name		Early Intervention Practitioner Name	
Address of temporary accommodation		Dates of temporary accommodation offer	From…../……/…….. To……/……./……

Expectation of the Service user

Expectation	Initial/Sign to show agreement
I agree to a minimum of one face to face meeting with the Early Intervention Practitioner per week and two further telephone/video conferencing contacts per week (3 contacts in total). I agree to let the Early Intervention Practitioner know if I am unable to attend an appointment or take a call.	
The following visitors are allowed in the accommodation but only whilst I am also there:	
The following visitors are allowed in the accommodation overnight:	
I agree that I will not use the accommodation for illegal activity.	

I agree to pay for any additional costs incurred whilst using the accommodation – such as room service.	
I am aware that I will be liable for any damage to the property.	
I agree to respect staff and other guests including keeping noise levels to a minimum.	
I agree to follow any other guidance/general terms & conditions of the hotel.	
I agree not to return to the family home for the duration of the accommodation period.	
I commit to not phoning my ex-partner more than 2 times in a day. I understand that phoning any more than 2 times in one day may be seen as bullying or harassing.	
I understand that if I am unable to meet the above expectations that this could result in the offer of temporary accommodation being withdrawn.	
I understand that either myself and/or my partner can withdraw from the offer of temporary accommodation at any time and that the Early Intervention Practitioner and Social Care practitioner will work with us to move back in together or find alternative accommodation.	

Arrangements for children

I understand that the children will reside at:	
I understand that the following arrangements will be in place for me to see/have contact with the children: - Where there children will remain resident: - Access to children – specific times and dates: - How and when handover of children will take place: - What communication will happen between the non-resident parent and the Children: - How and when telephone communication with the children will take place:	

I agree to continue to provide financial support for my partner for the children and to contribute to running the family home including rent, household bills, food etc.	

Expectation of the Early Intervention Practitioner and the project

Commitment to a minimum of one face to face meeting with the Early Intervention Practitioner per week and two further telephone/video conferencing contacts per week (3 contacts in total)	
To provide support for myself, my partner and my children	

Additional expectations:

Signed

Service User Name: Service User signature: Date:

Early Intervention Practitioner Name: Early Help Practitioner signature: Date

Risk Management & Intervention Plan V1

In constructing the Risk Management & Intervention Plan the Early Intervention Practitioner will collaborate with the Child Welfare/Protection Practitioner to bring together their understanding of the risks posed by the client (informed by risk information on available DASH's, chronologies, reports etc.) and construct a plan to create more stability, less risk and positive behaviour and relationships.

Client name/ID: ……	Practitioner: ……
Created on: ……	Review date: ……

Summary of presenting issues:

Summary of risk:

Needs:

Clients goals (if known):

Motivation for change:

Victim/Survivor strengths and efforts to support/provide safety and well-bring for the child:

Safety Considerations

Risk Management and Intervention Strategies:

Area of support and Date	Action agreed	Proposed date for completion	Completed	Action Taken/Notes
				.

Follow up plan (if applicable):

Before uploading this document onto any IT system or administrative platform, You must obtain consent from EIP Project to comply with the processing of personal data to operate to deliver the services that individuals have requested as governed by the General Data Protection Regulation 2016/679 Legitimate Interest being based on relevant Articles 6 & 9.

Risk Management & Intervention Plan V2

Every Intervention Plan will follow the Risk Needs Responsivity principles (Bonita and Andrews, 2007) with additional elements of Service User directed goals and formulation employing the 3d frame work (Hart and Logan, 2011). In an ideal situation, the clients goals and Early Intervention Project goals are coterminous; often this will not be the case, but where possible the Intervention Plan will be informed by clients aspirations. In constructing the initial intervention plan the early intervention practitioner will bring together their understanding of the risks posed by the client from the DASH and other sources where appropriate; the significant concerns from the Needs Analysis and the most concerning elements of the Attitudes and Treatment Viability Grid to construct a plan to create more stability, less risk and positive behaviour and relationships.

Client name/ID: ……

Practitioner: ……

Created on: ……

Review date: ……

Summary of presenting issues:

Summary of risk:

Needs Assessment:

Service User goals (if known):

Summary of Attitudes and Treatment Viability Assessment:

Victim/Survivor strength and efforts to support/provide safety and well-bring for the child:

Formulation (*see guidance below):

Drivers:

Disinhibitors:

Destabilisers:

Scenario Planning:

NATURE - What kind of abuse? - Who are the likely victims? - Why? (Goal/Motivation?)

SEVERITY – What is the potential level of harm? – Could it escalate - life threatening?

IMMINENCE – How soon? – Warning signs?

FREQUENCY/DURATION – How often might the abuse occur? – Is the risk recurring or acute?

LIKELIHOOD – How common is this type of abuse? – How likely will it occur? – Is risk increasing, decreasing or stable?

Safety considerations:

Risk Management and Intervention Strategies:

Area of support and Date	Action agreed	Proposed date for completion	Completed	Action Taken/Notes
				.

Formulation notes/summary:
Follow up plan (if applicable):

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Appendix I: EIP Risks & Mitigations

Risks to the individuals involved

Risk	Mitigation
Risk escalates during intervention or risk factors identified which were present but unknown prior to intervention.	- Risk assessment at start of intervention includes input and professional judgement from DA specialist – EIP. - Risk reviewed frequently by SCP and EIP using the DASH risk assessment tool - EIP and SCP are familiar with local high and medium risk pathways for DA responses and refer as appropriate.
Service user uses the time away from the victim to continue to exert control by 'proving' how much he is needed. 'You can't manage without me'.	- EIP and SCP are alert to signs of controlling behaviour - SCP works with the victim to carry out a needs assessment and ensures that wrap around support is offered as required including drawing on other voluntary and statutory services as appropriate. Needs may include – managing finances, child care, household tasks, mental health, additional support needs, disabilities, transport, - agencies who could offer additional support include – Adult social care, housing, vol sector services (eg. DA services, Homestart), Citizens advice etc.
Service user moves into temp accommodation and then discontinues engagement with EIP.	- Service user signs agreement at start of intervention which includes commitment to regular contact with EIP including weekly face to face contact and 2 x phone or online contact. Breach of this agreement would mean an end to this part of the intervention. - Ongoing support and intervention would be offered when the Service user returns to family home or moves to alternative accommodation (see below).
Victim and/or Service User decide at the end of (or during) the 4 week intervention that separation, or living separately, is their preferred outcome.	- The array of potential outcomes are discussed with victim and service user at the beginning of the intervention. EIP and SCP to scenario plan with both victim and service user, so that both are made aware of local options for housing. - EIP and SCP develop relationship with local homelessness teams and/or housing providers to plan for this outcome at the start of the project launch. - Explore finding options available to extend the temporary housing arrangement for a further two weeks to give time to secure more permanent arrangements.
Escalation of risk due to Service user returning to family home following a breach of the agreement.	- As above re mitigations around risk escalation. - Review risk assessment – refer to high/med risk specialist services as appropriate.

One of the family members becomes symptomatic of covid-19.	The EIP and SCP will work with the family to take appropriate action taking account of the most up to date government guidance.

Acronyms used

EIP – Early Intervention Practitioner

SCP – Social care practitioner

DA – Domestic abuse