CHANGING LIVES

Virgin money foundation

Too complex for "complex needs"?

Learning from work with victims of domestic abuse, who also have multiple and complex needs.

Final Report – November 2018

Changing Lives

“Everyone knows their name, but no-one knows their face. We have all this information on paper, but we don’t really know them at all.”

Changing Lives Manager

With many thanks to the wonderful Changing Lives staff who delivered these services and provided the data and other material for this report: Helen Aitchison, Sarah Charlton, Andrea Gartland, Faye Green, Kate MacGonnell and Sarah Price.

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[1] All names used in this report have been changed.

Introduction

This evaluation looks at three related interventions, delivered by Changing Lives, supporting victims of domestic abuse who have multiple and complex needs. The interventions are all funded for at least one year and take an intensive approach to meeting the needs of vulnerable victims/survivors.

A first-stage report set the scene, giving information about the approach being taken and using case studies to highlight the real-life situations victims are dealing with. This second report pulls together data about the impact of the project interventions on the lives of individuals, using a range of measures, alongside a selection of up-dated and new case studies.

There is currently a great deal of interest around how to best meet the needs of victims of domestic abuse who have multiple and complex needs. A review of domestic abuse provision carried out by the Department for Communities and Local Government (DCLG) in 2015 found that "victims with the most complex needs find it particularly difficult to access appropriate support, further intensifying the risks they face." The Government's Ending Violence against Women and Girls Strategy 2010-20 states that by 2020 "specialist support, including accommodation-based support, will be available for the most vulnerable victims, and those with complex needs will be able to access the services they need". This strategy expects one outcome will be "better access to integrated pathways of support to meet the needs of victims experiencing multiple disadvantages" and committed (then) DCLG to launching a new funding programme to develop and promote new forms of forms of services for victims with the most complex needs. It is this funding programme that supports two of the pieces of work being discussed here.

In the meantime, national domestic abuse agency AVA (Against Violence and Abuse) and Agenda: the Alliance for Women and Girls at Risk have commissioned research about the needs of women and girls facing multiple disadvantages and mapping current service provision (or lack thereof). They launched a joint National Commission looking domestic and sexual violence as it affects the most marginalised women and girls. The Commission has been taking evidence early in 2018 and will report in autumn 2018.

A note about the Case Studies

Feedback from the first report highlighted the value of the case studies we used to demonstrate the complexity of the women's lives. We have re-visited some of these case studies in this second report, adding additional background information where it has become available and adding up-dates to the women's situations – these updates and additional background information are in italics.[2] Several themes have emerged as impacting on the women's safety and well-being, including involvement with the criminal justice system, childhood experiences of violence and abuse, experience of sexual violence as an adult, mental ill-health etc. Where relevant we have highlighted these in bold throughout the case studies.

This evaluation is part-funded by Virgin Money Foundation.

The evaluator, Cullagh Warnock, is a freelance consultant who has worked with and for the violence against women and girls sector in various roles over the last fifteen years.

[2] Due to the introduction of new General Data Protection Regulation legislation in May 2018 we have included a smaller number of compliant case studies in this final report.

Summary of key learning points

Whilst this evaluation looks at a relatively small number of interventions, over a very short time period, we have been able to learn the following:

1. The approach taken by the Changing Lives staff - using assertive outreach techniques, building trust and working with a woman's own priorities, rather than meeting agency's needs - has enabled them to **build and maintain trusted relationships** with women whom other services have failed to engage.

2. In mainstream domestic abuse services (including refuge and IDVA services), describing a woman as having complex needs often means that in addition to her experience of domestic abuse she also has significant mental health problems or problematic substance use which cause her additional difficulties when dealing with the domestic abuse. However, for the women supported by these services, their experience of **domestic abuse (whilst often very serious and high risk) is almost the least of their worries**. Many of them are dealing with mental ill health and substance misuse and homelessness, whilst coping with a succession of current and historic traumatic experiences. In light of this, it is perhaps no surprise that they can be considered 'too complex for complex needs' provision

3. The complexity of these women's lives, the long-term impact of the trauma they have experienced and their vulnerability to further adversity, means that there are no quick fixes. For some women it has taken them six months just to start trusting the CL worker and it will take a **much longer intervention** to support her to make the changes she needs to.

4. In the context of victims of domestic abuse, **repeat referrals to MARAC**, **eviction from refuge or refusal of a place in refuge** because of 'complex needs' might all be useful indicators that a more intensive intervention such as these is needed.

5. **Trauma**, experienced (often repeatedly) both in childhood and adulthood, is common for these women but is often hidden to professionals, masked by the more obvious, noisy issues of substance use, mental ill-health and homelessness. Women disclose this information when a trusting relationship is established. Once professionals have the whole picture they are able to support women more appropriately and therefore more effectively.

6. **Sexual violence, exploitation and abuse,** both current and historic, is so prevalent in women's lives that they often do not even perceive it as a problem but just 'the way things are'. This normalisation of violence and abuse (not only by the women but also by other people around them) means they are even less likely to disclose or to seek support to help them deal with their experiences, or to be safer.

7. There are some clear opportunities to **enhance the approach of existing mainstream services** so that they are better able to meet the needs of these women. For example, better understanding about the dynamics and risks around domestic abuse would help substance use agencies provide a safer, more accessible and appropriate service for women, especially when their (abusive) ex/partner is also accessing that service.

8. Some professionals' **lack of empathy** for these women can create additional barriers for them when they attempt to seek help. They appear to be particularly prone to **victim-**

blaming, where the focus of professionals is on the woman's behaviour, rather than on the perpetrators. This can be an issue with statutory agencies (police, health and children's services) but also with some specialist domestic abuse professionals.

9. Professionals can also struggle to work with women who exhibit behavioural difficulties. The CL workers have had some interesting discussions with colleagues about different thresholds regarding tolerance of **challenging behaviour** – for example these projects would not stop working with an individual woman because she swore at a member of staff, although they would challenge her and work with her to improve her future behaviour.

Joanne was referred to CL by an independent sexual violence advisor. She was experiencing on-going domestic and sexual abuse (from a current partner) which was getting progressively worse. Joanne has a history of violent relationships and domestic abuse and is a survivor of childhood sexual abuse.

Joanne has significant health problems, she experiences regular seizures. Her health issues are exacerbated by chronic alcohol misuse. She has had numerous falls, resulting in injuries. Professionals find it difficult to confidently ascertain if Joanne's injuries are as a result of her seizures or domestic assaults.

Joanne's children have been recently removed from her care and are being put up for adoption. She is struggling to deal with this. The removal of her children may also mean her home is at risk because of increasing rent arrears due to the effects of the so called bedroom tax.

Engagement with services has been a challenge for Joanne in the past, exacerbated by the fact that she did not have a phone. At the point of referral she only had on/off contact with drug and alcohol services.

The CL worker used assertive outreach techniques to contact Joanne, and has now established regular contact with her and developed a good relationship.

The CL worker has supported Joanne with the following:

- Attending family court
- Referred her to a project which specialises in supporting parents whose children are in the care of the local authority
- Supported her to attend GP and hospital appointments
- Referred her to Rape Crisis for specialist therapeutic support
- Discussed safety planning and requested safety measures to be installed in her home
- Made three referrals to adult safeguarding on her behalf and provided information to support referrals to MARAC
- Reaching out to the drug and alcohol services, to try and improve Joanne's engagement

On referral, Joanne scored 39 out of 49 on the NDTA, six months later she still scores 39. CL staff believe that, given everything that has happened in Joanne's life in the last six months, were it not for their support her score would be much higher.

About Changing Lives

Established in 1971, Changing Lives is a national organisation working across the North and Midlands. It provides specialist support to 6,000 vulnerable people each month; reaching out into communities to engage people at the edges of society – people experiencing homeless, mental health problems, addiction, exploitation and/or abuse. It aims to tackle the causes of social exclusion, not just the effects, so many of its interventions are designed to address underlying issues, rather than just responding to crises. Its provision includes:

- Short and long-term housing for vulnerable people in housing need, including emergency accommodation, Housing First solutions, semi-independent living units and independent tenancies.
- Recovery services across the North East and North Yorkshire to help those abstaining from substances.
- Community outreach services for people with different needs, including those living on the streets, helping them re-engage with services and improve their life skills.
- Specialist services for women offenders / at risk of offending, offering holistic, trauma-informed interventions designed to meet women's specific and complex needs.
- Support for women and men with experience of sex work / survival sex / sexual exploitation, delivering specialist services, facilitating peer research and training local agencies. Nationally it leads the field in this area.
- Services for victims/survivors of domestic abuse, providing refuge, advocacy, move-on support and sanctuary schemes.

One of the organisation's strengths is its ability to work with the people with the most complex needs, across the traditional 'silos' of abuse, mental health, substance use, homelessness etc. This approach means it works effectively with people that other services find 'hard to reach'. It also has a strong ethos of involving its service users in all aspects of the organisation's work, including as volunteers and staff – currently over 20% of its workforce have previously used services and are 'experts by experience'.

Changing Lives' Theory of Change[3] is a three-stage model – Being, Becoming, Belonging - which was co-produced with women with complex needs and is now used across the whole organisation. Each stage is equally important to ensure sustained well-being, move-on from services and a fulfilling, flourishing life.

Changing Lives is also a core partner in the Fulfilling Lives Newcastle and Gateshead partnership – an eight-year Big Lottery Fund programme seeking to help people with complex needs to better manage their lives by ensuring that services are more tailored and better connected to each other. The Fulfilling Lives team helps those people who often spiral around the system(s), are excluded from the support they need and experience a combination of at least three of the following four problems: homelessness; re-offending; problematic substance misuse; mental ill health. It has become clear from the work of this and other Fulfilling Lives programmes across the country, that for women with such complex needs, understanding and addressing their experience of domestic and sexual violence and abuse is also critical.

[3] See appendix one

The Interventions

In **Newcastle**, the Women's Intensive Support Work (WISW) service supports women victims/survivors of domestic abuse who face multiple disadvantages[4], and who therefore may struggle to access and engage with existing provision. Based within Newcastle Integrated Domestic Abuse Service (NIDAS), the WISW project complements the existing provision. Working closely with the IDVA service, two dedicated staff provide additional specialist resource to bridge the gap in service provision for women at risk of domestic abuse with multiple and complex needs. The WISW project offers one-to-one, assertive, wrap-around outreach support for women who have either: been repeatedly subject to the MARAC process, but for whom this process has yielded poor outcomes, due to women struggling to engage, or to women who struggle to access mainstream domestic abuse support. Commissioned by Newcastle Council using funding from the Department of Communities and Local Government (DCLG), staff started work in August 2017 and to date have supported 40 women over a ten-month period; 11 other women were referred but did not engage with the service.

In **South Tyneside,** the Complex Domestic Abuse Service (CDAS) supports both women and men who are victims/survivors of domestic abuse who face multiple disadvantages and may therefore struggle to access mainstream provision. A similar approach to "multiple disadvantage" is used. Working closely with the homeless outreach team, one dedicated member of staff provides one-to-one, assertive, wrap-around support to individuals referred from a range of other services. Commissioned by South Tyneside Council using funding from DCLG, this project started work in September 2017. In the first nine months, 37 women (and men) were referred or self-referred, of whom five did not engage. Of the 32 who did engage: six received brief interventions (up to five working days involvement) usually to get them into supported / safe accommodation; three disengaged; 23 have received long-term, intensive support.

In **Sunderland,** the Women at the Edge (WATE) project supports female victims/survivors of domestic abuse who are living in one of the city's private hostels or are street homeless. The project is aimed at women who have fallen through the safety net of mainstream domestic abuse provision or find that provision difficult to access because of their multiple and complex needs. Working alongside Changing Lives' hostel in-reach team, one full time member of staff and three volunteers attend hostel in-reach sessions and drop-ins, engaging the women there and slowly building trusting relationships. A specialist part-time group work facilitator leads therapeutic recovery work. This pilot project is funded by Virgin Money Foundation (VMF) for one year only and began in mid-October 2017. In the first six months, 42 women were referred or self-referred, of whom five did not engage. Of the 37 who did engage: 14 received brief interventions (up to five working days involvement) usually to get them into supported / safe accommodation; two disengaged; 21 have received long-term, intensive support. Seed funding from VMF was awarded to demonstrate the need for this work and to help Changing Lives make the case for longer-term statutory resources.

[4] For the purposes of these projects, "multiple disadvantage" encompasses five key areas (from *'Women and girls at risk: evidence across the life course'*, Lankelly Close, 2014):

- Contact with the criminal justice system
- Homelessness
- Sex work/sexual exploitation
- Severe mental health issues
- Substance misuse

Changing Lives' Approach

Changing Lives' approach to this work is encapsulated in the following:

- Changing Lives' **theory of change** - Being, Becoming, Belonging - is a three-stage model of change used across all its' services as a foundation to help women to transform their lives. This underpinning framework is used ensure services are meeting the aspirations and needs of the people it works with. (See appendix one)
- Staff take a **trauma-informed approach**, recognising that experience of trauma can affect women's reactions to situations and their ability to cope.
  Staff recognise that behaviours and attitudes often mask trauma; their priority is not to re-traumatise clients with repeated assessments or internal processes. Instead they focus on engagement, using empathy, consistency and good boundaries to build strong, trusting relationships.
- Staff use **Dialectic Behavioural Therapy** (DBT) skills in their interactions with women to help them understand what has happened to them, validate the emotions they are experiencing, and learn to process, manage and contain their emotions. This supports women to recover from trauma, address destructive patterns of behaviour and access the support they need.
- Services are delivered in **psychologically informed environments** (PIE) where the overall approach and day to day delivery of the intervention has been designed to take into account women's emotional and psychological needs, especially those who have experienced complex trauma. The purpose of a PIE is to help staff understand causes of behaviours and work more creatively and constructively to address them.
- Staff take an '**strengths-based' approach** with women[5], focusing on their strengths, talents and interests, rather than on the things they lack. This whole-system approach uses bespoke tools in a personalised support model, focussing on people's strengths, talents, goals and aspirations to help build their identity and increase self-efficacy, independence and resilience.[6]
- These interventions prioritise working at women's own pace and focus on what **her priorities** are, rather than what agencies consider to be her most pressing needs. Staff focus on building trusting relationships and making **assertive and persistent offers of support**. Many women will take a long time to trust the worker and will reject offers of help repeatedly. Staff are **non-judgemental** but provide a clear challenge when necessary, modelling appropriate, boundaried and safe relationships.
- Where appropriate the interventions can offer a similar level of support to a **Housing First** model and focus on securing and maintaining somewhere safe for the women to live as a priority. They also work with the existing Housing First projects in each area, which are operated by CL.
- Some of the staff and volunteers delivering these interventions are **experts by experience** and bring particular understanding and inspiration to their work.

[5] This model (developed by Mayday Trust for use with homeless people), has a strong evidence base for its effectiveness.

[6] There is an irony inherent in this report in that whilst the CL staff take a strengths-based approach, the emphasis in the case studies is very much on 'deficits'. This is due to an intention to demonstrate the complexity of the women's lives and the multiple barriers they face. It is not a reflection of the approach taken by staff working with individuals.

What do we mean by 'complex needs' in this context?

When commissioners and service providers talk about people with multiple and complex needs they are usually referring to people who are dealing with / involved in three or more of the following: homelessness; offending; problematic substance use and/or mental ill-health.

However, the starting point for these projects is the individual's experience of domestic abuse, where their ability to access both support and safety is complicated by other factors. For the 106 women supported through the three projects, the issues of homelessness, offending, substance use and mental ill-health were all prevalent. However, other issues also featured.

Experience of domestic abuse	100%
Mental health issues (both diagnosed and undiagnosed)	96%
Referred to MARAC (repeat referrals)	82% (63%)
Problematic substance use	80%
Housing issues (including homelessness)	64%
Experience of sexual violence and/or child sexual abuse (where disclosed) *	60%
Involvement with the criminal justice system	58%
Loss of custody of one or more child (usually to care of the local authority) *	43%
Reporting of self-harm and/or suicidal ideation*	38%
Involvement in sex work / sexually exploited (where disclosed)	36%
Experience of domestic abuse in childhood (where disclosed) *	28%
Physical ill-health or disability	22%
Learning disability (where known)	19%

Differences between the projects

The referral routes to the three projects differed. All women referred to the Sunderland service were homeless or living in unsafe / unsecure accommodation. This included women who were sleeping rough, sofa-surfing or living in a private (unsupported, mixed-gender) hostel. Similar referral routes meant the South Tyneside project saw 86% of individuals in similar housing situations. In contrast only 18% of women supported by the Newcastle service were identified has having issues with housing. This was the only significant difference between the profiles of the women accessing the different services.

*These issues were only monitored by the Newcastle service but the common profile of the women across the three services would suggest an equivalent prevalence of these issues amongst the women supported by all three projects.

Kara was referred to the service by a CL outreach team, at the point of referral she was **rough sleeping** with two males who were being violent and abusive to her. She was already known to both homeless and substance user services.

She had numerous failed tenancies with both private and temporary accommodation providers. She has a history of **alcohol misuse** and also had a number of unsuccessful attempts at detox and rehabilitation. She was not considered suitable for refuge provision because of her alcohol use. She had three children, one of whom had **been adopted**. The other two children live with her former partner. She has no family support.

Kara had multiple attendances at A&E due to assaults from a partner and to alcohol withdrawal. She has also been admitted to hospital on several occasions as a result of overdosing. She was diagnosed with **depression and anxiety** and does not take her prescribed medication for these conditions. Her alcohol use means she struggles to engage with the GP for help with her mental health. She does not have access to specific dual diagnosis support.

At the point she was referred Kara's benefits had been suspended (sanctioned) due to her failure to attend an appointment at the job centre when she was homeless – and therefore had not received the letter. The CL worker supported Kara to appeal this decision and her benefits were reinstated. Once the CL worker had established a relationship with Kara, she supported her to follow a rapid reduction plan for her alcohol use and access a voluntary sector specialist service for one to one and group work support. The CL worker also accompanied Kara to primary care appointments.

The worker helped Kara make a homeless application and register for housing. Taking a 'housing first' approach, she was given a private tenancy and daily visits from the CL worker to help her cope. During these regular one-to-one sessions Kara disclosed a twelve-year history of serious domestic abuse, including violence, coercion and emotional abuse from her former partner. This had resulted in numerous broken bones. Kara had fled their home because she thought it was unfair that the children were witnessing the violence. She also knew that because of her drinking, she could not look after them. She did not have any contact with the children because she was afraid of her former partner.

As Kara got to know and trust her CL worker, she disclosed years of **childhood trauma**. She recalled panic attacks and nightmares from a young age; she **attempted suicide** as a teenager. She revealed she had spent several years in the care of the local authority, in residential homes and out of the area in a secure unit.

Kara's daily visits with her CL worker have a pattern, going out somewhere in the community, once a week and spending another weekly session looking at her mood diary. Kara has been going to the gym and attending recovery meetings. The hope is that, if she can keep participating in these activities, she will gain new social skills, meet people and feel less lonely.

Kara has weekly counselling with a CL counsellor. She hopes to start the DBT skills group very soon. She can now link the trauma that she experienced as a child to her deteriorating mental health and understand the impact it had on her life. She has poor dental hygiene due to prolonged rough sleeping; she has a dental appointment to start treatment.

Kara is successfully managing her tenancy and she is currently not drinking. She now has contact with her two children, who stay overnight with her once a week in her home. She hopes that in future she can have shared custody of them.

On referral to Changing Lives Kara scored 47 (out of 40) on the NDTA, now down to 13.

Measuring impact – the New Directions Toolkit Assessment

The projects use the New Directions Toolkit Assessment[7] (also known as the Chaos Index - see appendix two) to assess the suitability of people referred and measure the impact of the intervention on individuals. The NDTA uses the following indicators: Engagement with frontline services

1. Intentional self-harm
2. Unintentional self-harm
3. Risk to others (including offending behaviour)
4. Risk from others (including domestic and sexual violence and abuse)
5. Stress and anxiety (ability to cope with, and reaction to, stressors)
6. Social effectiveness and life skills
7. Alcohol and/or drug abuse
8. Impulse control
10. Housing

The Sunderland and South Tyneside projects worked with individuals scoring over 36 (out of 49) on the Index, the Newcastle service worked with those scoring over 20 (but where the risk of harm from domestic abuse was high). An assessment is undertaken at referral and then repeated at regular intervals to track changes / improvements. Looking at these scores for individuals in the different services the picture is, unsurprisingly, as complex as the lives of the women themselves.

The **Newcastle service** completed a NDTA for 22 women at referral and six months. Some of the biggest changes in scores (e.g. from 34 to 14) were at least in part due to external factors such as an abusive partner being in prison. Another significant reduction (e.g. from 35 to 26) was linked to the woman successfully engaging with a methadone reduction programme; Another woman scored 36 at referral with no change at six months; during that period her children were removed to care, and she began a relationship with a new, abusive partner. Of the 22:

- nine women scored significantly less (between 9-22) at the six-month review
- ten women scored slightly less (between 1-5)
- three women saw no change in their scores – but enormous changes in their situations

The **South Tyneside service** completed a NDTA for 23 individuals at referral and six months. One of the biggest decreases in the score (from 47 to 13) was where a woman had been sleeping rough and abusing alcohol but was then supported in her own tenancy, stopped drinking and accessed health care. Of the 23:

- ten women scored significantly less at the six-month review
- seven women scored slightly less
- six women saw no change or a slight increase in their scores

The **Sunderland service** completed a NDTA for 29 individuals at referral and six months. Again, the biggest decrease in an individual's score (from 45 to 19) was where a woman had been street homeless and substance using, having just given birth. Six months on she was maintaining her own tenancy and engaging with health services. Of the 29:

- 11 women scored significantly less at the six-month review
- 14 women scored slightly less
- four women saw no change or a slight increase in their scores

[7] An NHS tool used by developed by Making Every Adult Matter (MEAM).

Judith is currently living in a mixed-gender, private hostel with little on-site support. The Changing Lives homeless in-reach team work in this hostel and the complex needs project has established a women's drop-in service there. This is where CL staff first met Judith. She has two children who have been **removed from her care**; she has no contact with them. She has previously had problems with **alcohol misuse** but that is not an issue at the moment.

During her adult life Judith has experienced **domestic abuse** from several different partners. She did have her own tenancy, but the property was damaged by her ex-partner and Judith was evicted. Judith suffers from **anxiety and depression**; she is prescribed medication for these conditions which she takes regularly. Judith has a **learning disability**.

Judith also has significant **health problems** which cause her mobility problems and she uses a wheelchair when she is out and about in the community. One of the first things the CL worker did with Judith was to work with social services to ensure a capability assessment was made and Judith now has a care package in place.

The private hostel is not suitable (or safe) for Judith. The CL worker has liaised with Social Services to find her appropriate accommodation. This has been difficult because of her age (she is under sixty). However, she has been able to secure a place in a pilot scheme in sheltered housing. She will be able to move in within the next few months and is really looking forward to it.

In the meantime, Judith continues to attend the hostel drop-ins and often brings other women with her. She has grown in confidence and is able to speak out more during these sessions. She has attended a Changing Lives' domestic abuse awareness course and understands more about the dynamics of her previous relationships. She also attends weekly craft sessions which she really enjoys – she had picked up the habit of knitting when in recovery and still really enjoys it.

Judith lacked many daily living skills and the CL worker has assisted her in learning some basics including how to make a cup of tea. Judith is feeling positive and excited to be moving to a suitable, safe accommodation which meets her needs.

On first accessing the service, Judith scored 38 (out of 49) on the NDTA, she now scores 22.

Measuring Impact – Cost Benefit Analysis

The projects have also piloted a **cost-benefit tool**[8] (see appendix three) to analyse the impact of the intervention for individuals and for the service as a whole. This tool attempts to make a link between the results of those interventions and a reduction in public service costs. It includes costs relating to an individual's interaction with and/or use of various statutory services:

Housing – accommodation, housing benefit entitlement, making a new housing benefit claim, making a homeless application and being evicted.
Crime – arrest, charge, caution, nights in police custody, prison, court proceedings, probation activities.
Fire – fire service call-outs.
Health – 999 calls, ambulance call-outs, A&E attendances, hospital stays, outpatient visits, GP services and prescriptions.
Mental Health – inpatient and outpatient treatment, support from various outreach and community mental health teams and various therapeutic appointments.
Substance Use – residential rehab, inpatient detox, specialist prescribing, outpatient and community outreach alcohol and drug services.
Social Services – contact with social workers and weeks children spent in care.
DWP – new JSA/UC claim and amount of benefit entitlement.

CL staff used this tool with information about a small sample of women on referral, and then again six months on. It demonstrates that engagement with these services may contribute to considerable savings (see below) and adds something to arguments about the cost effectiveness of targeted intensive services. However, there are several caveats to bear in mind:

- This tool does not reflect the costs of the repeat victimisation of women, e.g. police call outs, referrals to MARAC, civil orders, criminal proceedings, family court and counselling. If services wanted to quantify the impact of services for women where domestic and sexual violence were a significant issue, these costs should be included in a revised tool.
- It may often be desirable to see increased (if more appropriate) use of services e.g. being in supported accommodation or refuge, rather than sofa surfing; accessing mental health services, rather than continuing without treatment; going into rehab etc.
- Significant financial savings might mask a less positive outcome e.g. a woman's child being moved from foster care to being adopted – which results in a saving to the local authority but means the women has lost any opportunity to have contact with her child.
- Whilst significant savings can be demonstrated across local public services, in reality most of those services will remain over-subscribed and savings are rarely 'cashable'.
- Many of the changes that contribute to a reduction in cost may not be as a direct result of work undertaken by these projects but may be due to other interventions or circumstances.

[8] This tool was developed by the Fulfilling Lives programme

Individual cost benefit analyses for seven women – each cost relates to a single month.

	1	2	3	4	5	6	Totals
At referral	£9,399	£6,240	£7,030	£8,190	£10,896	£5,692	£47,447
At six months	£951	£1,926	£5,192	£1,355	£3,382	£5,310	£18,116
Difference	£8,448	£4,314	£1,838	£6,835	£7,514	£382	£29,331

Vicki referred herself to the Changing Lives service via the private hostel drop-in. At the point of self-referral she was **street homeless**, living in a city where she has no local connection. She had an issue with substance misuse extending over a ten year period and received support from the substance misuse service. Vicki is a **prolific offender** and has been convicted of shop lifting, criminal damage, being drunk and disorderly and assault. Most of her offending is related to funding her drug habit. She has not been to prison.

Vicki has **two children who were taken into the care** of the local authority then placed in the care of her ex-partner.

Vicki has been (and continues to be) the victim of domestic abuse from both her current and previous partners. She has been considered to be a high risk and has been **referred to MARAC**, but her risk level is not currently considered to be high because she is now living in a neighbouring local authority area. She has been admitted to hospital on numerous occasions; this has included domestic abuse-related hospital admissions and **admissions due to overdoses** she has taken because of the abuse. The perpetrator (her current partner) has been in jail for domestic abuse-related offences but not towards her. Vicki has been accommodated in a refuge in the past but was asked to leave because of instances of theft and of drug and alcohol use. She is now unable to access support from that route. She is also known to other hostels in the city – she has been asked to leave several of them, usually because of rent arrears and anti-social behaviour by the perpetrator.

Vicki has been formally diagnosed with PTSD and is on medication for this.

Since her self-referral the CL worker has focused on helping Vicki to secure a private tenancy out of the area. She has supported her to register with a GP and secure medication for her mental health needs. She has accompanied Vicki to Job Centre appointments and helped her to provide additional information. She is now providing on-going support to help Vicki maintain her new tenancy. Vicki will be offered a place on the DBT skills group in the New Year.

Six months on Vicki is still in her new tenancy. She is no longer with the perpetrator and has not been referred to MARAC again. She is starting to put down roots in her new area. Her drug use is no longer problematic, and she complies with regular drug testing to enable her to have supervised contact with her children. She experienced some initial problems in her tenancy when she moved to Universal Credit. Her housing benefit was paid directly to her (rather than direct to the landlord as was the previous system) and she spent it, putting her into significant rent arrears. CL staff intervened and negotiated future housing benefit payments to go directly to the landlord and she is re-paying the rent arrears. Vicki has been discharged from the CL service but knows she can get back in touch if she needs to.

When she first contacted CL Vicki scored 49 out of 49 on the NDTA, this fell to 41 after three months and she is now at 19.

What have we learnt?

Initial conversations with local and national commissioners, funders and service managers revealed a common set of questions about this area of work. We must emphasise that these **small-scale projects** have been working with women for **less than a year**. However, we know a little more in some of the areas originally identified as of interest.

Who are these women, what are their backgrounds and what factors complicate their lives?

All specialist domestic abuse services work with some women whose situations are complicated by additional needs such as mental ill-health or problematic substance use. However, the women being supported by these interventions are living in such complex and chaotic situations that mainstream services (including specialist domestic abuse provision) are unable to engage them effectively. We were interested in exploring the different issues these women experience and how they interact to prevent them from getting the help they need.

Our starting point was that all these women are victims/survivors of domestic abuse and as expected housing issues (including homelessness), mental health issues and problematic drug and alcohol use feature significantly in their lives. However, we have also identified a number of other issues which further complicated their lives.

The women were often at high risk from at least one domestic abuse perpetrator, with 82% of the women having been referred to MARAC. 63% had been **referred to MARAC repeatedly** but agencies had failed to engage effectively with them.

96% had significant (diagnosed or undiagnosed) **mental health issues** (and 38% had a history of self-harm and/or suicidal ideation). Women reported struggling to engage with treatment, often because of substance use or the transience of their living situation. Other health issues were also reported: 22% had poor **physical health** and/or a physical disability and 19% were known to have a **learning disability**.

80% had significant **drug and/or alcohol issues**. Again, women reported struggling to engage with specialist treatment and support. Too often an abusive partner(s) also used substances and this was a further barrier to engaging with treatment. Substance use was also presented as a coping mechanism, not just as a way of managing mental ill-health but also as a way of coping with violence and abuse, both current and historic.

64% had **housing issues** (including insecure or unsafe tenancies, street homelessness or sofa-surfing). Additionally, staff noted that for some women the **transient life** they were caught up in also had an impact – as they moved between hostels and other accommodation, in and out of prison, between different local authority areas, they found it difficult to put down roots and have any sense of belonging or security.

58% were involved (as perpetrators) with the **criminal justice system**, often relating to acquisitive crime. There was no sense that women's engagement with the CJS was supportive of any meaningful change. One women's experience of prison as a 'safe space' was immediately negated when she was accommodated with a dealer on release. Appointments with court, the probation service etc often represented just one more agency to juggle in a complex existence.

60% of women were known to have experienced **sexual violence and abuse** as an adult and/or as a child, often throughout their lives, by multiple perpetrators. 36% were known to have engaged in **survival sex** or been **sexually exploited** as an adult. Whilst many recounted specific incidents of sexual violence or exploitation to staff, others minimised the repeated sexual violence they experienced – 'they don't see it as rape, they think that's just the way things are'. Unsurprisingly, **childhood sexual abuse** was only disclosed once a trusting relation had been established. However, once a woman disclosed abuse, this often became a key issue around which she sought on-going support. 28% reported experiences of **domestic abuse in their family when a child.** Again, information about such adverse childhood experiences tended to be volunteered as a trusted relationship was developed. The prevalence of all these issues is therefore likely to be under-reported at this stage.

43% of the women had one or more **children who had been taken into care** or were no longer living with them. A number of women also disclosed that they too had been in the care of the local authority at some point during their childhood. The impact of losing their children represents another trauma that the women were dealing with, often with little acknowledgement or support.

Overall the picture that emerges from both the case studies and these figures is one of **significant levels of repeated trauma**, often over long periods of time. Anecdotally staff noted that some women had suffered other childhood trauma, with the death of their mum or another significant care-giver or close relative a common feature.

Where might we have intervened earlier?

It is difficult, with such a small sample, to identify definitively any obvious opportunities for early intervention with these women. However, the women's stories suggest it would be helpful to refer women for more intensive support:

- at the second or third referral to MARAC
- on eviction from a refuge
- on refusal of a refuge space on the grounds to 'complex needs'

Substance misuse teams might also consider seeking advice from such projects when they notice women service users who only ever access their appointments in the company of their (using or non-using) partner. The CL staff cited examples where the substance misuse service was the only place a woman was 'allowed' to go by their controlling partner. How sensitively substance service staff deal with a situation can make an enormous difference, get it right and her appointment can double up as an opportunity for safety planning and a route into greater protection, get it wrong and she may be stopped from accessing this service too and be placed at even greater risk. Training for reception staff, as well as front-line practitioners is needed here.

Many of the women were also involved with the criminal justice agencies as offenders. We know that women's offending is often linked to, or because of, their victimisation. We were struck by the sense in which CJS interventions appeared to be just another appointment or hurdle the women had to contend with, rather than an opportunity for support to help them turn their lives around that a properly resourced, women's centred approach brings.

What are the barriers to accessing support? Where are the opportunities for positive change?

Again anecdotally, the services saw examples of barriers to women receiving appropriate and timely support such as:

- substance misuse services not acknowledging the impact of on-going domestic abuse for a woman in treatment.
- a single (often relatively minor) violent incident following a woman in her case notes, preventing her from accessing supported accommodation many years after the incident.

Positive changes CL staff have seen during the last year include:

- A local drug and alcohol service has changed its practice and no longer sees couples for joint appointments.
- A different drug and alcohol recovery service has allowed women to have counselling and support around domestic abuse whilst still in recovery and has rolled this change out across other services, in other local authority areas.

Sadly, the most prevalent barrier, and possibly the hardest to overcome, is reported as being a **lack of empathy and understanding** for these women from (some) other professionals. CL staff encountered several situations where professionals would announce they, or their agency, 'wanted nothing more to do with' an individual woman – sometimes in situations where the woman herself was at significant risk of serious harm. Staff characterised these attitudes as **'victim-blaming'** and noted a level of judgement about her actions, without commensurate attention being paid to the actions of the perpetrator, or any acknowledgement about her limited space for action.

However, there were also examples of professionals prepared to 'go the extra mile', such as the neighbourhood police officer who took enormous trouble to support one woman to finally make a statement about her abusive partner, or the hostel worker who had kept safe one women's photo album, long after she had moved out.

What works in engaging these women and in sustaining that engagement?

Changing Lives staff take a trauma-informed approach, working with women at their own pace. They are persistent and consistent in their offer of support to women who might initially reject such an offer. These approaches have worked in engaging women who are typically characterised as "hard to reach". Whilst women using the service have not been interviewed as part of this evaluation, one woman fed back to her support worker that:

> *She knows that the service is there for her, even if she doesn't always engage. She trusts the worker; the worker makes her smile. She knows the worker cares and goes the extra mile. The service does not give up on her.*

This feedback chimes with staff reflections about the different approach they take:

- Being persistent and consistent in their offers of support and offering it in ways that work for women e.g. getting in touch via text rather than using phone calls or letters
- Having a strong understanding of trauma and the impact trauma has on women's capacity to engage with support
- Listening to the woman and focusing on her priorities, not the priorities of other agencies
- Being flexible about when and where they meet women, fitting around other commitments
- Having a positive attitude toward the individual woman and focusing on her strengths and abilities, rather than her deficits
- Finding the things that women liked to do, or that made them feel good about themselves, building self-esteem and laying the groundwork for positive change in the future.

Where resources have allowed, staff have found it enormously valuable to offer women opportunities for positive experiences, no matter how small, to help build their resilience and self-esteem. Something as simple as a small birthday gift and card can have a huge impact.

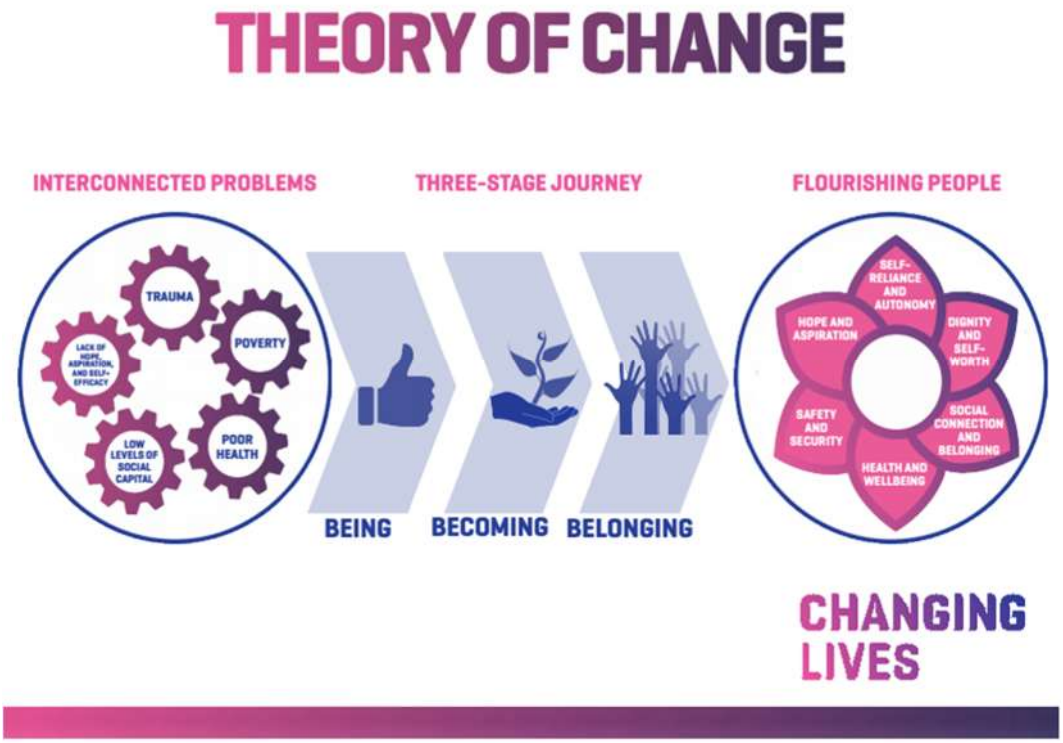
They have used arts projects to bring some of the women together in small groups, where otherwise this would be incredibly difficult. The Sunderland service has used volunteer counsellors to offer additional support which women have really appreciated. This service also has the capacity to offer therapeutic group work.

In terms of the challenges staff themselves faced in doing this work:

- One issue staff noted was their own lack of standing sometimes with other professionals when they needed to advocate on behalf of a woman and challenge the other professionals view.
- When working with women needing this level of intense support, one member of staff suggested a case load of 15 women a year would be more manageable.

However, the over-riding message is that the complexity of these women's lives, the long-term impact of the trauma they have experienced and their vulnerability to further adversity, means that there are no quick fixes. For some women it has taken them more than six months just to start trusting the CL worker and it will take a much longer intervention to help her make the changes she needs to.

Appendix One



What is it?

Changing Lives' Theory of Change - Being, Becoming, Belonging - is a three-stage model of change which every one of our wide range of services uses as a foundation to help people to transform their lives. Each stage is equally important to ensure sustained wellbeing, move-on from services and a fulfilling, flourishing life.

The Theory of Change is an underpinning framework which we use ensure our services are meeting the aspirations and needs of the people we work with, communicate the diversity and impact of our work, and try to influence policy which affects the people we work with. The Theory of Change is not a specific method or tool to work with people.

How has it been developed?

Our Theory of Change has been developed through consultation with people who use our services, learning from our front-line staff and exploring current research and best practice as well as many years of experience delivering frontline services.

The details

The people Changing Lives helps are affected by a wide range of interconnected social, psychological, physical and economic factors which have not only caused them to experience extreme difficulty and disadvantage in their lives but which continue to prevent them from living healthier and more fulfilled lives.

Trauma: Trauma associated with early negative life experiences and traumatic incidents in adulthood can have a devastating impact long term.

Poverty: Financial, emotional, mental and spiritual poverty is a significant and under-stated factor in trapping people and preventing change.

Poor Health: Most of the people we work with experience poor physical and mental health. Addiction can sometimes be seen as self-medication to manage untreated mental health issues.

Social Capital: Social capital is social relations that have productive benefits. Many people we work with have limited positive relationships, instead having 'survival groups' where people with a common problem band together to cope.

Hope, Aspiration and Self-Efficacy: Lack of hope and aspiration is a hallmark of the lives of the people we work with, and coupled with low levels of self-efficacy acts to prevent people from believing anything can be different.

Changing Lives' Theory of Change is our way of understanding how the people we work with become trapped but also how we can help people build on their own strengths to progress and move on – through **BEING, BECOMING AND BELONGING.**

BEING

- Reaching out and engaging with people
- Accepting people where they are at now
- Getting to know people and their aspirations
- Consistent, reliable, honest, empathetic communication and actions
- Creating environments in which people feel safe and comfortable
- Clarity about what the service can and can't do, where, when and how

BECOMING

- Starting the journey of recovery and building emotional resilience
- Acknowledging trauma and helping to understand intense emotions
- Develop the skills to manage distressing emotions and better regulate feelings
- Focus on the internal and external assets required to initiate and sustain long-term recovery
- Strengths-based work to build a sense of self and increase self-efficacy

BELONGING

- Supporting people to continue developing internal and external resources in their own lives & communities
- Support and facilitation for each individual to find their own place within a community which supports their recovery journey
- Our exit point is when people have developed social networks within their own chosen communities and find purpose and meaning to their lives whatever this may be

What does it mean for me?

All Changing Lives' services fit within the Theory of Change. There may be some services which are commissioned specifically to provide just one stage. However, this support is provided with an understanding and mindfulness of the wider context and end-to-end journey for each individual we support.

Being, Becoming, Belonging can be used in any way that is useful to services and the people we are working with, including to reflect on the service offer and how it meets the three stages, alone or in partnership, and as a way of simply communicating what the service offers.

CHANGING LIVES

Appendix Two

CHANGING LIVES

Complex DA Service Clients

Details

Client Name:_____Date of birth: _____

Address:_____

Telephone: HOME:_____MOBILE:_____

Referrers name, organisation and contact details: _____

Person carrying out assessment:_____Date: _____

Select **ONE** statement that best applies to the person being assessed. Base all scores on the past **one month**.

(Notes: when completing this section consider whether the client is capable of attending appointments and activities on their own, without support from one particular individual) **Question 1. Engagement with frontline services**

0 = Rarely misses appointments or routine activities; always complies with reasonable requests; actively engaged in tenancy/treatment
1 = Usually keeps appointments and routine activities; usually complies with reasonable requests; involved in tenancy/treatment
2 = Follows through some of the time with daily routines or other activities; usually complies with reasonable requests; is minimally involved in tenancy/treatment
3 = Non-compliant with routine activities or reasonable requests; does not follow daily routine, though may keep some appointments.
4 = Does not engage at all or keep appointments

Question 2. Intentional self-harm
(Notes: this could include drug and/or alcohol misuse)

0 = No concerns about risk of deliberate self-harm or suicide attempt
1 = Minor concerns about risk of deliberate self-harm or suicide attempt
2 = Definite indicators of risk of deliberate self-harm or suicide attempt
3 = High risk to physical safety as a result of deliberate self-harm or suicide attempt
4 = Immediate/extreme risk to physical safety as a result of deliberate self-harm or suicide attempt

Question 3. Unintentional self-harm

0 = No concerns about unintentional risk to physical safety
1 = Minor concerns about unintentional risk to physical safety
2 = Definite indicators of unintentional risk to physical safety
3 = High risk to physical safety as a result of self-neglect, unsafe behaviour or inability to maintain a safe environment
4 = Immediate/extreme risk to physical safety as a result of self-neglect, unsafe behaviour
or inability to maintain a safe environment

Question 4. Risk to others
(Notes: this could include danger to members of the public whilst under the influence of drugs/alcohol including falling on people)

0 = No concerns about risk to physical safety or property of others
2 = Minor antisocial behaviour
4 = Risk to property and/or minor risk to physical safety of others
6 = High risk to physical safety of others as a result of dangerous behaviour or offending/criminal behaviour
8 = Immediate risk to physical safety of others as a result of dangerous behaviour or offending/criminal behaviour

Question 5. Risk from others / Relationships
(Notes: This does not need to be abuse or exploitation which is convicted in a court of law but can be known to an agency)

0 = No concerns about risk of abuse or exploitation from other individuals or society
2 = Minor concerns about risk of abuse or exploitation from other individuals or society
4 = Definite risk of abuse or exploitation from other individuals or society
6 = Probable occurrence of abuse or exploitation from other individuals or society
8 = Evidence of abuse or exploitation from other individuals or society

Question 6. Stress and anxiety

0 = Normal response to stressors
1 = Somewhat reactive to stress, has some coping skills, responsive to limited intervention
2 = Moderately reactive to stress; needs support in order to cope
3 = Obvious reactiveness; very limited problem solving in response to stress; becomes hostile and aggressive to others
4 = Severe reactiveness to stressors, self-destructive, antisocial, or have other outward manifestations

Question 7. Social Effectiveness / Life Skills
(Notes: the client can have a conversation with someone, but this needs to be answered in relation to the bigger picture around their engagement with services e.g. once under the influence of alcohol they can no longer engage)

0 = Social skills are within the normal range
1 = Is generally able to carry out social interactions with minor deficits, can generally engage in give-and-take conversation with only minor disruption

2 = Marginal social skills, sometimes creates interpersonal friction; sometimes inappropriate
3 = Uses only minimal social skills, cannot engage in give-and-take of instrumental or social conversations; limited response to social cues; inappropriate
4 = Lacking in almost any social skills; inappropriate response to social cues; aggressive

Question 8. Alcohol / Drug Abuse[9]

0 = Abstinence; no use of alcohol or drugs during rating period
1 = Actively engaging with treatment services
2 = Occasional use of alcohol or abuse of drugs without impairment
3 = Some use of alcohol or abuse of drugs with some effect on functioning; sometimes inappropriate to others
4 = Recurrent use of alcohol or abuse of drugs which causes significant effect on functioning; aggressive behaviour to others
5 = Drug/alcohol dependence; daily abuse of alcohol or drugs which causes severe impairment of functioning; inability to function in community secondary to alcohol/drug abuse; aggressive behaviour to others; criminal activity to support alcohol or drug use

Question 9. Impulse control

0 = No noteworthy incidents
1 = Maybe one or two lapses of impulse control; minor temper outbursts/aggressive actions, such as attention-seeking behaviour which is not threatening or dangerous
2 = Some temper outbursts/aggressive behaviour; moderate severity; at least one episode of behaviour that is dangerous or threatening
3 = Impulsive acts which are fairly often and/or of moderate severity
4 = Frequent and/or severe outbursts/aggressive behaviour, e.g., behaviours which could lead to criminal charges / Anti-Social Behaviour Orders / risk to or from others / property

Question 10. Housing

0 = Settled accommodation; very low housing support needs
1 = Settled accommodation; low to medium housing support needs
2 = Living in short-term / temporary accommodation; medium to high housing support needs
3 = Immediate risk of loss of accommodation; living in short-term / temporary accommodation; high housing support needs / unsafe return address / unsafe discharge
4 = Rough sleeping / "sofa surfing" / homeless in hospital

Scoring

Please insert the assessed score against each criterion point and add up the total score. Priority will be given to clients scoring

[9] Drugs include illegal street drugs as well as legal highs and over the counter and prescribed medications.

Criterion	Score
1. Engagement with frontline services	_____
2. Intentional self-harm	_____
3. Unintentional self-harm	_____
4. Risk to others	_____
5. Risk from others	_____
6. Stress and anxiety	_____
7. Social Effectiveness	_____
8. Alcohol / Drug Abuse	_____
9. Impulse control	_____
10. Housing	_____
TOTAL SCORE	**_____ / 48**

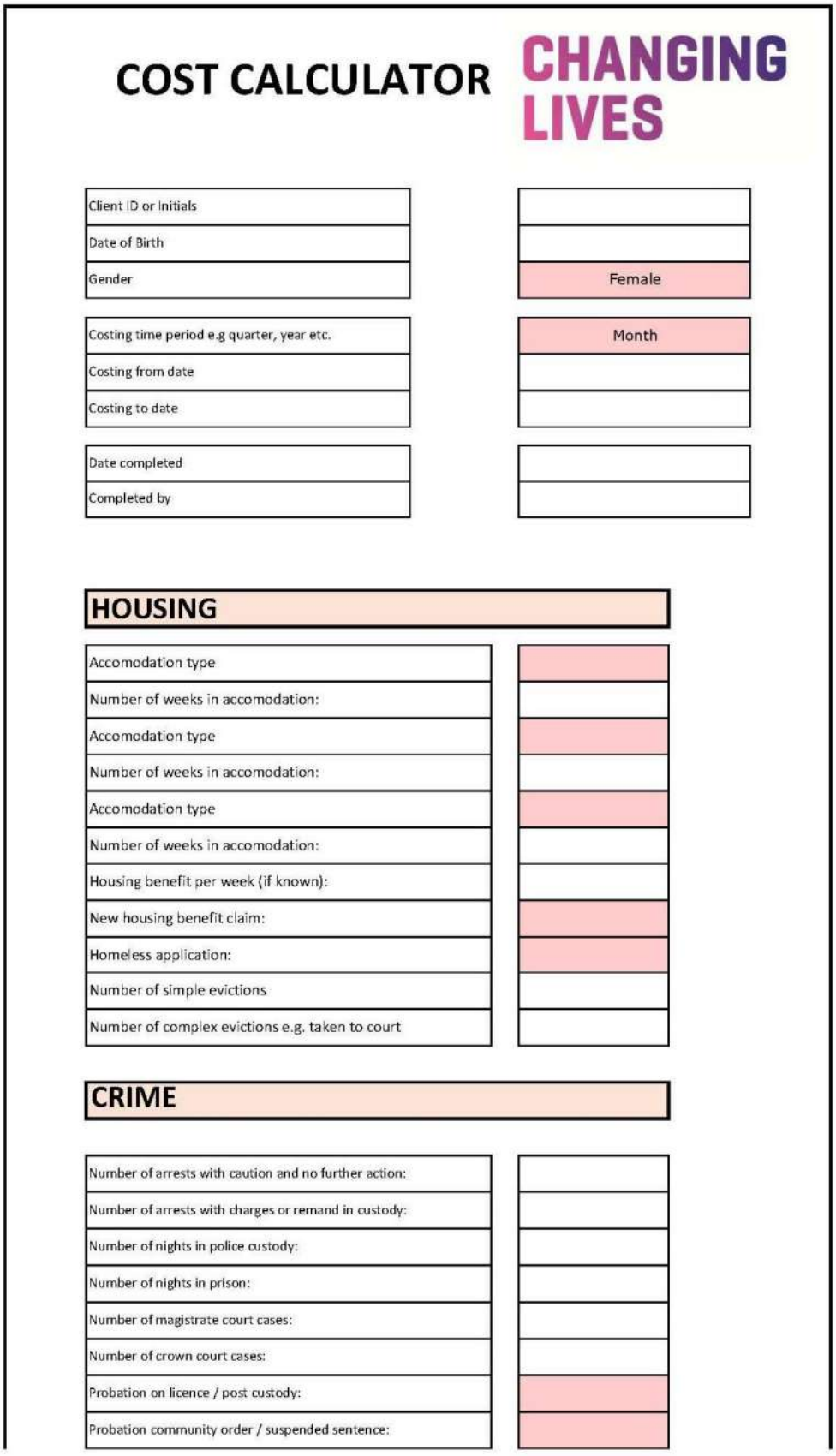
High score - 36 +
Medium score - between 20 – 35
Low score - below 20

Outcome

Referral accepted: YES / NO

If not accepted what advice guidance has been given to referrer?

Appendix Three – cost benefit analysis



COST CALCULATOR

CHANGING LIVES

Client ID or Initials	
Date of Birth	
Gender	Female
Costing time period e.g quarter, year etc.	Month
Costing from date	
Costing to date	
Date completed	
Completed by	

HOUSING

Accomodation type	
Number of weeks in accomodation:	
Accomodation type	
Number of weeks in accomodation:	
Accomodation type	
Number of weeks in accomodation:	
Housing benefit per week (if known):	
New housing benefit claim:	
Homeless application:	
Number of simple evictions	
Number of complex evictions e.g. taken to court	

CRIME

Number of arrests with caution and no further action:	
Number of arrests with charges or remand in custody:	
Number of nights in police custody:	
Number of nights in prison:	
Number of magistrate court cases:	
Number of crown court cases:	
Probation on licence / post custody:	
Probation community order / suspended sentence:	

FIRE

Number of fire service call outs:	

HEALTH

Number of 999 calls - call only no ambulance:	
Number of ambulance call outs:	
Number of attendances at A&E with no investigation and no treatment:	
Number of attendances at A&E with investigation and treatment:	
Number of hospital inpatient stays (not separate nights):	
Number of hospital outpatient visits:	
Number of GP visits to see Doctor:	
Number of GP visits to see Nurse:	
Number of new prescriptions from GP:	

MENTAL HEALTH

Number of nights as a mental health inpatient:	
Number of nights as a mental health inpatient secure unit:	
Number of mental health outpatient attendances:	
Number of weeks in a LA mental health care home:	
Number of weeks in a voluntary sector mental health care home:	
Number of contacts with CMHT	
Number of contacts with crisis resolution team	
Number of contacts with assertive outreach team	
Number of contacts with early intervention team	
Number of counselling appointments	
Number of CBT appointments:	
Number of IAPT appointments:	
Number of contacts with criminal justice mental health liaison services:	
Number of contacts with A&E mental health liaision:	

SUBSTANCE MISUSE

Number of weeks spent in residential rehab:	
Number of days spent in inpatient detox:	
Number of contacts with specialist prescribing services:	
Number of attendances with outpatient alcohol services:	
Number of contacts with alcohol services community outreach:	
Number of attendances with outpatient drug services:	
Number of contacts with drug services community outreach:	
Number of attendances at pharmacist:	

SOCIAL SERVICES

Number of contacts with social worker:	
Number of weeks child spent in care (multiply by number of children e.g. 4 weeks for 2 children would be 8 weeks):	
Number of weeks child with emotional or behavioural needs spent in care (as above with multiple children):	

DWP

New JSA claim	
Benefit amount (excluding housing benefit) per week:	

TOTAL COST: £0.00