Too complex for "complex needs"?

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

Final report – August 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.

Contents

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

Georgia was 39 years old and six months pregnant on referral. She has **three children, none of whom are in her care**. She is currently serving a **one-year suspended sentence** for harassment. Georgia had been **repeatedly referred to MARAC** with multiple perpetrators but had been unable to engage and was excluded from domestic abuse services. She has **mental health diagnoses** of schizophrenia, depression and anxiety, and has made **multiple suicide attempts**. She has a history of **alcohol and drug/prescription medication dependence** and anti-social behaviour; specifically, she has been known to be aggressive/verbally abusive to professionals. It is for this reason that she is not allowed to access refuge accommodation. *She threw a pot of paint at a police officer nine years ago and has 'never lived it down'.* She moved around 10 times in a three-year period when living in North Tyneside. Some moves were initiated by services for her safety, but the majority were due to demands by the perpetrator. Georgia has suffered severe psychological and physical abuse (including strangulation) during two different long-term relationships. This led to alcohol dependency and mental ill-health.

She was given a **one-year suspended sentence** and issued a life-long restraining order, relating to harassment of her perpetrators' partner. An emergency non-molestation order was issued against her most recent perpetrator, but Georgia did not attend the final hearing due to intimidation, so the order was dropped. She has missed multiple appointments with her probation officer. The perpetrator will stand trial next year for 21 breaches of this order while it was still in place. Georgia had made **four rape allegations** against the perpetrator and disclosed a further rape to the CL worker. She has felt consistently disbelieved by services.

Georgia was supported to move to Newcastle by the DVA complex needs worker in North Tyneside and the Newcastle Changing Lives (CL) worker. The CL worker has been doing consistent work with Georgia to build trust, encourage disclosure, manage aggressive behaviours and develop strategies around impulse control. Her behaviour towards frontline services, including the CL worker can be erratic, aggressive and highly impulsive. The CL worker is taking a co-ordinated approach with the probation officer to help Georgia to attend appointments, so she can complete her order. Georgia walked out of several appointments with the CL worker early on, but this has improved.

The perpetrator was arrested for further harassment of Georgia but was bailed the day before the court hearing – Georgia wasn't informed. He was found not guilty; Georgia feels let down by the criminal justice system. Georgia's baby was born in chaotic circumstances. Initially she was allowed to go home with the baby to her brother's in North Tyneside (near to where one of her perpetrators lived). This situation broke down almost immediately; the baby was removed and eventually put up for adoption.

However, Georgia's CL worker reports big changes in her over the last nine months. She is much less threatening to professionals and more appropriate in how she gets in contact and asks for help. She hasn't gone missing or made any suicide attempts for six months. She has also been able to take actions herself e.g. to sort out a problem with her Universal Credit claim. She attended all her appointments around the adoption of her baby and only 'kicked off' once – in a situation when, as the worker commented, any reasonable person would have felt severely frustrated and upset. Her ability to identify, name and express her emotions has increased significantly. The CL worker re-referred Georgia to MARAC and the IDVA team leader expressed shock at the extreme level of risk she continued to be at, whilst other professionals still 'wanted nothing to do with her'.

On referral Georgia scored 38 out of 49 on the NDTA[2], eleven months later she scores 12.

[2] [2] See page 14 for further information about the New Directions Toolkit Assessment (also known as the Chaos Index).

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 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 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. 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.

Linsey is aged 36. She was **put into care** at age 11. *Her foster parents were going to adopt her but changed their mind at the last minute - Linsey did not know why. Her brother also died when she was young.* She has no family or support networks She was referred to the Changing Lives service by the IDVA team who had made repeated attempts to offer her support. She was at high risk of being seriously harmed or killed by her current partner. He had previously subjected her to a very violent assault, for which he served a three-month prison sentence. On his release they resumed their relationship.

Linsey struggles with **drug and alcohol misuse**, injecting cocaine into her arms and drinking whatever she can afford daily. When she runs out of money she does **survival sex work** (has sex or other sexual acts for money, drugs and alcohol). Her partner has also pimped her out to obtain drugs and alcohol for him. Linsey has no family and feels that her partner is the only person she has. She uses the substance use service but does not attend consistently.

Linsey has two children who have been **removed from her care**. She had her youngest son in her care for a while, she was doing well and moved from a hostel into a flat of her own. *She began to struggle and asked for support but didn't receive any – other professionals have since reflected that this was a missed opportunity.* She met a new partner, started using drugs again and her son was removed from her care. Linsey talks about her son and has a Peter Rabbit book with photos in, other photos are kept at a hostel; she has moved so often she has lost a lot of her things.

Linsey suffers from **depression and anxiety** and **self-harms** as a coping mechanism; she is open about this stating sometimes she can't cope. There are concerns she may **take her own life**. Linsey has lived in various hostels, however, an incident when she was violent toward another resident continues to prevent her securing safe accommodation. She is currently **sofa surfing**; she struggles to live by herself. The police safeguarding team want her to move out of the area for her own safety, but she doesn't want to go. Some professionals think she puts herself at risk.

A letter from the safeguarding police team, expressing the view that Linsey should move from the area, caused significant difficulties. When she presented as homeless in Newcastle she was turned away because of it – so she slept in a car with the perpetrator instead. The CL worker advocated on her behalf. Eventually the police changed their advice and Linsey is now housed in a women's hostel in an area she knows and feels safe in. The CL worker thought professionals often just wanted to tell Linsey what to do and weren't listening to her about what she needed. The CL worker felt it was important to help Linsey get her voice heard.

Linsey also had positive experiences with professionals. Following a very serious assault, a neighbourhood police officer went out of his way to take a full statement and support the prosecution – her partner finally received a two-year custodial sentence after years of abuse.

The CL worker continues to use assertive outreach techniques to engage with Linsey, attending the hostel on numerous occasions and maintaining a consistent offer of support. They have built a relationship and the CL worker says she has had a brief glimpse into what it's like for Linsey, trying to deal with different, competing requirements and appointments from different agencies – she found it incredibly frustrating. Linsey says: "this is what I mean, this is what happens".

The CL worker, at Linsey's request, prioritised helping her get her teeth sorted out, which has increased her confidence. She is now working with Linsey to help her attend more of her substance use appointments as her drug use continues to be a significant issue. Linsey appreciates the worker's understanding of the impact of her substance use on her attendance.

On first referral Linsey scored 38 (out of 49) on the NDTA, six months later she scores 27.

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 don't 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.

Joanne is 31 years old and was referred to the CL service by an independent sexual violence advisor. She was experiencing on-going **domestic and sexual abuse** (from a current partner) which was getting progressively worse. She is a survivor of **childhood sexual abuse** and has experienced domestic abuse in several of her previous relationships. Joanne has significant **struggles with alcohol** daily. She left this partner (father to her younger three children) and is now in another high-risk DV relationship and continues to be (re)referred to MARAC.

Joanne has five children. Her two eldest children live with a family member, one is currently in long-term foster care and the youngest two have been **removed from her care** and are being put up for adoption. She has a strained relationship with her family. She also has significant **health problems** i.e. a bleed to the brain, causing regular seizures, exacerbated by chronic alcohol misuse. She has had numerous falls resulting in a broken arm which, because of further falls, has been slow to heal. Professionals find it difficult to be confident in judgements as to when Joanne's injuries are because of seizures and when as a result of domestic abuse.

The CL worker initially had difficulty contacting Joanne as she didn't have a phone. However, she persisted, using assertive outreach techniques, and is now in regular contact with her. Keeping hold of a phone has been an issue for Joanne in the past. The police have given her phones in the past she has lost or broken. A minor recent milestone has been that she has managed to keep hold of the phone that the CL worker uses to contact her.

Joanne is currently only in touch with the CL worker and has on/off contact with a substance use service – no other agencies are involved. The CL team are concerned about Joanne's wellbeing because of the ongoing domestic abuse and the impact the assaults, and her alcohol misuse, are having on her health. They are concerned about her capacity, whilst heavily intoxicated, and her ability to understand risk from the perpetrator and take measures to safeguard herself. She is not fully aware of what is happening to her when she is at the perpetrators address. Police have also reported concerns about her presentation when they attended the address.

CL staff have reached out to the drug and alcohol service, concerned that Joanne's eyes are looking very yellow, perhaps due to the level of alcohol misuse however Joanne struggles to engage with this service.

Joanne is struggling to deal with the recent loss of her children, particularly the adoption of her two youngest with whom she will have no further contact. She may also lose her family home due to her not having the children and increasing rent arrears due to the bedroom tax.

The team has made three referrals to adult safeguarding on her behalf and have provided information to support referrals to MARAC. The CL worker has discussed safety planning with Joanne and has requested safety measures to be installed in her home. The police have also made a safeguarding referral and a stage three safeguarding meeting is about to be held.

The CL worker has developed a good relationship with Joanne and has supported her to attend family court; she has also referred her to a project which specialises in supporting parents whose children are in the care of the local authority. The worker has focused on Joanne's health issues, supporting her to attend GP and hospital appointments. She has also referred her to Rape Crisis for specialist therapeutic support.

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

Marcia is 43 years old and grew up in Yorkshire. She moved to South Shields seven years ago to get away from her father who **sexually abused her as a child**. The only person she knew in Shields was her partner who she met on-line. He is 20 years older than she is and the relationship started out as controlling, then became physically abusive. The perpetrator has broken several of Marcia's bones and she has been **referred repeatedly to MARAC**. She lives in her own tenancy (a council property) but the perpetrator lives just around the corner, so she is not safe.

Marcia started to hear voices when she was 13years old. She has been diagnosed with **schizophrenia** and has a mild **learning disability**. She was sectioned when she was 16 years old and detained for four years. She was discharged into her own flat at 19 years, with no living skills, little support and a discharge grant of £200 – she started to drink and developed a significant **alcohol problem**. She was then in and out of mental health treatment services for a number of years. She understands that the medication for her schizophrenia doesn't work when she drinks and so doesn't take it when she is drinking. Services view her as non-compliant; she uses alcohol as a coping mechanism. She has done detox and been in rehabilitation several times in the past. Having a dual diagnosis of both mental health and substance use problems has made it hard for her to access the right help in the past. She finds it hard to make friends and is lonely.

When she moved to Shields she bounced around various private bed and breakfast establishments and now has her own tenancy. She was referred to Changing Lives by a floating support worker. Despite the perpetrator putting pressure on her not to go into treatment, she is currently abstinent and in rehab. The CL worker is doing work with Marcia around domestic abuse whilst she is in rehab, rather than waiting until she leaves. The CL worker has negotiated dual housing benefit during her stay in rehab, so she will not lose her tenancy. She is going to AA meetings and has joined a gym. She enjoys cross-stitch and creative writing.

Marcia has reported her father to the police and CPS are proceeding with a prosecution. This will put additional strain on Marcia as she will be a key witness – the CL worker is trying to negotiate that her stay rehab is extended so that she remains there during the court case. One positive development is that her mother will also be a witness and they are re-building their relationship.

Six months on Marcia is doing well. She has completed rehab and is back in her local authority property – the perpetrator still lives nearby but she only went back to him once and since then has stayed away. She volunteers three days a week and is studying for level three qualifications in maths and English. It has been a bumpy road, but staff have seen significant changes. When she was first referred Marcia wouldn't engage with services. More recently, however, even when she has relapsed she has still engaged with support.

However, there are still major challenges ahead for Marcia – the CPS have decided she is a reliable witness and she will be called to give evidence against her father. Her mother has recently been diagnosed with terminal cancer. CL staff consider Marcia continues to be at risk of relapse and will continue to offer her support.

Staff engaged with colleagues working in the rehabilitation service to convince them to allow Marcia to undertake work around domestic abuse whilst she was still in rehab. This worked so well for her that the rehabilitation service has changed its policy on this more widely and has since referred another woman to the domestic abuse service.

On referral Marcia scored 40 (out of 49) on the NDTA, she now scores 10.

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 didn't 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 didn't 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 didn't 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

[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

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.

Gemma is 32 years old and living in a private hostel in Sunderland. In the past she has had numerous failed tenancies in her name – largely due to the behaviour of her long-term partner. She has a history of **problematic alcohol and benzodiazepine use** – she self-medicates to cope with her problems. She suffers from **anxiety, depression and PTSD** and has been admitted to hospital on numerous occasions following **overdoses**.

Gemma suffered domestic violence, coercion and controlling behaviour from her partner, who is also the father of her two children and she has been **repeatedly referred to MARAC**. She left her partner, taking her children into a refuge. Children's services put a child protection plan in place whilst she was in the refuge. However, Gemma didn't adhere to the plan as the perpetrator pressured her into visiting him with the children several times. Children's services decided she was unable to keep the children safe and they were placed in foster care (the **children have now been adopted**). Gemma's alcohol consumption and use of benzodiazepines increased significantly and her behaviour when under the influence was problematic, so she was asked to leave the refuge.

When Gemma presented at the local housing options team she was street homeless and was placed in a private hostel. The private hostel is a large (30 beds) mixed-gender facility with no staffing other than very basic concierge and maintenance. The majority of other residents are male, including a significant number with a history of perpetrating violence and abuse. Gemma continues to be under the influence of her former partner whose level of control over Gemma is so significant that she has smuggled illegal drugs into HMP Durham where he is currently imprisoned for assaulting her. He is due to get out of prison in Feb 2018 and is still considered to be a threat to her.

Gemma **shoplifts to fund her drug and alcohol use**. She is currently on a Drug Rehabilitation Requirement order but her engagement with Probation has been sporadic. Gemma self-referred to the Changing Lives service via the in-reach weekly drop-in which CL provides at the hostel. Gemma attends the drop-in every week and has started counselling with a CL counsellor. The CL worker has undertaken forensic work on her tenancy history and established she is eligible to receive the higher rate of local housing allowance, giving her a better chance of obtaining and keeping her own tenancy. The CL worker is currently working with Gemma on her independent living skills, accompanying her to attend GP appointments, supporting a referral to IAPT and supporting her to engage more consistently with Probation.

Six months later and a lot has happened. Gemma went to prison for ten weeks for a historic shop-lifting offence. CL staff continued to support her and visited her in prison. Gemma liked the structure of prison and felt safe. She became something of a mother figure and referred other women to the CL service. She came out feeling very motivated but on release was accommodated in shared housing with a dealer and now she is on heroin and back living with her perpetrator in unsupported accommodation. For a while Gemma wasn't in touch with any services and it was too dangerous (for Gemma) for CL staff to try to contact her when she was with the perpetrator. He isn't in touch with any services but attends any appointments Gemma has. She is now back in touch with the recovery service and CL staff are liaising with staff there and plan to discreetly reach out to her when she has an appointment.

On first accessing CL support, Gemma scored 41 (out of 49) on the NDTA, she now scores 40.

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.

Rachel is 26 years old and lives in Sunderland. *As staff got to know her they learnt she had been **in care between the ages of 13-16**. Her mother had been unable to cope; her grandmother looked after her for a while but then died. She had 11 different foster placements and expresses a deep sense of abandonment.* Rachel has four children who are in the care of the local authority. Her long-term partner (and father of all her children), with whom she is still in a relationship, has subjected her to abuse, coercion and control in the past. This abuse is on-going. There has been no police involvement and her case has not been heard at MARAC. She is currently only in contact with Changing Lives. She has been convicted several times for **shop-lifting** but has not been in prison.

Rachel is known to local services but does not access support e.g. she doesn't attend drug appointments made for her with the local substance misuse service. She has been **using substances** for six years, her partner also uses substances and legal highs. She was pregnant recently and used crack cocaine during her pregnancy. When she gave birth, the baby was immediately removed by children's services and Rachel discharged herself from hospital, despite medical staff's concerns about her health. She is in **poor physical health** and has been at high risk of infection due to discharging herself from hospital. CL staff believe she may have undiagnosed **post-natal depression**.

Rachel was identified by the homeless outreach team, she was sleeping in a city centre doorway with her partner. She had been sofa surfing before this. Rachel is known to hostels in the city - she had previously lived in some of them but was asked to leave due to her partners violent outbursts. She is currently living in a private rented property with her partner that Changing Lives helped them to secure.

The CL worker is supporting Rachel to secure her own tenancy with a private landlord, including making an application for housing benefit. She has accompanied Rachel to GP appointments to start addressing her physical health issues. She has also supported her to make contact with children's services regarding contact with her new born baby.

Six months on Rachel is coming to terms with the adoption of her baby. She is attending regular doctors' appointments and starting to address issues regarding her (under)weight. Her tenancy is going well, and her landlord is very supportive. There have been no further incidents of domestic abuse. Her partner has engaged with the homeless outreach service and disclosed significant childhood trauma. He has registered with a doctor and is on the waiting list for counselling to deal with depression.

On referral to Changing Lives Rachel scored 45 (out of 49) on the NDTA, now down to 19.

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 is 33 years old. She was referred to the South Tyneside service by a CL outreach team who already knew her. At the point she was referred she was **sleeping rough** in a garage with two males not previously known to her – they were being violent and abusive to her. 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 wasn't 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 was already known to both homeless and substance use services. She has 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 is 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. She also went with her 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 12-year history of serious domestic abuse, including violence, coercion and emotional abuse with 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 couldn't look after them. She didn't 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** at 13 years old. She revealed that she had spent seven 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 pro-longer 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 weekly contact with her two children, who stay overnight with her once a week in her home. She hopes that in the future she can have shared custody of them.

On referral to Changing Lives Kara scored 47 (out of 49) 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:

1. Engagement with frontline services
2. Intentional self-harm
3. Unintentional self-harm
4. Risk to others (including offending behaviour)
5. Risk from others (including domestic and sexual violence and abuse)
6. Stress and anxiety (ability to cope with, and reaction to, stressors)
7. Social effectiveness and life skills
8. Alcohol and/or drug abuse
9. 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. Whilst one women 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 so 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 so no change or a slight increase in their scores

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

Judith is 47 years old and has lived in various hostels around the city centre over the last eight years. She is currently living in a mixed-gender, private hostel with little on-site support. The Changing Lives homeless in-reach team work into 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 isn't 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 set on fire 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 (relatively young) age. 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, new 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 crafts 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 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 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 is 33 years old and is currently **street homeless** or sofa surfing in Sunderland. She is originally from County Durham and moved into the area three years ago, placed in Sunderland by Housing Solutions County Durham. She doesn't have a local connection to the city. She has been **using crack cocaine and amphetamine** for over ten years and has previously used heroin. She is receiving 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 three years ago, and 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 at 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 drugs 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 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.

Vicki referred herself to the Changing Lives service via the private hostel drop-in. 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 unsupervised contact with her children. She currently has regular contact with her daughter and is building a relationship with her son. 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 her 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 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 in 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 haven't 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.

Kirsty is 32 years old. She was previously known to Changing Lives homeless team as she had been **sleeping rough** in a car. They had helped her secure temporary accommodation in a local hostel and continued to offer her support. Kirsty has **mental health problems** and has been **alcohol-dependent** for over ten years. She has dabbled in **drugs** including cocaine, amphetamines and cannabis and has also misused prescription drugs at different points in her life, including when she was sleeping rough. At this point, Kirsty was not getting any support for either her addictions or her mental health.

Kirsty moved to the midlands with her female partner. This relationship was **abusive** with Kirsty's partner controlling her financially and emotionally, as well as using physical abuse. When the relationship began to breakdown Kirsty fled back to Sunderland where she was rough-sleeping again.

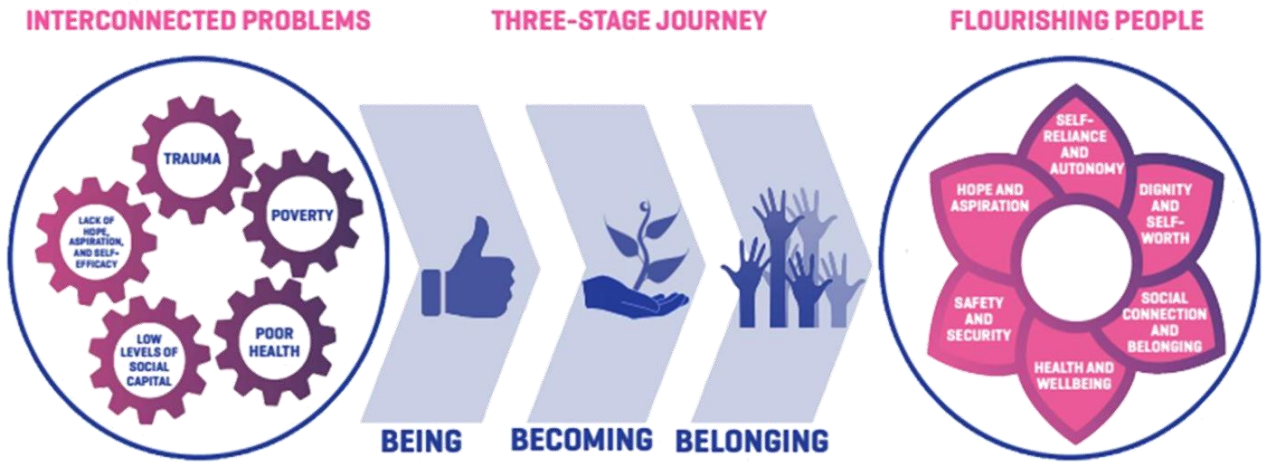
CL staff helped Kirsty secure supported accommodation. However, while she was in supported accommodation she was involved in an incident that led to her being remanded in custody. When Kirsty was released she was homeless again. CL staff helped her claim job seekers allowance and supported her to secure a tenancy with a housing management agency in an area where she felt safe. They also helped her to move into the tenancy, made applications for additional furniture that wasn't provided and helped with donations of small items to make the flat start to feel like a home.

CL staff supported Kirsty to attend medical appointments about her mental health, she is now taking her medication and her mental health has improved. She is no longer using any substances. Kirsty continues to come to CL drop-in sessions. She gets one-to-one support and help with budgeting. She enjoys the weekly craft sessions and has been attending courses to improve her basic living skills at the local college.

On referral Kirsty scored 36 (out of 49) on the NDTA, three months later she scores 13.

Appendix One

CHANGING LIVES THEORY OF CHANGE



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 – please insert 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