Roadmap Evaluation
Final Report

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Roadmap Evaluation Team

Connect Centre, University of Central Lancashire, University of East London, Manchester Metropolitan University and Bangor University

Evaluation Team

University of Central Lancashire (UCLan)
Professor Nicky Stanley
Professor Christine Barter
Dr Kelly Bracewell
Dr Helen Richardson Foster
Katie Martin
Professor Lorraine Radford
Dr Rachel Robbins

Additional Research Support:
Dr Vicky Baker
Dr Nicola Farrelly
Paul Hargreaves

Bangor University
Professor Rhiannon Tudor Edwards
Eira Winrow

University of East London
Dr Emma Howarth

Manchester Metropolitan University
Professor Khatidja Chantler

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Joint Foreword

Farah Nazeer, Chief Executive, Women's Aid, and Suzanne Jacob, Chief Executive, SafeLives

Five years have passed since we started the Roadmap project. During this time there have been significant developments, opportunities and challenges. The ongoing global pandemic has had a huge impact on how organisations are able to respond to survivors and on our ability to run our organisations. During this testing time the racist murder of George Floyd took place resulting in the impact of the Black Lives Matter movement which sparked an important moment of reflection in our sector, with charities striving towards change and centring anti-racism in their approach. This continues to be both important and difficult work, which challenges the power dynamics that exist across all our working environments. The report has highlighted that our sector has a long way to go, but we are committed to making important changes. The VAWG sector anti-racism charter is vital in bringing charities together with a consistent approach to anti-racist practice.

We are very proud of our teams, and the staff working for frontline local organisations, for their resilience and determination during the pandemic. They have worked relentlessly to deliver change for survivors of domestic abuse. The ambassadors, professionals and local area representatives for our projects have also demonstrated huge commitment to end abuse against women and girls during this time, and much has been achieved despite the many challenges of the past couple of years. In May 2021, we were both delighted to finally be able welcome the Domestic Abuse Act, which was a critical step forward in the response to survivors. Of course, it still does not go nearly far enough to deliver protection for all women, particularly migrant women. Reforms are also still urgently required to ensure the Act is accompanied by a sustainable funding future for all specialist domestic abuse services. Our organisations will continue to campaign on both of these issues.

We started this work and end it with a commitment to transform the lives of women and girls by a systemic change to policy, practice and commissioning that promotes early intervention and reduces the prevalence, impact and tolerance of domestic violence and abuse. Women's Aid's approach - Change that Lasts- comes from a needs-based perspective, placing the survivor at the heart and building responses around her needs and the strengths and resources available to her, acknowledging that if services listen to what women say they need and build on their strengths, outcomes are often better and sustained. SafeLives' approach – the Whole Picture - works from a risk-led perspective, tailoring responses to all family members who are at risk, or who pose a risk. A Whole Picture approach provides focused support to the whole family - from identification of concerns through to step down and recovery, to respond more effectively to families living with different kinds of abuse and adversity.

We thank UCLan and colleagues for their hard work in conducting this evaluation, and the findings that they have produced will provide valuable learning for ourselves and the wider sector. The Evaluation found that the Roadmap interventions resulted in a number of positive achievements, at the individual, community and systemic level. We have not met all of our ambitions, and some barriers have been challenging – from budget constraints to our local interventions not being as diverse and inclusive as we had intended. We also had a lack of engagement from some who do not consistently see domestic abuse as their business, with national health and education services proving difficult to engage with. However, we were able to engage with some local health agencies, which was important, and we have learned a great deal from this journey.

Despite the hurdles, we celebrate some significant positive outcomes. In all sites, respondents to surveys and interviews said they better understood the value of having victim/survivors involved not just in 'rating' the response they received, but in strategic design and creation of the response. In one site, the concept of having survivor voice even in the most sensitive commissioning decisions is now understood and welcomed, which is a huge step forward. In our teams, survivors of abuse were at the heart of the work, and it was important for us to work with women and girls of different age ranges and demographics. Both organisations engage with men and boys in a range of different ways, however due to the gendered nature of domestic abuse this evaluation, supported by the National Lottery, focused on the impact on women and girls.

System change is a lifetime's work and even five years is just a blink of an eye on the way, compared to the scale and nature of domestic abuse. Knowing from the start that an 'end date' is looming is always fraught in terms of embedding change, and life always intervenes in the shape of local disruptions such as restructure or inspection of statutory agencies, as well as challenges in commissioning cycles and funding for voluntary services. The programme clearly demonstrates the need for long-term, equitable funding with streamlined reporting requirements, so that services can be delivered in a planned, sustainable, and efficient way.

While our approaches are clearly different, we are united in being committed to system change. Working together on this important programme has brought us together as organisations, and identified clear need in three important areas: for there to be a gendered approach at the heart of service provision; for the services provided to have evidence based quality standards; and for there to be sustainable, secure funding for specialist domestic abuse response. Through this collaboration we have already submitted our first ever joint submission to the Government's spending review and continue to work closely together on this area.

Our huge thanks go to everyone involved. We will take this important learning back to our organisations, and it will inform how we now build and develop our work to provide the best possible outcomes for women and girls living with domestic abuse, who inspire all parts of our work.

Contents

Glossary

CSC	Children's Social Care
CtL	Change That Lasts
DVA	Domestic violence and abuse
DWP	Department of Work and Pensions
EOI	Expression of interest
HAYGO	'How are you getting on' forms
Idva	Independent domestic violence advisor
Isva	Independent sexual violence advisor
LGBTQ+	Lesbian, gay, bi, trans, queer, questioning and ace
MARAC	Multi-agency risk assessment conference
POWeR	Personal Outcomes and Wellbeing Record
REVA	Responding Effectively to Violence and Abuse
SL	SafeLives
SLCDPs	SafeLives Co-Designed Pilots
SROI	Social return on investment
SV	Sexual violence
SWEMWBS	Short Warwick-Edinburgh Mental Well-Being Scale
VAS	Visual Analogue Scale
WA	Women's Aid - used to refer to local Women's Aid organisations affiliated to WAFE
WAFE	Women's Aid Federation of England - national organisation
WSS	Whole system survey

Executive Summary

Introduction

Women's Aid Federation England (WAFE) and SafeLives (SL) collaborated over five years (2016-21) to develop and implement the Roadmap Programme which aimed to transform the lives of women and girls through systemic change to policy, practice and commissioning by promoting early intervention and reducing the prevalence, impact and tolerance of domestic violence and abuse (DVA). Funded by the Big Lottery's Women and Girls Initiative, WAFE and SL collaborated with DVA survivors and expert partners in specialist frontline services to develop and implement two contrasting interventions in five different sites in England. Both organisations were committed to making DVA services more accessible and responsive to survivors' needs and both aimed to achieve wider system change in the sites where the programmes were delivered.

However, the two organisations chose different but complementary routes by which to reach these broad goals:

WAFE's *Change That Lasts* (CtL) Programme[1] aimed at developing a 'whole community response' that would increase responsiveness to DVA services at three levels: i) the community ii) frontline professionals in organisations that were not specialist DVA organisations and iii) services delivered by DVA specialist organisations. The programme comprised three interventions targeted on these three different audiences and delivered in three sites – Sunderland, Nottingham and Nottinghamshire (Nottingham/shire) and Surrey. *Ask Me* aimed to address cultural and attitudinal barriers to change through training and supporting Community Ambassadors who volunteered to increase awareness and responsiveness to DVA in their local communities. *Trusted Professional* combined training with organisational development to improve expertise and responsiveness among frontline professionals. The VOICES intervention was designed to re-connect specialist DVA services to a strengths-based, needs-led, trauma-informed approach centred on the survivor for practitioners in specialist DVA organisations.

The SafeLives Programme, designed by SafeLives, alongside Pioneers (survivors and experts by experience) and specialist frontline DVA partners, comprised an integrated suite of multiple interventions that would allow survivors and their families to access five different interventions within the same organisation. Two independent services, in Norwich and West Sussex (Worthing, Adur, and Crawley), were commissioned to deliver the interventions, hereafter referred to as the SafeLives Co-Designed Pilots (SLCDPs). These interventions were tailored to the needs of different groups so that survivors and their families could move between and through them on their journey to recovery. The intervention aimed to break down silos between services and deliver a 'whole family' service informed by DVA survivors' views. The SLCDPs were targeted at those assessed as at medium risk of harm; people who wanted to remain in their relationships; those with complex needs; survivors recovering from abuse and children and young people. A wide range of individual and group interventions was utilised and training and skills development were provided to partner agencies.

[1] Described in detail at: https://www.womensaid.org.uk/wp-content/uploads/2020/11/Change-That-Lasts-Impact-Briefing-1.pdf

The Evaluation

The independent evaluation undertaken October 2017-June 2021 was led by Professor Nicky Stanley working with Connect Centre researchers at the University of Central Lancashire together with researchers from Bangor University, University of East London and Manchester Metropolitan University. The mixed-methods study was designed to both measure change achieved by the specific interventions delivered by WAFE and SLCDP and to examine whether and how wider system change was achieved in the five Roadmap sites. The study aimed to explore those factors that facilitated or impeded change both for specific interventions and at the wider level of the whole system.

A realist approach (Pawson and Tilley 1997)[2] which examines what works for whom in what setting was adopted and, in line with this approach, iterative feedback was provided to WAFE and SL. Advice on the evaluation was provided by an Expert Advisory Group and a Survivors' Advisory Group with the latter assisting the recruitment of Survivor Researchers who worked alongside research team on aspects of the Evaluation.

A wide range of methods was utilised to capture data on the process and outcomes of the study. These included:

- Site profiles detailing demographic information, DVA rates and services in the five sites
- Two series of consultation groups with key stakeholders in all five sites
- Surveys of local agencies and Roadmap staff
- Interviews with: survivors and children using Roadmap services, Roadmap staff and managers, trainers and co-ordinators, training participants and with staff in a range of specialist DVA organisations in the five sites.
- Pre- and post- training surveys, Expressions of Interest forms, and How Are You Getting On (HAYGO) questionnaires completed by those participating in Ask Me and Trusted Professional training.
- Outcome measures, including both tested and bespoke measures completed by survivors using both VOICES and SLCDP services.
- Routine monitoring data collected by WAFE and SLCDP through their OnTrack and Insights systems was made available for analysis.
- Social Network Analysis which captured organisations' networks and patterns of influence as well as referral pathways.
- Social Return on Investment analysis, a form of economic analysis that examines the difference an intervention makes in terms of financial savings and which takes account of value for the individual, community and wider stakeholders.

Sensitivity to the ethical and data protection issues involved in conducting research with individuals who have experienced DVA (Women's Aid 2020a)[3] was central to the research and the study received ethical approval from the University of Central Lancashire's Ethics Committee.

[2] Pawson, R. and Tilley, N. (1997) *Realistic Evaluation*. London: Sage.
[3] Women's Aid (2020a) *Research Integrity Framework for Domestic Violence and Abuse.* https://www.womensaid.org.uk/evidence-hub/research-and-publications/research-integrity-framework/

WAFE Interventions

Ask Me Key Findings

'…by 8 o'clock that night, she was on her way to freedom. It was amazing, she was really grateful for what I'd done and I felt proud...' (Participant 12, Sunderland)

- 326 Ambassadors completed Ask Me training in the three sites during the evaluation period. Implementation of the training was assisted by earlier piloting of the intervention, strong local networks, local Women's Aid (WA) organisations' engagement and excellent training materials.
- Nearly all Ask Me volunteers[4] were women (286 women and 4 men attended the training) with the majority aged between 25 and 54: the average age of 42 was younger than the national profile of volunteers. DVA survivors made up a substantial proportion of those attending the Ask Me training.
- People with disabilities attended the training: 34 (12%) disclosed one or more disabilities.
- Most Ambassadors described themselves as White British, 30 (11%) reported having a Black and minoritised background and 15 (5%) reported 'other white background' such as Eastern European. While the ethnic diversity of Ask Me trainees was in line with the ethnicity profile of the country as a whole, more diversity among Ask Me participants might have been anticipated in sites with substantial Black and minoritised populations.
- Immediately post-training, pre/post questionnaires revealed positive changes in knowledge of DVA and skills and confidence to respond to DVA disclosures.
- Interviews provided examples of increased knowledge, confidence and Ask Me Ambassadors (as volunteers were known post-training) improved their ability to respond to survivors post-training*: '…not frightened to broach the subject…almost like breaking the silence'* (Participant 6, Surrey)
- HAYGO forms showed that 78% (n=93) Ambassadors reported having between them at least 598 conversations about DVA since the training. Half of these conversations addressed someone's personal experience of DVA.
- 64% (n=72) of Ambassadors reported providing information and signposting those who had disclosed DVA to national or local DVA organisations.
- Community-focused awareness raising activities were reported by Ambassadors post-training, but the most frequently reported activities were facilitating discussion and disclosure of DVA: *'…by 8 o'clock that night, she was on her way to freedom. It was amazing, she was really grateful for what I'd done and I felt proud...'* (Participant 12, Sunderland)
- Ambassadors suggested top-up training and more regular follow-up support that could be both pro-active and reactive: *'if I then found myself in a situation where I was supporting somebody. I think that's when I would go to them and say, what do I do now?'* (Participant 8, Sunderland)
- Ambassadors' experiences of camaraderie, *'sisterhood'* and belonging to a '*tribe of women'* embodied the importance of combatting DVA collectively and as part of a movement.

[4] While there is no contractual arrangement between Ambassadors and WAFE, for the purposes of this evaluation, Ask Me Ambassadors are conceptualised as volunteers as their activities are voluntary and fit the National Council of Voluntary Organisation's definition of volunteers.

Ask Me Recommendations

- Recruitment strategies for Ask Me should ensure that, when professionals attend Ask Me, they participate in their role as a community member rather than as a professional.
- Recruitment and programme design should aim to achieve a diverse range of participants in Ask Me training.
- Online delivery (introduced in response to Covid-19 restrictions) of the Ask Me training requires robust evaluation, including capturing participant experiences and monitoring whether online delivery impacts adversely on specific groups.
- Given the time commitment required to attend the training, maintaining the current flexible approach to delivery of the two-day course would potentially extend the reach of Ask Me.
- The success of the training programme could be developed further by an increased focus on enhancing understanding of DVA and gender and DVA and Black and minoritised communities. This would help to challenge a gender-neutral approach and increase the confidence of Ambassadors in responding to diverse communities.
- Interview participants recommended 'top-up' training on a range of issues; additional support for Ambassadors both during and post-training to identify how they could make a difference within communities is essential to capitalise on the achievements of the training.
- The piloting of the social franchise model of Ask Me to assess its viability is recommended as this model has not been tested to date.

Trusted Professional Key Findings

'…everybody knows a little bit about domestic violence…but I certainly didn't understand the levels of violence and control…it opened my eyes.' (Training Participant 12, Nottingham/shire)

- The Trusted Professional intervention started off as a stand-alone training day and was developed into a more holistic systems-based intervention for practitioners in statutory organisations and other support services. However, delivery of the new intervention was delayed by the time taken for development, resource issues and the pandemic; consequently, limited data on the revised model was available to the Evaluation.
- In total, 404 professionals from children and families services, the Department of Work and Pensions (in Surrey) and housing completed the Trusted Professional training in the three sites. Fewer health professionals participated in the training.
- The use of local member services to co-deliver the intervention meant that local knowledge and networks maximised implementation opportunities.
- The training was well received with positive comments on the content and delivery from participants: *'I genuinely felt it had been one of the best bits of training I've done in a very long time, …the quality of the training…was excellent'*(Training Participant 19, Sunderland)
- Immediately following the training, positive short-term changes were found in knowledge, attitudes and confidence across the three sites and understanding of coercive control increased*:* *'…everybody knows a little bit about domestic violence…but I certainly didn't understand the levels of violence and control…it opened my eyes.'* (Training Participant 12, Nottingham/shire)
- Post-training interviews provided early evidence of how training translated into practice and showed it had the potential to increase practitioners' readiness to ask questions and respond appropriately: *'…the thing that I walked away with more than anything else, was to be professionally curious, to be unafraid to ask questions'* (Training Participant 3, Nottingham/shire).

- Interviews showed how training translated into practice, particularly where it was supported by organisational cultures conducive to the intervention's philosophy. More challenges were encountered where organisations such as children's social care conceptualised risk differently.
- Interviews with participants, trainers and co-ordinators suggested strengthening training content with additional material addressing diverse forms of abuse, perpetrators and children.
- The future sustainability of the intervention is uncertain as it moves from a free intervention to one where participating organisations will be expected to meet the costs of the intervention alongside the time commitment required.

Trusted Professional Recommendations

- The time and resources required for developing the intervention and engaging interested organisations need to be fully recognised in roll-out and implementation of Trusted Professional.
- The sustainability of the intervention requires careful auditing to assess the viability of the proposed new model for delivering Trusted Professional in the future.
- The partnership model between WAFE and member services is important for effective delivery of the intervention and should be nurtured.
- Preliminary findings on impact from evaluation of the enhanced Trusted Professional model are encouraging, further evaluation is required to assess the longer-term benefits more fully.
- Trusted Professional should continue to target a wide range of organisations, particularly in those statutory sector organisations where DVA is regularly encountered and training should be tailored to reflect different professional groups' knowledge and awareness of DVA.
- The intervention needs to develop strategies to adapt/challenge organisational priorities and working practices which may be antithetical to survivor-led and strengths-based approaches.
- Trusted Professional training needs to address the diverse forms of violence and abuse experienced by survivors and include information on work with DVA perpetrators and children.
- On-going training was recommended by several participants to help embed a survivor-centred approach.

VOICES Key Findings

'[my worker] was always available and always there whenever I needed her to be' (Case Study B)

- The VOICES approach and tools were not implemented until Year 4 of the Roadmap Programme. Buy-in from services and training staff in the VOICES approach took longer than anticipated
- WAFE's OnTrack data showed that 2125 survivors across the three sites received VOICES; over 96% (n=2045) were women.
- 26-35 year olds comprised the largest group of VOICES survivors (36%, n=765).
- 4.5% (n=97) of VOICES survivors were from a Black and minoritised backgrounds. WAFE's OnTrack records were missing data on ethnicity for 24% of survivors.
- Once adopted by practitioners, the VOICES approach and tools were seen as transformative by the majority of practitioners: *'Using the VOICES tools has…raised my personal awareness of the physical, psychological and social impact of trauma on a person's everyday coping.'* (Staff Survey participant).
- The move away from a risk-led to a more survivor-centred approach was valued by most practitioners.
- Survivors had negative experiences of services previously encountered but were very positive about their experiences of VOICES services. One survivor reported dissatisfaction with VOICES staff responses to the racism she was experiencing within the service.

- OnTrack data revealed limited engagement with Black and minoritised communities, this was particularly notable in areas with high levels of Black and minoritised communities.
- Under 1% of cases related to forced marriage or honour-based violence (HBV) across the whole data set.
- A consistent relationship between practitioner and survivor was highly valued and survivors saw this as key to developing their self-confidence, independence, and belief in themselves: *'[my worker] was always available and always there whenever I needed her to be'* (Case Study B).
- Analysis of available data on outcomes demonstrated positive improvements on most items, but very few of these were statistically significant, usually because insufficient numbers of completed measures meant that tests for significance could not be undertaken at both baseline and 12 weeks follow-up.
- Most survivors who reported improvements in safety, coping and mental wellbeing attributed improvements to services, indicating a high level of satisfaction with VOICES.
- Survivors' health outcomes were significantly lower than the accepted UK population norms, indicating that service users experienced worse health than that of the general population.
- Practitioners were generally positive about the support they received for emotionally demanding work and reported that there was rarely any conflict between colleagues. However, over half the staff reported that workloads were too high.

VOICES Recommendations

- Earlier buy-in from member services and adequate preparation and training for staff to adopt VOICES would facilitate implementation.
- Staff need to be trained and equipped to challenge racism when they encounter it.
- All DVA services need to be accessible to Black and minoritised communities and work in a respectful and equal partnership[5] with Black and minoritised DVA services to offer choice and increase uptake of services.
- Ensuring that staff are supported to undertake emotionally demanding work will continue to be essential for VOICES.
- Ensuring that workloads are manageable would contribute to sustaining the VOICES approach.

SafeLives Co-Designed Pilot Interventions

'they're all singing off the same sheet. They're all working with you as a team and I think that is amazing.' (Survivor 5, West Sussex)

'it's helped me be a better mum to the children and helped me understand them and what they've been through more' (Mother, Case Study B)

Findings on implementation and delivery of the SafeLives Co-Designed Pilots (SLCDPs) are presented first, providing wider context for the highly positive findings on the impact and experience of services for survivors and their children.

Implementation and Delivery of the SafeLives Co-Designed Pilots – Key Findings

- The central role of the SafeLives Pioneers in the development of the SLCDPs, alongside the contribution of expert partners, was highly valued – *'it was all shaped by the survivors'* (Senior

[5] See Ascent & Imkaan (2017) Good Practice Briefing: Uncivil Partnerships? Reflections on collaborative working in the ending violence against women and girls sector

Manager 2, SL) - however, locating the development work in the sites themselves would have allowed more consideration of the local context and piloting a whole family approach, rather than individual interventions, would have been beneficial to implementation.

- Planning and set-up of this multi-component integrated intervention in a limited timeframe was an ambitious task. Senior staff agreed that the time allowed for planning and initial implementation in the local sites was insufficient. A fuller picture of the local context might have assisted understanding of local needs and informed decisions about staff salary levels.
- The competitive tendering process in Norwich had a negative impact on partnership working and referral pathways due to the decision not to award the contract to a local high-risk DA provider .
- The expertise and training provided by SafeLives was key for staff in the implementation period.
- A higher proportion of referrals for survivors in West Sussex came from DVA/SV agencies, while in Norwich, Children's Social Care (CSC) was the primary referral agency; some Norwich staff felt this changed the nature of their work with families.
- The importance of an integrated approach, based on trauma informed, strength-based practice, multi-agency working, and a flexible user-led approach to support were consistently identified as the core components of successful delivery across the sites by senior managers and staff.
- The majority of adult service users were white British and heterosexual reflecting the demographic landscape in both sites. Female survivors were predominantly aged 26 to 45, the majority had a child involved in their case and half of these children had CSC involvement. Most children were aged 8-11. Nearly all those using the Engage intervention for perpetrators were male and most were aged 20-39.
- Nearly all survivors had experienced DVA in the past 12 months and roughly a third had experienced multiple forms of DVA. Perpetrators were predominantly an ex-partner.
- The most common form of complex needs for survivors using the service were housing problems, mental health issues or a physical disability or illness. These groups, alongside those survivors still living with the perpetrator, were described as more difficult to engage by staff.
- While multi-agency work was described as well-developed with some organisations, multi-agency communication was less well established with some of the organisations such as GPs and mental health services. These are the organisations more likely to refer those with complex needs or multiple barriers.
- The Complex Needs Idva role required particular expertise and skills to undertake outreach work with potential service users and to establish referral pathways. Where it was achieved, continuity of staff facilitated this work, particularly in the context of establishing a new service.
- The complexity of delivering multiple interventions was viewed as challenging and ambitious in the timeframe, especially in relation to the Engage work which was affected by staff shortages common to this type of work. This intervention reached fewer perpetrators than had been planned. Nevertheless, most staff reported that the ambition of creating an integrated, flexible service had been achieved.
- The variety of complimentary interventions and toolkits was considered to have facilitated tailoring and flexibility in meeting individuals' needs.
- Between November 2018 and December 2020, SafeLives Insights monitoring system recorded closed cases for 362 survivors, 187children and 45 perpetrators. Overall, 69% of survivors received a service just for themselves and 31% received some form of targeted family support.
- Among survivors with children, 60% received support just for themselves and 40% received some form of targeted family support which included parenting support and/or support for their child/ren. Overall, around 40% (n=94) of children received a service just for themselves with no accompanying survivor or perpetrator receiving a SLCDP intervention.
- Barriers to delivery encountered in one or both sites included: challenges concerning staff retention for the Engage and Complex Needs posts, lack of clarity around roles and integration

of interventions, especially Engage work; engagement with survivors with complex needs; and training issues.

- Staff considered that confining the service to those at a specified level of risk was confusing for potential referrers; it could lead to *'shutting and opening the service door'* (Senior Manager 3, SLCDP) and undermine consistency of service for survivors.
- Staff turnover proved a major challenge for one site and was attributed to a shortage of relevant skills in the local area and uncompetitive rates of pay for staff: *'because we are so understaffed, sometimes we have to put a hold on referrals... we've only done that twice, but, unfortunately, then that does get the stigma attached.'* (Staff 9, SLCDP)
- In response to Covid-19 restrictions, service providers developed innovative ways of delivering services to survivors, and, to a lesser extent, their children.

Recommendations on the Implementation and Delivery of the SafeLives Co-Designed Pilots

- More planning time and activity at the local level would ensure a better fit in local service landscapes and enhanced integration of different programme components.
- A whole family administrative system would support more effective and efficient monitoring.
- Whole family DVA training for staff should be an essential prerequisite for any programme seeking to integrate different interventions for family members.
- The SLCDP services targeted a very broad group of survivors and needs: rebalancing resources to increase the capacity of family-focused interventions might enable more survivors and families to access a 'whole family' service when needed.
- Although patterns of SLCDP service use reflected local demographics in terms of Black and minoritised populations, interventions still require further development and testing in areas with greater levels of diversity to determine if they require adaption to meet the needs of different groups of survivors and their families.
- Consideration should be given to ensure the geographical catchment area for the service is sufficiently wide to enable clear routes for local referral agencies.
- Recruitment and retention of staff with expertise require salaries to match local rates: this is an issue for those commissioning services.
- A reconsideration of risk-based service criteria might assist in clarifying referral pathways and increase consistency of support for survivors and their families. Risk levels can fluctuate rapidly and are not easily understood by those using or referring to DVA services. Commissioners should consider other approaches to targeting services that are more comprehensible and reflect survivors' lived experience.

Impact of the SafeLives Co-Designed Pilots – Key Findings

- Survivors identified that the opportunity to receive services for their children as well as parenting support were key reasons for using the service, support for older children and work with perpetrators were also mentioned as motivating factors: *'Helping me to… parent during that time because there were so many things that were going on whilst they were having contact with their father…'* (Survivor 17, West Sussex).
- Previous barriers to DVA help-seeking were commonly identified, including limited/inappropriate provision of DVA services, especially support for children, and services' risk thresholds.
- Prior to referral, survivors reported receiving very little information about the SLCDP service.
- A flexible service, responsive to the needs of survivors, which offered an appropriate level of support was highly valued. Survivors were positive about the range of integrated interventions

which targeted both their own and their children's needs: *'they're all singing off the same sheet. They're all working with you as a team and I think that is amazing.'* (Survivor 5, West Sussex).

- All women interviewed valued their relationships with workers, feeling listened to and understood and considered that the work matched the pace that was comfortable for them: '*I just felt that I was listened to and that… what I was saying was being acted on, so it was very much sort of led by me…'* (Survivor 4, West Sussex)
- Authenticity was important to survivors, and this was enhanced when programmes were delivered by those with relevant experience or expertise.
- The use of creative and engaging toolkits and activities, such as Helping Hands and craft sessions, was viewed very positively by survivors and children.
- Groupwork was highly valued and enabled survivors and children to share their DVA experiences in a supportive environment and to recognise they were not alone.
- Some barriers to service engagement were also identified including: not being able to access support when needed, especially for children due to waiting lists; staff turnover and a lack of evening group work sessions which were not consistently available.
- During Covid-19, survivors generally felt supported by workers through regular telephone or online contact, although some missed the opportunities provided by face-to-face groups and engagement with some children was challenging.
- Most survivors reported feeling confident and optimistic about their own and their children's prospects for the future and considered their initial goals had been met. Mothers reported more confident parenting, increased understanding of the impact of DVA for their children and enhanced family communication and relationships – *'it's helped me be a better mum to the children and helped me understand them and what they've been through more' (Mother, Case Study B)* - although some still had concerns about child contact.
- Children included in the family case studies experienced improvements in mood, sleep, physical health and reductions in fear and anger. There were examples of them successfully navigating key transitions in their lives: *'[my worker] really helped me. I feel more secure and I know people will listen to me and what I want more. I think I am more confident.'* (Family Case Study A)
- Practitioners interviewed for the family case studies described seeking children's opinions and representing their voice in decisions about contact and in child protection cases. Advocacy work with Children's Social Care was common across the wider sample.
- Outcome measures completed by survivors showed improved safety 12 weeks from baseline and this was statistically significant for five out of six questions asked. Survivors' safety also increased further at 6 months, although changes were only statistically significant in respect of safety in the home and neighbourhood. Between baseline and service exit, there were moderate or small statistically significant improvements for all six safety questions.
- Measures of coping and confidence showed improvements on most questions at 12 weeks, although this was only statistically significant for four of the 11 dimensions. At six months from baseline, improvements were found on nearly all these dimensions with change reaching statistical significance on six dimensions. At service exit, four of these dimensions showed statistically significant improvements, all with small effect sizes: dealing with daily life, speaking about experiences of abuse, sleeping well and feeling in control of my life.
- Survivors' improvements in mental wellbeing at six months and service exit reached statistical significance: *'My mental health has obviously got a lot better…I'm not waking up every morning feeling like I'm going to be sick, fearful.'* (Survivor 22, West Sussex)
- Health questionnaires showed some positive change at 12 weeks from baseline and at service exit but a slight decline in health status at 6 months, all changes were not statistically significant.

The visual analogue scale (VAS thermometer), which is easier to complete, showed positive health change at 12 weeks and service exit and a small decline at 6 months.

- Survivors' self-reports showed substantial improvements in safety, coping and confidence, wellbeing and, to a lesser extent, health, since using the SLCDP service. A high proportion of survivors reported this change was entirely or mostly due to their use of the SLCDP service, although attribution of change to the service was lower for health improvements.

Recommendations on Impact of SafeLives Co-Designed Pilots

- The positive outcomes achieved for survivors and children indicate that a survivor-centred service, co-designed with survivors and delivered in a flexible and creative way provides a model for future service provision.
- When first engaging with the SLCDP service, survivors require more detailed explanation of the different support services encompassed by the service.
- A wide range of positive outcomes was reported by survivors and children, however increasing the capacity of whole family provision, including work with children, would reduce waiting times for support, and enable all family members to receive support when they need it.
- Online support was appropriate and necessary during Covid-19 and this was preferred by some survivors, while others required/preferred face to face contact, at least at the outset to support relationship building.
- Ongoing support with managing child contact is an area where continued or follow-up work might be beneficial.

Whole System Impact Key Findings

- Consultations with key stakeholders in the five Roadmap sites in 2019 and 2020 found that clarity of referral pathways was lacking. Fragmentation of DVA services and confusion regarding catchments, referral processes and service offers (with different services working with different levels of risk) were identified as barriers to effective DVA service development and delivery.
- DVA training provided to other local professionals by both WAFE and SLCDPs aimed to improve the wider response to DVA and to strengthen referral pathways. The training was judged to have achieved impact by both stakeholders and staff with WAFE senior managers highlighting the engagement of DWP staff in Surrey in Trusted Professional and SLCDP senior managers flagging the training and collaboration achieved with Children's Social Care.
- However, not all relevant organisations were reached by this training. Health organisations proved more difficult to engage and the Social Network Analysis undertaken found that none of the Roadmap organisations interacted with any health organisation on a regular basis.
- While in 2020, more stakeholders considered that DVA services were accessible for children and young people, remaining gaps were identified for survivors with complex or multiple needs, Black and minoritised survivors and LGBT survivors.
- Stakeholders and senior managers identified early evidence of shifts in language and increasing acceptance of the concepts underpinning Roadmap services across the local sites, but progress in respect of moving away from a focus on risk (for WAFE sites) and readiness to engage perpetrators in change (for SLCDP sites) was considered incremental.
- Senior managers highlighted evidence of impact on commissioning structures in Roadmap sites, *'[to] have somebody local with lived experience on their board that's going to oversee all of that work and…five years ago they wouldn't have had [that]'* (Senior Manager) and: *'we've been really*

successful in building the needs-led into the commissioning strategies …that's a really key piece of sustainability work' (Senior Manager).

- Stakeholders considered that Covid-19 restrictions had little impact on multi-agency work and in some instances multi-agency collaboration was judged to have improved as a consequence of remote working. However, the reduction of face-to-face DVA services was considered to have been detrimental for survivors.
- The collaboration between WAFE and SL on developing the Roadmap required substantial effort and resources but provided a positive experience of working together which led to a number of joint initiatives, including a co-ordinated approach to campaigning: *'…in the public policy space, we're much stronger together…There's been some real wins, in terms of speaking together.'* (Senior Manager). However, the benefits of this partnership appeared to have been confined to the national organisations with little evidence of it flowing down to local levels.

Social Return on Investment Analysis – Key Findings

Social Return on Investment (SROI) analysis was used to examine the economic impact of the Roadmap Programme from the perspective of a wide range of stakeholders. The SROI drew on data captured for both the specific WAFE and SLCDP interventions and information on costs supplied by the two organisations. All Roadmap interventions were found to generate substantial SROI values comparable to those reported for other DVA interventions[6,7,8]:

- The analysis for the Trusted Professional intervention considered the impact of the training for professionals and found a range of social return on investment value of between £3.18 and £8.30, with a base-case scenario or mid-range figure of **£5.31:£1**.
- Outcomes for both volunteers and those in the community living with DVA were analysed for the Ask Me intervention which generated a range of social return on investment of value of between £2.64 and £8.96, with a base-case scenario or mid-range figure of **£5.13:£1.**
- For VOICES, change was identified for survivors, staff and partner organisations and the SROI showed a range of social return on investment value of between £4.51 and £7.37 with a base-case scenario or mid-range figure of **£5.50:£1**
- The SafeLives Co-Designed Pilots achieved outcomes for survivors, their children and volunteers who contributed to service development and delivery and a range of social return on investment of value of between £4.18 and £6.75 with a base-case scenario or mid-range figure of **£5.36:£1**
- The benefits of the Roadmap programme were found to extend beyond the direct benefits for survivors and their families. Social value and cost-savings were identified for a wide range of stakeholders including survivors; their children; volunteers; Women's Aid and their staff; SafeLives and SLCDP staff; children's services; other social care services; and state agencies such as the police, criminal justice system and health services.
- The contribution of volunteers (many of whom were themselves survivors) produced considerable benefits for both organisations and for the volunteers themselves – the community, organisations, volunteers and DVA survivors all benefited from the time taken to train volunteers and the time 'donated' by volunteers.

[6] Selsick, A. and Atkinson, E. (2016) *Refuge: A Social Return on Investment Analysis*. London: New Economics Foundation.
[7] Solace (2015) *Social Impact Report of Ascent Advice & Counselling* https://www.solacewomensaid.org/get-informed/professional-resourcessocial-impact-report-ascent-advice-counselling
[8] Women's Resource Centre (2011) *Hidden value: Demonstrating the extraordinary impact of women's voluntary and community organisations.* https://socialvalueuk.org/wp-content/uploads/2016/03/Hidden%20Value_WRC%20SROI%20Report_%202011%20(2).pdf

11. Wider Messages for Innovative Interventions in DVA

Messages re Implementation of Innovative Interventions

- The time required to develop, implement and evaluate new services is likely to be lengthy when organisations seek to involve survivors and relevant stakeholders. There can be long-term benefits in engaging local stakeholders who bring expert knowledge of the local context and conditions to this process.
- Commissioning arrangements may have long-term effects on referral pathways with competitive tendering processes proving particularly damaging. These arrangements require careful thought and consortium or other approaches may offer useful alternative models for commissioning DVA services (see Barter et al 2018)[9].
- Understanding of the local context where new services are to be introduced is essential and this includes gathering and using knowledge of the skills available in the local workforce, and local wage levels to inform recruitment strategies so that staff turnover is reduced.

Increasing Routes to DVA Support

- DVA services need to have clearly defined user groups that can be easily identified both by other services that refer and signpost survivors to DVA services, but also by survivors themselves. DVA services should identify their target groups using descriptors that are easily understood and communicated, such as geographical catchment areas, survivors with children, survivors recovering from DVA, survivors currently living with DVA etc.
- Survivors value a flexible service that recognises that needs change over time, that acknowledges that both groupwork and individual work can be beneficial, that many survivors need help with parenting as well as support in their own right and that works with children and their parents as well as providing advocacy. However, an integrated service with many constituent interventions can be challenging to sustain and requires substantial resource and a clear remit.

Key Features of Responsive DVA Services

- Both Roadmap interventions demonstrated the value of survivor-centred services. Survivors receiving both WAFE and SLCDP interventions highlighted the importance of feeling that they could exert choice over the pace and type of interventions they received and they reported increased confidence and self-esteem as well as improvements in mental wellbeing.
- Survivors benefited from staff's availability, consistency and good communication skills and these were enhanced by the use of toolkits and visual images.
- The Roadmap services delivered under Covid-19 showed that it is feasible to deliver DVA services remotely to both survivors and perpetrators but this is easier where worker and service user have already established a face-to-face relationship. Particular difficulties emerged in delivering remote services to children, although in some instances, older children felt less pressured by support sessions delivered online.

[9] Barter, C, Bracewell, K., Stanley, N., Chantler, K. (2018) *Scoping Study: Violence Against Women and Girls Services*. Connect Centre, UCLan and Comic Relief. http://clok.uclan.ac.uk/24762/

Responding to Diversity

- Understanding of both diverse forms of DVA and the needs of diverse groups experiencing DVA was considered important by those participating in DVA training. Most of the Roadmap sites did not serve substantial Black and minoritised populations; for the future, it is important that the relevance of Roadmap interventions for Black and minoritised survivors and their families is studied.
- Survivors with complex or multiple needs made up a sizeable proportion of those using Roadmap services. Survivors came to both VOICES and SLCDP services with generally low levels of health and, for SLCDP service users, low mental health. For work with all survivors, especially those with complex or multiple needs, to be effective, DVA services need to establish joint strategic planning and good channels of communication with mental health services, substance misuse services and other services in the health sector. This was a field where DVA organisations' networks and communication were found to be less well developed and the DVA sector should draw on relevant pilots and initiatives[10,11,12] in strengthening these links. Strengthening collaboration with the DVA sector is also a goal for health services as advocated by the 2014 NICE Guideline on domestic violence and abuse for health and social care[13] and this guideline could usefully be updated and reinforced.

Roadmap Evaluation Team: Prof Nicky Stanley, Prof Christine Barter, Dr Kelly Bracewell, Prof Khatidja Chantler, Dr Emma Howarth, Prof Lorraine Radford, Dr Helen Richardson Foster, Dr Rachel Robbins, Prof Rhiannon Tudor Edwards, Katie Martin, Eira Winrow.

[10] Feder G, Davies RA, Baird K, Dunne D, Eldridge S, Griffiths C, et al. (2011) Identification and referral to improve safety (IRIS) of women experiencing domestic violence with a primary care training and support programme: a cluster randomised controlled trial. *Lancet*. 378(9805):1788–95.

[11] Oram, S., Capron, L., Trevillion, K. (2016) *Promoting Recovery in Mental Health*: Final Evaluation Report. London: King's College London.

Pawson, R. (2013) *The Science of Evaluation: A Realist Manifesto.* London: Sage.

[12] Dheensa, S., Halliwell, G., Daw, J., Jones, S.K., Feder, G. (2020) "From taboo to routine": a qualitative evaluation of a hospital-based advocacy intervention for domestic violence and abuse. *BMC Health Serv Res* **20,** 129. https://doi.org/10.1186/s12913-020-4924-1

[13] NICE (2014) *Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively*. https://www.nice.org.uk/guidance/ph50/resources/guidance-domestic-violence-and-abuse-how-health-services-social-care-and-the-organisations-they-work-with-can-respond-effectively-pdf

Chapter 1: Introduction

1.1 Background

The Roadmap programme of interventions in domestic violence and abuse (DVA) was developed in response to increasing concerns that DVA provision in England was inadequate to meet need, often difficult for survivors to access and unresponsive to survivors' needs, especially for those survivors with complex/multiple needs or multiple barriers to receiving services (AVA and Agenda 2019; House of Commons Home Affairs Committee 2018; Barter et al 2018). Funded by the Big Lottery's Women and Girls Initiative, Women's Aid Federation England (WAFE) and SafeLives (SL) collaborated over five years (2016-21) to develop and implement the Roadmap Programme which was designed to transform the lives of women and girls through systemic change to policy, practice and commissioning so promoting early intervention and reducing the prevalence, impact and tolerance of domestic violence and abuse (DVA). The Roadmap aimed to build evidence that can be used by frontline services, the community, commissioners, funders, and policy makers to support women and girls affected by DVA.

The independent evaluation of the Roadmap Programme was undertaken by researchers from the Connect Centre for International Research on Interpersonal Violence and Harm at the University of Central Lancashire (UCLan) in partnership with the University of East London, Manchester Metropolitan University and Bangor University. The evaluation (2017-21) adopted a realist approach (Pawson and Tilley 1997) which examines what works for whom in what setting. This approach takes account of context, audiences and mechanisms of change as well as measuring outcomes and seeks to make theories of change explicit. The approach was well suited to the Roadmap programme which included a range of interventions delivered in five different sites to a variety of groups including survivors, their children, professionals delivering front-line services to DVA survivors and community volunteers.

1.2 The Roadmap Programme

WAFE and SL had common goals for the Roadmap programmes which entailed making DVA services more accessible and responsive to survivors' needs. Both aimed to develop holistic approaches for those experiencing DVA that were informed by survivors' views and both organisations were committed to achieving wider system change in the sites where the programmes were delivered. However, the routes by which the two organisations planned to reach their goals were different although complementary.

WAFE's *Change that Lasts (CtL)* programme was intended to develop a 'whole community response' that would increase responsiveness to DVA services at three levels: i) the community (Ask Me), ii) frontline professionals in organisations that were not specialist DVA organisations (Trusted Professional) and iii) services delivered by DVA specialist organisations to those experiencing DVA (VOICES).[14] The two central programme aims were to combat gender-neutral discourses of DVA, since WAFE understand DVA as a gendered crime, and to strengthen a needs-based, strengths-based approach to working with women and children experiencing DVA. Women and girls would benefit from holistic coordinated approaches and would play an enhanced role in shaping services to meet their needs. Delivered in three sites – Sunderland, Nottingham and Nottinghamshire

[14] See https://www.womensaid.org.uk/wp-content/uploads/2020/11/Change-That-Lasts-Impact-Briefing-1.pdf

(Nottingham/shire) and Surrey – the programme had three core components targeted on different audiences. The Ask Me intervention aimed to address cultural and attitudinal barriers to change and increase awareness and responsiveness to DVA through training and supporting Community Ambassadors or volunteers in local communities[15]. Trusted Professional combined training with organisational development to increase expertise and responsiveness among frontline professionals working in non-specialist DVA settings such as social care, health, housing and benefit services. The VOICES intervention was designed to introduce a trauma-informed approach centred on the survivor delivered by practitioners in specialist DVA organisations.

Ask Me and Trusted Professional had both been developed and piloted in other sites prior to the Roadmap Programme[16], although considerable rethinking and revision of both programmes, especially Trusted Professional, occurred during the evaluation, stimulated in part by early evaluation findings. VOICES was developed in the course of the Roadmap programme and its implementation therefore occurred later in the programme and unfortunately coincided with the restrictions imposed by Covid-19 (for more detail see Chapter 6).

The SafeLives Programme, designed by SafeLives, alongside Pioneers (survivors and experts by experience) and specialist frontline DVA partners, comprised an integrated suite of multiple interventions that would allow survivors and their families to access five different interventions within the same organisation. Two independent services, in Norwich and West Sussex (Worthing, Adur, and Crawley), were commissioned to deliver the interventions, hereafter referred to as the SafeLives Co-Designed Pilots (SLCDP). These interventions were tailored to the needs of different groups so that survivors and their families could move between and through them on their journey to recovery. The intervention aimed to break down silos between services and deliver a 'whole family' service informed by DVA survivors' views. The SLCDPs were targeted at those assessed as at medium risk of harm; people who wanted to remain in their relationships; those with complex needs; survivors recovering from abuse and children and young people. SLCDP services were designed to complement and work with existing provision for survivors at the highest risk from abuse. A wide range of individual and group interventions was utilised and training and skills development were provided to partner agencies.

Whole System Change – both SafeLives and Women's Aid were committed to working in partnership with local organisations in each site and the Roadmap Programme sought to transform the local landscape of service provision, strengthen pathways between services and improve collaboration. Whole System Change aims included increasing the role of survivors in the production of services and mobilising change across local communities and services so that, in line with the aims of the Big Lottery funding programme, women and girls experiencing DVA were supported by holistic and coordinated approaches that increased safety, early intervention and resilience.

1.3 The Evaluation

The evaluation was designed to both measure change achieved by the specific interventions designed by WAFE and SL and to examine whether and how wider system change was achieved in the five sites where the Roadmap programme was delivered. The study aimed to explore those factors that facilitated or impeded change both for specific interventions and at the wider level of the whole system. Social Return on Investment analysis was included in the evaluation. The

[15] While there is no contractual arrangement between Ambassadors and WAFE, for the purposes of this evaluation, Ask Me Ambassadors are conceptualised as volunteers as their activities are voluntary and fit the National Council of Voluntary Organisation's definition of volunteers.
[16] See: https://www.womensaid.org.uk/our-approach-change-that-lasts/about-change-that-lasts/

experiences of diverse groups of survivors informed the design and practice of the research as well as being a primary focus for study.

The evaluation was undertaken over 45 months between October 2017 and June 2021. This time span allowed for change to be captured and iterative feedback provided by the Evaluation team to WAFE and SL in the course of the study was used to refine and redesign some elements of the interventions. The Evaluation Team and representatives of WAFE and SL met regularly to review the progress of the study and a series of interim reports was produced. An Expert Advisory Group offered advice and access to relevant networks. A Survivors' Advisory Group also advised the research team and assisted the recruitment of Survivor Researchers who worked alongside the Evaluation Team researchers on some aspects of the study.

1.3.1 Achievements and Challenges

Demands on front-line staff in the intervention sites, together with other monitoring responsibilities and, in some cases, limited administrative support, contributed to difficulties in capturing outcome measures from service users. Providing these measures in online formats was effective in some cases but not in others. The Evaluation Team worked closely with front-line staff to increase returns of measures and front-line staff made considerable efforts to assist the study in this respect.

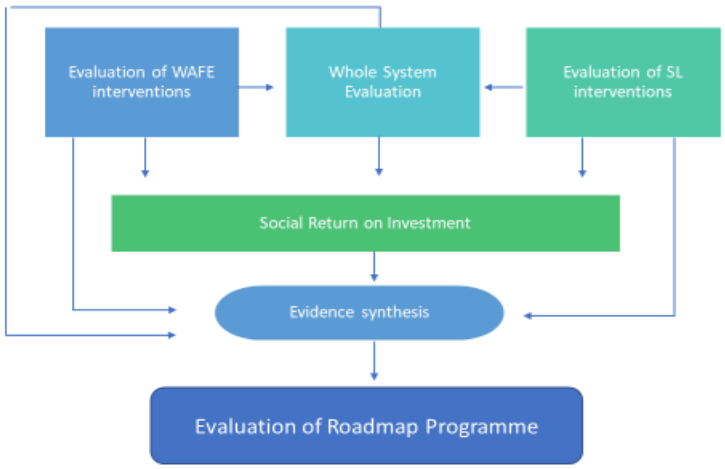
The restrictions imposed by Covid-19 in 2020 placed substantial pressure on staff delivering Roadmap services and required the Evaluation Team to adopt new and safe approaches to remote data collection. Together, these circumstances created barriers to recruiting survivor participants, obtaining their consent and completing research measures and interviews. Moreover, restrictions on movement, together with childcare responsibilities, made it harder for survivors to respond to requests to provide consent for research participation and participate in the study. Difficulties in collecting data from children and young people under Covid-19 restrictions led to the development of new approaches that ensured that children's and young people's perspectives were included in the study. In addition to introducing adaptations to the evaluation plan and tools in response to Covid-19, the Evaluation incorporated questions that addressed the experience of delivering and receiving DVA services under lockdown and was able to examine the ways in which Roadmap services adapted to the pandemic.

Chapter 2: Evaluation Methods

This was a complex mixed methods evaluation which aimed to capture outcomes but also to provide in-depth accounts from those using, designing and delivering services that would illuminate the facilitators and barriers to change and provide case studies and accounts that would contribute to and influence wider change. Care was taken to ensure that the views of survivors and their children were central to research design. The realist evaluation approach adopted takes an iterative approach to construction of theories of change (Pawson 2013) and this thinking underpinned the ongoing dialogue between the independent evaluators and the two organisations designing and delivering the Roadmap interventions.

Figure 2.1 shows the key components of the Roadmap Evaluation with the different components of the study feeding into the synthesis stage which produced the final evaluation.

Figure 2.1 The Roadmap Evaluation



2.1 Evaluation of Specific Interventions across both Programmes

2.1.1. Evaluating Direct Work with Survivors and Children

1. Data on referrals, service uptake, engagement, service use, delivery and outcomes available from WAFE's OnTrack and SL's Insights data management and collection systems were analysed to provide a picture of the reach and nature of the work undertaken in the evaluation period, as well as capturing survivors' and staff perceptions of the services.
2. In total, 98 survivors and children were interviewed (or participated in focus groups for those taking part in group programmes) about their perceptions of the services received from the Roadmap Programme. Programme staff elicited survivors' consent for interviews and facilitated arrangements for interviews. While some early interviews took place face-to-face, the majority were completed by phone or online due to Covid-19 restrictions. Difficulties in recruiting children to interview, especially under Covid-19 restrictions, resulted in a case study approach being adopted for the evaluation of the SLCDP in respect of their work with children and this assisted in building a rounded picture of work undertaken with children and their families (see Chapter 8 for more detail).

3. Outcome measures assessing wellbeing, safety and health were completed by survivors at baseline (within the service's initial assessment period) and then at two or three follow-up points (dependent on the length of the intervention) by all survivors who consented to do so. Programme staff administered the outcome measures in the form of either a hard copy or an on-line survey, with the evaluation team following up at Time 3 where consent to do so and the assurance that it was safe to do so had been received. During 2020, Covid-19 restrictions resulted in survivors completing some measures online or via telephone calls with the researchers.

2.1.2. Outcome Measures

The Evaluation Team developed a composite outcome measure (see Appendix 2) which included a mixture of tested measures and bespoke questions. Used with survivors from both programmes, it was designed to be accessible and quick to complete and addressed the following:

- Wellbeing (Short Warwick-Edinburgh Mental Well-Being Scale) (SWEMWBS) (Stewart-Brown et al, 2009)
- Safety (Evaluators' own scale adapted from Wellbeing and Safety questions, part of the Space for Action scale in Kelly et al, 2014)
- Control and Coping questions from REVA (Responding Effectively to Violence and Abuse) (Kelly et al 2014) scale
- Health (EQ-5D-3L) (EuroQol Research Foundation, 2018) and visual analogue scale (VAS thermometer)
- Perceptions of service as supportive and enabling
- Confidence and Optimism

An additional outcome measure was designed for use with children in SLCDP sites and this included the health measure CHU-9D (Stevens, 2012) which has been validated for use with children aged 7-11 (Furber and Segal, 2015).

2.1.3 Evaluating the Ask Me and Trusted Professional Interventions for Volunteers and Professionals in Frontline Organisations

Evaluation of both these interventions included:

1. Pre/post training questionnaires to assess whether knowledge, beliefs, confidence and skills had changed immediately after training.
2. Follow-up telephone interviews with training participants at 3-6 months post-training.
3. For Ask Me, analysis of Expression of Interest (EOI) data and How Are You Getting On (HAYGO) forms.
4. Interviews with WAFE trainers and coordinators and with senior managers.

2.2 Whole System Change

Five data sources were used for the whole system evaluation which took a similar form across both programmes (with some variations where appropriate):

1. Routinely collected demographic and service data contributing to building site profiles which provided a picture of context and trends in the designated sites. These were first produced in 2019, when they were shared with WA and SL, and were updated in 2020 (see Appendix 1).
2. An online survey of a wide range of community organisations in the five sites was completed in Spring 2018 to create a baseline picture of DVA need and service provision.

3. Telephone interviews (16) were undertaken with other DVA organisations in the five sites in Summer 2018 to provide depth and expertise.
4. Social Network Analysis (Gillieatt et al 2015; Sabot et al 2017) designed to identify the organisations' networks and patterns of influence as well as referral pathways was undertaken. The analysis was based on interview questions completed by 27 staff members (including managers) across the five sites (these questions were integrated into other staff interviews to minimise demands on staff) in 2019/20. These interviews were followed up by two online surveys in 2020 asking staff about network ties and referral patterns.
5. Stakeholder meetings were held in 2019 and 2020 in all five sites to capture the views of local stakeholders with respect to the implementation and impact of each programme. Key local stakeholders were identified with the assistance of local co-ordinators and programme staff.
6. A survey of all programme staff and interviews with senior managers, both completed in 2020, provided their perspectives on system change. This survey included questions on workplace and workload drawn from the Health and Safety Executive's Management Survey.[17]

2.3 Social Return on Investment Analysis (SROI)

Social Return on Investment (SROI) analysis is widely used in Public Health to evaluate services and interventions. It allowed the Evaluation to take account of a wide range of stakeholders and to consider the outcomes for a much broader set of stakeholders than more traditional methods used in Health Economics. The Cabinet Office (2012) guide for SROI as recommended by the SROI Network and the New Economics Foundation informed this aspect of the evalution.

Hard outcomes are reported widely using traditional methods of evaluation and are easier to report as they use numerical data to demonstrate differences. Soft outcomes are more difficult to report, as they often depend on subjective measures such as changes in confidence or behaviour. SROI offers the opportuity to report hard and soft outcomes in tandem, resulting in an evaluation that reveals the difference an intervention can make not just in figures, but in terms of the difference the intervention has made to the person, community and wider stakeholders.

The SROI drew on data provided by WA and SL in respect of:

- Staff wages
- Staff training
- Overheads (property, utilities, IT, etc.)
- Intervention materials (course materials, support and development materials etc.)
- Start up and running costs of the programmes
- Other costs (including any local matched funding) associated with running and developing the programmes

The SROI also drew on the outcome measures completed by those using Roadmap services and on the wide range of interviews, stakeholder groups and survey data collected in the course of the Evaluation. The analysis enabled us to assign a monetary value to any outcome. The monetised outcomes were compared to the total cost of administering and running the interventions, and resulting in an SROI metric showing the social value generated for every £ spent on the programme.

The methodological approach for this economic analysis included the development of an SROI Impact Map. This is a spreadsheet that explores the relationship between the inputs (the resources used for the programmes), the outputs (the programmes themselves), and the observed outcomes.

[17] https://www.hse.gov.uk/stress/standards/step2/surveys.htm

By identifying a wide range of stakeholders, it is possible to explore the potential costs and cost savings across sectors which may be attributed to these programmes. We used widely available national data to demonstrate where spending may increase or decrease.

2.4 Working with Survivor Researchers

In line with the principles articulated in the Research Integrity Framework (Women's Aid 2020a) and with both WAFE's and SL's commitment to co-producing knowledge with survivors, survivors were actively involved in the Evaluation, both in an advisory capacity and, more actively, as survivor researchers. The first Survivors' Advisory Group Meeting was held early in the study's life in March 2018 and the plan was to recruit and train survivor researchers subsequent to that group. However, this timetable was insufficiently aligned with programme implementation and the time-lag between the first tranche of training being delivered to survivor researchers in 2018 and opportunities becoming available to involve survivor researchers in interviewing and focus group work in 2019/2020, together with difficulties in transferring and storing confidential data, resulted in additional survivor researchers being recruited via specialist DVA organisations in Lancashire in 2019. This approach allowed for increased support to be available for survivor researchers and aimed to facilitate data protection and secure data transfer. The project followed good practice in respect of preparing, informing and supporting survivor researchers as laid out at www.invo.org.uk.

Five survivor researchers were recruited with the assistance of WAFE and SL, the Survivors' Advisory Group and via the Connect Centre's links with local domestic abuse services in Lancashire. Survivor researchers were defined as women with experience of DVA who had received specialist DVA services. Co-production with survivor researchers harnesses their 'expertise through experience' and can develop their skills and confidence as well as ensuring that research is sensitive to the communities and issues researched. These survivor researchers received training in December 2018, September 2019 and September 2020 as well as individualised training and support to equip them to contribute to the research. Meetings and training events were followed up by regular contact with the research team to update on study progress. The survivor researchers were involved in data analysis workshops, undertaking telephone interviews and the co-facilitation of focus groups in 2020.

While not all those who volunteered as survivor researchers were able to sustain their involvement with the study due to a variety of issues, including the restrictions imposed by the pandemic, those survivor researchers who worked on the Roadmap Evaluation reported that they enjoyed their involvement and they contributed valuable insights to data analysis. Their involvement in interviewing and focus groups ensured that the language utilised was appropriate and their involvement elicited useful data.

Key learning points from the involvement of survivor researchers in the Evaluation were as follows:

- Clarity regarding implementation timetables is required so that recruitment and training of survivor researchers can be aligned with research tasks and long gaps between training and researching are avoided.
- Continuing engagement with survivor researchers between research tasks is key to successful retention – a named member of the research team who builds rapport and facilitates survivor engagement with the study is valuable.
- It is essential to ensure that adequate support mechanisms are in place should survivor researchers require them.

- Recruiting and supporting survivor researchers needs to be adequately resourced: this entails ensuring that research budgets allow sufficient time for engagement work as well as compensating survivor researchers for their time.
- Ensuring that data collected and transferred by survivor researchers is consistent with ethical and GDPR requirements requires consideration and planning.

2.5 Ethical Issues

The University of Central Lancashire's Research Ethics Committee scrutinised all aspects of the study, reviewing and approving different stages of the evaluation on an ongoing basis as tools were designed and tested**.**

Sensitivity to the ethical issues involved in conducting research with individuals who have experienced or who are at risk of experiencing DVA along with other forms of gendered abuse (Women's Aid 2020), was sustained throughout the research. The participating sites and individuals were provided with appropriately formatted information about the Evaluation and were informed that data was confidential and anonymised. Individual participants were assigned a numerical identifier to ensure their anonymity and interviewing procedures (including those introduced to facilitate remote interviewing under Covid-19) were developed to ensure that interviews could take place safely without being overheard.

All data collected in the course of this study has been securely stored. No data that could identify a particular individual is included in any outputs or publications and all quotations used in this report have been anonymised.

Chapter 3: The Roadmap Context

This chapter sets the context for the evaluation by firstly describing key characteristics of the five Roadmap sites: Nottingham and Nottinghamshire, Sunderland and Surrey (WAFE), Norwich and West Sussex (SLCDPs). Secondly, we draw on stakeholder groups, a baseline survey of local community organisations and interviews with specialist domestic abuse organisations completed in 2018/19 in all sites to paint a picture of commissioning, service provision, local awareness and responsiveness to DVA in all five sites. Chapter 9 examines evidence for change in the whole system across the Roadmap sites in 2020. All site profiles were last updated in January 2021.

3.1 The Five Roadmap Sites

The five site profiles (see Appendix 1) provide an overview of the main characteristics of each location where the Roadmap interventions were delivered (see Figure 3.1). Data sources and citations are included in the full site profiles in Appendix 1. In some instances, we report on the city of Nottingham and Nottinghamshire separately due to substantial differences and in some instances only county-wide level data was available.

Figure 3.1 Map of Roadmap Sites

3.1.1 Population Demographics

Size: Surrey has the largest population of the five sites - over 1 million - Nottinghamshire and West Sussex have approximately three-quarters of a million people, while Sunderland and Norwich both have under 300,000, with Norwich having the smallest population (140,000). However, we need to note that these figures are based on the 2011 Census which is now very dated.

Age: The average age across all five sites was between 33 and 45. In West Sussex , Sunderland, Surrey and Nottinghamshire the average age was slightly above the national average of 40, while in the City of Nottingham and Norwich, it was below the national average, with the City of Nottingham having the lowest average age at 30.

Ethnicity: Sunderland has the lowest Black and minoritised population at 4%, West Sussex, Norwich, Surrey and Nottinghamshire all have between 7% and 10%, whilst the City of Nottingham has the highest level of Black and minoritised groups making up roughly 35% of the population. Surrey was estimated to have the fourth largest Gypsy, Roma and Traveller community in Britain in 2014. In three sites, 90% of the population spoke English.

3.1.2 Location

Sunderland, Norwich and Nottingham are all urban locations, Nottinghamshire, West Sussex and Surrey have a mixture of urban and semi-rural (with rural locations in parts of Nottinghamshire).

3.1.3 Disadvantage

Poverty: Sunderland, Nottingham and Norwich have very high to high levels of poverty, while Surrey and West Sussex have low levels of poverty although, in West Sussex, there are variations across the county with some pockets of deprivation. Nottinghamshire, excluding Nottingham, has a more mixed picture of very high and very low poverty. Child poverty reflects this pattern across the five sites.

Employment: Unemployment is higher than the national average in Sunderland, Nottingham and Norwich and lower than the national average in West Sussex and Surrey.

Housing: Levels of social housing are highest in Nottingham, Sunderland and Norwich which are all substantially above the national average, whilst Surrey, West Sussex and Nottinghamshire are below the national average.

3.1.4 Crime

Overall, total recorded crime is substantially above the national average in Northumbria and slightly above the national average in Nottinghamshire and below the national average in Surrey, Sussex and Norfolk. For crimes involving violence against a person, Northumbria and Nottinghamshire are above the national average. Similarly, in relation to stalking and harassment and sexual offences, Northumbria and Nottinghamshire are both slightly above the national average.

3.1.5 Health

Nottingham City and Sunderland had a lower life expectancy for women and men compared to the national average in England, Norwich and Nottinghamshire and women in West Sussex were broadly comparable to the national average while men and women in Surrey and men in West Sussex had higher than average life expectancy.

3.1.6 Brexit

Sunderland, East Midlands (including Nottingham) and West Sussex voted to leave membership of the EU; Norwich and Surrey voted to remain.

3.1.7 Domestic Violence and Abuse

There is considerable variation and inconsistency in the publicly available data making it difficult to provide a robust overview of DVA rates across the five sites. Police data is likely to be an underestimate of prevalence rates as not all experiences of DVA are reported.

Police Reported DVA:

Table 3.1 Combined domestic abuse-related incidents and offences 2016/17 & 2019/2020

	2016-2017		2019-2020	
	Number	**Rate/1000**	**Number**	**Rate /1000**
Surrey	13,179	11	13,777	12
Nottinghamshire	14,228	13	20,628	18
Sussex	23,559	14	29,004	17
Norfolk	15,880	18	17,835	20
Northumbria	30,534	21	41,992	29

Surrey had around 3,000 DVA crimes and incidents reported to the police between 2016 and 2017 and between 2019 and 2020, although this varied significantly across the county, equating to 12 DVA incidents per 1,000 population in 2020.

Nottinghamshire police recorded just over 14,000 DVA crimes from 2016 to 2017, with a greater concentration in Nottingham, this increased to almost 21,000 between 2019 and 2020, equating to 18 DVA incidents per 1,000 population.

West Sussex had 23,559 DVA incidents and crimes reported to Sussex police between 2016 and 2017 2017, rising to 29,000 between 2019 and 2020, equating to 17DVA incidents per 1,000 population.

Norfolk had almost 16,000 DVA incidents and crimes reported to the police between 2016 and 2017, rising to nearly 18,000 between 2019 and 2020, equating to 20 DVA incidents per 1,000 population.

Northumbria constabulary area had around 30,000 DVA incidents and crimes reported to the police between 2016 and 2017, rising to almost 42,000 in 2019 to 2020; equivalent to 29 DVA incidents per 1000 population. However, wide variations were found between different areas ranging from 9 to 52 DVA incidents per 1000 population.

Overall, police reported DVA Incident rates ranged from 12 to 28 per 1,000 with Northumbria, Norfolk and Nottinghamshire having the highest levels.

Multi-Agency Risk Assessment Conferences (MARAC) referrals:

Table 3.2 Referrals to Marac 2016/17 & 2018/2019

	2016-2017	2018-2019
	Rate/1000	**Rate /1000**
Surrey	15	23
Nottinghamshire	30	41
Sussex	28	37
Norwich	37	45
Sunderland	52	60

Although Marac data is not directly comparable to police incidents, since it incorporates only high-risk cases, some area differences and dates, in each site, DVA referrals to Maracs per 1,000 were higher than official police reports indicating under-reporting in the police data. Marac referrals 2018-2019 ranged from 23-60 per 1,000, with Sunderland, Norwich and Nottinghamshire having the highest levels, reflecting the Police data.

Marac Disability Data: Across all sites Maracs reported the number of survivors who had a disability, Nottingham reported the highest proportion with an increase from 19% to 36% over a three year period (2016 to 2019), West Sussex had the second highest proportion of survivors with a disability (20% in 2018-2019), followed by Norwich (16%).

DVA Homicide: Between two and twelve domestic homicides were recorded between 2016 and 2018 across the five sites, Surrey and West Sussex recorded the most domestic homicides and Norfolk the least.

DVA as a contributing factor to Child in Need Assessments: Across England, 50.6% of families receiving a Children in Need assessment had domestic violence as a factor. Nottinghamshire, including Nottingham, and Surrey reported comparable DVA factors in their Children in Need assessments whilst Norwich, Sunderland and West Sussex reported slightly higher DVA rates (55% 56% and 61% respectively).

DVA Services: These are services provided by specialist DVA staff working in the independent sector who have a gendered understanding of DVA.

Overall changes in DVA Provision 2016-2020: Routes to Support[18] data showed that rates of DVA service provision remained roughly the same or increased slightly in this four -year period across all five sites. However, this does not necessarily mean that services had sufficient staffing capacity to respond to need. Looking at the recommended minimum number of Independent Domestic Violence Advisors (Idvas) for each area, as calculated by SafeLives, only Nottinghamshire and West Sussex had above the minimum recommended staffing levels, while all other sites had below the minimum levels, with Surrey having the lowest at only 31% (SafeLives Practitioners Survey 2018-2019, SafeLives 2020a). During this period, reductions in the value of funding contracts were an ongoing

[18] Routes to Support is the UK violence against women and girls service directory run in partnership with Women's Aid Federation of Northern Ireland, Scottish Women's Aid and Welsh Women's Aid https://www.womensaid.org.uk/routes-to-support/

concern for local DVA services with Samuel (2021) noting that in 2019-20, 59% of local authorities introduced a real-time cut to their DVA funding. This affected four out of the five Roadmap sites.

Refuge spaces: All sites, except Sunderland, lacked the expected level of refuge spaces, although it is important to note that refuge provision is a national resource.

3.1.8 Covid-19

During the Covid-19 pandemic, the need to stay at home increased the likelihood of women and children experiencing DVA. Survivors have indicated that abuse has intensified during the lockdown, with access to support reduced (Women's Aid 2020b, SafeLives 2020a). Regional differences in lockdowns meant that Sunderland, and to a lesser extent Nottingham, experienced greater amounts of time in the higher and more restrictive tiers, compared to the other three sites. In all sites, DVA services were required to pivot to providing services remotely while experiencing staff shortages due to the pandemic.

3.1.9 Specific site factors

Sussex

- In May 2019, West Sussex Children's Social Care was rated as 'inadequate', with frequent changes in workforce[19], particularly at a corporate and management level, being part of the problem. The impact this had on children and families was described as 'profound'[20].
- PEEL (Police Effectiveness, Efficiency and Legitimacy) Inspection 2020: in February 2020, Sussex Police was inspected by HM Inspectorate of Constabulary, with the force being rated satisfactory in most areas, but 'ineffective' at protecting domestic abuse victims[21] (similar concerns were raised in an inspection in 2016).
- Sussex Police Response to Domestic Abuse: during Lockdown Sussex Constabulary's response to domestic abuse during lockdown was recognised nationally in the Government's 'Hidden Harms summit' held in May 2020.

Sunderland

- Sir Paul Ennals, the independent chairman of Sunderland Safeguarding Children Board, argued that Sunderland DVA rates were higher than the rest of the country and identified high levels of local tolerance of DVA as a contributing factor.
- In 2018, the BBC News[22] published an article detailing the rise of far-right activism in Sunderland and their attempt to hijack the Violence against Women and Girls agenda to their own campaigns.

Surrey

- New Refuge: The Surrey Domestic Partnership used funding from the Coronavirus Respond Fund to establish a new refuge, which immediately supported eight families and has space for up to 20.

[19] https://www.communitycare.co.uk/2019/05/10/staff-turnover-council-failure-meet-social-work-standards-ofsted-finds/
[20] https://www.bbc.co.uk/news/uk-england-sussex-48202585
[21] https://www.bbc.co.uk/news/uk-england-sussex-51415430
[22] https://www.bbc.co.uk/news/uk-46635022

Nottingham

- In February 2020, councillors announced[23] that over the next four years, £1,554,746 would be available to help support adults and children affected by domestic abuse. This would help fund a free 24-hour helpline, Young People's Violence Advocate, support accessing the criminal justice system and housing, benefits and welfare support.
- In 2019, the Office of the Police and Crime Commissioner funded the first Stalking Advocacy Service[24] in Nottingham. The service, provided by Juno Women's Aid, Nottinghamshire Women's Aid and Equation, offers a one-stop support service to victims of stalking who were previously excluded from domestic abuse services.

Norfolk

DVA and its impact featured in the Norfolk Safeguarding Children's Board Annual Report for 2017 to 2018[25]. The report identified DVA as a strategic challenge that required a direct response from various agencies and services, particularly in relation to preventing children from becoming victims.

- Most schools (46/50) in Norwich are signed up to Operation Encompass, the police and education early referral partnership (Norfolk SCB Annual Report 2018).

Site Profiles Summary

Overall, the urban areas of Sunderland, Nottingham, and in some respects Norwich, have higher level of deprivation, crime, social housing and greater health inequalities compared to Surrey and West Sussex. DVA services have not reduced substantially in the five sites since 2016, although only two areas, West Sussex and Nottinghamshire, had above the minimum number of Idvas. A high proportion of service users with a disability was reported across all sites, being especially high in Nottinghamshire. It is of note that the lowest levels of children's referrals to social care with DVA as a contributing factor were in Surrey and Nottinghamshire, with West Sussex the highest at 61%. The site profiles provide a useful context for the evaluation and help to illustrate how applicable the findings are to other areas. However, any variations in the data reported, for example in Marac figures or referrals to children's social care, cannot be directly attributed to the Roadmap interventions.

3.2 The Baseline Picture across the Five Sites

3.2.1 Background Information

The whole system evaluation aims to assess system transformation in the five Roadmap sites, as evidenced by i) professional and community awareness of domestic abuse and appropriate responses to it and ii) inter-agency communication and strength of partnership working, as well as the level of co-ordination underpinning the community response to DVA. This section reports the whole system baseline findings drawing on:

- The Whole System Survey (WSS) of just under 100 local practitioners and managers undertaken in Spring 2018 (see Appendix 3 for participating organisations);

[23] https://www.nottinghamshire.gov.uk/newsroom/news/domestic-abuse-funding-update
[24] https://www.nottinghamshire.pcc.police.uk/News-and-Events/Archived-News/2019/PR-717.aspx
[25] https://www.norfolklscb.org/wp-content/uploads/2018/11/NSCB-Annual-Report-2017-18_FINAL.pdf

- Telephone interviews with specialist Domestic Violence and Abuse (DVA) organisations[26] (n=17) in Summer 2018;
- Stakeholder consultation groups in all five sites (n=38) conducted Jan-March 2019. These groups were repeated in 2020 (see Table 3.2, Appendix 3 for details of participating stakeholders);
- Social Network Analysis undertaken with staff in Roadmap sites 2019-20 to identify the organisations' networks and patterns of influence as well as the type and nature of referrals and referral pathways. The findings are reported in Chapter 9.

3.2.2 Funding Context

The programme of austerity, initiated in 2010 by the Conservative and Liberal Democrat coalition government, sought to eliminate the financial deficit by reducing government funding for services. This was widely viewed by stakeholders as resulting in limited, short-term funding for specialist DVA organisations and they noted that this coincided with statutory organisations raising thresholds for service provision. The knock-on impact as reported by DVA service providers was that they were working with women with more entrenched and complex/multiple needs, due partly to limited capacity in other services:

…the nature of those needs that they come to us with are much more complex than they used to be… thresholds with statutory agencies now are so high that often they're not able to meet those thresholds and/or services have been withdrawn, particularly around mental health, substance abuse and all that…. (Participant 11, DVA Specialist Service Interview)

Commissioning arrangements were generally perceived as failing to reflect the DVA needs of local areas. In particular, the focus on funding for innovation was considered problematic as organisations were constantly under pressure to innovate so that basic 'bread and butter' work and previous innovation projects became difficult to sustain:

Every funding opportunity wants you to innovate but be sustainable as well…You don't do both really. (Participant 4, Norwich Stakeholders Group).

Whilst short-term innovation funding was more readily available, the temporary nature of funding undermined long-term planning, sustainability and stability of DVA services. Managing services with multiple contracts ending at different times also caused problems and was described by as a '*minefield*'. In contrast, where long-term commissioning and funding processes were in place (e.g. Nottingham City Joint Commissioning Group), this was considered to reduce the pressures mentioned above.

Multiple systems of monitoring and reporting to funders and commissioners were considered onerous for already over-stretched services which struggled to meet demand as reflected here:

…we basically are monitoring for every single grant that we've got coming in…there are…specific methods of reporting outcomes that those grant holders request but we've also got kind of bespoke outcome reporting. (Participant 12, DVA Specialist Interview)

Clearly, there is a strong case to be made for streamlining reporting mechanisms to free up time for organisations to focus on work with DVA survivors and their families.

[26] Specialist DVA organisations are usually considered to be organisations based in the independent sector. However, one DVA organisation included in this sample was a local authority service.

3.2.3 Multi-agency Partnerships

Positive partnership working was connected to the identification of DVA as a strategic priority by stakeholders in all sites and this was thought to be achieved through shared understanding, aims and objectives:

I think it helps that we've got domestic abuse and VAWG as a strategic priority in the city…we've had a cross partnership group which has brought people together from safeguarding children and adults, health and wellbeing, community safety and brought them together… (Participant 5, Sunderland Stakeholders Group).

Positive partnership relationships were also perceived to support implementation of the new Roadmap interventions.

However, attempts to keep such partnerships alive were described as time consuming, particularly when organisational structures, priorities and key personnel changed and all sites identified that involving the 'right' individuals could be difficult and that staff turnover in partner agencies could present barriers to collaboration:

…having that sort of turnover of people within the role and making sure that that buy-in is maintained is quite a difficult job… (Participant 4, Norwich Stakeholders Group).

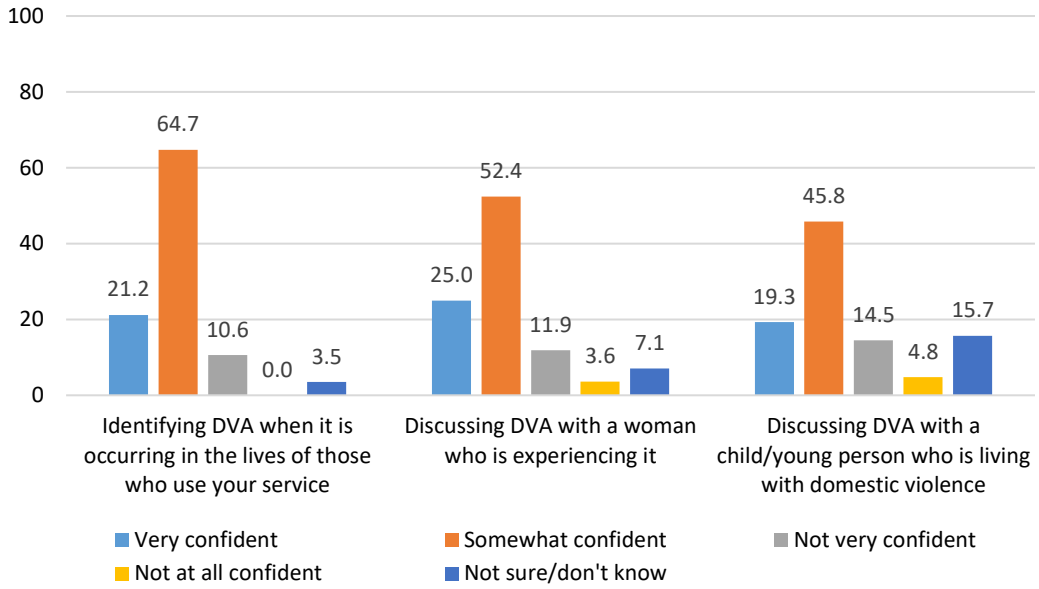
The responses to the whole system survey indicated that interest in and commitment to DVA services was variable outside the specialist DVA sector. It was particularly noticeable that very few responses were received from some key sectors, such as education.

3.2.4 Confidence in Local Services' Readiness to work with DVA

The WSS completed in 2018 showed that, overall, 21% of respondents, who were mostly managers representing a wide range of local organisations and services, reported that their staff were 'very knowledgeable' about DVA and 44% said that staff in their organisation had 'some knowledge' about DVA. Respondents in Norfolk and Nottingham/shire were more likely to state that staff in their organisation were very knowledgeable.

Figure 3.1 below also illustrates that, whilst practitioners responding to the WSS were relatively confident in identifying DVA in their work with service users, they were less sure about discussing DVA with women currently experiencing it and even less so with children.

Figure 3.1: Staff confidence in responding to DVA (n=85)
How confident are staff in your organisation about...



In contrast, the consultation groups showed that local stakeholders' confidence in frontline staff who were not DVA specialists to identify and respond to DVA was limited, with most participants neither confident or unconfident:

Table 3.3 Confidence in frontline professionals to identify and respond to DVA

	Not at all confident	Not confident	Neither	Confident	Very confident	Don't Know	Total per site
Norwich	0	4	1	2	0	0	7
Nottingham/shire	0	1	6	2	1	0	10
Surrey	0	2	3	1	0	0	6
Sunderland	1	3	3	0	0	0	7
West Sussex	0	3	3	0	0	2	8
Total	**1**	**13**	**16**	**5**	**1**	**2**	**38**

Specialist DVA agencies presented a more mixed picture of their confidence in statutory sector workers as illustrated below:

Similarly, with social workers, you, you'll get really great ones who'll work with us, work with the client, understand the dynamics of domestic abuse and then others who don't. (Participant 11, DVA Specialist Interview)

3.2.5 Empowering DVA Service Users

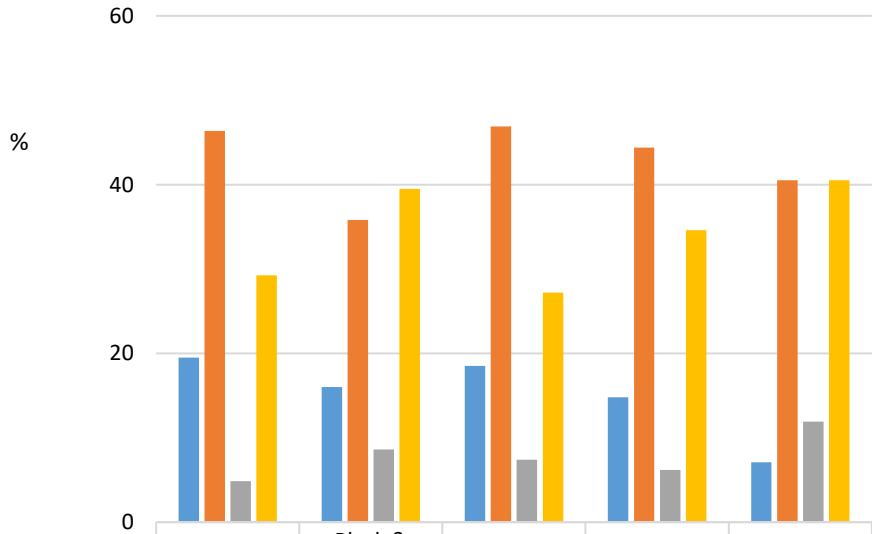
WSS respondents were asked whether local DVA services assisted women experiencing DVA to make their own choices. Overall, 30% of the 82 respondents to this question felt that most women were

'fully assisted' to make their own choices and over a third (37.8%) said they did not know. Data analysis by site showed that respondents from Surrey were more likely to consider that women were fully assisted to make their own choices about help and support, compared to other sites. Respondents in Norfolk were most unsure when answering this question. Few respondents from Sunderland answered this question. This level of uncertainty suggests a lack of familiarity as to how local DVA services engage with women or possibly, due to the high level of non-responses, a wider lack of general understanding around empowerment and choice. Interviews with survivors reported in Chapters 6 and 8 reveal more information about the modality and impact of interventions.

3.2.6 Gaps in DVA Provision

WSS respondents' perceptions of the availability of services for particular groups were broadly similar regardless of which group was addressed. Figure 3.2 below shows that most respondents stated that, for all the groups they were asked about, there were services available, but they were insufficient to meet needs. In the WAFE sites, there was only one specialist provider for Black and minoritised groups at the time of the survey, indicating that the responses below do not reflect the reality of provision. Further, a substantial minority were unaware of the service availability for Black and minoritised groups. The question regarding support for child to parent violence was only asked in the SLCDP sites.

Figure 3.2 How available are services for the following groups?



	Women with aditional needs (n=82)	Black & Minority Ethnic Women or NRPF (n=81)	Children exposed to DVA (n=81)	Girls under 18 experiencing DVA (n=81)	Children abusive to their parents (n=42)
There are sufficient services	19.5	16.0	18.5	14.8	7.1
There are services but they are insufficient to meet need	46.3	35.8	46.9	44.4	40.5
There are no services	4.9	8.6	7.4	6.2	11.9
Don't know	29.3	39.5	27.2	34.6	40.5

Interviews with specialist DVA services and the stakeholder consultations probed further about gaps in services and also found that levels of service provision did not meet the needs of marginalised groups of women and girls experiencing DVA, including services for Black and minoritised groups , children and young people, older women, those with complex/multiple needs and LGBTQ+ groups:

…we have quite a large…Eastern European population, so in an ideal world we'd have, you know, community engagement workers that could not only work directly with those women but do the education stuff around it as well to meet the cultural differences, so I would say that's a big provision gap. (Participant 14, DVA Specialist Interview).

…we've identified that there's a need to do more focused work with lesbians and bisexual women in particular. (Participant 16, DVA Specialist Interview).

3.2.7 Anticipated Impact of the Roadmap Programme

The stakeholder consultation groups identified anticipated changes in the local service landscape as a result of the Roadmap Programme. In spite of the challenging funding context discussed above, stakeholders were optimistic that Roadmap would result in an increase in both specialist DVA organisations and other frontline services, so increasing local capacity to respond to DVA. Examples of this included working with different forms of violence and targeting different groups, for example, adolescent-to-parent violence and work with families including perpetrators (in West Sussex and Norwich). Training in DVA at both community and professional levels was also cited as increasing capacity since it would enable frontline professionals in non-DVA specialist agencies to be better equipped to identify and respond to DVA:

There was a time when people was like 'oh that's in the too hard box, I don't really want to know, that's not part of my job, that's something else, that's social services work with that, that's the agency that works with that'. Now it is part of everybody's job because everyone's absorbing more so they need the training, which is good. (Participant 6, West Sussex Stakeholders Group)

Stakeholders commented that if other frontline practitioners were more able to respond appropriately to DVA, pressures on specialist DVA staff might be relieved, thereby enabling them to focus on more complex work.

Stakeholders in Norwich identified that offering interventions for families with the perpetrator remaining in the home might have the effect of relieving pressure on housing services by avoiding the need for the children and survivors to move out– providing that remaining together was the best and safest solution. Surrey and Nottingham/shire stakeholders considered that early help promoted by WAFE services might reduce the need for MARAC referrals:

…if the whole system approach was working, we wouldn't need… [or] have as …many Marac referrals because… the risks would be identified and they would be mitigated before you got to the point you needed to have a …multiagency meeting because, actually with 25 meetings a day…effective decision making is seriously compromised. (Participant 3, Nottingham Stakeholders Group)

3.3 Summary

The key findings provide a baseline picture of the challenges and opportunities for developing DVA provision, knowledge and awareness across the five sites:

- There are some key differences between the Roadmap sites with Sunderland, Nottingham, and in some respects Norwich, having higher level of deprivation, crime, social housing and greater health inequalities than Surrey and West Sussex. Only Nottinghamshire and West Sussex had above the minimum number of Idvas.
- Limited and short-term funding had restricted service provision in both the DVA sector and other allied sectors, so increasing demand and complexity for the DVA sector.

- Stakeholders identified that available funding needed to focus on both innovation and on the long-term sustainability of existing work.
- Monitoring and reporting for DVA services needed to be streamlined so that services were not over-burdened with different requirements from multiple funders/commissioners, enabling monitoring to focus on key outcomes for survivors and their families.
- Successful multi-agency working was described as requiring shared understanding of DVA across specialist and mainstream organisations and was seen as a pre-requisite for successful implementation of Roadmap interventions.
- The work required to sustain positive partnership working should not be under-estimated.
- The WSS showed that only 21 % of respondents perceived staff to be 'very knowledgeable' about DVA, the stakeholder groups and interviews with specialist DVA organisations also indicated that non-specialist DVA staff needed to strengthen their understanding of the dynamics of DVA.
- Gaps in services were identified for Black and minoritised women, LGBTQ+ populations, older women and children and young people in most sites.
- Stakeholders identified reduced pressure on housing services, fewer MARAC referrals and increased capacity to identify and respond to DVA as anticipated outcomes of Roadmap.

Chapter 4: Ask Me

4.1 Introduction

Ask Me, Trusted Professional and VOICES were the three components of WAFE's *Change That Lasts* (CTL) Programme, which aimed to combat gender-neutral discourses of DVA and to strengthen a needs-based, strengths-based, trauma informed approach to working with women and children experiencing DVA:

… been a real push to that gender-neutral, higher risk, crisis led intervention, and Change That Lasts is offering an alternative to that. (Senior Manager 1, WA).

Ask Me aimed to increase awareness of DVA in local communities by challenging the myths associated with DVA and increasing openness to discussing DVA in local communities. Ask Me participants were recruited from groups with community reach (originally conceived as community members such as hairdressers, shop assistants, and church members). They took part in a two-day community-based training programme that enabled them to raise awareness, challenge myths and assumptions and to give an appropriate response to survivors within their communities disclosing abuse, including signposting them to specialist DVA services. Components of the training included: information about the prevalence of DVA, myths and stereotypes surrounding DVA, challenging victim-blaming, dynamics of abuse including coercive control, the impact of DVA, skills and qualities required of Ask Me Ambassadors (as those who completed the training were known), signposting to specialist DVA organisations and self-care. The training employed a variety of methods including whole group activities, small group discussions, presentations, role play and videos. The restrictions imposed by the pandemic resulted in Ask Me training being delivered online from Summer 2020. Post-training Ambassador activity was captured via 'How are you getting on' (HAYGO) forms and interviews with Ambassadors. Although there is no contractual arrangement between Ambassadors and WAFE, for the purposes of this evaluation, Ask Me Ambassadors are conceptualised as volunteers as their activities fit the National Council of Voluntary Organisation's (NCVO's) definition of volunteers[27] and so these terms are used interchangeably in this report.

This chapter is based on data analysis from pre/post training surveys (n=326) completed in years 1 and 2 of the programme (February 2018- February 2020); four structured research observations by UCLan staff; interviews with Ambassadors (conducted 3-6 months post-training, n=31); trainer/co-ordinator interviews (n=10); and senior manager interviews (n=3). It also includes analysis of expression of interest (EOI) forms and HAYGOs. Year 2 EOIs were only available for those who attended the training. This means that we are not able to compare all those who applied for training with those who actually attended and are unable to report fully on attrition across the two years of the intervention. We were also unable to link all EOIs with HAYGO forms due to administrative shortages. This made for difficulties in tracking Ambassadors' trajectories post-training. Events such

[27] NCVO 'define volunteering as any activity that involves spending time, unpaid, doing something that aims to benefit the environment or someone (individuals or groups) other than, or in addition to, close relatives. This can include formal activity undertaken through public, private and voluntary organisations as well as informal community participation and social action': https://www.ncvo.org.uk/policy-and-research/volunteering-policy#:~:text=We%20define%20volunteering%20as%20any,in%20addition%20to%2C%20close%20relatives.

as coffee mornings were introduced from summer 2019 to ensure completion of HAYGO forms at consistent time points but difficulties remained and information on frequency of or attendance at these events is limited due to the high levels of administration required to collect this data.

4.2 Implementation of Ask Me

Ask Me had already been developed in other parts of the country and was perceived as requiring little development from the perspective of WAFE senior managers. The programme was delivered in partnership between WAFE trainers and local member services staff as explained below:

Yes, so we were invited, as part of the Ask Me programme, the local kind of Women's Aid organisations were asked to…work in partnership. They wanted to localise the training, so have actually, specialist DV workers delivering and facilitation of the training alongside Women's Aid England. (Trainer/Coordinator 3)

However, this model of delivery was difficult at times with constant changing of trainers and pressures on local services:

And sometimes I'd have a different trainer each day, never mind for each block. So it meant that I've had to learn every single time how to sort of map in with that trainer to deliver, what their delivery styles are. (Trainer/Coordinator 9)

… we very much want to co-deliver with the member services. But, at the same time, we have to be mindful that, you know, it's an ask of a service to have two days out of their time, which isn't free time, it's two days taken away from their role, their casework… (Trainer/Coordinator 10)

Facilitators to implementation included strong local networks, prior learning, member services' engagement with Ask Me and excellent training materials. The quote below reflects a county-wide commitment to CtL as a whole, and demonstrates how local engagement was central to take-up and delivery:

It was a bit of kudos being able to co-chair that domestic abuse management board, because that took me right into the senior leaders, and then spending time building relationships with them.... Attending lots of Community Safety Partnerships, lots of Domestic Violence Forum Groups... it's took a good six months really…working strategically, getting myself known, getting in there, and just being very consistent. (Trainer/ Co-ordinator 6)

The time taken to hone the intervention and recruit ambassadors were both identified as factors that delayed implementation:

The thing is, it was a new project and new projects take time because you're learning all the time, different approaches. If I'm honest, I think we didn't reach what works quick enough, but we have now. (Trainer/Coordinator 2)

It's not just going to happen that people are going to say, 'oh I'd like to do a domestic abuse course, where is one?' you know. That's not on people's [agenda], so you have to kind of be out there recruiting, do talks at women's centres and things like that to get recruits. (Trainer/Coordinator 6)

Saturation appeared to be an issue in Year 2, as illustrated by this trainer/co-ordinator:

And then to keep that kind of momentum kind of going, so you've reached out to all your contacts who didn't need much persuading to come on the programme. And now you're trying to persuade people to come on the programme. (Trainer/ Co-ordinator 6)

Lack of administrative support was also mentioned: *'so that the person can take the expression of interest, put them into an Excel sheet and it's all kind of done. Whereas, instead, loads of people are doing it, it never gets done right and it's just always a nightmare.'* (Trainer/Co-ordinator 6). This also impacted on the evaluation and will be discussed below.

4.3 Ask Me Delivery

In both years, Ask Me training was delivered face-to-face and, whilst delivery moved online during the pandemic, we have no data relating to how Ask Me was experienced by participants who completed the training remotely.

The Evaluation team analysed 175 Expressions of Interest (E0Is) collated by WAFE between January and August 2018 (Year 1). This showed that about half of those that expressed an interest took up the offer of Ask Me training; the highest level of attrition was found in the 35-44 age group. We also used this EOI data to ascertain who attended the training in Year 1 and if there were gaps in representation of particular social groups. Table 4.1, Appendix 4, shows that the vast majority of applicants were woman with none of the three men who applied in Year 1 attending. At the EOI stage in year 1, 75% of Ask Me candidates were heterosexual and 73% were white. Out of 12 participants who withdrew from the training after starting on a course, 10 were DVA survivors, all were female and white British. One person with multiple disabilities attended the training, other participants disclosed one disability or medical condition. The numbers of disabled people and those from Black and minoritised groups attending the training were limited but they were accepted onto the training at the same rates as other groups (see Table 4.2, Appendix 4). However, a higher number of Black and minoritised participants might have been anticipated in Nottingham due to the ethnic diversity of the city - approximately 34.6% are from Black and minoritised groups (Census, 2011). Ethnic diversity of an area is widely used as a minimum benchmark to indicate adequate representation and uptake of services. Whilst Ask Me recruitment across the three CtL sites was comparable with national ethnicity rates, local areas with higher density of Black and minoritised communities may need to do more to attract Ambassadors from these communities. In Year 1, married women were the largest group to attend the training (32%) (Appendix 4, Table 4.2). The age range for all participants was 19 to 71; the mean age was 44 years.

Key characteristics of all Ambassadors attending the training across both cohorts are shown in Table 4.3, Appendix 4, and summarised below:

- Of the 290 participants who indicated their gender, 286 women and 4 men attended the training.
- Out of 280 participants who answered the question, 246 said they did not consider themselves to be disabled; 34 (12%) disclosed one or more disabilities.
- The age range of Ambassadors was 19-71, with the average age being 42.

- Most Ambassadors described themselves as White British, 30 (11%) reported having a Black and minoritised background and 15 (5%) reported 'other white background' such as Eastern European.
- Most ambassadors described themselves as heterosexual (91%); 13 (5%) identified as gay, lesbian, or bi-sexual and 13 (5%) chose not to disclose.

EOI data for those attending Ask Me training across both cohorts shows that women aged between 25 and 54 formed the majority (77%) of those attending Ask Me training (see Table 4.3, Appendix 4). In contrast, national data on volunteering shows that in 2018-19, people aged 65–74 were most likely to volunteer on a regular basis (NCVO, 2020). NCVO data also shows that men and women regularly volunteer in the same proportions, whilst Ask Me Ambassadors are overwhelmingly women. NCVO data reports that in 2018/19, 14% of all volunteers were involved in formal regular volunteering (i.e. through a club or organisation) in the most deprived areas of England compared with 29% in the least deprived areas. This may have implications for targeting areas where uptake for Ask Me might be higher. The self-identified class category in the EOI did not yield useable data.

Wanting to help others is a common motivation for volunteering in national data (45% of volunteers in the NCVO 2020 report) as well as for Ask Me Ambassadors, a substantial proportion (40%) of whom disclosed that they were DVA survivors. Other motivations for attending included knowing someone who had personal experience of DVA, to learn more about supporting people who had experienced DVA or to pursue a career or volunteer opportunities in work with DVA survivors:

…just in my personal life, needing to be more prepared as to how to support my friends and my family, and to help heal myself as well, there's an element of that. (Participant 7, Sunderland, Year 2)

I wanted to be able to help others because I found that being a domestic abuse survivor some ten years ago, there wasn't the support in the community, and I had to really fumble my way through issues like housing, benefits, raising a small child on my own. (Participant 11, Surrey, Year 2)

Some participants were aware of DVA as a prevalent issue in their community (or the community in which they worked/volunteered) and wanted to be better able to support survivors and make a difference. One participant specifically reported undertaking the training with a view to delivering something similar in the workplace to improve the work environment for '*people losing their jobs because of domestic abuse*' (Participant 15, Sunderland, Year 2).

In Year 1, Ask Me training often attracted professionals who might have been better suited to Trusted Professional. This caused difficulties on training days where some participants were unable to relinquish their professional identities. Clearly, people have multiple social identities and co-ordinators reported that the community-based focus of this intervention had been emphasised to potential professional recruits in Year 2:

They turn up presenting as a professional, with their lanyard on and everything like that. And you try really hard to keep shifting them out of that professional space and say…you said that you were involved in these… community groups or you volunteer here, think about it from that perspective. (Trainer/Coordinator 10)

Interestingly, two participants in year 2 described accessing the training to develop knowledge and skills to address gaps in community DVA provision due to austerity:

['to have] a knowledge about that at the moment, to be able to help and, you know, signpost… [due to] …austerity, how that's affected refuges and services and access to services and everything. (Participant 6, Surrey, Year 2)

Ask Me required participants to give up the equivalent of two days of their time to participate in the training and for those who were working this might pose a barrier as '*generally, people are using leave, and I think that's a big ask*' (Trainer/Coordinator 5). In year 2, Ask Me remained a two-day training course however, to support attendance, days were delivered flexibly rather than in a block, e.g. as one day per week over two weeks or in the evenings.

Trainers/Coordinators also expressed a need to recruit a more diverse group of Ambassadors:

I think more could be done across all of the sites to make sure that the people attending are more diverse, particularly from all marginalised groups…it's mostly about that community outreach that's done…and working with pre-existing groups in the community that come from different communities (Trainer/Coordinator 11)

Following Evaluation recommendations in Year 1, the Ask Me training package was modified to enhance accessibility and include representation of diverse groups in its resources and case studies. Interview participants confirmed it was very comprehensive. In contrast to Year 1, all 15 interview participants in Year 2 reported confidence in supporting women from Black and minoritised and LGBTQ+ communities as well as both older and younger women who had experienced DVA (except for one participant who felt less confident supporting younger women). Participants also suggested further training around these groups, see below for further discussion.

The shift to online training precipitated by the pandemic was viewed with uncertainty by some trainers due to the high numbers of survivors participating in the training and attendant support requirements: '*I'm just not sure. I mean for every single one of the Ask Me training events that I have…there was at least one woman who was upset and needed support outside of the room*' (Trainer/Coordinator 7). In the event, it appears that these concerns were allayed:

And now they've done several deliveries [online], the feedback they're getting from some who've done both online and face to face, is that they prefer online, that it's more accessible to them. And, you know, they're having great success with it. So, I think we've surprised ourselves really in that. (Senior Manager 3, WA).

4.4 Post-Training Support

Post-training support aimed to keep Ambassadors active and involved and its importance was emphasised by most trainers and coordinators:

I would like to put a bit more work and emphasis on the post-delivery… because that's the hard bit, keeping people on board with it. (Trainer/Coordinator 2).

Participants in both years 1 and 2 found accessing ongoing support from other Ask Me Ambassadors through social media platforms, including Facebook and WhatsApp groups, beneficial. In Sunderland, for example, Ambassadors made use of an online group, but other face-to-face initiatives were not always so successful:

Well there's a Facebook group that's just for Ask Me Ambassadors. I think there's 150, it's for everyone across the country, it's a really supportive environment. (Participant 5, Sunderland, Year 2)

Locally, we've just started to move to monthly Ambassador catch ups…they've been a bit ad hoc, to be honest...because there's not always been that interest... we've had quite small numbers… (Trainer/Coordinator 10)

Despite attempts to strengthen follow-up support systems, six of the 15 Ask Me Ambassadors interviewed in year 2 reported that no post training support had been received. A small number recalled receiving an email, newsletter or had accessed the online forum but they had expected more substantial activities to constitute post-training support. Furloughing of coordinators during the pandemic clearly had an impact and three participants commented that post-training support had been affected by Covid-19:

…if lockdown hadn't happened, they were talking about, you know, group meetings and things like that. That would have been good but, obviously, I appreciate that that couldn't happen. (Participant 13, Sunderland, Year 2)

Only one interview participant in Year 2 reported that they had attended monthly meetings and that these were highly valued:

Well we have monthly meetings…everyone's very respectful, everyone listens to each other and what they have to say…it's amazing because everyone's so sort of charged up…we've all got so many ideas and we're bouncing off each other...(Participant 5, Sunderland, Year 2)

One participant who had been the only attendee at a recent post-training meeting suggested that post training support might be more welcomed if delivered as and when it was needed:

I would go back to them if I then found myself in a situation where I was supporting somebody. I think that's when I would go to them and say, what do I do now? (Participant 8, Sunderland, Year 2)

Other participants reported that telephone support was available if required and this had been utilised by two interviewees:

The course instructors were fantastic…hugely dedicated and they did provide sort of telephone calls and emails after the course, and did give us their own mobile numbers to call…they absolutely are there if we need them. (Participant 10, Sunderland, Year 2)

Other participants reported that, although it had been offered, they were unable to take up the post-training support on offer due to caring responsibilities, a lack of connection with other group members or distance to meeting locations.

4.5 Impact of Ask Me Training

To evaluate impact, pre/post questionnaires, HAYGOs and interviews with Ambassadors were analysed. The total sample for analysis of pre/post questionnaires was 326, including Ambassadors in Sunderland (n=160), Surrey (n=91) and Nottingham (n=75). Although the data was not distinguished by training year, year two of the training represented most of the sample (n=228, 70%). Data were initially analysed by site but as there were no significant differences between sites, findings were aggregated.

Nine questions on knowledge and beliefs and four questions on skills and confidence were asked pre/post training. The results are summarised in Table 4.1 below. Each domain was analysed using a Wilcoxon signed-ranks test with a bar chart showing changes (see Figures 1-13 in Appendix 4).

Table 4.1 – Pre/Post Questionnaire Results

	N	Pos. Change (n)	Neg. Change (n)	No Change (n)	Median pre-post change	Stand-ardised Test Statistic (Z score)	Asymp-totic Sig.[a] (2-sided test)	Effect Size (Cohen 's r)[b]
Knowledge of DVA questions								
Women form the majority of DVA victims	309	157	27	125	1	8.313	.000	.33
Men form the majority of DVA victims	304	145	35	124	0	7.711	.000	.31
Men find it harder than women to come forward as victims	307	95	49	163	0	3.644	.000	.15
Women in abusive relationships should just leave	306	168	13	125	1	10.311	.000	.42
Some people choose abusive partners	303	187	15	101	1	11.414	.000	.46
Survivors are 'experts' in their own experiences	309	203	30	76	1	11.467	.000	.46
People who get into abusive relationships have low self-esteem	310	161	31	118	1	8.833	.000	.35
Anger, drugs and drink are responsible for DVA	308	182	30	96	1	10.439	.000	.42
DVA is part of some BME cultures	306	116	81	109	0	2.019	.044	.08
Skills and confidence questions								
Understanding coercive control and DVA	314	247	2	65	1	13.928	.000	.56
Starting conversations about DVA	313	245	7	61	1	13.593	.000	.54
Managing and responding to DVA disclosure	314	250	2	62	1	14.052	.000	.56
Sharing information and signposting survivors	312	251	1	60	1	14.023	.000	.56

a. The significance level is .050.

b. Thresholds for Cohen's r effect sizes: small < .3, medium .3 – .5, large > .5

Table 4.1 demonstrates significant positive changes in all the above domains. Where there was limited significant positive change, this was usually because participants already had good

understanding of the issue (e.g. on the question - women form the majority of DVA victims). Two areas that could be further refined in training were DVA and Black and minoritised communities and men accessing support for DVA. The statement that survivors are 'experts' in their own experience and understanding of coercive control showed the most positive change. Interview participants confirmed that the training helped to facilitate understanding about why women might not leave abusive relationships and could reduce victim-blaming:

…it did completely change my thinking, my thoughts about people living in abused relationships. And I do consider myself a caring individual, otherwise I wouldn't be in this kind of role. But I was quite shocked at how narrow minded I had been previously, and I didn't think I was. (Participant 10, Sunderland, Year 2)

Structured observations and interviews identified learning from other participants as key to change:

…it was the interaction and those open discussions and how the day flowed between everybody, and the trainers, was as much the benefit as, you know, the theory and the detail. (Participant 4, Surrey, Year 2)

Overall, Ask Me training increased confidence in responding to DVA immediately post-training. Whilst the training was judged to be comprehensive, further training was also considered useful for ongoing knowledge development. Areas of interest identified included: DVA survivors in the criminal justice system or going through family/ criminal court processes; LGBTQ+ or Black and minoritised women, media representation of DVA and knowledge of different DVA services available to inform victims/survivors:

I do wish that there'd been a bit more information specifically to minority groups. But they do send out like newsletters once a month and there's a forum as well for the Ask Me Ambassadors. So that's been helpful because you can read information on there. (Participant 5, Sunderland, Year 2)

Structured observations and interview participants consistently identified additional benefits of the training which extended beyond the original aims of Ask Me. These included: meeting other members of the community; increased self-reflection; feeling empowered, motivated, or enthusiastic to do something or be involved in something pro-active. Participants stated that it was these feelings of camaraderie, and 'empowerment' *'a sense of sisterhood in the room'* (Participant 7, Sunderland, Year 2) that motivated them to return to complete the training and further developments might consider how to harness these experiences to maintain engagement:

I was excited that I could make a difference in the community. And that there was this kind of tribe of women…I felt really excited and empowered that there was something that we could do collectively, to change things for women in Sunderland. (Participant 16, Sunderland, Year 1)

4.6 Post-training Activities

Post-training activity was assessed by interviews and HAYGO forms that aimed to measure the level of Ambassadors' DVA activities post-training. A total of 112 HAYGO forms were received from Ambassadors across the three sites for both years. Of those completing HAYGOs, 49% identified themselves as survivors at EOI stage, suggesting that survivors are particularly likely to remain engaged with Ask Me or at least be more willing to return information about activities as

Ambassadors. There were no major differences between those who completed the training and those who returned HAYGO forms.

The most frequent activity reported was conversations about DVA. In total, 93 (78%) Ambassadors reported having between them at least 598 conversations[28] about DVA since the training, with over half of these conversations addressing someone's personal experiences of DVA. Conversations were more likely to occur with friends or family (n=58), clients or customers (n=39), colleagues (n=37) or online via social media (n=14). Other groups of people who Ambassadors had talked to about DVA included neighbours, colleagues in other organisations or fellow students. Ambassadors reported that 173 people had shared their experiences for the first time. For 170 of all those people they talked to, the abuse was current while, for 275 of those people, the abuse had happened in the past. Where timescales were known, the abuse had most frequently continued for between one and five years (n=139). Seventy-two (64%) Ambassadors reported providing information and signposting those who had disclosed DVA to national or local DVA organisations. In a minority of instances, the police or an employer were informed by the Ambassador.

The Ambassadors interviewed described putting up posters, discussing the Ask Me training, spreading awareness via social media, challenging myths or stereotypes surrounding DVA or providing information to someone else about becoming an Ambassador. Some had become more involved with their local DVA services, and a few had given talks about DVA. In total, 20 interview participants talked about raising awareness of DVA in their local communities by initiating conversations with people around them. These conversations included discussions about healthy relationships and media reporting of DVA and were considered key to addressing the silence surrounding DVA:

…not frightened to broach the subject…not sort of like be specific with people, but just sort of bring up various conversations and everything…almost like breaking the silence. (Participant 6, Surrey, Year 2)

One participant explained that she would also introduce information about local services within a conversation to ensure others had this knowledge if needed. The Ask Me badge was worn by some participants and some described wearing it every day to in initiate conversations about DVA:

Ask Me, what's Ask Me, why have you got that badge on? So…obviously…, that starts the conversation for me to explain what training I've been on. (Participant 4, Surrey, Year 2)

Ambassadors had utilised social media to share information or resources around DVA. They were able to signpost to local services or challenge myths around DVA:

…people who, again, are saying, that's absolutely crazy, why has she stayed with him? You're able to go and comment and say, well, hang on, this is, you know, think of it this way. (Participant 8, Sunderland, Year 2)

That was 8 o'clock that morning, by 8 o'clock that night, she was on her way to freedom. It was amazing, she was really grateful for what I'd done and I felt proud... (Participant 12, Sunderland, Year 2).

[28] This figure is likely to be an underestimate as HAYGO forms only offer Ambassadors the option of logging 1-10+ conversations.

Other participants had mostly utilised their learning at work but sometimes also with family and friends. Participants described a change in their responses when there might be a '*hint*' about DVA from a woman and they described themselves as more confident to ask questions, listen and signpost. For example, one participant identified a change in her practice at work, proactively contacting people who did not attend appointments, where she had DVA concerns, rather than presuming this was their choice. Another identified working with their Human Resources department to better inform other members of the staff team about DVA.

The evidence above illustrates the levels of positive activity and impact of Ask Me following the training. However, some participants who had completed the training were uncertain about how to put their training into action:

I'm not really sure what to do with the training that I have, if that makes sense. (Participant 8, Sunderland, Year 2)

Others were unsure how proactive they could be*: 'we don't quite get how to help people further, unless they come to you'* (Participant 2, Surrey, Year 2) and also wanted further guidance to keep up momentum as *'a way of keeping us engaged, as…things wane after a little while'* (Participant 6, Surrey, Year 2). Interview participants who decided not to become an Ambassador post-training described a lack of capacity due to competing personal commitments or because of lack of contact with potential victims/survivors in their employed role or because nobody had shared their experiences since the training. Across both cohorts, a small number of participants highlighted their deliberate avoidance of social media to avoid potential contact with an abuser:

I don't post anything on social media particularly about anything because the police told me… not to put too much on there about anything, because I just disappeared, nobody knows where I am. (Participant 2, Nottingham/shire, year 1)

Interview participants in year 2 identified a range of challenges in performing the Ambassador role. Firstly, the impact of Covid-19 restrictions was felt to inhibit both face-to-face disclosure and picking up non-verbal cues:

…now we're all in masks. So, this is what we look like, so you can't see whether I'm going, yes or, it is still very difficult, but at least you've got the physical contact, if not the facial recognition. (Participant 10, Sunderland, Year 2)

Secondly, appropriate services might not be available locally, for example, a participant in Surrey mentioned the lack of LGBTQ+ services in the area. Others cited cultural barriers in the workplace or community coupled with a lack of funding for awareness raising activities to address such attitudes:

…culturally, the issue that I've come up against time and time again, which is when there is known domestic violence, what religious leaders try and do, is they try and bring the respective partners together to mediate. And it's a big, big, no, no, in everything that I've ever been taught… (Participant 6, Surrey, Year 2)

4.7 Future Plans for Ask Me

One trainer/co-ordinator suggested that, in future, Ask Me should be targeted on particular community organisations:

…it might be good to kind of do organisations. So I approached a woman's centre, where they have training programmes for their volunteers, and asked if, you know, Ask Me could be part of their training programme. So in that way it's embedded within their kind of curriculum, you know, they have their own premises and everything... (Trainer/ Co-ordinator 6)

In future, Ask Me is to be delivered via a social franchise model and its continuation will depend on local member services' ability to fund it:

Ask Me is free at the point of delivery, so there's no training money that can come from Ask Me, but members have generated in-kind support through Ask Me. But it's harder to justify the cost of it and we've worked it out at about 40 grand a year to run, so members have to find that somewhere. (Senior Manager 1, WA)

An external evaluation of the Ask Me Plus scheme delivered in sites not included in the Roadmap Programmed confirmed that ongoing evaluation of this social franchise model was required (Edwards and Brook 2020).

4.8 Summary

- Facilitators to implementation included earlier piloting of the intervention, strong local networks, local WA organisations' engagement with Ask Me and excellent training materials.
- The administration tasks associated with Ask Me were described as unwieldy and a '*nightmare*' and coordinators also mentioned that they had not appreciated that they would have to recruit participants. Recruiting new participants in the future was also anticipated as being problematic as it was considered that saturation levels might have been achieved.
- Local member services were also expected to work with multiple WAFE trainers which meant training styles had to be adapted, often at short notice. Covid-19 restrictions particularly impacted on delivery of post-training support.
- DVA survivors made up a substantial proportion of those attending the Ask Me training.
- The ethnic diversity of Ask Me trainees was in line with the ethnicity profile of the country and people with declared disabilities also attended the training. However, given that the Black and minoritised population in Nottingham is 35%, more diversity among Ask Me participants would be anticipated there.
- Immediately post-training, pre/post questionnaires revealed positive changes in all domains.
- Two areas where participants wanted more programme coverage concerned addressing myths around DVA and Black and minoritised communities and men and DVA.
- Interviews (conducted 3-6 months post-training) provided examples of increased knowledge, confidence and Ambassadors' improved ability to respond to survivors post-training.
- Some Ambassadors suggested top-up training and more regular follow-up support addressing ways in which the training might be used.
- Ongoing Ask Me support needs to be flexible and both pro-active and reactive which inevitably would have time and resource implications. Several methods were used to retain Ambassadors' engagement with Ask Me with varying degrees of success.
- Ambassadors initiated numerous activities both at an individual level as well as at a community level. The most frequent of these was facilitating disclosure of DVA, but community-focused activities also included putting posters up in the local community, utilising the Ask Me lanyard as a means of starting conversations about DVA; commenting on social media about news or television coverage of DVA.

- Ambassadors' experiences of camaraderie, *'sisterhood'* and belonging to a '*tribe of women'* embodied the importance of combatting DVA collectively and as part of a movement.

4.9 Recommendations

- Allocating one WAFE trainer to work in each site would allow a training relationship to develop between WAFE and local areas.
- Central WAFE administrative systems for Ask Me could be strengthened and clarity on who should input which data would assist local trainers and co-ordinators.
- Recruitment strategies for Ask Me should ensure that, when professionals attend Ask Me, they participate in their identity as a community member rather than as a professional.
- Recruitment and programme design should aim to achieve a diverse range of participants in Ask Me training to maximise inclusivity within communities.
- Online delivery of the Ask Me training requires robust evaluation, including capturing participant experiences and monitoring of whether online delivery impacts adversely on specific groups (e.g. older women).
- Given the time commitment required to attend the training, maintaining a flexible approach to delivery of the two-day course (e.g. in shorter evening sessions, over weekends etc) would potentially extend the reach of Ask Me.
- Overall, the training programme is highly successful but could be developed further by an increased focus on enhancing understanding of DVA and gender (including men as victims) and DVA and Black and minoritised communities. This would help to challenge a gender-neutral approach and increase the confidence of Ambassadors in responding to diverse communities.
- Interview participants recommended 'top-up' training on a range of issues including DVA survivors involved with the criminal justice system or with family proceedings; minoritised groups such as LGBTQ+ or Black and minoritised women, media representation of DVA and knowledge of different DVA services available
- Support for Ambassadors both during and post-training to identify how they could make a difference within communities is essential to capitalise on the achievements of the training. The variety of approaches currently used to deliver this support (e.g. social media, newsletters, face-to-face meetings) should be maintained.
- Regular and systematic collection of HAYGO forms, ideally linked back to Expression of Interest forms, should be undertaken to identify patterns of activities and provide data on those Ambassadors who continue or cease Ask Me engagement.
- The piloting of the social franchise model of Ask Me to assess its viability is recommended as this model has not been tested to date.

Chapter 5: Trusted Professional

The Trusted Professional intervention had two iterations during the evaluation. The first phase (October 2017–March 2018) comprised a standalone one-day training event aiming to increase survivor-centred, strengths-based, trauma informed and needs led approaches to DVA survivors by non-specialist frontline professionals. The second phase (June 2019–March 2020) was an enhanced intervention that built on previous work and drew on the findings from the evaluation of Phase 1.

WAFE define the Trusted Professional programme as a 360-degree intervention, combining policies and practice reviews with training and development to ensure that professionals and organisations create space for action for women survivors. It comprised a system-orientated intervention designed to wrap around the whole organisation. In addition to the one-day training programme, it included focus groups with staff (Professional Voice) and survivors (Survivor Voice) at the outset to understand their views and experiences of DVA services and to highlight good practice. Focus group findings directed DVA policy development with organisations participating in Trusted Professional and informed reflection days with staff following the training. The Phase 2 intervention also included assessment of the longer-term impact of the enhanced offer regarding changes in practice with DVA survivors. Based on researcher observations, the one-day training session in Phase 2 provided detailed explanations of DVA, emphasising: coercive control, widening the survivor's space for action, strength-based ways of working, power within services and systems, trauma-informed approaches, building change through language, record keeping and self-care.

Data sources informing this chapter include: pre/post training surveys (n=404), interviews with i) professionals who had received Trusted Professional training (n= 31); ii) trainers and coordinators (n=10); iii) senior WAFE managers (n=3) and iv) researcher observations (n=3). Descriptive statistics were used to analyse pre/post interviews and interviews were analysed thematically. There is limited data available on the enhanced Trusted Professional offer since development took longer than anticipated and both delivery and the evaluation were interrupted by the pandemic.

5.1 Implementation

Trusted Professional had been successfully delivered in other areas of the country prior to the Roadmap Programme and this learning assisted implementation in the three sites. Implementation varied between sites depending on the strength of local networks and whether it had been possible to embed CtL within commissioning arrangements. Surrey recruited statutory sector organisations (especially in Phase 2), whilst Sunderland largely recruited from the voluntary sector. Nottingham/shire had commissioned the existing DVA training provider and joint delivery was initiated.

Implementation relied on central WAFE delivery in partnership with local member services and CtL coordinators. This approach capitalised on local connections and reduced the burden on member services. Implementation of the enhanced Trusted Professional offer was delayed for the reasons given above but it also took time to build an appetite for and commitment to the programme in local organisations:

I think maybe if we'd have got hold of Trusted Professional a bit earlier…I would have liked to have seen that, yes, deliver more with different audiences and checked that that worked for everyone. (Senior Manager 1, WA)

So, in terms of approaching organisations, that took a lot longer because it's a big commitment from the organisation. (Trainer/Coordinator 10)

On reflection, senior managers also recognised that CtL coordinators were over-stretched and the task of implementing three different interventions was ambitious:

… we had one full time worker, who was expected to … do all of that local stakeholder management, raise the profile, do all of that kind of strategic piece, alongside planning, administrating and delivering Trusted Professional, Ask Me…And I think that…we were limited in what we could achieve by the capacity that we had within each area. (Senior Manager 1, WA)

5.2 Training Delivery

Face-to-face DVA training was the key delivery mechanism across both phases. Pre/post questionnaires were completed prior to and immediately following the training to measure immediate changes in knowledge, confidence and skills to intervene in DVA (n= 404: phase 1 n=99; phase 2 n=305). Most participants were female (85%; n=344); 56 were male (14%) and two preferred not to say. Most participants stated that they had already received DVA training in their current role (72%; n=288). However, 17% indicated that this had been for a period of less than two hours (n=50). Table 4.1 provides an overview of the service sectors from which training participants were drawn. The majority came from children and families services, including Early Help Services in the independent sector as well as Children's Social Care, the Department of Work and Pensions (Surrey only) and Housing Associations.

Table 5.1 Participating Sectors by Site 2017-2020

Sector	***Geographical Location***			***Total***
	Nottingham	***Sunderland***	***Surrey***	
Children and families	48	50	95	193
Department of Work and Pensions (DWP)	-	-	93	93
Housing	30	30	-	60
Health	-	-	20	20
Youth Offending	-	1	-	1
Community Safety	15			15
Local Authority Health & Wellbeing Service			12	12
Unknown	10	-	-	10
Total	**103**	**81**	**220**	**404**

NB. Some inaccuracies in assigning participants to sectors may have occurred among some Year 1 participants where their sector was not always clearly distinguished.

Pre/post questionnaires included seven potential DVA indicators (substance misuse, financial difficulties, childcare issues, injuries, anti-social behaviour, mental health difficulties, physical health issues) agreed between WAFE and the research team. These indicators were used to assess the extent to which professionals participating in the training already inquired about DVA in current practice. In the Year 2 cohort (where participants' workplaces were easier to identify), on average, 25% of those working with children and families stated that they had 'always' or 'nearly always' asked about DVA/Sexual Violence (SV) in the previous six months compared to 20% working in the health sector, 10% in the DWP and 8% in housing. A higher proportion (67%, n=106) of those who stated they had 'always' or 'nearly always' asked about DVA/SV in the previous six months, identified new cases compared to those who had 'sometimes' asked (45%, n=44) and 'seldom' or 'never asked' (16%, n=22). On identification, the most common response was to provide information (78.2%; n=136), offer validating statements (70.1%; n=122) and ask the victim what was most important to them (68.9%; n=120).

Trainer/Coordinator interviews revealed several challenges when delivering the training including the challenges of delivering to a multi-professional group; participants requesting more information about perpetrators; challenging gender-neutral attitudes among some participants; space required for participants disclosing DVA; and organisational practices that were not conducive to working in a survivor-centred manner. In mixed professional groups, understanding different professional roles was considered central to influencing post-training practice:

I think it works better if the trainer understands the roles of the people in the room. So, yes, it doesn't matter, you see, if you've got a mixture of social workers, housing and whoever in the room, as long as the person that's delivering the training understands the role of adult social care, understands the role of children's social care, understands the role of a housing officer. (Trainer/Co-ordinator 2).

Plans for Phase 2 revolved around targeting specific organisations and so were more likely to include single professional groups, thus making the organisational context of delivering changes in practice more central.

There was also recognition that expanding delivery to a wider group of statutory sector professionals would be beneficial as these were settings where DVA was routinely encountered:

Drug and alcohol …I think it would be valuable for them…[Also] mental health professionals, I think it would be beneficial to them as well. (Trainer/Coordinator 7).

Different professional groups had markedly varied understandings of DVA and so training needed to reflect this and be tailored accordingly:

Maybe this is just about tailoring it to the different organisations and the different levels, because if you are working with family support workers, I imagine they do have a much greater understanding of abuse than a DWP worker. But for the DWP workers… it didn't seem that they were particularly coming in with a greater understanding of abuse than any ordinary community member. (Trainer/Coordinator 11)

The content and quality of training delivery was valued by participants. This was confirmed via interviews with professionals, training feedback forms and researcher observations of the various training activities. For example:

I genuinely felt it had been one of the best bits of training I've done in a very long time, …the quality of the training, before you then got into the subject, was excellent, and I found it very useful…for me, it was very much back to basics. I feel like we stripped the issue right back to the absolute fundamentals of what DVA is about. (Training Participant 19, Sunderland, Phase 2)

5.3 Impact

The impact of Trusted Professional was examined via the pre/post questionnaires and follow up interviews with training participants, senior managers and trainers/coordinators. To measure the impact of DVA training on professionals' confidence and capability to recognise and manage DVA cases, participants were asked to 'indicate how much you agree with the following' in relation 17 statements using a five-point Likert scale ranging from '*1. Strongly disagree'* to '*5. Strongly agree'*. Change was measured using a Wilcoxon Signed-Ranks test. Positive ranks (higher code response post to pre training) indicated increased confidence and capability. Negative ranks (lower code response post to pre training) indicated confidence and capability had reduced post training. Tied ranks (pre-training response = post-training response) indicated no change. A proportion of ties included those who selected 'strongly agree' pre- and post-training, therefore positive change was not possible. There was a significant relationship between DVA training and increased confidence and capability immediately following the programme across all 17 statements, $z = -.15.25$, $p < .001$. (see Figure 5.1, Appendix 5). Positive change was more prevalent in Surrey (see table 5.1, Appendix 5). Increased understanding of and confidence to recognise coercive control was a key area where positive change was most evident. Those agreeing they had sufficient training to assist women experiencing DVA doubled immediately post-training. To measure change in beliefs about DVA, participants were asked to select 'true', 'false' or don't know' in response to six statements (see Figure 5.2, Appendix 5 for changes in beliefs pre/post training). Overall, Trusted Professional training had a positive

influence on DVA beliefs, with most professionals showing positive changes immediately following the training.

Interviews consistently indicated that professionals valued the opportunity to increase their knowledge, skills and confidence to respond to DVA, and they associated this with improved practice. Even where participants reported that nothing new had been learnt from the training, they reflected that the training was important for reinforcing key messages and maintaining motivation. Observations by UCLan researchers noted that participant knowledge was variable at the start and some participants might benefit from DVA awareness training prior to Trusted Professional intervention, particularly for professionals who have limited training, knowledge or experience of working with DVA. The training also helped to update professionals about local services and awareness of their own professional role in identifying DVA in their everyday practice also improved. Overall, the impact of the intervention was widely reported as increasing understanding of the dynamics of DVA:

…everybody knows a little bit about domestic violence…but I certainly didn't understand the levels of violence and control…it opened my eyes. (Training Participant 12, Nottingham/shire, Phase 2)

Most of the 19 professionals interviewed (3-6 months post-training) during Phase 2 were confident in their understanding of 'survivor-led working', describing this approach as a means of enabling individual choices and actions led by the survivor whilst supported by professionals:

after the training, we understood that… we're not to try and fix it, that we're not to make, you know, suggestions of what the person should do…you let them know that you are available to help or you do know places where they can get help, you know, when they are ready…(Training Participant 10, Surrey, Phase 2)

I hadn't kind of been aware of it, about survivor led intervention, if you like. It makes perfect sense to me. The person who is being affected, should have the most say. It has to suit them, you can't impose solutions on people. You have to work with people and that may be that you don't get to do the thing that you want to do. (Training Participant 12, Nottingham/shire, Phase 2)

Participants also described how language could facilitate the process of building trust with survivors and open up dialogue about their experiences. Researchers noted that the activities and cases used in training emphasised that language and changes to approaches needed to be meaningful. Across the interviews, professionals reported increased confidence to think differently and ask the questions that would enable those experiencing DVA to disclose. They described positive attitudinal change towards DVA in their practice and an increased intent to ask relevant, probing questions:

I can remember a couple of occasions when people have attended in the office and, basically, because of the training I had, I asked questions at that point that I wouldn't have asked before, just to make sure people were safe and things were OK. (Training Participant 11, Surrey, Phase 2)

Phase 1 participants reported that the training improved understanding and knowledge of DVA but not necessarily rates of identification, possibly because these professionals were already working in facilitative environments regarding DVA. However, in Phase 2, managers reported improvements in frontline workers' ability to recognise DVA, particularly coercive control, and to identify strategies to engage individuals about their DVA experiences. The training provided examples of how and which questions to ask, improving confidence to start conversations which practitioners had found difficult to broach previously:

…the thing that I walked away with more than anything else, was to be professionally curious, to be unafraid to ask questions (Training Participant 3, Nottingham/shire, Phase 2).

Professionals reported feeling more skilled and competent to ensure appropriate time and space for individuals to share their DVA experiences following a disclosure. This connected to feeling better

equipped to listen effectively and respond directly to DVA rather than just signposting to other services:

…if an individual takes a step to tell somebody they're working with that there is an issue with their life they need some support with, what they don't want, is to then be passed to another person who they've never met before…that's one of the biggest changes…staff are able to support women with that issue, without passing them on to…another stranger…that's been one of the most powerful things. (Training Participant 19, Sunderland, Phase 2)

While most participants in Phase 2 reported increased confidence in working with DVA, Covid-19 restrictions meant that some practitioners had not been able to put the training into practice. Additional training around identifying signs and symptoms of DVA in the Covid-19 context was suggested. For others, the training had been helpful in recognising DVA and they were able to transfer this learning to the Covid-19 context: '*…some of those small things have become more exaggerated during lockdown, more obvious.'* (Training Participant 6, Nottingham/shire, Phase 2). Interviews indicated that maintaining this confidence long-term required ongoing and consistent training within and across all agencies including the provision of up-to-date information about available services or changes to the service landscape.

Most professionals interviewed in Phase 2 valued the training which was described as '*very informative', 'enjoyable'* and *'very well delivered*'. However, interviewees also offered a range of suggestions about how the training might be improved. These included adding video scenarios, greater knowledge of DVA services and more time for questions. Participants across both phases requested more information about other forms of abuse including violence in same-sex relationships, male DVA victims, so called 'honour-based violence', child to parent violence and perpetrators.

Phase 1 participants emphasised the importance of the intervention moving beyond a standalone training day. Phase 2 aimed to do this, and some managers reflected on changes to the way they supervised staff, encouraging staff to be alert to signs of DVA. Two professionals reported organisational policy changes: one reported policy improvements for staff experiencing DVA; another reported improved public office space to offer privacy for those disclosing DVA experiences. Phase 2 of the intervention also responded to Phase 1 suggestions for tools, activities and resources professionals could use with survivors to strengthen professional practice. For example, professionals were supported to use a practical advocacy tool designed to be used with a survivor to elicit the 'bigger picture'. Activities observed were also designed to support professionals to make changes within their case notes and reporting.

Most professionals participating in Phase 2 reported existing opportunities to practice reflection and self-care within their organisations, commonly during supervision sessions. Four professionals across the three sites reported improvements to self-reflection practices in their organisation since the intervention. These ranged from a one-off meditation session, open and reflective discussions among staff teams, to more structured opportunities for reflection. One professional spoke positively of a WAFE reflection session providing opportunities for professional development via peer support:

…sharing the kind of experience with other people who might have gone through the same training, and just kind of keeping note of that and how do we record it?...that helps, knowing that other people have done the same…peer support is really relevant…We can learn from each other…because we might not come across the same cases. (Training Participant 2, Nottingham/shire, Phase 2)

A needs-led and trauma-informed approach to working with DVA was widely supported. However, it was acknowledged that conflict could occur for staff in organisations working with families with a priority to safeguard children that used a risk-led model of intervention. While professionals from

children's services appreciated the importance of a needs-led approach, they raised concerns about how this could be achieved within the context of prioritising the children's safety. Trainers and co-ordinators interviewed also identified potential for conflict here with suggestions that additional material in the training addressing children might be appropriate and help professionals to understand how a survivor-led approach could support children's safety in practice. Despite these tensions, professionals indicated attitudinal change towards adopting a strength-based approach and working towards the empowerment of survivors.

Professionals reported that understanding, attitudes and approaches to survivor-led working had improved following the training. For professionals already working within a strengths-based framework (e.g. Home Start), it is likely that the intervention was successful in reinforcing survivor-led working. Participants considered that continuous training was essential to embedding this approach. In comparison, survivor-led working represented an innovative and challenging approach for some organisations (e.g. Children's Services). Whilst individual professionals could see the value of this approach, organisational priorities and practices could present a barrier to change:

sometimes we go in and go bang, bang, bang, which is what we want to do…we will put this into place to help you, we'll sort your housing out, we'll sort your debt management…That's what we'll do. But that's not really what we're supposed to do. We're supposed to be led by them… (Training Participant 1, Nottingham/shire, Phase 2)

From a WAFE senior manager's perspective, the increase in referrals from a wider range of organisations was an indicator of success: '*The positive outcomes of the project…with Trusted Professional…we're seeing positive signs that specialist services are getting increased referrals coming from those kind of organisations'* (Senior Manager 1). In future, organisations engaging in Trusted Professional will be required to cover the costs of member services delivering the programme. At the time of writing, delivery of Trusted Professional had moved online in response to Covid-19 restrictions.

5.4 Summary

- The Trusted Professional intervention started off as a stand-alone training day and was developed into a more holistic systems-based intervention.
- The time taken to develop the new offer, the resources available (particularly at a local level) and the impact of Covid-19 delayed the new intervention and limited data was available for evaluation.
- The use of local member services to co-deliver the intervention meant that local knowledge and networks maximised implementation opportunities. The wider context of austerity and cutbacks to welfare and specialist DVA services may make this difficult to achieve.
- The training was well received with most participants drawn from children and families services, the Department of Work and Pensions (in Surrey) and housing. Fewer health professionals participated in the training.
- Immediately following the training, positive short-term changes were found in knowledge, attitudes and confidence across the three sites and understanding of coercive control increased.
- Post training interviews illustrated how training translated into practice, particularly where it was supported by organisational cultures conducive to the intervention's philosophy. More challenges were encountered where organisations conceptualised risk differently.
- Interviews with participants and trainers and co-ordinators suggested that training content could be strengthened by additional material addressing diverse forms of abuse and work with perpetrators and children. For example, Respect's Make a Change Programme,[29] developed in

[29] https://www.respect.uk.net/pages/34-make-a-change

collaboration with WAFE, addresses frontline work with perpetrators and could provide a useful source for additional material on this topic.
- The future sustainability of the intervention is uncertain as it moves from a free intervention to one where participating organisations will be expected to meet the costs of the intervention alongside the time commitment required.

5.5 Recommendations

- The time and resources required for developing the intervention and engaging interested organisations need to be fully recognised in roll-out and implementation of Trusted Professional.
- The sustainability of the intervention requires careful auditing to assess the viability of the proposed new model for delivering Trusted Professional in the future.
- The partnership model between WAFE and member services is important for effective delivery of the intervention and should be nurtured.
- Adequate resources at a local level for coordinators and member services to develop and implement future interventions should be made available via future commissioning arrangements.
- Preliminary findings on impact from evaluation of the enhanced Trusted Professional programme are encouraging, further evaluation is required to assess the longer-term benefits more fully.
- Trusted Professional should continue to target a wide range of organisations, particularly in those statutory sector organisations where DVA is regularly encountered. Training should be tailored to reflect different professional groups' knowledge and awareness of DVA.
- The intervention needs to develop strategies to adapt/challenge organisational priorities and working practices which may be antithetical to survivor-led and strengths-based approaches.
- Trusted Professional training needs to address the diverse forms of violence experienced by survivors to ensure that intersectional needs are responded to. Additional content to inform participants' work with DVA perpetrators and children was also suggested.
- On-going training was recommended by several participants to help embed a survivor-centred approach.

Chapter 6: VOICES

Whilst Trusted Professional and Ask Me are outward-facing interventions, VOICES aimed to build skills and competence in assessment and support among specialist DVA services.

The intervention was delivered by staff in Women's Aid member services. In total, WAFE supports 180 member organisations providing just under 300 frontline services to women and children across England. These member services offer a range of local support services such as online support, outreach, independent domestic violence advocacy (Idvas), refuge accommodation, floating support, aftercare and resettlement.

VOICES provided practitioners in four WAFE member services[30] in the three CtL sites with a new assessment framework, training and planning tools. Work was also undertaken with managers and boards to encourage a more reflective and woman-centred approach to DVA. Like Trusted Professional, VOICES' trauma-informed approach was conceived as a whole organisation approach, incorporating organisational culture, leadership, supervision and experiences of using the VOICES approach for both practitioners and survivors.

In their literature, WAFE conceptualise the service response to DVA as increasingly moving towards a gender-neutral, risk-based model, with the aim of providing a standardised approach[31]. Instead, WAFE propose that an effective and sustainable service response is built on women's own strategies and enables what is positive within such strategies. VOICES aimed to embed this response through a framework, training and coaching for frontline DVA practitioners that would reconnect them to this strengths-based, needs-led, trauma informed approach.

The evaluation of VOICES (30/11/19 – 30/11/20) included thematic analysis of interviews with survivors (n=17), staff (n=11) senior managers (n=3) and trainers/coordinators (n=3). It also included the Evaluation's outcome measures completed at three time points by survivors using VOICES services between October 2019 and December 2020 and a staff survey. WAFE's OnTrack data was used to establish a picture of all survivors using the VOICES services as well as survivor outcomes.

6.1 Implementation

VOICES was the last of the CtL interventions to be implemented and was introduced from September 2019. It took longer than anticipated to plan and develop, and its focus and content changed during the development process. It was intended to be trialled across five organisations in the three study sites in September 2019; two organisations dropped out of the evaluation due to capacity issues and the evaluation focused on one organisation in each of the three sites. Of these, Nottingham/shire was only involved at the outset and then did not continue the intervention due to staff shortfalls. Nevertheless, the early data made available from Nottingham/shire has been included in this report. The pandemic affected VOICES particularly severely as the intervention was newly developed, had not been piloted previously and had been delivered for less than six months at the start of lockdown:

…then Covid hit [which] has definitely slowed what we would have expected to have seen from VOICES in the latter parts of the project. So…VOICES has been a bit harder to implement… (Senior Manager 3, WAFE)

[30] Your Sanctuary Outreach Team (Surrey), Wearside Women In Need Refuge Team (Sunderland), Wearside Women In Need Outreach Team (Sunderland), Nottinghamshire Women's Aid Outreach Team (DASWA).
[31] Women's Aid (2020c) https://www.womensaid.org.uk/wp-content/uploads/2020/11/Change-That-Lasts-Impact-Briefing-1.pdf

However, there were several other factors that hampered implementation. Implementation relied heavily on coordinators in each of the three sites but, as has been highlighted in previous chapters, their existing work on the Trusted Professional and Ask Me interventions meant they were unable to support the development as intended. This workload therefore had to be absorbed by WAFE centrally, potentially contributing to the delays. Co-production with member services and survivors was central to VOICES but proved time and resource intensive:

And then the VOICES tools we co-produced with member services... So, [my colleague] and I coordinated a group of…eight services, that really represented the diversity of…the federation. So, we…would do…the heavy lifting of development, and then it would go to that group to kind of say, what do you think about this? And they would take it back to their service users and then it would come back to us. So, it was quite a long process of development that way. It does, it takes ages to co-produce (Senior Manager 1, WAFE)

Other factors which slowed implementation included the tasks of persuading local member services to adopt the new framework and to move away from a 'risk-led' culture to a needs-led culture:

...when we were trying to bring members in to deliver VOICES, we had to do an awful lot of work, in terms of their values and making sure that they were still, yes, just undoing some of that cultural knot [risk culture] that they were all operating in…So…maybe in hindsight, I would have started with a member offer. (Senior Manager 1, WAFE)

Resistance to new ways of working was also reported:

I think anything new, our first instinct… wow, my clients won't like that. So, we get that defence up and we're like… we're not going to go too intensely with this, we're going to take it really slow (Staff interview 2, Surrey)

Staff across the three services suggested that implementation difficulties might be linked to a lack of time to introduce or understand changes or complete new paperwork and that additional training would have been welcomed. A long gap between the initial VOICES training and implementation contributed to a perception that workers were not always confident about the approach. While VOICES was seen as a different way of working for some staff, others considered that it was simply structuring their existing way of working into a different format or that they already worked in a strengths-based way:

…the strengths-based approach because I feel that we were already doing that before the VOICES (Staff interview 7, Nottingham/shire)

Some staff felt that VOICES record keeping was inconsistent with their existing database or created duplication alongside their current support plans and case notes. Additionally, VOICES was not embedded across an entire organisation but instead was piloted by specific services within the three organisations. It is also important to acknowledge that implementation of VOICES at the level of the individual practitioner is likely to have varied both between practitioners and across cases. This evaluation was not able to measure fidelity to the model.

6.2 Referral Pathways

WAFE OnTrack data showed that, across all three sites, referrals were most likely to come from the police (31.7%, n=1255), followed by MARAC (20.2%, n=800) (see Table 6.1). Self-referrals were highest in Sunderland. Across all services, referrals from the national DVA helpline[32], education,

[32] Helplines often signpost rather than directly make referrals. Self-referrals might therefore be a consequence of contact with the national helpline.

children's services, probation, solicitors, health services and other voluntary and community groups were consistently low. The data suggests that some services received more than one referral for a service user, i.e. they might have received a referral from an organisation and a woman might also have contacted them directly (see Table 6.1). Refuges, by their nature, have different referral pathways.

Table 6.1 Referral Routes

	All		Your Sanctuary (Surrey)		WWIN Outreach		WWIN Refuge		WA Nottingham	
	n	%	n	%	n	%	n	%	n	%
Self-referral	506	12.8	51	4.1	355	17.0	70	20.6	30	10.7
Police	1255	31.7	662	53.3	555	26.5	36	10.6	2	0.7
Probation	20	0.5	9	0.7	5	0.2	6	1.8	-	-
MARAC	800	20.2	198	15.9	601	28.7	1	0.3	-	-
Adult Social Services	56	1.4	40	3.2	8	0.4	6	1.8	2	0.7
Children's Services	187	4.7	4	0.3	151	7.2	31	9.1	1	0.4
Another VAWG Service	109	2.8	12	1.0	39	1.9	57	16.8	1	0.4
National DV Helpline	2	0.1	-	-	-	-	-	-	2	0.7
A&E	62	1.6	-	-	57	2.7	5	1.5	-	-
GP	12	0.3	5	0.4	6	0.3	-	-	1	0.4
Mental Health	49	1.2	5	0.4	38	1.8	3	0.9	3	1.1
Drugs / Alcohol	27	0.7	2	0.2	15	0.7	10	2.9	-	-
Specialist CYPS Support	46	1.2	-	-	-	-	-	-	46	16.4
Parenting Support	7	0.2	-	-	-	-	-	-	7	2.5
Education	8	0.2	2	0.2	2	0.1	-	-	4	1.4
Housing	116	2.9	2	0.2	34	1.6	70	20.6	10	3.6
Solicitor	2	0.1	-	-	-	-	-	-	2	0.7
Voluntary / Community Group	91	2.3	5	0.4	75	3.6	11	3.2	-	-
Other	188	4.8	127	10.2	40	1.9	7	2.1	14	5.0
Missing Data	412	10.4	119	9.6	110	5.3	27	7.9	156	55.5
Total Referrals	**3955***		**1243**		**2091**		**340**		**281**	
Total Survivors	**3543**									

*Figures suggest that some services received more than one referral for a service user, i.e. they might have received a referral from an organisation and a woman might have contacted them directly.

Table 6.1, Appendix 6, indicates that half of those referred to VOICES within the 12-month period were accepted onto service although, in one area, almost a quarter had to be placed on the waiting list (22.9%, n=64) at the time of reporting. Refuges are required to be immediately responsive as they are needed at the point of fleeing the home and so a woman will often move to where there is space rather than be placed on a waiting list.

Practitioners participating in the staff survey reported that referral routes had not substantially changed since the introduction of VOICES. One survey respondent stated that the approach had encouraged them to review their processes, with two describing the expanded breadth and depth of referral forms and processes which in turn made it clearer what external support from other services would be most beneficial for survivors. Respondents also highlighted that they used the VOICES tools to structure their conversations with external agencies and in some cases, the trauma-focused approach helped to combat a culture of victim-blaming:

Our referral forms into refuge are now more in-depth and when we are making referrals to outside agencies we use the tools and the information provided to get the most appropriate support to meet the women's needs as directed by the women (Survey Respondent)

Understanding more about trauma-informed practice has enabled us to challenge negative comments from other professionals who victim-blame and state that problems are due to drug and alcohol use and not trauma lived experiences.' (Survey Respondent)

A minority of staff interviews revealed the challenges of working in a strengths-based way in multi-agency settings:

I think it can be quite difficult in a multiagency setting, when other people are more focused on risk and maybe sometimes weaknesses and vulnerabilities. Whereas, we are looking at women's strengths and how that sort of helps them move forward… (Staff interview 10, Sunderland)

6.3 Demographics and DVA Histories of VOICES survivors

6.3.1 Demographic Information

Table 6.2 draws on WAFE's OnTrack data to provide demographic information for all service users accessing the service (n=2,125) during this period[33].

[33] Some referrals will have been received prior to 30/11/19 so referral figures don't correspond exactly with service user figures.

Table 6.2 Demographic Information for Voices Service Users

	All		Your Sanctuary (Surrey)		WWIN Outreach		WWIN Refuge		WA Nottingham	
	n	%	n	%	n	%	n	%	n	%
Female	2045	96.2	733	91.5	1029	99.0	109	100.0	174	98.8
Male	65	3.1	54	6.7	10	1.0	-	-	1	0.6
Intersex	1	0.0	-	-	-	-	-	-	1	0.6
Do not know	14	0.7	14	1.8	-	-	-	-	-	-
Total Survivors	**2125**	**100**								
0-15	2	0.1							2	1.1
16-25	378	17.8	116	14.5	195	18.8	25	22.9	42	23.9
26-35	765	36.0	238	29.7	436	42.0	45	41.3	46	26.1
36-45	507	23.9	183	22.9	249	24.0	28	25.7	47	26.7
46-55	256	12.0	106	13.2	111	10.7	10	9.2	29	16.5
56-65	77	3.6	45	5.6	25	2.4	1	0.9	6	3.4
66-75	38	1.8	17	2.1	17	1.6	0	0.0	4	2.3
76+	16	0.8	12	1.5	4	0.4	0	0.0	0	0.0
Missing Data	86	4.0	84	10.5	2	2.0	-	-	-	-
White	1513	71.2	243	30.4	1006	96.7	97	89.0	167	94.9
Mixed/Multiple ethnic groups	12	0.6	5	0.6	4	0.4	1	0.9	2	1.1
Asian/Asian British	52	2.4	34	4.2	12	1.2	6	5.5	0	0.0
Black/African/Caribbean/Black British	20	0.9	6	0.7	7	0.7	2	1.8	5	2.8
Another ethnic group	13	0.6	5	0.6	4	0.4	3	2.8	1	0.6
Do not know/declined/not asked	515	24.2	508	63.5	6	0.6	0	0.0	1	0.6
No religion	902	42.4	39	4.9	693	66.6	64	58.7	106	60.2
Christian	178	8.4	26	3.3	112	10.8	15	13.8	25	14.2
Hindu	2	0.1	2	0.2	-	-	-	-	-	-
Jewish	1	0.0	1	0.1	-	-	-	-	-	-
Muslim	34	1.6	18	2.3	10	1	6	5.5	-	-
Sikh	4	0.2	-	-	2	0.2	2	1.8	-	-
Buddhist	2	0.1	-	-	1	0.1	1	1	-	-
Any other religion	17	0.8	2	0.2	10	1	3	2.8	2	1.1
Do not know/declined/not asked	985	46.4	713	89.0	211	20.3	18	16.4	43	24.5
Heterosexual	1669	78.5	408	51.0	994	95.6	101	92.7	166	94.2
Bisexual	17	0.8	1	0.1	13	1.3	2	1.8	1	0.6
Lesbian	11	0.5	1	0.1	9	0.9	-	-	1	0.6
Gay	6	0.3	2	0.2	4	0.4	-	-	-	-
Queer	2	0.1	2	0.2	-	-	-	-	-	-
Pansexual/Other	2	0.1	-	-	-	-	1	0.9	1	0.6
Do not know/declined/not asked	418	19.7	387	48.4	19	1.8	5	4.6	7	4.0
Single	738	34.7	159	19.9	457	43.9	56	51.4	66	37.4
In relationship not cohabiting	144	6.8	33	4.1	94	9.1	6	5.5	11	6.3
Cohabiting	182	8.6	66	8.2	96	9.2	9	8.3	11	6.3
Married	232	10.9	120	15.0	80	7.8	10	9.2	22	12.4
Civil partnership	5	0.2	1	0.1	3	0.3	1	0.9	-	-
Separated	373	17.6	83	10.4	211	20.3	22	20.1	57	32.4
Divorced	36	1.7	17	2.1	15	1.4	-	-	4	2.3
Widowed	3	0.1	1	0.1	1	0.1	1	0.9	-	-
Other	10	0.5	8	1.0	-	-	1	0.9	1	0.6
Do not know/declined/not asked	402	18.7	313	39.1	82	7.9	3	2.8	4	2.3
Child(ren) Yes	972	73.4*	-	-	773	74.4	76	69.7	123	69.9

Women comprised 96.2% (n=2045) of service users referred to the VOICES intervention but it was also used with male service users, particularly in Surrey (n=54). According to the Crime Survey for England and Wales (ONS 2020) women aged 16 to 19 years were more likely to experience DVA in the last year than all other age groups. This contrasts with the VOICES cohort where service users were most frequently aged 26-45 years, indicating that more could be done to make DVA services more accessible to younger DVA victims. OnTrack data also shows that older women were less likely to access refuge provision.

Service users were mostly of White British heritage (71.2%, n=1513), although this data was missing for almost a quarter of survivors (n=515), predominantly from one organisation (n=508). Only 97 service users (4.5%) were recorded as being from Black and minoritised communities which is much less than the national average Black and minoritised population. Utilising site profile data on ethnicity (see Chapter 3), Sunderland has the lowest Black and minoritised population, but the highest proportion of Black and minoritised women (11%) in refuge; Nottingham only had 4.5% Black and minoritised women in its services compared to the city's Black and minoritised population of 35%. It should be noted that Nottingham was part of VOICES for a short time only and there may be Black and minoritised specific DVA services in the city which were used by Black and minoritised survivors in preference to the VOICES service. Nevertheless, the disparity in Nottingham strongly suggests that accessibility of VOICES services to Black and minoritised communities could be improved. Religion was frequently recorded as missing or not asked (46.4%, n=985).

Service users were most likely to be heterosexual (78.5%, n=1669) and single (34.7%, n=738), although there was a large amount of missing data from one organisation. Other sexual preferences represented just under 2% of VOICES service users. Almost three-quarters of service users (73.4%, n=972) had children with 2,821 children recorded across the four databases. This may suggest that service users are more likely to engage in support when they have children.

Data for income type was recorded for just under 30% of women (see Table 6.5, Appendix 6). Where this information was recorded across the services, service users were most likely to be in receipt of universal credit (11.7%, n=248) or in employment (8.4%, n=178). Data on living arrangements was available for just under 60% of service users. Of these, most were living in the private sector (See Table 6.3, Appendix 6). For the 2,125 service users accessing VOICES services, the majority were not living with the perpetrator at the time of referral (see Table 6.4, Appendix 6), although data was missing in this respect for 20.3% of survivors (n=432).

6.3.2 DVA Histories

Table 6.6, Appendix 6, highlights that service users experienced multiple forms of abuse, the most commonly recorded was emotional abuse (99%, n=2103), followed by physical abuse (61.6%, n=1310), jealous/controlling behaviour (57.1%, n=1214) and surveillance/ harassment/ stalking behaviours (39.5%, n=840). The figures for one of the services for this last field were much lower than in the other areas, perhaps indicating that it is not as well recognised as a form of DVA or, alternatively, that the fields were not populated. The average length of time a woman had experienced abuse prior to accessing VOICES was seven years. Women accessing refuge support were more likely to disclose experiences of sexual abuse (27.6%, n=35) compared to other services. Only one service recorded financial abuse. Service users in Sunderland and Nottingham/shire were also more likely to have experienced abuse previously (Table 6.7, Appendix 6) which might also be linked to more detailed recording or assessment by staff. Under 1% of cases related to forced marriage or Honour-based Violence (HBV), suggesting that the VOICES services may need further development to address diverse forms of DVA. Sixty-three percent of women were recorded as

having multiple needs such as mental health, physical health, alcohol and/or drug issues. Mental health was most frequently recorded (35.5%; n= 755). Interestingly, no women were recorded as having 'no recourse to public funds' under support needs. It is not possible to say if women had multiple or intersecting needs as aggregated data was not provided and individual data would be subject to General Data Protection Regulations (GDPR) (see Table 6.9).

There was a large amount of missing data for most domains, particularly from one organisation. Given that staff have to enter data into a number of different reporting and monitoring systems, recording formats need to be less onerous to complete. Currently there are missed opportunities for utilising service data to understand who service users are, who VOICES works for and how these analyses might contribute towards further refinement of services and building a case for future funding.

6.3.3 Service Exit

OnTrack data showed that, on average, survivors used VOICES services for between 1.73 – 3.27 months. Reasons for case closure are given in Table 6.10, Appendix 6, and have been further categorised into planned and unplanned closures (Table 6.10.1, Appendix 6). Roughly half of all closures were planned. The most common reason for unplanned closure was client disengagement which constituted a survivor ceasing to use services without informing the worker (22%; n= 444). This is followed by 'client never engaged' (16.1%, n=325), i.e. referrals made by other agencies but services not being taken up by the survivor.

6.4 Accessibility and Experiences of Delivery

Seventeen women who had received the VOICES intervention were interviewed: 4 in Nottingham/shire; 6 in Surrey; and 7 in Sunderland. Survivors interviewed had used refuge (n=8) and/or community services such as outreach support (n=7) and/or accessed group work programmes.

All interviewees had previous experiences of accessing support from other agencies. In contrast to their experiences of VOICES services, survivors across the three sites commonly described previous experiences of help seeking negatively, commenting that they hadn't felt listened to or respected, and that other agencies had lacked knowledge and understanding. For example, in Sunderland, women reported feeling pressured by police to press charges *'when you really just want to be left alone when there's been an incident'* (Survivor 6, Sunderland), or being instructed '*you're not going back'* (Survivor 7, Sunderland) by social workers who prioritised children's safety. Previous workers were considered to lack empathy, as one woman observed *'when they spoke they got a kind of, you know, the well-meaning smile'* (Survivor 16, Sunderland); another said of her VOICES worker that, compared to previous providers, *'she doesn't do lip service, she helps you'* (Survivor 17, Surrey). Other agencies were described as lacking expertise and sympathy in responding to disclosures of DVA:

…the man on the other end of the phone was rude and he said to me, you know, you've got no rights unless your husband's actually hitting you. He was just like, it's just tough. (Survivor 10, Surrey)

Most survivors' comments on the accessibility of VOICES services were positive. Engagement was achieved through workers' approachability and flexibility, and by providing sufficient time and via opportunities for women to talk at the time when they needed support:

…there was one point where I was really down, and I just picked up the phone. And she didn't say, 'oh can you talk tomorrow because I don't have time and we have to book an appointment'. (Survivor 9, Surrey)

Women valued having good relationships with and being listened to by staff and when staff worked well together in a team. Efficient communication between staff so that *'you haven't got to re-explain everything'* (Survivor 10, Surrey) was valued by most, although there were divergences in respect of this:

…when we say something to one staff, so automatically everyone knew and sometimes we don't want to tell everything to everyone…I don't want...ten people knowing… what happened to me and what's gone wrong in my life … (Survivor 14, Sunderland)

The quality of the relationship between survivor and worker was highly prized and positive change was attributed to this relationship by 12 of the 17 survivors interviewed rather than to the wider organisation. Being allocated to a single worker for support and advice was reassuring and empowering:

I felt relieved because … I would have one person and she would always kind of be there for me… She was amazing… gave me the confidence and the strength. (Survivor 10, Surrey)

Authenticity was important and this was enhanced when workers had relevant experience or expertise:

…the staff are so easy to talk to and they just understand everything. Because some of them that work there, have actually been through what we're all going through. (Survivor 7, Sunderland)

Case Study A illustrates how a supportive relationship that promoted exploration of trauma, combined with advocacy and parenting support, had achieved very positive outcomes for a mother and her child.

Case Study A

This woman and her young child were referred to the VOICES refuge service by social services following concerns for their immediate safety after her violent ex-partner had discovered their whereabouts. She described feeling anxious and isolated on entry to the refuge, but encouragement from her key worker enabled her to build the trust and confidence that enabled her to engage with the support on offer. She felt in control of this process reporting that '*…they didn't actually tell us what to do…they like kind of advised us*'; support was delivered through both individual and group work.

The woman described that without the worker's input: '*I wouldn't actually have my [child] with us now. And [they're] still with us and because of all the work we've done'*. This had been achieved through a range of interventions: for example, the VOICES worker had supported her during care proceedings and had advocated on her behalf during meetings with social workers about her parenting capacity. In comparison to her relationship with her social worker, who was considered to lack empathy, she felt able to open up about her experiences to her VOICES workers and this had impacted significantly on her emotional safety:

Basically, like talking and just getting things out that I've like kept bottled in for years, everything, basically. If it weren't for them, I would have probably killed myself before now.

Input from workers had built her confidence, independence and parenting skills and she described how, as a result of this, *'me and my [child] have actually had the closest relationship ever… it's unbelievable. It's everything I ever wanted'.*

VOICES workers had helped this survivor to secure a nursery place for her child, as well as a new home which they were due to move into. This was described by her as both an exciting and daunting prospect, however she felt reassured that ongoing support and outreach would be provided once

they had moved on. When asked how she felt about their future, she reflected that it was '*a lot brighter than what it was. I can actually see the light*.'

Whilst experiences of service delivery were overwhelmingly positive and trust in workers was high, a few negative experiences were also reported. Two survivors reported that they had insufficient contact with their allocated workers, possibly due to Covid-19 restrictions:

I just haven't had contact. But, obviously, I haven't initiated but there's been a Covid situation…I haven't chased it either. (Survivor 13)

One survivor from a minoritised community reported that staff had generally been supportive, that she trusted them and felt safe from her abuser. However, she described examples where staff had failed to challenge racism from other service users. The response to this was to move her to another service rather than addressing the racist behaviour displayed towards her. This parallels some DVA interventions where the victim is expected to move to keep safe:

I don't understand why…because somebody from Britain is so dangerous and horrible. People from Britain don't accept another culture. (Survivor 9)

Whilst the quality of the relationship between worker and survivors (or service users) is well recognised as a key element of support, the next section discusses the specific tools introduced as part of the VOICES intervention.

6.5 Impact

6.5.1 VOICES Approach and tools

The staff survey (n=16) showed that most respondents reported that the introduction of VOICES had either definitely (n=7/16) or partially (n=5/16) changed their approach to working with survivors. Those describing positive changes (n=10) highlighted that the approach assisted them to structure group and individual work, as well as their note-taking, discussions, and in turn, their thinking around the diversity of survivor needs, safety and the impact of trauma. This meant that discussions with survivors were less interrogative and covered a wider range of potential issues so that individual plans were more reflective of the needs of adult survivors and their children:

The categories give us a lot of scope to gain information to help us support the women and children in a way which does not seem as though we are interrogating them. (Staff Survey Participant)

Survey participants also described VOICES as being less risk and safety driven and more strengths-based and survivor-led – enabling survivors to make their own choices. This was also confirmed by survivors (see below). Specifically, the Tree of Strength tool was identified as helpful in the visualisation of survivor strengths – although it was also critiqued by a minority who reported that '*it didn't feel like a natural flow'* and that it was *'dictatory and regimented'*. A small number of respondents felt that this approach was not new to them, but for the majority, VOICES had helped to provide a space that was physically and emotionally safe for women.

The Tree of Strength is a visual tool designed to be used as a conversation guide and to help women identify their priorities. It was described as a non-threatening method of building up a detailed picture of survivors' lived experiences which could be used to identify their strengths and diversity of needs. Importantly, it also enabled identification of potential barriers to accessing support and therefore, where adaptations were needed. This tool was considered to offer a more survivor-centred, less risk-focused, tool for assessment. The use of the tool varied with some staff presenting the Tree to survivors whereas others used it as a reference point for themselves:

…when I'm explaining this to women, it is giving a more holistic approach to supporting women. You know, we've got the visuals, the tree, women tend to quite really like that. (Staff interview 12, Nottingham/shire).

VOICES was also described as raising practitioner awareness of trauma and its impacts and allowing for a more open and honest approach to be taken with survivors:

Using the VOICES tools has given me a benchmark to work to and raised my personal awareness of the physical, psychological, and social impact of trauma on a person's everyday coping. (Staff Survey participant)

Several staff survey respondents commented on the improved breadth of coverage that the tools enabled, allowing them to consider all aspects of a woman's life and a wide range of emotions. This in turn helped survivors themselves to reflect more widely on their own lives:

VOICES supports the professional to have a conversation with a survivor about all aspects of their lives and their emotions in regards to that element. This structure is clear to read in regards to case management showing clear direction in action. (Staff Survey Participant)

Staff also described the VOICES tools as particularly useful in structuring case notes, providing clarity around survivor experience and perspectives, and supporting the case management process – for example, when cases were handed over to other professionals. Lastly, the VOICES tools were described as assisting staff self-reflection, as well as helping them to recognise the signs and symptoms of trauma.

Whilst survivors were unfamiliar with the 'space for action' terminology on which VOICES is based, they conveyed that they felt empowered to recognise what they needed and in control of both the process and pace of support as the case study below demonstrates.

Case Study B

This woman had been signposted to the VOICES service by a member of her local community. At the start of the intervention, she had regular brief chats with workers by telephone, but she didn't want further involvement until she felt ready to leave her partner; this point came after a period of six months. At this time, she was assigned a key worker, and described feeling '*relieved*' that she would have one person to support her throughout the process. Input from the worker gave her '*the confidence and the strength*' to leave safely, and this occurred three months after being assigned to the VOICES worker. She described feeling fully in control of this process:

It went at my pace, completely at my pace. I was not pushed to do anything any quicker. I was not held back at all. It was completely, she just worked with me and supported me and we went exactly at the pace I wanted to go.

The intervention aimed to support the survivor to recognise what she needed, and the type of support required to help her progress. She described how, as a result of being able to communicate effectively with her worker, feeling listened to and understood, they were able to collaborate on a plan to enable her to leave safely:

I mean she's really helpful at understanding what I was going through and helping me…That was all very, very helpful, at managing situations. And she gave me the confidence that I would be able to get out of that situation.

Regular and consistent contact with the worker was highly valued and the survivor described feeling that her worker '*was always available and always there whenever I needed her to be*'. Being provided with information about different sources of support strengthened her capacity to leave by providing her with a '*network of support*'.

Having been supported by VOICES to leave her abusive partner, this survivor was now living in her own home with her young child and had started to retrain for a new job. She described feeling liberated and optimistic about their future:

I'm doing studying, there's so much, there's everything that I do, every minute of the day is stuff that I do and I can do. I can do things when I like, I can do what I like. I go out with my friends, you know….and I keep reminding myself, I can do all this stuff now.

Although she felt well supported by the service as a whole, she reflected that it was the relationship she had with her individual worker that was key to her being able to achieve change:

I know that I could have phoned [the service]. If I'd never been given [her] as a key worker, it wouldn't have been anywhere near as good. She's been pivotal in changing my life.

Survivors and staff confirmed that the work was focused on supporting women to build confidence, self-esteem and resilience to identify their goals which could address any of the 'space for action' domains: parenting, education, employment, relationships with friends or family, housing, self-efficacy, coping strategies, health or wellbeing. Additionally, survivors also reported increased recognition of DVA: several survivors had not previously understood what was happening to them as abuse. For some, this increased recognition of DVA facilitated a movement away from blaming themselves for the abuse experienced:

I was feeling like everything was my fault, I did this, why it could have happened and all that. But after having that course and speaking with the staff as well, they made me understand that it's never my fault. (Survivor 17, Sunderland)

6.5.2 Well-Being, Safety and Health Outcomes

Three sources of data were used to examine outcomes: survivor interviews, the Personal Outcomes and Wellbeing Record (POWeR) included in OnTrack data and the Evaluation's outcome measures. Improvements in physical and emotional safety were widely reported in survivor interviews. Increased confidence, well-being and a sense of self helped to increase feelings of personal safety. A key factor was feeling listened to, believed, validated and supported across various aspects of their life as discussed above. Examples of the range of safety advice and support offered by workers across the sites included: carrying mobile phones, blocking calls from abusive ex-partners, deactivating the location device in mobile phones, and planning what action to take if abusers discovered their whereabouts. Re-locating to a different town or city unknown to ex-partners helped women to feel safer. Support around women's emotional safety was also offered, for example offering advice, reassurance, and calming techniques:

She said that if I get frustrated or I feel like I need space, to go for a walk, go out. Make sure the kids have got like somebody there and then just go out. (Survivor 5, Nottingham/Shire)

For some women, support with their emotional safety was ongoing, for example, where women had recently left their abusive relationship or, in one instance, where an ex-partner was due for release from prison. Most women interviewed reflected positively on their future and the focus on career or employment plans and parenting described in Case Study 6.2 was typical of the aspirations expressed.

For a minority of women, the future still appeared bleak with understandable anxiety about the outcome of a pending court decision on child custody for one, and another who needed support around her ex-partner's addiction: '*I don't think I've reached the, my glass is half full, just yet.*' (Survivor 11, Surrey)

6.5.3 Survivor Outcome Measures

Quantitative analysis is based OnTrack POWeR data and the Evaluation's outcome measure. Both sets of data represent a very small proportion of service users as noted below.

POWer Forms

POWeR forms are completed with service users usually at entry, then approximately every 12 weeks with another at the end of engagement with the service. Data was provided by WAFE for every service user who completed two or more POWeR forms at different time points. [34] POWeR forms comprise seven items related to how women have been feeling over the previous two weeks. One of the services did not use the POWeR form, and instead used the Warwick-Edinburgh Mental Wellbeing Scales (WEMWBS) separately which were unavailable to the research team. Where the same items are used on the POWeR form and WEMWBS, data has been analysed where available. This only applied to one item (safety). Excluding those who never engaged with services, the completion rate of paired POWeR forms was 6.8% for most items (based on three services) and 16.6% for one item (based on four services). See Table 6.12, Appendix 6.

Data provided by WAFE categorised the seven items as showing levels of improvement between times when the POWeR form was completed (see Figures 6.1 – 6.7, Appendix 6). Over 65% of survivors across services reported an improvement in feelings of safety with a small proportion (3-8%) reporting that their safety had worsened (Figure 6.1, Appendix 6). Over 80% of survivors reported an improvement in confidence with only 3% stating that their confidence had worsened (Figure 6.2, Appendix 6). Self-esteem had improved for over 75% of survivors (Figure 6.3, Appendix 6); over 60% also reported improved feelings of connection (Figure 6.4, Appendix 6) and over 75% reported an improved ability to deal with problems (Figure 6.5, Appendix 6). More than 70% said their decision-making had improved (Figure 6.6, Appendix 6) and similar proportions had an improved sense of optimism about the future (Figure 6.7, Appendix 6). Whilst this is an encouraging picture, the completion rates for POWeR were below 7% and these improvements have not been tested for significance.

Evaluation Outcome Measure

The Evaluation's outcome measures were collected between October 2019 and December 2020. Services struggled to implement the measures due to staffing capacity, duplication of existing paperwork or lack of confidence to offer the measures to service users due to concerns about being intrusive. Having dedicated responsibility within an organisation and frequent check-ins by the research team helped to improve completion of outcome measures. Only one service completed the outcome measures online with service users. It is difficult to specify the exact impact of Covid-19 on completion rates, but services were preoccupied with responding to the changing restrictions from March 2020. From August 2020, the Evaluation team provided support for service users to complete follow-up measures by telephone.

Table 6.3 shows that outcome measures were completed by 109 survivors at three different time-points. T1 or baseline was completed within two weeks of assessment, T2 was completed 6-8 weeks from T1 and T3 was completed 12-16 weeks from T1. The highest number of outcome measures were received from Sunderland.

[34] The exit POWeR form contains some additional questions around impact e.g. confidence to recognise abusive behaviour, to ask for help, and parenting as well as any improvements in support networks and reduced feelings of self-blame. However, since these questions are only answered at one time-point, this additional data is not included in the analysis.

Table 6.3 Outcome Measures completed

Surrey	Sunderland	Nottingham/ shire	Unknown Area	Total	Completion Rate
18	74	6	11	109	**6.1%**

However, for some survivors, while T2 and/or T3 forms were received, no T1 measures were completed. Further, T1, T2 and T3 completion rates for different items were highly variable: we therefore report subsample sizes by each item/test for T1 and T2. Excluding those who never engaged with services, this means 6.1% of all service users completed outcome measures at T1 with attrition at T2 and T3 (see Table 6.2, Appendix 6). This level of attrition and the small sub-sample numbers mean that findings reported here can only offer early evidence of the intervention's effectiveness.

Due to the small size of the sample and the need to ensure that only meaningful change was identified, the five-point scale responses used for safety and coping questions were transformed into three-point scale responses. Statistical tests on T1 and T2 pairs were performed and reported on the transformed three-point scales, although the tests were repeated on the five-point scales to check for any differences in test results.

Safety

The outcome measures (see Appendix 2) comprised six items to establish whether women reported changes in safety. For each of these items, frequencies and proportions were produced at T1 and T2 (see Table 6.a and Table 6.b, Appendix 6). T3 findings are not included in the analysis here as the numbers of paired measures received (T1 and T3) were too low and because there were no significant differences between T1 and T2.

Table 6.4 Test statistics for Wilcoxon signed-ranks – T1 to T2 change on Safety items

	N	Positive Change (n)	Negative Change (n)	No Change (n)	Median T1-T2 Change	Standard-ised Test Statistic (Z score)	Asymp-totic Sig.[a] (2-sided test)	Effect Size (Cohen 's r)
I have felt safe	37	7	2	28	0	1.667	.096	.19
My home felt safe and secure	33	5	2	26	0	1.265	.206	.16
I have felt safe moving around my neighbourhood	34	6	1	27	0	1.933	.053	.23
I have felt safe online	30	8	4	18	0	1.374	.169	.18
I have felt that it is safe for my children to spend time with their father (if relevant)	23	3	2	18	0	1.242	.214	.18
I know where I can go for help when I need it	34	1	5	28	0	-1.730	.084	-.21

* Denotes significance at the p < .05 level

As Table 6.4 above shows, there were no statistically significant differences in safety between T1 and T2. This may be partly explained by the high proportion of survivors at baseline reporting feeling safe. Of the six safety items, five scored 65% or over at baseline for often/all of the time. The item, '*I have felt it is safe for my children to spend time with their father'* showed that 39.7% (n=25/63) reported that their children were not safe or rarely safe to spend time with their father. The proportions shifted positively for five items (at T2 and at T3) and changes between T1 and T2 are shown in Table 6.a, Appendix 6). However, these improvements were not statistically significant.

Coping and Confidence

Eleven items were used to assess coping and confidence. Frequencies and proportions are provided in Table 6.b, Appendix 6, for T1 and T2. The proportions of survivors providing positive responses increased between T1 and T2 for ten of the eleven items. '*I have been able to manage my use of alcohol/medication/drugs (if applicable)*' showed a slight decline between T1 and T2. Of the 11 items, three items showed a statistically significant positive change between T1 and T2: i) '*I have felt able to deal with my daily life'*; ii) '*I have been able to get a good night's sleep*'; and iii) '*I have been able to recognise if other people have been behaving abusively*' as illustrated in Table 6.5 below.

Table 6.5 Test statistics for Wilcoxon signed-ranks – T1 to T2 Change for Coping and Confidence items

	N	Positive Change (n)	Negative Change (n)	No Change (n)	Median T1-T2 Change	Standard-ised Test Statistic (Z score)	Asymp-totic Sig.[a] (2-sided test)	Effect Size (Cohen 's r)
I have felt able to cope if things have gone wrong	36	7	9	20	0	-.688	.491	-.08
I have felt able to deal with my daily life	36	10	3	23	0	2.066	**.039***	**.24**
I have been able to make my own decisions	36	5	3	28	0	1.100	.271	.13
I have felt able to speak to people about my experiences of abuse, if I wanted to	36	9	6	21	0	-.358	.721	-.04
I have been able to manage my use of alcohol/ medication/drugs (if applicable)	23	1	2	20	0	-.816	.414	-.12
I have been able to get a good night's sleep	32	8	2	22	0	2.070	**.038***	**.26**
I have been confident about doing new things	35	9	4	22	0	1.500	.134	.18
I have felt in control of my life	36	11	7	18	0	1.091	.275	.13
I have good relationships with my children	31	0	1	30	0	-1.000	.317	-.13
I have known that I was not responsible for the abuse that happened to me	35	9	4	22	0	.775	.438	.09
I have been able to recognise if other people have been behaving abusively	35	8	1	26	0	2.333	**.020***	**.28**

* Denotes significance at the p < .05 level

Mental Wellbeing

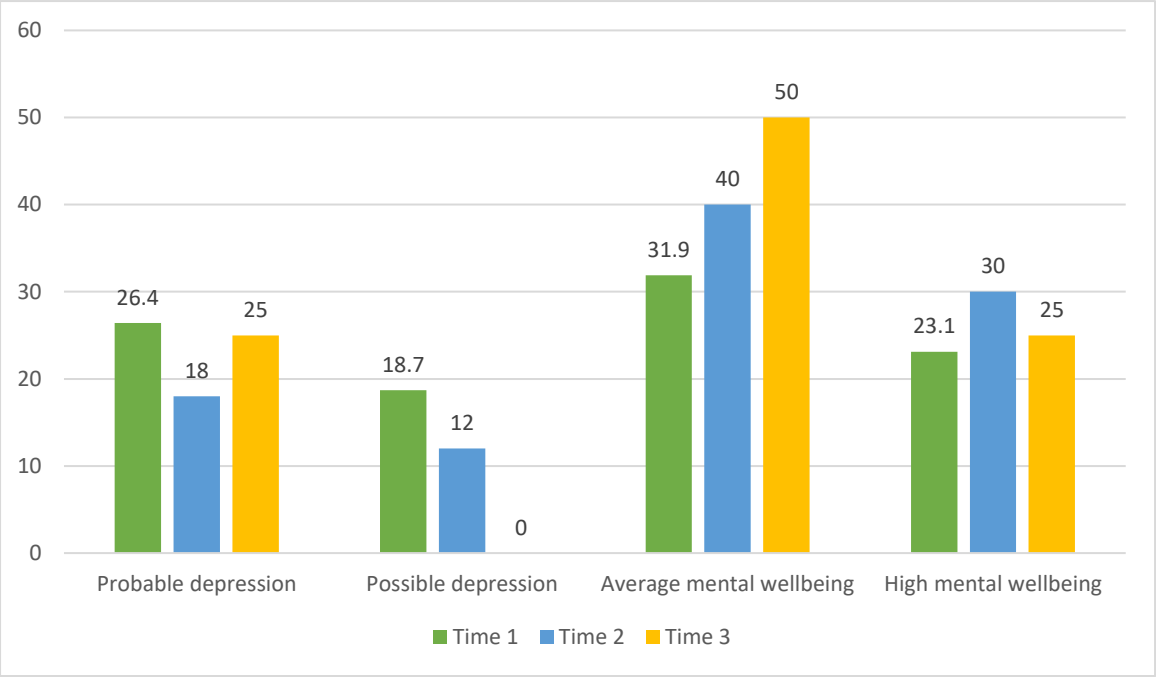
The 91 survivors who responded to the seven mental wellbeing questions at T1 had a mean average sum score of 22.72, a score which sits at the lower end of the 'average mental wellbeing' range of scores (21 – 27) for the short form of the Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS) used and sits just below the UK population norm for women (23.6) (Ng Fat et al, 2017). At T2, 50 survivors completed the seven questions, producing a slightly higher mean average sum score of 24.41 - this also sits in the middle of the 'average mental wellbeing' range of scores for the SWEMWBS and is slightly higher than the UK population norm for women. The 20 survivors completing the mental wellbeing questions at T3 produced a very similar a mean average sum score of 25.20. Table 6.15, Appendix 6, provides a full breakdown of descriptive statistics for all three time points.

Cut scores were applied to the SWEMWBS sum scores from T1, T2 and T3. These enabled the scores to be divided into the categories of 'probable depression', 'possible depression', 'average mental wellbeing' or 'high mental wellbeing'. As can be seen in Table 6.6 below, a small majority of respondents at T1 (50:55%) had scores categorised as indicating either 'average' or 'high' mental wellbeing, the remaining (41:45% were identified as having scores that indicated 'probable' or 'possible' depression. These proportions shifted at T2, with (35:70%) of respondents categorised as having 'average' or 'high' wellbeing, and (15: 30%) categorised as having 'probable' or 'possible' depression. At T3, (15:75%) of respondents were classed as having 'average' or 'high' mental wellbeing, with (5:25%) classed as having 'probable' depression. See Table 6.6 and Figure 6.1 below. While these findings show an encouraging trend, the level of attrition in completion of measures between the three time-points means that these findings should be treated as indicative only.

Table 6.6: Frequencies and proportions for mental wellbeing thresholds at T1, T2 and T3

		Probable depression (7 to 17)	Possible depression (18 to 20)	Average mental wellbeing (21 to 27)	High mental wellbeing (28 to 35)	Total
Time 1	N	24	17	29	21	91
	%	26.4	18.7	31.9	23.1	100.0
Time 2	N	9	6	20	15	50
	%	18.0	12.0	40.0	30.0	100.0
Time 3	N	5	0	10	5	20
	%	25.0	0.0	50.0	25.0	100.0

Figure 6.1: Mental wellbeing proportions for all survivors completing measures at T1, T2 and T3



Changes in mental wellbeing between T1 and T2

Only 35 survivors answered questions on mental wellbeing at both T1 and T2. Analysis using a paired-samples t-test indicated that the mean decrease in wellbeing (.444) between T1 (*M* = 23.59, *SD* = 6.32) and T2 (*M* = 24.04, *SD* = 6.44) was *not* statistically significantly different from zero, *t*(34) = .547, *p* = .588, *d* = -.09. As there were T1 and T3 paired data for only eight survivors, no inferential statistical analysis was performed on potential change between T1 and T3.

Were improvements in safety, coping and confidence and wellbeing attributable the service?

At T2, survivors were asked whether they had experienced improvements in safety, coping and confidence and wellbeing since having contact with the service. Table 6.7 shows that most service users who had experienced improvements (89%, 89%, 96% and 78% respectively) were very positive about services with between 60-73% attributing their improvements across the four domains either mostly, or entirely to the VOICES service. Between 24-31% attributed changes partly to services and 2-10% attributed changes mostly or entirely to other factors.

Table 6.7 Improvements and Attribution

	Entirely due to service % (n)	Mostly due to service % (n)	Partly due to service % (n)	Mostly due to other things % (n)	Entirely due to other things % (n)
Experienced improvements in safety (n=41/46)	34.1 (14)	39.0 (16)	24.4 (10)	2.4 (1)	0.0 (0)
Experienced improvements in coping and confidence (n=41/46)	26.8 (11)	36.6 (15)	26.8 (11)	4.9 (2)	4.9 (2)
Experienced improvements in mental wellbeing (n=45*/47)	25.0 (11)	36.4 (16)	29.5 (13)	4.5 (2)	4.5 (2)
Experienced improvements in health (n=35/45)	31.4 (11)	28.6 (10)	31.4 (11)	5.7 (2)	2.9 (1)

* One respondent who reported improvements in wellbeing did not answer the attribution question (i.e. n=44)

Health

There was significant drop off in the completion of the validated EQ-5D-3L health questionnaires used for the study. However, there was a 2.1% change in the scores between time one and time two and a significant change of 11.7% between time one and time three. The visual analogue scale (VAS thermometer) also showed positive change between time one and time two and time one and three. The VAS is easier to complete and asks the participant to indicate how their health is today on a scale of 1-100, rather than the five health-state questions of the EQ-5D-3L questionnaire.

The results at all time points were significantly lower than accepted UK population norms for the EQ-5D-3L, indicating that service users across all time points are experiencing health states worse than the general population.

Table 6.8 EQ-5D-3L Health Outcomes

EQ-5D-3L	T1	T2	T3
COMPLETE	93	47	21
AVERAGE	0.639	0.660	0.756
STDEV	0.311	0.383	0.226
NORM	0.86	0.86	0.86

Table 6.9 VAS (Thermometer Outcomes)

VAS (Thermometer)	T1	T2	T3
COMPLETE	84	49	20
AVERAGE	62.35	65.98	69.25
STDEV	18.94	26.24	18.87
NORM	82.48	82.48	82.48

6.6 Organisational Culture, Leadership and Supervision

For an organisation to be trauma-informed, a whole organisation approach is necessary, and the staff survey and interviews addressed the organisational culture and support available to practitioners. Overall, staff survey respondents reported good levels of supervision, with nearly all (n=13/14) having received regular supervision, which in most cases (n=8/14) was management supervision. Only half of respondents (n=7/14) felt they had received sufficient training to enable them to deliver the VOICES programme to survivors and their families as intended, and over half (n=8/14) indicated that further training and/or supervision would have been helpful, most commonly, general/further programme training (see Table 6.16, Appendix 6, for frequencies and a full list of training and supervision recommendations).

The majority of respondents (n=12/14) felt that they were supported through emotionally demanding work, that they were clear about what was expected of them (n=11/14) and that their deadlines were achievable (Table 6.16, Appendix 6). This was also explored in staff interviews where overall staff felt *'..that you're supported and feel safe to…carry out the job'* (Staff interview 5, Sunderland) Staff were generally clear about how changes would work in practice (n=8/13), although sometimes *'a change gets put in place before we're all kind of updated on it. And then it's like, oh we do this now, by the way.*' (Staff interview 4, Sunderland). However, most felt that there was rarely conflict between colleagues (n=11/14) (Table 6.17, Appendix 6). Survey respondents were fairly mixed in their responses to workload questions, with exactly half (n=7/14) reporting that their workload was too heavy and with most respondents (n=13/14) indicating that at some point they had neglected tasks due to their high workload (Table 6.18, Appendix 6). This was corroborated by interviews with staff who reported that they *have a lot, a lot to do…at the moment, so in the past six months in particular…very, very busy, even after the 1st of April…* (Staff interview 3, Surrey.) High workloads are connected to limited funding and high demand. Over the last 10 years the DVA sector has experienced severe cutbacks to services which make new initiatives difficult to sustain (Samuels, 2021; Barter et al, 2018; Chantler and Thiara, 2017).

Survey respondents were generally positive about their working environment and about the administrative/IT support they had received prior to the pandemic, with the majority feeling that their office space was 'Good' (n=9/14), their work space was 'Good' or 'Excellent' (n=11/14) and the administrative and IT support was described as 'Good' or 'Excellent' (n=13/14).

6.7 Summary

- Several factors impeded implementation of VOICES apart from Covid-19 including: time taken to co-produce the intervention, the limited capacity of coordinators to support VOICES, initial resistance from local member services, the volume of paperwork and a perception that more and timely training would have been beneficial.
- Once adopted by practitioners, the VOICES approach and tools were seen as transformative by the majority of practitioners, although a few reported that they were already working in a trauma-informed, strengths-based way.
- The move away from a risk-focused to a more survivor-centred approach was valued by most practitioners.
- Survivors had negative experiences of services previously encountered but were very positive about their experiences of VOICES services.
- Whilst the terminology of 'Space for Action' was unfamiliar to survivors, the case studies clearly illustrate intervention and change across the multiple Space for Action domains that practitioners utilised in their casework. However, this was not always apparent in OnTrack data which had substantial gaps.
- A consistent relationship between practitioner and survivor was highly valued and survivors saw this as key to developing their self-confidence, independence, and belief in themselves.
- A trauma-informed, strengths-based, needs-led approach to service delivery was valued by survivors.
- Two survivors reported negative experiences of VOICES: one related to confidentiality and the other to practitioners' responses to racism.
- OnTrack data revealed limited engagement with Black and minoritised communities. This was particularly notable in areas with high levels of Black and minoritised communities.
- Under 1% of cases related to forced marriage or 'so-called honour-based violence' (HBV) across the whole data set.
- Together, the three points above addressing Black and minoritised communities indicates that a more intersectional approach is required with adequate funding for DVA specialist services as well as Black and minoritised women's DVA organisations.
- There were gaps and inconsistencies in OnTrack recording between WA organisations with some services having large amounts of missing data in most fields.
- Due to the low proportion of survivors completing the POWeR outcomes and the Evaluation's outcome measures at T1 and further attrition at T2 and T3, conclusions drawn are indicative. The attrition at T3 may be a function of the timing (12-16 weeks after T1) as OnTrack data showed that most VOICES service users were in services for between 1.73 – 3.27 months.
- The analysis of POWeR forms and the Evaluation's outcome measures demonstrated positive improvements on most items, but very few of the improvements found on outcome measures were statistically significant as insufficient numbers of completed measures were available for analysis at both baseline and follow-up.
- At both T1 and T2, survivors reported 'average mental wellbeing' (SWEMWBS) and at T2 this was slightly higher than the UK population norm for women.
- For those survivors that reported improvements in safety, coping and mental wellbeing, most of this was attributed to services, indicating a high level of satisfaction with VOICES services.
- Findings in respect of health outcomes were significantly lower than the accepted UK population norms, indicating that service users across all time points experienced worse health than that of the general population.

- Practitioners were generally positive about the support they received for emotionally demanding work and reported that there was rarely any conflict between colleagues. There was more ambivalence regarding workload: half the staff survey respondents reported that workloads were too high, this was also reported in staff interviews. This may indicate under-resourcing of specialist DVA services.

6.8 Recommendations

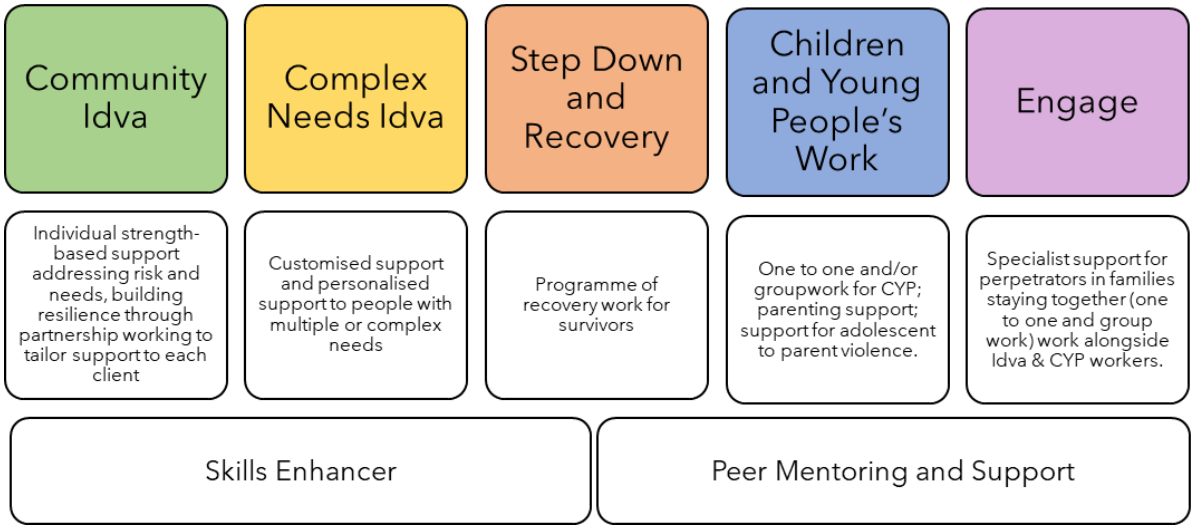
Unlike Trusted Professional and Ask Me, VOICES was a completely new approach and these recommendations are made for future pilots and/or roll out of VOICES. These may help to iron out the issues discussed above by practitioners and trainer/coordinators and to strengthen the intervention:

- A trauma-informed, strengths-based, needs led approach needs to be central to DVA service provision.
- Adequate time should be allocated to develop and implement new interventions such as VOICES.
- Earlier buy-in from member services and adequate preparation and training for staff to adopt VOICES would facilitate implementation.
- Staff need to be trained and equipped to challenge racism when they encounter it.
- All DVA services need to be accessible to Black and minoritised communities and work in a respectful and equal partnership with Black and minoritised services to offer Black and minoritised women a choice of services and to increase uptake of services.
- Ensuring that staff are supported to undertake emotionally demanding work will continue to be essential for VOICES.
- Ensuring that workloads are manageable is also likely to contribute to sustaining the VOICES approach.
- Commissioners need to ensure that DVA services are adequately funded to continue to provide existing services and introduce new interventions.
- Streamlining VOICES monitoring requirements and ensuring that these are compatible with the OnTrack recording system will assist local services to provide more robust data on service users' profiles, needs and outcomes for those planning and managing services and for commissioners wanting evidence on the efficacy of VOICES.

Chapter 7: SafeLives Co-Designed Pilots: Development, Implementation and Delivery

The SafeLives Co-Designed Pilots (SLCDPs) comprised a suite of interventions for survivors, their children and perpetrators. In combination, these interventions provided a 'whole family' approach (Stanley and Humphreys 2017). The intention was that all those using the service would be able to move between interventions with regard to need and according to the stage reached on their journey to recovery. Five strands of interventions were delivered to families: Community Idva support; Complex Needs Idva support; Step Down and Recovery Groups for survivors; Children and Young People's work, including individual and group work for children, and parenting support; and the Engage strand of the service which worked with the whole family, including the perpetrator. In addition, a 'Skills Enhancer' was employed to deliver internal and external training and provide consultation with local professionals. Peer mentoring and support was facilitated by a dedicated worker. Figure 7.1 identifies the five strands which together made up the intervention.

Figure 7.1: The SafeLives Programme



The programme was designed by SafeLives, alongside SafeLives Pioneers (survivors and experts by lived DVA experience) and specialist frontline domestic abuse expert partners. Two independent services, in Norwich and West Sussex, were commissioned to deliver the interventions.

This chapter reports on the development, implementation and delivery of the SLCDP interventions in Norwich and West Sussex. This provides the wider context for the positive findings on the impact of the SLCDP services for survivors and their children reported in Chapter 8.

The chapter draws on: SafeLives' Insights monitoring and outcomes data, which staff completed for service users at intake and exit between November 2018 and December 2020; baseline data collected via the Evaluation's outcome measure (see Appendix 2); 14 staff interviews completed between February and May 2020; five interviews with senior managers, including frontline service managers and senior SafeLives staff, undertaken between November and December 2020, and a staff survey (n=15), completed in Autumn 2020. While interviews with staff were largely completed before Covid-19 restrictions were introduced, interviews with senior managers and the staff survey provided opportunities to reflect on the impact of the pandemic.

7.1 Development of the SLCDP

The programme was developed by SafeLives Pioneers alongside expert frontline partners from specialist women's organisations including Advance, Aurora New Dawn, Cheshire Without Abuse, Oasis and North Devon Against Domestic Abuse. The SafeLives Pioneers guided the identification of service gaps, the range of interventions needed, format of delivery and integration of services for the whole family:

The amount of work that had gone into designing this project and looking at each different intervention, you couldn't ask for more, because they had a couple of years and it was all shaped by the survivors. (Senior Manager 2, SLCDP)

The time spent developing services with frontline expert partners was considered highly valuable, although one senior manager felt planning might have been more effective if undertaken directly in the delivery sites, enabling greater adaptations to the local context. Others thought the development time for the individual interventions had been too long given the move to an integrated service, which required careful planning, and that the programme would have benefitted from a longer commissioning and implementation stage.

7.2 Implementation

7.2.1 The Commissioning Process

All senior managers interviewed recognised that the tendering process had created specific issues for implementation in both sites. In Norfolk, the competitive tendering process resulted in a single non-specialist DVA organisation gaining the contract rather than a local long-standing DVA service. This outcome contributed to a range of ongoing challenges for successful implementation and delivery, affecting referral pathways and routes to support. This impacted on service delivery as the Norwich service was unable to establish a positive working relationship with the local high risk DVA service provider and consequently received few referrals from this service for women whose risks had reduced. In West Sussex, although the challenges were less prominent, some local service providers had questioned if all the commissioned services were needed due to overlaps with established provision.

Although some strategic conciliatory work was undertaken with support from the commissioners, this was largely unsuccessful in Norwich. Some senior managers thought that commissioners might have provided more support to try and overcome these problems, recognising this was not a service issue but a system problem. One senior member of staff commented that *'it should have been followed up with some further conversations to introduce the new service…that kind of restorative approach, … we're all here to support families of domestic abuse, so how are we going to do that? That, that would have helped.*' (Senior Staff 5)

Both services were launched in November 2018 and services were in high demand from the outset. Norwich had staff in place a month before West Sussex and facilitated visits from service managers across the county to establish partnership relationships. In West Sussex, a consortium of predominantly regional DVA organisations won the tender, enabling the service to '*hit the ground running much quicker because of the relationship that they already had with those existing services'* (Senior Manager, SLCDP 4). This was further facilitated by the Local Authority secondment of the West Sussex manager, an experienced Idva; the benefit of this for effective implementation was recognised by all senior staff. Senior managers also highlighted the impact of funding partnerships for implementation: West Sussex had one Local Authority funding partner while Norwichhad six partners, which resulted in challenges regarding decision making and multiple monitoring requirements.

7.2.2 Resources for planning, implementation, and delivery of the programme

Senior staff had mixed views on the level of resources available for planning and implementation of the service. Most thought resources had generally been sufficient, especially around training, although some difficulties were also highlighted (see Section 7.12). Senior staff felt that more targeted resources could have supported greater communication and learning between sites. One senior manager interviewed identified a need for greater support from SafeLives in their role as intervention/programme developers, given the implementation challenges encountered and questioned the feasibility of the management resources especially around multiple reporting, monitoring and line management responsibilities. The West Sussex service had some resource issues around 'consistent team office space', as original plans to use the County Council's rooms did not materialise, and the service lacked wider office facilities, such as bulk printing, which became a prominent issue under lockdown. The lack of suitable long-term spaces for group work was also a significant challenge in West Sussex. Another resource issue identified in West Sussex was staff recruitment and retention due to wage discrepancies in the area (see Section 7.10). One senior manager concluded: '*Was there enough resource [for learning and delivery across sites]? I think our activities and interventions were too optimistic and I think that probably will show itself in not enough resource'* (Senior Staff, SLCDP 5).

7.2.3 Time scales for planning and implementation of the programme

All senior staff agreed that the 12-week planning and implementation period was insufficient. A lack of time was compounded by the introduction of new monitoring and reporting systems, staff recruitment, marketing activity, training requirements and associated travel, implementing multiple interventions and toolkits as well as embedding the service locally through outreach to support referral pathways. Many staff commented that the Engage work had been especially challenging in this period due to the need for marketing, outreach, and integration of this new intervention into the service. As well as a longer period for implementation to reduce conflicting priorities, it was suggested that having senior managers in place for a more extended period before other team members started would have facilitated a more consistent implementation and managers would not have felt overwhelmed. However, the commitment of staff throughout this period was recognised by senior staff:

I think it's important that I pay testament to the sheer resilience of the team, their attitude and how they kept finding solutions to the challenges of setting up a brand new service from scratch (Senior Manager 1, SLCDP).

7.3 Building Local Support for Implementation and Delivery

In West Sussex, Early Help was the main local partner, facilitated by the West Sussex service sharing some office space. In addition, the high-risk DVA service, also part of Early Help, was highly supportive of the West Sussex service. Some staff moved across from the county council on secondment and brought with them their established connections and knowledge of the area. In Norwich, the service also sat within the Early Help Hub and this helped to ensure that multi-agency partners were aware of the service and its objectives from the start although, as a new provider, local support for the service had to be built over time: '*What that translated to was, in West Sussex, the local authority embedded [SLCDP service] in their system but in Norfolk it was a much more standalone thing'* (Senior Manager 5, SLCDP). Despite this challenge, staff felt that they were now well established in their local areas: '*We've only been going eighteen months; everybody tends to know about the [Norwich] service now…We are well known'* (Staff 11, SLCDP).

A central mechanism to build local support was the work of the Skills Enhancers who established links with local agencies, promoted the service and organised free culture of change training designed to enable practitioners in other local services to work more effectively and confidently with victims, survivors and perpetrators. SafeLives' figures show that, between November 2018 and December 2020, 444 attendees in West Sussex and 1642 in Norwich received training.

External agency feedback on training was described as positive with practitioners reporting increased awareness and confidence to work with DVA. However, making links with some agencies and setting up training was challenging. Norwich staff reported that, despite positive meetings with Children's Social Care (CSC), no whole team training courses had been confirmed for this organisation at the time of interviews, although CSC did regularly refer into the service (see section 7.4). Some services did not respond to training offers, and others who took up training did not refer into the service. In West Sussex, there was felt to be an overlap with SL's Whole Picture Matters training which was being delivered across the county.

7.4 Referrals

In total, SLCDP administrative data showed 1307 referrals of female survivors were made between November 2018 and December 2020: 755 in West Sussex and 552 in Norwich (see Table 7.1). Referral numbers were higher in the West Sussex site in both years. Most referrals (63%) were received through either Children's Social Care (CSC) (39%) or Domestic Violence and Abuse/ Sexual Violence (DVA/SV) services (24%) (see Table 7.1). However, sites had distinct referral patterns. A greater proportion of referrals for survivors in Norwich came from CSC (48% compared to 33%), while West Sussex received a higher proportion from DVA/SV agencies (35% compared to 7%). There was a larger proportion of self-referrals in Norwich (11%) compared to West Sussex (5%). Health services, including mental health and children's health services, accounted for 4% referrals overall.

Table 7.1 Referral source by site

	West Sussex		Norwich		Total
	N	Percent	N	Percent	
Children's Social Care	245	32.5	263	47.6	508
DVA/SV Services	267	35.4	40	7.2	307
Internal service referral	3	0.4	-	-	3
Self	40	5.3	61	11.1	101
Children's Centres	-	-	12	2.2	12
Early Help	163	21.6	-	-	163
Police	-	-	38	6.9	38
Education	2	0.3	39	7.1	41
Housing	15	2.7	15	2.7	30
Health (including mental health	21	2.8	35	6.3	56
Probation	2	0.3	3	0.5	5
Adult Social Care	4	0.5	15	2.7	19
Substance misuse	3	0.4	2	0.4	5
Voluntary Sector	-	-	16	2.9	16
Norwich City Council	-	-	11	2.0	11
DWP	-	-	2	0.4	2
Total	**755**	**100%**	**552**	**100%**	**1307**

In West Sussex, the strength of some referral pathways such as that from the police, may have been obscured by referrals coming through the Early Help Hub which accounted for 21% of referrals, and this was confirmed in staff interviews. In addition, self-referrals were often encouraged by GPs or social workers. However, staff interviews confirmed that some agencies were not routinely referring into the service including housing, education (in West Sussex only), GPs and probation. In addition, staff commonly reported that individual practitioners often made repeat referrals while others in the same agency had not made any referrals (see Social Network Analysis, chapter 9).

The sites recorded 399 declined referrals (183 West Sussex, 216 Norwich). In Norwich, the main reason that referrals were declined was due to them coming from outside the service's catchment area (49%), which may reflect the relatively small catchment area of the service. In West Sussex, this was only a factor in 9% of declined referrals. High risk referrals accounted for 21% of declined referrals in Norwich and 28% in West Sussex. Other reasons included 'inappropriate' referrals or the client declining the offer of support.

The SL outcomes measurement tool, Insights, also recorded 179 'other contacts' with the service. This category was used for survivors who had a one-off contact with the service, or who did not consent to further monitoring of their data on the SL insights system. Most of these contacts (82%) were recorded by the Norwich site. The main reason provided was the client chose not to continue with the service (39%) or was not suitable for the service (12%). A small number of individuals (9%) did not consent to further monitoring of their data. The referral route was not noted in all cases, but as with the other referral data, Children's Social Care was the most frequent referrer (40%). Telephone or face to face support was offered, regarding topics such as safety, children and parenting matters, child contact and housing. Referrals on to other services were noted in some cases, most usually to another DVA service, housing or mental health services.

Staff interviewed stressed that in the case of unsuitable referrals, which were usually due to survivors from out of the catchment area in Norwich or inappropriate risk levels, they would always provide signposting and advice on appropriate support.

A range of support and outreach strategies had been used to try and increase awareness of referral criteria and expand referral routes, including: training for professionals in other agencies; GP awareness meetings; information sharing with schools, youth and community projects; offers to attend discussions with service users (including perpetrators) to explain the support provided by the SLCDP services; and attending multi-agency forums. Norwich staff commented on the benefits of attending the regular Early Help multi-agency hub which enabled confidential information sharing to inform appropriate referrals. Staff also commonly reported on the need to build stronger relationships with schools to raise awareness of the service and to support schools in undertaking comprehensive risk assessments to ensure appropriate referrals. Some staff recognised engagement strategies had produced positive results. One Norwich staff member stated they had recently seen an increase in Police referrals, although '*the issue is often the risk level has increased once we see them and therefore they have to refer them back*' (Staff 7, SLCDP). This reflects a wider issue around risk levels raised by several staff (see Section 7.9).

7.5 The Service Users

7.5.1 Survivors

The evaluation included only female survivors; three-quarters (74%) of the 481 survivors recorded on SL Insights as using the service were aged 26 to 45 years old (see Table 7.2). The majority were predominantly heterosexual (94%, n=450) and most (83%, n=400) described themselves as White, 5% (n=26) as Asian/Asian British and 2% as mixed ethnicity; reflecting the ethnic breakdowns in the site profiles. Nearly a third stated they were unemployed (29%, n=138), a quarter (27%) were employed part-time, 11% full-time, and a fifth (21%, n=102) described themselves as a 'stay at home parent'. This is a greater proportion of people not in work when compared to national and local rates. A fifth (22%) of adult survivors had a disability, of whom 53% described a mental health impairment and 36% had a physical disability.

Table 7.2 Demographic Details of Survivors: November 2018 - December 2020

	West Sussex		Norwich		Total	
Age	**N**	**%**	**N**	**%**	**N**	**%**
17-25	26	8.6	27	15.1	53	11
26-35	125	41.4	74	41.3	199	41.4
36-45	100	33.1	58	32.4	158	32.8
46-55	36	11.9	16	8.9	52	10.8
Over 55	15	5	4	2.2	19	4
Ethnicity						
White	236	78.1	164	91.6	400	83.1
Mixed / Multiple ethnic groups	9	3	3	1.7	12	2.5
Asian / Asian British	22	7	5	2.8	27	5.6
Black / African / Caribbean / Black British	14	4.6	3	1.7	17	3.5
Other ethnic group	6	2	0	0	6	1.3
Not disclosed /don't know	15	5	4	2.2	19	4.0
Employment						
Unemployed	52	17.3	87	48.3	139	28.9
Retired	4	1.3	1	0.6	5	1.0
Part-time employment	91	30.2	36	20	127	26.4
In education or training	0	0	4	2.2	4	0.8
Full-time employment	36	12	18	10	54	11.2
Self-employed	10	3.3	2	1.1	12	2.5
Volunteering	3	1	0	0	3	0.6
Stay at home parent	79	26.2	23	12.8	102	21.2
Other	2	0.7	3	1.7	5	1.0
Part-time and education or training	1	0.3	3	1.7	4	0.8
Don't know/ not disclosed	23	7.7	3	1.7	26	5.4
Are children involved in the case?						
No	38	12.6	40	22.2	78	16.2
One or more	263	87.4	140	77.8	403	83.8
Total					**481**	**100**

7.5.2 Families

Most survivors had a child involved in their case (82%, n= 402). Sixty-seven (17%) of survivors with children had a disability. Most (75%) had a child aged under 12, with only 38% having a child aged under 4. SafeLives Insights data showed that 270 children and young people received support from the service, in roughly equal numbers by gender. The majority (41%) were aged 8-11 years (mean age 9.48, SD=3.21), 27% were aged 5 to 7 and 28% between 12 and 17 (see Table 7.3) Most were of White ethnicity (83%) and 12% were described as from mixed or multiple ethnic groups.

A quarter of survivors had some form of CSC involvement, most commonly at the higher level of Section 47 inquiries or on a child protection plan (n=71), 34 families were classified as at the Child in Need level. Just over half of children (58% n=270) had some involvement with CSC, and for a minority (15%, 40/270) this was at the higher level of Section 47 inquiries or on a child protection plan. Reflecting referral routes across the two sites, three-quarters of children in Norwich had some form of CSC involvement compared to half of children in West Sussex.

Table 7.3 Age and ethnicity of children and young people accessing SLCDP services November 2018-December 2020

	West Sussex		***Norwich***		***Total***	
	N	**%**	**N**	**%**	**N**	**%**
Age range (years)						
0-4	5	3.4	6	5	11	4.1
5-7	38	25.5	34	28.1	72	26.7
8-11	70	47.0	41	33.9	111	41.1
12-17	36	24.2	40	33.1	76	28.1
Ethnicity						
White	121	81.2	104	86.0	225	83.3
Mixed / Multiple ethnic groups	18	12.1	13	10.7	31	11.5
Asian / Asian British	5	3.4	0	0	5	1.9
Black / African / Caribbean / Black British	5	3.4	1	0.8	6	2.2
Other ethnic group	0	0	2	1.7	2	0.7
Total	**149**	**100**	**121**	**100**	**270**	**100**

Most perpetrators using the Engage intervention (n=56) were male (53/56) and aged 26-35 (41) or 36-45 (30%). All stated they were heterosexual and most (82%) identified as White (see Table 7.4). A third (37%) were unemployed and 45% were in full-time work. This is similar to national and local area figures.

Table 7.4 Demographic Details of Perpetrator SLCDP Service Users, November 2018-December 2020

Age	N	%
17-25	11	19.6
26-35	23	41.1
36-45	17	30.4
46-55	5	8.9
Over 55	-	-
Ethnicity		
White	46	82.1
Mixed / Multiple ethnic groups	3	5.4
Asian / Asian British	4	7.1
Black / African / Caribbean / Black British	-	-
Other ethnic group	-	-
Not disclosed /don't know	3	5.4
Employment		
Unemployed	21	37.5
Retired	-	-
Part-time employment	1	1.8
In education or training	-	-
Full-time employment	25	44.6
Self-employed	6	10.7
Volunteering	1	1.8
Stay at home parent	1	1.8
Other	-	-
Part-time and education or training	-	-
Don't know/ not disclosed	-	-
Total	**56**	**100**

7.5.3 Survivors' Experiences of Domestic Violence and Abuse

The majority of the 481 survivors (71%) receiving a service had experienced DVA in the past 12 months and roughly one third (29%) had experienced multiple forms of DVA (physical violence, sexual violence, stalking and coercive control) with most reporting the severity level as either standard or moderate. Controlling, coercive and jealous behaviours were experienced by two-thirds (67%) of all survivors in the sample. The majority had experienced DVA for more than a year: a third of survivors had experienced DVA for between 1 and 4 years and a further 41% for over five years. DVA perpetrators were predominantly an ex-partner (76%,) or, to a lesser degree, a current partner (19%), with the majority of survivors not living with the perpetrator when referred (74%), although nearly a quarter (24%) lived with the perpetrator full-time or intermittently.

Insights data for the 270 children accessing the services showed that 42% were currently exposed to DVA at home and a quarter were currently exposed to witnessing physical violence. A substantial proportion (40%) of children were described in Insights records as experiencing emotional abuse. In Norwich, a higher proportion of children were recorded as experiencing neglect (25% compared to 5% in West Sussex) and exposure to parental mental illness was a more frequent concern in this area (35%:3%). Some children (14%) were recorded in the SL Insights data as being worried about getting

hurt at home. More children in Norwich lived with the perpetrator (30% compared to 10% in West Sussex) and more expressed concern about harm to a parent (61%) or sibling (31%) compared to those in West Sussex (39%:16% respectively). For around a quarter of children, DVA perpetrators had used contact visits as an opportunity to continue the abuse, with contact featuring in the cases for half of the Norwich children (49%).

SL Insights data provided the rationale for perpetrators' use of the Engage programme with 68% doing so to improve their relationship with their partner or ex-partner; 39% aiming to improve their relationship with their children; 29% wanting to stop abusive behaviours; and 16% prompted by issues around child contact. SL's Insights records also provided space for perpetrators to explain the difference accessing support had made to their lives and why. One father stated:

So in the past whereas I might have told the kids to stop crying like little girls now over the last couple of months I felt myself hugging them in that moment which is something I would never have done in the past. So being able to emotionally engage with the individuals slightly better than I would have done in the past for me is a massive step in the right direction. (Insights data)

7.5.4 Complex Needs

Table 7.5 shows that the most common complex need among survivors using the services concerned housing issues (36%). Overall, 23% of survivors had a disability, most commonly a mental health issue (12%) or a physical disability or neurological illness (10%). Norwich supported a higher proportion of survivors with complex needs relating to mental health issues compared to West Sussex (55%: 44%), although nearly all survivors with risks around honour-based violence and forced marriage who received a service were in West Sussex (n=18/19).

Table 7.5 Survivor with complex needs using SLCDP services

Complex need	N	Percentage (of 481)
Any disability	108	22.5
- Physical, neurological, and/or progressive illness	45	10.0
- Learning disability or difficulties	16	3.3
- Mental health	58	12.1
Problems with drug misuse	24	5.0
Problems with alcohol misuse	40	8.3
Housing issues	176	36.6
Problems with access to public funds	9	1.9
Forced Marriage	3	0.6
Honour-based violence	17	3.5
Female Genital Mutilation	3	0.6
Total	**481**	**100**

Only 10% of children were recorded as having complex needs, these included Hyperactivity Disorder (ADHD), autism, physical disability or learning disability. For perpetrators, similar rates of physical (n=5/9%) or learning disabilities (n=5, 9%) were noted. Seven perpetrators were recorded as having mental health needs at intake (13%). This low level of recorded mental health need is surprising in

the light of other research undertaken on whole family interventions and on perpetrator interventions (Trevillion et al 2020, Hester et al 2020).

7.5.5 The Survivors at Baseline

The majority of the 188 survivors who completed the Evaluation's outcome measures at baseline were white British (69%) or white other background (6%), most (67%) were aged 30 to 49, with 41% aged 30 to 39, the majority were heterosexual, and three-quarters (n=128/163) had at least one child under the age of 18. A quarter of survivors (26.6%; 50/188) had a complex need (this figure excludes complex needs recorded as 'housing' as this term covers a wide range of issues). Thus, the demographics of the sample completing the Evaluation outcome measures were broadly reflective of service users recorded on Insights, although the survivors who completed baseline outcome measures were slightly older.

Baseline measures addressed three areas: Safety, coping and confidence and wellbeing. For the safety and coping questions, survivors could answer: *none of the time; rarely; sometimes; often; all of the time*. For analysis, these were condensed into three responses: *none of the time and rarely; sometimes; often and all of the time*.

Although, at baseline, the majority of survivors reported feeling safe often/all the time, in their home, their neighbourhood and online, 40% had felt safe none of the time/rarely or sometimes, 42% said they felt safe at home none of the time/rarely or sometimes and the same proportion (42%) reported feeling safe in their neighbourhood none of the time/rarely or sometimes (see Table 7.1, Appendix 7). Fewer online safety concerns were reported with only 21% stating they felt safe online none of the time/rarely or sometimes. When asked whether they felt it was safe for their children to see their father, the proportion of survivors answering none of the time/rarely or sometimes was 65% with 44% responding none of the time/rarely. However, most survivors (75%) reported that they knew where to go for help often or all of the time (see Table 7.1, Appendix 7).

At baseline, the majority of survivors felt they were coping well often/all the time in the following five areas: relationships with their children (84%); alcohol and drug use (81%); decision making (64%); being able recognise if other people have been behaving abusively (63%) and, to a lesser extent, knowing they were not to blame for the abuse (54.5%) (see Table 7.2, Appendix 7). In other areas, responses were more varied, for example, 49% felt they were able to deal with everyday life often/all of the time and 42% sometimes; similarly, 45% felt they could cope if things went wrong often/all of the time and 40% sometimes. In some areas, more prominent coping concerns were highlighted, for example, in response to 'been able to get a good night's sleep', 34% said none of the time/rarely and 38% stated only sometimes. Similarly, 28% stated they felt they had control in their lives none of the time/rarely and 28% sometimes (see Table 7.2, Appendix 7).

Wellbeing was measured using the Short Warwick–Edinburgh Mental Wellbeing Scale (SWEMWBS) (n=175), the mean score was 21.10 with a range of 11.25-35. The SWEMWBS scoring thresholds showed that wellbeing was low at baseline: 34% of survivors had average mental health, 30% had possible depression, 26% had probable depression and 10% had high mental wellbeing.

The results of the health questionnaire EQ-5D-3L indicated that survivors at baseline experienced health states that were worse than those of the general population.

7.5.6 Evaluation Children's Outcome Measures at Baseline

Children (n=77) completing outcome measures at T1 were mostly White (84%); 9% were from mixed/multiple ethnic groups and 4% were Black. Slightly more were male (56%) than female (44%) and 52% were aged 7-10 years with 48% aged 11-17 years. Eight children had a disability, for seven of this group, this was a mental health difficulty or condition such as ADHD or autism. The majority of children (61/77) were receiving support from the service for historical abuse and 16 were currently experiencing DVA. Most were receiving one-to-one support from SL's CYP workers (50/77, 65%), and a further 13 received support from the Engage caseworker. The children (n=71) completed a child health questionnaire (CHU-9D) at baseline, the average score was 0.814 with the SD PF 0.107, where perfect health is rated as 1.

7.6 Implementing and integrating different components of the intervention

Overall, the complexity of delivering *seven different interventions* (including the Skills Enhancer and Peer mentoring roles) *with five toolkits* was viewed as hugely challenging and, as two senior staff argued, may have been too ambitious in the timeframe. More assistance was required in the implementation and delivery stage to understand how the different components worked together in practice. This was especially important in the early stages as the services had been developed and piloted in isolation rather than as an integrated service:

…we could have provided a better service if someone had helped us to map those interventions together a bit more… we've worked it out over two years, but there isn't a flowchart, a roadmap. (Senior staff 1, SLCDP)

Nevertheless, the majority of respondents to the staff survey (n=13/16) felt that co-ordination between different elements of the service had either been 'good' or 'excellent', with nearly two-thirds reporting that the ambition of creating an integrated, flexible service had been achieved. However, in interviews, staff commonly reported a lack of clarity around their different roles and how these might contribute to the wider whole family approach, especially at the beginning:

An Idva is trying to learn how to do the Engage work, to learn how to do the Community Idva work and also, learning how to do the APV work. So we're asking people who are used to delivering one intervention, to learn three interventions. (Staff 6, SLCDP)

Integration was particularly challenging for the Engage strand of the programme where greater understanding was needed on how work with perpetrators could be integrated into the wider SLCDP model and '*especially around more traditional*' Idva and children and young people's work, which were seen as easier to implement and integrate. However, not all aspects of work planned for children and young people, for example the Adolescent to Parent Violence (APV) groups, were implemented due to issues with capacity and sufficient numbers for group work. Staff in both sites noted the need for step-down work with children: in Norwich, groups with a local arts agency were developed to respond to demand but, in West Sussex, staff capacity had restricted similar development. The ambition of creating a flexible integrated approach to support all family members at the time when they needed it was sometimes undermined by capacity issues, below one staff member reflected on how delays in being able to provide survivors with support, due to waiting lists, meant that work with perpetrators could not begin:

…but we can't start with them (perpetrators) until we start with the victim. So that means that we will lose some perpetrators but by the time the victim and the children can both get a service, that perpetrator might well have lost motivation (Staff 1, SLCDP).

7.6.1 Interventions Received

Insights data showed that a total of 869 interventions were delivered to 481 adult survivors, 270 children and 56 perpetrators over the two-year period that the service was being delivered and evaluated (see Table 7.6). The most frequently accessed interventions across both sites were Community Idvas, Children's Caseworkers and Step Down and Recovery Group interventions. West Sussex delivered more Step Down and Recovery groups to survivors and Norwich undertook higher levels of Engage work with children and perpetrators. The adolescent to parent violence intervention (Tandem) was only delivered to nine children across both sites in the Evaluation period, this was due to a range of reasons, for example, in West Sussex a similar established service was already available. It should be noted that there was some fluidity in moving between and categorising some interventions such as Community Idva and Step Down and Recovery work.

Table 7.6 Interventions accessed by all SLCDP service users by 18 December 2020

Interventions*	**Total**		**West Sussex**		**Norwich**	
Survivor only	**n**	**%**	**n**	**%**	**n**	**%**
Community Idva - Medium risk	231	26.6	148	28.6	83	23.6
Community Idva - Complex needs	29	3.3	7	1.4	22	6.3
Step Down and Recovery Group Interventions	159	18.3	111	21.4	48	13.7
Children only	**n**	**%**	**n**	**%**	**n**	**%**
Children's caseworker – one to one	191	22.0	118	22.8	73	20.8
Children's caseworker - Monkey Bob - groups	15	1.7	0	0.0	15	4.3
Children's caseworker – Groups	14	1.6	14	2.7	0	0.0
Children's caseworker - Monkey Bob - one to one	13	1.5	9	1.7	4	1.1
Parenting	**n**	**%**	**n**	**%**	**n**	
Grow Together - Advice	11	1.3	11	2.1	0	0.0
Grow Together - Groups	8	0.9	0	0.0	8	2.3
Grow Together - one to one	1	0.1	0	0.0	1	0.3
Survivor and child	**n**	**%**	**n**	**%**	**n**	**%**
Parent and child support - Side by Side - groups	31	3.6	25	4.8	6	1.7
Parent and child support - Tandem - one to one	7	0.8	4	0.8	3	0.9
Parent and child support - Tandem - groups	2	0.2	1	0.2	1	0.3
Survivor, child and perpetrator	**n**	**%**	**n**	**%**	**n**	**%**
Community Idva - Engage	68	7.8	39	7.5	29	8.3
Children's caseworker - Engage	32	3.7	8	1.5	24	6.8
Case manager - Engage	57	6.6	23	4.4	34	9.7

*the percentage figure shown is for interventions and individuals may have received more than one intervention. The number of interventions for perpetrators is greater than service users as includes a repeat service user.

7.7 Exits and Case Closures

Over the Evaluation period, cases were recorded on the SL Insights system as closed for 362 survivors (63 survivors with no children under 18 and 299 survivors with children involved in the case), 187 children and 45 perpetrators (see Table 7.7). For this group of service users, it is possible to examine the full range of support accessed from the service. Overall, 69% (n=251) of survivors received a service just for themselves and 31% (n=111) received some form of family support. In addition, four survivors without children used Engage support. Looking only at survivors with children (n=299), 64% (n= 192) received support just for themselves and 36% (n=107) received support which included parenting support and/or support for their child/ren. Overall, around 40% (n=76) of children received a service just for themselves with no accompanying survivor or perpetrator support. The service may still have engaged with the parent but may not have completed an Insights data form for them. In the majority of the 187 closed children's cases, the children had received support from a one-to-one caseworker support (69%) or the Engage caseworker for children and young people (13%). Groupwork was less developed for children, possibly due to lockdown restrictions however, in total, 20% of children attended one or more group sessions such as Monkey Bob, Side by Side or general group work.

The average length of service use for survivors was 7.5 months. Most survivors (56%) had ten or less contacts, (M=13.56, SD 13.16) (Insights records define a contact as a face-to-face or telephone meeting in which meaningful direct communication with the client took place). The majority of children (59%) received a service for over six months, with most (75%) having ten or fewer contacts (M=7.39, SD 4.96). Children were supported as a consequence of witnessing DVA (95%), directly experiencing abuse (40%) and in respect of their own harmful behaviour towards others (16%). A higher proportion of Norwich children received support for their behaviour towards others (26%, compared to 10% in West Sussex). For the 45 perpetrators where cases had been closed, just over half (n=25) had ten or less contacts with the service (M=12.62, SD 11.09).

Looking at the number of interventions accessed by those service users whose cases had been closed, for survivors who used services only for themselves (n=252), 96% (n=240) received a single type of intervention from the service. Of the 252 who had an adult intervention only, most received support from the Community Idva service (146, 58% of survivors) and recovery group work (99, 39% of survivors) and 12 survivors had a combination of these two interventions. In the group of 110 survivors receiving targeted parenting or family interventions (whole family support), the most common intervention used was one-to-one CYP services (38%), followed by Engage Idva (40%) support, 16% of these survivors participated in the Grow Together intervention and 15% participated in Side by Side group work at the same time as their child. Of the 110 survivors who accessed targeted parenting or family interventions, 62% received more than one intervention which was most usually a combination of CYP one-to-one support with recovery group support (16%).

Table 7.7 Intervention type by cases closed by 18t December 2020

Survivors – Closed cases	**All**		**West Sussex n=232**		**Norwich N= 130**	
	n	**%**	**n**	**%**	**n**	**%**
Community Idva	180	43.8	124	46.6	56	38.6
Community Idva - Engage	46	11.2	24	9	22	15.2
Community Idva - Complex needs	20	4.9	6	2.3	14	9.7
Step Down and Recovery Group Interventions	133	32.4	91	34.2	42	29
Adult parenting support - Grow Together - groups / one to one / advice	18	4.4	10	3.8	8	5.5
Parent and child support - Side by Side - groups	11	2.7	9	3.4	2	1.4
Parent and child support - Tandem - groups	1	.2	1	0.4	0	0
Parent and child support - Tandem - one to one	2	.5	1	0.4	1	0.5
Children – Closed Cases	**All n=187**		**West Sussex n=114**		**Norwich n=73**	
	n	**%**	**n**	**%**	**n**	**%**
Children's caseworker - one to one	127	67.9	88	77.2	39	53.4
Children's caseworker - Engage	26	13.9	6	5.3	18	24.7
Children's caseworker - groups	16	8.6	13	11.4	0	0.0
Children's caseworker - Monkey Bob - one to one	8	4.3	6	5.3	2	2.7
Children's caseworker - Monkey Bob - groups	11	5.9	0	0.0	11	15.1
Parent and child support - Side by Side - groups	17	9.1	12	10.5	5	6.8
Parent and child support - Tandem - groups	1	0.5	0	0.0	1	1.4
Parent and child support - Tandem - one to one	2	1.1	1	0.9	1	1.4
Perpetrators- closed cases	**All n=45**		**West Sussex n=18**		**Norwich n=27**	
	n	**%**	**n**	**%**	**n**	**%**
Engage Case Manager	45	100	18	100	27	100

Exit data for survivors (n=362) showed that a quarter of exits were unplanned (n=96) with more unplanned exits occurring in Norwich than in West Sussex (37% and 21% of all exits respectively. The Insights monitoring database (SafeLives 2020b) indicated that this level of unplanned exits was in line with that experienced by other DVA outreach services. The main reason for an unplanned exit was disengagement from the service (72%), followed by the service user moving out of the area which accounted for 8% of unplanned exits. A slightly higher proportion of unplanned exists involved survivors who, at the referral stage, stated they were in a current relationship with the perpetrator. Survivors with complex needs or families with CSC involvement did not experience higher levels of unplanned exits. Three-quarters of unplanned exits had occurred by the time of the tenth contact with the service. Exit data for the 187 children showed that 18% had an unplanned exit.

Barriers to engagement identified in interviews with staff included: women's fear of losing their children; feeling overwhelmed by their own situation; not believing their situation could change; and fear of the repercussions if their abuser discovered they were receiving support. Although staff reported that children engaged well with services, staff also felt that children were commonly told

not to discuss their family situation with professionals. Restrictions due to Covid-19 meant that CYP workers were not always confident they could elicit the child's perspective on the family situation.

Staff interviewed noted that in practice it was sometimes difficult to know when to close a case, especially when support for a child had been completed but there was still the possibility of concerns occurring in the future, for example, due to ongoing court cases. In Norwich, staff reported that the ongoing nature of recovery work, including peer support sessions, made it difficult to close cases, *'At the moment, the way we work, is that people can access, can kind of do recovery for as long as they want and they can access as many groups as they want'* (Staff 10, SL). This may have inadvertently increased the number of unplanned exits if service users did not take up the ongoing support offer.

7.8 Facilitators to SLCDP delivery

Senior SLCDP managers felt that one of the most important achievements was the way in which the services had adapted and responded to survivors' needs and continued to do so. The importance of an integrated approach, based on trauma informed, strength-based practice, multi-agency working, and a flexible user-led approach to support were consistently identified as the core components of successful delivery across the sites by senior managers and staff. One staff survey respondent noted that the use of trauma-informed practice was a particular area of work that had gone well:

Implementation of trauma-informed practice with focus on understanding the impact of trauma and ACEs that clients have experienced. This is a very powerful strengths-focused approach and has enabled clients to make sense of their past experiences and to regain strengths and self-worth. (Survey respondent, SLCDP)

Staff surveyed commonly identified that the wide variety of complimentary interventions and toolkits allowed for significant tailoring and flexibility; specifically, the recovery service, volunteer interventions and therapeutic fund for survivors and perpetrators, were considered to be successful in addressing the needs of survivors and behaviours of perpetrators.

The achievements of the survivor-led work were illustrated by the number of service users who, after completing the programme, had joined the peer support network and volunteered to help other survivors. When asked to comment on what they felt had worked well within the service, staff survey respondents' comments (n=14) focused around three main themes: the positive nature of client support, multi-agency collaboration, and strong leadership and supervision. Three staff spoke very positively about the specialist clinical supervision they had received.

All staff interviewed said that they felt the service managed risk either 'very well' or 'quite well' and most mentioned the value of using the domestic abuse, stalking and harassment risk assessment (DASH) form. However, some differences between staff emerged around identifying risk in work with perpetrators:

Q: And with the family, do you encounter differences in understandings of risk and how do you negotiate that…in managing Engage?

A: We do and I think that's where the cultural background and the, you know, beliefs and values come in. Because I know that our [Engage workers] can see a perpetrator as somebody who needs some help with expressing themselves healthily, controlling their emotions, communication skills…And there the risk is different from someone like that guy, who was borderline dysphoric, completely ego centric. His way was the only way and he was a very dangerous man. When our

Idvas tend to view every perpetrator as an intimate terrorist, our Engage [workers] don't. (Staff 1, SLCDP)

Staff interviewed agreed that the effectiveness of the Norwich Complex Needs Idva service was due to sustained outreach work which supported referral pathways and joint working, further facilitated by having a single site and consistent staff in place. Relationship building with survivors who had complex needs was often a long-term process, as indicated by one worker who described contact with a potential service user:

……if I see her in the streets when I go for a walk, I'll always get her a drink, I always chat to her and she knows the service I work for…that's been going on for five months. (Staff 15, SLCDP)

The offer and take up of direct work with children and young people were also viewed as a success, although delivery of the APV group intervention in West Sussex had been affected by competition with an existing service. Despite some challenges around integration of the Engage work, as highlighted earlier, work with perpetrators was viewed as an important achievement that had enabled perpetrators to develop greater insights into their behaviour, build healthy relationships with their children and had enabled survivors and families to feel safer: '*Working with the perpetrators, having that ongoing dialogue and mirroring sessions… I think that that has worked really well.'* (Staff 2, SLCDP). Norwich staff identified that weekly check-in meetings between Engage workers and Idvas had enhanced teamwork on cases and 'Signs of Safety' case discussions had been used to explore practice. More widely, staff in both sites stressed the importance of case meetings to bring together different team members and this had been facilitated by co-location of teams.

Establishing peer mentors in the two sites had taken time but was felt to have gone from *'strength to strength'* (Senior Manager 3, SL). Development work required networking with other organisations and establishing training programmes and the peer mentors in both sites shared expertise with each other. The availability of survivors to become mentors had been addressed by recruiting other survivors directly into the mentoring role as well as training those who had received SLCDP services. Service user involvement had also included participation in other ways: in Norwich, survivors were supported to be part of recruitment interview panels, including children for the CYP worker interviews and, in West Sussex, sessions had been held to facilitate survivors' response to local DVA strategy consultations.

7.9 Barriers to delivery

The enormity of the task of embedding and delivering an integrated whole family DVA response, which worked with perpetrators and with couples wishing to stay together, was recognised by many staff:

…the shift from working only with victims to families and engaging with people in a relationship was culturally (challenging], we knew was going to be hard but it is much harder than we thought and it's shown itself in so many different ways (Senior Staff 5, SLCDP)

Both sites encountered difficulties in recruiting to the Engage posts, perhaps reflecting a wider lack of expertise and specialist knowledge around working with DVA perpetrators (Stanley and Humphreys, 2017). In Norwich, senior staff thought this problem was compounded by the new nature of the role and lack of clarity in the job title which was later amended to *Behaviour Change Practitioner.* The West Sussex team was also unable to re-recruit a Complex Need Idva which meant they lacked the capacity to undertake outreach activity to support partnership working for survivors with complex needs.

Staff shortages (see Section 7.10) also meant that at some points referrals into West Sussex had to be placed on hold which one respondent felt reduced trust and damaged professional reputation: '*because we are so are understaffed, sometimes we have to put a hold on referrals... we've only done that twice, but, unfortunately, then that does get the stigma attached.'* (Staff 9, SLCDP). However, it should be noted that stakeholder meetings reported very positive partnership relationships in both sites. In some cases, capacity issues resulted in long waiting lists or closing referrals for specific time frames, limiting the extent to which delivery could be flexible and responsive to client needs as, '*we are not always supporting the different members of the family at the same time*' (Staff Survey, SLCDP), potentially making for a disjointed whole family approach. Both SLCDP sites only accepted referrals for children whose parent was willing to engage meaning that children and young people could not access support directly in their own right.

Staff survey respondents (n=11) provided comments on which areas of the service could be improved, these focused on three main themes: the intervention offer, especially around communicating with survivors who may have been referred by children's social care as part of a child protection plan, that the service was voluntary and not compulsory and letting survivors whose partners were receiving Engage support know support was available for them; additional support for perpetrators to address emotion regulation and behavioural change; and expanding the service's remit to include 'high risk' perpetrators. The issue of risk thresholds determining which service families could access, and the impact of this on a survivor's journey to recovery, was also raised in interviews with staff and senior staff managers who described this as '*shutting and opening the service door'* (Senior Manager 3, SLCDP). Another senior manager highlighted the discontinuity that occurred when survivors' risk levels changed and consequently they needed to be referred to another service that targeted service users with a different level of risk:

The high risk, medium risk, I feel, for victims, that then go from medium risk and having lots of support and engaging well and building a rapport with our team, to then have to move to a different team…that does have an impact. (Senior Manager 5, SLCDP).

One staff member reflected that the prominence of referrals from CSC, especially in respect of child protection cases, had impacted on the nature of support provided, such as being able to work flexibly at the service user's pace, as *'it becomes solely around trying to put work in place and have outcomes within a very short space of time, so that their children aren't removed, completely changes the kind of work that you do.'* (Staff 7, SLCDP).

Staff survey responses identified that some groups had been more difficult to engage, most commonly, survivors who were homeless, had mental health issues and/or substance misuse and survivors who were living with the perpetrator (as confirmed by the unplanned exit data reported above). Survey respondents also identified that, at times, multi-agency collaboration and partnerships could be challenging, which made it difficult to respond to families' needs effectively: *'The different organisations involved can sometimes have different beliefs in terms of the way the service works …which can make things tricky'* (Staff Survey Respondent, SLCDP).

Cultural norms were also described by a staff member as a possible barrier to accessing services,

I feel that people from Asian backgrounds, you know, people from different cultures…the culture teaches you that you need to be closed with your feelings and emotions, and nobody needs to know about what you are going through. (Staff 16, SLCDP)

A lack of capacity, time and resources was reported as a barrier to *'really overcome some of those barriers about why we're not reaching those communities'* (Staff 3, SLCDP) including LGBTQ+, male victims, and older survivors. In Norwich, staff commented that they felt the service had *'identified*

the scale of the gaps that it was designed to meet, but it's also identified how much other need there is out there' (Staff 6, SLCDP). Establishing ties with local services that supported marginalised groups was viewed as essential to widening engagement. Staff reflected on some of the barriers women experienced in accessing groups, for example, lack of flexibility around working times, lack of transport or childcare, mental health or physical disability, as well as social anxiety. The capacity to provide individual work with women who were unable to attend groups was often restricted, limiting the ability of services to be inclusive for all women. Lastly, the online counselling support had not been utilised as much as anticipated which staff attributed in part to the service provider.

Nevertheless, despite the challenges, staff's commitment to delivering a whole family intervention was clearly recognised and valued by senior staff: *'… they're [staff] so passionate, and that just screams through…they're second to none'* (Senior Manager 1, SLCDP).

7.10 Workforce Issues

Turnover of staff was high in both sites and occured across all roles: 17 staff had resigned or left in the 26 months from October 2018 to November 2020. Nine posts were vacant for more than one month, in particular, the Complex Needs Idva role in West Sussex was vacant for 25 months despite many recruitment attempts. In Norwich, for the majority of the 26 months of the evaluation, only one Behaviour Change Practitioner was in post, with two being in post for five months. Sites reported significant workforce issues around recruitment and retention, with this being particularly challenging in West Sussex due to higher salaries being offered locally for similar posts. This caused additional demands on staffing resources due to ongoing recruitment, inductions and training requirements. In West Sussex, workforce difficulties associated with delivering a complex service in two different sites were also highlighted: '*in essence we're set up and are running two teams and two different areas'* (Senior Manager 2, SLCDP). However, there was reflection from a senior manager that the switch to remote working during the pandemic in 2020 had provided an opportunity to bridge the gaps between the teams, such as through video meetings:

The communication now is probably the strongest it's ever been because we're using all the technology to stay in contact with each other, which wasn't there before, you know, we weren't doing video calls with each other. So, it has made us re-evaluate that and, you know, make sure we actually put time aside to come together and catch up and look at our wellbeing and team meetings and things. (Senior Manager 2, SLCDP)

Reasons for staff turnover included staff being offered longer term contracts and higher salaries and for a small number, feeling undervalued or 'burned out' due to high caseloads. High staff turnover is a frequent problem for sectors such as the DVA sector that are characterised by short-term funding (Berry et al 2014).

Staff shortages may have also impacted on workloads with just over half of the staff survey responses (8/15) reporting that their workload was too heavy and nearly all those responding (12/14) felt that their deadlines were unachievable (Tables 7.7 and 7.4, Appendix 7). Ten of 14 respondents indicated that they sometimes or often neglected tasks due to their high workload (Table 7.7, Appendix 7). However, most staff felt supported through emotionally demanding work (Table 7.5, Appendix 7). These questions were taken from the HSE Management Standards toolkit to measure workplace stress which state that employees should feel able to manage demands on their time and local systems should be in place to respond to individual concerns. The findings indicate that demands on staff were high but they reported receiving support from their managers.

7.11 Monitoring

Most staff understood and appreciated the benefits of routine monitoring for building evidence of effectiveness, highlighting areas for improvement and to support future funding applications. However, some staff were less supportive, citing that routine monitoring was not a priority in the context of a pilot service:

I don't think it was realistic to set this project up to meet a service need… and to test these models at the same time… you're asking people to deliver and produce outcomes immediately from day one, as well as go through some fairly fundamental internal change in their professional practice. (Staff 12, SLCDP)

Conflicts between the workloads of front-line staff and the demand for effective monitoring, as well as data requirements for the current evaluation, were acknowledged, and on rare occasions this could lead to pausing work with service users:

They have been really behind. So, we've had to put a bit of pressure on and actually stop them seeing clients, so that they can catch up and get things up to date. (Senior Manager 1, SLCDP)

Some staff stressed that the Insights recording system was too complicated, they were unsure if all the questions were necessary and felt that the system was not tailored to reflect the integrated nature of the service. The Evaluation Team would concur with this last point – difficulties in marrying up Insights data for children and mothers hampered the analysis. Some staff also questioned whether the Evaluation Team's outcome measures properly reflected the whole family approach and some felt it was overly burdensome. Staff suggested that specific training on the role and value of routine monitoring and outcome measures would be helpful.

7.12 Training

The expertise and training provided by SafeLives was key for staff in the implementation period. Training included a mixture of compulsory DVA outreach training and training modules/blocks based on their roles. Staff interviewees involved in the implementation stage felt this had enabled them to understand the vision of the programme as well as establishing working relationships within their team and connections to the other delivery sites. All staff survey respondents stated they had received sufficient training to enable them to deliver the SLCDP services as intended. However, over a third (n=6/15) indicated specific areas where they would like further training such as: adolescent to parent violence, managing volunteers, the impact of trauma on children. Two staff not undertaking Idva roles mentioned that Idva training would have been beneficial for them.

The delivery of the training was also highlighted as an area for improvement in staff interviews. The blocked nature of courses meant that staff who missed the first sessions had to wait to complete the full training and this meant that some new staff completed components out of sequence. Staff also commented on the need for a more integrated training format to support a common understanding around how interventions and roles joined up to provide a whole family response, this was seen as particularly important for the Engage roles: '*…with hindsight, to bring Engage and the Idva training together, rather than doing them separately, would have been beneficial, so that everybody started off from a common understanding'* (Staff 1, SLCDP). One staff member suggested that four days training on working with perpetrators compared to twelve days training on working with victims was insufficient:

in terms of specific, yes, typology, what to do when this happens, what to do in this situation type training around perpetrators, I feel we could have benefited from more. (Staff 6, SLCDP)

7.13 Impact of Covid-19

Senior staff reflected on service delivery during the Covid-19 pandemic. The lockdown had prompted managers and staff to '*think outside the box'* in developing their service response. Responses included delivering adult recovery groups online, providing one-to-one support by phone or video call and sending out materials and newsletters to service users. Issues of privacy and safety were central to the delivery of support for all service users during lockdown and this was an additional challenge when staff were also working from their own homes. Remote working was not appropriate for all service users, and although efforts were made to connect with children individually, restrictions on school visits and the curtailment of face-to-face group work caused a backlog of cases. The training work provided by the Skills Enhancer was also affected.

Survey respondents were asked to indicate which three statements best described the impact of Covid-19 on the service, the three most common responses were: they had made 'effective use of remote ways of working with survivors' (n=9/15); had been 'concerned for the safety of some of our service users' (n=9/15); and had found 'new and innovative ways of delivering services' (n=8/15). No respondents selected any negative statements, suggesting that the services adapted well to the challenges of Covid-19.

7.14 Summary

- The central role of Pioneers in the development and implementation of the SafeLives Co-Designed Pilots, alongside the contribution of expert partners, was highly valued, however locating the development work in the sites themselves would have allowed the local context to be taken into consideration and piloting a whole family approach, rather than individual interventions, would have been beneficial to implementation.
- The importance of an integrated approach, based on trauma informed, strength-based practice, multi-agency working, and a flexible user led approach to support were consistently identified as the core components of successful delivery across the sites by senior managers and staff.
- There were mixed views on the level of resources available for planning and implementation of the integrated service, although all senior staff agreed that time allowed for planning and initial implementation in the local sites was insufficient. A fuller picture of the local context might have assisted understanding of the local need for a child-to-parent abuse service and informed decisions about staff salary levels.
- The expertise and training provided by SafeLives was key for staff in the implementation period.
- The competitive tendering process in Norwich had a negative impact on partnership working and referral pathways due to the decision not to award the contract to a local high-risk DA provider.
- A higher proportion of referrals for survivors in West Sussex came from DVA/SV agencies, while in Norwich Children's Social Care was the primary referral agency; some Norwich staff felt this changed the nature of their work with families.
- Nearly all adult service users were white British and heterosexual. Female survivors were predominantly aged 26 to 45, the majority had a child involved in their case and three-quarters of these families had CSC involvement. Children roughly used the service in equal numbers by gender and the majority were aged 8-11. Nearly all perpetrators on the Engage strand of the programme were male and most were aged 20-39.
- Nearly all survivors had experienced DVA in the past 12 months and roughly three-quarters had experienced coercive control and a third multiple forms of DVA. Perpetrators were predominantly an ex-partner.
- The most common form of complex needs for survivors using the service were housing problems, mental health issues or a physical disability or illness. Despite a flexible approach to addressing need, these groups, alongside those survivors still living with the perpetrator, were described as most difficult to engage by staff.

- Most staff reported that the ambition of creating an integrated, flexible service had been achieved. However, the complexity of delivering multiple interventions was viewed as challenging and ambitious in the timeframe, especially in relation to the Engage support, which was affected by staff shortages and reached fewer perpetrators than had been planned.
- While multi-agency work was viewed as well-developed with some organisations although multi-agency communication was less well established with some of the organisations more likely to refer those with complex needs such as GPs and mental health services.
- The Complex Needs Idva role required particular expertise and skills to undertake outreach work with potential service users and to establish referral pathways. Where it was achieved, continuity of staff facilitated this work, particularly in the context of establishing a new service.
- The Engage and Complex Needs Idva interventions were innovative delivery models which required greater levels of staff resources such as training, outreach work and new approaches to facilitate their successful delivery.
- The variety of complimentary interventions and toolkits was considered by staff to have facilitated tailoring and flexibility in meeting individuals' needs.
- Over the evaluation period, Insights recorded closed cases for 362 survivors, 187 children and 45 perpetrators. Overall, 69% of survivors received a service just for themselves and 31% received some form of targeted family support. Among survivors with children, 60% received support just for themselves and 40% received some form of targeted family support which included parenting support and/or support for their child/ren. Overall, around 40% (n=94) of children received a service just for themselves with no accompanying survivor or perpetrator receiving a SLCDP intervention.
- Targeted family support most commonly included combinations of: one-to-one CYP services with Community Idva, recovery groups or Engage support for parents, targeted parenting support was less frequently used.
- Barriers to delivery included: challenges concerning staff retention for the Engage and Complex Needs roles, lack of clarity around roles and integration of interventions, especially Engage work; engagement with survivors with complex needs; and training issues.
- Staff questioned whether the Insights monitoring system, as well as the UCLan co-produced outcome measures, were well suited to a multi-component, integrated services such as theirs.
- Despite being deliberately conceived to address the noted gap in services for medium risk survivors, staff considered that confining the delivery of some parts of the service to those at a specified level of risk was confusing for potential referrers and could undermine consistency of service for survivors.
- Staff turnover proved a major challenge for one site and was attributed to a shortage of relevant skills in the local area and uncompetitive rates of pay for staff.
- In response to Covid-19 restrictions in 2020 SLCDP service providers developed innovative ways of delivering services to survivors and, to a lesser extent, their children

7.15 Recommendations

- More planning time and activity at the local level would ensure a better fit in local service landscapes and enhanced integration of different programme components.
- A whole family administrative system would support more effective and efficient monitoring.
- Whole family DVA training for staff should be an essential prerequisite for any programme seeking to integrate different interventions for family members.
- The SLCDP services targeted a very broad group of survivors and needs: rebalancing resources to increase the capacity of family-focused interventions might enable more survivors and families to access a 'whole family' service when needed.

- Although SLCDP service use was reflective of local demographics in terms of Black and minoritised populations, interventions still require further development and testing in areas with greater levels of diversity to determine if they require adaption to meet the needs of different groups of survivors and their families.
- Recruitment and retention of staff with expertise require salaries to match local rates: this is an issue for those commissioning services.
- Consideration should be given to ensure the geographical catchment area for the service is sufficiently wide to enable clear routes for local referral agencies.
- A reconsideration of risk-based service criteria might assist in clarifying referral pathways and increase consistency of support for survivors and their families. Risk levels can fluctuate rapidly and are not easily understood by those using or referring to DVA services. Commissioners should consider other approaches to targeting services that are more comprehensible and reflect survivors' lived experience.

Chapter 8: The SafeLives Co-Produced Pilot Programme: Impact

This chapter reports on SLCDP programme impact drawing on qualitative and quantitative data. Individual and focus group interviews were completed with survivors between October 2019 and December 2020**.** Difficulties in completing interviews with children receiving the service resulted in a change to the research design and six case studies that included children's, mothers' and staff's perspectives were completed between September and November 2020 to ensure that children's experiences and assessments of the intervention were captured. Quantitative impact data was collected from SL's Insights recording system and through outcome measures completed by survivors at multiple time-points. This evaluation focused on survivors and their children in line with the women and girls remit of the Big Lottery's funding programme. Perpetrators using the Engage service were invited to complete parenting measures, but none did so. Other studies have also found that perpetrators using whole family services are less accessible to researchers than survivors (Trevillion et al 2020) but their perspectives are also worth capturing. However, a recent study has demonstrated the positive outcomes that can be achieved through working with DVA perpetrators and victim-survivors (Hester et al 2020).

8.1 Characteristics of Survivors Interviewed

Table 8.1 shows that 54 survivors who used the SLCDPs were interviewed individually. The majority of these were telephone interviews with 13 interviews completed face-to-face in community venues in the two sites. In addition, five online focus groups were conducted on Microsoft Teams or Zoom, using the group's existing arrangements. The focus group interview either replaced or followed the group's planned session. In total, 21 individuals participated in focus groups, three focus group interviewees were also interviewed individually, and one person took part in two focus groups following different courses. Four of the six mothers who were interviewed as part of the case studies had also been interviewed previously in their own right. In total 74 individual survivors participated in the evaluation data collection, as shown in table 8.1 below.

Table 8.1 Interviews with Survivors and their Families

	Norwich	West Sussex	Total
Survivors interviewed	24	30	54
Family Case Studies	3	3	6
Focus groups (participants)	1 (2)	4 (19)	5 (21)

The majority of the 54 survivors interviewed were White British (38) and other ethnic backgrounds included 'any other white' (5) and Black African or Caribbean (3). Most were aged 30-39 (20/54) or 40-49 (17/54). Six were currently living with the perpetrator. The majority were in employment (28/54) and 12 were unemployed and eight were listed as a stay-at-home parent. The sample was broadly similar to that of the SL Insights survivors' data in terms of ethnicity and age, but a greater proportion were in employment (52% of interviewees compared to 40% of survivors in the SL Insights dataset). Whilst efforts were made to contact and interview survivors from a range of backgrounds who experienced all interventions, the sample does have some limitations. For example, those receiving support as part of the Engage intervention were under-represented. Contact was only made with survivors who indicated they wished to be interviewed, and during the 2020 lockdown, where it was safe to contact them by telephone. Thus, those still living with their partner may have been less willing to participate in a telephone interview during this time.

Interventions Used by Survivors Interviewed

Interviews were conducted with survivors who had experienced at least one SLCDP intervention and had been receiving support for at least three months, 32 were open cases at the time of interview and were still receiving some support either for themselves or their child.

About one third of participants (22/54) had received Idva support and a small number (n=4) had received support from the Complex Needs Idva in the Norwich site, due to mental health or substance misuse issues. The majority of participants had children aged under 18 (48/54). Just over half of those interviewed with children under 18 (25/45) had received 'whole family support'; a mixture of support for themselves, parenting groups, and services for themselves and their children, in most cases Side by Side groups. Survivors' children had received a range of one-to-one and group-based support, including 'Monkey Bob' sessions for younger children. Support for adolescent to parent violence was also planned but delivery was restricted (see Chapter 7) and no survivors interviewed received this for their families. Two interviewees and two focus group participants had received Engage support with their family. Overall, half the survivors had participated in Recovery Group support, this included 'Pathways to Progress' and the 'Freedom' programme, with additional recovery programmes such as 'Pattern Changing' or the recovery toolkit usually run as a second stage. Other recovery work included workshop sessions in Sussex, and the Craft Group in Norwich. A peer mentoring and support scheme was also run using survivors to assist with group and individual support for others. Descriptions of these different programme components are provided in Table 81, Appendix 8.

8.2. Early Experiences of Referral and Accessing the Service

Most survivors interviewed had been referred by another DVA service. For many, the decision to seek help was linked to concerns about their children. The opportunity to receive services for their children as well as parenting support was key to motivation to use the service:

I thought I can't cope with this anymore and referred myself to Social Services…saying that I couldn't cope...They sent me an Early Help person round who then said, there's absolutely nothing wrong with your parenting but I do agree that the domestic abuse is causing issues for your family…and then she referred me on to [SLCDP service] (Survivor 4, West Sussex)

Eight survivors had been referred by children's social care, including some who indicated they had felt compelled to use the service as part of their child protection plan. Other referral sources included GPs, adult mental health services and CAMHS. A small number of women had self-referred. Many had accessed DVA support previously, including through other DVA services, counselling, drug and alcohol services, but still required support for their child:

I had been involved with Social Services…but I actually had an alcohol problem because of the domestic abuse that I'd suffered. So it was a case of, that I was really on the road to recovery but I was worried about some of the effects that were happening to my child. (Survivor 11, Norwich)

Some of the innovative elements of the SLCDP interventions, such as support for older children and work with the perpetrator, were also cited as reasons for accessing the service: '*One thing that attracted me is because they were able to work with the perpetrator as well. But, initially, that's what I was hoping, that he would cooperate with them and things will be better and we don't have to separate'.* (Survivor 20, Norwich)

However, in this case, the perpetrator had not taken up the offer of support and the relationship ended. The survivor described receiving the support of the SLCDP Idva throughout the separation.

Survivors identified previous barriers to DVA help-seeking, including limited or inappropriate provision of DVA services. Many identified the lack of support services for children as a barrier. Others commented that they had been told that they had not met the criteria for services that only assisted women who were 'high risk' and whose experience of DVA was not current. For example, this survivor described how she '*gave up'* seeking support when she was told she was ineligible for a high risk service:

I had an assessment by a psychiatrist, and he said, I think you would benefit from accessing domestic abuse services…he signposted me to…a high risk service, which I didn't fall under…So, I rang them several times and nobody ever phoned me back, and then when they did finally phone me back, they told me that they couldn't really help me, and then I gave up, for ages, I gave up. (Survivor 16, West Sussex)

8.2.1. Experience of seeking help and initial contact

Survivors reported receiving very little information from referral agencies about the SLCDP service, which was described as frustrating and led some to access online information themselves. Although information was provided at the initial assessment meeting, many said they would have liked this information earlier in the referral process:

I'd like to have known a bit about that course content…the first couple of sessions were really quite shocking, we just liked dived straight into the domestic violence we'd been through in the past and I didn't think it was going to be that at all, I was…quite upset actually. (Survivor 26, West Sussex).

More information about the nature of the service, the different roles of staff, the timescales involved and, where relevant, what the work with children might involve were common requests.

Although survivors were broadly positive about the initial introductions to the services and assessments, describing these meetings as informative and reassuring, some had experienced lengthy delays, especially in West Sussex, where high levels of demand had resulted in waiting lists. Problems with room bookings, delaying the start of some services, had been exacerbated by Covid-19 restrictions:

It was about six months but [workers] did call me every couple of weeks, just for a check and see how things were, and whether I needed anything whilst waiting. So, I wasn't forgotten. (Survivor 11, West Sussex)

8.2.2. Survivors' Goals and Aims

Most survivors had been able to identify key goals they wanted to achieve from the support. However, a small number indicated that, although they recognised they needed support, their initial goals were less clearly defined: *'I didn't really have any expectations, all I knew was I wanted to get better…I kind of went in it with my eyes shut, hoping for the best'* (Survivor 1, Norwich). The process of defining and achieving goals was described as a collaborative process between the survivor and the worker '*I told her what I wanted and she kind of told me how it was achievable and how we can do it'* (Survivor 6, West Sussex). One woman reported feeling initially cynical that she could be helped: '*Actually, at the beginning I was like okay, I will listen to them but still I didn't believe that someone can help me… so after a… first meeting, I start to believe that actually this is working…'* (Survivor 6, Norwich)

A common goal identified was the need to recover and move on from their DVA experiences, for themselves and their family: '*my goal was that we all got on as a nice family and we learnt to get on*

together and be that normal family' (Survivor 5, West Sussex). Group based programmes offered important opportunities for women who experienced isolation, often due to the perpetrator's controlling behaviour, to reconnect with others:

I needed just contact because my husband was very controlling and while living with him, I didn't get any friendship or any relationships with other people. So, I was completely isolated. So, for me, group work was something to get connected with other people. (Survivor 18, Norwich)

Gaining confidence and re-building self-esteem were important goals for some survivors. Other goals included practical support to access housing, employment, finances, education, childcare and legal advice and advocacy for court applications including non-molestation and restraining orders, divorce proceedings and child contact. A need for support with managing contact between children and the perpetrator was reported by six women, mostly in West Sussex:

Helping me to sort of, to, to parent during that time because there were so many things that were going on whilst they were having contact with their father and, and she was there to kind of say, you know, this is, this is what is it and you need to do. (Survivor 17, West Sussex)

Safety was reported as the immediate goal for a small number of women: *'…I was still in the relationship and he was still living with us, it was, literally, safety was the priority.'* (Survivor 10, West Sussex). Section 8.4 explores whether survivors felt that they had achieved their goals.

8.3 Survivors' Views of the SLCDP Approach

8.3.1 A multi-component, integrated service

Mothers reflected positively on the range of interventions which targeted both their own needs and the needs of their children's. For some, support for their children had been difficult to access previously. The combination of different elements of support was also felt to be *'really helpful'* and some identified this as their main reason for using the service. The range of services were viewed as complementary, for example, Grow Together parenting support reinforced concepts introduced in the Freedom course, such as the impact of witnessing DVA on children. The flexibility of the support tailored to each family member was also welcomed:

She explained everything that they could help, for me, and for the children. And always individually…It was like, we can offer this for [older son], we can offer this for [younger son], and I thought, it was always really personalised. (Survivor 7, West Sussex)

Some noted that team members had different strengths or expertise, such as work with children support or legal knowledge. Communication and co-ordination within the team was also recognised with one survivor saying they felt that the service had been consistent and that '*they're all singing off the same sheet. They're all working with you as a team and I think that is amazing*.' (Survivor 5, West Sussex).

The scheduling of the various family-based interventions was reported as an important factor for engagement: '*they were all at the right time for where I'm at and this has helped me like at this stage of where I've, I'm going, it's helped me sort of put into practice things I've learned.'* (Focus Group 1, Norwich)

Although a range of whole family interventions were offered, factors preventing engagement with particular programme components were identified. These included having a child taken into care, co-residency of children with their father, mother's work commitments, waiting lists for courses and postponement of courses due to Covid-19 restrictions. Women valued having choice and ownership over decisions about whether to participate in the range of interventions on offer, particularly as

women were at different stages in their recovery. One mother reflected that the Grow Together course was not suitable for her at the time it was offered:

I went to one and found it very difficult, not because the course was bad, but because of my situation at the time with my children. I felt horribly detached from my boys because I was in so much trauma. And I don't think I was quite ready to deal with that. (Survivor 15, Norwich)

8.3.2 Facilitators to service use for survivors

A flexible service, responsive to the needs of survivors, which offered an appropriate level of support was valued highly: '*they were always there if you needed extra support and talking to, whether on the phone or at the end of one of the lessons*' (Survivor 16, Norwich). Another interviewee described the combination of Idva and group work as *'holistic'.* All the women interviewed spoke very positively about their relationship with staff, reporting that they felt listened to and understood. This rapport enabled survivors to talk openly about their experiences, with enough time to ensure they could speak at their own pace, so they didn't feel like a *'burden'.*

I just felt that I was listened to and that what, what I was saying was being acted on, so it was very much sort of led by me, if that makes sense, and what I needed. (Survivor 4, West Sussex)

Consistent and regular contact with Idvas helped to facilitate women's engagement and most respondents who commented on the frequency of their appointments were highly satisfied with this aspect of the service. Most contact took place weekly or fortnightly, either face-to-face or by telephone, and this was important for promoting stability and relationship building: '*I really feel like she cares'* (Survivor 15, Norwich). Others commented on the value of workers offering flexibility: '*she would say, you know, how often do you need me to phone you?'* (Survivor 23, Norwich).

Flexibility with regards to location was an important factor for women and children receiving individual support. Sessions took place in a range of places including survivors' home, cafes, community buildings and schools. Central venues were convenient for many women and participants spoke positively about location in relation to safety and accessibility of venues. Offering group sessions on different days or times meant survivors were able to fit sessions around home or work commitments. A welcoming environment contributed to participants' ability to relax and engage with the programme material.

Group workers' skills and sensitivity were important for engagement and survivors valued having workers available both before and after sessions if additional support was needed. Authenticity was important to survivors, and this was enhanced when programmes were delivered by those with relevant experience or expertise. The groupwork provided opportunities for discussion and to learn from other women. The opportunity for survivors to realise that they were not alone in their experiences was important:

…when people are just in the same situation, you are free to speak and you have hope that things can get better, just as it was with them. (Survivor 18, Norwich)

Peer support provided a safe space to be sad and also to find humour and support each other. 'Step down' support was valuable for addressing any issues arising from the course when regular individual support was no longer required and it offered opportunities for self-development through being encouraged to put elements of the course in practice and report back to the group. Norwich survivors who had attended the craft group sessions said that they had enjoyed the social aspect as well as the opportunity to learn new skills.

8.3.3. Facilitators for work with children

Staff's responsivity to children's needs and attention to ensuring children felt safe and relaxed in their preferred environment meant that children were more likely to engage in the sessions. For some, school-based sessions were convenient and *'their time'* (Survivor 28, West Sussex) but for some this was not an appropriate setting and mothers valued the flexibility shown by workers:

that was a big thing that [CYP Worker] was able to meet elsewhere…which helped the children no end, especially [my son] because he was away from the environment that he didn't like …so he could open up more... (Survivor 9, Norwich)

Some mothers noted that children participating in groupwork benefited from realising they were not the only family who had experienced domestic abuse:

…he realised that there are other people and other people's families, they have mummies and daddies who get angry and shout and get cross…it was just, like for him to be able to normalise it. (Survivor 11, Norwich).

Survivors described a range of creative methods and exercises being used in one -to-one sessions with children, such as dream-catchers, worry dolls, or the 'Helping Hands exercise', which were valuable: '*someone there who shows that they care, shows that they actually want to listen, take the time to talk to them and actually sit there and do something that they like doing…'* (Survivor 17, West Sussex)

8.3.4 Barriers to service use

Staff changes were reported by a small number of women, however effective handovers between workers meant that this was not overly problematic: one woman found it beneficial that the replacement workers already knew about her circumstances and therefore she did not have to repeat her story; another woman reported that, despite her worker leaving, the service had continued to support her until her case was closed. In contrast, others noted that staff unreliability and inconsistency could affect confidence in relationships with workers and this was especially poignant for those receiving support for their children: '*She's leaving as well and I think that's a really hard thing [..] different people but it can't be helped*.' (Survivor 27, West Sussex)

A lack of support for children was raised by several women; lowering the minimum age for children to access sessions[35] was suggested by some survivors, while others commented on the length of time their children had waited to receive a service. Some said that it was difficult to achieve progress for their children when contact with their father continued to be difficult.

Some commented that evening group work sessions were not available for all courses which made engagement challenging: '*they need an evening version for that programme, for people who can't take that amount of time out of their working day or childcare responsibilities'* (Survivor 16, West Sussex). Provision of onsite creche facilities would have been beneficial for those with young children. A small number of women commented that the group work content was challenging, leading to them drop out. This was often mentioned with regards to Pattern Changing which explored negative past experiences and responses to behaviour, or when the course covered topics that were not relevant to them.

[35] The SLCDPs worked with children aged 4-17

8.3.5 Areas for improvement

As reported earlier, some participants would have liked more information about the service, particularly at the referral and assessment stages. More detail about the different elements of the service, the content of sessions and courses, and the planned frequency and duration of sessions was requested by some survivors. This was noted as an issue for adults and children, for example, the mother of a child with autism noted that clearer information would be useful to prepare her child for the sessions. Written information about legal options and routes was also suggested by one survivor.

Many said they would like more groups and follow on sessions. Some felt that more frequent sessions over a longer time period would have allowed topics to be covered in greater depth, and more '*time to absorb the knowledge'*. Extending the duration of the programme could provide enhanced opportunities for participants to '*gel as a group'* and for the group to feel comfortable to engage in the programme topics. Opinions varied on the ideal duration of sessions.

8.3.6 Covid-19 – Impact On delivery

Participants frequently reported that staff had continued to support them during lockdown through regular telephone or online calls and this was highly appreciated. Survivors described workers emailing and posting materials to them to read, and 'packs' of activity materials for children when online work was possible. However, at the start of lockdown, groups for survivors and children had been cancelled which was disappointing for many and resulted in long waiting lists. Changes in the format of group sessions from face-to-face to online delivery were welcomed by some women who had already attended several face-to-face sessions, and by others who were meeting in online groups for the first time. Online groups were more convenient for some women who had busy lives or childcare commitments. Some said they had *'spoken more openly and honestly'* and others felt that it made accessing group work less traumatising: '*I was in my comfort zone in my room, so I felt safe there. Secondly, I can kind of just close the camera and, like if I cry or something, so I feel, again, safe, you know'* (Survivor 28, West Sussex).

Although online groups were reassuring for some women, others missed the opportunities that face-to-face groups provided to talk informally and build relationships or to offer physical comfort. Some women felt that online groups at home did not offer the space or privacy of face-to face groups and were concerned about their children overhearing discussions.

Some reported delays in the criminal justice system due to lockdown, such as delayed responses from the police, and difficulties with making child contact arrangements. For example, this survivor had received support from the service with problems about contact under Covid-19:

I did try and cut down the amount of time we did handovers with my little boy because of Covid, and the fact that I didn't want to go on my own, because I moved out of my parents' place. And he got nasty over that but [SLCDP] have been brilliant and helped me. (Survivor 14, West Sussex)

8.4 Survivors' Perceptions of Change in their Own Lives

Survivors spoke very positively about changes in their lives due to receiving support from the SLCDP service. Most interviewees (n=33/54) considered that their initial goals had been met. Women widely reported feeling confident in their ability to recognise abusive behaviours and had gained a better understanding of the impact of their past DVA experiences; both of which substantially contributed to their recovery process. Women talked positively about a range of practical goals that

had been achieved, for example leaving relationships, finalising divorces, help with housing, managing contact with ex-partners, having more positive relationships with children and feeling safe. However, a minority felt that achieving their goals remained an ongoing process in relation to their own or their children's recovery or, in some cases, due to pending court hearings.

8.4.1 Mental health, wellbeing, confidence and self-esteem

Many interviewees reported positive changes in their mental health, including feeling less scared, anxious or depressed; *'My mental health has obviously got a lot better…I'm not waking up every morning feeling like I'm going to be sick, fearful.'* (Survivor 22, West Sussex). However, some were still experiencing mental health difficulties. For example, this survivor who was receiving support from the Complex Needs Idva and was planning to leave her husband, spoke about taking '*baby steps*' towards feeling strong enough to leave her husband, and that her mental health was fluctuating:

…on my bar from one to ten, today my bar was on a six. Last week it was on a five, so it's going up. But the next week I could go back down again…I need to reach that ten. (Survivor 10, Norwich).

Another survivor was receiving counselling paid for via the service which she explained was addressing issues of childhood abuse as well as recent DVA, however she expressed her concerns that this was due to finish:

I'm kind of feeling that anxiety thing coming back, and the fact that I've only got two more sessions of the counselling and then it's like, then what? (Survivor 8, Norwich)

Improvements in overall wellbeing and coping were also commonly highlighted. Women reported increased self confidence and self-esteem, often linked to greater awareness of abuse and understanding of their past experiences: '*I beat myself up a lot less now… I'm not mad, I'm not doing anything, you know, so it's been good for me, for my esteem and to kind of, to get that in my head*' (Survivor 27, West Sussex). Some women described how workers had prompted them to do self-care activities, including exercise, which encouraged them to focus on their own needs: '*So, giving me those techniques that helped my wellbeing, they also helped me having a focus on where I want to be and where I want to go'* (Survivor 20, Norwich). Others explained that support concerning boundaries and assertiveness had positively impacted on wider aspects of their lives, for example, being able to function better at work. Survivors gave examples of how increased self-confidence and a sense of empowerment had led them to take positive action in their lives, such as seeking counselling, applying for a new course, trying new social activities, or separating from their abusive partner and feeling able to cope if difficulties arose in the future:

I'm a completely different person now, you know. I'm sort of really positive, confident, I've started my own business. (Survivor 13, West Sussex).

These positive changes in wellbeing, mental health and coping and confidence were also found in the outcomes data (reported later in section 8.10).

However, others seemed less ready or able to benefit from the service and as noted above, had found programme content challenging or upsetting. For example, one survivor described a '*breakdown*' that happened whilst she was attending the 'Pattern Changing' recovery course, which explored past experiences of DVA, including childhood experiences of abuse. Individual counselling support was organised via the SLCDP therapy fund and she was able to return to the group work at a

later date. She commented on the support she had received from staff and peers on the course during this time.

8.4.2 DVA Awareness

Whilst some survivors were already aware of DVA, many reported an increased understanding of the different types of DVA, including coercive control, had recognised the impact of DVA on their mental health and felt empowered to manage future interactions with the perpetrator where this continued to be an issue. Survivors described increased awareness of the emotional and psychological impacts of DVA and for some, the concept of trauma was valuable in this respect:

[worker] talked me through what sort of trauma is, what our brains are doing when we're in trauma. Why our bodies react the way they do to it… (Survivor 15, Norwich).

However, one survivor found the concept of trauma threatening, especially when applied to young children:

[CYP Worker] wanted to see actually [my son] because she told me [my son] can have a trauma that comes with a kind of situation like this, but [my son] never experienced any trauma. (Survivor 22, Norwich)

Increased awareness had enabled survivors to come to terms with what had happened and to address feelings of guilt and self-blame and realise '*it wasn't actually my fault'* (Focus Group 3, West Sussex). Linked to this increased DVA awareness, survivors discussed feeling validated and reassured by sharing experiences with other women during group sessions. Survivors also expressed an increased awareness of unhealthy relationships and harmful behaviours, which they attributed to the SLCDP recovery courses, such as the 'Parent Adult Child' module in Grow Together or concepts introduced in the Freedom programme:

Freedom Programme wasn't just a wake-up call to what my ex had done to me, it was also a wake-up call as to how my friends had treated me, how my family was with me. Because there was a lot of abuse from my childhood as well. (Survivor 14, Norwich).

For those still living, or in contact, with the perpetrator, this increased awareness informed their response and management of further incidents. One survivor described being able to recognise and '*handle differently*' the behaviour of her son who had received support from the Engage worker: '*recognising it's happening and recognising what it is, and how it impacts on me and handling it differently'* (Survivor 5, West Sussex).

Being able to recognise '*red flag'* warning signs associated with a perpetrator, including perpetrator characteristics were also considered important outcomes with implications for future relationships:

I've started a new relationship and all I could see was [Group Worker] was raising her red flags because he text too much and I was like, [Idva] help me, and I went through it all with her and she, and she calmed me down and talked me through what a respectful relationship is…
(Survivor 4, Norwich)

8.4.3 Relationships and communication

Although some interviewees said they had been able to talk about their experiences of DVA before using the SLCDP service, for others, being able to speak openly and no longer feeling '*ashamed'* of

the abuse they had experienced was a major achievement: *I used to feel ashamed of it, do you know what I mean? I was ashamed of it. Now, it weren't my thing to be ashamed of* (Survivor 17, Norwich).

For those who were managing abuse currently or were in the process of leaving the perpetrator, being able to talk about their experience was essential to their safety. However, for some survivors, this remained too difficult: '*…a lot of it I don't ever want to talk about with my family or my friends. To be perfectly honest, even my very closest friends don't really understand*.' (Survivor 16, West Sussex).

Some described how discussing their experiences on the SLCDP programme, particularly in groups, enabled them to talk about their experiences with others and seek support, which positively impacted on their relationships. Survivors who had been isolated from friends described being able to renew friendships. Friendships and peer support developed through group sessions were also cited as valuable, and these links could be maintained once groups ended:

We set up a WhatsApp group and, you know, there was a lot of texting support, and still now, you know, we're texting and sort of, how are things going? (Survivor 11, West Sussex)

Some described how the support and learning they'd received from the SLCDP programme had been beneficial for developing new or current relationships: *I am now in a new relationship that I can see is healthy* (Survivor 4, West Sussex).

8.4.4 Safety and Risk

Most survivors felt safer due to the support they had received, although one survivor reported that the support offered was '*No real help, it's only talking*'. Another expressed her frustration with the lack of police response and currently felt very unsafe. Changes in safety were related to a combination of physical safety measures, such as police markers on houses, legal measures such as non-molestation orders and safety planning discussions. Women described feeling comforted knowing that the service would be available in the future if required. Others said they felt empowered through increased knowledge and the impact this had on their safety. One survivor, who had received Idva and group support described changes to her safety, stating that whilst she did not feel safer at first, and was on "*high alert*" with her ex-partner still living nearby, the support she received had "*helped massively*":

I felt a lot more supported and a bit calmer in myself because I knew I had that [contact with the service] as a fallback option…I knew that I could ask them, OK, now this has happened, what do I do then, in relation to safety or, indeed, child contact? (Survivor 10, West Sussex)

Some survivors were currently experiencing abuse and living with the perpetrator while others no longer had any contact with the perpetrator but had sought recovery work. In some cases, a safety plan was not required, either because there were no concerns around physical safety or because they had no contact with the perpetrator and were seeking recovery work.

In contrast, safety was critical for some survivors accessing the service, and a thorough consideration of safety measures was valued. Survivors reported that workers understood what was important to them and recognised where their understanding of safety measures was already well-developed. Many gave examples of how workers recognised their safety issues varied and were available to discuss developments with them. Ongoing support and understanding from Idvas was described:

I had a thing with not being able to lock my front door, because I saw it as my way out, rather than someone's way in...every week she'd ask if, you know, if I'd been able to do it. And I gradually got to the point where I was doing it all the time…(Survivor 21, Norwich)

However, some survivors did not always agree with, or understand, the actions advised by staff. For example, this survivor describes how she was urged to act quickly to seek a non-molestation order:

I didn't really understand the whole process or why it was so urgent. And I thought, well that's a bit extreme, I don't want to do that because then it means he doesn't see his son, which I didn't want to stand in the way of...And she kept saying, you're at risk, you need to do this. (Survivor 10, West Sussex)

8.5 Survivors' Perceptions of Change in their Children's Lives

8.5.1 Increased Awareness and Discussion of DVA with children

Survivors reported an increased awareness of the impact of DVA on their children due to the parenting support they had received individually, as part of a group or via the recovery programme. Some were now more aware of the ongoing impact that contact with the perpetrator might be having on their children:

…my daughter started wetting the bed and to me I know exactly what that is… that's not normal, surely that's a big red flag and, you know, [CYP worker] was there and they were all there to sort of say, okay, this is what needs to happen. (Survivor 17, West Sussex)

Many reported an increased ability to discuss their DVA experiences with their children. This may reflect an increased understanding and *'reassurance'* received from parenting group sessions, or individual work with CYP workers or Idvas. Some described how their relationship with their children had improved, with more communication about feelings and increased trust:

...he [my son] can tell me everything and he is doing this so I know he trusts me and he feels safe with me, because before he didn't speak with me because he was afraid. (Survivor 6, Norwich)

A minority of survivors spoke of feeling unable to speak to their children about the abuse, such as this survivor who was a few weeks into receiving support from the service, having only attended the Pathways to Progress group:

I've never ever explained to them about the violence and stuff, erm, and that's always like a bit …of a taboo between me and my children. I'm sure they're obviously aware of it being there because they, they used to witness it happening but it's, it's never spoken about, so…I wouldn't know how to tackle that, so. (Survivor 26, West Sussex)

A small number of survivors interviewed had not sought support for their children as they believed their child did not need it, or in some cases, because they thought the child was too young to be affected.

Where children had received services, mothers reported changes in their emotional regulation and ability to communicate their feelings, so reducing their anger and anxiety. Some considered that their children were more able to share their upset or anger in appropriate ways. Children were described as better able to speak to their mothers about their feelings. This mother identified how she and her son had used the tool provided by workers to improve their communication:

The first week he came home with this chart with different faces on it, and the face is put on paper. So each day we have a conversation about how he's feeling. (Survivor 11, Norwich)

Similarly, another said their house felt '*calmer*' and one mother described how her daughter's emotional literacy had increased with her noticing her '*triggers*' and acquiring the language to describe her feelings after attending the Side by Side course. Children were reported to be happier

and calmer at school as well as at home and some described how their children had managed transitions to a new school well.

Contact with the father/perpetrator was a concern for some mothers, and children had been able to express their views about contact with their father:

…it's sort of given her the control, because…there was issues with her dad and she didn't want to go and see him. So, knowing that she could stop and nobody would think any less of her, was a big help for her. (Survivor 11, West Sussex)

Another key benefit for children reported by mothers was the value of having another person to speak to about their experiences or feeling. These discussions reassured children and feelings of guilt or blame were reduced:

when [CYP worker] went through everything [my son] got then to understand that actually there was nothing he could have done to help anything because he was still a child. (Survivor 9, Norwich)

As noted above, not all mothers interviewed had received support for their child from SLCDP. One mother described how her children had been reluctant to share information with CYP worker so only a few sessions had taken place. However, she stated that her children were reassured knowing that she was being supported by the service. One mother wanted support for her son, however his abusive father, who had joint custody, prevented access.

Whilst respondents generally identified positive changes in family relationships and home life, some interviewees reported that, although they had initially seen improvements in their children's behaviours, since the support from the service had ended, these had 'slipped back' (Survivor 15, West Sussex). However, their own responses to their children's behaviour had shifted due to the parenting support they had received.

8.5.2 Parenting

Mothers described how the support they had received had improved their parenting. Those who attended SLCDP's Grow Together or Side by Side courses recounted the benefit of learning from the course concepts, such as the 'Parent Adult Child' model, a theory drawn from Transactional Analysis. Others mentioned the benefit of creative activities and techniques that they could implement at home, such as having scrapbook of activities that they did together and being reminded of the value of one to-one time with their children:

CYP worker was able to sort of explain to me that [older son] maybe feels sometimes that [younger son] gets all the attention, you know, and he doesn't get any time with me, which is not true, but it's interesting that he thinks that. So then I was able to try and put a bit more effort into making sure that [older son] knew that he was getting special time just with me. (Survivor 11, Norwich)

One mother explained how she had been able to discuss her children's negative behaviour with them as well as their past experiences of DVA and, with the support they had receiving from their CYP worker, this had led to positive changes for the family:

They were just fighting and I said, can you two stop it please? And we had this conversation, I said, you know, boys, what we've been through, do you think that's acceptable behaviour? So, I think it's that conversation we had and that time they were seeing [CYP worker] that all stopped. (Survivor 28, West Sussex)

Some of the mothers whose children had not received support in their own right spoke of how the knowledge and support provided by their Idva, or the recovery courses, had positively impacted on

their parenting, for example, enabled them to maintain boundaries and assertiveness in respect of contact with their former partner:

... they were like, no, that's fine, you can tell your son that that's not on. Because I always thought I'd get in trouble for saying that Daddy's not being kind, you know, especially going through court. (Survivor 14, West Sussex)

Similarly, another survivor raised concerns at a recovery group session about her son's contact with his father and described feeling confident to take action following discussion with the group worker:

I had the confidence two weeks ago, to say that he's not staying with him anymore, having spoken to [worker] at the end of one of those sessions. (Survivor 13, Norwich)

8.5.3 Children's safety and safety plans

Around half of the survivors interviewed (n=26) mentioned discussions with workers about their children's safety. Some mothers felt that this was not an issue that needed to be addressed, either due to the age of the child or because the DVA had not been directed at or affected the child.

Safety plans also addressed other forms of interpersonal violence, for example, one mother talked about how she and her children had received support from their worker to develop a plan in response to her older son's violent behaviour:

…my eldest got really bad, because he's not quite at that point again, but he was getting quite – physically, he hasn't actually done it – but he's had fists raised and that sort of thing… (Survivor 5, West Sussex)

She also remarked that this support provided reassurance and validation for her other children that the violence in the home was not acceptable, illustrating how the SLCDP service worked to support the whole family:

I think because somebody was listening, and somebody was listening to them and telling them that it wasn't right and this is what you need to do. So I think it definitely helped… (Survivor 5, West Sussex)

Mothers whose children had direct support described how they had worked with the CYP worker to address issues of safety, and safety planning. Conversations between CYP workers and children led to discussions between mothers and children about safety at home, including planning for incidents that might occur in the future:

…we've had like a big safety talk about the house and things, and not opening the door and not being by the window. And maybe sometimes mummy doesn't want to open the door if someone's there and we're in, and that's OK as well. (Survivor 16, Norwich).

Another mother talked about how the CYP worker provided an additional 'safe person' for the child to speak to about any concerns (see also Family Case Study A below). Positive changes in children's behaviour, such as no longer being clingy or locking doors, were reported.

Safe contact was an important area that workers assisted mothers and children with. In this case, the workers had liaised with the ex-partner and contact services:

I had issues with the Contact Centre. So, I spoke to [workers] about it and they did actually try and contact him...they were then making sure that she was safe to go to the Contact Centre and what measures were being put in place to make sure she was safe… (Survivor 19, Norwich)

For some, child contact was a way in which perpetrators continued to exert control over survivors and survivors expressed a need for ongoing support from the service with this:

Because that's the only tie left, that's the only way they can control you, is through that child. And the fact that they know they're going to see you at handovers…there will always be something going on in that situation. (Survivor 10, West Sussex)

8.6 Family Case Studies

This section reports on findings from analysis of six family case studies (3 from each SLCDP site) selected to represent the range of family work undertaken across both SLCDP organisations. As noted above, a range of sources including interviews with children aged 7-11 (6 plus one set of written comments), mothers (6), and SLCDP staff (10), as well as information drawn from the case records for each family (6) contributed to a rounded picture of 'whole family' work undertaken by the two services.

8.6.1 Accessing and receiving SLCDP services

Most case study cases were referred to SLCDP service by another DVA service for Idva support for the mother, with support for children (or child focussed support) offered later. One referral came from children's social care, and although the mother did not initially wish to receive support herself, her view changed over time. Case Study A below provides an example of a mother whose engagement with the service was relatively low and informal.

Families presented with a range of issues relating to their experiences of abuse, however in most cases parents were seeking specific support around child protection proceedings and contact issues with fathers. Parents also hoped that their children would be able to talk about their experiences to someone other than themselves or other family members.

…I'm not sure that [daughter] always wants to talk to me about everything. And so, I was concerned that if she just had an outlet, that she could just say, 'I'm so upset about this and I don't want to talk to mummy because I don't want to upset her. I can't talk to daddy because he'll get cross with me… (Mother, Case Study 6)

Practitioners and parents identified a number of issues around which children required support, such as: understanding and making sense of their experiences, feeling able to talk about the abuse, recognising and managing their emotions, understanding healthy relationships and managing ambivalent feelings about the abusive parent.

Before beginning any direct work with children, practitioners usually undertook sessions with mothers to gather information about children's support needs, their current understanding of the situation. Work was guided by mothers' preferences and views:

…we'll talk about what mum feels would be sort of the best venue…what she thinks they would feel most comfortable with. And then also, gaining consent to talk with other agencies or anyone else involved, like school, for example, if the appointment's going to be at school. (Practitioner, Case Study 4).

8.6.2 Support delivered by SLCDP Services

The work undertaken across the six cases varied but took four main forms: direct work with parents, child focussed work with parents, direct work with children and child focussed advocacy.

Support for parents: It was common for mothers to access a range of interventions, one after the other. Emotional support for mothers was often offered on an ad-hoc basis and could be initiated by parents or practitioners. Much of this support related to ongoing court and contact proceedings, as well as support regarding separation from their abusive partner. In terms of interventions focussed on their own recovery, mothers accessed combinations of the following: the Freedom Programme, Pattern Changing, Pathways to Progress, Step Down and Recovery, the Recovery toolkit and Peer Mentoring. One woman received peer mentoring to support her work on the recovery toolkit.

Child focussed work with parents: This usually took place with mothers alone, rather than jointly or in parallel involving children. Much of this can be attributed to having to move sessions online during the lockdown, which made children's participation difficult, although mothers were able to participate in online groups. Mothers communicated with CYP workers highlighting issues for follow up in individual child sessions; and CYP workers reciprocated, feeding back relevant information about the work they were undertaking with children:

If I'd contact [worker] just to say that [my daughter's] feeling a bit low or there was something that was worrying me, and she'd just ring in to see if she's OK. She'd print off little activities that we could do together, like Helping Hands. (Mother, Case Study 1)

Practitioners described mothers' engagement with the service as facilitating the support they were able to offer children:

…how it worked well, was mum's engagement…mum going, yes, I will do that course actually, and keeping in contact with me around how she feels the children are doing. So, we're not working in silo, it's very much that she was part of it from the start, all the way through. (Practitioner, Case Study 4)

Direct support for children: Direct work with younger children was delivered via the Monkey Bob intervention, whereas work with older children was usually on an individual basis and often child-led, with some steer from parents (see above and Case Study A). As reported elsewhere in this chapter, practitioners and children themselves described a range of creative and fun activities designed to facilitate conversation around issues such as identifying supportive adults (see also Case Studies A and B) and exploring ambivalent feelings about the abusive parent:

…she recommended this worry monster thing, it's like a teddy and its mouth opened up, so I could write something I'm worrying about and put it in… I'd do that whenever I felt worried… (Child, Case Study 2)

Case Study A highlights the value of the tools and activities used with children to facilitate expression of feelings and build resilience (see also Case Study B).

Case Study A

This family was referred to SLCDP by children's social care following concerns about Mum's ex-partner's contact with the children. The worker was able to visit and assess Mum and the two children once in person before lockdown restrictions were introduced. Thereafter, all contact was online. Although Mum had regular brief chats with the worker, she didn't feel ready for further involvement. The worker held separate weekly sessions online with the two daughters, one of whom was primary school age while the other was a teenager, over a period of 5.5 months. Mum felt that

online delivery was particularly helpful in making sessions less pressurised for the older child: '*there wasn't anyone in the room with her to put pressure on'.*

The intervention aimed to assist the children to make sense of their feelings around contact and to have a voice in the future management of contact. Work with the older child focused on developing resilience and capacity for emotional regulation and used a wide range of tools and materials to encourage her to express and manage her feelings. Work with the younger child drew on established interventions and used craft materials, toys and photographs to promote expression of feelings. These enabled her to develop safety plans and support strategies with teachers: '*I know I can speak out to my teachers if I am worried or have had bad dreams. They are my "helping hands"'.*

Mum described how, as a result of the worker's input with her older daughter, she and her daughter were able to communicate and collaborate on safety plans involving the school:

'…she understands the reasons behind me doing that, is to keep her safe. Whereas, beforehand, she'd just turn round and say, I hate you, you're ruining my life, and I just want to get on and not think about it.'

Mum considered that the worker had enabled both children to:

'*find a voice and she made them realise that what had happened to them was not their fault' …after six sessions, [younger child], for the first time, started speaking about what had happened… [she's] much more outspoken. She's met with the safeguarding team because she wanted to… she understands that her voice will be heard*.'

The worker supported the children to contribute their views to a report that would inform future court proceedings. The younger child made a successful transition between schools following the intervention and the worker helped her produce a safety plan for her new school. This child felt that her worker had: *'really helped me. I feel more secure and I know people will listen to me and what I want more. I think I am more confident.'*

In line with mothers' early aspirations for support for their children, practitioners and parents emphasised the importance of children receiving support that was 'just for them': *'It was just…finding [the SLCDP CYP worker] comfortable to speak [to], you know, he can speak whatever he likes and it's not mum, if that makes sense'* (Mother, Case Study 4). However, in one case, a mother described her disappointment that this relationship was unable to develop due to a lack of consistency in the worker's visits:

They just need a constant, you know…To have that extra person, just to go, phew, I know that [my daughter's] safe with this person, she can talk to them about whatever and they can build a relationship…There just hasn't been that. (Mother, Case Study 6)

However, a supportive relationship combined with the use of various toolkits and activities was insufficient for some severely traumatised children. One practitioner reported that, although a family had engaged well with the service and had made discernible progress, she felt ill equipped to work with the level of trauma exhibited by the children:

…the family's moved on loads with the court process, and I think we've supported the family loads, but I think the work with the children, it's just been so difficult because the trauma is too high for both children. And while I'm trauma informed, I'm not a therapist or a counsellor. (Practitioner, Case Study 1)

This highlights a need for established pathways between DVA services and child and mental health services (CAMHS) and the need for specialist therapeutic provision for some children experiencing DVA.

Child focused advocacy: As noted elsewhere in this chapter, practitioners described seeking children's opinions and representing their voice in decisions about contact and in child protection cases. Case Study A above provides an example of this work and its impact on children's daily lives. Case Study B illustrates advocacy focused on supporting the family through involvement with Children's Social Care and protracted court proceedings.

Family Case Study B

The family was referred to SLCDP by a local DVA service for victims at high risk as the mother required Idva support. Both children were living with their father at the time of the referral. The case quickly escalated when a child protection plan was put in place due to concerns around emotional abuse. The older child moved to alternative care and the younger child went to live with mum. The family were going through court proceedings for custody. The Idva worker reflected on the change in priorities: '*we had planned to do Side by Side. That was an initial goal. But, obviously, court took over and all the risks and everything else took priority'.*

Direct work with the mother involved emotional support throughout the court process. She noted that: *'[the Idva worker and the CYP Worker] rung me regularly, just to check in, see how I was and things like that…in a stressful situation, having them, obviously, helps a lot. I suddenly thought I was on my own but, no, they were still there, so that was nice.'* The workers also helped with emotional regulation: '*contacting me and giving me like mindful techniques and grounding techniques, when I was getting stressed and things.'*

Alongside the emotional support, the SLCDP staff provided advocacy and liaised closely with Children's Social Care: '*The first psychological assessment, which the court ordered, I suddenly got really upset and I got really down…And I rung [name of worker] and she talked me through it and she gave me some advice … even the social worker didn't believe the report and asked for a second psychologist to do a report. But [name of worker] I definitely needed her then.'*

Wider group work for mum, including the Freedom Programme and Pattern Changing, provided support to move on from the abuse, reduced victim-blaming, increased assertiveness and decision-making skills.

Both children received face-to-face individual support over a number of months which later moved online due to Covid-19. The youngest child told her worker she didn't feel able to talk openly in the online meetings at school, as her teacher was in the room, so these meetings were moved to the child's home. Work with the youngest child concerned supporting her to identify safe adults to talk to and being able to express her worries and concerns, especially to her mum. The creative and engaging format of Monkey Bob and Helping Hands toolkits enabled reflection on sources of help:

'*What you've got to do is you've got to get some paint, put it on your hand, then you put it on a piece of paper and after you get a black pen and write who you'd talk to about your worries.'*

The CYP worker described the work with the youngest child: '*Monkey Bob was huge for her, in that she really took everything on board that was said'.*

Support for the older child focused on recognising the impact of DVA, and emotional abuse from her father, including victim-blaming: *he'd manipulated her so much, our sessions were just her slating her mum… we did a pie diagram, ... she split the diagram into abuse from dad to mum, mum to dad, … she did it herself and that was the first time she'd admitted to anybody that dad was responsible for some of it' (CYP Worker).*

At the time of the Evaluation interviews with the family, the court reports had all recommended that the children should live full-time with their mother, although the court hearing was still pending. The older child had resumed contact with her mum and their relationship was being rebuilt. However, both workers felt the family required in-depth, court-mandated therapeutic work. Mum described changes in her parenting and in her youngest child:

'*it's helped me be a better mum to the children and helped me understand them and what they've been through more. I think she's [my daughter's] starting to relax a little bit more with me. She's very positive and she's definitely starting to open up and talk if she's got problems, so that's really good.'*

Contact issues often prevented women from feeling able or confident to move on from the service and the service was able to respond to requests for ongoing support:

…I came to the end of all the groups and everything I can do, but…I didn't really want to be kind of left in the lurch at the moment… and [worker] said about…the peer mentor. … they're very supportive because it helps me realise a lot of things as well. *(Mother, Case Study 1)*

8.6.3 Key features of the SLCDP service

Regular and responsive input: Women and practitioners talked about the importance of regular contact and the ability to get in touch on an ad-hoc, as needed, basis. Again, much of this support focussed on issues arising from ongoing court cases around contact or was requested following contact visits or court appearances as Case Study B demonstrates.

Co-ordination and continuity: Several practitioners talked about the value of being able to offer multiple programmes within the same service, which they felt lead to smoother transitions between programmes and deeper relationships with mothers:

…and what's worked well is knowing that she's not on her own, that she can get that support through different parts of the service but she's not having to leave the service to get it… (Practitioner, Case Study 4)

The ability to seek advice from colleagues and the possibility of mobilising other parts of the service when new issues emerged in a case was identified as a particular strength of the model, that improved the quality of service provided to families:

…my main focus is the children, but if I identify, through the assessments, that actually, I think the parent needs support, then I can either take it back to the team, for example, and say, I think an Idva support might be helpful here, or it might be that I can advocate for the Pathway to Progress Group and talk about the benefits of that, so there's support in mum's own right. (Practitioner, Case Study 4).

Impact of Covid-19 on Delivery: Tensions were experienced in delivering a family-focused service during the pandemic. The lockdown interrupted several interventions, particularly those for or

involving children. As noted elsewhere in this chapter, younger children especially missed the face-to-face contact with a worker:

…the only thing was I would like to have seen her [the worker] here. But Corona meant she couldn't come to see us anymore. (Younger child, Case Study 5)

On the other hand, as noted in Case Study A above, both the parent and the practitioner felt that a young person had benefitted from support being delivered online. One worker also noted that online delivery reduced the time associated with offering support *…if I'd gone and visited, the fact that they're not even in my area, that would have been a whole morning out, going there, doing the session and coming back*. (Practitioner, Case Study 5)

Resourcing: In contrast, another practitioner felt that Covid-19 had exacerbated resourcing issues, which prevented her from doing as much therapeutic work with children as she would have liked. High caseloads meant that, once she knew children were safe and parents were being supported, she needed to move on to work with other families experiencing safety and safeguarding issues.

This sense of needing to move people on to create capacity was echoed by one parent:

I don't think my children were quite ready to leave because they'd made such a lovely connection with [worker]… the pandemic interrupting, and I understand they became completely swamped with people that needed the help. So, anybody that they probably could move off, they maybe did. (Mother, Case Study 5)

A second practitioner talked about how staff turnover followed by lockdown severely delayed the delivery of any direct work with children in one family, the impact of which was compounded by poor communication. This left both mother and her child feeling severely let down by the service:

…it has been very on and off and it has been quite, I would say, it's been actually quite disruptive to [my daughter]. I don't think it's been a particularly positive experience in some respects because she's been let down a few times. And some of those times haven't been actually communicated with me… (Mother, Case Study 6)

8.6.4 Case Study Outcomes and mechanisms of change

Benefits experienced by children: Parents, professionals and children themselves reported a range of benefits. In several cases, parents and workers described children developing greater understanding of their feelings and the ability and confidence to articulate their thoughts.

So, he's really in touch with how he feels and said like, yes, I will do it or no, I won't. So, because we were very controlled as well, so we didn't have much voice, any of us. So, now [son's] like, you know what, I'm warming up a little bit. (Mother, Case Study 4)

Children also experienced improvements in mood, sleep, physical health and reductions in fear and anger. Parents and children themselves noticed improvements in behaviour and reported using constructive coping strategies to deal with stressful situations:

I do get angry, but I'm a little bit better. Yes, I'm a little bit better. It's more whenever like somebody calls me names. Back in my old school I'd normally punch them. (Child, Case Study 4)

There was also evidence, as shown in Case Study A, of children successfully navigating key transitions in schooling:

…she's a lot more happier…she started high school September and went into that, and that's all been a positive… whereas before, she was like, she didn't have hardly any friends and she weren't happy, and she was always ill. But there's none of that now and she's making new friends and getting a bit cheeky as well… (Mother, Case Study 2)

Mothers reported the benefits of realising that they were 'not alone' and attributed this to the service in general but also the Grow Together group intervention:

…how we've talked about it, and how it is on the meetings, is really, really good, it's very positive. It's very, you know, thought provoking at times and it can be quite sort of upsetting as well…And you're there with like-minded people that have been through similar situations. (Mother, Case Study 6)

Parents reported engaging in self-reflection and discovery as a result of the support they had received which in turn led to greater awareness about how the abuse and their own feelings may have affected their children:

…because the support I received and the support the children received, …I have more knowledge now, before I didn't have… just understanding - …then I did the course…- that impact was on the children as well. So, I can see that more clear...and it's just easier to deal with that as well. (Mother, Case Study 4)

Women and practitioners reported positive impacts on the amount and style of communication between mothers and children, particularly in regard to talking about the abuse that they had all experienced. This enhanced communication had a positive effect on mothers' ability to manage their children's behaviour and enabled children to gain greater insight and develop empathy for their mothers:

after…a few sessions with him, I don't know what exactly she done, but he became like, OK, I see. So, it's kind of listening to my side as well, instead of like, no, you're wrong...then we kind of manage to have a conversation. (Mother, Case Study 4)

8.7 Advocacy with Children's Social Care and Other Services

A high portion of families had been referred to the service by Children's Social Care (CSC), especially in Norwich. A small number of interviewees described the support provided by SLCDP workers whilst they were on a Child Protection plan. Representation and support at meetings such as case conferences was welcome. For example, the mother in Case Study 1, who had one child living away from home and the other on a child protection plan, praised the support provided by the CYP worker in contacting social workers, attending conferences and supporting her children individually. Another said she initially felt that she had '*no choice*' in attending the Pathways to Progress course online, however, she was pleased when the group worker offered to attend child protection conferences alongside her, and to update CSC on her progress:

…she said because I've got so much good to say about you [name] that you co-operate and you've got so much to say about your kids and your involving yourself so much I think it could help you out (Survivor 24, West Sussex)

Two women, both participants in the West Sussex online Pathways to Progress group, described feeling compelled to participate in interventions, reflecting staff concerns around compliance being driven by CSC involvement as reported in Chapter 7:

…because lots of it's done through like the court and Social Services. So I'm, basically, told what work I need to be doing. (Focus Group 1, West Sussex)

Other interviewees had been referred after addressing DVA as part of their child protection plan. One interview participant was concerned about emotional abuse from her ex-partner during contact visits and noted that her SLCDP worker was contacting CSC on her behalf. In contrast, others described feeling '*terrified*' about any future involvement of CSC. For example, one mother whose child's behaviour had prompted a safeguarding referral was reassured when no further CSC involvement was deemed necessary due to the service working with the family.

In some cases, CSC services, including support for disabled children, were delivered by CSC practitioners alongside the SLCDP service. One mother, who was supported by the Complex Needs Idva, felt it was appropriate that she received support from the service for herself while her children received CSC support:

I feel I need that thing for myself…The children have got the support of parent support and Early Help. (Survivor 10, Norwich)

Staff also supported survivors to access other services. Some had received external support with housing issues including accessing social housing, information on grants and financial support and practical support to assist a move to new accommodation. Other agencies staff liaised with included the police, CAFCASS, schools and children's social care (see Chapter 9).

As noted in Case Study B above, SLCDP support and advice throughout court proceedings were also welcomed:

I felt really bad because I was just like, okay, you're just sitting there, but it was just the fact that I felt supported… you don't really find that in, in many other organisations. (Survivor 17, West Sussex)

The reassurance and legal expertise of workers were appreciated and some noted that the discussion of available legal options gave sense of security and safety, even if they did not plan to use them immediately.

8.8 Further support survivors wanted from the service

More support for children was a common response from survivors, many of whom were interviewed whilst their children were on a waiting list for support from the service. Some children had not been offered support due to lockdown, long waiting lists or due to their age – either being too young (pre-school age) or too old to receive support from the service, including older teenagers (over 17 year of age) who were being violent. Survivors expressed concern about needing support with potential issues in the future, particularly with regard to upcoming court processes and contact with their children's father/perpetrator.

Others noted that their children needed more specialist mental health support and some survivors also said they wanted more mental health support for themselves, such as counselling. The Recovery Groups were valued by survivors – and those who had completed all the recovery groups expressed a desire to attend more courses, to meet others and continue their journey. Some were apprehensive about no longer receiving support from the service:

…I'm coping with my depression and I feel that, you know, it's like spring, I started to grow [laughs] but the group is over. (Focus Group 1, Norwich)

In some cases, survivors were still receiving support from the service at the point of interview and some were experiencing difficulties which were not yet resolved, for example, in ongoing child

custody legal procedures, or with legal or financial issues, usually related to housing or divorce. In some instances, this was beyond the remit of the SLCDP and survivors had been signposted to other relevant services, in other cases, SLCDP staff continued to provide a service.

8.9 Next Steps

When asked to reflect on their feelings about the future, most participants reported feeling confident and optimistic about their own and their children's prospects. Those who felt less optimistic reported feeling fearful about starting afresh, leaving their homes, or leaving their partner. Uncertainty about where women might be placed when applying for housing was described as '*a really scary prospect'*, particularly considering previous experiences of isolation within their abusive relationships. Awaiting outcomes of pending court decisions meant some women felt insecure and '*stressed'* about their future.

Some interviewees stated that they were planning to volunteer with the service as a peer mentor in future. One Sussex survivor was about to commence volunteering as a peer supporter in online groups and had recently completed training to do this. This was completed online due to the pandemic and she had found this difficult, due to a lack of group support and the difficult nature of the topics. One Norwich survivor was currently volunteering as a supporter on the Freedom Course, and was planning to progress to being a peer mentor when this was possible. She described the training as "brilliant" and summarised her motivation thus:

I really want to volunteer to give something back, just because of all the support and help I've had. (Survivor 11, Norwich)

8.10 Survivor Outcomes

In this section, we report findings on outcomes captured from the measures (see Appendix 2) completed at three or four time-points by survivors and children.[36]

Sample Characteristics T1-T2

Of the 188 of survivors who completed outcome measures at T1, 88 also completed an outcome measure at T2, a 53% attrition rate. In this sample, 58 (66%) were from West Sussex and 30 (35%) were from Norwich. The majority of the sample at T2 were white British (73% n=64), 6% were white other, 5% were Black/British/ African/Caribbean and 4% were from another ethnic group (10 missing). Most survivors were aged between 30 and 49 (73%), with an age range from 18 to 69. Most (74%) had a child under 18 and a third (33%) had a complex need. The majority received one intervention (63%) and 30% had received two although, as mentioned previously, due to the flexible and fluid approach to addressing need, it was sometimes difficult to separate out the different forms of support received. Only four survivors who completed evaluation outcome measures at T1-T2 had an unplanned exit, which is lower than found in the Insights monitoring data and may indicate survivors who were engaged in the service were more willing to complete outcome measures at T2 or that survivors who disengaged did so before T2 data collection. We compared survivors who only completed a T1 outcome measure to those who completed subsequent measures. Younger survivors and survivors who reported greater child contact issues in the safety questionnaire were slightly less likely to complete subsequent outcome measures

[36] The Alabama Parenting Questionnaire was used to measure positive and negative parenting styles however the very low number responses received from survivors and perpetrators prohibited analysis of the findings.

TI-T2 Outcome Findings for Survivors

Safety at T2 (12 weeks from T1 baseline)

The findings reported in Chapter 7 showed that at T1 a substantial minority of survivors reported feeling safe none of the time/rarely in their homes, neighbourhoods and to a lesser extent online. A high proportion of survivors at T1 felt it was safe for their children to have contact with their father none of the time/rarely or only sometimes. However, most survivors reported that they did know where to go for help often/all of the time. We wanted to know whether survivors reported improved safety and knowledge about help-seeking at T2.

Survivors reported improved safety for each question, and this was statistically significant for five out of six safety questions using the Wilcoxon Signed Ranks test, although all had small effect sizes (see Table 8.2 /Appendix 8). For example, in respect of the question *I have felt safe*, 85 survivors responded to this question at both T1 and T2, of these, 20 demonstrated a positive change, 57 demonstrated no change, and 8 demonstrated negative change, which was statistically significant (z = 2.758, p = <.006) although the median change was 0. Similarly, for the question *My home felt safe and secure*, 84 survivors responded to this question at both T1 and T2, of these, 24 demonstrated a positive change, 52 demonstrated no change, and 8 demonstrated negative change, which was statistically significant (z = 2.803, p = <.005). For those who answered the question I *have felt that it is safe for my children to spend time with their father* (n=65), 15 reported a positive change, 43 no change and for 7 there was a negative change (z=1.975,p=<0.048).

The only question that was not statistically significant for positive change was *I know where to go for help when needed* probably due to high level of awareness at T1 (76% answered often/all of the time at T1 rising to 86% at T2).

Coping and Confidence at T2

The T1 findings reported in Chapter 7 showed that a substantial minority of survivors reported a range of coping and confidence issues, this included feeling they were never/rarely: in control of their lives; able to deal with everyday life; or able to cope if things went wrong.

At T2, survivors showed some improvements on most (9/11) of the coping and confidence questions, although this was only statistically significant for four questions using the Wilcoxon Signed Ranks test (see Table 8.3, Appendix 8). The notable examples of change included *I have felt in control of my life*: 83 survivors responded to this question at both T1 and T2, of these, 31 demonstrated a positive change, 42 demonstrated no change, and 10 demonstrated negative change, a statistically significant median increase from T1 to T2 (z = 3.15, p = <.002). Similarly, *I have been able to get a good night's sleep* also showed a statistically significant median increase from T1 to T2 (z = 2.305, p = <.021): 71 answered this question with 23 showing a positive change, 40 no change and for 8 there was a decrease. For *I have been able to recognise if other people have been behaving abusively*, 81 survivors responded to this question at both T1 and T2, of these, 21 demonstrated a positive change, 52 demonstrated no change, and 8 demonstrated negative change, a statistically significant median increase (z = 2.601, p = <.009). The last area of significant change was for *I have known that I was not responsible for the abuse that happened to me* where 23 of the 83 who answered reported a positive change, for 52 there was no change and 8 demonstrated negative change (z=2.25, p = <.0024).

Two questions showed very limited change. 'I have been able to manage my use of alcohol/medication/ drugs' showed little improvement, although response rates for this question were low. Similarly, 'I have good relationships with my children', also showed limited positive change, due to very high positive responses at T1.

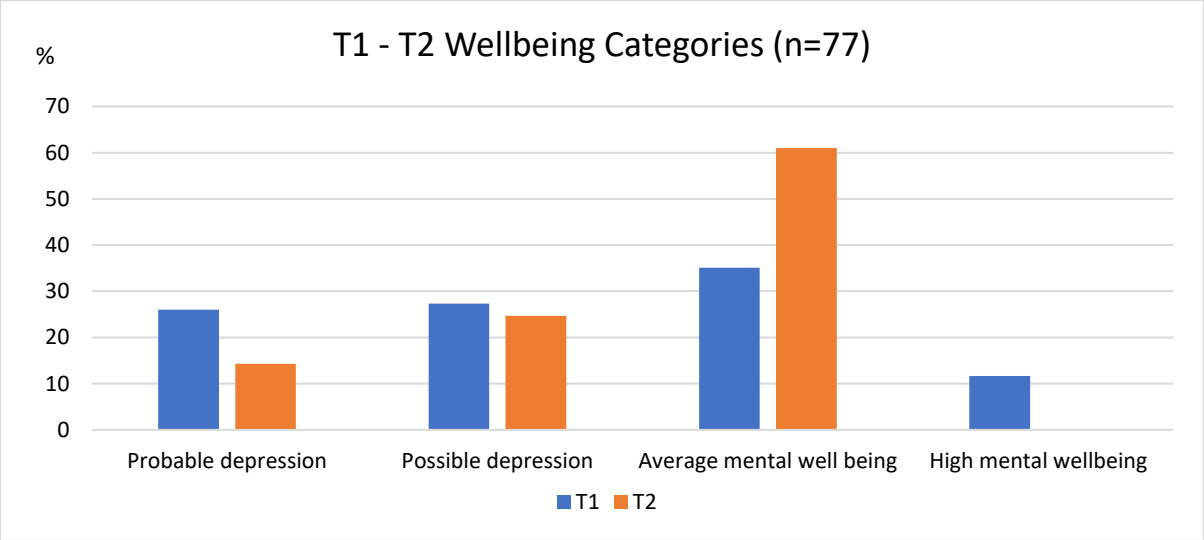
Mental Wellbeing at T2

A single wellbeing score was derived from the answers to the seven wellbeing (SWEMWBS) questions. Raw scores were transformed into a metric score using the SWEMWBS conversion table.

A total of 77 survivors completed the SWEMWBS at both T1 and T2. The mean score at T1 was 21.55 and this rose to 22.68 at T2, an increase of 1.13 (t (76) = -2.130, p=.036), although this did not reach statistical significance. This is still lower than the national average for women of 23.6 (Ng Fat et al., 2011) but does show an improvement in self-reported wellbeing. Survivors with complex needs reported slightly lower wellbeing scores compared to those without multiple needs, although this was not a statistically significant mean difference (22.1380 compared to 22.8938 respectively).

The SWEMWBS can also be categorised using 'cut scores' which divide scores into 'probable depression', 'possible depression', 'average mental wellbeing' or 'high mental wellbeing'[37]. Figure 8.1 shows that survivors' wellbeing had improved at T2 with more survivors in the average mental wellbeing group and fewer in the probable depression category.

Figure 8.1 Mental Wellbeing at T1 and T2



Physical Health at T2

At T2, there was significant drop off in completion of the EQ-5D-3L health questionnaires used for the study, which did not show any significant improvement (see Table 8.5, Appendix 8). However, there was a 2% change in the scores between T1 and T2 and the visual analogue scale (VAS thermometer) also showed positive change between T1 and T2. The VAS is easier to complete and asks the participant to indicate how their health is today on a scale of 1-100, rather than the five health-state questions of the EQ-5D-3L questionnaire.

The results at T2 were significantly lower compared with accepted UK population norms for the Adult EQ-5D-3L, indicating that service users across all time points are experiencing health states worse than the general population.

[37] https://warwick.ac.uk/fac/sci/med/research/platform/wemwbs/using/howto/

Survivors' self-reports on improvements in their safety, coping and confidence, wellbeing and health since using the SLCDP service at T2

In addition to using tested scales, we asked survivors at T2 to self-report any improvements in their safety, coping and confidence, wellbeing and health since using the SLCDP service (see Table 8.2). A high proportion of survivors reported positive change for each area, ranging from 92% for wellbeing to 69% for health, even though the Adult Health EQ-5D-3L measure did not find any significant change. Survivors with complex needs self-reported slightly greater levels of improvements for safety (96%, n=24) and coping and confidence (92%, n=22) compared to survivors without multiple needs (84% n=48, 77% n=43 respectively). We also asked survivors who reported an improvement to estimate the extent to which this was due to the services they had used. Most survivors who reported improvements for safety, coping and confidence and wellbeing mostly (45%, 48%, 45% respectively) or entirely (22.5%, 18%, 15% respectively) attributed these to the service. However, improvements in health were seen as less attributable to the support, although 44% stated improvements were entirely or mostly due to the service, nearly half of survivors (47%) stated this was partly due to the service and 9% stated it was mostly due to other things.

Table 8.2 Improvements in safety, coping and confidence, wellbeing and health since using the service at T2

Have you experienced improvements in your:	Yes %	No %	Entirely due to the service	Mostly due to the service	Partly due to the service	Mostly due to other things	Entirely due to other things
Safety (n=82*)	89	11	22.5%	44.9%	31.5%	1.1%	0%
Coping and confidence (n=80)	77	23	17.7%	47.9%	30.2%	3.1%	1%
Wellbeing (n=80)	92	8	15.1%	45.2%	33.3%	6.5%	0%
Health (n=59)	69	31	14.5%	29.1%	47.3%	9%	0%

* Number of survivors who reported an improvement and also provided an attribution

Outcome Findings for Survivors at T3 (6 months from T1 baseline)

Of the 188 of survivors who completed outcome measures at T1, 57 also completed an outcome measure at T3, a 70% attrition rate. The sample characteristics at T1- T3 did not differ substantially from the sample at T1-T2, except a slightly higher age range and a higher proportion had received two or more interventions (47%).

Safety at T3

At Time 3, survivors (n=56) reported proportional increases, to varying degrees, for each of the 11 safety questions, however this change was only statistically significant for two questions using the Wilcoxon Signed Ranks test (see Table 8.4, Appendix 8).

'*My home felt safe and secure'* and *'I have felt safe moving around my neighbourhood'* showed statistically significant increase in median scores at T3, although both had small effect sizes. For

example, of the 54 who answered '*I have felt safe and secure'* at T1 and T3, 14 had a positive change, 35 had no change and 5 had a decrease in median scores (z = 2.428, p = <.015).

For responses which did not reach statistical significance, some increases in safety were indicated, for example, '*I have felt that it is safe for my children to spend time with their father'* showed a 9% increase for often/all of the time, however little change was evident in the none of the time/rarely responses. Less change occurred for 'I know where I can go for help when I need it', due to very high positive responses at baseline.

Coping and Confidence at T3

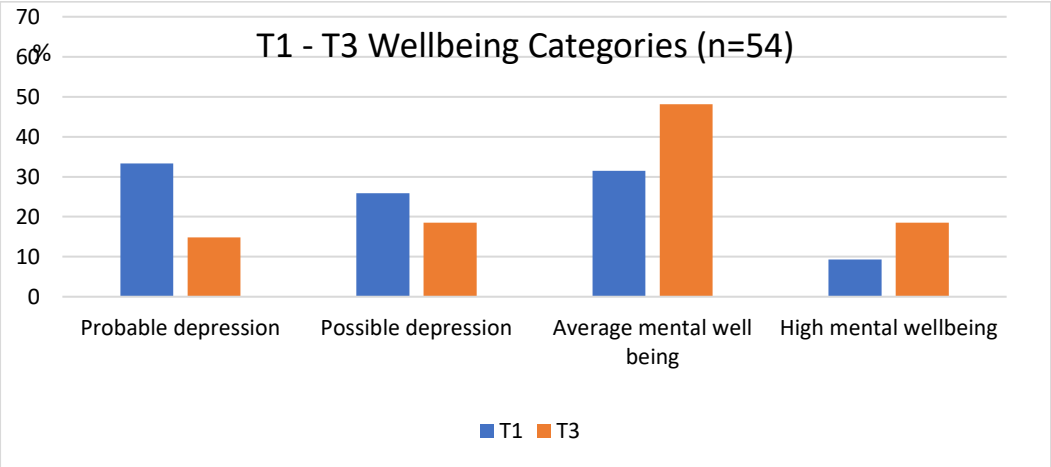
At Time 3, survivors (n=55) reported improved coping and confidence in nearly all areas, except 'I have good relationships with my children'. Overall, six of the 11 questions showed a statistically significant increase from T1 to T3 using the Wilcoxon Signed Ranks test (see Table 8.6, Appendix 8), although five had small effect sizes. The largest effect size was for the question *I have felt able to speak about my abuse if I want to:* of the 52 who answered at T1 and T3, 25 showed a positive change, for 22 there was no change and for 6 there was a decrease in the median score (z =3.318, p = <.001, d=.32). Other areas which showed a statically significant change were *I have felt in control of my life* (z =2.992, p = <.003, d=.29); *I have known that I was not responsible for the abuse that happened to me* (z =2.401, p = <.016 d=.23); *I have felt able to deal with my daily life* (z =2.2, p = <.028, d=.21); *I have been confident about doing new things* (z =2.172, p = <.03, d=.21); and *I have been able to recognise if other people have been behaving abusively* (z =2.307, p = <.021, d=.22).

Less change was found for management of alcohol and drugs (although again this had a low response rate) and for 'I have good relationships with my children' (due to high scores at T1).

Mental Wellbeing at T3

A total of survivors completed the SWEMWBS at both T1 and T3. The mean at T1 was 20.71 and this rose to 23.3 at T3, a statistically significant increase of 2.54, (t(53) = -4.254, p=<.001). This is still lower than the national average for women of 23.6 but does show an improvement in self-reported wellbeing. Survivors with complex needs reported slightly lower wellbeing scores compared to those without multiple needs, although this was not a statistically significant mean difference (22.8370 compared to 23.3114 respectively).

Figure 8.2 Mental Wellbeing at T1 and T3



Physical Health at T3

At T3, the EQ-5D-3L health measure did not show any significant improvement in survivors' health and the VAS thermometer showed a slight decline in health status (see Table 8.9, Appendix 8). The results at T3 were significantly lower compared with the accepted UK population norms for the EQ-5D-3L, indicating that service users across all time points are experiencing health states worse than the general population.

Survivors' self-reports on improvements in their safety, coping and confidence, wellbeing and health since using the SLCDP service at T3

As at Time 2, survivors at Time 3 self-reported any improvements in their safety, coping and confidence, wellbeing and health since using the service (see Table 8.3). Reflecting T2 findings, the majority of survivors reported positive improvements for each area, ranging from 95% for coping and confidence to 66% for health, even though the EQ-5D-3L measure did not find any significant change. Survivors with complex needs self-reported slightly lower levels of improvements for safety (79%, n=15) and health (44%, n=7) compared to survivors without multiple needs (87.5%, n=28, 73% n=19 respectively). Most survivors who reported improvements either mostly or entirely attributed this change to the SLCDP service they had used, reiterating T2 findings. There was also some indication that at T3 survivors were more likely to attribute their health improvements mostly or entirely to the service (57.5% at T3 compared to 43.5.% at T2).

Table 8.3 Improvements in safety, coping and confidence, wellbeing and health since using the service at T3

Have you experienced improvements in your:	Yes %	No %		Entirely due to the service	Mostly due to the service	Partly due to the service	Mostly due to other things	Entirely due to other things
Safety (N=66)*	88	12		23.2%	41.1%	26.8%	8.9%	0%
Coping and confidence (N=65)	95	5		21.3%	45.9%	29.5%	3.3%	0%
Wellbeing (n=67)	93	7		13.3%	48.3%	30%	8.3%	0%
Health (n=56)	66	34		17.5%	40%	30%	10%	2.5%

* Number of survivors who reported an improvement and also provided an attribution

Outcome Findings at Service Exit for Survivors

For 37 survivors, T2 (n=12) or T3 (n=25) outcome measures were completed at service exit. This section therefore combines T2 and T3 findings to provide a picture of survivor outcomes at service exit. However, not all survivors answered every question. Around two-thirds of this group (68%) were from West Sussex, 32% from Norwich. The age range was broadly similar to the T1-T2 and T1-T3 samples, however only 24% (n=9) had a complex need, a lower proportion than the T1-T2 sample of 33%, or T1-T3 of 37%, prohibiting separate analysis for this group of survivors. Due to the small

sample size, and the reduced proportion of survivors with complex needs, caution is required in interpretation of these findings.

Safety at Service Exit

Analysis of safety questions for T1 to end of service (n=27) using the Wilcoxon signed ranks test, found six areas showed statistically significant changes, with three having moderate effect sizes and three small effect sizes (see Table 8.10, Appendix 8).. The most significant change was for 'I have felt safe online'. The only question which did not show a statistically significant change was '*I know where I can go for help when I need it*', and, as noted above, this was probably due to high levels of awareness at baseline.

Coping and Confidence at Service Exit

Of the 11 coping and confidence questions, four showed statistically significant improvements, all with small effect sizes, these were: *I have felt able to deal with my daily life, I have felt able to speak to people about my experiences of abuse if I wanted to, I have been able to get a good night's sleep* and *I felt in control of my life* (see Table 8.11, Appendix 8). However, one item regarding drug and alcohol use was only answered by 17 survivors.

Mental Wellbeing at Service Exit

Wellbeing increased significantly from T1 to service exit for the 28 survivors who had valid scores at both time points, with a change in the mean SWEMBS score from 21.28 to 24.1 (df(27), t =-2.604, p=<0.015), indicating that most had average mental wellbeing at the end of service use. Although, as already stated, very few survivors with complex needs completed the end of support outcomes and this may have impacted on the wellbeing scores.

Physical Health at Service Exit

Analysis of the EQ-5D-3L for 27 matched pairs revealed an increase in self-reported health of 1.7% at the end of the programme, but the average score of 0.746 is significantly lower than the accepted UK population norm of 0.86 (see Table 8.12, Appendix 8).

The VAS (thermometer) element of the questionnaire revealed an increase of 11.68% across the 25 participants who completed this measure (see Table 8.12, Appendix 8). Whilst this is still lower than the accepted UK population norm of 82.48, this is a significant increase at the end of the programme.

Survivor self-reported improvements for safety, coping and confidence, wellbeing and health at Service Exit

At service exit, levels of self-reported improvements for safety, coping and confidence, wellbeing and health were comparable to earlier time points, with health remaining the lowest at 73%. Attribution questions showed that 97% of those responding at this point said their coping and confidence had improved and for 62% this was entirely or mostly due to the service. Similarly high proportions attributed improvements in safety and wellbeing to the service and 47% said they had experienced changes in their health entirely or mostly due to the SLCDP service.

Table 8.4 Survivor self-reported improvements for safety, coping and confidence, wellbeing and health at service exit

	Yes	No	Entirely due to the service	Mostly due to the service	Partly due to the service	Mostly due to other things	Entirely due to other things
Safety (n=35)*	86%	14%	21%	48%	24%	6.9%	0%
Coping& Confidence (n=35)	97%	3%	18%	44%	29%	6%	3%
Wellbeing (n=35)	89%	11%	15.5%	50%	19%	15.5%	0%
Health (n=26)	73%	27%	19%	28%	43%	10%	0%

* Number of survivors who reported an improvement and also provided an attribution

8.11 Insights Survivor DVA Outcomes at Service Exit

Insights data for survivors with closed cases showed reductions in DVA at exit. Overall, for recorded responses to physical DVA escalation (total = 198), 47% reported a reduction in physical violence, a similar proportion (41%), showed no change and 14 survivors reported an increase in severity of physical DVA. For recorded responses to sexual violence escalation (n=158), a third (35%) reported a reduction, 61% reported severity was unchanged and for six survivors it had increased. In respect of harassment and stalking (n=204), 56% reported a decrease, 38% no change and 11 survivors reported an increase in severity of harassment and staking. Lastly for controlling behaviours (n=212), 59% reported a decrease, 34% no change and 13 survivors reported an increase in severity.

Overall, 58% of the 362 survivors had ongoing contact with the perpetrator at case closure compared to 36% who had no contact. The main reason for ongoing contact was due to their children seeing the perpetrator (40%), being in a relationship with the perpetrator (28%), or due to financial arrangements (12%). As interviews with survivors reported above confirmed, child contact arrangements were a source of ongoing concern for survivors: of the 82 survivors who reported continuing contact with the perpetrator due to their children, 89% reported ongoing conflict around child contact arrangements and 82% stated the perpetrator used contact arrangements to continue the abuse.

Most survivors who lived permanently with the perpetrator at referral continued to do so at exit (63%), however, for those survivors who were only intermittently lived with the perpetrator at referral (n=18), only one third were living with the perpetrator at exit.

8.12 Children's Outcomes

Children aged over 7 participating in CYP interventions completed outcome measures at baseline (T1), 12 weeks later (T2) and at end of service use. The paediatric health related quality of life measure, the Child Health Utility 9D (CHU-9D) was given to all children. To measure wellbeing, the Strengths and Difficulties questionnaire (SDQ) was used for children aged 11 and over, and for children aged 7-11, their parents complete the SDQ on their behalf. However, the very low number of matched responses prohibited analysis of the SDQ findings.

At T1, 71 children completed a questionnaire, 46 (65% from West Sussex and 25 (35%) from Norwich, overall 55% were aged 7-10 and 45% were aged 11-17 years.

All children completed a child health questionnaire (CHU-9D), but there was a significant drop-off in the completion rate. There was no significant difference between children's scores at T1 and T2, but there was a change of almost 5% between T1 and T3. We cannot assume that this is representative of all children receiving services due to the low number of completed questionnaires, but it does indicate that the children's health may have improved after they used the SLCDP service support.

Table 8.5 Child Health Questionnaire (CHU-9D) at T1, T2 and T3

CHU9D	T1	T2	T3
COMPLETE	71	27	12
AVERAGE	0.814	0.815	0.859
STDEV	0.107	0.106	0.128

Insights children's data at service exit reported very few children being a witness to DVA at case closure compared to levels at intake: for example, of the 132 who witnessed physical DVA at referral (71%), only nine children (5%) continued to witness this at exit (5%). Similarly, 152 children had witnessed controlling behaviour at referral (81%) but only 20 (11%) were still witnessing this form of DVA at exit. A similar pattern was also recorded in relation to direct child abuse, except for emotional abuse where 39% of the 72 children had experienced this at intake and 19% experienced this form of abuse at exit. However, this figure was comprised mostly of children who were not recorded as experiencing emotional abuse at point of entry to the service.

At service exit, 78 children were recorded as receiving support with safety, for 45 children (58%) this had greatly increased their safety and for 30 (38%) it had been slightly improved. Fewer children (n=59) received support for their relationships with family members, with 27 (46%) having a slightly improved and 20 (34%) a greatly improved relationship with their family. Among children who received mental wellbeing support (n=47), this had slightly improved wellbeing for 23 (49%) and for 22 children (47%) wellbeing had greatly improved.

8.13 Summary

- The SLCDP pilot services were designed to address gaps in DVA support for families. Survivors identified that the opportunity to receive services for their children as well as parenting support was a key reason for using the services, support for older children and work with perpetrators were also mentioned as motivating factors.
- Previous barriers to DVA help-seeking identified by survivors included limited/inappropriate provision of DVA services, especially targeted support for children, and services' risk thresholds.
- Prior to referral, some survivors reported receiving very little information about the SLCDP service.
- A flexible service, responsive to the needs of survivors, which offered an appropriate level of support was valued highly. Mothers reflected positively on the range of integrated interventions which targeted both their own needs and the needs of their children.
- All women interviewed valued their relationships with workers, feeling listened to and understood and that the work matched the pace that was comfortable for them.
- Authenticity was important to survivors, and this was enhanced when programmes were delivered by those with relevant experience or expertise.
- The use of creative and engaging toolkits and activities, such as Helping Hands and craft sessions were viewed very positively by survivors and children.

- Groupwork was highly valued enabling survivors and children to share their DVA experiences in a supportive environment and to recognise they are not alone. Similarly, children valued the realisation that DVA happened in other families.
- Some barriers to service engagement were also identified including: not being able to access support when needed, especially for their children, due to waiting lists; staff turnover and a lack of evening group work sessions.
- During Covid-19, survivors generally felt supported by workers through regular telephone or online contact, although some missed the opportunities provided by face-to-face groups and engagement with some children was challenging.
- Most survivors reported feeling confident and optimistic about their own and their children's prospects for the future and considered their initial goals had been met.
- Mothers reported more confident parenting, understandings of the impact of the DVA for their children and enhanced family communication and relationships, although some still had concerns about child contact.
- Family Case Study children experienced improvements in mood, sleep, physical health and reductions in fear and anger. There were examples of them successfully navigating key transitions in their lives.
- Family Case Study practitioners described seeking children's opinions and representing their voice in decisions about contact and in child protection cases and advocacy work with Children's Social Care was found across the wider sample.
- When asked to reflect on their feelings about the future, most survivors reported feeling confident and optimistic about their own and their children's prospects.
- Outcome measures completed by survivors showed improved safety 12 weeks from baseline and this was statistically significant for five out of six questions asked. Survivors' safety also increased further at 6 months although changes were only statistically significant in respect of safety in the home and neighbourhood. Between baseline and service exit, there were moderate or small statistically significant improvements for all six safety questions.
- Measures of coping and confidence showed improvements on most questions at 12 weeks, although this was only statistically significant for four of the 11 dimensions. At six months from baseline, improvements were found on nearly all these dimensions with change reaching statistical significance on six dimensions. At service exit, four of these dimensions showed statistically significant improvements, all with small effect sizes: dealing with daily life, speaking about experiences of abuse, sleeping well and feeling in control of my life.
- Mental Wellbeing outcomes increased at six weeks, although this was not statistically significant. However, improvements in mental wellbeing at six months and service exit reached statistical significance.
- Health questionnaires showed some positive change at 12 weeks from baseline and at service exit but a slight decline in health status at 6 months, all changes were not statistically significant. The visual analogue scale (VAS thermometer), which is easier to complete, showed positive change for 12 weeks and service exit and a small decline at 6 months.
- Survivors' self-reports showed substantial improvements in safety, coping and confidence, wellbeing and, to a lesser extent, health, since using the SLCDP service. A high proportion of survivors reported this change was entirely or mostly due to their use of the service, although attribution of change to the service was lower for health improvements.

8.11 Recommendations

- Positive outcomes for survivors and children suggest that a survivor-centred service, co-designed with survivors and delivered in a flexible and creative way provides a model for future service provision.
- Survivors require more detailed explanation of the different support services offered with the SLCDP model and how they seek to support the whole family in moving on from DVA and recovery at point of referral.
- A wide range of positive outcomes were reported by survivors and children, however increasing the capacity of whole family provision, including work with children, would reduce waiting times for support, and enable all family members to receive support when they need it.
- Although online support was appropriate, and was preferred by some survivors, others require face-to-face contact, at least at the outset, to support relationship building.
- Ongoing support with managing child contact is an area where continued or follow-up work might be beneficial in future whole-family work.

Chapter 9: Whole System Change

9.1 Stakeholders' Perceptions of Change

The stakeholder consultation groups held in the five Roadmap sites in 2019 (see Chapter 3) were repeated between March and July 2020. The Covid-19 pandemic resulted in half of this second round of meetings being conducted remotely. It was not possible for all participants to attend both meetings but some were able to do so. The organisations represented by the 38 or 39 participants attending in 2019 and 2020 are shown in Table 3.1, Appendix 3. Organisations involved in delivering the Roadmap assisted the Evaluation Team in identifying key local stakeholders. Some of those attending represented partner organisations involved in the delivery of the Roadmap interventions and their views of impact may have been influenced by their role.

Participants provided ratings of the local DVA landscape and services similar to those completed in 2019 and below we report key changes identified and relevant issues raised in discussion.

9.1.1 The Local Landscape

In 2020, the proportion of stakeholder group participants who would be confident or very confident in referring a family member or friend to existing DVA services, increased from two-thirds (n=25) in 2019 to four-fifths (n= 31) of the group, with no participants reporting a lack of confidence to do so.

However, participants' ratings of community attitudes to DVA in their local communities failed to shift between 2019 and 2020 with most continuing to state that the local community was mixed in its attitudes towards DVA. Although WAFE co-ordinators interviewed noted difficulties in extending the recruitment of Ask Me Ambassadors (see Chapter 4), stakeholders in Sunderland, suggested that the number of Ambassadors needed to be substantially increased to achieve significant impact in this respect. Stakeholders were keen for the reach of this programme to be extended:

…fantastic, we've got more than I think was originally planned, but 150 people is a drop in the ocean in a population our size… (Sunderland, consultation 2)

Nevertheless, in the ensuing discussion, participants from Surrey and West Sussex described an increased public awareness of DVA as a consequence of public messages and media coverage under Covid-19.

9.1.2 Referral Pathways

In 2019, participants in four of the five sites described referral into DVA services as sometimes difficult and they considered that clarity of referral pathways was lacking. This was attributed to the number of services operating across counties, often with different catchments and addressing different levels of risk. These complexities could represent a barrier for potential service users and other professionals.

In 2020, group participants in Norwich and West Sussex, where the SLCDPs were new to those areas, considered that referral pathways to the SLCDPs still lacked clarity for many. In West Sussex, where the SLCDP served different districts, boundary issues had led to '*toing and froing about whether they...couldn't take any more referrals in particular areas or in particular areas of intervention*' and this had resulted in '*confusion, possibly, then led to social workers maybe not referring so much*' (West Sussex, consultation 2). However, examples were also cited of close communication between the SLCDP and another organisation helping to prevent delay in sending high risk cases directly to an Idva (Norwich, consultation 2), and increases in '*two way referral*' (West Sussex, consultation 2).

Restructuring of Children's Services in Norwich to introduce a specialist support team with a focus on DVA was envisaged as a means of improving communication and referral pathways.

Multi-agency mechanisms for collaboration and ease of referral which were felt to be working well in 2020 included the Encompass scheme (Norwich, Nottingham and Surrey), the local MASH (Nottingham), Early Years partnerships and the Domestic Abuse Referral Team (DART) (Nottingham). Sunderland reported an increase in DVA referrals from GP practices and the hospital-based Idva and, in Surrey, GP referrals were felt to be working well in the east of the county as a result of the IRIS programme.

9.1.3 Equal Access to Services across Sites

Participants' views as to whether DVA services in their area were equally accessible to different groups of women became more positive between 2019 and 2020. In 2019, 15 of the 38 participants disagreed or strongly disagreed with this statement while, in 2020, none did so and the majority (22 of 39) agreed with the statement somewhat. Similarly, participants' views changed on the issue of whether DVA services were equally accessible to different groups of children and young people. In 2019, over half (22 of 39) stakeholders disagreed that DVA services were equally accessible to different groups of children and young people while, in 2020, this had reduced to 14 of 39 of respondents. While this shift might be attributed to the SLCDP services in Norwich and West Sussex, there had been other positive developments with regards to services for children in both Sunderland and Surrey. However, in Nottingham, a participant reported that funding for children and young people's refuge workers had ended and children's centres had closed, emphasising the fragility of some services.

In 2019, Black and minoritised women and children were identified as a group who did not always have equal access to DVA services and there was limited change discernible in respect of this in 2020 although Sunderland and Surrey stakeholders both described developing plans for collaborative work with specialist Black and minoritised organisations. Stakeholders in Nottingham in 2020 described an increase in referrals from Black and minoritised communities and the Black and minoritised refuge was considered a valuable resource, but language barriers created difficulties when trying to move women into more generic DVA services. Commissioning of specialist services for Black and minoritised women and children was an area of concern for some stakeholders in both 2019 and 2020. A shortfall in services for women with no recourse to public funds (NRPF) continued to be identified in a number of sites, although Surrey and West Sussex reported new projects targeting this group.

The consultation groups found particular barriers to accessing services for survivors with complex or multiple needs in 2019 and in 2020 this remained a theme. It was noted that Covid-19 restrictions might have impacted especially heavily on this group:

…women that are homeless or women that are disadvantaged by a number of other things to do with, you know, mental health and things like that, we're not having any contact with them at all because they don't have phones and laptops and iPads and stuff like that (West Sussex, consultation 2)

Gaps in provision for LGBTQ+ survivors also continued to be identified in 2020.

9.1.4 Knowledge and Assessment of Roadmap Interventions

In one of the WAFE sites, participants were still unclear about the differences between the Ask Me and Trusted Professional interventions in 2020. This lack of knowledge was attributed to less frequent meetings of multi-agency networks which were likely to have been affected by Covid-19 restrictions. Knowledge of the VOICES intervention was also limited with some participants thinking

that it did not differ substantially from current practice in WA services. However, participants in all three WAFE sites noted that WAFE co-ordinator capacity had been stretched over large areas.

The training provided to other local professionals by both WAFE and SLCDPs was judged to have achieved impact although this was difficult to quantify. Trusted Professional was considered to have improved recognition and responsiveness to DVA among Early Years staff in Sunderland and was thought to provide a 'train the trainer' approach which could help with sustainability and staff turnover (cited as a key challenge in most sites). A large number of DWP staff had been trained as Trusted Professionals in Surrey and this intervention had led to DWP engagement with relevant partnership working groups. In 2020, participants identified that, although small in number, queries were beginning to come through to DVA services from professionals who had completed the Trusted Professional training.

Consultation participants in WAFE sites in 2020 were very positive about the remodelled version of Trusted Professional and described it as exceeding their expectations. However, it had been anticipated that the intervention would have reached services such as substance misuse and mental health. Engaging these services in DVA training was identified as a long-standing challenge:

…we struggle, I think, with getting mental health staff to come on local training because they've got their own safeguarding training…. Mental health, there's nearly always an issue in DHRs as well. (Sunderland, consultation 2)

Impact was felt to have been limited in Nottingham/shire but this was attributed to local pressures and high workloads rather than the CtL programme. VOICES, which had been introduced much later than the other WAFE interventions, was considered to have evoked mixed responses and stakeholders noted that it made additional demands on practitioners to collect data and use new tools. However, it was considered useful, and an example was provided of DVA specialist services using the VOICES framework to assist in producing a court report.

The Whole Picture Matters training delivered by the SLCDPs had encountered problems with uptake (delivery was affected by Covid-19 restrictions) but was considered to have promoted whole family engagement and been accessible to social care and early help practitioners. Norwich stakeholders in 2020 reported that the training delivered had raised awareness of the relationship between mental health, substance use and domestic abuse, increasing practitioners' confidence in respect of work on these issues.

Wider influence on conceptions of DVA intervention was also identified. Stakeholders in all three WAFE sites described increased use of a '*shared language*'. CtL terminology, such as 'space for action', had influenced service standards for local DVA service providers and had been adopted in some local domestic homicide reviews. However, stakeholders in both Sunderland and Nottingham/shire in 2020 considered that other professionals' responses to DVA remained generally risk-led rather than needs-led, and '*moving to a needs-led approach would require a huge culture shift*' (Nottingham/shire, consultation 2).

There were indications in the SLCDP sites that a multi-disciplinary approach to work with the whole family had gained traction: *'everybody has got a part to play in working around the family'* (Norwich, consultation 2). There was however less confidence that increased readiness to engage and work with perpetrators had been achieved across other services in the SLCDP sites.

9.1.5 Facilitators and Barriers to Change

Effective partnership working that extended across local authority boundaries continued to be seen as key to identifying DVA as a strategic priority in 2020. Stakeholders emphasised that partnerships

were strengthened when new interventions built on existing infrastructure. Consistency in local authority political leadership was also identified as a key facilitator of DVA service development.

The move to delivering services remotely under Covid-19 was considered to have assisted effective working where organisations had speedy access to the necessary technology. Stakeholders in the SLCDP sites felt that remote means of communication had facilitated engagement with perpetrators:

some quite, you know, honest and deep conversations with these people over the phone…really challenge, and probably challenge better, in some respects… [since] 'I'm not in the same room as somebody who I know is, potentially, quite a dangerous individual. (West Sussex, consultation 2)

However, online working had created barriers to sustaining DVA work with children and young people in SLCDP sites due to the sensitive content of the work and the need to ensure they were left in a safe and supported space afterwards.

The fragmentation of DVA services and confusion regarding catchment areas, referral processes and service offers (with different services working with different levels of risk) were all identified as barriers to effective DVA service development and delivery. While stakeholders were positive about what the Roadmap training for other professionals had achieved to date, in both SLCDP and WAFE sites, there was a view that this training needed to embrace the harder-to-reach professional groups. Staff turnover was highlighted as a further challenge to training impact.

9.2 Staff Perceptions of Whole System Impact

The survey completed by staff working on the Roadmap Programme in Autumn 2020 captured practitioner views of whole system impact. Some SLCDP staff considered that the training offered to other professionals had achieved widespread impact and had elicited positive feedback:

…the training offer has been a huge success…confidence...appears to be rising. The trauma informed practice sessions have been picked up by the local safeguarding children's groups and…deliver[ed] to a multi-agency forum for each of the groups. The scope of the training has also been successful with CcoE [Creating a Culture of Engagement] and trauma informed practice attracting health, probation, social care, voluntary sector and education participation. (Staff Survey, SLCDP)

The survey asked whether staff considered that their service had improved professional and community awareness of DVA and appropriate responses, the majority of SLCDP respondents (n=10/15) stated that it had 'greatly', with the remainder indicating that it had 'in some respects. However, difficulties in achieving local take-up of the training were also reported and it was noted by staff interviewed that offering a number of different types of training may have created '*a bit of confusion about, well which training do I go on?*' (Staff Interview 5, SLCDP).

As a group, SLCDP staff were cautious in their response to the survey question about whether their service had improved inter-agency communication and co-ordination, with the majority of respondents (n=10/15) stating that it had 'in some respects', while the remainder indicated that it had 'greatly'. However, this staff member argued when interviewed that the service had provided a positive model of interagency collaboration:

I think this pilot has really increased the ecosystem around domestic abuse. I think there is a lot better cohesion now around cases, that strong principle of …being multiagency…professionals love us, for the simple reason, that when we get a referral, we phone them up and talk about it. (Staff Interview 6, SLCDP)

When interviewed early in 2020, WA staff delivering VOICES were clear that there was a high need for training on DVA among staff in other agencies such as housing, adult social care and, in particular, children's social care:

…there's still a real lack of education in a lot of different agencies, about what domestic abuse really is and who's actually responsible…there's still so much victim blaming happening. (Staff Interview 2, WA)

In response to the staff survey asking whether the CtL programme had improved professional and community awareness of domestic abuse and appropriate responses to it, the majority of WA respondents (n=11/15) stated that it had 'in some respects'.

When asked whether the programme had improved inter-agency communication and co-ordination, the majority of WA survey respondents stated either that it had 'in some respects' (n=7/15) or that it had 'a bit' (n=5/15).

9.3 Social Network Analysis

9.3.1 Social Network Analysis Approach and Methods

We used Social Network Analysis (SNA) methods (see Gillieatt et al 2015; Sabot et al 2017) to capture practitioners' local networks and patterns of influence. The aim was to document the local organisations that WAFE and SLCDP organisations connected with in providing a response to DVA, and to describe and quantify the relationships between WA/SLCDP organisations and other organisations within the network at two time points. Comparison of the size of the network and strength of relationships over time was undertaken to identify areas where WA and SLCDP organisations may have influenced or been influenced by the wider system, and also those areas in the system that may need to be further strengthened.

Data on networks was collected from the perspective of WA and SLCDP staff. Data collection had two stages: 1) name generation where a roster of organisations in a network was developed in interviews with staff; 2) name interpretation where the nature of ties between organisations was explored against six dimensions (see below) via a survey delivered at two time-points.

Respondents spanning a range of roles (management, frontline, administration) were identified by the Evaluation team in collaboration with each site. As Table 9.1, Appendix 9, shows, there was a reasonable response rate across four of the five sites, reflecting the experiences of a range of staff. There were difficulties in obtaining the details of prospective participants from Nottingham/shire with only one of four potential respondents participating at Time 2, and therefore Nottingham/shire has been excluded from the analysis. In total, 27 (16 SLCDP; 11 WA) staff across all sites participated in stage 1 interviews generating the names of the organisations within local networks; 31 staff participated in stage 1 of the survey and 33 participated in stage 2. Table 9.1 in Appendix 9 provides a breakdown of participants and their responses.

Name generator phase: Four questions were asked in the context of a broader qualitative interview to elicit information about organisations in the sites' networks:

i) Which organisations aside from your own are important in identifying and responding to DVA in [your area]?
ii) Which organisations frequently refer into the service? (*By frequently we mean once a month or more*);
iii) Which potentially important organisations rarely refer into the service? (By rarely, we mean less than 5 separate referrals per year);
iv) Which organisations would you interact with if you had a client with one of the following needs (e.g. mental health, LGBTQ+).

This information was combined with information yielded from document analysis to develop a roster or list of organisations perceived as playing some role (ranging from peripheral to central) in the response to adults and children experiencing DVA. Organisations were categorised under five headings: Legal/justice, health and well-being, social care, specialist DVA/SV, and other. The rosters were shared with members of each organisation and feedback was incorporated.

Name interpreter phase: The roster along with socio-demographic questions was presented to participants as an online survey. At time 1 (May 2020), participants were required to rate the nature of the relationship with each organization in the previous 12 months, against six dimensions: the frequency of seeking advice, giving advice, receiving referrals, making referrals, joint working, and the amount of trust they had in professionals at the organization to deliver an effective response to survivors of DVA. At time 2 (November 2020), participants reflected on the previous 6 months. The five dimensions relating to frequency were rated on a five-point scale (1: daily, 2: weekly, 3: monthly, 4: yearly, 5: never). Trust was rated on a four-point scale (1: a lot, 2: quite a lot, 3: little, 4: none). In all cases, participants were able to answer 'don't know'. In each of the five categories, participants were able to indicate organizations that had not been included in the roster. Mean scores were computed for site by sector and dimension. The coding means that a low score is interpreted as a sector being more central in an organization's network, and a high score as a sector being more distantly positioned.

9.3.2 Results of Social Network Analysis

Time 1 Networks

As can be seen in Table 9.2, Appendix 9, characteristics of local networks at Time 1 varied across sites. The size of each network ranged between 36 and 62 organisations. *Norwich* had frequent interaction with social care when it came to giving and getting advice, making and receiving referrals and joint working. In examining the strength of relationships with agencies comprising the social care category, it was apparent that in *Norwich* the relationship with children's social care was somewhat stronger than with adult social care, which is consistent with the pattern of referral data discussed in Chapter 7. These data indicate that the relationship with social care was reciprocal and extended beyond referrals to the exchange of advice and the type of work undertaken.

West Sussex's network was characterised by fewer close ties with other sectors, although contact with justice and health sectors seemed particularly infrequent (across most dimensions); referrals to and from other specialist DVA/SV organisations were infrequent (mean rating 3.9-4.3, which approximates to yearly). This finding is at odds with the referral data discussed in Chapter 7 which indicates that 30% of referrals into the service were made by specialist DVA/SV services. A closer look at the frequency of referrals in and out of individual organisations within this category revealed frequent referrals to and from (weekly-monthly) the local authority DVA agency dealing with high risk cases, but more infrequent referrals to other specialist DVA services in the area, with several rated as never referring in or out.

Sunderland appeared to have frequent interactions with social care and justice/legal services in relation to giving advice and receiving referrals. The link with justice/legal services appeared to be reciprocal with this organisation also frequently accessing advice from the justice/legal services as well as making referrals.

Surrey's network seemed to be characterised by fewer close ties with other sectors, with interactions across the dimensions of interest tending to be on a monthly or yearly basis. It was notable that interaction with health and 'other' types of organisations seemed to be particularly infrequent.

It was perhaps surprising to observe that ties with health, across all sites, were not stronger, given the impact of DVA on mental and physical health, the opportunities that health workers may have to identify DVA, and policy that places health as a key contributor to the DVA response for families, adults and children. (NICE, 2014; Trevillion et al., 2012). In looking more closely at the ratings for individual organisations in the health category, it was not the case that the combined sector score obscured variations in the positioning of individual organisations within the network, i.e. some links were close, whilst others were distant. None of the sites interacted with any health-related organisation (across any of the dimensions) on a daily basis, and it was extremely uncommon to see weekly interaction. Instead it was much more likely that interaction was on a monthly or yearly basis. However, despite its distant positioning in the networks of the four organisations, trust in the health sector was high across the board, as it was for other sectors.

Change in networks over time

We explored the changes in networks over six months by comparing the time 1 and time 2 ratings for each sector (see Table 9.2, Appendix, 9). We observed little change in the nature of relationships over time, the exceptions being that West Sussex gave more frequent advice to the justice/legal sector at time two, and conversely Surrey gave less frequent advice. These changes were not reflected in the other dimensions assessed, although these findings could be early signals of change.

9.3.3 Covid-19 as a context for inter-organisational relationships

Across all four sites, staff comments in relation to partnership and multi-agency working at time one were, on the whole, positive. Key multi-agency meetings had continued online *'Child Protection Conferences. Core Groups and Maracs have all taken place via telephone conferencing'(West Sussex, T1)* and, as noted elsewhere in this chapter, three organisations identified instances where they felt collaboration had improved as a consequence of remote work–ng - *'Lots more collaboration and communication between services'* (Surrey, T1) or where there had been close partnership working with particular organisations:

There has been a good collaboration with some schools during lockdown. We have been given a platform by some of the schools to support our CYPs virtually, with the school assistance. We have been able to send a relevant toolkit to schools for support workers to use with our CYPs when no access to CYPs available for CYP Workers. (Norwich, T1)

Housing services have worked with us to support our women who, before we went into lockdown, were preparing to move into properties they had been offered. Staff in managerial roles were liaising with each other to ensure that as much could be done as possible and within lockdown guidelines. (Sunderland, T1)

However, staff in some sites (Norwich, W. Sussex, Sunderland) also described negative impacts on the availability of services, with some services being closed or working at reduced capacity due to staff shortages. A frontline worker from Norwich observed that lockdown had reduced the level of contact they were having with other third sector organisations, with another staff member from the same organisation noting: '*a lot of orgs have not actually met the clients they are referring in, making it harder to assess risk'*. (Norwich, T1)

In general though, the negative impacts on inter-organisational relationships at time one were seen as less significant than the impact on service users: '*…we have seen that no face-to-face contact has had a negative impact, especially with women who have been unable to have this contact with mental health and drug and alcohol services. Teams and Zoom have helped but the women are saying it is not as effective for them as face to face contact'*. (Sunderland, T1). Safety concerns about remote delivery, especially in respect of children, were also identified.

At time two, respondents were asked to quantify the impact of Covid-19 on their ratings of inter-agency relationships. In Norwich, five of eight respondents felt their answers had been greatly or somewhat affected (vs 3/5 a bit or not all). In West Sussex, two of six respondents felt their answers had been somewhat affected (vs 4/6 a bit or not all). In Sunderland, all six respondents felt their answers at time two had been somewhat affected and, in Surrey, three of four respondents felt their answers had been greatly or somewhat impacted.

9.3.4 Summary of SNA Findings

There were no systematic differences between the networks of organisations implementing the different approaches to system change. Instead, the extent to which particular sectors were centrally or peripherally positioned seemed to reflect the existing professional capital of managers and key workers and also the commissioning arrangements for each of the sites. This is perhaps unsurprising, but it is an important consideration at the outset of programming so as to highlight areas for strategic recruitment in order to strengthen particular links, or to capitalise on existing strengths in a system.

Generally, health was positioned peripherally in each of the four networks examined, although ratings of trust for health services were high. This finding is consistent with findings from the stakeholder consultations groups and managers' interviews reported elsewhere in this chapter. It also reflects a body of evidence describing the barriers to fully integrating health into the co-ordinated community response to DVA (Garcia-Moreno et al., 2014; Hegarty et al., 2020) and the need for initiatives to strengthen links between health and the specialist DVA sector (Devine et al., 2012; Halliwell et al., 2019).

It is difficult to know whether the networks we observed accurately reflected those in place prior to the Covid-19 pandemic. Baseline data collection for the survey began in May 2020, and by this time the pandemic had been ongoing for two months. We asked respondents to reflect on the previous 12 months, but the salience of the pandemic may have skewed participant ratings. Qualitative comments collected at time one seemed to suggest some difficulties in accessing other community-based services, although they also highlighted areas where there had been concerted efforts between organisations to remain connected and to continue with business as usual.

The level of work required for organisations to stand still during the pandemic may account for the lack of change that we observed over time, and the fact that we did not observe any marked distancing of relationships may indicate the lengths that sites went to in order to maintain their networks during this unprecedented time. That said, maintenance of inter-organisational relationships was not sufficient to mitigate the impact on service users, who were considered to have been adversely affected by the lack of face-to-face contact with DVA organisations and other community agencies. The lack of change in networks over time may also reflect the fairly short period between data collection points or the fact that we were unable to collect data in the first few months of implementation. It may have been the case that organisations actually started from a lower bar than is reflected in the baseline data which in SLCDP sites was collected following the initial implementation period.

Overall, these data extend the usual exploration of referral patterns to consider other dimensions of inter-agency working such as the exchange of information, joint working and perceptions of trust, and allowed us to explore whether relationships were reciprocal or largely unidirectional. However, it should be borne in mind that these data only reflect the organisation's own perceptions of its interagency relationships, which could feasibly diverge from the views of those other organisations. This type of data collection, whilst fairly labour intensive, is straightforward and could provide means for commissioners and organisations to monitor the strength of their wider networks and

develop focussed strategies to target areas of weakness (e.g. lack of interaction, lack of reciprocity, low trust) with a view to enhancing the co-ordinated community response to DVA.

9.4 Senior Managers' Perceptions of Whole System Impact

9.4.1 Shifting Understandings of DVA Responses

Senior managers agreed that, despite the distractions of local priorities and changes in local structures and key senior figures in some sites, there had been substantial impact on local conceptions of DVA need and services. WAFE managers considered that the Change that Lasts model had influenced shifts to service models focused on survivors' needs rather than risk. Nottingham City was described as having:

…remodelled their service from a completely needs led approach, stepping away from Idvas and high risk case management triage and doing something very revolutionary, completely inspired by Change That Lasts and the Voices Framework... (Senior Manager1 WA)

While in Surrey:

…instead of reporting to a risk-based framework, they're all reporting to Space for Action. And so, they're using OnTrack to demonstrate how they're meeting survivors needs across all of the domains for Space for Action. (Senior Manager1, WA)

As noted in the stakeholder groups, a WAFE senior manager highlighted ways in which the conceptual framework underpinning *Change that Lasts* had gained traction:

we've been asked to comment on domestic homicide reviews in a couple of the areas, and there is a sort of starting to use the Change That Lasts language in their approach, which is really positive. (Senior Manager 2, WA)

This confirms findings from the 2020 stakeholders' consultation group in this area as noted above.

SLCDP senior managers acknowledged that achieving culture change was a gradual process and they considered that the SLCDP interventions had contributed to growing recognition of the need to shift towards interventions that addressed perpetrators and focused on the whole family:

we've helped work with the right people to say, we need to switch the narrative here, and we need to start asking…'why don't they stop, not, why doesn't she leave?' I think that has, definitely started in those areas and I think that looking at how the whole family, how all the work of individuals impacts the whole family… (Senior Manager 4, SLCDP)

However, they noted that services had had to work with some resistance to the idea that '*perpetrators can change'* (Senior Manager 1, SLCDP) and this is consistent with doubts expressed in the Stakeholder Consultation Group that widespread change in the attitudes of professionals had been achieved in this respect.

9.4.2 Changes in Commissioning

WAFE managers highlighted the influence of Change That Lasts on local commissioning guidelines:

…we've been really successful in building the needs-led into the commissioning strategies in Nottingham and Surrey, that's a really key piece of sustainability work. (Senior Manager 1 WA)

They anticipated being similarly influential in Sunderland where they had been consulted on tendering processes in the past.

Similarly, SLCDP senior managers reported influencing commissioning in Norwich and in Norfolk more widely where a pan-Norfolk whole family service based on the Norwich SLCDP service was to be put out to tender. Moreover, commissioners had been impressed by the SLCDP practice of including survivors in decision making and planned to *'have somebody local with lived experience on their board that's going to oversee all of that work and…five years ago they wouldn't have had [that].*' (Senior Manager 5, SLCDP)

9.4.3 Reach of Impact Achieved

WAFE's three interventions were seen to have varied in respect of the reach of impact achieved. Ask Me was considered to have made substantial progress in reaching '*community members, who would never normally come into this world at all, and equip them with knowledge and skills that enable them to have better conversations in their community*' (Senior Manager 3, WA). While it was acknowledged that the impact of Trusted Professional was, as yet, limited (with the pandemic restricting the impact of both Trusted Professional and VOICES), some evidence of impact in '*changing the narrative and approach of professionals*' (Senior Manager 3, WA) was cited and DWP's engagement with Trusted Professional in the Surrey site was singled out as a particular achievement:

DWP…want to kind of spread it out across all of their services…historically, in my experience of working in the sector, they were just such a challenging organisation, in terms of their attitudes and responses to survivors, so that's great. (Senior Manager 3, WA)

Likewise, SLCDP managers noted that '*we've upskilled a ton of really great people, who, after the life of this project, will still be…using those skills. I think we have changed the way domestic abuse is thought of…'* (Senior Manager 1, SLCDP)

SLCDP managers highlighted their success in engaging with children's social care and commented that close collaboration between a DVA organisation and children's social care on referrals and cases was not something that had happened previously in the SLCDP sites. A high proportion of children's social care practitioners across both sites had received DVA training which had included information on the model used in the SLCDPs and, although consultation and training work had been restricted by Covid-19, there had been progress towards:

wider system change, around the culture shift, about how they respond to sort of whole family approach…about professionals doing that work with the children and feeling confident that they've got the skillset and ability tIo it...that longevity stuff. (Senior Manager 2, SLCDP)

WAFE senior managers were clear that they had intended '*to bring people to the table that didn't normally engage with the issue*' (Senior Manager 1, WA), especially those outside the community safety and criminal justice sectors. While they highlighted their success in engaging DWP as a stakeholder, they agreed that they had generally been less successful in engaging stakeholders from health services and referral sources for the SLCDPs (see Chapter 7) indicate that this may also have been an issue for these interventions.

9.4.4 Future Plans for Roadmap Services

As noted above, at the time of writing, it was anticipated that the SLCDPs would be commissioned on a pan-county basis in Norfolk. Commissioners had agreed to extend the work of the West Sussex service until the end of 2021.

WAFE planned to deliver VOICES as part of the membership training package for local services affiliated to the national organisation. Trusted Professional would be marketed and sold to a wide range of organisations as part of WAFE's national training offer, while Ask Me was to become a

social franchise service that local WA organisations could '*adopt and own and deliver themselves, rather than being delivered directly from head office'* (Senior Manager 2, WA).

9.5 Impact of the Roadmap Partnership for WAFE and SafeLives Collaboration

Building the partnership that planned and delivered the Roadmap Programme was considered to have taken a good deal of work and resources because the two organisations came to the partnership with different, although complementary, strategies and approaches. However, communication had been 'respectful' (Senior Manager 3, WA) and the work involved in setting up systems for partnership working '*means that we're working more effectively as a partnership and sharing learning on a regular basis*' (Senior Manager 2, WA). Collaboration on developing the Roadmap had given the two organisations a positive platform on which differences could be debated and addressed:

the Roadmap has given us how much does it cost, what does good quality look like? What does gender, the gendered nature of domestic abuse really mean? It has given us those hangers to say let's bring our differences together around this and work it out together. I do feel like it has provided a positive framework to have those very difficult conversations previously, in a positive way. (Senior Manager 5, SLCDP)

Senior managers were able to identify a number of joint initiatives that had flowed from the Roadmap partnership:

…we've done work on the costings that we see we needed to fund the domestic abuse sector, and we've actually put in a joint submission to the Treasury for a spending review this year, which we've never done before. We also are working on…the joint statement, some joint communications work around the gendered nature of abuse…And then we're doing some joint work around standards in the sector as well. (Senior Manager 2, WA)

A willingness to collaborate on campaigns was seen to have benefits that would spread across the DVA sector:

we definitely both see the benefits in us being joined up for the sector and us having joint messaging on things and also being clear on where we differ, rather than pulling people apart we need to try and pull people together. (Senior Manager 4, SLCDP)

…in the public policy space, we're much stronger together…There's been some real wins, in terms of speaking together. (Senior Manager 1, WA)

The experience of collaborating on the Roadmap was considered to have contributed to co-ordination of the two organisations' work on the Domestic Abuse Bill and on wider co-ordination across the DVA sector on the response to the pandemic:

We've started those conversations and they've built and built and built really so now you've got nine or eleven different organisations being funded by the Lottery to work together for a whole financial year around Covid and I really don't think, there's no way SafeLives would have signed up to that five years ago, no way. (Senior Manager 5, SLCDP)

Senior managers noted the need for the new approach engendered by the WAFE-SL partnership to '*trickle through*' (Senior Manager 4, SL) and there were as yet no examples of the benefits of partnership extending beyond the senior levels of the two organisations. At the local level, managers had had no involvement with their counterparts in the other organisation and identifying ways in which collaboration built through the Roadmap Programme might extend beyond WAFE and SafeLives' central organisations to be reflected in local delivery and partnerships could be an objective for the future.

9.6 Summary

- In most of the Roadmap sites, clarity of referral pathways was considered to still be lacking by stakeholders consulted in 2020. Fragmentation of DVA services and confusion regarding catchment areas, referral processes and service offers (with different services working with different levels of risk) were identified as barriers to effective DVA service development and delivery.
- DVA training provided to other local professionals by both WAFE and SL aimed to improve the wider response to DVA and to strengthen referral pathways. The training was judged to have achieved impact by both stakeholders and staff (see also Chapter 5 for the findings on the impact of Trusted Professional training) with WAFE senior managers highlighting the engagement of DWP staff in Surrey in Trusted Professional and SLCDP senior managers flagging the training and collaboration achieved with Children's Social Care.
- However, not all relevant organisations were reached by this training. Health organisations, in particular, proved difficult to engage and the Social Network Analysis undertaken found that none of the Roadmap organisations interacted with any health-related organisation on a regular basis. This picture is consistent with existing evidence on collaboration between the health and specialist DVA sectors.
- Social Network Analysis found no systematic differences between the networks of the five Roadmap organisations participating in this element of the Evaluation. Instead, practitioners' relationships with different sectors reflected the pre-existing networks of managers and key workers and the commissioning arrangements for organisations.
- While more stakeholders considered that DVA services were accessible for children and young people in 2020, remaining gaps were identified for survivors with complex/multiple needs, Black and minoritised survivors and LGBTQ+ survivors.
- Stakeholders and senior managers flagged early evidence of shifts in language and increasing acceptance of the concepts underpinning Roadmap services across the five sites but, for WAFE designed services, progress in moving away from a focus on risk was considered incremental. Likewise, in SLCDP sites, readiness to engage perpetrators in change was judged slow to develop among other professionals and services.
- Covid-19 restrictions had little impact on multi-agency work and in some instances multi-agency collaboration improved as a consequence of remote working. However, the withdrawal of face-to-face DVA services was considered by staff and stakeholders to have had a detrimental impact on survivors.
- The collaboration between WAFE and SL on developing the Roadmap required substantial effort and resources but provided a positive experience of working together which led to a number of joint initiatives, including a co-ordinated approach to campaigning. However, the benefits of this partnership appeared to have been confined to the national organisations with little evidence of it flowing down to managers and practitioners at the local level in the five Roadmap sites.

Chapter 10: Social Return on Investment

This chapter employs Social Return on Investment (SROI) methodology to consider the economic impact of the Roadmap Programme from the perspective of a range of stakeholders. It draws on data captured by the Evaluation for the WAFE and SLCDP interventions. SROI findings identify positive outcomes from the interventions and demonstrate the social value of investing in DVA services.

The SROI approach was successfully used in relation to DVA and other specialist services for women in a ground-breaking study undertaken by the Women's Resource Centre and the New Economics Foundation (NEF) in 2011 (Women's Resource Centre, 2011). This research was the first of its kind in considering multiple organisations offering specialist services for women, and it found a social return of between £5 and £11 for every £1 spent on specialist domestic violence provision and other specialist women's services. This was a London-based study with a strong emphasis on the use of volunteers and on addressing the needs of Black and minoritised women. It demonstrated the impact of women's community organisations and recommended that commissioners and policy makers needed to recognise the value of the women's voluntary sector and understand that supporting women supports families and wider society. Today, in 2021, following a decade of austerity with the effects of the Covid-19 pandemic becoming apparent, it is important that women's organisations are able to demonstrate and communicate the economic, social and environmental value that they generate.

To generate the SROI values, we used the Impact Map method as recommended by the Cabinet in 2009, updated in 2012 in collaboration with NEF and the SROI Network (Cabinet Office, 2012). The Impact Map is an excel spreadsheet-based exercise in which all of the data collected for the SROI is analysed to generate the SROI figures. All of our proxy values were obtained from the HACT Social Value Bank (HACT, 2014; Trotter et al, 2014) and the values were inflated to 2019/20 using the Bank of England Inflation Calculator. The HACT Social Value Bank is a collection of robust values for use in the calculation and analysis of SROI compiled from methodologically sound studies of social value.

10.1 Stakeholders

In order to explore the value of the Roadmap services, we identified the stakeholders who benefit from the services as a whole. In SROI terms, stakeholders are defined as the people or organisations who experience positive or negative change attributable to the activity, programme or intervention being evaluated (Cabinet Office, 2012).

For the purpose of this SROI, we considered the change for:

- Survivors and their children – because they are the direct recipients of this programme.
- Practitioners in other frontline organisations, including DVA specialist services because changes in the way DVA services are delivered will have a direct effect on their services and their referral and signposting routes to WAFE and SLCDP services. Further, training courses delivered via the Roadmap programme will enhance their existing skills.
- Any volunteers or other professionals engaged in the programmes.
- Partner organisations and commissioners of services.
- The state – including the police, social services and other government organisations.
- The wider community – because raising awareness of domestic violence services will aid community members to signpost others to relevant DVA services, and reduce the stigma attached to living with DVA.

- Women's Aid and SafeLives – because they manage the finances and funded and implemented the programmes.

10.2 Inputs

Inputs from stakeholders are not always expressed in pounds and pence, and we detail stakeholder input to the programmes and the Evaluation.

Below are examples of inputs that we do not assign a monetary value to, but without which the programmes would not exist in this setting:

- Survivors and their children – contributed their time to the development of the programmes and participated in the interventions;
- Other professionals in the Roadmap sites – gave time to attending Stakeholder Consultation meetings and completing surveys; contributed time to advising service development; making referrals to and liaising with the Roadmap services;
- The wider community – volunteering for Ask Me training in their own time.

All monetary costs will be attributed for this analysis to WAFE and SL. This will avoid double counting by breaking down charitable funding and donations, as both organisations are responsible for their own budgets. WAFE and SL have provided the calculated running costs of the programmes for the duration of this research project (2017-21).

10.3 SROI Methodology

We identified potential outcomes for the stakeholders by exploring existing evidence and the full range of both quantitative and qualitative data collected across both programmes and as part of the wider system change evaluation.

Outcome measures relevant to economic analysis and SROI analysis (see Chapter 2 and Appendix 2) were completed by both SLCDP and VOICES service users. 'Financial proxies' were used to put a potential value on the outcomes we identified. Financial proxies are used in this type of analysis to put a value on outcomes that are intangible.

We were careful to estimate any other factors which may have influenced the programme outcomes, and use the terms 'attribution', 'deadweight', 'displacement' and 'drop off' to adjust our financial proxies accordingly. Sensitivity analysis allows us to test different scenarios in the research. Changing the elements of deadweight, displacement, attribution and drop-off in the Impact Map excel spreadsheets affects the SROI ratio, and it allows us to assess which of the assumptions we have made have the biggest effect on the final figures. By performing this analysis, we generate a range of three possible return rates per pound invested and report the 'base-case' – our mid-range finding.

10.4 WAFE Trusted Professional

For this element of the programme, we considered the impact of the training for professionals participating in the programme. Primarily, the professionals taking part came from Early Help Services, Children's Social Care, the Department of Work and Pensions (Surrey) and Housing Associations.

Over the course of the Trusted Professional intervention, 404 frontline practitioners took part in the training. The Evaluation found the following positive short-term outcomes:

- Positive change in awareness about DVA
- Better understanding of DVA, especially coercive control
- Managers reported improvements in frontline workers' ability to recognise DVA and to engage individuals in discussion about their DVA experiences.

Using values from the HACT database with regards to work-related training, we found that the Trusted Professional intervention has generated a range of social return on investment value of between £3.18 and £8.30, with a base-case scenario or mid-range figure of **£5.31:£1**.

Figure 10.1 Social Value Created: Trusted Professional

The nil cost of this free training package and the benefits to the participants should also be considered as a considerable cost saving to the organisations participating in the Trusted Professional training. Whilst the benefits of this programme will improve the signposting of women to appropriate services, the employees are the main social value beneficiaries of this intervention at a cost saving to their employers.

The social value created by the Trusted Professional intervention is based on the fact that WAFE (drawing on their Big Lottery grant) funded the development and delivery of the programme. The social value may change if this programme is rolled out nationally with organisations paying for the programme, but it would not necessarily change dramatically as the funding by Women's Aid would be replaced by funding per organisation.

10.5 WAFE Ask Me

Volunteers and people who have experienced or who are experiencing DVA were identified as those experiencing change in the Ask Me intervention.

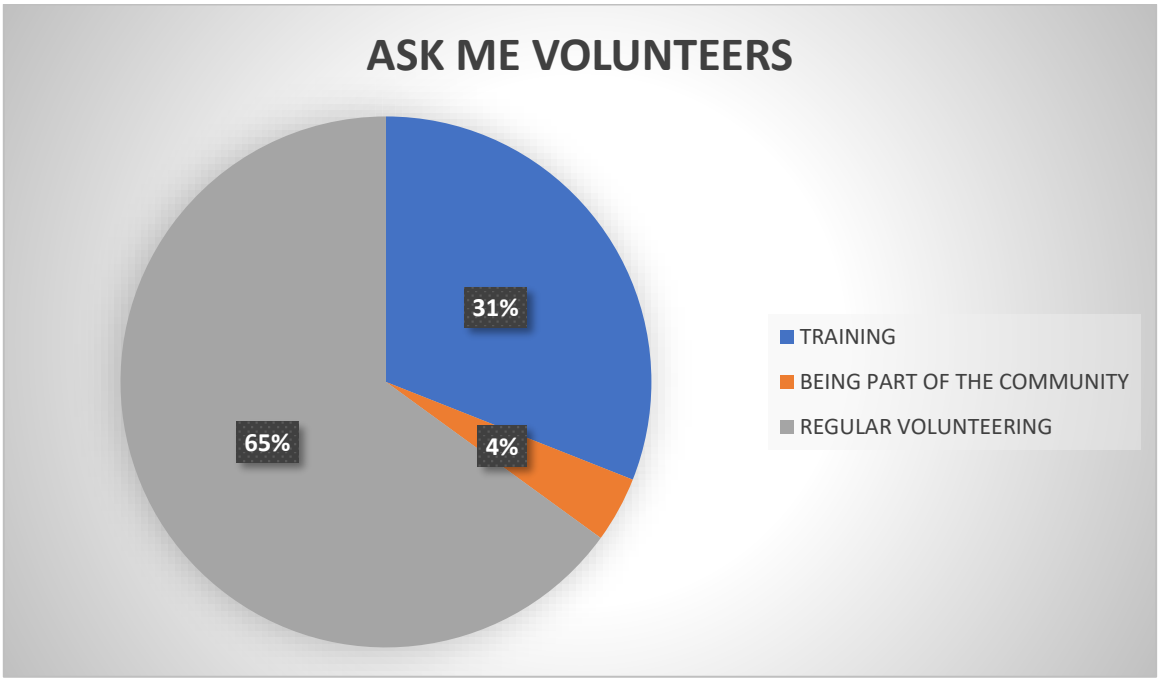
326 pre/post training questionnaires were completed by the Ask Me Ambassadors (AMA) and we identified the following positive outcomes:

- Ambassadors/volunteers received training in new skills and knowledge to use in their communities and workplaces
- 247 volunteers indicated improved knowledge of DVA
- Volunteers reported increased confidence in signposting to services
- 170 reported conversations with people currently experiencing DVA
- 72 Ambassadors/volunteers reported signposting people experiencing DVA to appropriate services
- 20 Ambassadors/volunteers reported raising awareness of DVA in their communities

Using values from the HACT database concerning volunteering and training, we found that the Ask Me programme generated a range of social return on investment of value of between £2.64 and £8.96, with a base-case scenario or mid-range figure of **£5.13:£1.**

Figure 10.2 shows the breakdown of the elements we used to generate the Ask Me SROI figure. The Ambassadors/volunteers were the stakeholders for whom the most social value is created through training, being a part of the community and regular volunteering. Although people experiencing DVA will undoubtedly benefit by being signposted to appropriate services, the Ambassadors/volunteers gain skills which generate *wider* social value in this intervention.

Figure 10.2 Elements of Social Value: Ask Me Volunteers



The unit cost of DVA in the UK is £34,015 per person according to the Home Office in 2017 (Oliver et al, 2017). This figure includes costs to the individual in terms of physical and emotional harm, loss of economic output (absence from work), the cost to health and victim services, and cost to the police and criminal and legal service. There were 170 conversations with people who were living with DVA at the time of the conversation, suggesting a potential economic and social cost for those people alone of £5.7m. The Ask Me Ambassadors reported signposting 72 people to appropriate services following conversations about DVA , and using the same economic and social cost of DVA could result in a potential saving of £2.4m if all 72 people made use of those services to escape DVA.

Figure 10.3 Social Value Created: Ask Me

10.6 WAFE VOICES

Staff members, partner organisations and people experiencing DVA were identified as those experiencing change in the WAFE Voices intervention.

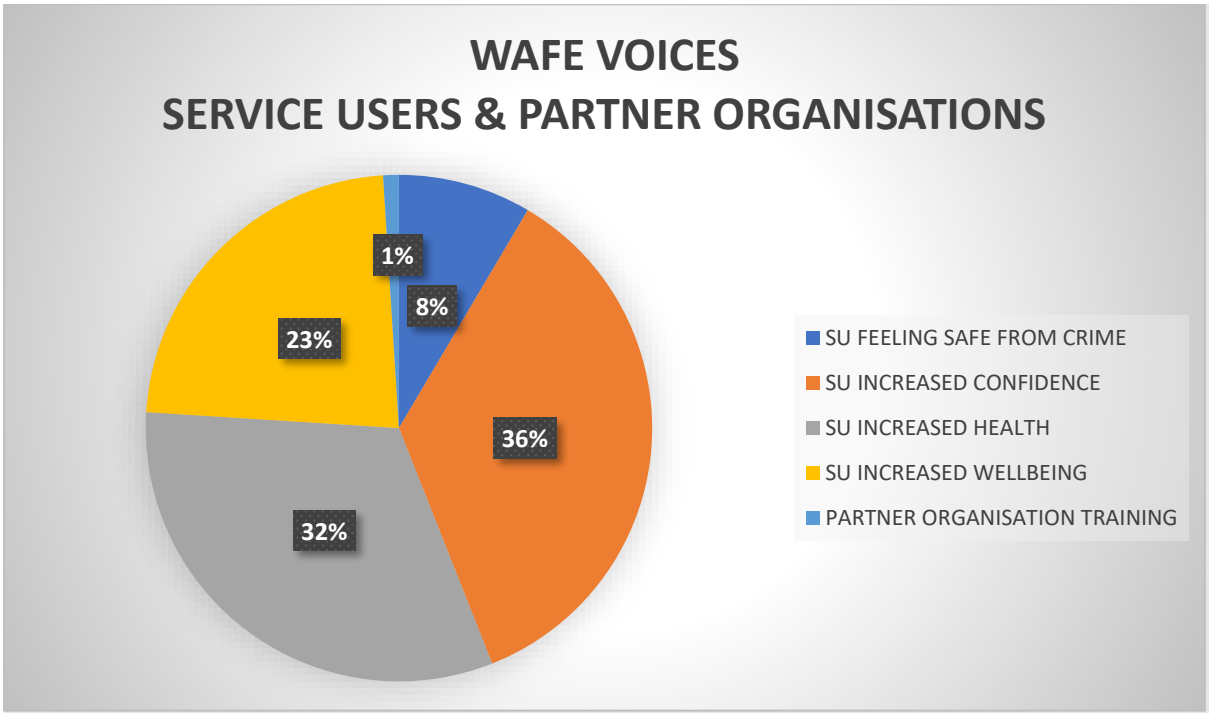
- 109 service users/survivors completed outcome measure questionnaires
- 57% of respondents attributed positive change in their mental wellbeing to the interventions
- 46% of respondents attributed positive change in their health to the interventions
- 15% of respondents reported feeling safer in their home
- 56% of respondents reported improved confidence
- 6 senior managers took part in face to face interviews

Using values from the HACT database concerning health improvement, wellbeing improvement, feeling less fear of crime, the value of feeling confident, and the value of work related training for improved job skills (for staff), we found that the VOICES intervention generated a range of social return on investment of value of between £4.51 and £7.37 with a base-case scenario or mid-range figure of **£5.50:£1**

Figure 10.4 shows the breakdown of the elements we used to generate the WAFE VOICES SROI figure. Service users or survivors were those benefiting from the greatest generated social value in this instance in the areas of improved health, wellbeing and confidence.

The VOICES intervention provided training for staff in affiliated WA partner organisations which is beneficial to those organisations in terms of developing their staff members' skills and beneficial to the staff in terms of learning new skills and their personal development.

Figure 10.4 Elements of Social Value: WAFE VOICES



Analysis of the data collected for the evaluation of VOICES showed that the average length of time the service user had experienced abuse prior to accessing help through the VOICES programme was 7 years. We received 109 completed outcome questionnaires for the VOICES intervention, and using the Home Office unit cost of DVA in the UK of £34,015 per person (Oliver et al, 2017), the potential cost of DVA in these 109 cases would be £3.7m, but many of these survivors experienced DVA over 7 years so this could be considered a conservative estimate. The data collected for the VOICES intervention demonstrates that it has the potential to contribute not only to the safety of survivors, but also to the cross-sector costs calculated for the Home Office report.

Figure 10.5 Social Value Created: WAFE VOICES

10.7 SafeLives Co-Designed Pilots

We identified survivors and their children as those experiencing positive change whilst involved in the SLCDPs, and volunteers who helped to develop and deliver those services:

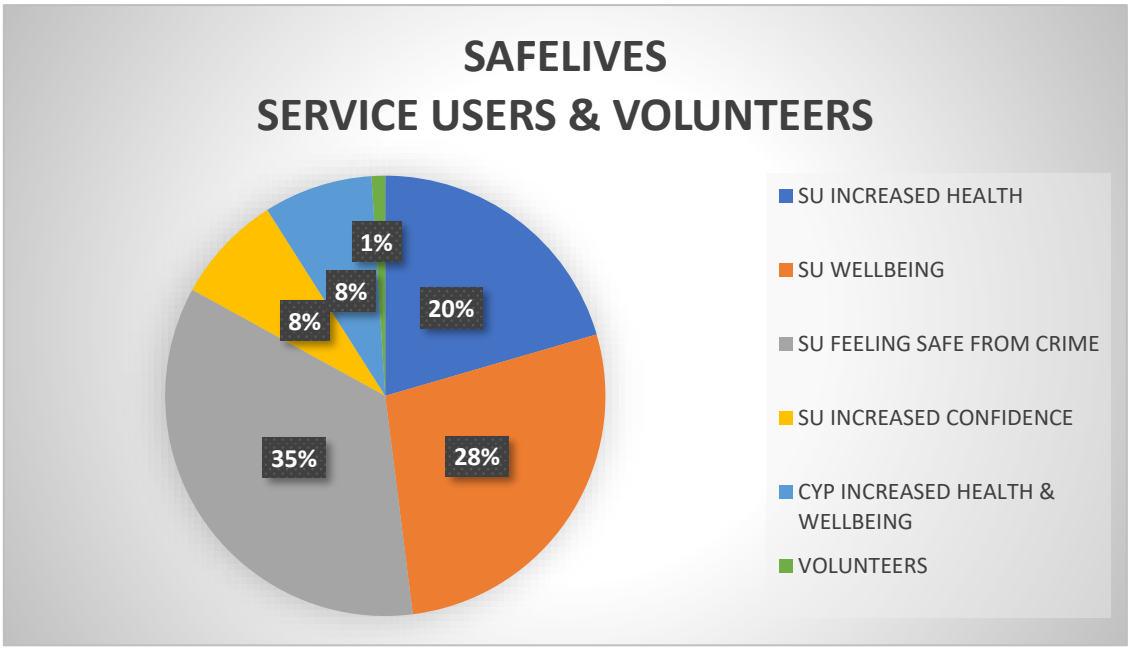
- 362[38] service users were direct recipients of interventions
- 270[39] children and young people used the dedicated services
- A total of 445 volunteer hours were recorded over two years
- Of 67 survivors who completed outcome measures, 62 (93%) attributed positive change in their mental wellbeing to the interventions
- Of 56 survivors completing outcome measures, 37 (66%) attributed positive change in their health to the interventions
- 75% of all survivors completing outcome measures reported feeling safer in their home
- 77% of all survivors completing outcome measures reported improved confidence

Using values from the HACT database concerning health improvement, wellbeing improvement, feeling less fear of crime and the value of volunteering, we found that the SLCDPs generated a range of social return on investment of value of between £4.18 and £6.75 with a base-case scenario or mid-range figure of **£5.36:£1.**

Other potential beneficiaries of the SLCDPs might include children who did not receive a service for themselves but who were living in families where their parents and parenting benefited from the service, or perpetrators who are not included as beneficiaries in this evaluation which focused on women and girls.

Figure 10.6 shows the breakdown of the elements we used to generate the SLCDP SROI figure. Service users (SU) were the stakeholders benefitting from the greatest generated social value with increased improvements in health, wellbeing and feeling safe from crime. Their children (CYP) benefit in terms of improved health and wellbeing, and a small proportion of the social value benefits volunteers in this instance.

Figure 10.6 Elements of Social Value: SafeLives Co-Designed Pilots



[38] In order to evaluate the service effectively we have used the data collected on closed cases to provide a complete picture

[39] As CYP access the services at different time points, often subsequent to survivors' use of services, we have used all data for CYP using the SLCDPs, including open cases.

Ninety-seven percent of the service users had experienced DVA in the last year, and 56% had experienced DVA over two years. Using the unit cost of DVA in the UK of £34,015 per person (Home Office, 2017), the potential cost of DVA in these cases could be as much as £11.7m. The data collected for the SafeLives interventions demonstrates that they have to potential to contribute not only to the safety of survivors, but also to the cross-sector costs calculated for the Home Office report.

Figure 10.7 Social Value Created: SafeLives Co-Designed Pilots

10.6 Summary

- Across all of the Roadmap interventions, we found generated social value across a range of £2.64 - £8.96, with a base case or mid-range value of between £5.13 and £5.50 for every £1 invested. This compares favourably with other evaluations of services in the UK, such as:
    - The Social Impact Report on Ascent Advice & Counselling (Solace, 2015) which provides services for women and girls affected by violence and abuse found an SROI of £5.99:£1.
    - The Refuge SROI Evaluation (Selsick & Atkinson, 2016) which found an SROI of £4.94:£1 in relation to their refuge housing, community outreach services, independent domestic violence advocacy services, and sexual violence services
    - The SROI Evaluation of the Women and Girls Network (Women's Resource Centre, 2011) which provided specialist counselling for survivors of gendered violence found an SROI of £5:1.

- The individual interventions produced the following social value:
    - WAFE Trusted Professional £5.31:£1
    - WAFE Ask Me £5.13:£1
    - WAFE VOICES £5.50:£1
    - SafeLives Co-Designed Pilots: £5.36:£1

- Volunteering has substantial benefits for the organisations and for volunteers (many of whom are themselves survivors) – in the case of the Roadmap programme, the community, organisations, volunteers and DVA survivors all benefit from the time taken to train volunteers and the time those volunteers 'donate'.

- The collection of health and wellbeing data was a valuable tool for this evaluation and allowed us to use proxy costs to demonstrate the value of improving these outcomes from baseline across the duration of the interventions

- This SROI analysis has demonstrated that the benefits of the Roadmap programme extended beyond those for the survivors alone. We have identified social value and cost-savings for a wide range of stakeholders including survivors; their children; volunteers; Women's Aid and their staff; SafeLives Co-Designed Pilots and their staff; children's services; social care services; state agencies such as the police, criminal justice system and health services.

Chapter 11: Conclusion and Key Messages

This chapter begins with separate accounts of the conclusions from the evaluations of the two organisations' interventions and then proceeds to report conclusions in relation to whole system change across the Roadmap Programme. We then draw out practice, commissioning and policy messages aimed at all those developing and delivering innovative DVA interventions.

11.1 Conclusions from the Evaluation of Women's Aid Interventions

The implementation of all three WAFE interventions was assisted by strong local partnerships and links that were in part provided by local WA organisations affiliated to WAFE, but also by co-ordinators engaging with relevant local networks. Ask Me and Trusted Professional had both been piloted previously and programme content was well-developed when the Roadmap Programme was introduced. The VOICES intervention was planned and developed in collaboration with survivors during the course of the Roadmap and the time devoted to development, together with the impact of Covid-19 in 2020, restricted the implementation period and the data available for this evaluation.

WAFE staff generally agreed that the resource provided via the co-ordinator roles was insufficient to deliver and oversee three different interventions in three different sites and delivery of all elements of the CtL programme was affected by staff turnover and the impact of the pandemic. Both Ask Me and Trusted Professional reached diverse audiences but it was notable that Trusted Professional training attracted small numbers of health professionals.

The content and format of both Ask Me and Trusted Professional were refined in the course of the Roadmap using feedback from the Evaluation and this has resulted in interventions that are more comprehensive in their engagement with their target groups and which acknowledge diversity among DVA survivors.

Both Ask Me and Trusted Professional were successful in achieving immediate improvements in understanding and confidence to ask about DVA in relation to their target audiences of community volunteers and frontline professionals from non-specialist organisations. Both volunteers and professionals showed significant gains on a number of dimensions, but notably in relation to their understanding of coercive control and the need for solutions and responses to be survivor-led. Follow-up data collected from participants in both programmes indicated longer-term benefits. These included Ask Me Ambassadors facilitating discussions and disclosures of DVA and signposting survivors to relevant services as well as engaging in DVA awareness activities in their communities. Recipients of Trusted Professional training described themselves as more prepared to ask questions about DVA that they had previously found difficult and there were early indications that their organisations were giving them opportunities and support to spend time listening and provide appropriate support themselves rather than simply signposting survivors elsewhere.

Recommendations for both these interventions focused on the follow-up support needed to sustain DVA knowledge and activity among those who are not encountering or working with DVA on a regular basis. Future plans for both these interventions should include built-in mechanisms for the provision of follow-up support and advice. Monitoring systems should be reviewed and refined to ensure that the long-term benefits of these interventions can be easily captured.

VOICES was delivered directly to survivors by existing WA member organisations and some difficulties were encountered in respect of practitioners' initial resistance to new ways of working,

the demand for additional paperwork, and the amount and timing of staff training offered. However, once implemented, practitioners valued the VOICES tools, especially the Tree of Strength, and appreciated the shift to a more survivor-centred approach. Analysis of POWeR forms and the Evaluation's outcome measures demonstrated positive improvements on most items for survivors, but very few of these were statistically significant. For those that reported improvements in safety, coping and mental wellbeing, most of this was attributed to services indicating a high level of satisfaction with services. Findings in respect of health outcomes were significantly lower than the accepted UK population norms, indicating that service users across all time points experienced worse health than that of the general population.

Survivors interviewed described a consistent relationship with their practitioner as building their self-confidence, independence, and belief in themselves. Whilst the terminology of 'Space for Action' was unfamiliar to survivors, the case studies illustrate the multiple domains for action and intervention that practitioners utilised in their casework.

All three WAFE interventions were found to generate substantial SROI value, comparable to those produced by other DVA interventions. The involvement of volunteers (many of whom were survivors) in programme development and in Ask Me contributed to benefits for themselves and for a wide range of stakeholders.

11.2 Conclusions from the Evaluation of SafeLives Co-Designed Pilots

The planning and development of the SLCDP services drew on the expertise of both survivors and key partners however, more planning time and activity at the local level might have ensured a better fit in the local service landscapes and perhaps better integration of the different programme components. Delivering multiple interventions in an integrated framework was challenging and ambitious, especially in the two years' timeframe available, but staff considered that the range of complimentary interventions and toolkits utilised produced a service that could be tailored to meet individual need. Survivors confirmed this picture in their accounts of moving from one intervention to the next according to readiness and need, but waiting lists, especially for children, meant that services were not always readily available when needed. While staff described some lack of clarity around the roles and integration of the different interventions that made up the SLCDP services, integration of programme strands was assisted by training and supervision, good communication in the staff teams and strong leadership.

Although referral pathways were well-developed in respect of some organisations, especially Children's Social Care and specialist DVA/SV organisations, multi-agency communication and training was less well established with those organisations more likely to identify and refer survivors with complex/multiple needs, such as primary care and mental health services.

The SLCDP services offered a series of graduated interventions for individual survivors in their own right which survivors progressed through on the journey to recovery as well as a service that addressed survivors in the family context, delivering support for them as parents and for their children. Insights data provided by SL indicated that the largest group of service users was those who accessed services in their own right rather than in the context of family. It may have been that the allocation of staff roles and responsibilities within the two SLCDPs failed to take account of the complexity and demands of family work which could involve multiple children within one family and intensive work on cases involving Children's Social Care; some survivors were concerned that their children had been unable to access the service. The services also experienced staff shortages which

affected delivery of some of the planned work, especially work with perpetrators where numbers accessing the services were lower than anticipated, and staffing shortfalls resulted in waiting lists. The SLCDP services targeted a very broad group of survivors and needs, rebalancing resources to increase the capacity of family-focused interventions might enable more survivors and families to access a 'whole family' service when needed.

Both qualitative and quantitative data collected on outcomes showed positive, and in some cases, statistically significant, improvements in safety, coping and confidence and mental wellbeing. Less change was evident in respect of survivors' physical health. The majority of survivors considered that such changes were entirely or mostly due to the SLCDP service. Most felt they had improved safety, greater awareness of DVA, and a better understanding of healthy relationships and the warning signs of perpetrator behaviour. They valued the relationships developed with individual SLCDP workers who they experienced as authentic and listening and groupwork was also considered very beneficial. Survivors reported that work moved at a pace that suited them. Mothers reported more confident parenting, improved understanding of the impact of DVA for their children and enhanced family communication and relationships, although some still had concerns about child contact. The Family Case Studies demonstrated that children experienced improvements in mood, sleep, physical health and reductions in fear and anger. There were examples of them successfully navigating key transitions in their lives. Most survivors interviewed were optimistic about the future for them and their children and some looked forward to being actively involved in SLCDP service delivery as peer mentors.

SROI analysis found that the SLCDP interventions produced substantial social value, comparable to that produced by other DVA interventions. The involvement of survivors in programme development and as peer mentors contributed to benefits for themselves and for a wide range of stakeholders.

11.3 Conclusions from Evaluation of Whole System Change

The provision of free training to other professionals and organisations played a part in building referral pathways into the new services and in raising knowledge and understanding of DVA in key organisations making frontline contact with DVA survivors and their families. The Trusted Professional training was particularly successful in increasing participants' understanding of coercive control. While there was considerable success in engaging organisations such as housing associations, child and family services and DWP, not all relevant organisations were reached by this training and health services such as mental health services and substance misuse services, both services likely to refer survivors with complex/multiple needs, were under-represented among those organisations that received either Trusted Professional or SLCDP training. In line with this, health organisations were notably peripheral in the networks of all WA and SLCDP organisations. Health professionals often look to their own organisational provision when accessing training but, given the impact of DVA on health and the opportunities available to frontline NHS workers to detect and respond to DVA (Howarth et al, 2009; SafeLives 2016; NICE, 2014), extending the provision of DVA training to this sector could have substantial benefits, especially for DVA survivors with complex/multiple needs.

There was early evidence that the Roadmap had succeeded in shifting the language and understandings of DVA in some of the sites but some key barriers to the widespread transformation of DVA services remained. For WAFE, this was conceptualised as a sustained prioritisation of risk; for

the SLCDPs, other professionals' and organisations' lack of readiness to engage with behaviour change for perpetrators was a key barrier.

Categorising DVA services by levels of risk was identified by staff, survivors and stakeholders as confusing for both those using services and those referring to them. This practice contributed to survivors being turned away from services with the result that both survivors and other professionals lost confidence in the capacity of DVA services to provide a timely response.

Increased public awareness of DVA and its impact was attributed to public messaging and media coverage of the impact of Covid-19. Ask Me provides a valuable example of an intervention designed to raise awareness of DVA across communities. Its reach could be extended further and it is unclear whether the programme will be sustained as responsibility for funding the programme shifts to local commissioners and WA member organisations. Public health might have a role in commissioning this intervention in future and evaluation of the longer-term benefits of Ask Me might be a means of accessing public health engagement with the intervention.

11.4 Wider Messages for Innovative Interventions in DVA

11.4.1 Messages re Implementation of Innovative Interventions

- The time required to develop, implement and evaluate new services should not be under-estimated. The service design phase is likely to be lengthy when organisations seek to involve survivors and a range of relevant stakeholders in the development of services. There can be long-term benefits in engaging local stakeholders who bring expert knowledge of the local context and conditions to this process.
- Commissioning arrangements may have long-term effects on referral pathways with competitive tendering processes proving particularly negative. These arrangements require careful thought and consortium or other approaches may offer useful alternative models for commissioning DVA services (Barter et al 2018). Follow-up work to rebuild partnerships may be needed following competitive tendering.
- Understanding of the local context where new services are to be introduced is essential and this includes gathering and using knowledge of the skills available in the local workforce, and local wage levels to inform recruitment strategies so that staff turnover is reduced.
- New approaches requiring change to existing models of service provision may encounter resistance and the staff involved in delivering change are likely to require extensive training and on-going support through supervision and consultation.

11.4.2 Increasing Routes to DVA Support

- DVA services need to have clearly defined user groups that can be easily identified both by other services that refer and signpost survivors to DVA services, but also by survivors themselves. Targeting services on survivors with specified levels of risk is not always helpful in this respect as risk varies over time, may have differing impacts for survivors and children (Stanley et al., 2011) and is assessed differently across regions and organisations (Almond et al., 2017). It can be underestimated by survivors and may impact on their views of eligibility for a particular service. It is an approach that can result in survivors being turned away from services. DVA services should identify their target groups using descriptors that are easily understood and

communicated, such as geographical catchment areas, survivors with children, survivors recovering from DVA, survivors currently living with DVA or survivors requiring emergency accommodation/refuge.

- Survivors value a flexible service that recognises that needs change over time, that acknowledges that both groupwork and individual work can be beneficial, that many survivors need help with parenting as well as support in their own right and that works with children and their parents as well as providing advocacy. However, an integrated service with many constituent interventions is challenging to sustain in terms of management and staffing and requires substantial resource and a clear remit that can be easily communicated to survivors and referring organisations.

11.4.3 Key Features of Responsive DVA Services

- Both Roadmap interventions demonstrated the value of survivor-centred services. Survivors receiving both WAFE and SLCDP interventions highlighted the importance of feeling that they could exert choice over the pace and type of interventions they received and they reported increased confidence and self-esteem as well as improvements in mental wellbeing.
- Survivors benefited from staff's availability, consistency and good communication skills and these were enhanced by the use of toolkits and visual images such as Helping Hands and the Tree of Strength.
- Both services aimed to be trauma-informed and staff found the language and concepts of trauma helpful for their work. There were fewer examples of survivors engaging with the concept of trauma and care should be taken in explaining it to survivors. However, survivors did talk about gaining insight into the harm they had experienced and its effects on them.
- Groupwork succeeded in in reducing feelings of isolation and stigma for both adults and children, especially when an active element such as craft work was incorporated.
- Advocacy was a key element of the support offered by both organisations: this involved support with court cases, with contact negotiations and with Children's Social Care.
- The Roadmap services delivered under Covid-19 showed that it is feasible to deliver DVA services remotely to both survivors and perpetrators but this is possibly easier where worker and service user have already established a face-to-face relationship. Particular difficulties emerged in delivering remote services to children, although in some instances, older children felt less pressured by support sessions delivered online. Whilst many will welcome the return to face-to-face support, services should consider developing their online responses to ensure these are available for those who prefer to access services this way or who are unable to access face-to-face services. Online delivery is likely to be particularly useful for those with caring responsibilities or living in geographically dispersed areas.

11.4.4. Responding to Diversity

- Understanding of both diverse forms of DVA and the needs of diverse groups experiencing DVA was considered important by practitioners participating in DVA training.
- The evaluation captured limited information on work with Black and minoritised survivors as, with the exception of the City of Nottingham where VOICES was not fully implemented, none of the Roadmap sites had substantial Black and minoritised populations and numbers of Black and minoritised participants were low in all samples. For the future, it is important that the relevance of Roadmap interventions for Black and minoritised survivors and their families is studied.

- Survivors with complex or multiple needs made up a sizeable proportion of those using both VOICES and the SLCDPs. This reflects stakeholders' view that austerity policies had increased demands on DVA services. Moreover, survivors came to both VOICES and SLCDP services with generally low levels of health and, for SLCDP service users, low mental health. For work with all survivors, especially those with complex/multiple needs, to be effective, DVA services need good channels of communication and collaboration with mental health services, substance misuse services and other services in the health sector. This was a field where DVA organisations' networks and communication were found to be less well developed and the DVA and health sectors should explore means of strengthening these links. Some examples of joint initiatives between the DVA and health sectors already exist, such as the IRIS programme (Feder et al., 2011), the Promoting Recovery in Mental Health (PRIMH) intervention (Oram et al., 2016) and the location of Idvas in NHS settings (Dheensa et al., 2020). These initiatives offer indications of how communication and co-ordination might be strengthened in future. Strengthening collaboration with the DVA sector is also a goal for health services as advocated by the NICE (2014) Guideline on domestic violence and abuse for health and social care and this guideline could usefully be updated and reinforced.

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Appendix 1: Site Profiles

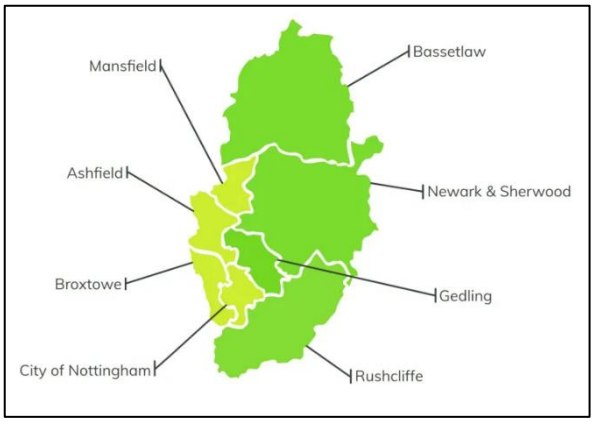
City of Nottingham and Nottinghamshire Site Profile 2020

City of Nottingham is a unitary authority that is surrounded by the Nottinghamshire County council area in the East Midlands. Nottingham covers an area total of 74.61 km2 and Nottinghamshire covers a total area of 2,085km^2

The Nottinghamshire Police force serves both the county and city areas. Nottingham is also the home of two universities, University of Nottingham and Nottingham Trent University.

This site profile reports on data collected for both the City of Nottingham and Nottinghamshire county areas separately, with police data being reported at the Nottinghamshire Constabulary level.

The City of Nottingham and Nottinghamshire site is one of three national Women's Aid Change That Lasts (CTL) pilot sites.



Location of Nottingham in the UK and the location of City of Nottingham within the county.

Population of City of Nottingham and Nottinghamshire

Gender

Nottinghamshire has a population of 828,224, with the City of Nottingham accounting for 40% of this population (n=332,900). At a county level, 51% of the population is female (n=420,214) and 49% of the population is male (n=408,010). For the City of Nottingham, 51% of the population is male (n=169,010), whilst 49% of the population is female (n=163,890) (ONS, 2020a).

Ethnicity

According to the 2011 Census, most people living in Nottinghamshire and the City of Nottingham were White, born in the UK, with English being their first language (see Tables 1 and 2).

Of the two areas, the City of Nottingham had a higher proportion of people from a Black and minoritised background (34.6%), compared to Nottinghamshire (7.4%). At a national level, 14% of the population were from a Black and minoritised background.

Table 1: Percentage Overview of the City of Nottingham, Nottinghamshire and England and Wales by Ethnicity (ONS, 2012a)

Ethnicity	City of Nottingham	Nottinghamshire	England and Wales
White (all groups)	71.5%	95.5%	85.9%
Asian/Asian British	13.1%	2.2%	7.5%
Black/African	7.3%	1%	3.4%
Mixed	6.7%	1.2%	2.2%
Other	1.5%	0.3%	1%

Table 2: Place of Birth and First Language of People Living in the City of Nottingham, Nottinghamshire and England and Wales (ONS, 2012b)

	City of Nottingham	Nottinghamshire	England and Wales
Place of Birth			
UK	80.5%	93.6%	86.6%
Outside of UK	19.5%	6.4%	13.4%
First Language			
English	85.6%	96.8%	90.9%
Not English	14.4%	3.2%	9.1%

Religion

A higher proportion of people in Nottinghamshire identified themselves as Christian in the 2011 Census (61.3%), compared to the City of Nottingham (44.2%) and nationally (59.3%) (Table 3).

Table 3: Comparison of Religion in the City of Nottingham, Nottinghamshire and England and Wales (ONS Census, 2012c)

Area	Religion						
	Christian	None	Muslim	Sikh	Hindu	Buddhist	Jewish
City of Nottingham	44.2%	35%	8.8%	1.4%	1.5%	0.7%	0.3%
Nottinghamshire	61.3%	29.3%	0.9%	0.4%	0.4%	0.2%	0.1%
England & Wales	59.3%	25.1%	4.8%	0%	0%	0.4%	0.5%

Age

In 2019, the average age of people in the City of Nottingham was 29.7 years old (ONS, 2020b), with this increasing to 43.8 years for people living in Nottinghamshire (ONS, 2020c). Across England, the mean age was 40.3 years old (ONS, 2020b).

For the City of Nottingham (ONS, 2020b):

- People aged 15 or under account for 18.8% of the population.
- Working aged people (16 to 64) amount to 69.6% of the population.
- Over tenth of the population are aged 65 to 84 (11.6%).
- Those aged 85 and older represent 1.7% of the population.

In Nottinghamshire (Nottinghamshire Insight, 2020):

- Children aged 0 to 17 represented 20% of the population.
- The working population (18 to 64) accounted for 59% of the population.
- Over a fifth of the population was aged 65 to 84 (21%).
- People aged 85 or older accounted for 3% of the population.

Population trends by age groups for both areas are reflective of national trends.

Marital Status

Data from the 2011 Census showed that over half of the population living in the City of Nottingham were single (51.3%), with this being higher than the general English population (34.6%). Conversely, in Nottinghamshire, 50.2% of the population were married, with this also being slightly higher than national figures (46.6%) (Table 4).

Table 4: Marital Status of Norwich and England in 2011 (ONS Census, 2012e)

Marital Status	City of Nottingham	Nottinghamshire	England
Single	51.3%	29.9%	34.6%
Married	31.6%	50.2%	46.6%
Divorced	9%	9.6%	9%
Widowed	7%	7.5%	6.9%
Separated	2.7%	2.5%	2.7%
Same-sex civil partnership	0.2%	0.2%	0.2%

Poverty Indicators

Index of Multiple Deprivation (IMD)

In 2015, Nottingham scored 36.9 on the IMD, ranking 8th most deprived area of the 326 local authorities in the country. and it ranked 8th of 326 local authorities (where 1 is most deprived) in the country. A third of the lower super output areas[40] in the city were in the top 10% most deprived in England (Department for Communities and Local Government, 2015).

In Nottinghamshire, the overall IMD score was 18.9 and ranked the 98th out of 152 deprived upper-tier authority area. At a district level, Mansfield and Ashfield had higher levels of deprivation, positioning 56th and 79th respectively. The borough of Rushcliffe had very low levels of deprivation (Department for Communities and Local Government, 2015).

Child Poverty

In 2018, 38.2% of children aged 16 or younger in the City of Nottingham were living in low income families (Children and Young People's Scrutiny Committee, 2018), with this being double the national average of 18% (Department of Work and Pensions, 2020). Over a fifth of under 16s were living in out of work households (23.7%), with this also being twice the national average of 10.3% (NOMIS, 2020a). Free school meals were provided for 22.9% of children living in the City of Nottingham, much higher than the national average of 13.7% (Public Health England, 2020a).

Within England, 10.3% of children live in out of work households, with Nottinghamshire having a similar proportion of children living in out of work households (10.7%) (NOMIS, 2020a). A lower proportion of children living in Nottinghamshire received free school meals (9.1%), compared to the City of Nottingham (22.9%) and the national average of 13.7% (Public Health England, 2020a).

[40] Lower super output areas - smaller areas than wards and have an average population of 1,500.

Homelessness

Table 5 provides a comparison of homelessness in the City of Nottingham, Nottinghamshire and within England. Rates of homelessness in the City of Nottingham and Nottinghamshire are very similar, with rates of homelessness per 1,000 of the population and family homelessness being higher than rates across England (Public Health England, 2020b).

Table 5: Comparison of Homelessness in the City of Nottingham, Nottinghamshire and England 2018

Type of Homelessness	City of Nottingham	Nottinghamshire	England
Statutory Homelessness - not priority need	0.5%	0.3%	0.8%
Statutory Homelessness - households in temporary accommodation	1.7%	1.7%	3.4%
Statutory Homelessness per 1,000 households	4.1%	4.2%	2.4%
Homeless young people aged 16 to 24	0.9%	1.1%	0.5%
Family homelessness	3.2%	3.3%	1.7%

Housing and Tenure

The average house price in the City of Nottingham in January 2019 was £142,561, with this increasing to £176,028 for Nottinghamshire. House prices for both areas were lower than the national average of £244,567 (HM Land Registry, 2020).

The City of Nottingham had lower rates of owner-occupied housing (45.6%) and higher levels of socially rented households (29.8%), compared to Nottinghamshire (72.1% and 13.5%) and the UK (64.1% and 17.7%) (Table 6, ONS Census, 2012d).

Table 6: Home Ownership in Norwich and Nationally (ONS Census, 2012d)

Ownership Type	Location Comparison		
	City of Nottingham	Nottinghamshire	UK Average
Owner occupied	**45.6%**	**72.1%**	**64.1%**
Owned outright	19.9%	35.7%	30.6%
Owned: mortgage/loan	25.1%	35.9%	32.8%
Shared ownership	0.6%	0.5%	0.8%
Social rented households	**29.8%**	**13.5%**	**17.7%**
Council	20.8%	9.3%	9.4%
Housing Association or Social Landlord	9%	4.2%	8.3%

Private landlord or letting agency	23%	13.1%	15.4%

From the 2011 Census, 2.4% of households in the City of Nottingham and 1.4% of households in Nottinghamshire lacked central heating, with this being reflective of the national figure (2.7%) (ONS Census, 2012f).

Employment, Education and Qualifications

In 2019, 63.9% of people in the City of Nottingham and 78.6% of the population of Nottinghamshire were employed. Whilst Nottinghamshire reflected national levels of employment (76.8%), the City of Nottingham fell below this average (NOMIS, 2020b). Most people were employed by someone else (City of Nottingham, 56%; Nottinghamshire, 68.3%), with 7.9% of people in the City of Nottingham self-employed, compared to 10.1% in Nottinghamshire. Unemployment rate was 6.9% for the City of Nottingham and 3.6% for Nottinghamshire, whilst nationally 3.9% of the population were unemployed.

The average hourly pay during 2019 was £12.31 for the City of Nottingham and £13.78 for Nottinghamshire, with both areas being below the national average of £14.94 per hour (NOMIS, 2020c). By May 2020, 7.7% of the City of Nottingham population and 5.5% of people living in Nottingham were claiming out of work benefits. Nationally, 7.8% of the population were claiming out of work benefits (NOMIS, 2020d).

The level of qualifications held by people in City of Nottingham and Nottinghamshire are depicted in Table 7, with local trends reflecting national trends (NOMIS, 2020e).

Table 7: Qualification Levels of Norwich and the UK (NOMIS, 2020e)

Level of Qualification	City of Nottingham	Nottinghamshire	UK
NVQ4 +	31.8%	33.4%	40%
NVQ3 +	48.3%	55.7%	59%
NVQ2 +	68.1%	74.3%	76%
NVQ1 +	83.5%	85.9%	86%
Other Qualifications	5.8%	6.5%	7%
No Qualifications	10.6%	7.6%	8%

'Brexit' – Voting on Membership of the EU

In Nottingham, 50.8% of people voted to leave the EU, whilst 49.2% of people wanted to remain. At a national level, 48.1% of people voted to remain, with 51.9% of people opting to leave (The Electoral Commission, 2019).

Health, Wellbeing and Disabilities

Life Expectancy

Table 8 provides an overview of the average life expectancy of people from birth between 2016 and 2018, with life expectancy of people living in Nottinghamshire reflecting national averages (Public Health England, 2020c).

Table 8: Life Expectancy of Women and Men Living in the City of Nottingham, Nottinghamshire and England, in 2016 to 2018 (Public Health England, 2020c)

Location	Women	Men
City of Nottingham	81.3	77.2
Nottinghamshire	82.7	79.6
England	83.4	79.8

Health Statistics

For both the City of Nottingham and Nottinghamshire, more men per 100,000 population were admitted to hospital due to alcohol than women during 2018 to 2019 (Public Health England, 2020d). At a national level, rates of admission for alcohol was higher for both genders and areas (Table 9).

Table 9: Hospital Admissions due to Alcohol by Gender for the City of Nottingham, Nottinghamshire and England, 2018 to 2019, per 100,000 population

Gender	City of Nottingham	Nottinghamshire	England
Male	1,138	886	809
Female	644	536	473

Between 2016 to 2018, the suicide rate for 100,000 population of the City of Nottingham was 9.9, with Nottinghamshire having a lower rate of 7.6. Both areas were similar to or lower than the average rate for England (9.6 per 100,000 population) (Public Health England, 2020e).

Crime

Recorded Crime

In the year ending 2019, the overall crime rate per 1,000 people in Nottinghamshire was 94.3 (ONS, 2020d), with this being slightly higher than the crime rate in England (88 per 1,000 population) (Table 10).

Table 10: Police Recorded Crime (per 1000 population) in 2019 for Nottinghamshire and England (ONS, 2020c)

Type of Crime	Nottinghamshire	England	Difference
Total recorded crime (excluding fraud)	94.3	88	↑
Violence against the person	29.5	29.1	↑
Violence with injury	10.7	9.1	↑
Violence without injury	10.1	12	↓
Stalking and harassment	8.6	8	↑
Sexual offences	3	2.7	↑

Domestic Violence and Abuse

Table 11: Combined domestic abuse-related incidents and offences 2016/17 & 2019/2020

	2016 - 2017		2019 - 2020	
	Number	**Rate/1000**	**Number**	**Rate /1000**
Nottinghamshire	14,228	13	20,628	18

Nottinghamshire police recorded just over 14,000 DVA crimes from 2016 to 2017 (population 786,000, 2012), with a greater concentration in Nottingham, this increased to almost 21,000 between 2019 and 2020, equating to 18 DVA incidents per 1, 000 population (Table 11).

A total of nine domestic homicides were recorded by Nottinghamshire police during 2016 and 2018. During the same period, 336 domestic homicides were recorded in England (ONS, 2019b).

Hate Crime

Data published by the Home Office (2018) shows that between 2017 and 2018, 1,495 hate crime incidents were recorded in Nottinghamshire. During the same period, 87,465 hate crimes were recorded across England, with Nottinghamshire accounting for 1.7% of such crimes.

Children's Social Care Data

By the end of March 2019, there were 892.6 per 10,000 children with a Children in Need Plan within the City of Nottingham and 475.6 children per 10,000 in Nottinghamshire. Across England, the rate was 592.9 per 10,000 children (Department for Education, 2020a).

48% of families receiving a Children in Need assessment in the City of Nottingham had domestic violence as a contributing factor. Similarly, of the 9,839 cases in Nottinghamshire, 50% of cases identified domestic violence as a factor. Across England, 50.6% of cases identified domestic violence as a factor (Department for Education, 2020b).

DVA Provision (SafeLives & Women's Aid Data)

Challenges for Victims and Survivors

The SafeLives Co-Designed Pilots practitioner survey conducted in 2018, records that the top three challenges facing victims and survivors of domestic violence in Nottingham and Nottinghamshire were:

1. Risks and needs are only identified when a case has been escalated.
2. Lack of safe and affordable housing.
3. Lack of support for children and male victims.

MARAC Information

Multi-Agency Risk Assessment Conferences (MARAC) are held three times a month to discuss those victims that are at the highest risk of serious harm or death. Since 2016, the number of MARCS have increased, particularly those that involve children (Table 12). The proportion of cases being referred to MARAC from partner agencies (not the police) has increased from 56% in 2016/17 to 68% in 2018/19.

Table 12: Number of MARACs between 2016 and 2019

Case Type	2016 - 2017	2017 - 2018	2018 - 2019
All MARAC referrals	1,362	1,515	1,866
With children (including repeats)	1,772	1,968	2,447
With children (excluding repeats)	-	1,455	1,909

In 2016/17, there were 30 MARAC referrals per 10,000 adult females in Nottingham, with this increasing to 33 per 10,000 females in 2017/18 and to 41 females per 10,000 population in 2018/19. The number of repeat referrals has been consistent across the three-year period, with repeat referrals accounting for 22-26% of all referrals.

The characteristics of cases are outlined in Table 13, with figures remaining stable across the three-year period. Although there has been a year on year increase in the number of referrals involving victims with disabilities.

Table 13: Characteristics of MARAC Referrals from 2016 to 2019

Case Characteristic	2016 - 2017	2017 - 2018	2018 - 2019
Male victim	3.7%	4.7%	5.5%
LGBT victim	0.9%	1.3%	1.6%
Disabled victim	19.3%	25.9%	36.1%
Young victim (16 to 17)	3%	2%	2.1%

Services

Table 14 provides an overview of the number of support services and resources in the area recorded in the Women's Aid 'Routes to Support' dataset. This shows that for most types of support resources have either remained consistent or increased in number.

Table 14: Overview of Support Service and Resources

DVA Provision in Nottingham/Nottinghamshire (Routes to Support Data, Women's Aid, 2020)				
Number of Services	**2016-2017**	**2017-2018**	**2018-2019**	**2019-2020 (Snapshot 01/05/20)**
Refuges (number)	9	9		9
Floating support (number)	2	2		3
Helpline (number)	1	2		4
Outreach (number)	7	7		6
Drop-in	3	2		2
Support groups	7	7		10
Counselling	0	0		3
Idva (number)	3	3		4
Isva (number)	0	0		0
Dedicated CYP service (number)	9	11		12
Resettlement (number)	6	5		5
Prevention & education (number)	1	0		4
Refuge spaces available	78	78		79

In 2019 Women's Aid estimate the shortfall in refuges spaces for Nottingham to be 37 spaces.

Staffing Levels

The data provided by the SafeLives Practitioner Survey provides information on the number of staff in DVA Services in the Nottingham/Nottinghamshire area. Table 15 shows that from 2016 to 2019 the number of staff in post has fluctuated.

Table 15: DVA Staffing Levels 2016 – 2019 (SafeLives Practitioner Survey)

Position	2016-2017	2017-2018	2018-2019
Idvas	18.5	21.8	27
Outreach workers	3.75	25.5	20
Refuge workers	Data unavailable	11.6	Data unavailable
Young person's violence advisor	Data unavailable	6.2	4
Children's support workers	Data unavailable	8.3	Data unavailable

SafeLives calculate that in 2018/19 the number of Idvas in post exceeded their minimum staffing level (133% of their recommended staffing level, SafeLives Area Profile Tool, 2020).

Across Nottingham and Nottinghamshire, Women's Aid 'Routes to Support' data reports 12 different services offering a range of support. Table 16 summarises the staffing levels across these 12 organisations at May 2020.

Table 16: Staffing Levels, May 2020 (Routes To Support)

Site Location	Staffing Levels May 2020
Amber House	1 FT Support Worker / 3 PT Staff
Broxtowe Women's Project Ltd	16 FT Staff / 33 PT Staff, inclusive of: 7 Children Workers; 11 High/Medium risk workers; 5 Outreach Workers
Juno Women's Aid	2 Adult Outreach Workers 1 PT Complex Needs Worker 7 Children and Teen Support Workers 5 Idvas 9 Helpline Staff 4 Staff on management team
Juno Women's Aid - Serenity Refuge	2 PT Children's Workers 3 PT Outreach Workers 1 PT Training and Awareness Officer 1 PT Business and Fundraising Manager
Juno Women's Aid - Zola BMER Refuge	2 FT Refuge Support Workers 2 PT Refuge Support Workers 1 PT Team Leader 1 PT Children's Support Worker
Midlands Women's Aid	3 FT Support Workers 2 PT Support Workers 1 Manager 1 Children's Worker
Newark Women's Aid	3 FT Staff / 3 PT Staff, inclusive of: 1 Children's Worker
NIDAS	3 FT Staff 2 PT Staff 1 PT Children's Worker
Nottingham Central Women's Aid	5.57 FTE staff, inclusive of: 1 Complex Needs Worker, 1 Children's Worker
Nottinghamshire Women's Aid Ltd	6 FTE Staff
Umuada Refuge	3 PT Staff
VA Housing Provider (Jericho Refuge)	2 Complex Needs Support Workers 2 General Support Workers 1 Children's Worker 1 Manager 1 Freedom Programme Facilitator with Support

The Local Picture

Improving the response to domestic violence and abuse in Nottinghamshire: A Whole Systems Approach. Consultation launched 2020

Nottinghamshire Police, Nottinghamshire OPCC, Nottingham City Council and Nottinghamshire County Council consultation which ran from August to November 2020. The results are due to be reported in early 2021.

https://www.nottinghamshire.pcc.police.uk/Get-Involved/Consultations-and-Surveys/Improving-the-response-to-domestic-violence-and-abuse.aspx

Position paper at August 2020 states:

2. The County's Domestic and Sexual Abuse Framework is due to expire in 2020 and the City's Violence Against Women and Girls ("VAWG") strategy is still in development. There is a gap for a city/county wide domestic abuse strategy which sets out clear measures of success. Given the link between domestic abuse, sexual violence, honour based abuse, female genital mutilation ("FGM") and stalking, and the need for any strategy to address all aspects of domestic abuse, including prevention activity as well as supporting survivors, a PCC led VAWG Strategy for Nottinghamshire would enable all strands to be brought together under one overarching plan with clear success measures. (pg1)

19. Strong existing partnership structures helped to ensure a swift response to changes to domestic abuse provision during the lockdown. In addition, the PCC used emergency MoJ funding to bolster support services, however, more financial help may be needed when the national funding expires. There is a need to identify and implement the domestic abuse specific lessons learnt from the pandemic and an opportunity for public sector partners to work together strategically to ensure that employers in Nottinghamshire have the capacity to respond to domestic abuse experienced by employees. (pg 5-6)

Nottinghamshire County Council

Information about the local domestic abuse picture can be found on Nottinghamshire County Council website, with the website containing information about service provision, funding and data trends.

In February 2020, councillors announced that over the next four years, £1,554,746 will be available to help support adults and children affected by domestic abuse. This will help fund a free 24-hour helpline, Young People's Violence Advocate, support accessing the criminal justice system and housing, benefits and welfare support.

Nottinghamshire County Council also secured £500,000 of Government funding to maintain safe accommodation and services for survivors of domestic abuse and their children for 2020/21. This will enable 40 family units and 206 beds across the county to be available.

The council have also been proactive in monitoring and responding to trends during COVID-19, with domestic abuse referrals to Multi-Agency Safeguarding Hubs (MASH) increasing. During 2019/20, just over 5% of referrals related to domestic abuse, however, during the lockdown period (March to July), this figure increased to over 10%. To ensure cases do not escalate, the council have focused more attention on awareness campaigns and access to remote services and support.

Nottinghamshire Office of the Police and Crime Commissioner

The Police and Crime Commissioner for Nottinghamshire, Paddy Tipping, has supported various campaigns, appeals and initiatives. These have included inviting survivors of domestic abuse to share their experiences to help enhance support, requesting government to put a stop to 'fees for evidence' for victims of domestic abuse and providing additional funding opportunities and support during the Covid-19 pandemic.

In 2019, the Office of the Police and Crime Commissioner funded the first Stalking Advocacy Service in Nottingham. The service, which is provided by Juno Women's Aid, Nottinghamshire Women's Aid and Equation, offers a one-stop support service to victims of stalking that were previously excluded from domestic abuse services.

Additional information about the Police and Crime Commissioner's role in, and support of, local domestic abuse service can be found on their website.

Covid-19

During the Covid-19 pandemic, the need to stay at home has increased the likelihood of women and children becoming the victims of domestic abuse, with support services, such as Women's Aid, needing to adapt their services to reflect government guidelines. Whilst services are trying their best to support those affected by domestic abuse, survivors of domestic abuse have indicated that experiences have got worse since the lockdown due to them spending more time with their abuser.

In response to the situation, Nottinghamshire and Nottingham, like other areas, have increased awareness campaigns and provided additional funding for resources. For instance, Nottinghamshire received £220,661 to help support commissioned domestic abuse services during the pandemic and a further £95,483 for those services that are not currently commissioned by the police and crime commissioner.

Nottingham has also back the national #YouAreNotAlone campaign, which aims to reassure those affected by domestic violence that they can still access services and support during the lockdown.

News stories

In March 2020 the Domestic Homicide Review was published regarding the murder of Janet Scott in 2018. This DHR reported the failures of the probation service https://www.nottinghampost.com/news/nottingham-news/revealed-catalogue-failures-led-murder-3902091

On the 2nd March 2020, West Bridgford Wire published an article relating to the sentencing of Adrian Jacks, who had been found guilty of assault, controlling and coercive behaviour towards his fiancée. Jacks was sentenced to two and a half years in prison.

CBJSpotlight, a news outlet produced by Nottingham Trent University, ran a story in 2019 around Louise Bacon's experience of domestic abuse and her call for Nottinghamshire to do more to help support victims of domestic abuse. In particular, the article acknowledges the impact of funding cuts upon domestic violence organisations and resources.

An array of domestic abuse related news stories can be accessed via the Nottingham's Women's Centre website.

Research and Data

The University of Nottingham have developed a project that focuses upon the domestic abuse experiences of older women, with survivors sharing their stories in creative ways. This may include making artwork, creative writing or talking about their experiences. The project also asks survivors to think about what practitioners need to know about older women who have experienced domestic abuse. Through this method, an interactive resource has been developed that can be accessed by the public as well as professionals.

In 2014, the University of Nottingham undertook a mixed methods evaluation of Nottingham City's Response to Complexity project. Findings from the research emphasised the importance of providing a wrap-around support for survivors of domestic abuse, with levels of engagement typically being high. An updated summary of this project can be found here.

Data and information relating to domestic abuse can be found on the Nottinghamshire Insight website. On the Joint Strategic Needs Assessment page, the most up to date report of domestic abuse in Nottinghamshire can be found, with data showing that since 2016 there has been a 14% increase in domestic abuse reported crimes. The report also outlines unmet needs and emerging gaps, as well as recommendations that could be considered by commissioners.

Sunderland Site Profile 2020

Sunderland is the second biggest local authority area in Tyne and Wear covering a total of 137 square kilometres. Sunderland has a university, the University of Sunderland and an industrial heritage of shipbuilding and coalmining.

Northumbria Constabulary serves the areas of Northumberland and Tyne and Wear including Sunderland, a combined population of 1.46 million.

This profile reports on data for Sunderland local authority. Police data is gathered and reported at the Northumbria Constabulary level and SafeLives practitioner data is also reported at this level.

Sunderland is one of three national Women's Aid Change That Lasts (CTL) pilot areas.

Location of Sunderland in the UK and within Tyne and Wear.

Population of Sunderland

Gender

Sunderland has a population size of 277,705, with 51% of the population being female and 49% of the population being male (ONS, 2020a).

Ethnicity

According to the 2011 Census (ONS, 2012a):

- 94.8% of Sunderland's population was White British.
- 4.1% of the population were from a Black, Asian or minority ethnic background.
- 94.4% were born in the UK.
- 97.3% of people living in Sunderland speak English.

In England and Wales, 86% of the population was White, with 14% of the population coming from a Black, Asian or Minority ethnic background.

Religion

Most people in Sunderland identified themselves as Christian (70.3%), with this being higher than national trends (59.3%) (**ONS Census, 2012b**).

Table 1: Comparison of Religion in Sunderland and England and Wales (ONS Census, 2012b)

	Religion						
	Christian	None	Muslim	Sikh	Hindu	Buddhist	Jewish
Sunderland	70.3%	21.6%	1.3%	0.3%	0.2%	0.2%	-
England & Wales	59.3%	25.1%	4.8%	0.8%	1.5%	0.4%	0.5%

Age

In 2019, the average age of people in Sunderland was 42.2 years old, with this being two years older than the average age of people living in England (40.3 years old). Age trends in Sunderland resembled national trends (Table 2).

Table 2: Percentage Overview of Sunderland and England by Age Groups (ONS, 2020b)

Age Group	Sunderland	England
0 to 15	17.7%	19%
16 to 64	62.5%	62.5%
65 to 84	19.7%	18.5%
85+	2.3%	2.5%

Marital Status

Within Sunderland, 45.1% of the population were married, with 35.3% were single (ONS Census, 2012c).

Table 3: Marital Status of Sunderland and England in 2011 (ONS Census, 2012c)

Marital Status	Sunderland	England
Married	45.1%	46.6%
Single	35.3%	34.6%
Divorced	9.2%	9%
Widowed	7.9%	6.9%
Separated	2.4%	2.7%
Same-sex civil partnership	0.1%	0.2%

Poverty Indicators

Index of Multiple Deprivation (IMD)

In 2015, Sunderland was an area with high levels of deprivation, with 38% of the population living in the 20% most disadvantaged areas in England (Department for Communities and Local Government, 2015).

Sunderland was most disadvantaged in the employment and health domains: within these domains, 48% and 64% of the population respectively lived within the 20% most disadvantaged areas in the country (Department for Communities and Local Government, 2015).

Overall, Sunderland scored 29.7 and was ranked the 31st most deprived local area out of 326 local authorities (district level) (Department for Communities and Local Government, 2015).

Child Poverty

During 2018 and 2019, 20% of children aged 16 or younger in Sunderland were living in low income families, with this being 2% higher than national trends of 18% (Department of Work and Pensions, 2020). Within the North East, 16.8% of under 16s were living in out of work households, compared to the national average of 10.3% of children aged 16 of younger living in out of work households (NOMIS, 2020a).

A fifth of children under the age of 16 received free school meals in 2018 (20.9%), with this being higher than the national figure of 13.7% (Public Health England, 2020a).

Homelessness

Table 4 provides a comparison of homelessness in Sunderland and within England, with rates of homelessness in Sunderland being below national trends (Public Health England, 2020b).

Table 4: Comparison of Homelessness in Sunderland and England 2018

Type of Homelessness	Sunderland	England	Difference
Statutory Homelessness - not priority need	0.2%	0.8%	↓
Statutory Homelessness per 1,000 households	0.7%	2.4%	↓
Homeless young people aged 16 to 24	0.2%	0.5%	↓
Family homelessness	0.6%	1.7%	↓

Housing and Tenure

The average house price in Sunderland in January 2019 was £114,688, with this being very much lower than the national average price of £244,567 (HM Land Registry, 2020).

During the 2011 Census, 27.1% of people lived in social housing, with this being higher than the national average (17.7%) (ONS Census, 2012d) (Table 5).

Table 5: Home Ownership in Sunderland and Nationally (ONS Census, 2012d)

	Location Comparison		
Ownership Type	**Sunderland**	**National Average**	**Difference**
Owner occupied	60.1%	64.1%	↓
Owned outright	21.1%	30.6%	↓
Owned: mortgage/loan	32.7%	32.8%	-
Shared ownership	0.3%	0.8%	↓
Social rented households	27.1%	17.7%	↑
Council	14%	9.4%	↑
Housing Association or Social Landlord	13.1%	8.3%	↑
Private landlord or letting agency	10.9%	15.4%	↓

From the 2011 Census, 0.8% of households lacked central heating, with this being much lower than the national figure rate of 2.7% of households.

Over a third of households did not have a car (35%), with this being higher than the national average of 25.6% (ONS Census, 2012f).

Employment, Education and Qualifications

In 2019, 69.3% of people were employed, with this being lower than the national average of 76.8% (NOMIS, 2020b). Most people were employed by someone else (62.1%), with 7.1% of people being self-employed. Unemployment rate was 6.5% with this being higher than the national average of 3.9%.

The average hourly pay during 2019 was £12.31, with this being lower than the national average of £14.94 (NOMIS, 2020c). By May 2020, 8.3% of people were claiming out of work benefits, with this being lower than the national average of 7.8% (NOMIS, 2020d).

The level of qualifications held by people in Sunderland were lower than national trends (Table 6), with a higher proportion of the population having no qualifications (9.9%) compared to UK averages (8%) (NOMIS, 2020e).

Table 6: Qualification Levels of Sunderland and the UK (NOMIS, 2020e)

Level of Qualification	Sunderland	UK	Difference
NVQ4 +	27.4%	40%	↓
NVQ3 +	50.2%	59%	↓
NVQ2 +	73.1%	76%	↓
NVQ1 +	84.7%	86%	↓
Other Qualifications	5.4%	7%	↓
No Qualifications	9.9%	8%	↑

‘Brexit’ – Voting on Membership of the EU

In Sunderland, 61.4% of people voted to leave the EU, compared to 38% who wanted to remain. At a national level, 48.1% of people voted to remain, with 51.9% of people opting to leave (The Electoral Commission, 2019).

Health, Wellbeing and Disabilities

Life Expectancy

Table 7 provides an overview of the average life expectancy of people from birth between 2016 and 2018, with the life expectancy of women and men in Sunderland being lower than national trends (Public Health England, 2020c).

Table 7: Life Expectancy of Women and Men Living in Sunderland in 2016 to 2018 (Public Health England, 2020c)

Location	Women	Men
Sunderland	81.4	77.2
England	83.4	79.8

Health Statistics

More men per 100,000 population were admitted to hospital due to alcohol than women during 2018 to 2019 (Public Health England, 2020d). Compared to national trends, rates of hospital admissions in Sunderland were higher for both genders.

Table 8: Hospital Admissions due to Alcohol by Gender for Sunderland and England, 2018 to 2019, per 100,000 population

Gender	Sunderland	England	Difference
Male	1,294	809	↑
Female	726	473	↑

Between 2016 to 2018, the suicide rate for 100,000 population was 11.1, with this being higher than the average rate for England (9.6 per 100,000 population) (Public Health England, 2020e).

Crime

Recorded Crime

In the year ending 2019, the overall crime rate per 1,000 people in Northumbria was 101.8 (ONS, 2020c), with this being much higher than the crime rate in England (88 per 1,000 population). As Table 9 illustrates, crime rates in Northumbria were typically higher than within England.

Table 9: Police Recorded Crime (per 1000 population) in 2019 for Northumbria and England (ONS, 2020c)

Type of Crime	Northumbria	England	Difference
Total recorded crime (excluding fraud)	101.8	88	↑
Violence against the person	32.2	29.1	↑
Violence with injury	9.4	9.1	-
Violence without injury	12.7	12	-
Stalking and harassment	10.1	8	↑
Sexual offences	3.1	2.7	↑

Domestic Violence and Abuse

Table 10: Combined domestic abuse-related incidents and offences 2016/17 & 2019/2020

	2016-2017		2019-2020	
	Number	**Rate/1000**	**Number**	**Rate /1000**
Northumbria	30,534	21	41,992	29

Northumbria constabulary area had around 30,000 DVA incidents and crimes reported to the police between 2016 and 2017, (population 1.46 million) rising to almost 42,0000 in 2019 to 2020 in the year; equivalent to 29 DVA incidents per 1000 population. However, wide variations were found between different areas ranging from 9 to 52 DVA incidents per 1000 population.

In 2016-18, there were six domestic homicides. During the same period, 336 domestic homicides were recorded in England (ONS, 2019b).

Hate Crime

Data published by Northumbria police (2019) shows that between 2017 and 2018, 298 hate crime incidents were recorded. During the same period, 87,465 hate crimes were recorded across England (Home Office, 2018).

Children's Social Care Data

By the end of March 2019, there were 839.9 per 10,000 children with a Children in Need plan within Sunderland, with this being higher than the rate across England (592.9 per 10,000 children) (Department for Education, 2020a).

At the end of Children in Need assessment, of the 2,934 cases that had assessment information available, 56% of cases identified domestic violence as a contributing factor. Across England, 50.6% of cases identified domestic violence as a factor (Department for Education, 2020b).

DVA Service Provision (Women's Aid & SafeLives Data)

Challenges for Victims and Survivors

The SafeLives Practitioner Survey conducted in 2018, reports that the top three challenges facing victims and survivors of domestic violence in Sunderland were:

1. Services putting high expectations on victims of abuse and not the perpetrators.
2. Support when facing complex needs including mental health and substance misuse
3. Access to housing and legal funding.

MARAC Information

Multi-Agency Risk Assessment Conferences (MARAC) are held weekly to discuss those victims at the highest risk of serious harm or death. Since 2016, the number of MARCS has increased, with the presence of children within a referral also increasing year on year (Table 11). A quarter of all MARAC referrals came from partner agencies (25%), rather than the police, over the three-year period.

Table 11: Number of MARACs between 2016 and 2019

Case Type	2016 - 2017	2017 - 2018	2018 - 2019
All MARAC referrals	3,170	3,058	3,643
With children (including repeats)	5,070	5,088	5,743
With children (excluding repeats)	-	3,536	3,905

In 2016 to 2017, there were 52 MARAC referrals per 10,000 adult females in Sunderland, with this increasing to 60 per 10,000 females in 2018 to 2019. The number of repeat referrals has remained consistent during 2016 to 2019, with 31 to 33% of cases being repeats.

The characteristics of cases is outlined in Table 12, with figures remaining stable across the three-year period.

Table 12: Characteristics of MARAC Referrals from 2016 to 2019

Case Characteristic	2016 - 2017	2017 - 2018	2018 - 2019
Male victim	5.1%	4.4%	5.5%
LGBT victim	1.5%	2%	1.6%
Disabled victim	2.3%	2.4%	1.4%
Young victim (16 to 17)	1.5%	1.3%	1.8%

Services

Table 13 provides an overview of services and resources in the area recorded for 2016-20 in the Women's Aid 'Routes to Support' dataset. Data for 2018 to 2019 was not provided, but services have remained consistent over the three-year period. DVA staff in Sunderland number 29, including Idvas and volunteers. Women's Aid have one refuge in Sunderland, and no shortfall in spaces was recorded for the period 2016 to 2019.

Table 13: Overview of Support Service and Resources

DVA Provision in Sunderland (Routes to Support Data, Women's Aid, 2020, Number of Services	2016-2017	2017-2018	2018-2019	2019-2020 (Snapshot 01/05/20)
Refuges (number)	1	1		1
Floating support (number)	0	1		1
Helpline (number)	1	1		1
Outreach (number)	1	1		1
Drop-in	1	1		1
Support groups	1	1		1
Counselling	0	0		1
Idva (number)	1	1		1
Isva (number)	0	0		0
Dedicated CYP service (number)	1	0		1
Resettlement (number)	1	1		1
Prevention and education (number)	0	0		0
Perpetrator case workers		8.5		1

Staffing Levels

Table 14 provides an overview of staffing in DVA services in the Northumbria Constabulary area, as detailed in the SafeLives practitioners' surveys from 2016 to 2019. During this time, the number of Idvas and outreach workers has increased, as well as the FTE number of young person's violence advisors, whilst other posts, such as refuge workers and Isva, have reduced.

Table 14: DVA Staffing Levels 2016 -2019 (SafeLives Practitioner Survey)

Position	2016-2017	2017-2018	2018-2019
Idvas	23.8	22.7	27
Outreach workers	Data unavailable	42.1	67
Refuge workers	Data unavailable	15.3	Data unavailable
Isva	Data unavailable	4	Data unavailable
Young person's violence advisor (FTE)	Data unavailable	9.6	30
Children's support workers	Data unavailable	7.5	Data unavailable
Perpetrator case workers	Data unavailable	8.5	Data unavailable

SafeLives calculate that in 2018/19 the number of Idvas in post was 72% of their recommended staffing level (SafeLives Area Profile Tool, 2020).

The Local Picture

Sunderland City Council

Information about DVA processes, practices and resources are found on the Sunderland City Council website. Here , the importance of partnership working and the roles and responsibilities of the Sunderland Domestic Violence Partnership are highlighted. The Sunderland Domestic Violence Health Needs Assessment (2017) recommends further investigation of the needs of BME, LGBT, travelling community and other minority groups of services that are specific to meeting the needs of children, such as Children's Idvas.

During the Covid-19 pandemic, the council, police and local DVA services have worked together to raise awareness during lockdown. A DVA survivor in Sunderland has spoken in the national media about the impact of the lockdown on DVA incidents.

Office for the Police and Crime Commissioner

During the pandemic, the Northumbria Police and Crime Commissioner, Kim McGuinness, launched the Children Affected by Domestic Abuse emergency fund that ringed fenced £120,000 of Home Office funding for specialist services. In addition to this funding, a further

£500,000 was secured by the Police and Crime Commissioner to help organisations respond to the increase in demand for services and support.

A survey conducted by Wearside in Need during the lockdown, found that victims of domestic abuse were most likely to confide in a friend or family member. The Police and Crime Commissioner used these findings to influence awareness campaigns and ensure that information relating to support and advice was accessible to all.

Media Coverage

In January 2020, Chronicle Live ran a story reporting that people are 'too accepting' of domestic abuse in Sunderland. The story cited Sir Paul Ennals, the independent chairman of Sunderland Safeguarding Children Board, who argued that Sunderland DVA rates were higher than the rest of the country, and identified high levels of local tolerance of DVA as a contributing factor. The story highlighted the need to change local perceptions and attitudes.

A local furniture scheme for women fleeing DVA has been launched by three survivors. Help Me Out aims to provide essential household goods for victims of abuse who often start again with very little.

The establishment and importance of Clare's Law has also featured within media outputs, with Sunderland Echo reporting on Debra Wright's experience of being a survivor of domestic abuse. In 2019, Debra was forced to flee her home after being brutally attacked by her partner and is now in the process of rebuilding her life. Debra explains the difficulties of trying to make people believe her ordeal happened and that her abuser did attack her. Incidents of being called a liar has motivated Debra to work with Women in Need to promote Clare's Law.

The murder of Kay Martin by her husband was reported on BBC News in 2019. An inquest heard that the police had given Kay's killer the keys back to their house after being questioned over an allegation of rape, with 10 domestic violence reports being logged by police between 2011 and 2018.

A Domestic Homicide Review was published in April 2020 concerning Julie Parkin, a teacher who was killed in 2017.
https://www.chroniclelive.co.uk/news/north-east-news/julie-parkin-death-controlling-relationship-17812401
https://www.sunderland.gov.uk/article/17004/Domestic-homicide-review-Carol-

In 2018, the BBC News published an article detailing the rise of far-right activism in Sunderland and their attempt to hijack the Violence against Women and Girls agenda to their own campaigns.

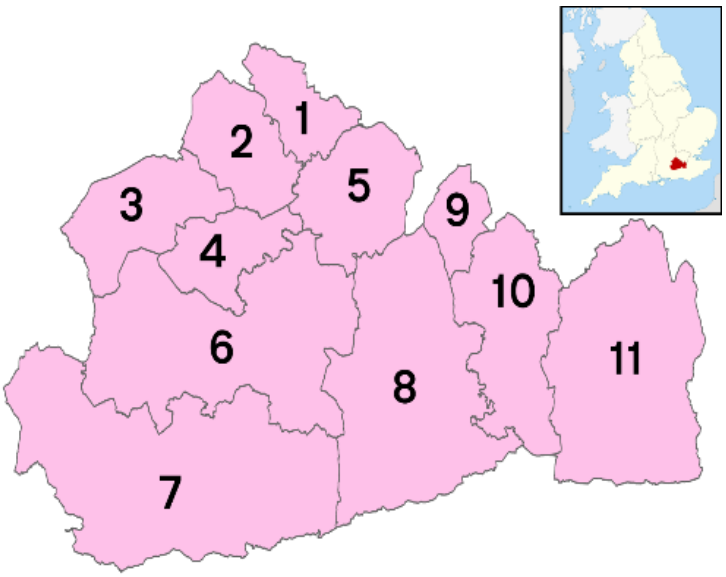
Surrey Site Profile 2020

Surrey is a county area in the South East of England that covers a total of 1670 square km. Its largest towns are Guildford and Woking, with most of the north of the county being urban and close to Greater London. Surrey has three universities: Surrey University, Royal Holloway and the University of Creative Arts.

The county is served by Surrey Police.

This profile reports on the whole Surrey county area, although some data in the domestic violence and abuse (DVA) service provision section refers only to East Surrey.

Surrey is one of three national Women's Aid Change That Lasts (CTL) pilot sites.



Districts and Boroughs:

1. Spelthorne Borough
2. Runnymede Borough
3. Surrey Heath Borough
4. Woking Borough
5. Elmbridge Borough
6. Guildford Borough
7. Waverley Borough
8. Mole Valley District
9. Epsom and Ewell
10. Reigate and Banstead
11. Tandridge District

Location of Surrey in the UK and District and Borough Areas.

Population of Surrey

Gender

Surrey has a population size of 1,196,236, with 51% of the population being female and 49% of the population being male (ONS, 2020a).

Ethnicity

According to the 2011 Census (ONS, 2012a):

- 90.3% of the population were White:
  - 83.5% White British.
  - 6.8% White Other.
- 9.7% of the population were from a Black, Asian or minority ethnicity.
- 89.4% were born in the UK.
- 94.1% of people in Surrey speak English.

> In England and Wales, 86% of the population was White, with 14% of the population coming from a Black, Asian or Minority ethnic background.

Religion

The religious make up of Surrey is depicted in Table 1.

Table 1: Comparison of Religion in Surrey and England and Wales (ONS Census, 2012b)

	Religion						
	Christian	None	Muslim	Sikh	Hindu	Buddhist	Jewish
Surrey	62.8%	24.8%	2.2%	0.3%	1.3%	0.5%	0.3%
England & Wales	59.3%	25.1%	4.8%	0.8%	1.5%	0.4%	0.5%

Surrey has the fourth largest Gypsy, Roma and Traveller (GRT) community in Britain, with between 10,000 to 12,000 individuals identifying as GRT (Surrey Council, 2014). Approximately 1,400 young children from the GRT community are enrolled in Surrey schools.

Age

The average age of people living in Surrey is 41 years old (ONS, 2012c), with this being older than the average age for England (40.3 years old) (ONS, 2020b). Age patterns resembled those for England (Table 2).

Table 2: Percentage Overview of Surrey and England by Age Groups (Surrey-I, 2020 and ONS, 2020b)

Age Group	Surrey	England
0 to 15	20.8%	19%
16 to 64	61.5%	62.5%
65+	18.7%	21%

Marital Status

Data from the 2011 Census showed that just over half of individuals living in Surrey were married (52.6%), with this being higher than the national average (46.6%).

Table 3: Marital Status of Surrey and England in 2011 (ONS Census, 2012d)

Marital Status	Surrey	England
Single	30.1%	34.6%
Married	56.2%	46.6%
Divorced	8.1%	9%
Widowed	6.7%	6.9%
Separated	2.3%	2.7%
Same-sex civil partnership	0.2%	0.2%

Poverty Indicators

Index of Multiple Deprivation (IMD)

In 2015, Surrey had low levels of deprivation, ranking 150 out of 152 counties within England (Department for Communities and Local Government, 2015). Overall, Waverly was the least deprived, with Spelthorne being the most deprived.

Child Poverty

In 2016, 9.10% of children aged 16 or younger in Surrey were living in low income families, with this being lower than national trends (18%) (Department of Work and Pensions, 2020).

Across the South East, 6% of under 16s were living in out of work households, again lower than the national average of 10.3% (NOMIS, 2020a).

Nationally, 13..3% of children aged 16 or younger received free school meals, with this figure being much lower for Surrey (7.2% of children) (Public Health England, 2020a).

Homelessness

Table 4 provides a comparison of homelessness in Surrey and within England, with rates of homelessness in Surrey being lower than national figures (Public Health England, 2020b).

Table 4: Comparison of Homelessness in Surrey and England 2018

Type of Homelessness	Surrey	England	Difference
Statutory Homelessness - not priority need	0.1%	0.8%	↓
Statutory Homelessness - households in temporary accommodation	1.7%	3.4%	↓
Statutory Homelessness per 1,000 households	1.3%	2.4%	↓
Homeless young people aged 16 to 24	0.3%	0.5%	↓
Family homelessness	0.9%	1.7%	↓

Housing and Tenure

The average house price in Surrey in January 2019 was £440,219, with this being much higher than the national average price of £244,567 (HM Land Registry, 2020).

Most people in Surrey own their home (72.9%), with rates being higher than national figures (64.1%). Socially rented housing accounted for 11.4% of ownership type, with this being lower than the national average of 17.7% (Table 5).

Table 5: Home Ownership in Surrey and Nationally (ONS Census, 2012e)

	Location Comparison		
Ownership Type	**Surrey**	**National Average**	**Difference**
Owner occupied	72.9%	64.1%	↑
Owned outright	34.8%	30.6%	↑
Owned: mortgage/loan	38.1%	32.8%	↑
Shared ownership	1%	0.8%	↑
Social rented households	11.4%	17.7%	↓
Council	4.9%	9.4%	↓
Housing Association or Social Landlord	6.5%	8.3%	↓
Private landlord or letting agency	12.2%	15.4%	↓

From the 2011 Census, 1.6% of households lacked central heating, with this being lower than the national figure of 2.7% of households. Nationally, 25.6% of households did not have car in 2011, with this figure being lower in Surrey (13.1%) (ONS Census, 2012f).

Employment, Education and Qualifications

In 2019, 81.1% of people in Surrey were employed, with this being higher than the national average of 76.8% (NOMIS, 2020b). Most people were employed by someone else (66.2%), with 15.4% of people being self-employed. Unemployment rate was 2.1% with again being lower than the national average of 3.9%.

The average hourly pay during 2019 was £18.66, with this higher than the national average of £14.94 (NOMIS, 2020c). By May 2020, 4% of people were claiming out of work benefits, with this being lower than the national average of 7.8% (NOMIS, 2020d).

The level of qualifications held by people in Surrey was above national trends (Table 6).

Table 6: Qualification Levels of Surrey and the UK (NOMIS, 2020e)

Level of Qualification	Surrey	UK	Differ
NVQ4 +	51.8%	40%	↑
NVQ3 +	67.7%	59%	↑
NVQ2 +	82.3%	76%	↑
NVQ1 +	89.9%	86%	↑
Other Qualifications	5.1%	7%	↓
No Qualifications	5%	8%	↓

'Brexit' – Voting on Membership of the EU

In Surrey, 51.5% of people voted to remain in the EU, compared to 48.5% who wanted to leave. At a national level, 48.1% of people voted to remain, with 51.9% of people opting to leave (The Electoral Commission, 2019).

Health, Wellbeing and Disabilities

Life Expectancy

Between 2016 and 2018, women in Surrey had a higher life expectancy (85.1 years) compared to England as a whole (83.4 years). The life expectancy of men (81.8 years) was also higher than national trends (79.8 years) (Public Health England, 2020c).

Health Statistics

When compared to national trends, rates of hospital admissions for alcohol in Surrey were low for both male and females (Table 7) (Public Health England, 2020d).

Table 7: Hospital Admissions due to Alcohol by Gender for Surrey and England, 2018 to 2019, per 100,000 population

Gender	Surrey	England	Difference
Male	670	809	↓
Female	389	473	↓

Between 2016 to 2018, the suicide rate for 100,000 population of Surrey was 8, with this being slightly lower than the average rate for England (9.6 per 100,000 population) (Public Health England, 2020e).

Crime

Recorded Crime

In the year ending 2019, the overall crime rate per 1,000 people in Surrey was 64.7 (ONS, 2020c), with this being lower than the crime rate in England (88 per 1,000 population). Compared to crime rates in England, crime rates in Surrey were lower across various crime types (Table 8).

Table 8: Police Recorded Crime (per 1000 population) in 2019 for Surrey and England (ONS, 2020c)

Type of Crime	Surrey	England	Difference
Total recorded crime (excluding fraud)	64.7	88	↓
Violence against the person	20.2	29.1	↓
Violence with injury	6.1	9.1	↓
Violence without injury	9	12	↓
Stalking and harassment	5.1	8	↓
Sexual offences	1.8	2.7	↓

Domestic Violence and Abuse

Table 9: Combined domestic abuse-related incidents and offences 2016/17 & 2019/2020

	2016-2017		2019-2020	
	Number	**Rate/1000**	**Number**	**Rate /1000**
Surrey	13,179	11	13,777	12

Surrey had around 13,000 DVA crimes and incidents reported to the police between 2016 and 2017 and between 2019 and 2020(population 1.190 million, 2012) although this varied significantly across the county, equating to 12 DVA incidents per 1,000 population in 2020 (Table 9).

A total of seven domestic homicides were recorded by Surrey police during 2016 and 2018. During the same period, 336 domestic homicides were recorded in England (ONS, 2019b).

Hate Crime

Data published by the Home Office (2018) shows that between 2017 and 2018, 1,802 hate crime incidents were recorded. During the same period, 87,465 hate crimes were recorded across England, with Surrey accounting for 2% of such crimes.

Children's Social Care Data

By the end of March 2019, there were 546.5 per 10,000 children with a children in need plan, with this being lower than the rate across England (592.9 per 10,000 children) (Department for Education, 2020a).

At the end of children in need assessment, of the 9,601 cases that had assessment information available, 48% of cases identified domestic violence as a contributing factor. Across England, 50.6% of cases identified domestic violence as a factor (Department for Education, 2020b).

DVA Service Provision (Women's Aid & SafeLives Data)

Challenges for Victims and Survivors

According to the results of the SafeLives practitioner survey conducted in 2018, the top three challenges facing victims and survivors of domestic violence were:

1. Access to mental health support.
2. Expectations of behaviour change put on victims of abuse, rather than the perpetrator.
3. Access to housing.

MARAC Information

Multi-Agency Risk Assessment Conferences (MARAC) are held monthly to discuss those victims at the highest risk of serious harm or death. Since 2016, the number of MARACS in Surrey have increased, particularly those involving children (Table 10). During this time, between 21 and 27% of referrals came from partner agencies, rather than the police.

Table 10: Number of MARACs between 2016 and 2019

Case Type	2016 - 2017	2017 - 2018	2018 - 2019
All MARAC referrals	730	1,006	1,098
With children (including repeats)	816	1,241	1,391
With children (excluding repeats)	-	905	988

In 2016 to 2017, there were 15 MARAC referrals per 10,000 adult females, with this increasing to 23 per 10,000 females in 2018/19. The number of repeat referrals has been consistent at around 27 to 29% of all referrals.

The characteristics of cases is outlined in Table 11, with figures remaining stable across the three-year period.

Table 11: Characteristics of MARAC Referrals from 2016 to 2019

Case Characteristic	2016 - 2017	2017 - 2018	2018 - 2019
Male victim	6.2%	6.6%	4.2%
LGBT victim	1.2%	1.3%	0.7%
Disabled victim	0.5%	1.5%	1.4%
Young victim (16 to 17)	1.4%	0.9%	1.7%

Services

Table 12 provides an overview of the number of support services and resources in the Surrey area as recorded in the Women's Aid Routes to Support data. This shows resources increasing over the last four years. However, it should be noted that the 2019-2020 snapshot is for the whole County of Surrey rather than East Surrey as was the case in previous years.

Table 12: Overview of Support Service and Resources

DVA Provision in East Surrey / Surrey (Routes to Support Data, Women's Aid, 2020)				
Number of Services	**2016-2017**	**2017-2018**	**2018-2019**	**2019-2020 Surrey-wide 01/05/20**
Refuges (number)	1	1		3
Floating support (number)	0	0		0
Helpline (number)	1	1		2
Outreach (number)	1	1		4
Drop-in	0	0		0
Support groups	1	1		5
Counselling	1	1		3
Idva (number)	1	1		4
Isva (number)	1	1		1
Dedicated CYP service (number)	2	2		6
Resettlement (number)	0	0		2
Prevention & education (number)	1	1		3
Refuge spaces available	33	34		34

Women's Aid calculate that there is a shortfall figure of 86 spaces in the Surrey area, based on the calculation of one refuge space per 10,000 population and using 2019 population estimates. However, in 2020, the PCC worked collaboratively with the Surrey County Council, Surrey Community Foundation and other partners to open a new refuge, with local provider, Reigate & Banstead Women's Aid.

Staffing Levels

The data provided by the SafeLives practitioner survey provides information on the number of staff in Surrey DVA Services. Table 13 shows a substantial reduction in numbers of Idvas and Outreach Workers between 2016 and 2019.

Table 13: DVA Staffing Levels 2016-2019 (SafeLives Practitioner Survey)

Position	2016-2017	2017-2018	2018-2019
Idvas	16	3.8	6
Outreach workers	-	25.8	8
Young person's violence advisor	Data unavailable	3.3	0
Children's support workers	Data unavailable	1.6	Data unavailable

SafeLives calculate that in 2018/19 the number of Idvas in post was 31% of their recommended staffing level (SafeLives Area Profile Tool, 2020).

Table 14 below shows data provided from the Women's Aid 'Routes to Support' dataset in August 2020. This provides a breakdown of the support staff resources recorded in Surrey at May 2020.

Table 14: DVA Organisations' Staffing Levels (Women's Aid - Routes to Support Data)

Service	Staffing Level May 2020
East Surrey Domestic Abuse Services	3 Idvas 3 Outreach Workers 1 Children's Worker
North Surrey Domestic Abuse Outreach	4 FT Staff / 1 PT Staff Inclusive of: • 1 Children's Worker
Reigate and Banstead Women's Aid	4 FT Staff / 5 PT Staff Inclusive of: • 3 FT Outreach Worker • 1 PT Outreach Worker
South West Surrey Domestic Abuse Outreach Service	4 FT Staff / 10 PT Staff / 30 Volunteers Inclusive of: • 2 Counsellors • 2 PT Children's Workers
South West Surrey Refuge	5 FT Staff / 3 PT Staff Inclusive of: • 2 Children's Workers
Your Sanctuary	2 PT Children's and Young People's Workers 3 Idvas

The Local Picture

Surrey County Council

Information about domestic abuse and service provision is located on Surrey's County Council website, with resources relating to the identification and impact of domestic abuse, support during COVID-19 and useful contacts.

In 2017, Surrey County Council commissioned SafeLives to conduct a needs assessment consultation. The work has been split into various stages, with the first stage looking that current needs and provisions in the area. The report from this stage identifies prevention, early identification and holistic provision as three priority areas

Office for the Police and Crime Commissioner

Recent activity reported on Surrey Police and Crime Commissioner website has included the building of more refuge accommodation for families escaping domestic abuse and the securing of £338,000 to help support organisations working with victims of domestic abuse during the COVID lockdown.

Like other areas, Surrey has backed the #YouAreNotAlone campaign that was initiated during the lockdown period. The £400,000 from the Ministry of Justice was used to support organisations not already supported by the Commissioner and part was allocated to support protected or minority groups.

Surrey-i.

Surrey-i provides up to date data on domestic violence incidents by ward per month.

COVID-19

Surrey Live published an article in March 2020 focusing on the 'fear' of homicides increasing during the lockdown. The paper also reported the introduction of a hand signal domestic abuse victims can use to indicate that they are in distress over a video call.

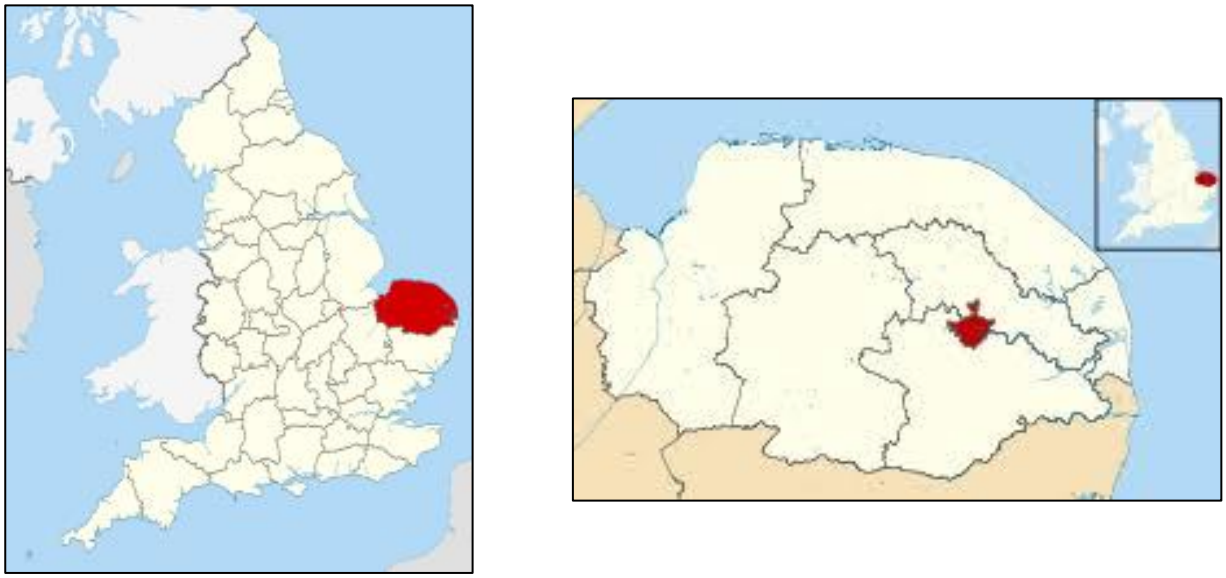
New Refuge: The Surrey Domestic Partnership used funding from the Coronavirus Respond Fund to establish a new refuge, which immediately supported 8 families and has space for up to 20.

Norwich Site Profile 2020.

Norwich is a city in the County of Norfolk in the East of England. The city and surrounding urban area cover a total of 52.6km^2.

Norwich City Council is one of seven city or borough councils within the county. Norfolk Constabulary serves the wider Norfolk area. Where possible, data in this profile is presented for Norwich, however some datasets are only available at County level.

Norwich is one of two national SafeLives Beacons pilot sites.



Location of Norwich in the UK and within the county of Norfolk.

Population of Norwich

Gender

Norwich has a population size of 140,573, with 51% of the population being female and 49% of the population being male (ONS, 2020a).

Ethnicity

According to the 2011 Census (ONS, 2012a):

- 90.8% of Norwich's population was White:
  - 84.7% was White British.
  - 6.1% was White Other.
- 9.2% of the population was from a Black, Asian or Minority ethnic background.
- 87.1% were born in the UK.
- 92.1% of people living in Norwich speak English.

> In England and Wales, 86% of the population was White, with 14% of the population coming from a Black, Asian or Minority ethnic background.

Religion

Norwich is the 'least religious' city in England and Wales with the highest proportion of people reporting 'no religion' at 42.5% (BBC News, 2012).

Table 1: Comparison of Religion in Norwich and England and Wales (ONS Census, 2012b).

	Religion						
	Christian	None	Muslim	Sikh	Hindu	Buddhist	Jewish
Norwich	44.9%	42.5%	2%	0.1%	0.8%	0.7%	0.2%
England & Wales	59.3%	25.1%	4.8%	0%	0%	0.4%	0.5%

Age

In 2019, the average age of people in Norwich was 33.5 years old, which was approximately seven years younger than the average age of people in England (40.3 years). 68% of Norwich's population were aged 16 to 64.

Table 2: Percentage Overview of Norwich and England by Age Groups (ONS, 2020b)

Age Group	Norwich	England
0 to 15	16.9%	19%
16 to 64	68%	62.5%
65 to 84	15.1%	18.5%
85+	2.4%	2.5%

Marital Status

Data from the 2011 Census showed that just under half of those living in Norwich were single (46.9%), with this being higher than the national average.

Table 3: Marital Status of Norwich and England in 2011 (ONS Census, 2012c).

Marital Status	Norwich	England
Single (never married or registered same sex partnership)	46.9%	34.6%
Married	33.4%	46.6%
Divorced	10.7%	9%
Widowed	6.1%	6.9%
Separated	2.6%	2.7%
Same-sex civil partnership	0.3%	0.2%

Poverty Indicators

Index of Multiple Deprivation (IMD)

In 2015, Norwich was an area with high levels of deprivation, with 41% of the population living in the 20% most disadvantaged areas in England (Department for Communities and Local Government, 2015). Table 4 provides a comparison of deprivation for six key domains between Norwich and England, with averages in Norwich being higher than the national average. Those living in Norwich were particularly disadvantaged in education and health.

Table 4: Comparison of Indices of Deprivation for Norwich and England (Department for Communities and Local Government, 2015)

Indices of Deprivation	Norwich	England Average	Difference
Index of Multiple Deprivation	41%	20.1%	↑
Income domain	39.8	20.1%	↑
Education domain	44.5	19.8%	↑
Health domain	45.8%	19.8%	↑
Barriers to Housing and Services domain	4.8%	21.2%	↓
Living Environment domain	38.5%	20.9%	↑

Child Poverty

During 2018 and 2019, 18% of children aged 16 or younger in Norwich were living in low income families, with this reflecting the national picture (Department of Work and Pensions, 2020). At a county level, 8.7% of under 16s were living in out-of-work households, compared to the national average of 10.3% of children aged 16 of younger living in out-of-work households (NOMIS, 2020a).

Within Norwich, 13% of children under the age of 16 received free school meals in 2018, with this being similar to the national figure of 13.7% (Public Health England, 2020a).

Homelessness

Table 5 provides a comparison of homelessness in Norwich and within England, with rates of homelessness in Norwich being the same as or below national trends (Public Health England, 2020b).

Table 5: Comparison of Homelessness in Norwich and England 2018

Type of Homelessness	Norwich	England	Difference
Statutory Homelessness - not priority need	0.9%	0.8%	↑
Statutory Homelessness - households in temporary accommodation	0.6%	3.4%	↓
Statutory Homelessness per 1,000 households	1.5%	2.4%	↓
Homeless young people aged 16 to 24	0.4%	0.5%	↓
Family homelessness	1.0%	1.7%	↓

Housing and Tenure

The average house price in Norwich in January 2019 was £209,244, with this being below the national average price of £244,567 (HM Land Registry, 2020).

The 2011 Census reported that 32.7% of people lived in social housing, with this being higher than the national average (17.7%) and the Norfolk average (15.9%) (ONS Census, 2012d). Under half of houses were owner occupied (43.8%), with 32.7% of houses socially rented (Table 6).

Table 6: Home Ownership in Norwich and Nationally (ONS Census, 2012d)

	Location Comparison		
Ownership Type	**Norwich**	**National Average**	**Difference**
Owner occupied	43.8%	64.1%	↓
Owned outright	20.7%	30.6%	↓
Owned: mortgage/loan	23.2%	32.8%	↓
Shared ownership	0.7%	0.8%	-
Social rented households	32.7%	17.7%	↑
Council	25.2%	9.4%	↑
Housing Association or Social Landlord	7.4%	8.3%	↓
Private landlord or letting agency	13.4	15.4%	↓

From the 2011 Census, 2.6% of households in Norwich lacked central heating, with this reflecting the national figure (2.7%).

Over a third of households did not have a car: this was higher than the national average of 25.6% of households (ONS Census, 2012f).

Employment, Education and Qualifications

In 2019, 72.3% of people in Norwich were employed, with this being slightly lower than the national average of 76.8% (NOMIS, 2020b). Most people were employed by someone else (63.6%), with 8.7% of people being self-employed. The unemployment rate was 4.4%: higher than the national average of 3.9%.

The average hourly pay during 2019 was £12.83, which was slightly lower than the national average of £14.94 (NOMIS, 2020c). By May 2020, 6.7% of people were claiming out of work benefits, with this being lower than the national average of 7.8% (NOMIS, 2020d).

The level of qualifications held by people in Norwich was lower than the national figure (Table 7), with Norwich having a higher proportion of individuals with no qualifications (10.6%) compared to the UK average (8%).

Table 7: Qualification Levels of Norwich and the UK (NOMIS, 2020e)

Level of Qualification	Norwich	UK	Differ
NVQ4 +	31.8%	40%	↓
NVQ3 +	48.3%	59%	↓
NVQ2 +	68.1%	76%	↓
NVQ1 +	83.5%	86%	↓
Other Qualifications	5.8%	7%	↓
No Qualifications	10.6%	8%	↑

‘Brexit’ – Voting on Membership of the EU

In Norwich, 56.2% of people voted to remain in the EU, compared to 43.8% who wanted to leave. At a national level, 48.1% of people voted to remain, with 51.9% of people opting to leave (The Electoral Commission, 2019).

Health, Wellbeing and Disabilities

Life Expectancy

Table 8 provides an overview of the average life expectancy of people from birth between 2016 and 2018, with women living in Norwich having a shorter life expectancy than the national average (Public Health England, 2020c).

Table 8: Life Expectancy of Women and Men Living in Norwich in 2016 to 2018 (Public Health England, 2020c)

Location	Women	Men
Norwich	83.1	78.4
England	83.4	79.8

Health Statistics

Within Norwich, more men per 100,000 population were admitted to hospital due to alcohol than women during 2018 to 2019 (Public Health England, 2020d). At a national level, rates of admission due to alcohol were higher for both men and women.

Table 9: Hospital Admissions due to Alcohol by Gender for Norwich and England, 2018 to 2019, per 100,000 population

Gender	Norwich	England	Difference
Male	832	809	↑
Female	537	473	↑

Between 2016 to 2018, the suicide rate for 100,000 population of Norfolk was 11.4, with this being higher than the average rate for England (9.6 per 100,000 population) (Public Health England, 2020e).

Crime

Recorded Crime

In the year ending 2019, the overall crime rate per 1,000 people in Norfolk was 72.7 (ONS, 2020c): lower than the crime rate in England (88 per 1,000 population). Compared to crime rates in England, Norfolk had slightly higher rates sexual offences (Table 10).

Table 10: Police Recorded Crime (per 1000 population) in 2019 for Norfolk and England (ONS, 2020c).

Type of Crime	Norfolk	England	Difference
Total recorded crime (excluding fraud)	72.7	88	↓
Violence against the person	27.3	29.1	↓
Violence with injury	8	9.1	↓
Violence without injury	13.3	12	↑
Stalking and harassment	5.9	8	↓
Sexual offences	3.1	2.7	↑

Domestic Violence and Abuse

Table 11: Combined domestic abuse-related incidents and offences 2016/17 & 2019/2020

	2016-2017		2019-2020	
	Number	**Rate/1000**	**Number**	**Rate /1000**
Norfolk	15,880	18	17,835	20

Norfolk had almost 16,000 DVA incidents and crimes reported to the police between 2016 and 2017 (population 903,690, 2018) rising to nearly 18,000 between 2019 and 2020, equating to 20 DVA incidents per 1,000 population (Table 11).

A total of two domestic homicides were recorded by Norfolk police during 2016 and 2018. During the same period, 336 domestic homicides were recorded in England (ONS, 2019b).

Hate Crime

Data published by the Home Office (2018) shows that between 2017 and 2018, 1,022 hate crime incidents were recorded in Norfolk. During the same period, 87,465 hate crimes were recorded across England, with Norfolk accounting for 1% of such crimes.

Children's Social Care Data

By the end of March 2019, there were 485.6 per 10,000 children with a Children in Need plan within Norfolk, with this being lower than the rate across England (592.9 per 10,000 children) (Department for Education, 2020a).

At the end of children in need assessment, of the 5,508 cases that had assessment information available, 55% of cases identified domestic violence as a contributing factor. Across England, 50.6% of cases identified domestic violence as a factor (Department for Education, 2020b).

DVA Service Provision (Women's Aid & SafeLives Data)

Challenges for Victims and Survivors

According to the results of the SafeLives practitioner survey conducted in 2018, the top three challenges facing victims and survivors of DVA were:

1. Getting cases heard at court.
2. Access to mental health support.
3. Domestic abuse services closing due to lack of funding.

MARAC Information

Multi-Agency Risk Assessment Conferences (MARAC) are held monthly to discuss those victims that are at the highest risk of serious harm or death. Since 2016, the number of MARCACs in Central Norfolk have increased, with the presence of children within a referral decreasing over the last 12-months (Table 12). During this time, between 20 and 22% of referrals came from partner agencies, rather than the police.

Table 12: Number of MARACs between 2016 and 2019

Case Type	2016 - 2017	2017 - 2018	2018 - 2019
All MARAC referrals	1,366	1,640	1,654
With children (including repeats)	1,607	2,185	1,810
With children (excluding repeats)	-	1,704	1,303

In 2016 to 2017, there were 37 MARAC referrals per 10,000 adult females in Norfolk, with this increasing to 45 per 10,000 females from 2017 to 2019. The proportion of repeat referrals increased from 16% in 2016-2017, to 22% in 2017-2018 to 28% in 2018-2019.

Characteristics of cases are outlined in Table 13, with figures remaining stable across the three-year period. However, there has been a year-on-year increase in referrals involving victims with disabilities.

Table 13: Characteristics of MARAC Referrals from 2016 to 2019

Case Characteristic	2016 - 2017	2017 - 2018	2018 - 2019
Male victim	5.1%	4.8%	6%
LGBT victim	0.6%	1%	0.9%
Disabled victim	12.5%	15.6%	16.3%
Young victim (16 to 17)	1.4%	1.7%	0.9%

Services

Table 14 below shows data provided from the Women's Aid Routes To Support dataset in October 2020. This shows an overview of the support services and resources recorded in the Norfolk area since 2016.

Table 14: Overview of Support Service and Resources

DVA Provision in Norwich/Norfolk (Routes to Support Data, Women's Aid, 2020, *indicates Norfolk-wide data)				
Number of Services	**2016-2017**	**2017-2018**	**2018-2019**	**2019-2020 (Snapshot 01/05/20)**
Refuges (number)	1	1		1
Floating support (number)	0	0		0
Helpline (number)	0	0		1
Outreach (number)	1	1		1
Drop-in*	1	1		1
Support groups*	1	1		1
Counselling*	0	0		0
Resettlement (number)	0	0		1
Prevention & education (number)	1	1		1
Refuge spaces available*	43	52		61

The Routes to Support Data shows that at 1st May 2020, most services had remained constant. New services shown on the table are a helpline and resettlement service Drop in, support group and counselling figures are for the whole county of Norfolk. Refuge spaces shown are also for the whole Norfolk authority area, and 55 of the 61 spaces are shared with Suffolk County Council. Women's Aid figures for Norfolk in 2019/20 put the shortfall figure for the whole county at 30 refuge spaces per 10,000 population, an increase from 20/10,000 the previous year.

Staffing Levels

The data provided by the SafeLives practitioner survey provides information on the number of staff in Norfolk DVA Services. Table 15

shows that from 2016 to 2019, the number of Idvas and outreach workers has increased, whilst other posts, such as Isva and young person's violence advisor, have reduced. Most of these figures show the number of full time equivalent (FTE) posts, but the figures for refuge and children's support workers is a count of workers.

Table 15: DVA Staffing Levels in Norfolk 2016 - 2019 (SafeLives Practitioner Survey).

Position	2016-2017	2017-2018	2018-2019
Idvas (FTE)	10	9	12
Outreach workers (FTE)	7	7.5	21
Refuge workers (number)	Data unavailable	11.3	Data unavailable
Isva (FTE)	Data unavailable	3	Data unavailable
Young person's violence advisor (FTE)	Data unavailable	2	0
Children's support workers (number)	Data unavailable	4	Data unavailable

SafeLives calculate that in 2018/19 the number of Idvas in post was 63% of their recommended staffing level (SafeLives Area Profile Tool, 2020).

Women's Aid 'Routes to Support' data for Norfolk in 2020 shows the staffing levels for three organisations in the Norfolk area, these are show in Table 16 below.

Table 16: Staffing Levels for Norfolk DVA services (Routes to Support Data)

Site Location	Staffing Level May 2020
Leeway Domestic Violence and Abuse Services	5 full time and 16 part time staff in refuge including children's workers. 12 full time and 17 part time staff in non-refuge services
Pandora	2 full time, one Idva and one CYP worker, 5 part time
Norwich Connect	1 Business support staff, 1 Complex Needs Idva, 2 community Idva, 2 Engage workers, 3 Children and Young person's workers, 1 Group worker, 1 Skills Enhancer, 1 Peer Co-Ordinator and the Project Lead.
The Haven Project	No data available

The Local Picture

Norfolk Office of the Police and Crime Commissioner

A scoping exercised conducted to inform the needs analysis document published by the Norfolk Office of The Police and Crime Commissioner in 2016 detailed the level of service provision in Norfolk. This showed variance in service provision across Norfolk and Norwich was the district with the highest number of DVA services while North Norfolk and South Norfolk districts had the least (see Table 17 below).

Table 17: OPCC Norfolk - Domestic Abuse Needs Assessment Data 2016

	DA services	IPV services	Sexual abuse	Familial
Norwich	92	65	63	62
Norfolk	65	43	42	41

The needs assessment document also draws attention to the need for specific services for the LGBTQ+ community, ethnic minority groups and children.

A needs assessment of DVA services for children and young people found that service provision across Norfolk for children and young people experiencing DVA was extremely unequal with children in some areas unable to access any provision. As with the OPCC needs analysis report, service provision in Norwich was found to be better than for the County as a whole. Most schools (46/50) in Norwich are signed up to Operation Encompass, the police and education early referral partnership (Norfolk SCB Annual Report 2018)[41].

Current information about the local domestic abuse picture can be found on the Office of the Police and Crime Commissioner website. The OPCC support Norwich Connect, together with Norfolk County Community Partnership, SafeLives and Spurgeons Children's Charity.

DVA and its impact also featured in the Norfolk Safeguarding Children's Board Annual Report for 2017 to 2018. The report identified DVA as a strategic challenge that required a direct response from various agencies and services, particularly in relation to preventing children from becoming victims. Key initiatives for children identified include: closer alliances between Norfolk Safeguarding Children's Board and the Domestic Abuse and Sexual Violence Board, the introduction of Encompass that enables any schools who are signed up to the programme to be alerted when a pupil has been involved in a domestic abuse incident and the establishment of a charity working with adolescent perpetrators.

Project CARA (Conditional Cautioning and Relationship Abuse) was publicised in December 2019. This project will see some DVA perpetrators given Conditional Cautions prior to compulsory attendance on a two-day workshop.

[41] https://www.norfolklscb.org/wp-content/uploads/2018/11/NSCB-Annual-Report-2017-18_FINAL.pdf

Norfolk County Council Resources.

Norfolk's Community Safety Partnership includes a Domestic and Sexual Violence Board (DASVB).In 2016, the Norfolk Domestic Abuse Change Programme was launched, with both groups working together to improve integration of services, increase community resilience and protect the most vulnerable groups (Office of the Police and Crime Commissioner for Norfolk, 2016).

The Domestic Abuse Change Champions Network, was established by Norfolk County Council in 2015. A team of Domestic Abuse Change Coordinators recruit and train frontline workers including council employees, community groups, and beauticians and hairdressers, to be able to recognise and respond effectively to DVA.

Awareness campaigns are also part of the DASVB remit, with the board recently promoting the 'Things Need to Change' campaign which included six short videos involving victims addressing their abuser being released.

Additional information and resources can also be found on the Norfolk County Council website. On this site various topics are covered, including advice on how to get help, links for professionals and employers and workplace policies.

Information on children, young people and DVA is located on Norfolk Insight website, with Norfolk County Council and Norfolk Constabulary producing a joint strategic document in 2018 focusing upon young people and DVA indictors and interventions.

Covid-19

Emergency Covid-19 funding of £250,000 from the Ministry of Justice, managed by the OPCCN was distributed to DVA organisations in Norwich in May 2020. Organisations included Norwich Connect – additional hours for one staff member (and to Leeway, Daisy and other services:
https://www.norfolk-pcc.gov.uk/news/vital-funding-secured-for-domestic-abuse-and-sexual-violence-services-in-norfolk/

Norfolk Constabulary launched the You Are Not Alone campaign to encourage victims of domestic abuse to seek help, with domestic abuse helplines recording a 25% increase in calls since the start of the pandemic (Lynn News, 2020a).

Similarly, Norfolk County Council and Norfolk Children's Safeguarding Partnership have designed a series of social media assets to encourage the public to work together to help vulnerable populations, including victims of domestic abuse. Their key message has been 'See Something, Hear Something, Say Something'.

Live multi-agency online forums and chats have been initiated during lockdown as offering another means for agencies to reach out to DVA victims (Lynn News, 2020b).

BBC Norfolk (2020) reported that the pandemic has caused court hearings to be delayed or cancelled due to social distancing guidelines.

Other news stories (2018-2020)

Continued funding for the Domestic Abuse Change Coordinators Scheme was reported in the local press in January 2020.

https://www.edp24.co.uk/news/politics/pledge-over-cash-for-domestic-abuse-scheme-1-6465318

In February 2019, Channel 5 aired The Abused, a documentary describing Norfolk Constabulary's investigation of two DVA incidents and the impact of these attacks for victims.

Murder of Kerri McAuley

In January 2017, Kerri McAuley was killed by her ex-boyfriend in her home. The brutal nature of this crime attracted media attention, awareness campaigns and conversations with government ministers.

Following her murder, Kerri's friends and family worked with local DVA organisation Leeway and the local Eastern Daily Press newspaper on 'Kerri's Campaign' to raise awareness of DVA.

In 2018, Kerri's Campaign was used to inform government policy on DVA and contributed to the Domestic Bill.

Kerri's story has also been used to promote the Domestic Abuse Champions' work, with training events for domestic abuse co-ordinators featured on the Victoria Derbyshire programme in February 2019.

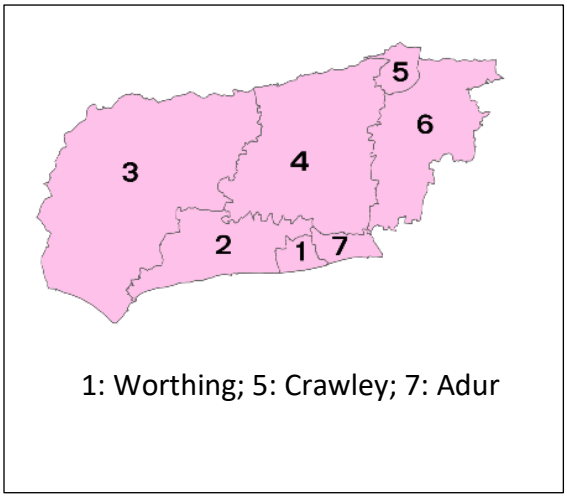
West Sussex Site Profile

West Sussex is a county area in the South East of England that covers a total of 1991km^2. The area is policed by Sussex Constabulary and sits across East Sussex County Council and Brighton and Hove City Council.

This profile reports on data at the West Sussex county level, with information about the three 'intervention districts' presented where available. Police data and SafeLives practitioner data are gathered and reported at the Sussex Constabulary level.

The SafeLives interventions are being delivered in three of the seven district or borough councils: Worthing, Adur, and Crawley. Adur District Council and Worthing Borough Council are neighbouring areas on the coast and Crawley Borough Council is in the north of the county on the border with Surrey.

West Sussex is one of two national SafeLives pilot sites.



1: Worthing; 5: Crawley; 7: Adur

Location of West Sussex in the UK and the location of SafeLives sites within the county.

Population of West Sussex

Gender:

West Sussex has a population size of 863,980, with 51% of the population being female and 49% of the population being male (ONS, 2020a).

Ethnicity

According to the 2011 Census (ONS, 2012a):

- 93.7% of West Sussex's population was White:
  - 88.9% White British.
  - 4.8% White Other.
- 2.1% of the population was from a Black, Asian or Minority ethnic background.
- 89.9% were born in the UK.
- 85.4% of people in West Sussex speak English.

> In England and Wales, 86% of the population was White, with 14% of the population coming from a Black, Asian or Minority ethnic background.

Religion

Table 1 compares the religious make up of West Sussex and the three SafeLives area, with Christianity being the main religion. Crawley has a higher than average percentage of people identifying as Muslim and Hindu compared to West Sussex and national trends.

Table 1: Comparison of Religion in West Sussex, the three SafeLives areas and England and Wales (ONS Census, 2012b)

	Religion						
	Christian	None	Muslim	Sikh	Hindu	Buddhist	Jewish
West Sussex	**61.8%**	**26.9%**	**1.6%**	**0.1%**	**0.9%**	**0.4%**	**0.2%**
Adur	58.6%	31.3%	1.0%	-	0.2%	0.3%	0.4%
Crawley	66.1%	26%	7.2%	0.7%	4.6%	0.4%	0.1%
Worthing	58.1%	30.2%	1.3%	0.1%	0.5%	0.6%	0.2%
England & Wales	59.3%	25.1%	4.8%	0%	0%	0.4%	0.5%

Age

The average age of people living in West Sussex was 44.7 years old (West Sussex JSNA, 2020), with this being four years older than the mean age of 40.3 years for the whole of England

(ONS, 2020b). Table 2 provides an overview of age trends per SafeLives site areas, alongside national trends.

Table 2: Percentage Overview of Age Profile of SafeLives Site Areas and National Trends (ONS, 2020b)

Age Group	Adur	Crawley	Worthing	England
0 to 15	18.5%	22%	17.8%	19%
16 to 64	58%	64.4%	59.6%	62.5%
65 to 84	23.5%	13.6%	22.6%	18.5%
85+	3.4%	2.1%	3.7%	2.5%
Mean Age (years)	45.7	37.5	45.2	40.3

Marital Status

Data from the 2011 Census showed that just over half of individuals living in West Sussex were married (50.6%), with this being higher than the national average (46.6%).

Table 3: Marital Status of West Sussex and England in 2011 (ONS Census, 2012c)

Marital Status	West Sussex	England
Married	50.6%	46.6%
Single	28.8%	34.6%
Divorced	9.7%	9%
Widowed	8.2%	6.9%
Separated	2.5%	2.7%
Same-sex civil partnership	0.2%	0.2%

Poverty Indicators

Index of Multiple Deprivation (IMD)

West Sussex is one of the least disadvantaged 'upper tier authority' areas in England, ranking 131st out of 152 authorities in the indices of multiple deprivation (Department for Communities and Local Government, 2015). However, there is variation across the county, with pockets of deprivation being identified. Broadfield South ward, in Crawley, was in the top 20% deprived areas in England. Adur did not have any wards in the top 20% of the most deprived areas but did have three lower super output areas[42] in the top 20% deprived areas in England (Sussex Community Foundation, 2016).

[42] Smaller areas than wards which have an average population of 1,500.

Child Poverty

In 2016, 11.3% of children in West Sussex lived-in low-income families while 17% of children nationally were living in low income households (West Sussex County Council, 2019).

Across the South East, 6% of children under the age of 16 lived in out of work households in 2018, with this being lower than the national average of 10.3% (NOMIS, 2020a).

Less than a tenth of children living in West Sussex received free school meals in 2018 (7.4%), with this also being lower than the national average of 13.7% (Public Health England, 2020a).

Whilst levels of child poverty in West Sussex's are lower than the rest of the UK, figures from End Child Poverty (2019) indicate that between 2017 and 2018, 30% of children in Crawley, 24% of children in Adur and 23% of children in Worthing were living in poverty.

Homelessness

Table 4 provides a comparison of homelessness in West Sussex and within England, with rates of homelessness at a local level being lower or similar to national trends (Public Health England, 2020b).

Table 4: Comparison of Homelessness in West Sussex and England 2018

Type of Homelessness	West Sussex	England	Difference
Statutory Homelessness - not priority need	0.7%	0.8%	-
Statutory Homelessness - households in temporary accommodation	1.7%	3.4%	↓
Statutory Homelessness per 1,000 households	1.7%	2.4%	↓
Homeless young people aged 16 to 24	0.5%	0.5%	-
Family homelessness	1.2%	1.7%	↓

Housing and Tenure

The average house price in West Sussex in January 2019 was £325,907, with this being the higher than the national average price of £244,567 (HM Land Registry, 2020).

The 2011 Census reported that 71.4% of people owned their home in West Sussex, with this being higher than the national average of 64.1% (ONS Census, 2012d). Social housing accounted for 12.8% of ownership, with this being below the national average of 17.7% (Table 5).

Table 5: Home Ownership in West Sussex and Nationally (ONS Census, 2012d)

	Location Comparison		
Ownership Type	**West Sussex**	**National Average**	**Difference**
Owner occupied	71.4%	64.1%	↑
Owned outright	36.4%	30.6%	↑
Owned: mortgage/loan	34.2%	32.8%	↑
Shared ownership	0.7%	0.8%	-
Social rented households	12.8%	17.7%	↓
Council	4.9%	9.4%	↓
Housing Association or Social Landlord	7.9%	8.3%	↓
Private landlord or letting agency	13.1%	15.4%	↓

From the 2011 Census, 2.4% of households lacked central heating, with this reflecting the national figure (2.7%). Nationally, 25.6% of households did not have a car, but in West Sussex, this figure was 17.8% (ONS Census, 2012f).

Employment, Education and Qualifications

In 2019, 82% of people were employed, with this being higher than the national average of 76.8% (NOMIS, 2020b). Most people were employed by someone else (67.7%), with 13.4% of people being self-employed. The unemployment rate was 3%, similar to the national average of 3.9%.

The average hourly pay in 2019 was £15, with this being close to the national average of £14.94 (NOMIS, 2020c). By May 2020, 5.5% of people were claiming out of work benefits, with this being lower than the national average of 7.8% (NOMIS, 2020d).

The level of qualifications held by people in West Sussex was slightly higher than the national (Table 6).

Table 6: Qualification Levels of West Sussex and the UK (NOMIS, 2020e)

Level of Qualification	West Sussex	UK	Differ
NVQ4 +	41.9%	40%	↑
NVQ3 +	60.3%	59%	↑
NVQ2 +	79.1%	76%	↑
NVQ1 +	89.9%	86%	↑
Other Qualifications	4.9%	7%	↓
No Qualifications	5.2%	8%	↑

'Brexit' – Voting on Membership of the EU

In West Sussex 46.5% of people voted to remain in the EU, compared to 53.6% who wanted to leave. At a national level, 48.1% of people voted to remain, with 51.9% of people opting to leave (The Electoral Commission, 2019).

Health, Wellbeing and Disabilities

Life Expectancy

The life expectancy of women living in West Sussex (84.2 years) was reflective of national figures (83.4 years), with the life expectancy of men (80.8 years) slightly above the national average (79.8 years) (Public Health England, 2020c).

Health Statistics

More men per 100,000 population were admitted to hospital due to alcohol than women during 2018 to 2019 (Public Health England, 2020d). At a national level, rates of admission due to alcohol were lower for both genders (Table 7).

Table 7: Hospital Admissions due to Alcohol by Gender for West Sussex and England, 2018 to 2019, per 100,000 population

Gender	West Sussex	England	Difference
Male	739	809	↓
Female	448	473	↓

For 2016-18, the suicide rate for 100,000 population was 8.5, with this being lower than the average rate for England (9.6 per 100,000 population) (Public Health England, 2020e).

Crime

Recorded Crime

In the year ending 2019, the overall crime rate per 1,000 people was 74.8 (ONS, 2020c), with this being lower than the crime rate for England (88 per 1,000 population). Crime rates in Sussex were lower than national crime rates (Table 8).

Table 8: Police Recorded Crime (per 1000 population) in 2019 for Sussex and England (ONS, 2020c)

Type of Crime	Sussex	England	Difference
Total recorded crime (excluding fraud)	74.8	88	↓
Violence against the person	25.7	29.1	↓
Violence with injury	8.7	9.1	↓
Violence without injury	11.3	12	↓
Stalking and harassment	5.6	8	↓
Sexual offences	2.8	2.7	-

Domestic Violence and Abuse

Table 9: Combined domestic abuse-related incidents and offences 2016/17 & 2019/2020

	2016-2017		2019-2020	
	Number	**Rate/1000**	**Number**	**Rate /1000**
Sussex	23,559	14	29,004	17

In Sussex there were 23,559 DVA incidents and crimes reported to Sussex police between 2016 and 2017 (population 858,000, 2012), rising to 29,000 between 2019 and 2020, equating to 17DVA incidents per 1,000 population (Table 9).

A total of 12 domestic homicides were recorded by Sussex Constabulary during 2016 and 2018. During the same period, 336 domestic homicides were recorded in England (ONS, 2019b).

Hate Crime

Data published by the Home Office (2018) shows that between 2017 and 2018, 736 hate crime incidents were recorded in Sussex?. During the same period, 87,465 hate crimes were recorded across England, with Sussex accounting for less than 1% of such crimes.

Children's Social Care Data

In March 2019, 421.8 per 10,000 children had a Children in Need plan within West Sussex, with this being lower than the rate across England (592.9 per 10,000 children) (Department for Education, 2020a).

At the end of children in need assessment, of the 7,660 cases that had assessment information available, 61% of cases identified domestic violence as a contributing factor.

Across England, 50.6% of cases identified domestic violence as a factor (Department for Education, 2020b).

DVA Service Provision (Women's Aid & SafeLives Data)

Challenges for Victims and Survivors

The SafeLives' practitioner survey conducted in 2018 reports that the top three challenges facing victims and survivors of domestic violence in West Sussex were:

1. Housing.
2. DA service provision is insufficient to meet demand.
3. No long-term support available.

MARAC Information

Multi-Agency Risk Assessment Conferences (MARAC) are held monthly to discuss those victims that are at the highest risk of serious harm or death. Since 2016, the number of MARCS have increased, particularly those involving children (Table 10). Over half of all MARAC cases are referred by partner agencies (53-58%), rather than the police.

Table 10: Number of MARACs between 2016 and 2019

Case Type	2016 - 2017	2017 - 2018	2018 - 2019
All MARAC referrals	1,939	2,101	2,549
With children (including repeats)	2,120	2,533	3,120
With children (excluding repeats)	-	1,801	2,309

In 2016 to 2017, there were 28 MARAC referrals per 10,000 adult females, with this increasing to 37 per 10,000 females in 2018/19. The number of repeat referrals has decreased from 32% in 2016/2017, to 26% in 2018/19.

The characteristics of cases is outlined in Table 11, with the biggest increase in referrals associated with disabled victims.

Table 11: Characteristics of MARAC Referrals from 2016 to 2019

Case Characteristic	2016 - 2017	2017 - 2018	2018 - 2019
Male victim	4.5%	13.1%	6%
LGBT victim	2.5%	7.9%	3.2%
Disabled victim	14.4%	13.6%	20.4%
Young victim (16 to 17)	1.5%	0.6%	4.7%

Services

Table 12 provides an overview of the number of support services and resources recorded in the Women's Aid 'Routes to Support' dataset since 2016. Overall support services and resources in West Sussex are shown to have remained consistent over the four-year period, although there has been an increase in dedicated CYP services and support group provision.

Table 12: Overview of West Sussex Support Service and Resources between 2016 and 2020.

DVA Provision in West Sussex (Routes to Support Data, Women's Aid, 2020)				
Number of Services	**2016-2017**	**2017-2018**	**2018-2019**	**2019-2020 Snapshot 01/05/20**
Refuges (number)	2	2		2
Floating support (number)	0	0		0
Helpline (number)	0	0		0
Outreach (number)	0	0		2
Drop-in	0	0		0
Support groups	1	1		2
Counselling	1	0		1
Dedicated CYP service (number)	1	2		2
Resettlement (number)	0	1		0
Prevention & education (number)	0	1		1
Refuge spaces available	19	19		17

In 2019 Women's Aid estimate the shortfall in refuges spaces for West Sussex to be 69 spaces.

Staffing Levels

Table 12 provides an overview of staffing levels from the SafeLives practitioners survey in the period 2016 to 2019. During this time, the number of Idvas and outreach workers has increased. The number of perpetrator case workers was not requested in 2018/19.

Table 13: DVA Staffing Levels 2016 – 2019 in Sussex (SafeLives Practitioner Survey)

Position	2016-2017	2017-2018	2018-2019
Idvas	14.1	25.9	38
Outreach workers	5	3.8	10.4
Refuge workers	Data unavailable	2.6	Data unavailable
Isva	Data unavailable	2	Data unavailable
Young person's violence advisor	Data unavailable	2	3.2
Children's support workers	Data unavailable	0.6	2
Perpetrator case workers	Data unavailable	4	Data unavailable

SafeLives calculate that in 2018/19 the number of Idvas in post exceeded their minimum staffing level (127% of their recommended staffing level, SafeLives Area Profile Tool, 2020).

The Local Picture: Activity at a County Level

West Sussex County Council.

Information about domestic abuse can be found on the West Sussex County Council website. There are links for professionals, details of support services, information for friends and family and the signs of an abusive relationship.

In May 2019, West Sussex Children's Social Care was rated as 'inadequate', with frequent changes in workforce, particularly at a corporate and management level, being part of the problem. The impact this has on children and families was described as 'profound'.

Office of the Police and Crime Commissioner

Work done by the Sussex's Office of the Police and Crime Commissioner (PCC) in relation to preventing DVA and supporting service provision can be found on their website.

Sussex received £700,000 in emergency funding from the Ministry of Justice to help charities and organisations to support victims during the COVID-19 lockdown. This money will help fund additional roles, maintain support channels and purchase communication equipment. The PCC Office has helped to distribute shopping bags with domestic abuse support branding throughout the county. These bags offer a means of raising awareness of the support on offer and how it can be accessed.

The Sussex Police and Crime Plan 2017 to 2021 can also be accessed on the site, with this document making a commitment to increase the reporting of domestic abuse incidents and creating more services for victims.

Media Coverage

Domestic Homicide During Lockdown in March 2020 the death of a man, woman and their two children received national media attention. A murder enquiry has been launched. The incident took place in Woodmancote, near Horsham (not one of the SafeLives sites). https://www.theguardian.com/uk-news/2020/mar/30/family-of-four-and-their-dog-found-dead-at-their-west-sussex-home

Sussex Police Response to Domestic Abuse During Lockdown Sussex Constabulary's response to domestic abuse during lockdown was recognised nationally – in the governments 'Hidden Harms summit' held in May 2020 and in a visit by the Home Secretary. The Hidden Harm's press release stated: *"Cumbria, South Wales and Sussex Constabularies are piloting new approaches to tackling domestic abuse, including methods for better identifying those posing the highest risk of offending and multiagency approaches to prevent re-offending. Forces will be working with the College of Policing to evaluate the effectiveness of these approaches with a view to wider dissemination across forces as appropriate"* https://homeofficemedia.blog.gov.uk/2020/05/22/hidden-harms-summit-factsheet/

PEEL (Police Effectiveness, Efficiency and Legitimacy) Inspection 2020 In February 2020, Sussex Police was inspected by HM Inspectorate of Constabulary, with the force being rated satisfactory in most areas, but 'ineffective' at protecting domestic abuse victims (similar concerns were raised in an inspection in 2016). Although the force was seen to effectively deal with incidents when they respond to a call, responses to non-emergency 101 calls was high, causing incidents not to come to police attention at all.

Following the death of Shana Grice in 2016, Sussex Police were ordered to improve stalking probes, since Shana had contacted the police on numerous occasions to report her ex-boyfriend for stalking. At the time, Shana was fined for wasting police time. Not long after, her ex-boyfriend had murdered her. Shana's death resulted in three police officers facing disciplinary action due to the way they handled her calls and the commissioning of a report into the case by the Police and Crime Commissioner.

Drive Between 2016 and 2019, West Sussex, along with Essex and South Wales, were part of SafeLives' Drive programme that provided one-to-one counselling for DVA offenders. The evaluation of this intervention found that working with offenders and supporting victims reduced incidents of domestic abuse more than just supporting the victim. Drive is now being recommended as a national perpetrator intervention programme.

Appendix 2: Outcome Measure for Service Users

Shared Roadmap for System Change

Transforming the response to women and girls who have experienced domestic abuse

Evaluation of {name of service}

Outcome measure for service users: T1

Service user number:	
Date of birth:	
Area Code:	
Today's date:	/ /

You are being asked these additional questions by researchers from the University of Central Lancashire who are evaluating this service. We want to identify any changes in your life that occur while or after you are using the service. The questions should only take about 5 minutes to complete.

It is your choice whether to complete these questions. There are no correct answers and your responses will be confidential.

Please put your completed form in the attached envelope, seal it and hand it to the member of staff who gave it to you and they will post it directly to the researchers.

Many thanks for your help – completing these questions will help us understand whether this service is making a difference.

Your Safety

1. Can you rate the following statements thinking about your experience <u>over the last 2 weeks</u>.

	None of the time	Rarely	Sometimes	Often	All of the time
I have felt safe	❑	❑	❑	❑	❑
My home felt safe and secure	❑	❑	❑	❑	❑
I have felt safe moving around my neighbourhood	❑	❑	❑	❑	❑
I have felt safe online	❑	❑	❑	❑	❑
I have felt that it is safe for my children to spend time with their father (if relevant)	❑	❑	❑	❑	❑
I know where I can go for help when I need it	❑	❑	❑	❑	❑

Your Coping and Confidence

2. Can you rate the following statements thinking about how you have felt <u>over the last two weeks:</u>

	Never	Not very often	Some of the time	Most of the time	All of the time
I have felt able to cope if things have gone wrong	❑	❑	❑	❑	❑
I have felt able to deal with my daily life	❑	❑	❑	❑	❑
I have been able to make my own decisions	❑	❑	❑	❑	❑
I have felt able to speak to people about my experiences of abuse, if I wanted to	❑	❑	❑	❑	❑
I have been able to manage my use of alcohol/medication/ drugs	❑	❑	❑	❑	❑
I have been able to get a good night's sleep	❑	❑	❑	❑	❑
I have been confident about doing new things	❑	❑	❑	❑	❑
I have felt in control of my life	❑	❑	❑	❑	❑
I have good relationships with my children	❑	❑	❑	❑	❑
I have known that I was not responsible for the abuse that happened to me	❑	❑	❑	❑	❑
I have been able to recognise if other people have been behaving abusively	❑	❑	❑	❑	❑

Your Wellbeing

3. Please tick the box that best describes your experience of each over the past 2 weeks:

	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future	❑	❑	❑	❑	❑
I've been feeling useful	❑	❑	❑	❑	❑
I've been feeling relaxed	❑	❑	❑	❑	❑
I've been dealing with problems well	❑	❑	❑	❑	❑
I've been thinking clearly	❑	❑	❑	❑	❑
I've been feeling close to other people	❑	❑	❑	❑	❑
I've been able to make up my own mind about things	❑	❑	❑	❑	❑

Your Physical and Mental Health

The following questions are used in many settings to ask about people's general health and wellbeing. Please fill them in. They may or may not apply to your health today.

4. By placing a tick in one box in each group below, please indicate which statements best describe your own health state today.

Mobility

I have no problems walking about ❑

I have some problems walking about ❑

I am confined to bed ❑

Self care

I have no problems with self-care ❑

I have some problems washing or dressing myself ❑

I am unable to wash or dress myself ❑

Usual Activities
(e.g. work, study, housework, family or leisure activities)

I have no problems with performing my usual activities ❑

I have some problems with performing my usual activities ❑

I am unable to perform my usual activities ❑

Pain/Discomfort

I have no pain/discomfort ❑

I have moderate pain/discomfort ❑

I have extreme pain/discomfort ❑

Anxiety/Depression

I am not anxious/depressed ❑

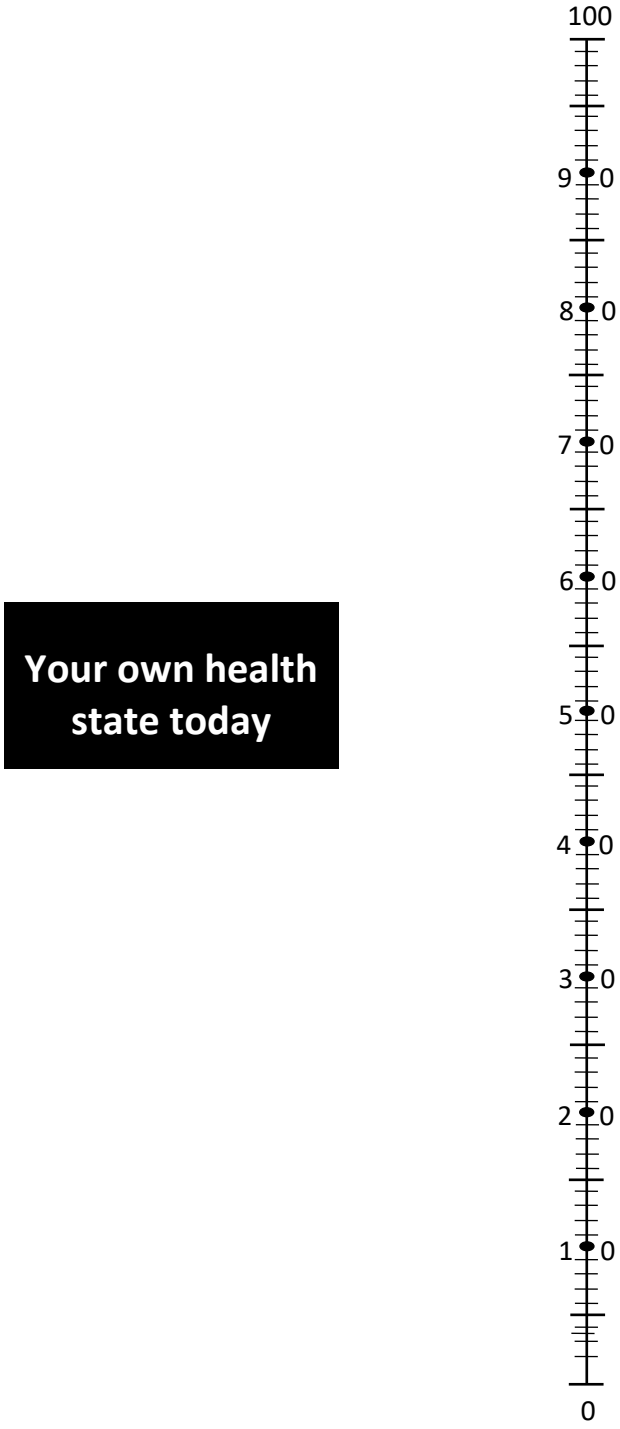
I am moderately anxious/depressed ❑

I am extremely anxious/depressed ❑

5. **To help people say how good or bad a health state is, we have drawn a scale (rather like a thermometer) on which the best state you can imagine is marked 100 and the worst state you can imagine is marked 0.**

   We would like you to indicate on this scale how good or bad your own health is today, in your opinion. Please do this by drawing a line from the box below to whichever point on the scale indicates how good or b

Best imaginable health state/
best health state I can imagine



Worst imaginable health state/
worst health state you can imagine

Appendix 3: Roadmap Context

Table 3.1 Attendees at Stakeholder Consultation Groups 2019 (Year 1) and 2020 (Year2)

	Norwich		Nottingham /Shire		Sunderland		Surrey		West Sussex		Total	
Year	**1**	**2**	**1**	**2**	**1**	**2**	**1**	**2**	**1**	**2**	**1**	**2**
Community Safety			2	2	1		1				**4**	**2**
Local Authority		2			1	1	1	2		4	**2**	**9**
Early Help/ Intervention	4				1	1			1		**6**	**1**
Health		2	1					1			**1**	**3**
Housing / Homelessness					1	1					**1**	**1**
Roadmap Intervention Provider	1		2	1	1	3	2	2	2		**8**	**6**
Other DVA Agency		1	1						2	2	**3**	**3**
Police/OPCC	1	1	2	1			2	1			**5**	**3**
Probation			2						1		**3**	**0**
Public Health	1	1		3		1					**1**	**5**
Safeguarding Board					1						**1**	**0**
Other Service Provider		3		4	1			1	2		**3**	**8**
Total	**7**	**10**	**10**	**11**	**7**	**7**	**6**	**7**	**8**	**6**	**38**	**41**

Table 3.2: Whole System Survey responses by site

Organisation	Site	Response	%
SafeLives	Norfolk	31	31.6
	West Sussex	20	20.1
	Not stated /missing	1	1
Women's Aid	Nottingham/shire	13	13
	Surrey	18	18
	Sunderland	15	15.3
	Total	**98**	**100**

Table 3.3: Organisations responding to the Whole System Survey by Sector

	Frequency	%
Health	26	26.5
Local authority	23	23.5
Education	14	14.3
Housing	8	8.2
Law	9	9.2
Community organisations	11	11.2
DVA /multi-agency organisation	1	1.0
Other	6	6.1
Total	**98**	**100.0**

Appendix 4: Ask Me

Table 4.1 Gender and Ethnicity of Training Participants (Year 1 only)*

These tables indicate the attrition between the Expression of Interest (EOI) stage and completion of training.

	Surrey			Sunderland			Nottingham/shire		
	Applied to the training	**Attended the training**	**Attended the training percentage**	**Applied to the training**	**Attended the training**	**Attended the training percentage**	**Applied to the training**	**Attended the training**	**Attended the training percentage**
Sex									
Female	51	25	49%	44	22	50%	51	20	39%
Male	1	0	0%	0	0		2	0	0%
Unknown	10	6	60%	1	0	0%	15	3	20%
Transgender	0	0		0	0		1	0	0%
Would rather not say	0	0		0	0		1	0	0%
Total	62	31	50%	45	22	49%	70	23	33%
Ethnicity									
Any other mixed/multiple background	1	1	100%	0	0		0	0	
Any other White background	5	2	40%	1	1	100%	0	0	
Arab	0	0		2	1	50%	0	0	
Black British	1	0	0%	0	0		1	0	0%
Asian Background	2	1	50%	3	0	0%	0	0	
White and Asian	0	0		0	0		1	0	0%
White and Black Caribbean	1	1	100%	0	0		1	1	100%
White British	40	16	40%	38	20	53%	50	19	38%
Unknown	12	7	58%	1	0	0%	15	3	20%
Total	62	28	45%	45	22	49%	68	23	34%

* This data is not available for Year 2 participants.

4.2 Age Disclosed Disabilities, Relationship Status and Sexuality of Training Participants (Year 1 only)

	Applied for Ask Me training	Attended the Training	Proportion of applicants attending Ask Me Training
Age			
18-24	12	5	42%
25-34	34	15	44%
35-44	36	9	25%
45-54	37	19	51%
55-64	20	9	45%
65-74	3	2	67%
Unknown/Missing	33	13	39%
Total	**175**	**172**	98%
Disabilities disclosed			
Physical	0	0	
Mobility	5	1	20%
Blind/sight impairment	0	0	
Deaf/hearing impairment	1	1	100%
Speech impairment	0	0	
Mental health condition	8	3	38%
Learning difficulties	2	0	0%
Long-term illness	11	3	27%
'Something else'	6	4	67%
Total	**33**	**12**	36%
Relationship status			
Cohabiting but not married	23	8	35%
Divorced/separated	19	9	47%
In a relationship (not cohabiting)	14	6	43%
Married	56	22	39%
Single	29	13	45%
Widowed	3	1	33%
Unknown/Missing	28	11	39%
Prefer not to say	3	0	0%
Total	**175**	**70**	40%
Sexuality			
Bisexual/ pansexual	5	1	20%
Gay woman/ lesbian	2	1	50%
Gay man	1	0	0%
Heterosexual/ straight	131	57	44%
Unknown/Missing	31	11	35%
Total	175	72	41%

Table 4.3 Demographic details of all training participants for whom an EOI was received (n=318)

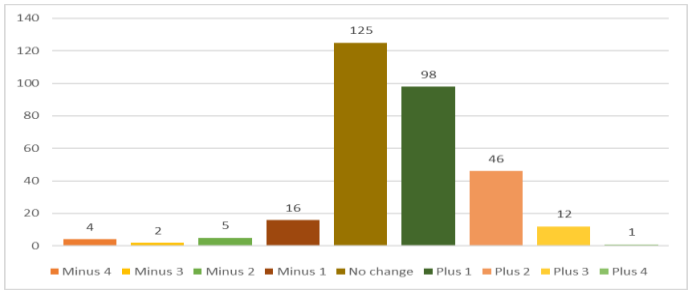
The table below provides details for all those who attended the Ask Me training and completed a WAFE EOI for the period of the whole intervention.

Demographic	Combined EOI data – Y1 and Y2	% of the known sample
	Sex	
Female	286	99%
Male	4	1%
Total	**290**	
Missing	28	
	Ethnicity	
White British	239	84%
BAME	30	11%
Other White Background	15	5%
Total	**284**	
Missing	34	
	Disability	
Yes	34	12%
No	246	88%
Total	**280**	
Missing	38	
	Age	
18-24	22	8%
25-34	64	22%
35-44	76	27%
45-54	79	28%
55-64	35	12%
65-74	9	3%
Total	**285**	
Missing	33	
	Sexuality	
Bisexual/ Gay/ Lesbian	13	5%
Heterosexual/ straight	255	91%
Rather not say	13	5%
Total	**281**	
Missing	37	

Changes in attitudes and understanding for Ask Me Ambassadors immediately following Training

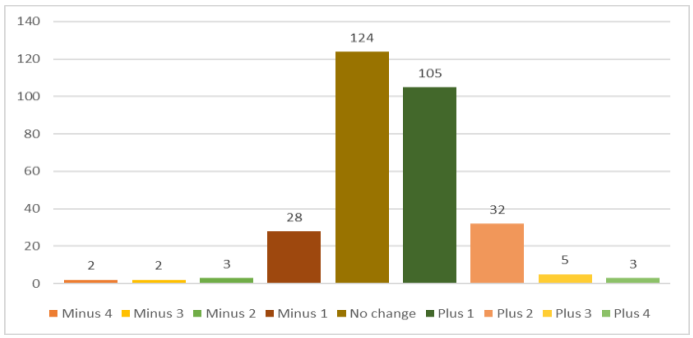
For Figures 4.1-4.13, The non-parametric Wilcoxon signed-ranks test was carried out on all tests relating to these questions due to data being ordinal in nature and not normally distributed. The difference scores, however, were approximately symmetrically distributed, meaning the assumptions of the test were fully met.

Figure 4.1 Pre/post training results for 'Women form the majority of domestic abuse victims and are largely abused by their male partners/ex-partners'



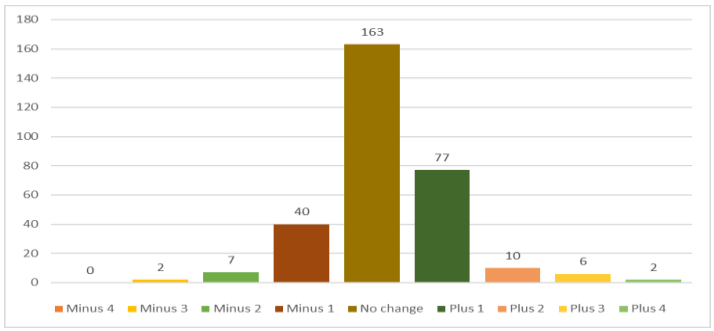
'Minus' = A decline in knowledge; 'Plus' = An improvement in knowledge

Figure 4.2: Pre/post training results for 'Men form the majority of domestic abuse victims and are largely abused by their female partners/ex-partner'



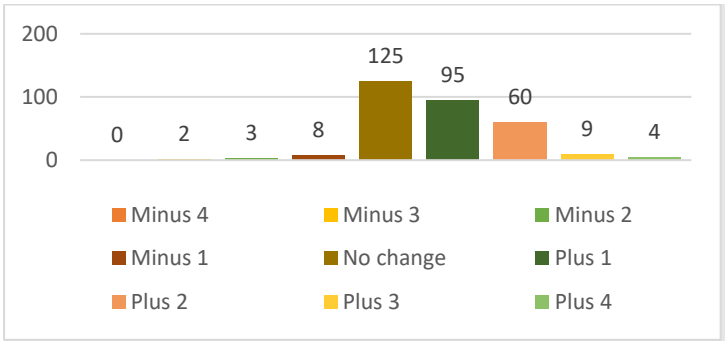
'Minus' = A decline in knowledge; 'Plus' = An improvement in knowledge

Figure 4.3: Pre/post training results for 'Men find it more difficult than women to come forward as domestic abuse victims'



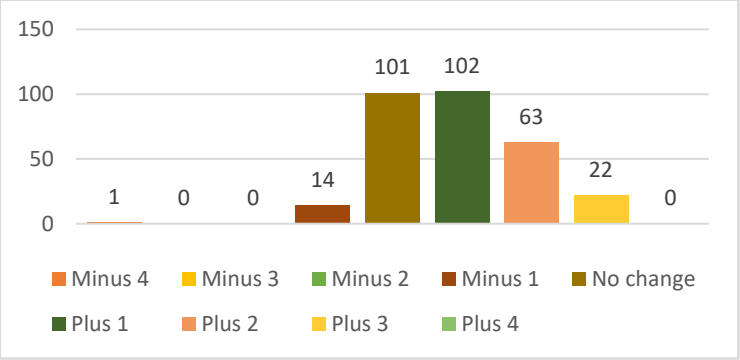
'Minus' = A decline in knowledge; 'Plus' = An improvement in knowledge

Fig. 4.4: Pre/Post training results 'Women in abusive relationships should just leave the relationship'



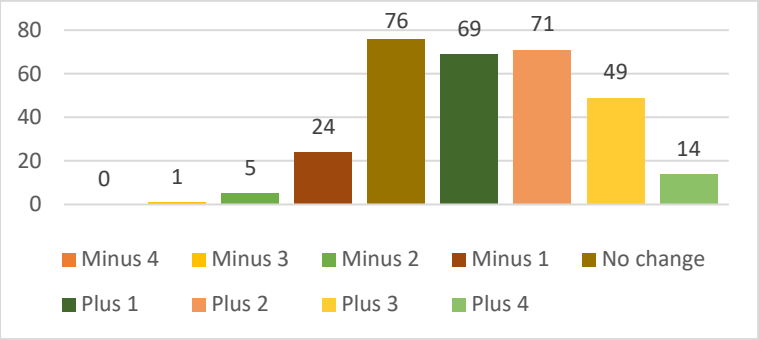
Minus' = A decline in knowledge; 'Plus' = An improvement in knowledge

Figure 4.5: Pre/Post training results ''Some people choose abusive partners'



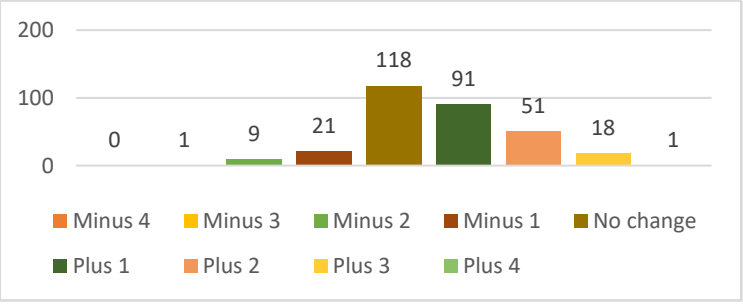
Minus' = A decline in knowledge; 'Plus' = An improvement in knowledge

Figure 4.6 'People who are in an abusive relationship are 'experts' in their own experiences and know how to keep safe'



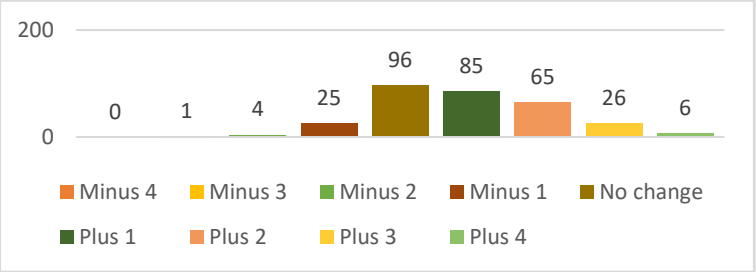
'Minus' = A decline in knowledge; 'Plus' = An improvement in knowledge

Figure 4.7Pre/post training results 'People who get into abusive relationships have low self-esteem problems'



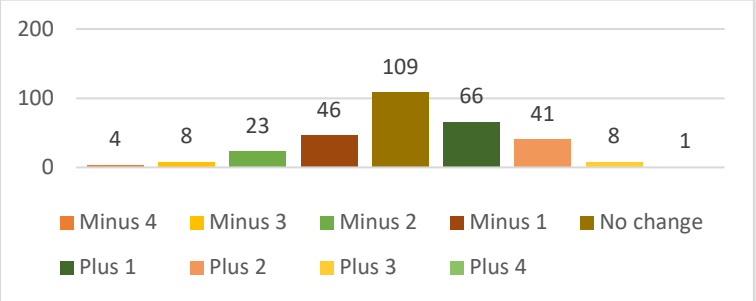
‘Minus’ = A decline in knowledge; ‘Plus’ = An improvement in knowledge

Figure 4.8 Pre/post training results ‘Anger, drugs and drink are largely responsible for abusive behaviour towards partners’



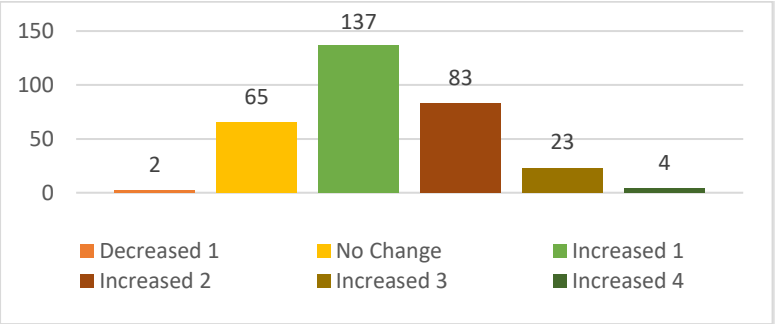
‘Minus’ = A decline in knowledge; ‘Plus’ = An improvement in knowledge

Figure 4.9 Pre/post training results ‘Domestic abuse is part of some black and minority ethnic people’s culture’



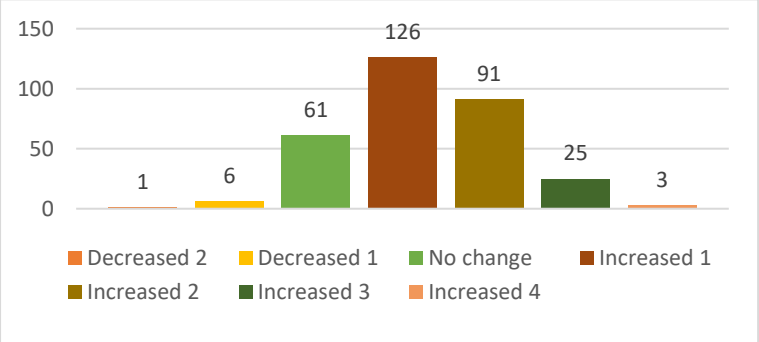
‘Minus’ = A decline in knowledge; ‘Plus’ = An improvement in knowledge

Figure 4.10 Pre/post training results: How would you rate your ability to understand patterns of coercive control and domestic abuse?



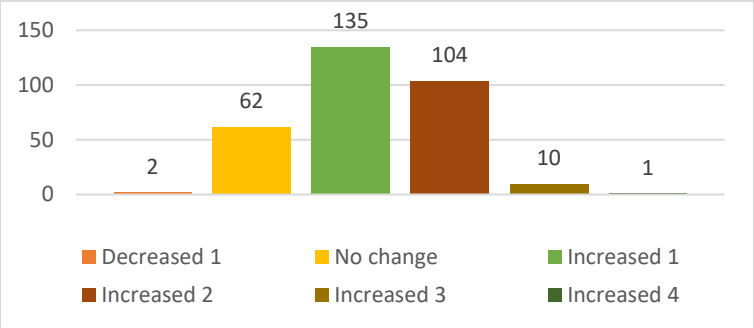
'Decreased' = A decline in perceived skill or confidence; 'Increased' = An improvement in perceived skill or confidence

Figure 4.11 Pre/post training results: How confident do you feel to start a conversation about domestic abuse with others?



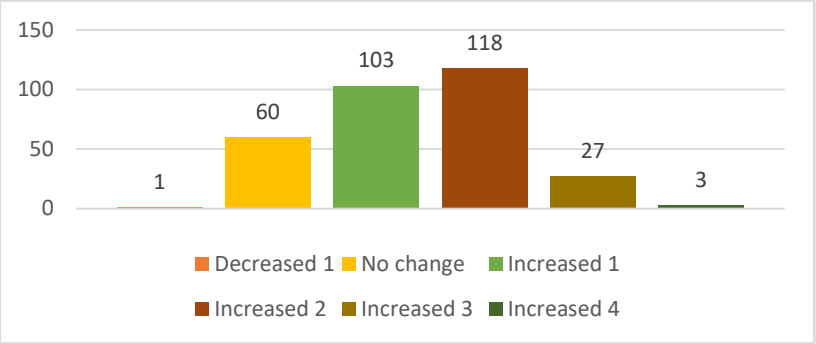
'Decreased' = A decline in perceived skill or confidence; 'Increased' = An improvement in perceived skill or confidence

Figure 4.12 Pre/post training results: 'How do you currently rate your skills and ability to manage and respond to someone sharing their personal experience of domestic abuse'



'Decreased' = A decline in perceived skill or confidence; 'Increased' = An improvement in perceived skill or confidence

Figure 4.13 Pre/post training results 'How confident do you feel in using your skills to share information and help signpost a survivor of an abusive relationship to get support?'



'Decreased' = A decline in perceived skill or confidence; 'Increased' = An improvement in perceived skill or confidence

Appendix 5: Trusted Professional

Knowledge and Confidence re DVA

Figure 5.1 Change in confidence and capability to manage DVA cases pre-post Trusted Professional training

Change pre-post training

Negative | No change | Positive

(n) = max/min pre and post

Responses N pre-post training

	Pre	Post
I have a responsibility to respond when I think someone might be experiencing DA		
strongly disagree/disagree	7	9
neither disagree/agree	8	4
agree/strongly agree	366	368
Total responses pre and post		381
*All participants (n=404)		
I have sufficient training to assist individuals in situations of DA		
strongly disagree/disagree	121	17
neither disagree/agree	101	43
agree/strongly agree	160	322
Total responses pre and post		382
*All participants (n=404)		
I am confident I can make appropriate referrals for CYP who have experienced DA		
strongly disagree/disagree	85	35
neither disagree/agree	80	63
agree/strongly agree	195	262
Total responses pre and post		360
*All participants (n=404)		
I understand what coercive control is		
strongly disagree/disagree	40	2
neither disagree/agree	57	6
agree/strongly agree	296	385
Total responses pre and post		393
*All participants (n=404)		
strongly disagree/disagree	46	5
neither disagree/agree	74	13
agree/strongly agree	272	374

Table 5.1 Pre and post respondents (N) by geographical location showing increase (positive ranks) decrease (negative ranks) no change (tied ranks) in DVA knowledge following training.

Table 5.1

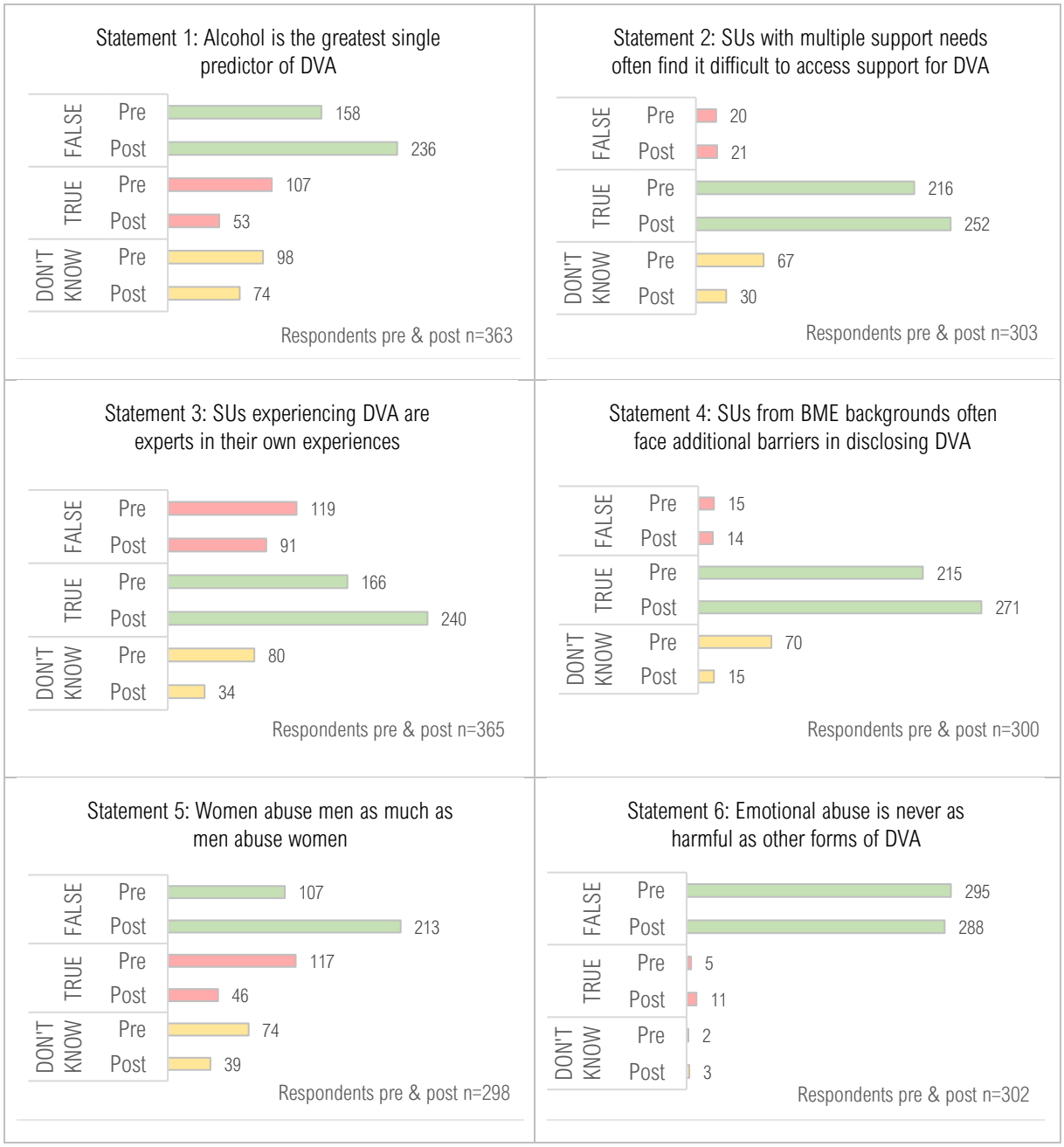
		Pre to post DVA training				
Area	N	Positive Ranks	Negative Ranks	Tied Ranks	z value	Sig.
Nottingham	103	85 (82.5%)	12 (11.7%)	6 (5.8%)	-7.66	**
Sunderland	80	63 (78.9%)	10 (12.5%)	7 (8.6%)	-6.07	**
Surrey	219	206 (94.1%)	8 (3.6%)	5 (2.3%)	-12.42	**

** significance = p <.001.

Beliefs about DVA

To measure change in beliefs about DVA, participants were asked to select 'true', 'false' or don't know' in response to a series of six statements. Figure 5.2 below provides a breakdown of response pre/post DVA training.

Figure 5.2 Changes in beliefs about DVA pre- and post-DVA training



Appendix 6: VOICES

Table 6.1 Referral Outcomes 30 November 2019- 30 November 2020

	All		Your Sanctuary (Surrey)		WWIN Outreach		WWIN Refuge		WA Nottingham	
Referrals	n	%	n	%	n	%	n	%	n	%
Accepted	1644	50.1	678	56.4	820	51.3	-	-	146	52.1
Rejected	1326	40.4	478	39.8	778	48.7	-	-	70	25.0
Waiting list	110	3.4	46	3.8	0	0.0	-	-	64	22.9
Total Referrals	**3080**		1202		1598				280	

*WWIN refuge record outcomes differently according to the summary data received.

Table 6.2 Completion of Outcome Measures at T1, T2 and T3.

Safety, Coping & Wellbeing	
Time Point	**Sample Size Range***
T1	63-95
T2	33-50
T3	14-21
T1-T2 Change (paired)	23-37

*Survivors did not complete all items on the measure

Table 6.3 Living Arrangements

	All		Your Sanctuary (Surrey)		WWIN Outreach		WWIN Refuge		WA Nottingham	
Living arrangements	n	%	n	%	n	%	n	%	n	%
Bed and Breakfast	1	0.0	-	-	-	-	1	0.9	-	-
Children's Home / Foster Care	5	0.2	-	-	1	0.1	1	0.9	3	1.7
Home Office Asylum Support	4	0.2	-	-	3	0.3	1	0.9	-	-
Hospital	1	0.0	-	-	1	0.1	-	-	-	-
Hostel	4	0.2	-	-	2	0.2	2	1.8	-	-
LA General Needs	134	6.3	1	0.1	84	8.1	3	2.8	46	26.1
Living with Family / Friends	163	7.7	8	1.0	126	12.1	10	9.2	19	10.8
Military Accommodation	1	0.0	-	-	1	0.1	-	-		-
Mobile Home/Caravan	1	0.0	-	-	-	-	-	-	1	0.6
Other	55	2.6	49	6.1	5	0.5	-	-	1	0.6
Owner Occupier	153	7.2	13	1.6	109	10.5	-		31	17.6
Private Sector	304	14.3	10	1.3	249	24.0	17	15.6	28	15.9
Rough Sleeper	1	0.0	-	-	-	-	1	0.9	-	-
RSL General Needs	108	5.1	-	-	106	10.2	1	0.9	1	0.6
Residential Care Home	1	0.0	1	0.1	-	-	-	-	-	-
Sheltered Housing	1	0.0	-	-	1	0.1	-	-	-	-
Social housing	205	9.6	22	2.8	150	14.4	23	21.1	10	5.7
Sofa Surfing	11	0.5	-	-	7	0.7	4	3.7	-	-
Student Accommodation	5	0.2	1	0.1	4	0.4	-	-	-	-
Supported Housing	43	2.0	1	0.1	31	3.0	4	3.7	7	4.0
Temporary Accommodation	16	0.8	4	0.5	8	0.8	2	1.8	2	1.1
Women's Refuge	41	1.9	1	0.1	7	0.7	33	30.3	-	-
Don't Know	191	9.0	137	17.1	31	3.0	3	2.8	20	11.4
Missing Data	681	32.0	553	69.0	113	10.9	8	7.3	7	4.0
Total	**2130**		**801**		**1039**		**114**		**176**	

Clients can change addresses (and accommodation type) during the time they are supported by the service, which explains the small discrepancy in figures.

Table 6.4 Living with the Perpetrator

	All		Your Sanctuary (Surrey)		WWIN Outreach		WWIN Refuge		WA Nottingham	
Living with perpetrator	n	%	n	%	n	%	n	%	n	%
Yes, all the time	318	15.0	195	24.3	98	9.4	6	5.5	19	10.8
Yes, some of the time	48	2.3	7	0.9	34	3.3	5	4.6	2	1.1
No	1327	62.4	294	36.7	809	77.9	81	74.3	143	81.3
Not Asked/declined	20	0.9	15	1.9	1	0.1	-	-	4	2.3
Missing	412	19.4	290	36.2	97	9.3	17	15.6	8	4.6
Total Survivors	**2125**									

Table 6.5 Income Type

	All		Your Sanctuary (Surrey)		WWIN Outreach		WWIN Refuge		WA Nottingham	
	n	%	n	%	n	%	n	%	n	%
Employed	178	8.4	1	0.1	143	11.4	6	4.2	28	13.2
ESA[1]	46	2.2	-	-	33	2.6	8	5.6	5	2.4
Working Tax Credit	13	0.6	-	-	12	1.0	1	0.7	-	-
Maternity Pay	5	0.2	-	-	5	0.4	-	-	-	-
Carer's Allowance	7	0.3	-	-	7	0.6	-	-	-	-
Carer's/Attendance Allowance	5	0.2	-	-	4	0.3	1	0.7	-	-
Income Support	30	1.4	-	-	19	1.5	4	2.8	7	3.3
Job Seeker's Allowance (JSA)	12	0.6	-	-	5	0.4	4	2.8	3	1.4
Pension Credits	2	0.1	-	-	-	-	-	-	2	0.9
State Pension	10	0.5	1	0.1	7	0.6	-	-	2	0.9
Child Benefit	132	6.2	-	-	106	8.4	15	10.4	11	5.2
Child Tax Credit	69	3.2	-	-	58	4.6	2	1.4	9	4.2
Income from partner	3	0.1	-	-	1	0.1	-	-	2	0.9
DLA or PIP[2]	35	1.6	-	-	25	2.0	8	5.6	2	0.9
Universal Credit	248	11.7	3	0.4	177	14.1	46	31.9	22	10.3
Housing Benefit	43	2.0	-	-	25	2.0	7	4.9	11	5.2
No Income	3	0.1	-	-	-	-	3	2.1	-	-
Student Loan	4	0.2	-	-	4	0.3	-	-	-	-
Do not Know	19	0.9	-	-	13	1.0	-	-	6	2.8
Not Asked	28	1.3	-	-	21	1.7	-	-	7	3.3
Missing Data	1524	71.7	796	99.4	593	47.1	39	27.1	96	45.1

[1]ESA=Employment and Support Allowance; [2]DLA or PIP= Disability Living Allowance or Personal Independent Payment. Women might have more than one income type e.g. be in employment and receive working tax credits.

There are higher levels of missing data as income is an optional field in the OnTrack database. If services do not have to report on this to funders it is unlikely that they collect this data. However, this is a key area for some women in terms of their space for action.

Table 6.6 Current Exposure to Abuse

OnTrack categories changed during the data collection period following suggested improvements by WAFE members.

	All		Your Sanctuary (Surrey)		WWIN Outreach		WWIN Refuge		WA Nottingham	
	N	%	n	%	n	%	n	%	n	%
Abuse type										
Domestic abuse	2060	*96.9*	634	*84.8*	1065	*92.3*	119	*93.7*	242	*95.2*
Forced marriage	1	*0.0*	1	*0.1*	-	-	-	-	-	-
HBV	17	*0.8*	11	*1.5*	3	*0.3*	3	*2.4*	-	-
Gang related violence	2	*0.1*	-	-	-	-	2	*1.6*	-	-
Harassment/stalking	485	*22.8*	88	*11.8*	314	*27.2*	40	*31.5*	43	*16.9*
Rape	103	*4.8*	32	*4.3*	52	*4.5*	14	*11.0*	5	*1.97*
CSA	6	*0.3*	2	*0.3*	4	*0.4*	-	-	-	-
Sexual offences excluding rape	95	*4.5*	29	*3.9*	49	*4.3*	14	*11.0*	3	*1.18*
Sexual exploitation	28	*1.3*	3	*0.4*	11	*1.0*	10	*7.9*	4	*1.57*
Trafficking	3	*0.1*	1	*0.1*	-	-	2	*1.6*	-	-
Prostitution	7	*0.3*	2	*0.3*	-	-	4	*3.2*	1	*0.39*
Types of abuse experienced										
Emotional/psychological	2103	*99.0*	683	*91.3*	1058	*91.7*	115	*90.6*	247	*97.2*
Financial	96	*4.5*	-	-	-	-	-	-	96	*37.8*
Physical	1310	*61.6*	392	*52.4*	697	*60.4*	98	*77.2*	123	*48.4*
Sexual	311	*14.6*	69	*9.2*	170	*14.7*	35	*27.6*	37	*14.6*
Jealous/controlling behaviour	1214	*57.1*	274	*36.6*	648	*56.2*	85	*66.9*	207	*81.5*
Surveillance/ harassment/stalking	840	*39.5*	182	*24.3*	502	*43.5*	61	*48.0*	95	*37.4*

Survivors had experienced DVA for an average of 7 years. Survivors might seek support for current or historical abuse, or a combination of both. Figures for those accessing support for historical abuse is lower, as per the table below.

Table 6.7 Historical Exposure to Abuse

	All		Your Sanctuary (Surrey)		WWIN Outreach		WWIN Refuge		WA Nottingham	
	N	***%***	**n**	***%***	**n**	***%***	**n**	***%***	**n**	***%***
Abuse type										
Domestic abuse	325	*15.3*	29	*18.8*	215	*64.8*	9	*32.1*	72	*84.7*
Forced marriage	1	*0.0*	1	*0.7*	-	-	-	-	-	-
HBV	1	*0.0*	1	*0.7*	-	-	-	-	-	-
Gang related violence	3	*0.1*	-	-	2	*0.6*	1	*3.6*	-	-
Harassment/stalking	58	*2.7*	2	*1.3*	42	*12.7*	3	*10.7*	11	*12.9*
Rape	38	*1.8*	5	*3.3*	23	*6.9*	5	*17.9*	5	*5.9*
CSA	4	*0.2*	2	*1.3*	2	*0.6*	0	-	-	-
Sexual offences excluding rape	38	*1.8*	5	*3.3*	27	*8.1*	3	*10.7*	3	*3.5*
Sexual exploitation	9	*0.4*	-	-	7	*2.1*	2	*7.1*	-	-
Trafficking	2	*0.1*	-	-	1	*0.3*	1	*3.6*	-	-
Prostitution	1	*0.0*	-	-	-	-	1	*3.6*	-	-
Types of abuse experienced										
Emotional/psychological	283	*13.3*	25	*16.2*	187	*56.3*	8	*28.6*	63	*74.1*
Financial	32	*1.5*	-	-	-	-	-	-	32	*37.7*
Physical	232	*10.9*	19	*12.3*	156	*47.0*	9	*32.1*	48	*56.5*
Sexual	100	*4.7*	11	*7.1*	62	*18.7*	9	*32.1*	18	*21.2*
Jealous/controlling behaviour	181	*8.5*	15	*9.7*	109	*32.8*	6	*21.4*	51	*60.0*
Surveillance/ harassment/stalking	90	*4.2*	3	*2.0*	57	*17.2*	4	*14.3*	26	*30.6*

Table 6.8 Support Needs Identified

The table below indicates support needs identified where women were asked about their support needs by their support worker at the outset. Further needs might come to light during support. The percentage indicated is linked to where information is known. Data was missing to varying degrees across all support needs, this has been excluded.

	Total Sample Across sites			Your Sanctuary (Surrey)		WWIN Outreach		WWIN Refuge		WA Nottingham	
Sample Size	2125			801		1039		109		176	
Support Needs	n	Women asked	%	N	Women Asked	n	Women Asked	n	Women Asked	n	Women Asked
Mental health	755	1358	55.6%	81 42.0%	193	506 56.6%	894	69 65.1%	106	99 60.0%	165
Physical health	210	1344	15.6%	21 12.1%	174	146 16.3%	895	27 25.5%	106	16 9.5%	169
Alcohol issues	154	1320	11.7%	20 11.8%	170	105 11.9%	882	24 22.6%	106	5 3.1%	162
Drug issues	120	1310	9.2%	12 7.3%	164	71 8.0%	885	27 25.5%	106	10 6.5%	155

Table 6.9 Accommodation at Exit

Outcome	All n	All %	Your Sanctuary (Surrey) n	Your Sanctuary (Surrey) %	WWIN Outreach n	WWIN Outreach %	WWIN Refuge n	WWIN Refuge %	WA Nottingham n	WA Nottingham %
Accessed Crisis Accommodation	112	20.6	1	4.8	57	15.2	52	44.4	2	6.5
Avoided Eviction Through Support	20	3.7	1	4.8	15	4.0	4	3.4	-	-
Found Suitable Social Housing	105	19.3	3	14.3	73	19.5	20	17.1	9	29.0
Perpetrator removed from survivor property	116	21.4	10	47.6	94	25.1	2	1.7	10	32.3
Resettled Through Support	147	27.1	2	9.5	97	25.9	38	32.5	10	32.3
Scheme Improvements to Security	43	7.9	4	19.0	38	10.2	1	0.9	-	-
Total	**543**	**100.0**	**21**	**100.0**	**374**	**100.0**	**117**	**100.0**	**31**	**100.0**

Table 6.10 Reason for Closure

The table below gives reasons for closures and have been further categorised as planned and unplanned closures. * Fields are more ambiguous (7.7%) and could be either planned or unplanned, so the range for planned closure is 47.6% -55.3% and for unplanned closure 44.4-52.1%

	All		Your Sanctuary (Surrey)		WWIN Outreach		WWIN Refuge		WA Nottingham	
Reason	n	%	n	%	n	%	n	%	n	%
*Entered acute psychiatric hospital	2	0.1	-	-	1	0.1	-	-	1	0.8
*Internal move	51	2.5	1	0.1	36	4.1	11	8.9	3	2.4
*Moved out of area	103	5.1	46	5.2	49	5.5	5	4.1	3	2.4
Total	156	7.7	47	5.3	86	9.7	16	13	7	5.6
Unplanned Closure										
Abandoned tenancy/ refuge stay	21	1	-	-	-	-	21	17.1	-	-
Client disengaged	444	22	161	18.2	252	28.5	4	3.3	27	21.4
Client identified as perpetrator	14	0.7	3	0.3	1	0.1	-	-	10	7.9
Client never engaged	325	16.1	245	27.7	73	8.3	6	4.9	1	0.8
Client unsafe to work with	69	3.4	3	0.3	3	0.3	-	-	63	50
Evicted/asked to leave	12	0.6	-	-	-	-	12	9.8	-	-
Died	2	0.1	1	0.1	1	0.1	-	-	-	-
Support needs too high	11	0.5	2	0.2	6	0.7	2	1.6	1	0.8
Total Unplanned	898	44.4	415	46.8	336	38	45	36.7	102	80.9
Planned Closure										
No longer wants support	321	15.9	103	11.7	181	20.5	20	16.3	17	13.5
Completed prog (non-refuge only)	590	29.3	314	35.5	276	31.3	-	-	-	-
Planned exit from refuge	42	2.1	-	-	-	-	42	34.1	-	-
Ineligible for support after start	6	0.3	3	0.3	3	0.3	-	-	-	-
Total Planned	959	47.6	420	47.5	460	52.1	62	50.4	17	13.5
Missing Data	3	0.1	2	0.2	1	0.1	-	-	-	-
Total	**2016**	**99.8**	**884**	**99.8**	**883**	**99.9**	**123**	**100**	**126**	**100**

Table 6.10.1 – Planned and Unplanned Closures

	All		Your Sanctuary (Surrey)		WWIN Outreach		WWIN Refuge		WA Nottingham	
Reason	n	%	n	%	n	%	n	%	n	%
*Planned/Unplanned	156	7.7	47	5.3	86	9.7	16	13	7	5.6
Unplanned	898	44.4	415	46.8	336	38	45	36.7	102	80.9
Planned	959	47.6	420	47.5	460	52.1	62	50.4	17	13.5
Missing Data	3	0.1	2	0.2	1	0.1	-	-	-	-
Total	2016	99.8	884	99.8	883	99.9	123	100	126	100

Impact

The tables below indicate the impact of the VOICES approach and tools for staff working in specialist DVA services and survivors at exit.

Table 6.11 Staff survey: VOICES approach

	Frequency	Percent
Has VOICES changed your approach to working with survivors?		
Yes	7	*44*
Partially	5	*31*
No	4	*25*
Has VOICES increased the service's focus on survivor needs?		
Yes	12	*75*
No	4	*25*
Has VOICES led to a more strengths-based, trauma-informed approach?		
Yes	10	*62.5*
No	6	*37.5*
Has VOICES led to a change in referral pathways?		
Yes	4	*25*
No	12	*75*

Table 6.12 Completion Rates of POWeR forms

			Your Sanctuary	WWIN Outreach	WWIN refuge	Notts WA	Total completed	Total SUs	Completion Rate (%)
I have been feeling safe			38	171	25	64	298	1800	16.60%
I have been feeling confident			38	13	-	64	115	1691	6.80%
I have been feeling good about myself			38	13	-	64	115	1691	6.80%
I have been feeling close to others			38	13	-	64	115	1691	6.80%
I have been dealing with problems			38	13	-	64	115	1691	6.80%
I have been able to make up my own mind			38	13	-	64	115	1691	6.80%
I have been feeling optimistic about the future			38	13	-	64	115	1691	6.80%

Figure 6.1 Survivors' improved feelings of Safety

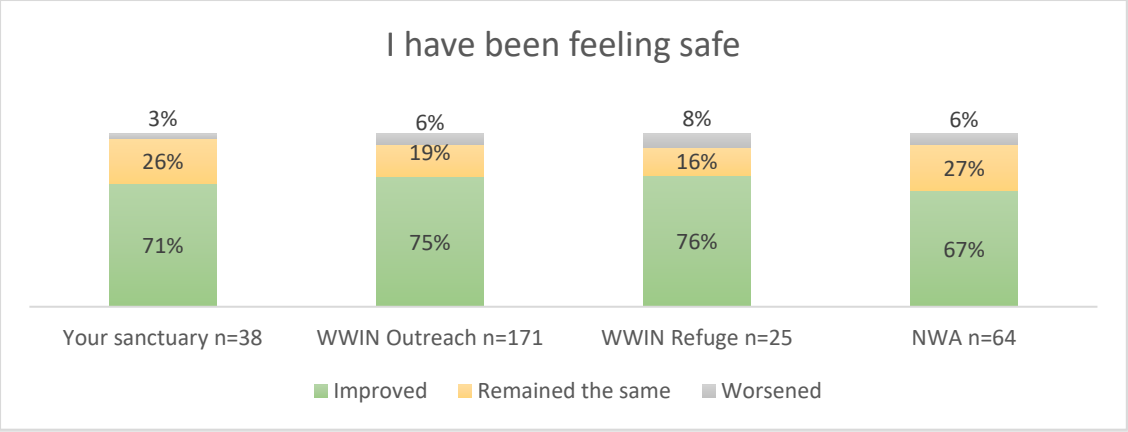


Figure 6.2 Survivors' improved feelings of Confidence

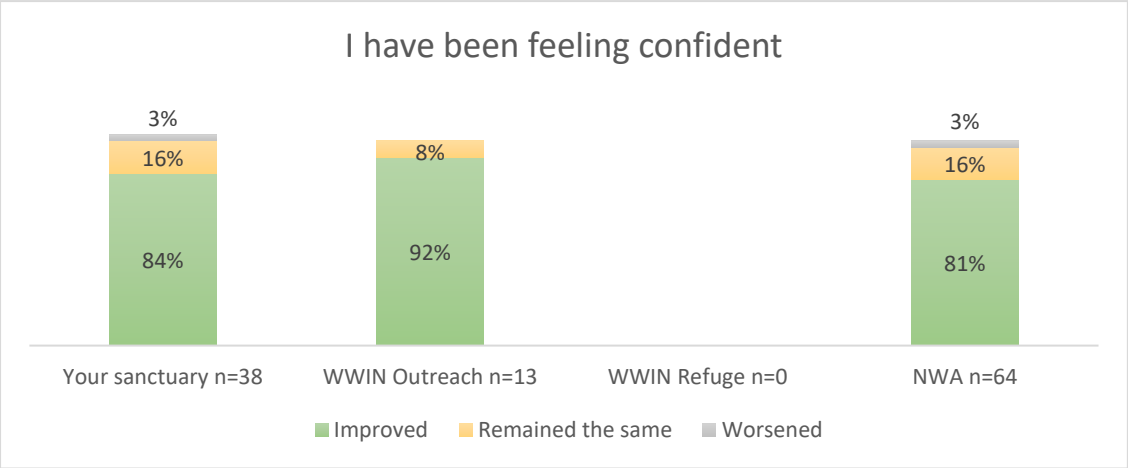


Figure 6.3 Survivors' improved feelings of Self-esteem

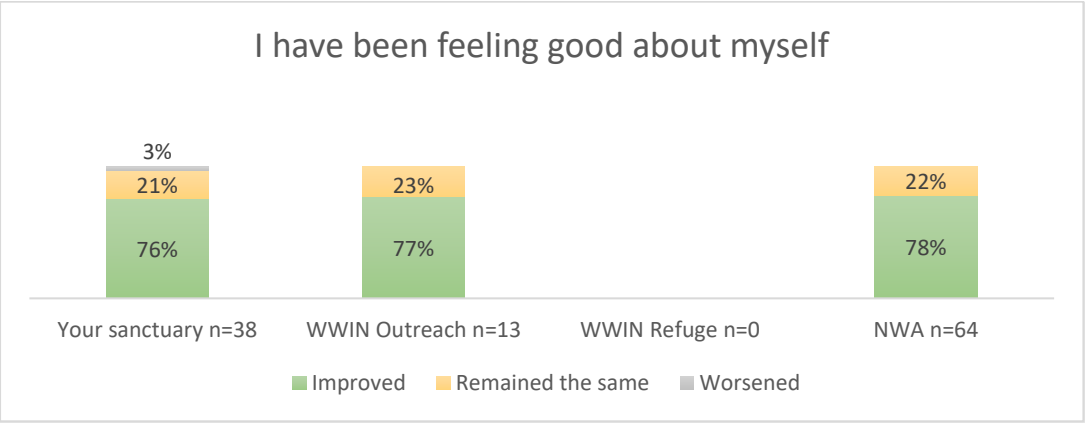


Figure 6.4 Survivors' improved feelings of Connection

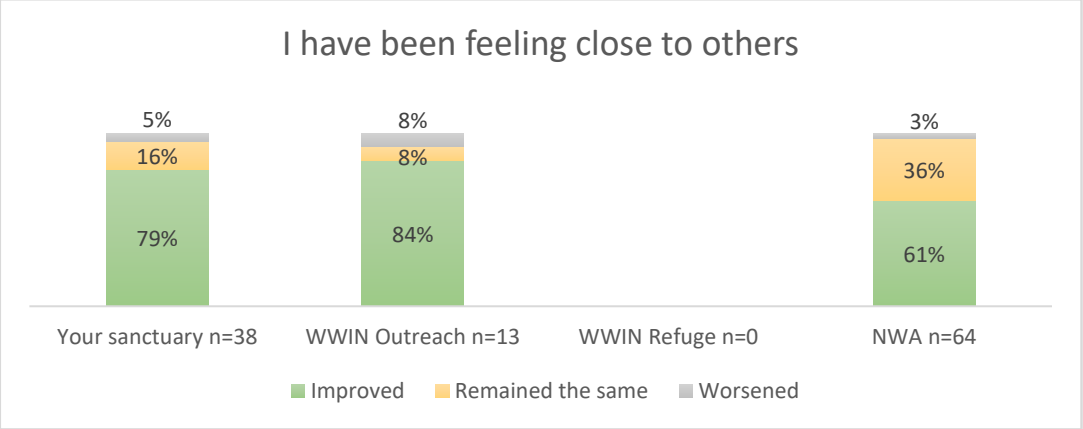


Figure 6.5 Survivors' improved Ability to Deal with Problems

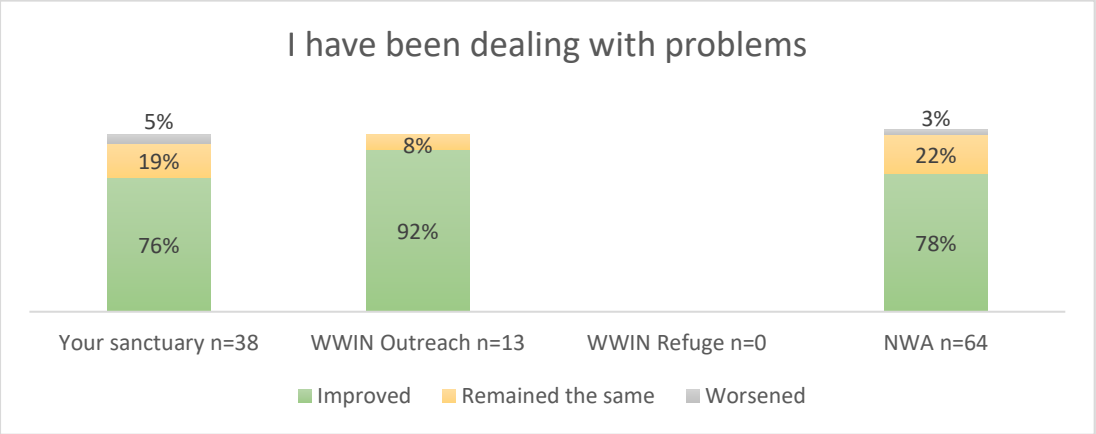


Figure 6.6 Survivors' improved Decision-Making

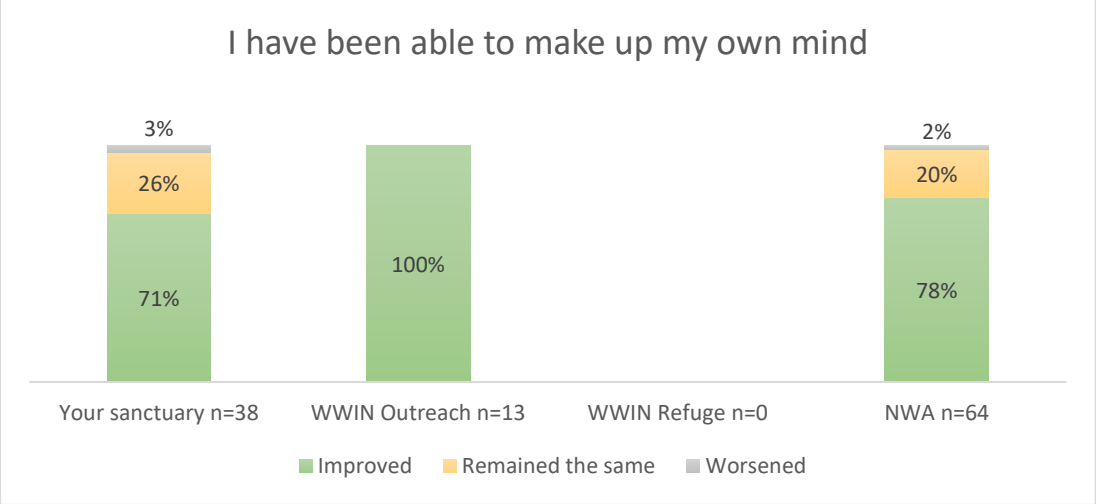


Figure 6.7 Survivors' improved Feelings of Optimism

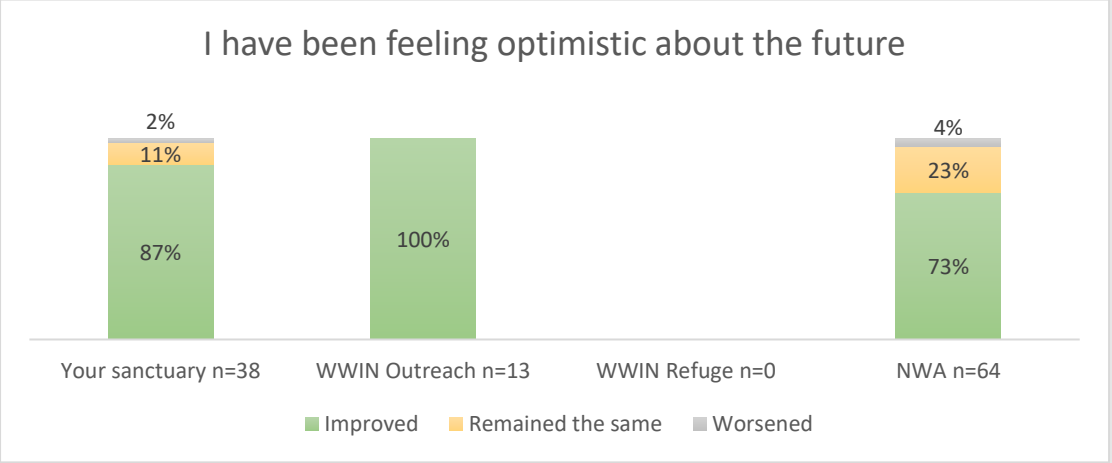


Table 6.13 Frequencies and Proportions for Safety items: T1 – T2 (Evaluation Outcome Measure)

			None of the time / rarely	Sometimes	Often / all of the time	Total
I have felt safe	T1	N	7	24	64	95
		%	7.4	25.3	67.4	100.0
	T2	N	2	8	40	50
		%	4.0	16.0	80.0	100.0
My home felt safe and secure	T1	N	11	18	64	93
		%	11.8	19.4	68.8	100.0
	T2	N	3	8	36	47
		%	6.4	17.0	76.6	100.0
I have felt safe moving around my neighbourhood	T1	N	16	19	58	93
		%	17.2	20.4	62.4	100.0
	T2	N	1	13	34	48
		%	2.1	27.1	70.8	100.0
I have felt safe online	T1	N	10	15	62	87
		%	11.5	17.2	71.3	100.0
	T2	N	5	6	34	45
		%	11.1	13.3	75.6	100.0
I have felt that it is safe for my children to spend time with their father (if relevant)	T1	N	25	12	26	63
		%	39.7	19.0	41.3	100.0
	T2	N	13	3	17	33
		%	39.4	9.1	51.5	100.0
I know where I can go for help when I need it	T1	N	2	13	78	93
		%	2.2	14.0	83.9	100.0
	T2	N	4	5	39	48
		%	8.3	10.4	81.3	100.0

Table 6.14 Frequencies and Proportions for Coping and Confidence item responses T1 -T2

			Never / not very often	Sometimes	Most / all of the time	Total
I have felt able to cope if things have gone wrong	T1	N	12	39	43	94
		%	12.8	41.5	45.7	100.0
	T2	N	9	14	27	50
		%	18.0	28.0	54.0	100.0
I have felt able to deal with my daily life	T1	N	6	31	57	94
		%	6.4	33.0	60.6	100.0
	T2	N	3	5	42	50
		%	6.0	10.0	84.0	100.0
I have been able to make my own decisions	T1	N	8	15	71	94
		%	8.5	16.0	75.5	100.0
	T2	N	3	6	41	50
		%	6.0	12.0	82.0	100.0
I have felt able to speak to people about my experiences of abuse, if I wanted to	T1	N	16	26	52	94
		%	17.0	27.7	55.3	100.0
	T2	N	8	7	35	50
		%	16.0	14.0	70.0	100.0
I have been able to manage my use of alcohol/medication/drugs	T1	N	4	2	68	74
		%	5.4	2.7	91.9	100.0
	T2	N	2	4	32	38
		%	5.3	10.5	84.2	100.0
I have been able to get a good night's sleep	T1	N	40	22	28	90
		%	44.4	24.4	31.1	100.0
	T2	N	9	14	20	43
		%	20.9	32.6	46.5	100.0
I have been confident about doing new things	T1	N	32	25	37	94
		%	34.0	26.6	39.4	100.0
	T2	N	6	16	27	49
		%	12.2	32.7	55.1	100.0
I have felt in control of my life	T1	N	26	30	38	94
		%	27.7	31.9	40.4	100.0
	T2	N	10	10	28	48
		%	20.8	20.8	58.3	100.0
I have good relationships with my children	T1	N	2	4	77	83
		%	2.4	4.8	92.8	100.0
	T2	N	3	2	39	44
		%	6.8	4.5	88.6	100.0
I have known that I was not responsible for the abuse that happened to me	T1	N	14	23	57	94
		%	14.9	24.5	60.6	100.0
	T2	N	4	8	35	47
		%	8.5	17.0	74.5	100.0
I have been able to recognise if other people have been behaving abusively	T1	N	10	25	57	92
		%	10.9	27.2	62.0	100.0
	T2	N	3	4	42	49
		%	6.1	8.2	85.7	100.0

Table 6.15 Descriptive Statistics for SWEMWBS sum scores at T1, T2 and T3

	N	Mean
Time 1	91	22.7216
Time 2	50	24.4142
Time 3	20	23.9860

Table 6.16 Supervision and Training

	Frequency	**Percent**
Do you receive regular supervision?		
Yes	13	*81*
No	1	*6*
Missing	*2*	*12.5*
If yes, what type of supervision? (n=14)		
Management supervision only	8	*57*
Clinical supervision only	3	*21*
Management AND clinical supervision	3	*21*
Have you received sufficient training to enable high-fidelity implementation?		
Yes	7	*44*
No	7	*44*
Missing	*2*	*12.5*
Would you have liked any further training or supervision?		
Yes	8	*50*
No	6	*37.5*
Missing	2	*12.5*
If yes, what would have been helpful? (n=6)		
Further VOICES and Change that Lasts training	4	*75*
Training in criminal and family court	1	*17*
More frequent clinical supervision	1	*17*

Table 6.17 Quality of supervision and leadership

	Frequency	Percent
'I am supported through emotionally demanding work'		
Strongly agree	4	*25*
Agree	8	*50*
Neutral	2	*12.5*
Disagree	0	*0*
Strongly disagree	0	*0*
Missing	*2*	*12.5*
'I am clear what is expected of me at work'		
Always	5	*31*
Often	6	*37.5*
Sometimes	3	*19*
Seldom	0	*0*
Never	0	*0*
Missing	*2*	*12.5*
'When changes are made, I am clear about how they will work in practice'		
Always	1	*6*
Often	7	*44*
Sometimes	5	*31*
Seldom	0	*0*
Never	0	*0*
Missing	*3*	*19*
'I have some say over the way I work'		
Strongly agree	2	*12.5*
Agree	8	*50*
Neutral	4	*25*
Disagree	0	*0*
Strongly disagree	0	*0*
Missing	2	*12.5*
'There is friction or anger between colleagues'		
Never	6	*37.5*
Seldom	5	*31*
Sometimes	3	*19*
Often	0	*0*
Always	0	*0*
Missing	*2*	*12.5*

Table 6.18 Workload

	Frequency	Percent
How would you describe your workload?		
Always appropriately weighted	0	*0*
Usually appropriately weighted	7	*44*
Often too heavy	5	*31*
Always too heavy	2	*12.5*
Missing	*2*	*12.5*
'I have unachievable deadlines'		
Strongly agree	0	*0*
Agree	1	*6*
Neutral	4	*25*
Disagree	8	*50*
Strongly disagree	1	*6*
Missing	*2*	*12.5*
'I have to neglect some tasks because I have too much to do'		
Always	1	*6*
Often	3	*19*
Sometimes	5	*31*
Seldom	4	*25*
Never	1	*6*
Missing	*2*	*12.5*

Appendix 7: SafeLives Co-Designed Pilots - Development, Implementation and Delivery

Table 7.1 Safety Outcome measures at Baseline

Safety Questions		None of the time/rarely	Sometimes	Often/All of the time	Total
I have felt safe	N	25	47	109	181
	%	13.8	26.0	60.2	100.0
My home felt safe and secure	N	27	49	104	180
	%	15.0	27.2	57.8	100.0
I have felt safe moving around my neighbourhood	N	28	48	104	180
	%	15.6	26.7	57.8	100.0
I have felt safe online	N	15	22	141	178
	%	8.4	12.4	79.2	100.0
I have felt that it is safe for my children to spend time with their father (if relevant)	N	62	29	50	141
	%	44.0	20.6	35.5	100.0
I know where I can go for help when I need it	N	12	33	135	180
	%	6.7	18.3	75.0	100.0

Table 7.2 Coping and Confidence Outcome Measures at Baseline

		None of the time/rarely	Sometimes	Often / all of the time	Total
I have felt able to cope if things have gone wrong	n	27	72	80	179
	%	15.1	40.2	44.7	100.0
I have felt able to deal with my daily life	n	16	75	87	178
	%	9.0	42.1	48.9	100
I have been able to make my own decisions	n	19	45	114	178
	%	10.7	25.3	64.0	100.0
I have felt able to speak to people about my experiences of abuse, if I wanted to	n	36	57	88	181
	%	19.9	31.5	48.6	100.0
I have been able to manage my use of alcohol/medication/ drugs (if applicable)	n	7	17	103	127
	%	5.5	13.4	81.1	100.0
I have been able to get a good night's sleep	n	58	65	48	171
	%	33.9	38.0	28.1	
I have been confident about doing new things	n	39	71	69	179
	%	21.8	39.7	38.5	100.0
I have felt in control of my life	n	50	60	70	180
	%	27.8	33.3	38.9	100.0
I have good relationships with my children	n	6	21	142	169
	%	3.6	12.4	84.0	100.0
I have known that I was not responsible for the abuse that happened to me	n	23	58	97	178
	%	12.9	32.6	54.5	100.0
I have been able to recognise if other people have been behaving abusively	n	18	49	113	180
	%	10.0	27.2	62.8	100.0

Tables. Staff Survey Results 2020 – SafeLives CDP

Service quality and efficacy

Table 7.3

		Greatly	In some respects	A bit	Not at all	*Missing*
Has the service improved professional and community awareness of domestic abuse	N	10	5	0	0	1
	%	*62.5*	*31*	*0*	*0*	*6*
Improvement to inter-agency communication and co-ordination	*N*	5	10	0	0	1
	%	*31*	*62.5*	*0*	*0*	*6*

Supervision, training and workload

Table 7.4

		Always	Often	Sometimes	Seldom	Never	*Missing*
'I am clear what is expected of me at work'	N	4	9	1	0	0	*2*
	%	*25*	*56*	*6*	*0*	*0*	*12.5*
'When changes are made, I am clear about how they will work in practice'	N	2	8	4	0	0	*2*
	%	*12.5*	*50*	*25*	*0*	*0*	*12.5*

Table 7.5

		Strongly agree	Agree	Neutral	Disagree	Strongly disagree	*Missing*
'I am supported through emotionally demanding work'	N	6	6	1	0	1	2
	%	37.5	37.5	6	0	6	12.5
'I have some say over the way I work'	N	5	9	0	0	0	2
		31	56	0	0	0	12.5
'I have unachievable deadlines'	N	6	6	1	0	1	2
	%	37.5	37.5	6	0	6	12.5

Table 7.6

		Never	Seldom	Sometimes	Often	Always	*Missing*
'There is friction or anger between colleagues'	N	4	8	2	0	0	2
	%	*25*	*50*	*12.5*	*0*	*0*	*12.5*
'I have to neglect some tasks because I have too much to do'	N	1	3	6	4	0	2
	%	*6*	*19*	*37.5*	*25*	*fsta0*	*12.5*

Table 7.7

		Always appropriately weighted	Usually appropriately weighted	Often Too Heavy	Always Too Heavy	*Missing*
How would you describe your workload?	N	2	5	6	2	1
	%	*12.5*	*31*	*37.5*	*12.5*	*6*

Appendix 8: SafeLives Co-Designed Pilot Programme - Impact

Table 8.1: Guide to Interventions in the SafeLives Co-Designed Pilots

Intervention	Description
Side By Side	This group runs for 8-10 weeks and is a version of the 'Grow Together' group which is adapted to be completed with you and your child. Half of each session is completed together and the other half of the session is completed with the adults and the children in separate spaces. It is designed for a parent and a child aged 8-14.
Tandem	Intervention for families experiencing adolescent to parent violence. Aimed at children aged 13-17), where the child has witnessed abuse and is displaying harmful behaviour towards their parent(s). Support is offered separately to parents and children either in group or one to one sessions. Developed by Cheshire without Abuse https://www.mycwa.org.uk/programmes
Monkey Bob	Sessions for children aged 4-7 delivered in group or on a one to one basis to help them explore and express their feelings, as well as helping them to learn how to keep themselves safe. Developed by Cheshire Without Abuse https://www.monkeybob.org.uk/
Freedom Programme	A ten week recovery programme for women who have experienced domestic violence and abuse which explores the general behaviours and beliefs of abusive and non-abusive partners and includes a session on the impacts of domestic abuse on children. https://www.freedomprogramme.co.uk/
Pathways To Progress	Domestic Abuse recovery group used in the West Sussex site and developed by the West Sussex SDR practitioner. Delivered in groups for 6-8 sessions. Content included the impacts of abuse, recognising abusive behaviours and considering future relationships and boundaries.
Pattern Changing	Recovery course for survivors, lasting 12-14 weeks which aims to build confidence and self-esteem and to explore the impact of abuse. Developed by North Devon Against Abuse https://www.ndada.co.uk/courses/pattern-changing/
Grow Together	Sessions for non-abusive parents who have experienced domestic abuse that focuses on supporting the relationship between parent and child (aged 8-14) and promoting recovery. Explores the effect of DVA on families. Originally developed by North Devon Against Domestic Abuse and intended to be offered as a 6-8 week course, but was also delivered in one to one sessions. Developed by North Devon Against Abuse. https://www.ndada.co.uk/projects/grow-together-project/
Side by Side	Side by Side is a parallel, designed for mothers and a child (aged between 8-14) to complete together. The course covers the same content as Grow Together but is delivered in a combination of whole group and separate parent and child only group sessions. Developed by North Devon Against Abuse https://www.ndada.co.uk/side-by-side/

Table 8.2 Comparison of Responses to Safety Questions at T1 and T2

Question	Time		None of the time / rarely	Sometimes	Often / all of the time	Total	Wilcoxon Signed Rank Test
I have felt safe	T1	N	13	18	52	83	
		%	15.7	21.7	62.7	100.0	
	T2	N	4	18	65	87	Sig. (z= 2.758, p<.006)
		%	4.6	20.7	74.7	100.0	
My home felt safe and secure	T1	N	15	20	48	83	
		%	18.1	24.1	57.8	100.0	
	T2	N	6	16	65	87	Sig. (z= 2.803, p<.005)
		%	6.9	18.4	74.7	100	
I have felt safe moving around my neighbourhood	T1	N	17	17	49	83	
		%	20.5	20.5	59.0	100.0	
	T2	N	3	22	61	86	Sig (z=3.043, p =.002)
		%	3.5	25.6	70.9	100	
I have felt safe online	T1	N	8	10	64	82	
		%	9.8	12.2	78.0	100.0	
	T2	N	1	10	75	86	Sig (z=2.342 p =.019)
		%	1.2	11.6	87.2	100	
I have felt that it is safe for my children to spend time with their father (if relevant)	T1	N	27	15	25	67	
		%	40.3	22.4	37.3	100.0	
	T2	N	24	15	34	73	Sig (z=1.975, p=0.048)
		%	32.9	20.5	46.6	100	
I know where I can go for help when I need it	T1	N	5	15	64	84	
		%	6.0	17.9	76.2	100.0	
	T2	N	3	9	75	87	
			3.4	10.3	86.2		

Table 8.3 Comparison of responses to coping and confidence Questions at T1 and T2

Question	Time		Never / not very often	Sometimes	Most / all of the time	Total	Wilcoxon Signed Ranks Test
I have felt able to cope if things have gone wrong	T1	N	9	33	42	84	
		%	10.7	39.3	50.0	100.0	
	T2	N	9	22	51	82	
		%	11.0	26.8	62.2	100.0	
I have felt able to deal with my daily	T1	N	8	31	45	84	
life		%	9.5	36.9	53.6	100.0	
	T2	N	6	17	60	83	
		%	7.2	20.5	72.3	100.0	
I have been able to make my own decisions	T1	N	11	14	57	82	
		%	13.4	17.1	69.5	100.0	
	T2	N	5	14	63	82	
		%	6.1	17.1	76.8	100.0	
I have felt able to speak to people about my experiences of abuse, if I wanted to	T1	N	12	26	46	84	
		%	14.3	31.0	54.8	100.0	
	T2	N	9	22	52	83	
		%	10.8	26.5	62.7	100.0	
I have been able to manage my use of alcohol/medication/ drugs (if applicable)	T1	N	3	8	49	60	
		%	5.0	13.3	81.7	100.0	
	T2	N	1	8	48	57	
		%	1.8	14.0	84.2	100.0	
I have been able to get a good night's sleep	T1	N	20	33	25	78	
		%	25.6	42.3	32.1	100.0	
	T2	N	9	33	32	74	Sig (z=2.305, p=0.021)
		%	12.2	44.6	43.2	100.0	
I have been confident about doing new things	T1	N	13	33	36	82	
		%	15.9	40.2	43.9	100.0	
	T2	N	8	28	46	82	
		%	9.8	34.1	56.1	100.0	
I have felt in control of my life	T1	N	24	23	36	83	
		%	28.9	27.7	43.4	100.0	
	T2	N	9	24	51	84	Sig. (z=3.15
		%	10.7	28.6	60.7	100.0	

Question	Time		Never / not very often	Sometimes	Most / all of the time	Total	Wilcoxon Signed Ranks Test
I have good relationships with my children	T1	N	3	7	68	78	
		%	3.8	9.0	87.2	100.0	
	T2	N	3	3	73	79	
		%	3.8	3.8	92.4	100.0	
I have known that I was not responsible for the abuse that happened to me	T1	N	12	23	48	83	Sig. (z=2.25, p= 0.024)
		%	14.5	27.7	57.8	100.0	
	T2	N	6	15	63	84	
		%	7.1	17.9	75.0	100.0	
I have been able to recognise if other people have been behaving abusively	T1	N	8	24	51	83	Sig. (z=2.601, p=0.009)
		%	9.6	28.9	61.4	100.0	
	T2	N	1	17	65	83	
		%	1.2	20.5	78.3	100.0	

Table 8.4 Mean Change in Wellbeing T1 -T2 Paired Samples Test Details

Mean	Std. Deviation	Std. Error Mean	95% Confidence interval of the difference		t	df	Sig. (2-tailed)
			Lower	Upper			
-1.13169	4.66118	.53119	-2.18965	-07373	-2.130	76	0.36

Table 8.5 Adult Health QuestionnaireEQ-5D-3L results at T2

Adult Health Questionnaire (EQ-5D-3L	T1	T2
COMPLETE	171	98
AVERAGE	0.676	0.698
STDEV	0.295	0.346
NORM	0.86	0.86
VAS (Thermometer)	T1	T2
COMPLETE	167	96
AVERAGE	59.07	68.66
STDEV	19.90	20.69
NORM	82.48	82.48

Table 8.6 Comparison of responses to safety Questions at T1 and T3

Question			None of the time/Rarely	Sometimes	Often/All of the time	Total	Wilcoxon Signed Rank Test
I have felt safe	T1	N	8	13	34	55	
		%	14.5	23.6	61.8	100.0	
	T3	N	2	13	41	56	
		%	3.6	23.2	73.2	100.0	
My home felt safe and secure	T1	N	9	13	33	55	
		%	16.4	23.6	60.0	100.0	
	T3	N	4	8	44	56	Sig. (z=2.120, p=.034)
		%	7.1	14.3	78.6	100.0	
I have felt safe moving around my neighbourhood	T1	N	7	18	30	55	
		%	12.7	32.7	54.5	100.0	
	T3	N	3	9	43	55	Sig. (z=2.428, p=.015)
		%	5.5	16.4	78.2	100.0	
I have felt safe online	T1	N	2	8	45	55	
		%	3.6	14.5	81.8	100.0	
	T3	N	0	5	51	56	
		%	0.0	8.9	91.1	100.0	
I have felt that it is safe for my children to spend time with their father (if relevant)	T1	N	22	12	13	47	
	T1	%	46.8	25.5	27.7	100.0	
	T3	N	21	7	16	44	
	T3	%	47.7	15.9	36.4	100.0	
I know where I can go for help when I need it	T1	N	1	11	43	55	
	T1	%	1.8	20.0	78.2	100.0	
	T3	N	3	7	46	56	
	T3	%	5.4	12.5	82.1	100.0	

Table 8.7 Comparison of Responses to Coping and Confidence Questions at T1 and T3

Question			Never / not very often	Sometimes	Most / all of the time	Total	Wilcoxon Signed Ranks Test
I have felt able to cope if things have gone wrong	T1	N	7	22	26	55	
		%	12.7	40.0	47.3	100.0	
	T3	N	6	14	35	55	
		%	10.9	25.5	63.6	100.0	
I have felt able to deal with my daily life	T1	N	5	20	30	55	
		%	9.1	36.4	54.5	100.0	
	T3	N	4	11	40	55	Sig. (z=2.2,
		%	7.3	20.0	72.7	100.0	
I have been able to make my own decisions	T1	N	7	10	37	54	
		%	13.0	18.5	68.5	100.0	
	T3	N	3	10	42	55	
		%	5.5	18.2	76.4	100.0	
I have felt able to speak to people about my experiences of abuse if I wanted to	T1	N	14	19	22	55	
		%	25.5	34.5	40.0	100.0	
	T3	N	5	12	37	54	Sig. (z=3.318,
		%	9.3	22.2	68.5	100.0	
I have been able to manage my use of alcohol/ medication/ drugs (if applicable	T1	N	0	6	31	37	
		%	0.0	16.2	83.8	100.0	
	T3	N	0	4	36	40	
		%	0.0	10.0	90.0	100.0	

Question			Never / not very often	Sometimes	Most / all of the time	Total	Wilcoxon Signed Ranks Test
I have been able to get a good night's sleep	T1	N	20	15	18	53	
		%	37.7	28.3	34.0	100.0	
	T3	N	14	16	25	55	
		%	25.5	29.1	45.5	100.0	
I have been confident about doing new things	T1	N	15	22	18	55	
		%	27.3	40.0	32.7	100.0	
	T3	N	11	18	26	55	
		%	20.0	32.7	47.3	100.0	
I have felt in control of my life	T1	N	18	15	22	55	
		%	32.7	27.3	40.0	100.0	
	T3	N	8	11	36	55	Sig. (z=2.992,
		%	14.5	20.0	65.5	100.0	
I have good relationships with my children	T1	N	1	4	49	54	
		%	1.9	7.4	90.7	100.0	
	T3	N	2	4	45	51	
		%	3.9	7.8	88.2	100.0	
I have known that I was not responsible for the abuse that happened to me	T1	N	13	12	30	55	
		%	23.6	21.8	54.5	100.0	
	T3	N	5	12	38	55	Sig. (z=2.401,
		%	9.1	21.8	69.1	100.0	
I have been able to recognise if other people have been behaving abusively	T1	N	5	22	28	55	
		%	9.1	40.0	50.9	100.0	
	T3	N	2	14	39	55	Sig. (z=2.307,
		%	3.6	25.5	70.9	100.0	

Table 8.8a & 8.8b Mean Change in Wellbeing T1 -T3 Paired Samples Test

Mean	Std. Deviation	Std. Error Mean	95% Confidence interval of the difference		t	df	Sig. (2-tailed)
			Lower	Upper			
-2.54444	4.39550	0.59815	-3.74419	-1.34470	-4.254	53	0.000

Table 8.9 Adult Health Questionnaire EQ-5D-3L results at T3

Adult Health Questionnaire EQ-5D-3L	T1	T3
COMPLETE	171	67
AVERAGE	0.676	0.673
STDEV	0.295	0.322
NORM	0.86	0.86
VAS (Thermometer)	T1	T3
COMPLETE	167	69
AVERAGE	59.07	67.47
STDEV	19.90	20.34
NORM	82.48	82.48

Table 8.10 Comparison of Responses to Safety Questions at T1 and at exit

Question			None of the time/ Rarely	Sometimes	Often/ All of the time	Total	Wilcoxon Signed Ranks Test
I have felt safe	T1	N	6	16	5	27	
		%	22.2	59.3	18.5	100.0	
	End	N	0	5	32	37	Sig. (z=3.625, p=.000)
		%	0	13.5	86.5	100.0	
My home felt safe and secure	T1	N	6	15	6	27	
		%	22.2	55.6	22.2	100.0	
	End	N	1	4	32	37	Sig. (z=3.740, p=.000)
		%	2.7	10.8	86.5	100.0	
I have felt safe moving around my neighbourhood	T1	N	4	17	6	27	
		%	14.8	63.0	22.2	100.0	
	End	N	1	3	33	37	Sig. (z=3.871, p=.000)
		%	2.7	8.1	89.2	100.0	
I have felt safe online	T1	N	2	23	2	27	
		%	7.4	85.2	7.4	100.0	
	End	N	0	2	34	36	Sig. (z=4.481, p=.000)
		%	0.0	5.6	94.4	100.0	
I have felt that it is safe for my children to spend time with their father (if relevant)	T1	N	7	11	5	23	
	T1	%	30.4	47.8	21.7	100.0	
	End	N	10	7	11	28	Sig. (z=2.134, p=.033)
		%	35.7	25.0	39.3	100.0	
I know where I can go for help when I need it	T1	N	0	20	7	27	
		%	0.0	74.1	25.9	100.0	
	End	N	0	4	33	37	Sig. (z=3.578, p=.000_
		%	0.0	10.8	89.2	100.0	

Table 8.11 Comparison of Responses to Coping and Confidence Questions at T1 and at exit

Question			Never / not very often	Sometimes	Most / all of the time	Total	Wilcoxon Signed Ranks Test
I have felt able to cope if things have gone wrong	T1	N	3	12	12	27	
		%	11.1	44.4	44.4	100.0	
	End	N	2	7	26	35	
		%	5.7	20.0	74.3	100.0	
I have felt able to deal with my daily life	T1	N	1	12	14	27	
		%	3.7	44.4	51.9	100.0	
	End	N	0	7	29	36	Sig.(z=2.138, p=.033)
		%	0	19.4	80.6	100.0	
I have been able to make my own decisions	T1	N	2	6	19	27	
		%	7.4	22.2	70.4	100.0	
	End	N	1	3	32	36	
		%	2.8	8.3	88.9	100.0	
I have felt able to speak to people about my experiences of abuse if I	T1	N	8	7	12	27	
		%	29.6	25.9	44.4	100.0	
	End	N	3	9	24	36	Sig. (z=2.696, p=.007)
		%	8.3	25.0	66.7	100.0	
I have been able to manage my use of alcohol/medication/ drugs (if	T1	N	0	3	16	19	
		%	0	15.8	84.2	100.0	
	End	N		4	26	30	
		%		13.3	86.7	100.0	
I have been able to get a good night's sleep	T1	N	8	8	9	25	
		%	32.0	32.0	36.0	100.0	
	End	N	5	8	21	34	Sig. (z=1.99, p=.046)
		%	14.7	23.5	61.8	100.0	
I have been confident about doing new things	T1	N	4	12	11	27	
		%	14.8	44.4	40.7	100.0	
	End	N	4	9	23	36	
		%	11.1	25.0	63.9	100.0	

Question			Never / not very often	Sometimes	Most / all of the time	Total	Wilcoxon Signed Ranks Test
I have felt in control of my life	T1	N	7	9	11	27	
		%	25.9	33.3	40.7	100.0	
	End	N	3	3	29	35	Sig. (z=2.984, p=.003)
		%	8.6	8.6	82.9	100.0	
I have good relationships with my children	T1	N		4	22	26	
		%		15.4	84.6	100.0	
	End	N	1	3	27	31	
		%	3.2	9.7	87.1	100.0	
I have known that I was not responsible for the abuse that happened to me	T1	N	3	9	15	27	
		%	11.1	33.3	55.6	100.0	
	End	N	3	4	29	36	Sig. (z=1.811, p=.070)
		%	8.3	11.1	80.6	100.0	
I have been able to recognise if other people have been behaving	T1	N	1	7	19	27	
		%	3.7	25.9	70.4	100.0	
	End	N	2	2	32	36	
		%	5.6	5.6	88.9	100.0	

Table 8.12 Adult Health Questionnaire EQ-5D-3L results at Exit

EQ-5D-3L	T1	END
COMPLETE	27	27
AVERAGE	0.729	0.746
STDEV	0.295	0.280
NORM	0.86	0.86
VAS (thermometer)	T1	END
COMPLETE	26	25
AVERAGE	59.12	70.80
STDEV	20.496	19.902
NORM	82.48	82.48

Appendix 9: Social Network Analysis Tables

Table 9.1: Characteristics of Staff participating in SNA

		T1 (n)	T2 (n)
	SLCDP Norwich		
Invited	11	10	
Consented	9	10	
>50% complete	7	8	
Answered Covid Question	3	8	
Respondents who completed T1 and	NA	8	
	Respondent role		
	Management of Staff	1	3
	Direct Work with Clients	6	5
	Administration	0	0
	Other	2	2
	SLCDP West Sussex	**T1 (n)**	**T2 (n)**
Invited	10	12	
Consented	6	7	
>50% complete	5	5	
Answered Covid Question	3	6	
Respondents who completed T1 and	NA	4	
	Respondent role		
	Management of Staff	0	0
	Direct Work with Clients	4	4
	Administration	0	0
	Other	2	2
	WA Nottingham	**T1 (n)**	**T2 (n)**
Invited	0	4	
Consented	NA	1	
>50% complete	NA	1	
Answered Covid Question	NA	1	
Respondents who completed T1 and	NA	NA	
	Respondent role		
	Management of Staff	NA	0
	Direct Work with Clients	NA	0
	Administration	NA	0
	Other	NA	1

	WA Surrey	**T1 (n)**	**T2 (n)**
Invited	7	7	
Consented	5	5	
>50% complete	5	2	
Answered Covid Question	2	4	
Respondents who completed T1 and	NA	4	
	Respondent role		
	Management of Staff	1	1
	Direct Work with Clients	4	4
	Administration	0	0
	Other	0	0
	WA Sunderland	**T1 (n)**	**T2 (n)**
Invited	19	19	
Consented	11	10	
>50% complete	6	6	
Answered Covid Question	4	6	
Respondents who completed T1 and	NA	9	
Respondent role			
Management of Staff	1	2	
Direct Work with Clients	9	8	
Administration	0	0	
Other	1	0	

Table 9.2 Mean Network Dimension Ratings by Sector and Site

		Sunderland Total 36 justice 3 health 6 social 8 specialist 6 other 13		Surrey Total 62 justice 3 health 7 social 8 specialist 16 other 28		Norwich Total 51 justice 4 health 13 social 3 specialist 13 other 18		Sussex Total 48 justice 5 social care 4 specialist 14 health 15 other 10	
give advice		T1	T2	T1	T2	T1	T2	T1	T2
Justice									
	Missing values	8.0	9.0	4.0	0.0	7.0	16.00	9.0	14.0
	Mean	1.8	2.1	2.5	3.4	2.8	2.68	4.0	2.8
	SD	0.9	0.7	1.4	1.4	0.9	1.16	4.0	1.0
health									
	Missing values	21.0	30.0	10.0	0.0	32.0	59.00	24.0	57.0
	Mean	2.6	3.4	3.4	4.0	3.0	3.32	3.9	3.5
	SD	1.2	1.0	0.9	1.0	1.0	0.93	1.2	1.1
social									
	Missing values	23.0	22.0	4.0	0.0	2.0	7.00	6.0	6.0
	Mean	2.3	3.1	2.2	2.6	1.9	2.31	2.8	2.5
	SD	1.0	1.0	1.1	1.2	0.9	0.84	1.3	1.1
specialist									
	Missing values	29.0	36.0	19.0	4.0	33.0	54.00	25.0	43.0
	Mean	2.6	2.5	2.9	3.3	2.7	3.20	3.7	3.1
	SD	1.2	1.1	1.4	1.5	1.0	1.01	1.2	1.1
Other									
	Missing values	62.0	68.0	52.0	2.0	55.0	94.00		
	Mean	2.4	2.7	3.8	3.6	2.6	3.06		
	SD	1.1	1.1	1.1	1.1	5.9	1.13		
get advice									
Justice									
	Missing values	11.0	12.0	2.0	3.0	6.0	24.0	5.0	15.0
	Mean	2.0	1.8	2.6	3.3	2.2	2.7	3.9	3.5
	SD	0.9	0.5	1.5	1.2	0.8	0.9	1.2	1.2
health									
	Missing values	30.0	39.0	6.0	7.0	26.0	87.0	22.0	73.0
	Mean	2.8	3.0	3.9	3.8	2.9	3.1	4.0	3.8
	SD	1.3	1.2	1.2	1.1	0.9	0.7	1.1	1.2
social									
	Missing values	39.0	29.0	3.0	8.0	3.0	13.0	6.0	12.0
	Mean	2.4	2.5	2.8	3.1	1.6	1.9	2.8	2.8
	SD	0.7	1.2	1.0	0.9	0.6	0.7	1.1	1.1
specialist									
	Missing values	36.0	39.0	20.0	17.0	25.0	76.0	21.0	57.0
	Mean	2.6	2.5	3.1	3.4	2.7	3.1	3.4	3.5
	SD	1.3	1.2	1.3	1.4	0.9	0.9	1.2	1.1
Other									
	Missing values	81.0	94.0	50.0	29.0	61.0	133.0		
	Mean	2.8	2.6	3.8	3.4	2.4	2.6		
	SD	0.9	1.0	1.0	1.0	0.9	0.9		
Receive referrals									
Justice									
	Missing values	15.0		4.0		7.0		15.0	
	Mean	1.9		1.8		3.7		4.3	
	SD	1.0		0.4		1.0		1.0	
health									
	Missing values	36.0		7.0		26.0		36.0	
	Mean	3.4		2.1		3.6		4.6	
	SD	1.2		0.8		1.2		0.6	
social									
	Missing values	39.0		9.0		13.0		10.0	
	Mean	2.2		2.2		4.9		2.6	
	SD	1.0		0.8		0.4		1.1	
specialist									
	Missing values	43.0		30.0		33.0		34.0	
	Mean	2.9		1.6		3.7		4.3	
	SD	1.5		0.5		1.0		1.1	
Other									
	Missing values	83.0		76.0		66.0			
	Mean	3.1		2.2		3.7			
	SD	1.1		0.6		1.1			
Make referrals									
Justice									
	Missing values	11.0	13.0	1.0	3.0	7.0	24	13.0	23.0
	Mean	2.3	2.2	3.6	3.2	2.7	3.2	4.2	4.0
	SD	0.5	0.7	1.9	1.7	0.6	0.99	1.0	1.3
health									
	Missing values	39.0	39.0	2.0	7.0	30.0	73.0	52.0	75.0
	Mean	3.0	3.2	3.6	3.4	2.9	3.2	3.3	4.1
	SD	1.1	1.1	1.2	1.2	0.7	0.9	0.7	0.9
social									
	Missing values	42.0	39.0	9.0	8.0	2.0	11.0	13.0	13.0
	Mean	2.7	2.6	3.1	3.0	2.2	2.2	3.1	2.7
	SD	1.2	1.0	1.4	1.0	0.7	0.5	0.5	1.4
specialist									
	Missing values	34.0	44.0	8.0	16.0	25.0	70.0	39.0	62.0
	Mean	3.5	3.2	3.6	3.6	3.2	3.4	3.9	3.5
	SD	1.4	1.0	1.3	1.2	0.9	0.8	1.0	1.3
Other									
	Missing values	73.0	96.0	16.0	28.0	49.0	124.0		
	Mean	3.0	2.9	4.5	3.6	3.1	3.4		
	SD	0.9	1.1	0.8	1.0	1.1	1.1		
Joint working									
Justice									
	Missing values	16.0	14.0	5.0	3.0	6.0	21.0	13.0	19.0
	Mean	2.3	2.4	3.3	3.5	2.6	2.8	3.6	3.6
	SD	1.0	0.9	1.7	1.6	-0.8	-1.3	0.9	1.1
health									
	Missing values	36.0	47.0	10.0	7.0	36.0	82.0	54.0	80.0
	Mean	3.3	3.4	4.2	4.6	3.2		3.8	4.2
	SD	1.0	1.3	0.9	0.5	1.1	1.0	0.9	1.0
social									
	Missing values	46.0	40.0	9.0	8.0	2.0	10.0	8.0	13.0
	Mean	2.5	2.8	2.4	3.1	1.7	2.3	2.4	2.7
	SD	0.9	1.3	1.1	0.9	0.8	0.7	1.0	1.4
specialist									
	Missing values	38.0	1.4	30.0	16.0	25.0	74.0	42.0	1.3
	Mean	3.0	3.2	3.0	3.9	3.0	3.5	3.5	3.5
	SD	1.3	1.4	1.4	1.2	1.1	1.3	1.2	1.3
Other									
	Missing values	87.0	98.0	77.0	36.0	52.0	130.0		
	Mean	2.9	3.0	3.9	4.1	2.7	2.9		
	SD	0.9	1.1	1.0	0.8	1.2	1.4		
Trust									
Justice									
	Missing values	13.0	8.0	4.0	3.0	4.0	20.0	11.0	16.0
	Mean	1.8	3.5	1.8	2.6	1.9	2.9	1.7	3.4
	SD	0.6	0.5	0.4	0.7	0.7	0.8	0.6	0.5
health									
	Missing values	28.0	40.0	7.0	7.0	33.0	81.0	37.0	55.0
	Mean	1.7	3.2	2.1	2.6	1.9	3.1	1.7	3.1
	SD	0.7	0.7	0.8	0.7	0.7	0.6	0.7	0.6
social									
	Missing values	35.0	38.0	9.0	11.0	1.0	9	6.0	12.0
	Mean	2.0	3.3	2.2	2.2	1.9	3.3	1.7	3.2
	SD	0.6	0.8	0.8	1.1	0.8	0.5	0.6	0.5
specialist									
	Missing values	33.0	39.0	30.0	22.0	18.0	64	27.0	44.0
	Mean	1.3	3.6	1.6	3.7	1.4	3.5	1.4	3.7
	SD	0.5	0.6	0.5	0.5	0.6	0.6	0.6	0.5
Other									
	Missing values	74.0	100.0	76.0	35.0	65.0	133		
	Mean	1.9	3.3	2.2	2.9	2.0	3.2		
	SD	0.5	0.7	0.6	0.7	0.8	0.7		