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RESPONSE TO COMPLEXITY (R2C)

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FINAL EVALUATION

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Response to Complexity (R2C)

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ABBREVIATIONS

AVA	Against Violence and Abuse
CDP	Nottingham Crime and Drugs Partnership
Central	Nottingham Central Women's Aid
CPN	Community Psychiatric Nurse
DCLG	Department of Communities and Local Government
DSVA	Domestic and Sexual Violence and Abuse
EH	Emmanuel House Support Centre
HHT	Homeless and Healthcare Team (CityCare)
IDVA	Independent Domestic Violence Advocates
IRIS	Identification and Referral to Improve Safety
NHCFT	Nottingham Healthcare Foundation Trust
ON	Opportunity Nottingham
R2C	Response to Complexity
RCNW	Rise Complex Needs Specialist Domestic Violence Worker
RiN	Recovery in Nottingham
WAIS	Women's Aid Integrated Services

1. PROJECT BACKGROUND

Nottingham has a long history[1] of developing local services and initiatives in an effort to provide effective responses to Domestic and Sexual Violence and Abuse (DSVA), which dates back to 1974 and the opening of Central Women's Aid Refuge. In 2002 Nottingham published its first domestic abuse and mental health good practice guidance. In 2011 a refuge review identified the need for a complex needs refuge, but no funding for this was committed so Nottingham Crime and Drugs Partnership worked with Women's Aid Integrated Services (WAIS), Rape Crisis, Equation and AVA to develop '*Complicated Matters' a toolkit for complex survivors*. The report highlighted the barriers to service and the forms of abuse a complex needs survivor may have experienced.[2]

The demand for a service for survivors with complex needs was identified by Nottingham City's Joint Strategic Needs Assessment (Coppel, Pierce and Lewis, 2013) and The Stella Project (2013). According to AVA (2013) and Alcohol Concern and AVA (2016) DSVA is the most common cause of depression and other mental health difficulties in women. Self harm and suicide rates among survivors are reportedly four times higher than the general female population (Kaplan and MannDeibert, 2012). Women who have experienced gender-based violence are three times more likely to be substance dependant than those who have not been affected. AVA's recent report highlight that 25-75% of people who have survived abusive or violent experiences report problematic alcohol use (compared to 10-30% of accident/illness/disaster related trauma). Significantly, 38% of Domestic Homicide Review cases victim was identified as experiencing problems with alcohol (Alcohol Concern and AVA, 2016).

This report provides an evaluation of a Department for Communities and Local Government (DCLG) funded project, which had the following mission statement:

> **To take a coordinated multi agency response in delivering a service for women survivors of domestic and sexual violence and abuse with complex needs (substance misuse and mental ill health) aligned with the DSVA [Domestic and Sexual Violence and Abuse] Strategy and outcomes framework and then evaluate it for needs assessment.**

1.1 What is meant by complexity?

The R2C project sought to provide a service in Nottingham for women survivors (with or without children) of domestic and sexual violence and abuse with complex needs, which includes mental ill health, substance misuse (including alcohol) and/or dual diagnosis.

The aim of the DCLG funded project was to provide:

- 1 additional refuge with 4 bed spaces with wrap around support services from multi-agency specialists, including substance misuse, mental health and homeless health team support in refuge.

[1] See Appendix 1 for timeline of Nottingham services and initiatives compiled by Jane Lewis CDP (2016)
[2] Appendix 2 contains an adapted version of forms of abuse experienced documented by AVA (2013).

- Wrap around services would also include: access to specialist complex needs domestic violence support worker; additional language translation and interpretation services; health and welfare advice; and post-accommodation support after refuge in the community.

1.2 R2C Steering Group

The R2C Steering Group was established in December 2015 and included the following stakeholders[3]:

• Nottingham Central Womens Aid	• Womens Aid Integrated Service Nottinghamshire	• DSVA Lead from the Health Shop (Representing Recovering in Nottingham [RiN] and Nottingham Health Care Foundation Trust).	
• Housing Aid	• Opportunity Nottingham	• Homelessness and Health Team (Nottingham City Care Partnership)	• Nottingham Crime and Drugs Partnership

All project partners agreed **terms of reference** which aimed to:

- Ensure DCLG project funding was used effectively to deliver a service through the Delivery Plan.
- Evaluate the services and utilise evaluation to identify local need and explore future funding opportunities.
- Ensure all partners engaged in the delivery of the service.
- Embed learning from the project with partners across the sectors.
- Build on the learning of the Stella Project (2013) (linking domestic violence, sexual violence, substances misuse and mental ill health).
- Identify gaps in specialist service provision (including specialist domestic abuse related psychological support from mental health services for mentally distressed survivors).

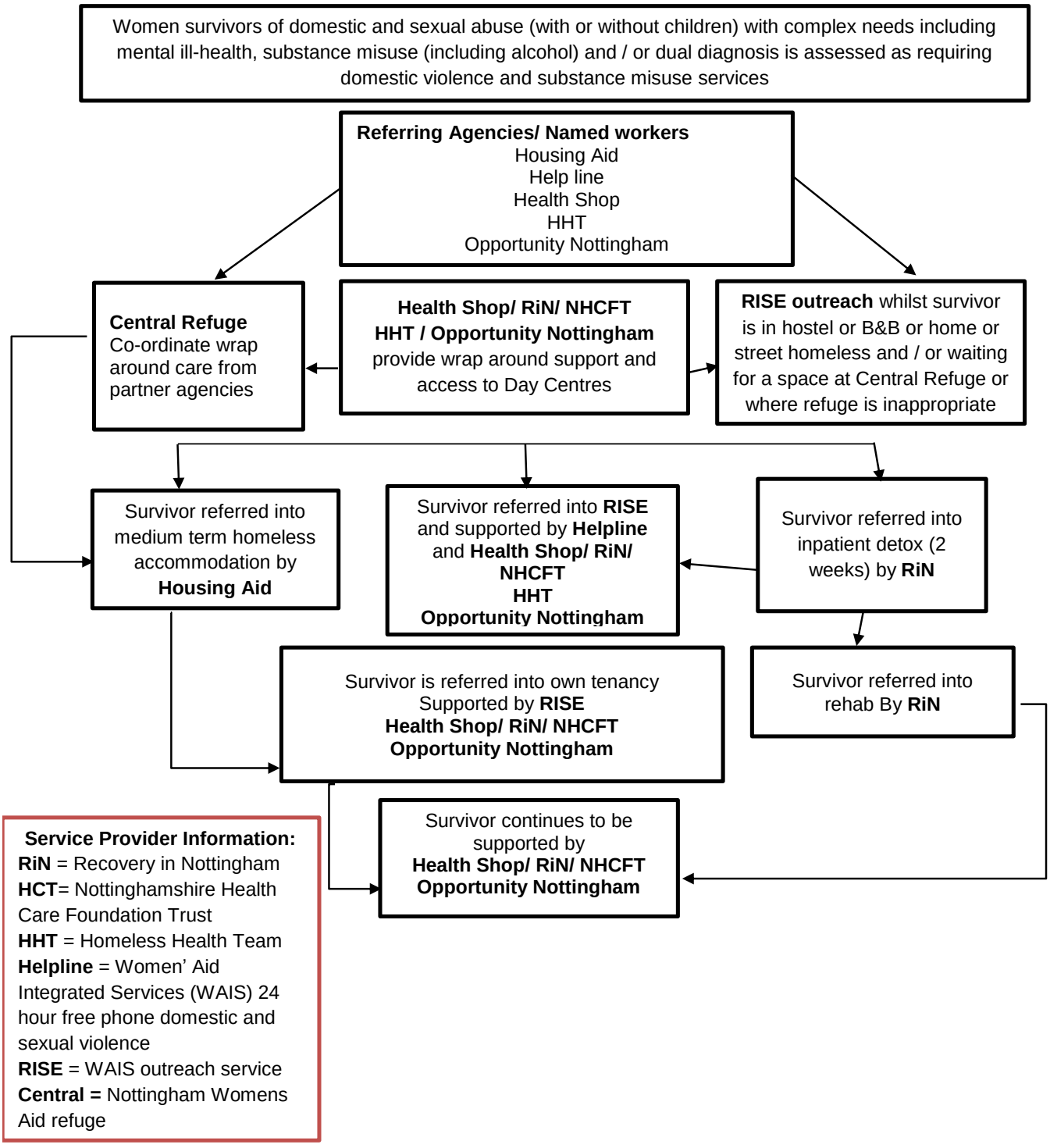
R2C key performance indicators relating to The Steering Group included:

- Meeting the needs of women survivors with complex needs by providing innovative and appropriate wrap around support service.
- Improvement in the rate of professional support service engagement with traditionally hard to engage women survivors with complex needs.
- Maintaining relationships between partners and service users and also identifying areas of best practice.

[3] See Appendix 3 for detailed overview of each stakeholder

1.3 Referral Pathway

Fig. 1 DCLG co-ordinated response to complex survivors of DSVA: Referral route 17th December 2015 DRAFT Agreed at Steering Group Meeting. (Jane Lewis, 2015)



2. EVALUATION OBJECTIVES

• Assess to what extent did the project meet local need and what gaps remain?

• Collate empirical evidence from service providers and service users regarding their experiences of wrap around service provision both from DSVA sector to substance misuse/mental health sector and from substance misuse/mental health sector to the DSVA sector.

• Assess the level of engagement of all partners engaged in the project.

• Assess the impact of the project.

• To map the journey for survivors from identification of need including: referrals made into service, or not made into service (and why); referrals accepted and not accepted (and why); whether client engages or doesn't engage (and why); and the outcome for the client.

2.1. Indicators of Success

Based on the R2C Steering Group Terms of Reference and the aims of the DCLG funded project to build on the learning of the Stella Project (2013) the following indicators of success can be identified:

1. Service users (survivors) engage with wrap around support service provision from project partner agencies.
2. Service users (survivors) receive wrap around support service are in settled accommodation.
3. An effective referral pathway is competently implemented.
4. Effective multiagency partnership working exists.
5. Demand for service in Nottingham for survivors of DVSA with complex need is identified.
6. Any barriers to accessing services in Nottingham for survivors of complex needs are identified.

Given the project was only funded for 6 months it was agreed by the Steering Group that 'settled accommodation' can mean medium term accommodation or survivors being supporting in their own home.

3. RESEARCH METHODS

The evaluation research design was co-produced by the author and R2C Steering Group. The project began January 2016 and on 1st February 2016 the researcher attended a first meeting with the CDP. Data collection began from 18th April – 30th June (quantitative) end of July 2016 (qualitative).

A mixed-method approach was taken to include:

- **A statistical analysis of:**
  1. Demand for the service including the volume of survivors who accessed the service or were eligible for the service.
  2. Initial outcomes of the service provided by the project. This was to be based on information held on OnTrack system and service providers sharing outcome data.

This data was coded and used to measure the demand for the service and initial outcomes.

Given the short duration of the project and the limited statistical data available it was also deemed necessary to employ qualitative research methods to ensure an in-depth and rich understanding and exploration of the experiences of R2C.

• **Semi-structured interviews with project service providers** to assess the experience of practitioners in relation to:

- Assessment of the project processes and performance indicators;
- Experience of partnership working and effectiveness of referral process;
- Experience of engaging with survivors with complex needs (exploring survivor case studies of women who have been assessed as benefiting from the project and why individuals dropped out of service);
- Identification of any barriers to project success and what lessons have been learned;
- Exploration of any additional or unintended consequences of implementing the project.

Interviews were completed with 5 project partner stakeholders. A group interview was conducted with staff at Womens Aid Integrated Services (WAIS) including WAIS Head of Service (City & IDVA); Rise Team Leader; The 24 Hour Helpline Team Leader; and Rise Complex Needs Worker (RCNW). Two follow up interviews were conducted with the RCNW who was the nominated case worker in the referral process to explore her specific experiences (she was not a member of the Steering Group) as the project developed. A group interview was also conducted with the Project Support and Development Worker and a Support Worker at Central Refuge. Individual interviews were conducted with DSVA Lead at Opportunity Nottingham; Safeguarding and Domestic Violence Lead at The Health Shop; and the Nurse Specialist from Homeless Health Care Team. Requests were submitted to the Housing Aid Steering Group representative for an interview but requests were unsuccessful. Due to organisational changes within RiN and Last Orders it was not possible to interview a member of that team involved in the wrap around care for complex needs survivors in the R2C project. Nevertheless the data provided by survivors and other service providers outlined the active involvement of both of these agencies.

- **Semi-structured interviews based on a convenience sample with survivors of DSVA with complex needs who accessed services to explore:**
  - The complexity and individual needs of the survivor.
  - Experience of accessing services and any barriers to engagement they may have faced in the past and present;
  - Experience of services provided and how appropriate they were to their needs and what improvements, if any, needed to be made to facilitate continued engagement.

9 survivors were interviewed in total: 5 had been provided refuge at Central and 4 further survivors had experienced a variety of wrap around services and had been referred into the project by different partners.

- **Content Analysis of Referral Forms**

Interviews with the 5 survivors from Central Refuge were also supplemented by access to copies of their referral forms, obtained with the consent of the survivors. This information was used to contextualise the interviews and to cross reference information provided.

The purpose of a combination of these methods was to ensure case studies could be as detailed as possible from point of entry into the project and the survivor's journey at the time of interview.

- **Participation observation of R2C Steering Group Meetings**

The researcher engaged in the monthly R2C project meetings. Minutes were circulated within a week of attending and included a detailed action plan for the steering group members. Participation in the meetings allowed the researcher to observe the decision making process and action-led approach to the project.

3.1 Challenges, Limitations and Ethical Considerations

The researcher was not involved at the start of the project, which posed a number of **methodological challenges regarding the collection of baseline data.** Efforts were made to cross-reference information held by WAIS and Central to ensure consistency with the recording of information. All project partners used the same referral form but the data was stored separately. In some cases where survivors had been housed in Central and were also on the RCNW case load there was a repetition of survivor data recorded. This risk became apparent when tracking referral information (discussed in findings below). To minimise the risk of double counting the researcher triangulated the data held by Central with the RCNW on a case by case basis, which was only possible due to the small number of cases involved (2).

It was not possible to collate data that would allow for a comparison of experiences at entry into the project compared with end of project due to the limited time frame and the evaluator not being in post at the beginning of the project. This influenced the researcher's choice of semi-structured interviews as a means to explore with each participant's experiences of the project. The evaluation would have been strengthened by interviews with Housing Aid, RiN and Last Orders, which not possible due to the organisational change. This raises important questions regarding how to mitigate for political context and organizational change in research design for an evaluation of a project such as R2C in the future.

Ethical approval was obtained from the University of Nottingham School of Sociology and Social Policy Research Ethics Committee in February 2016. In addition, the researcher was required to apply for a Disclosure and Barring Service Enhanced Certificate, which was successfully received on 18th April 2016. No interviews were completed until after this date.

The researcher was 'keen to establish rather than deny a relationship between the researcher and the researched with a commitment to **flexibility in interviews** to encourage elaboration and empowerment of interviewees' (Hoyle, 2007:148). In addition, the researcher was fully aware of the challenges that can be posed when trying to obtain survivor feedback about service provision and the risk of re-traumatising (Dunn, 2007:264-65). As a result of these two factors it was agreed, in consultation with the R2C Steering Group, that each survivor would be offered the opportunity to be interviewed with their key worker in the room. **Seven survivors (n:9) asked for their key worker to remain present during the interview**. The rationale for offering this additional support was considered necessary to minimise risk to the survivor as a result of being interviewed (Chang et al, 2005). Alternative methods were considered such as questionnaires and surveys but the complexities experienced by the survivors interviewed could have meant that the questionnaire would be seen as another bureaucratic measure in the lives of survivors. Practically, some of the survivors may also have struggled to complete any written or electronic questionnaire without the help of their keyworker. Survivors were initially approached by either the RCNW or keyworker and provided a participant information sheet. Once a survivor had given consent to their keyworker, we arranged to meet in a safe location known to each survivor. Each survivor was asked to complete a participant consent form[4] and all interviews were recorded and stored secured on an encrypted USB data stick. The researcher also ensured that each survivor interviewed provided continued consent throughout the interview using the following methods: confirmation that project was understood by talking through the participant information sheet prior to the interview commencing. In the first interview conducted it became clear early in the interaction that the survivor had learning difficulties and struggled to understand what written on the forms. This influenced the researcher's decision to not assume levels of literacy; verbal confirmation of participant consent was obtained for each interview. Before each interview the researcher ensured that the person

[4] See Appendix 4

being interviewed was made aware of the presence of a dictaphone and indicated how the survivor/service provider could know if the interaction was being recorded. The researcher directly asked each survivor/service provider at points throughout the interview if they felt comfortable to continue and monitored body language to ensure continued consent. Additionally, at the end of the interview each survivor/service provider was asked if they would like a copy of the transcript for their own records and advised they could withdraw from the evaluation at any time and how to contact the researcher. All service providers waivered the offer of anonymity and all survivors were provided anonymity by the use of pseudonyms and the removal of details in publications that might reveal their identity. Careful attention was given in the compilation of case studies. It is possible that service providers in R2C may identify the survivor due to knowledge of working with that particular survivor but efforts have been made to change locations where possible and not reveal exact dates and names provided by survivors in interviews.

The researcher was engaged in reflexive practice throughout. Interviews lasted approximately 1 hour in length, with some variation when necessary. Two survivor interviews included the use of an interpreter funded by the CDP. In one of these cases the survivor spent the entire allotted time discussing her experience of domestic abuse and how she came to be housed at Central. The researcher was very keen, as mentioned above, to maintain good rapport with survivors and given the nature of the information being shared it did not seem appropriate to press the survivor to stop talking and direct her to the referral process of experience of the services provided. We were unable to complete the interview in the allocated session, and she was very keen to have her voice heard, so we arranged a follow up interview, a week later.

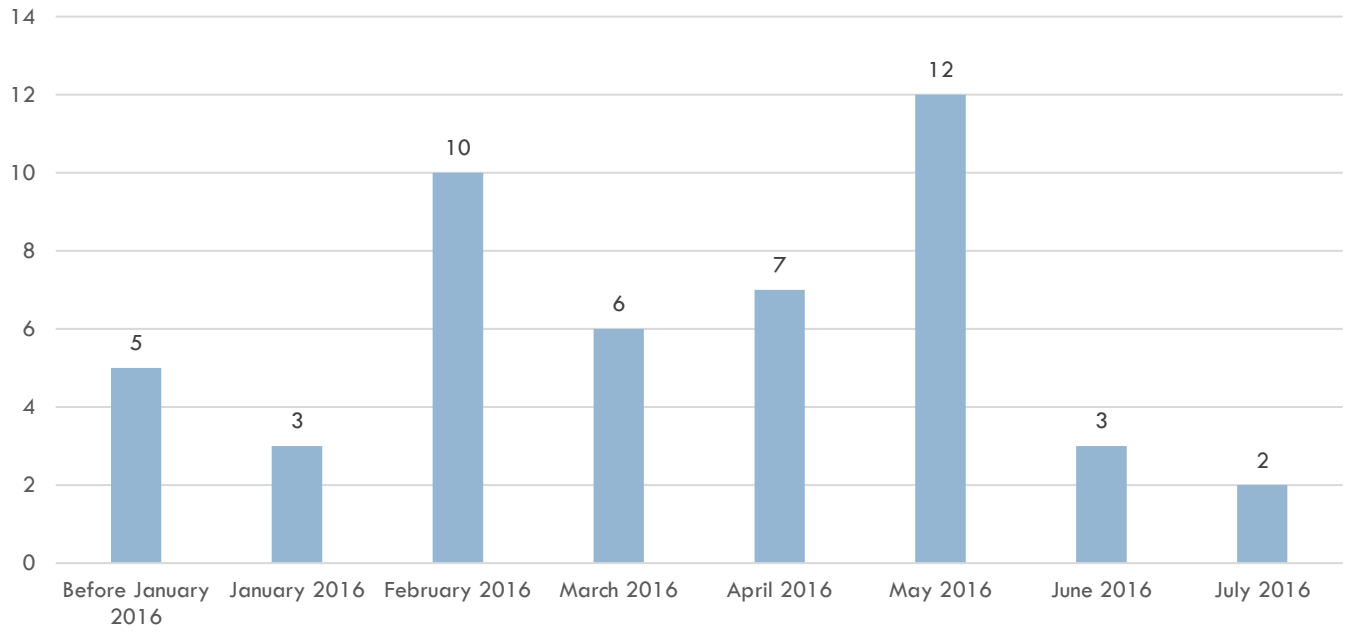
All interviews were transcribed by the researcher to allow for immersion in the data. Once transcribed the researcher engaged in a **thematic analysis of the interview data**.

4. FINDINGS

4.1 Number of Survivors

According to CDP data obtained Nottingham Police received 12,358 domestic violence and abuse related calls in 2015/16 of which 2,460 were recorded as crime. 36% of all recorded violence in the city in 2015/16 were Domestic Violence and Abuse. The project bid identified a need for resources to provide support for 25-300 survivors per year. A total number of **48** survivors were referred into the R2C project during a six month period. Five survivors were identified as eligible for additional wrap around services who were previously known to or accessing services from either Rise or Central Refuge.

Table 1: Number of Survivors (n:48) Entering Project by Month



Discussion with service providers indicates that the lower number of cases referred into the project in June represented the uncertainty surrounding the future of the project as funding was drawing to a close. The current political and financial climate mean that domestic and sexual violence services have suffered from a reduction in funding (Westmarland and Kelly, 2016). Service providers indicated that because **they had built up trust with the women they work with** they were reluctant to refer survivors to the Rise Complex Needs Worker in case the role would no longer be funded.

> **Our difficulty is that we have women who we are working with that we just feel like we can't get anywhere near in order to make the referral… Sometimes, particularly because we are hugely under pressure at the moment [organisational restructure and staffing cuts]; I think historically we would have been a lot more creative about how we were going to do that first, initial contact… I think we still always needs to be creative about how we create space…**

Equally, service providers also expressed concerns regarding **possible barriers to survivors being referred** into the project including:

- Need to **raise awareness of the project** with statutory and healthcare professionals (but there was also an expressed reluctance to do so given uncertainty relating to the project ending).
- **Scope to reconsider referral agencies.** The majority of service providers felt that no other agencies should be able to refer directly into the project. However, a suggestion was provided that ***police custody nurses*** might be a very useful addition to increase the opportunity to engage survivors and the number of referrals.

I think a good person would be the custody nurse…you know a lot of the time if people have just been brought in for drunk and disorderly or affray or something or anti-social behaviour it is only for a few hours and the clock ticks in custody and they are fairly swiftly dealt with and then they are back out again. While you've got that short space of time you can guarantee, especially if someone is a drinker that the custody nurse will get them medicated and will perhaps call the doctor (HHT, July 2016)

Equally important was an expressed need for opening the referral process to enable a greater use of ***secondary mental health services.***

I think because at the moment although it has got the Healthcare Trust down, I didn't massively promote [R2C] in secondary mental health services just because I was aware that there was only 1 RCNW and there is potentially hundreds if not more survivors with complex needs. I kept it focused on drug and alcohol services and inpatient wards because at least on inpatient wards they could contact RCNW before and RCNW has been to those wards and she's done all of that. So, I think how it could be improved long term would be that mental health services could also refer in (Health Shop, 2016)

Mental health services in the same way as drugs services faces similar barriers and similar time pressures and similar barriers in terms of those women who won't always be easily given refuge places and those women won't find it easy to go into Women's Aid or think to phone, particularly if somebody has psychotic episodes quite frequently you know, trying to get them to think about targeting appointment times. You know, it's all the same barriers. I think that in terms of referrals it would be better if mental health services could have more of an active role. I don't think that should be pushed until there is provision to provide that and I guess what I wouldn't want is that all of that is done too quickly without the provision there and then the effective work can't be happening for the people who need it (Health Shop, June 2016)

- There was consensus expressed from all service providers that women survivors with complex needs were often hard to reach individuals and if they pressed too hard for survivors to engage or to make a referral there might also be **the possibility of increasing the risk to the survivor.**
- The **reduction in public and healthcare funding** is believed to have restricted creative ways used in the past to engage survivors.

> **Trying to get the collective drugs services to make referrals [is a barrier] [and for staff] to ask the questions at the right time. It is a constant battle, I think, within the secondary mental health and drugs services to recognise domestic abuse and not because people don't understand it but because I think people are so focused on the idea that they are not here to provide a domestic abuse service, that we are here to provide a drugs service. So I'll be saying yes you are, however if you do not respond right to that fact that they are experiencing domestic abuse then you will never have any chance of dealing with their drug taking because how could someone who is coping with being abused by taking drugs [react] if you try and take those drugs away from them and they are still being abused? Then you are potentially putting that person at risk of harm so you have to be able to deal with the two simultaneously (Health Shop, June 2016)**

4.2 Complex Needs of Survivors

Over half of the survivors referred into the R2C project had more than one complex issue with 24 survivors having 2 issues and 1 survivor needing support for all three complex needs covered by the project.

Figure 2: Complex Issues of Survivors of domestic abuse

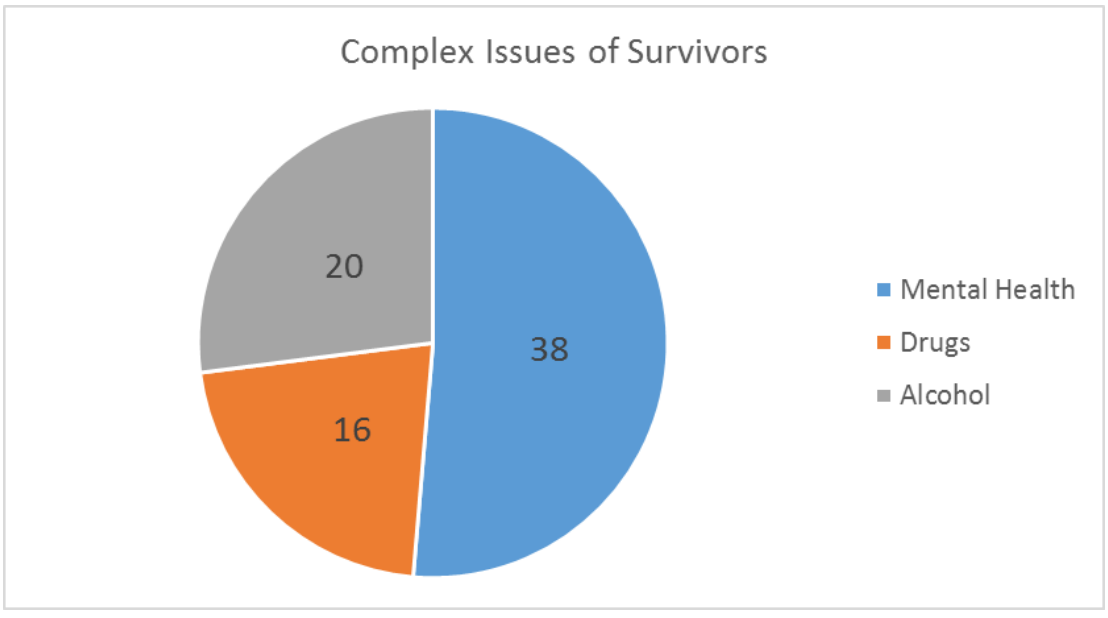
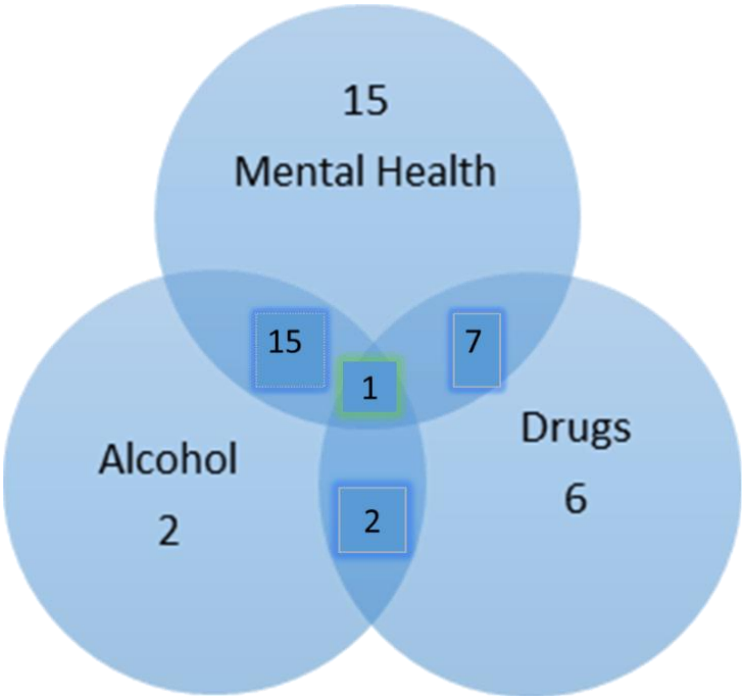


Figure 2 demonstrates the most significant issue disclosed by survivors in the project was mental health, with 38 survivors disclosing a mental health condition. However, when combined it is clear to see that a

total 36 survivors disclosed some form of substance misuse: 20 presented with alcohol misuse and 16 for drugs. These statistics need to be taken in context of the overall breakdown of support needed for survivors referred into the project. Figure 3 demonstrates the overlapping complexity of issues presented by survivors.

Figure 3: Overlap of Complex Needs of Survivors



4.3 Analysis of Referral Data

Table 2: Number of Referrals Made into R2C Project by Source* (December 2015 – July 2016)

Referral Source	Cases Referred to Rise Complex Needs Worker	Cases Referred to Central Refuge
Helpline	19	5
Health Shop	7	1
Recovery in Nottingham	3	1
Opportunity Nottingham	2	
Central Refuge	2	
Police		1
Other Refuge in Nottingham		2
Out of area		4
Other	6	

* There are more referrals than cases as there were concurrent referrals to both Rise Complex Needs Worker and Central Refuge

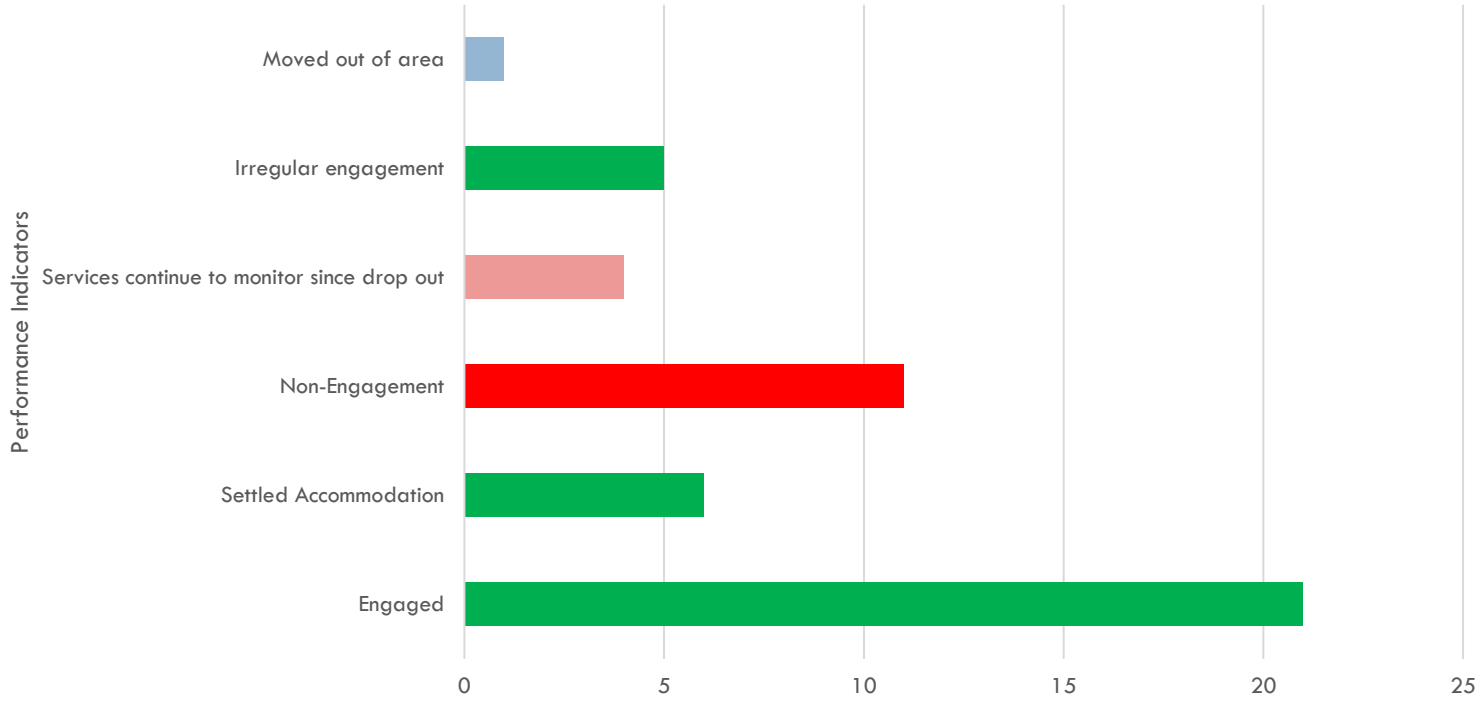
4.4 Access to Wrap Around Care

The project aimed to ensure wrap around care was provided for survivors based upon the survivors individual support needs:

- 22 survivors in the project were provided 1additional service to the referring agency (2 support services in total).
- 8 survivors were engaged with 2 additional services (3 support services in total).
- A further 8 were engaged with 3 additional services (4 support services in total).
- 3 survivors benefited from being engaged with 4-5 additional services.
- 7 had no further engagement with any additional services: From this total, 3 of these cases were closed due to non-engagement following referral and 4 are currently recorded as uncontactable but remain open.

4.5 Meeting Project Outcomes: Measuring Engagement

Figure 4: Project Outcomes



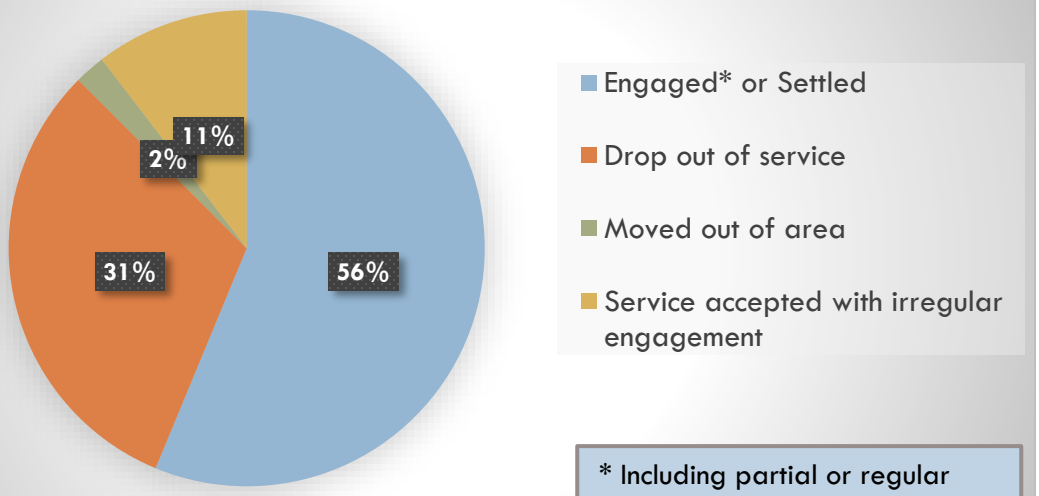
	Engaged	Settled Accommodation	Non-Engagement	Services continue to monitor since drop out	Irregular engagement	Moved out of area
Numbers of Survivors	21	6	11	4	5	1

The Rise Complex Needs Case Worker categorised her assessment of levels of engagement or support provided to each survivor on her case load. Those categorised as 'engaged' mean regular contact either by phone or face to face meetings between the case worker and the survivor. Irregular levels of engagement were said to reflect survivors who accessed DSVA specialist services when in crisis or on a needs basis. **The data highlighted in green could be assessed as indicators of success** (See page 15). 1 survivor had moved out of the area so had necessarily dropped out of service. Although some survivors (4) had ceased to engage with services **a strength of this project was that information sharing has resulted in those individuals still being tracked through multi-agency meetings chaired by the Homeless and Health Team Specialist Nurse.** So, although the wrap around care had not been sustained for these individuals they were still known to services and therefore had not entirely become invisible again to professional services. All 4 survivors were signposted to the Helpline and had the Rise Complex Needs Case Worker's contact details should they require specialist domestic abuse or refuge support in the future. As described by the Homeless Health Team Specialist Nurse:

> **So, mostly, even if people drop out of the project once they've been referred to [RCNW], they've not gone completely because the wrap around is still there and eventually we do think that certain people, because now it's there, they are almost a success because they know [RCNW] now, they know that she'll talk to us. They know. It's kind of a semi-success because they have been engaged and they are highlighted (HHT, July 2016)**

In total 11 out of 48 survivors referred into the R2C Project did not engage. The reasons recorded for this ranged from the survivor being uncontactable or unwillingness to leave perpetrator and request refuge. **Of note, 2 survivors dropped out of service due to a lack of refuge bed space at a time of crisis** (1 was unwilling to move out of area so returned back to the perpetrator and the location of the other survivor is now unknown).

Figure 5: Indicators of R2C Success



As illustrated in Figure 5. This project has already produced significant results in engaging hard to reach, often most marginalized groups in society in a very short period of time (6 months).

One of the most important aspects of this project is being able to work in a way that is flexible to meet the needs of the woman as opposed to the woman needs to meet the needs of the service (WAIS, April 2016)

Table 3: Duration and Outcome of Cases Closed by WAIS Rise Complex Needs Case Worker (January – July 2016)

Outcome	Number of cases	Average Case Length (days)	Min (days)	Max (days)
Settled accommodation	5	129	43	216
Non Engagement	6	86	64	111
Not engaged but tracked	3	81	56	123

The shortest duration of any closed case was 43 days.

Some of the ongoing cases will take significantly longer to conclude than the cases highlighted above. **Current length of open cases are on average 100 days with a significant increase in the number of days when the survivor has been provided refuge accommodation**

(Current maximum 437 days).

Service providers and survivors both expressed a key aspect of this project was the ability to meet the needs of individuals.

Case Studies

The following case studies resulted from detailed analysis of referral data and follow up interviews with RCNW. These three cases illustrate the variety of complexities and levels of wrap around support provided to survivors as a result of the R2C project.

Case 1: Irregular Engagement

Tina is a disabled women who had lost sight in one eye due to previous experience of domestic abuse. Tina was previously known to WAIS but had failed to engage in the past (number of missed appointments and had declined service to go back to perpetrator. Tina has experienced multiple perpetrators. Perpetrator 1 was in prison. Referred to project through Health Shop following attendance there and experience with Perpetrator 2. The Rise Complex Needs Worker (RCNW) contacted survivor's complex needs worker at Emmanuel House (EH) [Housing for homeless and vulnerable adults]. Rise Complex Needs Worker had number of phone conversations with survivor including:

3.1 Was to re-establish contact; ensure woman knew who RCNW was and service that could be provided; explore what needs she might have for support; arrange a face to face meeting.
3.2 Refuge query – aggressive when heard from RCNW saying she was an alcoholic and why does anyone want to support her?
3.3 Woman called RCNW back the next day, oblivious to call previous day.

In addition to phone support RCNW also engaged with the survivor face to face. This included:

1) With Emmanuel House complex needs worker went to Tina's property but woman wasn't home and property was damaged. RCNW then advised EH worker of steps needed to ensure woman's safety. EH range Tina but there was no answer. RCNW advised EH to text and tell Tina that if she didn't answer they would have to call the Police to do a safe and well check on her property as they didn't know where she was and her house was smashed up. Tina responded straight away to EH worker and established contact and confirmed perpetrator was responsible for damage to the property and Nottingham City Homes knew about it.
2) Re-arranged to meet woman again. Went to property again and woman in but perpetrator home. Did a safety check. EH worker arranged to meet her again.

RCNW followed up with a phone call to check how Tina was and Tina confirmed she wanted support. However, she was reluctant to leave perpetrator. The issues were that she wanted to move but Nottingham City Homes would only move her but on the condition that it was without perpetrator due to anti-social behaviour and complaints from neighbours about noise. Risk for NCH was too high. Tina unhappy with information provided by Nottingham Homes. EH worker continued to be supported by RCNW. EH was due to end support due to restrictions on allocated case times so a multi-agency meeting was called including: Opportunity Nottingham (ON), Tina, RCNW and Adult Safeguarding Perpetrator 1 was in prison and RCNW managed to speak to probation and ensure license conditions to ensure he was not allowed anywhere near her address or certain parts of area or contact her directly or indirectly. If he broke conditions would be recalled back to prison.

Safeguarding said that Tina needed to live in a property that was adapted to her needs including support with handrails and safety etc but at this time Tina and perpetrator 2 were experiencing breakdown of relationship with neighbours due to noise caused by both domestic arguing and domestic abuse. Neighbours threatened Tina and damaged property. Police were called. Tina rang to say too frightened to stay in property. Left with perpetrator 2 and stayed with friends elsewhere. At Multi-agency meeting support workers discussed support that could be put in place – this centred on need for Tina to leave perpetrator to access alternative housing with NCH but RCNW explored with Housing Aid other possibilities including the offer of refuge (refused by Tina as not fleeing perpetrator but neighbours). RCNW spoke to ON due to EH closure of case (time limit) and the need to ensure survivor remained engaged. Safeguarding said once Tina settled they would come back and make adaptations to her property. Tina was reluctant to leave at this point.

3-4 weeks later RCNW received a call from ON worker saying Tina was now ready to flee and was seeking refuge. Checked refuge – space at Umuada. Postcode check revealed that woman was fleeing same area perpetrator was from and refuge refused. Tina was adamant did not want to leave Nottingham – specialist refuge in Northampton was offered but wouldn't go and Central did not have any spaces.

Tina then retracted refuge request and then said she'd still like support due to trouble with neighbours. RCNW reiterated that problems with neighbours was harassment and not DV so not eligible for refuge but they could go to Housing Aid without progression. Remains supported by Opportunity Nottingham and staying with friends but has occasional contact with RCNW when needed

Case 2: Successful Regular engagement

Katie has a long history of drug misuse and historic alcohol misuse. Katie had been a victim of multi perpetrators in past. She was also previously engaged in sex work. She presented through R2C referral with a personality disorder and PTSD from trauma experienced in life. Married 4-5 years to perpetrator with 1 child. Child currently on child protection so social services involved. Perpetrator charged with bail conditions in place not to approach Katie's home or her. However, but when Katie was on holiday there was evidence to suggested perpetrator had broken in. Katie is described as "Very complex and chaotic". She was previously known to Rise in the past for resettlement support. Following referral from Recovery in Nottingham (RiN) Rise Complex Needs Worker (RCNW) took on Katie's case for further support. Regular support. Historical sex abuse has been disclosed and now under police investigation. Belief is perpetrator arranged her rape while she was at usual place for acquiring drugs.

RCNW has attended all multi agency meetings and over 12 meetings with other support agencies. Katie has additional support from: Edge of care worker; Social Worker; child's School; Housing Aid and RiN. She was incorrectly referred to MARAC on basis of the manager of social services saying that a firm recommendation of housing wouldn't take place until the woman had been to MARAC. However RCNW highlights that MARAC was not necessary as there were too many workers involved and there had to be a recent incident or safety concerns. MARAC stated it wouldn't be considered after seeing RCNW notes that it wasn't necessary.

Before RCNW was involved in Katie's case it was agreed a firm recommendation was going to be made for housing. Agreed beginning of year and still not completed first week in July. Since RCNW involvement Katie has been offered refuge although took 4-5 weeks to get her into refuge 4 different refuges claimed that Katie was too high needs and they were already housing at least one complex needs survivor and Central had no space. RCNW explained refuges that support demands for refuge staff would be reduced as Katie just needed a place of safety and the wrap around care put in place as a result of the project would support Katie and Housing Aid were already involved. Currently housed in refuge outside of area. Survivor's dog unfortunately ended up in care of perpetrator. Although RCNW referred case to pets fostering through Helpline Katie was unable to confirm the breed of the dog and ensure safety of pet workers. Perpetrator's sister, who had previously supported Katie, said she would feed dog but then gave dog to perpetrator. RCNW has ensured Katie's property is not sitexed and her belongings secure. Housing have confirmed that a firm recommendation will be made following discussion with social worker and something should be in place by end of the week so in 2-3 weeks should Katie can expect a direct offer of suitable housing. Support continue with service providers.

Case 3: Closed Case By Rise Complex Needs Worker

Referred through helpline. Housed in Central refuge. RISE Complex Needs Worker (RCNW) could not establish regular phone contact and relied on information sharing from Central Refuge. Baljit had support from Recovery in Nottingham (RiN) as she had no prescription when she arrived. Drugs worker came and RCNW accompanied her to RiN and met worker there for assessment for a script and began support. RCNW maintained RiN contact. RCNW maintained fortnightly attendance at Central Refuge in early stage of project. RCSNW said she looked at board to see if Central had any vacancies and noticed Baljit's name was no longer there so she asked where woman was and was then informed that she had been evicted. RCNW lost contact for a while but recently received phone call from woman to confirm she was homeless in the county (Meaning RCNW couldn't support) and had

returned to perpetrator. RCNW provided Helpline number for county team for additional help. RCNW believes Baljit was lost 'for too long'. Returned to perpetrator but still in contact with Opportunity Nottingham

4.6 Multi-Agency Working: Performance and Achievements

As discussed above, during the duration of the project, partner service providers were experiencing their own organisational changes due to pressures relating to austerity. Organisational change did not appear to hamper inter agency cooperation at the Steering Group level. Indeed service providers reported the following successes of the project:

Ways of accessing these women for services generically is quite difficult because unless you are working on a ground level they are invisible in other services. So having [Rise Complex Needs Worker] was a huge difference because what it meant was that she could go to the services where the women were presenting and just be there and available at times that we wouldn't be able to get Womens Aid to come in the past (Health Shop, June 2016)

- **Availability and access to specialist domestic violence support for both survivor and service providers.**

- **Increased awareness** of the roles and responsibilities of each agency and **respect for constraints** facing partner agencies and had a **shared vision** to increase quality of wrap around support to complex needs survivors.

- **Access to additional training** that enhanced ability to provide support to survivors including specialist drugs awareness and a workshop raising awareness of the impact of trauma on survivors of domestic and sexual abuse and self-harm.

- The R2C Steering Group **increased understanding and co-operation between agencies**. Consequently this has resulted in improved access to support for survivors with complex needs.

- **A reduction in the number of inappropriate referrals** between agencies and the number of times a survivor has to 'tell their story'.

- **Increased reporting to multi-agency groups outside of R2C** where required from both Rise Complex Needs Worker and Opportunity Nottingham.

4.7 Multi-Agency Working: Barriers to Project Success

Service providers were asked to reflect upon challenges they faced in the implementation of the project and, as the project progressed, how challenges were overcome. As mentioned above, the R2C Steering Group facilitated the discussion of implementing service provision addressing obstacles to survivors' health and wellbeing when they arose and the researcher observed the leadership team engaged and committed to finding solutions.

Some of the issues that arose during the project which were resolved included:

- **Negotiating access to survivors housed at refuge** and considering the most appropriate time of day, duration and regularity of visits from the Homeless HealthCare Team.

- **Referral Forms** – although there was some dissatisfaction expressed regarding the length – a new referral form was created for the R2C project. Any issues relating to chasing documentation and sharing information were resolved at the Steering Group level.

- **Identification of skills and knowledge gaps.** As discussed above, the R2C Steering Group identified training and knowledge exchange opportunities. This meant that training opportunities were identified and offered to the services the steering groups represented. Trauma training and information sharing relating to drugs and the use of naloxone was reported as significantly useful for service providers in their interactions with and supporting survivors.

- **Access to emergency prescriptions for management of substance misuse.** The Health Shop facilitated emergency prescriptions for survivors who were in refuge and unable to access GP services in a reasonable time period. This aided staff at Central and survivors.

Barriers to increasing referrals into the project included:

1. Due to restructuring and changes in staffing, **Housing Aid** was unable to participate in Steering Group activity as much as they would have liked. All support workers expressed concern with the apparent lack of understanding of complex needs survivors conveyed by Housing Aid staff. Although they recognised the commitment to the project from The Prevention and Assessment Manager and from the Head of Service who supported the original bid to DCLG.

2. **Having only 1 Rise Complex Needs Support Worker funded by the project** meant that all project partners did express concerns relating to the associated size of caseload as the project developed. Although any concerns raised about how the RCNW might manage cases were always done so with acknowledgement that there was no evidence that the service provided by RCNW had been compromised by size of case load.

3. **Utilising the services offered by and increasing numbers of referrals into Opportunity Nottingham**. This was partially resolved by inviting the Opportunity Nottingham Domestic Abuse Lead to talk to other service provider teams. However, the underlying difficulty was that Opportunity Nottingham have criteria for referral which means that survivors must have 3 out of 4 criteria (homelessness, offending, substance misuse and mental ill health). This meant that individuals on the RCNW case load or individuals in Central Refuge could not referred into and become beneficiaries of Opportunity Nottingham. Some discussion had taken place during the R2C Steering Group about possibilities for referral criteria being amended to include domestic abuse but this issue was not resolved during the time period being evaluated.

Gaps in partnership working reported included:

Service providers all expressed some levels of dissatisfaction working with agencies not included in the R2C project. Interviews revealed service providers felt there was a perceived lack of awareness and understanding of the barriers faced by survivors with complex needs in most cases.

> **The survivors themselves are often deemed as non-compliant because they are non-compliant, we know this, but there are reasons for why they are non-compliant and that can often be that big sort of stumbling block [to accessing services]… so I've been able to advocate for the patients but it's been quite difficult to get that message across (HHT, July 2016).**

- Frustration was expressed by Central Refuge staff and HHT Specialist Nurse regarding obstacles to **accessing GP practices to support survivors with complex needs.** 2 separate cases were discussed in detail during interviews which demonstrated that there was a lack of understanding of survivors needs. The R2C agency Steering Group did document the issues and were keen to address these with the Clinical Commissioning Group.

- **Lack of awareness of the R2C project; lack of understanding and engagement in stereotyping of the challenges facing survivors with complex needs; and a lack of acknowledgement of the professional roles of service providers revealed in interactions with social workers.**

> **I think the main challenges are around how this client group are perceived by other services. I think there is still the concept of deserving and undeserving victims. Even within services that you think that shouldn't be the case. (Opportunity Nottingham, June 2016)**

You see this in MARAC all of the time, there is constantly this interplay between engagement [of the survivor] and the possibility of holding the perpetrators accountable. So, it is like we put all of this energy into saying to survivors you need to go into refuge, you need to do x, y and z, you need to do such a thing, you need to be responsible, you need to act protectively for you and your children, the language that services use is so blaming of the survivor and I still hear it at MARAC: Social Services will say, she is not acting protectively and I will nearly always say, "She has kept herself and her children alive in the face of the most high risk domestic abuse and how she has done that is all of the things you are saying she is not acting protectively. So for her a disclosure may increase risk. If risk is increased and she tries to leave then she is at more risk of being killed. So she thinks in her mind that she'll just keep quiet and do what he says because then it might reduce the risk then she is acting protectively. It doesn't mean that we get rid of the risk because we have to hold the perpetrators accountable for the abuse that they're perpetrating (Health Shop, June 2016)

Service providers expressed concern that social workers appeared to dismiss the contributions made by them in case meetings. Four service providers expressed the view that they felt they were often regarded as advocates without professional experience and capacity to provide impartial contributions in case meetings. Statements relating to frustration with social services were always framed within an acknowledgements of the challenges and difficult job social workers have with safeguarding in the current political environment and "blame culture". However, all service providers interviewed stated a commitment to try and overcome cultural barriers and "rather than proportioning blame and walking away" they continue to try and engage social services where necessary to consider how a survivor may have been acting protectively.

EXAMPLE 1 BARRIERS TO SERVICES:

"Non-Compliant" Individuals

A survivor in Central Refuge disclosed to the Homeless Health Team (HHT) Specialist Nurse that she was experiencing significant discomfort and it was suspected the survivor had a case of thrush. The survivor had already phoned the GP surgery and been advised to go to a pharmacist, which she did and she followed the advice and treatment given. This had not resolved the issue. Therefore, the survivor was asked to swab herself and the HHT nurse sent it off for analysis. In the meantime, the HHT nurse – who is a qualified triage nurse – contacted the GP receptionist to try and arrange an appointment. The receptionist spoke to the GP and there wasn't an appointment until the following week so the advice given was to go to the GUM Clinic or to go to the pharmacist. The survivor had already been to the pharmacist because that was the advice she had been given a few days before, which she had acted upon the advice she had already been given on the telephone. The treatment had not worked and a few days had passed.

Advising the survivor to go to the GUM Clinic was identified by the HHT specialist nurse as putting the woman in unnecessary risk as, "The likelihood is that if she'd gone to the Gum Clinic the perpetrator might be there or people who know the perpetrator might be there. They can get followed so they know where they live then" (July, 2016). The HHT nurse identified the need to 'build bridges' with the GP surgery and inform them of the service being provided by R2C. The HHT nurse went to the pharmacy and got more treatment but the pharmacist gave the treatment stating that he would only provide the treatment if it was followed up with the GP if the survivor was no better. On the basis of that information, the nurse visited the GP receptionist and managed to book the survivor in for an appointment for the following day. When the survivor visited the doctor the following day the doctor advised that they had to wait for the swab results to come back so just use some warm water, as nothing else could be done at the moment. What the survivor did instead was return to the city she had previously fled because she knew the doctor there well and received 5 days of treatment and got herself better. Again, it was highlighted this put the woman at unnecessary personal safety risk and at risk of dropping out of service.

In this case, the survivor was interviewed and discussed the same situation but highlighted just how thankful she was to the HHT nurse for all her efforts to help. The trust in staff at Central refuge was also mentioned as a key motivating factor for remaining engaged in service.

EXAMPLE 2 BARRIERS TO SERVICES:

Supporting Complex Needs Survivors with Mental Ill Health

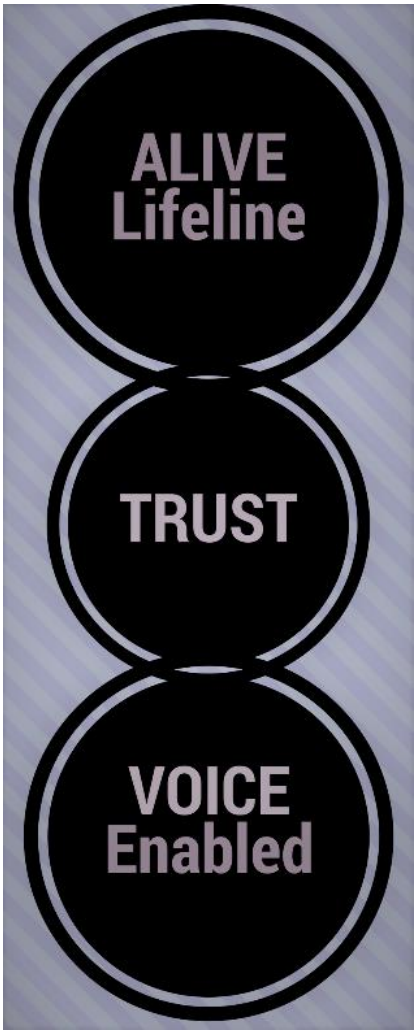
1. A survivor had mental health problems was treated and worked with a Community Psychiatric Nurse (CPN) in a previous city, which she fled. Once in refuge the survivor sought assistance from the local GP who was reported as saying they could not treat her and **could not do anything about her condition until the GP got to know her better.** The HHT Specialist Nurse asked the care coordinator to get in touch with the CPN in the previous city to get the information.

2. **The lack of suitable mental health interventions for women survivors with complex needs** was highlighted by all service providers. It was reported that there was very little psychological support that was done by qualified people for DSVA survivors with complex needs mainly due to the lack of psychological therapies available. The choices and challenges are discussed were outlined as:

> **Let's Talk Wellbeing (which may offer 6 sessions, which if you are the women we are talking about in this project, is not even going to touch the sides); also they would be assessed as not suitable for the service because their needs are too high. If their needs are not currently high but they had history of risk it is possible that they might get 20 sessions with Step 4 Psychological Therapies but they have to have no active drug taking, no active self-harm, their risk has to be really low. Again, for a lot of people that we work with it's not. Or, you can go through to the CATS service [Clinical and Assessment Treatment Services] but you have to have a diagnosis of mental health disorder so if you've been somebody who has been repeatedly abused, even if it is real life, if you don't have a diagnosis by a psychiatrist you can't get that help. So, loads of the women that we see in drugs services and also, this is the other thing, if you have a primary drug problem then mental health services will say well it's because she's got a drug problem and if she stopped her drug taking then she wouldn't have these issues (Health Shop, June 2016).**

Two survivors in Central Refuge had completed the Lets Talk Wellbeing and it was observed by the HHT nurse that at the time of interview that one of the survivors was "moving on a little bit" but the other was "caught in limbo because she's not quite ready for the crisis team but she's not quite just for talking therapies either so she is kind of caught in that situation".

4.8 Survivors Experiences of R2C



A number of common themes emerged throughout the transcription and analysis of survivor interviews. Each survivor was asked to discuss how they accessed services and all survivors identified the **ease** with which they felt they were referred into the project.

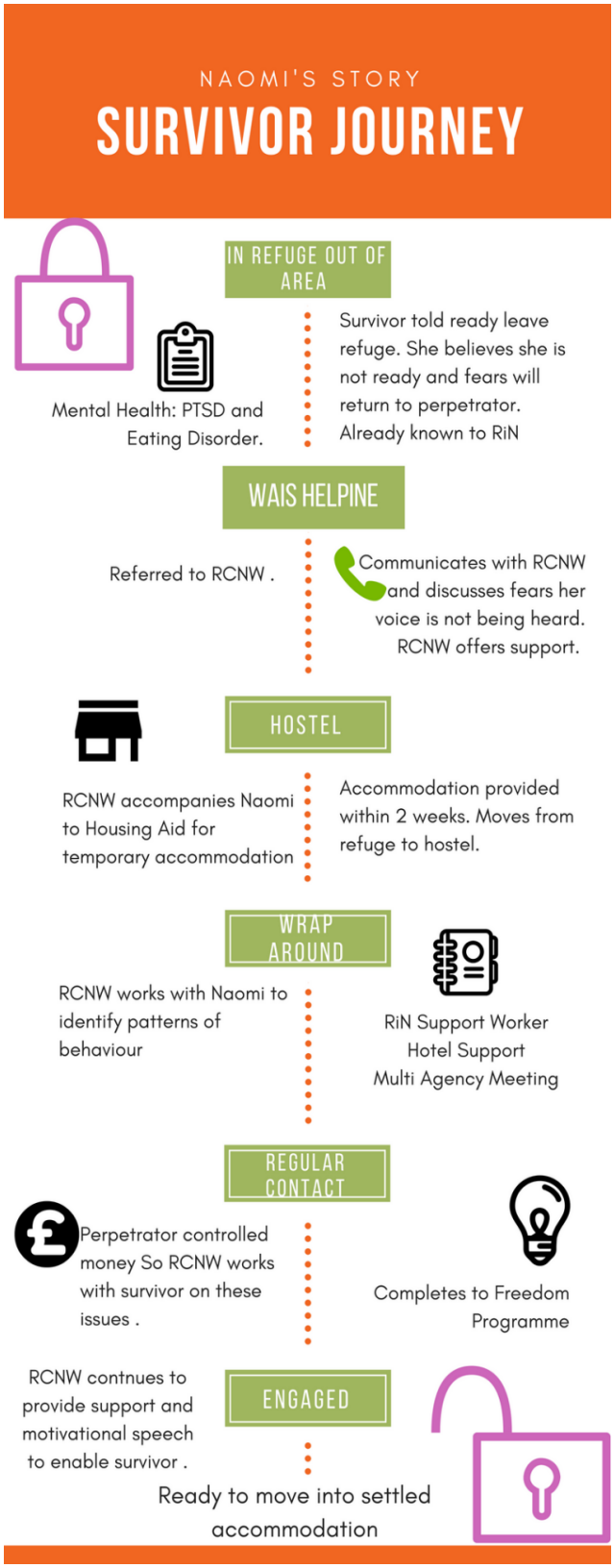
Trust was also an apparent theme. Survivors who had previously disengaged from services discussed how they had often felt misunderstood and were frustrated with the number of times they had to tell their story. Survivors discussed the need to build relationships and individuals in refuge were more likely to engage with a service and the professionals introduced to them by their keyworker. Indeed, many of the survivors who had more than one wrap around service did not seem deterred by a higher number of service providers because they identified how each service provider was offering help in different areas of their lives.

Every survivor interviewed disclosed how they personally felt their **health and wellbeing had been improved** through engagement in services.

Eight (n:9) expressed frustration with statutory agencies not adequately listening and responding to their needs or concerns relating to child protection, criminal justice, housing provision or some GP surgeries.

Three (n:9) survivors discussed how they felt the RCNW enabled and provided and opportunity for their voice to be heard. Survivors have also expressed the feeling that they were **no longer being "passed from pillar to post" without getting anywhere** or at least no longer feeling like someone understood their concerns.

4.9 Mapping Survivor Journeys: 3 Examples **Naomi's Story[5].**



Naomi had a long history of dropping out of services and returning to the perpetrator (a multiple perpetrator). Naomi had one child and a grandchild in the town she fled. This was the fourth time she had left perpetrator and had specifically moved out of area to reduce the risk of returning or being found. She initially sought refuge in Nottinghamshire following information disclosed as a result of The Domestic Violence Disclosure Scheme (Clare's Law).

Naomi discussed the reason she returned to the perpetrator in the past were due to her eating disorder and when she felt in crisis with that she believed she was safer with him:

"A lot of the time in the past one of the big reasons why I would return because it felt safer when I was with [perpetrator]. He just took control of my food and everything like that it just felt kind of life was better when I was with him rather than being in the cycle of the eating and vomiting. So, when that started to happen and staff at the refuge felt that I was ready to move on, I knew I wasn't and I thought if I get a flat in Nottingham and I didn't know where I wanted to live, I still had so many like…I just wasn't ready. I knew I wasn't ready. ***I didn't feel I was being heard.*** I thought that if I get a flat in this state plus I had made the decision so I didn't know whether I wanted to return or be nearer [family and home town]. It just felt too much at that time. I still occasionally do have like ideas that, "well maybe it could work out" but then I discuss these issues with [RCNW]…like yesterday I was worried sick he might have killed himself because family told me someone was looking for me and I thought it was because of a card I'd sent saying that I couldn't have any contact at all anymore for my own recovery."

Naomi had already been accessing services provided by Recovery in Nottingham. She discussed how in the past she had attempted to complete the Freedom Programme but this actually led to her return to the perpetrator as she was questioning whether it was "really us" and "really describing him". Naomi received regular support from RCNW which included a range of things such as:

- Weekly telephone calls to check on general wellbeing and/or face to face meetings with coffee and in a relaxed environment.

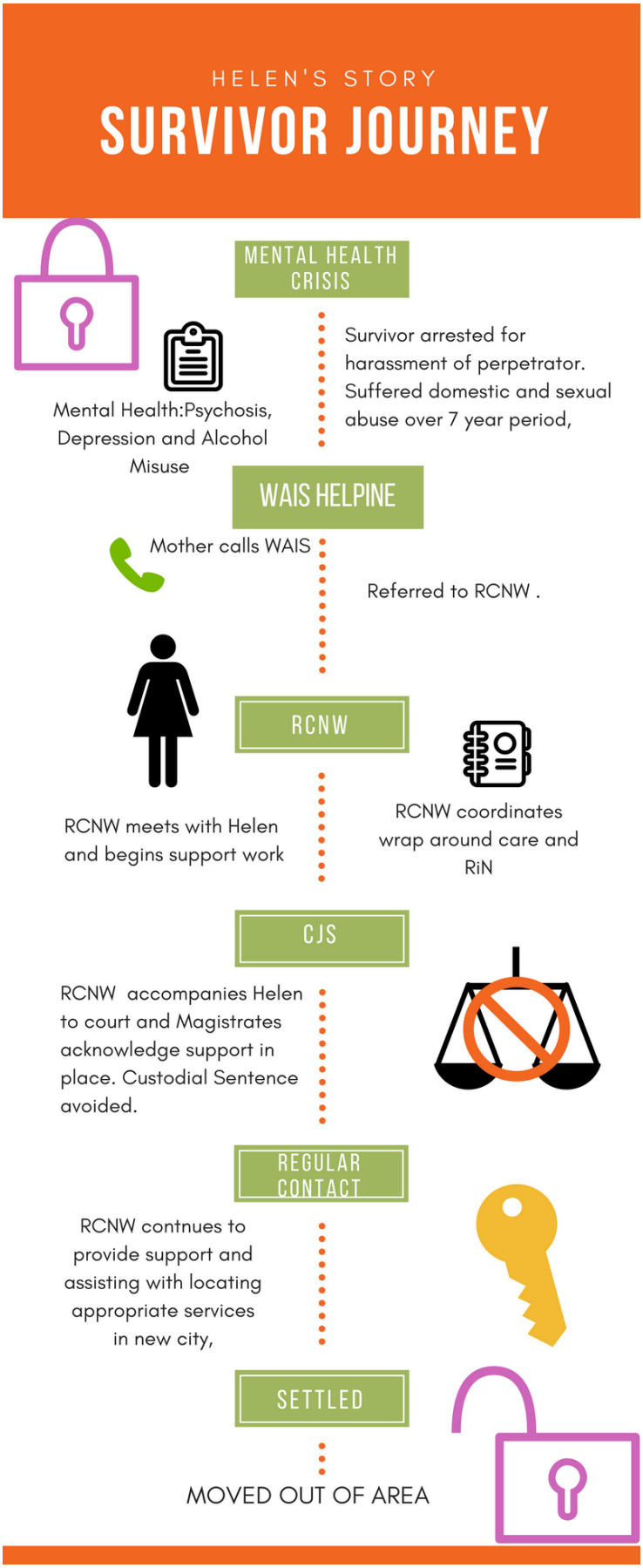
[5] All names have been changed.

- Accompanying Naomi shopping as she was not used to being able to make choices as her shopping budget and finances were controlled by her perpetrator.
- When in crises Naomi would also contact RCNW and discuss fears and issues specifically related to returning to the perpetrator.
- Discussing Naomi's needs at multiagency meetings.
- Accompanying Naomi to Housing Aid and assisting with finding suitable accommodation and during transition from refuge to hostel.

Naomi stated that she felt she was "now living" because of the support provided by RCNW and she described how the RCNW specifically helped with domestic violence related experiences and RiN were instrumental in her mental health and addiction recovery. The RCNW was able to build rapport quickly with Naomi who reported that,

> I had just had an instant connection time thing. I felt at ease with her and she was bright and cheerful. It wasn't like this was some great big heavy thing. Oh my God like look what's happened to your life and how are you going to get through it? It was just like, "it's in the bag; don't worry about it". You know she made it easy.

Naomi described how she thought that "…moving into a flat on my own in Nottingham made the reality of what has happened to my life real". Her fears of engaging with settled accommodation were treated seriously and the RCNW was able to provide continued support to work towards settled accommodation by confidence building and motivational speech. Naomi completed the Freedom Programme whilst resident in the hostel and has found it much easier to do so this time with the additional support of RCNW and the wrap around service.



Helen's Story

Helen described being in an on off relationship with a perpetrator for 7 year. In 2015 the violence escalated and she describes being almost killed on a number of occasions during this year:

"…we got back together and the relationship slowly descended into a sort of toxic, co-dependent situation that resulted in intense and very brutal violence against myself to the point that I was almost killed on a number of occasions. I also got into trouble myself during that period of time I was sort of going through a period of psychosis after a while of the violence and I had become and I had lost touch with reality essentially so I was going back to him almost daily despite the fact that he was hitting me. To the point that he contacted the police against me to say that I was harassing him. It was a non-violent situation but he was essentially saying that I was harassing him. I could see now that it looked like that and it could be taken as that but unfortunately it was a product of the psychosis I was going through, which was a result of the violence and the physical and not just the physical but the mental and verbal abuse".

Helen's mother sought help as the family was struggling to provide the support to Helen they thought she needed. Helen was experiencing psychosis, depression and engaging in alcohol misuse. The RCNW contacted Helen and arranged to meet her in her home. Helen described the relief in the household when she first met RCNW,

"…my mum had been acting as my support worker and because she was obviously emotionally hurt by what I'd experienced it wasn't working. It was too much for the household to take that burden. So for someone else coming in as a third party, who is outside of the situation but could and had experience and understanding and ultimately the most important thing, empathy, it was great and I knew I was in good hands. I didn't feel scared anymore".

As detailed above, Helen was charged with harassment related offences and was due to

attend court. The RCNW accompanied Helen to court. Helen was confident that RCNW presence prevented a custodial sentence as she recalled,

> "Yeah she came to the court room and essentially the harassment charges that were against me carried with them a possibility of custody and they made it very clear that had it not been for her presence, I would have been given custody. So by her being there and showing that I was getting support from a service, like Women's Aid, gave them the hope that I could be, in their minds, rehabilitated because in their minds they weren't coming from a perspective of me. They were coming from his perspective in that particular setting, he was the victim and I was the perpetrator even though it was all very grey and it was intense on his part. They made it really clear that if it weren't for her presence they would have treated me a lot different."

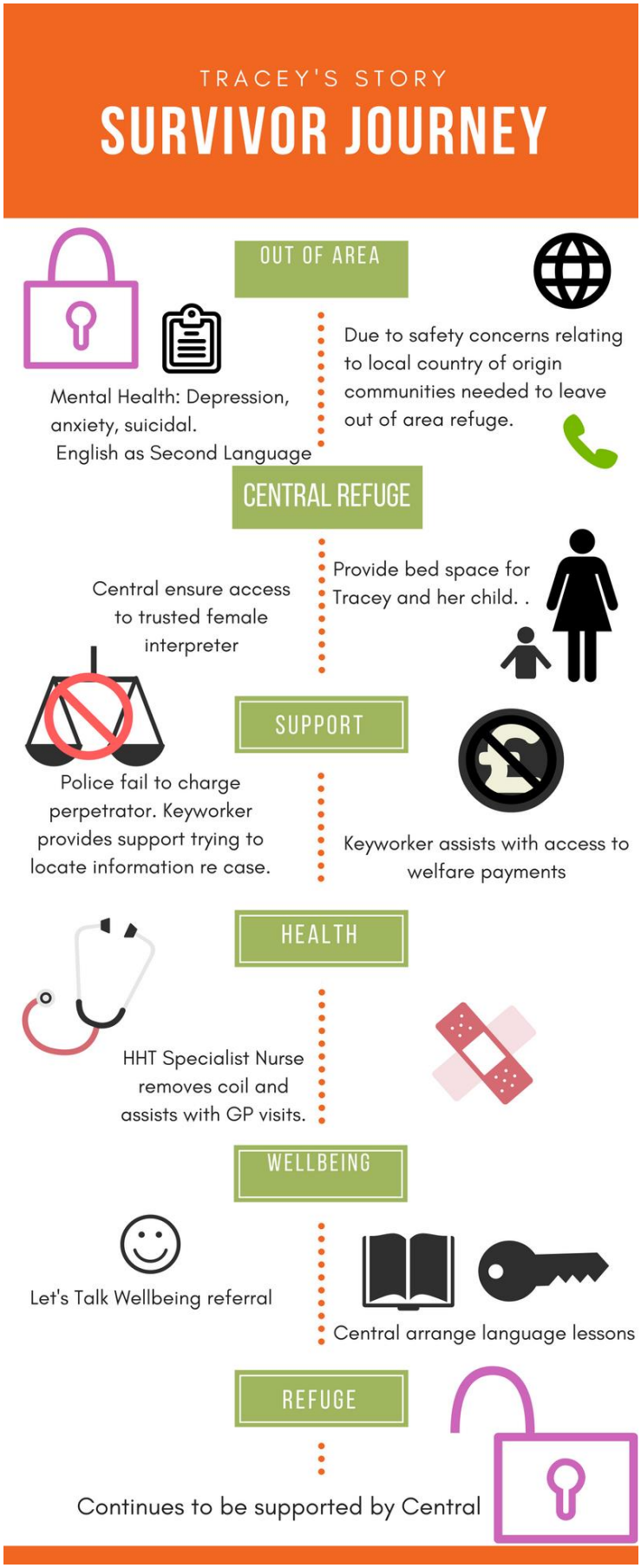
Helen also went on to discuss how the RCNW supported her in the period during and following the court case. Helen found the court experience "humiliating" and recollected how,

> It was horrible. It made me feel absolutely humiliated. I had just come out of a relationship where I was humiliated, physically beaten to within an inch of my life, urinated on, just stripped of my dignity and then having to go into court and face the fact I had had a breakdown and I had done stuff that wasn't so great. I wasn't violent…The court experience is very isolating, very humiliating, it is demoralising and the magistrates they are doing a job but unfortunately the justice system is not catered to the individual.

The RCNW provided support in the court room with her physical presence and following the court case continued to work with Helen. This was particularly important to Helen as in addition to feelings of "shame" she identified above, she also disclosed the impact of the pre-sentencing probation report that concluded she didn't have victim empathy,

> When she [probation officer] said I didn't have victim empathy I was just like, I didn't talk about him in terms of what I had done. I was very honest. I was going through serious psychosis and I have deep, deep abandonment issues and this person was giving me all of the support and then ripped it away whilst being violent towards me. She wrote in the report I was a fantasist and she said, we are trying to figure out what the trigger might be for her behaviour! She didn't call the crisis team who were involved with me. She didn't call anyone.

The RCNW continues to work with Helen and ensure that her connection to mental health services in Nottingham are continued as she moves out of area.



Tracey's Story

Tracey and her child wanted to leave an out of area refuge she had fled to following years of domestic and sexual violence and abuse. She recalled how she did not feel safe in the town she had previously been provided refuge as it was populated by a large ethnic minority community from which she and the perpetrator originated. Tracey originally came to the United Kingdom following an arranged marriage with man of Middle Eastern origin. During the interview Tracey described in depth the financial, physical and sexual abuse she was subjected to throughout a 5 year period. Tracey's experience highlighted the additional difficulties that can be faced when trying to meet the needs of survivors with complex needs and English as a second language.

After 2 previous opportunities to report the abuse were lost due to language barriers. Tracey finally reported the perpetrator to the police after a violent incident that took place in front of her child.

Tracey reported high levels of satisfaction with the services provided to her in refuge. She detailed the support the keyworkers have given in ensuring access to welfare payments and in supporting both her and her child.

Since I have been in the refuge, every holiday they have taken us on trips and the sea sides: My child was like he was wild he had never seen anything like that before. I have never been so happy in my life when my son is so welcome in that place.

Indeed, the only improvement Tracey mentioned she would like in service provision was the opportunity for more trips but she appreciated the financial barriers in place for Central to accommodate this.

It was clear that Tracey still felt that she had a long way to go in her mental health recovery but the lack of criminal prosecution of the perpetrator after 9 months was still distressing. This was mainly expressed through discussion of cultural issues where members of her family and the perpetrator's family refused to believe domestic and sexual violence had taken place as "Britain had strict laws where you

could go to prison for selling cigarettes illegally", which they believed meant the lack of any criminal prosecution brought against the perpetrator meant he was innocent.

> What upset me so much was that I lost a lot: I changed my telephone number because the police advised me that. They told me not to give anyone my number except my sister in case something happened to me. My mum, she doesn't have my phone number and I haven't spoken to my mum for two months now because I can't tell her why I can't give her my number. Who is losing out? Me. I am living but I am like a dead person. I have no Facebook, I have no nothing. He is doing everything and I am not allowed to do anything. Still they [police] don't do anything for me.

Tracey's frustrations were reportedly recognised by Central Refuge Support Workers and Tracey felt that she had been given all of the support her and her family. The Homeless Health Team Specialist Nurse provided a number of services including removal of Tracey's coil. Tracey described how life changing her experience at Central had been and the benefit of accessing English language classes, which was one way the perpetrator used to control her:

> When I arrived at Central I thought I would rather die but with their help and the mental health team they have helped me through Let's Talk Wellbeing and they give me life. They give me hope. If it wasn't for them I thought my life was over. I thought it was gone. Now I feel I am a new person because of them.

Tracey discussed how she had met the RCNW but they had a discussion that she was adequately supported for the time being and when she was ready to move into permanent accommodation the RCNW would begin further support.

5. SUMMARY AND RECOMMENDATIONS

To date the project clearly demonstrates, in a short period of time, the positive impact this multi-agency approach can have in engaging survivors with complex needs and providing good quality wrap around service that is needs-based. Central to the positive outcomes reported in this evaluation has been the following:

- **The R2C Steering Group –** this forum contained **personally committed and engaged individuals** from the project partner agencies. These individuals had **capacity or influence** in effecting and coordinating and leading change within their own agencies for the benefit of both survivors and good multi-agency partnership working.

- **The Rise Complex Needs Specialist Domestic Violence Support Worker** and the ability of this individual to use professional skills to support both survivors and other project partners has been discussed throughout this report.

- **Availability of bed space for complex needs survivors -** As discussed above, there was occasion when a survivor was unable to access additional bed space and later dropped out of service. Where additional bed space had been provided the combination of wrap around care and support resulted in high levels of survivor engagement, which minimised the risk to their safety and improved health and wellbeing.

- **Responsiveness to Survivors' Needs** The survivor journey maps and evidence provided by survivors and service providers illustrates that when agencies have the capacity to, it is important to respond to the needs of the survivor. Having service providers who engaged or were knowledgeable of a trauma informed, needs-based approach appears to have increased the rate of engagement for this group of survivors. This resulted in positive outcomes for the health and wellbeing of survivors who were engaged. Where survivors had engaged temporarily but dropped out of service these individuals were still known to services and discussed at multi agency meetings.

Possible Improvements to Project:

1. FURTHER DEVELOP MULTI-AGENCY RELATIONSHIP BUILDING AND INCREASE R2C PROJECT VISIBILITY

- Building on the STRIDE St Ann's pilot project, funded by the Police Innovation Fund and Priority Families to provide specialist agency support from Womens Aid (survivor) and Equation (perpetrator) to Social Care and Family Support Teams. Experiences of service providers in R2C suggests further relationship building and agency awareness is needed to ensure quality wrap around care for survivors engaged with agencies not included in the Steering Group:
  - Social Workers –a reported need to increase recognition of the professional services being provided to survivors. **R2C project is a good example of a successful multi-agency partnership that may help the local region in implementing recommendations of the Wood Review (2016) and increase safeguarding of children and survivors.** The discussion of social services by

both survivors and service providers suggests Hester's (2011: 850). 'Three Planet Model' continues to be a pressing concern and a need to acknowledge the process of gendering that are 'situating women as culpable victims'.

- GPs - **Consultation with Identification and Referral to Improve Safety (IRIS) Lead and GPs in area to raise awareness of the project and the roles of the various project support service providers.** There have been some key issues with GP practices supporting survivors with complex needs discussed above, which the multi-agency Steering Group was keen to address with the Clinical Commissioning Group.
- Housing Aid - **Housing Aid employees should receive specialist DSVA training, especially in relation to complex needs survivors** by utilising the free of charge services of Equation / R2C.
    - The Steering Group would benefit from the knowledge and experience that Housing Aid could offer for future Steering Group/Multi-agency Meetings and would welcome Housing Aid participation in resolving issues for the complex survivors.

- **Consider widening referral agencies to include police custody nurses.** This may help widen access to services for complex needs survivors and equally help promote cultural change within services of specific challenges faced by complex needs survivors, which will help to address misconceived ideas relating to victim culpability discussed by some survivors and service providers during this evaluation.

2. INCREASE CAPACITY

To support a greater number of survivors through the recruitment of additional specialist domestic violence support workers with experience of supporting survivors with complex needs.

- This would address service provider hesitation to refer into R2C.
- Ensure quality of service is maintained.

3. EFFECTIVE MONITORING AND TRACKING OF SURVIVORS COULD BE IMPROVED.

There was some dissatisfaction expressed with the referral forms used (amount of detail) and the statistical analysis for this evaluation has also highlighted the need to cross reference between Rise Complex Needs Worker and Central Refuge to avoid any gaps between services.

- Greater understanding of the differentiation of support service provided by Rise Complex Needs Worker and Central Refuge is required.
    - A decision needs to be made concerning whether the Rise Complex Needs Worker should be alerted to all complex needs cases housed in Central Refuge this may depend upon provision of service made in the earlier recommendation.
    - **Steering Group could have a standard agenda item to include specific case by case update.** This may help improve referral follow up and survivor journey mapping.

4. ADDRESS GAPS IN PROVISION RELATING TO EQUALITY AND DIVERSITY:

- Survivor and service provider interviews have revealed there may still be **gaps in the service for survivors whom English is not their first language.**
- **Widen access to some healthcare services.** The Homeless Health Care Team identified a need for complex needs survivors **to be invited to have cervical**

screening as a result of the R2C Project. However, The Homeless Health team have been unable to provide the service due funding issues relating to funds already being provided to GP surgeries for this activity. Lack of support for implementing a smear test service demonstrates either a lack of awareness of the specific needs and risk for survivors with complex needs on behalf of funding commissioners or the lack of a joined up approach between GPs and the project needs. Elizabeth Pain's (2016) Cervical Screening Audit for City Care of 83 homeless females between the age of 25-64 clearly identified a need to engage homeless women fleeing domestic violence and/or substance misuse or mental health difficulties.

- **Increase support available to survivors with mental health difficulties.** City Care had appointed a CPN at the end of the project evaluation who would be attending Central Refuge with the Homeless Healthcare Specialist Nurse. However, the issues raised in the evaluation suggest that there is a need to review what additional support and recovery options are available for complex needs survivors beyond, Let's Talk Wellbeing.

R2C Policy Relevance

The R2C project was designed to improve confidence and understanding between the partnership agencies and build knowledge on a range of practical issues affecting survivors of DSVA with complex needs. The referral pathway established and wrap around care model was intended to meet the needs of survivors in a safe space rather than expecting them to access mix gendered drug and alcohol services which their perpetrator may also have been accessing. As discussed above the project did increase the health and wellbeing of survivors who engaged. R2C allowed individuals who were previously invisible to services to have access to special DSVA support that would meet their needs. R2C would be a good vehicle to ensure social inclusion and that access to survivors who have complex needs remain visible to services and their needs are understood. As AVA (2013) outlined the challenges facing survivors with complex needs who have experienced DSVA are significant and can result in an increase in risk (Barnes and Gunby, 2014). At a national level, HM Government (2016) *Ending Violence Against Women and Girls* [VAWG] *Strategy* stated a commitment to

> '…working toward new forms of services for victims with the most complex needs as too often they are turned away from services. We want to see innovation and creativity to ensure these vulnerable women get the help they need' (2016:32)

The R2C project is an example of a model that demonstrates precisely the requirements being asked of service providers. What is required, at noted above, is the need to increase project visibility and education of service providers who are not referral agencies to increase understanding of the challenges facing complex needs survivors of DSVA.

At a local level, although it is too early to tell long term impact and whether there has been a reduction in repeat victimisation. There was certainly evidence that this project may help the Nottinghamshire Police and Crime Commissioner in delivering strategic priorities of protecting and supporting victims and vulnerable people (Nottinghamshire PCC, 2015). If barriers to referral outlined above are addressed it is possible that R2C will contribute to the PCC's commitment to ensuring 'targeted provision is available, effective and focused on those most vulnerable to victimization and offending' (2015:21).

For individuals supported in R2C the impact on their lives was reportedly significant and for many life-changing. The findings of this evaluation substantiate the claims made by Macy et al (2010) that to achieve success in this kind of wrap around service provision, there needs to be a 'call for funding and policy attention to the emerging area of trauma-informed services, including attention to facilitating collaborations among domestic violence, sexual assault, mental health and substance abuse providers' (2010:1156). Placing R2C in national context of other projects such as *Promoting Recovery in Mental Health* (2016) may also influence policy developments that could result in change in service provision to ensure the needs of all survivors of DVSA are met.

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APPENDIX 1: Nottingham and UK history of key events in Domestic and Sexual Violence and Abuse: December 2016

Year	Local Services and initiatives	Local good practice, policy, strategy and needs assessments	National developments, policy, strategy and significant reports	Legislation
1971			Chiswick refuge opened – first in UK	
1972				
1973				
1974	Central Womens Aid refuge established Nottingham		Women's Aid Federation England established	
1975			Government Select Committee on violence in marriage recommended 1 refuge place per 10,000 population	
			Rights Of Women legal advice and training centre founded London	
1976				Domestic violence Bill (Domestic Violence and Matrimonial Proceedings Act)

Year	Local Services and initiatives	Local good practice, policy, strategy and needs assessments	National developments, policy, strategy and significant reports	Legislation
1977				Housing Act acknowledges domestic violence as a cause of homelessness
1978	Rushcliffe Womens Aid refuge opened and subsequently closed			Domestic Proceedings and Magistrates Court Act
	Nottingham Womens Centre opened on Shakespeare St home to groups which became Rape Crisis and Womens Aid Advice Centre			
1979			Southall Black Sisters founded to challenge domestic and gender violence particularly against Black women	
1980	Nottingham Rape Crisis counselling line established			
	Nottingham Womens Aid Advice Centre phone line and drop in established			
1981				
1982				

Year	Local Services and initiatives	Local good practice, policy, strategy and needs assessments	National developments, policy, strategy and significant reports	Legislation
1983				Matrimonial Homes Act
1984	Nottingham East refuge opened (closed 2009/10)			
1985	Roshni Asian Womens Aid launched (refuge closed 2011) Outreach services still delivered			
1986				
1987	Nottingham Womens Centre moved to Chaucer Street		First National domestic violence help line established by Women's Aid Federation England	
1988				Housing Act 1988
1989	Nottinghamshire Domestic Violence Forum launched in partnership with local statutory and voluntary agencies			Childrens Act 1989
1990			Law Commission Enquiry into domestic violence	
1991			First National Inter-agency working party on domestic violence	Rape in Marriage criminalised in England

Year	Local Services and initiatives	Local good practice, policy, strategy and needs assessments	National developments, policy, strategy and significant reports	Legislation
1992	Nottingham Agenda voluntary male perpetrators programme established (closed 2003)			
	National Perpetrator Programme Network established			
1993			Home Affairs Select Committee into domestic violence	
1994	Umuada Womens Aid refuge established for African Caribbean women and children		Women's Aid Federation England and Home Office first national publicity campaign	
1995	Childrens Workers in refuges posts established		National Postcard Campaign by Body Shop	
1996	NDVF quarterly seminar and domestic violence awareness training programme established		Why mothers die: report on confidential enquiries into maternal deaths in the United Kingdom 1994-1996 (including domestic violence) published by the DoH	Family Law Act Part IV gives more effective civil remedies and automatic power of arrest

Year	Local Services and initiatives	Local good practice, policy, strategy and needs assessments	National developments, policy, strategy and significant reports	Legislation
1997	Nottinghamshire County Council domestic violence policy officer post established		Greater London Domestic Violence Project established and became AVA (Against Violence and Abuse) in 2010	Protection from Harassment Act 1997
				Crime and Disorder Act 1998
1998			Women's Aid Federation England publish Families without Fear the precursor to the first National Strategy	
			Counting the Costs Stanko published report on financial cost of domestic violence to public	
1999	Nottingham City Council establish first domestic violence policy officer post		Government launch Living Without Fear first National Strategy	
2000	First Free phone 24 hour helpline in the UK launched in Nottingham by Womens Aid	Mental health and domestic violence policy for Nottingham City Council	National health and domestic violence campaign launched by DoH	
	Nottingham Interagency domestic violence awareness campaign launched – Free From	Children and domestic violence sub group established	Standing Together Against domestic violence launched and initiated the Co-	

Year	Local Services and initiatives	Local good practice, policy, strategy and needs assessments	National developments, policy, strategy and significant reports	Legislation
	Fear included first TV adverts about domestic violence in UK		ordinated Response Against domestic violence	
	Nottingham Black and Red information cards launched including in community languages (adopted by DoH)	Nottingham City Council Best practice developed on domestic violence and social care (children and adults)		
	NDVF training and seminar programme launched	Housing and domestic violence subgroup established		
	Respect established (national perpetrator and male victims agency)	Nottingham City Council domestic violence strategy group established		
2001	Amber House refuge established (North refuge closed)	Area Working Groups on domestic violence established		
2002	NDVF first schools project launched (Educator project)	Police Domestic Violence Policy published	Broken Rainbow helpline for LGBT survivors of domestic violence established	Children and Adoption Act (including domestic violence) 2002
2003	TRI male perpetrator project launched at NDVF	Nottingham City Council Homeless Strategy including domestic violence launched	Hitting Home National Campaign	Anti Social Behaviour Act 2014 (Civil powers for local authorities can be used against perpetrators)

Year	Local Services and initiatives	Local good practice, policy, strategy and needs assessments	National developments, policy, strategy and significant reports	Legislation
	NDVF sign up to National White Ribbon Campaign lead by men against domestic violence	Nottingham Health Action Zone includes domestic violence action plan		
	NDVF Male Perpetrators Good Practice Guidance developed		National Free phone 24 hour helpline launched	
	NDVF Impact Project working with hard to reach young people launched			
	Womens Aid Traveller and Prostitution outreach worker launched			
2004	NDVF Male Victims Good Practice Guidance developed	Nottingham City Council Employee Domestic Violence policy published	Women's Aid Federation England Refuges on line launched	Domestic Violence Crime and Victims Act 2004 (refreshed 2012)
	Respect launched minimum standards for perpetrator programmes	Nottingham City Council Corporate domestic violence strategy launched	Local Government Association domestic violence consultation	
	Police Domestic Abuse Support Unit launched	Housing Policy published	Specialist Domestic Violence Courts launched nationally	
	Family Care Time 4U therapeutic programme for children launched	Supporting People Strategy developed	National Rape Crisis Federation launched	

Year	Local Services and initiatives	Local good practice, policy, strategy and needs assessments	National developments, policy, strategy and significant reports	Legislation
	Nottingham Open Door outreach service for survivors developed into the Outreach Service			
	Womens Aid Outreach Project launched		Crown Prosecution Service use of expert witness testimony policy launched	
2005		Nottingham City Council sets Local Area Agreements domestic violence targets	Women's Aid Federation England Body Shop survivors handbook launched	
		Nottingham City Council set BVPI 225 targets	National BVPI 225 domestic violence targets set for all local authorities	
		Disability and domestic violence Good Practice Guidance developed by NDVF for local partners	Co-ordinated Action Against Domestic Abuse (CAADA) launched	
		NDVF undertook Disability Discrimination Act (DDA) audit of all local refuges	Department of Health Domestic Violence Handbook published	
			Bristol midwifery training rolled out nationally	

Year	Local Services and initiatives	Local good practice, policy, strategy and needs assessments	National developments, policy, strategy and significant reports	Legislation
		Nottingham Primary Care Trust publishes health domestic violence policy	End Violence Against Women (EVAW) established	
			Crown Prosecution Service second edition of domestic violence policy	
2006	Sanctuary Scheme launched delivered by Housing Aid in partnership with Womens Aid	LCJB establish domestic violence action delivery group	National policy of Co-ordinated Community Response to domestic violence launched	Gender Equality Duty 2006
	Integrated Domestic Abuse Programme for perpetrators with Womens Safety Scheme launched in Nottingham	PCT develop domestic violence action plan		
	Specialist Domestic Violence Court planning starts	PCT publish domestic violence policy		
	Women's Aid Federation England National Service Standards for domestic and sexual violence services published	GOEM establish regional domestic violence working group (ended in 2010)		

Year	Local Services and initiatives	Local good practice, policy, strategy and needs assessments	National developments, policy, strategy and significant reports	Legislation
2007	Nottingham PCT employed specialist domestic abuse nurse post established	Nottingham City Council review of refuge services and options appraisal completed	Mental Health Bill regulatory impact assessment: revised version June 2007 (includes domestic violence)	Forced Marriage Civil Protection Act 2007
	Nottinghamshire Sexual Assault Referral Centre (Topaz)launched		Stella Toolkit launched by AVA (substance misuse and domestic violence)	
	Shine domestic violence floating support project launched			
	Safe contact centre launched (closed 2 years later)			
	Happy Days play project for refuges and hostels launched (has now closed)			
	SDVC launched in Nottingham (ISVA's and Court IDVA's)			
	MARAC launched in Nottingham (IDVA's)			
2008	Womens Institute launches campaign against domestic violence	Good Practice Guidance on children and domestic violence	Making the Links first national report on impact of domestic	

Year	Local Services and initiatives	Local good practice, policy, strategy and needs assessments	National developments, policy, strategy and significant reports	Legislation
		launched by Safeguarding Board	violence on disabled women launched	
	Shine womens floating support scheme established by NCHA funded by Nottingham City Council	Domestic violence Joint Strategic Needs Assessment completed	Mental Health Act 2007: guidance on the extension of victims' rights under the Domestic Violence, Crime and Victims Act 2004	
	NDVF launch Respect not Fear First website for young people on domestic violence and subsequently the GREAT website for younger children			
2009	Nottinghamshire Mental Health Care Trust establish domestic violence post	Good Practice Guidance on substance misuse and domestic violence launched	Improving Safety and Reducing Harm, children, young people and domestic violence (DoH)	
	PCT commissioned NUH emergency department specialist domestic abuse nurse		Findings of the Forced Marriage IDVA pilot (Dept Justice)	
	Pet Fostering Project launched by Womens Aid		Together we can End violence Against Women and Girls National Strategy	

Year	Local Services and initiatives	Local good practice, policy, strategy and needs assessments	National developments, policy, strategy and significant reports	Legislation
	Stronger Families therapeutic programme for children and their mums launched		Partner exploitation and violence in teenage intimate relationships report published	
	Embrace Pilot project trailed through APAS funded by Alcohol Concern to look at new approaches to support families where there is Alcohol misuse and Domestic Violence / Abuse			
2010		Second Domestic Violence JSNA completed	Women's Aid Federation England Real Man campaign	
	AVA project - Communities of Interest launched - domestic, sexual violence substance misuse and mental health building on Stella Project	PCT launch health domestic violence Pledge for all health agencies signed by Chief Officers	Health Task force on the impact of domestic violence on womens health report published	
	Empowerment project pilot (joint work with children and young people affected by domestic violence , substance misuse and being young carers) began and ended	Safer Notts Board establish strategy group	Freedom Programme launched	

Year	Local Services and initiatives	Local good practice, policy, strategy and needs assessments	National developments, policy, strategy and significant reports	Legislation
	National Mens Advice Line for male victims launched by Respect			
2011	Nottinghamshire Domestic Violence Forum GREAT project in schools launched		Sojourner Project for women with no recourse to public funds piloted	
			Sexualisation of Young People report	
			Girls affected by gangs report	
	NDVF Whole School Approach Launched		Call to End Violence Against Women and Girls national strategy and action plan launched	
	Zola BMER refuge launched		Commissioning services for women and children who experience violence or abuse – a guide for health commissioners published	
	NDVF first IPhone application on domestic violence developed	Domestic and Sexual Violence Strategic Needs Assessment completed	Family Justice Review impact on children (Dept Justice)	

Year	Local Services and initiatives	Local good practice, policy, strategy and needs assessments	National developments, policy, strategy and significant reports	Legislation
	NDVF male IDVA post established		Stern Review on Rape published by Home Office	
			CPS guidance on prosecution of domestic violence cases	
			CPS guide for victims of domestic violence	
2012	Man Enough Campaign Launched	Nottinghamshire Police Authority domestic violence review	New definition of domestic violence proposed by the Home Office	Implementation of section 13/14 of crime and victims act
	Aspley Whole Community Approach Campaign launched	Victim Support review of victims and survivors experience	Domestic violence Homicide Reviews established	
	Domestic Abuse Referral Team launched and based with the Police Domestic Abuse Support Team	Womens Aid Chief Officer resigns to become the Deputy Police and Crime Commissioner	Domestic violence protection orders piloted	
	Girls affected by Gangs pilot • Outreach post at NGY • Programme for girls identified by schools		Claire's Law piloted (Disclosure Scheme)	
	IRIS health project Womens Aid working with GP's launched		UK border agency responsible for funding	

Year	Local Services and initiatives	Local good practice, policy, strategy and needs assessments	National developments, policy, strategy and significant reports	Legislation
			places for women with no recourse	
	DHR policy adopted and first Nottingham DHR undertaken		Striking the Balance: Practical Guidance on the application of Caldicott Guardian Principles to Domestic Violence and MARACs (Multi Agency Risk Assessment Conferences)	
	Domestic Abuse Repeats Panel piloted (DAR / CDAP)		Consultation on criminalisation of forced marriage	
	Domestic abuse midwife post established in NUH		Standing Together publish a new edition of the Guide to Effective Partnerships	
	NDVF change their name to Equation		United National Convention on Violence Against Women	
	Womens Aid 24 hour helpline extend their services to provide referral into sexual violence services			

Year	Local Services and initiatives	Local good practice, policy, strategy and needs assessments	National developments, policy, strategy and significant reports	Legislation
2013	Integrated Offender Management (Police, Probation) project launch planned	Nottinghamshire Health Care Trust domestic violence strategy launched	Definition of domestic violence changes to include 16 year olds and coercive and threatening behaviour	
	Teen advocate pilot funded by PCC and delivered by Women's Aid Integrated Services	Nottingham City Council and partner agencies Safe From Harm review concludes and funding maintained for DSV services	Changes in Welfare Benefits impact on refuges and other domestic violence services	
	Aspley Whole Community Approach concludes and Fire Break is launched	Nottingham County DSV review is launched	Reduction in access to Legal Aid impact on survivors capacity to take legal action	
	Girls affected by Gangs research funded by PCC and delivered by the Health Shop is launched		Closing Magistrates Courts has impacted on SDVC	
	Domestic abuse specialist nurse on the ward at QMC and City Hospital funded by NUH charity and evaluated by Nottingham University		CAADA roll out training for teen advocates and seek to identify advocates in all local authorities	
	Girls affected by gangs pilot programme funded by Lloyds TSB delivered by Equation and		Violence against Women and Girls strategy updated by the Home Office	

Year	Local Services and initiatives	Local good practice, policy, strategy and needs assessments	National developments, policy, strategy and significant reports	Legislation
	becomes Know More programme			
	Pilot programme for emerging perpetrators developed with YOT and Equation becomes Choices programme in schools			
	Whole School Approach concludes and develops into Equate programme for secondary schools			
	ISAS deliver sexual violence counselling in Nottingham			
	Nottinghamshire Probation Service commissions WAIS Women's Safety Worker service to support female partners of perpetrators attending the IDAP programme			
2014	Research Group launched by Dr Julie Mc Garry	DSV joint commissioning group launched chaired by the Director CDP	Domestic violence Disclosure Scheme (Claire's law pilot) is rolled out nationally	Domestic Violence Protection Orders rolled out nationally

Year	Local Services and initiatives	Local good practice, policy, strategy and needs assessments	National developments, policy, strategy and significant reports	Legislation
	Medium risk Repeats pilot launched funded by PCC and delivered by Women's Aid Integrated Services it is evaluated by Leicester University in partnership with Equation	County DSV review is concluded and services commissioned		Care Act 2014 includes Domestic abuse
	St Anns DSV group is launched to develop on the learning from Aspley	Outreach, Sanctuary and Shine projects re-commissioned as one project		Forced Marriage criminalised through Anti Social Behaviour, Crime and Policing Act 2014
	South Nottingham DSV group launched	NHS England fund the SARC and ISVA's and develop a county wide sexual violence strategy group		
	Central Locality DVA group launched			
	Clinical Commissioning Group tender out the IRIS project across Nottingham	DHR Assurance and Learning Implementation Group established to progress the action plans and recommendations to improve		

Year	Local Services and initiatives	Local good practice, policy, strategy and needs assessments	National developments, policy, strategy and significant reports	Legislation
		learning from Domestic Homicide Reviews.		
	Rights And Recovery Project funded by OPCC and delivered in partnership by WAIS, Nottingham Women's Centre, Rape Crisis, the Health Shop and Equation (developing programmes for a range of survivors and providing therapeutic support for survivors of domestic abuse	Teen Advocacy Referral form developed alongside the Teen DASH RIC		
	Womens Aid Integrated Services Rise outreach service launched			
	WAIS Peripatetic Children's Work service launched			
2015	STRIDE St Anns pilot project is launched funded by the police innovation fund and Priority Families to provide specialist agency support from Womens Aid (survivor) and Equation	Gap Analysis is developed by the CDP on domestic violence	Probation Integrated Domestic Abuse Programme is replaced by Building Better Relationships	Coercive Control comes in as a new law under the Serious and Organised Crime Act 2015. Implemented 29/12/2015

Year	Local Services and initiatives	Local good practice, policy, strategy and needs assessments	National developments, policy, strategy and significant reports	Legislation
	(perpetrator) to Social Care and Family Support Teams			
	Integrated Research Group launched by University of Nottingham to link academics and practitioners on DSVA	CDP refresh DSVA strategy and change map	Priority Families (Troubled Families) includes domestic abuse in matrix	FGM Act 2003 amended by the Serious Crime Act to include FGM Protection Order
	Asian Womens Project launch Sakinah Domestic abuse project in partnership with Womens Aid and the CDP	Nottingham Labour Party Manifesto includes no cuts to DSVA services and a commitment to a reduction in repeat domestic abuse	National VAWG strategy is under vision	2015 – Disclosing private sexual photographs and films with intent to cause to distress (revenge pornography) – Criminal Justice and Courts Act 2015
	Violence against Women and Girls Network meetings are developed in partnership with Community Cohesion and the CDP	CDP work with Womens Aid England and National Rape Crisis to develop a performance framework for the commissioned services	Adolescent to Parent Violence and Abuse guidance published	
	Successful bid to the DCLG for a pilot project for 6 months for refuge spaces (Central Womens Aid) and outreach services (RISE) for survivors with complex needs. R2C	CDP with JCG tender out the DSVA services with aligned funding from Nottingham City Council (including Public Health), CCG, OPCC	DCLG funding available for additional refuge spaces	

Year	Local Services and initiatives	Local good practice, policy, strategy and needs assessments	National developments, policy, strategy and significant reports	Legislation
	Bid also for support to Women for whom English is not a first language in all refuges.			
	CAMHS identify a DSVA specialist lead	DART is reviewed and refreshed		
	Midwifery identify a DSVA specialist lead	FGM working group is set up by Public Health		
	Opportunity Nottingham identify a specialist domestic violence lead	FGM community group is set up by the OPCC		
	Equation Reel Equality project win national Film Awards	Girls Affected by Gangs report forms the basis for Multiple Perpetrator Good Practice Guidance		
	Equation Men's Service extended in the County to include Standard and Medium Risk alongside High Risk.	Women are Safer Summit held in Nottingham highlighting gender based violence and abuse.		
	Women's Aid Integrated Services hosts National IRIS Implementation Manager post	Implementation of the DSVA Safeguarding Group		

Year	Local Services and initiatives	Local good practice, policy, strategy and needs assessments	National developments, policy, strategy and significant reports	Legislation
2016	Encompass Launched DART to contact schools to alert that the police have been out to an incident of domestic abuse the evening before.	OPCC hold national DSVA conference with Evan Stark and Liz Kelly	DRIVE national pilot launched to examine practice on utilising Integrated Offender Management for domestic abuse perpetrators	
	STRIDE is extended City Wide and funded by Priority Families	Police, NPS and CRC develop new domestic abuse integrated offender management scheme	Change That Lasts national pilot launched by Womens Aid England with Safe Lives.	
	DART is aligned with the Social Services Front Door and leaves the Police Domestic Abuse Support Unit. The IDVA team join the DART.	Niche Police IT system launched.		
	Vanguard Plus joins the MARAC to aid with support for survivors of multiple perpetrators	Nottinghamshire Police develop an employee DSVA policy		
	Mojatu FGM community group launched and funded by the OPCC in Nottingham	Sexual Violence Action Network launched to co-ordinate campaigns and action around prevention of domestic abuse		
	Nottinghamshire and Nottingham are successful in bidding to be one of the 3	Rape Crisis launch a series of 'Listening Events' for survivors of rape and sexual violence		

Year	Local Services and initiatives	Local good practice, policy, strategy and needs assessments	National developments, policy, strategy and significant reports	Legislation
	Change That Lasts pilot areas with Womens Aid England.			
	Multiple Perpetrator Practice Guidance launched by CDP	CDP review whether to use IOM for domestic abuse. Decision to be made next year.		
	Womens Issues Reference Group launched by the OPCC			

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APPENDIX 2: Forms of DSVA Experienced by Survivors with Complex Needs

Physical and Sexual Abuse Encouraging substance use (introducing, buying, administering). Using physical violence to coerce substance use. Withholding psychiatric medication or overdosing. Controlling and/or physically restraining survivor's movements claiming for own safety (e.g mentally unable to cope/ drug dealer threat). Sexual violence when unable to consent (intoxicated or mentally unwell). Forced prostitution to support substance misuse	**Minimising, Denying and Blaming** Deliberately challenging understanding of a abuse that is occurring including statements "You're overreacting", "You're seeing and hearing things"; "It didn't happen – you're imagining things/crazy/high" Deliberately destroying property / harming others but stating survivor was culpable. Blaming injuries on self-harm
Emotional and Psychological Abuse Creating an environment where the survivor will feel incompetent because of mental health or substance use. Damaging self-esteem with verbal insults. For example, "Unfit mother", "Crazy/Mad/Junkie" Humiliation and manipulation by telling others of addiction or mental health problems in negative context.	**Isolation** Prevention from social activity due to embarrassment of addiction or mental health Preventing access to medical services/medication which exacerbates issues Telling victim/family that family/victim no longer want contact due to substance misuse or mental health.
Economic Abuse Telling survivor she has lost money or money is missing to create uncertainty and self-doubt. Taking control of finances and claiming it is due to survivor's inability to function. Restricting access to money. Taking money for perpetrator's own alcohol/drug use Forcing survivor to sell drugs	**Coercion and Threats** Threats of violence if she doesn't stop being "crazy"/drinking/using drugs Threaten to contact social care Threaten to have survivor sectioned Threaten to tell family/friends/employer about mental health or substance misuse if survivor has not already disclosed.
Children Encouraging children to insult and degrade mother because of mental health/substance use Making children question mental health.	

Table adapted from AVA (2013:262-263)

APPENDIX 3: OVERVIEW OF STAKEHOLDERS

Nottingham Central Women's Aid (Central)

Nottingham Central Women's Aid is a registered charity and company, which has existed since the 1970s to support women and children fleeing domestic abuse. The refuge reopened in January 2012 following a period of closure due to cuts in funding. Central aim to provide safe temporary accommodation, with support for women with or without children, who are living with or have experienced any form of physical, sexual, emotional, psychological or economic abuse, including so called "honour" based violence and FGM. The Refuge is housed in a large building which can accommodate six families. Communal areas include, sitting room dining/kitchen, laundry, children's playroom, equipped play garden and a further back yard with a separately housed craft room (Central Womens Aid, 2016). Members of Central Committee rotated membership on the R2C Steering Group. This included, Liz, Sam and Eva.

Nottingham Crime and Drugs Partnership (CDP)

The Nottingham Crime and Drugs Partnership (CDP) is a multi-agency organisation responsible for tackling and addressing crime and substance misuse in Nottingham. The partnership is made up of a number of statutory and non-statutory agencies including the Police, the City Council, the Fire and Rescue Service, the Probation Service, Public Health and the Clinical Commissioning Group, Health providers, the Drug and Alcohol Action Team, Nottingham Trent University, Nottingham City Homes, the Business Community and voluntary sector organisations such as Victim Support and Neighbourhood Watch. It is a statutory partnership created under the Crime and Disorder Act 1998, which requires all key agencies in Nottingham to work together in the prevention of crime and commissions services. The R2C bid and Steering Group was led by, Jane Lewis, The Community Safety Strategy Manager from the Community Safety Team within the CDP. Jane is also the Domestic and Sexual Violence Strategic Lead for the CDP.

Women's Aid Integrated Services, Nottinghamshire (WAIS)

Is an independent domestic abuse charity operating across Nottingham City and South Nottinghamshire which is free to access. WAIS has strong partnerships with other statutory, voluntary and community sector organisations. WAIS states that the aims of the agency, with over 30 years' experience, is to to reduce the harm caused by domestic abuse; to strengthen families; to empower women and children; to raise awareness about domestic abuse and its effects on women and children. Rebecca Smith, Head of Service (City and IDVA), represented WAIS on the R2C Steering Group.

RISE Team at WAIS

This service offers both immediate crisis support and ongoing emotional and practical support. This means that survivors are offered support, which can continue for up to 4 weeks and (or) non urgent emotional and practical support that can last for up to 12 weeks. All elements of the service can be delivered flexibly in the woman's own home or in safe, accessible community venue. Access to this service is by referral only and a dedicated support worker is provided to accompany the survivor through different elements of the service provision with the aim of 'providing end to end support from crisis to independence'. The crisis element of the service focusses on activities such as homelessness prevention; safety planning; assisting individuals with choices and options; referral both to additional specialist services and fast-tracked referrals to other WAIS services. The flexible, 12 week, ongoing support through face to face, telephone, text and internet-based peer support includes help with

health and wellbeing; drug and alcohol missuse; managing a tenancy or moving home; parenting; living skills; education, training; volunteering and employment; social networks and relationships. (WAIS, 2015b). The Rise team resourced and provided the Rise Specialist Domestic Violence Complex Needs Worker, and the team was led by Marsha Brown, an R2C steering group member.

WAIS Helpline

This service is a 24 hour domestic and sexual violence freephone (0808 800 0340) for any woman affected by domestic violence or abuse. It is available 7 days a week, 365 days a year. A team of specialist female staff and volunteers who are experienced and trained to understand domestic abuse and the impact it can have on woman and children (WAIS, 2015c). Gill McCourt leads the Helpline Team and also coordinates the 'Ref for Pets' referral service, which provides foster care for animals of survivors wishing take up refuge.

Housing Aid

Nottingham City Council service offering general help and guidance on housing, homelessness issues; tenancy sustainment and floating support. Housing Aid casework includes housing advice and homelessness, welfare benefits, homelessness prevention and debt. Debbie Richards represented Housing Aid on the R2C Steering Group and Housing Aid provided office space for the R2C Steering Group meetings.

Recovery in Nottingham (RiN)

Recovery in Nottingham (RiN) was an innovative consortium of local organisations that came together to deliver an integrated drug treatment system and recovery pathway for Nottingham. The consortium, driven by the RiN Partnership Board, comprised experienced and specialist health and social care providers with a proven track record of delivery. The service is the central component of a treatment system which aims to achieve sustained recovery from all types of drug misuse for individuals through the provision of fully integrated, personalised and evidence based treatment and re-integration. Clients could access The Health Shop, Access, Treatment and Aftercare services through RiN (Recovery in Nottingham, 2015). In 2016 during the project RiN was joined with Last Orders and renamed as Nottingham Recovery Network (Nottingham Recovery Network, 2016)

Last Orders

Last Orders offered a number of services to help people address their alcohol issues. Last Orders provided the single access point for all adult alcohol referrals within Nottingham. At this point patients were seen by a clinical nurse specialist who assessed their alcohol use and refer on to the most appropriate service. Last Orders also provided primary care clinics for extended advice and Last Orders Recovery Service for on-going alcohol support. Last Orders also employed a health promotion specialist for alcohol for Nottingham and provided training for health professional and other services (Framework, 2016). In 2016, during the project, Last Orders was joined with RiN and renamed as Nottingham Recovery Network (see below).

Nottingham Recovery Network (2016)

During the project Nottingham Recovery Network joined together the two existing support networks (Last Orders and RiN) to provide a publicly funded service to support people who misuse drugs and alcohol. The Nottingham Recovery Network provides a single point of advice, support and treatment for anyone in Nottingham City who wishes to change their relationship with drugs and alcohol (Nottingham Recovery Network, 2016).

Homeless and Healthcare Team (Nottingham City Care Partnership)

The aim of the Homeless Health Service is to address the specific healthcare needs and improve the health and social care of local homeless people by providing them with access to appropriate community nursing services in line with the national guidance.

The service aims to provide clinical treatment, advice and support to homeless and vulnerably housed people; to increase the number of homeless people accessing mainstream health and social care services; to increase the number of homeless people registered with a GP practice; to prevent inappropriate use of emergency services for people who are homeless (Nottingham City Care, 2016).

The Health Shop

Offer advice and support on a wide range of issues regarding substance abuse and sexual health. The sexual health service offers: testing for sexually transmitted infections for people who do not have any symptoms; Hepatitis B vaccinations; range of contraception and pregnancy testing. The service have a Clinical Psychologist who provides support for issues around sexuality, gender identity, HIV, problematic sexual behaviours (such as sex addiction) and problems having sex. The service also provides specific information on Chemsex and is a C-card registration and pick up point (a service for young people aged between 13 – 24 in Nottingham City. The service also focuses on harm reduction providing a needle and syringe exchange/ 1-1 Advice and Support Around Substance Use / Blood Borne Virus Testing and Vaccinations / LFT's for heavy drinkers and drug users / Harm Reduction Advice/Specialist Steroid and Image Enhancing Drugs Clinic / Auricular Acupuncture.

Donna Stenton-Groves, Domestic and Sexual Violence Lead at the Health Shop until June 2016, represented RiN and Nottingham Healthcare Foundation Trust on the R2C Steering Group. Following Donna's change in job, Louise Wilkins from Nottingham Healthcare Foundation Trust joined the R2C Steering Group.

Opportunity Nottingham

Opportunity Nottingham is part of the National Fulfilling Lives Programme and Big Lottery Funded until 2022. The service seeks to improve the lives of people with multiple and complex needs in Nottingham City, and deliver our work through a partnership of local agencies. Beneficiaries of Opportunity Nottingham need to be experiencing at least three out of the following four complex needs: homelessness, offending, substance misuse and mental ill health. In order to join the project, beneficiaries must be referred. Once a Beneficiary joins Opportunity Nottingham, a Personal Development Coordinator provides support, which is tailored to the beneficiary and involves working with specialist services and partner agencies around the four project criteria. Meetings take place in an environment the Beneficiary feels comfortable in, which could include a local café or their home. Personal Development Coordinators are also able to meet in more formal settings if required, such as a prison or hospital ward (Opportunity Nottingham, 2016). Justine Sadler, Domestic and Sexual Violence Lead, represented Opportunity Nottingham on the R2C Steering Group.

APPENDIX 4: CONSENT FORM AND PARTICIPANT INFORMATION SHEET (SURVIVORS)

University of Nottingham

Participant Consent Form [R2C Service Users]

Responding to Complexity (R2C): An evaluation of the Department of Communities and Local Government (DCLG) funded coordinated response to support survivors of domestic and sexual abuse with complex needs (mental ill-health, substance misuse including alcohol and/or dual diagnosis).

In signing this consent form I confirm that:

I have read the Participant Information Sheet and the nature and purpose of the research project has been explained to me.	Yes	☐	No	☐
I have had the opportunity to ask questions.	Yes	☐	No	☐
I understand the purpose of the research evaluation and my involvement in it.	Yes	☐	No	☐
I understand that my participation is voluntary and I may withdraw from the evaluation without having to give any reason.	Yes	☐	No	☐
I understand that information provided during the evaluation may be published by the academics involved in the research project.	Yes	☐	No	☐
I understand that confidentiality may be waivered should a serious threat to life be revealed.	Yes	☐	No	☐
I agree that extracts from my interviews and data provided may be anonymously quoted in any report or publication arising from the evaluation.	Yes	☐	No	☐
I understand interviews will be audio recorded.	Yes	☐	No	☐
I understand that data will be securely stored	Yes	☐	No	☐
I understand that the information provided can be used in other research projects which have ethics approval, but that my name and contact information will be removed before it is made available to other researchers.	Yes	☐	No	☐
I understand that I may contact the Dr Lyndsey Harris (University of Nottingham) if I require further information about the evaluation, and that I may contact the Research Ethics Officer of the School of Sociology and Social Policy, University of Nottingham, if I wish to make a complaint relating to my involvement in the research.	Yes	☐	No	☐
I agree to take part in the above research project.	Yes	☐	No	☐

Participant's name (BLOCK CAPITAL)	Participant's signature	Date
Researcher's name (BLOCK CAPITAL)	Researcher's signature	Date

Information for Participants [R2C Service Users]

RESEARCH PROJECT TITLE:

Responding to Complexity (R2C): An evaluation of the Department for Communities and Local Government (DCLG) funded coordinated response to support survivors of domestic and sexual abuse with complex needs (mental ill-health, substance misuse including alcohol and/or dual diagnosis).

WHAT IS THIS STUDY ABOUT?

The Crime and Drugs Partnership, Nottingham were awarded funding by the Department for Communities and Local Government to set up additional services for survivors of domestic and sexual abuse with complex needs. This research study is evaluating the benefits the additional services have had for survivors and assessing the need for these additional services in the local area. As a part of this evaluation, the researchers are interested in your experiences of the partner agencies that have been involved in the delivery of services and how/if the project has met your individual needs.

WHAT ARE PARTICIPANTS REQUIRED TO DO?

You will be asked to complete an interview (approximately one hour in length) with a member of the research team. During the recorded interview you will be asked to reflect upon your experiences of the services provided by the R2C project (refuge space, support services etc). Researchers are also interested in how you think the service could be improved.

WHAT ARE THE BENEFITS OF PARTICIPATING IN THE STUDY?

You can make a contribution to the enhancement of the services provided to survivors of domestic and sexual abuse with complex needs.

WHAT ARE THE FORSEEABLE RISKS TO YOU IF YOU PARTICIPATE?

Researchers will ensure your personal details remain anonymous and you cannot be individually identified in any quotes used by the researchers in the final written project. Although the information you provide will be treated confidentially and stored securely, you must be aware that should a serious threat to life be disclosed to researchers then we have an obligation to report this to appropriate agencies. In such cases it may be necessary to breach your confidentiality.

Researchers believe it is important to highlight that, as a survivor of domestic and/or sexual abuse, you may find discussing some of your experiences difficult. If at you feel uncomfortable at any time throughout the interview it is okay to pause the interview or stop it completely. If you do feel upset you should tell your keyworker and additional support can be provided.

ARE THERE ANY COSTS/INDUCEMENTS FOR TAKING PART?

No financial cost but there will be a time cost for taking part: Researchers have scheduled one hour for individual interviews.

PARTICIPATION INFORMATION AND RIGHT TO WITHDRAW

Participants have the right to withdraw from this project at any time.

WHAT HAPPENS TO THE DATA YOU WILL COLLECT?

The data collected by researchers will be collated by Dr Harris and will provide part of the basis for the final R2C project evaluation. The data will be secured electronically. The final evaluation will be presented to the R2C steering committee and copies will be made available to all participants.

WHAT WILL BE THE RESEARCH OUTPUTS?

- A service evaluation for Crime and Drugs Partnership Nottingham to submit to Department for Communities and Local Government following completion of the R2C project.
- Peer reviewed academic journal articles.

Contact details

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Complaint procedure

If you wish to complain about the way in which the research is being conducted or have any concerns about the research then in the first instance please contact *Dr Lyndsey Harris*. If this does not resolve the matter to your satisfaction then please contact the School's Research Ethics Officer, Dr Simon Roberts (tel. 0115 846 7767, email simon.roberts@nottingham.ac.uk

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