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"Before the project everything seemed a little bit woolly – now we are definitely clearer in terms of pathways for women."

Evaluating the Stella Project Mental Health Initiative

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Contents

Glossary

Organisations

ARA	Addiction Recovery Agency (Bristol – Substance Misuse Service)
AVA	Against Violence and Abuse
BDP	Bristol Drugs Project (Bristol – Substance Misuse Service)
CMHT	Community Mental Health Team (Hounslow – Mental Health Service)
BRC	Bristol Rape Crisis (Bristol – Violence Against Women Service)
CAMHS	Child and Adolescent Mental Health Service (Hounslow – Mental Health Service)
CAT	Community Alcohol Team (Nottingham – Substance Misuse Service)
CRI	Crime Reduction Initiative (Hounslow – Substance Misuse Service)
iHear	CRI became iHear during the evaluation (Hounslow – Substance Misuse Service)
EACH	Ethnic Alcohol Counselling in Hounslow (Hounslow – Substance Misuse Service)
FPS	Forensic Psychological Services
GCMHT	Gedling Community Mental Health Team (Nottingham – Mental Health Service)
NL	Next Link (Bristol – Violence Against Women Service)
OC	Oxford Corner (Nottingham – Substance Misuse Service)
RC	Rape Crisis (Nottingham – Violence Against Women Service)
R	Refuge (Hounslow – Violence Against Women Service)
RE2	Redwood 2 (Nottingham – Mental Health Service)
RO2	Rowan 2 (Nottingham – Mental Health Service)
SS	Second Step (Bristol – Mental Health Service)
TGH	The Green House (Bristol – Mental Health Service)
VS	Victim Support (Hounslow – Violence Against Women Service)
WISH	WISH for a Brighter Future (Bristol – Violence Against Women Service)
HDVOS	Hounslow Domestic Violence Outreach Service.

Terms used in the evaluation

REA	Rapid Evidence Assessment
DV	Domestic Violence
MH	Mental Health
SV	Sexual Violence
SPMHI	Stella Project Mental Health Initiative
SPMHIC	Stella Project Mental Health Initiative Coordinator (Jennifer Holly)
SU	Substance Use
VAW	Violence Against Women
ATRIUM	Addictions and Trauma Recovery Integration Model

Background

Services commissioned to support women with mental health problems, problematic substance use and experiences of domestic violence (DV) and sexual violence (SV) often work independently, despite the intersectionality of these issues. Frontline practitioners do not always have the training, assessment tools or referral pathways to address all three issues when they co-occur. Operational and monitoring frameworks do not always make the links between the issues which result in women falling through gaps in service provision. Therefore, the aim of the Stella Project Mental Health Initiative (SPMHI) was to empower service providers across the three sectors of substance use (SU), mental health (MH) and violence against women (VAW) to develop this work through knowledge transfer, policy development support and promoting strong partnerships and monitoring mechanisms. In assessing the efficacy of the SPMHI, an evaluation was commissioned which has collected data before and after the intervention took place. Before we consider the scope and findings of that evaluation, it is necessary to outline the nature of the SPMHI. There are several components, encompassing an action research based intervention, practice guidance development and the creation of online learning tools:

- **Policy and procedure development, training and partnership working.** The SPMHI co-ordinator (SPMHIC) worked with selected agencies working in the fields of VAW, SU and MH in three regions of the UK to develop an integrated response to survivors of gender based violence and who are experiencing problematic SU and psychological distress. This focused on providing:
  - Support to agencies to develop their policies and procedures (including risk assessments and care plans), referral pathways and multi-sector partnerships
  - Training to equip staff with skills and confidence to work with the complex issues and;
  - Support to embed issues in local authority and Primary Care Trust strategic policies.

- **Good practice guidance.** Following completion of the action research, good practice guidance was developed and disseminated across the UK through extensive networks. A series of interactive and innovative workshops focusing on equipping practitioners with the skills and understanding to implement the good practice guidance were held.

- **Online training course**. A web-based interactive training course was developed to address the overlapping issues. This can be accessed by any practitioner across the UK for free.

We asked the SPMHIC to reflect on the initiative, her thoughts are shown in Box 1 below. These reflections have not formed part of the evaluation but are intended to provide some context.

Box 1: Reflections on the SPMHI by Jennifer Holly (SPMHIC)

The SPMHI had two main aims: i) to develop a model of working with survivors and perpetrators of DV and SV who are also affected by SU and or mental ill-health, and ii) to fill a gap in the knowledge base about the process of facilitating closer partnership working between agencies who support people with multiple needs.

One of the key drivers in each of the sites was to create more established pathways between agencies – to formalise relationships rather than relying on old friendships. It is, however, the less formal connections between professionals that facilitate stronger links between agencies. Sharing referral protocols and aligning confidentiality policies facilitates referrals between agencies. Getting to know one another, on the other hand, so that we understand each other's services and appreciate the similarities and differences in the way we work are key to forging more integrated packages of support.

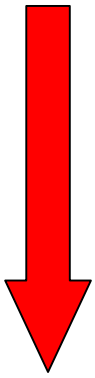
Two resources – a toolkit and e-learning programme – have been developed as part of the SPMHI. They offer two ways of learning about the links between the three issues addressed in the project and offer information and advice on overcoming some of the challenges to creating effective, multi-agency responses to survivors and perpetrators of DV and SV who have problems with drugs, alcohol and/or their MH. The resources can be accessed here: http://elearning.avaproject.org.uk.

The Stella Project selected three sites across England in the summer of 2010: Bristol, Nottinghamshire and the London Borough of Hounslow. To inform the selection process, frontline agencies were invited to submit expressions of interest to the identified strategic leads in their area, who in turn were responsible for selecting participating agencies (a total of seventeen agencies that together provided twenty services across the three sites[1]). The selection was based on the capacity and commitment of each agency to engage with the work. This work was fully funded by a three-year grant from the Department of Health. The timeline for the intervention and evaluation is shown in Box 2 below. The intervention comprised a programme of activities in each area that were delivered by, or in conjunction with, the SPMHIC. The activities were agreed on the basis of a needs assessment of each of the organisations participating in the project and the overall goal or aim of the working group in each area. As the three pilot sites varied greatly in terms of the organisations involved and the vision for the project, each area had different needs.

[1] See Table 1 on page 8 for details of how the services had changed during the project.

During the intervention, the SPMHIC supported individual agencies to draft and implement policies, delivered targeted training to build frontline staff confidence and skills, facilitated relationship building between agencies and aimed to raise awareness of the issues and the needs of survivors through attending and speaking at relevant policy and strategic forums and meeting with commissioners.

BOX 2: TIMELINE FOR THE INTERVENTION AND EVALUATION



October 2010 – March 2011	Design materials, obtain ethics approvals.
April – June 2011	Pre-intervention data collection
July 2011	Intervention begins
March – May 2012	Mid-point interviews with agency leads
May 2012	Interim report
June – September 2012	Finalise materials for post-intervention data collection.
September 2012	Intervention ends
October – December 2012	Post-intervention data collection
May 2013	Final report and end of project presentations

Objectives of the Evaluation

The evaluation had six objectives. The first was addressed at the outset of the evaluation and the remaining five were addressed during both stages of our evaluation 1) pre-intervention (April - July 2011) and 2) post-intervention (October – December 2012). The objectives were:

1) To compare alternative approaches (taken elsewhere) with those taken within Stella and to highlight lessons learnt within them. This archival component of the research is desk based and takes the form of a Rapid Evidence Assessment (REA) including grey literature, academic and policy documents.

2) To assess expectations for the project and of the project co-ordinator, and ascertain what contingencies are in place. Expectations of and for a project can be highly influential in its eventual outcomes. Also, expectations can provide another way to assess levels of shared understanding that feed into partnership working (see 3 below).

3) Does staff confidence in their own knowledge and skills change over the course of the evaluation? Here, we focused on staff confidence in their own knowledge and skills required to address the overlapping issues and to respond appropriately to disclosures made by service users, both directly and as part of referral. We also sought to explore the level, quality and nature of such confidence.

4) What are the levels of multidisciplinary partnership working, referrals and joint care planning between agencies over the course of the evaluation?

5) What was the level of monitoring of service users disclosing experiences of DV and SV, SU and mental distress (understood here to mean recording of and provision of support/referrals in light thereof) over the course of the evaluation?

6) To what extent did AVA's priorities feature in local service strategies and within strategic needs assessments (alcohol, VAW, drug treatment plans, homelessness) over the course of the evaluation?

Participants

Table 1 shows the services in each area of the country involved in the initiative. The number of staff members the organisation expected to participate in the initiative has a question mark after a figure if it is approximate.

Table 1. Services involved, their specialism and number of staff

Area	Organisation Specialism	Organisation Name	Number of staff and volunteers	
			Pre-Intervention	Post-Intervention
Bristol	VAW	Next Link	20	20
		WISH	5	N/A
		Rape Crisis	N/A	25[1]
	MH	The Green House	5?	9 PT (3.5FTE)
		Second Step	15?	N/A
	SU	BDP	30	30
		ARA	25	25
Nottingham	VAW	WAIS	20?	20?
		Rape Crisis	22	33[2]
	MH	Rowan 2	24	24
		Redwood	32	32
		GCMHT	30	30
	SU	Oxford Corner	15	15[3]
		CAT	30	25
Hounslow	VAW	Victim Support	3	3
		Refuge	15	15
	MH	CMHT	34	34
		CAMHS	<30	<30
	SU	EACH[4]	10?	10?
		CRI[4]	15	15

[1]There are 22 volunteers and 3 P/T staff

[2]There are 25 volunteers and 8 paid staff but they are about to lose 2 staff because of funding cuts

[3]At the time of writing the final report OC was going through major changes because of the separation of city and county alcohol services, so OC will still exist but only for City clients, as a result there will shortly only be 6 members of staff and consultant input.

[4]During the project the services delivered by CRI and EACH were taken over by the iHear partnership run by Cranstoun.

Many of the organisations involved in the project went through significant changes from the outset, for example;

- WISH in Bristol lost their funding in the summer of 2011 and therefore had to withdraw from the initiative. Before they withdrew, their staff had completed the staff survey and

their data have been retained for that stage of the evaluation. After discussion with the working group in Bristol, it was agreed that the three organisations that unsuccessfully applied to participate in the project from the outset would be asked if they were interested in joining the project at this later stage. Two organisations, People Can and Bristol Rape Crisis (BRC), re-submitted their applications. BRC was chosen over People Can as it focuses specifically on violence against women.

- Gedling Community Mental Health Team (GCMHT) in Nottingham was initially an integrated service, with health and social care staff being co-located in the same office. Over the past three years, the service has been restructured, with social care staff relocated within the local authority adult social care team. This means that whilst the numbers of staff have not changed, health staff are more stretched and the two teams do not have the extra opportunities for serendipitous sharing afforded through co-location.

Services that have been shaded in red in Table 1 did not actively engage in the project for a variety of reasons. For the three Hounslow organisations this included being reconfigured, changes in management and losing specialist workers. Despite this, some of their staff received training from the SPMHIC, papers from meetings and were invited to take part in every element of the evaluation, however they did not really engage. Second Step (SS) in Bristol did not engage in the evaluation at all despite receiving papers from meetings and invitations to take part in every element of the evaluation. They did not, however, withdraw. Further details about those who took part in each element of the evaluation are presented in the next section.

Method and Analyses

The research design was a triangulated, mixed methods approach, drawing on both prospective and retrospective research techniques. There were considerable concerns about the use of the terms 'Domestic Violence (DV)', 'Sexual Violence (SV)' and 'Violence Against Women (VAW)' which we discussed at length with the SPMHIC and the steering committee. It was agreed that the term VAW would be used because many women who experience DV will also experience SV and the splitting of DV and SV is a historical legacy from third sector devolution, but does not reflect real life. In order to ensure that we checked practitioners' understanding of the term VAW we built a question into the survey which asked them to define it. However because much of the research and evaluation in this area still uses the terms DV and SV we used those terms in conducting searches for the literature review.

Rapid Evidence Assessment (Objective 1)

A question-led adapted REA was conducted as resourcing limitations (time and labour) prohibited the undertaking of a systematic review of the literature. A REA is a tool for synthesising the available research evidence on a policy issue, as comprehensively as possible, within the constraints of a given timetable. A toolkit for undertaking a REA has been widely implemented since its inception by Government Social Research (see http://www.gsr.gov.uk/professional_guidance/rea_toolkit/sitemap.asp also examples of use by Brown et al., 2010; Disley et al., 2011; Itzin, Taket & Kelly, 2007). The terms of the REA, and the key terminology adopted, were formulated in consultation with AVA. Two overarching questions led the REA:

1. What integrated responses to any combination of two or more of the following issues: SV; DV; SU and MH exist? Have they been evaluated and if so what were the outcomes?
2. What is considered best practice for practitioners working with women with the overlapping issues of SV, DV, SU and MH?

Five specific questions provided a more detailed structure for the REA:

1) Do integrated responses to the combination of two or more of the issues of SV, DV, SU & MH exist? If yes, what are they and what are their success rates?
2) How effective are interventions that aim to improve the delivery of services to women experiencing DV, SV, SU and MH through partnership working or integration/coordination mechanisms at producing improved outcomes?
3) What makes an intervention based on integration mechanisms effective? Do integrated responses achieve improved outcomes?
4) What is best practice for frontline practitioners working with women with intersecting needs?
5) What is best practice for strategically linking work with women with overlapping needs? NB, the focus here is not on frontline practitioners, but those with strategic policy responsibilities.

In finding literature for the REA, we restricted the search to the last 15 years (1995-2010). To find academic literature, 13 search engines were used (see Appendix 1 for the full list). To find grey literature, we used the following search portals/approaches:

- http://opensigle.inist.fr/
- http://www.nationalschool.gov.uk/policyhub/
- evaluation team members and the SPMHIC sent requests to their extended networks of researchers and practitioners requesting relevant material
- current holdings by researchers and AVA were drawn on
- web searches were conducted through Google (and Google Scholar) using the same terms as the database searches and the first 50 hits from each search term were investigated.

Assessment of Expectations (Objective 2)

One focus group was conducted in each of the three areas pre- and post-intervention. Service and area leads were invited to take part. There were between four and nine participants in each focus group. An invitation, information letter and consent form were sent out to participants in advance of the focus group (see Appendix 2). The focus groups were run according to guides that were designed (see Appendix 3); these were used in conjunction with instructions for making eco-grams[2] (Appendix 4). In the post-intervention focus groups, eco-grams from the pre-intervention focus groups were also used. The participants in the pre- and post-intervention focus groups and their organisations are shown in Table 2 below.

Table 2. Participants in the pre- and post-intervention focus groups in each area

	Bristol		Hounslow		Nottingham	
	Pre	Post	Pre	Post	Pre	Post
Organisation	Next Link	Next Link	Community Safety Team	Community Safety Team	Redwood 2	Women's Aid Integrated Services
	NHS Bristol	NHS Bristol	Ethnic Alcohol Counselling in Hounslow	Supported housing	Nottingham Healthcare Trust	Nottingham Healthcare Trust
	Safer Bristol	Safer Bristol	Refuge	Refuge	Nottingham County Council	Nottingham County Council
	The Green House	The Green House	West London Mental Health Trust	IHear	Community Alcohol Team	Community Alcohol Team
	Bristol Drugs Project	Bristol Drugs Project	Crime Reduction Initiatives*		Oxford Corner	Oxford Corner

[2] Eco-grams are visual representations of relationships between individuals or organisations. Each individual or organisation is represented in a circle, the connecting line between them represents the strength of the relationship. Usually a heavy line indicates a strong relationship and a thinner or dotted line a weaker or tenuous relationship.

	WISH for a Brighter Future	Bristol Rape Crisis			Rape Crisis	
	Addiction Recovery Agency	Addiction Recovery Agency				
		Women's UFO				

*CRI became IHear between the pre and post intervention

A thematic analysis was conducted on each of the transcribed focus group discussions, with attention to the initial expectations of the pre-intervention focus groups, and the experiences and challenges subsequently encountered by the post-intervention focus groups. These were analysed by area, and in relation to the project's aims to develop effective integrated responses to women experiencing the intersecting issues.

Staff Confidence (Objective 3)

One online questionnaire was designed to address Objectives 3 and 5 (please contact the authors for a copy). The questionnaire covered three main topics: Staff Confidence, Staff Knowledge and Data Monitoring. Service leads were e-mailed by the evaluation team briefing them about the questionnaire and asking them to invite all of their staff to complete the questionnaire online (a link to the website hosting the questionnaire was provided). The service leads forwarded the email to all staff and they were given an eight week period both pre- and post-intervention to complete the survey (11th April 2011 – 3rd June 2011 and 15th October 2012 – 7th December 2012). Table 3 shows the number of staff who completed the survey in each area according to their organisation's specialism. Forty-two staff completed the survey from Bristol pre-intervention and thirty-five post-intervention (total=77[3]). In Nottingham, sixty-six completed the survey pre-intervention and thirty-one post-intervention (total=97[3]). In Hounslow, only thirty-one staff completed the survey at the pre-intervention stage and none at the post-intervention stage.

Table 3. Number of staff who completed the survey pre- and post-intervention

Area	Specialism	Pre-intervention				Post-intervention				Total
		Total	Time in Post			Total	Time in Post			
			≤2Yrs	3-5Yrs	≥6Yrs		≤2Yrs	3-5Yrs	≥6Yrs	
Bristol	VAW	6	1	3	2	0	0	0	0	6
	MH	4	2	2	0	9	3	5	1	13
	SU	26	11	9	6	26	8	7	11	52
Nd	VAW	17	5	8	4	0	0	0	0	17

[3] Many of these will have been the same people as at the pre-intervention stage however we cannot tell who did it more than once as the survey was anonymous.

	MH	11	6	3	2	0	0	0	0	11
	SU	3	0	1	2	0	0	0	0	3
Nottingham	VAW	17	6	7	4	3	0	1	2	20
	MH	20	1	2	17	12	1	1	10	32
	SU	8	0	0	8	16	2	4	10	24
Total		112	32	35	45	66	14	18	34	178

Hounslow was excluded from the analysis of the staff survey because there was no data for the post-intervention stage. The quantitative data from Nottingham and Bristol have been analysed to report descriptive statistics and to test for significant differences before and after the intervention. Because the data did not meet the assumptions needed to conduct parametric tests (i.e. normal distribution, see Field, 2009) non-parametric Mann-Whitney (U) tests[4] were conducted. Only statistically significant findings are reported. Where possible these will be presented in tables for clarity but where there are only one or two, they will be included in the text. Thematic analysis was conducted on the qualitative findings from the staff survey by area with attention to similarities and differences pre- and post-intervention.

Partnership working (Objective 4)

Two strategies were employed to address objective 4. Strategy 1 involves a database of monthly referrals for each service (see Appendix 5 for the variables included in the database). We originally proposed that data should be collected prospectively on a monthly basis from the start of the project until the post-intervention stage, drawn from existing agency records. However, it became apparent that given all of the demands on the services involved and the SPMHIC that this was not feasible. The SPMHIC proposed a series of alternatives to the service leads at working group meetings in July 2011. It was agreed that the following strategy would be used. Instead of prospective data collection of the life of the project, retrospective data collection for a four month period of each year of the project was used. Each agency was asked to complete a spreadsheet giving information about referrals which followed disclosures of VAW and/or SU and MH problems that were made between January 1st and April 30th for each year of the project. Therefore there were three waves of data collection for this element of the evaluation. The number of cases for which data were collected in each year and area are shown in Table 4.

Table 4. Data received[1] on cases where referrals were made following disclosures of SV, DV, SU or MH between January and April of each year of the project in each area

Area	Specialism	2011	2011 Area Total	2012	2012 Area Total	2013	2013 Area Total	Specialism Total

[4] According to Field (2009) it is more appropriate to report the Median (Mdn) than the Mean (M) for Mann-Whitney tests therefore this will be done throughout this report.

Bristol	VAW	47	75	21	21	0	0	68
	MH	19		0		0		19
	SU	9		0		0		9
London	VAW	4	15	0	0	0	0	4
	MH	0		0		0		0
	SU	11		0		0		11
Nottingham	VAW	43	81	14	42	1	66	58
	MH	0		3		35		38
	SU	38		25		30		93
Totals			171		63		66	300

[1]Many organisations struggled to provide us with the information required for this strand of data collection, null returns are more likely to be null reporting to the evaluation rather than null disclosures and referrals per se, though we cannot be certain (see limitations for further discussion).

Due to the large amounts of missing data shown in Table 4, descriptive statistics have been conducted where possible, and some tests for significant differences were conducted on the data from Nottingham which is most complete.

Strategy 2 was conducted twice (pre- and post-intervention) and was a desk based document analysis of all documentation relating to partnership working, referrals and joint care planning with other agencies (see objective 6 for further information). The eco-grams completed in objective 2 provided representations of partnership working; referrals and joint care planning, and were also used to give extra information for strategy 2.

Monitoring Data (Objective 5)

See objectives 3 and 4.

Adoption of AVA/Stella Project priorities within the target services/areas (Objective 6)

A desk based document analysis of local strategies/strategic needs assessments was conducted at pre- and post-intervention stages. The documents collected were analysed together with those collected through strategy 2 for objective 4, relating to partnership working, referrals and joint care planning with other agencies. Our intention was that at the post-intervention stage we would be able to map whether the same documents, and any new ones, have more cross-referencing in terms of the three issues and inter-agency working. However, very few policy documents could be located or accessed post-intervention. As a result, the corpus of policy documents did not contain sufficient data to map the changes (or lack thereof).

To supplement the data collected for objectives 1-6 mid-point telephone interviews with all agency leads from all three areas were conducted (see Appendix 6 for the invitation letter, consent form and interview schedule). These took place in March and April 2012. Thematic analysis was conducted on the notes taken during the interviews and these were checked against the other data in the study for complementary and contrasting views.

Rapid Evidence Assessment[5]

SV, DV, SU, and MH often co-occur (Alberta Council of Women's Shelters [ACWS], 2009; Chang et al., 2010; Humphreys, Thiara & Regan, 2005; Moses et al., 2003). However there exist very few programmes that deal with more than one of these issues concurrently. Integrated responses are more common in North America than in the United Kingdom (UK), although existing evaluation data do not permit robust comparisons between integrated programmes and single issue programmes. Thus, the success of such programmes is difficult to assess empirically.

Moses et al., (2003) found a small number of interventions that address at least two of the issues mentioned. For example:

- Seeking Safety which has been designed to help individuals who are coping with PTSD (which may be a result of DV) and problematic SU to establish some safety in their lives (Najavits, 2001);
- the Addictions and Trauma Recovery Integrated Model (ATRIUM) which seeks to teach women how trauma expresses itself in the body (Miller & Guidry, 2001); and
- the Triad Women's Group aimed at helping women find safety, prevent relapse, build supports and cope with distress (Fearday, Clark & Edington, 2001).

These programmes have been successful in America, but our search yielded no evaluations of similar programmes in the UK despite anecdotal evidence suggesting that local programmes may exist.

An evaluation of the Seeking Safety programme found 'significant improvements in substance use and areas such as family functioning, problem solving and didactic knowledge related to treatment'. This study also found a higher retention rate for the program and improved therapeutic relationships for participating women and their therapists (Najavits et al., 1998). An evaluation of women completing the ATRIUM programme found decreases in behaviours such as 'self-harm, substance abuse, suicidality and aggression' in (Miller, 2002, p. 161). Finally, the Triad Women's group resulted in 'an increase in adaptive coping skills and a decrease in avoidance behaviours associated with substance abuse and traumatized reactions. Women also experience a decrease in mental health symptoms' (Moses et al., 2003, p. 14). Furthermore, Bennett and O'Brien (2007) described findings from a pilot project initiated by the Illinois Department of Human Services in which women participating in the integrated services program saw a statistically significant increase in scores on the Domestic Violence Self-Efficacy scale (32.3 from 28.5), indicating an improved ability to handle their lives. Women also reported a statistically significant decrease in scores on the Women's Experience of Battering scale (25.4 from 28.4), demonstrating a lessening of the perception of vulnerability to violence.

In Australia, Laing, Irwin and Toivonen (2012) provided an example of an integrated response to women experiencing these intersecting issues. This project trialled a number of initiatives that included implementing routine DV screening in MH services. In terms of outcomes, MH practitioners identified many changes in their practices as a result of the action research.

[5] A longer version of the REA can be found in Appendix 7

Changes were linked to their increased understanding about the nature of DV and the services available, which would benefit women experiencing DV within the MH system.

Although limited, there is some literature that suggests positive outcomes from collaborative work in this field. Such positive outcomes include enhanced information sharing, collaborative case plans and improved client outcomes. Barriers to effective collaborative work include differences in philosophies across disciplines, communication issues, poor information sharing, lack of clearly defined roles, lack of a shared focus and lack of resources. Other concerns include a lack of practitioner knowledge of the intersecting issues, with many practitioners reporting discomfort in addressing issues for which they felt un-trained (Humphreys et al., 2005).

There is a considerable body of research that provides suggestions for the best way to achieve optimal collaboration and integrated responses. These include the development of a shared vision and the establishment of a shared set of key terms to encourage communication across different areas of practice. Joint training across services, the inclusion of service users in multi-agency training sessions, and regular multi-agency meetings have been identified as key practices for the development of effective integrated response teams (e.g. Carter, 2003; Women's Aid, 2005). However, it should be noted that these suggestions are grounded in a limited set of observations made by researchers concerned with the relative lack of effective, integrated responses.

There is a paucity of research on identifying best practice for women with overlapping issues. This is in part a likely consequence of the primary presenting issue being treated, in practice, as singular – or as masking other intersecting issues. The bulk of the existing literature on best practice for frontline practitioners working with women with intersecting needs has a focus on the needs of women initially presenting with DV and comes out of the DV/ women's sector. This literature emphasises, the importance of establishing women's safety – to include safety planning - which can be done by empowering women to take control of their lives and by helping them find safe spaces and relationships (Hein & Ruglass, 2009); adopting a 'woman-centred response' where the woman is treated as the expert in knowing what she needs; and identifying any overlapping issues, with an emphasis on routine enquiry, as well as finding appropriate responses that address them. Ideally, practitioners should have some comfort in addressing a range of intersecting issues even if they are not experts in each of those fields. Women's Aid (2005) further recommends that practitioners are trained to carefully document any disclosure of abuse so that, if necessary, this can be used in court. Practitioners may be reluctant to document other intersecting issues, however, as these may potentially be used against women in criminal or family court proceedings.

Best practice for the strategic development of work with women with overlapping needs aims to address the barriers to effective integrated responses (above) with a focus on communication and training. Improved communication between agencies may involve adjusting confidentiality requirements or creating protocols for addressing women who present with overlapping needs. These protocols should encourage multiple agencies to work together

and to share information, when appropriate. Other measures may include establishing the opportunity for regular networking between agencies, via the creation of a multi-agency forum. Also recommended is the implementation of routine questioning to screen for DV in women when they first present to a service in order to encourage disclosure; and ensuring that there is at least one staff member specifically tasked with addressing DV issues when they arise. Screening for MH/SU is often overlooked. Involving women who have survived these intersecting issues in the policy planning and implementing process is also recommended. Macy and Goodburn (2012) maintain that effective inter-agency collaborations require multidimensional strategies at various levels, including the provider, director, agency, and policy levels.

This literature review has highlighted a relative lack of literature that addresses the specific needs of SV survivors. Zweig, Schlichter and Burt (2002) report that sexual assault victims may be especially reluctant to access victim services if they had also experienced SU problems, which may contribute to this gap in the literature. In addition, more systematic empirical research is required to look at how effective the suggestions regarding collaborative approaches to addressing overlapping needs are in practice. The SPMHI represents a British intervention, the evaluation of which will go some way towards filling this gap by contributing to the evidence base.

Findings and Discussion

There were a number of challenges encountered during data collection for this evaluation. As a result, some strands of data are not as complete as we would have hoped. The focus groups proved to be our strongest and richest source of data so we decided to structure the findings around the themes that emerged from them. In order to do this, the major themes each group raised--regarding the extent to which their initial expectations for the project had been met at the post-intervention stage--were compared with the themes identified in the pre-intervention focus groups.

Our pre-intervention thematic analysis of the expectations of the focus groups from each of the three areas generated three interlinked themes. These were: partnership working; building staff skills, knowledge and confidence; and benefits to service users. We noted that these expectations closely mapped the information provided to the participating agencies by the Stella Project (Holly, 2011, pg. 2). This set forth the project's aims to develop effective integrated responses to women experiencing DV and SV, problematic SU and MH issues through "policy and procedure development, training and partnership working." Across all three areas, the post-intervention focus groups reported that their pre-intervention expectations of the impact of the Stella Project had, for the most part, been met, and in some cases exceeded. However, the focus groups also raised a number of challenges in the realisation of some of their pre-intervention expectations. The findings of the discussion are organised around the four themes identified from the pre- and post-intervention focus groups. These are:

1) Challenges and Solutions
2) Partnership Working
3) Building Staff Skills, Knowledge and Confidence
4) Benefits to Service Users.

The other findings, for example from the staff survey, analysis of local strategies/strategic needs assessments and monitoring data, have been incorporated where relevant and available throughout the themes. As previously noted, no staff from Hounslow completed the post-intervention stage therefore no data from them are considered. Hounslow will be excluded from all further analyses of the staff survey.

Within the four themes, we identified five points of interest, which highlight key issues for consideration. These are presented in blue boxes throughout this section.

Challenges and Solutions

The focus groups reported a number of challenges and solutions experienced as part of their involvement in the implementation of the SPMHI. These can be described under three main themes:

- Engagement with MH Services;
- Clients with intersecting issues portrayed as 'chaotic' and 'impossible to work with';
- Hopes for the future.

Each of these are described and discussed below

Engagement with Mental Health Services

Practitioners from all three areas recognised that the engagement of MH services and MH practitioners was crucial for the success and sustainability of the SPMHI. Slightly more initial involvement was reported in Hounslow and Nottingham than in Bristol.

However, at both pre-intervention and post-intervention stages, the lack of engagement of MH services was identified as the most significant on-going challenge to the SPMHI by all three areas.

> *I am concerned about the lack of involvement from the statutory mental health trust. We have a lot (of clients) with mental health problems and we haven't got such links or places we can turn for help, so forging these links and making better referral pathways ultimately (will make it) better for victims of DV*. (Bristol, Pre-intervention Focus Group)

The reasons suggested for the lack of engagement of MH services included:

- In Bristol:
  - The perception that the Mental Health Trust actively avoided involvement in the Stella Project
  - The background uncertainty of changes to the structure and funding of existing services had made it difficult to engage and retain the involvement of agencies in the Stella Project, this was also highlighted in Nottingham.
- In Hounslow:
  - Existing networks and working relationships with MH organizations were poor and MH services themselves appeared to regard themselves as 'limited' in terms of what they felt they could do to help clients presenting with the intersecting issues.
  - A divisive 'us' and 'them' dynamic in place which was seen as a long standing division that was part of a broader structural and attitudinal 'health and local authority' barrier. This dynamic was to the detriment of women presenting with the intersecting issues.
- In Bristol:
  - Referrals originating from MH services did not indicate a willingness to 'work in partnership' with other services, but rather were intended to eschew on-going involvement with clients with these intersecting issues.

- Uncertainty of changes and restructuring of services as mentioned above in Bristol.

The consequences of the lack of engagement from MH services varied according to the area. In Bristol they reported that they had largely refocused their efforts on the two intersecting issues of SU and VAW, and had placed MH on the 'back burner':

> *Mental health has been completely absent, from this whole process in terms of partnership working and probably half way through this process and these meetings we acknowledged that and have just been working on substance misuse and DV. Not in terms of mental health has been forgotten about, but it was so big a thing to tackle that we had to focus on what we could focus on.* (Bristol, Post-Intervention Focus Group)

Conversely in Hounslow, the post-intervention focus group reported that there had been a number of concrete accomplishments in terms of successfully engaging MH services. These included: the development of new outreach sessions in MH settings; the creation of new resources for frontline workers and other practitioners; the development of new assessment and screening tools and regular MH representation on MARAC. Further, post-intervention focus group members reported that they felt that many of the barriers to working with MH services had been 'broken down', so that they no longer felt that they were 'working in silos'.

POINT OF INTEREST 1: MENTAL HEALTH SERVICES AS THE 'WEAKEST LINK'

- Mental health issues were commonly seen as being a contributing factor to domestic violence, yet mental health services were regarded as 'limited' in terms of 'what we can do':

  > *A lot of our (mental health) clients have dual diagnosis, quite often presenting with substance misuse and DV. Substance misuse goes hand in hand with DV and mental ill health as well… (But) mental health services are limited in what we can do, quite often what is underlying DV is mental health issues.* (Hounslow, Pre-Intervention Focus Group)

- Mental health services are viewed as 'the 'weakest link' in the network of available services for women with these intersecting issues, and as such may be regarded with mistrust by other agencies, or as not able to respond appropriately to women with these needs (Zweig et al., 2002).

- This may in turn perpetuate the 'us' and 'them' dynamic between mental health and other services, which represents a further barrier to working in partnership to meet the needs of women with these intersecting issues. Laing et al., (2012) argue that building institutional empathy may reduce mutual blame when difficulties arise.

In Nottingham, the group reported that one key strategy in terms of engaging the Mental Health Trust in recognizing and prioritising the needs of clients with these intersecting issues lay in alerting the Trust to the sobering DV homicide statistics for the area. This worked to bring home the urgent need to work in partnership to identify and support women (and perpetrators) with these intersecting issues, as the following two focus group participants attest:

> *In parallel to this project we have had 2 DV homicides in the city and 6 in the county, nearly all of them had a mental health component, either survivor, perpetrator or both and that has had a massive impact on the trust in terms of thinking...*
>
> *We're gonna be in trouble.* (Nottingham, Post-Intervention Focus Group)

Clients with intersecting issues are 'chaotic' and 'impossible to work with'

Pre-intervention focus group participants in Hounslow also reported their anticipated difficulties in terms of the ability of MH, and other services, to engage successfully with clients experiencing these intersecting issues. This was attributed to the inability of such 'chaotic' clients to attend appointments, rather than to the need for services to develop strategies for engaging and supporting women with these intersecting issues:

> *Engaging with clients who have those dual issues of mental health and substance misuse and DV – because of their chaotic attendance at appointments* (Hounslow, Pre-Intervention Focus Group)

Linked to this, focus group participants in Nottingham described an on-going perception, by various MH services, that 'these clients are not our problem', with the result that, in many cases, there was 'nowhere' for clients with intersecting issues to go (within MH services) so such clients often 'fall through the gaps' in MH service provision:

> *We met with Psychological services about this and got this kind of confusion within the healthcare trusts – IAPT were like, "crisis, they're not ours", psychology were like, "we're psychological services, they're not ours,* [and] *the crisis team aren't commissioned to deal with it so we can't refer them on to them – so we came away from the meeting thinking there's a huge Trust but they are impenetrable.* (Nottingham, Post-Intervention Focus Group)

The difficulties of working with women with intersecting issues appears to be exacerbated by reports of institutionalised gatekeeping:

> *There's gate-keeping, certainly for mental health, you've got to get through your GP, or the crisis team, although you still need your GP to get through the crisis team.* (Nottingham, Pre-Intervention Focus Group)

A further barrier arises when agencies will not, for example, take on clients until their SU problems had been 'resolved' and thus left them 'stuck', as the following two focus group participants report:

> *The psychotherapy units will not take clients until they have been alcohol or drug free for a year so you've got a huge wait and that's post assessment and quite often if there is mental health involved… clients are stuck*
>
> *There's nowhere for them to go...* (Nottingham, Post-Intervention Focus Group)

In addition, barriers may come from the women themselves as a result of the stigma associated with MH, SU and VAW

> *…And then you've got mental health stigma on top of DV* (Nottingham, Pre-Intervention Focus Group)

However in Hounslow, the post-intervention focus group reported that they now felt more supported when working with clients who presented with MH difficulties:

> *We have had difficulties with some of our residents that we've had with mental health issues. They are impossible to work with and coming to Stella we have been able to overcome those barriers and even though we've still got a long way to go but we are getting there whereas before we were calling there leaving messages and they were not getting back to us. We didn't have that kind of relationship with them as we did with other services.*
>
> *We are growing to combine and work together.* (Hounslow, Post-Intervention Focus Group)

POINT OF INTEREST 2: ASSUMPTIONS ABOUT CLIENTS

- Across all three areas, at pre-intervention, clients with the intersecting issues were conceptualized as being 'difficult', 'hard to reach' and, by some mental health services as, 'not our concern'.
- While the perception that such clients are 'chaotic' and 'impossible to work with' remains commonly held, an important post-intervention change is that the participants in the Stella Project reported that they felt better able to support, engage and put referral pathways in place for these 'difficult' clients, post-intervention, than they did prior to their involvement in the Stella Project.
- A key 'next phase' raised by the post-intervention focus groups was to engage clients with intersecting needs as stakeholders and key informants as part of the action research ethos of the project.

Hopes for the future

In all three areas, despite many focus group participants feeling that the challenges had still not completely been resolved on reaching the post-intervention stage, they did describe hopefulness that now that MH services had been re-configured and/or re-commissioned, there were opportunities to engage and forge links that would allow them to address all three intersecting issues. For example, in Bristol:

> *The newly re-commissioned service is what we are pinning our hopes on (in terms of improvements to the mental health pathway) … We have looked at ways to influence the new service so they'll be met through that route.* (Bristol, Post-Intervention Focus Group)

Much of the hopefulness was credited to the SPMHI. In particular, the working partnerships formed had been instrumental in engaging the commissioners of the new MH services to meet with the organizations involved with the SPMHI to discuss the significance of these intersecting issues, including the importance of including DV as part of MH services' screening processes.

> *One thing that did happen as a result of having a group like this is we got the people who were commissioning the new mental health services to come and talk to us to tell us about how the new service will look and to hear our views on the fact DV should be part of their screening process and people should be able to understand how to refer people etc.* (Bristol, Post-Intervention Focus Group)

During the post-intervention focus group in Hounslow, participants reported that they were actively engaged in building their relationships with MH services, as they felt that prior to the SPMHI, they had not worked effectively with them. They also reported that the accountability

provided by the 'official' involvement of Hounslow in the SPMHI had provided a key impetus for encouraging the engagement of MH services. However, the lack of engagement from staff from Hounslow in other aspects of this evaluation, leads us to suggest that reports of progress from the focus group should be interpreted with caution as changes may not have filtered to staff on the front line. Alternatively it may be that invitations to take part in the evaluation were not cascaded properly or that they were and the services or staff invited did not want to participate in the evaluation.

> *One of the problems experienced has been engaging mental health services and I think being part of the Stella project has given us a tool to say we really should be doing this work because we're a pilot, it's going to be put in a report and there is going to be an emphasis on the work that Hounslow has done and I think that has helped us engage in mental health services.* (Hounslow, Post-Intervention Focus Group)

At the post-intervention focus groups in both Nottingham and Bristol, participants reported that they were engaged in on-going work to bring MH agencies and their overseeing bodies on board with the work, and that some progress had been made:

> *The trust is looking at developing a strategy which feels helpful – it has developed a policy which Stella provided that impetus to actually engage with it.* (Nottingham, Post-Intervention Focus Group)

In both areas, the training provided by the SPMHI had been instrumental in enhancing the knowledge and confidence of staff to deal with the intersecting issues:

> *The training was really useful to get an understanding of mental health and/or alcohol issues – gives more confidence when a referral is required or to get information.* (Nottingham, Post-Intervention Focus Group)

There was the perception in Hounslow that on-going efforts were necessary to supplement the training provided to workers from MH services. The group planned to develop outreach strategies (modelled on strategies used to successfully engage housing and DV services) to further build relationships between MH, SU and DV services:

> *The training (for mental health workers) is there but they still seem quite distant from the work that we are doing and we are hoping that these outreach sessions will bring DV services and mental health workers a bit closer together. We are mirroring what we did with housing as we had real difficulties with housing and DV services so what we agreed to do was develop some DV housing outreach sessions at the council.* (Hounslow, Post-intervention Focus Group)

Other concrete areas of positive engagement with MH services, supported by the SPMHI, include links between MH services and MARAC:

We definitely have better relationships with mental health trusts especially some of our high-risk survivors, the link have definitely been made around the MARAC. (Nottingham, Post-Intervention Focus Group)

With mental health attending the MARAC process that is fantastic, especially when they've got a high [risk] *case where they have got diagnosis it is positive that they are round the table now when they weren't before the Stella Project.* (Nottingham, Post-Intervention Focus Group)

Despite the reports of positive changes from the focus groups, these were not bourne out in the policies and procedures post-intervention. Pre-intervention documentation showed that in all three areas, organisations were working in partnership with a variety of other local statutory and non-governmental organisations, agencies and services. Some policies contained outlines of the nature of their relationship with other organisations, whilst others listed the organisations they worked with. However, they provided no insight into the policy level commitment to act on these issues in a joined-up fashion. Post-intervention we were not able to acquire documentation through which we could map any changes. This does not however mean that changes have not been made, rather that we have not been able to test whether any such changes have been codified, if made. As is apparent from the focus group data, the relatively low response rate to our request for the provision of updated policy documents is a partial consequence of the challenges reported by the focus groups across all areas, including: time pressures and capacity constraints; restructuring of services; and the impact of changing economic climate. Despite the paucity of available policy documents, the focus group discussions show qualitative evidence of an impact in terms of the reported levels of adoption of SPMHI priorities within each of the target areas (as outlined above). Thus the SPMHI appears to have made a positive and appreciable qualitative impact at a range of levels. This is despite the challenging context of a changing economic climate, the radical restructuring of service boundaries, and available services in some areas, and the structural and practice level challenges associated with engaging MH services across all three areas..

POINT OF INTEREST 3: INTERSECTIONALITY

- The intersecting issues were conceptualized in a range of different ways.
- Frequently, these were 'separated out', and mental health was regarded commonly as 'underlying' violence against women.
- These different theories of cause and effect may have an impact on referral pathways potentially conflicting with the stance of services from each area.
- For instance, although mental health issues were regarded as 'underlying', other issues, mental health services were regarded as 'limited' in terms of what they could do to engage with/assist clients. Thus, women with current substance use problems and who were currently experiencing domestic violence may have been unable to access other key relevant services until their substance use problems had been demonstrably addressed.
- Strategies and policies need to develop the ability of services to work together to address the intersectionality of women's needs.

Partnership working

Across all three areas at the pre-intervention focus groups, participants' expectations of the SPMHI centred on strengthened partnership working and networking with other agencies; in their words described as 'a better understanding of what is out there' and 'the types of services available' (Hounslow, Pre-Intervention Focus Group) or 'improved links with other agencies, which has already happened just by sitting round the table and putting names to faces.' (Bristol, Pre-Intervention Focus Group) and to 'work together to engage with clients and other agencies' (Nottingham, Pre-Intervention Focus Group). Some participants even went so far as to hope for 'working holistically together' (Hounslow, Pre-Intervention Focus Group) and 'joint thinking' (Bristol, Pre-Intervention Focus Group). In Hounslow the initial need for the SPMHI was exemplified by some participants sense of 'work[ing] in silos and not know[ing] what other agencies are doing' (Hounslow, Post-Intervention Focus Group)

Across each area, participants in the focus groups reported that these expectations had largely been met post-intervention. In Hounslow for example, participants said that:

> *'in terms of working in silos I think that has definitely broken down… We have gone a long way from when I came back 2 years ago to where we are now.'* (Hounslow, Post-Intervention Focus Group)

Better engagement and stronger links with a range of services were reported in all areas. In Nottingham, participants described a specific improvement explaining that 'referrals were now easier' due to their 'greater understanding' of the potential roles of the services available (e.g., 'the difference between the split between the Women's Aid and the Safety Centre' Nottingham, Post-Intervention Focus Group).

The staff survey asked about knowledge of services and networks that specialise in each area. As VAW incorporates SV and DV, there were up to 14 different services or networks that staff could have known about but for SU and MH it was only six (for a full list of the options please contact the authors). In Bristol and Nottingham there was a very broad distribution of knowledge about other services and networks and very few practitioners who reported not knowing about any services for all three issues pre- and post-intervention.

In Bristol, despite the changes reported in the focus groups, there were no statistically significant differences in the number of services known about post-intervention. The finding was replicated in Nottingham for MH and SU services known about, but post-intervention, staff knew about significantly more (Mdn=6) VAW services than they had done pre-intervention (Mdn=5, $U=540$, $z=-1.67$, $p<0.05$, $r=0.19$).

We tested whether length of time in post affected the number of services known across the whole sample (i.e. pre- and post-intervention) in both areas. Table 5 shows that staff in Bristol who had worked in their agency for more than two years knew about significantly more MH organisations than those who had worked in their agency for under two years. In Nottingham, staff from all sectors who had worked in their agency for more than two years knew about

significantly more MH and SU services than those who had worked in their agency for under two years.

Table 5. Mann-Whitney tests of differences in number of agencies known about according to length of time in post

Area	Type of agency known about	Median number of agencies known about		Significance
		Worked for more than two years	Worked for 2 years or under	
Bristol	VAW	5	4	NS
	MH	3	2	U=378.5, z=-2.18, p<0.05, r=-.26.
	SU	3.5	3	NS
Nottingham	VAW	5	4	NS
	MH	3	1.5	U=212.5, z=-1.84, p<0.05, r=-.21.
	SU	3	1.5	U=192, z=-2.18, p<0.05, r=-.25.

In Bristol and Nottingham very few practitioners knew about all the available services/networks for each issue so it is clear that more work is needed to improve this knowledge. It should be noted however that knowing about a service or network does not imply that practitioners knew how to refer to it or any more detail than that it existed. Focus group participants from Bristol and Nottingham described challenges they had encountered when working on improving and engaging with the relationships of focus for the SPMHI. In both areas particular challenges came from uncertainty, changes and restructuring of the available services. For example, the level of 'uncertainty in a lot of the agencies' and agencies who were initially engaged with the SPMHI subsequently 'dropping out' of the project (Bristol, Post-Intervention Focus Group) and '[there are] so many changes going on all the time – in both the country and the city - that you make a link but it then disappears because a service has a re-structure' (Nottingham, Post-Intervention Focus Group).

The post-intervention staff questionnaire showed that practitioners continued to identify a range of barriers to being able to effectively share information about a woman's experiences of violence, SU and MH issues. These included:

- barriers based in a lack of knowledge of how and when to effectively share information, or 'lack of knowledge of the issues';
- barriers pertaining to perceived Data Protection considerations, including 'other agencies' interpretation of client consent and Data Protection';
- practical barriers, such as incompatible information systems and databases; and
- concerns about obtaining client consent, or 'women not wanting to share the information at first'.

However, many staff did report experiencing 'no barriers', or that their initial (pre-intervention) perceptions of barriers to sharing information had dissipated after 'explanation of confidentiality and the rules and guidelines therein.'

The development of referral pathways to meet the needs of women with these intersecting issues can be examined via analysis of the eco-grams produced by the pre- and post-intervention focus groups. The pre-intervention focus groups each worked together to produce a group eco-gram depicting how their organisations could work together to improve responses to women who are experiencing violence, SU and MH issues. The post-intervention focus groups each produced a group eco-gram that represented the ways in which they worked together to support such clients. For these eco-grams, the centre circle represents a woman experiencing these intersecting issues.

There are clear developments in the pre- and post-intervention eco-grams across all three areas. The Hounslow (Figures 1 and 2) and Bristol (Figures 3 and 4) group eco-grams show the most dramatic developments in terms of the number and strength of the referral pathways depicted. The Nottingham post-intervention eco-gram (Figure 6) also shows clear development in referral pathways, although the pre-intervention eco-gram (Figure 5) was already far richer in existing referral pathways than the other two areas.

All three areas show a greater emphasis on, and stronger links to, MH services in the post-intervention eco-grams, but also that barriers still exist to linking survivors experiencing these intersecting issues to relevant MH services.

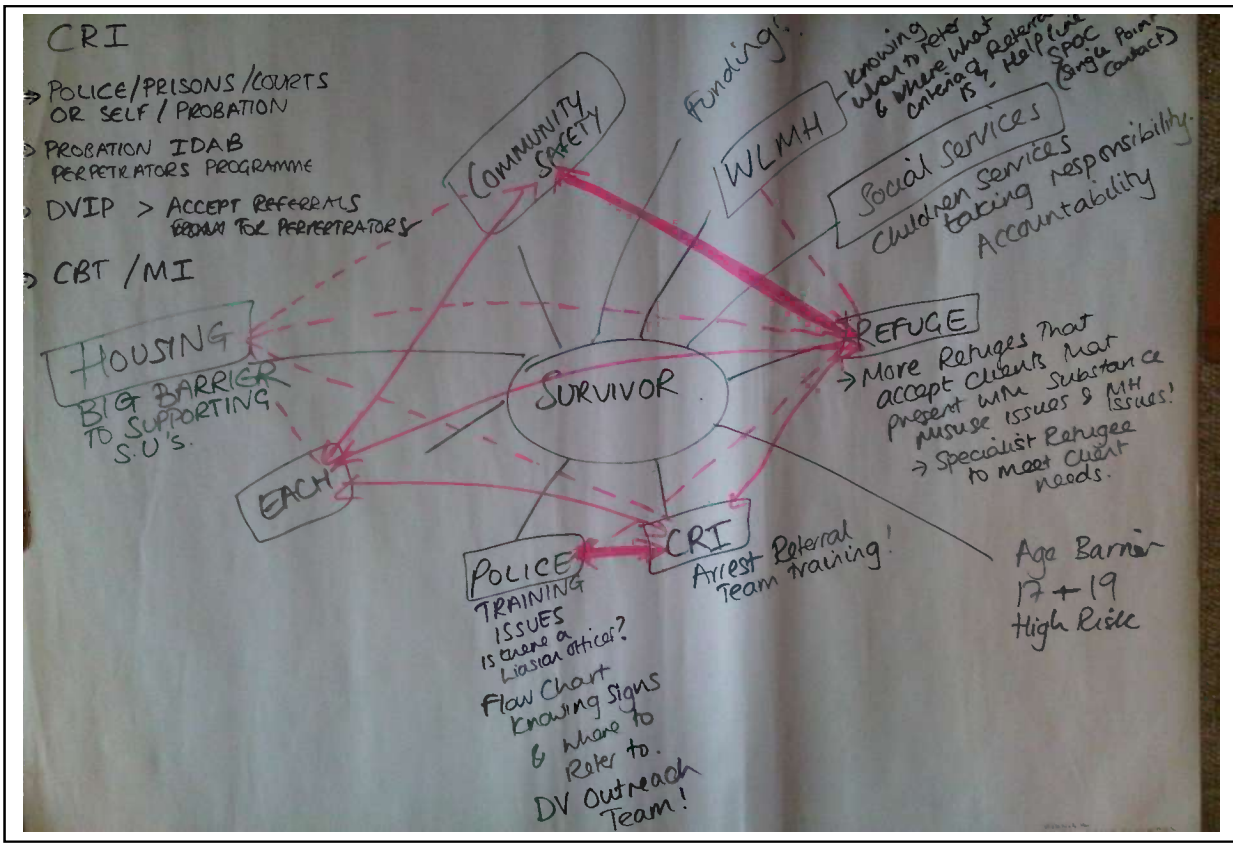


Figure 1. Pre-Intervention Group Eco-gram Hounslow

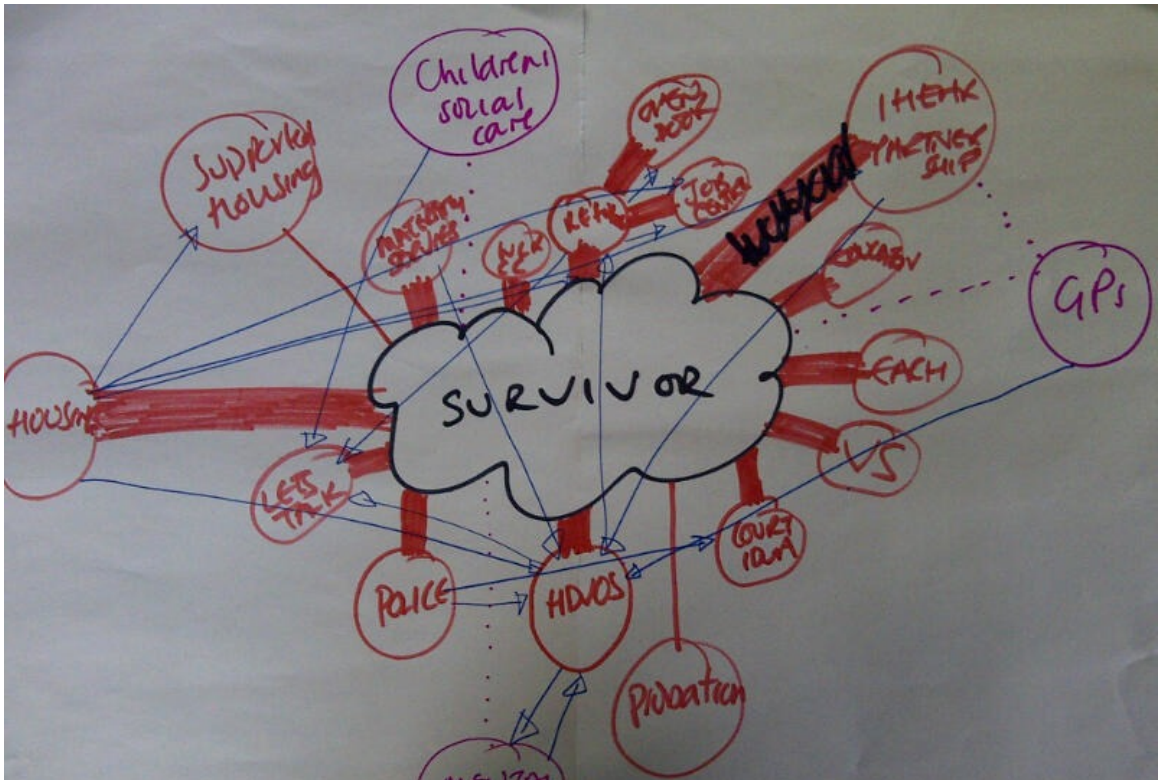


Figure 2. Post-Intervention Group Eco-gram Hounslow

The Hounslow post-intervention focus group used heavy red lines to show referral pathways for women experiencing these intersecting issues (Figure 2). These show the continuing prominence of the Police, and Refuge in supporting these women. Also represented as central, is the Hounslow Domestic Violence Outreach Service (HDVOS). Notably, the HDVOS was not represented in the pre-intervention group eco-gram (Figure 1). However, as the HDVOS is based within the Community Safety Unit of Feltham Police Station (although it operates across the borough of Hounslow) it would appear that the emphasis given to 'Community Safety' in the pre-intervention eco-gram prefigures this later more specific reference to the HDVOS by the post-intervention focus group, and perhaps indicates a greater awareness of the role of the HDVOS in facilitating the connections (and referral pathways) between agencies represented.

Weaker connections, in need of strengthening, are indicated with dotted lines. These indicate the strength of connections to MH services, GPs, and Children's Social Care. The referral pathways between agencies are represented by blue arrows. The majority of these are uni-directional, however they are bi-directional when they lead to (and from) the HDVOS. The hub for the majority of the referral pathways represented by the post-intervention focus group is the HDVOS. However, the HDVOS was not mentioned as a point of direct referral for clients in the referrals section in the post-intervention staff questionnaire. Of particular note in the post-

intervention eco-gram, (Figure 2) is the key role given to the HDVOS in terms of facilitating survivors' access to MH services, and vice versa. MH services are otherwise presented as difficult for survivors to access.

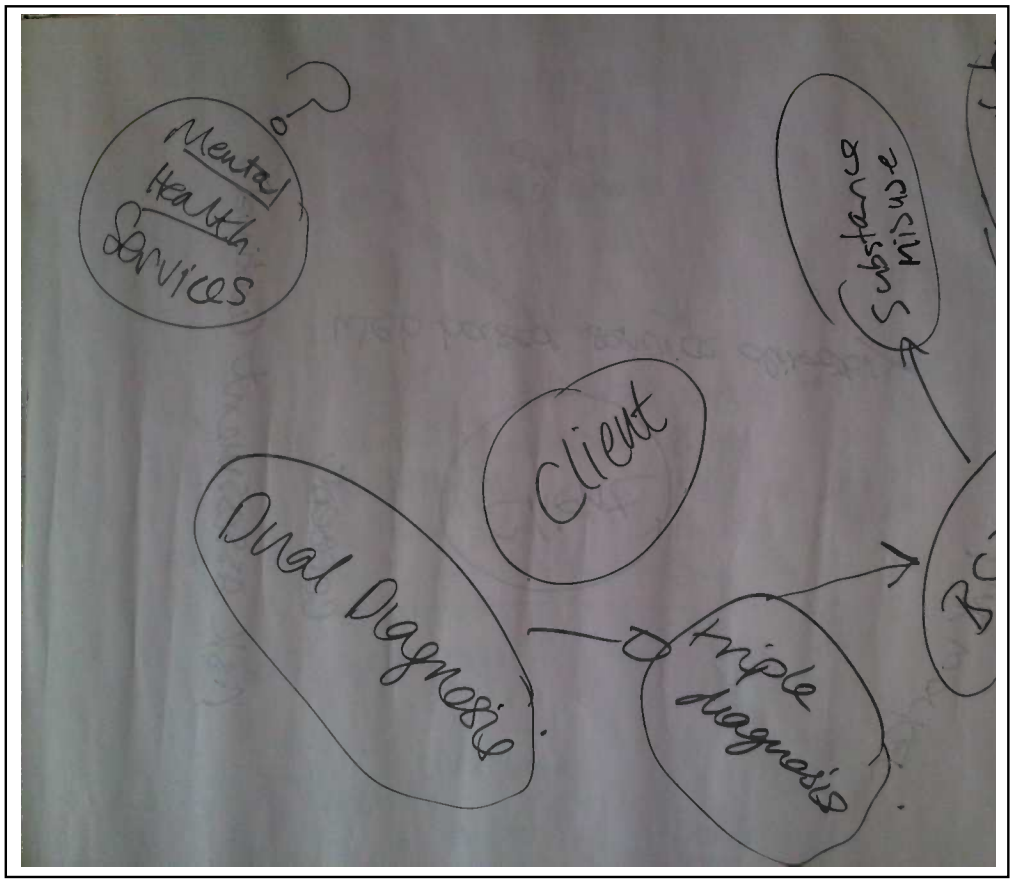


Figure 3. Pre-Intervention Group Eco-gram Bristol

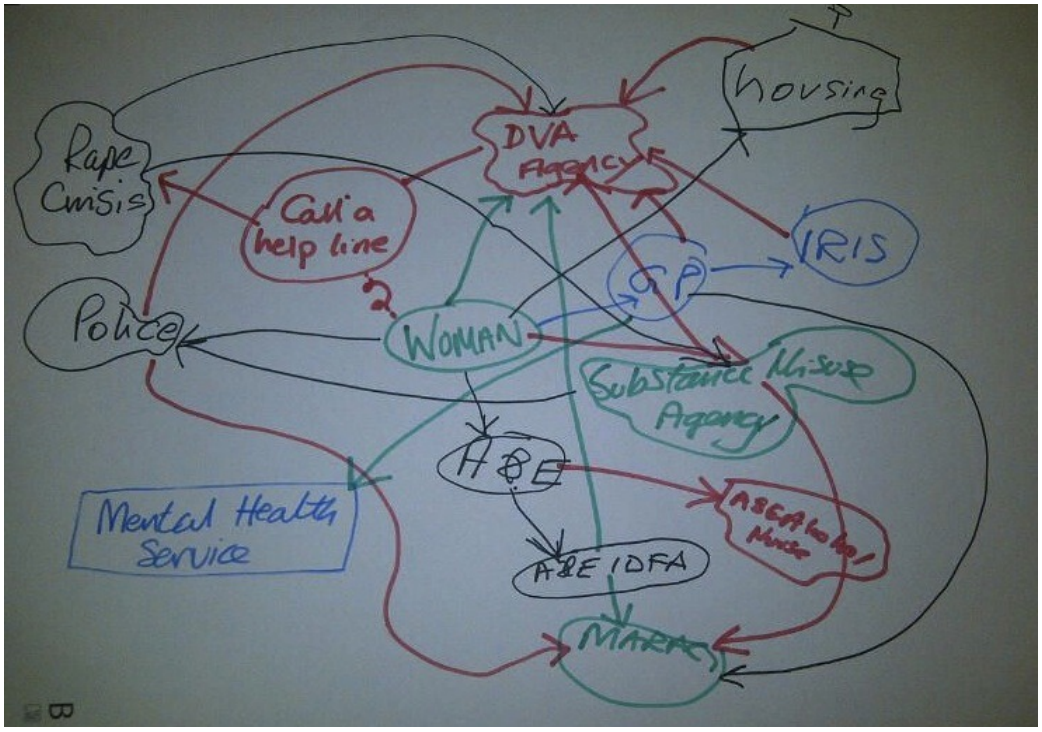


Figure 4. Post-Intervention Group Eco-gram Bristol

The Bristol group's pre-intervention eco-gram (Figure 3) was striking in that it clearly presented-- via the use of a question mark-- MH services as dislocated from both the 'client' and from the other services represented. Incorporating MH services was represented as a significant challenge. The Bristol group's post-intervention eco-gram (Figure 4) is more detailed than their pre-intervention eco-gram, showing more developed referral pathways. The DV agency, SU agencies and MARAC are given prominence, as indicated by the multiple referral pathways they are implicated in - represented here by coloured arrows. As with the pre-intervention eco-gram, MH services are represented as somewhat 'dislocated' from both the 'client' and from the other services represented. However, in contrast to the pre-intervention focus group, the post-intervention group indicated a developing operational link between GP and MH services.

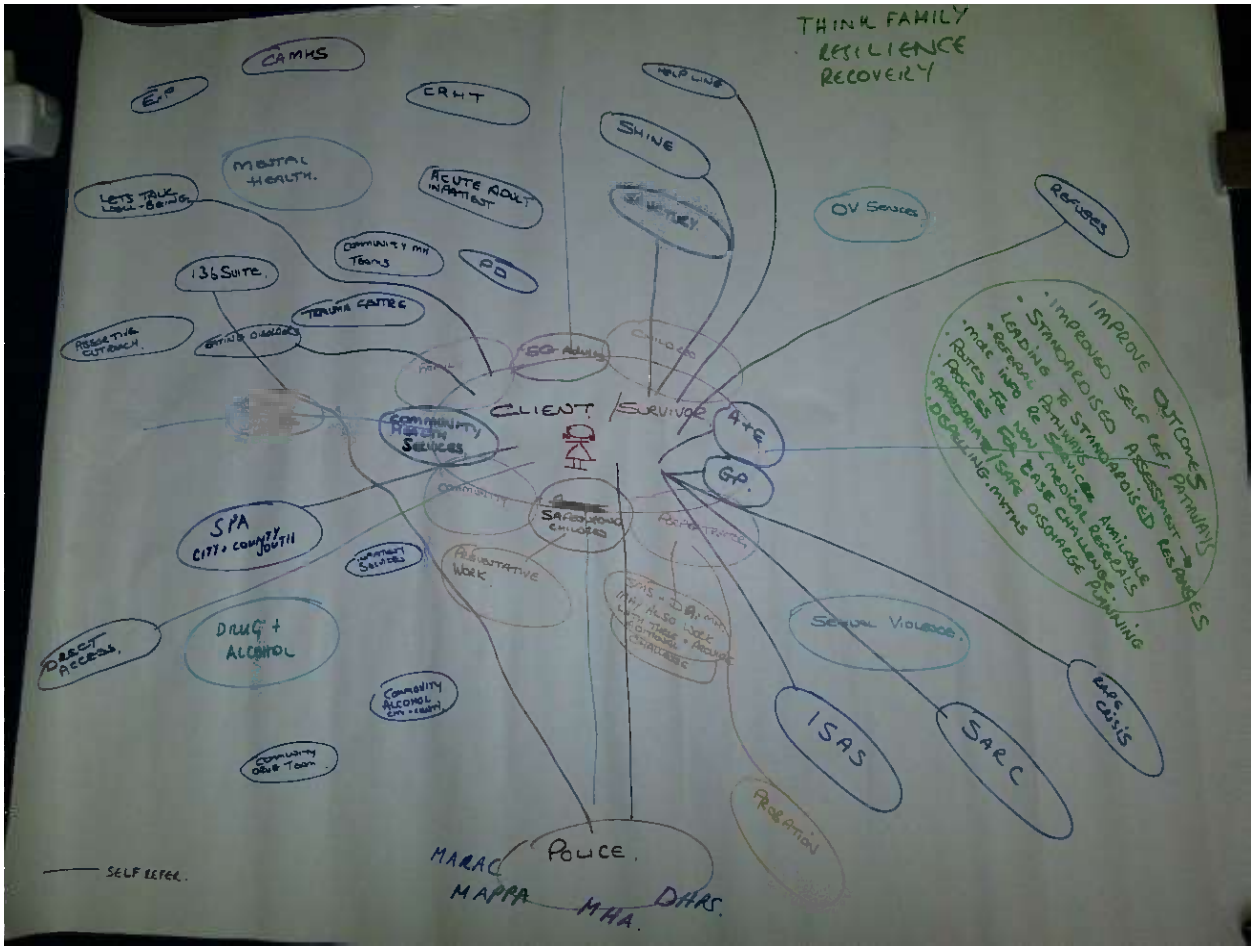


Figure 5. Pre-Intervention Group Eco-gram Nottingham

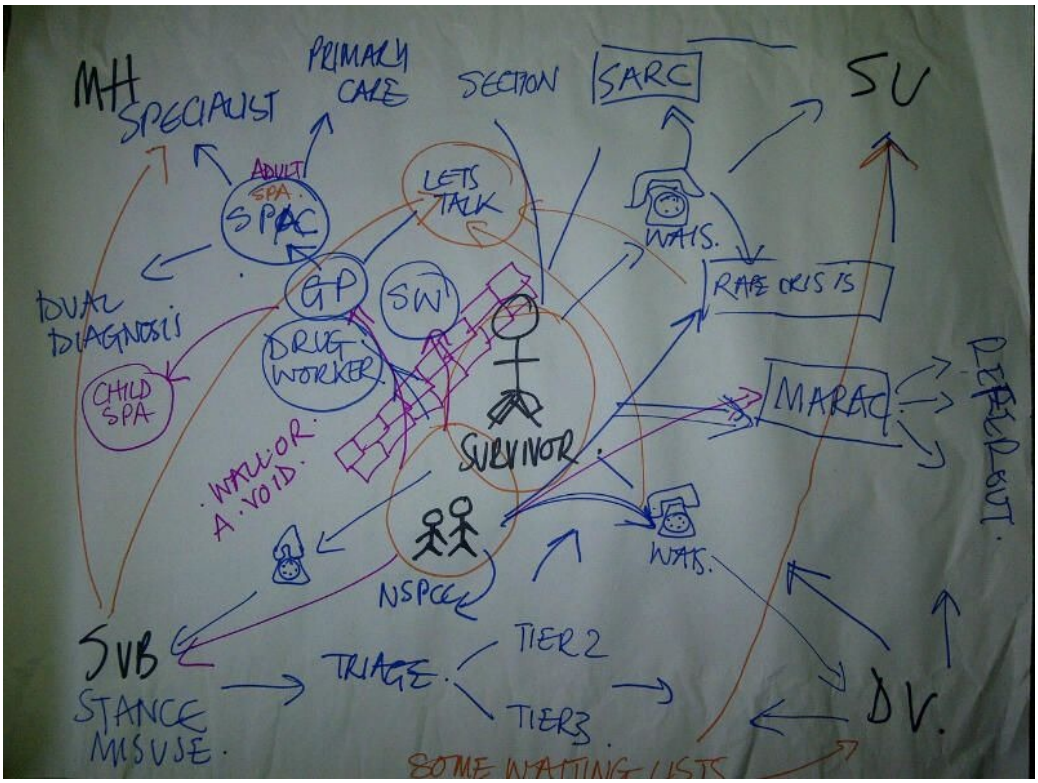


Figure 6. Post-Intervention Group Eco-gram Nottingham

The Nottingham pre-intervention group produced the most detailed eco-gram of each of the three areas (Figure 5). The group placed the client/survivor in context, with circles marked 'family', 'children', 'perpetrator', and 'community'. They also indicated a potential role for preventative work, and offered a strategic statement: "think family, resilience, recovery." This eco-gram is divided into quadrants. Each quadrant represents one of the intersecting issues: SV; drugs and alcohol; MH; and DV services. Over thirty-five services were represented. The Nottingham post-intervention group also produced a detailed eco-gram (Figure 6) divided into quadrants representing one of the intersecting issues. Barriers were presented using the striking visual metaphor of a brick wall, which shows the particular challenges survivors (and/or their children/families) may experience in accessing MH services. Although their referral pathways appear more developed than the other areas, the Nottingham group's post-intervention eco-gram shows that barriers still exist to linking survivors experiencing these intersecting issues to relevant MH services.

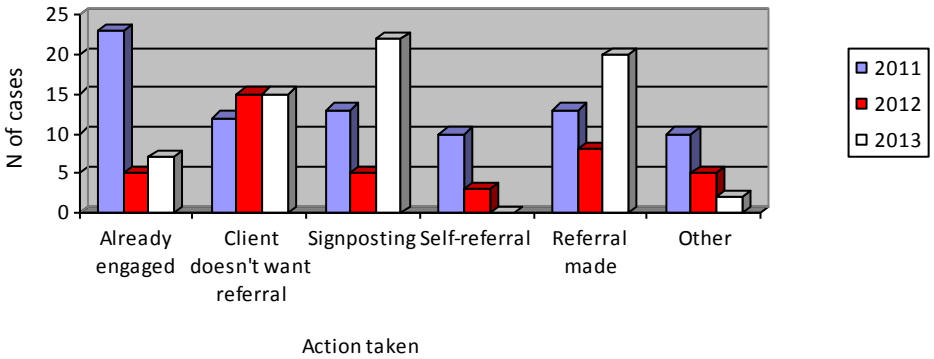
POINT OF INTEREST 4: ENGAGEMENT OF GPs

- GPs were not present in the pre-intervention eco-grams for Hounslow and Bristol; they were present but not emphasized or central in the Nottingham pre-intervention eco-gram.
- The post-intervention eco-grams show GPs as a key gatekeeper and link to mental health services.
- The role of GPs' practices in identifying and referring women with these intersecting issues was recognized and addressed by the SPMHI:

> *The SPMHIC produced an identification and referral protocol which is now on the GPs extranet, so the idea is if they now come across anyone experiencing DV or SV they should be able to pull that up on the extranet and it gives them ideas about where to go and the contact numbers."* (Hounslow Post-Intervention Focus Group)

In light of the changes identified through the eco-grams, monitoring data provide some insights into what actions agencies in Bristol and Nottingham took when women disclosed an additional issue. Figure 7 shows that in Nottingham, there was a shift from many clients who disclosed additional issues already being engaged with appropriate services to much more signposting and referrals being made in 2013. It is not possible to determine the cause of this however it should be noted that most of the data in 2011 was provided by VAW services whereas in 2013 it was from MH and SU services.

Figure 7. Action taken in cases where women disclose another issue to the one they were referred for by agencies in Nottingham during the three monitoring periods in 2011, 2012 and 2013



Note: 'Already engaged' means no action was taken by the agency because the client was already engaged with the relevant service; 'self-referral' means that the client was supported to make a self-referral.

Figure 8, suggests that in Bristol in 2011 and 2012 many women who disclosed another issue were already engaged with the relevant service to support them with that issue. The low number of cases for which we received information for 2012 makes it difficult to draw any further inferences (no data was provided by services in Bristol in 2013).

Figure 8. Action taken in cases where women disclose another issue to the one they were referred for by agencies in Bristol during two monitoring periods in 2011 and 2012

Note: 'Already engaged' means no action was taken by the agency because the client was already engaged with the relevant service; 'self-referral' means that the client was supported to make a self referral.

Referrals in Nottingham were made to a wide variety of organisations in 2011. The most common in Nottingham were GP (n=9), Women's Aid (for domestic violence support (n=7), NHS MH team (n=4) and counselling (n=4). In 2012 there were far fewer referrals made and organisations referred to, in Nottingham only nine were mentioned, compared to twenty-four organisations in 2011, the most common of which were SARC (Sexual Assault Referral Centre) (n=10), Gender specific worker at OC (n=4) and Women's Aid (n=4). In 2013 there was an increase in referrals made and eight different organisations referred to. The most common were WAIS (n=21), the Trust Safeguarding team (n=15) and the Local Authority Safeguarding team (n=6). Similarly to Nottingham, in 2011 in Bristol referrals were made to a wide variety of organisations, the most common were police (n=5), ISVA (Independent Sexual Violence Advisor) (n=5) and Missing Link (voluntary sector women's MH service; n=4). In Bristol in 2012 only one referral was specified to BDP, compared to 21 different organisations in 2011. No information about referrals was provided for 2013.

Building Staff Skills, Knowledge and Confidence

Expectations in all three areas at the pre-intervention stage were very similar: participants hoped that their agencies would develop an increased level of staff awareness, confidence and knowledge regarding identifying and responding effectively to the overlapping issues. Lack of confidence in assisting women with these intersecting issues was identified as a key barrier from the REA. One participant stated simply that they anticipated gaining the 'confidence to know what to do' (Nottingham, Pre-Intervention Focus Group). Others expected 'to develop some shared understanding of what good practice is... what the Stella Project is doing, with the training and the policies' (Bristol, Pre-Intervention Focus Group). These expectations extended to increased knowledge about referrals:

> *Skill my workers to be confident enough to deal with issues that are not just related to substance misuse, so that they have their skills and information of where to refer these clients.* (Hounslow, Pre-Intervention Focus Group)

There was a shared hope that the training delivered and the knowledge gained would lead to further training and the cascading of what had been learnt to other members of the organisations, ultimately some reported an expectation that they would be able to 'look at the strategic view and embed it in practice' (Nottingham, Pre-Intervention Focus Group).

During post-intervention focus groups, participants from each area reported that their expectations regarding improvements in staff skills, knowledge and confidence had been met. The post-intervention group discussed particular examples of the practical benefits of the project in terms of their capacity and confidence to address the needs of women presenting with these intersecting issues, even when the needs of such 'difficult' clients would previously have been regarded as not 'part of my brief':

> *Because she went on the training* [provided by the Stella Project] *she was able to support this woman (*with intersecting needs) *effectively whereas before she would not have been able to* (Hounslow, Post-Intervention Focus Group)

In Bristol and Nottingham the training provided by the SPMHIC was identified as central to the project in building staff skills, knowledge and confidence:

> *Staff feedback was that the training was really, really useful and they have really appreciated it.* (Bristol, Post-Intervention Focus Group)

Focus groups from Bristol and Nottingham also discussed increased discussion of VAW issues amongst their staff members:

> *The discussion around sexual abuse, domestic abuse is more part of the conversation now when we are talking about assessments… people aren't afraid to talk about it and say "this is what has been disclosed, I'm not sure where to go with it.* (Nottingham, Post-Intervention Focus Group)

Both groups identified the impact this increased awareness had on staff confidence, in that staff felt more confident in their ability to act to meet the needs of women with these intersecting issues. In Nottingham only, the group drew attention to their developing confidence in identifying the issues involved in working with perpetrators, as well as survivors – a direct benefit of the training provided by the Stella Project, in that they felt confident in "being able to not only support the worker working with the survivor but actually [addressing] the collusion side of working with the perpetrator." This comment raises questions which require investigation beyond the scope of this evaluation about staff perceptions of working with perpetrators, with consideration of why simply working with them seen as 'collusion', and an exploration of the alternatives.

POINT OF INTEREST 5: WORKING WITH PERPETRATORS

- As reflected in the Nottingham focus group, building confidence to deal with perpetrators within drug and alcohol treatment and mental health services was a key issue throughout the SPMHI and in each site
- A direct benefit of the perpetrator training organized through the SPMHI was workers' growing confidence in not 'colluding' with perpetrators.
- One of the major concerns voiced during the project was how to hold perpetrators accountable if someone does disclose perpetrating abuse and there are no referral pathways available. This often leaves professionals feeling helpless and frustrated.
- Support for perpetrators is an on-going issue to be addressed in Bristol and Nottingham. SU treatment and MH services are both ideal settings for running perpetrator programmes in that they usually already employ staff to deliver group-based behaviour change interventions. With additional knowledge and clear links with support services for survivors, staff could be retrained to run programmes for perpetrators who are also affected by SU and/or MH issues.

The staff survey provided us with information about the experiences of many more people than the focus groups. The picture that emerged was far more mixed and does not reflect the overwhelmingly positive account provided by the focus groups. In Nottingham, the findings are more clear cut than Bristol. There were no statistically significant differences between the amount of training[6] received by staff on VAW and SU issues in both Bristol and Nottingham, but in Bristol there was a significant decrease in the amount of MH training staff reported they had

[6] Staff were asked in the pre- and post-intervention surveys about the types of training they had received about VAW, SU and MH issues, from a range of six different types (e.g. watching a video, attending a lecture or talk). The number of different types of training staff had received about each topic was then calculated and summarised (see the limitations section).

received at the post-intervention (Mdn=1) compared to at the pre-intervention stage (Mdn=2), U=464, z=-1.99, p=.023, r=-.24. The reasons for this are unclear, however it could be that agencies thought that the SPMHI negated the need to provide other training, or that staff can only be released for so many days training each year and the SPMHI training was prioritised. Equally the changes in service provision as a result of restructuring could have meant training provision was delayed or cut. However because we do not have a control group design we cannot say for certain what the cause of this change was.

It is important to remember that the qualitative impact of the training offered by the SPMHI is difficult to capture through estimates of the number of training sessions attended alone. Further, it would seem that the training provided by the SPMHI was regarded by some focus group members as 'of higher quality' than other available local training, thus a count of the number of training sessions attended by staff may not provide an index of the impact of this training:

In addition, the SPMHIC was able to provide training that addressed the expressed needs of the practitioners receiving training, established via prior consultation:

> *Training has been done having consulted with people who need training – so has been very much practitioner focused – focused in terms of what people need – so (the SPMHIC) has effectively been able to provide bespoke training for those areas.* (Nottingham, Post-Intervention Focus Group)

The focus groups revealed challenges to staff attending the Stella-provided training. In particular, agencies noted limited capacity to release staff for training and other commitments, which may have impacted on the reported number of training sessions attended in the staff questionnaire. This capacity issue was overcome by some practitioners through 'delivering (the training) back' to the rest of their team after the formal training provided by the Stella Project. Although this was always envisaged as part of cascading learning gathered through the SPMHI, it is unclear whether staff receiving this informal 'in-house training' would classify this as 'training' per se, in their questionnaire responses:

> *Still working on having time to give all staff members that training – operation like that can be difficult – so that is still a work in progress – just delivering it back to the rest of the team and making sure all the team members feel competent enough to ask those questions and that we are being asked and checked as well.* (Hounslow, Post-Intervention Focus Group)

In Nottingham and Bristol staff generally perceived at pre-and post-intervention stages, that they had either had too little or the right amount of training on each issue although this does not necessarily have any bearing on actually how much training they had been offered or attended either before or during the project. Only a handful of individuals in Bristol and Nottingham reported that they had had too much training on any issue.

We measured changes in both staff confidence and knowledge about SU, MH and VAW because confidence and knowledge may be separate and serve different functions. We suspect that confidence and knowledge should be positively related to each other and changes in both are desirable. In Bristol and Nottingham the majority of staff reported high levels of confidence talking to clients about VAW, SU and MH, with only a handful admitting to low confidence at both pre- and post-intervention. There were no statistically significant differences in staff confidence talking to clients about VAW issues after the intervention in both areas. In Bristol, however, there was a medium strength difference in relation to talking to clients about SU issues pre-intervention, staff were only somewhat confident (Mdn=2) whereas post-intervention they were very confident (Mdn=1) $U=323$, $z=-3.70$, $p<.001$, $r=-.44$. In Nottingham a small difference was found in relation to how confident staff felt talking to clients about MH issues pre (Mdn=2) and post-intervention (Mdn=2), $U=459.5$, $z=-2.23$, $p<.05$, $r=-.26$. In summary, overall staff generally reported feeling confident talking to clients about all three issues, with significant increases in confidence being reported in Bristol for SU and Nottingham for MH at the post-intervention stage. There were no significant changes in either area as a result of the intervention on staff confidence to ask appropriate questions; respond appropriately to disclosures or ask follow up questions about each of the issues.

We used a hybrid version of the Stella knowledge training activity[7], embedded in the staff survey, in order to check staff knowledge about the three issues. There was a significant difference in staff knowledge about the three issues in Bristol, with staff at the pre-intervention stage demonstrating higher levels of knowledge (Mdn=8.50) than at post-intervention ((Mdn=7), $U=476.5$, $z=-1.79$, $p=.037$, $r=-.21$). This is somewhat surprising given that the intervention was intended to increase staff knowledge. Staff knowledge was not significantly different pre- and post-intervention in Nottingham. We do not have a control group and there are many other factors that could have influenced staff knowledge that we could not control for (e.g. whether the same or different staff from the same or different organisations completed the survey at pre- and post-intervention stages). We did know how many years staff had been in post so we tested whether this affected their knowledge but no differences were found in either area (due to low numbers it was not possible to consider years of experience and pre- and post-intervention separately so we tested across the whole sample).

We had hoped to be able to statistically test whether staff knowledge, length of time in post and the perceptions of the amount of training they had received affected their confidence talking about the different issues with clients, pre- and post-intervention. Unfortunately, the low numbers and non-normality of the data meant that it was not possible to conduct the required tests.

[7] Stella Project training typically incorporates activities that assess participants' existing levels of knowledge about VAW. This includes fact-based multiple choice quizzes and group discussions about commonly held beliefs and attitudes. For the staff survey it was adapted to ensure that it included a representative sample of questions about each topic (VAW, SU & MH) were included.

Benefits to service users

In pre-intervention focus groups in all three areas, participants were clear that the SPMHI would be of benefit to their service users. The ways they expected this would happen included by:

- enabling them to better assess, assist and support their clients and being more consistent when doing so, leading to better outcomes for those service users,
- by raising knowledge and skills of their staff,
- by encouraging staff not to 'think in isolation in terms of the client', and
- by learning to 'incorporate these skills in assessment and routinely ask these questions'.

In all three areas the post-intervention focus group reported that most of their expectations regarding benefits to service users had been met, and that they felt better prepared to assist service users by drawing on their increased knowledge of appropriate referral pathways. This level of proactive identification and referral of clients with these intersecting issues allowed agencies to offer avenues of support to even 'incorrectly referred' service users, as in the example given below:

> *Victims have called me saying 'my GP has said you can help me' and although I'm not quite the right person, at least I am able to give them the information* (Hounslow, Post-Intervention Focus Group)

> *[The] increased knowledge that other colleagues have got means that … our client group have been better supported.* (Nottingham, Post-Intervention Focus Group)

The staff survey provides limited and somewhat contradictory insights into possible benefits to service users when considering the data collected on case loads and the frequency with which staff discuss the three issues with their clients. There was not much variability in staff case loads pre- and post-intervention in Nottingham, the average case load pre-intervention was 8.02 and post was 9.52 (range=0-30). There was much more variation in Bristol, where pre-intervention the average case load was 7.47 women (range=0-48), whereas post-intervention it was 3.49 (range=0-16). There are a number of possible explanations for this variation in Bristol. The most likely is that, given we have relatively low numbers, the initial mean was skewed by the outliers (e.g. the one participant who reported a case load of 48), when this person's data are removed the average case load pre-intervention becomes 5.62 in Bristol. Other plausible explanations include: they received fewer referrals so case loads went down, the staff completing the survey at pre- and post-intervention were different and held different roles which have different cases loads (e.g. a helpline worker may have 200 cases and a counsellor only 6), the re-structuring led to changes in work priorities or, given the changes in organisations involved in the project, different organisations may have different ways of counting workloads. More regular long term monitoring of case loads is needed to create an accurate account.

Across all the areas very few people answered the question "How many of the women on your case load are currently experiencing each of the issues" so we are unable to draw anything from the data we have. The staff survey was quite long and this question appeared in the last third so it might be that many people did not answer because they had become fatigued or because they did not really understand the purpose of the question. Alternatively, it may be that staff were unable to answer the question without checking through case files which would have been time consuming. Despite this, many staff provided figures about the number of women that staff had discussed each of the issues with as part of their routine work in the three months prior to completing the questionnaire and the mean number of women who staff had on their case load in each area (see Table 6). Table 6 shows that pre-and post-intervention very few staff appeared to be routinely discussing the three issues with their clients in Bristol and Nottingham, and most of those who were engaged in such discussions had only discussed them with a handful of service users. This could suggest that staff simply do not remember and are then not able to report when they have discussed the issues with clients. Alternatively it could be that discussing these issues is not a routine part of their work which could be because it has not been embedded or that the clients they are seeing are either not experiencing or disclosing that they are experiencing these issues. Whichever explanation is accurate, there still appears to be a need for agencies to focus on prioritising discussion of all three issues with service users to ensure they receive support at the earliest stage and therefore feel the benefits sooner.

Table 6. Number of women staff from Bristol and Nottingham reported that they had discussed the three issues within the previous three months as part of their routine work and the mean number of women on their caseload.

		Mean n of women on caseload		Number of women discussed each issue in the last three months									
				0 or didn't answer		1-5		6-10		11-20		21 or more	
	Issue	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Bristol	VAW	7.47	3.49	12	25	14	5	2	3	4	1	4	1
	SU			9	23	15	8	4	2	5	2	3	0
	MH			6	25	17	3	6	3	6	4	1	0
Nottingham	VAW	8.02	9.52	14	20	15	5	2	4	5	0	9	2
	SU			14	21	13	3	6	4	5	3	7	0
	MH			12	22	6	2	7	4	8	3	12	0

Total N=36 pre- and N=35 post-intervention for staff who completed the survey in Bristol.
Total N=45 pre- and N=31 post-intervention for staff who completed the survey in Nottingham.

The referral pathways data for 2011 and 2012 somewhat contradict the staff survey findings as they suggest that the point at which service users make disclosures about other issues is during

early stages in their engagement with services. This may provide another explanation for the findings in Table 6, it may be that women are disclosing other issues without the staff having to pro-actively raise the issues which may explain the low numbers. Earlier disclosures should lead to benefits for service users because they should receive the support and assistance they need sooner. In Bristol, there was a clear shift to disclosures being made earlier between the two years we have data for. In 2011, there was a fairly even split between disclosures being made 'on referral' (33.3%), 'at a follow up appointment' (33.3%) and 'during initial assessment' (21%) whereas in 2012, 95% of the disclosures were made during initial assessment and 5% 'at a follow up appointment'. The four issues most disclosures were about across the two years were MH (40%) followed by SU (28%), SV (19%) and DV (13%). In Nottingham, where data was provided for all three years, there was a decrease in disclosures being made 'on referral'; 25% (2011), 19% (2012) and 7.6% (2013), but an increase in disclosures during initial assessment; 37%, 57% and 71.2% respectively. In each of the three years just around a fifth of the disclosures were recorded during follow up appointments (22%, 19% and 16.7% respectively). The pattern of issues disclosed, however, was different across 2011, 2012 and 2013 to Bristol, with just under half (42.3%) of the disclosures being about DV followed by MH (24.9%), SV (23.3%) and SU (3.7%).

Having stated in the previous paragraph that earlier disclosure should lead to earlier support and therefore benefits to service users, the focus groups highlighted that in all three areas, meeting the needs of service users with intersecting issues who might otherwise not be able to access particular services, especially if they had current SU issues, was an on-going challenge in need of sustained attention and monitoring. Although in the pre-intervention focus groups participants had simply noted this as a barrier they had intended to address through their involvement in the SPMHI, the post-intervention group in Bristol were able to describe their involvement in the review and development of appropriate policies to address this issue:

> *In terms of our face-to-face work we have quite a strict policy in terms of intoxication or substance use* (but we) *realise through this process that we were cutting out so many opportunities for service users and how can we look at our policies more… but without cancelling out access to so many service users. That work is still in development stage but it has been triggered from this* (Bristol, Post-Intervention Focus Group)

In Nottingham the role of the restructuring of available services, and consequent changes to referral pathways, was noted as being challenging in terms of being able to effectively support service users with intersecting needs. As one participant noted, access to appropriate services can be a matter of 'a postcode lottery'.

Summary of Findings and Limitations

Summary of Findings

Overall, the perception that women with intersecting needs are 'chaotic' and 'impossible to work with' remains commonly held. However, and despite this continuing negative perception, a very important post-intervention change is that the participants in the SPMHI reported that they now felt better able to support, engage and put referral pathways in place for these 'difficult' clients. In considering the findings in more detail, we have structured the following summary around the initial objectives of this evaluation.

1) In addressing Objective 1 of this evaluation, we compared alternative approaches made elsewhere with those taken within the SPMHI and we highlighted lessons learnt within them. We conducted a REA including grey literature, academic and policy documents. We found that there is a paucity of research on identifying best practice for women with overlapping issues. This is in part a likely consequence of the primary presenting issue being treated, in practice, as singular – or as masking other intersecting issues.

2) To address Objective 2 of this evaluation, we assessed expectations for the SPMHI and of the project co-ordinator. The expectations of the pre-intervention focus group regarding the benefits of their involvement in the project, and the work of the project coordinator, were largely met, if not exceeded. However, the focus groups also reported a number of challenges experienced as part of their involvement in the implementation of the SPMHI. Practitioners from all three areas recognised that the engagement of MH services and MH practitioners were crucial for the success and sustainability of the SPMHI. However, at both pre-intervention and post-intervention stages, the engagement of MH services was identified as the most significant on-going challenge to the SPMHI by all three areas. Some participants reported that this reflected a long-standing division that was part of a broader structural and attitudinal 'health and local authority' barrier (social vs clinicians). This is clearly a key area that will warrant further future attention.

3) In addressing Objective 3 of this evaluation, we examined whether the staff's confidence in their own knowledge and skills changed over the course of the evaluation. We focused on staff confidence in their own knowledge and skills required to address the overlapping issues and to respond appropriately to disclosures made by service users, both directly and as part of referral. We also explored the level, quality and nature of such confidence. There was some discrepancy between the findings of regarding staff confidence, knowledge and skills identified on the basis of the qualitative findings and the quantitative data analysed. It should be noted that there are some apparent discrepancies between some of the evidence provided by the qualitative and quantitative data we present here. Specifically, the pre- and post-intervention focus groups across all three areas were markedly more 'positive' regarding the increase in staff confidence, skills and knowledge in these intersecting areas than are the estimates provided by the post-intervention staff questionnaires. However, the focus groups were

able to give specific examples of the impact of the Stella Project on staff confidence and knowledge (e.g., being able to 'ask questions' they would not have previously asked; knowing where to refer women with intersecting needs). This discrepancy may be, in part, a reflection of the differing composition of the respondents to the staff questionnaire, which was completed by a range of staff from the agencies involved with varying levels of involvement with the SPMHI, and the members of the pre- and post focus groups, which drew together key representatives from each agency who had more direct involvement in the SPMHI.

4) To address Objectives 4, 5 and 6 of this evaluation, we examined the levels of multidisciplinary partnership working, referrals and joint care planning between agencies over the course of the evaluation. We also investigated the patterns of disclosures and subsequent referrals over the course of the evaluation. The monitoring data suggests that women had begun making disclosures about other issues earlier in their engagement with services at the post-intervention stage and that there were shifts in the type and number of agencies referrals were made to between the pre- and post-intervention stages. Our analysis of the eco-grams suggested partnership working was strengthened over the course of the project but this could not be considered within documentation. The engagement of MH services remains an on-going challenge for all three areas.

Limitations

Interventions and evaluations that are conducted over years, with multiple sites and services included, present numerous challenges to all involved, from maintaining engagement and enthusiasm to adapting when changes occur that are out of the control of the primary participants. This intervention and evaluation has taken place over a three year period during which there was great uncertainty as a result of significant changes to the structure and funding of the services involved. Many services had their funding significantly reduced which has meant that finding capacity to release staff to take part in the intervention and to engage with the evaluation activities has been particularly challenging. As a result, we were unable to obtain the quantity of evaluation data we had originally hoped to and the impacts have differed across the data strands. The missing data has limited the analyses we have been able to conduct.

Furthermore, it should be noted that MH services were less well represented in the focus groups across the three areas than were SU and VAW services. This reflects the broader pattern of lower levels of engagement of MH services in the SPMHI across all three areas. The widespread perception of MH services as 'the weakest link' by focus group participants may thus also be reflective of this lower level of representation in the focus groups themselves. Future evaluations would benefit from engaging in more proactive recruitment strategies to ensure that MH services are adequately represented in focus group discussions.

It was clear from the outset that there was limited funding for the evaluation which meant it was designed without a control group in consultation with the steering committee. This means that we cannot say for certain that any of the changes observed are definitely a result of the

SPMHI because we cannot compare the findings with a group who did not receive it. It was necessary when designing this evaluation, to make difficult decisions about what to ask about and what to leave out. For example we would have liked to ask staff in the survey for more details about content, duration and ultimate efficacy of the training they received but this level of detail was excluded in order to ensure all of the other required topics could be included.

Conclusions and Recommendations

Overall we conclude that practitioners from each of the areas should be encouraged to continue to work together to build a shared understanding of their different professional and practice philosophies, to foster mutual trust and respect, and to build a consensus on how best to integrate services for women with these overlapping issues. Agencies should continue to invest in improving the training, confidence and knowledge of their staff of these intersecting issues, with attention to the five key points of interest we have identified:

POINT OF INTEREST 1: MENTAL HEALTH SERVICES AS THE 'WEAKEST LINK'

MH issues were commonly seen as being a contributing factor to DV yet MH services were often viewed as 'the 'weakest link' in the network of available services for women with these intersecting issues, and as such may be regarded with mistrust by other agencies, or as not able to respond appropriately to women with these needs. Attention should be paid to the 'us' and 'them' dynamic between MH and other services. Focusing on strategies for building institutional empathy (Laing et al., 2012) may help to address this reductive dynamic and may reduce mutual blame when difficulties arise.

POINT OF INTEREST 2: ASSUMPTIONS ABOUT CLIENTS

Clients with the intersecting issues continue to be conceptualized as being 'difficult', 'hard to reach' and, by some MH services as, 'not our concern'. Post-intervention, participants reported that they felt better able to support, engage and put referral pathways in place for these 'difficult' clients, however these assumptions underlying this negative conceptualisation remain to be addressed. Engage clients with intersecting needs as stakeholders and key informants is a critical strategy for challenging these pernicious assumptions.

POINT OF INTEREST 3: INTERSECTIONALITY

Strategies and policies need to develop the ability of services to work together to address the intersectionality of women's needs. In order to do so, attention should be paid to the ways in which the intersecting issues are commonly conceptualized by services, and in particular, at the ways in which these issues tend to be 'separated out', and the impact of this on referral practices and pathways.

POINT OF INTEREST 4: ENGAGEMENT OF GPs

GPs are a key gatekeeper and link to MH services. The role of GPs' practices in identifying and referring women with these intersecting issues was recognized and addressed by the SPMHI and should continue to be prioritised through the development and implementation of identification and referral protocols for GPs.

POINT OF INTEREST 5: WORKING WITH PERPETRATORS

Building confidence to deal appropriately with perpetrators within drug and alcohol treatment and MH services should be a key area of focus. SU treatment and MH services are model settings for establishing viable perpetrator programmes as they often already have the capacity to deliver group-based behaviour change interventions. Given additional knowledge and clear links with support services for survivors, staff could be retrained to run programmes for perpetrators who are also affected by SU and/or MH issues.

We recommend that:

- Training on the intersections between SU, MH and VAW should be delivered by specialist agencies, like the Stella Project.

- Training materials should be developed that recognise and value the different approaches to working with clients adopted by practitioners from SU, MH and VAW backgrounds and focus effective engagement between them.

- Practitioners need accurate guidance and training on the impact of data protection legislation on how they can and when they should be sharing information within and between agencies. Standardisation, where possible should ultimately make their roles and responsibilities clearer and improve service users' experiences.

- To enhance the sustainability of the SPMHI project beyond the immediate funding period, it is recommended that more organisations, services and agencies are engaged in the project's networks, with particular attention to MH services. Related to this, mechanisms should be set up to ensure that the input from AVA is cascaded to new members of staff and those who have not received it. The SPMHIC should look at ways of developing best practice models of these mechanisms.

- The importance of collecting data on referral pathways needs to be given prominence in continuing the SPMHI's work. We suggest that organizations take this work forward, developing simple mechanisms for continuing to collect data and effectively use

evidence to identify both problems in pathways and examples of good practice that can be replicated. This could be facilitated through the networks established through the SPMHI.

- The process for referring women within and between agencies often appears to rely on 'old relationships'. We suggest that agencies focus on developing formalised clear referral pathways that exist independently of the individuals involved in them.

- More research is needed to identify the barriers to effective joint working, such as where agencies have rules or processes that mean clients with certain issues cannot be referred on to them and how to overcome them.

- Negative preconceptions and stereotypes about women with overlapping and complex needs are widely held that extend beyond the issues of SU, MH and VAW that were the focus of this work. A national campaign is needed to inform and educate both the general public and practitioners.

The following additional set of recommendations is derived from the detailed and invaluable feedback given during the pre- and post-intervention focus groups, and from the mid-point interviews with key representatives from the agencies involved in the SPMHI in each of the three pilot areas. The action-research foundation of this evaluation aims to recognize and foreground the expertise through experience of the frontline workers directly involved with the SPMHI, as they have direct knowledge of the challenges to the successful implementation of the project, of the strategies that appeared most fruitful in engaging agencies in the work of the SPMHI, and in identifying and responding more effectively, together, to the complex needs of women with these intersecting issues.

The key representatives from the agencies involved in the SPMHI suggested that future projects with similar aims should consider:

- Using partnership agreements to formalize working relationships;

- Involving senior officers/management in a formal commitment to encourage and support the attendance and engagement of their workers at SPMHI meetings, training and other activities;

- Emphasizing the accountability provided by the 'official' involvement of areas in the SPMHI, as this may provide a key impetus for encouraging the engagement of agencies, particularly MH services.

- Disseminating DV homicide statistics for each area may work effectively to 'bring home' the urgent need to work in partnership to identify and support women (and perpetrators) with these intersecting issues, and may help to secure the engagement of

agencies, particularly MH services. Building on this suggestion from the representatives we suggest that as well as disseminating DV homicide statistics after DV homicide reviews, the agencies women had been engaged with or attempting to engage with could be used to highlight both good and bad practice.

- Holding meetings quarterly, with dates planned well in advance, would allow even agencies with significant capacity issues to plan regular attendance;

- Incorporating and embedding the SPMHI working group into larger local VAWG strategy group(s) with an established structure may augment the reach and resources of the project;

- Developing outreach strategies (modelled on strategies used to successfully engage housing and DV services) to further build relationships between MH, SU and VAW services.

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Contents of Appendices

Appendix 1: Full list of search engines used in the REA

1) PSYCHINFO
2) PsycARTICLES
3) Medline
4) Lexisnexus
5) ScienceDirect
6) ISI Web of knowledge/Web of Science
7) Social Science Abstracts
8) J-Stor
9) Ingenta Connect
10) Home Office/RDS/Scottish, Welsh and NI equivalents
11) Cambridge Scientific Abstracts (Illumina)
12) RAND/JRF/Barnados, websites,etc.
13) ESRC/EDS archives

Appendix 2: Information letters and consent forms for the pre- and post-intervention focus groups

Information Sheet for Pre-Intervention Assessment of Expectations Focus Group

Dear X,

Thank you for agreeing to take part in the pre-intervention focus group for the Stella Mental Health Project. You have been invited to take part in your role as (service lead/area lead) to represent the views of your (service/area)[8].

The focus group will take place on *** at ****. The group will last for about two and a half hours. It is important that you are able to stay for all of that time.

Before the focus group starts you will be guided by the facilitator to create an eco-gram for your organisation (detailed instructions will be provided on the day). During the focus group you will be asked to discuss a series of questions and complete some simple tasks. There are no right or wrong answers; we simply want your opinion and that of your (organisation/area). Summaries of the material produced at the focus group will be used to prompt discussion in the focus groups that will be conducted after the Stella intervention and in the telephone interviews at the mid-point of the project.

When you arrive for the focus group you will be asked to sign a consent form (like the one on the next page) which will show that you understand what you are taking in part in and what the information you provide will be used for. We will video record all of the focus groups. We are video recording instead of audio recording to allow us to see your eco-grams when you are discussing them. Only the audio from the recording will be transcribed for analysis. The consent form will also be your way of letting us know that you consent to us video recording the focus group.

If you have any questions before the focus group please do not hesitate to contact Jennifer Holly (Tel: 020 7785 3862; jennifer.holly@avaproject.org.uk) or Miranda Horvath (Tel: 02084114532; m.horvath@mdx.ac.uk). We look forward to seeing you at the focus group.

Yours sincerely,

Dr Miranda Horvath
Evaluation Project Manager
Forensic Psychological Services
Middlesex University

[8] If you require this information in large print or in an amended format we would be happy to provide it, please just contact Miranda Horvath m.horvath@mdx.ac.uk or 02084114532

Pre-Intervention Assessment of Expectations Focus Group Consent Form

Before taking part in the focus group you need to read the statements below very carefully and tick, sign and date next to the appropriate box at the bottom of the page to indicate you consent to taking part.

- I voluntarily agree to take part in the pre-intervention assessment of expectations focus group for the Stella Project Mental Health Initiative.

- I have read and understood the Information Sheet provided. I have been given a full explanation by the evaluators of the nature, purpose, location and likely duration of the study, and of what I will be expected to do. I have been advised about any discomfort and possible ill-effects on my health and wellbeing which may result. I have been given the opportunity to ask questions on all aspects of the study and have understood the advice and information given as a result.

- I understand that the focus group will be video recorded and transcribed.

- I understand that the material produced from the focus group today will be summarised and used to prompt discussion in the focus groups that will be conducted after the Stella intervention and in the telephone interviews at the mid-point of the project

- I shall inform the evaluators immediately if I suffer any deterioration of any kind in my health or wellbeing, or experience any unexpected or unusual symptoms.

- I understand that all personal data relating to volunteers is held and processed in the strictest confidence, and in accordance with the Data Protection Act (1998). I agree that I will not seek to restrict the use of the results of the study on the understanding that my anonymity is preserved.

- I understand that I am free to withdraw from the study at any time without needing to justify my decision and without prejudice.

- I confirm that my anonymised data can be used for the Stella Mental Health Project and its evaluation and any subsequent publications.

- I confirm that I have read and understood the above and freely consent to participating in this study. I have been given adequate time to consider my participation and agree to comply with the instructions and restrictions of the study.

Please select the appropriate box:

Yes, I consent to the above ☐

Name _____ Signed_____ Date_____

No, I do not consent to the above ☐

Name _____ Signed_____ Date_____

Information sheet for Post-Intervention Reflection on Expectations Focus Group

Dear X,

Thank you for agreeing to take part in the post-intervention focus group for the Stella Mental Health Project. You have been invited to take part in your role as (service lead/practitioner) to represent the views of your service[9].

The focus group will take place on *** at ****. The group will last for about two and a half hours. It is important that you are able to stay for all of that time.

During the focus group you will be provided with a range of materials that were developed based on information from your organisations before the Stella Project. We'll ask you to reflect on how things have worked out subsequently. You will be asked to discuss a series of questions and complete some simple tasks. There are no right or wrong answers; we simply want your opinion and that of your organisation.

When you arrive for the focus group you will be asked to sign a consent form which will show that you understand what you are taking in part in and what the information you provide will be used for. We will video record all of the focus groups. We are video recording instead of audio recording to allow us to see your eco-grams when you are discussing them. Only the audio from the recording will be transcribed for analysis. The consent form will also be your way of letting us know that you consent to us video recording the focus group.

If you have any questions before the focus group please do not hesitate to contact Jennifer Holly (Tel: 020 7785 3862; jennifer.holly@avaproject.org.uk) or Miranda Horvath (Tel: 02084114532; m.horvath@mdx.ac.uk). We look forward to seeing you at the focus group.

Yours sincerely,

Dr Miranda Horvath
Evaluation Project Manager
Forensic Psychological Services
Middlesex University

[9] If you require this information in large print or in an amended format we would be happy to provide it, please just contact Miranda Horvath m.horvath@mdx.ac.uk or 02084114532

Post-intervention Reflection on Expectations Focus Group Consent Form

Before taking part in the focus group you need to read the statements below very carefully and tick, sign and date next to the appropriate box at the bottom of the page to indicate you consent to taking part.

- I voluntarily agree to take part in the post-intervention reflection on expectations focus group for the Stella Mental Health Project.

- I have read and understood the Information Sheet provided. I have been given a full explanation by the evaluators of the nature, purpose, location and likely duration of the study, and of what I will be expected to do. I have been advised about any discomfort and possible ill-effects on my health and wellbeing which may result. I have been given the opportunity to ask questions on all aspects of the study and have understood the advice and information given as a result.

- I understand that the focus group will be video recorded and transcribed.

- I shall inform the evaluators immediately if I suffer any deterioration of any kind in my health or wellbeing, or experience any unexpected or unusual symptoms.

- I understand that all personal data relating to volunteers is held and processed in the strictest confidence, and in accordance with the Data Protection Act (1998). I agree that I will not seek to restrict the use of the results of the study on the understanding that my anonymity is preserved.

- I understand that I am free to withdraw from the study at any time without needing to justify my decision and without prejudice.

- I confirm that my anonymised data can be used for the Stella Mental Health Project and its evaluation and any subsequent publications.

- I confirm that I have read and understood the above and freely consent to participating in this study. I have been given adequate time to consider my participation and agree to comply with the instructions and restrictions of the study.

Please select the appropriate box:
Yes, I consent to the above ☐
Name _____ Signed_____ Date_____

No, I do not consent to the above ☐
Name _____ Signed_____ Date_____

Appendix 3: Guides for running the pre- and post-intervention focus groups

Pre-Intervention Assessment of Expectations Focus Group Schedule

Thank you for coming to today's focus group, we realise that you are all very busy people. The purpose of this group is to get a sense of your expectations for the Stella Mental Health Initiative Project and to establish what contingencies you and your organisation have in place, should challenges arise in its implementation. Before we start the discussion, would you please all read the information sheet and consent form I've just handed out *(participants will have been sent the information sheet which includes informing them that we will be video recording in advance of the group).* If you have any questions, please ask them now. You'll notice from the form that we're going to be recording the discussion today so it's important that you give your consent to take part and be recorded.

Take questions then collect in signed consent forms

Before we start the focus group I'd like you each to individually create an eco-gram for your organisation. We will discuss these in the focus group. All the materials you will need (A3 paper, coloured pens) are provided and instructions are provided on the sheet I'm now handing out (*Facilitator hands out sheet and then goes through it in detail with the group taking questions).* You have 30 minutes to complete these. Now that you've completed the eco-grams we're going to start the focus group. I'm going to start the recorder now. *(Start video recorder)*

1) Could we go round the room now and everyone introduce themselves, please make sure you tell us where you work and what your role in that organisation is. It would also be helpful to say why your organisation wants to take part in this project.

2) What do you expect your organisation will get out of taking part in this project?

3) What structures have been put in place by Stella to facilitate the smooth running of this project? (these were outlined to you by Jennifer Holly during the meetings setting up the project and are available in the Risk Management Document she subsequently sent to each organisation)

4) What commitments have been given by Stella to your organisations to facilitate the smooth running of this project?

   Follow up questions/prompts
   Do you and your organisation understand these and how do you feel about them?
   - If not, what would be helpful?

5) What, if any, support/structures have you needed to put in place to facilitate the smooth running of this project?

Follow up questions/prompts
Do you and your organisation understand these and how do you feel about them?
- If not, what would be helpful?

6) What do you expect will be the major barriers to the success of this project?

Follow up questions/prompts
In the short, medium and long term? In other words what will be the initial/developmental and long term barriers?

7) What do you expect will be the major contributors to the success of this project?

At this point each person's eco-gram will be handed round the group and the group given 5/10minutes to look over these before question 8 is asked.

8) Before this focus group you were each asked to complete an eco-gram to share with the group now that you've had a chance to look over these individually, could each of you please show your eco-gram and talk us through it?

Follow up questions/prompts
Welcome comments and questions from the rest of the group

9) Now that we've considered everybody's eco-grams I'd like you to spend the last 30-45minutes of this focus group working together to produce an eco-gram that shows how your organisations can work together to improve responses to women who are experiencing violence, substance misuse and mental health issues. So instead of having your organisation at the centre of the eco-gram we'll have a woman.

Follow up questions/prompts
Think about referral pathways
Highlight possible barriers and facilitators

10) Now that you've finished the eco-gram I'm going to put it up so we can all see it. Could you now briefly talk to me through the eco-gram, it would be really helpful if you could mention any difficulties you had constructing it and any easy bits. Finally if you could each let me know how happy you are with the final product.

As mentioned in the information sheet, summaries of the material produced today will be used to prompt discussion in the focus groups that will be conducted after the Stella intervention and in the telephone interviews at the mid-point of the project. Thank you very much for taking the time to be here today, we hope that by sharing this information and working together, we'll be able to strengthen the Stella project and its running.

Post-Intervention Reflection on Expectations Focus Group Schedule

Thank you for taking the time to be here today, I appreciate that you're all busy. The purpose of this group is to reflect on your experiences taking part in the Stella Mental Health Initiative Project. During today's session you'll be provided with a range of materials that were developed based on information from your organisations before the Stella Project. We'll ask you to reflect on how things have worked out subsequently. Before we start the discussion, would you please all read the information sheet and consent form I've just handed out *(participants should have been sent the information sheet which includes informing them that we will be video recording in advance of the group).* If you have any questions, please ask them now. You'll notice from the form that we're going to be recording the discussion today so it's important that you give your consent to take part and be recorded.

Take questions then collect in signed consent forms

Before we start the focus group I'd like you each to individually create an eco-gram for your organisation. We will discuss these in the focus group. All the materials you will need (A3 paper, coloured pens) are provided and instructions are provided on the sheet I'm now handing out (*Facilitator hands out sheet and then goes through it in detail with the group taking questions).* You have 30 minutes to complete these. Now that you've completed the eco-grams we're going to start the focus group. I'm going to start the recorder now. *(Start video recorder).* I'm going to start the recorder now. *(Start recorder)*

1) Could we go round the room now and everyone introduce themselves, please make sure you tell us where you work and what your role in that organisation is. It would also be helpful if you could say a bit about why your organisation initially wanted to take part in this project and what you expected from it, originally.

2) The group will be shown a table with what each of the organisations expected to get out of taking part in the project and will be asked whether they think their organisation has got each of these things (in part or whole)

3) The group will be provided with summaries of the expectations of each organisation and asked to discuss whether these were matched, unmet, or exceeded.

4) Did the structures put in place by Stella facilitate the smooth running of this project?

   Follow up questions/prompts
   Can you explain why certain things did/did not work or stopped working or didn't initially work but now seem to be working or worked better than others or worked for one service but maybe not for yours?

5) The group will be provided with a summary of the commitments the Stella Project gave to each organisation at the start of the project. Were these commitments fulfilled?

Follow up questions/prompts
If they weren't fulfilled – why weren't they? What difference did it make to the project and your organisation?
If they were fulfilled what difference did it make to the project? What difference did it make to your organisation

6) What were the major barriers to the success of this project?
    a. How could we overcome these?
    b. How could you/your organisation overcome them?

Follow up questions/prompts
Show them some of the major barriers predicted by the pre-intervention focus group and ask them to reflect on how different/similar these are to the reality.

7) What were the major contributors to the successes in this project?
    a. How could we build on these?

Follow up questions/prompts
Show them some of the major contributors predicted by the pre-intervention focus group and ask them to reflect on how different/similar these are to the reality.

8) How has partnership working changed (or not) as a result of the intervention by the Stella Project?

9) If you had the opportunity to do this all again what would you do differently and why?

10) Is there anything that anyone feels should be added to how the project worked and what were its major strengths and weaknesses?

At this point the eco-grams created in the pre-intervention focus groups and the eco-grams these participants created directly before the focus group will be handed round the group and the group given 5/10minutes to look over these before question 8 is asked.

11) At pre-intervention focus groups individuals were asked to complete eco-grams which you can see now alongside the ones you completed before this focus group. Now that you've had a chance to look over these individually, could reflect on the similarities and differences between these eco-grams?

Follow up questions/prompts
Welcome everyone's comments and feedback

12) I'd like you to spend the last 30 minutes of this focus group working together to produce an eco-gram that shows how your organisations work together to improve responses to women who are experiencing violence, substance misuse and mental health issues.

13) Now that you've finished the eco-gram I'm going to put it up so we can all see it alongside the eco-gram that was created by the group in the pre-intervention focus group. Could you now briefly talk to me through your eco-gram, it would be really helpful if you could mention any difficulties you had constructing it and any easy bits. Also I'd like you to compare the two and reflect on the changes/similarities. Finally if you could each let me know how happy you are with the final product.

Thank you again for making the time to be here today. Your input is incredibly valuable.

Appendix 4: Instructions for making an eco-gram

How to Create an Eco-Gram

Eco-grams will be used in the evaluation of the Stella Mental Health Project to track new relationships, strengthened relationships, greater engagement and facilitated links between organisations. We also hope to be able to demonstrate changes in the sources and routes of referrals between organisations.

Please read all of the instructions below first and then follow them to complete your eco-gram.

- Draw a circle in the middle of the paper.

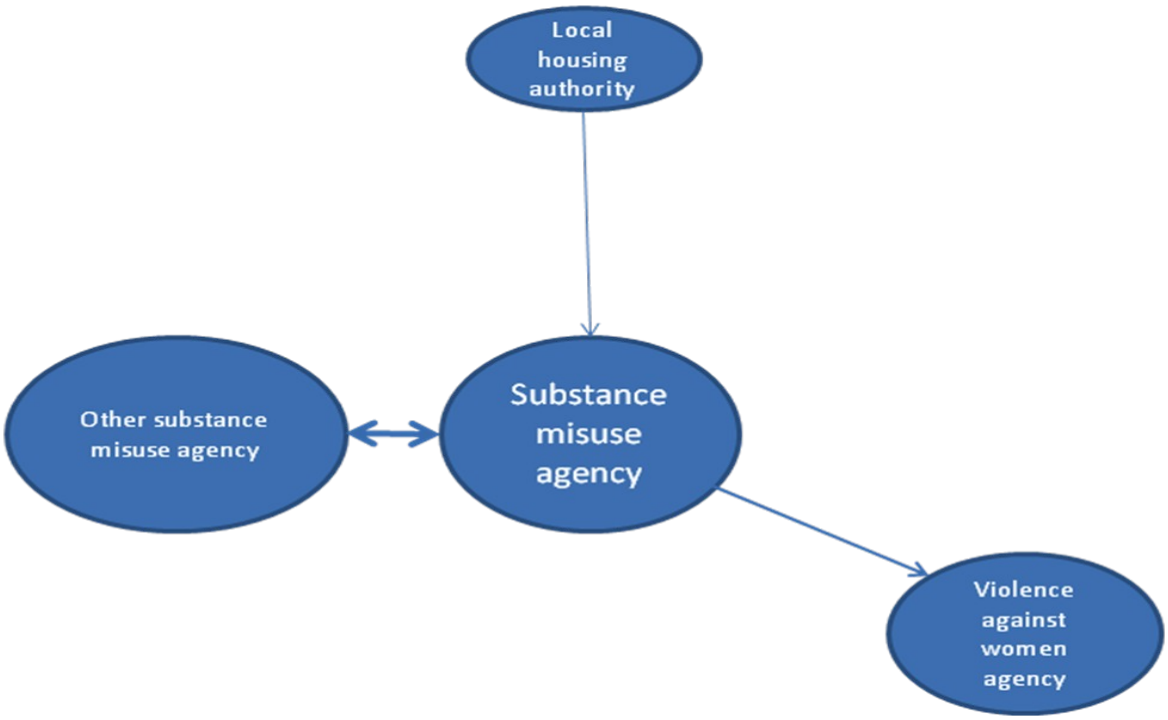
- Write the name of your organisation in a circle in the centre of the page.

- To create the eco-gram you're going to need to add more circles around your organisations circle. In order to help these reflect the relationships your organisation has with the other organisations we'd like you to use a number of different techniques, these are represented in the figure on the next page and outlined in the bullet points below:

    - The size of the circles around the central circle should show the importance of each organisation in relation to your organisation

    - The distance from the each smaller circle to the central circle should represent the degree of agreements and engagement that organisation has with your organisation. E.g. the closer a circle is to your organisations circle the more closely you work with that organisation.

    - Draw lines from the circle in the middle to the smaller circles, also where relevant draw lines between the smaller circles. The thickness of the lines should represent the strength of the relationships that that organisation has to your organisation and with each other. Also use arrows on the end of the lines to represent the direction of the relationships. So for example if there's an organisation that your organisation works closely with and you refer clients back and forth between you and you might even work collaboratively on projects then you should use a thick line with arrows on both ends.



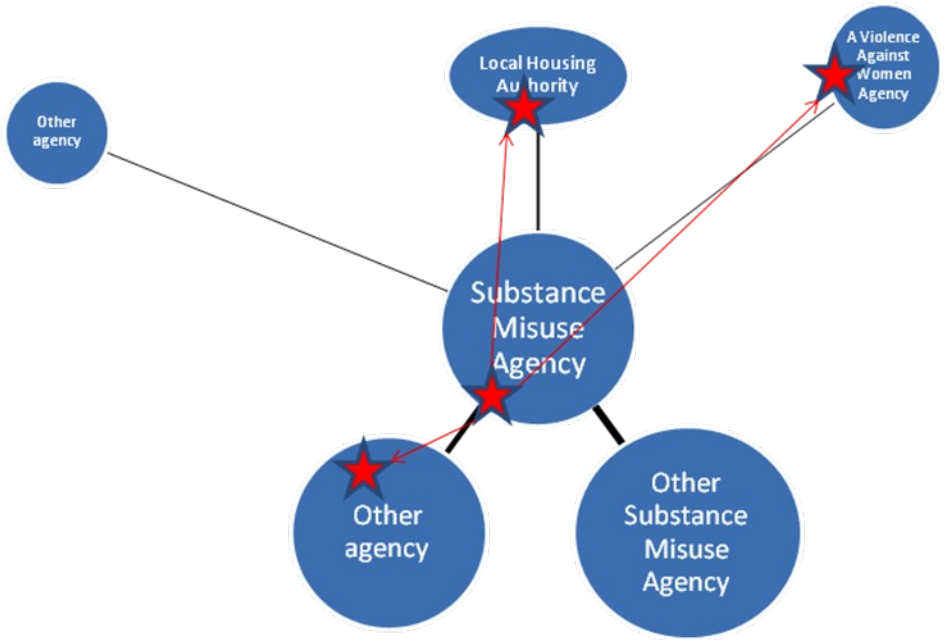
- The example shown here illustrates the three techniques listed above. So from this simple eco-gram we would interpret that:
    - The most important other organisation to the substance misuse agency in the centre is the other substance misuse agency, there is a high level of agreements and engagements between these organisations and the relationship works in both directions;
    - The substance misuse agency in the centre has a medium strength relationship with the violence against women agency but it is felt to be one directional from the substance misuse agency to the violence against women agency.
    - The local housing authority has the weakest relationship with the substance misuse agency in the centre, and it is one directional with the local housing authority sometimes feeding in to the substance misuse agency.

- In order to get started with your eco-gram on a separate piece of paper write a list of every organisation your agency works with.

- Using the list you've just written in the space around the circle, add circles for every organisation that your agency works with and label them. Use lines to link the circles.

- Once you have completed the eco-gram take a moment to look over it all and make any changes required.

- Once you are happy with the eco-gram please use a symbol and coloured lines to represent the pathway a client who has overlapping issues of substance misuse, experiences of violence and mental health issues would take once they had been referred to your organisation. In the example below the red stars represent a client/woman and the red lines the places the central organisation would refer her to (you can use any symbols or colours, red and stars were just used here as an example)



Appendix 5: Variables included in the monitoring database Invitation

1) Client reference

Numerical code, initials or full name (maybe not latter due to confidentiality)

2) Point of contact with client

a) Initial assessment; b) Follow-up appointment; c) 3-month review (if have them); d) 6-month review (if have them); e) Case closure; f) Other, please specify

3) Action taken

a) Signposting (giving information to client); b) Client supported to make self-referral (e.g. worker makes initial telephone call or requests referral form for completion by client); c) Make referral on behalf of client; d) Other, please specify

4) Which agency are you referring to?

a) Agency name *(to be coded by SP coordinator later)*

5) If referring, what was venue for first appointment?

a) Your office; b) Agency's office; c) Client's home; d) Other, please specify

6) Who attended first appointment?

a) Client attended by themselves; b) I accompanied the client to the venue but did not join appointment; c) I accompanied client to the venue and sat in on appointment; d) Another person from my office accompanied client; e) Client attended with another person (e.g. friend, family member); f) Don't know

7) Where a client engages with agency signposted/referred to, does this result in any joint-working?

a) No, there was no discussion of joint-working with agency; b) Yes, workers discussed jointly supporting client but agreed it was not appropriate or effective; c) Yes, workers agreed to jointly support client through enhanced communication via email and telephone; d) Yes, workers agreed to jointly support client through use of joint key working sessions and joint care/safety plan; e) Other, please specify; f) Don't know

8) Where a client does not engage after first contact, what is the reason?

a) Client did not fall within referral criteria (inappropriate referral); b) Following initial assessment, agency decide they were unable to meet client's need (e.g. do not provide appropriate service or support needs too high); c) Client reported agency or support available to did not meet their needs; d) Client reported they did not feel able to take up support (e.g. not right time or other personal reasons); e) Other, please specify; f) Don't know

Appendix 6: Invitation, consent form and interview schedule for the mid-point telephone interviews

Information sheet for mid-point telephone interviews

Dear X,

Thank you for agreeing to take part in the mid-point telephone interviews with agency leads for the Stella Mental Health Project[10].

The telephone interview will take place on *** at ****. The evaluators will phone you and the interview will last for approximately 30 minutes.

We are including with this letter images of eco-grams that were created at the pre-intervention focus groups and summaries of those focus groups. We'd like to ask you some questions about these during the telephone interview so would appreciate if you have them to hand and if you could look at them before that would be great. During the interview you will be asked to reflect on the project so far and think about what changes/improvements need to be made for the future. There are no right or wrong answers, we simply want your opinion and that of your (organisation/area).

We need you to sign a consent form (see the next page) which will show that you understand what you are taking in part in and what the information you provide will be used for. Please can you post the form back to the evaluators (Dr Miranda Horvath, Forensic Psychological Services, Department of Psychology, School of Health and Social Sciences, Middlesex University, The Town Hall, The Burroughs, Hendon, London, NW4 4BT). We will record all of the interviews. These will simply be used as a prompt in case there is a disturbance during the call which causes the interviewer miss one of your answers. The consent form will also be your way of letting us know that you consent to us recording the interview.

If you have any questions before the focus group please do not hesitate to contact Jennifer Holly (Tel: 020 7785 3862; jennifer.holly@avaproject.org.uk) or Miranda Horvath (Tel: 02084114532; m.horvath@mdx.ac.uk).

Yours sincerely,

Dr Miranda Horvath
Evaluation Project Manager
Forensic Psychological Services
Middlesex University

[10] If you require this information in large print or in an amended format we would be happy to provide it, please just contact Miranda Horvath m.horvath@mdx.ac.uk or 02084114532

Telephone Interviews Consent Form

Before taking part in the telephone interview you need to read the statements below very carefully and tick, sign and date next to the appropriate box to indicate you consent to taking part.

- I voluntarily agree to take part in the mid-point telephone interviews for the Stella Mental Health Project.

- I have read and understood the Information Sheet provided. I have been given a full explanation by the evaluators of the nature, purpose, location and likely duration of the study, and of what I will be expected to do. I have been advised about any discomfort and possible ill-effects on my health and wellbeing which may result. I have been given the opportunity to ask questions on all aspects of the study and have understood the advice and information given as a result.

- I understand that the interview will be audio recorded.

- I shall inform the evaluators immediately if I suffer any deterioration of any kind in my health or wellbeing, or experience any unexpected or unusual symptoms.

- I understand that all personal data relating to volunteers is held and processed in the strictest confidence, and in accordance with the Data Protection Act (1998). I agree that I will not seek to restrict the use of the results of the study on the understanding that my anonymity is preserved.

- I understand that I am free to withdraw from the study at any time without needing to justify my decision and without prejudice.

- I confirm that my anonymised data can be used for the Stella Mental Health Project and its evaluation and any subsequent publications.

- I confirm that I have read and understood the above and freely consent to participating in this study. I have been given adequate time to consider my participation and agree to comply with the instructions and restrictions of the study.

Please select the appropriate box:

Yes, I consent to the above ☐
Name _____ Signed_____ Date_____

No, I do not consent to the above ☐
Name _____ Signed_____ Date_____

Mid-point interviews with Agency Leads Schedule

Thank you for agreeing to be interviewed, I realise that you very busy. The purpose of this interview is to reflect on your experiences taking part in the Stella Mental Health Initiative Project to date. In particular we hope to identify any challenges you're facing in implementation and to establish if any changes need to be made.

Before we start the interview, I need to remind you that you will be audio recorded and thank you for returning the consent form (participants should have been sent the information sheet which includes informing them that they will be audio recorded in advance and asked to return the consent form prior to the interview). If you have any questions, please ask them now.

I'm going to start the recorder now. *(Start audio recorder)*

1) What did you think your organisation would get out of participating in the project?

2) Have the expectations your just described your organisation as having about taking part in this project been met to date? Why? Why not?

3) What have been the major challenges for your organisation to date?

4) What have been the major benefits to your organisation to date?

5) The Stella project have put in place a series of structures to help this project run smoothly

   a) What do you know about these structures? (prompt if necessary)

   b) Do you feel that they have helped to smooth the process? If yes, how, if no why not

   c) What would you suggest changing at this point? (thereby cutting out 5)

6) I hope you've been able to look at the eco-gram we sent you, could you please look at it again now and explain how it has or has not changed since the start of the project?

Thank you very much for taking the time to be interviewed today, by sharing this information and working together this will help improve partnership working and your work with clients. You have contributed to one of the first studies in this area.

Appendix 7: Extended Rapid Evidence Assessment

1) Do integrated responses to the combination of the intersecting issues of DV and/or SV with SU and/or MH exist? If yes, what are they and what are their success rates?

Please note that here we exclude the combination of SU and MH in isolation ('dual diagnosis') as out of the purpose of this REA. Similarly, while we searched the literature for DV and SV most of the literature found relates to DV, and little around SV.

BOX 2 - KEY FINDINGS FOR REA QUESTION 1

SV, DV, SU, and MH often co-occur (Alberta Council of Womens' Shelters [ACWS], 2009; Chang et al., 2010; Humphreys, Thiara & Regan, 2005; Moseset al., 2003). However there exist very few programmes that deal with more than one of these issues concurrently. Integrated responses are more common in North America than in the United Kingdom, although existing evaluation data do not permit robust comparisons between integrated programmes and single issue programmes. Thus, the success of such programmes is difficult to assess empirically. However, the literature does suggest a number of positive outcomes from collaborative work in these areas. These include enhanced information sharing, collaborative case plans and improved client outcomes. Barriers to effective collaborative work include communication issues and lack of information sharing; lack of clearly defined roles; lack of a shared focus; and lack of resources.

There is plenty of evidence that SV, DV, SU, and MH often co-occur (ACWS, 2009; Chang et al., 2010; Humphreys, Thiara & Regan, 2005; Moses et al., 2003). Further, as Zweig, Schlichter and Burt (2002, p. 170) assert, "the problems that many women victims of violence face, such as housing or employment, are compounded and complicated by the other issues in their lives.". The need for integrated service responses is increasingly recognised, with a consensus panel of DV and SU experts attesting that "failure to address DV issues interferes with treatment effectiveness and contributes to relapse" (Centre for Substance Abuse Treatment, 1997, p. 5). However, despite recognition of the need for integrated service responses for women survivors of violence with intersecting issues, there exist very few programmes that deal with more than one of these issues.

Integrated responses are more common in North America than in the United Kingdom, although existing evaluation data do not permit robust comparisons between such integrated programmes and single issue programmes. Thus the success of such programmes is difficult to assess empirically. However, the literature does suggest a number of positive outcomes from collaborative work in these areas. These include enhanced information sharing, collaborative case plans and improved client outcomes. Barriers to effective collaborative work include

communication issues and lack of information sharing; lack of clearly defined roles; lack of a shared focus; and lack of resources.

In a recent report on the need for enhanced collaboration between MH and DV services in Australia, Laing , Irwin and Toivonen (2012) provided an example of an integrated response to women experiencing these intersecting issues. The project trialled a number of initiatives, including the implementation of routine DV screening in MH services. The action research study suggests that building personal relationships and a commitment that built trust and a shared sense of purpose across both sectors were key aspects of the positive experience of practitioners in this new way of working. In order to overcome the barrier of the different organisational culture between MH and DV services, institutional empathy needed to be developed to enable both sectors to have realistic expectations of each other and reduce mutual blame when difficulties arose. Also, leadership and ultimately ownership of the process by all involved is required for successful collaboration to be achieved. In terms of outcomes, MH practitioners identified many changes in practice as a result of the action research. These changes linked to their increased understanding about the nature of DV and the services available, which would benefit women experiencing DV within the MH system.

There is some attempt in both the United States and Canada to facilitate better inter-agency co-operation for these overlapping issues, in different combinations. Two key contemporary Canadian projects are currently seeking to provide a more robust foundation for collaborative work. The BC Society of Transition Houses (2011) is developing a more co-ordinated approach to services for women who have experienced DV and who may also have MH and SU issues. They are currently piloting a programme that includes a toolkit and four day training programme for practitioners. The end product of the Reducing Barriers project will be a toolkit for agencies to use to adapt their policies, procedures and practices to more effectively serve the needs of women with these intersecting issues. The Woman Abuse Response Program (WARP) is currently undertaking a widespread consultation to identify the extent to which services in British Columbia are able to work together to meet the needs of women who have experienced DV and MH or SU problems. The consultation will inform systematic changes to "policy, funding and program planning for services that support women impacted by these three issues" (Canadian Women's Foundation, 2011, p. 37).

Moses et al., (2003) found a few treatment plans that address at least two of the issues mentioned. One is called Seeking Safety; run as group or individual sessions by MH and substance abuse clinicians to help individuals who are coping with PTSD (which may be a result of DV) and problematic SU to establish some safety in their lives (Moses et al., 2003). Another is the Addictions and Trauma Recovery Integration Model (ATRIUM). This is a group programme that teaches professionals about the problems related to trauma such as MH issues and addiction. It also aims to teach women how trauma expresses itself in the body (Moses et al., 2003). The Triad Women's Group is a cognitive-behavioural approach for women with SU and MH disorders who have experienced trauma. This group has multiple goals, which aim to help women find safety, prevent relapse, build support and cope with distress (Moses et al., 2003). These programmes have proved successful in America but our search of the literature did not

identify any evaluations of similar programmes in the United Kingdom despite anecdotal evidence suggesting that local programmes may exist. This highlights the importance of clearly documenting British programmes which address these intersecting issues.

Given that there are so few integrated intervention programmes it is hard to provide a strong assessment of how successful they are. Moses et al., (2003) discuss in their report the success of the three projects they mentioned. An evaluation of the Seeking Safety programme found 'significant improvements in SU, trauma related symptoms, suicide risk, suicidal thoughts, social adjustment, family functioning, problem solving, depression, cognitions about SU, and didactic knowledge related to treatment' (Moses et al., 2003, pg. 12). This study also found a sixty-three percent retention rate for the program, which according to the author 'was higher than most other studies of substance abuse populations with comparable lengths of treatment' (Najavits et al., 1998, pg. 451). The study also found improved therapeutic relationships for participating women and their therapists (Najavits et al., 1998). Another evaluation found decreases in behaviours such as 'self-harm, substance abuse, suicidality and aggression' in women who completed the ATRIUM programme (Miller 2002, pg. 161). Finally, the Triad Women's Group resulted in 'an increase in adaptive coping skills and a decrease in avoidance behaviours associated with substance abuse and traumatized reactions. Women also experience a decrease in MH symptoms' (Moses et al., 2003, pg. 14). Unfortunately, none of these evaluations mention a control group and in one study (Najavits et al., 1998), they discussed how the lack of a control was a 'methodological flaw and renders all outcome results tentative' (pg. 453). This makes it difficult to compare the success of these integrated programs to other, single-issue programs in order to see if integrated responses really are better.

Bennett and O'Brien (2007) described findings from a pilot project initiated by the Illinois Department of Human Services in which women who demonstrated a need for both DV and SU treatment were invited to participate in the project, which provided integrated treatment for both issues. Over a one year period, two hundred and fifty-five women participated in the project, with follow-up interviews conducted with 50% of the women (128 participants). These women experienced improvements in both SU behaviours and DV behaviours, e.g. they reported an increase in the average number of days attending a 12-step meeting, increasing from 57% to 87% in the most recent thirty days. The number of women reporting they had not used substances in the previous month was 87%, up from 57%. Regarding intimate partner abuse, women who reported they remained in a violent relationship decreased to 11%, from 21%. Additionally, women participating in the integrated services program saw an increase in scores on the DV Self-Efficacy scale (32.3 from 28.5), indicating an improved ability to handle their lives. Women also reported a decrease in scores on the Women's Experience of Battering scale (25.4 form 28.4), demonstrating a lessening of the perception of vulnerability to violence.

The Washington State Coalition Against DV project provides a manual directed to adequately screen women seeking services, and to accurately identify issues of concern (Patterson, 2003). There are calls for routine and continuous screening, in light of the difficulty some women have revealing the full extent of issues with which they are dealing. Initial interventions are described for the differing levels of substance involvement identified ranging from no involvement to

significant problem with SU to active in her addiction. The third step outlined by Patterson (2003) is information and referral, which is a reference to helping women get to the appropriate level of assistance depending on the initial intervention. The fourth step involves providing tools for relapse prevention and integrating the woman's safety plan with the plan for relapse prevention. The final directive is to continue providing emotional support for women struggling with co-occurring issues. The manual also provides content on crisis intervention, community information activities, support groups, transitional housing and legal advocacy. Evaluation of the effectiveness of this project has not addressed whether the intervention is successful in terms of dealing with the overlapping issues.

The literature on the benefits and challenges to establishing integrative work in these overlapping areas document both positive and negative outcomes. Darlington, Feeney and Rixon (2004) looked at a collaboration effort between MH workers and child protection workers and found that 57.7% of the cases they looked at experienced positive outcomes from collaborative work. These results included 'improved client outcome' and working well together by sharing information and generating case plans (Darlington et al., 2004, pg. 1185). However the research also identifies some barriers to collaborations such as communication issues, lack of information sharing, lack of clearly defined roles, differing focuses from the different workers, and not enough resources (Darlington et al., 2004; Mastache et al., 2008). One particularly problematic issue highlighted by 6, Bellamy, Raab and Warren (2006) is information sharing. They discuss the difficulties practitioners face when they are deciding what patient information to share with their team members and what they should keep confidential. There are conflicting ideas concerning confidentiality; there are rules that increase patient privacy such as the Code of Confidentiality but within the MH profession, there are now greater demands for sharing information (6, et al., 2006). An issue arises because practitioners 'are concerned about the possibility of being blamed either for sharing or not sharing when decisions turn out to lead to unwelcome outcomes' (6, et al., 2006, pg. 240). The research suggests that successful information sharing is key to any effective multi-agency collaboration effort but to achieve this, agencies must adopt processes to share relevant information whilst still protecting their patient's confidentiality.

There is considerable evidence available to explain why effective integrated responses are not common. According to Humphreys, Thiara and Regan (2005) it can be difficult for specialists from different backgrounds to work together because various disciplines have different philosophies (see BC Society of Transition Houses, 2011). For example, it may be common that services for victims of DV and SV take a feminist approach that aims to empower survivors whereas SU and MH services often work from a gender-neutral perspective (BC Society of Transition Houses, 2011; Humphreys et al., 2005). There can also be disagreements between disciplines about which issue to prioritise and the aetiology of co-occuring problems (Humphreys et al., 2005), which can raise the question of which issue to treat first (Zubretsky, 2002). Substance abuse programmes tend to centre around the SU issue first, however from a DV support perspective increasing the survivor's safety is prioritised (Zubretsky, 2002), although some DV services, particularly refuges, may prefer that SU issues be addressed prior to accepting women (Zweig, Schlichter & Burt 2002). Additionally, women might rely on

substances to help them cope with their lives in the face of danger, continuing to use them whilst exiting a violent situation (Zubretsky, 2002). Taken together, these findings seem to reflect a belief from both services and individual practitioners that 'treatment' should be serial, dealing with one 'problem' at a time depending on the 'need' and/or 'risk', which itself may be creating a further barrier to successful integrated response programmes.

Zweig, Schlichter and Burt(2002, p. 175) report a series of further barriers that may prevent agencies from effective integrated working with women who have experienced SV or DV and who have additional SU or MH needs. The agencies perceived by their respondents as representing 'the weakest links', in terms of successful inter-agency working, included criminal justice system agencies, health agencies, social services, MH and substance abuse services. Specific barriers included such agencies being "insensitive to, incapable of communicating with, or biased against women with multiple barriers… being insensitive to victims in general and … not tak(ing) DV and/or sexual assault seriously… not implement(ing) the policies that it has agreed to implement and not practic(ing) what it has promised… not car(ing) to change to address violence against women… (being) a bureaucracy with too much red tape; agenc(ies) want(ing) to serve "ideal" victims, not victims who are struggling with other concerns in addition to the violence; and … agenc(ies being) insensitive to victims' need for safety… lack of training for agency staff and lack of trust between agencies.".

Another concern evident in the literature regarding integrated services, is related to a perceived lack of knowledge about the overlapping issues amongst practitioners; many report that they do not feel comfortable addressing an issue in which they are not trained (Humphreys et al., 2005). Finally, there are funding and resource problems. It can be hard to get funding across specialities and then to maintain that funding in the future (BC Society of Transition Houses, 2011). It can also be difficult because different agencies do not have the resources to address more than one issue (Humphreys et al., 2005). As identified by a report released by the Stella Project, these resources may include 'funding, time, skilled staff and knowledge' (Carter, 2003, pg. 10). Macy and Goodburn (2012) echoed these challenges raised, but also suggested that fragmented governmental, legal, and policy systems were also a barrier to achieving successful collaborative relationships between DV and SU treatment service sectors.

2) What makes an intervention based on integration mechanisms effective? Do integrated responses achieve improved outcomes?

KEY FINDINGS – REA QUESTION 2

There is a considerable body of research that provides suggestions for the best way to achieve optimal collaboration and integrated responses. These include the development of a shared vision and the establishment of a shared set of key terms to encourage communication across different areas of practice. Joint training across services, the inclusion of service users in multi-agency training sessions, and regular multi-agency meetings have been identified as key practices for the development of effective integrated response teams. However, it should be noted that these suggestions are grounded in a limited set of observations made by researchers concerned with the relative lack of effective integrated responses.

There has been some research into reasons why there are so few successful integrated response programmes. Such research usually concludes with suggestions for how to implement a programme which effectively combines professionals from different fields. They include steps to follow to bring different agencies together in a successful collaboration, which involve ways to communicate effectively as well as ways to learn about other fields. There are commonalities between the suggestions provided by different research teams however there has not been any systematic empirical research done to look at how effective these suggestions are in practice. This highlights the need for further work in this area. The SPMHI represents a British intervention that will go some way towards filling this gap in the literature.

There is a considerable body of research that provides suggestions for the best way to achieve optimal collaboration and integrated responses (Cowley et al., 2002; Dion, 2004; Mackie & Morton, 2001; Moses et al., 2003; Moses et al., 2004). One of the first steps to creating a successful collaboration has been argued to be the development of a shared vision that all parties involved can agree on and that is interpreted the same way (Dion, 2004; Mackie & Morton, 2001; Moses et al., 2003; Moses et al., 2004). Next it has been proposed that the team must come up with shared meanings for terms so they can talk, listen and understand across disciplines (Caldwell & Atwal, 2003; Dion, 2004; Mackie & Morton, 2001; Moses et al., 2003). Different disciplines may use the same word to describe different contexts, for example 'comprehensive assessment' which has slight variations in meaning depending on the agency (Mackie & Morton, 2001).

Joint training involving individuals from the different agencies has also been suggested as a beneficial way to encourage people to meet each other as well as to teach them about fields that are not their primary specialism (Humphreys et al., 2005; Moses et al., 2003; Moses et al., 2004), as has meaningful user engagement (Moses et al., 2003). To keep the communication between the agencies frequent and functional, it is necessary to have meetings on a regular

basis that involve representatives from the different agencies who can discuss their role in the treatments (Cowley et al., 2002; Mackie & Morton, 2001; Moses et al., 2003). These steps combined have been argued to lead to the creation of an effective integrated response team based on observations of successfully integrated systems made by a few research teams (Cowley et al., 2002; Mackie & Morton, 2001; Moses et al., 2003). It should be noted however that these suggestions come from observations by researchers who are looking at why there are so few integrated responses. There is no follow-up research to show that these suggestions will lead to a successful integrated team, so it is important to use caution when following them.

3) What is best practice for frontline practitioners working with women with overlapping needs?

KEY FINDINGS – REA QUESTION 3

There is a paucity of research on identifying best practice for women with overlapping issues. This is in part a likely consequence of the primary presenting issue being treated, in practice, as singular – or as masking other intersecting issues. The bulk of the existing literature on best practice for frontline practitioners working with women with overlapping needs has a focus on the needs of women initially presenting with DV and comes out of the DV/women's sector. This literature emphasizes, firstly, the importance of establishing women's safety; adopting a 'woman centered response' where the woman is treated as the expert in knowing what she needs; and identifying any overlapping issues, with an emphasis on routine enquiry, as well as finding appropriate responses that address them. Ideally, practitioners should have some comfort in addressing a range of intersecting issues even if they are not 'professionals' in each of those fields. Women's Aid (2005) further recommends that practitioners are trained to carefully document any disclosure of abuse so that if necessary, this can be used in court, though practitioners may be reluctant to document other intersecting issues, as these may potentially be used against women in court.

Very little research has been done to identify best practice for women with the overlapping issues of abuse, SU and MH issues. There are, however, several resources that offer some recommendations for working with women who have a history of DV. There are also some DV services for female survivors that have addressed the issue of best practice when working with women with overlapping needs. These include suggestions generic to survivors of DV that are also applicable to women with multiple needs. They include listening to the woman as well as documenting abuse in case the woman plans to bring it to court. The literature emphasises the woman's abuse as the more important issue to address in order to make sure she is safe. It should be noted that some practitioners may be wary of recording and reporting multiple issues, as they are aware that these may be 'used' by perpetrators, and their legal counsel, against women. For instance, Zweig, Schlichter and Burt (2002) report that, "batterers use the problems women experience (e.g., substance abuse) as abuse strategies (e.g., supplying alcohol or drugs, not allowing women to take medication for MH issues)."

One major recommendation from several sources for best practice for any woman who is experiencing DV is to establish safety for her (ACWS, 2009; BC Society of Transition Houses, 2011; Hein & Ruglass, 2009; Women's Aid, 2005). This can be done by empowering women to take control of their lives and by helping them find safe spaces and relationships (Hein & Ruglass, 2009). It can also be useful for the woman if a safety plan is established that allows her to find safety when there is some threat of abuse (ACWS, 2009). A positive and trusting relationship with medical providers (Barry, 2007) is also a key factor, especially if women are going to feel comfortable enough to disclose matters such as trauma (Bauer & Rodriguez, 1995).

However, the Stella Project (2005) stresses that if services do not identify and address drug and alcohol issues, women experiencing violence may be placed at greater risk of harm, due to the impact of these intersecting issues on multiple aspects of their lives, including their capacity to access safe spaces, their experience of the criminal justice system and their anxiety about the security of their custody of their children.

The BC Society of Transition Houses (2011) offers several suggestions for best practice when working with women who present more than one issue. These include, providing a woman centred response where the woman is treated as the expert in knowing what she needs, ensuring that patients are not 'oppressed' further, and recognising the overlapping issues as well as finding a response that addresses them. The practitioner should have some comfort in addressing all of the issues even if he or she is not a professional in each of those fields, and should focus on ensuring the woman's safety so she can reduce stress and hopefully recover more successfully.

The British Columbia Centre of Excellence for Women's Health (2004) assert that women accessing DV refuges may be at a stage of readiness to address both their experiences of violence and their substance use issues. They found that "women's substance use decreased after their shelter stays both in shelters that offered brief interventions and those that offered more substantive interventions"(p. 11). Importantly, these interventions were not just drug and alcohol focused, but were provided in the broader context of attempts to assist women to 'restructure their lives' within an environment where they felt 'safe' to disclose and discuss other issues.

Women's Aid (2005) highlighted some other important practices for service providers who work with women with overlapping needs. They include being sure to believe a woman who says she was abused, carefully documenting any disclosure of abuse so that if necessary, it can be used in the courts later on and making sure to offer the woman several options for what steps to take in case she is not ready to leave her partner. Hein and Ruglass (2009) also recommend that practitioners be aware of the legal options that may be available to their patients in case they wish to use legal remedies.

However, the Stella Project (2003) notes that women with SU problems may have a high level of distrust of agencies and a high level of anxiety about coming into contact with the criminal justice system. This may be exacerbated if the woman has children, or if she is involved in illegal activities. Thus women with these intersecting issues may respond initially with anxiety and mistrust to frontline workers when presented with 'legal options' that involve 'going to court'. The Stella Project also report that women who are experiencing DV and substance use issues may have had negative encounters with service providers, ranging from feeling 'ignored' to being actively discriminated against. Thus, this stigmatised client group may be particularly vulnerable to feelings of alienation, shame and stigma and may be difficult to engage. The Stella Project recommends that frontline workers be aware of the negative stereotypes they, and workers from other sectors, may hold about women with these intersecting issues and that these services develop ways of engaging with, and positively screening individuals, so as not to alienate these women further.

4) What is best practice for strategically linking work with women with overlapping needs, i.e. not frontline practitioners?

KEY FINDINGS – REA QUESTION 4

Best practice for the strategic development of work with women with overlapping needs aims to address the barriers to effective integrated responses (above) with a focus on communication and training. Improved communication between agencies may involve adjusting confidentiality requirements or creating protocols for addressing women who present with overlapping needs. These protocols should encourage multiple agencies to work together and to share information, when appropriate. Other measures may include establishing the opportunity for regular networking between agencies, via the creation of a multi-agency forum. Also recommended is the implementation of routine questioning to screen for DV in women when they first present to a service in order to encourage disclosure; and ensuring that there is at least one staff member specifically tasked with addressing DV issues when they arise. Screening for MH/SU is often overlooked. Involving women who have survived these intersecting issues in the policy planning and implementing process is also recommended.

Best practice for strategic development of work with women with overlapping needs is mostly presented in the form of policy suggestions for organisations (BC Society of Transition Houses, 2011; Darlington & Feeney, 2008; Women's Aid, 2005). These policy suggestions address some of the barriers to effective integrated responses that were presented earlier. They deal primarily with communication and training concerns. Macy and Goodburn (2012) maintain that effective interagency collaborations require multidimensional strategies at various levels, including the provider, director, agency, and policy levels.

Darlington and Feeney (2008) conducted a study of professionals in the MH and child services disciplines and found that workers wanted to see improved communication between agencies,

which would involve changing the confidentiality requirements as well as creating protocols that force multiple agencies to work together. Their sample also expressed a desire for training programmes for the workers so they could know more about the different issues they might encounter. The workers in the Darlington and Feeney study (2008) also expressed concern about the inadequate resources their agencies were receiving, the need for more workers to fill existing caseloads, and better facilities. Some recommendations for how to address these problems can be found in an article by Secker and Hill (2001) who saw similar issues arising in a study of workers from thirty different agencies that deal with issues such as drug and alcohol use, criminal justice, housing, and MH. They suggest the development of training packages to provide to the various agencies as well as a detailed protocol list that would cover what information should be shared. In order to make sure the protocol is being followed and to allow a place for networking between agencies, they suggest a forum comprised of members from the various agencies (Secker & Hill, 2001).

In terms of addressing the needs of DV survivors, the Stella Project (Carter, 2003) and subsequently, Women's Aid (2005) offer some policy suggestions for services that work with women with overlapping needs. These include developing specific protocols in the organisation to address the needs of women who present overlapping needs and holding regular training sessions for SU and MH staff so they can be aware of DV issues, and vice versa. They stress the importance of being sure that their services are available to women of all cultural backgrounds (this applies to all victim-survivors whether they have overlapping needs or not). It is also considered essential to create and implement routine questioning to screen for DV in women when they first come to the service in order to encourage disclosure, even if the woman was not planning to do so. There is a further recommendation that agencies which do not deal exclusively or primarily with DV ensure that there is a member of staff who is in charge of DV cases when they arise. Other studies also suggest involving women who have survived some of these issues in the policy planning and implementing process because they offer a unique perspective on the issues and their presence can empower the women who are taking part in the programmes (BC Society of Transition Houses, 2011; Moses et al., 2003).

This REA has highlighted a relative lack of literature that addresses the specific needs of SV survivors. Zweig, Schlichter and Burt(2002) report that sexual assault victims may be especially reluctant to access victim services if they also had experienced SU problems, which may contribute to this gap in the literature.

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