Reducing the Risk of Domestic Abuse

Sapiens

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POLICE & CRIME COMMISSIONER THAMES VALLEY

Report to the Police and Crime Commissioner for the Thames Valley

Pilot Project: development of an Oxfordshire domestic abuse and mental health service

Second evaluation and report: July 2017

Oxfordshire Complex Needs Project
Integrated mental health and domestic abuse pilot service

REPORT June 2017.
This report may be read in its own right or as an update to our October 2016 report

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Introduction.
The Oxfordshire complex needs project has two underlying purposes:

1) To pilot a service combining expertise from both disciplines with the aim of developing more effective integrated interventions. This is because Mental Health (MH) and Domestic Abuse (DA) interact so that each increases the probability of the other. The combination can create a spiral of increasing risk and complexity which is difficult to break and can lead to service users being caught between services without having their needs fully addressed (revolving door service users).

2) To strengthen the capacity of services to support victims of domestic abuse with mental health needs through the length of their 'journey', i.e. encompassing:
i. early intervention
ii. high risk management
iii. stabilisation through intensive support
iv. therapeutic intervention to build resilience and support longer term recovery

The two principal elements of the pilot are:

- enhancing MH expertise within existing DA services to increase competency in: managing clinical risk; engaging emotionally vulnerable clients; signposting appropriately; and effectively supporting clients so that they build internal resources and resilience to keep themselves safe in the longer term and regain their independence

- the establishment of a specialist intensive support service which includes a new group called The Anchor Program (TAP). This specifically aims to build resilience for service users with DA and complex MH needs – so as to support recovery in the longer term. We believe this is the first programme of its kind.

Project structure

The project has drawn on and enhanced current services as well as utilising new resources funded through the Police and Crime Commissioner's grant. The new resources comprise:

- A half-time Project Development Manager with mental health qualifications and experience, based with Reducing the Risk. She holds an overview of the wider project, drives wider project activities, contributes clinically through IDVA case consultation and participation in the TAP service, and works collaboratively with Sapiens and ODAS in respect of evaluation of the TAP outcomes.

- Sapiens, an independent psychotherapy, mental health and consulting company with vast experience and specialism in working therapeutically with personality disorder, which provides essential expertise for TAP development and associated clinical supervision. Sapiens provided the framework, resources and theoretical content, inclusion and exclusion criteria, weekly supervision and teaching of the model that was delivered. The clinical expertise from Sapiens has been essential for the management of the risks and challenges which have arisen during therapeutic intervention.

- TAP Project Manager who holds an overview and lead in the practical delivery of TAP and provides support and additional supervision for the Complex Needs Outreach workers. She is also a team leader in ODAS and offers a wealth of expertise and experience regarding domestic abuse.

- Two specialist Complex Needs Outreach worker posts embedded within the ODAS service. Both workers were specifically selected by interview for their expertise and sensitivity when working with a complex, demanding client group and their interest in developing this further. Both have extensive experience of working within the ODAS service.

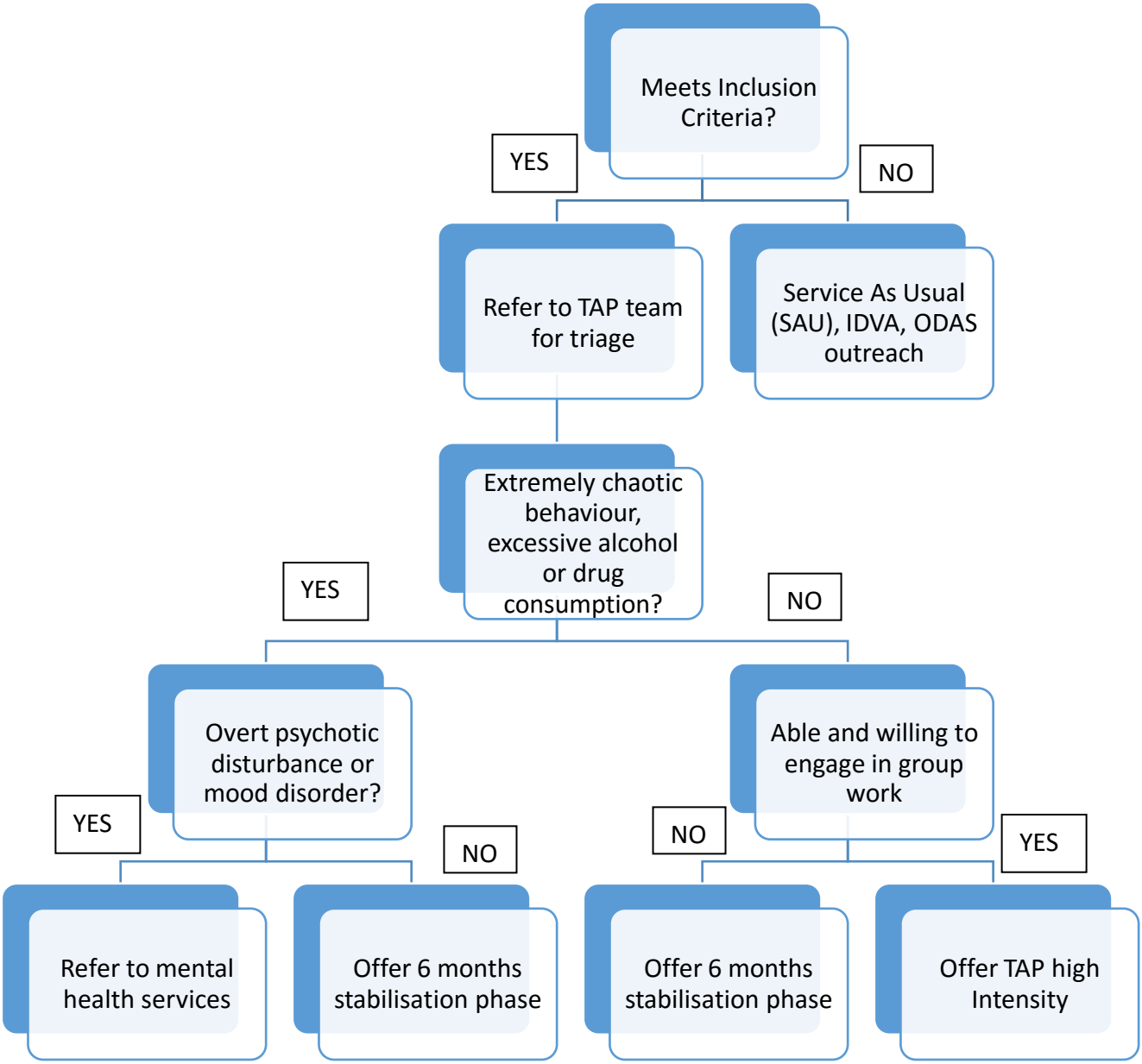
The project steering group comprises the Project Manager, the Director of Sapiens, the Service Manager of Oxfordshire Domestic Abuse (ODAS), the TAP Manager and the Chair of Reducing the Risk of Domestic Abuse.

The partnership between ODAS; Reducing the Risk and Sapiens, has been fundamental in the development of both TAP, the therapeutic program and the wider pilot. In addition, the project incorporates clinical support for Oxfordshire's existing IDVA team's high risk caseload i.e. support for initial work with high risk victims with fragile mental health prior to any potential referral to TAP.

The purpose of this full report

The steering group has compiled a short overview report of the project for the Police and Crime Commissioner which is available on the Reducing the Risk website (www.reducingtherisk.org.uk) The purpose of this report is to provide more detailed information on outcomes and to make available full data and analysis of TAP (pages 12 – 27) with view to future research.

Flow chart of referral process for TAP



Service User Data Jan 2016 – March 2017

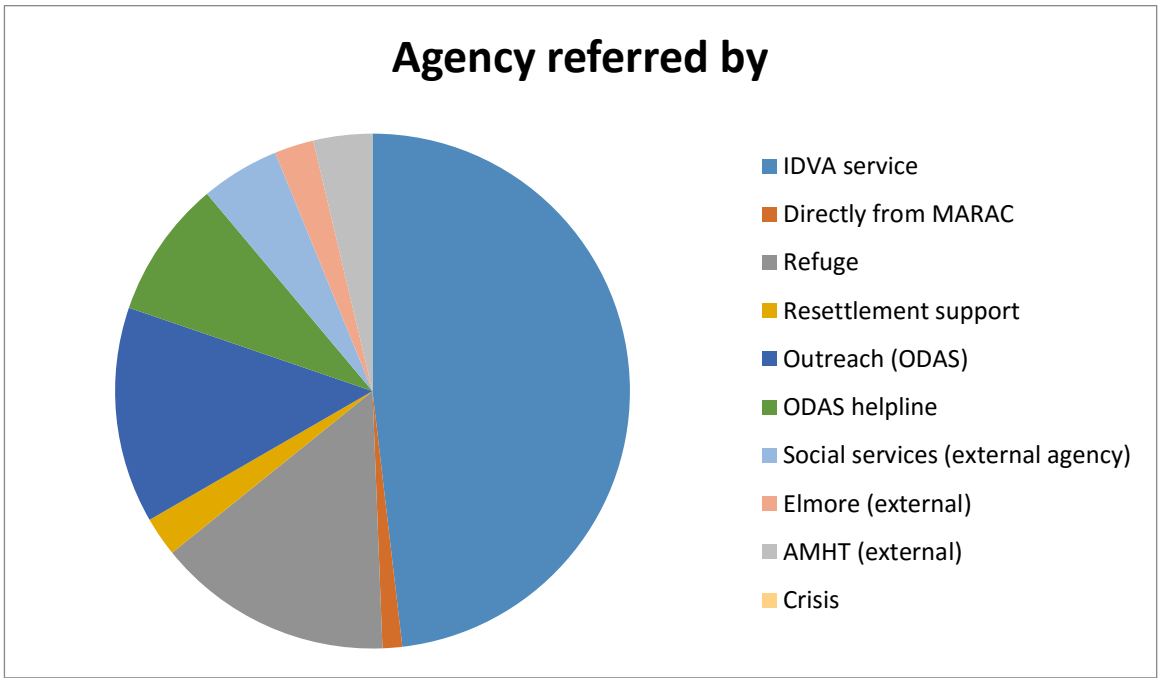
Referral source

The pilot has supported **86** service users between January 2016 – when the service effectively started, and May 2017**.**

72 were received through the Oxfordshire domestic abuse pathway ('internal referrals'):

- 39 were referred through the IDVA service (victims of abuse assessed as 'high risk').
- 1 was a MARAC agreed referral directly to the specialist MH outreach in the project
- 12 were referred by refuge and 2 after leaving refuge as part of resettlement support
- 11 were referred through district outreach workers
- 7 were referred through the Oxfordshire helpline

10 were referred from 'external agencies': 4 from social services; 2 from Elmore; 3 from the Adult Mental Health Team (AMHT); and 1 from Crisis



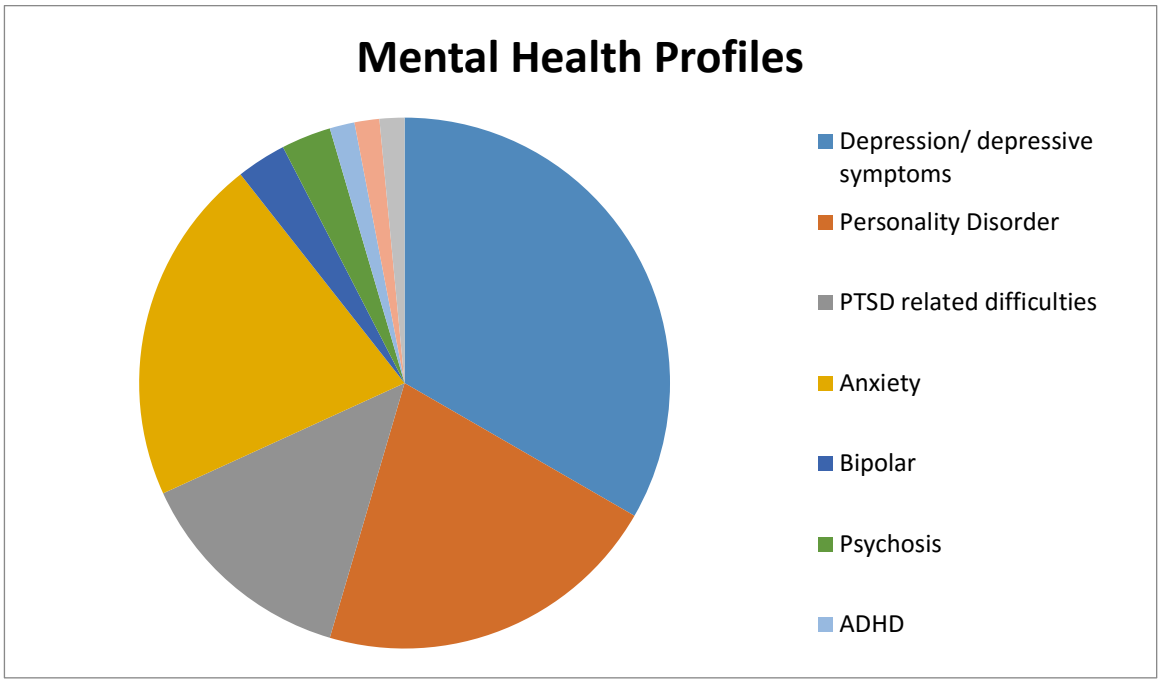
Profile of referrals

All victims of abuse referred into the project have been female

Referrals are broadly representative of the ethnicity of the Oxfordshire population as a whole.

All those referred exhibited significant traits within criteria for PD including Borderline Personality Disorder- fragile mental health which in the judgement of the referring agency, compromised their ability to keep themselves safe. Specifically:

- 22 had depression or depressive symptoms mostly managed in primary care by their GP through medication
- 14 had been formally diagnosed with some form of PD
- 9 had been diagnosed with PTSD or experiencing difficulties characteristic to PTSD including flashbacks
- 14 had symptoms of anxiety
- 2 had been diagnosed with bi-polar
- 2 were experiencing psychosis
- 1 ADHD
- 1 ASD (autistic spectrum disorder)
- 1 OCD, PD and trichotillo mania



14 that we know of had attempted suicide in the past or deliberately self- harmed and a further 20 had experienced suicidal ideation.

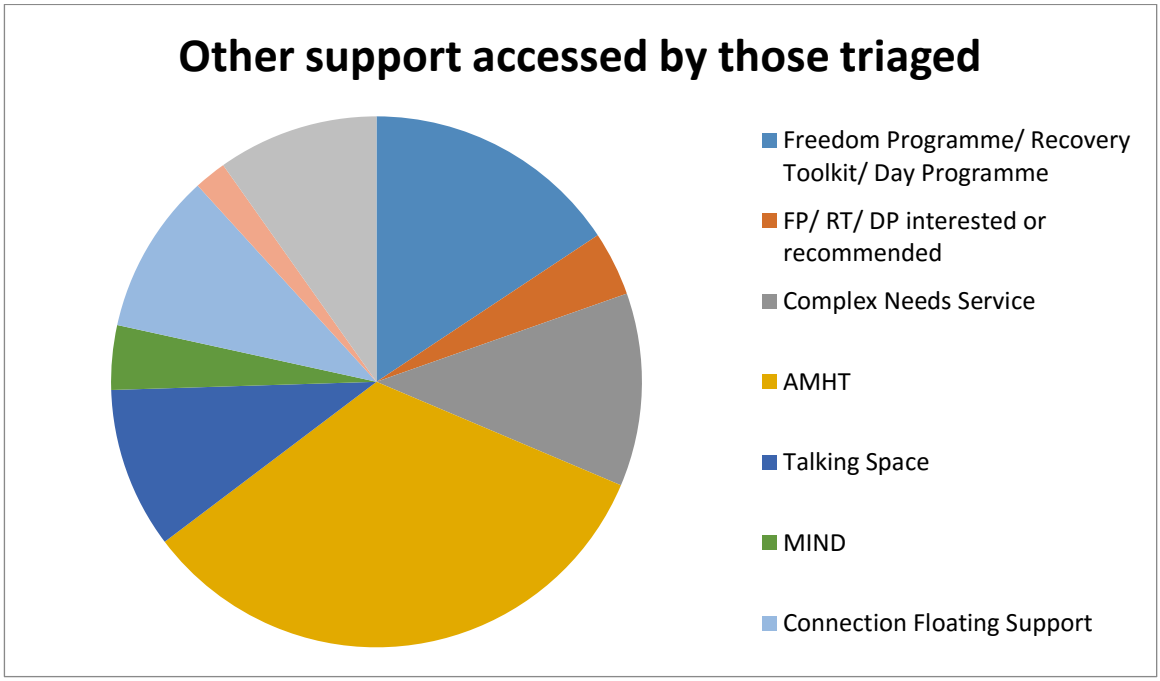
At least 28% were additionally vulnerable through substance misuse (17 had problems with alcohol and 6 with drug use- including prescription drugs). Service users with additional issues around substance misuse– i.e. the toxic trio, were offered the specialist stabilisation level of support and were only accepted for the group when their substance use was deemed sufficiently stable as to not impede their engagement with the material and ideas covered in the group. These cases are triaged and reviewed during the weekly group supervision with Sapiens.

One service user had a learning disability. The key-worker provides one to one support during the groups to help overcome any limitations/ barriers in understanding the material (e.g. a language barrier and/or a mild learning difficulty). The inclusion criteria for participating in the group itself however, does include sufficient capacity to engage with the material.

Range of therapeutic resources accessed by service users in addition to The Anchor Programme - either predating or post referral

- 8 completed the Freedom Programme, the Recovery Toolkit or the Day Programme; a further 2 were interested; and the programmes were recommended to a further 5.
- 6 were referred to or self-referred to the Complex Needs Service
- 17 AMHT
- 5 Talking Space
- 2 MIND
- 5 Connection Floating Support
- 1 received counselling through MEET (an organisation that provides EMDR- an evidence based clinical intervention for people with PTSD)
- 5 other mental health organisations including ELMORE

We have had concerns that the cutbacks in service provision across the sector over the last few years has made higher thresholds and longer waiting times difficult to avoid - with potential risk of increased drop-out rates. The fact that a significant proportion of project service users have been able to access other services suggests that one of the outcomes of the project is improved resilience in managing their own mental health and engaging with other services. This is also a specific measure for the TAP groups where we have seen improvements in all the MH Recovery Stars that were administered during both the groups.



Activities and impact of the pilot service to date

i. Professional training for effective early intervention

- We have trained existing Domestic Abuse Champions from our networks and GPs about the nature of the combined risk posed by DA and MH. This has included education on pathways into associated services across both sectors, including pathway into TAP.
- We have scoped existing mental health and therapeutic services and pathways. The map of services is currently used by both DA and MH services and we will be updating this after the end of the pilot.
- We have trained additional Domestic Abuse Champions specifically across mental health services. There are currently 49 in Oxfordshire. This includes 17 that were trained through an additional specifically designed training course for mental health professionals developed as part of this project.

Feedback from training and awareness raising events has been very positive. A significant indicator of the positive outcomes from these events is the increased number of appropriate direct referrals that have been received by TAP from other mental health services (including Elmore, the AMHT, CAMHS and Crisis).

ii. Risk reduction and initial support

All services users referred through a domestic abuse service have been risk assessed and made immediately safe through a range of measures including safety plans prior to referral.
Those referred through the helpline had already been risk assessed and advised on safety planning: any additional measures necessary to reduce risk have been undertaken by TAP.
Where service users have been referred from an external service, except in cases of historical abuse, TAP has undertaken risk assessment, implementation of immediate safety measures and safety planning.

When service users with mental health needs are first referred to DA services the focus is mainly on reducing risk of harm from the perpetrator and ensuring safety. Those at high risk are often in shock after a recent incident, and have real cause to fear that seeking help and accepting change will potentially increase the risk. They are unlikely to be able to engage with a more reflective therapeutic process at this stage until their fundamental needs for being and feeling safe are met.

Skills to engage and build trust in these early stages both enable the DA worker to reduce external risk and help to establish the foundation necessary for the 'stabilisation phase' of intervention leading eventually to more specialised therapeutic work where appropriate. Sapiens has delivered a one day interactive training to all DA professionals including Reducing the Risk IDVA and ODAS (outreach, helpline and refuge staff) specifically to help promote awareness of complex mental health difficulties characteristic to personality disorders. The training day focussed on the aetiology, types; relational impacts and prognosis of personality disorders and consequently helped professionals understand the emotional/behavioural complexities of some of the DA survivors they work with. Survivors may have additional mental health needs, possibly associated with their experiences of abuse. These include unstable emotions, impulsiveness and risk taking, self-harm and suicidal thoughts. The training explored ways of engaging and working with this particular client group with greater confidence. Feedback from the training has been extremely positive and we are exploring how to build on this as part of the continuous professional development of all DA staff. (see recommendations for 2017-18).

In addition to this:

- the IDVA team consult with the Project Manager for clinical advice on MH related issues at any stage of their case work

- the two MH outreach workers have clinical interests and backgrounds that has supported them with accessing training that is therapeutic and relational/systemic in nature. They also receive weekly group supervision that assists them with their case work.

iii. Stabilisation and intense therapeutic support

39 IDVA cases have been supported through the pilot.
5 of these cases received some clinical support/advice from the Project Manager at an early stage of risk management prior to consideration of any referral to TAP or where a referral to TAP was not appropriate. Of these,

- 1 was not high risk and after initial risk reduction was referred on for outreach support
- 3 were complex in their relationship dynamics but on further investigation were not victims of abuse – here clinical advice on mental health and interpersonal relationships proved extremely important.
- 1 despite all efforts and with clinical advice to support, did not respond to the service.

Outcomes below are based on the remaining **34** of whom 32 were specifically triaged for TAP. These included the service user in case study B who was initially supported by the IDVA service with clinical supervision, sectioned for her own safety, and subsequently supported through TAP (Case Study B).

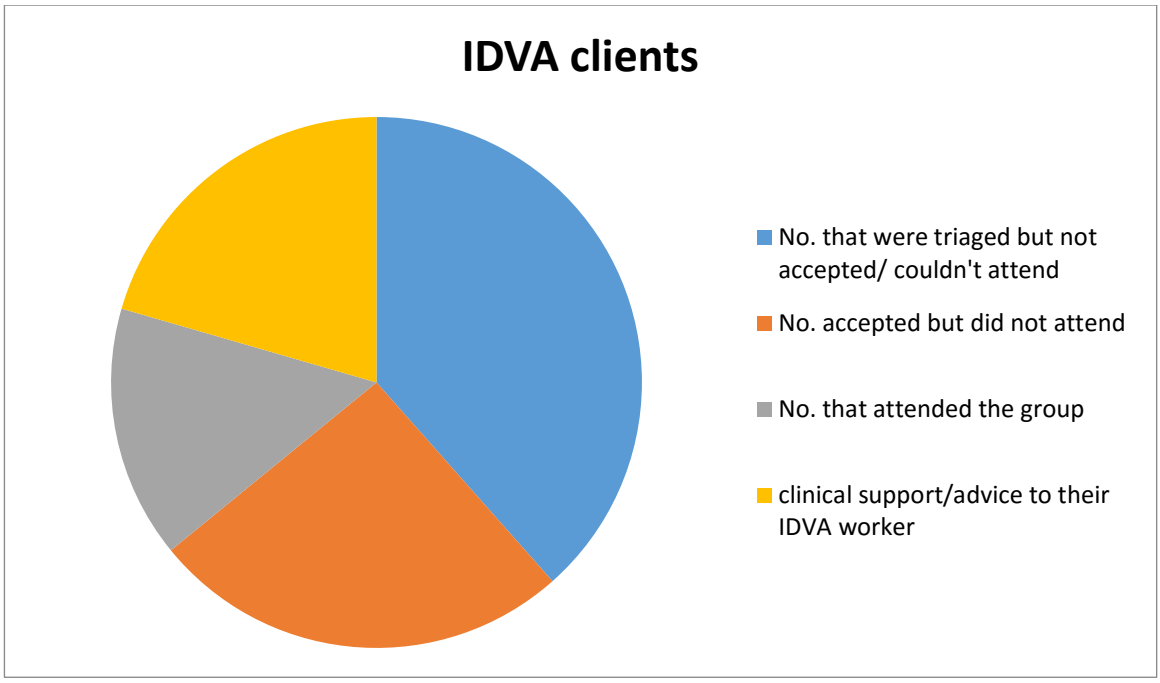
6 participated in either the first or second TAP group and **10** were accepted (ie TAP was appropriate) and supported within the stabilisation phase but did not attend group for a range of reasons. These included difficulties associated with their changing circumstances (eg impact of court cases) or logistics.

Of the remaining **18** the majority continued to be supported intensively and stabilised through IDVA with consultation with the Project Manager where helpful. Some were referred for alternative therapeutic support (please see the list of therapeutic resources accessed on Page 2).

The IDVA service also has strong links with other services and resources which enabled service users to access and/or engage variously with:
Police, Probation, Criminal and Civil Courts, solicitors
Children's centres, midwifery, child social care and support through child protection processes, Home-Start, Turning Point, OSAARC, Connections Floating Support, Housing, CAB, DWP, Aspire, Karma Nirvana, Embassy
Specifically, in relation to keeping safe the project has supported services users to obtain restraining orders and non-molestation orders and liaised to put in place: DVPOs, TecSOS phone, panic alarm.

Of concern is that a small number of IDVA service users neither engaged with TAP nor sustained their relationship with the IDVA service. A vital factor in the IDVA team's work to reduce risk and to help effect and sustain change is the quality of their relationship with service users. The team aim initially both to ensure safety and to build a relationship of trust. On this foundation, they create the potential for service users to feel more secure, to overcome trauma, gain insight, gain self-esteem and confidence and ultimately gain 'agency' and resilience so that they can sustain their own longer term safety and wellbeing.

The IDVA stays alongside and remains available for as long as this takes. The principle that 'availability and facilitating trust' is fundamental both for change and also for its maintenance and stability is well established in research with vulnerable families in the context of child protection (eg Platt 2012). There are similarities in work with vulnerable victims of abuse. Care is needed when considering referrals to other services to ensure the availability of the IDVA in whom trust has been invested is not lost – or felt to be lost - too soon. We will work to enhance the pathway from the IDVA service to TAP and try to find ways to further build the therapeutic alliance necessary for engaging well with TAP, such as initial joint sessions.



Outcomes for IDVA service users

Overall outcomes for the **34** high risk cases are encouraging.

Safety planning was undertaken with all 34

25 (74%) felt safer (but please see Page 14 for a comment on the complex interrelationship between feeling safer and capacity to keep safe)

31 (91%) were in secure safe accommodation – 19 in their own homes – the majority with measures to restrain the perpetrator, 1 moved away to a new home, 2 had a new tenancy in a new home, 6 were with family, 2 in student housing and 1 in Windmill House.
Of the remaining 3 one was in temporary accommodation but bidding for permanent and 2 homeless/unable to sustain tenancy.

19 (56%) cases were prosecuted, and 16 (47%) services users attended court with support.

For **28 (82%)** the longer-term risk was reduced to some degree. For 6, their capacity to keep themselves safe had not been increased: this was true for the two homeless service users, for three young service users who did not recognise the risk, and for one with overwhelming anxiety.

Outcomes for refuge users

14 cases were referred from refuge or as part of resettlement. Although the project hasn't influenced the licenced terms for accessing refuge, potentially enabling more complex clients to stay than before, it has significantly contributed to enhanced support for those already in refuge. As a result, refuge staff have been able to support residents in sustaining their tenure agreements- enabling victims with complex needs, who may previously have been evicted for not keeping to the terms of their refuge stay, to remain in the refuge for a longer period of time. This has led to a reduction in unplanned discharges; a greater opportunity to build resilience and greater potential for planned and successful resettlement.

Outcomes for ODAS service users referred for TAP triage

There have been **45** ODAS clients triaged for TAP to date: ie those referred to TAP from outreach, helpline, MARAC and independent sources.

At least **23** are in safe accommodation (51%), of whom 15 live in their own home (33%), 6 live in refuge (13%), 1 lives in her parent's home and 1 lives in Vineyard

At least 10 reported feeling safer (22%) but for 31 clients (69%) this information is not available because service users were not routinely asked this question directly. 3 reported not feeling safer (7%). All new service users triaged for TAP from now on will be routinely assessed for DA related measures including how safe they report feeling by a new measure introduced during the second group. (Please see page 12).

For at least 11 clients we know their DA related risk has reduced (24%), and for 5 (11%) their external risk had not reduced. We have not routinely collated this information within TAP and for 27 clients (60%) would need to ask others (their outreach workers etc) for this information. As above, from now on we will use and collate DA as well as MH measures routinely within the project.

For 24 service users (53%) we have undertaken some safety planning within TAP. For 20 (44%) there had been no safety planning by TAP professionals because these service users had already been made sufficiently safe before TAP.

29 service users (64%) needed some support around court issues but this support was largely provided by their DA workers and not their TAP workers (as this is not within the remit of TAP). Retaining their DA support workers, enabled their TAP workers to specifically focus on supporting them through a therapeutic process. 10 did not require any support through courts (22%). One of the MH outreach workers supported a TAP client, who attended the group, through court and is likely to support another client similarly in the future. One TAP client was supported by her key worker - the MH Outreach Worker to get a specific issues order and another needed support with a solicitor's letter.

Detailed analysis – outcomes to date of the two TAP groups

The body of this report is devoted to further evaluation of the TAP groups using a range of established mental health tools. In addition, for the second TAP group we have included a screening tool known as the SSO (the Supporting Survivor Outcomes tool). The SSO builds on a number of measures within the CORE tool that was administered in TAP1, but differs from the CORE in that it also encompasses the multiple impacts and experiences of violence and abuse on daily functioning and physical, mental and emotional well-being. The tool makes it possible to test the effectiveness of mental health interventions, while also giving helpful feedback to users of the service about their own progress. It differs from other tools by including measures that go beyond the clinical to encompass the impacts of violence and abuse on everyday life. It also provides an opportunity for service users to give direct feedback on the appropriateness and quality of services. Like all the other screening tools, the SSO was administered both at baseline and end point, and we managed to collate paired data for this particular tool for six clients.

Specifically, the SSO provides a measure for the following:

Questions relating to support

A) Asking for and receiving support
B) Feeling able to speak to others about their abuse if they wanted to
C) Awareness of what options are available to them

Coming to terms with their experiences of violence and abuse

D) Recognition if others are behaving abusively
E) Realizing that they were not responsible for the abuse that had happened to them
F) Able to set boundaries in relationships

Regaining control of their lives

G) Felt in control of their life
H) Felt able to make their own decisions
I) Managing responsibilities
J) Reported feeling safer
K) Satisfying relationships

Health and Wellbeing

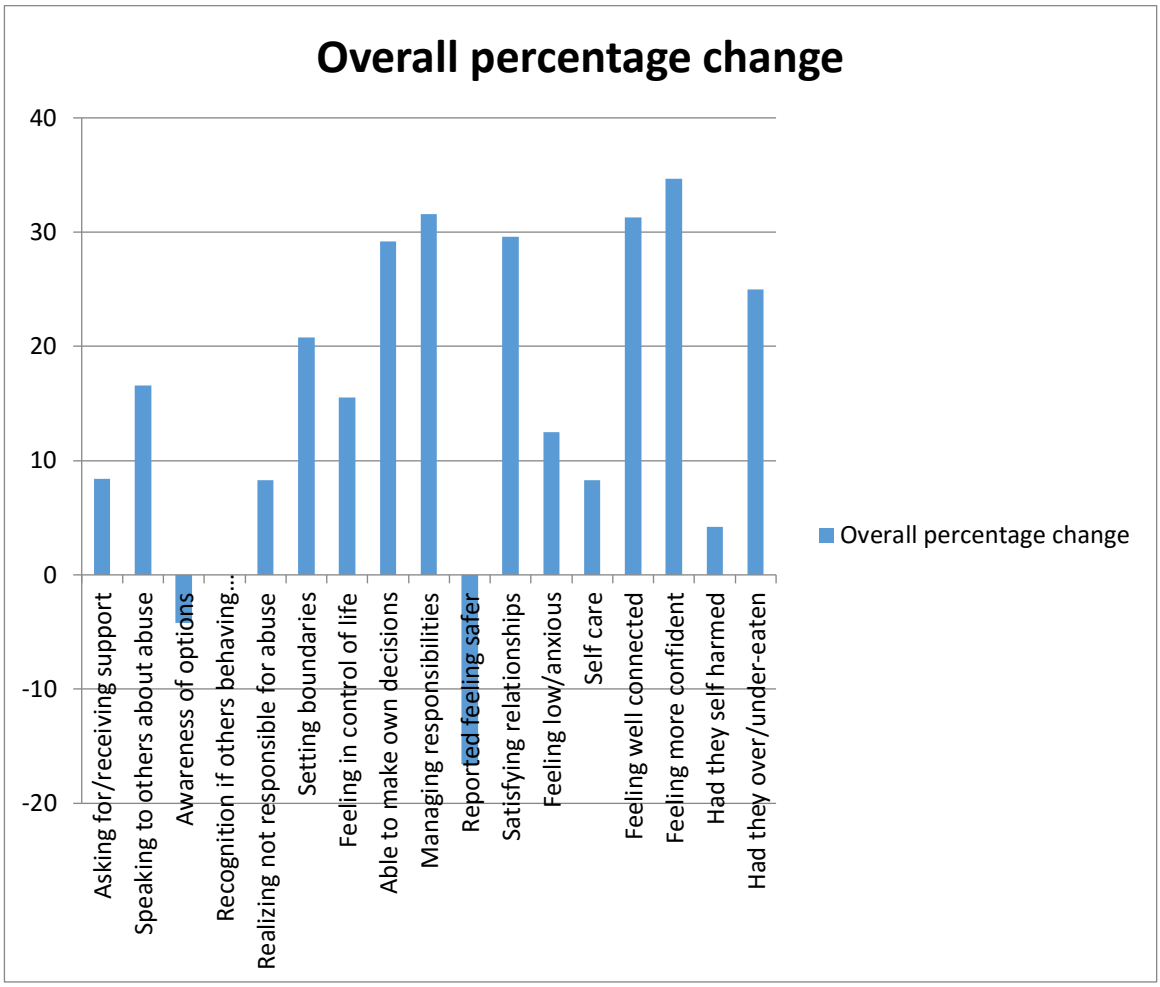
L) Felt low, anxious or depressed most or all of the time
M) Good self care
N) Felt well connected with others
O) Felt more confident
P) Had they self harmed
Q) Had they over or under eaten

Following this trial run we agreed to administer this tool routinely for everyone triaged for both stabilization and group from now on, as a more systematic and objective way of measuring external risk from DA and the impact of it.

Outcomes of the SSO to date

We obtained paired data for 6 clients on the SSO. The table below shows the average scores of all 6.

	Average percentage change for all six clients in TAP2
Questions relating to support	
Asking for and receiving support	8.4% improvement
Feeling able to speak to others about their abuse if they wanted to	16.6% improvement
Awareness of what options are available to them	4.2% deterioration
Coming to terms with their experiences of violence and abuse	
Recognition if others are behaving abusively	No change
Realizing that they were not responsible for the abuse that had happened to them	8.3% improvement
Able to set boundaries in relationships	20.8% improvement
Regaining control of their lives	
Felt in control of their life	15.5% improvement
Felt able to make their own decisions	29.2% improvement
Managing responsibilities	31.6% improvement
Reported feeling safer	16.6% deterioration
Satisfying relationships	29.6% improvement
Health and Wellbeing	
Felt low, anxious or depressed most or all of the time	12.5% improvement
Good self care	8.3% improvement
Felt well connected with others	31.3% improvement
Felt more confident	34.7% improvement
Had they self harmed	4.2% improvement
Had they over or under eaten	25% improvement



These highly significant outcomes show improvements in 14 out of the 17 domains related to DA.

In relation to how 'safe' clients reported feeling we observed a trend towards 'deterioration' according to this measure. This isn't surprising. As the rest of this measure demonstrates, our service users became significantly more aware of the insidious nature of DA. Increased awareness of both DA & MH (including internal states) is likely to improve recognition of personal safety and risk and also what DA encompasses. Prior to these interventions, many of our service users may not have recognized the seriousness of controlling behavior and emotional abuse. Additionally, as a result of this increased awareness, some service users are likely to be better able to make changes to keep themselves safe and avoid entering usual dysfunctional patterns. Making changes can initially also add to feelings of trepidation – so feeling less safe need not be indication of increased risk. Indeed, greater awareness is a key step in developing capacity to keep safe and to make positive changes.

As this measure reveals, most reported regaining control of their lives; being better at making independent decisions and setting boundaries. For those that were still in a relationship with the perpetrator, these improvements may have impacted on the dynamics of their relationship- potentially impacting on how safe they felt.

Mental Health: quantitative outcomes for the project to date

Service users referred to the specialist team have a full assessment with a focus on mental health at the point of referral. This can also be used to measure change through the project. Screening tools were re-administered at the end of support and compared with the baseline data collated as part of the assessment. The tools comprise:

- Clinical Outcomes in Routine Evaluation (CORE),
- Mental Health Recovery Star
- The Modified Overt Aggression Scale (MOAS),
- Standard Assessment of Personality Abbreviated Scale (SAPAS),
- Work and Social Adjustment Scale (WSAS),
- Fast Alcohol Screening Test (FAST)
- McLean's Screening Instrument for Borderline Personality Disorder (BPD)

We are currently collecting, collating and assessing outcome data to evaluate both the wider project and the 'Stabilisation Phase' as a stand-alone intervention. At this point we have data which demonstrates significant impact for clients engaged within the High-Intensity Phase from two consecutive TAP groups.

Specific outcomes of the two TAP groups

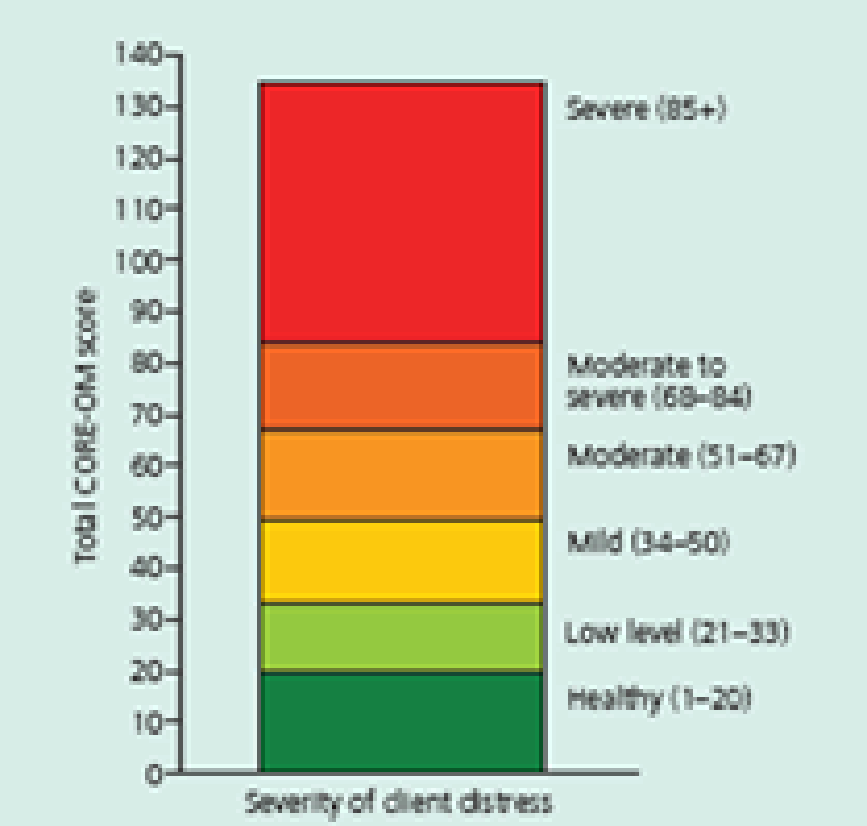
14 service users have engaged with a significant proportion of the high intensity phase of intervention - the group and key working sessions (at least 50% of sessions). We have paired data (a comparison of the end point measures from screening tools with data collated at baseline) for 12 service users. The remaining 2 service users made substantial progress but we were unable to obtain full set of measures.

The outcomes from TAP continue to demonstrate remarkable and significant improvements across a range of objective measures. In addition to these quantitative outcomes we have been able to collate many more qualitative outcomes for this second group than in our previous report of the first group. These have taken the form of interviews, evaluative feedback and case studies (captured in audio and video recordings with consent). This has proved far more effective in capturing how passionate participants have been about the benefits of the group.

The majority of service users reported experiences of some form of neglect or abuse as a child, and had been involved with a range of services as adults. The data is exciting in showing the potential of the group both in terms of reducing risk and increasing psychological wellbeing, functioning and resilience. We are continuing to add to the data and to work as a team in exploring ways to engage clients with this process of evaluation. We look forward to presenting the wider picture towards the end of the pilot stage.

The Clinical Outcomes in Routine Evaluation (CORE) is a client self-report questionnaire designed to be administered before and after treatment or intervention. The client is asked to respond to 34 questions about how they have been feeling over the last week, using a 5-point scale ranging from 'not at all' to 'most or all of the time'. The 34 items of the measure cover four dimensions: • Wellbeing • Symptoms (anxiety, depression, physical problems and trauma) • Functioning general (functioning, close relationships and social relationships) • Risk/harm (to self and risk to others **but not from others**).

The responses are designed to be averaged in order to produce a mean score to indicate the level of current psychological global distress (from 'healthy' to 'severe'). The questionnaire is repeated after the last session of treatment. Comparison of the pre-and post-intervention scores offers a measure of 'outcome' (i.e., whether or not the client's level of distress has changed, and by how much). The chart on the next page is used as a guide for determining the range of clinical significance.



Look-up scale of CORE-OM scores and severity levels

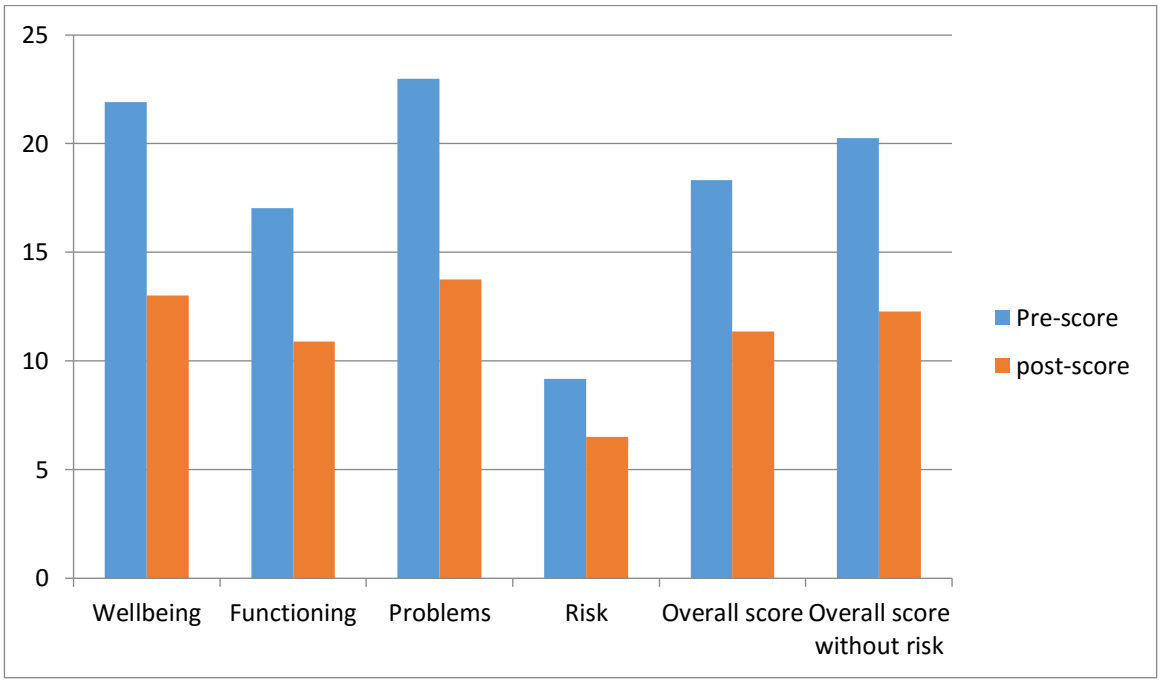
As the service is not a mental health service we would expect that clients scoring between 'moderate' and 'severe' would be identified through the triaging process and either referred to mental health services as first line of delivery or, where appropriate, engaged within the Stabilisation Phase of TAP until they are sufficiently able to undertake the High-Intensity Phase.

The High-Intensity Phase is designed to engage those with scores are at the low level and mild within the clinical need sections with a view to achieving a reduction of distress to within the sub-clinical (healthy) range.

We have collated paired data for 7 clients since the previous report, bringing the total number to 11. In addition, we have baseline data only for 8 clients on this tool from the TAP2 cohort bringing the total number to 10 combining TAP1 & TAP2.
Reduced scores after intervention indicate improvement

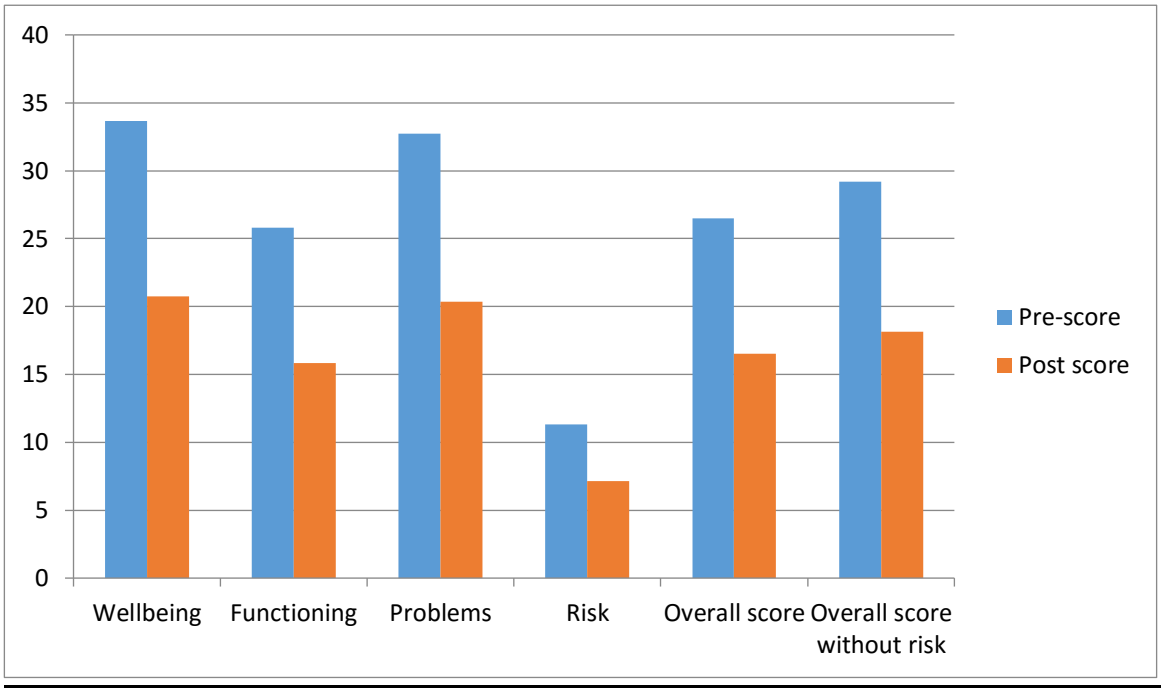
TAP2 clients only

Client	Wellbeing (baseline)	Wellbeing (end point)	Functioning (baseline)	Functioning (end point)	Problems (baseline)	Problems (end point)	Risk (baseline)	Risk (end point)	CORE (overall baseline)	CORE (overall end point)	CORE (overall minus risk) baseline	CORE (overall minus risk) end pt
A	3.25	4	1.91	3.58	3.92	4	1.67	2.33	2.68	3.56	2.89	3.82
B	4	0.5	3.17	0.66	3.25	1.08	0.33	0	2.79	0.67	3.32	0.67
C	1	0.25	0.05	0.08	1.83	0	0	0	0.94	0.06	1.14	0.08
D	3.75	0.75	2.67	0.5	3.92	1.75	1.67	0.33	3.06	0.94	3.36	1.07
E	3.5	2	2.92	1.83	3.33	1.92	2	1.17	2.97	1.76	3.18	1.89
F	2.92	2	3.5	1.75	3.33	1.92	2	1.17	3	1.74	3.18	1.86
G	3.5	3.5	2.83	2.5	3.42	3.08	1.5	1.5	2.88	2.64	3.18	2.89



CORE outcomes TAP1 & TAP2 combined

Client	Wellbeing (baseline)	Wellbeing (end point)	Functioning (baseline)	Functioning (end point)	Problems (baseline)	Problems (end point)	Risk (baseline)	Risk (end point)	CORE (overall baseline)	CORE (overall end point)	CORE (overall minus risk) baseline	CORE (overall minus risk) end pt
A	3.25	4	1.91	3.58	3.92	4	1.67	2.33	2.68	3.56	2.89	3.82
B	4	0.5	3.17	0.66	3.25	1.08	0.33	0	2.79	0.67	3.32	0.67
C	1	0.25	0.05	0.08	1.83	0	0	0	0.94	0.06	1.14	0.08
D	3.75	0.75	2.67	0.5	3.92	1.75	1.67	0.33	3.06	0.94	3.36	1.07
E	3.5	2	2.92	1.83	3.33	1.92	2	1.17	2.97	1.76	3.18	1.89
F	2.92	2	3.5	1.75	3.33	1.92	2	1.17	3	1.74	3.18	1.86
G	3.5	3.5	2.83	2.5	3.42	3.08	1.5	1.5	2.88	2.64	3.18	2.89
H	2.75	3	1.16	1.58	1.33	2.25	0.16	0	1.24	1.76	1.46	2.14
I	2.25	1.75	2.18	1	2.33	1.58	0	0	1.79	1.12	2.18	1.12
J	3	2	2.42	1.5	3	1.42	0.83	0.33	2.41	1.32	2.26	1.54
K	3.75	1	3	0.83	3.08	1.33	1.16	0.33	2.71	0.94	3.04	1.07



MH Recovery Star & Case Studies

The Recovery Star, which was developed by the Mental Health Providers Forum, is an outcome measure which enables people using services to measure their own recovery progress, with the help of support workers.

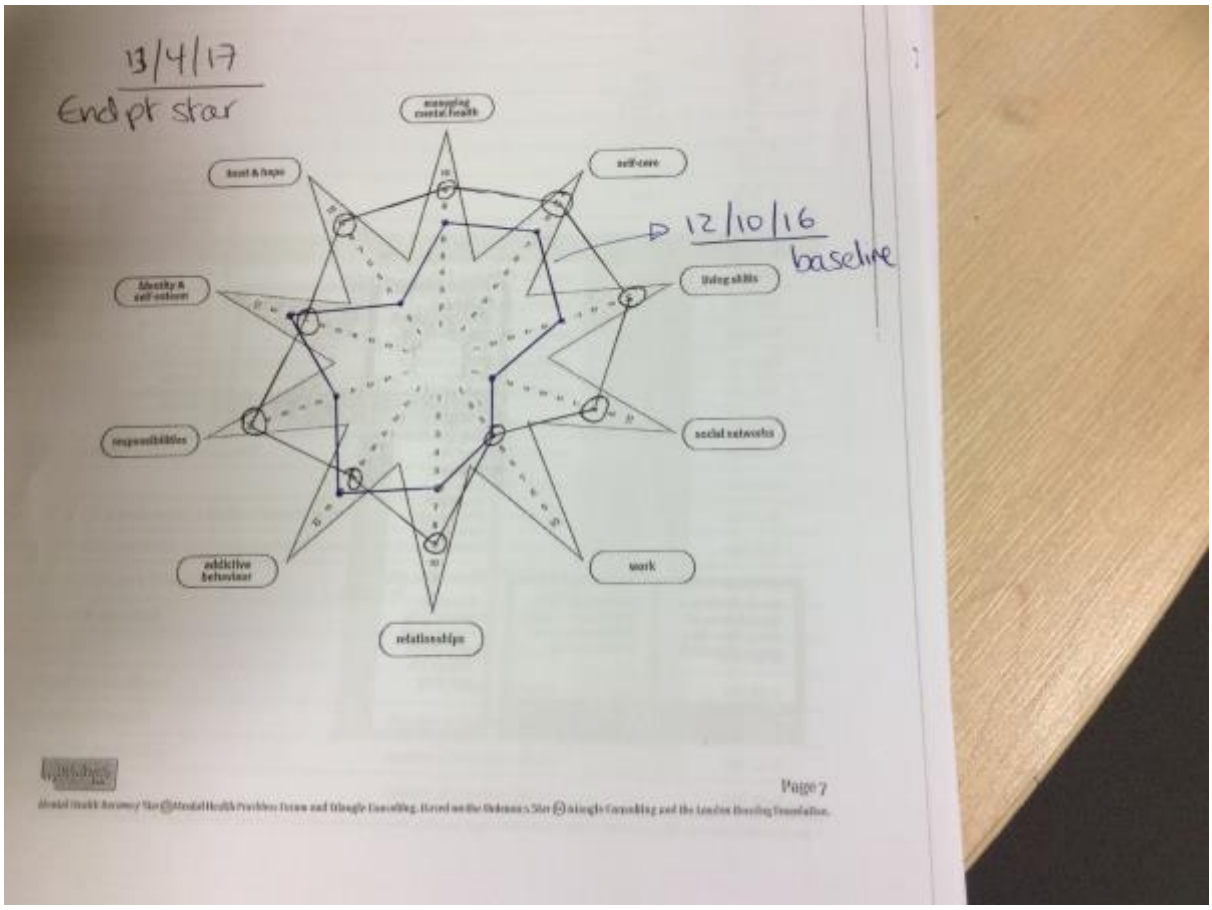
The 'star' contains ten areas covering the main aspects of people's lives, including living skills, relationships, work and identity and self-esteem. A scale of 1- 10 is used to measure progress across each dimension (1 denotes feeling completely stuck in that dimension and 10 denotes being self-reliant). Service users set their personal goals within each area and measure over time how far they are progressing towards these goals. This can help them identify their goals and what support they need to reach them, and ensure they are making progress, however gradual, which in itself can encourage hope.

Case study B

Client B was referred by her IDVA to TAP following significant paranoia and distress in the context of verbal and physical conflict with her husband that led to B being sectioned under section 2 of the Mental Health Act. She was admitted as an inpatient but appealed the section and discharged herself two weeks later. The section also prompted child protection proceedings by social and health care and all four children remain under a child protection plan. The consequent care arrangements have involved the oldest two children living with B with support from her family and the youngest two living with her husband, with the potential of B gradually resuming care of all four children as her MH stabilizes.

When her TAP keyworker met B initially, she was living with her mother at her mother's home and was heavily relying on her to manage day to day responsibilities. She wasn't allowed to return to the family home. B was breaching the recommendations and agreements on the CPP quite regularly at the time and also seemed to be in the minimisation phase in relation to the abuse she had experienced from her husband, which included an alleged miscarriage from a physical assault when she was five months pregnant. She was therefore in an ambivalent mind set about getting back together with her husband.

B attended the second group. The most significant outcome from the group was that within a few months, B resolutely decided that she wouldn't be getting back with her husband and has now formally separated from him, with a clear recognition of the abuse she had experienced. Over the course of the six months B gradually recognised the impact of the marriage on her family over the course of the six months – and in particular the verbal conflict the children would have been witness to, had they got back together. Her SW reports significant improvements in her presentation - potentially supporting her case for increased contact with her youngest two children. B has also reconnected with her friends and wider family since TAP and now reports feeling less socially isolated. She has moved back in the family home with her oldest two children and is now managing the day to day responsibilities independently with ease and competence. B also reports regaining her independence with regards to what she wears and does since the separation - with consequent positive impact on her self-confidence and image. B is due to start the Freedom Programme - to build on her increased awareness of issues related to DA and no longer needs further intervention from DA services apart from this. B describes healthier aspirations for future intimate relationships and seems to have developed an increased capacity to discern these. She has been discharged from the AMHT since TAP and her medication is being managed by her GP.



Case Study – Client D

Background to referral

D came into refuge with her three sons aged 12, 9 & 1, in June 2016 as a victim of domestic abuse at high risk. She has a diagnosis of Emotionally Unstable Personality Disorder. Before being accepted by ODAS, D had been declined by some refuges because they felt her mental health needs were too difficult to manage. She also had some diagnosed anxiety disorders such as agoraphobia and trichotillomania and some physical health issues.

On arrival at Refuge she was extremely anxious, found it very difficult to settle and was often on the verge of leaving. She was highly dependent on practical support from staff because she rated her own competences so poorly. The staff in her refuge had to tightly manage the behavioural challenges she posed - which otherwise had the potential to 'split' members of staff, as well as high levels of emotional distress and suicidal ideation. A referral was made to The Anchor Programme.

Support

The stabilization phase of intervention was initially offered with view to D attending the third TAP group. During this intervention, the TAP worker supported D with her emotional wellbeing using some of the content from the group (this was carefully thought out). This enabled her keyworker in Refuge to support her in more practical terms. She was supported to engage with her GP and AMHT for her frequent suicidal ideation and to manage the occasions when she became overwhelmed with negative emotions and intrusive thoughts such as running into a busy road. Her case was reviewed by her AMHT- they changed her medication and discharged her shortly after.

D gradually began to settle in the new area and to rely less on staff and her children to manage everyday tasks. She became calmer and the emotional highs and lows became less intense. However, her anxiety about attending the group persisted and when it came to starting the group,

she missed the first four sessions. Her TAP worker used a graded step by step approach to help her attend the group. This involved D being driven to the sessions, then her TAP worker joining her on her bus journey until she managed it by herself and finally meeting her at the bus stop and walked a short distance with her to the venue. This independence with travelling not only helped her to access the group but also opened up other opportunities for her. D is now able to go out with her children.

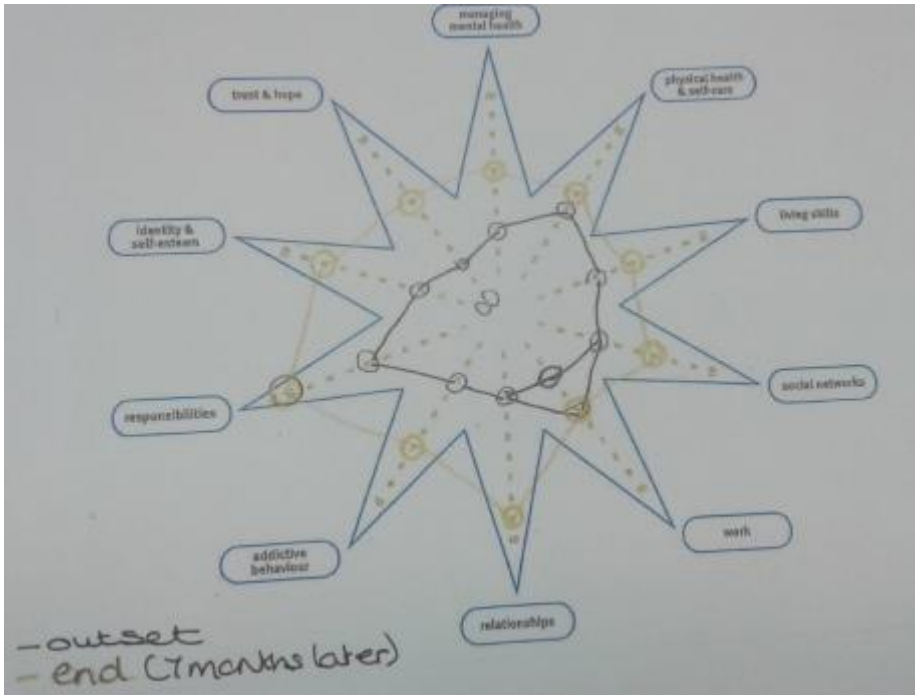
Outcomes

D attended 50% of the group sessions but did significant amounts of research into the material that was delivered in her own time. Her genuine passion and interest in the ideas significantly contributed to how effectively she was able to apply these to her own issues - especially with regards to how she related to herself and how she parented her children. She identifies that, although she had received support from other Mental Health services for years, TAP has been the most significant intervention for her with regards to effecting longstanding change. She reports significant self-reliance in managing her mental health which has helped her to regain control of her life. Although she still struggles with negative thinking and anxiety, she is able to contain these so that they do not affect her on an ongoing basis. She is also much less troubled by suicidal thoughts.

Although D was previously able to identify positive things about herself- these were fleeting and elusive whereas now her beliefs in her own self-worth and value seem to be on sturdier foundations. Hopefully this should also enable her to discern unhealthy or abusive relationships in the future.

She self-referred to the Complex Needs Service with view to engaging with the mentalisation group to further her understanding of her emotional states and management. Her physical health issues endure but she reports a reduction in the levels of her chronic pain and manages the impact of this much better. She is moving out of the Refuge into her own accommodation with her family and, although she remains anxious, she is managing many aspects of this move independently with minimal support from staff.

Her future plans are to participate in a Network Meeting and to talk in public about her experiences of the support she received from TAP; to attend College and improve her computer skills; to eventually volunteer in a role where she can support other vulnerable women who have experienced domestic abuse and to undertake further training that would support her employability. She identifies the positive impact this would have on her self-esteem and the strong and impressive female role model she would be to her children.

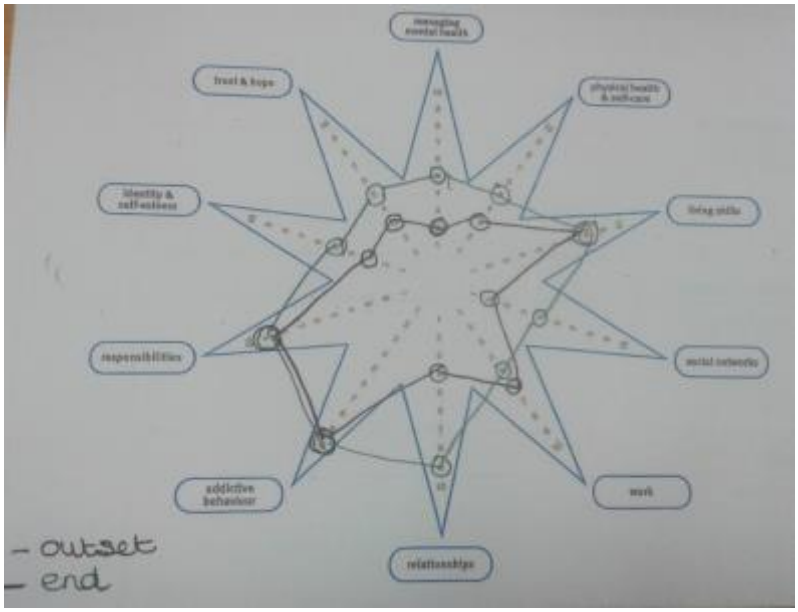


Client C

History: C is originally from the travelling community. She referred herself to ODAS/TAP following difficulties engaging with other services in Oxfordshire. According to accounts from C and her TAP worker, the most significant barriers to access had been a lack of awareness of the nature of her complex needs by services. The impact on her was to feel that she had been branded a 'time waster and manipulative'. Her experience of TAP challenged and invalidated the status she perceived she had been allotted as judgmental and discriminatory.

C had made a significant suicide attempt when she left her most recent abusive relationship. During assessment, it was further noted that she had two relationships prior to that, which were also abusive and that also led to suicide attempts when they ended. She desperately wanted to understand her relational patterns: why she equated a controlling physically abusive relationship with 'love' and then, when it ended, why she felt like such a failure particularly to her children - which often resulted in a suicide attempt as she felt they would be better off without her. This has been the main focus in her therapeutic work within TAP.

Outcomes: C reported improved self-awareness; a greater awareness of her internal states and relationships by the end of the group, as well as the realization of the support she would require towards her goals related to emotional wellbeing and confidence. In her evaluations, she fed back how helpful she had found the group on all measures.

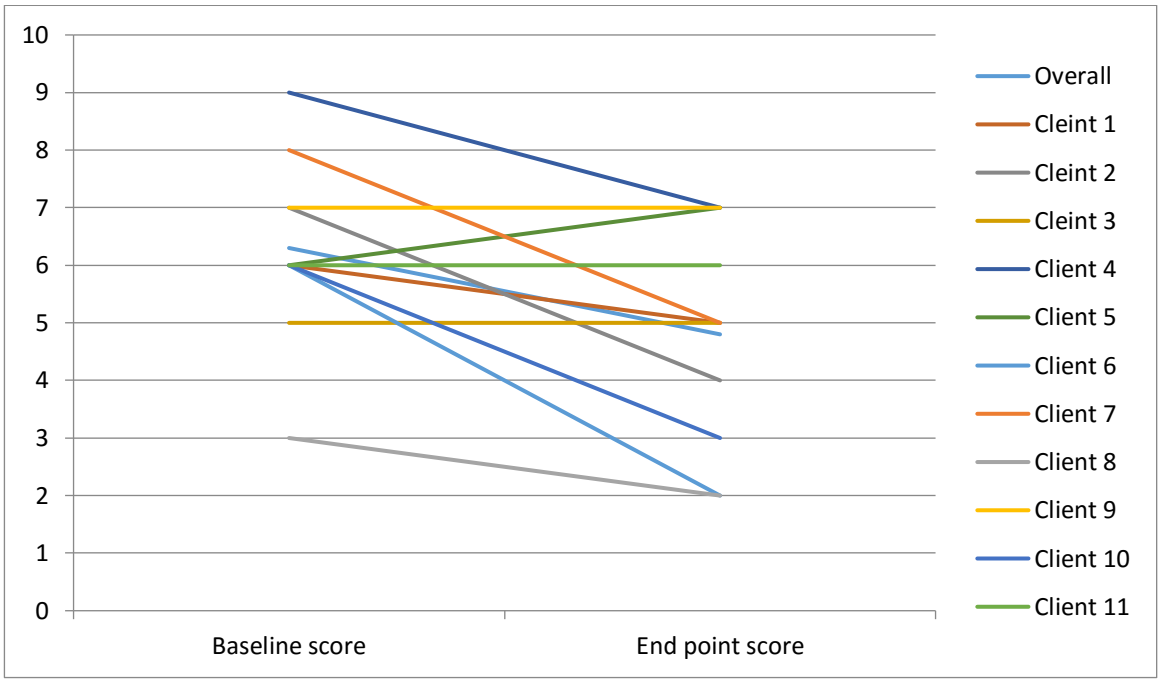


SAPAS- Standardized Assessment of Personality Abbreviated Scale

The SAPAS is a brief and simple screen for personality disorders consisting of nine questions. According to a preliminary validation study by Moran et al. in 2003, a score of 3 or above on the screening interview correctly identified the presence of DSM–IV personality disorder in 90% of participants. **Scores of 3 or above may point towards significant difficulties with how someone relates to themselves and others. The higher the score, the more problematic the presentation.** Interestingly, from the data we have so far on this measure, **nearly all our clients had scores of 3 or above. Only one client at baseline out of 18 had a score of under three (5%)**. This demonstrates the complexities of our client group in how they relate to themselves and to others - potentially contributing to their vulnerability to domestic abuse.

We had paired data for four clients who participated in the first group- and for a further seven clients from the second group bringing the total to 11. The highest score possible on the SAPAS is 9. **The average baseline score for all 11 was 6.3 and the average end point score was 4.8 showing an overall improvement of 16.6%.**

As the paired data from both groups reveal, 64% reported a reduction in scores over the course of the intervention - that is 7 out of 11 clients relate better with themselves and others at the end of the group compared to the beginning according to their scores on this measure. For two clients (18%) their end point scores reduced to below three- the clinical indicator of potential difficulties around relatedness. For three service users, their scores remained unchanged (27%). One of our clients scored higher at the end of the group than the beginning. This is consistent with her outcomes across all other measures. On the face of it this seemingly reveals a worsening pathology, however, a change in her circumstances had significantly contributed to her difficulties towards the end of the group.



WSAS- Work and Social Adjustment Scale

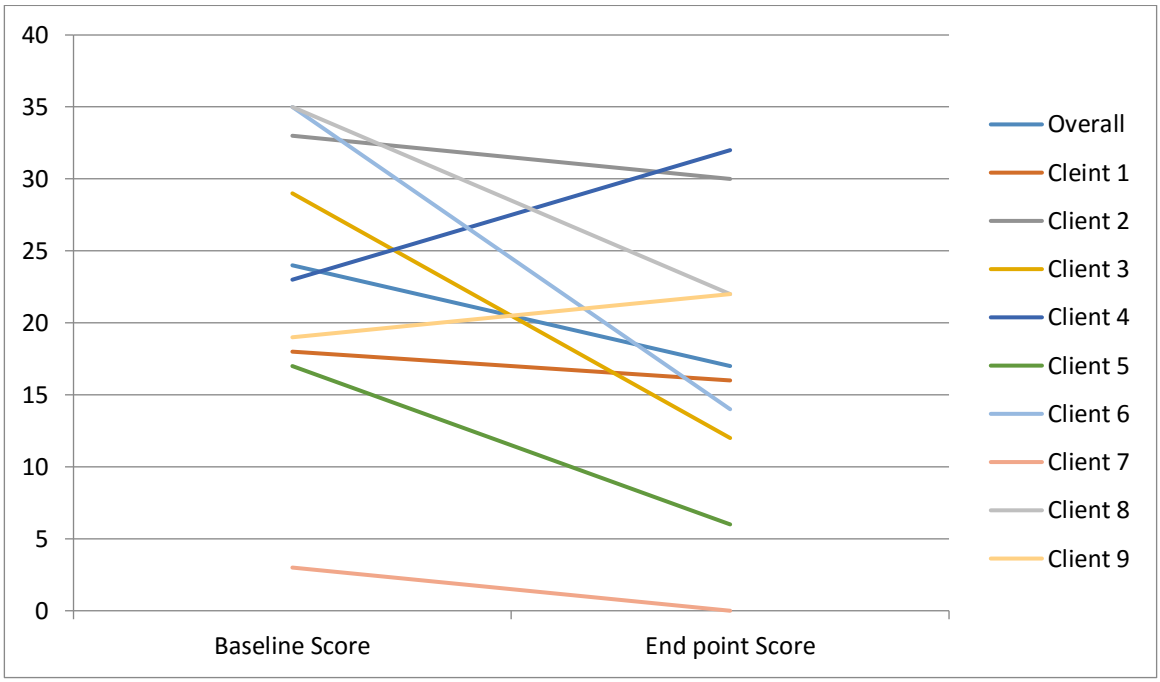
The Work and Social Adjustment Scale (WSAS) is a self-report scale of functional impairment often attributed to depression and anxiety. It consists of five questions. Each question can be scored from 0-8 so that the maximum score of the WSAS is 40. It measures how well someone is able to function across a range of different domains despite any difficulties they may be experiencing. The domains include their ability to work; home management; social leisure activities; private leisure activities and forming/maintaining close relationships. The higher the score, the greater their level of functional impairment in managing activities of daily living.

- A WSAS score above 20 appears to suggest moderately severe or worse psychopathology
- Scores between 10 and 20 are associated with significant functional impairment but less severe clinical symptomatology
- Scores below ten appear to be associated with subclinical populations

We had paired data for three clients from the first group for this measure and **all three reported improvements in their overall functioning towards the end of the intervention when compared to baseline.**

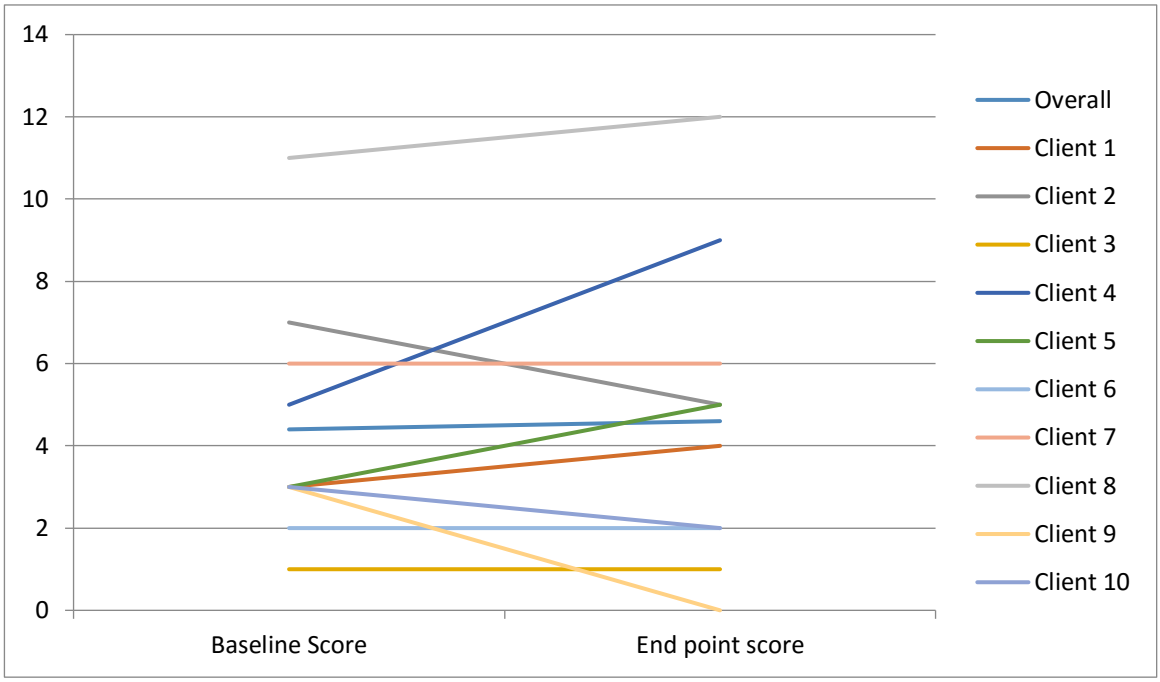
From the second group, we obtained paired data for a further six service users bringing the total to nine. Seven out of nine service users reported improvements (78%). They were functioning better across the domains described above and managing better with their activities of daily living. The overall average scores of all nine service users reduced from 24 to 17.

13 service users out of the 16 we obtained baseline data for (81%), had scores above 20, revealing a moderate/ severe functional impairment. This indicates that at the start of their interventions 81% of those who completed this measure were struggling significantly with daily activities and managing their lives because of their problems.



Mood Disorder Questionnaire (MDQ)

Bipolar Disorder is a psychiatric disorder characterized by periods of depression and episodes of 'mania'- extremely elevated mood. The MDQ is a brief self-report instrument for screening Bipolar Disorder. Scores of 7 or above are considered a positive screen for bipolar disorder.



Most service users had a negative screen for bipolar on this measure. 7 out of the 18 who completed this questionnaire had a positive screen (39%).

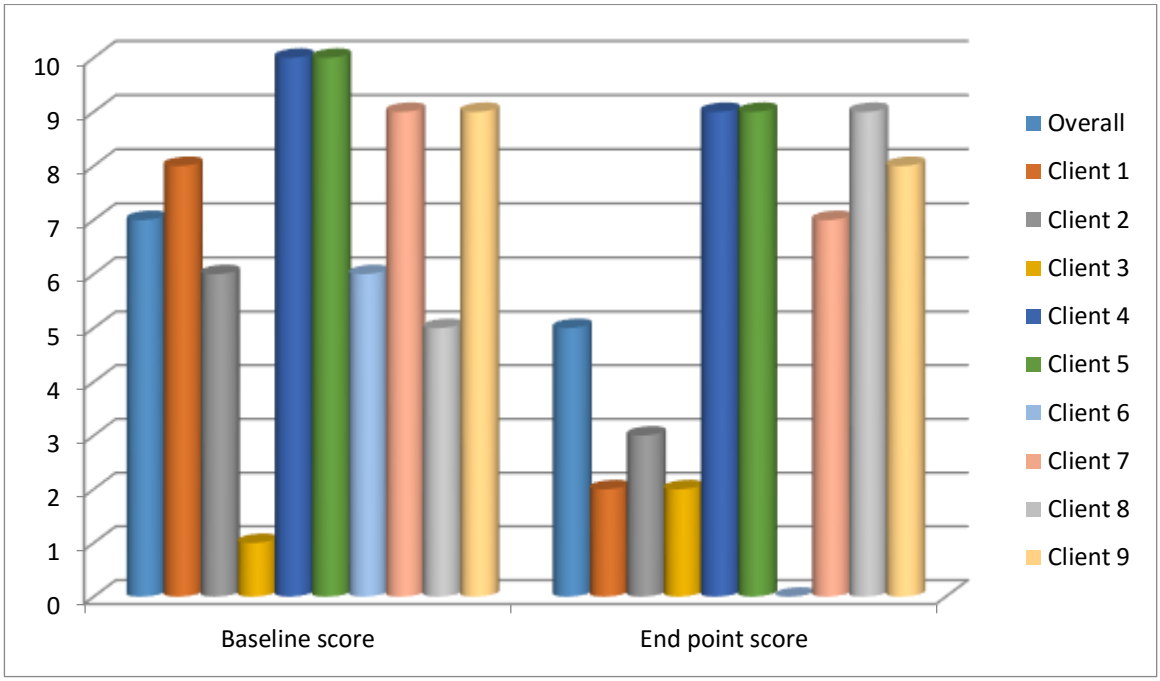
We had paired data for 10 individuals.

- ***one went from a positive screen to a negative by the end of the intervention***
- ***three had lower scores at the end of the intervention (30%), potentially indicating that these three service users have been having less difficulties with mood regulation characteristic of bipolar disorder***.
- There was no reported change for three service users on this measure.

The overall average scores for all 10 service users increased slightly from 4.4 to 4.6.

MacLean Screening Instrument for BPD- Borderline Personality Disorder

BPD is a psychiatric disorder characterized as a long-term pattern of abnormal behaviour; unstable relationships with other people; an unstable sense of self; and unstable emotions. Scores of 7 or above indicate that the service user could meet the criteria for BPD and further investigation would be appropriate. From the first group, 3 out of the 4 clients reported a reduction in scores pertaining to better stability and relatedness to themselves and others.



Of the 17 service users for whom we obtained baseline data, 10 (59%) had scores of 7 or above - the clinical indicator for BPD on this measure For the 9 service users for whom we have paired data, 7 (78%) had a reduction in scores towards the end of the group. The scores of 2 of these (22%) dropped from clinically significant at baseline, to below the clinical threshold by the end of the group.
The overall average scores of all 9 service users from both groups dropped from a 7 to a 5, pointing towards better outcomes with regards to relatedness.

Qualitative outcomes

A power point presentation and video interviews of the experiences of some of our TAP graduates are available. The audio recordings embedded in the presentation are some of the evaluative feedback we received at the end of the second group and perfectly capture 'impact' in a way that our quantitative measures cannot.

Learning outcomes since Oct 2016

All facilitators reported significantly greater confidence with the material delivered in the second group. A greater knowledge and awareness of ideas meant that concepts were conveyed more effectively, supporting improved learning and application of ideas. This is important for the fundamental reason that when clients understand the theoretical evidence based ideas/ principles related to emotional wellbeing, this is likely to create greater incentive and motivation for change. The science essentially reframes their perspective on why they are experiencing their problems; what maintains these problems and potential for change- securing a 'buy in' to the process.

This is supported by reports from many of our service users. Their positions fundamentally shifted from self-blame/criticism (i.e. there's something wrong with me') to attributing their difficulties to their historic attachment/relational experiences. The understanding that early adverse experiences correlate with a range of social and emotional outcomes in adulthood, really helped our group members to believe it wasn't their fault and that things can change. These ideas have therefore been essential for the process of developing shared formulations and actions during interventions.

In addition, this greater efficiency allowed for more time and focus on the therapeutic alliance and also for the opportunity to support clients more assertively in attending and engaging with sessions. Most of the evaluative feedback from clients emphasized how significant this relationship with their worker had been for their recovery. Research has consistently shown the importance of the therapeutic alliance on clinical effectiveness.

System and operational efficiency have been one of the most significant developments over these last few months. From setting up and establishing processes, structures, resources, databases and systems, the day to day management of tasks has become much more streamlined and faster. This has significantly impacted on administering and interpreting the outcomes of screening tools; preparing for sessions (both group and individual); recording statistical data related to demographics and outcomes and managing logistical issues related to the delivery of TAP.

As a result, the weekly supervision space has been taken up less with logistical challenges and more with issues related to case management: safeguarding and clinical interventions. The space evolved over time and the conversations became more clinically reflective and sophisticated, which in turn positively influenced the quality and efficacy of interventions and improved signposting to other services. Signposting became more thoughtful - there was the time to explore the most appropriate services and available support to meet the individual needs of our clients. We scheduled in additional reflective spaces during the week that became imperative for the development of clinical practice. The TAP Manager and the Manager for the wider project established additional peer support on a regular basis as well as pre-briefs and de-briefs for continuous review of group sessions.

Challenges

The primary focus on TAP in some ways may have taken away the time and opportunity to meet some of our other initiatives for the wider project. The Manager for the wider project is employed on 0.5 FTE, and outside TAP on 2.5 days, it can become difficult for her to manage these other initiatives.

There is scope for the development of the mental health related consultation/ supervision of the IDVA team by the Project Manager. Both the MH Outreach Workers are based within ODAS. They provide support for the stabilisation phase of TAP and are also TAP group facilitators. Without an equivalent MH Outreach Worker or complex needs specialist in the IDVA team, the IDVAs are not directly involved with the MH related stabilisation phase of support This has significant implications for engaging some of our more vulnerable IDVA supported clients with a MH process.

From our statistical analysis, we know that there have been some IDVA service users who might have benefitted from the group but were unable to engage. The Project Manager key-works the IDVA service users who attend the TAP group, but has limited capacity and is unable to offer this to all IDVA service users for whom TAP is appropriate. If there were capacity for a more specialist post within the IDVA team contributing to the TAP stabilization phase this might:

- help to engage more IDVA service users with TAP
- give opportunity to provide stabilisation as a stand-alone intervention for IDVA service users
- help avoid disruption of a key relationship with an IDVA before the service user is ready
- enhance the IDVA service through incorporating additional skills within the team.

The Project Manager and Chair of Reducing the Risk will conduct a further study of those cases that may have been considered/ triaged for TAP but didn't engage with either the stabilisation and/or group with view to doing as much as possible to provide effective support into TAP within current resources – and contribute to planning for any future service.

Next stage developments

Developing the MH related resources within the IDVA pathway into TAP is a priority. This also includes enhancing the availability of MH consultation to the IDVA service as a whole. The IDVA team has found clinical support and opportunities for group reflection with her very useful. However, the pressures on the project manager's time and her focus on TAP, have meant that this has not been fully integrated within the team's pattern of supervision and team meetings. In contrast the ODAS staff team, and the Service Manager and Team Leader, receive respectively monthly and weekly supervision from Sapiens. This has significantly added to the skills and knowledge of the entire ODAS team.

Although the Project Manager's time is restricted, now that TAP is well developed there is scope to focus further on MH consultation within the IDVA service. It could be developed into a more consistent and protected space - potentially through a group model. The initial MH screening of cases would become more collaborative as a result- creating opportunities for joint sessions where appropriate. The referral/triaging process should consequently become a more streamlined. It would potentially build capacity and independence within the team for conducting more comprehensive MH related screening including:

- discerning internal risk related to Deliberate Self Harm and suicidality.
- enhanced assessment skills to inform referrals into TAP or other MH services

As indicated in the previous section further capacity would significantly enhance the project:

- A more specialist post within the IDVA service would also provide additional support for managing high-risk clients with complex needs and offer the equivalent stabilization phase of intervention for some cases before they are considered for the group.
- Additional resources and capacity would enable systematic longer term follow up work for the 'graduates' of TAP. As longer term resilience is a key aim of the project this is important to evaluation – and we will undertake what we can/ However it be difficult to conduct this rigorously within the current level of resources.

One of our exclusion criteria for attending the group is significant drug and alcohol dependency impeding capacity to engage with the material covered and commit to a therapeutic process. Our data analysis shows that at least 28% of service users triaged for TAP were additionally vulnerable through substance abuse. Some were not able to access the group because of difficulties related to substance abuse. Others were offered stabilization until their substance abuse was deemed stable enough for them to participate in the group. Both the strategic group for the project as a whole and the TAP steering group who meet weekly for supervision would consider it hugely beneficial if a substance abuse worker participated in the project to address the 'toxic trio' more effectively. Their specialized skills and knowledge integrated within the team would be extremely valuable for TAP case

work. This would also potentially enable a broader piece of work to explore developing a more integrated approach to managing the 'toxic trio' more widely – with the possibility of seeking joint funding/ further strategic alignment.

Both quantitative and qualitative outcomes and data so far point towards exciting potential for TAP. Within the research and academic arena, there has been very little reported or documented about effective clinical interventions within domestic abuse. In addition to the immediate direct psychosocial outcomes from TAP which we have collated, there are potentially substantial wider benefits from these interventions which would make them a significant subject for research. Perhaps particularly important to consider and evaluate are the longitudinal and global outcomes from this model. We are aware, for example, of the significant research within public health that demonstrates correlations between a range of social, educational and health outcomes associated with adverse childhood experiences (ACE's). The greater the level of adversity during childhood, the poorer the life outcomes. Some of our service users who have been empowered by TAP are also parents. Parents are the most significant game changers in positively influencing the childhood experiences of the next generation. Some of our more empowered TAP graduates (who are relating better with themselves and others) are also parents, and are therefore likely to 'change narratives' in an intergenerational context. TAP has a potential contribution to make in breaking cycles of disadvantage. This includes, in terms of cost considerations, the potential that graduates may raise a generation of children who are likely to be less reliant on public resources in the future, saving money in the long term.

When the third group concludes in October there will be sufficient data for an academic paper and we are looking forward to reporting and publishing our findings in an academic context and on a national basis for a number of reasons. Firstly, we believe this is the first research of its kind. TAP evolved from an evidence based model that has been delivered within the NHS with patients who have a diagnosis of PD. An adapted model that addresses the complexities associated with PD within the context of DA hasn't been researched before to our knowledge. These findings will provide an empirical basis for reviewing and developing service provision (in the form of support and intervention) and informing policy on good practice within the DA sectors, nationally. The steering group will be developing a plan over the next few months on how we will present our findings nationally and include research and academic and clinical institutes relevant to this research. There may be scope for further collaboration and potential joint funding with academic institutions to research this area more systematically and robustly.

The steering group for this project is also meeting with our colleagues from the other two PCC funded 'DA Complex Needs' projects across the Thames Valley. This has provided a wonderful opportunity to share learning and discuss future development together. One key element is to consider the regional development of TAP. Together we will consider the components of the model and resources necessary to ensure clinical safety and effectiveness if it is rolled out across the region: and also explore creative ways by which all three projects can secure additional resources to support development of a broader Thames Valley 'complex needs' service.

Finally,

1) We hope to run and evaluate a fourth group as part of this pilot that would run until May 2018.

2) We will explore ways we could undertake longer term follow up for the 'graduates' of groups 1 and 2

3) We will review the landscape of MH services across the county in order to share with stakeholders across both sectors to improve signposting

4) We will do a further analysis on how TAP may have impacted on other services.

5) We are already working with service users who abuse drugs or alcohol. We have administered two screening measures related to drug and alcohol abuse for those participating in the group only: the DAST (Drug Abuse Screening Test) and FAST (Fast Alcohol Screening Test). We will continue to administer these measures during further groups we run. In addition:

i. if we are able to undertake longer term follow up for service-users in groups 1 and 2 we will ascertain whether the group had any long-term impact on their substance misuse.

ii. more broadly we will reflect on the benefits we would anticipate from incorporating substance misuse expertise within our complex needs model, the issues it may potentially raise and how this might work.

iii. We will continue to share learning with the other two PCC funded projects and collaborate on a potential specification for a complex needs service for the Thames Valley.

iv. We will consider the implications of any roll out of TAP across the Thames Valley and in particular quality assurance, clinical safety and effectiveness.

6) Over the year, in addition to TAP as the priority, we will:

i) provide further training for project staff as part of their continuous professional development. We have identified training on managing internal risk from suicide and self-harm potentially delivered by Sapiens as a starting point and will consider any further need.

ii) identify any learning about enhancing support for service users who do not access TAP

iii) consider whether there is any learning or tools from the development of TAP that could be potentially delivered a bit more widely in a safe and effective manner by generalist staff, that would contribute to early stabilisation. Discussions on what basis this would be safe and appropriate, would be paramount. (Mapping out the journey of a victim of abuse with mental health needs from first disclosure through to TAP and the support they receive is an approach we hope to use to identify gaps).

iv) identify any further useful work we can undertake with Champions - specifically how best to further strengthen and work with the mental health Champions network. A presentation of TAP at the super-network meeting in May for DA Champions will be an opportunity to showcase the model and outcomes. Staff from the other Complex Needs projects across Thames Valley have been invited.

v) consider any need/opportunity to strengthen links with other mental health providers and potentially raise the issue of gaps in service provision and barriers to access.

Co-authors and contributors to the DA and MH service pilot project

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Sally Brookes (Sapiens Psychotherapist): Clinical supervision and development of TAP
Marilyn Anderson: Team Leader ODAS and TAP Manager
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Karen Diver: A2Dominion/ODAS Service Manager
Romy Briant: Chair, Reducing the Risk (co-author)

Appreciation also to Michelle Plaisted-Kerr Reducing the Risk Training Development Manager (Domestic Abuse Champions) and to Trish Walsh, IDVA team manager and the IDVA team.

July 2017

Appendices: further individual data

SSO outcomes for individual service users

Client B

	Baseline score	End point score	Percentage change
Questions relating to support			
Asking for and receiving support	1	6	63% improvement
Feeling able to speak to others about their abuse if they wanted to	1	3	50% improvement
Awareness of what options are available to them	0	1	25% improvement
Coming to terms with their experiences of violence and abuse			
Recognition if others are behaving abusively	3	4	25% improvement
Realizing that they were not responsible for the abuse that had happened to them	3	3	No change
Able to set boundaries in relationships	0	4	100% improvement
Regaining control of their lives			
Felt in control of their life	7	12	31% improvement
Felt able to make their own decisions	1	4	75% improvement
Managing responsibilities	0	4	50% improvement
Reported feeling safer	3	4	25% improvement
Satisfying relationships	3	8	42% improvement
Health and Wellbeing			
Felt low, anxious or depressed most or all of the time	1	2	25% improvement
Good self care	1	3	50% improvement
Felt well connected with others	2	5	38% improvement
Felt more confident	2	11	75% improvement
Had they self harmed	3	4	25% improvement
Had they over or under eaten	0	1	25% kimprovement

Client A

	Baseline score	End point score	Percentage change
Questions relating to support			
Asking for and receiving support	5	3	25% deterioration
Feeling able to speak to others about their abuse if they wanted to	1	1	No change
Awareness of what options are available to them	4	2	50% deterioration
Coming to terms with their experiences of violence and abuse			
Recognition if others are behaving abusively	3	2	25% deterioration
Realizing that they were not responsible for the abuse that had happened to them	2	1	25% deterioration
Able to set boundaries in relationships	4	1	75% deterioration
Regaining control of their lives			
Felt in control of their life	7	4	19% deterioration
Felt able to make their own decisions	3	2	25% deterioration
Managing responsibilities	1	1	No change
Reported feeling safer	3	0	75% deterioration
Satisfying relationships	3	4	25% improvement
Health and Wellbeing			
Felt low, anxious or depressed most or all of the time	0	0	No change
Good self care	3	2	25% deterioration
Felt well connected with others	0	0	No change
Felt more confident	3	2	25% deterioration
Had they self harmed	3	2	25% deterioration
Had they over or under eaten	2	0	50% deterioration

Client C

	Baseline score	End point score	Percentage change
Questions relating to support			
Asking for and receiving support	8 (mean score 4)	8 (mean score 4)	No change
Feeling able to speak to others about their abuse if they wanted to	4	4	No change
Awareness of what options are available to them	4	4	No change
Coming to terms with their experiences of violence and abuse			
Recognition if others are behaving abusively	4	4	No change
Realizing that they were not responsible for the abuse that had happened to them	4	3	25% deterioration
Able to set boundaries in relationships	4	4	No change
Regaining control of their lives			
Felt in control of their life	15 (mean score 3.75)	15 (mean score 3.75)	No change
Felt able to make their own decisions	4	4	No change
Managing responsibilities	8 (mean score 4)	8 (mean score 4)	No change
Reported feeling safer	4	4	No change
Satisfying relationships			
Health and Wellbeing			
Felt low, anxious or depressed most or all of the time	3	3	No change
Good self care	4	4	No change
Felt well connected with others	6 (mean score 3)	8 (mean score 4)	25% improvement
Felt more confident	12 (mean score 4)	12 (mean score 4)	No change
Had they self harmed	4	4	No change
Had they over or under eaten	3	4	25% improvement

Client E

	Baseline score	End point score	Percentage change
Questions relating to support			
Asking for and receiving support	6 (mean score 3)	7 (mean score 3.5)	12.5% improvement
Feeling able to speak to others about their abuse if they wanted to	2	3	25% improvement
Awareness of what options are available to them	3	4	25% improvement
Coming to terms with their experiences of violence and abuse			
Recognition if others are behaving abusively	3	4	25% improvement
Realizing that they were not responsible for the abuse that had happened to them	3	3	No change
Able to set boundaries in relationships	0	2	50% improvement
Regaining control of their lives			
Felt in control of their life	7 (mean score 1.75)	11 (mean score 2.75)	25% improvement
Felt able to make their own decisions	1	3	50% improvement
Managing responsibilities	2 (mean score 1)	5 (mean score 2.5)	37.5% improvement
Reported feeling safer	2	3	25% improvement
Satisfying relationships	4 (mean score 2)	5 (mean score 2.5)	12.5% improvement
Health and Wellbeing			
Felt low, anxious or depressed most or all of the time	1	1	No change
Good self care	1	2	25% improvement
Felt well connected with others	1 (mean score 0.5)	4 (mean score 2)	37.5% improvement
Felt more confident	2 (mean score 0.33)	7 (mean score 2.33)	50% improvement
Had they self harmed	1	1	No change
Had they over or under eaten	1	1	No change

Client D

	Baseline score	End point score	Percentage change
Questions relating to support			
Asking for and receiving support	7 (mean score 3.5)	8 (mean score 4)	12.5% improvement
Feeling able to speak to others about their abuse if they wanted to	2	4	50% improvement
Awareness of what options are available to them	3	3	No change
Coming to terms with their experiences of violence and abuse			
Recognition if others are behaving abusively	-	4	-
Realizing that they were not responsible for the abuse that had happened to them	0	4	100% improvement
Able to set boundaries in relationships	1	3	50% improvement
Regaining control of their lives			
Felt in control of their life	6 (mean score 1.5)	15 (mean score 3.75)	56.25% improvement
Felt able to make their own decisions	1	4	75% improvement
Managing responsibilities	1 (mean score 0.5)	7 (mean score 3.5)	75% improvement
Reported feeling safer	4	3	25% deterioration
Satisfying relationships	7 (mean score 2.33)	6 (mean score 2)	8.3% deterioration
Health and Wellbeing			
Felt low, anxious or depressed most or all of the time	0	2	50% improvement
Good self care	2	3	25% improvement
Felt well connected with others	2 (mean score 1)	8 (mean score 4)	75% improvement
Felt more confident	2 (mean score 0.33)	9 (mean score 3)	66.6% improvement
Had they self harmed	0	1	25% improvement
Had they over or under eaten	0	4	100% improvement

Client G

	Baseline score	End point score	Percentage change
Questions relating to support			
Asking for and receiving support	8 (mean score 4)	7 (mean score 3.5)	12.5% deterioration
Feeling able to speak to others about their abuse if they wanted to	3	2	25% deterioration
Awareness of what options are available to them	4	3	25% deterioration
Coming to terms with their experiences of violence and abuse			
Recognition if others are behaving abusively	3	2	25% deterioration
Realizing that they were not responsible for the abuse that had happened to them	2	2	No change
Able to set boundaries in relationships	2	2	No change
Regaining control of their lives			
Felt in control of their life	11 (mean score 2.75)	11 (mean score 2.75)	No change
Felt able to make their own decisions	3	3	No change
Managing responsibilities	2 (mean score 1)	5 (mean score 2.5)	27.5% improvement
Reported feeling safer	3	3	No change
Satisfying relationships	6 (mean score 3)	4 (mean score 1.33)	41.6% deterioration
Health and Wellbeing			
Felt low, anxious or depressed most or all of the time	1	1	No change
Good self care	2	1	25% deterioration
Felt well connected with others	3 (mean score 1.5)	4 (mean score 2)	12.5% improvement
Felt more confident	1 (mean score 0.33)	6 (mean score 2)	41.6% improvement
Had they self harmed	4	4	No change
Had they over or under eaten	3	1	50% deterioration

The MOAS

Verbal aggression towards others	Aggression towards property	Aggression towards self	Physical aggression towards others	Client ID	TAP group
0	0	0	0	Client I baseline	1
0	0	0	0	I end pt	1
1	0	1	0	K baseline	1
1	0	0	0	K end pt	1
0	0	0	0	L baseline only	1
4	2	2	3	M baseline only	1
2	1	0	0	A baseline	2
2	1	3	0	A end pt	2
3	1	3	0	B baseline	2
0	0	0	0	B end pt	2
1	1	1	0	D baseline	2
1	1	3	0	D end pt	2
1	0	0	0	C baseline	2
1	1	0	1	C end pt	2
0	1	6	0	E baseline	2
0	1	6	0	E end pt	2
0	0	0	0	G baseline	2
1	0	0	0	G end pt	2
0	0	0	0	F baseline only	2
0	0	0	0	N baseline only	2
2	1	3	0	O baseline only	2
3	0	0	0	P Baseline only	2
3	3	3	1	Q baseline only	2

SAPAS

SAPAS score	Client ID	TAP group
6	H baseline	1
5	H end point	1
7	J baseline	1
4	J end pt	1
5	I baseline	1
5	I end pt	1
9	K baseline	1
7	K end pt	1
5	L baseline only	1
3	M baseline only	1
6	A baseline	2
7	A end pt	2
6	B baseline	2
2	B end pt	2
8	D baseline	2
5	D end pt	2
3	C baseline	2
2	C end pt	2
7	E baseline	2
7	E end pt	2
6	G baseline	2
3	G end pt	2
6	F baseline	2
6	**F end pt**	**2**
2	N baseline	2
4	O baseline	2
7	R baseline	2
5	P Baseline	2
6	Q baseline	2

WSAS

WSAS	Client ID	TAP group
18	J baseline	1
16	J end pt	1
33	I baseline	1
30	I end pt	1
29	K baseline	1
12	K end pt	1
10	H baseline	1
34	L baseline	1
26	M baseline	1
23	A baseline	2
32	A end pt	2
17	B baseline	2
6	B end pt	2
35	D baseline	2
14	D end pt	2
3	C baseline	2
0	C end pt	2
35	E baseline	2
22	E end pt	2
19	G baseline	2
22	G end pt	2
34	F baseline	2
24	O baseline	2
40	R baseline	2
2	P Baseline	2

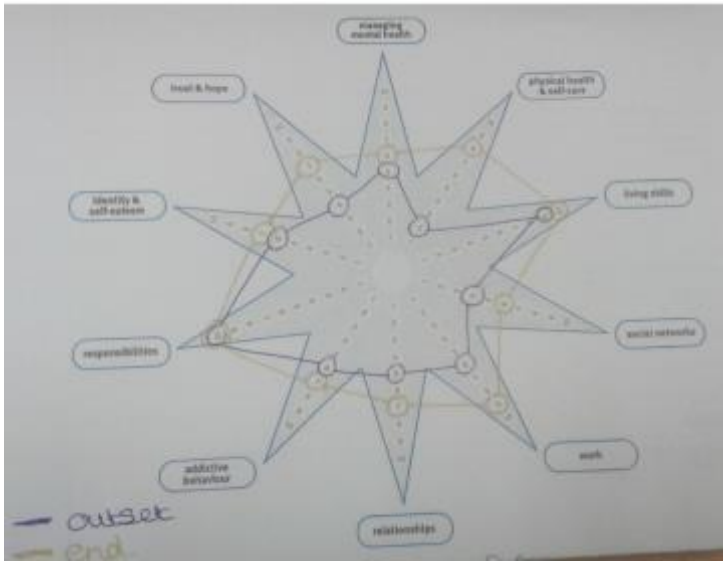
The Mood Disorder Questionnaire

Client ID	TAP group	MDQ Score	Positive or negative screen for bipolar
H baseline	1	3	N
H end point	1	4	N
J baseline	1	7	P
J end pt	1	5	N
I baseline	1	1	N
I end pt	1	1	N
K baseline	1	5	N
K end pt	1	9	P
L baseline	1	5	N
M baseline	1	1	N
A baseline	2	3	N
A end pt	2	5	N
B baseline	2	2	N
B end pt	2	2	N
D baseline	2	6	N
D end pt	2	6	N
C baseline	2	11	P
C end pt	2	12	P
E baseline	2	3	N
E end pt	2	0	N
G baseline	2	3	N
G end pt	2	2	N
F baseline	2	12	P
N baseline	2	4	N
O baseline	2	10	P
R baseline	2	3	N
P Baseline	2	11	P
Q baseline	2	8	P

Maclean scoring instrument for BPD

Client ID	MacLean BPD Score	TAP group
H baseline	8	1
H end point	2	1
J baseline	6	1
J end pt	3	1
I baseline	1	1
I end pt	2	1
K baseline	10	1
K end pt	9	1
L baseline only	8	1
A baseline	10	2
A end pt	9	2
B baseline	6	2
B end pt	0	2
D baseline	9	2
D end pt	7	2
C baseline	5	2
C end pt	9	2
E baseline	9	2
E end pt	8	2
G baseline	4	2
F baseline	5	2
N baseline	4	2
O baseline	13	2
R baseline	10	2
P Baseline	7	2
Q baseline	10	2

Recovery Star for client E



Recovery Star for Client F