Report to the Police and Crime Commissioner for the Thames Valley

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

Interim evaluation and report: October 2016

Contents

This report is intended to provide:
- an overview of the project
- information about progress including a profile of the 68 service users to date and initial outcomes
- a brief summary of future plans and potential developments.

Additional information is contained in the appendices

Appendices

Chapter 1 Brief project overview and description

Background.

This eighteen-month pilot project is funded by the Police and Crime Commissioner for the Thames Valley as one of three county based projects across the region which are intended to develop and innovate services for victims of abuse who are additionally vulnerable through 'complex needs'. In Oxfordshire we identified as priority the importance of developing more effective support for victims of abuse with mental health needs. This was in light of:

- the prevalence of this dual need – both because emotional fragility can increase vulnerability to abuse and abuse itself impacts on mental health
- the fact that the majority of service users returning to the IDVA (high risk) service through a repeat incident had mental health needs. In effect we could make them safe and provide reassurance and help to access resources in the short term but found it difficult to help them develop the stability and resilience they needed to keep themselves safe in the longer term.
- the fact that it was difficult to support people with unstable behaviours within refuge which reduced the support options available to this extremely vulnerable group
- In safeguarding terms the 'toxic trio' of domestic abuse, mental health and substance misuse is the most prevalent factor in serious case reviews of child death and serious harm. While this project focuses on adult victims it has significant implications for the welfare of children.

Additional evidence of need

Research has identified domestic abuse as the most prevalent factor associated with depression and other mental health difficulties in women (Astbury, 1999). Up to 73% of abused women experience depression or anxiety disorders which is three times greater than the general population (Charles, Griffiths and Morgan, 2000).

The Safelives policy report 'Getting it right first time' (2015) highlighted the significant number of high-risk victims described as having complex or multiple needs related to mental health and/or drug and alcohol. Quantitative data collated by Safelives from a UK study in 2011-2012 revealed similar findings: of the 2,653 clients referred to IDVA and seen at MARAC: 90% of these high risk victims were women and 40% reported MH issues; 20% reported abusing drugs and alcohol; 18% threatened or attempted suicide and 16% self-harmed.

A follow-on study in 2013-2014, established similar percentages though the intake number had more than doubled to 6,549. This study also looked at 'outcome figures' and found that 8% had engaged with MH services after having engaged with the IDVA's. This was a positive finding but raised the question of what was happening to the other 32% of this extremely vulnerable client group - and whether there might be further scope in enhancing the support and intervention for their MH. This is particularly in light of the fact that 'DA services rarely have clinical supervisory support in place to provide containment and a space to work through the projections, transference and counter-transference of victims with mental health needs' (Hughes and Pengely 1997).

In Oxfordshire over the past five years the complexity of the needs of clients using DA services has grown. It can be problematic for DA services to work with victims who have complex emotional needs or behavioural difficulties characteristic of a personality disorder. Presenting factors such as substance misuse; alcoholism; criminality; ambivalent or non-engagement with services; emotionally unstable mood swings; suicidal threats and attempts; manipulative behaviour and self-harm can create barriers to safe and sustained engagement and longer term resilience and recovery.

This poses a specific challenge for refuges. During 2015, five women accommodated in refuges in Oxfordshire, despite full assessment, were subsequently diagnosed with Borderline Personality Disorder, and three were using substances to manage their distress and trauma. Containing this client group in communal living is difficult because of the dynamics created with other residents. Eviction from the property can sometimes be the sole option following an 'emotional storm' episode.

It is an outcome, the refuge strives hard to avoid: it inevitably increases the risk to the victim, and homelessness adds to factors which may impel them to return to the perpetrator.

However there are simllar concerns and challenges for other agencies. As example, the fact that the police sometimes feel impelled to issue MOUs (Memorandums of Understanding)[2] to victims of abuse with complex needs illustrates how non mental health professionals can struggle to keep them safe.

The structure of the project and the rationale for this

1). In planning this project, we were clear that seeking to align and ensuring clear pathways between domestic abuse and mental health services in Oxfordshire was important, but not sufficient. The causes and consequences of domestic abuse and fragile mental health are so interwoven that for many victims tackling them through separate service interventions makes no sense.

- The fragility and instability of some service users we work with has its origin in key childhood relationships. They may not have experienced healthy attachments and relationships with family members and others, through which to build a strong sense of identity and self-worth and consequently develop poor internal working models. This renders them vulnerable to a range of abuse including domestic violence. They may be subject to a 'revolving door' phenomenon - passed between different health, child social care and law enforcement services but with their core vulnerability to abuse never fully addressed.

Rather than simply aligning services and risking a 'revolving door' between them we needed to bring together mental health and domestic abuse expertise into a single service and offer therapeutic support in a context where mental health difficulties can get thought about specifically in relation to domestic abuse. We envisaged that this innovative approach should increase our potential to:

i. keep service users safe, and reinforce their sense of being safely held, through an integrated service
ii. and thereby create opportunity to work more effectively to meet their more entrenched emotional and mental health needs and help build their longer term resilience.

2) We envisaged that the project should encompass and work towards better outcomes for victims of abuse with a broad range of mental health needs. However, because abuse is particularly associated with causing or exacerbating fragile self-esteem, emotional instability, problematic and impulsive behaviours and dysfunctional coping mechanisms all of which, in turn, increase risk, we prioritised developing resources to address this. We decided, within the compass of the broader service, to focus on the development of a new therapeutic programme to meet the needs of victims of abuse with these complex emotional needs - or those who are diagnosable with 'Personality Disorder'. From this evolved The Anchor Project (TAP). TAP is a two-tiered system which is based on an evidence-based intervention already in use across mental health which has been specifically adapted for work within the domestic abuse field. The first group cohort of this initiative was concluded earlier this month with remarkable outcomes.

3). In adopting outcome measures we agreed that the ultimate measure of the project is the increased capacity of our service users to keep themselves safe. Within this, we would utilise both domestic abuse outcomes related to safety and mental health measures related to internal and relational safety.

4) For ease of access, we decided that the gateway to the service should be through established domestic abuse pathways rather than creating a new referral point. These are the domestic abuse helpline for self-referral, or via referral to ODAS or, in the case of high risk, to MARAC and Reducing the Risk IDVA service.
As the gateway to referral would be the domestic abuse pathway, we established an internal mental health triaging process. Clinical overview of assessment of mental health needs, risk, referral

[2] *These usually take the form of a letter essentially saying 'you are aware of your risk and are not engaging with the risk management plan we are offering you, so we can no longer be responsible for what may happen in the future'*

acceptance and signposting has been held by Sapiens. In addition, the Project Development Manager provides clinical supervision and initial triaging for the IDVA service. This has enabled us to work flexibly to respond to the individual needs, circumstances, and domestic abuse risk level of service users at the point they engage with our services. Whether supported through outreach or IDVA, we have been able to work seamlessly to first ensure safety (including MARAC for high risk) and lay the groundwork towards readiness for change (Stage 1) followed by participation in more intensive therapeutic support (Stage 2).

Project resources

The project has drawn on and enhanced current services and utilised new resources funded through the PCC's grant. The latter 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 was imperative to manage risk and challenges that arose 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 vast 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) 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 programme and the wider pilot.

Chapter2 Preparatory Work

Publicity

Awareness of the new service has been raised through a range of channels and initiatives:

- partnership events and verbal summaries of the project to OSCB, Safer Oxfordshire, and the Oxfordshire Mental Health Partnership
- participation in a mental health conference
- through domestic abuse information channels: e.g. the champion networks, e-bulletin, the office of the PCC
- through including information in the current review of Oxfordshire's domestic abuse services
- and through liaison with Oxfordshire's Mental Health Trust

Service updates will be shared on the Reducing the Risk website and through the Reducing the Risk e-bulletin and Champion networks.

Scoping mental health services in Oxfordshire

The Project Manager has collated information on mental health services in Oxfordshire and clarified referral criteria and pathways to them. This is with the intention of making it widely available to improve referrals to mental health services and also identify any gaps. A copy of the scoping is attached in the appendix. It is used by mental health as well as domestic abuse staff. We are discussing processes to ensure that it remains updated after the lifetime of the project.

Staff training

At the start of the project Sapiens delivered two day training for IDVA and outreach workers which was also open to staff from other Thames Valley projects. Thirty professionals participated. The training focused on personality disorder and associated behaviours which compromise capacity to keep safe. All thirty staff were enthused, rated the training very highly and picked out in particular:

1 clarity of information and insights enabling greater understanding of PD: of service user feelings and behaviours - and of our reactions
2 practical aspects of training: managing situations, putting boundaries in place, responsibilities and safety of service user and staff, tools and signposting.

Feedback suggests there is scope and appetite for further training with more in depth mental health information and exploration of cultural issues.

Establishing clinical supervision arrangements

- Staff members from ODAS receive monthly case supervision with Sara Sanders, the Managing Director/ Psychotherapist from Sapiens and Psychotherapist, Sally Brookes.
- TAP facilitators including both Complex Needs Outreach Officers, the Project Development Manager and the Team Leader/ TAP Manager, as well as the Service Manager for ODAS receive weekly supervision from Sara Sanders and Sally Brookes. This supervision promotes an understanding/ awareness of issues related to complex emotional needs. For the Service Manager she is able to oversee ODAS and WBDAS more effectively as a result, which in turn supports service development.
- Members of the IDVA team consult with the Project Development Manager about any mental health related issues that arise with their cases including assessment/ screening, signposting (to both external agencies and also TAP) and about working with and advice to clients. This 'ad hoc' consultation may develop into regular supervision. The Project Development Manager will deliver enhanced training on MH screening and signposting to the IDVA team in the new year
- The Project Development Manager receives clinical supervision from Sara Sanders.

Chapter 3 Enhancing the work of existing services

Early Intervention

Domestic Abuse Champions

Oxfordshire's Domestic Abuse Champions are front line staff from a wide range of organisations (over 1000 in Oxfordshire), who are trained together, linked by data base and e bulletin, and meet together in networks for coordinated multi-agency early intervention. They act as source of expertise for their staff team and, through the network, conduit to the range of resources a victim seeking help may need. Domestic Abuse services are members of the networks to ensure a seamless pathway to risk management and specialist support. Champions also support risk management plans and help survivors to access services for ongoing recovery.

Work has been undertaken with existing DA Champions to enhance their skills in responding to and signposting victims of abuse with mental health needs. Most recently, in September, the Project Manager attended a half day Champions Network training event in September 2016 in order to update current Champions about the mental health pilot and TAP and confirm current pathways into the project and more broadly to explore collaboration between mental health and domestic abuse services. This included introducing the landscape of mental health services across the county to enhance signposting.

There has been a particular focus in the pilot on strengthening the network of DA Champions across mental health services. There are currently 32 champions in mental health and therapeutic settings in Oxfordshire (please see appendix for details). The Mental Health Trust has recently reviewed and enhanced its safeguarding structures and further Champions are being trained to strengthen the revised structures. An additional Champions training for staff across the new Mental Health partnership[3], has been planned for the new year which the Project Manager will co-facilitate with the Reducing the Risk's (RtR) Training Development Manager. Training will include core Champion training, the new service and pathways, and provide opportunity to discuss further collaboration between DA and MH services.

The Project Manager and the Champion Training Development Manager have attended regular meetings with strategic leads in Adult Mental Health to ensure Domestic Abuse is kept on the agenda amongst frontline staff. Together with the safeguarding lead from the Mental Health Trust, the Project Manager is in the process of organizing regular meetings for DA champions across MH services. The purpose of the meetings will be to

- review how Champions cascade DA related information,
- provide opportunity to discuss how to follow up any disclosures in their teams;
- strengthen pathways amongst MH services
- explore more joined up working between DA & MH.
  These meetings may also provide opportunity to talk about specific cases if appropriate – including discussion of any open to the Adult Mental health Team which might be appropriate for TAP. The safeguarding lead is exploring how this could potentially be accommodated within the existing 'Think Families' initiative in the Trust, rather than arranging an entirely separate meeting which busy staff may struggle to commit to.

While the focus of Champion trainings has been on early intervention, these initiatives may lay the foundation for developing more joined up work in terms of both shared case management (in addition to TAP) and ongoing support for recovery and to help sustain resilience. RtR's Training Development Manager has already begun exploring the latter in a preliminary way with Champions.

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[3] The Oxfordshire Mental Health Partnership is a new partnership that formally brings together six local mental health organisations from the NHS and the charity sector: Connection Floating Support, Elmore Community Services, Oxford Health NHS Foundation Trust, Oxfordshire Mind, Response and Restore.

GPs

Most staff across both MH & DA services recommend that clients should consult with their GP as an essential initial resource when either issue becomes problematic. It is therefore vital that DA & MH are kept on the agenda amongst frontline staff in primary care. Through the safeguarding lead for the Core Commissioning Group in the Trust, The Project Manager presented at the GP forum in September 2016. This was to build awareness of the interplay between MH & DA across primary care services, and also to give information about the pilot.

Work with high risk

IDVA service.

Victims at high risk are often referred to the service after an incident of abuse, without proactively seeking intervention. Continuing to manage the risk themselves may seem a familiar and potentially less dangerous option than seeking change. This often involves using the 'window of opportunity' after an incident to begin to build trust and suggest the possibility of change - before they fall back on their own coping mechanisms.

The initial work of the service which normally responds within a working day, is to make those referred immediately safe. What can follow is a vital period of working towards building capacity for longer term sustainable change. This inevitably depends on a robust IDVA-service user alliance, i.e. 'being reliably there for them', remaining alongside, valuing and responding, taking practical measures to ensure ongoing safety, offering insights, 'normalising', and seeking to develop a sense of inner safety in addition to ensuring 'external' safety.

This enables service users to develop confidence, own their own decisions and move on to increasing autonomy. Support subsequently takes the form of helping them to access services and resources for wellbeing, safety and independent living, to meet any additional needs they may have and to encourage development of a wider network of support.

For those with fragile mental health the core middle stage is potentially a long and difficult course. It primarily comprises 'stage 1' of their journey into health. Until they feel safe they are not ready to undertake the conscious reflection which a more intense therapeutic process entails. In addition external events, court processes etc. can disrupt progress.

The benefit of case consultation for the IDVA service, where cases have been discussed with the Project Development Manager and/or within the clinical supervision team, have been two-fold:

- It can help build skills, and cast additional light so as to provide more effective support at this early stage, such as ensuring that service users are accessing appropriate assessments and treatments at GP level, or advocating to ensure mental health services do not close a case.
- It can also help support the assessment and screening process at this point and subsequent referrals into TAP or other mental health service[5]

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[5] *Current IDVA service MH screening and outcome measures: Service users at high risk access the IDVA service through a risk assessment in relation to domestic abuse rather than mental health. Additional mental health consultation is offered by the Project Manager to the IDVA team during the relatively simple triaging process of IDVA cases to the mental health service. This includes advice on basic screening and assessment and she will deliver enhanced training on these for the IDVA team in the new year.*
Baseline mental health measures are administered to IDVA service users if they start TAP, as with all TAP service users against which outcomes are measured. For those not accepted in TAP, outcomes currently being used are the standard IDVA service outcomes which include measure of emotional resilience (insight, increased confidence, capacity to make choices, feelings of self-worth and feeling safe) but not specialist mental health measures.

There is strong anecdotal evidence of the value of mental health clinical consultation in support for IDVA in individual work with specific clients. There is a case for more systematic evaluation of the impact and exploring how support from the Project Manager could be used more effectively. We are reviewing the possibility of introducing regular clinical supervision as well as ad hoc consultation, although the limited capacity of the project development manager combined with IDVA team time constraints create logistical difficulties.

IDVA Case Study

Client A from the IDVA service for instance was accepted for the first TAP group, and both the Project Manager and her IDVA worker worked very hard together to help her engage with TAP. The IDVA worker consulted with the Project Manager during the preliminary screening process of A's mental health, and this in turn supported the IDVA worker to construct and submit her referral into TAP. A's extreme depression was compounding her capacity and functioning across all domains of her life including parenting and engagement with services. Social and Health Care had consequently remained involved in the long term. The only intervention she had received for her mental health difficulties was medication, managed by her GP, to little or no benefit. We therefore thought that AB would benefit from this unique opportunity to access some intensive support for her MH due to the additional resources that she wouldn't otherwise have available to help her engage with external MH agencies. From the intensive support of her IDVA worker, client A was able to attend a few sessions of the first module as a result. Her attendance began to wane however and it became increasingly difficult to help her engage with both the key-working sessions and the group. It soon became evident that client A wasn't in fact ready to engage with the group material in a way that would be helpful for her, and it was therefore decided that it would be of little value for her to continue with TAP at this stage. Her IDVA worker continues to support her quite intensively; with the view that client A will be better placed to access intervention by TAP at a later stage or an external MH agency. Her IDVA worker continues to consult with the Project Manager. Client A has since been re-referred to MARAC following further abuse from her son, who is not the original perpetrator, and faces losing her children due to increased safeguarding concerns. During a TAP triage this information was fed back from the TAP facilitator who regularly attends MARAC and the TAP team discussed and offered further support and advice around A's mental health needs to the IDVA service which has been taken forward. This illustrates the importance of joined up work and expertise from the TAP team in terms of high risk clients.

Refuge

Three of the clients who attended the first TAP group are living in refuge and received weekly one to one and group support like all the other TAP clients. Additionally there are two clients who are receiving one to one support on a weekly basis to prepare them for the group (not living in refuge).

Refuge Case Summary

According to reports by her Worker at the Refuge, Client B, one of the attendees of the first TAP group has been managing her impulsive 'emotional storms' more effectively since attending TAP, reducing the toxic dynamics in Refuge. When she first came to Refuge she was at risk of losing her tenancy due to her behaviour towards others. Since attending TAP she has managed her behaviour and emotions with greater mindfulness, and was consequently taken off tenancy sustainment measures. Although B has since ran into difficulties following the end of the group (which is likely to have stemmed from the endings and loss of the group), her keyworker continues to work with her on addressing her emotional management.

Chapter 4 Development of a new resource
The Anchor Programme (TAP)

Summary of progress and the potential of TAP

TAP is a newly designed model based upon an evidence-based therapeutic programme called Structured Clinical Management (Bateman and Krawitz, 2013) working with victims of abuse with personality disorders/complex emotional needs. The model involves advocacy and support, centres around problem solving, involves the co-creation of crisis plans and includes assertive outreach. TAP is innovative in addressing mental health issues specifically in the context of domestic abuse. To our knowledge, it is the first mental health related therapeutic resource, locally or nationally, aimed at victims of domestic abuse. We aim to run three consecutive cohorts over the course of the project drawing learning from each to enhance the next. Each group runs for six months.

TAP has been welcomed by both services and clients as an additional resource as part of the overall care package provided in the DA pathway. The first group finished at the beginning of October. Of the 16 accepted, 7 attended regularly and others participated for shorter periods. The majority had a childhood history of neglect, were extremely emotionally fragile and vulnerable to a range of abuse and addictions. Outcomes have been remarkable. Most group members reported improvements across most domains related to their MH as assessed by the MH Recovery Star and other clinical tools used at assessment.

The outcomes reflect the importance of a holistic approach for building resilience and disrupting the cycle of violence. They also suggest the broader effectiveness of this therapeutic intervention. Not only has it increased the group members' capacity to keep themselves safe in the context of both DA and MH, it has also helped the victims from a vocational; parenting; social; emotional; relational/ interactional perspective. While we are still at early stages in evaluating the pilot, it has potential for providing an intervention which targets resources effectively to interrupt the 'revolving door' between agencies and thereby also help reduce pressure on services such as CAMHS, police, children's services, and wider health services.

Safety

All service users are made safe at point of referral through the implementation of initial safety measures and safety planning. All service users at high risk have also been subject to MARAC action plans. Safety remains at the centre of the ongoing work.

While the detailed outcomes in this report are mental health measures, these have a substantial bearing on capacity of service users to manage risk and keep themselves safe. As the project continues we will be better placed to report in more detail directly on outcomes in relation to increased safety.

The two phases of TAP

TAP is delivered in two-tiers, the Stabilisation Phase and the High-Intensity Phase.

The Stabilisation Phase is for those clients who meet inclusion criteria or are working towards inclusion criteria but who need a little time and support to ground and stabilise in order to enter the High-Intensity Phase. Many of the clients referred will be chaotic in terms of their lifestyle and relationships, or may be working to gain sufficient control over their drug and alcohol use or simply take time to build sufficient trust with workers to embark on more intense work. Within this phase our specialist Complex Needs Workers will engage the client frequently (usually weekly) face to face for a period of up to 6 months by which time they will be reassessed in terms of progression into the High-Intensity Phase or for signposting into other, more appropriate services. Clients within the High-Intensity Phase who decompensate or are unable to continue for any reason will automatically revert to the Stabilisation Phase. The Stabilisation Phase is seen as a stand-alone intervention in its own right or as a preparatory stage for the High-Intensity Phase.

The High-Intensity Phase consists of a weekly, 2 hour, therapeutic, skills-based group. Whilst this is not therapy it holds significant therapeutic and healing value in terms of a safe space and peer connection and support. The group runs for a 6-month duration during which five modules are covered. These are:

1. Emotional regulation
2. Self-esteem and the development of core self
3. Abuse, coercion and control
4. Impulse control
5. Relationships and interpersonal skills

The aim is to help the client:

- Problem solve
- Manage a crisis
- Develop skills to manage emotions/impulses/ interpersonal interaction
- Use services appropriately
- Develop a better understanding of their own internal states of mind (internal states).
- Learn and practice skills to manage emotions/ impulses/relationships more effectively.
- Develop activities outside of services (vocational).
- Create short term and long term goals.
- Contain their impulsivity
- Reduce self-damaging, threatening, or suicidal behaviour
- Improve mental health to help clients move on with their lives in the aftermath of abuse,
- and better equipping those who are parents to meet the attachment and parenting tasks involving their children, hopefully contributing to protecting them from the intergenerational legacy of DA.

In addition to the group members in the High-Intensity phase also have weekly one-to-one sessions with their key worker from the TAP team during which any resistance to attending the group or any issues that emerge from the material covered can be processed and support given.

Inclusion and Exclusion Criteria

For the purposes of the TAP project we needed to define inclusion and exclusion criteria for referring agencies. This needed to reflect the target client group that had ben identified as presenting with the highest level of need and service demand which had informed the project development. The difficulties experienced by both clients and staff regarding this group indicated that their difficulties were consistent with traits associated with borderline personality disorder, antisocial personality

disorder and substance misuse. Whilst substance misuse was high on the agenda we had to be realistic about what an individual struggling with addiction would be able to helpfully undertake in terms of committing to a structured, psychologically informed intervention such as the High-Intensity Phase. For this reason those where the primary issue was substance misuse alongside domestic violence were triaged and signposted to Turning Point (addictions services) or supported in the Stabilisation Phase to gain control of their addiction or engage more fully with appropriate services.

Inclusion criteria:

- Basic traits of Borderline Personality Disorder
- Basic traits of Antisocial Personality Disorder (excluding overt risk to others)
- Those causing relational and behavioural difficulties in refuge.
- Individuals who are stable on methadone.
- Clients suffering from interpersonal problems and poor coping skills
- Interpersonal problems and behaviours that are inflexible and pervasive across a broad range of personal and social situations and lead to significant distress or impairment in social, occupational, or other important areas physical of functioning.

Exclusion criteria

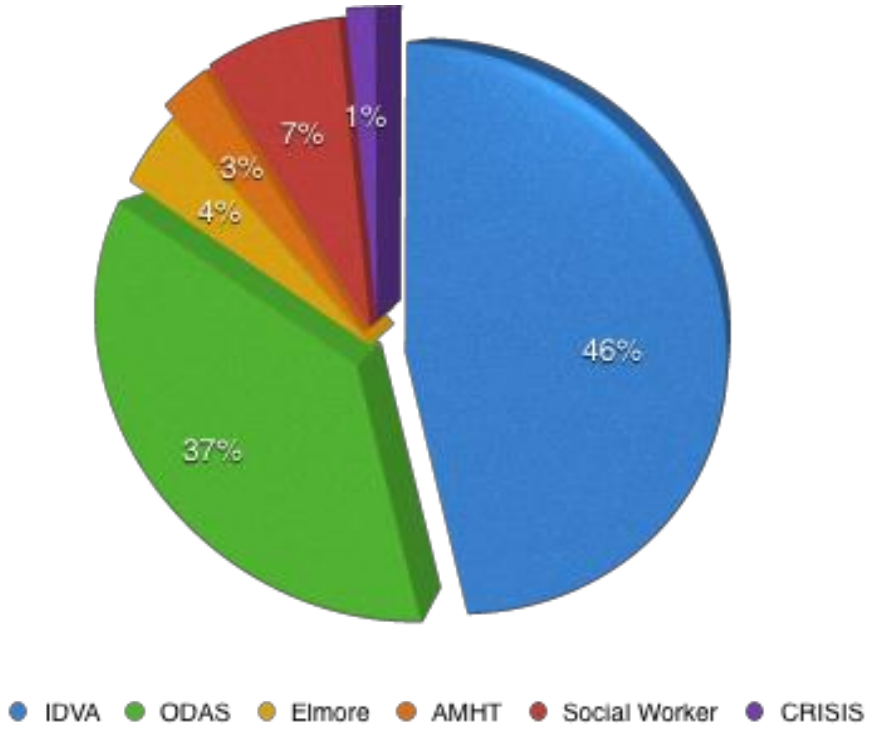
- Acute or untreated psychotic disorder*. These clients were triaged to mental health services.*
- Dependent on, or regular use of illicit drugs or alcohol*. These clients were triaged and referred to addictions services if they were using at a level that would inhibit engagement*
- Already engaged in another group program. *This is in order to not confuse interventions for the client.*
- Insecure housing*. Some of the material covered can caused clients to feel more vulnerable, therefore a secure base is imperative in order for them to safely engage with the intervention.*
- Poor command of English*. As this is a pilot project a reasonable command of the English language is required to follow the skills delivery component of the program.*
- Clients adamantly opposed to support in a group. *This is relevant for those wishing to engage in the High-Intensity Phase of the TAP process.*
- Clients whose problems appear to be due to autistic spectrum disorder or adult ADHD, or who are awaiting an assessment for ASD, without prior discussion. *This is relevant for the High-Intensity Phase as group interventions can be contraindicated for those on the autistic spectrum.*
- Clients with a BMI of 17.5 or lower. *Low BMI can potentially cause difficulties with engaging effectively with a psychologically informed intervention. These clients would be triaged and signposted to Eating Disorder services.*
- Clients with a learning disability, or an IQ lower than 70. Individuals with a borderline LD (IQ 70-80) may be referred after consultation. *This is due to the fact that clients would need to conceptually engage with the psychological ideas offered. Again, if they do not meet this criterion they would be signposted to learning disability services.*

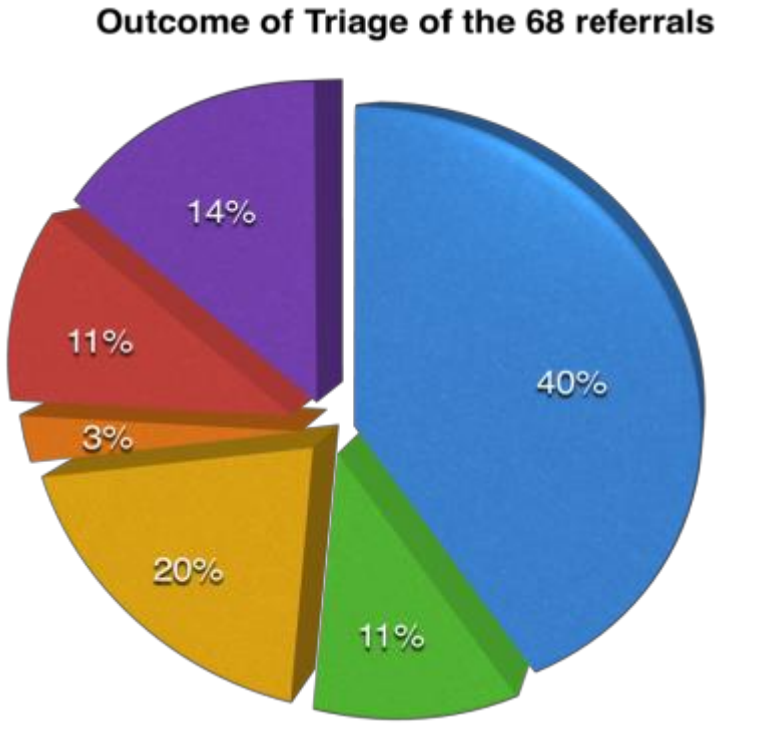
Sources of referral and outcomes of triage

There have been 68 referrals for triaging to date. Sources of referral for the first cohort of TAP came principally from services involved in the pilot. We anticipate a more varied referral stream for the next two cohorts as there is now much wider awareness of the service.

Of the 68 referrals only 14 were declined a primary service from the project (20%).
54 women (80%) have been actively engaged and are working at different levels across the TAP and the wider service. This includes those who have completed the first 6-month cohort and those involved in preparation and triage for the next cohort commencing imminently. Please see the following graphs for a more detailed breakdown.

Sources of referral for triage





- Stabilisation Phase (ODAS)
- High-Intensity Phase
- Signposted to other agencies or back to outreach service
- Offered High-Intensity but could not attend
- Client declined offer of support
- IDVA support

Service user profile

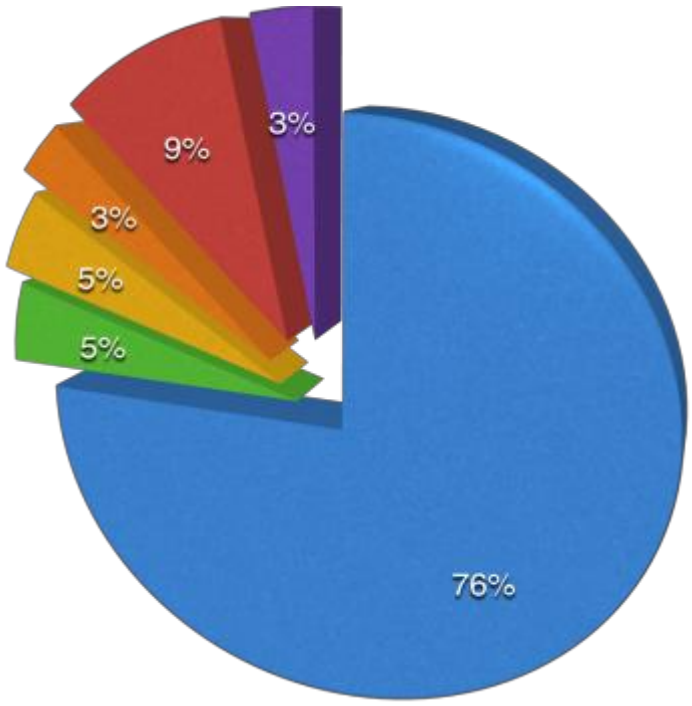
Of the 68 referred, all were within the age range of 18 to 65 years and all were female, despite the service being open to men also.

38 out of the 68 were parents – with 91 children -and two were pregnant highlighting the need for sound education around healthy relationship building and emotional regulation which is inherent within this project.

Ethnicity

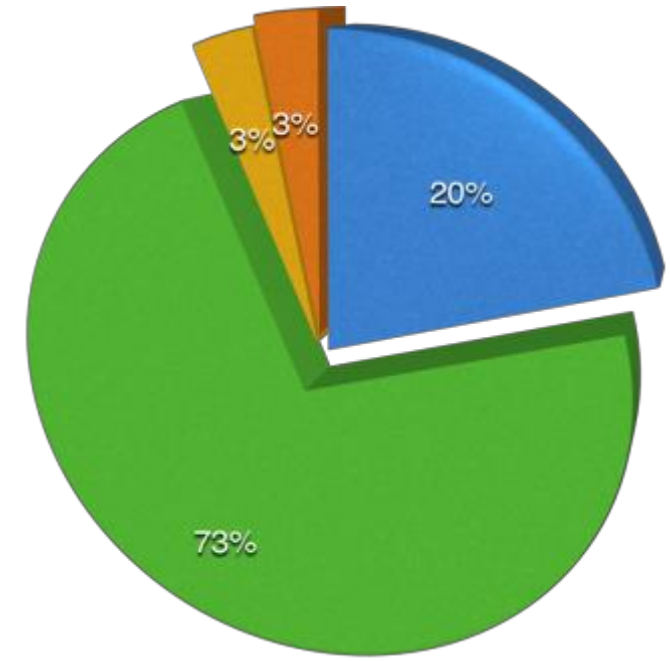
The ethnicity of those triaged was diverse, although the majority by far were white British

The 2011 census shows Oxfordshire's population as 9.2% BME and 6.3% white non British. The proportion of residents from ethnic minority groups is much higher in Oxford: 22% BME and 14% white non British. This profile falls between the two.



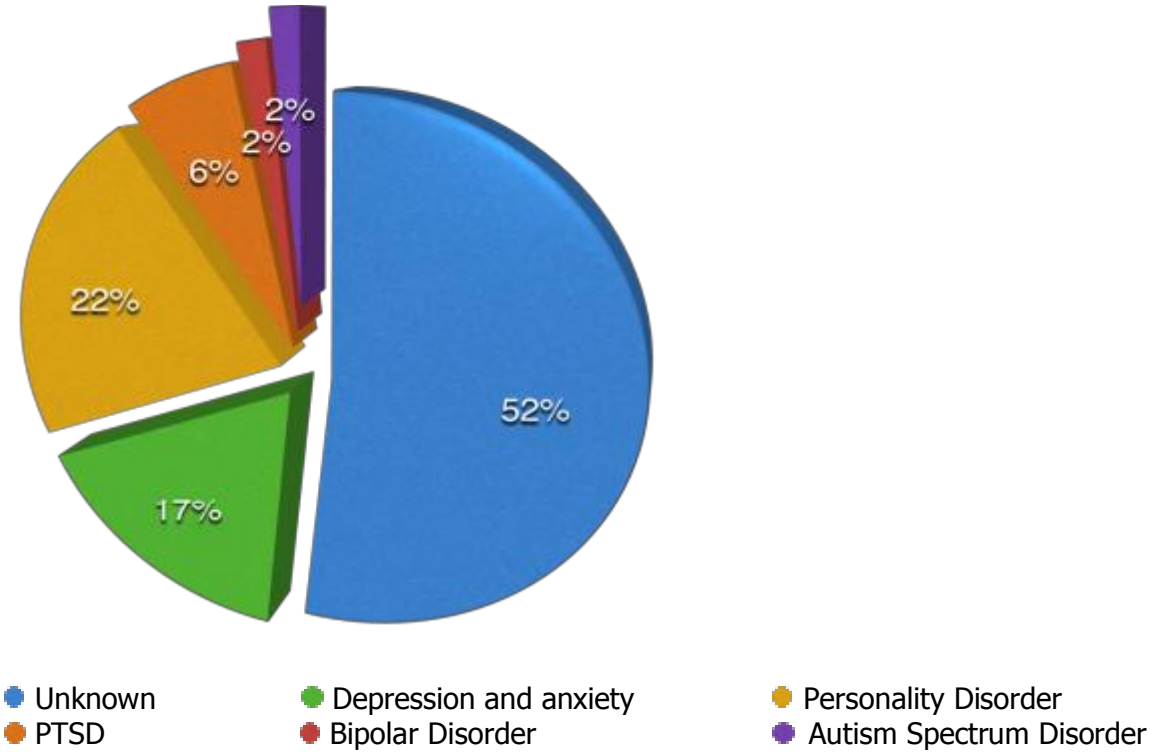
Relationship status with perpetrator

Whilst a high level of those triaged were separated from their perpetrator 20% remained in contact with them (see graph below) the domestic abuse services remained in contact with these women which helped to manage and minimise any risk from further harm and abuse. All those referred had experienced multiple incidents of abuse. Most had experienced abuse over several years.

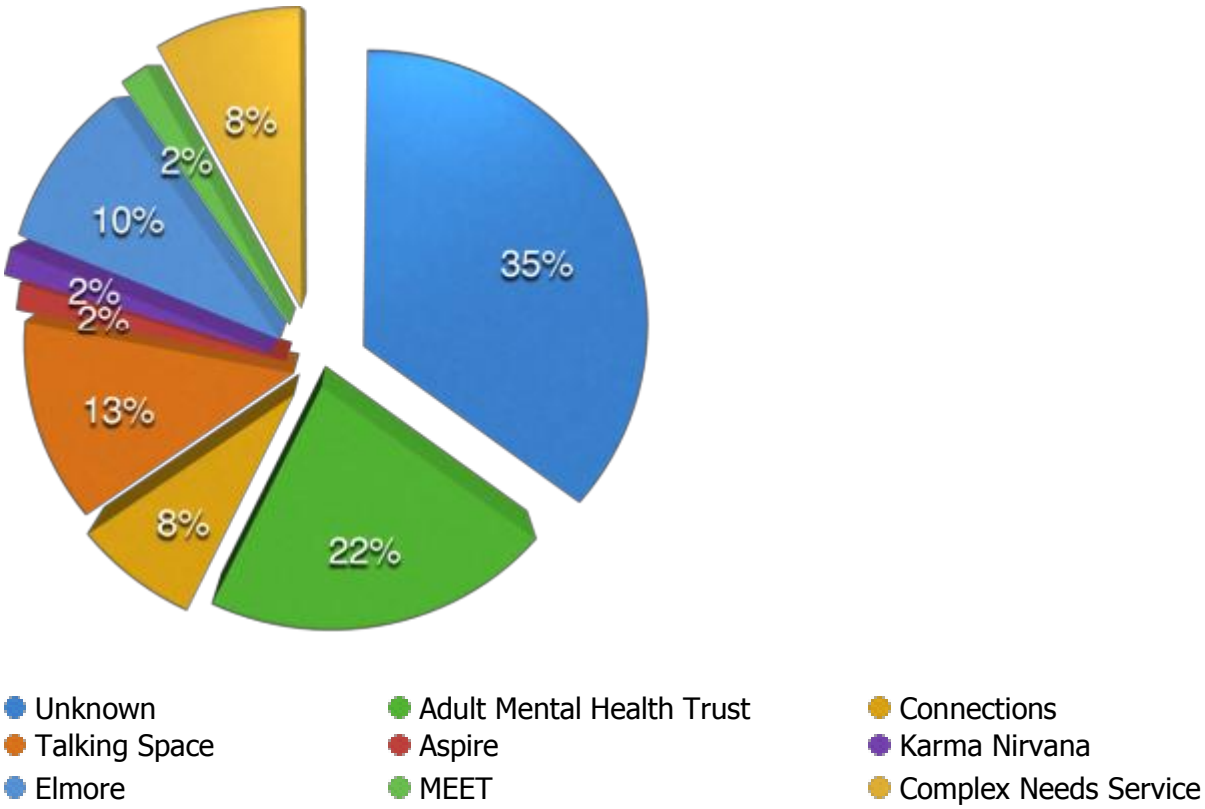


Previous mental health diagnosis

Of the 68 referred there were no individuals with a physical or learning disability but all were deemed to have a complex mental health presentation which compromised their ability to keep themselves safe and increased their vulnerability to further abuse. In terms of previous mental health diagnosis over half were unknown in this respect. The break down of those that remain is as follows:



Previous or current involvement with other services



Observations and reflections from the first TAP group

The TAP facilitators have worked intensively to engage this group of service users with complex needs and maintaining attendance has been difficult. For many, attending a group in itself presented challenges and they consequently struggled to sustain attendance to weekly group sessions, raising anxieties amongst facilitators of waning numbers. However our early experiences of the benefits of the group process for our service users have been very positive and encouraging. In hindsight there was definitely some scope for pre-group engagement and will be taken forward as a learning point for the second group, although time constraints are likely to be a limiting factor again for the level of pre-group engagement that facilitators would like. Continuing with key-working support post group is also important to ensure effective signposting and handovers. Other factors that were important for good group attendance include maintaining weekly key-working sessions and a central venue with good transport links.

We agreed that service-users accepted for the group, should retain their DA workers either in IDVA or ODAS in addition to their keyworker in TAP. This was to ensure that 1-1 key-working sessions were used to focus exclusively on group-related material and ideas, as opposed to DV/ crisis/ practical related issues. This was difficult to do at times in the first group, depending on the nature of the crisis, however where there was another DA professional involved, clients were encouraged to speak to them in relation to DV crises, and their TAP worker in relation to therapeutic models. It allowed the service users to get the most therapeutically out of their key-working sessions and they were likely to have gained greater benefits from the group as a result.

As the facilitators have become more familiar with the therapeutic ideas and material delivered in the first group, they reported a greater confidence and feel they will be able to focus on how to deliver the content more creatively and dynamically in the subsequent groups. We are consequently expecting the second and third group to be more engaging and interesting which should influence attendance and engagement.

On a multi-agency level, we had to maintain a clear and consistent boundary to ensure that the right and appropriate statutory services responsible for holding clinical risk and responsibility, remained involved where necessary. This in part involved conveying that we weren't a clinical service and clarifying the appropriate inclusion criteria for TAP, for instance, feeding back that the Adult Mental Health Team were the statutory service for holding suicide risk and not us (we observed a tendency for statutory agencies suggesting they were going to close cases that were a part of TAP).

Finally, the robust structure, expertise, framework and support around TAP (regular clinical supervision and consultation) has been absolutely imperative to ensure this group has been delivered in a safe and effective manner. We have all acknowledged that without this, it could have caused more distress for the client group, and resulted in high stress levels and potential sickness for staff members. As with any skills- based intervention, part of the task has involved raising awareness of psychosocial concepts in order to help clients find alternative helpful ways of dealing with the difficulties in their lives. Some of the module content brought up difficult things for our clients, and a lot of thought has been put in to manage this appropriately.

Next steps in the development of the project

Triaging for the 2nd group started in August. The "Meet and Greet" for the second group cohort commences on the 31st of October and the second group cohort is due to end on the 10th of April.

Over the next six months we will have:

- a larger cohort of service users and associated data
- reviewed pathways into the service and the 'journey' for victims at different risk levels
- collated further service user outcomes including:
    - outcomes and learning from the second TAP group
    - a greater understanding of the outcomes and learning from service users not in the group but receiving specialist team support
    - impact of the additional consultation/ supervision from the Project Development Manager on IDVA case work and associated outcomes
    - quality of referrals to other mental health services (with feedback where possible).

We would hope to have some initial findings about enhanced and effective interventions for this service user group and more acute understanding of the issues and challenges – including support for service users with both mental health and substance misuse needs.

In addition we will have:

- drawn from learning to plan and start the second TAP group
- begun to explore potential uses of modules from TAP in individual work and/or further development in individual work with services users where group work is not appropriate
- completed champions training and have feedback – with plans for gathering information on the impact of the extended network
- and practice staff from the different projects will have met to share experience and learning.

Chapter 5 Data: initial outcomes of TAP (Oct 2016)

The first TAP group cohort was concluded on the 3rd of October. Of the 16 accepted, 7 have attended regularly and others have participated for shorter periods. Service users referred to the specialist team have a full assessment with a focus on mental health at the point of referral which can also be used to measure change by the end of support. Screening tools were re-administered and compared with the baseline data that was collated as part of the assessment, namely:

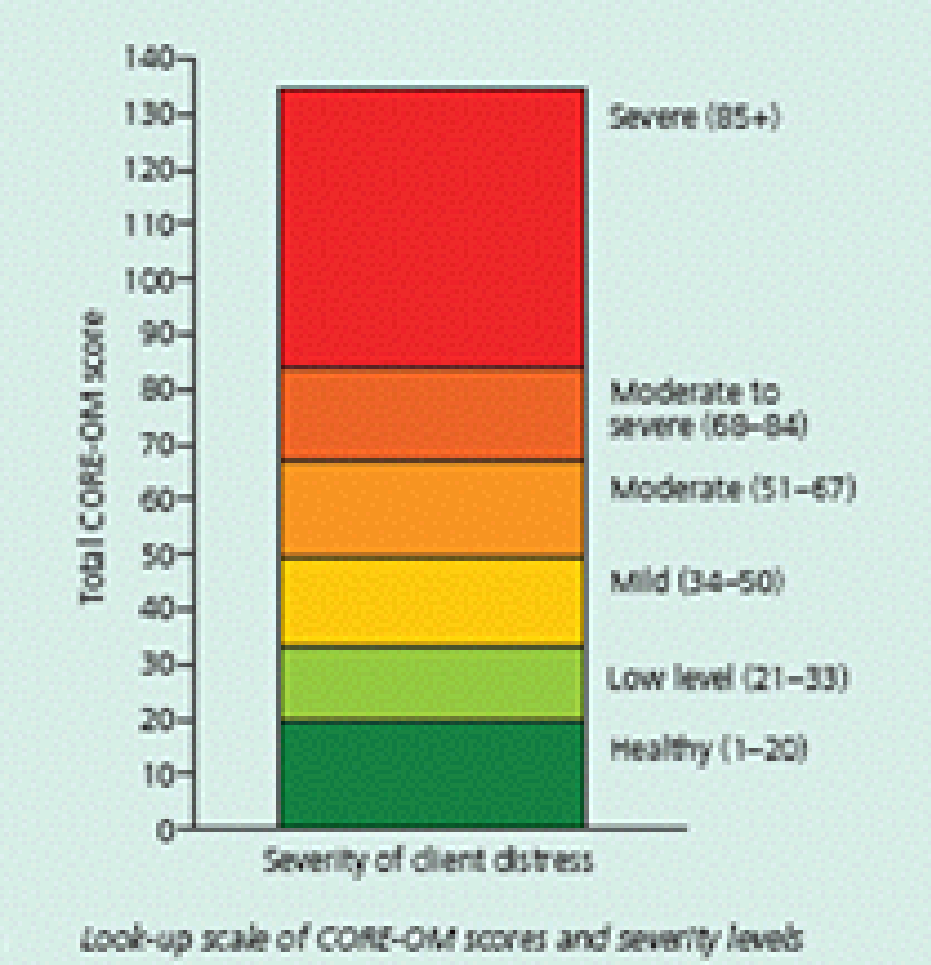
- Clinical Outcomes in Routine Evaluation (CORE),
- Mental Health Recovery Star
- The Modified Overt Aggression Scale (MOAS),
- Standard Assessment of Personality Abbreviated Scale (SAPAS),
- Work and Social Adjustment Scale (WSAS),
- Fast Alcohol Screening Test (FAST)
- McLean's Screening Instrument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

This is an interim report. We are continuing to collect, collate and assess outcome data to evaluate both the wider project and the 'Stabilisation Phase' as a stand-alone intervention. At this point we have preliminary data which demonstrates significant impact for clients engaged within the High-Intensity Phase.

Of the clients engaged with the High-Intensity Phase, we gathered 50% of full data sets to inform the preliminary results. The data sample size is therefore small, with 4 clients completing the full pre and post measures. However, the data shows exciting potential in terms of reducing both 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 below is used as a guide for determining the range of clinical significance.

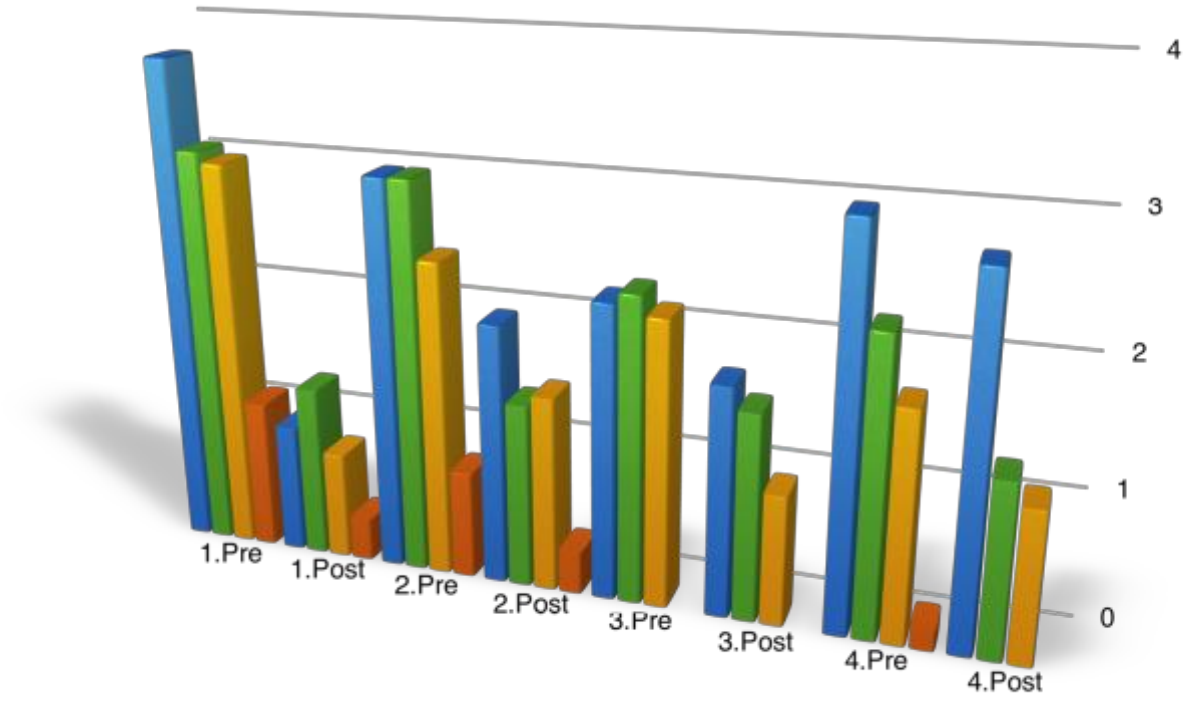


Look-up scale of CORE-OM scores and severity levels

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

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

Individual pre and post outcome data for the High-Intensity Phase (cohort 1)



Pre measures

Wellbeing Symptoms Functioning Risk

The graph above shows that pre-measures indicated all the respondents were suffering psychological distress within the clinical range across all domains except risk. It is important to note that this particular measure does not account for risk from others i.e. domestic abuse. This data is captured by the fact they are engaged within the domestic abuse pathway. Across the domains of wellbeing, symptoms and functioning all respondents scored within the low category with the exception of one who was in the mild category.

Post measures

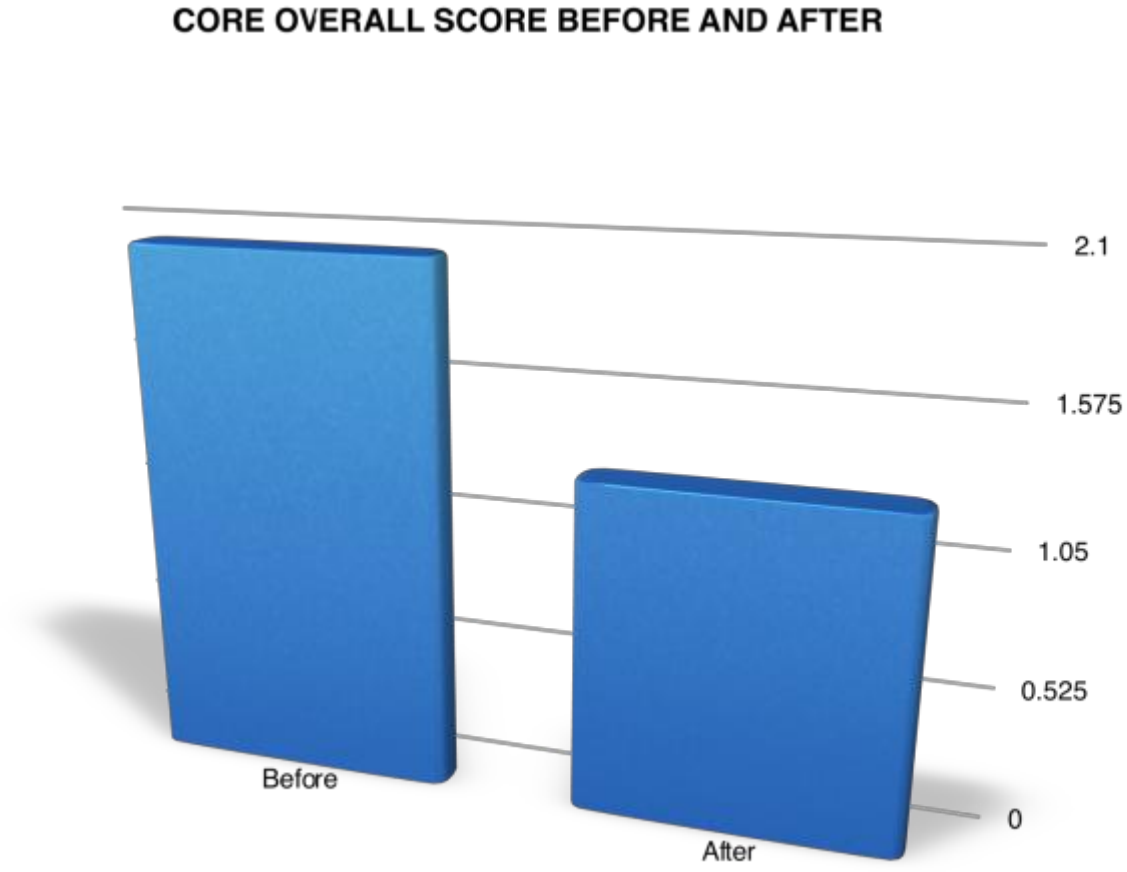
The post measures for all respondents show improvements across all four domains.

Whilst the sample size is small there is a trend towards **clinically significant** improvement as follows: Wellbeing:**25%** Functioning: **50%**

A significant shift from the low to the healthy tier in the remaining sections of all four domains demonstrating benefit and potential growth and resilience within all four areas.

Collated data

The overall scores of the CORE data combined show a **37% improvement** across all domains (graph below).



Further details of individual scores can be found at the end of this chapter

Case studies

Client C: C attended approximately a quarter of the group and key-working sessions. Along with TAP, C continued to receive support from her IDVA worker and Connections Floating Support. Together, her support workers provided C with the confidence to leave her husband of 20 years (the perpetrator) and start divorce proceedings. They supported her through her ambivalence surrounding the decision and helped her to keep herself safe. They also helped her with her financial difficulties until she was able to manage them independently. As a result no further referrals were made at the end of the group as C reported she was now able to work towards any mental health related goals independently, without any input from specialist services. Most importantly, C reported vast improvements in how she related to herself and others. TAP helped her to evaluate her expectations from intimate relationships and discern what was acceptable.

Client D: was an example of effective joint working between her CPN from the Adult Mental Health Team (AMHT) and the TAP Outreach Worker. The CPN has facilitated D accessing the group by accompanying her to the first meeting. D is open to the Warneford Hospital and frequently presented to them for acute episodes of deliberate self-harm with a high risk of death. In the first two months of the group, there was a period where D presented to an inpatient setting on almost a weekly basis and spent significant times in the hospital. With the CPN managing the risk and also supporting the TAP Outreach worker with her anxiety, the TAP Outreach Worker was able to engage D to support her in managing her distress in a safer way.

With this combined support D hasn't presented to an inpatient setting in the last couple of months and hasn't had any acute episodes of attempted suicide or deliberate self-harm. D expressed that attendance at the group was the intervention that she found most helpful in supporting her to change her coping mechanisms. D was referred to TAP by her Children's Social Worker because,

after the ending of her abusive relationship, D's capacity to parent her 4 year old daughter was significantly impaired by her mental health. During the period that D engaged with TAP she was able to gradually started taking back more parental responsibility for her daughter and now lives independently with her daughter with far less support from her family.

D also enrolled on a Level Two Beauty Therapy course at college and is independently attending and engaging with this course. She reports a returned ambition to become a self-employed hair and beauty therapist and an assertiveness to achieve this. Overall D presents as significantly more resilient with a less fragmented sense of self which has enhanced her reflective capacity around her emotional states. D has self-referred to Complex Needs.

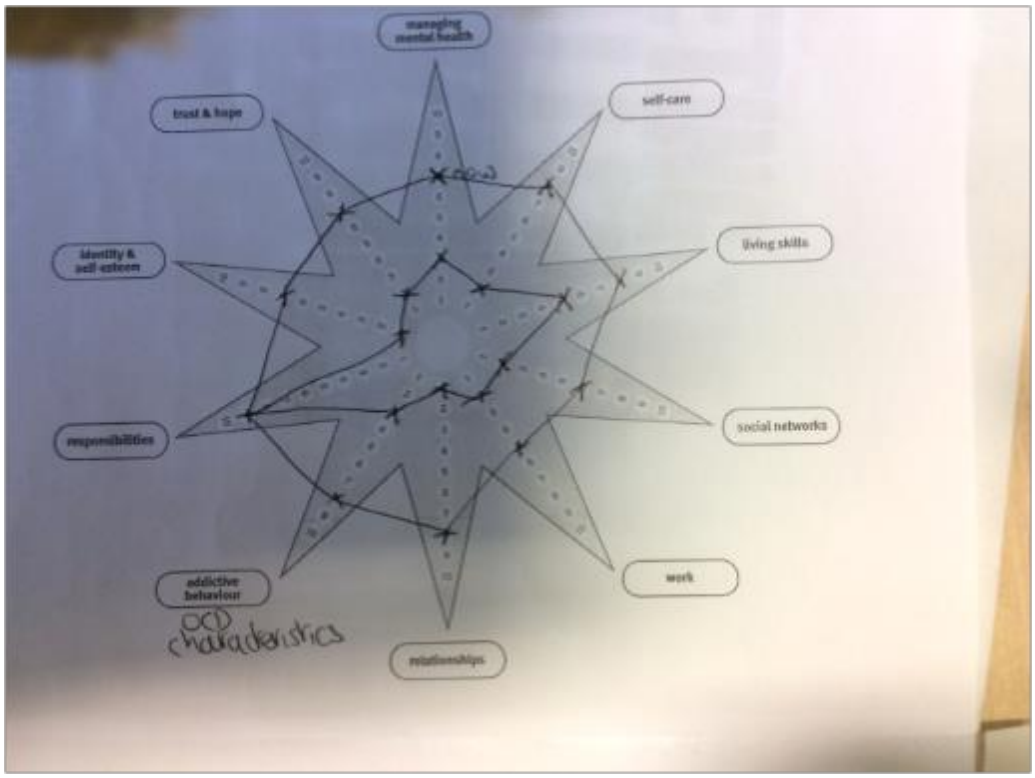
Client E: was referred by her Children's Social Worker to TAP. She has a diagnosis of Emotionally Unstable Personality Disorder. E was pregnant with her fourth child at referral and there are ongoing Court proceedings. Although E was accepted for the first TAP group she was unable to engage in the group due to her ill health in pregnancy and was only intermittently making herself available for one to one meetings. The TAP Outreach worker made a Safeguarding referral when E was not prioritizing her own health which had the potential for serious consequences for her unborn baby. The TAP Outreach worker considers that the capacity for more intensive outreach support was the catalyst that enabled E to engage, it gave the worker the ability to visit E and her newborn in hospital and create a more secure attachment with her. Since then they have met weekly and covered material on a one to one basis. E reports that she now thinks that 'it is ok to have a EUPD diagnosis' and has changed her belief that 'if you have been abused as a child, you will grow up to be abusive, I now know it is a choice'. E identifies that she has been able to work more openly and trustingly with other agencies and has been able to contact health professionals when she identified the need for more intensive support. E will be attending the second TAP group. Without the significant support and commitment E received in the stabilization phase of TAP from her key-worker/ Complex Needs Outreach Officer, E would never have been able to engage with the High Intensity phase of TAP.

The Mental Health Recovery Star

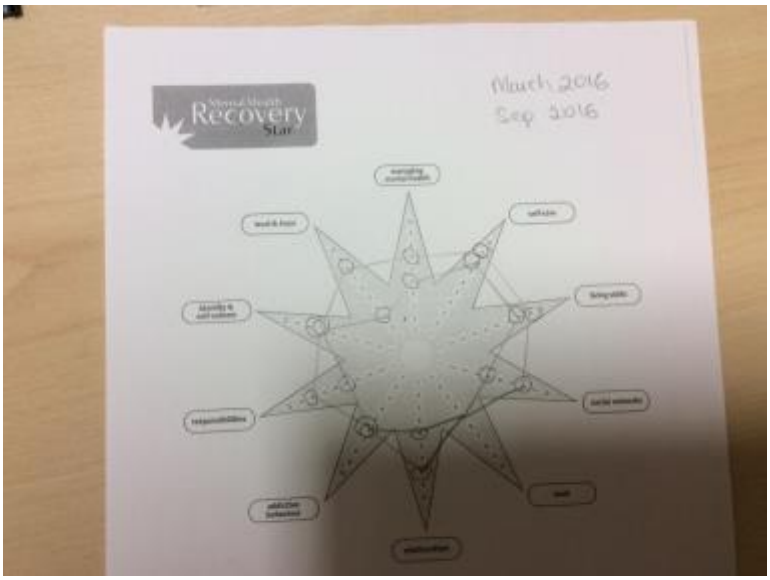
The Recovery Star developed by the Mental Health Providers Forum, is an outcomes measure which enables people using services to measure their own recovery progress, with the help of support workers.

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) and 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 itself can encourage hope.

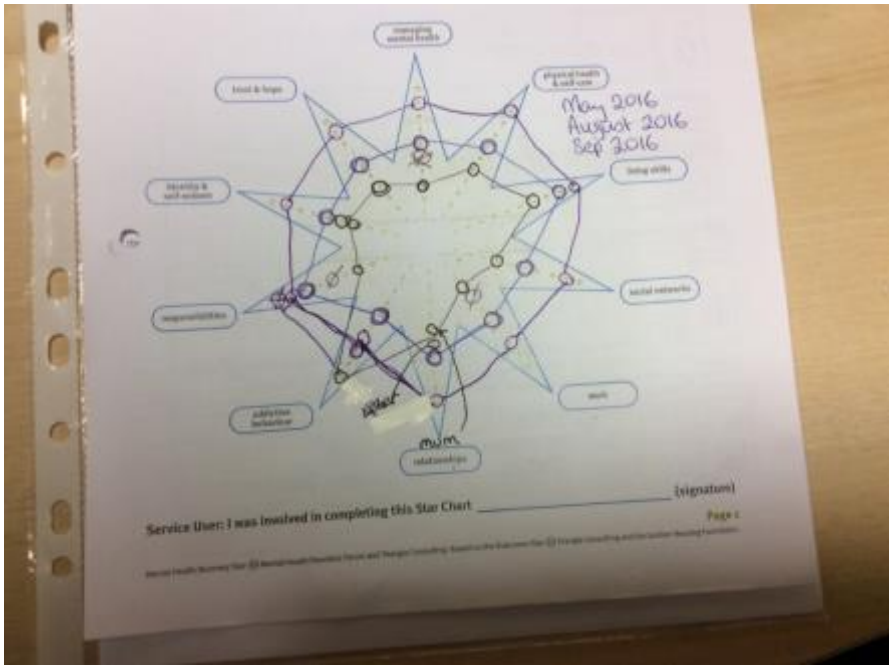
Client C: At the start of the group, C reported feeling suicidal and scored a one (the lowest possible score) on the 'Identity and Self Esteem' dimension on the Mental Health Recovery star. Towards the end of the group programme, C recorded a 7. Similarly, she recorded a 1 on relationships five months ago, and an 8 towards the end of the group programme. Client C reported significant improvements across 9 domains related to her Mental Health- see below. In fact, C reported greater independence with managing all 10 domains through the combined support from TAP, IDVA and CFS over the last five months.



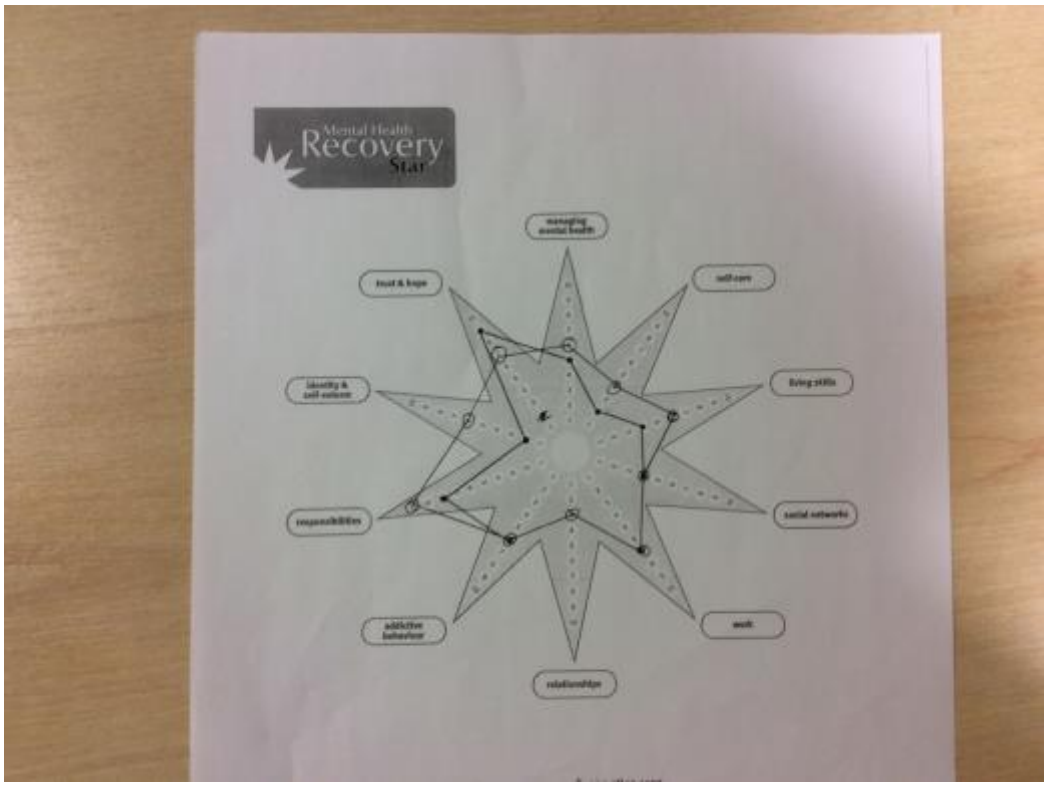
Client F: reported improvements on seven out of the ten domains, with significant improvements in her capacity to 'trust and hope'; she went up by half the scale in this particular area. On the three domains that F reported remained the same for her over the course of the group programme, her score in the 'work' domain was the lowest. F however fell pregnant towards the end of the group which impacted on her immediate professional aspirations and consequently her work- related outcomes. F had enrolled on an Open University course that she won't be able to continue at present, due to the pregnancy, but intends to resume one day.



Client D: reported significant improvements across all 10 domains over the course of the intervention - see below.



Client G: reported improvements across five of the domains related to her mental health, particularly in her identity and self esteem and reported no change in four of the domains. G started a course in social work towards the end of the group.



The Modified Overt Aggression Scale (MOAS)

The MOAS is a four-part behaviour rating scale designed to measure four types of aggressive behaviour as observed in the past week. Each section consists of five questions, with the first section regarding verbal aggression, the second section focusing on aggression against property, the third section measuring auto-aggression (aggression against self), and the fourth section concerning physical aggression.

Client G baseline scores:

Verbal aggression- 0
Property aggression- 0
Auto-aggression- 0
Physical aggression- 0

End point scores:

Verbal aggression- 0
Property aggression- 0
Auto-aggression- 0
Physical aggression- 0

There has been no reported change.

Client D baseline scores:

Verbal aggression- 1
Property aggression- 0
Auto-aggression- 1
Physical aggression- 0

End point scores:

Verbal aggression- 1
Property aggression- 0
Auto-aggression- 0
Physical aggression- 0

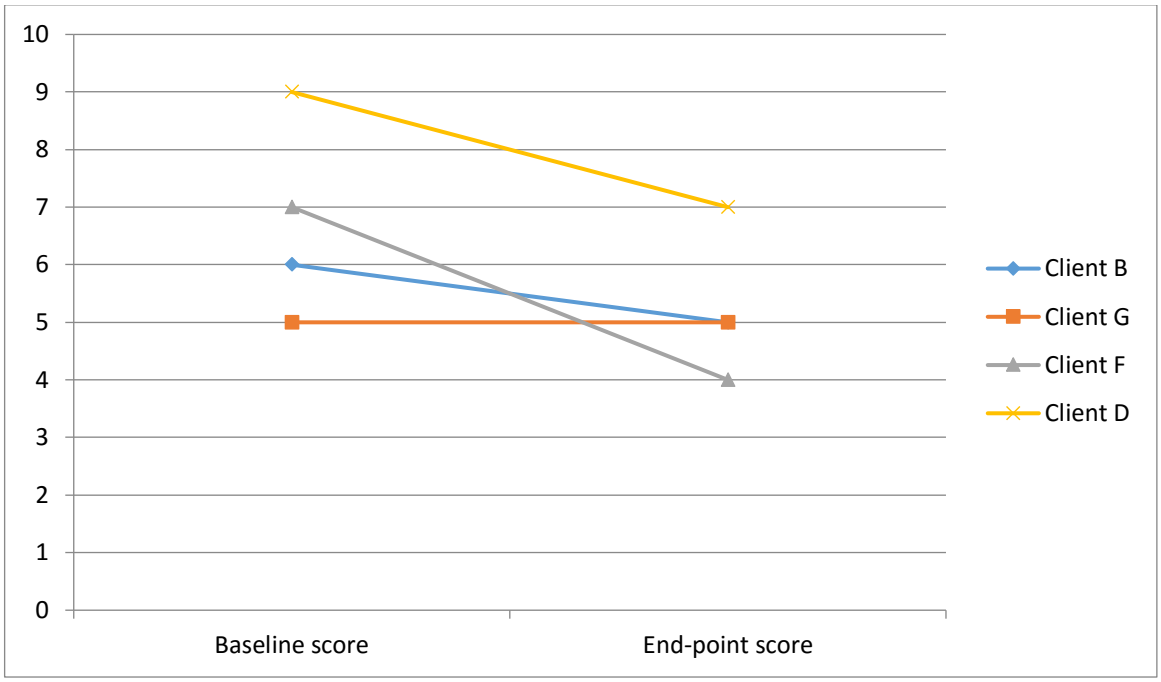
A 50% reduction in aggression.

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.

Client G's baseline and end point scores were both 5
Client D's baseline score was 9 and end point score was 7
Client B's baseline score was 6 and end point score was 5
Client F's baseline score was 7 and end point score was 4

Although 75% reported a reduction in scores over the course of the intervention, pointing towards better relatedness with themselves and others towards the end of the intervention, all their scores, both at baseline and end-point were higher than the clinical cut-off of 3, pertaining to significant difficulties in this area.

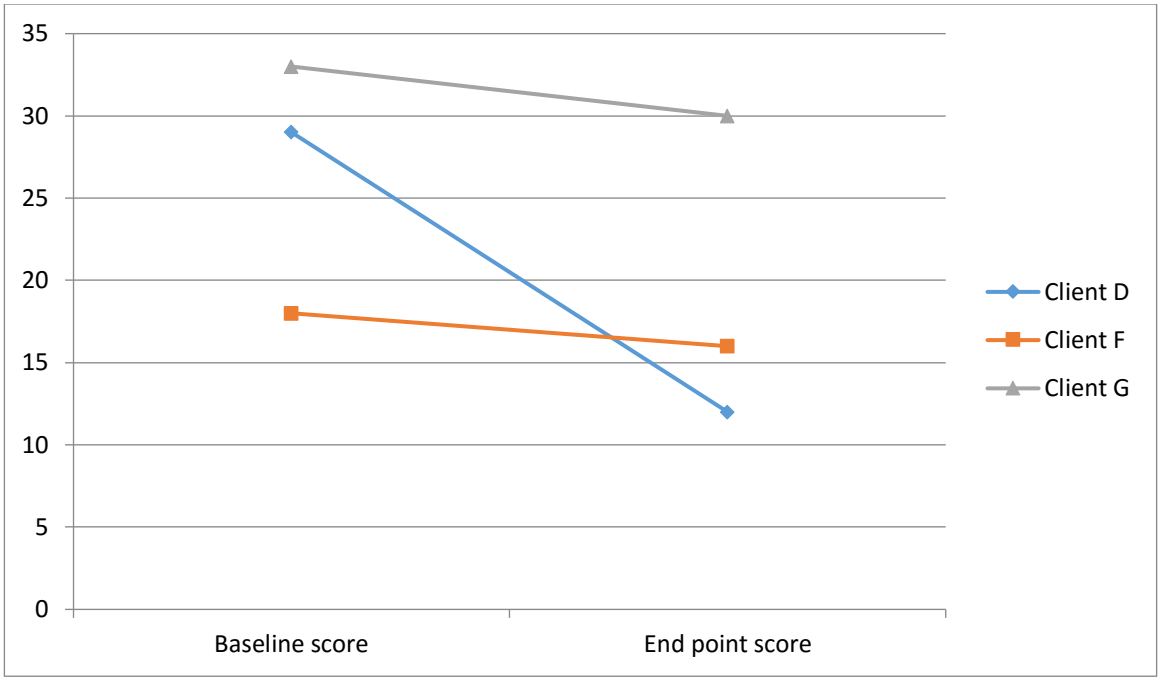


WSAS- Work and Social Adjustment Scale

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, and therefore the maximum score of the WSAS is 40.

- 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

Client	Baseline score	Endpoint score
F	18	16
B	10	-
D	29	12
G	33	30



For all three clients that we have both baseline and end point data, they all reported improvements in their overall functioning towards the end of the intervention when compared to baseline.

Mood Disorder Questionnaire

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.

Client	Baseline score	End point score
Client G	1 (negative screen for bipolar spectrum disorder)	1 (negative screen for bipolar spectrum disorder)
Client D	5 (negative screen for bipolar spectrum disorder)	9 (positive screen for bipolar spectrum disorder)
Client F	7 (positive screen for bipolar spectrum disorder)	5 (negative screen for bipolar spectrum disorder)
Client B	3 (negative screen for bipolar spectrum disorder)	4 (negative screen for bipolar spectrum disorder)

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 client could meet the criteria for BPD. Overall 3 out of the 4 clients reported a reduction in scores pertaining to better relatedness to themselves and others.

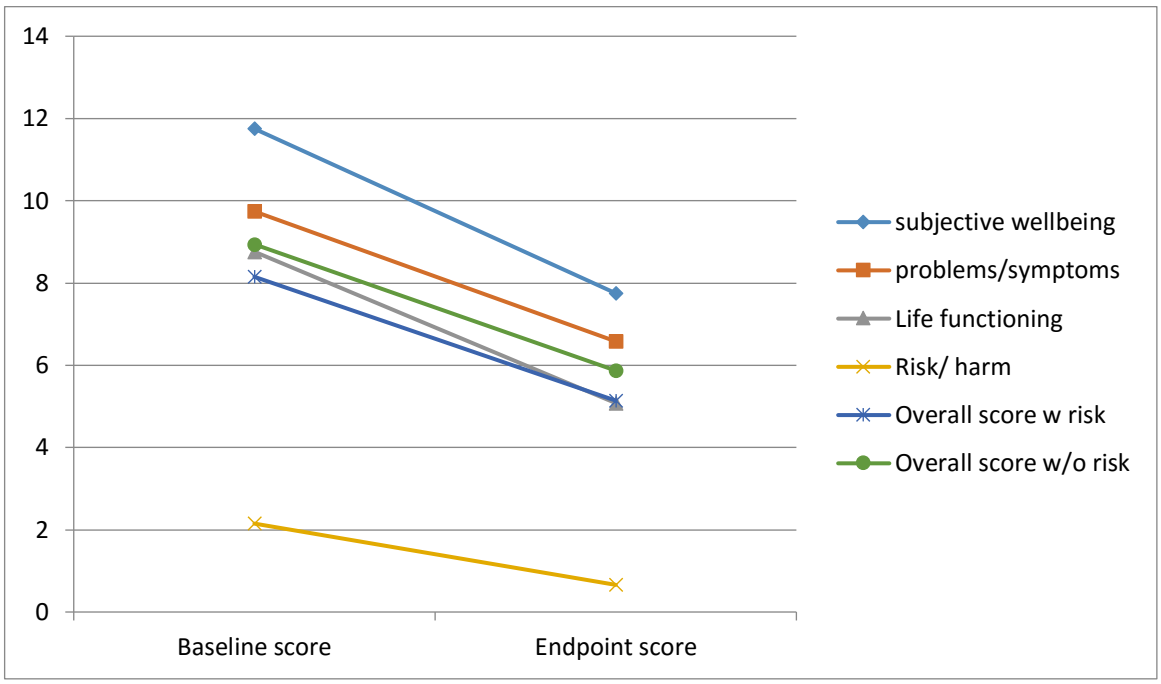
Client	Baseline score	End point score
Client G	1 (negative screen for BPD)	2 (negative screen for BPD)
Client D	10 (positive screen for BPD)	9 (positive screen for BPD)
Client F	6 (negative screen for BPD)	3 (negative screen for BPD)
Client B	8 (positive screen for BPD)	2 (negative screen for BPD)

The CORE screening tool – further data

As described at the beginning of this section, the combined scores of the four clients for whom we have both baseline and end point data on the CORE, demonstrate overall significant improvements across all four dimensions over the course of the group. Lower scores indicate healthier outcomes in each dimension. This is despite including client B's 'outlier' scores in the data set.

Baseline- combined data for all four clients:
W- 11.75
P- 9.74
F- 8.76
R- 2.15
Overall score- 8.15 (accounting for risk); 8.94 (not accounting for risk)

End point- combined data for all four clients at the end of the six month group:
W- 7.75
P- 6.58
F- 5.08
R- 0.66
Overall score (global distress)- 5.14 (accounting for risk); 5.87 (not accounting for risk)

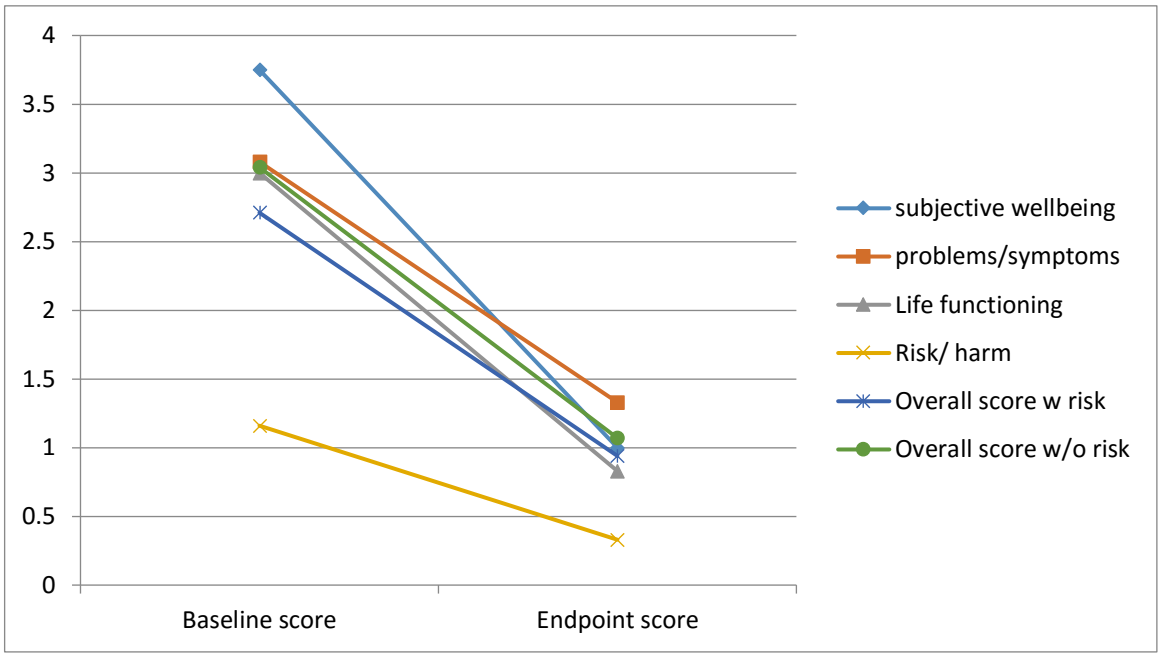


Client D significantly improved across all four dimensions over the course of the group. Lower scores indicate healthier outcomes in each dimension.

At baseline, client D reported mean scores of:
W- 3.75
P- 3.08
F- 3
R- 1.16
Overall score- 2.71 (accounting for risk); 3.04 (not accounting for risk)

At the end of the six month group, client D reported:
W- 1
P- 1.33
F- 0.83
R- 0.33

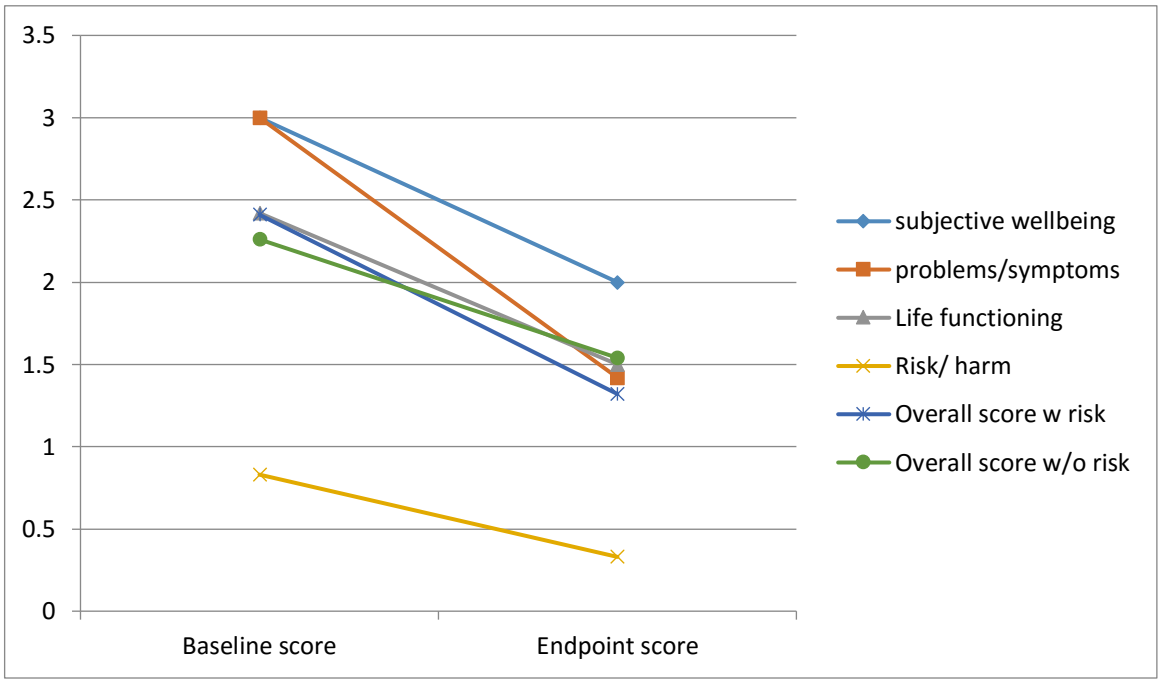
Overall score (global distress)- 0.94 (accounting for risk); 1.07 (not accounting for risk)



Client F significantly improved across all four dimensions.

Baseline scores:
W- 3
P- 3
F- 2.42
R- 0.83
Overall score- 2.41 (with risk); 2.26 (without risk)

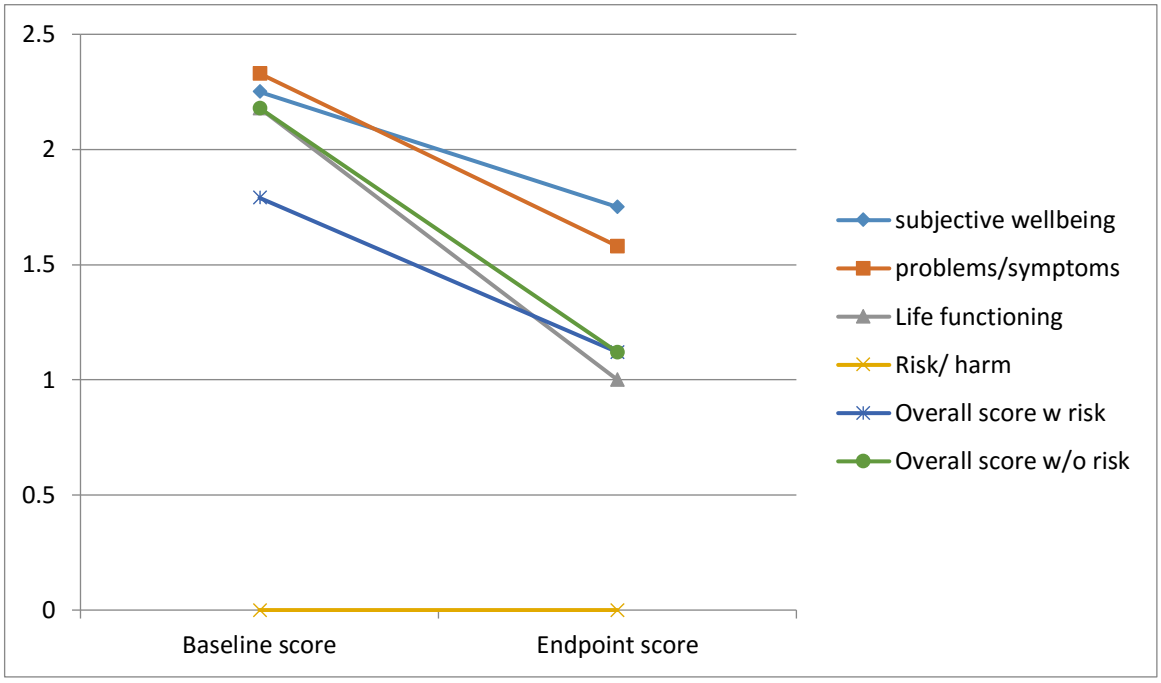
End point scores:
W- 2
P- 1.42
F- 1.5
R- 0.33
Overall score- 1.32 (with risk); 1.54 (without risk)



Client G reported improvements across all domains with no changes to risk:

Baseline scores:
W- 2.25
P- 2.33
F- 2.18
R- 0
Overall score- 1.79 (with risk); 2.18 (without risk)

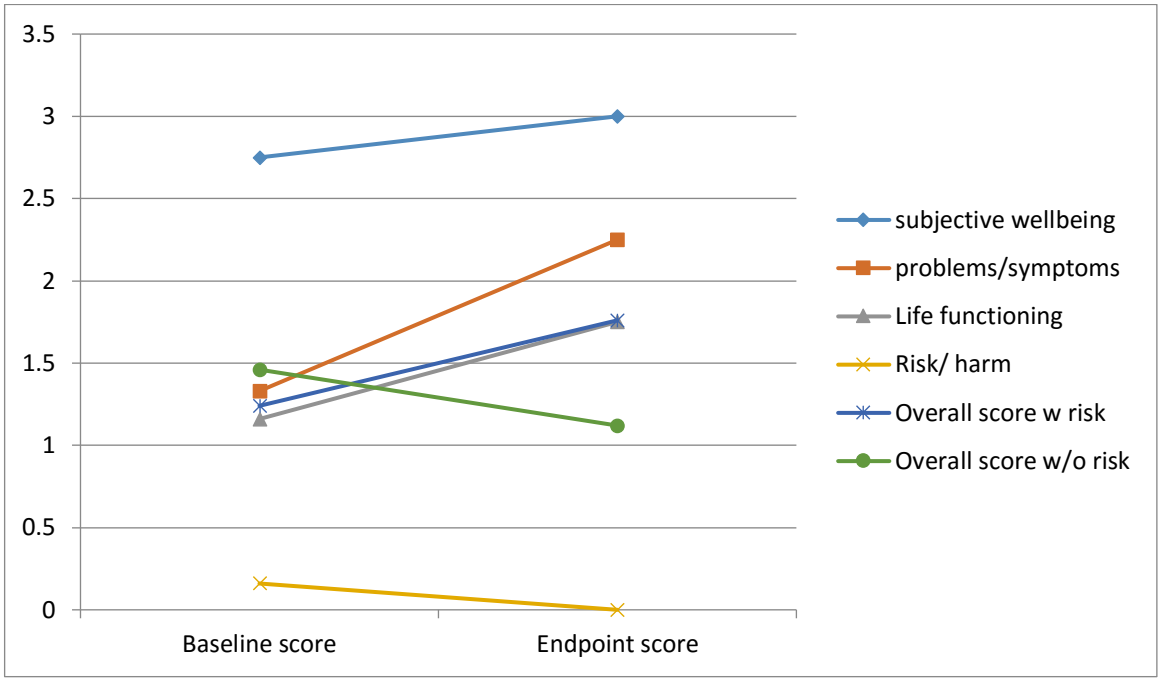
End point scores:
W- 1.75
P- 1.58
F- 1
R- 0
Overall score: 1.12 (with risk); 1.12 (without risk)



Client B was the only client whose scores seem to reveal greater distress towards the end of the intervention compared to baseline. However, according to accounts from both the practitioner and service user, she seems to have gradually developed a greater insight, emotional awareness and ability to self reflect over the course of the intervention. Her end point scores are therefore likely to be a more authentic indication of her emotional profile compared to her baseline scores.

Baseline scores:
W- 2.75
P- 1.33
F- 1.16
R- 0.16
Overall score- 1.24 (with risk); 1.46 (without risk)

End point scores:
W- 3
P- 2.25
F- 1.75
R- 0
Overall score: 1.76 (with risk); 2.14 (without risk)



Feedback from members of TAP1- evaluative accounts of the group

Client D: "I wouldn't have got to college without this. I would never have left my room before, or my house. Now I have my independence back, my life back…I have found my confidence. It has got me out of my house"
"It's changed my life completely. It's been so much more therapeutic than any other support I've ever had"

Client G: "I haven't enjoyed it as much as B because some of the content has been upsetting, but I found it very very useful. Now I have the language for how I feel and the ideas for understanding myself better"
"It's helped me normalize my experiences….it was helpful hearing that others, even those who I considered 'normal', can also feel like this"

Client B: "Felt like I'd already worked through this. It just made me re-live it*".*
This comment was made in the final session by someone who had developed greater capacity for self-awareness and expression over the course of the group. However this and the ending of the group prompted difficult feelings. There is ongoing support available for her.

Section 6: Recommendations for next stage development

1. We will continue to run and evaluate TAP and build on learning to date – as in 'next stages' (P17).

Given the significant outcomes of TAP to date, we would recommend developing this work beyond the time frame of the project - and incorporating longer term evaluation. We would like to work with the office of the PCC, and other partners, to consider possible sources of funding.

There is potential to further explore how far it is possible to incorporate elements of the group programme within individual support for those service users for whom group participation is not possible for emotional or logistical reasons. Outreach workers already draw on elements in their individual support of service users.

2. We would like to undertake a more rigorous analysis of outcomes for those service users for whom TAP is not suitable; e.g.

- any improvement in referrals from DA services into other mental health services - and identification of gaps
- outcomes for IDVA service users triaged but not accepted for or unwilling to use TAP

It would be valuable to explore, even in a theoretical way, whether there is scope for any further innovative work and alternative interventions to enhance support for some of these service users.

3. A shortcoming of the project has been that IDVA team members have not been directly involved in TAP. An IDVA member who is also a part of the TAP team would strengthen the pathway for and better integrate work with IDVA service users, and contribute substantially to the expertise of the IDVA team. In planning the project we recognized the complexity of cases reaching the county outreach services and the need as priority for a specialist outreach service. In addition to this, what would be valuable for service development, would be to add an IDVA post. In the meantime we will pursue funding to sustain clinical supervision for the IDVA service after the ending of the project.

4. There is exciting potential to build on the Champions work to further align practice between DA and MH services and to strengthen resources for recovery.

5. There is scope to explore barriers to accessing Mental Health services and begin to widen the remit of the project. A priority, in due course, would be to incorporate work to address substance misuse – potentially learning from other project work in the Thames Valley consortium.

Appendices

Appendix 1: Locations of current DA Champions in mental health/therapeutic settings (Oct 2016)
Appendix 2: Mental Health Service Scoping

Co-authors/ contributors to the pilot project

Sara Sanders: Managing Director of Sapiens, clinical supervision and development of TAP
Sally Brookes: Psychotherapist, clinical supervision and development of TAP
Kirren Mahmood: the Project Development Manager for the pilot and TAP facilitator
Karen Diver: Service Manager for ODAS
Marilyn Anderson: the Manager for TAP and the Team Leader for ODAS
Jane Armstrong: Complex Needs Outreach Officer in ODAS and TAP facilitator
Amanda Hall: Complex Needs Outreach Officer in ODAS and TAP facilitator
Romy Briant: Chair of Reducing the Risk and project lead for the PCC project contract

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