An evaluation of the Refuge Access for All Project

Creating a Psychologically Informed Environment in Solace Women's Aid services across five London Boroughs

solace women's aid

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Contents

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1. Executive Summary

This report evaluates the work of the “Refuge Access for All” project, carried out by Solace Women’s Aid in conjunction with five North London Boroughs, with consultancy and evaluation support from AVA (Against Violence and Abuse). At the heart of the project was the creation of a Psychologically Informed Environment (PIE) across Solace Refuges, to establish how effectively a concept developed in the homeless sector in the UK could be applied to the domestic violence sector. This included play therapy to ensure that the needs of children and young people in refuges were also addressed.

The evaluation shows that the project lead to a significant measurable increase in the understanding and confidence of staff in dealing with issues around mental ill health and substance use. Staff also reported feeling more supported in the workplace, in particular around issues of personal mental ill health, trauma and substance use.

Refuge residents also reported measurable improvements on a trauma informed practice scale over a period of only six months, showing an impressive impact on outcomes. The play therapy made a difference in the behaviour and emotional wellbeing of children and their mothers during their stay in the refuge.

The only area of the project where success was more limited was in working with local mental health and substance use services to develop joint protocols and pathways – this was due entirely to overcapacity and lack of resources in those services.

The conclusion is that the concept of the Psychologically Informed Environment is applicable to the domestic violence sector, and that the key components identified in this project can have a measurable and transformational impact on refuge residents and staff alike

2. About the Project

The "***Refuge Access for All"*** project was established to provide a model for working to improve access to, and the outcomes for, women and children in refuges with mental health and/or substance use issues who have experienced domestic abuse. It was funded by the Department for Communities and Local Government (DCLG) and was a partnership between Solace Women's Aid and the London Boroughs of Enfield, Barnet, Haringey, Islington and Camden. It involved training and infrastructural improvements to provide additional support to staff to ensure that Solace Women's Aid is better placed to accept mental health referrals and women with drug and alcohol issues to sustain a woman's place in the refuge through to successful move on.

There were three key elements to the project:

a) Setting up a steering group with service user representation and including all partners to ensure the outcomes were achieved and effectively evaluated.

b) Improving access to refuges for this vulnerable group of women and children outside of individual borough boundaries. This element focussed on the smooth transfer of cases where a woman is supported in the locality she is fleeing and early access to borough based services in her new area. It also sought to ensure structures are in place to enable smooth move on from the refuge and continuation of support/care. To achieve this the project sought to gather intelligence, develop proposals and reach agreements on joint work between mental health services and refuge services.

c) Establishing a Psychologically Informed Environment (PIE) within refuges with the aim of improving access to and support in refuges by:

- Carrying out a review of refuge assessment processes to ensure they are robust for women and children with mental health and/or problematic substance use support needs and that the assessment outcomes link through to safety and support planning and move on planning and support.
- Staff training to strengthen staff's mental health awareness by providing updated and ongoing training for staff in basic counselling and listening skills, trauma and mental health, drug and alcohol use and their relationship to domestic violence.
- Creating a mental health training programme for staff which is included in Solace's complex needs staff training programme, to ensure the sustainability of the project.
- Embedding reflective practice processes in case review meetings (including case reviews where a woman has been refused a space or where the placement has been disrupted), and ensuring this model is re-enforced in staff's clinical supervision.
- Assessing other elements of PIE with service user focus groups to ensure the refuge provides a conducive physical environment including access to groups supporting their mental health both internally and externally.

- Provision of play therapy for children with linked support for mothers in refuges across all Solace Women's Aid sites.

3. About Psychologically Informed Environments

A Psychologically Informed Environment (PIE) "…*is one that takes into account the psychological makeup - the thinking, emotions, personalities and past experience- of its participants in the way it operates "*[1]

It is an approach that has been developed in the homelessness sector, focussed particularly on clients who have experienced complex trauma. It also considers the psychological needs of staff: developing skills and knowledge, increasing motivation, job satisfaction and resilience. [2]

"*Refuge Access for All" is* a pioneering attempt to apply PIE principles to a refuge setting. The project was motivated by the lack of suitable support in the domestic violence sector for women with complex needs, in particular those women experiencing mental ill health and/or problematic substance use.

The purpose of a PIE is to help staff understand where client behaviours are coming from and therefore work more creatively and constructively with challenging behaviours.

A Psychologically Informed Environment[3] has 5 key elements:

1. Development of a psychological framework
2. The physical environment and social spaces
3. Staff training and support
4. Managing relationships
5. Evaluation of outcomes

The key objectives of each of these elements are expanded on below.

Key element 1: Development of a Psychological Framework

The aim is to develop a service culture that is reflective, thoughtful and compassionate. To achieve this, staff are introduced to insights and principles from psychological approaches to

[1] Robin Johnson , co-author of "Psychologically Informed Services for Homeless People- Good Practice Guide, 2012, Department of Communities and Local government
[2] Creating a Psychologically Informed Environment. Implementation and Assessment. No One Left Out Solutions Ltd. for Westminster City Council 2015
[3] Psychologically Informed Services for Homeless People- Good Practice Guide, 2012 Department of Communities and Local Government

working with people with complex needs. The aim is for staff to understand, and keep in mind, the connections between thoughts, emotions and behaviour. The organisational commitment to becoming a PIE should also be made clear.

Key element 2: The physical environment and social spaces

The aim is to create a non-institutional, safe and welcoming service that facilitates interaction between staff and clients. Clients should have choice and control over how and when they engage. There should be a sense of physical and emotional safety for both clients and staff, with a culture of health and wellbeing.

Key element 3: Staff Training and Support

The service reflects on its working practices to support continuous improvement. Staff competencies and confidence are developed in working with complex trauma, and all staff share an understanding of complex trauma. Staff manage and reflect on their own thoughts, emotions and behaviours and those of their clients, feeling confident and supported to work with risk and challenging behaviour.

Key element 4: Managing Relationships

Relationships are recognised as the key tool for change. The impact of positive peer relationships is harnessed and clients with complex needs are not excluded.

Key element 5: Evaluation of outcomes

Outcomes are collated and analysed in order to understand and verify what works and to support continuous learning and improvement. This also enables evidence to be made available to clients, staff and commissioners to increase understanding of the value of psychologically informed approaches.

Additional element: Reflective Practice

It is also worth noting that increasingly practitioners have argued that a better description of PIE would include 6 areas. According to Johnson the sixth area is reflective practice[4] . Reflective practice was incorporated into the Solace pilot model. Group reflective practice is a process of continuous learning from professional experiences.

[4] Private correspondence with Mental Health Foundation , quoted in “Psychologically informed environments: A Literature Review “ Mental Health Foundation Research Paper, 2016.

"There is a robust evidence base demonstrating that teams who regularly meet to reflect on their practice are more effective than those who do not. Furthermore, literature indicates that effective teams achieve better outcomes for their client group" [5]

[5] "Building team-based working: A practical guide to organisational transformation " West and Markiewicz, 2004

4. Key Project Activities

The following activities were carried out in delivering the project:

- **Establishment of a steering group** including representatives from each of the participating local authorities, Senior management and project staff from Solace Women's Aid, AVA as the consultant / evaluator, and a member of the Solace PIE Service Users Forum.

- **Partnership meetings took place** to gather intelligence, develop proposals and reach agreements on joint work between mental health, drug and alcohol and refuge services.

- **A review of Solace Policies and Procedures** was carried out by AVA (Against Violence and Abuse)

- **A training programme,** devised and delivered by Clinical Psychologist Roxane Agnew - Davies, was rolled out across the staff team. All refuge workers, refuge managers and the senior management team at Solace received 3 full days of training, on the following subjects:
    - mental health, substance use, counselling techniques and self-care.
    - trauma and the impact it has on mental health
    - trauma and coping mechanisms including drugs/alcohol and self-harming behaviours

- **Reflective Practice** was introduced across the organisation and continues to be embedded into case reviews at refuges to encourage an environment where ongoing learning is undertaken to improve service user experiences and engagement.

- **Compulsory Clinical Supervision** was introduced with attached elements of learning sessions in order to continue the PIE staff training.

- **Play therapy** was introduced for children.

It should be noted that all of this was in addition to established practice at Solace, much of which already reflected psychologically informed principles. This includes a comprehensive internal training programme covering issues including mental health and substance use, optional clinical supervision, and a process of regular case reviews.

5. Review of Policies & Procedures

This was carried out by AVA, the key recommendations of which were:

- That any changes introduced as a result of this review are made with the full involvement of staff and Solace service users.
- The referral guidance makes it clear that for many women re-engagement with the outside world post abuse is a gradual process needing support
- The House Rules be reviewed with the involvement of survivors with experience of mental ill health, in the language as well as the actual rules
- That consideration be given to replacing the House Rules document with an agreement between Solace and the refuge residents that sets out expectations on both sides and is signed by both parties
- The Exclusions Policy is reviewed to reflect:
    - The failure of some other refuges to understand the relationship between abuse, trauma and problematic substance use
    - The incremental nature of readiness to change in women experiencing multiple disadvantage
- That opportunities be identified to mainstream the Complex Needs Policy and Procedure into relevant Solace policies and procedures.
- Induction material and practices be reviewed to reflect the importance of staff being supported to build their own emotional resilience, and placing relationships at the heart of the organisation.
- Induction material and training should be reviewed to ensure that an understanding of how trauma affects client behaviour is embedded from the start of employment at Solace.
- Training relating to elements of PIE should be mandatory for all staff
- The staff supervision agenda should be restructured so that an explicit space to explore stress and trauma reactions is placed near the beginning of the session
- The tone and structure of the manager's handbook to be revisited, in conjunction with managers, to ensure that it reflects the importance of the key principles in moving to a psychologically informed environment.

Following consultation with members of the PIE service users' forum reviews to the following were prioritised:

- The introduction of One Page Profiles as a useful tool for supporting relationship building across the organisation. [6]
- The introduction of a House Pledge
- The introduction of House Expectations to replace House Rules
- Changes to the Warning letter, Policy and Procedure

[6] Further information can be found at www.sitra.org/policy-good-practice/personalisation/one-page-profiles

- The induction paperwork for refuges including the Support Agreement
- The Key Working Policy to include more specific details about how a key working meeting should be structured and to ensure it includes specific work around trauma, mental health and coping mechanisms.

6. The Impact of the project: Evaluation

The aim of the evaluation was to establish the degree of change generated by the model, and whether it was replicable by:

- Measuring the impact of the project on service users experience, perceptions and outcomes
- Measuring the impact of the project on staff practice, understanding and confidence
- Evaluating staff experience of different aspects of the programme, including training, clinical supervision and reflective practice
- Evaluating the impact of play therapy on children and young people

There is no established best practice method for evaluating the effectiveness of Psychologically Informed Environments. As the Mental Health Foundation point out in their evidence review "In terms of evidence it is difficult to establish results due to discrepancies in measures, approaches to evaluation and eventually publication[7]"
The overall approach was informed by using the University of South Florida Self-Assessment Audit Tool[8] as a framework. This enables an audit to be carried out using a number of different methods. The tool suggests using the following methods:

- Staff interviews
- User interviews
- Review of policies/procedures
- Client record review
- Treatment team or debriefing
- Observation

All of these, apart from the client record review were used here.

The evaluation also drew on pre and post project survey data for staff, management and service users, as well as qualitative feedback from service users, staff and management.

A separate evaluation was carried out for the Play Therapy, and the outcomes of this are included in section 13: Play Therapy.

[7] Breedvelt, JF (2016). Psychologically Informed Environments: A Literature Review. Mental Health Foundation, London
[8] Hummer V and Dollard N (2010) Creating Trauma Informed Care Environments : An organisational self-assessment , University of Florida , Tampa

7. Overall Impact on Refuge Admissions

Key finding: the project has clearly resulted in fewer women being refused admission because of mental health needs.

Between April and September 2015, Solace Women's Aid supported 152 women and 145 children in refuges. BME women made up 67% of residents. 90% (n=137) of women self-diagnosed depression. 24% (n=37) of service users had a diagnosed mental health condition, including depression and 8% (n=12) had drug and/or alcohol issues which were disclosed to Solace and were offered appropriate support. Solace had been unable to offer places to 6% (n=9) of women because of the level of their support needs and had to move 11% (n=17) women out of refuges because of their complex needs and behaviour.

Comparable figures for April-Sept 2016 showed that 158 women were accepted into refuge, and that only two women were unable to be accepted due to an inability to meet their support needs, In one case this was for mental health needs, and the other had no recourse to public funds.

The proportion of women who could not be accepted due to mental health needs fell from 6% (n=9) to 0.06% (n=1). On this measure, the project has clearly resulted in fewer women being refused admission because of mental health needs.

Direct comparisons of the number of women with diagnosed and self-reported mental health conditions in residence was not possible due to a change in database systems within Solace.

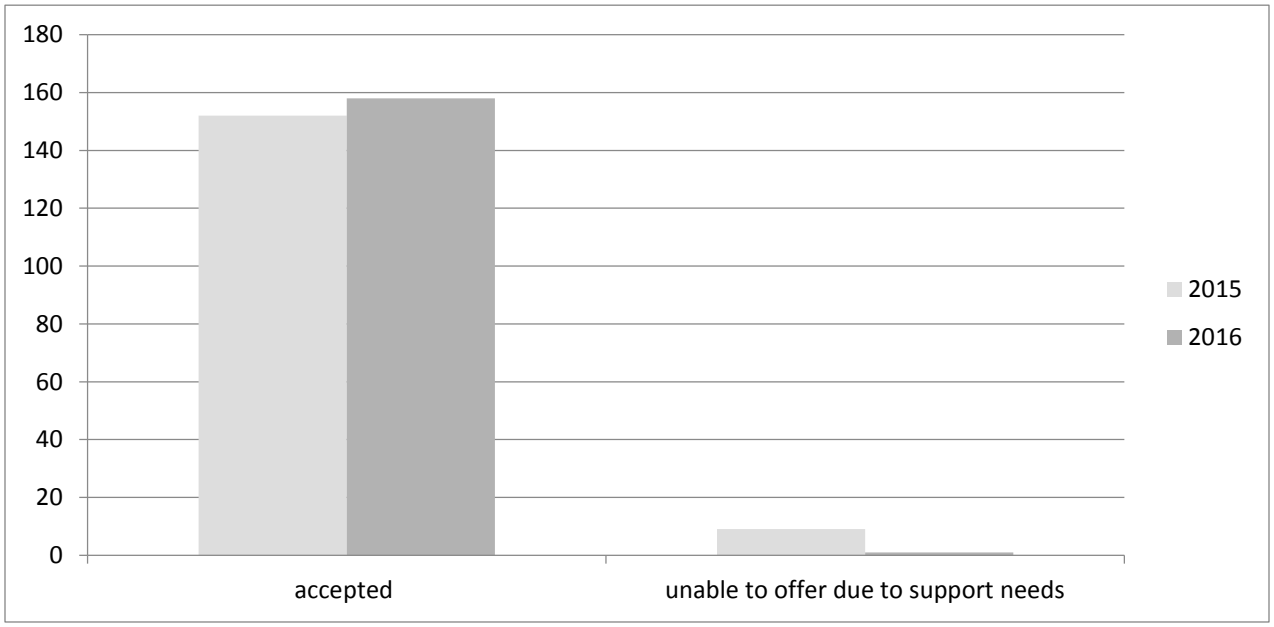

Chart 1: Impact on Solace Admissions

8. Impact on Staff

Staff were surveyed at the start and the end of the project, to establish changes in their confidence, knowledge and understanding of a range of issues relating to the establishment of a Psychologically Informed Environment. This was carried out as two separate exercises, in order to measure change in actual perceptions, rather than asking staff if they thought their knowledge and confidence had increased.

The survey findings showed a significant increase in staff confidence, knowledge and understanding of a range of issues that are central to developing a Psychologically Informed Environment. They also showed that staff had increased expectations of the support they could expect to receive from Solace for themselves as a result of the project.

8.1: Staff Confidence: Mental Health and Substance Use

Key Finding: Confidence levels amongst staff in dealing with mental health and substance use issues increased significantly during the period of the pilot.

When asked how confident they were in talking to a service user about mental health issues, the proportion of staff saying “very confident” rose from 10% to 32%. The proportion of staff identifying their confidence as average or above rose from 85% to 96%. In terms of talking about alcohol use, there was a similar trend with the proportion of staff feeling “very confident” rising from 15% to 32%, and the proportion rating their confidence at average or above rising from 85% to 96%. When asked about other (non-alcohol) drug use, the proportion of staff feeling “very confident” to raise issues with service users rose from 15% to 32%, and the proportion identifying their confidence level as average or above rose from 85% to 96%. The only noticeable difference between the three areas of confidence in the post project survey is that only 40% identified themselves as quite confident talking about drug use, as opposed to 48% when talking about mental health or alcohol use.

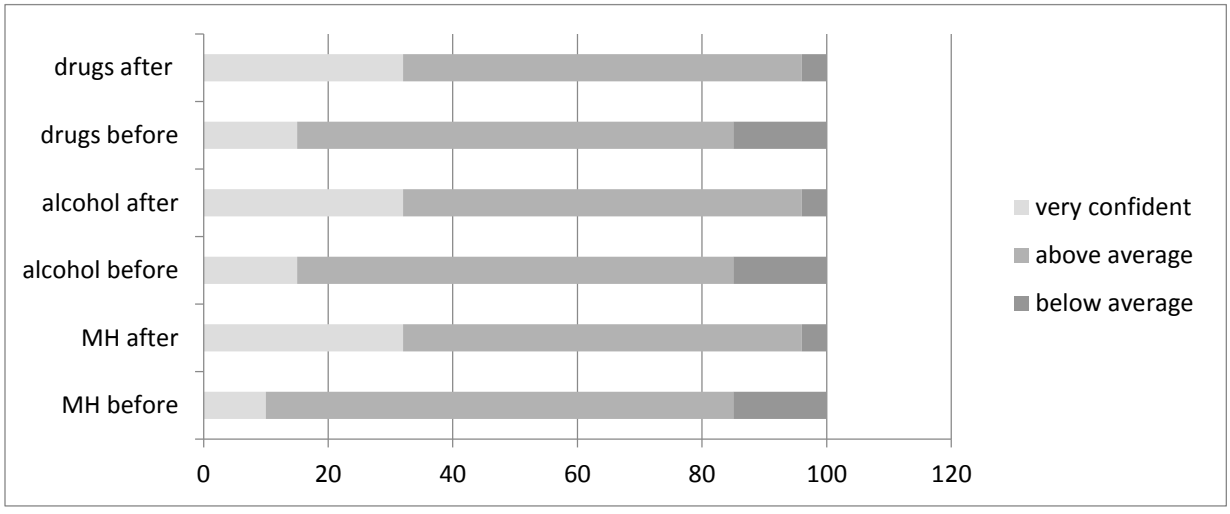

Chart 2: Confidence levels amongst staff

The surveys also sought to investigate knowledge in more detail on a range of issues. In response to the question "How much do you know about the following" staff indicated increased knowledge in each of the areas asked about as follows:

- There was a shift when asked about appropriate language to describe substance use issues- with the proportion saying they knew an average amount rising from 24% to 50%. The proportion saying a lot or quite a lot rose from 35% to 60%, although the increase in the proportion saying they knew "a lot" was small, shifting from 5% to 8%
- There was a more marked increase shown in people's sense of their knowledge when it came to appropriate language to describe mental health. The proportion who answered that they knew "a lot" rose from 5% at the start of the programme to 20% at the end
- There was less confidence in their knowledge of the signs or symptoms of mental ill health or substance use, although there was a still a marked increase at the end of the project. The proportion who felt they knew a lot or quite a lot about the signs or symptoms of substance use rose from 50% to 72%, with the figures for mental health rising from 55% to 68%
- A trauma informed approach has been key to this project, and staff understanding of the symptoms and signs of trauma rose significantly during the project. At the start 15% of staff felt they knew nothing or a little about the signs of trauma - this fell to 8% by the end of the project. The proportion who felt they knew "quite a lot" or "a lot" rose from 50% to 68%

A Psychologically Informed Environment places relationships at the heart of the organisation, and so questions were asked to ascertain how well staff felt able to ask clients questions about mental ill health and substance use.

- During the course of the project, staff knowledge of what questions to ask to identify mental ill health and substance use rose substantially. The proportion of staff who felt they knew "quite a lot" or a lot about what questions to ask to identify substance use issues rose from 25% to 56%. For mental health the equivalent figures were 30% and 64%
- When asked about responding appropriately to women with substance use issues, the proportion of staff who felt they knew "quite a lot" or "a lot" rose from 35% to 68%
- For mental health, the equivalent figures were 45% and 72%, with the proportion of staff who felt they knew nothing or a little when it came to responding appropriately to women with mental health concerns falling from 20% to 0% over the period of the project.

The surveys also tested staff knowledge on a number of practical issues relating to complex needs. They found that staff had significantly increased knowledge of the law and organisational issues.

When asked about the law relating to substance use, the proportion of women who felt they knew “quite a lot” or “a lot” rose from 25% to 36%, and the proportion of staff who felt they knew nothing or a little fell from 40% to 12%

In terms of documentation procedures,

- At the start of the project, only 24% of staff felt they knew a lot or quite a lot about how to document substance use in a woman’s record ; at the end of the project this had risen to 60%, with the proportion of staff who knew nothing or a little falling from 20% to 4%
- In terms of documenting mental health, the proportion of staff who felt they knew a lot or quite a lot rose from 30% to 68%, and the proportion of staff who knew little or nothing fell from 25% to 0%

Staff were also asked about appropriate responses to women experiencing problematic substance use or mental ill health.

- At the start of the project, only 35% of staff felt they knew a lot or quite a lot about how to respond appropriately to women with substance use issues, this had risen to 68% by the end of the project, with the proportion who knew nothing falling from 5% to 0%, and the proportion who knew little falling from 15% to 4%
- When asked the same question about mental ill health, there was a similar increase in knowledge. The proportion of staff who felt they knew a lot or quite a lot rose from 45% to 72% , and the nothing or a little responses fell from 20% to 0% , meaning that by the end of the pilot all staff felt they knew at least an average amount about how to respond appropriately to women experiencing mental ill health

The evaluation also sought to measure shifts in staff knowledge and understanding of referral sources for women experiencing substance use and mental health issues, including dual diagnosis. Knowledge improved in all 3 areas, with the key findings being:

- The proportion of staff who felt they knew a lot or quite a lot about referral sources for women who experience problematic substance use rose from 25% to 46% , with the proportion who knew nothing or a little falling from 35% to 12%
- When it came to referral sources for women experiencing mental ill health the proportion knowing a lot or quite a lot rose from 45% to 60% and the “little or nothing “ proportion fell from 25% to 4%
- For dual diagnosis, the proportion knowing a lot or quite a lot rose from 20% to 48%, and the proportion knowing nothing or a little fell from 25% to 16%

This shows significant increases in knowledge about referral sources for women experiencing substance use and mental health issues, including dual diagnosis. However, the figures remained relatively low at the end of the pilot, and this may reflect the issues regarding pressures on local services raised at the meetings with staff and managers, and the consequent lack of clear referral mechanisms for Solace residents to local services. This may also reflect

the slow progress in moving forward on reaching agreements on joint work between mental health services and refuge services (see section 11: Partnership Agreements)

So, overall, staff confidence in asking about, responding to, and supporting residents experiencing substance use and mental health issues increased significantly during the 6 months of the project.

The following case study shows a staff member putting an improved understanding of stress and trauma to effective use

Case Study: Encouraging Client Self Care

I have found the 'Self-Care PIE Strategies' resource particularly useful when supporting a resident.
This particular resident was the youngest in the house and had fled abuse from her family. This resident had never lived by herself before and was somewhat struggling to prioritise herself, particularly in the areas of healthy eating and work life balance. Many conversations, both inside and out of key work sessions, took place with this resident around empowering her to understand the importance of self-care.
This resident was very proactive in looking for work from arrival and has found a part time job, unfortunately with somewhat challenging hours. I encouraged the resident to prioritise work life balance using PIE resources to focus on wellbeing. On arrival resident expressed she was not ready for counselling but has now joined a gym to increase her emotional wellbeing and has also started to eat in a healthier manner. Overall she has learned to look after herself much better.

8.2: Staff Understanding: Mental Health and Substance Use

Key finding: staff understanding of issues around mental ill health and substance use improved significantly during the project

The surveys undertaken either side of the project also sought to look beneath the overall levels of confidence to get a sense of whether or not this was backed up by an increased understanding of the specifics of working with survivors experiencing mental health and substance use issues. The results indicate that the increases in confidence are underpinned by an increase in preparedness to carry out the specific tasks relating to supporting survivors.

Staff preparedness to ask appropriate questions rose significantly.

- At the start of the programme, only 23.07% of staff felt quite well or very well prepared to ask appropriate questions about substance use. This rose to 72% by the end of the pilot
- When it came to mental health, the proportion rose from 26.92% to 76%

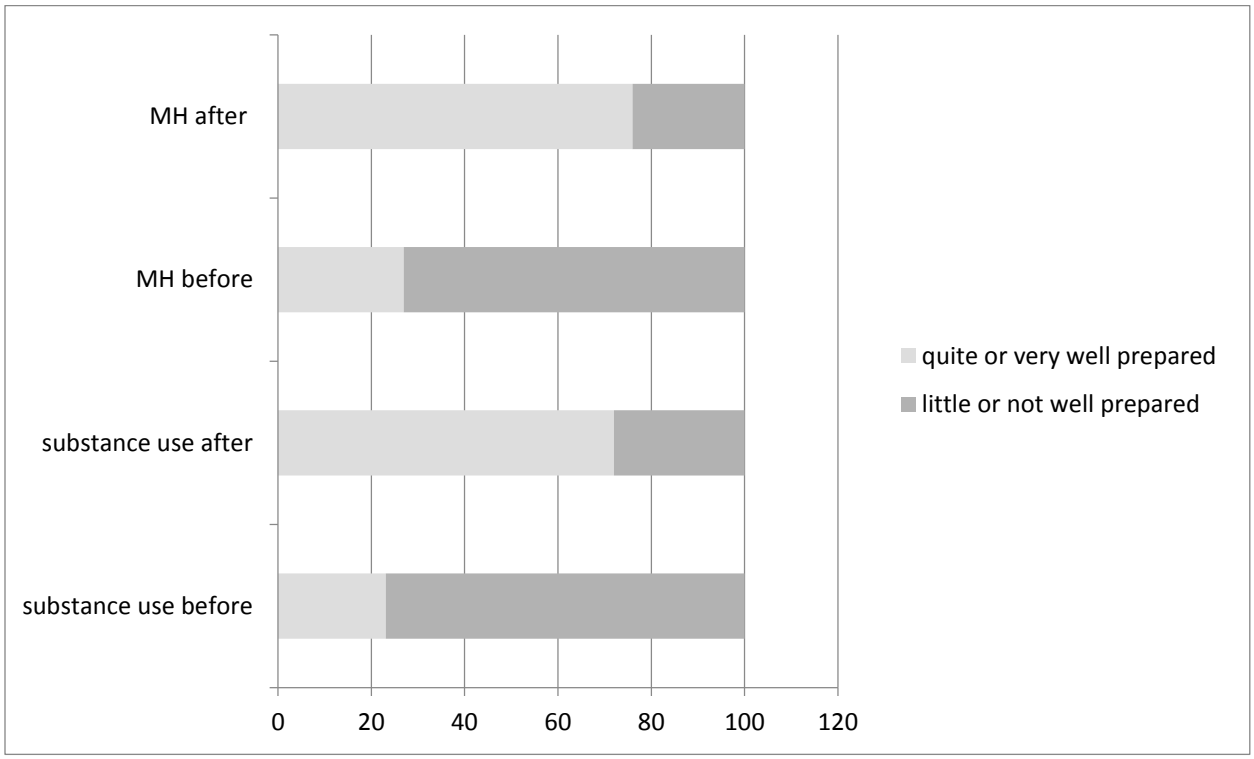

Chart 3: Staff preparedness to ask questions

Staff were also surveyed about their preparedness to ask follow up questions, and a similar pattern emerged.

- The proportion of staff who felt quite well or very well prepared to ask follow up questions rose from 23.07% to 76% for substance use, and from 26.92% to 80% for mental health.

In terms of preparedness to respond to disclosures, there were similar increases

- The proportion of staff who felt quite well or very well prepared to respond appropriately to disclosures rose from 30.69% to 72% for substance use, and from 34.61% to 76% for mental health. The proportion of staff who felt they were not very well prepared, or a little prepared , to respond appropriately to disclosures of mental health fell to zero by the end of the pilot (from 19.23% at the start of the pilot)

The impact of the project on risk assessment was also measured. Staff graded their ability to risk assess relating to substance use and mental health as having improved significantly during the project.

- The proportion of staff who felt quite well or very well prepared to risk assess relating to substance use was 23.07% at the start of the project and 84% at the end of the project.

- For mental health and risk assessment the proportion rose from 30.77% to 84%

Staff were asked about how well prepared they felt to document mental health and substance use issues, and the survey results show a substantial increase in preparedness.

- The proportion of staff who felt quite or very well prepared to document substance use issues in the service user's record rose from 34.61% to 76%, with the proportion of staff feeling not very well or a little prepared falling to zero by the end of the project
- For mental ill health the corresponding figures were 42.31% and 80%, and the figures for not very well or little prepared falling to zero.

Staff were asked about making referrals, and the project resulted in staff feeling significantly better prepared to make referrals for service users experiencing substance use and mental health issues.

- The proportion of staff who felt quite or very well prepared to make appropriate referrals for women who have experienced substance use issues rose from 42.31% to 80%, with the figures for mental health being identical. In both cases the proportion of staff who felt not very well prepared or little prepared to make these referrals fell to zero.
- Staff also showed increased knowledge re developing links with substance use and mental health agencies - crucial given the practical problems with referrals identified in discussions with staff and management.
- The proportion of staff who felt quite or very well prepared to develop links with women who have used substances problematically rose from 30.77% to 76%, and the corresponding figures for mental health were 38.47% and 76%. The proportion of staff who felt not very well or little prepared to develop links with agencies that work with women who have experienced mental ill health fell to 0 from 30.76%.

Staff were also asked questions to identify their actual practice at both the start and end of the pilot, with regards to women experiencing mental health or substance use issues. The results show that, whilst practice had improved, barriers to supporting and referring these clients remained in place.

- Staff were asked how easy it was, in their experience to meet the needs of service users who use substances problematically. There was no statistically significant difference from the start of the project to the end with the proportion of staff saying "no more difficult than for any other service user" moving from 7.69% to 8%
- There was some shift between the degree of difficulty experienced by staff between the beginning and the end of the project. At the start of the project, 53.85% of staff found it somewhat more difficult to meet the needs of these service users than for other service users - this had risen to 76% by the end of the project, with the proportion who found it significantly more difficult falling from 38.46% to 16%. This implies that the information and skills gained through the project are beginning to have a positive influence on staff's

ability to support women using substances problematically - a follow on survey after the project has had time to bed down would hopefully show a greater increase

Those staff who found it more difficult to support these service users were asked about the reasons, both against a list and in a free text section. Staff could indicate more than one reason.

The most commonly cited reasons before the project were:

- The stigma faced by service users (69.57%)
- Service users needing more intensive support (65.22%)
- Difficulties making referrals to relevant services (56.52%).

After the project, there was some shift with the most common reasons cited being:

- Service users needing more intensive support (78.26%)
- Stigma faced by service users creates barriers in accessing support (69.57%)
- Lack of appropriate support services (56.52%). This shift may reflect the increase in the number of women with substance use issues being supported by Solace during the project period.

Other reasons identified by significant numbers of staff were services lacking women only support and services not meeting the specific needs of BME clients.

Comments from staff (at the end of the project) included:

"*Women with problematic substance use do not confine their uses to their rooms; the shared areas are shared with children as well"*

"*Can create issues with other service users that are difficult to manage"*

"*It can be challenging to meet service user needs when services have limited capacity due to poor commissioning ; staff simply do not have enough time to accompany service users to meetings to ensure that they access services(particularly relevant as we think about developing PIE in community services)"*

A similar set of questions was asked regarding clients with mental health issues. These showed a shift during the project. When asked how easy it was, in their experience, to meet the needs of service users who have mental health issues, the proportion of staff saying "no more difficult than for any other service user" rose slightly, from 7.69% to 12%. The proportion of staff who felt it was "somewhat more difficult" rose from 57.69% to 72%, and those saying "significantly more difficult" fell from 34.62% to 16%.

In the post project survey, staff indicated higher levels of experiencing difficulties, but it is hard to say definitively whether this is due to a better understanding of the issues, or an increase in the number of women being accepted with mental ill health as a result of PIE.

At the start of the project, the most common challenges identified were stigma faced by service users (69.57%), followed by service users needing more intensive support (65.22%). At the end of the project, the most common challenges were identified as "service users needing more intensive support" (77.27%) and lack of appropriate support services (77.27%) to refer to.

Staff comments included views that the challenges of supporting residents with mental health needs were similar to those of meeting the needs of residents with substance use issues. Another typical comment was "*mental health teams very slow in providing the support needed at the time the client needs it* "

The evaluation also sought to measure the impact of the project on information sharing practices, and the practical support that staff felt they had available for service users.

When asked to rate four statements about information and multi-agency working within Solace, at the end of the project all staff indicated at least an average level of confidence in:

- Sharing information about women's substance use within the service
- Knowing when to share information about a woman's substance use with outside agencies
- The process for sharing information about a woman's mental ill health within the service
- Knowing when to share information about a woman's mental ill health with outside agencies

At the start of the project, some staff felt they had "little or no" confidence in these areas.

There was a big increase in the number of staff feeling very confident in these issues, between the start and the finish of the project:

- The proportion of staff feeling very confident about the process for sharing information about women's substance use within the service rose from 12.5% to 43.75%
- For sharing information about a woman's substance use with outside agencies, the proportion feeling very confident rose from 4.17% to 31.25%
- The proportion of staff feeling very confident about the process for sharing information about women's mental ill health within the service rose from 12.5% to 43.75%
- For sharing information about a woman's substance use with outside agencies, the proportion feeling very confident rose from 4.17% to 43.75%

Staff were asked about the provision of educational resources to women when they disclose substance use and mental ill health, and significant improvements in practice have been identified during the project.

- At the start of the project, 26.17% of staff did not provide women with educational resources when they disclosed substance use. At the end of the project, this had fallen to 18.75%.
- At the start of the project, 41.67% of staff did not provide women with educational resources when they disclosed mental ill health. . At the end of the project, this had fallen to 12.5%.

When asked what sort of information they gave out, the proportion of staff saying “I don't have access to this information” fell from 12.5% to 0% for substance use, and 12.5% to 0% for mental health.

8.3: Organisational culture

Key Finding: Staff felt the organisations ability to support and understand residents experiencing trauma increased significantly.

A series of questions were asked at the start and the end of the project to identify whether or not staff perceived changes in the culture of the organisation during this time.

These showed a more mixed impact of the PIE project.

In some areas the impact of PIE was clear. Examples of where staff have seen a significant improvement in organisational culture include:

- The proportion of staff who perceive that residents are given opportunities to explore and discuss the impact of trauma in the refuge “a lot” or “quite a lot” rose from 45.83% to 75%.
- Similarly, the proportion of staff who thought that “staff are trained to understand how trauma might impact on residents behaviour” the proportion saying “a lot” or “quite a lot” rose from 25% to 100%.

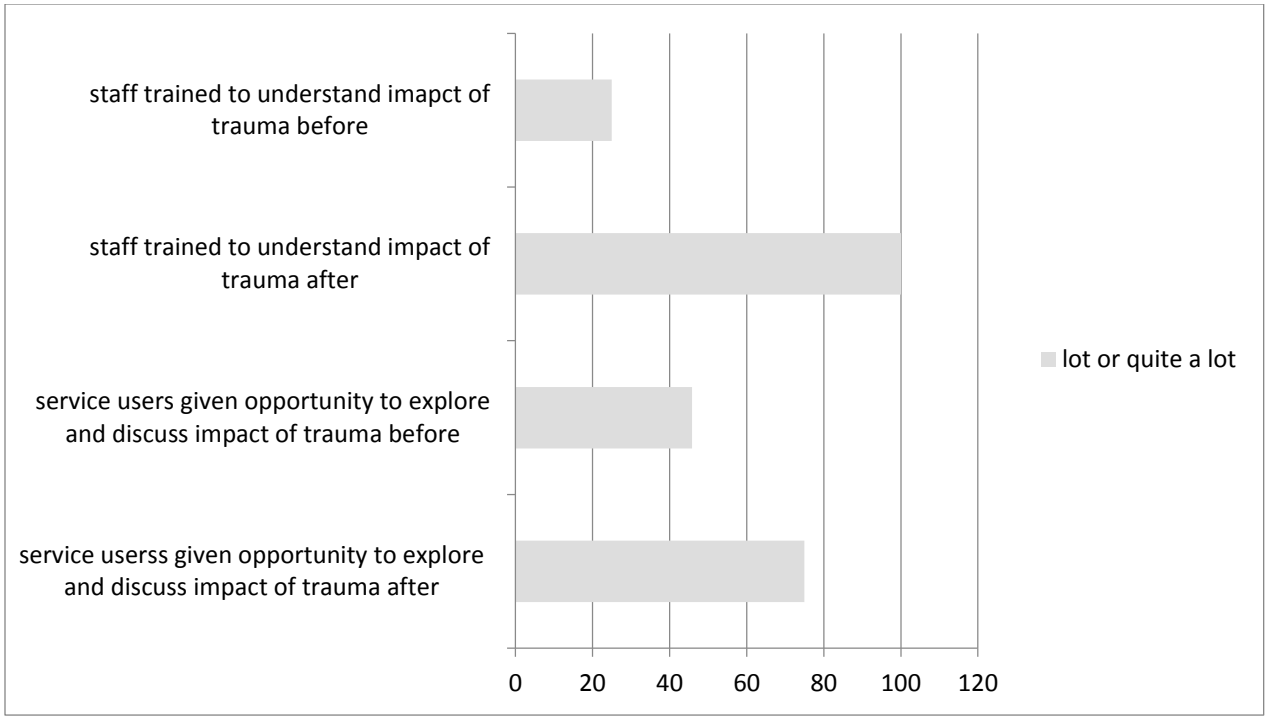

Chart 4: understanding and supporting trauma

On the other hand, the proportion of staff who felt that "outcomes are service user lead" a lot or quite a lot fell from 75% to 68.75% - a small drop but significant in that it might have been expected to increase.

There were also some findings which showed mixed views about the impact of the project on organisational culture. These include:

- The proportion of staff who felt that "service users are actively involved in shaping the content of key work sessions" " a lot" fell from 41.67% to 31.25%, although the proportion answering "quite a lot" increased from 37.5% to 50%
- A similar pattern was seen in response to the statement "service users are actively involved in creating their own support plans", where the proportion saying "a lot" fell from 41.67% to 31.25%, but the proportion replying "quite a lot" rose from 37.5% to 43.75%.
- It is not clear whether a shift in staff expectations of increased service user involvement coming out of the PIE work is partly responsible for the drop in staff answering "a lot" to the service users focussed questions.

The following case study shows how a staff member has been able to use their enhanced understanding of how trauma affects individuals

Improved understanding of trauma : case study

Case background

PC came to Hannah House in May 2016 after being violently attacked by her ex-partner. PC had been a victim of domestic violence and abuse from early childhood. As a child she witnessed her father try to murder her mum; as a young woman she was raped and when she reported it she was not believed by the police / other agencies. One previous partner had attacked her so severely that he had broken her jaw in three places. PC has been diagnosed with physical injuries, post-traumatic stress, hearing issues and thyroid issues. This was the second time that PC has been in refuge.

Issues for which support was needed

One of the most urgent immediate needs that I observed was that PC relied on immediate emotional support from me as she suffered with panic attacks, flash backs, anxiety and suicidal thoughts.

I feel that as a result of my PIE Training I have a more informed understanding of what suicidal thoughts are which in turn helped me to empathise with PC. So when PC was having suicidal thoughts I felt confident to explore her thoughts and where appropriate put in place an Inner Safety Plan which in turn enabled her to feel more in control.

Another really helpful resource that we used together was the 10 tips to lift your mood;, this was hugely beneficial to PC and she felt it really helped her to get through the day sometimes.

PC would often want to offload a lot on me; some of those discussions contained details of severe violence and were at times difficult to hear, so to ensure that I didn't suffer the effects of vicarious trauma and PC didn't become totally re-traumatised we discussed keeping a box with all the things she wanted to offload in there. We then started taking out one at a time in key work sessions which really helped with her anxiety, and allowed me to support her better.

8.4: Self Care and Staff Support

Key finding: staff felt significantly more confident that they could access support at work for personal issues relating to substance use, mental ill health and trauma

The final set of survey questions was around staff experience of working in the service, to reflect the emphasis on clinical supervision, self-care and reflective practice in the PIE project.

Staff were asked “Do you feel like you can access adequate support for yourself in your workplace and in the community”.

Staff definitely felt more supported by Solace at the end of the project than at the beginning.

The proportion of staff saying they felt they could access adequate support at work

- Rose from 33.33% to 75% for substance use
- From 50% to 75% for mental ill health
- From 45.83% to 81.25% for trauma

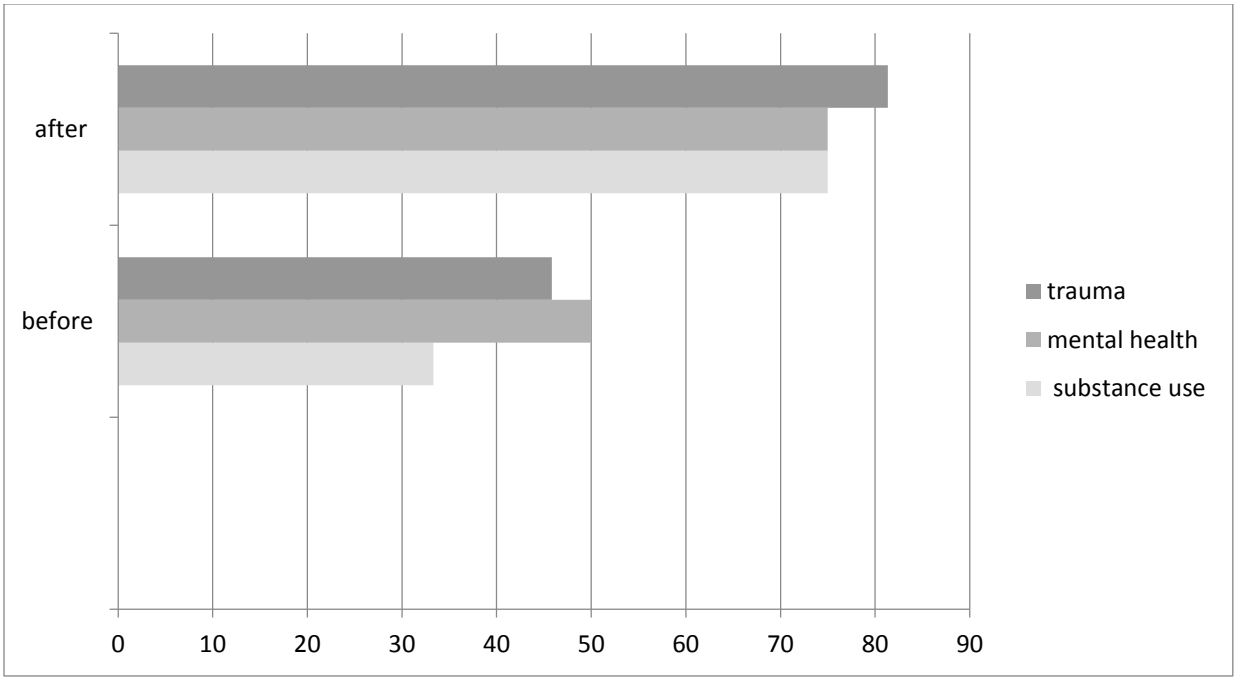

Chart 5: Proportion of staff feeling confident they can access support at work

The results on reflective practice were mixed. Staff were asked whether or not they were given adequate time to reflect on their own practice and that of their colleagues. Before the project began, 8.33% of staff said they had informal reflective practice sessions, and 33.33% said they

had formal reflective practice sessions. At the end of the project, the corresponding figures were 25% and 31.25%. This is disappointing, both due to the central role that reflective practice plays in Psychologically Informed Environments, but also because of the importance Solace placed on reflective practice in supervision even before beginning the project. It may be that staff still do not fully understand what reflective practice is, and this perception will improve as this practice beds down.

8.5: Final Thoughts

At the end of the project, staff were also asked if there was anything they would like to add about supporting service users using substances problematically or experiencing mental ill health (including trauma) and the comments offered up included:

"*More links to services and relationships need to be built to ensure* service user *needs are met*"

"Our *borough is very slow to respond to* service users *with mental health issues and is very under resourced - just getting records transferred takes weeks and further appointments take even longer"*

"More *support for staff to obtain vital information from women so as to better support them* "

9. Qualitative Feedback from staff and managers

Separate discussion groups were held at the end of the project with staff and managers, to obtain feedback from them as to their experience of the project, as well as their suggestions for moving the work forward. A number of key themes came out of these meetings.

9.1: Managers

Key finding: Managers felt that the project had met a clearly identifiable need within the refuges, and that team practice and residents experience had improved as a result.

The managers were very positive both about the concept of PIE when it was introduced, and also their experience of the project. There was a general sense that the project was needed, and met a clearly identifiable need within the refuges.

When asked about the impact of the project, managers were able to identify

- That staff were confident in dealing with Mental Health issues (this is borne out by the survey findings)

- That it gave new tools to staff who had a good understanding, helping to "*fine tune their understanding*"
- The manager of Frances House, the "complex needs" refuge was able to identify a reduction in referrals from other refuges - indicating that staff and managers were more able to support women with complex needs within generic refuges. The most recent referral had been because the woman needed 24 hour support.

In talking about managing staff during the project, the general feeling was that there had been some resistance at first, but that this had dropped off as staff saw the benefits. Some particular issues were identified in terms of the challenges of managing staff during the project, such as:

- Difficulties in getting buy-in from night and weekend staff - primarily because they don't do case work
- The work has not yet been integrated into supervision structure
- Some staff think PIE means being always available to service users, and managers needed to work with them to support them in improving their boundaries and recognising the importance of those boundaries.

Staff themselves identified other challenges with the project, and these are addressed in section 9.2

Some of the positives for staff that managers saw coming out of the project were:

- That the project had changed the way they themselves worked with staff and they were doing it in a more psychologically informed way.
- That there was a greater understanding and awareness of self-care issues.
- That it had encouraged them (the managers) to rethink the structure of team meetings (although staff feedback on this was decidedly mixed)
- Reflective practice had changed the structure of case reviews, and it was also being used to carry out more collective reviews of cases
- That the project has encouraged and empowered staff to be more solutions focussed.

Managers were all able to identify changes made as a result of the project.
These included:

- Unlocking staff toilets so that residents were able to use them when appropriate
- Reducing the amount of information on noticeboards so that residents were not overwhelmed.
- That whilst waiting for the new letter templates being introduced as a result of the policy review, managers were already altering their letters to bring them in line with PIE principles
- An example of a woman who left the refuge and whose room was marked as abandoned. She then returned and staff were able to work with her and understand why

this had happened , where as in the past she might have been turned away for breaching the rules

Clinical supervision

- Managers identified that having the Clinical Psychologist come to them for clinical supervision made a real difference, as people often don't attend if it is away from their own workplace.

Managers were asked to make suggestions about areas where the PIE process could be improved going forward and these included:

- That staff could use more training to help them understand what is going on when service users act out, by building their understanding of the impact of specific mental health conditions on behaviour e.g. splitting
- Complaints have increased - it is not clear if this is related to the project. Some managers thought that complaints might have increased as clients feel more empowered. Managers use complaints to discuss issues and improve services. There was some concern that the introduction of PIE meant that staff did not maintain strong boundaries because they did not want to be complained against. The issue of how the PIE project had affected staff and manager perceptions of boundaries was also raised at the staff focus group. (see section 8.2)
- Having more specific focus in training and briefing on personality disorder issues
- Reflective practice needs to be better incorporated into supervision and key work sessions
- There had been a long gap between PIE being started/training and new policies and procedures being issued and this has created uncertainty. The delays were down to the need for full and complete service user consultation, and as forums were only bi monthly this caused some delay. Senior management sign off also takes some time as there is a procedure that needs to be followed for all policy amendments.
- Some people who missed a training slot because of illness never got the chance to attend another. This was only an issue when staff were ill for the final session, otherwise they were offered alternative slots
- There needs to be a plan in place for how this is dealt with, as well as ensuring new staff are inducted in the PIE approach. Training on these issues for new refuge staff has now been introduced following the end of the pilot project.

One manager summarised the changes she and her team had implemented as a result of the PIE project:

Case Study: Improved team practice

Instead of weekly case meetings on each site we collaboratively hold fortnightly case meetings on alternate sites. This is where the team share examples of good practice and reflect on current practice & where we can be solution focussed in meeting the support needs of our most challenging clients.

I have also evaluated the skills and abilities of each of my team members and given them tasks and responsibilities which are relevant to their skills set to meet the support needs of service users.

Staff are more responsive and sensitive to those service users with complex needs and find means of explaining relevant paperwork to them.

We are now more than willing to take referrals for women with complex needs and endeavour to obtain information from agencies at the point of referral in order to make an informed and fair decision on whether we can meet their support needs within our refuge service.

Information about any new and upcoming services is readily accessible to service users and we discuss these in house meetings and consistently obtain feedback.

9.2: Staff discussions

Key finding: All participants were able to identify at least one positive change in their practice as a result of the project, although a degree of healthy scepticism remained.

A staff focus group was also held. The discussions touched on many of the same themes as the manager's discussion, but with a very different perspective in some cases.

The feedback from staff was generally positive, and they were able to identify ways in which the project had helped them improve their practice.

- Some of the longer serving staff identified the project as representing a return to how things used to be done. One participant said " *We have come full circle- used to do this before the drive to professionalism - this is a good thing* "
- Some staff also felt that the project validated their current practice - " *it's good that we know being supportive and psychologically informed is within our remit* "

They were able to give a number of examples of how the project had helped them improve their practice. These included:

- Using the concept of the verbal contract with service users.
- Using the concept of the "mountain" in helping people approach overwhelming activities.
- Handling closure issues more effectively. An example was given of supporting a mum to leave a book for people to sign to help her son have a proper ending to their time at the refuge.
- Improved key worker sessions. Several participants referred in particular to using the "drawing lots" approach to prioritising discussions in keyworker sessions when people are overwhelmed.

The power of the improvements to the key worker sessions was highlighted when one staff member spoke of asking a client what they had got out of the key worker session and receiving the reply "peace of mind"

Staff were unanimous in praising the training received as part of the project, and there was a lot of agreement with the member of the group who described it as "life changing".

Another staff member followed up after the group saying

"It *changed my whole thinking process with the women we work with and my own self-care".*

There were also a lot of positive comments about clinical supervision- significantly more so than with the managers and this may reflect the greater service user contact in front line roles, and the lack of other opportunities to discuss issues. Specific comments included:

- Appreciation that the supervision came to staff (this was also mentioned by managers) , thereby creating a therapeutic space in their usual workplace
- Appreciation that the clinical psychologist was someone who had worked in the sector herself. This was crucial in giving the supervision credibility, especially among some of the more sceptical staff.

Participants reported that the biggest concerns staff had around the clinical supervision were about trust and confidentiality.

Not all feedback was positive, however, and some staff raised issues that they, or their immediate colleagues, had concerns about. These included:

- A sense that "*PIE is just one more thing we have to do*"
- PIE can get in the way of doing the best for the majority- by putting pressure on refuges to accept people whose needs are too complex to be supported/have an impact on the life of the refuge
- Some staff perceive managers as feeling they are not allowed to refuse referrals anymore.
- Linked to this was a perception from some staff that managers did not understand the psychologically informed environment issues in the round, and the need for them to be

"tempered with common sense". This was summed up by the participant who said " Managers can't blame PIE for everything and have to accept we can't help everyone"

- The lack of external support which prevented them getting residents the assistance they needed. For example, long waiting lists for mental health services. The reluctance of crisis teams to give advice- "*they just say call us if she tries to kill herself again"* was also mentioned. A four month waiting list for an appointment with mental health services for a suicidal client was another example.
- This is reflected in the challenges that have been faced in those parts of the project seeking to develop links and agreed pathways with local services (see section 12: Partnership Agreements)
- Housing services were also mentioned as a major barrier.

There were some key suggestions from staff related to the culture of the organisation, the relationship between the staff and their managers. The points raised in discussion need to be read in conjunction with the substantially improved scores for proportion of staff feeling supported by the organisation on key issues identified in the staff survey, especially where these related to issues like mental health and substance use.

Suggestions raised in discussion were:

- Appreciation that there were very strong messages coming from the senior management team about self-care; the pressure on front line managers led to staff feeling that some individual managers did not commit to this in practice.
- Some refuges had been able to put new structures and systems in place to support staff further for example support workers scheduling gaps between service user key work sessions . However, in some refuges these changes had not been made with service users knocking on closed doors etc. Lunch break policies varied between managers.
- There were mixed views about the move to shorter meetings in some refuges. Concern was also expressed that in some cases the proposed policy changes were not being discussed in team meetings even though this was organisational policy
- The staff group felt that changed practice around supervision had not been embedded yet, and there was a strong sense that staff did not really value them and they were used as "box ticking exercises". A new agenda for staff supervision has been developed, and most importantly all managers are receiving training on new procedures and in particular supervision.

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Comments were also made about senior management's involvement in the project, with two points, in particular, being raised:

- Senior managers had been invited to reflective practice sessions, but only one of the three was able to attend . Staff felt it would have been beneficial for the organisation if time could have been found for senior managers to attend some of these sessions
- Staff also felt that senior management should have spent dedicated time in refuges at the start of the project to specifically inform the development of the project.

Staff feedback - case study

This case study, offered up by a member of staff, encapsulates how relationships with service users have been influenced by the work around this project

We have a resident who has historical mental health support needs and was sectioned in Ireland after giving birth to a still born baby She is currently pregnant and is due to be induced in March 2017.
We have discussed this resident's case at length within the team and are mindful that even if the baby is born safely (as we are sure it will be) that this may trigger past memories for her. We have put support in place both internally and externally to ensure she will have excellent post-natal care and all professionals involved are aware.
In key work sessions the resident presents as engaged and co-operative, however she will come down to the office on occasions in an emotionally unstable state and we give her emotional support. Using what I have learned from PIE, I am able to support this resident through her emotions and due to the time that this may take I have used some of the exercises in the time management booklet to help me prioritise what the crisis really is as a lot of the time the presenting issues are historical. I have also been able to utilise the PIE groups to discuss this particular case and was provided with an excellent support letter in order to refer her 12 year old daughter to the paediatric consultant for some health concerns; I gained permission from the resident before I sent this to the family GP.
The resident is very "up and down" which is influenced by external factors and her feelings around managing expectations re how she should be progressing. Due to this, I allow her a set time to talk about the past and a set time to do case work to move forward as she can sometimes just come to the office when she feels like it and expect me to do things for her. Due to the PIE training I have learned how to better support her and have a clearer understanding of her trauma responses from the domestic & sexual violence experienced and how this can sometimes manifest in women's behaviour who are on their journey of healing

10. Service User experience

Key finding: service user scores on the trauma informed practice scale rose during the project, showing that service users feel staff understand their needs and experiences, and respond appropriately.

Measuring service user experience with such a short timescale project is challenging, but essential. It is important that consideration of the results takes into account the very short timescale for the project to deliver changes that would be noticeable by service users.

Changes to service user experience were measured using the Trauma Informed Practice (TIP) questionnaire.[9]

This was used because it is vital to understand domestic abuse as a form of trauma. 'Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being '[10]. Domestic abuse certainly fits these criteria and can be exacerbated by the fact that the trauma is perpetrated by someone close to the victim and by the unpredictable nature of abuse. There are many common responses to trauma such as hyper-arousal, numbing, increased startle response, flashbacks, avoidance, sleep problems, anxiety, memory and attention problems, developmental delays and attachment issues to name a few. These are all normal responses to abnormal situations, but can feel very frightening and confusing to those experiencing them. service users were asked to complete the form at the start of the project, and at the end. Although there will have been resident turnover in that time, the questionnaire does allow us to sample the overall impression clients have of their time at Solace, and how this changed over the course of the project.

The TIP has been designed, piloted and evaluated in the US as the first tool to examine trauma informed practices from the survivor's perspective, and is the first tool of its kind. It measures a services' practice under a number of subscales, which reflect the six domains of trauma informed practice.

Agency: indicates the extent to which survivors feel that the organisation and its staff respect their agency and autonomy by offering opportunities for choice and control

Information: reflects the extent to which survivors feel that staff offer information that increases their understanding of trauma and coping skills

Connection: indicates the extent to which survivors perceive the service as one that creates opportunities for developing and strengthening mutually supportive relationships

[9] Sullivan CM, Goodman L (2015) A guide to using the Trauma Informed practice Scales (TIP) Scales.
[10] SAMHSA (2014) Concept of Trauma and Guidance for a Trauma-informed approach

Strengths: reflects the extent to which survivors perceive that staff recognise and value the unique strengths they bring from their family, culture, relationships and life experience.

Inclusivity: reflects the extent to which survivors regard staff as understanding of, and responsive to, various aspects of their identity, including culture, religion, sexual orientation, socioeconomic status and immigration status

Parenting reflects the degree to which survivors feel the service helps them strengthen their relationships with their children through support and education.

An analysis of the information from the questionnaires, which were completed at the start and at the finish of the programme, give an interesting insight both into how clients feel about Solace, and the extent to which the PIE project might have impacted on that. It also highlights areas that Solace might wish to focus on in future service developments.

It is a credit to the trust that refuge residents have in Solace, that 25 returned completed copies of the pre project questionnaire, and 23 returned the post project questionnaire, despite the challenging and demanding nature of some of the questions.

The survey results show that Solace already scored highly in many areas of trauma informed practice. The results are analysed under each of the 6 subscale headings described above. There was no space provided for free text, but where residents added comments to their forms this has been referred to.

Agency: Most of the answers here show an improvement in residents' already high perceptions of the support they receive from Solace.

- The proportion of residents saying "staff respect my privacy" rose from 92% to 95.65%
- The proportion saying "somewhat true" or "very true" to "staff are supportive when I am feeling stressed or overwhelmed" rose from 95.65% to 100%. One resident wrote on her form "*and very approachable, which is key*"
- The proportion saying "somewhat true" or "very true" to "I decide what I want to work on with Solace staff" rose from 87.5% to 100%. Within that, the proportion saying "very true" rose from 58.33% to 73.91% - a significant and important increase given the emphasis on relationships that sits at the heart of a Psychologically Informed Environment , and the feedback from staff regarding using newly learnt techniques in key work sessions that came out of the discussion groups. One resident identified "the suggestion box, group and 121 meetings" as ways in which this was done
- The proportion saying "somewhat true" or "very true " to "staff treat me with dignity" rose from 95.83% to 100% with the proportion saying "very true" rising from 75% to 86.3%
- The proportion saying "somewhat true" or "very true to " staff understand that I know what's best for me" rose from 88% to 95.65% with the proportion saying "not true at all" falling to zero.

- The proportion of residents answering “somewhat true” or “very true” to the statement “staff respect the choices that I make” stayed static, moving from 92% to 91.67%, but within this the “very trues" rose from 76% to 79.17%
- The proportion of residents answering “somewhat true” or “very true” to the statement “At solace I can share things about my life on my own terms and at my own pace” fell slightly from 100% to 95.83%
- The proportion of residents answering “somewhat true” or “very true” to the statement “Staff can handle difficult situations” fell from 95.84% to 87.5% - this may be a reflection of the increase in complex needs cases accepted by Solace during this time, especially when taken in conjunction with some of the staff comments about managers now feeling that they have to accept all referrals, regardless of the challenges posed in a communal living environment.
- The proportion of residents answering “somewhat true” or “very true” to the statement “I can trust staff” fell slightly from 91.66% to 87.5%, but the proportion answering “Very True” rose from 70.83% to 79.17% within that.

The strong feedback from clients showing improved key working is reflected in this case study provided by a member of staff

Case Study: Improved Key work sessions

I inducted a single woman into Minerva House. During her induction it became clear this woman had been seeking support for the DV she had suffered for a long period of time, and as this was the first time she had received support she immediately wanted to offload all her thoughts, feelings and emotions about her experience. During the induction this woman spoke openly and freely about abuse she suffered as a child and up to recent time. The woman gave me explicit details of childhood sexual abuse and details of the abuse she suffered recently. All of this was within half an hour of meeting me. During our first key work session it became apparent she wanted to tell me everything which was great as she felt comfortable enough to do so however it also became apparent this was not healthy for me or for herself as the level of trauma being offloaded and being heard meant I started to suffer with secondary trauma effects. Before the PIE training I would have continued to allow this woman to use the session this way if she wanted to; however at PIE training I learned skills such as asking the woman to make notes and placing them into a jar explaining that the notes were very important, and we will deal with one support need at a time. This helped the woman to be able to make the keyword session as healthy and beneficial as possible in addition to making it healthier for me to hear the trauma this woman had suffered.

Information

There was some improvement across all 5 questions on the subscale measuring “Access to information on trauma”,

- The proportion saying “somewhat true” or “very true” to “I have the opportunity to learn how abuse and other difficulties affect responses in the body “rose from 84% to 91.29%.
- The proportion saying “somewhat true” or “very true” to “I have the opportunity to learn how abuse and other difficulties affect people's mental health” rose from 79.16% to 95.65%, with the proportion saying “very true” rising from 58.33% to 65.22%
- The proportion of residents answering “somewhat true” or “very true” to the statement “ Solace gives me opportunities to learn how abuse , and other difficulties, affect people's ability to think clearly and remember things “ rose from 91.67% to 95.83% , with no one replying “ not true at all” to this question in the End of Project Survey.
- The proportion of residents answering “somewhat true” or “very true” to the statement “ Solace creates opportunities for me to learn how abuse and hardships affect people's relationships rose form 91.31% to 95.83%
- The proportion of residents answering “somewhat true” or “very true” to the statement “I am learning more about how to handle unexpected reminders of the abuse and difficulties I have endured” rose from 78.26% to 87.5%

Connection

The scores in relation to Connection were high and showed an improvement in 2 of the 3 questions.

- The proportion of residents answering “somewhat true” or “very true” to the statement “At Solace I have the opportunity to connect with others” rose from 88% to 91.68%
- The proportion of residents answering “somewhat true” or “very true” to the statement “I have opportunities to help other survivors of abuse at Solace” was fairly static, shifting from 84% to 83.34%
- The proportion of service users answering “somewhat true” or “very true” to the statement “I have the option to get support from peers or others who have had experiences similar to my own” rose from 83.33% to 91.67%

Strengths

The picture arising from the strengths subscale is more varied, and although the responses are overall very strong, Solace management may want to focus on some of the issues the question about “the strengths I bring to my relationships “ in developing the programme further.

- The proportion saying “somewhat true” or “very true” to “staff respect the strengths I have gained through my life experience” rose from 96% to 100% with a rise in the “very true” proportion from 68% to 86.36%
- The proportion saying “somewhat true” or “very true” to “”Staff respect the strengths I get from my culture or family ties” dropped slightly from 95.84% to 91.31% mainly due to a drop in the proportion replying “very true” from 79.17% to 69.57%. These figures still

reflect an organisational culture in which clients feel that their cultural and family ties are reflected, as fewer than 10% of residents did not feel that staff respected this.

- The proportion of residents answering “somewhat true” or “very true” to the statement “ The strengths I bring to my relationships with my children, my family , or others are recognised by Solace staff fell from 95.83% to 83.33%, although within this the proportion answering “very true” rose from 70.83% to 75% .

Inclusivity

In this section of the survey , residents had the opportunity to answer don’t know, and the proportion answering “don’t know” varied from 8% (the pre and post rates for “Solace treats people who face physical or mental health challenges with compassion” to 33% for the End of Project Questionnaire when asked “ Staff understand the challenges faced by people who are migrants” - these variations are most likely explained by the changing make-up of the clients completing the form at these two moments in time, in a very diverse part of the country.

The analysis in this section relates to the proportions of people who gave an answer other than “I don't know”

The analysis shows an improvement for most questions on the sub scale as follows:

- The proportion of residents answering “very true” to the question “People's cultural backgrounds are respected at Solace” rose from 80% to 89%
- The proportion of residents answering “very true” to the question “People's religious or spiritual beliefs are respected at Solace” rose from 80% to 90.47%
- The proportion of residents answering “very true” to the question ”Staff respect peoples sexual orientation and gender expressions” fell from 90% to 83.3%
- The proportion of residents answering “very true” to the question “Staff understand what it means to be in my financial position” remained static at 66.66% - noticeably lower than the “very true” levels for other questions.
- The proportion of residents answering “very true” to the question “Staff understand the challenges faced by people who are migrants” fell from 83.3% to 75%
- The proportion of residents answering “very true” to the question “Staff understand how discrimination impacts people's everyday experience” fell slightly from 72.72% to 70.85%
- The proportion of residents answering “very true” to the question “Staff recognise that some people or cultures have endured generations of violence, abuse and other hardships” rose from 77.27% to 85%
- The proportion of residents answering “very true” to the question “ Solace treats people who face physical or mental health challenges with compassion” rose from 77.27% to 81.82%

Parenting

The section on parenting was only completed by residents with children. This was the only category of the TIP questionnaire to show an overall reduction in scores at the end of the project. It may be explained in part by the fact that the End of Project Questionnaires will reflect the experience of mothers/carers who came to Solace after the play therapy budget had been exhausted, whereas the initial form was completed by mothers/carers who had the opportunity, where appropriate, for their children. In section 13 where the play therapy itself is evaluated it can be seen how valued it was by parents and children alike.

- In response to the statement" I am learning more about how children react emotionally when they have witnessed or experienced abuse or other hardships", the proportion answering "somewhat true" or "very true" fell from 100% to 88.24%
- In response to the statement " Staff help me explore how children's relationships can be affected by witnessing or experiencing abuse and other life difficulties" , the proportion answering "somewhat true" or "very true" fell from 94.4% to 89.48%
- In response to the statement "I am learning more about how my own experience of abuse can influence my relationships with my children" the proportion answering "somewhat true" or "very true" rose from 88.89% to 94.74%
- In response to the statement "Solace provides opportunities for children to get help dealing with the abuse and other hardships they may have experienced or been affected by " the proportion answering "somewhat true" or "very true" fell from 100% to 93.75%
- In response to the statement "Staff support me to strengthen my relationships with my children" the proportion answering "somewhat true" or "very true" fell from 89.47% to 88.89%

The following case study illustrates how staff have been able to improve the ways in which they support women with their parenting as a result of PIE.

Case Study: Improved parenting support

Woman and one child: Used setting goals to overcome anxiety. We talked about breaking tasks into smaller portions so she could cope even if the task was not finished, e.g. cleaning her room. She would normally take whole day to clean the room, and then would get very angry and anxious. So we started with 45 minutes a day for cleaning; Service user was not happy with this, but was encouraged to do this. The SU could see that small things were an achievement. Doing this for approx. 3 weeks it was increased and she realised she is not overly frustrated or as anxious.
We also discussed coping strategies - a good example was taking her daughter to nursery on time. If late it would mess up her whole day, feeling like a failure and be in a bad mood all day. It was discussed how some things cannot be helped and that nothing drastic will happen, so she started to look at things differently and has now started to manage this area much better. We worked around stressful thoughts, for example "How am I going to be able to deal with everything in the mornings". We put in a plan to arrange uniform the night before, the packed

lunch is ready, the child is made aware that she has nursery so is ready for it. This helped to relieve some of the anxieties around how Mum was feeling.

In conclusion, when studying the trauma informed practice scales before and after the project, it is clear that there are areas where the experience of Solace refuge residents has improved, and that in some cases these correlate with the initiatives introduced as part of the PIE project. Scores for both the start and the end of the project period were high, with the only one falling below 70% (for both the pre and post questionnaires) being the statement "Staff understand what it means to be in my financial position" and this is an issue that Solace may wish to explore further with service users, managers and staff . It should be noted that this question was asked as it forms part of the Trauma Informed Practice questionnaire, but it was not part of the original aims of the project at Solace to address this issue.

The overall picture that comes from these responses was well summed up by a client who wrote on her form

"The Solace Staff are very approachable, happy, down to earth people, dedicated to their jobs, working from their hearts, understanding and supportive. I commend them all. They help us find ourselves again "

11. Service User Forum

Key finding: The PIE Service User Forum relished the opportunity to get involved with the policy and practice changes at Solace and felt they would make a real difference to future residents

Key to the project has been the involvement of the PIE Service User Forum in advising on changes to practice. The forum consists of both current and past residents of Solace refuges. The changes introduced as part of the review of policies have been discussed at the forum, and they led on agreeing priorities for the work as well as contributing to the details of the specific policies and procedural changes made. Once the suggested amendments had been incorporated into polices, they were taken to the next forum meeting for sign off before they went to the Senior Management Team. This was not only to embrace the PIE service user element of the project but also as a genuine recognition that they are the experts by experience.

A discussion group was held at the end of the project to obtain feedback on forum members' experience of their involvement in the project.

Forum members reported that they were excited to be part of this project, particularly about influencing change and improving practice for other victims of abuse who would enter refuge when all the PIE changes had been implemented. They particularly value the fact that the forum is used as a working group to facilitate such changes and enjoy seeing their input and

discussions appear in the actual policies. This is reflected in the following quote from a participant

"I think the PIE project is a brilliant idea to bring positive change to policy and procedure in Solace refuges and an improvement in experiences for women who will access refuge in the future"

Feedback was also sought on the specific service changes that the forum had been consulted on at the time of the discussion group. These were

- The One Page Profiles

The forum collectively agree One Page Profiles are a great idea as they shift the focus from all the admin forms that are completed as a standard for everyone, to a document which asks women about themselves as individuals and acknowledges that Solace wants to support them individually rather than adopting a blanket one size fits all approach. One woman summed this up when she said:

"*The One Page Profile is a great idea because it actually asks me how I want to be supported - if I received this when I first came to refuge I would have felt valued and recognised as an individual rather than a victim of abuse or a problem that needed solving"*

- The new House Agreement

Forum members were very positive about the new House Agreement but actually decided that the term "House Expectations" was a better term for it – the Agreement is being renamed to reflect this. It was felt to be much easier to read, less traumatising, more inclusive and less hetero-normative. This contrasted to the previous document which they felt was institutionalising and authoritarian; the new document was about embracing and encouraging a more conducive environment for communal living.

Forum members were asked how they felt the new House Expectations might have made a difference based on their own experience of arriving at, and staying in, a refuge. They expected it to be less traumatising for women reading the new House Expectations rather than the stringent rules of the previous document. It is also trauma focused and reflects an understanding that women have already come from a very controlling environment so they don't want to have to deal with strict rules as soon as they enter which means they will have a better start to their stay. The new document reads better, the language is less formal and focuses on respecting each other to aid communal living.

One forum member commented:

"The new House Expectations feels less intimidating and more respectful to women who are living in the refuge"

"The new policy helps women feel more comfortable and less traumatised"

- Changes to Warning Policy and Procedure

The group were asked what difference they thought changing the warning letters to something that is more of a Support Agreement will make to women's experience of staying at the refuge, and what difference it would have made to them.

Forum members felt it was a much better way of working. They felt it provided an opportunity to understand why they were displaying behaviours such as anger and directing it at other residents or workers. They also felt it gave them an opportunity to sit down and talk about support needs with their worker without being handed a letter by the manager at what felt like a "telling off" meeting. Members also felt it was an opportunity to talk about the impact of trauma on them and how they could adopt healthier coping strategies to prevent future warnings for similar behaviour. The new Warning Support Letter also allows for a woman to reflect on taking responsibility and making positive changes to sustain her refuge placement.

Members of the forum provided compelling testimony about the impact this change could have on women's experiences in the refuge, as illustrated by the following two quotes:

"*I wouldn't have felt punished for expressing myself in a way that was normal to me - at least I could have spoken to someone about the reasons behind my anger instead of just being told off for it without any follow up"*

"when my worker saw me drinking wine in the garden on CCTV, if she had asked me why I was drinking I would have told her it's because my perpetrator's assault charges had been dropped by the court, instead I received a warning letter for breaking the house rules which set me back even more"

New Policies and Procedures: Case Study

The following case study from a staff member reflects the changes in approach that the Service User Forum expected to see as a result of the changes to policies and procedures:

SS has stayed at Frances House for 7 months; she was issued a 28 day Notice to Quit on the 9th of January this year because she had continued to engage in a relationship with her perpetrator on a weekly basis. However after much reflection in a team Case Review Meeting, we decided to extend the NTQ for another 28 day to give SS more time to decide what she wanted her Move On Plan to be and if she really wanted to leave the relationship. We supported SS to take her time while going through court processes, meet solicitors and

file Injunctions against her perpetrator, and give her time to consider what was right for her instead of feeling rushed and pressured into making decisions. We also consulted with SS on the issue and asked her what she wanted to gain from her stay in refuge and how we could help her in the next 28 days; we subsequently supported her in her decisions. We devised a new Support Plan together to re-address her Move On Plan.

Forum members were also asked what changes they would like to see as part of the project going forward. Suggestions were:

- Even more staff training or at least ongoing training, specifically around harm minimisation, attending to women who have self-harmed and on respecting resident's opinions and views.
- Improvement in practice for when women leave the refuge and the follow up work that is needed.
- Forum members were worried that once this project ended that there would be no one to push PIE and its benefits forward.

It is clear that not only has the Service Users Forum had a real impact on the transformation of Solace refuges into Psychologically Informed Environments, involvement in the project has been empowering for the women themselves, as summed up in the following comments from members:

"I have felt that Solace values my opinions on the everyday running of the service, this has made me feel like a person rather than another number on a system"

"I really feel I've had a positive impact on rewriting policies for Solace, in particular the house expectations and warnings policy"

"I feel really happy that I could be a part of the changes that Solace will make for future residents of the refuge, the project is a brilliant idea"

12. Partnership agreements

Key finding: partners wanted to engage with Solace, but lack of resources in outside agencies has hampered progress in this area

This proved to be the most challenging part of the project. The Project Coordinator made contact with all relevant services across the boroughs, and has had meetings with a number of service providers.

This includes local authority, mental health and drug and alcohol teams. She has met with IAPT teams in every borough.

No partnership agreements have been formally signed off yet for the following reasons:

- Service delivery partners want training for their staff before signing agreements
- They also want Solace to thoroughly understand their own limitations as a service and the fact that their resources are also overstretched and underfunded. This means that although partnerships can be formalised, this would not necessarily enable them to prioritise the referrals sent by Solace or to respond any differently. Partnership agreements may not on their own have much impact on referral routes and improved responses.
- Difficulties in getting meeting with Mental Health Commissioners - commissioners from some boroughs have not turned up at meetings as they have had to prioritise other meetings on those days.
- The biggest challenge has been with Crisis Teams, where no meetings have taken place due to their lack of capacity. This reflects the situation which staff reported on in terms of difficulties accessing support for clients from Crisis Teams. When they have offered to meet with the project manager, they have highlighted that it is only to discuss the services they offer and that they cannot make any changes to their response times to the service users referred by Solace.

Solace continues to show commitment to improving partnerships with specialist services, and appreciate that maintaining such partnerships over a long term period will require further resources and time.

Although there have not been any formalised partnership agreements signed off, there has at least been some movement towards the progression of this. There has also been some development in the borough of Barnet where funding has been secured for a worker to specifically train mental health workers on domestic violence and abuse which will further support Solace's dedication to improving partnership work.

13. Play Therapy

Key finding: The children and their mothers benefitted from the Play Therapy programme

The provision of play therapy was an integral part of the project. Living with domestic abuse is harmful to children, regardless of whether they have been physically abused directly, as living in an environment of coercion and control can have long-term impacts on attachment, development and well-being. Domestic abuse is rightly recognised as a form of child

maltreatment and is a factor in over half of serious case reviews[11]. This evaluation has already referred to the trauma caused by domestic abuse, and children and young people especially can be very scared by these reactions and may also find it hard to name their feelings, or indeed link their feelings and behaviours to what they have experienced.

When living with abuse, children are often hyper-vigilant, frequently in fight or flight mode, which can come at the expense of higher reasoning, memory and problem solving, many of which are not even available yet to younger children due to the complexity of brain development and the fact that the brain does not fully develop until our mid 20's.

When mothers and children move to refuges, once they feel settled it is normal for some of these feelings and suppressed memories to come to the surface. Some mothers can be upset by realising quite how much their child has experienced. The mother-child relationship may also have been compromised by the abuse and controlling nature of the perpetrator. Therefore, it is important for refuges, and other agencies, to provide support to help re-build the mother-child relationship and also help the child to make sense of what has happened, to validate their experiences, understand it was not their fault and learn how to comprehend and express their feelings.

The British Association of Play Therapists defines play therapy as '*a way of helping children express their feelings and deal with their emotional problems, using play as the main communication tool*'. In common with adult therapies, the aim of these experiences is to bring about changes in an individual's primary relationships, which have been distorted or impaired during development. The aim is to bring children to a level of emotional and social functioning on a par with their developmental stage, so that usual developmental progress is resumed[12]. In terms of its effectiveness as a method, one meta-analytic review of 93 play therapy outcome studies found that play therapy is an effective intervention for children dealing with emotional and behavioural difficulties[13]. Similarly, Play Therapy UK (PTUK) conducted a ten year review of their services and found that between 74% and 83% of children receiving play therapy, delivered to PTUK standards, show a positive change based on the strengths and difficulties measure.

However, there is a lack of research evidence looking specifically at the benefits of play therapy for children who have experienced domestic abuse.

There are various models of play therapy and several of these were used by the therapists employed by Solace during the project. The key features of the models used are explained below:

Non-Directive Play Therapy

[11] Sidebotham, P. et al (2016) Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011 to 2014: final report (PDF).

[12] Wilson, Kate and Ryan, Virginia Chapter 1 - Play Therapy: A Non-directive approach for children and adolescents. In: Play Therapy: A Non-directive Approach for Children and Adolescents. Elsevier, Edinburgh

13 Bratton et al (2005) The Efficacy of Play Therapy With Children: A Meta-Analytic Review of Treatment Outcomes.

This method was used with 17 children. This form of play therapy sees play in itself as a healing process. Children are given the opportunity to learn about themselves in relation to the therapist, who in turn offers mutual respect, empathy and acceptance and a safe space for the child to explore their experiences. Children are accepted without judgement and with no pressure to change. In non-directive play therapy, the therapist leaves responsibility and direction to the child and this approach is thought to be an effective and non-intrusive way of working with children who have experienced abuse, as it emphasises the child's choice and control of issues and goes at the child's pace.
Central to this are the eight basic principles of play therapy as set out originally by Axeline[14]
The therapist:

- Must develop a warm and friendly relationship with the child;
- Accepts the child as she or he is;
- Establishes a feeling of permission in the relationship so that the child feels free to express his or her feelings completely;
- Is alert to recognise the feelings the child is expressing and reflects these feelings back in such a manner that the child gains insight into his/her behaviour;
- Maintains a deep respect for the child's ability to solve his/her problems and gives the child the opportunity to do so. The responsibility to make choices and to institute change is the child's;
- Does not attempt to direct the child's actions or conversations in any manner. The child leads the way, the therapist follows;
- Does not hurry the therapy along. It is a gradual process and must be recognised as such by the therapist;
- Only establishes those limitations necessary to anchor the therapy to the world of reality and to make the child aware of his/her responsibility in the relationship.

Theraplay / Marshak Intervention Method

This method was used with 10 children. Theraplay is a short-term, attachment-based intervention and according to the Theraplay Institute, Theraplay is: 'a child and family therapy for building and enhancing attachment, self-esteem, trust in others, and joyful engagement. It is based on the natural patterns of playful, healthy interaction between parent and child and is personal, physical, and fun. Theraplay interactions focus on four essential qualities found in parent-child relationships: Structure, Engagement, Nurture, and Challenge. Theraplay sessions create an active, emotional connection between the child and parent or caregiver, resulting in a changed view of the self as worthy and lovable and of relationships as positive and rewarding'. During Theraplay sessions, the therapist works with both the parent/carer and child. In order to plan the sessions, the therapist may administer the Marschak Interaction Method (MIM). The MIM is a structured technique for observing and assessing the overall quality and nature of

[14] http://playtherapy.org.uk/ChildrensEmotionalWellBeing/AboutPlayTherapy/MainPrinciples/AxlinePrinciples

relationships between caregivers and child. It consists of a series of simple tasks designed to elicit behaviours in four primary dimensions in order to evaluate the caregivers' capacity to[15]:

- Set limits and provide an appropriately ordered environment (Structure)
- Engage the child in interaction while being attuned to the child's state (Engagement)
- Meet the child's needs for attention, soothing and care (Nurture)
- Support and encourage the child's efforts to achieve at a developmentally appropriate level (Challenge) and the child's ability to respond to the caregivers' efforts

It is important to note that the MIM tool is not yet standardised and is currently under study. The five therapists in this study used a variety of tools and play materials including puppets, dolls and figures, play-doh, paint, feathers, games, bubbles, water and sand.

Filial Therapy

This method was used with three children. Filial therapy is closely related to Non-Directive Therapy but includes parents or carers as well. In more traditional play therapy, the therapist may have an introductory session with the parent/carer but will then see the child alone. In Filial Therapy, the parent/carer is present in every session. After an initial assessment, the parent/carer is taught the basic filial skills and then runs weekly sessions with their child, observed by the therapist. Following this, the parent/carer and therapist usually debrief the session, focus on the positives and discuss any challenges. This model usually takes between 3 and 6 months. As well as the benefits to the child mentioned previously, parents also learn valuable skills including[16]:

- Understanding their child's worries and other feelings more fully
- Learning new skills for encouraging co-operation from their children
- Enjoying playing with their children and giving them positive attention
- Increasing their listening skills and developing open communication with their children
- Developing self-confidence as parents
- Becoming more able to trust their children
- Dealing in new ways with frustrations in family life

Evaluation of Play Therapy

Development of survey measures

This study collected pre and post intervention responses from children themselves (where old enough), parents and therapists. There are a variety of tools that can be used to measure the wellbeing of a child; however there is not a specific tool that measured the trauma symptoms that children who have experienced domestic violence commonly experience. Many studies use the Strengths and Difficulties Questionnaire, and although this is a useful measure for screening behaviours, it does not have a self-report questionnaire for children under 11. A new tool was developed by the evaluators using common symptoms of trauma associated with experiencing domestic abuse. The surveys were distributed to the five therapists to administer. The table

[15] http://www.therap-lay.org/index.php/the-mim-assessment
[16] http://www.filialtherapy.co.uk/

below shows how many responses were collected for the 42 children, parents and therapists pre and post intervention. Unfortunately, not all surveys were completed. Five children were too young to complete the form themselves. There were eight children where data was completed by themselves and their parents at both stages. There were only 6 of 42 children where a complete set of data was returned. For 12 children only the therapist closure report was provided with no other data. This is summarised below:

The Number of Surveys collected Pre and Post Intervention

Child Pre	Child Post	Parent Pre	Parent Post	Therapist Pre	Therapist Post	Therapist Report
18	12	24	14	22	17	31

42 children took part in play therapy in total. Of the 37 children where date of birth was provided, there were 22 boys and 15 girls. Ages ranged from 18 months to 12 years of age. This information is summarised below:

The ages of children taking part in play therapy

Age	1	2	3	4	5	6	7	8	9	10	11	12	Total
Boys	0	2	4	4	0	2	3	3	2	1	0	1	**22**
Girls	4	1	2	2	0	2	0	0	2	1	1	0	**15**
Total	4	3	6	6	0	4	3	3	4	2	1	1	**37**

Reasons for referral

There were many reasons for referring a child to play therapy. For some children, multiple reasons were provided. The most common reasons included aggression towards parent/siblings/other children (this was only reported for boys); problems with the relationship between mother and child; separation anxiety; controlling behaviour; hyper-vigilance; issues with sleep and night terrors; disassociation; bullying behaviour; low self-esteem; general anxiety; self-blame and issues with transitioning to refuge life. It should be noted that these are all normal reactions to trauma and domestic abuse.
Many of the referrals also mentioned the mother's mental health issues as a reason for referral in terms of the impacts of this on the children. Depression was frequently mentioned as an issue. One therapist noted: '*the mother was being treated for depression, and had known mental health difficulties and was finding it difficult to be emotionally available and present for her child*'. This seemed to be a common issue amongst the families referred. Again, this is a

common experience with rates of depression for survivors of domestic violence around four times as high as the rates for non-abused women[17].

Duration

Information on the duration of therapy was provided for 31 children. . All families were offered 12 or 15 week programmes. The majority of children attended at least 10 sessions, but some were unable to continue due to health issues or because they moved away from the refuge. Some appointments were cancelled or the family did not turn up. One therapist was asked by the refuge staff to stop any further engagement with the family after the mother had cancelled five sessions at short notice. The overall situation is summarised below:

Number of sessions	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Boy			1		1	1		1	2	4		5		1	3
Girl		1								3	1	5		1	1

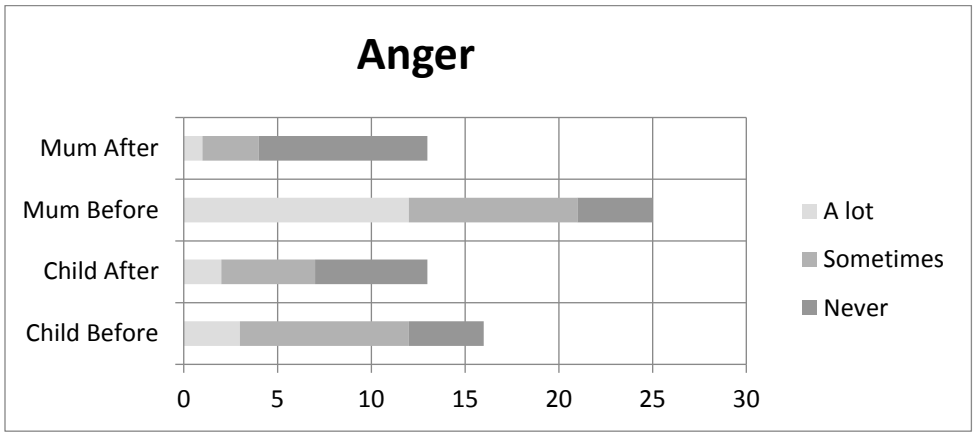
Results

Results are only available for the 29 children where data was returned. As noted above, there is only full data for six children. 42 children took part in the therapy in total.
Data was collected on 13 common trauma responses, namely: anger, shouting, hitting and kicking, crying and sadness, feeling scared, wetting the bed, separation anxiety, worrying, shyness, self-blame, forgetting things, nightmares and stomach/headaches. Other more positive signs were also measured including feeling happy, helping others, laughing and playing. This evaluation looks at five significant behaviours in more detail. The behaviours chosen to be analysed are: anger, hitting/kicking, worrying, separation anxiety and happiness. These have been chosen as they represent four common alarm responses for children who have been exposed to domestic abuse and trauma. They are also behaviours that mothers are often most concerned about and it is hoped that the play therapy intervention will help to reduce these responses. Happiness was included to ensure a positive variable was also measured as many children will display happiness as well as more negative responses.

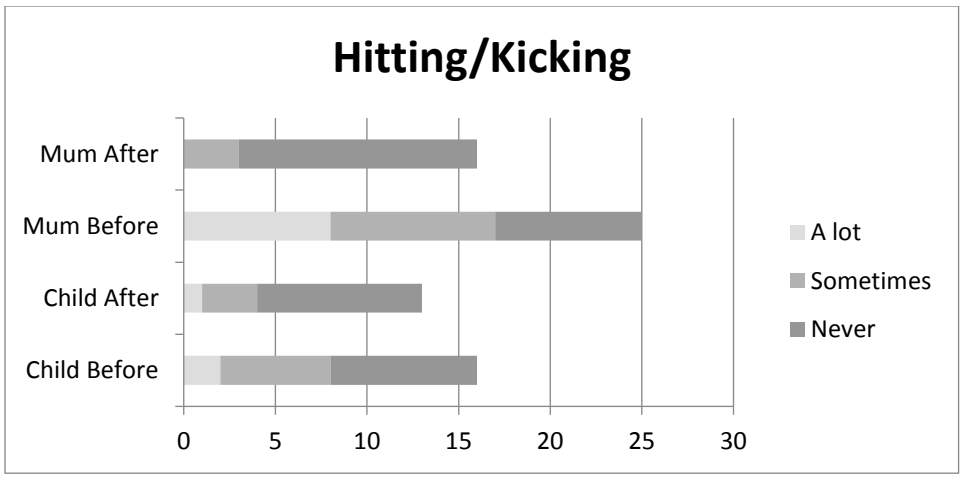
The charts below show the pre and post responses from mothers and children for anger, hitting and kicking, worrying, separation anxiety and happiness. The children are rating their own feelings/behaviours and the mothers are rating how they think their children feel and how often they behave in certain ways. It should be noted that not all children or mothers completed every section of the form. 16 children completed the pre intervention survey and 13 completed the post intervention survey. Of the mothers, 25 completed the pre-intervention survey and 16 completed the post-intervention survey. For this reason it is difficult to compare results, however

[17] Barron, J. (2005). Principles of Good Practice for working with women with mental health issues: Guidance for local domestic violence services. Bristol: Women's Aid; Walby, S. and Allen, J. (2004). Domestic violence, sexual assault and stalking: Findings from the British Crime Survey. London: Home Office Development and Statistics Directorate

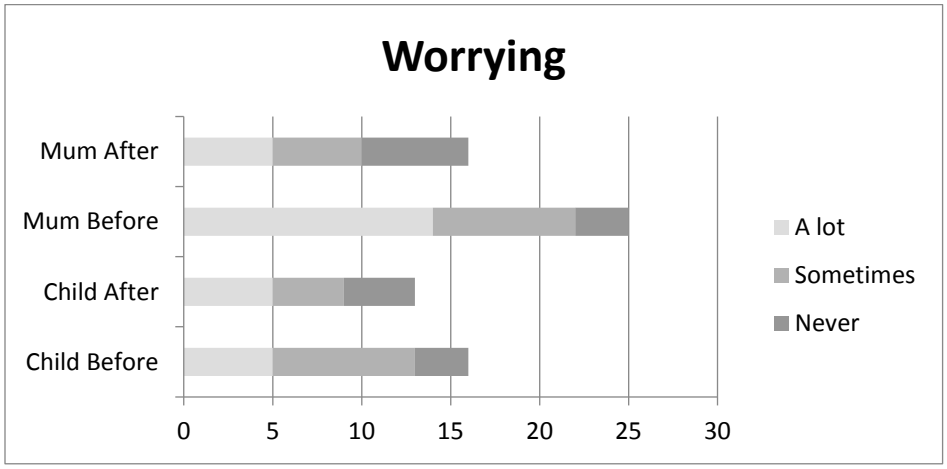
it can be seen that there are differences between how children self-report and how mothers view how their children are feeling both pre and post therapy.



Although more mothers completed this survey, there is still a marked difference in how many mothers perceived their children to be angry compared to how many children reported to feel anger. This may be because the mothers are projecting anger onto their children. It could also be because children have learnt to suppress feelings of anger as they associate that emotion with the perpetrator, or it may be that children who have experienced abuse and trauma lack the emotional literacy to be able to identify their feelings. No matter the reason, it shows a disconnect between mother and child which play therapy aims to work with and improve. The results show that after therapy, children feel less anger and mothers perceive them to be less angry.

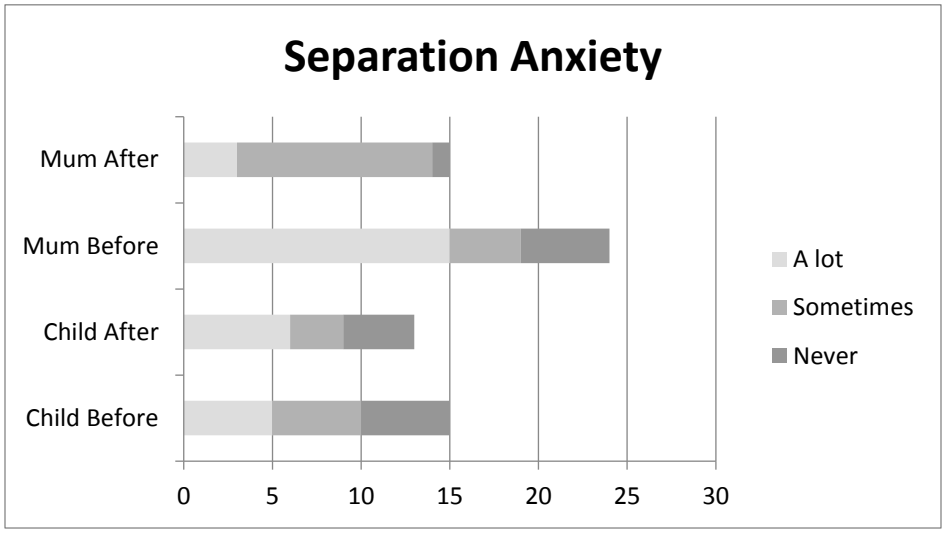


These figures show that before therapy, mothers report seeing their child hitting or kicking more than the child self-reports these behaviours. This could be due to the fact that the child may not want to admit that they use these behaviours, especially to a new person who they have just met. However, the results show that post therapy, these behaviours have decreased from both mother and child's perspective.



In terms of worrying, mothers seem to overestimate how much their children worry. This is a common response from women who have experienced domestic abuse and the concerns they have about the impacts on their child. Post therapy results indicate a reduction in worrying for both mother and child.

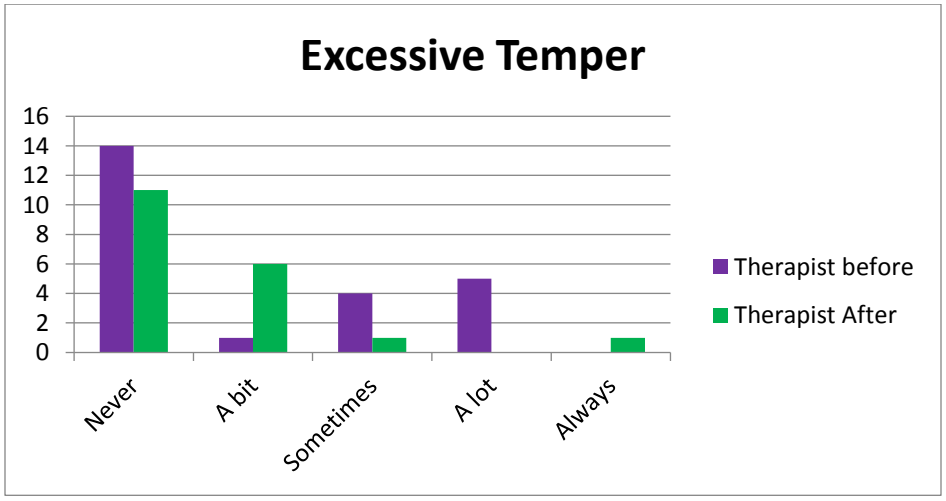
These figures show that despite the difficult circumstances, most children are still able to feel happiness. After therapy, there is a reduction in the number of children who only sometimes or never felt happy. This is an important finding and emphasises how some children are able to be resilient despite the trauma they have experienced.



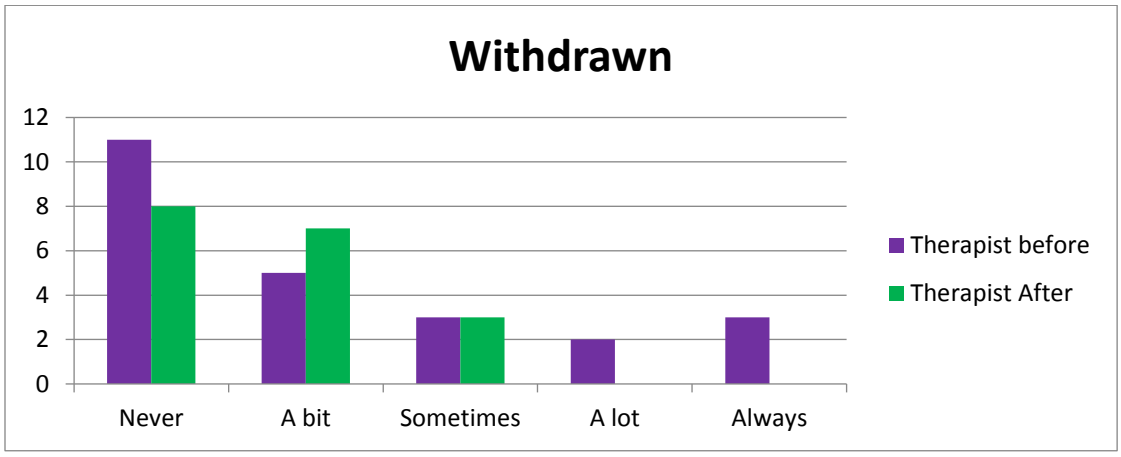
Pre therapy, mothers reported more separation anxiety than their children. However, post therapy, the children reported an increase in this whereas the mothers saw a marked decrease. We do not know the reasons for this from the data, but it could be that for some children, the therapy had brought up some difficult issues that made them more anxious to be away from their mothers. This may be especially true for those children who were only able to attend a few sessions and who may not have moved through the stages of therapy needed to reduce this anxiety and improve attachment.

Therapist Evaluations

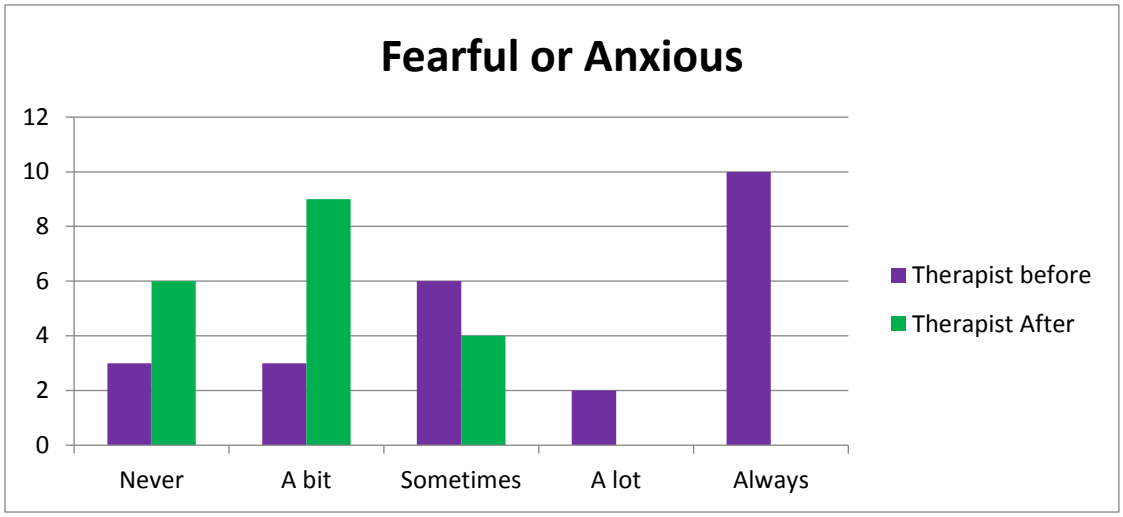
The responses for mothers and children were slightly different than the variables that the therapists were asked to rate. This was to make the surveys as easy to understand and complete as possible. Therapists were asked to rate the following responses: excessive temper, verbally abusive, aggressive behaviour, regressive behaviour, crying, startles easily, fearful or anxious, separation anxiety, withdrawn, lacking self-confidence, unable to trust others, self-blame, memory problems, nightmares, difficulty focusing, stomach or headaches. For this summary report, five responses have been analysed in detail. The pre therapy survey was completed for 24 children, and the post therapy survey for 19 children.



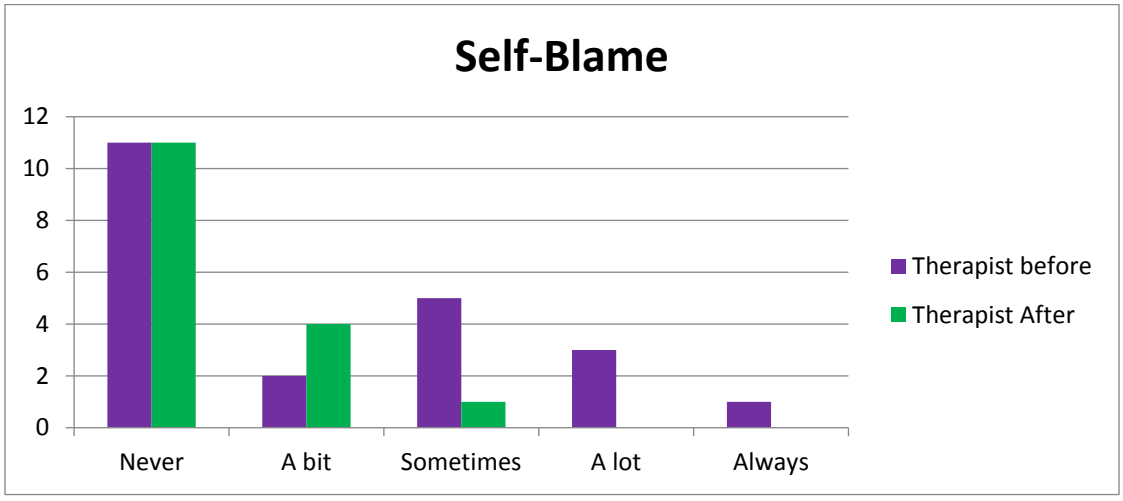
Most therapists did not witness excessive temper in the therapy sessions. However some did see an increase in those children who displayed this behaviour 'a bit'. This may be related to the children who had not had the full 12 or 15 sessions. It is quite usual for some children to display more anger after a few sessions of therapy, as they begin to feel safe to express this difficult feeling. This usually then decreases by the end of the sessions so if a child was taken out of therapy before this had happened, it may show an increase in this behaviour. Some children also reported feeling angry or sad that the sessions had ended.



On the whole, children seem to have become less withdrawn after therapy with no children being described as withdrawn a lot or always (compared to 5 who were described as such before therapy). However, due to the difference in therapists completing both pre and post surveys, it is unclear whether this is statistically significant.

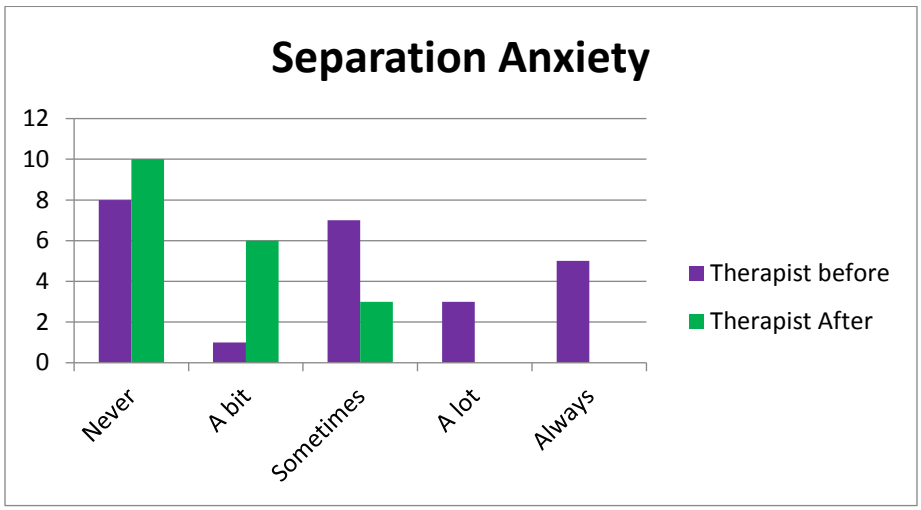


This seems to indicate a very positive finding, in that before therapy 12 children were described as being fearful or anxious a lot or always. Post therapy, no children were reported to be fearful or anxious. There was also a marked increase in children who were never or were a bit fearful or anxious. This is a positive indication that play therapy helps to reduce fear and anxiety, which are very common responses to domestic abuse and trauma.



Although most children did not seem to blame themselves for the abuse before or after therapy, 9 children did so sometimes, a lot or always. This reduced to just one child blaming themselves sometimes after therapy. This represents another positive indication that play therapy has an impact on reducing self-blame and responsibility for abuse. Due to young children's

egocentricity, they often have a tendency to blame themselves; to remove them of this burden is incredibly important.



Again, post therapy results indicate a reduction in separation anxiety for most children. Eight children were described before therapy as having separation anxiety a lot or always, compared to none post therapy. This mirrors what mothers reported, although children did report a slight increase in separation anxiety post therapy.

For 33 of the children, therapists also submitted closure reports. These varied in length and detail but typically addressed the presenting behaviours, an overview of what kind of therapy was used, and how the child and mother coped with therapy, a summary and any recommendations for future work. These reports were very useful and it is recommended that they are used in all future work with a universal format to assist in evaluating further therapy.

The evaluation also looked at some of the qualitative information coming out of the information returned by therapist, children and young people and their parents.

Common Themes

Violence, death and banishment

Many of the therapists mentioned that common play amongst children involved using dolls and figures in what was commonly termed 'war-play'.

"*I noticed that his battles were always full of darkness, but everything was described by him, (as a voice over) in a calm and detached way…week after week he played with the same material, enacting very elaborated stories of fighting, killing and deaths."*

"Games using the aggressive release toys were key in her being able to express her anger towards her father and her mother's helplessness".

Many of these children also used recurring themes of good vs evil, magic, protection and banishment of people they perceived to be 'bad'. Therapists surmised that these enactments

could be a reflection of the children's inner worlds which may feel chaotic and overwhelming. Initially the violent play often had no sense of safety but as sessions progressed this seemed to change
"*The safe and contained environment of the playroom seemed to become the recipient of the dense and powerful feelings which he was able to express with increasing clarity. The dichotomy of good/bad was replaced by the strong urge of being in control, being unbeatable and powerful*". In this way, the 'war-play' allowed the child to externalise his inner conflict and give him a sense of control and stability which helped to build his self-worth.

Rescue and Protection

Another common theme linked to the child's desire to protect and be protected. Some children still used the toys in an aggressive way but this time the focus was more on protecting the 'victim' toy from the 'enemy' who would try to hurt them.

"*X used the figures to create scenes of attack and the victims were covered in disgusting substances, when defending he allowed heroes with special powers and secret personalities to come to the rescue, although often heroes were mortally wounded in the process*."
"Using her magical powers, she was able to find special resources that could change and transport things and show help was just around the corner."

Boundaries

For many children who have experienced domestic abuse, boundaries are very important and need to be clearly set out. One child was very worried about playing the 'wrong way' or being in trouble; the therapist was able to sensitively respond by making a play contract that helped him feel safe and contained. Some children were able to use toys to bring a sense of order to the chaos they felt inside. Mothers as well benefited from guidance about how to set boundaries, including being mindful of how much they disclosed in front of their children.

Mother-Child Relationship

In the Filial Therapy sessions, mothers attended with their child. There were mixed responses to their involvement. Many mothers reported concerns about their relationship with their children, often feeling it had deteriorated as a result of the abuse they had experienced. Some mothers welcomed the intervention but some felt that it was only the child who needed to attend and saw the therapy as labelling them as a bad mother.
There were some very clear examples of how relationships had started to be repaired. One mother and daughter started to reconnect and 'delight in each other again'. The therapist commented that '*reflecting on their life experiences together and exploring movement from past to present, facilitated an awareness of mistaken beliefs of fault and blame that were able to be aired and clarified*".

Child: "*I wish we could keep on doing this forever, it feels so nice*";
Mother: "*I can see you are so like me, but smaller, still so very little*". This was an important awareness for the mother, as previously the child had had to regress in order to get a nurturing response from her.

"As the mother understood the child could respond to routine and consistency, she began to predict and understand the structure of the sessions and this structure also imparted to their daily life".

"This really made a difference to us - I don't think I could have got this from a parenting class".

Non-engagement

Only 24 children completed 10 or more sessions. In some cases, therapy was ended with no reason by the mother, or was closed due to non-engagement. Non-Directive Therapy is based on the assumption that the individual has within themselves the ability to solve their own problems but this can be a long-term piece of work. Traumatised children may take a long time to be able to trust a new person and to work through the abuse they have experienced. Only coming to a few sessions may, in some cases, do more harm than good. Thought should be given to how ready the mother and child are to attend therapy and how supported the mother is within the refuge to be able to attend sessions.

The Trusting Relationship between Child and Therapist

It was clear that the underpinning ethos of play therapy, of building trust and respect was crucial for the success of the intervention. This was hugely valued by the children. The therapist's reports showed how the children's trust gradually built up over the sessions.

"As therapy progressed, he started to make and maintain eye contact, asking me to interact with him in his play".

"Look at this cut (on finger), it's a little one but sometimes the little ones hurt the most. Can we fix it? No one else has time".

Any intervention with children who have experienced trauma must be built on a core foundation of a trusting relationship, but practitioners must understand that this takes patience, consistency and time to develop.

Overall, it seems that play therapy interventions have had a positive impact on children and also on their relationships with their mothers. Concerning feelings and behaviours such as anger and anxiety have reduced and overall happiness has increased. Despite the limitations of this analysis, this form of intervention is one that should be evaluated further and pursued with other children who have experienced domestic abuse.

14. Conclusion

To create a Psychologically Informed Environment across several refuges, working with partners across several boroughs, with limited funding, was an ambitious undertaking. Despite this, it is clear from this evaluation that the project has been successful on a number of measures:

- A significant reduction in the number and proportion of service users turned away because their mental health needs could not be met.
- A marked improvement in staff understanding, knowledge and confidence around the psychological needs of clients, and how best to support them
- Positive client feedback through the Trauma Informed Practice scales
- Staff and managers are able to clearly identify practical examples of improved service user support as part of the project
- A number of policy changes have been introduced with the involvement and support of the Service User Forum and managers alike
- Play therapy interventions have had a positive impact on children and also their relationship with their mothers.

15. Recommendations

The introduction of a Psychologically Informed Environment has been transformational for the refuge residents and staff at Solace Women's Aid. There are lessons from this, not just for Solace, but for commissioners, policy makers and other providers.

<u>For Policy Makers</u>

- The introduction of a Psychologically Informed Environment across five London boroughs has had a dramatic effect on Solace refuge residents' wellbeing in a short space of time and for limited additional spend. This provides a cost effective model for rolling Psychologically Informed Environment principles out across the refuge sector, and this should be considered when future priorities for funding innovation are being decided.
- The provision of adequate and appropriate mental health and substance use services outside of the refuges was the single biggest barrier to the success of the project. This needs to be addressed if survivors of domestic abuse are to be supported to rebuild their lives post abuse

For Commissioners

- Commissioners should consider funding the investment needed to create a Psychologically Informed Environment when commissioning services
- Invitations to tender should ask bidders to set out the steps they have taken, or will take, to ensure that their services are psychologically informed.

For Service Providers

- This evaluation shows that a modest financial investment and a strong management commitment can create a Psychologically Informed Environment that is transformational for service users and staff. The initiatives that form part of this project, such as reflective practice, play therapy and psychologically informed key worker sessions will not be new to many service providers in the domestic abuse sector. However, providers who are not already doing so should consider all of the elements of this programme in developing their services. The advantage of bundling a set of initiatives under the PIE umbrella, with a clear narrative to underpin them, cannot be understated.

For Solace Women's Aid

The challenge is to build on the success of the pilot and to sustain this transformation at a time when the women's sector continues to face financial challenges; this is partly about continuing good practice, but also about addressing those areas where progress to date has been more limited.

Recommendations are:

- That the work done in this project be replicated in any new refuges and services that Solace take on as a result of acquiring new contracts or increased funding
- To continue the work in developing partnership agreements with external services in the boroughs where Solace operates.
- To ensure that training is available to new starters that reflects the principles of PIE , and that refresher training is also available over time
- To continue to evolve improved ways of working with staff in individual refuges that reflects PIE principles, particularly around team meetings and supervision, so that reflective practice becomes integral to the management culture.
- To look at introducing new training and information for staff around specific mental health conditions , and specific behaviours such as splitting and self-harm

Solace Women's Aid should also take every opportunity to share the success of this project – to achieve such clearly measurable results in such a short space of time is remarkable.

Play Therapy

There is a lack of research evidence looking specifically at the benefits of play therapy for children who have experienced domestic abuse. Based on the findings of this evaluation, we would recommend to policy makers, commissioners and service providers that:

- Play therapy should be funded as a core priority for mothers and children in refuges, and that specifications for services should reflect this. Ideally mothers should participate in at least some of the sessions in order to rebuild the mother-child relationship and any potential issues with attachment.
- Mothers and children should be supported to attend therapy sessions. Consideration should be given to the timings and locations of the sessions to help mothers engage more easily.
- Children should be supported to attend a full course of therapy (ideally a minimum of 12 sessions). If children are taken out of the sessions it may interrupt the process and may even cause further trauma.
- Children in refuges must have access to consistent support where they are able to build a trusting relationship with a trained specialist in trauma informed care.
- More longitudinal robust evaluation should be conducted into the impacts of play therapy for children of different ages who have experienced domestic abuse