Evaluation of the Drive Project – a pilot to address high-risk perpetrators of domestic abuse
Year 1 Feasibility Study

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GLOSSARY

CM – Case Manager
CMS – Case Management System
CP – Child Protection
CRC – Community Rehabilitation Company
CSS – Children’s Social Services
DHR – Domestic Homicide Review
DVA – Domestic Violence and Abuse
DVDS – Domestic Violence Disclosure Scheme
H&S – harassment and stalking
IA – Institutional Advocacy
IDVA – Independent Domestic Violence Advisor
J&C – Jealousy and Coercion
MAPPA – Multi-Agency Public Protection Arrangements
MARAC – Multi-Agency Risk Assessment Conference
MARAT – Multi-Agency Referral & Assessment Team
MASH – Multi-Agency Safeguarding Hub
NPS – National Probation Service
OIC – Officer In Charge
OM – Offender Manager
RCT – Randomised Control Trial
RO – Restraining Order
SD – Standard Deviation
SUs – Service Users (perpetrators allocated to the Drive intervention)
V/Ss – Victim/Survivors
INTRODUCTION

The Drive Project is a new response to domestic abuse that aims to reduce the number of child and adult victims of domestic abuse by disrupting and changing perpetrator behaviour. It implements a whole-system, whole-family approach using an intensive individual case management approach alongside a co-ordinated multi-agency response to drive perpetrators to change their behaviour. The Drive Project focuses on increasing victim safety alongside the crucial protective work of victims’ services. The service has been developed to knit together existing services, complementing and enhancing existing interventions.

The Drive Project pilot focuses on priority high-risk or serial perpetrators, as this group carries the greatest risk of serious harm and engage poorly in available services. All Drive interventions are driven by the primary aims of reducing risk and increasing victim safety.

The Drive Project launched in April 2016 and is being piloted in three areas across England and Wales (Essex, South Wales and West Sussex) from 2016-2019. It is run by a partnership between Respect, SafeLives and Social Finance. The costs are being met by a combination of local funding from Police and Crime Commissioners and Local Authorities, Police Innovation Fund funding and philanthropic grants from Lloyds Bank Foundation for England and Wales, The Tudor Trust and Comic Relief.

By addressing perpetrators’ behaviour Drive targets the root cause of domestic abuse and improves outcomes for victims and children. The key objectives are to:

- Reduce the number of serial perpetrators of domestic abuse
- Reduce the number of repeat and new victims
- Reduce the harm caused to victims and children
- Intervene earlier to safeguard families living with high-harm domestic abuse

The Drive intervention takes randomly allocated high-risk perpetrators associated with victim/survivors (V/Ss) who have been referred to Multi-Agency Risk Assessment Conferences (Marac). The intervention lasts 10 months and is comprised of ‘direct’ one-to-one work carried out by Case Managers with Service Users (SUs); ‘indirect’ work carried out at a multi-agency level primarily to share information, manage risk and disrupt perpetration; and one-to-one Idva support for the linked victim/survivors. To the extent that Case Managers both assist SUs to meet basic needs (e.g. around housing or substance misuse treatment) and intervene to disrupt perpetration via the criminal justice system, the intervention can be characterised as comprising a combined ‘support’ and ‘disrupt’ element.
THE FEASIBILITY STUDY

Following a process of competitive tendering, a research team at the University of Bristol was commissioned to evaluate the Drive Pilot, led by Professor Marianne Hester.

There are three phases to the evaluation, of which Phases 1 and 2 have been completed for this report:

- **Phase 1** – This was a short Development Phase to establish processes of data collection and protocols with the Drive Project staff and relevant agencies and to obtain ethical approval from the University of Bristol Ethics Committee. (January to March 2016).

- **Phase 2** – This was an initial testing phase (March 2016 to June 2017) covering Year 1 of the intervention, to ascertain whether the intervention was feasible: looking at the acceptability of the pilot to perpetrators and victim/survivors of DVA, the feasibility of recruitment, randomisation and follow up, outcome measure completion for the first year of the intervention and process evaluation.

- **Phase 3** – This will constitute the main phase (June 2017 to June 2019), where longer term outcomes will be assessed more robustly, including behaviour change for a larger sample of perpetrators and life quality for victims and their children.

The evaluation team were tasked with providing a quantitative assessment of the efficacy of the Drive intervention, to demonstrate how outcomes are sustained over time, and to provide both quantitative and qualitative insights into which aspects of the intervention are core to any outcomes achieved. To this end, the evaluation team were asked to consider a number of key research questions, as follows:

1. How and why have perpetrators changed their behaviour? Is this change sustained over time?
2. Are adult victims and children living in households where domestic abuse is present safer?
3. What is the profile of the perpetrators worked with?
4. What were the interventions delivered and how did these differ between different types of case?
5. Are there other material impacts (e.g. school attendance, employment, health benefits)?
6. Is there any scope to intervene earlier?
7. In what ways does the model generate/require changes in agency behaviour, leadership and interaction/modes of operation?

This report covers the first year feasibility study of the evaluation (Phase 2 above). It has been possible to provide initial answers for questions 3 and 4 and there are emerging findings which have been captured in relation to questions 1, 2 and 7.

A logic model visually illustrating the aims of the evaluation is outlined below (Figure 1).
**Support**
- Aims to improve cooperation
- Voluntary engagement
- Substance misuse
- Housing
- Employment
- Family support

**Disruption**
- Unwillingness to engage in support services will prompt disruption
- Non-voluntary
- Criminal justice system
- Safeguarding activity

**Case Manager Interventions**
- Works with perpetrator and partners to tailor response to individual.
- Timeframe: Support over the long term, anticipated up to 12 months

**Interventions can either be direct or indirect:**
- **Direct** The Drive case manager is in direct contact with Drive user
- **Indirect** The Drive case manager does not have direct contact with Drive user but is co-ordinating interventions across multi-agency professionals involved in the case.

**Outcomes**
- Perpetrator risk level decreases
- Abusive behaviour decreases
- V/S perceived safety and wellbeing increases
- Child safety increases
Executive Summary of Feasibility Study Findings

Introduction

The Drive Project is ambitious, aiming to manage the risk and harm posed by perpetrators linked to victims referred to Marac. Considerable challenges were overcome in the first year, including building multiple new partnerships, embedding new approaches to working with high-risk, high-harm perpetrators of domestic abuse, establishing new or expanded services in each area to deliver Drive and finally, the technical challenges presented by the evaluation itself.

This evaluation shows that considerable progress has been made on all fronts. A number of practical and technical challenges have been overcome in relation to randomisation and data collection resulting in a feasible evaluation methodology. Most importantly, the case for working with this group of perpetrators has been strengthened by the data collected as well as the feedback from the practitioners on the ground. The data shows that this is a high-risk, high-harm cohort with a complex needs profile that is distinct from other perpetrator groups, such as those presenting at structured domestic violence perpetrator programme groups. Many have not been worked with in any consistent or focused way before. The emerging findings suggest that the model which combines both support and disrupt work is resulting in encouraging early data in cases where direct contact has been made. These emerging findings also demonstrate the clear need for, and potential of, a coordinated response for disruption where direct contact is not possible.

The feasibility study has highlighted that ongoing work is still needed in terms of system change to develop the quality and range of perpetrator information available at Marac, to develop processes for multi-agency disruption and to allow much swifter sharing of relevant information.

The emerging findings in terms of impact on risk and abuse are encouraging, albeit on small numbers of cases, reflecting the fact that relatively few perpetrators had completed the 10-month Drive intervention at this feasibility phase of the evaluation. The next stage of the evaluation will be completed in June 2019 and will include more data on outcomes both for perpetrators and for their partners or ex-partners.

The Feasibility of the Drive Project

This report is an evaluation of the feasibility phase of the Drive Project. It outlines the work carried out, and emerging findings in year one of the three-year Drive pilot and evaluation. This phase of the Drive evaluation sought to test and ascertain the feasibility of:

- participant recruitment, randomisation and follow up research;
- data collection processes and protocols;
- the acceptability of the pilot to perpetrators and victim/survivors of DVA;
- an evaluation of the Drive implementation and delivery process.
In addition to being able to confirm the feasibility of the Drive Project model, the data from the Year 1 evaluation has provided a detailed picture of the profile of Drive Service Users as well as the nature of the interventions delivered with some emerging data on their impact.

In relation to evaluation feasibility, our findings indicate that whilst there were considerable challenges to overcome in relation to randomisation, on-going data collection processes and outcome measurement during year one, adaptations were identified and made, resulting in a model and methodology that is feasible for full main phase evaluation in Years 2 and 3 of delivery (June 2017 – June 2019).

In relation to the Drive intervention feasibility, this evaluation established that it was possible for Drive Case Managers to combine support and disrupt interventions and to engage in both 1:1 direct contact work as well as indirect work to trigger and co-ordinate ‘disrupt strategies’ to be delivered in partnership with other agencies including police, probation, CRC and children’s social care.

There are also early emerging findings which indicate reductions in abuse by Service Users across the duration of the intervention, that victim safety is increased and that the pilot itself did not create greater harm to victims. As to be expected, the sample size of completed cases in the first year of a 10 month intervention is small and for that reason these emerging findings must be treated with caution.

The emerging findings discussed in this report are based on 198 perpetrator cases which were allocated to Drive during Year 1, 48 of which had completed the 10-month intervention by April 2017. In addition, analysis has been completed on the profile of a control group of perpetrators who were not assigned to Drive (1,574 perpetrators). The profile and outcomes data on victim/survivors who are engaging with Idva provision has also been analysed. This comprises 62 V/S linked to Drive cases and 379 V/S linked to control cases. This analysis has been supplemented by 34 practitioner interviews, 11 Service User interviews and 2 victim/survivor interviews.

As the evaluation now progresses to the main phase (June 2017 to June 2019), outcomes will be assessed more robustly for a larger sample size, with an estimated 250 Drive cases to be closed by the end of Year 2 (April 2018). This will also include longer term impacts on perpetrator offending and behaviour as well as the life quality for victims and their children.

Other key emerging findings

Other key emerging findings are summarised below.

1. The profile of Service Users supported by the Drive Project was the same as the control group. The average age was 34 years, the majority described themselves as White British and 93% were men. Service users presented with a high level of complex needs, distinguishing them from other perpetrator groups, for example, those who present at DVPPs.

   Based on analysis of the 48 Drive cases that had closed by April 2017, when information about complex needs was known: 69% reported substance misuse issues, 70% alcohol misuse issues, 68% housing issues and 71% mental health issues. More than a third of SUs (38.5%; n=15) had three complex needs, more than a quarter (28.2%; n=11) had one complex need, 12.8% (n=5) had two complex needs, and 7.7% (n=3) had four complex needs. Only 12.8% (n=5) did not have any complex needs.
More than half of Service Users had previous criminal offences and 40% had previous DVA offences. Homelessness was a common issue as were problems with literacy and other basic skills.

Drive relies on a functioning system of effective services for people experiencing multiple complex needs. Absolutely critical, given the needs profile of Drive Service Users, are adequate local provision in mental health, housing and substance misuse if the likelihood of generating and sustaining change is to be maximised.

2. One of the innovative aspects of the Drive intervention is the dynamic combination of both support and creative disrupt interventions in the same case. Considerable skill is required on the part Drive Case Managers to effectively balance these approaches to challenge behaviour whilst maintaining perpetrator engagement.

The evaluation found that Case Managers are in a unique position to challenge the perpetrator given: 1) high levels of information sharing, especially via the Marac and with the Idva; 2) the length of the intervention; and 3) the persistence of the Case Managers. Case Managers demonstrated particular nuance and skill in their work to:

- initially engage Service Users through a self-serving desire for support in order to do change work with a wider positive impact:

  “He’s the only one that’s helped me, and stuck by his word. So I’ll give him my respect, that’s why I agree to do this for him... [...] he found me the GP [...] rung him to see are they taking on people. He helped me out with shopping money, he helped me out with a deposit and that. He said if you need to go anywhere I’ll come with you, support.” (Drive Service User)

- explore vulnerability and the impact of past life experience, without allowing the SU to re-conceptualise themselves as a victim

  “She doesn’t judge me for the things I’ve done, she kind of wants to help me. She kind of realises that it may not be my … it’s my choices for what I think I’ve done, but there is a reason behind the choices that I’ve made, and she wants to kind of get to the root of them and try and change my way of thinking.” (Drive Service User)

- balance rapport-building and maintaining engagement with challenging problematic attitudes and belief

  “I was getting angry, you know, I was getting angry. [...] Well now I’ve calmed down you know.... when I’m angry I walk away. He’s tells me ‘go an ‘ave a little walk’ ‘go an do whatever you’ve got to do’ and ‘just keep feeding the good dog’. If you fed the bad dog, take the food back off him. You know, it’s… it’s just one of them things you know – I was ready to blow all the time you know. It’s really nice you know. Taking things out on people which support me the most, you know – you shouldn’t be doing that.” (Drive Service User)

3. Early findings show that where direct contact was made with a Drive Service User, there was a greater reduction in risk.
Direct contact is not always possible with this high-risk cohort for reasons that include victim safety and perpetrator non-engagement. Drive Case Managers were able to make direct contact with 19 out of 48 Service Users allocated to Drive (40%). The Drive intervention in these contact cases comprised a combination of engagement, support, disrupt and behavior change work. For the 29 cases (60%) where direct contact was not possible, the Drive intervention focused on co-ordinating a multi-agency response to increase risk management and disruption activity.

Drawing on analysis of closed Drive cases where information on risk was recorded, when direct contact was made Case Managers assessed reductions in risk in 64% of cases (9 out of 14 cases) compared to reductions in risk in 36% of cases where direct contact was not made (5 out of 13 cases).

4. **Securing effective multi-agency relationships and information sharing was critical to enabling Drive to effectively co-ordinate a multi-agency response to perpetrators.**

Co-ordinating a multi-agency response requires significant activity by Drive Case Managers to gather and share information, trigger, advocate and leverage action by other relevant agencies. This multi-agency work, that does not involve working directly with a perpetrator, is termed ‘indirect work’. Indirect work refers to all activity on a Drive case excluding ‘direct’ face-to-face or telephone contact between the Service User and the Case Manager. Within this indirect work, information sharing was by far the most prevalent form of activity. This was a challenging area of work for Drive. A significant proportion of Case Managers’ time is spent on multiple follow-up contacts to multi-agency partners seeking information. Factors that prevent the swift sharing of information include a lack of continuity in response from agencies due to staff turnover and staff leave, high workloads, competing priorities, and in some cases individual gatekeepers causing delays.

Escalation processes need to be available to Case Managers to help overcome some of these systems problems. There is also a need for a form of perpetrator-focused multi-agency forum to work alongside the Marac process to focus on effectively co-coordinating a multi-agency response to disrupt perpetrators’ abusive behaviour as well as monitor high-risk perpetrators over time to avoid future high-risk incidents.

5. **Greater opportunities to safeguard children connected with Drive Service Users**

Around 10% of recorded multi-agency working was concerned with child safeguarding. Case notes provide examples of Drive led activity informing and resulting in effective child safeguarding. This includes children being registered with children’s social services and child protection cases being reopened as a result of Drive-information sharing, as well as children being de-registered. For example, in one case a letter of commendation was sent from children’s social services to the Drive Service Manager detailing the progress made with the Service User including: “increased understanding of domestic violence, resulting in no further incidents during the period of registration; information, advice and reflection to assist change in behaviour and safer relationships; enabling the family to identify community resources that are available to advise and assist on matters such as benefits; assisting father to find employment; and ongoing support to the family post-registration that the family welcomed and valued.”
6. **A crucial factor for the effectiveness of information sharing and multi-agency work was the co-location of the Idva service with the Drive Case Managers**

Co-location of services was raised as a key strength in the practitioner interviews. Being able to work face-to-face was time-saving, relationship reinforcing and reduces email use.

7. **Aspirational and compulsory levers helped to change Service User behaviour**

Aspirational levers for change, for example to 'be a good father', had a strong impact on Service Users and were used in combination with more compulsory levers such as writing the need for engagement with a Drive Case Manager into a Service User’s license agreement through CRC or NPS. Prison was also found to be an effective place to engage and begin behaviour change work especially for younger Service Users.

As related by one victim/survivor, the hope in this kind of work is that it gets the perpetrator to a place where he is able to take responsibility.

“[CM] is working with my ex-partner, and, just helping him like, [...] just like trying to help him to get to the stage where he like admits a few things like, [...] He talks, he talks to [CM]. He is like trusting [CM] a bit now. It's like, it's like he opens up and then like tells him everything that's going on." (Drive V/S - VS1)

As related by this Service User, whose child protection plan stipulated engagement with Drive, they could see the impact of changing their behaviour:

“...even my girlfriend’s saying to me this is where we need to be, you know. But I think I could still get better you know, I don’t think I’m over that speed hump in the road [...] But yeah, I’m very happy the way it’s going. Well like I said, the family’s starting to recognise we’re getting on much sweeter…. Same with the kids, texts, I mean ‘daddy we love you’, know what I mean? The kids are phoning me up ‘I love you dad, love you’, I mean it’s nice … it’s nice to hear that…” (Drive Service User)

8. **Both Case Managers and Idvas judged that the risk posed towards victims by Service Users was reduced.**

Case Managers perceived the risk posed by Service Users to be reduced for 14 out of the 28 Drive cases completed in Year One where information was known (50%). Idvas judged there was a reduction in risk for 15 out of 19 victim/survivors associated with Drive cases (78.9%). This compared to a reduction in risk for 161 out of 221 control group V/Ss (72.8%). There was a greater reduction in risk posed by Service Users where Case Managers had made contact.

9. **There was a statistically significant reduction in the number of Service Users who were using physically abusive behaviour. In addition, there are emerging findings of a decrease in the proportion of SUs who used moderate and high levels of physical, sexual, and harassment and stalking behaviours.**

At intake, 29 Service Users (82.9%) were using physical abuse. At exit, the number of Service Users who used physical abuse decreased to 23 (65.7%). This change, which
is statistically significant, was a consequence of 6 Service Users who used physical abuse at intake but not exit. In addition, there are emerging findings of a decrease in the proportion of SUs who used moderate and high levels of physical, sexual, and harassment and stalking behaviours.

**Next Steps**

The main phase of the Drive Project evaluation will now proceed from June 2017 – June 2019. Learnings from the Year 1 Feasibility Study have been incorporated in amendments to the evaluation approach, data collection systems and processes as well as to the Drive delivery model.

The main phase evaluation will now look at the impact of Drive on reducing abuse, reducing risk and increasing victim safety with a growing sample size. This will include an increased number of victim interviews and, crucially, the analysis of Service User offending pre- and post- the Drive intervention alongside a cost-benefit analysis.

There will be further in-depth analysis of the nature of Drive intervention in both direct contact cases and in cases where direct contact is not possible. The latter will include analysis of disruption activity and the impact it has, including the analysis of where and how Drive has made a difference and where impact might have occurred anyway due to existing multi-agency activity.
METHODOLOGY

The evaluation design is multi-method and action-research based. The evaluation team provided feedback to the Drive Project partners and staff during Phase 1 and Phase 2 in order that any necessary changes could be made to the intervention, data collection and other aspects of the Drive Pilot.

The initial intention was to conduct a predominantly quantitative outcomes evaluation using a randomised control trial (RCT) design, with block randomisation and allocation of perpetrators identified as high-risk randomly allocated to the Drive intervention at the Marac stage (operated by SafeLives). Those not allocated to Drive would be seen as the control group. This placed a requirement on the Marac to provide detailed information ('core data') about potential Service Users (SUs) and their perpetration. During the early Phases, it became apparent that the core data available from Maracs regarding the perpetrators was not detailed enough to allow base lines to be ascertained on behaviour or other features such as complex needs. It has therefore not been possible to use the core data for analysis of outcomes. Instead, a more limited experimental design has been used, comparing intervention and control groups where associated victim/survivors (V/Ss) have contact with Ildvas. (See Appendix 4.)

The final design still involves a random control trial design, with allocation to Drive and control groups (at the Marac stage and operated by SafeLives). This results in a Drive intervention group, and a control group of perpetrators not allocated to Drive but whose associated V/Ss are in contact with Ildvas. Instead of core data it is thus possible to use data from the Ildva Insights system and Drive case management system ("CMS") to provide comparative outcomes for those who do or do not receive the Drive intervention (see Table 1 below for overview of intervention and control groups).

Table 1 – intervention and control groups

<table>
<thead>
<tr>
<th>Intervention groups</th>
<th>Control groups</th>
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</thead>
<tbody>
<tr>
<td>Perpetrators identified at Marac and randomly allocated to Drive (Drive SUs and main intervention group) (core data and CMS data) (N=198)</td>
<td>Perpetrators identified at Marac and not allocated to Drive (core data control group) (N=1,574)</td>
</tr>
<tr>
<td>Drive SUs with linked victim/survivors engaging with Ildva (comparative intervention group) (CMS and Insights data) (N=62)</td>
<td>Victim/survivors linked to perpetrators not allocated to Drive but engaging with Ildva (comparative control group) (Insights data) (N=379)</td>
</tr>
<tr>
<td>Drive SUs with linked V/S who were not engaging with an Ildva (no data) (n = 136)</td>
<td>V/S linked to perpetrators not allocated to Drive and not engaging with an Ildva (no data) (n=1195)</td>
</tr>
</tbody>
</table>

During the initial Phases it became apparent that qualitative data, i.e. interviews with practitioners, SUs and V/Ss, as well as qualitative analysis of Drive case notes, would provide important insights into the Drive intervention, and would overcome some of the shortcomings of the quantitative data (see also below). The evaluation was therefore refocused from a largely quantitative outcome evaluation to include a greater degree of qualitative methods.

In this Year 1 report we outline the initial findings relating to outcomes from the Drive pilot, feasibility, application of interventions, and process. The Year 1 evaluation included the following methods:
• Analysis of quantitative monitoring data (core data, CMS and Insights data) – to measure outcomes.

• Interviews with practitioners, Drive Service Users (SUs) and associated victim/survivors (V/Ss) – to assess feasibility and application of Drive, and provide detail for outcome and process evaluation.

• Analysis of Drive Case Manager (CM) case notes (CMS data) – to assess application of practice approaches, evaluate process and provide detail for understanding outcomes.

In the following sections we outline the methods and some of the challenges in more detail.

Quantitative Outcome Evaluation

Quantitative analyses were used to answer three questions:

• What is the profile of the perpetrators worked with?
• Have the perpetrators changed their behaviour?
• Are adult victims and children living in households where domestic abuse is present any safer?

Overall, the outcome evaluation drew from four sources of information: the core dataset, Case Manager case notes, the case management system data and Insights.

As indicated earlier, the core dataset was very limited, and the only aspects collected routinely were perpetrator and victim data on gender, age, and relationship between perpetrator and victim (i.e. ex/partner, family member).

The Drive Case Managers record information about Service Users and victims, as well as assessments of Service Users, in the electronic case management system. This provided two types of data: Case Manager (CM) case notes, and Drive Service User (SU) profile information. CM case notes consisted of information recorded by drive Case Managers about Service Users and actions taken by all staff. Case notes for those SUs who had completed Drive in Year 1 (N=48) were anonymised and extracted, and were coded for SU profiles: including gender, age, ethnicity, employment, perpetrator complex needs (housing issues, alcohol misuse, substance misuse, and mental health difficulties), and presence of children. Throughout the intervention (Intake, 3 months, 6 months, 9 months, and case closure), Case Managers assess and record the needs of the Service User and the risk of the Service User to the victim and children. Additionally, Case Managers record if contact has been made with Service Users, the type of contact, and Service Users’ level of engagement. These items were coded for the 48 cases and used to enhance quantitative analysis of relationship between behaviour change work and reduction in DVA behaviours.

The Drive partnership encountered a number of data related challenges which required changes to the data systems during Year 1. For instance, the evaluation team found that the case management system was not user friendly so Case Managers were (and some continue to be) confused about how to complete assessments. Faults in the CMS programming caused problems with access and saving information. Also, missing information was an overarching challenge, often as a result of SUs not engaging with CMs. Moreover, there were also challenges regarding Insights data, as collection and collation of data from the three sites was resource intensive and the data was variable across sites and sometimes low quality.
Core data, CMS and Insights - samples of participants

Drive intervention participants
During Year 1, there were a grand total of 1,772 perpetrators randomly allocated from Marac, of which 198 were allocated to the Drive intervention, and the remaining 1,574 were allocated to the control group. Out of the 198 Drive intervention group, the case notes were examined for the 48 SUs (24.2%) who had completed Drive by the end of April 2017.

Insights data for victim/survivors
The initial evaluation design assumed there would be information available for all of the victim/survivors (and children, if present) associated with the 1,772 perpetrators at Marac allocation and exit. Due to the challenges described above (lack of core data), information was available at intake for only 441 victim/survivors (24.9%) who were engaging with Idvas and therefore had data on Insights, of which 62 victim/survivors (14.1%) were associated with perpetrators in the Drive intervention group and 379 victim/survivors (85.9%) associated with perpetrators in the control group. Put another way, there was information for 31.3% of the Drive intervention group and 24.1% of the control group at intake. At exit, these proportions were even lower. Specifically, information was available for 9.6% of the V/Ss associated with the Drive intervention group (n = 19) and 13.0% of the control group (n = 204).

With regard to the 48 SUs who completed Drive by the end of Year 1, and whose case notes were examined, there was information on Insights for 21 associated V/Ss at intake (43.8%) and 6 V/Ss at exit (12.5%).

Qualitative analysis of practice and process
Qualitative analyses were used to answer three questions:

- What were the interventions delivered?
- How have the perpetrators changed their behaviour?
- In what ways does the model generate/require changes in agency behaviour, leadership and interaction/modes of operation?

Methods included in-depth semi-structured interviews with practitioners (N=34), Service Users (N=11) and Victim/Survivors (N=2); victim-perspectives focus groups with Idvas (N=2); analysis of Drive documentation; detailed analysis of Drive Service User case files (N=30, 10 per site) and ethnographic field notes taken during multi-agency meetings at the three Drive sites. For more information on the qualitative methodology, please see Appendix 5.

Interviews - approach and access
Interview questions for practitioners, Service Users and victim/survivors were developed with the Drive partnership over a series of iterations. The questions were further modified and their ordering amended following a pilot round of interviews in Site 2. Semi-structured interviews were used in order to allow openness and attention to aspects of the Drive process and model that had not been anticipated by the research team or the Drive Partnership.

Practitioner contacts for the interviews were made primarily through the Drive Practice Advisors and Service Managers at each site and subsequently from face-to-face contact at multi-agency meetings. Contact with SUs was facilitated by local Drive CMs and it was our intention at the outset to interview ten SUs per site. In practice, SUs were much harder to recruit than we anticipated, in part due to their higher than anticipated levels of complex need and chaotic lives. Given the lower than anticipated number of SU interviews collected, we
diversified methods - moving to case note analysis - to get a more comprehensive view of what was delivered and how and why change might or might not be occurring.

Contact with V/Ss proved to be even more difficult than with SUs. Again, this was in part due to the high levels of complex need but more so down to the strength of connection the research team were able to develop with Drive Idvas, who were the main contact point for V/Ss. Initially we attempted to contact V/Ss via Case Managers but as it became clear that this approach was not effective, we shifted focus to Idvas as our main point of contact for V/Ss and directed resources to collecting victim voices via an Idva focus group. The focus group model will be replicated in Year 2 and greater relationship building with Idvas to generate better access to Drive V/Ss.

Case note analysis

As noted earlier, Drive cases and the actions taken by staff on those cases are recorded on an electronic case management system (CMS). The evaluation team anonymised and extracted these case notes for the first 48 completed Drive cases. The first 30 of those 48 cases were analysed in much greater depth using a combination of defined and emergent coding categories in order to track, quantify and better understand the content and characteristics of direct and indirect work, especially multi-agency working. Within this we looked for examples and techniques of behaviour and attitudinal change over time and across the three Drive sites in order to better understand the emerging outcomes findings.

Ethnographic field-notes

In addition to interviews and case note analysis, field-notes were recorded during and shortly after site visits and multi-agency meetings. Reflection on these notes helped to build a clearer picture of the complexity of the Drive intervention, emerging issues and multi-agency dynamics and were critical to iterative development of the interview questions.
EMERGING FINDINGS FROM YEAR 1

What is the profile of perpetrators worked with?

Who were they? Biographical information for Marac cohort (N=1,772)

For both the Drive intervention group and control group allocated from Marac (core data N=1,772) the vast majority of perpetrators were men who were on average 34 years old and the vast majority of victim/survivors were women who were on average 33 to 34 years old (Table 1). There was a range of relationship types between the perpetrator and victim/survivor, in which approximately half could be characterised as ex-partners, one-quarter to one-third could be characterised as partners, ten percent as adult family members, and five percent as intermittent partners. These overall trends were similarly found for each of the three Drive sites. (See Appendix 1: biographical information for Marac cohort).

Table 1 – Marac cohort allocated to Drive intervention and control groups in Year 1

<table>
<thead>
<tr>
<th>Entire Core Dataset (N=1,772)</th>
<th>Perpetrator</th>
<th>Victim/Survivors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drive intervention group (N=198)</td>
<td>Control group (N=1,574)</td>
<td>Drive intervention group</td>
</tr>
<tr>
<td>Age: M = 33.9 (SD = 11.2, Median = 32.0)</td>
<td>Age: M = 34.4 (SD = 11.7, Median = 31.5)</td>
<td>Age: M = 33.0 (SD = 12.5, Median = 30.0)</td>
</tr>
<tr>
<td>Gender: 93.4% Men; 5.1% Women; 1.5% Don't know</td>
<td>Gender: 93.3% Men; 5.5% Women; 1.2% Don't know</td>
<td>Gender: 96.0% Women; 4.0% Men; 1.0% Don't know</td>
</tr>
</tbody>
</table>

Who were they? Biographical information – the 48 completed cases

Regarding the 48 cases completed by end of Year 1, the gender and age of the SUs were similar to the overall group of perpetrators in the core data, with an average age of 33 and most identifying as men. Where the employment status of the 48 SUs was known, the most commonly reported status was unemployed followed by full time employment. Where ethnic identity was known, the most common identification was White British followed by BME.

The age of the V/Ss was slightly lower than the overall Marac group, with an average age of 30. All of the V/Ss identified as women. When the ethnicity of the V/S was known, the most common ethnic identification was White British.

Children were involved in over three-quarters (77.1%) of these cases.

(See Appendix 2: biographical information – the 48 completed cases - for further demographic information on the SUs and victim/survivors.)

The most common type of relationship between the SU and V/Ss was ex-partners (50%), followed by partners (29.2%), adult family members (10.4%), intermittent partners (4.2%), and family members who were minors (2.1%). (See Table 2.)

Table 2. Relationship between Drive Service User and associated victim/survivors N=48

<table>
<thead>
<tr>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ex-partner</td>
<td>24</td>
</tr>
<tr>
<td>Partner</td>
<td>14</td>
</tr>
<tr>
<td>Intermittent Partner</td>
<td>2</td>
</tr>
</tbody>
</table>
Complex needs

The Drive Project set out to record if SUs had any of the following complex needs: substance misuse, alcohol misuse, housing difficulties, and mental health difficulties. However, about 40% of the complex needs information was missing. For those with information recorded, 69% misused substances, 70% misused alcohol, 68% had housing difficulties, and 71% had mental health difficulties.

When the total number of complex needs each SU had was calculated, the findings indicated more than a third of SUs (38.5%) had three complex needs, more than a quarter (28.2%) had one complex need, 12.8% had two complex needs, and 7.7% had four complex needs. Only 12.8% did not have any complex needs. (See Table 3.)

Table 3. Complex needs recorded for Drive Service Users N=48

<table>
<thead>
<tr>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 Complex Needs</td>
<td>5</td>
</tr>
<tr>
<td>1 Complex Need</td>
<td>11</td>
</tr>
<tr>
<td>Substance Misuse</td>
<td>2</td>
</tr>
<tr>
<td>Alcohol Misuse</td>
<td>2</td>
</tr>
<tr>
<td>Housing Difficulties</td>
<td>5</td>
</tr>
<tr>
<td>Mental Health Difficulties</td>
<td>2</td>
</tr>
<tr>
<td>2 Complex Needs</td>
<td>5</td>
</tr>
<tr>
<td>Alcohol and Substance</td>
<td>2</td>
</tr>
<tr>
<td>Substance and Mental</td>
<td>2</td>
</tr>
<tr>
<td>Alcohol and Mental</td>
<td>1</td>
</tr>
<tr>
<td>3 Complex Needs</td>
<td>15</td>
</tr>
<tr>
<td>Substance, Alcohol, and Mental</td>
<td>5</td>
</tr>
<tr>
<td>Substance, Housing, and Mental</td>
<td>4</td>
</tr>
<tr>
<td>Alcohol, Housing, and Mental</td>
<td>4</td>
</tr>
<tr>
<td>Substance, Alcohol, and Housing</td>
<td>2</td>
</tr>
<tr>
<td>4 Complex Needs</td>
<td>3</td>
</tr>
</tbody>
</table>

*represents proportion of total cohort with this number of complex needs

Numbers without the bold emphasis correspond to SUs with that particular combination of needs. For example, amongst the SUs with 1 complex need, there were 2 (18.2%) with substance misuse needs, 2 (18.2%) with alcohol misuse, 5 with housing difficulties (45.5%), and 2 with mental health difficulties (18.2%).

Previous offences
Out of the 48 Drive cases completed by the end of Year 1, more than half the SUs had previous offences recorded by the police, and 40% had previous DVA offences (n=9, 18.9% had only previous DVA offences, n=8, 16.7% had only previous non-DVA offences, and n=11, 22.9% had both DVA and non-DVA offences previously).

SUs who had complex needs were more likely (than SUs with no complex needs) to have previous DVA offences. SUs with and without complex needs were equally likely to have previous non-DVA offences (using Fisher’s Exact Test). (See Appendix 2 and Appendix 4 for more information.)

### Have Drive Service Users changed their behaviour?

**Service users’ DVA behaviours**

DVA behaviours were recorded by the Drive project as four types: physical, sexual, harassment and stalking (H&S), and jealousy and coercion (J&C). For each type of domestic violence and abuse (DVA), Drive project staff noted the levels of severity they deemed to be in evidence: none, standard, moderate, and high. Definitions of the type and severity of DVA behaviours were created by the Drive project.

To assess possible behaviour change by the Drive SUs from the beginning to the end of the Drive intervention, three separate analyses were conducted by the evaluation team:

For the first analysis, binary variables were created to examine if SUs used or did not use each type of DVA. **The findings suggested there was a statistically significant reduction in the number of SUs who used physical DVA.** Though there was a reduction in the number of SUs who used the other types of DVA (sexual, H&S, and J&C), the reductions were not statistically significant.

**Figure 1. SUs’ use of DVA behaviours**

![SUs - DVA Behaviours](image)

The second analysis examined how the severity of each type of DVA changed from the beginning to the end of Drive, by looking at the percent change in the number of SUs using that level of severity. There were two overall findings that suggested the Drive Project
**reduced SUs use of DVA.** The first was that the number of SUs who were no longer using physical, sexual, H&S, and J&C by the end of the Drive intervention increased. The second finding was there was a decrease in the proportion of SUs who used moderate and high levels of physical, sexual, and H&S.

Figure 2a. The number of SUs who did NOT use each type of DVA behaviour at intake and exit

![Figure 2a](image)

Figure 2b. The number of SUs who used DVA at intake and exit

![Figure 2b](image)

The third analysis looked at DVA behavioural changes amongst SUs with whom Case Managers did or did not do direct behaviour change work (see also sections below discussing case work in detail). Overall, the findings suggested that there was a greater reduction in
the use of each type of DVA amongst SUs who did behavioural change work. Additionally, the findings indicated that amongst SUs who did behavioural change work the severity of each type of DVA stayed the same whereas amongst SUs who did NOT do behavioural change work the severity increased in a small number of cases.

Figure 3. DVA behaviours used by SUs who did behaviour change work

(For further details, see Appendix 3: quantitative analysis.)

Corroborative findings from victim/survivors regarding Drive SU DVA behaviour

We carried out further analysis to compare the findings regarding SUs with those from the associated V/Ss, based on the ldva monitoring data, Insights.

Two analyses were conducted to see how V/Cs' experiences of DVA changed from intake to exit. The first analysis consisted of comparing the proportion of V/Ss who experienced each type of DVA (i.e. physical, sexual, H&S, and J&C) at intake to the proportion who experienced each type at exit. Tests were run separately for the control group of V/Ss and the Drive associated V/Ss group. The results suggested a significantly smaller proportion of control V/Ss experienced physical DVA, sexual DVA, H&S, and J&C at exit and a significantly smaller proportion of Drive associated V/Ss experienced physical DVA, H&S, and J&C.

Figure 4. DVA experienced by control and Drive V/Ss
The second analysis looked at how the severity of each type of DVA changed from intake to exit, by examining the percentage change in the number of V/Ss experiencing that level of severity. The analysis was run separately for the Drive associated V/Ss and control V/Ss groups. The findings for both groups suggested at the end of Drive the number of V/Ss who no longer experienced each type of DVA increased. This increase was larger for the Drive cohort of V/S. The findings also indicated there was a decrease in the number of V/Ss who experienced high levels of each type of DVA. This decrease was larger for the Drive cohort of V/Ss.

Overall, the findings from the V/Ss data indicates similar trends to the Drive data, and that Drive did appear to have a positive impact on SU DVA behaviour, in both extent and severity.
Figure 5a The number of control V/Ss who did NOT experience each type of DVA at intake and exit.

Figure 5b. The number of Control V/Ss who experienced DVA at intake and exit.
Figure 6a. The number of Drive V/Ss who did NOT experience each type of DVA at intake and exit.

Figure 6b. The number of Drive V/Ss who experienced DVA at intake and exit.
Are adult victims and children living in households where domestic abuse is present any safer?

Case managers and lDvas used their professional judgements to assess if adult V/Ss and children living in households with domestic abuse were safer, and recorded this on the CMS and Insights respectively. This data was used by the evaluation team to analyse possible changes in safety over the period of the Drive intervention.

*Case managers’ assessments of risk posed by SUs*

The analysis indicated that Case Managers perceived the risk posed by SUs to be reduced for half (50%, n=14) of completed Drive cases where information was provided. lDvas perceived there was a reduction in risk for over three-quarters (78.9%, n=15) of the associated V/Ss (and children, if present). Taken together, the findings suggest Case Managers and lDvas both thought that at a minimum 1 out of 2 V/Ss were safer and at a maximum 3 out of 4 V/Ss were safer.

As can be seen in Table 4 below, where information was known, Case Managers reported the risk was reduced in 50% of cases (n=14), did not change in 42.9% of cases (n=12), and increased in 7.1% of cases (n=2). The research team has not completed any follow up work to examine why risk increased in these two cases in detail.

When analysis took into account whether Case Managers were in direct contact with SUs, where information was known the risk was reduced in 64.2% of cases (n=9) and when Case Managers did not contact SUs, risk was reduced in 35.7% of cases (n=5). (See Figure 7.)

![Figure 7.](image)

<table>
<thead>
<tr>
<th>Reduction in Risk</th>
<th>SU Contacted</th>
<th>SUs not contacted</th>
<th>All SUs</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of SUs</td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Reduced greatly</td>
<td>8</td>
<td>57.1</td>
<td>4</td>
</tr>
<tr>
<td>Reduced slightly</td>
<td>1</td>
<td>7.1</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 4.
Idvas’ assessments of risk posed to V/Ss (and children)

The Insights Exit form included questions which asked Idvas to use their professional judgement to describe the change in risk posed to V/Ss (and children if present) and sustainability of reductions in risk. There was one additional question in which Idvas used their professional judgement to assess if V/Ss (and children) were safer in comparison to intake. The results of the descriptive analysis are presented in Table 5.

Idvas reported there was a reduction in risk for 78.9% of Drive V/Ss (n=15) and for 72.9% of control V/Ss (n=161).

For Drive V/Ss, Idvas described the risk as permanently eliminated for 20% of cases (n=3) and eliminated for more than 2 years in 13.3% of cases (n=2). This trend differed for control V/Ss. Idvas described the risk as permanently eliminated for 6.7% of cases (n=11) and eliminated for more than 2 years for 27.6% of cases (n=45).

Idvas reported that all Drive V/Ss were either much safer (68.4%, n=13) or slightly safer (31.6%, n=6) and amongst the control V/Ss, Idvas reported 62.1% (n=113) were much safer and 29.7% were slightly safer (n=54).

Table 5. – Idvas assessment of change in safety for V/Ss (both Drive and wider cohorts)

<table>
<thead>
<tr>
<th></th>
<th>Drive V/Ss</th>
<th>Control V/Ss</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change in risk to V/S</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Significant reduction</td>
<td>10</td>
<td>87</td>
</tr>
<tr>
<td>Moderate reduction</td>
<td>5</td>
<td>74</td>
</tr>
<tr>
<td>Limited or no reduction</td>
<td>4</td>
<td>35</td>
</tr>
<tr>
<td>Increased risk</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Don’t know</td>
<td>22</td>
<td>10</td>
</tr>
<tr>
<td>Sustainability of reduction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Permanently eliminated</td>
<td>3</td>
<td>11</td>
</tr>
<tr>
<td>Long term - more than 2 years</td>
<td>2</td>
<td>45</td>
</tr>
<tr>
<td>Medium term - 6 months to up to 2 years</td>
<td>6</td>
<td>75</td>
</tr>
<tr>
<td>Short term - 1 month to up to 6 months</td>
<td>4</td>
<td>13</td>
</tr>
<tr>
<td>Don’t know. Completely unpredictable situation</td>
<td>19</td>
<td>11.7</td>
</tr>
<tr>
<td>Is the V/S safer compared to intake?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Much safer</td>
<td>13</td>
<td>113</td>
</tr>
<tr>
<td>Slightly safer</td>
<td>6</td>
<td>54</td>
</tr>
<tr>
<td>No change</td>
<td>13</td>
<td>5</td>
</tr>
<tr>
<td>Not asked</td>
<td>2</td>
<td>0.9</td>
</tr>
<tr>
<td>Client not contactable</td>
<td>38</td>
<td>17.3</td>
</tr>
</tbody>
</table>
What were the interventions delivered and what seems to be working?

Year 1 of the Drive intervention can be broken down into two core areas of activity:

1. **Case work with Service Users (SUs) carried out by Drive Case Managers (CMs).** This involved:
   a. **Indirect work** - all activity on a Drive case excluding ‘direct’ face-to-face or telephone contact and/or email/letter between the SU and the CM. This formed the vast majority of multi-agency work.
   b. **Direct work** - all face-to-face, telephone and/or email/letter contact between the CM and the SU.

2. **Set-up and cultivation of multi-agency partnerships including the systemic changes required to enable Drive to function effectively.** This was carried out by the entire Drive team.

During year 1 it became apparent that the work by Idvas with associated V/Ss should be seen as a central part of the intervention in terms of the quantity of information sharing and safety planning activities that are carried out in partnership with Idvas.

In the analysis that follows we draw on analysed case notes and interviews with practitioners and SU interviews to describe in detail what was delivered with SUs, evaluate what worked and outline what key challenges remain.

**Indirect work**

Figure 8 – what was delivered?
Indirect work accounted for the overwhelming majority of activity on Drive cases as reported in the case notes of the 30 cases analysed in detail (see, Figure 8). Indirect work is carried out both alongside direct work and in cases where direct work was not possible due to non-contact with SUs.

Within the indirect work, information sharing was by far the most prevalent form of activity. Figure 9 shows the proportion of information sharing and other forms of multi-agency working. Work with Idva and Probation services were most prevalent, followed by the Police, Children’s Social Services, other multi-agency fora (principally Marac, MAPPA, MASH and MARAT), police and housing. A significant but much smaller proportion of this work was also recorded with mental health services, schools, alcohol and substance misuse and other victim/survivor services.

This prevalence of indirect work, and information sharing in particular, is explained by the fact that indirect work is not only what the CM does when direct engagement is not possible - indirect work forms a part of every case, usually involving a range of other agencies to gather and share information in order to inform, plan, and act on risk and to disrupt perpetration.

**Figure 9 - Drive multi-agency working (including information sharing)**

*Information sharing*

In order to ascertain, monitor and mitigate risk posed by the SU and, where possible, to safely make contact with the SU, a huge amount of information was required over the course of the 10 months intervention with SUs. The case notes record information requests and sharing on SU background, current and previous perpetration, the SU’s previous partners, drug and alcohol dependencies, mental health, children (including past and current Child Protection (CP) proceedings) accommodation and known attitudes and beliefs as they relate to abusive behaviours. Information gathering and sharing is, then, absolutely critical to and a core element of the Drive intervention as well as being central to its ongoing evaluation and monitoring. As we can see from Figure 10 the breakdown of recorded instances of information sharing by agency broadly reflects the recorded instances of multi-agency work.
The prevalence of references to information sharing in the case work, alongside largely positive comments in the practitioner interviews, suggest that a huge amount of work has been done at both the strategic and frontline level to establish the multi-agency relationships required for effective information sharing.

However, the case notes also show a significant proportion of CM time being spent on multiple follow-up calls and emails to agencies after having had no response to initial information requests (although improvements have been made since the close of the first 30 Drive cases). Delays here appear mostly due to a lack of continuity around staff turnover and leave; workload and priorities (particularly in the case of police, probation and Children’s Social Services (CSS)) and in other rarer examples, due to perceived or real intentional blockages by individuals. The point here is that regardless of top-level agreement to information sharing, an individual gatekeeper can cause severe delays. As such, alternative and escalation routes need to be clear to CMs to be able to make the most of the 10 month intervention period.

In the best casework analysed, CMs go first to the Marac referrer for initial background research on the case and, over the course of the intervention, look very quickly for alternative sources of case-critical information when it is not initially forthcoming. In poorer casework one or two requests for a given piece of information seem to be considered adequate and as a result the case can be stalled for a long time.

While information sharing is central to, and constituted a large proportion of the indirect work, it was not the only method, and was often a means to achieving other forms of indirect work. Other forms of indirect work included the following:

- **Disruption and risk management activities (1625 Refs, 30 cases)**

\[\text{Different areas refer to what we are calling ‘CSS’ in different ways – e.g. Social Services, CYPS, CSC – in accordance with differences in the way these services are organised/administered locally. For simplicity, we are calling those services that hold primary responsibility for child protection, ‘CSS’.}\]
As mentioned above, the vast majority of indirect work (including and excluding information sharing) was oriented towards disruption and risk management activities. In the analysis of the case notes, we highlighted only those activities that, based on what we knew, would not have happened without Drive involvement (as far as it is possible to know this) or in which Drive played a critical role. These included:

- Making Marac re-referrals where high level perpetration continued
- Negotiating SU license conditions with CRC and NPS offender managers
- Joint-agency and multi-agency meetings to respond to or review a particular problem/risk – for example Marac, MASH, or CSS Core Group
- Joint-agency (e.g. Drive & Housing) monitoring for hidden perpetration/substance misuse
- Arrest or recall of SU (e.g. for breach of RO or bail conditions) as direct result of Drive multi-agency working
- Information sharing in order to achieve disruption and/or manage risk.

● Safety planning around CM-SU contact

Also a form of risk management, but not linked to disruption, safety planning around CM-SU contact formed one of the most recorded areas of indirect/multi-agency activity and rationale for information sharing. Before making contact with a SU, CMs will have spoken to the Idva and OM (if involved), usually multiple times, often to CSS and the police officer in charge (OIC) and will have shared and requested feedback on the CM-SU contact strategy with them. Once the strategy has been agreed by the Drive Service Manager and in many cases, the Drive Expert/Practice Advisor, it will also be shared with and feedback requested from the Marac that first heard the case.

● Institutional advocacy (29 Refs, 13 Cases)

Drive CMs work on and between existing organisations and services, often to secure access to particular services for the SU - such as healthcare, housing and benefits - which the SU is already entitled to. Where this activity differs from the institutional advocacy (IA) practiced by an Idva, for example, is that the CM is not advocating for the SU first and foremost. Rather, the CM advocates for the safety of the V/Ss and at-risk children. In practice this often means advocating for the SU - for example, to secure housing that will give the SU fewer excuses to return to the VS’s address - but may also involve actions that materially disadvantage the SU at a particular moment - for example, informing CSS of the severity of abuse in order to initiate CP proceedings or informing probation that the SU has breached bail conditions.

This ‘mediated’ or ‘values-centred’ (rather than first-person-centred) advocacy activity encompasses a huge proportion of CM time, and as such we could understand much of what Case Managers do as institutional advocacy. However, ‘institutional advocacy’ does not only mean to advocate, but, to campaign to change – the term emerging in the late 1970s to refer to the activity of professionalised social movement actors and organisations operating in the burgeoning non-profit/NGO sector (Minkoff 1994)². In this analysis we have taken a narrow definition of institutional advocacy to refer only to those interventions

which aim to change the course of an already existing decision, policy or process. In the case notes, instances of Drive CM institutional advocacy were equally represented in relation to the Idva Service, CRC, Police, Housing & CSS. Examples of this included:

- Bringing a domestic abuse perspective to a multi-agency discussion where domestic abuse signals and implications had not been considered by other practitioners
- ‘Nudging’ Idvas to make contact with the Drive V/Ss
- ‘Nudging’ the OM or arguing for a recall/arrest of SU based on evidence of the SU having breached licence conditions
- Questioning/challenging an existing course of action for V/Ss or child safety grounds – for example, making the case that a closed CP case should be re-opened.

Techniques for leveraging action from other agencies ranged from friendly/gentle reminders drawing on the strength of personal relationships between front-line workers through to raising the ‘spectre’ of a domestic homicide review (DHR) in cases of heightened risk and/or lack of trust/confidence that action would be taken.

● Child safeguarding (129 Refs, approx. 10% 18/30 Cases)

Around 10% of all recorded multi-agency working (including information sharing), was concerned with child safeguarding and child safeguarding activity was present in 18 out of the 30 cases analysed in detail. The case notes provide examples both of children being registered with children’s social services, and CP cases being reopened as a result of Drive information-sharing and institutional advocacy, as well as children being de-registered – the SU being deemed to have made such an improvement over the course of the intervention as to not pose a significant risk to his children. In the latter example, CSS wrote a letter of commendation on the work of the Drive Case Manager expressing their view that the progress seen with the SU far outstripped their expectation and would not have been possible without Drive.

● Multi-agency working in support of the SU

While the vast majority of references in the case notes to multi-agency working referred to instances of disruption and risk management, approximately 5% referred to activities that were more straightforwardly3 in support of the SU. Crucially, this figure only refers to indirect multi-agency work in support of the SU – it does not account for all the support activities done with the SU present which will be addressed in the following sections. Examples of this kind of indirect multi-agency work in support of the SU included:

- Pursuing and booking housing, substance misuse, physical and mental health appointments and placements

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3 While support and disruption merge to the extent that support (e.g. around housing, benefits etc.) is itself intended to disrupt perpetration there are nonetheless poles to this continuum. It is therefore possible to differentiate arrest and recall as a ‘straightforwardly’ disruptive technique from help with housing as a form of support.
- Pursuing and securing prescriptions, particularly for SUs due to leave prison and with mental health needs who might otherwise face a significant gap in their medication (and as such pose an increased risk to their families/partners)
- Pursuing and securing employment/meaningful activity placements and/or training.
Figure 11 - The predominant agencies and their interaction with Drive (from analysis of case notes)

**Police**
- Information sharing on: SU activities, DA & Non-DA perpetration, welfare
- Information to CM on current & previous offending in order to: facilitate contact; challenge minimization and denial; argue that SU should be breached by their OM; build a picture of 'harder to prove' offences e.g. coercive control.
- Information from CM to police on: SU’s other offending (e.g. fraud, supply/production of illegal drugs) to minimize harm/reduce risk; show reciprocity
- Police acting to disrupt e.g. House call/welfare check, arrest - for DA or non-DA.; flag on the SU/SU vehicle

**IDVA Service**
- Information sharing on SU activities, perpetration, welfare
- A check on SU claims re. Perpetration/behaviour
- Planning safe contact esp. Contact strategy
- Background research especially re. people previously victimised by the SU.

**Probation**
- Information sharing on SU activities, history, perpetration, welfare.
- Planning safe contact esp. initial contact strategy
- Access point for initial contact - e.g. Joint meeting with CM & OM
- Creating levers/pressure for engagement e.g. Drive as RA days etc.
- Advocating/informing for a breach/recall.
- For SUs in Prison: working with NPS/Prison staff to arrange visits; working with Prison support officers e.g. housing, substance misuse, mental health, employment and the SU to set up links and where possible make key decisions to facilitate faster access upon release.

**Children's Social Services**
- Information both ways to assess and monitor current risk to children.
- CM can act as a unique form of external verification/or a check on SU behaviour claims either in writing or by attendance of the CP core group.
- Information to CM for background research (e.g. previous CP proceedings) and to inform contact strategy.
- Multi-agency working to make Drive engagement a requirement for the SU and/or VS under the CP plan.

**Housing**
- Information sharing to: locate SU; monitor for relapse (alcohol/substance and/or DVA); check welfare.
- Assistance locating the SU in order to make contact, assistance in disruption – flagging the residence, reporting incidents to police.
- Working to secure housing for the SU (support, support as disruption)

**Multi-Agency Fora**
- MARAC/MASH/MARAT/MADAP
- Information to CM for background research to inform contact strategy
- Information both ways/multi-agency working to agree appropriate contact strategy

**Mental Health**
- Information sharing re. Behaviour, perpetration and mental state.
- Background research re. appropriate treatment/level of risk
- Information from CM re. Perpetration, delusional talk, risk
- Working to secure appointments and placements
- Securing correct and consistent medication

**Drive Team**
- Information sharing on SU activities
- Planning safe contact esp. Contact strategy
- Background research especially re. people previously victimised by the SU.
Direct work

Overview:

- ‘Direct work’ refers to all face-to-face, telephone and/or email/letter contact between the Drive CM and the SU.
- Approximately 15% of references in case notes were to direct work (including failed attempts at contact) and these spanned 19 out of the 30 cases analysed.
- 81% of references to direct work were on cases in Site 2 which made up 9 out of the 19 cases in which some form of direct work was recorded. Reasons for the higher levels of direct work in this site seem to be a combination of: established multi-agency links resulting in comprehensive information sharing (please see Conclusion section for more information on differences in multi-agency working between sites), opportunities for long-lasting engagement on cases and the ingenuity of Case Managers in pursuing and maintaining engagement.
- Over half of all references to direct work (56%) were to making and sustaining contact, thus highlighting just how laborious it is to engage this user group. Just under a third (31%) of references to direct work referred to direct support activities – for example addressing a housing need with the SU – and again, these were mostly in Site 2 – present in 7 of the 9 cases where direct support was referred to.
- Most prevalent in the direct support activity were references to work on housing, substance misuse, benefits and personal finances, mental health and meaningful activity (see Figure 4).
  - The severity of SUs’ needs should not be underestimated and really distinguishes this user group from those that tend to be present at DVPPs. Substance misuse, health and mental health needs were commonly severe, while homelessness was a common issue as were literacy and other basic skills.
  - Every case where contact was made included some reference to direct support.
- Approximately 12% of references to direct work referred to behaviour change work (as more conventionally understood). Behaviour change work was recorded in 9 of the 30 cases analysed, 6 of which were in Site 2.
- References to direct work peak around the middle of the intervention and then decrease slightly.

Contact/non-contact

Out of the 48 cases where quantitative analysis was applied, CMs contacted 19 SUs (39.6%) at least once during the intervention and were able to do some form of behaviour change work with 11 of them. The remaining 29 (60.4%) were not contacted at all during the intervention.

Reasons for not contacting Service Users

On the case management system CMs could provide one of three reasons as to why they did not contact the Service User:

1. Contact planned or pending,
2. Contact on hold - CJS depending,
3. It was not safe to contact.

This was filled in at 3 months, 6 months, 9 months, and case closure. For 23 of the 48 cases, the reason for non-contact remained the same throughout the intervention - this broke down as 12 (52.2%) cases 'contact planned or pending', 7 (30.4%) cases 'contact on hold - CJS depending', and 4 (17.4%) cases 'it was not safe to contact'.

The reason for non-contact changed over the course of Drive in 6 of the cases. In 4 of those, the reason changed from 'contact planned or pending' or 'contact on hold' to 'it was not safe to contact'. For the other two cases, the final reason was contact planned or pending.

Comparing contacted Service Users and not contacted Service Users

Statistical tests\(^4\) were run to see if there was a difference in age between the contacted SUs and their primary V/Ss and those not contacted. The median age of contacted SUs was 27, statistically lower than the median age for those not contacted, which was 32. V/Ss of contacted SUs tended to be younger than V/Ss associated with not contacted SUs.\(^5\)

Direct work: support

“He’s the only one that’s helped me, and stuck by his word. So I’ll give him my respect, that’s why I agree to do this for him... […] he found me the GP [...] ran him to see are they taking on people. He helped me out with shopping money, he helped me out with a deposit and that. He said if you need to go anywhere I’ll come with you, support.”

(Drive SU6)

One of the innovative aspects of the Drive intervention is its provision of direct support and signposting to existing provision for perpetrators of domestic abuse. CMs tailor support to SU needs and as such are very varied. In the case notes we see examples of CMs assisting SUs in decision-making around options for meeting their basic needs; making telephone calls on behalf of the SU (arranging benefits, housing, healthcare, employment, substance misuse treatment); accompanying SUs to appointments; and assisting in ensuring SUs understand the advice of other professionals (whether verbal or written). The most common areas in which support was recorded were housing, substance misuse, mental health, benefits and personal finances – assistance with accessing food-banks was also provided in 2 of the 30 cases analysed.

The aim of support, as outlined in the Drive practice manual, was initially to get SUs to a level of life-stability where they are able to make better choices. Over the first year of delivery, this aim remains, but support has also come to be understood as a particular method of eliciting more profound self-reflection on the part of the SU (case work example 6 in Appendix 5), as well as a way of disrupting perpetration in its own right. In the words of one of the Drive CMs:

\(^4\) A Mann-Whitney U test. U = 168.00, z = -2.27, p = .023

\(^5\) A Mann-Whitney U test was run to determine if there was a difference in age of V/S. Distributions of age for contacted and not contacted SUs were not similar, as assessed by visual inspection. The age of V/S of SU who were not contacted was higher (mean rank = 27.38) than the age of V/S of SU who were contacted (mean rank = 20.11), but the difference was not statistically different, U = 192.00, z = -1.76, p = .078.
“It's removing his excuses. So his excuse of his mental health – that's kind of gone. The excuse that ‘oh it takes years to bid for a property’ – that excuse is removed because he’s just not trying. Yeah, and another excuse was all his benefits were messed ... well I can prove that they're not. So again it's just trying to empower his family to say to him everything he's saying to you about he's not having any help – he’s totally lying to you. (Drive Case Manager - CM6)

Here the CM uses support as means of ‘closing-off avenues’ for self-deception around perpetration as well as for opening a space of accountability in relation to the SUs family. As related by one the VSs, the hope in this kind of work, is that it gets the SU to a place where he is able to take responsibility.

“(CM) is working with my ex-partner, and, just helping him like, [...] just like trying to help him to get to the stage where he like admits a few things like, [...] He talks, he talks to [CM], He is like trusting [CM] a bit now. It's like, it's like he opens up and then like tells him everything that's going on.” (Drive V/S - VS1)

Of course, if the CM is successful in this aim, then we could see an increase both in SU self-reporting as well as CM reporting of DVA behaviours that would temper apparent positive outcomes of the intervention (as has been the case in DVPPs, and may explain why CM reporting of DVA behaviours for SUs was higher than that recorded by Idvas – see earlier section on outcomes).

Support is also increasingly seen as a way of disrupting perpetration in its own right, for example, support with housing has been utilised where the SU's only other place to stay has been V/S’s accommodation. Support with benefits has similarly been utilised where the SU's only income has been from the V/S and there has been a history of financial abuse.

As one of the Drive Practice Advisors pointed out when interviewed, the intention behind and the perception of support can be quite different. While support may be intended as a mode of disruption by the CM, for the SU it is often very well received - it is can also then be central to building trust between the CM and SU. A key tension regarding the support component is between support which cultivates dependency and that which cultivates self-reliance, particularly for SUs who have historically relied on their victims for support around basic need as a technique of control. In the case notes there are numerous examples of what might appear to be ‘excessive handholding’ but that further down the line do seem to have cultivated a greater degree of self-reliance in SUs. The sustainability of this as an intervention remains to be seen. The lesson here then is around the importance of CM judgement and awareness of this tension as opposed to a recommendation for weighting towards one side or the other.

Direct work: behaviour change

In the case notes analysed, we coded activities as ‘behaviour change’ where the CM was working directly/face-to-face with the SU on activities aimed explicitly at understanding and challenging DVA behaviours. As mentioned above, in the 30 sets of case notes analysed, 9 contained references to behaviour change work and 6 of those 9 were from Site 2. We gained a further insight into behaviour change work through interviews with CMs and with 11 SUs whose cases were open at the time of interview. These SU interviews also provided a little more balance across the sites with 5 interviewees from Site 2, 5 from Site 3 and 1 from Site 1.

As mentioned above, by the end of the Drive intervention the 9 SUs participating in behaviour change work (out of the 30 whose case notes were analysed) were less likely to be assessed as perpetrating DVA behaviour than their Drive peers not participating in behaviour change.
Whether this is down to the behaviour change work itself or to the fact that those with whom behaviour change work was possible were more likely to change anyway, is impossible to say at this early stage. The results are nonetheless promising. So what are CMs doing, and what seems to be having an impact on SUs such that it might be producing behaviour change? The aspects appear to be the following, and echo the techniques used more broadly in DVPPs albeit with exclusive focus on one-to-one work rather than group work:

1. The Case Manager - Service User relationship

   “It’s just someone that you can open up to, you know. And … like I said, I’d have never thought that I could go and speak to someone, I just thought I was that type of guy, I thought a, I withdraw to myself – bugger them off, you know. But I’m very happy we did speak. Because if it is a problem I just phones [my Case Manager] … he’s good as gold, you know.” (Drive SU1)

   I … what is the best thing about [Drive] if you can put it down to one thing?

   R Someone to talk to. (Drive SU2)

While support around basic needs was reported by SUs as being very important to them, those we interviewed commonly reported that the ‘best thing’ about Drive and/or what differentiates it from other interventions they have received, is simply ‘being heard’, ‘having someone to talk to’ and crucially ‘not being judged’. In the words of one SU:

   “It’s been very humbling and helpful to have [my Case Manager] fighting my corner for me. So … cos you know you commit a crime like mine which was really quite heinous and you kind of feel like everyone’s against you, and it’s nice to have someone see that you are still a human being not just a criminal.” (Drive SU4)

Here it seemed to be the fact of having an advocate – someone ‘fighting their corner’, and through doing so, persevering in seeing them as human – as much as what that advocate actually does that was important and central to building the kind of CM/SU relationship necessary to keep the SU engaged.

A commonality across the male SUs interviewed was their reported lack of close friends or family that they could talk to, three mentioning specifically that the only person they speak to is their mother. With this level of loneliness, the relationship with the CM, as someone who really listens, takes on increased significance. Asked whether he had been visited by the CM while in prison, one SU responded:

   R Yeah. He visited me twice when I was inside

   I Okay, and how was that?

   R I loved it. I didn’t have no one visit me when I was in there, so it was nice to see a familiar face. Know what I mean? (Drive SU5)

A number of SUs actively sought to differentiate Drive from previous interventions they had received highlighting the one-to-one nature of the intervention. In particular it was what they experienced as non-judgement and an expression of care by CMs about the root causes of perpetration that stood out as most impactful.

   “It was the fact that it’s the area we’re in, it’s enclosed in a room, it’s a small room, it’s only one on one, it’s not a big group of people. No matter what l’d say I felt that [my Case Manager] weren’t going to judge me for my actions in the past. And many
Engagement style was also critical to the ability of CMs to connect and build trust with SUs. This includes ‘basic’ signifiers of position like styles of speech and dress as well as the imperative to withhold judgement, or their perception of judgement even when challenging behaviour.

“Cos ultimately you know you turn up in a shirt and tie and smart trousers right, like they look at you thinking ‘The last person I spoke to with a shirt and tie on took my kids off me. I’m not interested in you mate’. And again it’s like … it’s having a bit of local knowledge as well…” (Drive CM32)

With this relationship building, of course, comes the risk of manipulation and collusion and this was something that the CMs we interviewed approached with great care. A key tension here in the one-to-one work is the delicate balance between rapport-building and challenging problematic attitudes and beliefs. There are numerous examples in the case notes, where the SU says something problematic and the CM chooses not to directly challenge in order to build rapport with the SU. This is clearly something where professional judgement is always needed and highlights the nuance and skill required to do this kind of case work. Conversely there are examples where a direct challenge was made in what reads as a judgemental tone and which result in the SU disengaging completely. Thus, while there is a clear imperative to be ‘tough’ on SUs in order to do justice to VSs, if done unskilfully, such an approach can lead to disengagement from SUs. This could potentially place V/Ss and families in greater danger particularly if there are few alternative levers available to the CM.

If the risk of challenging too severely opens open the risk of collusion, how do Case Managers avoid it? As one of CM recounts:

“Because we’re party to so much information beforehand, so all the Marac minutes and everything, [...] if I’ve had a chat with an Idva and they said well he’s tried to strangle her, he’s shoved her head down the toilet, he’s held a knife up to her throat, and he’s still not said any of those things to me, I guess [I] just going back – keep probing and prodding around like the worst incidents that comes to mind for him and … I think sometimes in work I’ve done previously you can have a couple of conversations with people around well what did the abuse look like, what do you think you did. And then that conversation is left and you never revisit it – that’s taken as read … but keep coming back to it after 6 weeks, a couple of months, 3 months. One of the guys you saw yesterday – it took him 3 months to admit that he had gone to get a knife and threatened to stab her, because they’re still wanting to present a picture of themselves that is not really accurate.” (Drive CM31)

Here then a combination of factors coalesces to uniquely position the CM as able to challenge effectively and thereby limit possibilities for collusion: 1) high levels of information sharing, especially via the Marac and with the Idva; 2) the length of the intervention; 3) the persistence of the CM (making the most of that duration). The oversight and supervision process is, of course, central to this. Drive Practice Advisors and practice boards, which bring together practitioners from other agencies to provide critical oversight on casework, provide an additional check on collusion and manipulation and have picked up on and challenged practices perceived to be weighted unduly in favour of the SU.

2. Leveraging engagement in change work
Drive caseworkers used two broad sets of approaches to leverage engagement by SUs: a) aspirational levers, offering SUs a space for positive self-redefinition linked to changed behaviour and b) compulsory/less voluntary levers which compel the SU to engage or face some form of sanction.

a. Aspirational levers

Focusing on the impact of the SUs behaviour on their children and the aspiration of being a ‘good parent’ was a crucial lever:

“Cos most of the time they will have committed incidents with the kids there. The three guys that jump to my mind all have kids, they’ve all done things in front of the kids. And it’s one of the main things they care about - it’s not so much the impact on the victim, it’s more the kids see it and witnessing what they’ve done.” (Drive CM31)

The desire to be a ‘good parent’ or, as in this quote, the shame associated with not being one is a powerful motivation to change that comes through interviews with CMs and SUs. Through motivational interviewing paired with activities focused on the impact of DVA behaviours on children, CMs make the link between responsible fatherhood and masculinity, providing a route for self-formation that is both acceptable and desirable to the SU and safer for his children.

R Well you grow in’it, you grow up, you change, you don’t want to be the person you was. Like do you know what I mean? Just want to be better for my daughter. (Drive SU5)

Child contact sits uneasily between aspirational and compulsory levers to the extent that non-contact with their children is understood by SUs (and some practitioners) as a sanction and contact does not necessarily entail a profound change in the parent. Contact is nonetheless a powerful motivator or lever to engage in behaviour change work and it is hoped that through this engagement, SUs will start to see the benefit of behaviour change in and of itself.

Another lever relates to the SU’s own health/wellbeing. Particularly for SUs, experiencing mental ill-health and/or with serious drug and alcohol dependencies and/or lack of employment opportunities, access to the support side of Drive was the key motivation for engaging and changing their behaviour. As with the issue of child contact, the skill of the CM in these cases, is to engage this self-serving desire (on the part of the SU) to do change work with wider positive impact.

b. Compulsory/less voluntary levers

“At first I just thought ‘what the fuck is this?’, and then he started talking about it, and I was like yeah I’ll do it. Even he said he didn’t think I would carry on with it – I’d walk down there and tell him to fuck off and not do it. But as you get into doing it, it’s a good project.” (Drive SU3 engaged while in prison)

While compulsory or ‘less voluntary’ engagement can pose a challenge for initial meetings due to SU resistance, CMs reported that some of their highest engaging and most visibly changed SUs were those who were initially required to engage through some kind of institutional leverage. It is too early to tell whether these perceived changes in SUs will be greater overall than those who have engaged more voluntarily, but the early indicators from the qualitative data seem to show that some compulsion can be an effective tactic. Key here was the length of the intervention - 10 months allowing time for CMs to demonstrate to initially
resistant SUs that Drive was unlike prior interventions they have received and that it might be in their interest to really engage. Compelling engagement at the start provided a sufficient 'nudge' to enable what seems to be a genuine engagement further down the line. We identified four main forms of 'less than voluntary' engagement:

i. Meeting the SU in prison provided an important lever:

“Well I think a lot of the work is about building relationships. So we have the time and the space to be able to go in and yeah start building that relationship with them, and then challenge in a way that isn't going to get them walking out of the room. And in prison that's pretty handy, cos they're less likely to walk out of the room. And actually I found that when they are in prison that's a great place to go and meet and build that relationship, and they've got lots of time to think, lots of time to reflect.” (Drive CM31)

“It was once a week, and it was for anything up to 2 hours once a week. Which was a reprieve anyway, because you was in your cell for 23 hours a day. So just to be out of your cell talking to someone that isn’t your cell mate was quite nice for a couple of hours. It was difficult at first cos you’re sort of having to talk to a stranger about really quite personal things. But [my Case Manager’s] a lovely guy, made me feel very relaxed and at ease, very down to earth. So yeah it was very easy to open up and talk to him.” (Drive SU4)

As these quotes demonstrate, engagement in prison contains a significant voluntary component, reliant on building a relationship with the SU that will weather a challenge from the CM. While the CM does reference physical confinement as a lever to stay in the room, from the perspective of the SU, being in the room with the CM is seen as a ‘reprieve’ from their more punishing confinement in their cell. Sadly, effectiveness here may be in part down to the loss of other opportunities and cuts to services for people in prison. One Service User made this connection quite explicitly reflecting on the difference between his Drive CM and his probation worker:

R   Well yeah they don't do nothing, they're crap to be honest with you. My probation worker's changed twice since I've been in jail, and [my Case Manager] ... he's the only one who's told me that it's changed – they haven't told me theirself.

I   Right.

R   So [...] when I got out I wouldn't know who my probation worker is. I don't know, it's like they're not ... seems not to be bothered. Cos last time I come to jail my probation worker used to come to see me every fortnight, every month. And now they don't, they said ... what is it, cos they're limited, they've got less funding. (Drive SU3)

Though anecdotal due to the small sample size at this stage, interview data also suggests that prison as a starting point for Drive engagement may be most effective for younger Service Users, as one Case Manager relates here:

“And a lot of the guys that I'm working with are late 20s and it feels like they're at that point, they've made so many errors, repeated their mistakes, but they're just young enough that they can ... it feels like they're not stuck in their ways that there's the capacity for change and a want for change, whereas if you add another 10, 20 years
– kids are all grown up, I could see … and certainly within my colleagues’ cases, there’s less motivation for wanting to look at themselves and reflect on themselves.” (Drive CM31)

From the quantitative outcomes analysis, we can see that younger SUs were more likely to be contacted by CMs.

Additional ‘less voluntary’ levers included:

ii. Writing Drive engagement into the sentence plan/licence agreement was the preferred option by Case Managers interviewed for post-incarceration engagement.

iii. Working with the OM to allow SUs rehabilitation activity (RA) days to be used on Drive (if Drive engagement is not already written into the SU’s licence agreement) was another approach.

iv. Using the probation appointment as a place to initially engage (if Drive engagement is not already written into the SU’s licence agreement) was also used effectively.

These approaches have the practical benefit that is more likely the SU will attend, and serves a performative function – presenting Drive (a non-statutory intervention) as ‘official’ in the eyes of the SU and demonstrating a degree of multi-agency unity while at the same time offering a space for the CM to differentiate her/himself from the OM/Probation.

Writing Drive engagement into SU’s child protection plan was also used. Like all ‘less voluntary’ levers and especially child contact, writing Drive engagement into the child protection plan risks the SU ‘going through the motions’ in order to obtain their own goal without changing behaviour. The key here, as mentioned above, is the time available and the skill of the CM in demonstrating a benefit to the SU of more profound behaviour change. One SU interviewed, whose child protection plan stipulated engagement with Drive, reports how he was beginning to see this benefit (what Hester et al 2006 also talk about as shifting from ‘loss’ to ‘win’):6

R    Yes, even my girlfriend’s saying to me this is where we need to be, you know. But I think I could still get better you know, I don’t think I’m over that speed hump in the road […] But yeah, I’m very happy the way it’s going. Well like I said, the family’s starting to recognise we’re getting on much sweeter.

I    Same for the kids?

R    Same with the kids, texts, I mean ‘daddy we love you’, know what I mean? The kids are phoning me up ‘I love you dad, love you’, I mean it’s nice … it’s nice to hear that like. (Drive SU1)

3. Behaviour change tactics

“I mean my ex-partner and me haven’t spoke since the day I got arrested, there’s an indefinite restraining order against me. So I don’t really know how my behaviour’s affected her. But obviously she’s scared to the point that she doesn’t ever want to see

me again … it’s resulted in me not seeing my son. So it’s had major impacts. As for my family and friends, you know they saw the sorry state of the man that I was when I went to prison, I was at rock bottom, and to see where I’ve got to this point, I’m a lot more … I’m a lot more chilled, a lot more open. I don’t know just slower to react to bad situations. Like I’ve really learnt how to sit with a bad feeling and mull it over and make a more conscious informed decision rather than just instinctively reacting to situations.”

CMs use a wide range of tools and tactics with SUs depending on the SU’s particular needs and perceived readiness to change. While some of these sit across the categories outlined below, the following were common to varying degrees, across the cases where behaviour change was reported:

**Psycho-Educational Tools - understanding DVA and its impact**

CMs commonly explored the meaning of ‘domestic abuse’ and ‘high-risk’ with Service Users, unpicking written definitions and/or using video and audio to allow the SU to gain some critical distance from their own behaviours in order to see them differently. Central to and often following on from this work were activities aimed at understanding the impact and/or cultivating empathy, again using video, drawing on relevant research and employing role play and role-reversal to develop empathy with the V/S. As mentioned above, impact on children and family members was often used as a way-in to helping the SU empathise with and/or understand the impact on the primary victim (as also used in DVPPs more generally).

**Reflective Practices and Cognitive Behavioural Interventions**

Many of the techniques in this category sought to provide the SU with a way of reflecting on and intervening on their own thought process in order to challenge those patterns of thought associated with their abusive behaviours. This involved looking at their triggers/reactivity, self-talk, attitudes and beliefs and mobilising self-image/how they seen by others to elicit this reflection and motivation to change.

One technique used in this respect was Positive Self talk, such as “Feeding the good dog”

“I was getting angry, you know, I was getting angry. […] Well now I’ve calmed down you know…. when I’m angry I walk away. He’s tells me ‘go an ‘ave a little walk’ ‘go an do whatever you’ve got to do’ and ‘just keep feeding the good dog’. If you fed the bad dog, take the food back off him. You know, it’s… it’s just one of them things you know – I was ready to blow all the time you know. It’s really nice you know. Taking things out on people which support me the most, you know – you shouldn’t be doing that.”

The SU quoted here was having obsessive and paranoid thoughts imagining his partner’s infidelity and, in an attempt to quell these thoughts, would exhibit highly controlling behaviours. He was also feeling angry and expressing that anger through abusive behaviours. The CM
used the analogy of ‘feeding the good dog or the bad dog’ to refer to the way in which the SU cultivates negative or positive self-talk/mental narratives about his partner and children. Framing his experience in this way offered the SU an opportunity both to observe his thought process and, crucially, to exercise some choice about which process to follow. It functioned then as an anger management tool, but more profoundly as a technique for addressing jealousy and control - a way of interrupting the ‘jealousy to anger’ thought process. This seemed to really stick, with the SU coming back to it again and again at interview and both the Idva and CM reporting positive behaviour change.

Central to the behaviour change work was the creation of alternatives for positive (i.e. less harmful) self-redefinition, such as focusing on ‘The Better side of me’

R  My girlfriend’s noticed it the most.
I  Right, and what does she say?
R  Cos when I was first going out … we used to talk all the time, we broke up because I just talked to her like a twat and I was worried about what she was doing. More-so like when she was going out, talking to boys and that, if she was talking to boys – you get scared. Cos you don’t know what they’re doing out there … but now I’ve realised that she ain’t a cheat and she knows me for who I am … but the better side of me now. (Drive SU3)

To do this, CMs explored and/validated positive traits, skills and behaviours and attempted to explore, challenge and/or redirect problematic aspects of the SU’s self-view and/or views of others. Redefining masculinity in ways that incorporated responsible fatherhood (as mentioned above) and allowed for attention to feeling and vulnerability - ‘you get scared’ - were common themes, as this CM recounts:

“And so we analysed it, [...] you know, when I mentioned ‘Well you were obviously vulnerable’ – ‘I’m not vulnerable, I’m not vulnerable’ – didn’t like the term ‘vulnerable’. So I said ‘Well tell me about how you felt then?’ – ‘Well I was pissed off like’ – ‘Yeah but that’s entitlement’ I said, ‘but what did you really feel?’ And he said, ‘Well I don’t want someone else bringing up my kids’ – boom ‘That’s your vulnerability then!’ and I said ‘and that’s nothing to be ashamed of, that is a genuine real concern that if you split up with your partner, and she meets somebody else, your daughter’s going to be … whether you like it not, they’re gonna be living with somebody else [...] ‘and that is a perfectly acceptable vulnerability for you to have’.” (Drive CM32)

Here, the CM uses what is quite a traditional (albeit fragile) component of masculinity - the biological father guarding ‘his’ children - as a way of connecting the SU to his own vulnerability. Through the reinforcement, ‘that is a perfectly acceptable vulnerability’, he grants permission, allowing the SU to feel no shame - a technique made possible perhaps by the CMs own gender status as a respected male.

Another way of getting to vulnerability, exploring possible triggers for abusive behaviour and for building relationship, was through working with the SUs background and life experience. This was particularly appreciated by one young SU whose previous experience of adult authority had been very negative.

“Yeah and if I talk about my previous history, the police and stuff like that, she doesn’t judge me for the things I’ve done, she kind of wants to help me. She kind of realises that it may not be my … it’s my choices for what I think I’ve done, but there is a reason behind the choices that I’ve made, and she wants to kind of get to the root of them and try and change my way of thinking.” (Drive SU7)
Interestingly the SU here links this experience to his taking responsibility for his choices rather than seeing himself as victim. This highlights a key skill within the direct work - that of exploring vulnerability and the impact of past life experience, without allowing the SU to re-conceptualise themselves as a victim, as this CM notes,

“...I think most importantly, trying to get them to take responsibility for what they’ve done and build empathy for other people – which is lacking a lot of the time, not get stuck in the victim mode that they’re in an awful lot. [...] Just trying to hold a mirror up to them really – what they look like, what it feels like for the other person, what the impact is on the kids – trying to find those.” (Drive CM3)

Parenting guidance or other direct/focused intervention on the SUs parenting was carried out with great care but, on the basis of the interview data seems to have had a significant impact, with 4 of the SUs interviewed mentioning it in positive terms unprompted by the interviewer. CMs also intervened indirectly on the parenting of SUs through the positive effects of non-parenting-specific-behaviour change work impacting on SUs children, as this SU recalls:

“R I feel fantastic, cos it’s transferrable into so much of your everyday life. You know I’m a father, I’ve got three children, and kids can get right under your skin. Even with the way that I deal with my children you don’t feel like you have to just shout at them and tell them off, you can you know talk to them calmly on a good level and explain to them what they’ve done, their behaviour that’s not good, and explain to them how they should behave. And you can deal with it a lot better, and the kids don’t get shocked and scared at you shouting, you know they’re more likely to listen to you if you take them away from the situation and talk to them rationally and explain things. They’re a lot more switched on and focussed in what you’re saying.” (Drive SU4)

**Direct work: working with/alongside SU’s family where possible**

Two of the completed cases analysed and one of the open cases discussed in practitioner interviews have involved significant work with the SU’s family by the CM. In all of those cases the SU had been manipulating family members, mostly for money and emotional support under the premise that the CM and the SU were making progress. Viewing family collusion with the SU as detrimental to behaviour change, the CMs worked in different ways to empower family members to challenge SU behaviour. This involved sharing information, being supportive to family members and directing them to appropriate support services - in one case, counselling.

**Direct work: positioning Drive with and against ‘the system’**

Central, it seemed, to the success of engagement with drive SUs and thus to subsequent behaviour change was CM’s ability both to differentiate Drive from other interventions SUs had received yet simultaneously to show unity with other agencies. Techniques for this varied - occasionally CMs would seem to unite with and mobilise the SU’s oppositional mentality to ‘prove them [other agencies] wrong’ that the SU cannot change. In other contexts CMs would perform neutrality where SUs were reacting negatively to other practitioners. Conversely, CMs would perform unity - for example with probation through joint agency meetings and appointments, in order to establish the authority and legitimacy of the Drive intervention in the eyes of the SU.

In one example the OM accompanied the SU to his child protection conference and requested that the chair meet with them in advance to go through the paperwork. The SU experienced high anxiety, frustration and anger in contexts where his inability to read and write might be exposed. He had previously stormed out of CP conferences and prior to the preceding one, had taken an overdose. Using the prior meeting, the CM and CSS chair were able to explain
key terms – including those the SU might react negatively to – and the implications of particular actions. The SU was able to be present through the subsequent conference and now has regular overnight contact with his daughter. However, this again brings up the possible tension between support and collusion regarding the perpetrator, given that the V/S is probably still expected to be in the same room as the perpetrator and sees him getting overnight contact.

In another example the CM used the NPS Probation appointment as a site for initial engagement. Through a series of unhelpfully phrased statements, the NPS OM elicited frustration and resistance in the SU. Through the ensuing conflict, the CM performed neutrality, endorsing neither side and simply listening. When asked for his phone number by the OM at the end of the meeting, the SU responded that he didn’t have a phone. As the three of them left the meeting the SU turned to the CM and passed him his phone number “so long as you don’t give it to my OM”.

Interestingly, 3 of the 11 SUs interviewed explicitly differentiated Drive from their experience of probation, perceiving their Drive worker to be more consistent and reliable in terms of number of visits (while in prison) and ability to help them. In the words of one SU:

“He’s helped me more than my probation worker – I’ve seen my probation worker once since I’ve been in prison. And [my Case Manager] spoke to him about helping me with housing, cos if you’ve got nowhere to go, what are you going to do with yourself? [...] All [probation] said was if he’s got nowhere to go we’ll try and find him a hostel, but it’s not a guarantee. But even if I don’t get into this place [my Case Manager will] be looking into other things to help me.” (Drive SU3)
Conclusion and challenges from year one:

In what ways does the model generate/require changes in agency behaviour, leadership and interaction/modes of operation?

As a novel, multi-agency, multi-sited intervention, getting Drive off the ground and into the delivery phase was a massive undertaking that required significant collaboration across areas and sectors. In this section, building on the in-depth analysis presented above, we highlight the key learning on the Drive process after Year 1. It is important to note that the context for establishing Drive was different in each site, with different existing levels of multi-agency working, service providers with varying levels of existing local engagement, and different Marac processes. The differences in sites and associated challenges and successes in establishing multi-agency working and delivering Drive are outlined below and have generated learnings that can be taken forward if Drive were to be set up in new areas.

Multi-agency relationships

One year into delivery, Drive has developed strong multi-agency partnerships across the three sites – these relationships have been absolutely critical to delivering the Drive intervention which is primarily composed of indirect multi-agency work. With these relationships now well established, we would anticipate multi-agency working to be faster and more effective in Year Two. Importantly, however, relationship building should not be understood as ever complete, but rather, as an ongoing process, requiring continual maintenance.

The case notes and practitioner interviews highlight staff turnover and capacity in other agencies to be a key barrier to multi-agency working. Those sites that demonstrated best practice at a multi-agency level have been those that benefitted from pre-existing strong multi-agency relationships and/or have structured relationship-building into their ongoing processes through formalised rolling introductions and repeated agency-specific tailored messaging to communicate the aims and remit of the Drive project. What would improve this further would be if the request that Drive makes to other agencies – in terms of actions and resource – were also communicated in as clear and specific terms as possible. Conversely, those sites that have been slower to get moving on Drive casework have been those where pre-existing multi-agency relationships were less well established and relationship building mechanisms were slower to be put in place.

Differences between sites in terms of multi-agency working can be explained by a number of factors. At one site historic organisational conflict, and in another, the fact that the Drive provider (delivery organisation) was not local, slowed the pace of setting-up effective multi-agency relationships. Pre-existing conflict and not being known to other agencies had a similar effect: not being trusted. Trust and the assumption of benevolent intent that comes with it are crucial to eliciting the goodwill necessary to enable multi-agency working to be effective. While multi-agency work must be, and usually is costed in, in practice sufficient time is rarely allocated to do it well. When a new initiative like Drive comes along, it will inevitably be an additional draw on this already-stretched practitioner time, usually without amendments to the contracts of frontline staff. Multi-agency work thus requires some goodwill at the practitioner level. Thus, at the Drive sites where trust was lacking, there was a corresponding ‘push back’/resistance to the additional requests made on staff to one another. Interestingly, this
resistance was commonly expressed in terms of scarcity of resource. Framing resistance in these terms served to ‘professionalise’ and legitimise it while decoupling it from the more emotive issue of trust. In contrast, at those sites and in those contexts where pre-existing trust was high, the same levels of resource were seen as sufficient to do the work.

An additional and crucial factor for the indirect multi-agency work was the location of the ldva service. The ldva service is the most active partner for Drive multi-agency work. Thus, where the ldva service was ‘in-house’ – i.e. provided by the same provider as Drive SU work – there could be significant time-savings especially if Drive SU workers and ldva service were co-located. Conversely, those teams where the ldva was externally provided and/or not co-located with the Drive team, were at a disadvantage.

One site in particular stood out for the apparent levels of already-existing of trust and multi-agency partnership. While this is difficult to categorically explain, practitioner interviews suggest a number of factors contributed to this:

- Low levels of workforce mobility and a relatively small geographical spread mean that staff are more likely to have worked together previously or even to know one another personally.
- DA has ‘built-in’ to multi-agency working to a greater degree than in the other areas. The existence of specialist DA courts demonstrate an institutional commitment to the importance of seriously tackling DA and require additional training for agency staff on how to work with them which will have filtered through agency practice/culture. Unfortunately, we do not know whether the existence of DA courts is an effect or cause (or indeed both) of a better commitment to tackling DA, for example this commitment could be attributable to something else e.g. strong women’s movement, one effect of which was the creation of the courts.
- The Police VAWG lead is from the Victim Services’ Sector and plays a central role in strengthening commitment to tackling DA through statutory services especially police.

In one area, there were particular challenges to overcome to establish the trust and multi-agency partnerships that are key to making Drive a success. This included:

- A lack of strategic and operational communication between Drive and delivery partners and multi-agency partners. Related to this, a lack of clarity about what partners would offer to Drive - especially in terms of disruption.
- Idva service delivered by a separate provider, with whom the Drive provider has had historic disagreements.
- The site was undergoing a transformation in its Marac processes and ways of working at the same time Drive was preparing for delivery.

In the final area, there were separate challenges in establishing multi-agency working due to the service provider not having an existing presence or history within the area.

Marac & perpetrator fora

The functioning of the Marac has also been critical to the success of Drive at the three sites. Marac is the first point of contact for Drive CMs with other professionals and is the initial channel for information about the SU and V/Ss.
- Face-to-face Marac serves some additional functions:
  - relationship building & recognition
  - communicating Drive aims, remit and requests
  - performance of insider status/reliability/authority that is crucial to gaining trust

Each area had its own Marac arrangement, each of which have changed over the course of the first year and which may change further. While Marac is crucial to Drive work (in the ways described above), each area saw the need for something in addition to the Marac in order to deliver Drive effectively. Triggered as it is by a high-risk incident, the Marac is a one-off and principally victim-focused forum – the case is heard, actions are assigned and agencies move on to the next case. For Drive work, many areas felt the need for a systematic multi-agency method for checking up on and sharing information about known high-risk perpetrators, before another high-risk incident occurs. Whether this was done as an extension to the Marac or as a separate perpetrator-focused forum like a MARAT, or indeed, whether this function was fulfilled by some other multi-agency arrangement or meeting is not important. The key point is some kind of consistent multi-agency check-up on known high-risk perpetrators is required.

Set-up phase

- **Importance of bringing as many partners together as early as possible.** The core task is **relationship building** - at all levels: buy-in must run top-down & bottom-up. Where buy-in has been partial there have been issues. Local co-development and senior strategic sponsorship from PCCs is key to establishing these strong local relationships.

- **Setting up data systems and cultivating relationships to facilitate data sharing is an ongoing and iterative process** - not something that is ever complete and thus blurs boundary between ‘setup’ and ‘delivery’ as well as between ‘casework’ and ‘systems change’.

- **Information sharing:** getting this established was a much larger piece of work than anticipated - Police & CSS and some therapeutically oriented third sector organisations were most challenging.
  
  o Drive access to police data systems e.g. Niche - would be a massive time-saver for CMs and Police.

- **Tailored messaging** to different constituencies is required to ensure aims, methods and limitations are clear to all agencies.

- **Relationship building/messaging** is never ‘done’ - need for an ongoing/rolling approach to mitigate rapid staff turnover and that busy humans forget.

- **Care needed around bidding processes** - attention to existing agency relationships and/or historic conflicts. In one case, the competitive bidding process triggered a conflict which one side later claimed could have been averted if a more conciliatory approach had been taken from the outset.

- Additional time/resource is required where the **delivering agency is not known** and connected in the locality.
Where CMs are already locally known, trusted and respected, a huge amount of time is saved in building relationships, and as such, in getting started on casework. The importance of strong relationships at an individual as well as an agency level cannot be overstated.

**Delivery phase**

- **As outlined above for Drive to work, some kind of perpetrator-focused multi-agency forum is required.** The precise form this takes should be decided at the local level, what matters is that it fulfils the following function:
  - Ongoing multi-agency check-in on high-risk perpetrators *before* another high-risk incident occurs.
  - Systematic method for sharing known information about high-risk perpetrators.

- **Lack of knowledge about high-risk perpetrators.** Related to the previous point, while it was initially thought that sufficient information would come from the Marac, it is now clear that very little is known about high-risk perpetrators. For Drive to work, and indeed for any intervention to effectively target this group, much more consistent and systematic data gathering on high-risk perpetrators is required. Despite the existence of Clare’s Law, Case Managers noted that Services Users who changed areas were a challenge because they disappeared from services.

- **Criminal justice proceedings hold** – Initially, Drive engagement was put on hold for those SUs who were in criminal justice proceedings. The intention here was, quite rightly, to avoid Drive engagement being used in court as evidence of the defendant taking steps to change potentially resulting in them being treated with greater leniency than the same defendant not engaging with Drive. This reasoning still stands and the hold should certainly be in place where this might be a factor. However, given the levels of criminality within this user group, a blanket criminal justice hold puts severe delays on the progression of casework when the risk, in many cases of Drive engagement being used in court in the way described is minimal to nil. As such, and as has already been actioned by the Drive partnership, we recommend taking the criminal justice hold on a case-by-case basis especially given the fact that engagement during criminal justice proceedings can for some SUs be highly effective.

- **Need for in-house and properly financed Idva support.** Idva capacity was the largest single issue that came up in the early practitioner interviews. Drive Idvas provide 10 months support to the primary V/S of a Drive SU (as compared to 10 weeks which is usually the standard amount of engagement). This entails significant additional frontline engagement work as well as additional multi-agency working, especially with the Drive CM. Lower initial estimates of the volume of this work, and the consequent perception by some Idva services of it being undervalued, slowed progress especially in areas where there had been historic conflict and/or the Idva service was provided separately from the Drive SU case management (see above). For any replication of the model, the Idva service must be adequately costed, with consideration given to the need for parity of pay between key Drive personnel.

- **Co-location:** co-location of services came through as a key strength in the practitioner interviews, especially from the Drive team, Idva service and CSS. Given the volume of
inter-agency communications, many of which are quick checks or advice requests, rather than information sharing requiring a paper trail, being able to work face-to-face was time-saving, relationship reinforcing and reduces email use, although risks that V/S and SU may be in the same vicinity if meeting near to the co-located site need to be managed

- **Ensuring that risk management is about de-risking the VS**, not de-risking the organisation. We did not see evidence of this occurring, however this was raised as a consideration by a multi-agency partner in one site.

- **Caseload**: The initial estimate of feasible caseload was 33 cases per Drive CM. Feedback from service and Case Managers suggests this was over-optimistic and that 20 cases is a more realistic number. One of the things that differentiates Drive in the eyes of engaging Service Users is the feeling that someone is really ‘on their case’ consistently and repeatedly. This consistency is extremely time-intensive, especially when pursuing SUs with highly chaotic/unpredictable lives. The danger of case overload is that these SUs are precisely the ones who tend to slip through the net of other interventions and be at the highest risk of dropping off.

**General on-going challenges**

- **Victim-blaming** among agencies is minimal but there were infrequent and low level examples in Drive case notes, for example terms such as ‘victim failed to engage’ are present in some cases.

- **Length of intervention.** It is still too early to tell but there is certainly a good case for early closing of cases where it is extremely unlikely any progress will be made and, in rare cases, for some extension on imminent safety or significant change grounds.

- **Reduced provision** (to refer out to). Drive relies on a functioning ecosystem of services for people experiencing multiple challenges and deprivation. Absolutely critical given the needs profile of Drive SUs are adequate local provision in:
  - Mental health
  - Housing
  - Substance misuse

- **Agency capacity**
  - There were issues with Police, CSS and CRC capacity at different points recorded in case notes. This links, of course, in with a lack of capacity in local provision mentioned above.

- **Drive being seen as ‘the solution’** by agencies eager to ‘offload’ complex cases/seemingly intransient clients. This is a particular risk in a resource-scarce multi-agency context, where high-risk perpetrators with complex needs represent a significant burden on agency time and resources.

- ‘**Push back**’ around spending money on perpetrators was much less than anticipated from early practitioner aims - sign of both a culture shift and an indicator that Drive is being well received/perceived to be necessary. However, a key theme of
focus groups held with Idvas was the impact of the cost of perpetrator work on victim services in a context of reduced social spending.

- While links to the Idva service are strong, there have been questions (in the interviews) about how Drive interacts with the wider V/S sector. Part of this is about a perception that resources were being drawn away, and part of it is simply about making use of existing risk-appropriate provision. While this may be down to the higher level of risk involved, the case note analysis shows multi-agency working with the wider domestic abuse sector is very low.

Indirect work – ongoing challenges

- **Sole informant problem and low SU engagement with other services** - As mentioned above, all Drive activity is contingent upon high-quality and current information about the SU and their activities and this is particularly the case for disruption activities. In order to disrupt perpetration, knowledge on whereabouts, activity and risk factors are absolutely crucial. Correspondingly, when these are not available, or the sole route for this information is the current V/S, disruption becomes very difficult. If it is clear to the SU that information to disrupt has come from the V/S then this, obviously, places the V/S, and perhaps their children, at considerable risk. This was raised in interviews with Case Managers as a key challenge and can prevent Case Managers from being able to make contact. The sole informant problem, and lack of information more generally, is a particular problem with SUs who have not had recent contact with other services. Thus there is a risk that SUs experiencing multiple disadvantages (poverty, lack of housing, poor mental health, physical disabilities) may be disproportionately sanctioned in comparison to their high-risk peers experiencing fewer socio-economic disadvantages.

- **Less-than-hoped-for disruption response from police/probation** - While some excellent multi-agency working is occurring with police and probation, coming through the interview data and in some of the case notes, it is also clear that responses from police and probation to disruption requests have not always been as timely or consistently acted upon as hoped for by Drive Case Managers. Explanations for this are varied. On the police side, capacity/priorities seems to play a part, with some considerable difference between responses of individual officers. On the side of probation, and CRC in particular, while some excellent collaborative work has been completed, there is a perception by Case Managers reflected in the case notes of a reticence by OMs to recall SUs on the basis that a recall signifies poor performance of the service’s goal of rehabilitation. With this Service User group such ‘breach threshold’ inflation poses an increased risk to victims and children as well as a challenge for Drive CMs.

- **Higher than expected levels of drug and alcohol dependencies and severe mental health difficulties** - Those cases where little to no progress has been made in terms of behaviour and attitudinal change and/or engagement has not been possible or not attempted due to risk level, have also tended to be those where the SU has a severe drug and/or alcohol dependency and/or severe mental health difficulties. These cases have also tended to be extremely time-consuming for CMs. There is then a question to be asked, that given the severity of these complex needs, whether Drive is the most appropriate and/or cost-effective intervention for these individuals. With this,
it also needs to be acknowledged that without Drive, these individuals, who do pose a high risk of harm to others, would have very little else. Also, though time-consuming and of limited measurable short to medium-term behaviour change effect, significant safeguarding and risk-management activity have been carried out in these cases.

- **Information leakage** - There was one case in which information about V/S disclosure got back to the SU. While it is unclear how this happened (for example whether it was due to agency leakage - police were named in that particular case - or via the V/S’s friends/family), it highlights the tension between multi-agency information sharing and confidentiality. The lesson here is in stressing the confidentiality to agencies with whom information is shared. This happens already but cannot be overstated.

- **CRC Offender Managers need additional skills for Drive work** - The case notes show the critical importance of the Offender Manager in many of the cases and also what can happen when communication breaks down or is not established between the CM and OM. A number of cases were severely set back by CRC staff turnover, sickness, annual leave and new staff taking time to get up to speed with the case. This raises the question of whether Drive OM workers require additional training to engage more effectively with Drive Service Users?

### Direct work: ongoing challenges

- **Making contact safely** – in a number of cases, contact was either delayed or not attempted because there was no way to contact the SU without placing the V/S in more danger. This was especially the case where the information about perpetration had come only from the V/S and Idva and no other agencies were involved.

- **Making contact when other agencies are not involved** - Related to the previous point, when safety is not a barrier, sometimes simply tracking the SU down can be extremely difficult especially when other agencies have not been involved.

- **The most difficult-to-engage SUs have been those with extremely high levels of alcohol/substance misuse dependency and/or mental health difficulties.** Is Drive the best way to help these people? If so, what else needs to be in place for Drive to work? Additional drug and alcohol training?

- While all the SUs interviewed showed signs of progress from where they had come, **all exhibited denial, minimisation or blame to some degree.** This may well be an unavoidable feature of dealing with such a high-risk group and with attempting to change deeply ingrained habits and thought patterns over a relatively short time-period. Nonetheless, it remains important to highlight that even amongst those for whom the intervention has been most effective, more work could be done.

- **Appropriate Relapse Prevention Group or similar for high engagers?** What happens after Drive for high engaging Service Users is currently very unclear. A number the of SUs interviewed, when asked about how they will cope after Drive, responded by saying they will give their Case Manager a phone call if they have any problems. While this is a positive sign of the trust developed over the course of the intervention, it is not a sustainable strategy. It was anticipated by practitioners at the outset of the pilot that SUs might move into DVPPs however only one SU out of the 30
cases analysed was referred. Having interviewed CMs on more recently closed cases, we do understand the number of DVPP referrals to be increasing, and in particular we are seeing the use of pre-DVPP one-to-one work as a way of ramping down the intervention yet maintaining some engagement. These however remain a small proportion. What this suggests is that in addition to DVPP provision in Drive areas, that more one-to-one work may be needed, perhaps at a lower intensity and, given the preponderance of severe drug and alcohol mental health needs, high quality provision of these services in each area will be needed to maximise the likelihood of sustaining change.
Appendix 1: Biographical information for Marac cohort (N=1772)

Figure 1. Relationship types between perpetrators and victim/survivors for Marac cohort.

Table 1. Biographical information for the South Wales Marac cohort.

<table>
<thead>
<tr>
<th></th>
<th>South Wales</th>
<th>Victim/Survivor</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Drive</td>
<td>Control</td>
</tr>
<tr>
<td><strong>Perpetrator</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drive</td>
<td>M = 31.6</td>
<td>M = 33.4</td>
</tr>
<tr>
<td></td>
<td>(SD = 10.8, Median = 28.5)</td>
<td>(SD = 10.8, Median = 31.0)</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td>95.7% Men; 4.3% Women;</td>
<td>94.0% Men; 5.0% Women; 0.9% Don’t know</td>
</tr>
</tbody>
</table>
Figure 2. Relationship types between perpetrators and victim/survivors for the South Wales Marac cohort.

Table 2. Biographical information for the West Sussex Marac cohort.

<table>
<thead>
<tr>
<th></th>
<th>West Sussex</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Perpetrator</td>
</tr>
<tr>
<td></td>
<td>Drive</td>
</tr>
<tr>
<td>Age: $M = 34.9$ (SD = 10.6, Median = 33.0)</td>
<td>Age: $M = 34.6$ (SD = 11.3, Median = 32.5)</td>
</tr>
<tr>
<td>Gender: 93.4% Men; 6.6% Women;</td>
<td>Gender: 94.4% Men; 5.6% Women;</td>
</tr>
</tbody>
</table>
Figure 3. Relationship types between perpetrators and victim/survivors for the West Sussex Marac cohort.

Table 3. Biographical information for the Essex Marac cohort.

<table>
<thead>
<tr>
<th>Essex</th>
<th>Perpetrator</th>
<th>Victim/Survivor</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Drive</td>
<td>Control</td>
</tr>
<tr>
<td>Age:</td>
<td>$M = 37.1$ (SD = 13.0, Median = 35.0)</td>
<td>Age: $M = 34.4$ (SD = 11.8, Median = 32.0)</td>
</tr>
<tr>
<td>Gender:</td>
<td>91.0% Men; 4.5% Women; 4.5% Don't know</td>
<td>Gender: 90.9% Men; 6.3% Women; 2.8% Don't know</td>
</tr>
</tbody>
</table>
Figure 4. Relationship types between perpetrators and victim/survivors for the Essex Marac cohort.
Appendix 2: Biographical information - the 48 completed cases

Table 1. Profiles of 48 Drive Service Users and associated victim/survivors

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>48 SUs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean age</td>
<td>32.5</td>
<td></td>
</tr>
<tr>
<td>S.D</td>
<td>11.8</td>
<td></td>
</tr>
<tr>
<td>Range</td>
<td>(17, 76)</td>
<td></td>
</tr>
<tr>
<td>Men</td>
<td>45</td>
<td>93.8%</td>
</tr>
<tr>
<td>Women</td>
<td>3</td>
<td>6.3%</td>
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<tr>
<td>White British</td>
<td>25</td>
<td>52.1%</td>
</tr>
<tr>
<td>White Other</td>
<td>2</td>
<td>4.2%</td>
</tr>
<tr>
<td>White Other Mixed</td>
<td>1</td>
<td>2.1%</td>
</tr>
<tr>
<td>Romanian</td>
<td>1</td>
<td>2.1%</td>
</tr>
<tr>
<td>Kurdish</td>
<td>1</td>
<td>2.1%</td>
</tr>
<tr>
<td>Mixed White and Black Caribbean</td>
<td>1</td>
<td>2.1%</td>
</tr>
<tr>
<td>Mixed Other</td>
<td>1</td>
<td>2.1%</td>
</tr>
<tr>
<td>Unknown ethnicity</td>
<td>16</td>
<td>33.3%</td>
</tr>
<tr>
<td>Full-time employment</td>
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<td>8.4%</td>
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<tr>
<td>Part-time employment</td>
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<td>2.1%</td>
</tr>
<tr>
<td>Self-employed</td>
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<td>2.1%</td>
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<tr>
<td>Unemployed</td>
<td>20</td>
<td>41.7%</td>
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<tr>
<td><strong>Missing Employment Status</strong></td>
<td>21</td>
<td>43.8%</td>
</tr>
<tr>
<td><strong>Victim/Survivors of 48 SUs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean age</td>
<td>29.7</td>
<td></td>
</tr>
<tr>
<td>S.D</td>
<td>19.9</td>
<td></td>
</tr>
<tr>
<td>Range</td>
<td>(15, 54)</td>
<td></td>
</tr>
<tr>
<td>Women</td>
<td>48</td>
<td>100%</td>
</tr>
<tr>
<td>Men</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>White British</td>
<td>18</td>
<td>37.5%</td>
</tr>
<tr>
<td>White Irish</td>
<td>1</td>
<td>2.1%</td>
</tr>
<tr>
<td>White and Black African</td>
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<td>2.1%</td>
</tr>
<tr>
<td>White Other</td>
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<td>4.2%</td>
</tr>
<tr>
<td>Polish</td>
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<td>2.1%</td>
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<tr>
<td>Indian</td>
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<td>2.1%</td>
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<tr>
<td>Caribbean</td>
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<tr>
<td>Unknown ethnicity</td>
<td>22</td>
<td>45.9%</td>
</tr>
<tr>
<td>Children Involved</td>
<td>37</td>
<td>77.1%</td>
</tr>
<tr>
<td>Children Not Involved</td>
<td>7</td>
<td>14.6%</td>
</tr>
<tr>
<td><strong>Missing Children Involved Status</strong></td>
<td>4</td>
<td>8.3%</td>
</tr>
</tbody>
</table>
Table 2. Complex needs of the 48 Drive Service Users.

<table>
<thead>
<tr>
<th></th>
<th>All 48 SUs</th>
<th>SUs Contacted (n = 19)</th>
<th>SUs Not Contacted (n = 29)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance Misuse</td>
<td>20 (41.7%)</td>
<td>8 (42.1%)</td>
<td>12 (41.4%)</td>
</tr>
<tr>
<td>Missing Substance Misuse</td>
<td>19 (39.6%)</td>
<td>5 (26.3%)</td>
<td>14 (48.3%)</td>
</tr>
<tr>
<td>Alcohol Misuse</td>
<td>19 (39.6%)</td>
<td>97 (36.8%)</td>
<td>12 (41.4%)</td>
</tr>
<tr>
<td>Missing Alcohol Misuse</td>
<td>21 (43.8%)</td>
<td>6 (31.6%)</td>
<td>15 (51.7%)</td>
</tr>
<tr>
<td>Housing Difficulties</td>
<td>19 (39.6%)</td>
<td>5 (26.3%)</td>
<td>5 (17.2%)</td>
</tr>
<tr>
<td>Missing Housing Difficulties</td>
<td>20 (41.7%)</td>
<td>0 (0%)</td>
<td>20 (69.0%)</td>
</tr>
<tr>
<td>Mental Health Difficulties</td>
<td>20 (41.7%)</td>
<td>8 (42.1%)</td>
<td>12 (41.4%)</td>
</tr>
<tr>
<td>Missing Mental Health Difficulties</td>
<td>20 (41.7%)</td>
<td>5 (26.3%)</td>
<td>15 (51.7%)</td>
</tr>
</tbody>
</table>

¹ There were no statistically significant differences across the contact and not contacted group.

* There was a statistically higher proportion of missing information about housing difficulties for SUs not contacted by Case Managers, χ²(1) = 20.61, p < .001

Analysis examining the links between needs and previous offences among the 48 Drive Service Users

Fisher’s Exact tests were run to see if complex needs were associated with previous offences. There was not a statistically significant association between complex needs and previous non-DVA offences, p > .05. There was a trend pointing towards a statistically significant association between complex needs and previous DVA offences, p = .057.

The findings suggested SUs who had complex needs were more likely to have previous DVA offences but were not more likely have previous non-DVA offences.
Appendix 3: Quantitative analyses

Quantitative rationales for analyses

Quantitative analyses were conducted for three research questions. The quantitative approach for each research question for the Year 1 report is below.

1) What is the profile of the perpetrators worked with?
There were two databases analysed to answer this question. The first was the Core dataset, which had biographical information about perpetrators and associated V/Ss who were randomly allocated to either the control group or the Drive intervention group. Descriptive statistics (e.g. mean, median, minimum, etc.) were used to summarise information about perpetrators and associated V/Ss in the control group and in the Drive group. There are additional analyses that could be run to compare the control and Drive groups on information such as the perpetrator’s age, in order to see if randomisation was achieved. However, such statistical tests comparing biographical information in a RCT design “is superfluous and can mislead investigators and their readers” (CONSORT 2010).

The potential to mislead investigators and readers can be found in understanding when a statistical test is considered to be significant. When a test is run, an alpha value is generated that gives the probability the test result occurred by chance. The usual standard is to set alpha at 5% so if the alpha value generated by the test was less than 5%, the test result would be considered to be statistically significant. In other words, it would be considered that the test result did not occur by chance. It is still possible, though, the statistically significant test result did occur by chance, a 5% chance to be precise. If fact, one out of 20 statistical results would produce such a result. Then, we would expect comparisons of baseline information to produce statistically significant results, due to the nature of statistical tests, not the process of randomisation. Put more succinctly, “performing a significance test to compare baseline variables is to assess the probability of something having occurred by chance when we know that it did occur by chance” (Altman, 1985). A methods paper should inform readers if randomisation occurred properly. The evaluation team is in the process of writing up a methods paper that will be peer reviewed.

The second database used to answer this research question was the one containing the known completed SU cases in Year 1. This database was used in addition to the Core dataset because of the large amount of missing information in the Core dataset. By reading the case notes of the 48 known completed cases, we could reduce the amount of missing information and provide more biographical information about the perpetrators. As we were trying to capture a snapshot of the biographical information of SUs had completed, descriptive statistics were used.

2) How have the perpetrators changed their behaviour?
The overall approach to answering this question was to take a repeated measures approach, in which DVA is assessed at two points in time. The points in time were intake and exit. Two sources of data (CMS and Insights) were used to see how perpetrators have changed their DVA behaviour from intake to exit. There was information in the CMS for 48 known completed cases and there was information in Insights for 204 Control V/Ss and 19 Drive V/Ss. The specific quantitative approach to analysing the CMS data is described first followed by the specific quantitative approach used to analyse the Insights data.

CMS data for 48 cases
DVA behaviours were recorded by the Drive Project as four types: physical, sexual, harassment and stalking (H&S), and jealousy and coercion (J&C). The Drive Project could record yes, a SU used that type of DVA behaviour or no, a SU did not used that type of DVA.
If the Drive Project indicated a SU used a type of DVA, then they would note the levels of severity they deemed to be in evidence: none, standard, moderate, and high. Definitions of the type and severity of DVA behaviours were created by the Drive Project.

Three analyses were conducted to look at how SUs’ use of DVA behaviours have changed from intake to exit. The available statistics for these analyses were limited by the small sample size and the nominal nature of the data.

For the first analysis, we wanted to compare the proportion of SUs who used each type of DVA with the proportion who used each type at exit, e.g. proportion using physical at intake compared to proportion using physical at exit. This approach was chosen because the DVA information recorded by the Drive Project was nominal (yes, no). Other approaches could have been taken up if DVA behaviours were recorded as continuous, e.g. paired samples t-test, or if the sample size was larger and there was less missing information, e.g. multi-level regression modelling.

Proportions were calculated by summing the numbers of yes responses and then dividing the sum by the number cases where information was known. Once the proportions were calculated McNemar’s tests were run, as it can be used to compare the proportion of SUs who used each type at intake with the proportion of SUs who used each type at exit. (This test also shows how many SUs who used a type of DVA behaviour at intake but not at exit.)

The first analysis provided an overall picture of changes in types of DVA behaviour over the course of the Drive intervention but it did not clarify if and how there were changes in severity of types of DVA used. The second analysis focused on the changes in severity. As a first step, tables were created that showed the severity used at intake and exit. See Table 1 below for an example. This table was taken from SU Analysis 2, which is below.

**Table 1. Severity of physical DVA SUs used at intake and exit**

<table>
<thead>
<tr>
<th>Severity of Physical at End of Drive</th>
<th>No Physical</th>
<th>Standard</th>
<th>Moderate</th>
<th>High</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Physical</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Standard</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Moderate</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>High</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>16</td>
<td>22</td>
</tr>
<tr>
<td>Total</td>
<td>12</td>
<td>1</td>
<td>3</td>
<td>18</td>
<td>34</td>
</tr>
</tbody>
</table>

The rows in the table show the number of SUs who used each severity level at intake. For example, a total of 6 SUs used no physical DVA at intake, a total of 1 used a standard level, a total of 5 used a moderate level, and a total of 22 used a high level. The columns show the number of SUs who used each severity at exit: a total of 12 used no physical DVA, 1 used a standard level, 3 used moderate, and 18 used a high level.

From the tables further calculations can be done, such as the proportion of SUs who used each severity level at intake and exit. For example, 6 out of 34 SUs (17.6%) did not use physical DVA at intake and 12 out of 34 SUs (35.3%) did not use physical DVA at exit. (There wasn’t any information for 14 SUs.) This information can then be used to determine the percent change. The increase from 6 to 12 SUs in this example would be a 100% increase in the number of SUs who did not use physical DVA. These calculations were done for every level of severity for each type of DVA and presented in Figure 2a and Figure 2b in the main report.
The tables also allowed the reader to easily see if and how many SUs increased the severity. In Table 1 above, we can see that there were 2 SUs who increased the severity of physical DVA they used (2 SUs used a moderate level at intake and a high level at exit). This information could be presented as 2 out of 34 or 5.9% increased the severity used whereas the remaining SUs showed no change in severity or decreased their severity.

The third analysis emerged from the qualitative analysis of interviews with Service Users and Case Manager case notes. The findings provided positive indicators that Case Managers’ behavioural change work with SUs reduced SUs’ use of DVA. This qualitative finding was explored quantitatively by grouping the 48 cases according to whether the Case Manager recorded doing behavioural change work with them. Then the first and second analyses were run for each group.

**Insights**

The first two analyses used for the CMS 48 closed cases were followed twice to investigate the Insights data, once for the control group of V/Ss and once for the Drive group of V/Ss. These analyses were repeated twice for the Insights data because of the small sample size of Drive V/Ss. If the sample size is large enough, in Year 2 we will undertake multi-level regression modelling which allow us to compare control V/Ss and Drive V/Ss while taking into account information such as, length and nature of DVA support, location, and prior history of DVA.

3) Are adult victims and children living in households where domestic abuse is present any safer?

Two sources (CMS and Insights) were used to examine if V/Ss and children were safer.

**CMS data for 48 cases**

Descriptive statistics were used to summarise Case Managers’ assessments of changes in risk posed by SUs to V/Ss and children. Descriptive statistics were used because the data was taken at one point in time and there was a small sample size. With a higher number of closed cases, it may be possible to examine relationships between DVA behaviour changes and changes in risk posed to V/Ss and children.

**Insights**

Descriptive statistics were used to illustrate Idvas’ assessments of risk posed to V/S (and children if present), sustainability of reductions in risk, and changes in safety. Descriptive statistics were used because the data was taken at a point in time and the sample size of Drive V/Ss was small. With a larger number of Drive V/Ss with exit information, it may be possible to statistically compare control and Drive Idvas’ assessments of risk posed to V/Ss in a way that takes into account data such as Marac repeat referrals.

**Findings on SUs’ DVA behaviour**

**SU Analysis 1: proportions of SUs using DVA behaviours at intake and exit**

At intake, 6 SUs did not use physical DVA (17.1%) and 29 did (82.9%). At exit the number of SUs who did not use physical DVA increased to 12 (34.36%) with a concomitant decrease in numbers who used physical DVA to 23 (65.7%). This change was a consequence of 6 SUS who used physical DVA at intake but not at exit. An exact McNemar’s test determined that the difference in the proportion of SUs using physical DVA at intake and exit was statistically significant, \( p = .031 \).
At intake, 22 SUs did not use sexual DVA (75.9%) and 7 did (24.1%). At exit the number of SUs who did not use sexual DVA increased to 24 (82.6%) with a concomitant decrease in numbers who used sexual DVA to 5 (17.2%). This change was a consequence of 3 SUS who used sexual DVA at intake but not at exit and one SU who did not use sexual DVA at intake but did at exit. An exact McNemar’s test determined that the difference in the proportion of SUs using sexual DVA at intake and exit was not statistically significant, $p = .625$.

At intake, 13 SUs did not use harassment and stalking (43.3%) and 17 did (56.7%). At exit the number of SUs who did not harass and stalk increased to 17 (56.7%) with a concomitant decrease in numbers who did harass and stalk to 13 (43.3%). This change was a consequence of 7 SUS who harassed and stalked at intake but not at exit and 3 SUs who did not harass and stalk at intake but did at exit. An exact McNemar’s test determined that the difference in the proportion of SUs who harassed and stalked at intake and exit was not statistically significant, $p = .344$.

At intake, 12 SUs did not use jealousy and coercion (44.4%) and 15 did (55.6%). At exit the number of SUs who did not use jealousy and coercion increased to 14 (51.9%) with a concomitant decrease in numbers who did use jealousy and coercion to 13 (48.1%). This change was a consequence of 2 SUS who used jealousy and coercion at intake but not at exit. An exact McNemar’s test determined that the difference in the proportion of SUs harassed and stalked at intake and exit was not statistically significant, $p = .500$.

**SU Analysis 2: severity of types of DVA SUs used at intake and exit**

The tables below describe how many SUs used each level of severity (none, standard, moderate, and high) for each type of DVA. For example, there were 6 SUs who did not use physical DVA at intake and this number rose to 12 at exit. The increase was due to 6 SUs who reduced the severity from high at intake to none at exit.

The frequencies presented in Tables 1 through 4 were used to calculate the percent changes, which is presented in Figure 2a and Figure 2b in the body of the main report. For example, the increase in SUs who did not use physical DVA from 6 to 12 was calculated as a 100% increase. When considering all of the percent changes shown in Figure 2, the findings suggested there was an increase from the beginning to the end of Drive in the number of SUs who did not use each type of DVA and there was a decrease in the number of SUs who used moderate and high levels of physical, sexual, and H&S.

The extent of the percent change was limited due to some SUs increasing the severity from the beginning to the end of Drive. The instances where this occurred are marked in Tables 2 through 4 as highlighted cells. There was a total of 7 instances, which corresponded to 3 SUs, all of whom were from Site 1. (There was no corresponding V/Ss data for these 3 SUs.)

**Table 1. Severity of physical DVA SUs used at intake and exit**

<table>
<thead>
<tr>
<th>Severity of Physical at Beginning of Drive</th>
<th>Severity of Physical at End of Drive</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Physical</td>
<td>No Physical</td>
</tr>
<tr>
<td>Standard</td>
<td>6</td>
</tr>
<tr>
<td>Moderate</td>
<td>0</td>
</tr>
<tr>
<td>High</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>12</td>
</tr>
</tbody>
</table>

63
Table 2. Severity of sexual DVA SUs used at intake and exit

<table>
<thead>
<tr>
<th>Severity of Sexual at End of Drive</th>
<th>No Sexual</th>
<th>Standard</th>
<th>Moderate</th>
<th>High</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severity of Sexual at Beginning of Drive</td>
<td>No Sexual</td>
<td>21</td>
<td>0</td>
<td>0</td>
<td>22</td>
</tr>
<tr>
<td></td>
<td>Standard</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Moderate</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>High</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>24</td>
<td>0</td>
<td>2</td>
<td>3</td>
<td>29</td>
</tr>
</tbody>
</table>

Table 3. Severity of H&S SUs used at intake and exit

<table>
<thead>
<tr>
<th>Severity of H&amp;S at End of Drive</th>
<th>No H&amp;S</th>
<th>Standard</th>
<th>Moderate</th>
<th>High</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severity of H&amp;S at Beginning of Drive</td>
<td>No H&amp;S</td>
<td>9</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Standard</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Moderate</td>
<td>3</td>
<td>0</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>High</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Total</td>
<td>15</td>
<td>0</td>
<td>4</td>
<td>9</td>
<td>28</td>
</tr>
</tbody>
</table>

Table 4. Severity of J&C SUs used at intake and exit

<table>
<thead>
<tr>
<th>Severity of J&amp;C at End of Drive</th>
<th>No J&amp;C</th>
<th>Standard</th>
<th>Moderate</th>
<th>High</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severity of J&amp;C at Beginning of Drive</td>
<td>No J&amp;C</td>
<td>11</td>
<td>0</td>
<td>0</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>Standard</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Moderate</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>High</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>Total</td>
<td>12</td>
<td>0</td>
<td>3</td>
<td>9</td>
<td>24</td>
</tr>
</tbody>
</table>

SU Analysis 3: DVA behaviours used by SUs who did and SUs who did NOT do behaviour change work

Case managers did behavioural change work with 11 SUs. This was 22.9% of the total group of 48 SUs and 57.9% of the group of SUs with whom Case Managers had contact.

The third analysis consisted of analysing the behaviour changes within two groups: SUs with whom Case Managers did behaviour change work and SUs with whom Case Managers did NOT do behaviour change work. For each group, two analyses were conducted. The first analysis looked at the proportions of SUs using DVA behaviours and the second looked at the severity of DVA behaviours used at intake and exit.

When comparing the two groups, two overall trends can be seen. First, there was a greater reduction in the use of each type of DVA amongst SUs who did behavioural change work. (See Analysis 3A.) Second, amongst SUs who did behavioural change work the severity of each type of DVA stayed the same whereas amongst SUs who did NOT do behavioural change work the severity increased. (See Analysis 3B.)

Analysis 3A

SUs who DID behaviour change work
At intake, 1 SU did not use physical DVA (11.1%) and 8 did (89.1%). At exit the number of SUs who did not use physical DVA increased to 4 (44.4%) with a concomitant decrease in numbers who used physical DVA to 5 (55.6%). This change was a consequence of 3 SUs who used physical DVA at intake but not at exit. An exact McNemar’s test determined that the difference in the proportion of SUs using physical DVA at intake and exit was not statistically significant, \( p = .250 \).

At intake, 7 SUs did not use sexual DVA (70.0%) and 3 did (30.0%). At exit the number of SUs who did not use sexual DVA increased to 8 (80.0%) with a concomitant decrease in numbers who used sexual DVA to 2 (20.0%). This change was a consequence of 1 SU who used sexual DVA at intake but not at exit. An exact McNemar’s test determined that the difference in the proportion of SUs using sexual DVA at intake and exit was not statistically significant, \( p = 1.000 \).

At intake, 4 SUs did not use harassment and stalking (50.0%) and 4 did (50.0%). At exit the number of SUs who did not harass and stalk increased to 6 (75.0%) with a concomitant decrease in numbers who did harass and stalk to 2 (25.0%). This change was a consequence of 2 SUs who harassed and stalked at intake but not at exit. An exact McNemar’s test determined that the difference in the proportion of SUs who harassed and stalked at intake and exit was not statistically significant, \( p = .500 \).

At intake, 5 SUs did not use jealousy and coercion (71.4%) and 2 did (28.6%). At exit the number of SUs who did not and who did use jealousy and coercion was the same.

**SUs who did NOT do behaviour change work**

At intake, 5 SUs did not use physical DVA (19.2%) and 21 did (80.8%). At exit the number of SUs who did not use physical DVA increased to 8 (30.8%) with a concomitant decrease in numbers who used physical DVA to 18 (69.2%). This change was a consequence of 3 SUs who used physical DVA at intake but not at exit. An exact McNemar’s test determined that the difference in the proportion of SUs using physical DVA at intake and exit was not statistically significant, \( p = .250 \).

At intake, 15 SUs did not use sexual DVA (78.9%) and 4 did (21.1%). At exit the number of SUs who did not use sexual DVA increased to 16 (84.2%) with a concomitant decrease in numbers who used sexual DVA to 3 (15.8%). This change was a consequence of 2 SUs who used sexual DVA at intake but not at exit and one SU who did not use sexual DVA at intake but did at exit. An exact McNemar’s test determined that the difference in the proportion of SUs using sexual DVA at intake and exit was not statistically significant, \( p = 1.000 \).

At intake, 9 SUs did not use harassment and stalking (40.9%) and 13 did (59.1%). At exit the number of SUs who did not harass and stalk increased to 11 (50.0%) with a concomitant decrease in numbers who did harass and stalk to 11 (50.0%). This change was a consequence of 5 SUs who harassed and stalked at intake but not at exit and 3 SUs who did not harass and stalk at intake but did at exit. An exact McNemar’s test determined that the difference in the proportion of SUs who harassed and stalked at intake and exit was not statistically significant, \( p = .727 \).

At intake, 7 SUs did not use jealousy and coercion (35%) and 13 did (65%). At exit the number of SUs who did not use jealousy and coercion increased to 9 (45%) with a concomitant decrease in numbers who did use jealousy and coercion to 11 (55%). This change was a consequence of 2 SUs who used jealousy and coercion at intake but not at exit. An exact McNemar’s test determined that the difference in the proportion of SUs harassed and stalked at intake and exit was not statistically significant, \( p = .500 \).

65
Figure 1. Use of DVA behaviours by SUs who did NO behaviour change work

<table>
<thead>
<tr>
<th>% of SUs who did NO behaviour change work</th>
<th>Intake</th>
<th>Exit</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHYSICAL</td>
<td>80.6%</td>
<td>69%</td>
</tr>
<tr>
<td>SEXUAL</td>
<td>22.7%</td>
<td>17.4%</td>
</tr>
<tr>
<td>H&amp;S</td>
<td>57.1%</td>
<td>48%</td>
</tr>
<tr>
<td>J&amp;C</td>
<td>65.4%</td>
<td>52.2%</td>
</tr>
</tbody>
</table>

Analysis 3B

SUs who DID behaviour change work

The frequencies presented in Tables 5 through 8 were used to calculate the percent changes displayed in Figure 4. The results shown in Figure 4 suggested that amongst SUs who did behavioural change work with Case Managers, there was an increase in SUs who did not use physical, sexual, and H&S and there was a decrease in the numbers of SUs who used moderate levels of sexual and H&S, and high levels of physical. The number of SUs who used J&C did not change from intake to exit.

Perhaps most importantly, the frequencies presented in Tables 5 through 8 highlighted the severity of DVA used by SUs who did behaviour work stayed the same overall (and decreased for some types of DVA).
Figure 2. Changes in severity of DVA behaviours by SUs who did behaviour change work

Table 5. Severity of physical DVA used at intake and exit by SUs who did behaviour change work

<table>
<thead>
<tr>
<th>Severity of Physical at End of Drive</th>
<th>No Physical</th>
<th>Standard</th>
<th>Moderate</th>
<th>High</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severity of Physical at Beginning of Drive</td>
<td>No Physical</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Standard</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Moderate</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>High</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>4</td>
<td>0</td>
<td>1</td>
<td>4</td>
<td>9</td>
</tr>
</tbody>
</table>

Table 6. Severity of sexual DVA used at intake and exit by SUs who did behaviour change work

<table>
<thead>
<tr>
<th>Severity of Sexual at End of Drive</th>
<th>No Sexual</th>
<th>Standard</th>
<th>Moderate</th>
<th>High</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severity of Sexual at Beginning of Drive</td>
<td>No Sexual</td>
<td>7</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Standard</td>
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<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Moderate</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
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<td>High</td>
<td>0</td>
<td>0</td>
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<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>8</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>10</td>
</tr>
</tbody>
</table>
Table 7. Severity of H&S used at intake and exit by SUs who did behaviour change work

<table>
<thead>
<tr>
<th>Severity of H&amp;S at Beginning of Drive</th>
<th>No H&amp;S</th>
<th>Standard</th>
<th>Moderate</th>
<th>High</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>No H&amp;S</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Standard</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Moderate</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>High</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>6</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>8</td>
</tr>
</tbody>
</table>

Table 8. Severity of J&C used at intake and exit by SUs who did behaviour change work

<table>
<thead>
<tr>
<th>Severity of J&amp;C at Beginning of Drive</th>
<th>No J&amp;C</th>
<th>Standard</th>
<th>Moderate</th>
<th>High</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>No J&amp;C</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Standard</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Moderate</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>High</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
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<td>Total</td>
<td>5</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>7</td>
</tr>
</tbody>
</table>

SUs who did NOT do behaviour change work

The frequencies presented in Tables 9 through 13 were used to calculate the percent changes displayed in Figure 6. The results shown in Figure 6 suggested that amongst SUs who did NOT do behavioural change work with Case Managers, there was an increase in SUs who did not each type of DVA and there was a decrease in the numbers of SUs who used standard levels of J&C, moderate levels of physical and sexual, and high levels of physical and H&S.

The frequencies presented in Tables 9 through 13 indicated there were 7 instances in which the severity of DVA behaviours increased. These 7 instances corresponded to 3 SUs who were all based in Site 1.
Figure 3. Change in severity of DVA behaviours by SUs who did NOT do behaviour change work

Table 9. Severity of physical DVA used at intake and exit by SUs who did NOT do behaviour change work

<table>
<thead>
<tr>
<th>Severity of Physical at Beginning of Drive</th>
<th>Severity of Physical at End of Drive</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Physical</td>
<td>No Physical</td>
</tr>
<tr>
<td>Standard</td>
<td>Standard</td>
</tr>
<tr>
<td>Moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td>High</td>
<td>High</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Severity of Physical at Beginning of Drive</th>
<th>No Physical</th>
<th>Standard</th>
<th>Moderate</th>
<th>High</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>60%</td>
<td>0%</td>
<td>-50%</td>
<td>-7%</td>
<td>5</td>
</tr>
<tr>
<td>Standard</td>
<td>7%</td>
<td>0%</td>
<td>-50%</td>
<td>0%</td>
<td>1</td>
</tr>
<tr>
<td>Moderate</td>
<td>13%</td>
<td>0%</td>
<td>0%</td>
<td>-11%</td>
<td>4</td>
</tr>
<tr>
<td>High</td>
<td>17%</td>
<td>-100%</td>
<td>0%</td>
<td>0%</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>8</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>15</td>
</tr>
</tbody>
</table>

Table 10. Severity of sexual DVA used at intake and exit by SUs who did NOT do behaviour change work

<table>
<thead>
<tr>
<th>Severity of Sexual at Beginning of Drive</th>
<th>Severity of Sexual at End of Drive</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Sexual</td>
<td>No Sexual</td>
</tr>
<tr>
<td>Standard</td>
<td>Standard</td>
</tr>
<tr>
<td>Moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td>High</td>
<td>High</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Severity of Sexual at Beginning of Drive</th>
<th>No Sexual</th>
<th>Standard</th>
<th>Moderate</th>
<th>High</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>14</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>15</td>
</tr>
<tr>
<td>Standard</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Moderate</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>High</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>16</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>19</td>
</tr>
</tbody>
</table>
Corroborative findings from V/Ss regarding Drive SU DVA behaviour

**V/S Analysis 1: proportion of V/Ss experiencing DVA at intake and exit**

McNemar’s tests were run to compare the proportions of V/S who experienced each type of DVA at intake with the proportions at exit. The details of the tests run for the control cohort are presented first followed by the Drive cohort. In brief, the findings indicated for the control cohort, there was a significant reduction in the proportion of V/Ss who experienced physical, sexual, H&S, and J&C at exit and for the Drive cohort, there was a significant reduction in the proportion of V/Ss who experienced physical, H&S, and J&C but not sexual DVA.

**V/Ss associated with perpetrators in the control cohort**

At intake, 45 V/Ss did not experience physical DVA (20.5%) and 159 did (79.5%). At exit the number of V/Ss who did not experience physical DVA increased to 172 (84.3%) with a concomitant decrease in numbers who experienced physical DVA to 32 (15.7%). This change was a consequence of 127 V/Ss who experienced physical DVA at intake but not at exit. A McNemar’s test with continuity correction (Edwards, 1948) was run to determine if there was a difference in the proportions at intake and exit. The proportion of experiencing physical DVA decreased from .795 to .157, a statistically significant difference, $\chi^2(204) = 125.01, p < .001$

At intake, 156 V/Ss (76.5%) did not experience sexual DVA and 48 did (23.5%). At exit the number of V/Ss who did not experience sexual DVA increased to 194 (95.1%) with a concomitant decrease in numbers who experienced sexual DVA to 10 (4.9%). This change was a consequence of 42 V/Ss who experienced sexual DVA at intake but not at exit. A McNemar’s test with continuity correction (Edwards, 1948) was run to determine if there was a difference in the proportions at intake and exit. The proportion of experiencing sexual DVA decreased from .235 to .049, a statistically significant difference, $\chi^2(204) = 29.76, p < .001$
At intake, 74 V/Ss (36.8%) did not experience H&S and 127 did (63.2%). At exit the number of V/Ss who did not experience H&S increased to 163 (81.1%) with a concomitant decrease in numbers who experienced H&S to 38 (18.9%). This change was a consequence of 95 V/Ss who experienced H&S at intake but not at exit. A McNemar’s test with continuity correction (Edwards, 1948) was run to determine if there was a difference in the proportions at intake and exit. The proportion of experiencing H&S decreased from .632 to .189, a statistically significant difference, $\chi^2(201) = 76.67, p < .001$

At intake, 33 V/Ss (16.2%) did not experience J&C and 171 did (83.8%). At exit the number of V/Ss who did not experience J&C increased to 164 (80.4%) with a concomitant decrease in numbers who experienced J&C to 40 (19.6%). This change was a consequence of 135 V/Ss who experienced sexual DVA at intake but not at exit. A McNemar’s test with continuity correction (Edwards, 1948) was run to determine if there was a difference in the proportions at intake and exit. The proportion of experiencing J&C decreased from .838 to .196, a statistically significant difference, $\chi^2(204) = 123.36, p < .001$

V/Ss associated with perpetrators in the Drive cohort

At intake, 4 V/Ss did not experience physical DVA (21.1%) and 15 did (79.9%). At exit the number of V/Ss who did not experience physical DVA increased to 17 (89.5%) with a concomitant decrease in numbers who experienced physical DVA to 2 (10.5%). This change was a consequence of 14 V/Ss who experienced physical DVA at intake but not at exit. An exact McNemar’s test was run to determine if there was a difference in the proportions at intake and exit. The proportion experiencing physical DVA decreased from .799 to .105, a statistically significant difference, $p = .001$

At intake, 15 V/Ss (83.3%) did not experience sexual DVA and 3 did (16.7%). At exit the number of V/Ss who did not experience sexual DVA increased to 18 (100%) with a concomitant decrease in numbers who experienced sexual DVA to 0 (0%). This change was a consequence of 3 V/Ss who experienced sexual DVA at intake but not at exit. An exact McNemar’s test was run to determine if there was a difference in the proportions at intake and exit. The proportion of experiencing sexual DVA decreased from .167 to .000 but this difference was not statistically significant difference, $p > .05$

At intake, 5 V/Ss (27.8%) did not experience H&S and 13 did (62.2%). At exit the number of V/Ss who did not experience H&S increased to 14 (77.8%) with a concomitant decrease in numbers who experienced H&S to 4 (12.2%). This change was a consequence of 9 V/Ss who experienced H&S at intake but not at exit. An exact McNemar’s test was run to determine if there was a difference in the proportions at intake and exit. The proportion of experiencing H&S decreased from .622 to .122, a statistically significant difference, $p < .001$

At intake, 3 V/Ss (15.8%) did not J&C and 16 did (84.2%). At exit the number of V/Ss who did not experience J&C increased to 15 (78.9%) with a concomitant decrease in numbers who experienced J&C to 4 (21.1%). This change was a consequence of 12 V/S who experienced sexual DVA at intake but not at exit. An exact McNemar’s test was run to determine if there was a difference in the proportions at intake and exit. The proportion of experiencing J&C decreased from .842 to .211, a statistically significant difference, $p < .001$

V/S Analysis 2: severity of DVA V/Ss experienced at intake and exit

The tables below describe how many V/Ss experienced each type of DVA at different levels of severity (none, standard, moderate, and high). For example, amongst the control group there were 45 V/Ss who did not experience physical DVA at intake. This number rose to 172 at exit. The increase was due to 105 V/Ss who experienced a high severity at intake but none
at exit, 14 V/Ss who experienced moderate severity at intake but none at exit, and 8 V/Ss who experienced a standard severity at intake but none at exit.

The total numbers of V/Ss experiencing each level of severity at intake and exit were used to calculate the percent changes, which is presented in Figure 2 for the control group and Figure 3 for the Drive group. The findings for both groups suggested there was an increase in the number of V/Ss who did not experience each type of DVA and there was a decrease in the number of V/Ss who experienced high levels of each type of DVA. For both groups, there was an increase in V/Ss who experienced standard levels of physical DVA and J&C and there was no change in V/Ss who experienced standard levels of H&S. For control V/Ss there was a decrease in V/Ss who experienced standard levels of sexual DVA whereas there was no change for V/Ss in the Drive group. There was no change in the number of V/Ss who experienced standard levels of H&S. For both groups, there was a decrease in the V/Ss who experienced moderate levels of physical DVA, sexual DVA, and J&C. For the control group, there was a decrease in the V/Ss who experienced moderate levels of H&S whereas there was no change in the V/Ss in Drive group who experienced moderate levels of H&S.

Of note was 7 of the V/Ss in the control group experienced an increase in severity whereas only 1 V/S in the Drive group experienced an increase in severity.

V/Ss associated with perpetrators in the control cohort

Of note were three instances that limited the extent of the percentage change. The first occurred when looking at those V/Ss not experiencing H&S. There was 25% increase of V/Ss not experiencing H&S at exit. The increase could have been larger (50% instead of 25%), if not for 3 V/Ss who experienced no H&S at intake but experienced moderate or high levels at exit. The second occurred when looking at those V/Ss experiencing no J&C. There was an increase of 397%. This change could have been an increase of 406% but three V/Ss s who experienced no J&C at intake experienced moderate or high levels at exit. The last instance occurred when looking at high levels of J&C. There was a decrease of 87%, which could have been 90% if not for two V/Ss who experienced moderate levels at intake experiencing high levels at exit.

Another way to consider this information is to look at the number of V/Ss cases where the severity increased. There was a total of 8 instance of V/Ss in the control group where the severity increased. The 8 instances corresponded to 7 V/Ss, 4 of whom were based in Site 2, 2 in Site 1 and 1 in Site 3.

<table>
<thead>
<tr>
<th>Severity of Physical at End of Drive</th>
<th>Severity of Physical at Beginning of Drive</th>
<th>No Physical</th>
<th>Standard</th>
<th>Moderate</th>
<th>High</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severity of Physical at End of Drive</td>
<td>No Physical</td>
<td>45</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>45</td>
</tr>
<tr>
<td>Standard</td>
<td>8</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Moderate</td>
<td>14</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>14</td>
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<td>High</td>
<td>105</td>
<td>9</td>
<td>6</td>
<td>16</td>
<td>136</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>172</td>
<td>10</td>
<td>6</td>
<td>16</td>
<td>204</td>
<td></td>
</tr>
</tbody>
</table>

Table 13. Severity of physical DVA experienced by control V/Ss

<table>
<thead>
<tr>
<th>Severity of Sexual at End of Drive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severity of Sexual at End of Drive</td>
</tr>
</tbody>
</table>
Table 15. Severity of H&S experienced by control V/Ss

<table>
<thead>
<tr>
<th>Severity of H&amp;S at End of Drive</th>
<th>No H&amp;S</th>
<th>Standard</th>
<th>Moderate</th>
<th>High</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severity of H&amp;S at Beginning of Drive</td>
<td>No H&amp;S</td>
<td>9</td>
<td>0</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Standard</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Moderate</td>
<td>3</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>High</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>7</td>
<td>10</td>
</tr>
<tr>
<td>Total</td>
<td>15</td>
<td>0</td>
<td>5</td>
<td>8</td>
<td>201</td>
</tr>
</tbody>
</table>

V/Ss associated with perpetrators in the Drive cohort

There was one instance in which the extent of the percentage change was limited. This occurred when looking at the V/Ss who experienced standard levels of physical DVA. There was an increase of 100%, which was due to one V/S who experienced none at intake but standard levels at exit. If not for this one V/S the percent change could have been 0. (This victim/survivor was located in Site 1.)

Table 17. Severity of physical DVA experienced by Drive V/Ss

<table>
<thead>
<tr>
<th>Severity of Physical at End of Drive</th>
<th>No Physical</th>
<th>Standard</th>
<th>Moderate</th>
<th>High</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severity of Physical at Beginning of Drive</td>
<td>No Physical</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Standard</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Moderate</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>High</td>
<td>12</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>13</td>
</tr>
<tr>
<td>Total</td>
<td>17</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>19</td>
</tr>
</tbody>
</table>

Table 16. Severity of J&C experienced by control V/Ss

<table>
<thead>
<tr>
<th>Severity of J&amp;C at End of Drive</th>
<th>No J&amp;C</th>
<th>Standard</th>
<th>Moderate</th>
<th>High</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severity of J&amp;C at Beginning of Drive</td>
<td>No J&amp;C</td>
<td>30</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Standard</td>
<td>6</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>Moderate</td>
<td>31</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>36</td>
</tr>
<tr>
<td>High</td>
<td>97</td>
<td>11</td>
<td>5</td>
<td>12</td>
<td>125</td>
</tr>
<tr>
<td>Total</td>
<td>164</td>
<td>19</td>
<td>7</td>
<td>14</td>
<td>204</td>
</tr>
</tbody>
</table>

Table 18. Severity of Sexual DVA experienced by Drive V/Ss

<table>
<thead>
<tr>
<th>Severity of Sexual at End of Drive</th>
<th>No Sexual</th>
<th>Standard</th>
<th>Moderate</th>
<th>High</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severity of Sexual at Beginning of Drive</td>
<td>No Sexual</td>
<td>15</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Standard</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Moderate</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>High</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>18</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>18</td>
</tr>
</tbody>
</table>
Table 19. Severity of H&S experienced by Drive V/Ss

<table>
<thead>
<tr>
<th>Severity of H&amp;S at End of Drive</th>
<th>No H&amp;S</th>
<th>Standard</th>
<th>Moderate</th>
<th>High</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severity of H&amp;S at Beginning of Drive</td>
<td>No H&amp;S</td>
<td>Standard</td>
<td>Moderate</td>
<td>High</td>
<td>Total</td>
</tr>
<tr>
<td>No H&amp;S</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Standard</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Moderate</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>High</td>
<td>6</td>
<td>0</td>
<td>3</td>
<td>1</td>
<td>10</td>
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<td>Total</td>
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<td>3</td>
<td>1</td>
<td>18</td>
</tr>
</tbody>
</table>

Table 20. Severity of J&C experienced by Drive V/Ss

<table>
<thead>
<tr>
<th>Severity of J&amp;C at End of Drive</th>
<th>No J&amp;C</th>
<th>Standard</th>
<th>Moderate</th>
<th>High</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severity of J&amp;C at Beginning of Drive</td>
<td>No J&amp;C</td>
<td>Standard</td>
<td>Moderate</td>
<td>High</td>
<td>Total</td>
</tr>
<tr>
<td>No J&amp;C</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Standard</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Moderate</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>High</td>
<td>10</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>13</td>
</tr>
<tr>
<td>Total</td>
<td>15</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>19</td>
</tr>
</tbody>
</table>

Additional findings from Insights database about Idvas’ support of and interventions with V/Ss

Following the writing of the Year 1 report, additional analyses were carried out comparing Drive Idvas and control Idvas on length of support provided, number of contacts with V/Ss, and the interventions delivered. Data for each of these comparisons was taken from the Insights exit form. There was data for 19 Drive V/Ss and 204 Control V/Ss.

The results of the analyses could be summarised as the length of support provided by control and Drive Idvas was similar and the number of contacts control and Drive Idvas had with V/Ss was similar. Additionally, the results showed support with immigration was the only intervention in which a higher proportion of Drive V/Ss received this support in comparison to proportion of control V/Ss. For all other interventions, similar proportions of Drive and control V/S received each type.

Discussions with Idvas suggest that Idvas are doing more sustained (and perhaps intensive) work on Drive (as opposed to non-Drive) cases where VS engagement is possible, but also that there are many Drive cases where there was very little to no contact with the VS. Due to the limited amount of data about Drive V/Ss for Year 1, it is not possible to statistically examine Idvas suggestions. However, we would like to look further into their suggestions in Year 2 if there is sufficient data.

Length of support
The length of support variable was calculated by summing the number of days from the intake date to the exit date. (Idvas recorded these dates.) Descriptive statistics showed that the average number of days of support provided by Idvas was 97.3 (SD = 71.5, Median = 82) and by Drive Idvas was 150.6 (SD = 115.2, Median = 184.0).

The initial statistical test chosen to compare control and Drive Idvas on the length of time they provided support was an independent samples t-test. Before running this test, the data was checked to see if the six assumptions of independent samples t-test were met. The first three
assumptions are: a continuous dependent variable (i.e. length of support); independent variable has two groups (Drive and control); independence of observation (each V/S length of support is independent of other V/S). These assumptions were met.

The next assumption is the data must be normally distributed and this can be tested with the Shapiro Wilk test. The Shapiro Wilk test showed length of support was not normally distributed for the control group, \( p < .001 \). The data could have been transformed if the shape of the distribution for the control group and Drive group was similar but they were not. The non-parametric Independent Samples Mann Whitney U test was run, as the data met the assumptions of the test.

The first three assumptions of the Mann Whitney U test are the same as the independent samples \( t \)-test. The fourth assumption is that the distribution of the data for the control group and the Drive group was similar. This assumption was not met so the Mann Whitney U test was used to compare the mean rank of the control group (116.19) and Drive group (144.92). The difference in these ranks was not statistically significant, \( U = 2563.5, z = 1.76, p = .079 \). In other words, the length of support provided by control and Drive Idvas was not statistically different.

**Number of contacts**

The process used to analyse the length of support was carried out to compare the control and Drive Idvas on the number of contacts they had with V/Ss. The initial statistical test chosen to compare control and Drive Idvas was an independent samples \( t \)-test. The first three assumptions of an independent \( t \)-test were met. The Shapiro Wilk test showed number of contacts was not normally distributed for the control group and Drive group, \( p < .001 \) and \( p < .001 \), respectively. The non-parametric Independent Samples Mann Whitney U test was run.

The first three assumptions of the Mann Whitney test (see description of assumptions above) were met. The fourth assumption was met so the Mann Whitney test was used to compare the median number of contacts by Idvas with control V/Ss (median = 9.0) and Drive V/Ss (10.0). The difference in the median number of contacts was not statistically significant, \( U = 2011.5, z = -.18, p = .861 \). Put another way, control and Drive Idvas contacted V/Ss a similar number of times.

**Interventions delivered**

The aim was to see if there were differences in the interventions delivered to control V/Ss and Drive V/Ss. Idvas could record on the Insights exit form yes, they delivered any of the following interventions or no they did not:
- Safety planning
- Marac
- Support with criminal court proceedings
- Liaison/support with probation
- Support with civil justice orders
- Support with housing
- Financial/ benefits: support and advice
- Support with immigration
- Health/wellbeing advice and support
- Support group with children and young people
- Honour based violence/ Forced marriage

As the information provided by Idvas on the exit form was binary, taken at only one point in time, and nominal, Chi-square tests of association were the best test to compare the interventions delivered by Drive and control Idvas. More specifically, chi-square tests of association were used to compare the proportion of Drive V/S who received each intervention with the proportion of control V/S who received the same intervention.
There are three assumptions for Chi-square tests. The first is the data is measured at the nominal level and the second is there is independence of observation. The first and second assumptions were met for each of interventions. The third assumption is the expected count is greater than 5. This assumption was met for the following interventions: liaise/support from police, support with the criminal court process, support with housing, support with children and young people. When the third assumption was not met, a Fischer’s Exact test was used. A Fischer’s Exact test was used to compare the following interventions: safety planning, Marac referral, liaise/support with probation, support with civil justice orders, financial/benefits support and advise, support with immigration, health/wellbeing advice and support, honour based violence/forced marriage. The results of the tests are below.

In brief, the results showed that support with immigration was the only intervention in which a statistically significant higher proportion of Drive V/S (2 out of 19 or 10.5%) received this support in comparison to proportion of control V/S (2 out of 219 or 0.9%). For all other interventions, similar proportions of Drive and control V/S received each type.

Details of results of analyses

Safety Planning: A Fischer’s Exact test showed there was not a statistically significant association between cohort groups (i.e. control group and Drive group) and receiving a safety planning intervention, \( p = .530 \).

Control: 96.4% of control received safety planning
Drive: 94.7% of Drive received safety planning

Marac: A Fischer’s Exact test showed there was not a statistically significant association between cohort groups (i.e. control group and Drive group) and ldva referral to Marac, \( p = .688 \).

Control: 45.2% of control referred to Marac
Drive: 47.4% of Drive referred to Marac

Liaise/support from police: A Chi-square test of association showed there was not a statistically significant association between cohort groups and receiving support from the police to put protective measures in place, \( p = .636 \).

Control: 58.4% of control liaised or received support from the police
Drive: 52.6% of Drive liaised or received support from the police

Support with the criminal court process: A Chi-square test of association showed there was not a statistically significant association between cohort groups and receiving support with the criminal court process, \( p = 1.000 \).

Control: 45.2% of control received support with the criminal court process
Drive: 52.6% of Drive received support with the criminal court process

Liaise/support with probation: A Fischer’s Exact test showed there was not a statistically significant association between cohort groups and receiving support with probation, \( p = .483 \).

Control: 12.7% of control liaised or received support from the probation
Drive: 5.3% of Drive liaised or received support from the probation

Support with civil justice orders: A Fischer’s Exact test showed there was not a statistically significant association between cohort groups and receiving support with civil justice orders, \( p = .758 \).
Control: 18.1% of control received support with the civil justice orders
Drive: 21.1% of Drive received support with the civil justice orders

Support with housing: A Chi-square test of association showed there was not a statistically significant association between cohort groups and receiving support with housing, \( p = 1.000 \).

Control: 54.3% of control received support with housing
Drive: 52.6% of Drive received support with housing

Financial/benefits support and advice: A Fischer’s Exact test showed there was not a statistically significant association between cohort groups and receiving support with civil justice orders, \( p = 1.00 \).

Control: 25.3% of control received support and advise with financial/benefits.
Drive: 26.3% of Drive received support and advise with financial/benefits

Support with immigration: A Fischer’s Exact test showed there was a statistically significant association between cohort groups and receiving support with immigration, \( p = .032 \).

Control: 0.9% of control received support with immigration.
Drive: 10.5% of Drive received support with immigration

Health/wellbeing advice and support: A Fischer’s Exact test showed there was not a statistically significant association between cohort groups and receiving health/wellbeing advise and support, \( p = .261 \).

Control: 76.9% of control received health/wellbeing advise and support.
Drive: 89.5% of Drive received health/wellbeing advise and support

Support group with children and young people: A Chi-square test of association showed there was not a statistically significant association between cohort groups and receiving support with children and young people, \( p = .229 \).

Control: 42.1% of control received support with children and young people
Drive: 57.9% of Drive received support with children and young people

Honour-based violence/ Forced marriage: A Fischer’s Exact test showed there was not a statistically significant association between cohort groups and receiving support around honour based violence/ forced marriage, \( p = 1.000 \).

Control: 0.9% of control received support with honour based violence/forced marriage
Drive: 0.0% of Drive received support with honour based violence/forced marriage
Appendix 4: Additional notes on quantitative methods

No control group for SUs
There was not a control group for the SUs. The original evaluation design included a perpetrator control group involving all the perpetrators identified at Marac (intervention group and the control group – i.e. the core data set) and the Drive intervention groups. The intention was that SafeLives would collect baseline information about the control group and intervention group from Maracs. Specifically, they would collect information on perpetrators’ age, gender, sexual orientation, ethnicity, employment, and complex needs (drug and alcohol misuse, financial difficulties, mental health issues); victims’ age, gender, sexual orientation, and ethnicity; and number of children. Additionally, it was intended to record information on the presence or absence of physical violence, sexual violence, harassment and stalking (H&S), and jealousy and coercion (J&C). They found the quality and consistency of the information recorded during meetings varied across and within sites, which in turn led to a large amount of missing information. See the table below for how much was missing.

Table 1. Percentage of missing data for perpetrator and victim data in core dataset

<table>
<thead>
<tr>
<th>Perpetrator Demographics</th>
<th>% Missing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>1.2</td>
</tr>
<tr>
<td>Age</td>
<td>1.1</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>37.9</td>
</tr>
<tr>
<td>Sexual Orientation</td>
<td>89.5</td>
</tr>
<tr>
<td>Disability</td>
<td>89.2</td>
</tr>
<tr>
<td>Employment Status</td>
<td>58.5</td>
</tr>
<tr>
<td>Perpetrator Complex Needs</td>
<td></td>
</tr>
<tr>
<td>Substance Misuse</td>
<td>62.9</td>
</tr>
<tr>
<td>Alcohol Misuse</td>
<td>70.3</td>
</tr>
<tr>
<td>Mental Health Issues</td>
<td>64.9</td>
</tr>
<tr>
<td>Financial Difficulties</td>
<td>75.5</td>
</tr>
<tr>
<td>Victim Demographics</td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td>1.0</td>
</tr>
<tr>
<td>Age</td>
<td>0.5</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>29.9</td>
</tr>
<tr>
<td>Sexual Orientation</td>
<td>82.0</td>
</tr>
<tr>
<td>Perpetrator Victim Relation</td>
<td>5.8</td>
</tr>
<tr>
<td>Children</td>
<td></td>
</tr>
<tr>
<td>Number of Children</td>
<td>11.3</td>
</tr>
<tr>
<td>DVA Characteristics</td>
<td></td>
</tr>
<tr>
<td>Physical DVA</td>
<td>23.3</td>
</tr>
<tr>
<td>Sexual DVA</td>
<td>84.8</td>
</tr>
</tbody>
</table>
The SafeLives team saw that it would not be possible to obtain all of the wanted information from the Maracs so they developed relationships with police departments, with the aim of supplementing the Marac data and reducing the amount of missing data. While this relationship was fairly well established in one area, in the other two areas it took over 4 months to negotiate information sharing agreements, to develop processes for sharing, and to receive information. Once shared, it became clear the information shared was not as comprehensive as discussions between SafeLives and police departments initially indicated. For example, one police department said it would be possible to record the type of DVA but the information was for the type of offence (e.g. sexual, physical), not information describing the dynamics of the environment. Another example occurred when a police department suggested it would be possible to record perpetrators' complex needs. The police ticked if the perpetrator has any complex need but did not specify which one. An additional challenge occurred in one area when the police department noted that they had the resources to provide information for the intervention group but not the control group. The challenges of extracting data from Maracs and police departments led to a high percentage of missing data.

The evaluation team accounted for this by shifting the focus from looking at the Drive intervention group and control group to only perpetrators in the intervention group who had completed Drive. Case manager case notes were extracted for this group and used as a supplementary source of information.

Taking Marac repeat cases into account
The SafeLives team leads the process of randomly allocating perpetrators to the Drive intervention or the control group. This means all identifiable information for a perpetrator is shared and recorded by them. If a perpetrator in the Drive or control group is referred to Marac for a second time, the SafeLives team has the pertinent information to know it is a repeat case. When a perpetrator is identified as a repeat case, the perpetrator is excluded from the randomisation process. SafeLives notes if and when a perpetrator appears again in a Marac. This information about original and repeat referrals to Marac was included as part of the Insights database.

The Insights database for Year 1 has 652 cases. However, some of those cases were not relevant to the evaluation, which meant the database was difficult to setup and ever more difficult considering the short period of time. What was possible was to go through each and every one of the 652 cases to check to see if the information was original (i.e. not a copy of another case), the Marac date was within the time frame of Year 1 of Drive, and the case was a Marac repeat. Each of the 652 cases was reviewed once before analysis. The breakdown of categorising the cases in this way was: 80 cases in which the Marac date was recorded as occurring prior to the start of Drive; 83 cases in which the information entered was the same as another case; and 8 cases (6 control and 2 Drive) Marac repeats with Year 1 of Drive. These cases were removed from the analysis because the aim of the analysis within the limited time was to capture a rough snapshot of change from intake to exit.

For Year 2, we aim to identify and analyse 5 groups within the Insights database which we were not able to do for Year 1. These groups are: 1) identical records for V/Ss, 2) V/S repeat at Marac, 3) same perpetrator difference partner, 4) same V/S different perpetrator, and 5) history of DVA before Drive. If numbers are sufficiently large enough, we would like to analyse and compare these groups.
Appendix 5: Qualitative analysis techniques

The research team anonymised and extracted case notes for the first 30 completed Drive cases (10 per site). Case notes were analysed in-depth using a grounded theoretical model combining pre-set and emergent (open) coding categories that were developed over successive iterations in response to emerging themes. This enabled tracking, quantifying and better understanding the content and characteristics of direct and indirect work, especially multi-agency working, and highlighted examples and techniques of behaviour and attitudinal change over time and across the three Drive sites.

To quantify particular kinds of CM activity - for example, information sharing - the number of references to that activity in the case notes and the number of cases in which that reference occurred were used. While numbers of references in the case notes give an indication or guide to the CM time devoted to that activity, it is only an indication. Reference counts in the case notes tell how many times an activity was recorded – activities that were carried out but not recorded do not show up and activities that are time-consuming, for example, a meeting will accrue the same count an activity that may be quick – for example a phone call or an email. What they do show most accurately is the breakdown of activity within activities – for example, which agencies are contacted the most or whether behaviour change work or support activities predominate within direct work. Nonetheless, given that a mix of shorter and longer lasting activities occur within each category, some comparison across categories is meaningful.

It was not possible to get a comprehensive picture of behaviour change from the case notes - this was better captured within the start and end assessments by Case Managers and Idvas. However, it was possible to see some of the techniques mobilised by Case Managers in an attempt to precipitate change. This qualitative data was analysed using a discourse analytic approach, for example, highlighting discourses of responsible fatherhood in SU and CM narratives.

Reflection on fieldnotes helped to build a clearer picture of the complexity of the Drive intervention, emerging issues and multi-agency dynamics and were critical to iterative development of the interview questions. Since the evaluation was not at its core an ethnographic study (which would have involved living and working at the sites for extended periods e.g. months at a time) there are insufficient notes to warrant their own write up as a separate piece of work. As such, these notes were ‘written up’ in the report itself to the extent that they helped shape the questions asked and the way in which data was analysed.
Appendix 6: Casework examples

Casework examples:

1. **Removing property from the V/S’s front garden.**

A drive SU had possessions in the front garden of the V/S’s council property. The Council were threatening the V/S with eviction if she didn’t remove them. The SU was using the fact that his possessions were there as an excuse to return to the property resulting in multiple breaches and repeat perpetration. Given the severity and frequency of breaches, difficulties with engaging the SU, his state of mind/apparent lack of ‘readiness to change’ during the intervention, harm/risk-reduction with the V/S was pursued as an alternative strategy. Drive worked with the local Council, OM, Idva and the V/S to stall the eviction, get storage for the possessions and arranged and paid to have them removed. The V/S was reportedly (case notes) very grateful and, while the SU did go on to perpetrate elsewhere, he did not with this V/S.

2. **Case oversight**

The police and probation backgrounds of some of the CMs was both an asset and occasionally a challenge for initial casework. A supervisor interviewed describes how a CM had been trained in his previous police role to see the ‘facts of the case’ as his viewpoint. This was noted in supervision by his inability to tell the supervisor about the relationship between the SU and VS, despite having a lot of detail on ‘objective'/recorded ‘facts’ - such as the breach of a restraining order. The CM was sent to speak to the Idva to get the background on the relationship in order to put the breach in context. This resulted in a turnaround for the CM in terms of his understanding of the initial breach - which rather than being seen in isolation was seen within the context of a 10-year relationship involving significant but otherwise unreported emotional abuse, physical violence and attempts by the V/S to leave. This understanding then radically changed the contact strategy and approach taken by the CM with the SU.

3. **Idva, CM and Police working together to disrupt/reveal SU & V/S are in contact**

In this case the V/S had a restraining order in place against the SU. When the V/S dropped engagement with the Idva at the same time as the SU dropped engagement with the CM, the Idva and CM suspected that the SU was in breach of his order. The CM and Idva worked together, comparing timelines of disengagement and called on the Police to do a welfare check on the V/S. The police found the SU at the property and arrested him. The Idva felt that the speed of this intervention would not have been possible without Drive. Drive enabled more information to be available in order to make a safe and informed choice about how to intervene.

4. **Child de-registered as a result of Drive work**

In this case, the Drive SU had a child who had been registered with CSS. The CM got involved in child protection proceedings early on, attending the core group meetings and assisting CSS in the assessment of the family. Meanwhile, through weekly meetings, the CM pursued behaviour change with the SU. The SU’s case notes record a letter of commendation from CSS to the Drive Service Manager (the CM’s line-manager) detailing the progress made with the SU including: “increased understanding of domestic violence, resulting in no further incidents during the period of registration; information, advice and reflection to assist change in behaviour and safer relationships; enabling the family to identify community resources that are available to advise and assist on matters such as benefits; assisting father to find
employment; and ongoing support to the family post-registration that the family welcomed and valued.” As a result of the apparent progress with the SU, the core group voted unanimously to de-register the child.

5. Information flow to Idva

In one example given by an Idva, Drive information sharing with the Idva enabled the V/S to see that SU’s drug use was much worse than she thought which gave her a chance to make a more informed choice about the relationship - which in this case was to end it. Asked whether the she thought this was possible because of Drive, the Idva dealing with the case responded, “I think so yes, because [...] I would never get to meet her partners, and it was through the work that the Drive support worker had done through the prison, and the contact he had with [the SU], and also the contact after [...] we could have an understanding of what drugs he had been using, cos he was using drugs in prison, he was managing to get the legal highs in prison. So that shows that it’s a really … you know, really entrenched behaviours.” (26 SW IS)

6. Support as disruption

In this case a 19-year-old SU had bail conditions not to attend his girlfriend/the V/S’s ‘nice clean flat’. The SU had suicidal thoughts, no access to benefits and his main place of residence was his grandmother’s, which the CM has referred to the RSPCA as unfit for animals (of which there were many) to live in. The CM argued that in this situation ‘we’re setting him up fail’ and worked with housing and the OM to get the SU prioritised for housing to give the SU fewer reasons to go back to the V/S. Unfortunately, the SU did ultimately return but only after some time. Crucially, as this CM pointed out, the SU will now have fewer excuses. One theory of change here is that by stripping away the most basic excuses (such as housing, money, food), even though the SU may continue to return, it becomes possible, as the excuses become more and more convoluted, to elicit the self-reflection that they are indeed excuses – that the SU is fooling himself.

7. Informing SU’s new partner of SU’s history

In this case the CM requested information from the police database on the SU which was provided and then shared with the MASH. The Idva and CM then made a Clare’s Law (DVDS) disclosure to the SU’s new partner.

8. Institutional advocacy: CM working with Idva to have a CP case reopened

In this case the CM and Idva looked at the child protection case closure assessment of the SU’s family and noted that there was no reference to DVA, despite the fact that the SU had been to court for DVA during the period of the case being open (the case had been thrown out of court after the V/S’s witness statement had been withdrawn). The Drive CM re-referred the case to CSS, which, in combination with concerns from the school about the presentation of the child, resulted in the child protection case being reopened. The Idva felt that this event prompted a more profound questioning of the relationship by the V/S and may have ‘strengthened her resolve’ to get out.

9. Compelling the SU and the V/S to engage via CP proceedings

In this case the SU’s child was registered with children’s social services due to violence perpetrated by SU against the mother and the child. The parenting capacity of the mother was not in doubt and a restraining order was arranged to be in force for the SU when he got out of prison (incarcerated for DVA against the mother). Based on the SU’s previous history, the CM
suspected the restraining order would be breached. Without Drive, options for further risk reduction would be very limited and almost non-existent for behaviour change (other than waiting for him to breach the RO and hoping that he might change in prison). Through work with CSS and Probation, Drive were able to have Drive engagement written into the SU’s sentence plan and, via CSS, compel the V/S to engage with the Idva.