Final evaluation report for

The Stella Project Young Women's Initiative

Miranda A.H. Horvath, Susan Hansen, Shola Apena Rogers & Joanna R. Adler, Forensic Psychological Services, Middlesex University August 2013

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AVA Stella Project

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Glossary

ADVANCE	ADVANCE Advocacy Project, Kensington & Chelsea
AVA	Against Violence and Abuse
DV	Domestic Violence
EDIP	Westminster Drugs Project (WDP)
EYOS	Enfield Youth Offending Service
FPS	Forensic Psychological Services
INSIGHT	Blenheim-CDP Insight Young People's Substance Misuse Project
LBE	London Borough of Enfield
PSU	Problematic substance use
RBKC DIP	Kensington and Chelsea Drug Intervention Programme
RBKC	Royal Borough of Kensington and Chelsea
SORT IT	Compass Sort It Young People's Substance Misuse Service
SMU	Substance misuse
SPLC	Stella Project London Co-ordinator (Shannon Harvey)
SPYWI	Stella Project Young Women's Initiative
SV	Sexual Violence
SWA	Evolve Advocacy Projects, Solace Women's Aid
VAWG	Violence Against Women and Girls
VS	Victim Support, Kensington and Chelsea
YW	Young Women

Background and Origins / Objectives

1. Background and Origins

AVA's Stella Project has been working to improve services for adult women affected by overlapping Domestic Violence (DV) and Problematic Substance Use (PSU) for over ten years. Through provision of training and development work with practitioners, the organisation received frequent requests to advise agencies about how these matters affected younger women. Although this was an issue that was increasingly identified by practitioners, the UK evidence base on how to effectively support such young women was weak. In 2010, AVA successfully sought funding from the John Paul Getty Jnr Charitable Trust for a research and development project to address this gap in the evidence base.

Following an open invitation to tender, AVA commissioned Forensic Psychological Services at Middlesex University to conduct the research phase of the project and to evaluate the Stella Project's intervention with agencies working with young women affected by DV and Sexual Violence (SV) and PSU. The project's scope allowed the Stella Project to support two London boroughs in developing their responses to these young women. AVA invited all London boroughs to submit an Expression of Interest to be involved. From 14 interested boroughs, AVA selected the London Borough of Enfield (LBE) and the Royal Borough of Kensington and Chelsea (RBKC), primarily because they are different demographically but also based on their strategic commitment to the project and the existence of relevant agencies to participate in the project. In both boroughs, the Domestic Violence Co-ordinator and the Drug and Alcohol Action Team Manager nominated four relevant agencies to participate in the project. Within each borough, agencies were selected to represent both the Violence Against Women and Girls (VAWG) and substance misuse sectors, and to cover the full age range of young women whose needs the project would address (14 to 25 years). In both boroughs, this resulted in representation from the Independent Domestic Violence Advocacy services, the young people's substance misuse services and the Drug Intervention Programmes (DIPs), and in Enfield, the Youth Offending Service.

2. Objectives

This project was divided into two sections. Firstly, to conduct research to develop the evidence base on the intersecting issues of DV, SV, alcohol and other drug use and young age as experienced by 14 to 25 year old women accessing specialist Violence Against Women and Girls (VAWG) or specialist substance misuse (SMU) services in two London boroughs (see Horvath, Hansen, Apena-Rogers & Adler, 2012, available from http://goo.gl/TtmO9). Secondly, to evaluate the efficacy of the training and consultancy support provided by the Stella Project with the intention of improving practitioners' responses to intersecting issues faced by such young women. In order to provide a comprehensive background for both sections, our first objective was to conduct a literature review focusing on the existing body of evidence for the intersections of problem substance use and DV and SV experienced by young women (see Horvath et al., 2012 for the full review, particularly pages 12-19). The evaluation objective was to assess whether training and consultancy support from the Stella Project could improve practitioners' responses to the overlapping issues faced by young women and was addressed at the two stages of our evaluation 1) pre-intervention (Time 1) and 2) post-intervention (Time 2).

The Intervention

In the first year of the project (September 2010 – August 2011), pre-intervention evaluation data was collected and the research element of the project conducted. Year two (September 2011 – August 2012) saw the launch of the research report in May 2012 (see Horvath et al., 2012, available from http://goo.gl/TtmO9) and the bulk of the 'intervention' by the SPLC which included:

- Three new training courses based on the research findings, these were attended by 126 professionals from 49 agencies across the two boroughs:
  - 'Working in Partnership' – delivered to participants from 20 agencies in each borough in January 2012.
  - 'Working with young people experiencing SV and DV and PSU' – as a basic level 1[1] course and an advanced level 2[2] course. Both level courses were delivered three times in year two, once in RBKC and twice in LBE.

- Borough action plans were developed and agreed with the Community Safety Team and Young People's Substance Misuse Commissioners in both boroughs.

[1]Level 1 courses are for any practitioner working with young people
[2]Level 2 courses are for practitioners seeking to take the lead in their agency on these issues

- An online forum was set up in June 2012 to share information and put practitioners in touch with each other.

The final year of the project (September 2012 – August 2013) comprised four days of multi-agency training for both boroughs and tailored workshops for targeted groups of professionals, for example school nurses. The SPLC also delivered presentations at strategic forums in the two participating boroughs and shared learning from the project more widely, with frontline practitioners at three conferences, to a policy makers' forum hosted by the Home Office and to the London Heads of Community Safety. In the final year of the project, the training courses and other professional development opportunities were delivered to 347 commissioners, service managers and frontline practitioners. The post-intervention evaluation data was collected between April and July 2013. The SPLC published commissioning guidance in July 2013 and practice guidance in September 2013.

3. Method

The research design was a triangulated, mixed methods approach, drawing on both prospective and retrospective research techniques. The research and evaluation gained ethical approval from Middlesex University's Department of Psychology Ethics Committee and the London Social Care Research Ethics Committee. There were three strands to the evaluation, each was assessed twice, pre and post intervention:

Strand 1: This strand revolved around monitoring data on disclosures of the intersecting issues made by young women accessing services and where referrals are made to partner agencies. Initially the intention was that prevalence scoping data would be based on data for one calendar month from the information already being collected by agencies about the young women they see (and that it would include some extra information). During the data collection month, the agencies involved were asked to add extra questions to their standard assessment process. Before the data collection began, frontline workers were provided with training in local referral procedures, interviewing technique and good practice, and a guide was provided for workers giving advice about how to address sensitive topics alongside details of sources for further information. It quickly became apparent that for both boroughs, collecting data was challenging (for further discussion of this see Methodological Challenges). As a result in Enfield, we collected data between 1st June and 31st July 2011. In RBKC, we did the same but received no information about any women. It is, however, unclear whether this was due to the agencies not completing the screening or not gaining consent to pass the information to the research team. We then re-ran the screening in RBKC at ADVANCE and INSIGHT, and included the Young People's Substance Misuse Worker from the council's own team (this worker provides satellite services in the Youth Offending Team). The second screening period was 19th September - 31st October 2011. At the post-intervention stage, the same procedure was used for collecting the data between May – July 2013.

Strand 2: This involved an online questionnaire for frontline staff in the agencies concerned, that covered issues relating to staff confidence, knowledge and skills in addressing intersecting issues of young women's substance misuse and experiences of DV and SV, and current partnership work taking place with other specialist agencies, and related organisations (see http://www.avaproject.org.uk/media/89948/survey_20979917.pdf for the full questionnaire). Service managers were emailed by the evaluation team briefing them about the questionnaire and asking them to invite all of their staff to complete the questionnaire online (a link to the website hosting the questionnaire was provided). The pre-intervention survey was completed between May and November, 2011 and the post-intervention survey between April and June, 2013[3].

Strand 3: This strand consisted of an analysis of the policies and procedures from participating agencies and strategic documents produced by the local borough strategic partnerships. The analysis was guided by six questions:

1. What are the procedures for receiving a referral for a young woman with the overlapping issues of problematic substance use, sexual and/or domestic violence?

[3] Initially the staff questionnaire was only due to be available for one month at both stages but due to poor completion rates the period was extended and numerous reminders were sent to the agencies.

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2. What are the procedures for supporting/working with a young woman with the overlapping issues of problematic substance use, sexual and/or domestic violence?

3. What are the agency policies for supporting/working with a young woman with the overlapping issues of problematic substance use, sexual and/or domestic violence?

4. Does the local borough have strategic partnerships for responding to young women with the overlapping issues of problematic substance use, sexual and/or domestic violence?

5. If the local borough has strategic partnerships for responding to young women with the overlapping issues of problematic substance use, sexual and/or domestic violence what are their policies?

6. Has the agency adopted the local borough's policies?

a. If yes, how?

b. If no, why not?

At pre-intervention, ten policies, procedures and strategic documents were collected from Enfield, and eleven from RBKC. At post-intervention, six policies, procedures and strategic documents were collected from Enfield and seven from RBKC.

Participants

The tables below represent the services in each London borough involved in the initiative. Table 1 shows each service's specialism, the type of service and the service name. Table 2 shows the age group of the service users and the number of staff. The agencies in Table 1 participated in the SPYWI.

Table 1. **Service specialism, type and name in both boroughs**

Specialism	Service type	Service name	
		Enfield	Kensington & Chelsea
Domestic & sexual violence	Independent Domestic Violence Advocacy (IDVA) service	Evolve, Solace Women's Aid	ADVANCE Advocacy Project
			Victim Support
Substance misuse	Young people's substance misuse service	Compass Sort It Young People's Substance Misuse Service	Blenheim CDP Insight Young People's Substance Misuse Service
	Drug Intervention Programme	WDP Enfield DIP	CRI Kensington & Chelsea DIP[4]
Offending	Youth Offending Service	Enfield Youth Offending Service	

[4]Kensington & Chelsea DIP was re-commissioned in October 2011 and CRI are no longer the provider. The DIP is now provided to both RBKC and Hammersmith & Fulham by Blenheim CDP. No data was collected from the service after the transition.

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Table 2. Age group of service users and number of staff for services in both boroughs

Age group of service users	Enfield		Kensington & Chelsea	
	Service name	Number of staff*	Service name	Number of staff*
14-18	SORT IT	10		
	Enfield YOS	15-20		
14-25			INSIGHT	3
			Victim Support	4
15-25			ADVANCE	34
18-25	SWA	2	RBKC DIP	6
	Enfield DIP	8		

* Numbers of staff could only be confirmed at the pre-intervention stage.

The literature review and the policies and procedures analysis involved no participants because they used existing literature and documentation. The participants for the remaining strands are detailed below.

Strand 1 – Monitoring data on disclosures
At the pre-intervention stage in the two months that data was collected in Enfield, information about 17 young women was included on the prevalence database. In the three and a half months data was collected in the RBKC, information about ten young women was added. From the information available, it appears that these represent the majority of the young women the agencies saw in the two months but some problems with record keeping and missing information means that we cannot be certain. At the post-intervention stage during the three month data collection, information was only provided from one agency in each borough, about four women in Enfield and six in RBKC. From the information available, we conclude that investment and commitment to the evaluation had dwindled by this point so agencies were not prioritising evaluation tasks.

Strand 2 – Staff Questionnaire
At the pre-intervention stage, 26 staff started to fill in the questionnaire however six were excluded because they had only filled in one or two questions. The final sample was 20, ten from each borough. At the pre-intervention stage the percentage of staff invited from each borough completing the questionnaire was 25% from Enfield and 58.8% from RBKC. At the post-intervention stage, 21 staff attempted to fill in the questionnaire however 12 were excluded because they had only filled in one or two questions. The final sample was nine, with eight from Enfield and one from RBKC. It could not be confirmed at the post-intervention stage how many people the survey was sent to.

Methodological Challenges
In investigating the intersecting issues of DV, SV, PSU and young age, the scope of the research was limited to young women accessing specialist services for either DV or SV, substance use or youth offending.

In RBKC, the local authority re-commissioned its Independent Domestic Violence Advocacy (IDVA) service during the pre-intervention monitoring data collection phase, resulting in a change of providers halfway through the first screening period. Frontline practitioners were required to prioritise obtaining client consent to transfer personal information to the new provider, and so did not implement the prevalence screening questions with their clients during this time. In the DIP services in both boroughs, the service managers reported that very few women aged 25 years and under accessed the service during the pre-intervention monitoring period. Both services also reported instances of a young woman attending the service but not engaging long enough to complete an assessment.

Also, although the young people's substance misuse services in both boroughs did implement the monitoring data process, service managers and staff in both areas reported that their clients are disproportionately young men and that, similar to the DIPs, young women often attend on a drop-in basis but do not engage to the point of assessment.

These pre- and post-intervention challenges were compounded by personnel changes and dwindling resources for participating agencies. Sustaining all parties' commitment to, and time invested in, the project required greater co-ordination to promote stronger relationships throughout intervention.

Finally some specific challenges emerged implementing some elements of the method. The need to extend data collection for Strand 1 to 3.5 months in RBKC means that we had a shorter follow up time between pre and post data collection. Also, although there are no obvious reasons why this occurred more than half of the participants at pre-and post-intervention stages failed to complete the online survey beyond a question or two. It can be speculated that some were simply called away to do something else or others were not motivated to continue. Furthermore, we did not ask staff for any identifying information when they completed the survey in order to ensure they remained anonymous. As a result we did not match pre- and post-intervention participant responses. Therefore it is possible that we had different participants completing the survey at the different stages.

Findings

Summary of Research Findings[5]

Rapid Evidence Assessment (Literature review). The connection between DV, SV and PSU is complex. The links between DV and PSU experienced by women are increasingly coming to the attention of agencies, and whilst a few studies have sought to address this issue (Humphreys, Thiara & Regan, 2005), the evidence base remains largely undeveloped in the UK. Young women's use of substances may be associated with current or historical experiences of abuse (Humphreys, Thiara & Regan, 2005) or may develop partly as a way of coping with trauma symptoms and for managing the stress of living in a violent situation (Scottish Women's Aid, 2005). Women with PSU are also more vulnerable to violence due to their relationships with others who use substances and because of impaired judgment while using substances (Covington, 2003). Furthermore, for substance-using women with histories of childhood abuse, there is an increased risk of re-victimisation (DV and SV) in adulthood (Casey & Nurius, 2005; Colman & Widom, 2003).

In England around 60% of 14 year olds and 80% of 15 year olds have consumed alcohol (Sutton & Bridges, 2011). Early drinking appears to increase risks for progression to problem use in young adulthood and early transitions, such as younger age at first drink is linked with risk for substance use disorders and has been associated with sexual victimisation (Grant & Dawson, 1997). Adolescent girls and young women are four times more likely to experience sexual coercion than older women and early use of alcohol may play a role in this heightened vulnerability (Catalano, 2006; Koss, Gidycz & Wisniewski, 1987). Many adolescents also use substances other than alcohol. In England, for example, cannabis is the most frequently consumed drug, with 8.2% of 11-15 year olds reporting in 2010 that they consumed it in the last year (Omole, 2011). Sexual abuse, physical abuse, and witnessing violence are associated with increased pre-teen alcohol use and with binge drinking (Hamburger, Leed & Swahn, 2008). Young women leaving state care are especially susceptible to PSU and to commercial sexual exploitation (Coy, Lee, Kelly & Roach, 2010; Coy, Thiara & Kelly, 2011; Cusick, 2002).

Literature on the prevalence and incidence of the overlapping issues of PSU, DV and/or SV for young women is limited and originates mostly from North America. However research from Australia also found an association between experience of DV and PSU (Brown et al., 2009). In England and Wales, the recent widening in the Government definition of DV to include 16 and 17 year olds reflects the growing recognition that DV is relevant to this population (Home Office, 2013): UK data suggests that 88% of adolescents have experienced IPV (Barter, McCarry, Berridge & Evans, 2009). Research on rates of substance use among young victims of domestic violence is limited to say the least, but a picture is emerging that suggests experiencing violence or abuse is associated with an increased risk of substance use, often to reduce negative affect or as a response to stress. Teenage victims of domestic abuse have additional vulnerabilities; with recent research reporting that 8% of the 183 victims aged under 18 years old experienced alcohol misuse and 5% misused drugs (CAADA, 2012)[6]. For adolescents, abuse by an intimate partner is associated with increased illicit substance use, antisocial behaviour, risky sexual behaviour and suicidal behaviour (Roberts, Klein & Fisher, 2003). Sexual victimisation also increases the likelihood of non-medical use of prescribed opioid analgesics and sedative medication amongst adolescent girls (Young, Grey, Boyd & McCabe, 2011).

[5] See Horvath et al., (2012) for the full findings, available from http://goo.gl/TtmO9

There are very few evidence-based integrated programmes that address co-occurring issues such as PSU and DV and/or SV experienced by young women. Recommendations have been made suggesting that interventions focusing on preventing SV and PSU together rather than targeting just one of these behaviours are vital for successful outcomes (Humphreys, Thiara & Regan, 2005). In the UK, Barnardo's have run sexual exploitation prevention and support services for young people up to the age of 18, many of whom have experiences of drug and alcohol misuse. Evaluations of the impact of these specialist services, however, have been limited by low levels of survey completion around experiences of substance misuse and violence (Scott & Skidmore, 2006). The National Drug Treatment Monitoring System (NDTMS) in England collates data on individuals accessing structured drug and alcohol treatment. Additional questions, e.g. "young person involved in sexual exploitation?", have been incorporated for young people's providers to be asked pre- and post-treatment, but data from this has not yet been linked and it is therefore unclear as to whether drug and/or alcohol treatment was associated with a decrease in the incidence of sexual exploitation (National Treatment Agency for Substance Misuse, 2009).

To be more accessible to hard to reach young people, services should be delivered in a respectful, non-stigmatised way. An NSPCC consultation carried out with groups of children living in special circumstances, including girls and young women vulnerable to sexual exploitation, found that the most important aspect was that someone listened to them. They preferred services that had clear policies on confidentiality and were based in attractive, welcoming places where they could have fun and not just focus on their difficulties (Thorpe, 2003). Among the disadvantaged young people participating in research, help-seeking was restricted by young people's fear that they would not be taken seriously by professionals, nor be believed. They were concerned that social workers would neither respect their confidentiality nor provide consistency of support. Social workers were also seen as focused on the whole family rather than on the young person (Humphreys et al., 2005; Wood, Barter & Berridge, 2011).

At a strategic level, a range of needs must be addressed for those experiencing PSU and DV and/or SV in order to cater for these individuals appropriately. PSU and DV organisations require the political will and drive to respond with appropriate service development to include multi-agency working at operational and strategic levels. This means that adequate training across both sectors so that staff are consistently and systematically asking questions for domestic violence and problematic substance use must be consistently provided. The ethos should include service users in the development of practice so they are responsive to service user needs. The biggest gain to be achieved in supporting women with DV, SV and PSU issues would be the development of specialist services to support mainstream services (Humphreys et al., 2005; Wood, Barter & Berridge, 2011). In particular, a provision for young women would be a significant step in dealing with these overlapping issues.

Interviews and focus groups with young women and practitioners

Three focus groups were completed: two in RBKC (both groups had six young women) and one in Enfield (five young women took part). Two young women from Enfield and three young women from the RBKC were interviewed individually. The transcripts were

Table 4. Summary of Young Women's Experiences

Substance Use	Violence in relationships
To deal with problems	Sexual violence
Peer pressure	Emotional abuse
For fun	Controlling behaviour
To deal with stress	Association with alcohol use
Because addicted	Perpetrator's lack of awareness due to substance use
May lead to health problems	Peer pressure on young men
May lead to depression and behavioural and personality changes	Blaming young women and excusing young men for violence and SV
Loss of self-control and self-awareness	
May lead to violence	
May lead to SV	

[6] It is unclear how much higher the rates in the CAADA research are than among the general young population as comparison data is not available.

thematically analysed in order to gain insight into young women's experiences of both substance use and violence and abuse as well as their experiences of help seeking and referral pathways. Table 4, shows the major themes identified in young women's experiences of substance use and of violence in relationships. A full account of these themes can be found in Horvath et al., (2012).

The areas shaded in red show the intersectionality in young women's accounts of their experiences. In particular, they regarded substance use as an activity that 'may lead to violence'. Young women themselves, however, often mitigated their identification of alcohol consumption as being linked to young men's violent behaviour. Excessive alcohol and drug consumption were identified by young women as 'the problem', and young men/perpetrators who were 'under the influence' were described as not being aware of, or responsible for, their abusive conduct.

Confidentiality
Some young women asserted that they were cautious when interacting with services, in terms of actively managing the level of detail they were willing to disclose. They regarded such 'controlled' conversations as detrimental, and as inhibiting them from disclosing 'the worst bit' or even talking to 'some sort of professional' – preferring to talk to their family, a friend, or a friend of the family in an established position of trust:

> *I'd speak to my family, or like someone I know that I could trust – a friend or member of family rather than a professional because I would worry that it's not confidential or that they might say something or judge me or call some other services like Social Workers. I would much rather prefer to talk to a friend or family member.* (RBKC focus group 2)

However, other young women noted that although they might prefer to talk to friends rather than services, friends may not be an ideal source of help as they can regard such issues as 'none of their business' and may not wish to get involved.

Uncertainty about the kinds of assistance and support that young women might be able to access is a deterrent to approaching services. They believed that young women might be more willing to access services when they felt they were given more information about practical sources of help, not simply going in order to 'tell them your problems'. Young women's perceived lack of confidence in, and knowledge of, the forms of practical assistance that may be available is described as a potential source of 'embarrassment' and 'shame'. These concerns, coupled with young women's anxieties about the limits of confidentiality, and the repercussions of disclosure, represent significant barriers.

Pre- Intervention Themes in Practitioners' Knowledge of the Issues
At pre-intervention, one member of staff from each agency taking part in the project and the SPLC were interviewed. Nine telephone interviews were conducted in total. The interviews were transcribed and thematically analysed in order to gain insight into practitioners' knowledge of the intersecting issues. Box 1, below, shows the major themes identified. A full account of these themes and the methods used for analysis can be found in Horvath et al (2012).

Box 1: Key themes in Practitioners' (Pre-intervention) Knowledge of the Intersecting Issues

- Young women may use alcohol to cope with being in, or having exited, an abusive relationship
- Young women may become trapped in a relationship with the perpetrator due to shared substance dependency
- Problematic substance use by young men may lead to aggressive behaviour which may put young women at risk of violence
- Young women may be at risk of sexual coercion and SV associate with their substance use
- Young women experiencing DV may be at risk of experiencing SV.

Beliefs about the 'causative' effects of drugs and alcohol
Both the young women and the majority (75%) of the practitioners expressed the belief that alcohol and drugs could cause violent behaviour. Their accounts reinforce existing cultural beliefs about gender, and in particular (young) women's culpability in their own victimhood and young men's mitigated responsibility for the perpetration of violence. Some practitioners discussed this in terms of young people's 'bad reactions to substances' leading to 'difficult situations' where 'young women are

being put severely at risk from their partners'. Alcohol and drug use was regarded as 'bringing out some of their worse characteristics', which include 'paranoia's, misunderstandings and aggressive behaviour.' Others went further to suggest that the type of abuse experienced by young women may be influenced by the particular substance being used by the perpetrator. Alcohol was described as causing physical violence, and crack as causing SV.

Barriers to disclosure

There was some disagreement amongst practitioners as to the length of time necessary to establish the level of trust that would encourage young women to disclose intersecting issues. Some asserted that this would take a significant period of time, whilst others admitted that they would never feel comfortable asking about such issues, and would leave it up to the client to self-identify and disclose these. Others were critical of placing the burden of disclosure on young women, and thought that core assessments should be adapted in order to prompt practitioners to ask about these intersecting issues.

Practitioners described a range of reasons why young women may be reticent to disclose intersecting issues and to involve other agencies. These included a desire to 'keep it private'; new services being intimidating; anxiety about the consequences of disclosure (from the perpetrator, the community, or from social services); anxiety about the impact on custody of or access to children; lack of trust in practitioners; lack of self-identification of intersecting issues (through minimisation, normalisation and denial; lack of understanding/recognition of problem).

The reasons given by practitioners for this reluctance sometimes diverge from the reasons given by young women themselves. Many practitioners asserted that young women's reluctance was due to their feelings of shame and of being intimidated by the formality of services. 'Shame', however, did not feature as a major theme in young women's accounts. When shame was mentioned by young women, this was in the context of their discussion of what it would feel like to talk to service providers about their problems if they were unsure whether the service provider would be able to offer them any practical assistance, and of the stigma of presenting at particular services in terms of their peers seeing them and becoming aware of their personal problems. That is, shame was associated with the act of presenting at services, and of the disclosure of problems, but not with the act of help seeking itself. Rather the issues that young women discussed in relation to their reluctance to access services centred around their concerns about the negative consequences of disclosure, the limits of confidentiality, and the repercussions of these concerns in terms of the involvement of their parents, or of other agencies without their consent.

Evaluation Findings

Strand 1 – Monitoring Data on Disclosures

Demographic information about the women across the two boroughs for whom monitoring data on disclosures were collected at pre- and post-intervention is presented in Table 6.

	Pre-intervention	Post-Intervention
Number of women	27	10
Age Range	14-25	17-24
Mean Age	17	21.8
Ethnicity		
White	12 (48%)	6 (60%)
Mixed	5 (18.5%)	N/A
Other (Turkish, Moroccan)	5 (18.5%)	N/A
Black	4 (14.8%)	1 (10%)
Pakistani	1 (3.7%)	1 (10%
Bangladeshi	N/A	1 (10%)
Asian	N/A	1 (10%)

Table 6. Demographic information about women for whom disclosures were monitored

Subsequent data are presented according to the borough the women were from to allow initial comparison across them. However, due to the small amount of data collected, no formal analysis has been conducted between the types of agencies in each borough. It should be noted that we do not know whether the pre- and post-intervention disclosures were from the same or different young women. Figure 1 shows young women's experiences of PSU, DV and SV in Enfield.

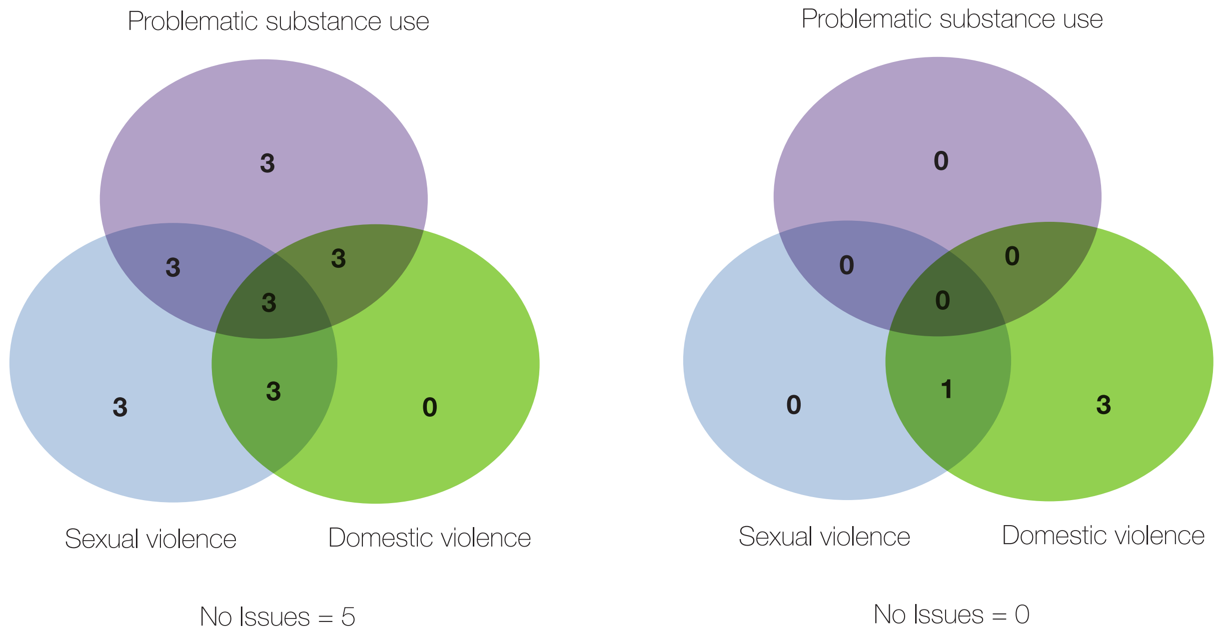

Figure 1. Young women's experiences of PSU, DV and SV in Enfield, pre-intervention on the left and post-intervention on the right

Those perpetrators who had been violent towards young woman (who reported having previously experienced DV) in Enfield included: ex-boyfriends and partners; family and ex-brother in law; and witnessing 'dad hit mum'. Current DV was being perpetrated by partners, ex-partners and family. Previous SV experienced by the young women was perpetrated by: 'Dad's best friend'; partner; ex-boyfriend and stranger.

Figure 2 shows young women's experiences of PSU, DV and SV in the RBKC pre- and post-intervention. Perpetrators of previously experienced DV in RBKC included: boyfriends, husbands and partners; brothers; ex-partners; family members' boyfriends. Current DV was being perpetrated by ex-partners and husbands. Previous SV was perpetrated against the women by: ex-partners; husbands and uncles. Current SV was being perpetrated by a friend's partner.

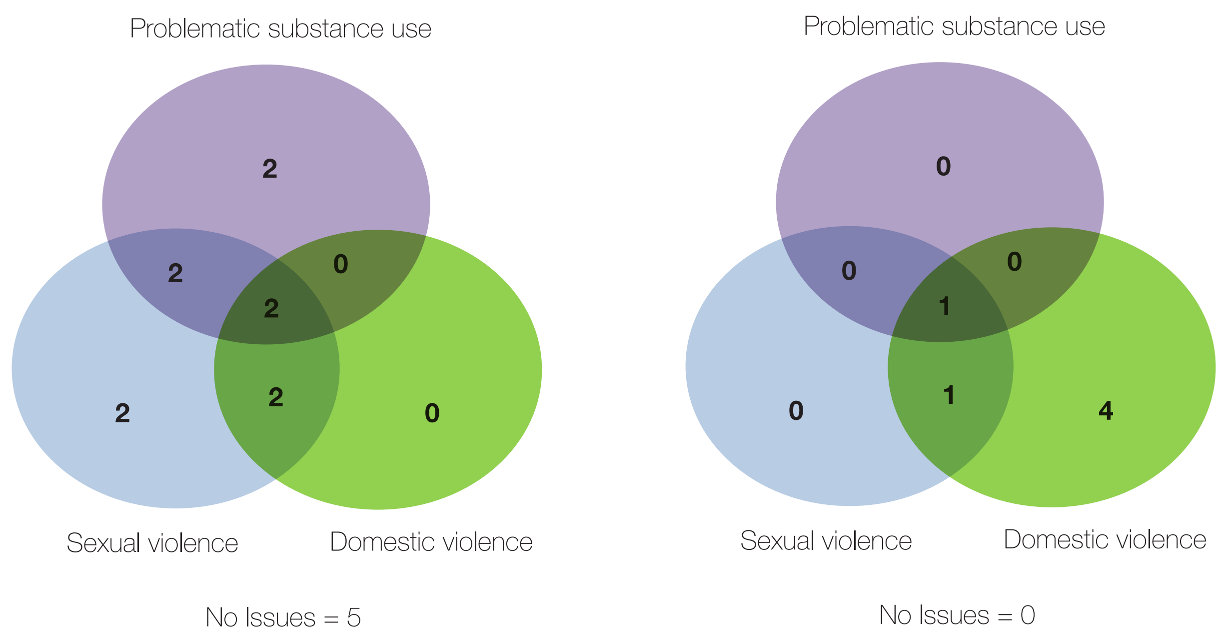

Figure 2. Young women's experiences of PSU, DV and SV in RBKC, pre-intervention on the left and post-intervention on the right

Young women were asked if they ever take drugs or drink alcohol to cope with their experiences of violence. During the pre-intervention monitoring in Enfield, five young women said that they did, and a slightly lower number of women (2) from the RBKC said the. In the post-intervention monitoring in Enfield two (50%) young women reported that they take drugs or drink to cope with their experiences of violence, and similarly a lower number of women from RBKC said the same (n=1, 17%). When the practitioners conducting the interview were asked if they perceived any links between a young woman's PSU and her experiences of violence, the figures were lower. At the pre-intervention stage in Enfield for two women (11.8%) practitioners saw a link but in the RBKC it was only perceived for one woman (10%). Conversely, at the post-intervention stage none of the practitioners in Enfield saw any links but practitioners in RBKC said they saw links for about half of the young women that were screened.

Young women were asked why they used alcohol or drugs to cope with their experiences of violence, the reasons given at both pre- and post-intervention stages were very similar and included:

> *Using drugs to mask/cover the abuse I was faced with.*
>
> *They make me forget everything.*
>
> *Smoke cannabis to deal with gang related violence.*
>
> *Drank sometimes to make me forget, put me in a better mood, go out and drink socially to take my mind off it.*

One young woman described how after a violent outburst with her partner they smoked skunk to calm themselves down before making up. Another described drinking and binging on skunk and cocaine but did not explain why, whereas another young women stated that drinking a lot of alcohol definitely was helping her to cope with the DV. Happily for her she no longer drinks as heavily, nor is she in an abusive relationship.

No practitioners at the post-intervention stage gave reasons for their perception of links between PSU and violence amongst the young women, however at the pre-intervention stage the reasons given were 'to cope with feelings' and as a result of 'gang involvement'. Another stated that one young woman told her she was introduced to crack by her ex-partner who also physically abused her. Finally one practitioner felt that there was so much to uncover she did not know at this time.

The monitoring data obtained was far more limited than initially anticipated. As a result it is not possible to draw many firm conclusions. In terms of the effectiveness of the intervention, it does not appear that monitoring of disclosures improved, but rather, decreased over the length of the project. However, it should be noted that many services had their funding significantly reduced over the course of the evaluation which may have impacted on the capacity to release staff to take part in the intervention and to engage with the evaluation activities.

Strand 2 – Staff Questionnaire

The pre- and post-intervention staff surveys were completed by 29 practitioners (20 pre-intervention and nine post-intervention). As a result of overall low numbers, and particularly as all but one post-intervention survey was completed by practitioners in RBKC, it is not possible to run meaningful analysis comparing changes in the two boroughs separately. Therefore, all possible comparisons between pre- and post-intervention are presented below on the aggregated findings for participants from all services in each borough. We did not match pre- and post-intervention participant responses so it could be that we have different participants completing the survey at the different stages.

In order to assess practitioners' understanding of the key issues (DV, SV, PSU), the first questions of the pre- and post-intervention questionnaires asked them to provide a brief definition of each term, which were then analysed thematically. The definitions for DV provided at both stages were similar, and referenced "physical, mental, emotional, sexual and financial forms of abuse". However, the post-intervention responses differ from the pre-intervention definitions in that several respondents made reference to age and young people, and to the new Home Office definition of DV, which "takes into account… young people from the age of 16 upwards… and controlling and coercion." The only reference to age made in the pre-intervention definition of DV was to restrict it to adult relationships. There were few differences between the definitions provided pre- and post-intervention for SV, but at both stages, a range of definitions were given, many of which made clear reference to the role of consent and coercion. Some definitions made further reference to 'unwanted' sex, and the role of some victim/survivors' 'lack of understanding' of 'sexualised behaviours'. Finally when asked to define PSU, there were few differences in the definitions provided between the two periods. Some definitions were brief, and restricted to the act of drug consumption, or "harmful use of any substances." The

majority of definitions, at both pre and post intervention, made reference to the impact of pre- and post-intervention, on users' "social functioning", "ability to carry out day to day activities" and "problems within the user's life, such as with mental health, finance, parenting, physical health and isolation." However, the post-intervention definitions were distinct from the pre-intervention definitions in that they also contained reference to PSU being "common within survivors of DV/SV as a coping mechanism or being forced to use substance by the perpetrator." Also specific to the post-intervention definitions was the reference made to the "use of alcohol and drugs to either control a person, or to support and mask difficulties in life" or to "help them manage other issues." That is, at post-intervention, practitioners reflected on some of the reasons that victim/survivors and perpetrators might use substances problematically, demonstrating a more intersectional appreciation of PSU.

Overall, the definitions provided suggest that the majority of practitioners have a good working understanding of the issues being addressed by the SPYWI but that there were not major shifts in their understanding as a result of the intervention.

Training

We asked participants about the types of training they had received about each of four intersecting issues (SV, DV, YW, PSU) ranging from watching a video or completing web based programme through to in-depth training (more than 4 hours) or attending a university course. Pre- and post-intervention participants had received at least one type of training on PSU and at post-intervention at least one type of training on DV. For the other issues, some participants had received no training (Pre: SV=5; YW=3; DV=1; Post: SV=1; YW=2). The most common types of training practitioners had received pre- and post-intervention were a lecture or talk, skills-based, or other in-depth training. There were no significant differences between participants pre- and post-intervention on any of the types of training or on the number of types of training practitioners had received. Across all four topics practitioners at both the pre-and post-intervention stage tended to have received about two or three types of training. However, it should be noted that it is possible that the practitioners completing the questionnaires may not have directly received the training provided by the intervention, which may well have been attended by other members of their organisation who did not complete the survey. Unfortunately our data do not permit further exploration of this possibility.

Table 5 shows participants' responses to questions about whether they felt there were any gaps in their training on each of the issues. There was no difference between the pre- and post-intervention stages for DV, but for the other three issues, significant differences were found. For SV and YW, participants at the post-intervention stage overall reported fewer gaps in their training than at the pre-intervention stage. The reverse was found for PSU, for which pre-intervention participants reported fewer gaps in their training than post-intervention participants. Overall, these findings can be considered encouraging, despite no change in relation to DV, as the focus of the project on young women seems to have been reflected.

Table 5. Participants' perceptions of gaps in their training on each of the issues.

Topic	Time	Are there any gaps in your training on each of the issues?				
		No gaps	A few gaps	A lot of gaps	No training	No answer
Sexual Violence*	Pre	2 (10%)	13 (65%)	3 (15%)	2 (10%)	0 (0%)
	Post	4 (44.4%)	2 (22.2%)	0 (0%)	1 (11.1%)	2 (22.2%)
Domestic Violence	Pre	5 (25%)	12 (60%)	1 (5%)	2 (10%)	0 (0%)
	Post	1 (11.1%)	7 (77.8%)	0 (0%)	0 (0%)	1 (11.1%)
Problematic Substance Use**	Pre	8 (40%)	8 (40%)	2 (10%)	2 (10%)	0 (0%)
	Post	1 (11.1%)	5 (55.6%)	0 (0%)	0 (0%)	3 (33.3%)
Young Women***	Pre	0 (0%)	11 (55%)	5 (25%)	4 (20%)	0 (0%)
	Post	2 (22.2%)	2 (22.2%)	1 (11.1%)	1 (11.1%)	3 (33.3%)

* Fishers Exact p=0.13; ** Fishers Exact p=0.40; *** Fishers Exact p=.008

There were no significant differences pre- and post-intervention on how confident practitioners felt talking to young women about the issues. Participants felt most confident responding to young women affected by PSU issues, followed by DV and least confident with clients experiencing SV. The data suggest that despite the intervention practitioners lack skills and training in relation to SV in particular, and in both domestic and SV as they relate to young people. It is possible that the staff being asked to complete the survey did not receive the training offered by the SPLC and/or that SV may always be a difficult topic to talk about irrespective of training received.

Participants were asked to respond to a series of questions in relation to DV, SV and PSU about how much they know about: risk indicators; what questions to ask to identify issues; how to respond appropriately to disclosures and how to record issues on a young woman's file. For the majority, there were no differences between participants' responses pre-and post-intervention. Surprisingly, there was a significant difference for each of the three issues for participants pre-and post-intervention for how much they felt they knew more about how to record information on a young woman's case management file (SV: Fishers exact $p<.005$; DV: Fishers exact $p<.05$; PSU: Fishers exact $p<.05$). Contrary to expectations, overall pre-intervention participants reported knowing more than post-intervention participants. We did not, however, match pre- and post-intervention participant responses so it could be that we have different participants completing the survey at the different stages which could explain the difference.

In terms of how prepared practitioners were to engage with young women and support them in various ways (for example through asking questions, responding to disclosures, making referrals, etc) there were almost no differences between the pre- and post-intervention stages. There was one exception in relation to how prepared practitioners were to ask questions about SV (Fishers exact $p<.05$).By the post-intervention stage the percentage of practitioners who were 'not well' or 'not very well' prepared had fallen from 80% (pre-intervention) to 44.4%.

The staff survey asked about a range of other issues including: their knowledge of services and networks that specialise in each of the three issues; how practitioners shared information about the issues within their services and with other services; how practitioners give young women information about the issues; did practitioners have support within and outside their organisation to support them and what referral services were available to them within their boroughs. There were no significant differences between pre-and post-intervention on any of these measures.

Towards the end of the pre-intervention staff survey, we asked some open-ended questions. When circulating the post-intervention staff survey, however, the decision was made to remove some of those questions and as such comparisons cannot be made for all questions. At pre-intervention, although most practitioners reported that they experienced 'no barriers' to recording information in client records regarding violence and PSU, some stated that they felt that this sometimes did not occur due to it being "time consuming" and "bureaucratic". Another participant identified a barrier located in practitioners' lack of understanding:

> *Someone else may not understand and seek to engage that person in discussion in a session without fully understanding the context and or checking it out to confirm if it is appropriate to discuss, as people often feel they are sufficiently experienced to talk about subjects they have limited knowledge in and do more harm than good.*

Post-intervention data on barriers to recording this information were not available, however practitioners were asked about barriers to sharing data about young women's experiences of violence and PSU. Although some respondents reported that there were 'no barriers' to sharing information, others referenced 'confidentiality' and The Data Protection Act:

> *We are bound by confidentiality and the data protection act, however, where any person is deemed to be at risk of violence or discloses that they intend to hurt either themselves of someone else, I am duty bound to move the information forward even if this means breaking confidentiality.*

MARAC was also mentioned as a vital resource for practitioners in overcoming barriers to sharing information:

> *If there are barriers I use the MARAC as a forum to share all relevant and proportional info*

Findings

as I do not need to get the woman's consent to refer to MARAC. I have not encountered too many problems with sharing info as I'm aware of the acts I can use to justify sharing without consent, although I would only do this where I felt the data I wanted to share was vital and would try and balance the risk of disengaging my client.

One barrier particular to being able to share information about young women's experiences of violence was located in practitioners' lack of knowledge of available appropriate services:

Domestic violence and sexual violence agencies do not make themselves known to us and there is a lack of communication.

However, the post-intervention survey responses show that most practitioners were able to give an account of how they would go about effectively sharing information about young women's experiences of violence. These avenues for information sharing included during team meetings; during case review; through supervision; safeguarding meetings; clinical meetings; and by entering this information on an electronic case management system to which all appropriate staff have access.

Post-intervention survey responses also show that practitioners identified avenues for sharing information about young women's PSU. In contrast to the pre-intervention survey, where one respondent asserted that they would not share this information because "this is confidential", all of the post-intervention responses indicated that they would share this information (through particular practical avenues). These included MARAC (if high risk), services that deal with substance misuse, supervision and case review meetings, and in team meetings.

Strand 3 – Policies and Procedures

Locating relevant policies and procedures was challenging at both pre- and post- intervention. At both stages, we were unable to locate any documents that outlined agency procedures for receiving a referral for a young woman with issues other than those for which she would have been initially referred to the specialist organisations. As stated in the methodology section, the policies and procedures analysis was guided by six questions.

At pre-intervention and post-intervention, only one service from RBKC had any procedures for supporting/working with a young woman with the overlapping issues. These stated:

Services for families and young people support the victims of domestic abuse and abuse related to drugs and alcohol. A holistic approach encompassing housing, health and nutrition, money, education, training and employment. They provide intensive practical interventions to include information and advice on parenting skills, sexual health and drugs awareness.

At pre-intervention, we identified three policies for supporting/working with a young woman with the overlapping issues of PSU, SV and/or DV all from RBKC. These were:

Continued working with the Domestic Violence partnership, to ensure that access to appropriate services is available to those affected and the perpetrators. Ensure domestic violence provisions are considered and included, where possible in the Drug and Alcohol Action Team Treatment Plan, Child and Adolescent Mental Health Strategy (Name of Organisation) must take steps to develop positive working relationships with substance misuse and mental health services programmes. They must maintain appropriate links with specialist agencies, use multi-agency networks to promote access to services, and offer victims and witnesses information about the range of services available to them, and allow them to express choices.

At pre-intervention, at the local borough level, the only indication of any strategic partnerships for responding to women with overlapping issues came from two statements, again from RBKC, shown below. However it should be noted that these responses to the overlapping issues are targeted around responses to adult women and do not necessarily reflect specific responses to young women.

The Kensington and Chelsea DAAT is represented on a number of other partnerships including the domestic violence partnership. Services to victims of domestic violence and abuse are provided in partnership with other relevant agencies.

At pre-intervention, there was however no indication from the policies and procedures we received from RBKC of any policies emerging from the strategic partnerships for responding to young women with the overlapping issues of PSU, SV and/or DV. Moreover, it was also impossible to identify if, where they exist, policies have been adopted by individual agencies.

Conclusions

However, as discussed in our literature review and the interim report (Horvath et al., 2012), this is not an area of work that has received much attention. Both boroughs engaged in this project as they recognised a deficit in this area and a desire to make changes, and thus we anticipated greater evidence of strategic-level policies and implementation of procedures at the agency level at post-intervention. Due to the paucity of data provided by participating agencies this proved difficult to assess at the agency-level, however it may be examined at borough level.

The Home Office's (2012) recent updated definition of domestic violence to include 16-17 year olds is reflected in post-intervention strategic level policy documents, where young women's needs feature more prominently in discussions of domestic violence than in pre-intervention policy documents. For example, the Kensington and Chelsea Domestic Abuse and Sexual Violence Strategic Partnership (2013 – 2014) has a focus on early intervention and prevention, and efforts to identify gaps in service in relation to 'teenage domestic violence', and young people's issues in accessing relevant services. However, this focus does not extend to consider any of the other overlapping issues for young women.

Although the RBKC's Tri-borough Substance Misuse and Offender Health Needs Assessment (2012-13) has no clear focus on young women's needs, this needs assessment notes that 'the highest levels of alcohol dependence are in men aged 25 to 34, and women aged 16 to 24' and further notes the "impact of substance misuse on domestic violence situations", and that it is thus crucial to:

> *Define, promote and ensure pathways are utilised between Family and Children's Services and substance misuse treatment and mental health services and substance misuse services… Ensuring identification within specialist substance misuse services and clear pathways into local domestic violence support is … a priority.*

The RBKC's Local Safeguarding Children Board Annual Report (2011-2012) includes in its objectives a focus on 'ensuring we maintain a focus on children and young people affected by domestic violence, parental mental ill health or substance misuse.' Although the intersecting issues are clearly referenced here, it is largely the impact of parental domestic violence and substance misuse on young people that is considered, and not young people's direct experiences of violence in relationships and problematic substance use nor when historic witnessing and current abuse intersect.

The NTA JNSA Data for Young People Kensington and Chelsea notes that from 2013 Health and Wellbeing Boards will commission specialist interventions for young people. These specialist interventions will allow for the recognition of intersecting issues and challenges in the lives of young women, and encourage services to work together to support young women with complex needs:

> *Good practice is to meet their substance misuse needs as part of a broader package of care that involves support with housing, education and family relationships. For those with the most complex needs, the best outcomes occur when services such as Child and Adolescent Mental Health Services, Youth Offending Teams and Children's Social Care work with substance misuse practitioners.*

The Enfield Safer and Stronger Communities Board Partnership Plan (2012-13) cites the aims of the Stella Young Women's Initiative in emphasising Enfield's involvement with the pilot and their recognition of the importance of addressing these overlapping issues for young women:

> *Strong links have been formed with substance misuse services and Enfield is now one of only two London Boroughs to pilot a "Young Women's Initiative", in which young people accessing drugs and alcohol services will be asked routinely whether they have concerns about domestic violence.*

The Partnership Plan further notes the role of the Safe Choices programme in addressing the needs of young women. While this programme does not explicitly address all of the overlapping issues (that is, it does not address substance misuse) it does address young women's experiences of relationship violence and sexual violence within the context of prevention and risk reduction. This programme is also referenced in Enfield's Domestic Violence Briefing Crime and Safety Scrutiny Panel.

The Enfield Safeguarding Children Board Protocol for Working with Sexually Active and Possible Sexual Exploitation of under 18s also underscores the importance of these intersecting issues for young women, and includes substance use as a risk factor in their risk assessment framework for sexual exploitation. The Protocol notes the:

> *… increasing amount of evidence of the role of drugs and alcohol in 'risky' teenage sexual activity…and sexual exploitation… Factors to be considered include: the impact of alcohol and drugs; mental health considerations and experience of domestic or other violence.*

Both boroughs initially agreed to take part in the Stella Initiative as they recognised the importance of these intersecting issues for young women, and could see that there was very little existing work in this area. However, our expectation that there would be greater evidence of strategic-level policies and implementation of procedures at the agency level at post-intervention was only partly met. The lack of data provided by participating agencies meant that this was not possible to assess at an agency-level, however we could see some evidence of an increasing recognition of some of these intersecting issues for young women in strategic-level policies at borough level. Additionally, it is hoped that the Home Office's (2012) updated definition of domestic violence to include 16-17 year will help to encourage a more prominent focus on young women's needs.

Conclusions

Overall we conclude that there is still a vast amount of work needed in order to ensure that young women who have experienced domestic and/or sexual violence and problematic substance use are offered the support they are legally entitled to. Practitioners should be encouraged to work together, to learn from each other to develop effective services for young women. The beliefs that both young women and practitioners hold about the relationship between substance use and domestic and sexual violence, and about the issues involved in confidentiality and disclosure when working with young women, also warrant on-going attention. We have organised our recommendations so they are targeted at specific groups.

Recommendations for Service managers

Investigating Low Prevalence Figures

- The very low numbers of young women identified through the prevalence screening (pre-and post-intervention) suggests a number of possible explanations which need to be fully explored, including:

    - Young women are experiencing these issues but do not know where to seek help.

    - Young women are experiencing these issues and are seeking help but the agencies are not seeing them or if they are seeing them, are not identifying their intersecting needs. This could be because agencies are not asking young women about the issues, or young women are not disclosing when asked.

    - Young women experiencing the intersecting issues are seeking help through more generic services or institutions, such as schools and colleges, but are not being referred on to/accessing specialist services. Which suggests that wider outreach for referrals may be required.

    - Young women experiencing intersecting issues are not engaging sufficiently with specialist services in order to complete an assessment and be asked the screening questions.

    - It may be that the agencies did not have the time or willingness to engage with the research and evaluation so young women with the overlapping issues are being seen by the agencies but that information was not passed on to us.

    - Young women did not give consent to being involved in the research.

Engaging and Informing Young Women and Addressing their Concerns about Confidentiality

- Engaging young women is challenging, as is encouraging them to disclose these intersecting issues. Young women may normalise and minimise these issues, and may even excuse young men from responsibility, while also sometimes engaging in a degree of self-blame.

Conclusions

- Young women may also be anxious about disclosure, and about having to visit a new agency and talk to new people. Young women may benefit from further information on these intersecting issues, as well as the options available to them, and the practical sources of assistance that may be available to them.

- Young women's concerns about the limits of confidentiality and the repercussions of disclosure need to be addressed from the outset. This is a priority area for the Stella intervention to work on.

Further Training and Support for Practitioners

- Practitioners may benefit from further training and support focused on how to identify and act on these intersecting issues, and the available referral options appropriate to young women.

- Practitioners may benefit from a clearer understanding of young women's own perspectives regarding their apparent 'reluctance' to disclose. Both young women and practitioners note this tendency, but the sense practitioners make of this may influence whether they are willing, for example, to engage in early questions about these issues; whether they feel it best to rely on young women to self-identify; or whether to invest further time in 'building a connection' prior to asking such questions.

- Practitioners may benefit from a regularly updated electronic directory of relevant agencies. However an updated directory alone is not enough. In order to be able to use it effectively and respond to women appropriately, practitioners require a more integrated understanding of, and responses to, the issues and the ways the issues intersect in each service. As well as referring young women to other services, each service should be able to do some work with each woman on the intersecting issues. Or at least start with such an intention.

Developing Services in Response to Young Women's Needs

- Services should spend more time identifying the differences between the younger and older women, and develop their work in order to ensure they respond to their needs more appropriately. For example do services for women aged 16+ sufficiently address the differences in needs for younger women (e.g. 16-18) compared with adult women (over 18)?

- If young women are still in education, do partnerships exist that serve their needs? More partnerships should be developed between specialist services and generic services/institutions.

Recommendations for Policy makers

- Policies and procedures addressing young women with overlapping issues appear to be virtually non-existent in both boroughs at both an agency and borough level. Alternatively it may be that they do exist and we were not provided with them. This remains a key area in need of addressing – ensuring that policies and procedures for working with the young women and between the agencies are developed and implemented for each borough.

Recommendations for Commissioners

- More recognition is needed that being young can be an intersecting issue, and that services need to develop specific responses for young women that are different from the service they provide to adult women experiencing the three overlapping issues. This should be reflected in policies and procedures.

- Little is yet known about the differences between the younger and older women, nor about how services are responding to their needs. For example are services for women aged 16+ sufficiently addressing the differences in needs for younger women (e.g. 16-18) compared with older women (over 18)? Many young women aged under 16 expressed concerns about the limits to confidentiality, which warrant further exploration.

- Many of the young women and practitioners held inaccurate and sometimes confused attitudes and beliefs about the intersections of drugs (particularly alcohol) and violence. Challenging these should be a priority area for the Stella intervention to address.

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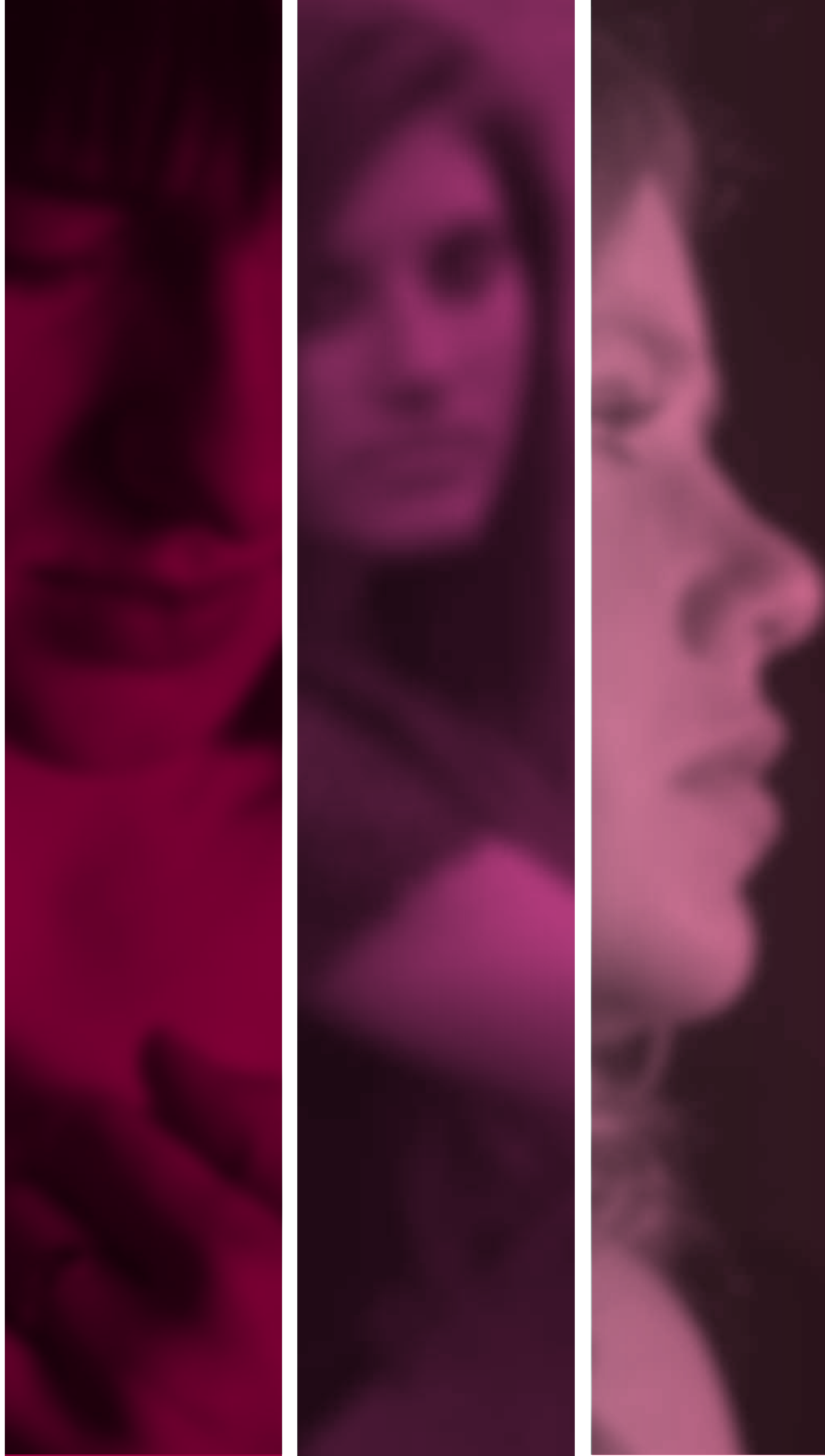

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AVA (Against Violence & Abuse),
4th Floor, Development House,
56-64 Leonard Street, London
EC2A 4LT,
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