



Spotlight #7

Podcast Transcript

Welcome to Spotlight. The podcast for the domestic abuse sector. In this series SafeLives is shining a spotlight on people who are affected by domestic abuse who are also experiencing mental health problems. In this podcast Collette talks to Dr Kylee Trevellion from the Women's Mental Health Department at Kings College.

I: Kylee you're based in the section of women's mental health at Kings College. Can you tell us more about the type of research that's being carried out in your department regarding domestic abuse and mental health?

R: Yes. So I joined the section ten years ago and at that point Professor Louise Howard who leads our section was thinking about moving towards research around domestic violence. And in that time we've done a lot of work in that area. So for example, and thinking about where we are now we've got some very interesting projects that are going on currently. We have a PhD student, Roxanne, who is looking at piloting the impact of a mental health programme which includes a component on education around domestic violence for women in Ethiopia. Because there's high levels of domestic violence in that kind of setting and wanting to think about addressing and providing some support. It might be based lower level appreciating the lower resource settings that they're working in.

We've also got a PhD student, Karen Bailey, who's looking at developing a complex intervention to address issues of interpersonal abuse, trauma and substance use amongst women. One of our colleagues, Fraser Anderson, we're doing some collaborative work with her looking at women's experiences of interpersonal abuse and early mother child interactions. And Louise and my colleague Sian have recently been awarded a new violence abuse and mental health network which is bringing together experts from a range of different disciplines. And it's looking to enhance policy and research areas in this field.

So I started here as a research assistant with Louise on a project which was looking at assessing first of all the issues around identifying and addressing domestic violence in mental health services. And I was fortunate enough within that project to do a PhD part time. And within that I was really able to explore these issues in detail. Generally what we found from that work is that many people that have severe or chronic mental health needs have experiences of domestic violence. And that, unfortunately at the time, and I think it's still a factor to a degree now, mental health services didn't have very robust policies or strategies for addressing these issues. So there's, when we started doing this work we found that about only between 10 and 30 percent of cases of domestic violence were being identified by mental health services. But yet we think, there are some figures that suggest maybe, in our literature we found about a third of all women and maybe a third of men might be reporting with these issues. But they're just not being picked up.

So we've spent time within our section looking at why that is. So what are the barriers for staff and what might be the barriers for service users in talking about these issues. I've been working on some small evaluation projects to look at how we might improve the

response of mental health services based on this work. So to inform that we've done some surveys with staff looking at some of their experiences of asking about domestic violence and also responding. And we've looked at the literature to see what kind of treatments might be available for people with chronic or severe mental health problems. And at this particular point in time there's a limited evidence base. Specifically around supporting people who are engaged with mental health services.

But some of the things that are coming out from the reviews of the literature on interventions is the value of having psychoeducation in any kind of treatments, looking at the causes and consequences of domestic violence. But specifically having treatments that are focusing on ongoing risks, the development of cognitive and emotional skills in relation to helping people address the trauma, symptoms related to their experiences and models that are looking at building on survivor strengths. We've also worked with a group, so a third sector organisation against violence and abuse were developing a programme of work looking to improve the response at a strategic level for mental health services to domestic and sexual violence. And my colleague Sian and I did an evaluation of that project. What we found before that, it was based in two trusts, one in London and one in a more rural area. We found that the responses by the trusts were quite inconsistent. For example one of the trusts had a policy, the others had one in development but there wasn't a clear strategy active at the time. The work that AVA did was to try and work with the trust senior team and leadership to develop protocols informed by the NICE Guidelines around domestic violence. She also looked to deliver training for staff and to establish train the trainer. So giving more intensive training to certain members of staff around these issues so they could then continue the education for their teams once the project finished. And they also did a lot of work in helping staff when they're identifying domestic violence to refer on with local specialist third sector agencies.

And at the end of that project we found there was increased access. Staff were reporting they had increased access to support around responding to issues of domestic and sexual violence. But there was a need to really embed that as part of core business.

I: So that's a huge range of projects that you're undertaking at the moment in the department. It's really impressive and there's so much to ask you more about. I know some of your past work has included conducting a systematic review on the relationship between domestic abuse and mental disorders. So I guess as just a basic starting point could you tell us a bit more about what you see to be the relationship between those two things?

R: Yeah so a few years ago we wanted to have a look at what was the current evidence base for this. And the ideal situation at that time would have been able to do a direct comparison between people that have mental health concerns and their experiences of violence against people who don't have mental health concerns. Because that allows us to really explore are there increased risks or vulnerabilities for these groups. So we looked at the international literature in this field. And what we found is that across the diagnostic spectrum of what we understand classifications for mental health problems that both men and women who have experiences of mental health problem are reporting high rates of domestic violence and they're showing increased vulnerability to these experiences when compared to people who don't have mental health problems.

When we look at the kind of cause or pathways of that are there's less evidence following people up over long periods of time in order to see which, whether the violence proceeds mental health problems or is a result of that. But when we can see from the literature that's out there is it's likely to be a bi-directional relationship. So there is evidence out there that people who are in violent relationships, it has a very detrimental impact on their mental health and it may lead to the development of mental health problems. But also that people who have mental health problems they may be vulnerable to experiencing domestic violence. And in the wider literature for people with chronic and severe mental

health problems we see that they're at risk, increased risk for a range of violent experiences and interpersonal abuse compared to the general population.

I: Yeah and I imagine that in the analysis it then gets quite tricky to try and separate things out because people don't present with single issues, people are, you know, there's a complexity around the different issues that people would have experienced and the different harms they might have experienced over their lifetime.

R: Yeah and I think one of the things that we, there is a lot of research out there looking at victimisation. That's the phrase that they use, experiences. But not, increasingly there has been but in the past there's not been much work teasing out what type of experiences they are. Because within that there's a lot of things. It could be a burglary or a mugging. But there's also the interpersonal and domestic and sexual violence elements to it. And in the past they were kind of clustered very much together. But one of the things that we are keen to do within this section is think about those repeat violence experiences by people in interpersonal and intimate relationships which potentially has a bigger impact on mental health over the long term than say a single isolated event.

I: So could we think in particular about victims of domestic abuse who will be classed as having chronic enduring and severe mental health issues? So what do we know specifically about their experience?

R: So my colleague Hind Khalifeh who's based in our section as part of her PhD work she was able to draw on the, what used to be the British Crime Survey but now the Crime Survey for England and Wales. She was able to draw on that data from the general population which asks about experiences of domestic violence and compare that to a group of mental health service users who have chronic and severe mental health concerns. Using the same questions that they asked in both surveys what she was able to tease out is that the people with chronic and severe mental health problems are reporting higher experiences of domestic and sexual violence within the past year. And they're at greater risk than people without, than the general population. But also that the people with chronic and severe mental health concerns who have experienced abuse, when you compare their perceptions and experiences to people without these issues but have experienced domestic violence you see that their perception of the assault is that it was much more serious. They report more injuries. They're feeling more emotionally affected by the experience that's happened to them. When you adjust for other factors that might influence their experiences you find that people with chronic and severe mental health concerns are less likely to attend hospitals in response to their injuries following their assault or to seek medical attention. And that they are less likely to be implementing safety strategies in comparison to the general population. So I think there's key things that mental health services can do there to support people with these issues to think about supporting their safety and helping them get support for their health needs in relation to this.

So also thinking that for Idva's as well when they are working with clients to think about risk and safety not being an absolute but it being subjective to each person's experience. So you might have one client that's able to employ certain strategies but another client that doesn't feel able to. And to be thinking about risk and need in that way rather than in static risk factors.

And I think one of the things that I've found with my PhD work when interviewing service users is that there's also a lot of stigma and shame that we might see across people with the experiences of domestic violence. But there is that potentially double discrimination of the concern that they, because of their mental health needs they may not be believed in their narratives, if they're talking to people about what's happened to them. And so one of the concerns also for mothers is that if their disclosing their experiences because of

their mental health needs that services might question their parenting capabilities. And that might become a key barrier for them in disclosing what's happening to them.

I: Yeah so for the individual they can feel like the factor that will really influence safeguarding responses is their mental health rather than the trauma and the abuse that they're experiencing.

We tend to hear that the detection rate of domestic abuse is relatively low amongst psychiatric services and at the beginning you said that your departments been looking at that issue. So what are your thoughts on the barriers? Like where are they and what do those barriers look like?

R: Yes so we did some surveys with staff a few years ago looking at what their practices are around identifying issues of domestic violence. And what we found is that there's not, generally staff are not employing routine enquiry about issues of domestic violence in their practice. And that many of them feel that they don't really have the confidence to know how to respond if someone makes a disclosure or that they're aware of local or national services to support people who have experienced domestic violence. And when we've delved into that a bit more deeply by doing interviews with staff and thinking about the structures of services we find that traditionally mental health professionals have not been trained around issues of domestic and sexual violence. So they aren't sure about how to start that conversation. Overall they generally know that this is an issue and they see that it does have an impact on their wellbeing of the service users that they're seeing. But because they don't feel they have the confidence and skills to support them sensitively when they've made a disclosure or to refer them to the right services it acts as a barrier for them starting that conversation.

What we've also found when we've worked and done interviews with service users and professionals together is that they talk a lot about how the current structure within mental health services is very much on a biomedical model. So the focus is on identifying and treating presenting symptoms. And the overriding focus on management of symptoms means that there's little room for exploring the underlying factors that are affecting peoples mental health and why they might be developing these symptoms. So I think another issue is that there's little consideration of the role of domestic violence in precipitating or exacerbating mental health problems within the current format of this, of the assessments and treatment models which means that creates another barrier to exploring these issues.

You can see that that mind set and that model of working, how that might play into medical professionals not undertaking work in domestic abuse or finding out more about that because in their mind they might be thinking if they're symptoms of domestic abuse then I might refer to a domestic abuse service but it's not within my remit to be incorporating that into my conversations with a patient. But that's a shame because of course you know, a patient is the whole person and they may really want to talk to their mental health practitioners about what's going on at home.

Yeah and I think it's encouraging the professionals themselves do see those limitations and actually they do see it as part of their remit but actually the way that the current structure is make it difficult for them to even have the time to explore these issues or there's scope within that. And I think one of the things that would help these things is to think about training staff in knowing how to ask sensitively and how to immediately respond in an appropriate way and then the get people access to specialist services.

I: So there's a role for domestic abuse services to get to know their mental health teams and to empower them I guess and equip them to do some, to start those conversations with people that they're seeing.

R: Yeah I think they can be very powerful. And one of the programmes of work that we've done is tried to bring the two sectors together. Also the NICE Guidelines on domestic violence talk a lot about thinking about training programmes with trusts, working with the voluntary and community specialist organisations to develop a training package that's informed and has the right, can impart the right knowledge to professionals. But also to be working with the teams to create commissioning pathways to ensure that the resources, the clear pathways are there. As it is when we started this research the initial conversation isn't happening and as a consequence of that it's not being picked up. Service users because the discussions we had in the previous question have a lot of barriers to starting that conversation and find it difficult to know how to initiate the conversation. They're also sometimes picking up on the sense from professionals that they're not so certain with these issues and their understanding that the focus is very much on just the symptoms that they're presenting with at that assessment. So they're not being able to help, think about formulating a treatment plan or support plan for them.

I: **You were saying earlier about co-leading a project to increase the capacity of mental health trusts to effectively respond to domestic and sexual violence. So I'm just wondering what you would see as a good response by a trust? Do you have any examples of what that might look like?**

R: I think there's some key things there. One of the things that would be very useful is improved information sharing between agencies. So having some clear protocols and methods between agencies about sharing information because people are often engaged with many services and in order to develop a kind of holistic coordinated response it would be important to be able to share information in order to make the care plan as holistic as it should be for people. Also I think again I mentioned commissioning, thinking about a coordinated commissioning response which works across relevant agencies. So in many settings there are numerous local voluntary sector organisations that have been working for years in this area and are specialists in supporting people in domestic violence. And having a commissioning pathway that staff can utilise to refer people to these services would be very important. Again based on what we talked about I think training is key to this. And again this is reinforced by the NICE Guidelines, that health and social care practitioners who are involved in caring or assessing people should be trained in issues of violence and abuse and domestic violence and should be able to feel confident to start the conversation and to know how to build a form of support around individuals. And working with those expert local agencies to develop this training.

To facilitate that then routine enquiry should be something that's used and utilised within services and making sure that staff are routinely enquiring. But another key part that I found from the projects that we've done is issues around documentation and clear documentation in notes, clinical case notes about the discussions that have been had about the formulation of treatment plans. So there's work that's been done showing that the reporting can be quite patchy. So it's hard for people to know, if they're seeing someone what might have been explored in the past, if there's any kind of support around the domestic violence or the issues for that. And then that makes it very difficult for people to know if it's been addressed. And also for service users as well there's a concern that they have to keep maybe repeating these traumatic experiences to many people and not having a coordination around what their plan is. I think that would be very useful. And then finally having a clear referral pathway. So if the trusts themselves have a domestic violence policy which has all these things outlined and they're working towards ensuring that those are in place I think that'll be really, a game changer really.

I: **I mean I think in terms of recording something that we do see for domestic abuse workers, a lack of clarity sometimes around when somebody has a diagnosis of a mental health condition and what that means in terms of how it's going to impact on risk. And when there is self-reported mental health symptoms but not necessarily a diagnosis which means a care plan or treatment and just a lack of**

clarity around that. Both for people experiencing domestic abuse but also alleged perpetrators of domestic abuse. And that can make it quite difficult sometimes for domestic abuse workers to navigate. So what service is this person getting or should they be getting and who do I report my concerns to. So I was just thinking that that recording issue could be really significant for frontline workers as well.

R: Yeah. And I think with thinking about the Marac's that exist, making sure there's been some work done previously showing that attendance at those meetings by mental health representatives might again be patchy in certain areas and that would, if that was improved that would definitely help provide and support that coordinated response and those shared learnings. And something that Louise and I did a few years ago was when we did our review of the evidence base to see what kind of treatments might be available for people with chronic or severe mental health concerns and experiences of domestic violence, as I mentioned there was a limited evidence base there. But we saw some good developing work from primary care settings and also the community about domestic violence advocacy. So we looked to adapt a model and to implement that within mental health services. So we had some Idva services within the local community around the same area as the mental health teams that we were working with. And what we did is bring, second a couple of the Idva's to this project. They received some training from our team early on about how to support people with chronic and severe mental health problems. Also getting them to become familiar with the structures in mental health services, what terminologies and language they use. And then what we did is to embed them within the community mental health teams with the professionals with the idea of them to have a reciprocal education. So that the mental health professionals could help to continue the learnings of the advisors in how to work with mental health services or work with service users who have mental health needs, but also that the Idva's could really help to train up staff about issues of domestic violence. Which was something again, the same thing we've seen from our surveys, that staff had lack of training, they didn't feel confident. They were worried about opening a Pandora's Box and not knowing how to respond sensitively. So the Idva's could work with them. They did regular training with staff. Some intensive training at the beginning of the programme delivered by an experience clinical psychologist. But then the Idva's continued for the two years that the project was running to educate staff around specific issues. And staff kind of came to them with certain things that they were getting aware of in their practice that they wanted advice on. So like housing support for people experiencing domestic violence, honour related violence. And what worked really effectively here is that the staff, with the training, were starting to ask people more regularly, to explore these issues of domestic violence. By starting that conversation service users felt able and it was a safe place to disclose. And then because the Idva's were embedded within the team they had a named person and a professional that they could go to immediately to discuss the case. And if necessary the advocate could take them on and provide advocacy for them.

The advocates in reflecting on their practice noticed that they were working, their general advocacy work tends to be a bit longer with these client groups because they have maybe more needs than they might see in a community population. But that they could really, for themselves being embedded in the service it really helped them think about how they could support the whole holistic needs of service users by working with the mental health staff to support, to provide the advocacy work they're doing but also the mental health support that they might need.

And then recently I was involved in an evaluation in a North London mental health trust looking to do a similar thing. And again we saw with the training package and embedding the advisors in services it did make a difference in making mental health professionals feel confident to start these discussions and know where to refer.

I: And the more people have those conversations the more confident they're going to be at picking up more subtle signs of coercive control because they'll just become

much more fluent in the language of domestic abuse and exploring it with somebody. I was thinking also what a huge benefit it must have been for those Idva services to have those Idva's take part because that learning being embedded within a mental health service, they'll be able to take that and apply to all their future clients but their colleagues as well and just the conversations they would be having with their colleagues around the work that they're doing how that would really enrich their colleagues work with their client groups as well. So just huge kind of beneficial knock on benefits from that.

So I think that's a really lovely example of some promising practice that we might be able to start thinking okay how can we replicate that in other areas of the country. So I wondered whether there are other pockets of like emerging promising practice that you're seeing in this area.

R: Yes so I think, I mean I know that SafeLives do a similar kind of work of embedding Idva services within A & E settings. So more acute settings. And I think increasingly, these are small research projects that we've been doing in the mental health side and SafeLives are doing a bigger scale in A & E. But they really do seem to be working effectively and they are helping to at least receive from the smaller evaluations that we're doing to change practice and increase confidence. So I think those models work really well. And thinking about how to ensure sustainability of these kind of programmes, I think what's really critical is making sure that there is support for these interventions and these projects at the very senior level of the trust. So it needs to be both a bottom up and a top down approach to making sure that it becomes part of, this response to domestic violence becomes part of core business for services who have clients that come to them who have mental health needs, that this becomes a part of the core agenda and that the organisation itself are, a safe and open space to be facilitating those discussions. But also that the staff that are working there are trained and feel confident to pick up these issues and to get people to the right places.

I: So you and your team must have spoken to lots of people that have experienced domestic abuse. I'm wondering what it is that they say about their experiences of services and what they would like and what they don't want from a response?

R: So what we see is that service users do want to be, they do want their health professionals to be asking them about experiences of domestic violence. And I talked before about needing someone to initiate that conversation. We see from the literature that people who have experienced violence feel more confident to disclose to a health professional than say the police or other services. So the health sector are a critical person to be starting and helping to facilitate disclosures. What service users want is for staff to be asking these questions but also be acknowledging, to be aware. Coming to that point again about training. To know what domestic violence is and how that manifests. So people have said that they've had, professionals have come to see them when they're at home or with their partner or the abusive person and that they haven't picked up on those behaviours. We talked about the coercive control, those more subtle behaviours are maybe being missed sometimes.

Also by staff talking about these issues people have told us that sometimes it's been hard for them to identify that they're experiencing these things because of those subtle coercive behaviours. It can be very hard for people to understand what's happening. And particularly we see that abusers may often tell people when they've got mental health problems that this is just all in your head and this isn't really happening and you're unwell. And so they start to really question whether this is happening. But if staff are able to talk to them about this is what domestic violence is, these are the kind of behaviours. We know it affects a lot of people. Is this something you might have experienced? I think they feel is very important. But interestingly although service users are quite, identify the importance of starting this discussion when we talk to staff some of them are concerned

about routinely asking in case they might offend people who haven't had these experiences by asking them if they have been affected. And also that worry about potentially re-traumatising people by raising these issues. But the service users themselves tell us that actually they want to talk about it. And for those that don't have these experiences they recognise that this is a factor that affects many people and it has an impact on their wellbeing. And so they wouldn't feel offended if they're asked these issues. And actually they think it's important that it is routinely asked. So I think that's an important point to convey to professionals that both those that do and don't have those experiences think it's important to be raising the topic.

In relation to this is what the evidence base currently suggests to us. And we've done, we have engaged with many service users but there are still some groups who aren't represented both in the research literature and that's thinking about transgender groups. When I talked about the prevalence figures earlier. There is a lack of literature around there for these groups within the context of mental health service users or people with chronic and mental health needs. But we come from some of the literature and the general population that these groups are particularly vulnerable to these issues. And similarly some other marginalised groups are maybe not so well represented in the research that's out there to date. Increasingly there is a focus on these groups in trying to get a better picture of their experiences. But it's still something that needs to be worked on.

I: I think it's a really good point that we're thinking about victims of domestic abuse who are experiencing mental health problems as a hidden or marginalised group but they're not a homogenous group. And within that there'll be people that have other factors which put them at even further disadvantage and make them even more removed and hidden from services because of these other factors around their identity.

So there's a couple of projects that Kings College are involved in which sound really really interesting so I wanted to ask you a bit more about them. So the For Baby's Sake programme that you're involved in and also LARA. Could you tell us a bit more about what those are and what they aim to do?

R: So the For Baby's Sake programme is being implemented, it was developed and implemented by the Stefanou Foundation. And they have recognised, they're thinking about this idea of adverse childhood events and the impact that that can have over the life course in affecting the children's future families. So what they did as part of this programme is bring together experts in the field. So experts who work with supporting women overcome their experiences of domestic violence. Also bringing together the experts that work with men who are using violence in intimate relationships to think about developing a treatment model for them. And then also bringing in early intervention practitioners and experts to think about how to best support the development of young children. So the programme is a two year intensive programme where these three types of treatment models have been brought together and developed into a very comprehensive treatment model which is currently being piloted with groups, two teams in different settings in urban and a more rural setting in England. And they are working with families where the mum is pregnant and the biological father is someone who's been using violence in the relationship. And they do intensive therapeutic work with mothers and fathers separately. If it's safe to do some at some point in the programme they might do some work together. And then they're also looking at trying to help both mothers and fathers with their interactions and relationship with their children. Because whether the programme takes the approach that people may or may not want to stay together but they are both coming to the programme because they want to be co-parents in the child's life and they're trying to develop a programme of work that will lead to ending the violence and improving the support for the emotional and physical development of the children.

I: And I guess with the ultimate aim of reducing the number of care proceedings that then have to be followed and children being removed because right from pregnancy we're working with families, supporting families to try and prevent it getting to that point.

R: I mean it would be interesting to see if that's something that could potentially be a future outcome for the project.

I: And the LARA project could you tell us a bit about that?

R: Yeah so the LARA project is, Louise and I started that a few years back and that's the model I talked to you about about trying to bring together the domestic violence and mental health sectors to work in conjunction to provide a holistic response to people who have mental health concerns and experience domestic violence. So it's a kind of reciprocal training model but also a way of setting up a clear pathway to a trained advocacy model with IDVA's that are competent in supporting people with complex mental health needs. We did some pilot work within the community teams that I mentioned earlier and now Louise and I and my colleague Sian and some other collaborators that we're working with and Emma in our group, we're looking to try and do some work around, to working out how to upscale that to think about formally testing it on a bigger scale. By thinking about what training packages we need to do. We need to update that because it was a number of years ago. We also when we started, when Louise and I were doing the LARA project that mental health professionals were talking to us about the fact that they also come into contact with users or have contact with people who are perpetrating violence in their intimate relationships or their close familial relationships. And they weren't sure how to think about addressing those issues. So as part of the works to extend on that programme and roll it out on a bigger scale we're also thinking about what kind of resources and support might staff need in picking up those elements of their practice and making sure that they are able to best support both clients' needs around the domestic violence.

I: Yeah. So really thinking about a whole family approach not just the response to the victim of domestic abuse but also thinking about how medical practitioners can work with, speak to perpetrators of domestic abuse as well.

R: Yeah it's something that they see in practice. They do work with users who have these issues, abusing violence. And they're often unsure about where to direct people. The same things about what their care pathways are, what services are available. How to best think about helping them to overcome those behaviours. So it's, yeah we'll try to be doing, working within that programme to also concentrating on best ways or promising models to address those things.

I: Kylee thank you so much. It's just been so fascinating talking to you and I feel like we could just set up camp at Kings College 'cause there's so much good stuff going on here. We could just spend a week here like finding out more about it all. So thank you so much for taking the time to speak to us as part of this Spotlight series and we'll make sure we include some links to your website and to the various papers that you've been referencing.

R: Thank you. And it's a pleasure for me to be involved in this series 'cause I draw on your Spotlight work in my work so it's a real honour. Thank you.

I: Thank you.

