

Guidance for multi-agency meetings: Mental Health

Aims of this report

Following our latest National Scrutiny Panel (NSP), this report aims to highlight areas of improvement that can be made to how we support people affected by domestic abuse who are also experiencing mental health problems.

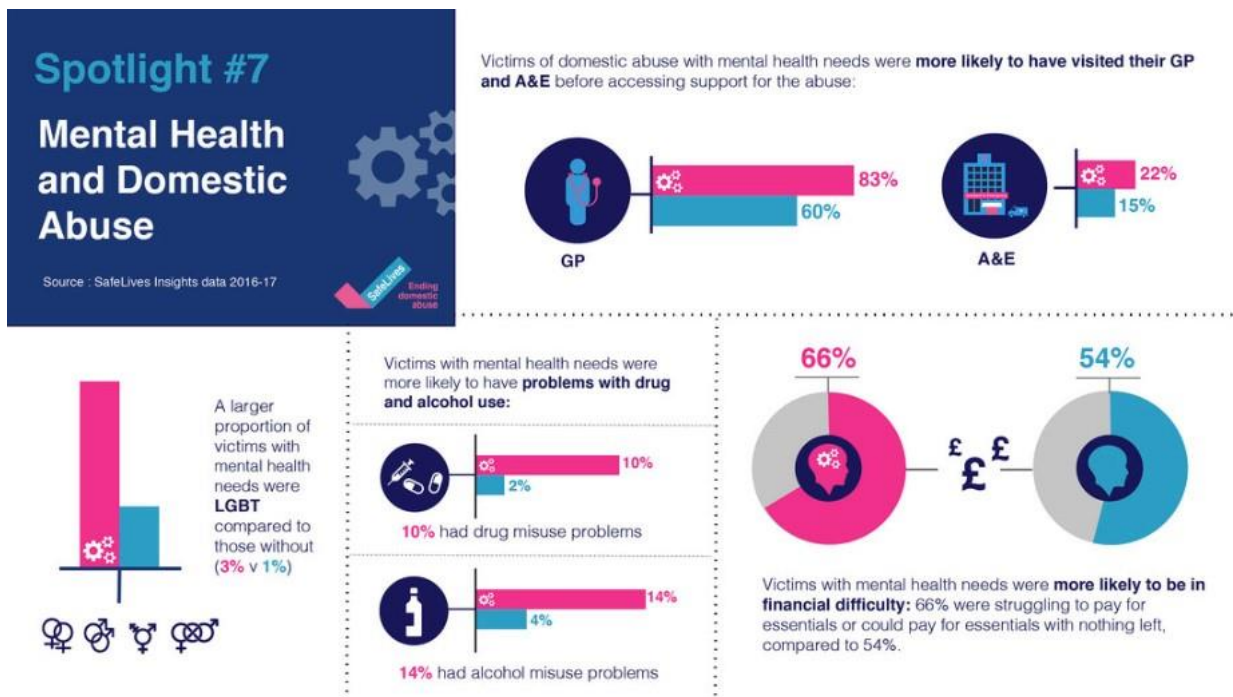
We know that people experiencing mental health problems will face additional barriers; to disclosing, to being believed and to accessing services. As such they form a 'hidden' group, whose voices are rarely heard. It is important that we identify the barriers, and examine what both frontline practitioners and those with a strategic role can do, to ensure services are more inclusive and responsive.

The NSP brought together a range of people with expertise in mental health and with experiences of multi-agency responses to domestic abuse. Together they looked at four cases involving victims at high risk and/or perpetrators of domestic abuse where mental health was a significant factor. Their remit was to examine the information shared and the actions taken by the multi-agency groups that had originally heard these cases. The panel drew out good practice and areas for development, and the lessons learned helped formulate the recommendations in this report.

Whilst auditing cases for the NSP we found common themes which we have captured in this report. A number of our recommendations have been informed by findings from our [National Dataset of Insights services](#) and our recent [Spotlight series on domestic abuse and mental health](#).

Common themes arising

1. The importance of involving mental health services in ending domestic abuse



- Our Insights data illustrates that the co-occurrence of mental ill health and domestic abuse is a significant dynamic for multi-agency forums to understand. Health services are uniquely placed to help identify victims/survivors and perpetrators of domestic abuse and to refer them to appropriate support.
- Victims and survivors with mental health problems are not a homogenous group. Some people will have enjoyed good mental health until experiencing domestic abuse. For others, abuse in adulthood follows childhood experiences of domestic abuse, compounding the mental health impacts. Furthermore, having a mental health problem can create vulnerability which abusers seek to exploit. Abusers may attempt to misdirect professionals that the victim/survivor's presentation is symptomatic of their mental health condition(s), rather than *indicators* of abuse. Mental health problems among perpetrators of abuse also show wide variation.
- Understanding a person's mental health history and whether they have experienced repeated traumas is important for assessment, support and selecting interventions. [Mental health services](#) need to be equipped and confident in talking about domestic and sexual abuse with their service users.
- Multi-agency forums such as the Marac process provide a framework in which agencies can upskill each other in their particular area of expertise. The Panel shared examples of good practice, for example one London Marac noted a high rate of personality disorders amongst victim/survivors and perpetrators referred to the Marac. A link was established between the domestic abuse service and Personality Disorder Unit, resulting in reciprocal training.
- Improving links between domestic abuse and mental health sectors will enable practitioners to make better assessments. This increases the likelihood of victim/survivors being seen by the most appropriate service, avoiding lengthy waiting times for inappropriate services e.g. low-intensity counselling. This may be achieved through creating specific roles that sit across the sectors, for example in [North Devon](#) a pilot project saw the creation of a mental health Idva. There is also emerging evidence of the efficacy of domestic abuse advocates within mental health services, including pilot projects for [Linking Abuse and Recovery through Advocacy \(LARA\)](#) and [For Baby's Sake](#).
- The co-occurrence of substance misuse and mental health problems is common, yet can dramatically reduce access to services. People with dual diagnosis often find that neither substance misuse nor mental health services are able to accept their referral. Multi-agency processes should provide a framework for agencies to agree how they will work together. Both mental health and substance use services are core members of the Marac process and their regular attendance and engagement is critical for establishing collaborative responses to people with dual diagnosis.
- The Panel highlighted that there is an increased risk of relationships developing where both parties have mental health difficulties. This presents a particular risk dynamic. Wanting to access help for their partner's mental health was thought to be a key driver for victims/survivors disclosure. Both Marac and MAPPA processes present an opportunity for professionals to action plan around the perpetrator's mental health needs.
- The Panel highlighted that the role of the [GP](#) within the whole mental health economy is crucial as they are often the gateway to mental health services. GPs should be the central point of care coordination, but it was apparent that links between multi-agency processes and GPs are not consistently formed. Attendance at the Marac meeting by individual GPs is not ordinarily efficient or practical. Therefore, each Marac needs to establish which representative is best placed to undertake liaison with GPs as and when needed. We would suggest that Marac steering groups agree this process. We have several [resources for GPs](#) and encourage GPs to explore accessing the [IRIS service](#).
- In respect of Maracs, representation needs to reflect the whole mental health economy; A&E, primary health, secondary health etc. This is because the actions that can be offered by e.g. A&E liaison compared to secondary mental health services will vary greatly. This may be achieved by including a number of representatives. It is not, for example, uncommon for [A&E to attend Marac](#). It may also be achieved by careful selection of a Marac representative who is able to liaise widely. We would suggest that Marac steering groups review whether current representation at Marac reflects the whole mental health economy and whether representatives are sufficiently resourced to be able to undertake the level of liaison required.

2. Unclear and confusing pathways

- It was evident within the cases looked at that referral pathways were not always clear and that service users were getting 'lost' within the system. The Panel noted examples of service users being frequently 'bounced' between GP and Psychiatric services. In one case, the Idva was told by the GP to request psychiatric assistance from A&E who referred her back to the GP.
- The Panel felt that the examples looked at were indicative of a problem which occurs on a wider scale. Being 'bounced' between departments is not only confusing for people experiencing mental health, but that it also negatively impacts their wellbeing. One panellist also described a parallel of "*the bouncing back and forth between professionals mirroring her experience with her abuser*". Mental health representatives can help improve the response to victims of domestic abuse by taking opportunities for advocacy or supporting the Idva/Idaa to do so.
- The Panel also highlighted how differing thresholds sometimes meant that victims of high risk domestic abuse with serious mental health problems were still considered ineligible for mental health services. In one example, a woman receiving monthly anti-psychotic depot injections who had been referred to Marac nine times within a year, was still assessed as being below the threshold for support from Mental Health services.
- It was noted that non-mental health practitioners within multi-agency forums sometimes struggle to escalate concerns when service users appear not to be receiving the mental health input they need. The Panel saw this particularly in relation to Maracs without consistent mental health representation. It was difficult for Idvas/Idaas and Marac Chairs to know how and where to escalate their concerns. Multi-agency processes provide an opportunity for services to learn about each other's resources, referral pathways and escalation policies and it's important that representatives take the opportunity to upskill their colleagues from other sectors. We are producing guidance for domestic abuse practitioners which will be available late January 2019.
- The Panel called for a better understanding of the differences between counselling and psychiatry; these are often confused or conflated resulting in people being referred inappropriately.
- The Panel highlighted the importance of bringing domestic abuse into other safeguarding arenas and not relying solely on the Marac process to address the risks presented. The Panel particularly noted the responsibility that Adult Social Care (ASC) has regarding safeguarding and highlighted that Adult at Risk procedures provide guidance that could prove to be effective in these cases; including having a lead from ASC (Adult Protection in Scotland) coordinating a multi-agency approach. The Panel noted that more common approaches saw an over-reliance on the voluntary sector to manage such cases.
- The cases demonstrated a need for clarity regarding the roles of ASC and mental health services. The Panel raised concerns that ASC may defer to Mental Health but Mental Health may not recognise the safeguarding issue or undertake necessary enquiries. There was evidence that there needs to be much clearer collaboration and a shared understanding of risk and need.

3. Participation not just representation

- The NSP highlighted how vital it is to make the issue of mental health central to any multi-agency plans and responses. For this to happen safely and effectively, the active participation of mental health practitioners is vital.
- It was felt that within some multi-agency forums, the full extent of the role of the mental health was not being realised and/or enabled. This resulted in mental health representatives tending to share information only, rather than sharing their knowledge and expertise to enhance risk analysis and action planning. Examples of this included mental health representatives relaying relevant information about a service user e.g. their diagnosis or their history, without offering analysis or explanation, and examples of representatives providing information verbatim from their records even when that information was incomplete or vague.

- In some of the cases, the victim/survivor was referred to as having multiple diagnoses without clarity around where these diagnoses originated. The Panel expressed caution about people being labelled as having particular mental health conditions without formal assessment by psychiatrists. The Panel queried if these were actual diagnoses or symptoms reflecting a diagnostic criterion but which could also be symptomatic of domestic abuse. For example, anxiety which can be both a diagnostic criterion and a normal reaction to coercive control.
- It is important to have mental health representatives who are supported and equipped to provide expert insight. Mental health representatives can offer guidance crucial to risk analysis and action planning in a number of ways;

They can demystify jargon, explain pathways, treatment options and give guidance on how to escalate concerns. They can clarify the 'primary' diagnosis where several diagnoses have been given over a period of time. They can give case specific information on the extent and impact of someone's mental health condition. They can offer detail, enabling forums to identify areas of risk, vulnerability and of strength and resilience, resulting in plans that speak to the whole person and not a generic medical condition. They can give general insight into the impact of mental health conditions, for example, how PTSD may impact on a victim/survivor's responses.

- It was noted that within some Trusts or Boards, there may not be a clear description of the role of the Marac mental health representative or that the role may not be written into any particular job description. This can impact on time and resource allocation. The level of participation needed requires support from Mental Health Trusts and commitment to the process from senior management. In practice, this means agencies valuing the role, providing a full induction to the Marac process, and the ongoing support needed to successfully represent the mental health sector. SafeLives have online [resources](#) and [e-learning packages](#) to help new Marac representatives understand the scope of their role.

4. Trauma informed working

- There were several examples given of systems not being adapted to meet the needs of people with mental health problems, and as a result, vulnerable people finding themselves unable to engage with the services on offer. Symptoms of mental ill health can often be a barrier to accessing services. Some professionals will wrongly interpret this as a lack of motivation to engage. Potential service users may be described as 'failing to engage'; language which places responsibility upon that person to take services as they are offered, rather than services acknowledging that they may need to adapt their approach or style in order to achieve equal access for all.
- Adverse Childhood Experiences (ACEs) is a growing approach to understanding how experiences in childhood that create stress, can increase the risk of poor health outcomes in adulthood. The Panel aired concerns that sometimes ACEs is poorly applied in a fatalistic way, creating a blunt instrument that results in children being limited by the low aspirations set for them. It was also highlighted that ACEs assessment needs to be linked to support, prevention, and resilience building in order for it to be useful for children. We believe that if used correctly, the theory and data behind the ACEs approach could offer significant value. There is opportunity for colleagues in England, Scotland and Northern Ireland to learn from early progress in [Wales](#).
- The Panel also felt that trauma informed therapies should be routinely considered for adult and child survivors of abuse.
- Victim/survivors with complex needs are sometimes overlooked for referral to Marac. For example, practitioners wanting to conduct an assessment of risk in a particular prescribed manner, and then not assessing if the victim/survivor is not able to engage. It is vital that practitioners see risk assessment as more than just the completion of the Dash and that they tailor their approach to get the best assessment for each individual.
- Victim/survivors may feel that other issues in their life e.g. their substance use, mental health or housing, are more pressing than the domestic abuse they're experiencing. Practitioners should value the priorities that victim/survivors have. This is a cornerstone of the Motivational Interviewing approach which we recognise as good practice.

- Discharge planning meetings from inpatient mental health services were flagged as a good opportunity for Idva/Idaa engagement. If Idva/Idaas are part of this process (with consent from the service user), they can highlight risk that may not have been previously considered. For example, whether or not the proposed accommodation will be safe for the survivor. Relapse is less likely if the survivor is housed appropriately and offered ongoing support by the Idva/Idaa service. Exploration of information sharing with Idva/Idaa should be considered for discharge planning for perpetrators as this presents an opportunity for further safeguarding.
- Some current responses suggest a lack of understanding of trauma informed care. One of the cases highlighted how emergency A&E based psychiatric liaison is sometimes inappropriately used in lieu of a long-term care plan for victims/survivors. In the specific case examined, the survivor had a learning disability as well as trauma and complex needs. In spite of her level of need, she was still expected to wait at A&E for long periods of time when unwell. This is stressful and not conducive to supporting 'recovery' from mental ill health.
- Featured in the [SafeLives Spotlights series](#) are a number of projects and initiatives created to upskill practitioners to respond better where mental ill health and domestic abuse co-occurs. In some areas, specific mental health Idva provision has helped bridge the two sectors, resulting in more cohesive support to this client group. A recent example of this is the successful pilot of specialist psychological advocates within the [Psychological Advocacy Towards Healing \(PATH\)](#) programme which was recently evaluated (also see [here](#)).
- Domestic abuse services should consider reaching out to perinatal mental health colleagues. Perinatal mental health services tend to have a lower threshold for intervention and so there is potential opportunity for domestic abuse services to reach a greater number of victim/survivors, and to engage with them at a time when they may be more receptive to support.

5. Whole person, whole picture approach

- When supporting a survivor who has mental ill health, it is important to see past the label of the mental illness and understand the impact upon them. One Panel member called for professionals to “see the human, not the label to try to identify how the label is impacting them”.
- The cases showed examples of professionals casting doubt on disclosures of domestic or sexual abuse, based on their opinion that such disclosures could be symptomatic of a mental health condition. Not being believed is dangerous for victims of domestic and sexual abuse and for those experiencing mental health issues, fear of not being believed is a prominent barrier. Practitioners must think critically and enact professional curiosity with information that is shared. Information shared within multi-agency meetings should always be factual and accurate. Where professional opinion and judgements are voiced, it should be made clear and distinguished from factual information sharing.
- The Panel highlighted that perpetrators appear to be held less accountable when the victim/survivor is suffering from mental health problems, particularly if the perpetrator also has mental health problems. It is crucial that information about the mental health of both victims and perpetrators is used to enhance risk assessment and to inform actions. Careful assessment is vital and the mental health problems of either party should never be used as evidence that abuse is trivial, excusable or that it is mutual.
- Multi-agency forums such as MAPPA and Marac also need to consider how well they are joining up their approach in relation to managing risk. Learning from Domestic Homicide Reviews demonstrates that we are not consistently linking these processes. When there are multiple concerns and complexities such as mental ill-health and substance use, a professionals meeting is likely to be appropriate. It is important that the National Probation Service, Community Rehabilitation Companies, or Criminal Justice Social Work Service are embedded in Marac and are including Idva/Idaa services in planning meetings. Members of multi-agency forums should also be aware of local perpetrator provision, and the extent to which that links to mental health services.
- Whilst parents may be encouraged to seek help for mental health problems and/or domestic abuse, the fear of how children’s social care will judge their parental capacity, can be the driver for some to hide their symptoms. It is important that professionals consider how they can reduce these [barriers](#).

- The Panel highlighted potential inconsistencies with how risk is perceived by Children's Social Care. Specifically, mental ill-health experienced by a mother can sometimes appear to be given a greater risk weighting, than the weighting given to the abusive actions of an ex-partner/partner. In one of the cases a child displaying clear signs of trauma (violence, arson, substance use), was allowed to continue to reside with his father, who had exposed him to years of domestic abuse.
- The Panel were also concerned that in some cases, referrals were being made to Marac without a parallel referral to children and young people's services despite there being clear safeguarding concerns. It was highlighted that all agencies need to improve the way in which safeguarding referrals are made. Specifically, that practitioners be clearer about their concerns for children living with domestic abuse,
- It is important that assessments and interventions offered are cognisant of the dynamics of domestic abuse. For example if victim/survivors are asked to end contact with the perpetrator, this might result in 'pressure' on that victim/survivor to agree to actions they cannot manage, and the case being closed rapidly without ongoing support in place.
- It is essential to consider the co-relation of mental ill health with aspects of someone's identity e.g. sexuality, gender identity, age and physical disability, and consider how multiple disadvantage may impact on their options for support. As an example, our Insights data revealed that a larger proportion of victims of domestic abuse with mental health needs were LGBT compared to those without (3% v 1%). We have produced [guidance for multi-agency forums](#) on considering a range of diversity issues. Our [Spotlights series](#) and [the corresponding reports](#) are also sources of further information.
- It is important to consider how mental ill health can increase vulnerability to exploitation and abuse. For example, [cuckooing](#); the targeting of vulnerable people whose homes are then taken over for the purposes of drug use and selling and other forms of criminal behaviour.
- The Idva/Idaa can encourage practitioners from other sectors to consider the risk implications of safety measures they may usually recommend. For example, sanctuary measures such as door blocks and additional locks may not be safe when emergency services are likely to need to gain entry to ensure the survivor's welfare.
- Multi-agency forums also need to consider what can be offered to victims of domestic abuse when separation is unlikely. In the case of supported housing which stipulates that the perpetrator cannot come to the premises, it is not realistic to assume that this results in no contact. Instead contact happens off site and away from the monitoring and support of staff. It is important that action plans are individual and speak to the risks where and when survivors are likely to face them.
- Multi-agency forums should also consider potential risk from multiple perpetrators. [Survivors from some communities](#) may be under pressure to hide their mental ill-health and this may increase the [risk and barriers they face](#). There are links between Borderline Personality Disorder (BPD) and childhood trauma, and whilst this will not be the case for everyone experiencing BPD, practitioners should consider with the survivor whether living with or accessing support from family is safe and suitable.
- The Panel highlighted that wealthy and 'advantaged' women are more at risk of completing a suicide but that this risk is often not recognised by services. It is important that multi-agency forums do not assume that wealth or social status act is a protective factor or automatically increase the options and support a victim of domestic abuse has open to them.

Prior to Marac

A single point of contact with a trusted professional

- Survivors are best supported when there is a single point of contact (SPOC); a consistent, independent advocate working in a trauma informed way, who can coordinate support and facilitate relationships with other practitioners and services. The SPOC can be critical in helping victim/survivors communicate the full extent of their symptoms to medical professionals. This is usually the Idva/Idaa. There are examples, albeit rare, of specific complex needs and/or mental health Idva/Idaa roles. In areas where this is not the case, it may be more appropriate to appoint a different lead support worker, while keeping the Idva/Idaa closely involved. This might be a mental health specialist or social worker that has already formed a trusting relationship with the

victim/survivor. It is important that statutory agencies are holding responsibility in cases where adults with enduring or severe mental health problems are at risk. There is currently no such clarity for perpetrators.

Get the right people around the table

- Maracs are most effective when they have consistent representation of all the core agencies and when those appointed representatives are senior enough to be able to confidently make decisions and allocate resources on behalf of their organisation. It is our understanding that nationally, Maracs are finding attendance and participation by mental health representatives is patchy or non-existent.
- It is vital that the infrastructure is in place to support mental health and health services in general, to participate fully with the Marac process. Problems with participation should be escalated to the Marac local governance structure to address.
- We do not advocate routinely inviting frontline practitioners to the Marac meeting e.g. GPs, CPNs etc. This is because sporadic attendance to the meeting can be disruptive, it can take the Marac meeting into the territory of case management (which should sit outside the Marac meeting) and it is not sustainable. A more efficient and sustainable approach is to ensure that someone within the Marac meeting has responsibility for liaising with relevant colleagues in health. On the occasions where it is pressing to invite a frontline practitioner, this must be agreed to first by the Chair. There should also be a full briefing of the person attending so that they understand the process and their role within it.
- Each new representative should be offered a full induction to the Marac process ensuring that they have a clear understanding of their role and responsibilities. We have [e-learning packages](#) and other resources to help support the induction process.

Effective Action planning

- You can find more details on the type of information agencies can equip themselves with in [SafeLives' Marac toolkits](#), including this [toolkit for mental health](#).
- It is important to remember when feeding back to victim/survivors that thought is given to what information can and can't be safely shared with them. For example, are they at risk of repeating information that could put them at risk if they were to become unwell?

Outside the Marac meeting

If you are part of a Marac strategic or governance group

- Ensure that the Marac is properly recording (and reporting in their returns to SafeLives) the numbers disabled victim/survivors and perpetrators being discussed at Marac. Mental ill health is a recognised form of disability if it has long-term effects on normal day-to-day activities.
- Reflect on the attendance rate of all core agencies and consider what steps can be taken to support the full engagement of mental health within the process.
- Map your local mental health services/organisations and reach out to them, building their capacity to identify high risk victim/survivors.
- Understand where pathways can be created from mental health services to domestic abuse services (for both victims and perpetrators) and vice versa.
- Provide training to mental health workers about the dynamics of domestic violence and abuse and how this intersects with mental health. For example, King's College, with support from Medical Research Council and King's Health Partners, produced a free resource which you can access by emailing admin-swmh@kcl.ac.uk.
- Consider carrying out a case audit focused on victim/survivors with mental health problems in order to look at the standard of the response they have received. SafeLives can provide you with [tools](#) to assist you to do this. You might also want to commission support from a specialist service, such as AVA. Ensure the Marac area records data correctly in its returns to SafeLives, so that you have a true picture of your local response and to enable proper performance management.

If you are a commissioner

- Consider the value of specific health and mental health Idva/Idaas who can offer specialised support to vulnerable victims of domestic abuse with complex needs. Specialists can also upskill practitioners, within both domestic abuse and mental health services, and disseminate good practice.

If you are domestic abuse coordinator or forum

- Review your domestic abuse campaigns ensuring that they are cognisant of and responding to the needs of people with mental health problems. And that these campaigns are targeted at mental health services and practitioners.
- Ensure that local Marac training has embedded key messages on mental health, including that whilst mental ill health can increase the risk and volatility of perpetrators of domestic abuse, this does not take away their responsibility to seek help with their behaviour.
- Consider opportunities that can be created to upskill and support mental health practitioners in respect of domestic abuse disclosure.