Pathfinder
Enhancing the response to domestic abuse across health settings

Pathfinder Profile: Mental health practitioners

Guidance for mental health practitioners responding to domestic abuse

This guidance paper has been designed for mental health practitioners, as part of the Pathfinder project, which aims to establish a comprehensive health practice in relation to domestic abuse and wider issues relating to Violence Against Women and Girls in healthcare. It will provide practical advice and outline how to ask about abuse and respond to disclosures from patients, refer and signpost victims of domestic abuse and share best practice approaches of responding to domestic abuse in mental health hospitals.

The UK definition of domestic abuse is "any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to psychological, physical, sexual, financial, emotional." It includes coercive control, which is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.

Each year an estimated 2 million adults in England and Wales experience some form of domestic abuse – 1.3 million female victims and 695,000 male victims[1]. These figures are likely to be an underestimate, because all types of domestic violence and abuse are under-reported in health and social research, to the police and to other services.

Domestic abuse costs the health services £2,333 million every year[2] and every practitioner in the health system will already be treating patients who are experiencing abuse. NICE guidelines have created four quality statements[3] which should be used in conjunction with this briefing paper which are:

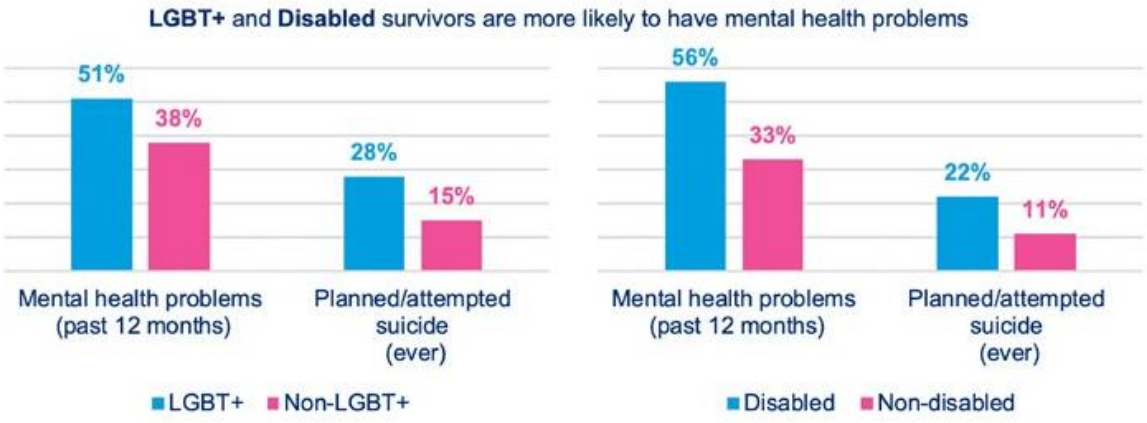
1. People presenting to frontline staff with indicators of possible domestic violence or abuse are asked about their experiences in a private discussion.
2. People experiencing domestic violence and abuse receive a response from level 1 or 2 trained staff.
3. People experiencing domestic violence or abuse are offered referral to specialist support services.
4. People who disclose that they are perpetrating domestic violence or abuse are offered referral to specialist services.

Current or previous experience of domestic abuse, sexual abuse and other linked issues is extremely prevalent in mental health service users. In the view of Shirley McNicholas, Women's Lead for Camden and Islington NHS Foundation Trust and founder of Drayton Park Women's Crisis House, "These issues are so prevalent that people should only come in to the mental health profession if they're motivated to deal with these issues."

[1] ONS (2018), March 2018 Crime Survey for England and Wales (CSEW)
[2] Home Office (2019), The economic and social cost of domestic abuse
[3] National Institute for Health and Care Excellence (2016), Domestic violence and abuse

Identifying victims of domestic abuse in mental health hospitals

SafeLives national dataset shows that people with mental health needs were more likely to have experienced abuse[4]. The SafeLives Cry for Health report revealed higher levels of mental health needs amongst victim/survivors within hospital settings (57%), compared to those within community-based domestic abuse services (35%). Nearly twice as many hospital-based victim/ survivors had self-harmed or planned/attempted suicide than those in specialist community services (43% compared to 23% respectively). Previous Spotlights reports show that mental health problems are more prevalent and severe amongst certain groups of victims and survivors. As shown in the below graphs, those identifying as LGBT+ and those who have a disability are more likely to have mental health needs at the point of accessing domestic abuse services. It is therefore crucial that professionals working with people with mental health difficulties are aware of and know how to identify and support those experiencing abuse.



Large numbers of those who access mental health services will have faced domestic abuse. Yet, a large proportion of those accessing mental health services are not asked about their experiences of domestic abuse. Routine enquiry about domestic abuse is recommended for all mental health services.

Asking about experiencing domestic abuse

Routine enquiry will only be effective in an environment that promotes safe disclosure. Before asking ensure privacy for the service user - a private room where conversations cannot be overheard and away from the patient's family members/partner. Do not use friends, family or carers as translators, and avoid unhelpful assumptions, for example that two people of the same sex attending together must be friends rather than partners.

It is important that you feel comfortable and confident in asking service users about domestic abuse. It is helpful to have some questions prepared and to be clear why you are asking. You could start with a general phrase such as *"People's mental health is affected by how things are at home and how people treat them. How are things with your partner/ex-partner/family?"* Sometimes, the only way to start a dialogue is to ask specific questions. Four questions were developed as a framework for helping to identify victims of domestic abuse and have been found to be a sensitive and accurate tool:

- **H**umiliation: "*In the last year, have you been humiliated or emotionally abused in other ways by your partner/family member?" "Does your partner/family member make you feel bad about yourself?" "Do you feel you can do nothing right?"*
- **A**fraid: "*In the last year have you been afraid of your partner or ex-partner?" "What does your partner do that scares you?"*
- **R**ape: *"In the last year have you been raped by your partner or forced to have any kind of sexual activity?" "Do you ever feel you have to have sex when you don't want to?" "Are you ever forced to do anything you are not comfortable with?"*

[4] SafeLives (2019), Safe and Well

- **K**ick: *"In the last year have you been physically hurt by your partner?" "Does your partner threaten to hurt you?"*

The aim is to have a supportive and explorative conversation to help you better understand the needs of your service user. Do not force a disclosure and always adopt a non-judgemental approach.

It is important to understand that an abuser may be using someone's mental health against them – they may be providing a caring role, they may be taking control of medication or making someone think that they will not be believed because of their mental health. If a disclosure is made you should respond with empathy and understanding, letting your service user know you believe them and remind them that being a victim of abuse is not their fault.

Supporting yourself and colleagues who are experiencing domestic abuse

There is no typical victim/survivor of domestic abuse. People impacted by domestic abuse are in every office, live on every street, behind every kind of front door. The information shared here is not only for patients. It is for anyone affected by domestic violence and abuse including yourself and your colleagues. If you are affected by domestic abuse or know someone who is then please ask for help through one of the channels suggested here or pass on that information.

It can be difficult to spot signs of abuse in colleagues and uncomfortable to enquire about it. Be aware of signs which can be indicative of experiencing abuse, such as frequent absence, lateness, obsession with time keeping, change in manner of dress, isolating themselves from other colleagues. If you have concerns speak to your HR department. For further information on how to support colleagues, please read SafeLives' guidance paper on responding to colleagues experiencing domestic abuse[5].

Responding to disclosures of domestic abuse in mental health hospitals

Ensuring the safety of the service user is your priority. If someone discloses abuse all professionals should check if the person is in immediate danger: do they fear for their life, do they have somewhere they can go where they feel safe?

Standing Together Against Domestic Violence advises for practitioners to move away from stereotypical understandings of domestic abuse as isolated incidents of physical violence. Being aware of the inherent high-risk posed by coercive controlling behaviours that are not physical or sexual - such as harassment and jealous surveillance – and how they relate to risk is paramount[6].

Using standardised risk assessments, such as the Dash rick checklist, are useful. Risk assessments should only be undertaken by those who have been trained to use them and where there are clear referral pathways. All hospitals will have a safeguarding policy and named safeguarding leads. You have the responsibility to safeguard adults at risk – in the context of domestic abuse this may mean making a referral to a Multi Agency Risk Assessment Conference (Marac), guidance on which you can find on the SafeLives website. If and when you do make referrals to Marac, don't underestimate how valuable your understanding of the individual's mental health situation could be. You and your team will be the experts in that part of a person's situation.

Remember that children living with families experiencing domestic abuse will also experience it themselves. Please follow your local routes for safeguarding children. Additionally, SafeLives Insight data has found that children's outcomes significantly improve after support from specialist children's services[7]. Some specialist domestic abuse services will provide support for children – please find your local service which does this to ensure effective support is also provided to children experiencing abuse.

Referring to specialist domestic abuse services

[5] SafeLives, Respond to colleagues experiencing domestic abuse: practical guidance for line managers, human resources and Employee Assistance
[6] Standing Together Against Domestic Violence (2016) Domestic Homicide Review (DHR) case analysis
[7] SafeLives (2014) In plain sight: Effective help for children exposed to domestic abuse

After a disclosure of domestic abuse has been made and you have completed sufficient safety planning with the service user, you should ask them if they would like to be referred to a local specialist domestic abuse service. It is helpful if you are already familiar with services in your local area (this information is publicly available online). Ensure you know what service the service offers and what their referral pathway is. If they do not wish to be referred to a specialist service, provide them with the National Domestic Abuse Helpline free-phone number 0808 2000 247 (which is run 24 hours a day, 7 days a week and answered by fully trained female support workers and volunteers). The helpline is a member of the Language Line and can provide an interpreter if needed. You can also provide them with Galop's national domestic abuse helpline number for LGBT+ victims 0800 999 5428 (which is run Monday to Friday at varying times).

If the victim/survivor is BME, they may face additional barriers preventing them from accessing the help they need. They may prefer to access a specialist BME service –find out what your local specialist BME services are and what kind of support they provide. Alternatively, the national helpline mentioned above will also be able to provide you with information on local, specialist services.

Responding to perpetrators of domestic abuse in mental health hospitals

A study of domestic homicides committed in England and Wales between 1997 and 2008 showed that 14% of perpetrators of intimate partner homicide and 23% of perpetrators of adult family homicide had been in contact with mental health services in the year before the offence and more than a quarter of perpetrators convicted of the homicide of an adult family member in England and Wales between 1997 and 2008 had symptoms of psychosis at the time of homicide[8]. Whilst this is not to suggest that mental health is the cause of perpetration of domestic abuse, the prevalence of mental health issues in perpetrators means that mental health hospitals are an appropriate environment to spot early signs, challenge and support them. Mental health problems may increase vulnerability to intimate partner violence (IPV) or develop as a consequence of it. An analysis of Domestic Homicide Reviews found that nearly two thirds (15/24) of intimate partner homicide perpetrators had support needs related to their mental health[9].

If a service user discloses domestic abuse perpetration, attempt to assess the risk they pose on others. This may be difficult when establishing information from the perpetrator, however Respect (a charity working with perpetrators of domestic abuse) have created a risk assessment checklist which can be used as a guide. If you are unsure on what to do call the national Respect phone line **0808 802 4040** (open Monday to Friday 9am-5pm)**.** It is also recommended that staff need to ensure appropriate handover of the perpetrator/victim mental health plan back to their GP[10].

If a domestic abuse perpetrator is seeking help for their behaviour, you can support them in referring to a behaviour change programme. Please check your local provision, this information is available publicly online. You can also call Respect for information on the nearest accredited behaviour change programme. Please do not refer perpetrators to an anger management programme. Specialist change behaviour programmes are tailored to tackle domestic abuse in a way anger management programmes are not, making them unsuitable for perpetrators.

Disclosure and data recording of domestic abuse

Disclosures of domestic abuse made to health practitioners are not always recorded- this can be due to lack of consistent recording, lack of understanding of abuse, no structural framework requiring such data to be recorded, concerns over GDPR legislation and many others. It is, however, important to collect and record such information, as it will allow practitioners to better understand the root cause of some of their patient's illnesses and offer better support.

Not only is effective data recording useful for practitioners, it is also helpful for survivors themselves. Recording disclosures in case notes means victims do not have to repeat their story to multiple

[8] Oram S, Flynn SM, Shaw J, Appleby L, Howard LM. Mental illness and domestic homicide: a population-based descriptive study. Psychiatric services. 2013;64(10):1006-11.

[9] Standing Together Against Domestic Violence (2016) Domestic Homicide Review (DHR) case analysis

[10] Ibid

professionals, which can be traumatising and impact their mental health and wellbeing. Every practitioner who is working with and supporting the victim/survivor should know about their experience of abuse. This means that disclosures of domestic abuse must be clearly recorded in a factual manner on case management systems. Practitioners need to be aware of safety implications of this for themselves and the victim and ensure this is done sensitively- the perpetrator should not be able to gain access or be able to see that this has been recorded.

Best practice

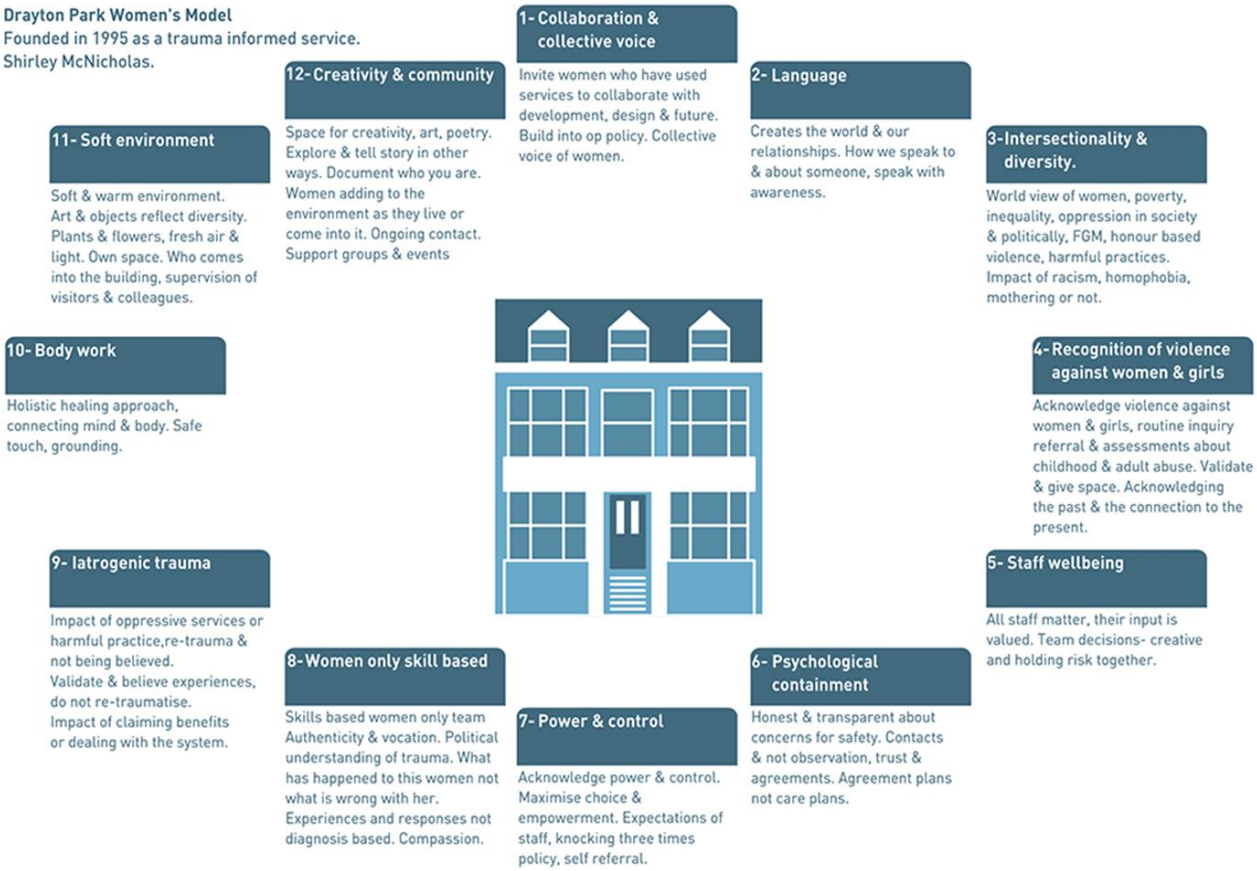
Drayton Park Crisis House- mental health facility

Drayton Park is a crisis house for women suffering from ill mental health in Islington and Camden. Its service is based on trauma informed care. Their service users are in a midst of a mental health crisis and stay short-term whilst they stabilise. Since opening in 1995 it has been run based on a model where the trauma of abuse suffered by its service users is taken into account. It is one of the few women only community mental health facilities in England. It uses trauma informed care to put the service user at the centre of their ethos. It ensures that the service users feel safe and comfortable during their stay. They achieve this through several methods, some of which include:

- Giving the service user privacy- knocking three times, introducing themselves and warning of the door opening prior to coming into a bedroom
- Maximising choice for the service user- this can be as small as giving them choices in what they would like to drink, if they want sugar in their tea
- Being understanding of their trauma**- think 'what has happened to her' not 'what is wrong with her'**
- Validating and believing the experiences of service users

These simple steps could be adapted by all mental health services in how victims of domestic abuse are responded to. It could reduce re-traumatisation and improve the outcomes of service users being treated.

Image 1: Trauma informed model used in Drayton Park crisis house



Further reading:

- National Institute for Health and Care Excellence (2016), Domestic violence and abuse
- King's College London (2018), LARA-VP: A resource to help mental health professionals identify and respond to domestic violence and abuse
- SafeLives (2019) Safe and Well
- AVA (2017), Promoting recovery in mental health evaluation
- AVA, Complicated Matters Toolkit
- Standing Together Against Domestic Violence (2016) Domestic Homicide Review (DHR) case analysis