Ending domestic abuse

Practice briefing for Idvas/Idaas
Engaging and working with people with mental health difficulties.

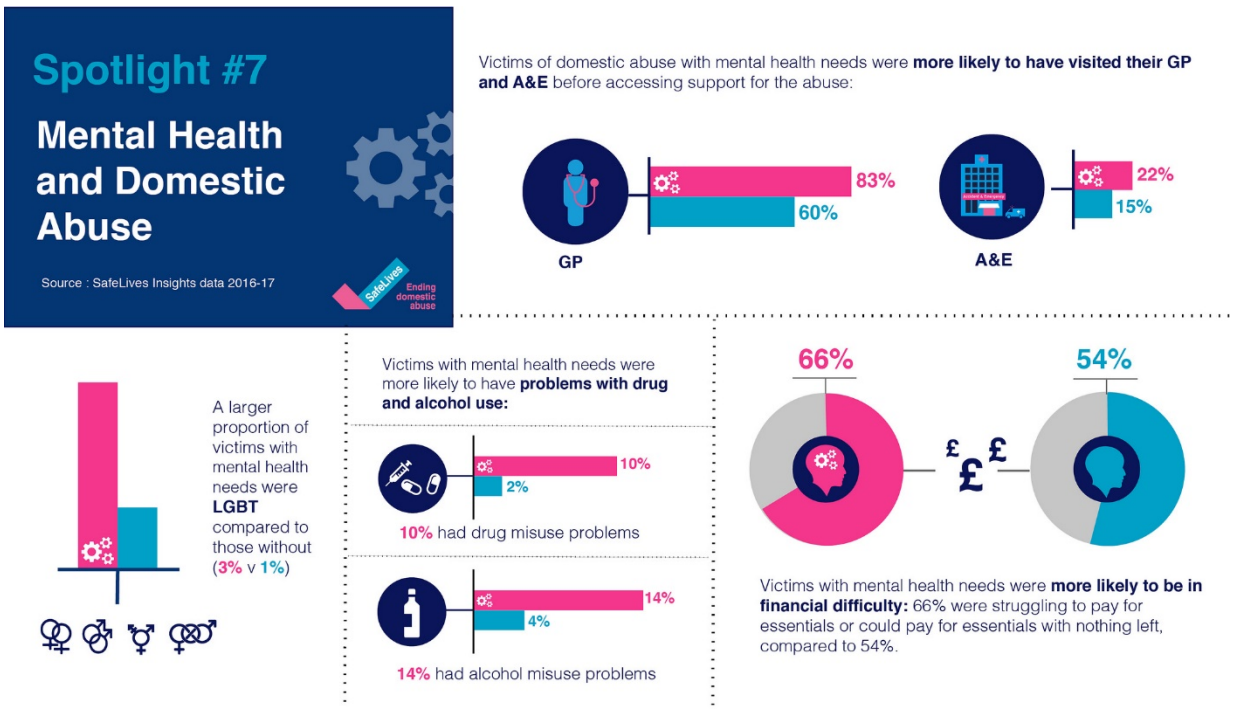
The relationship between mental health and domestic abuse

Data from SafeLives' national dataset shows that people with mental health needs were **more likely to have experienced each type of abuse**, particularly sexual abuse (27% v 19%). By considering the profile of those within the SafeLives' national dataset of victim cases, this practice briefing will reflect on the additional needs such clients present and seek to identify how Idvas/Idaas can work to better engage and support this marginalised group.

This practice briefing will explore:

- Client profile
- Language
- Barriers to disclosure
- The structure of mental health services
- Common mental health problems
- Reflections for practice

We know that domestic abuse can have a severe and lasting impact on mental health, and that survivors often find it difficult to access the support they need. Our research also shows that victims and survivors with mental health problems are more likely to have other complex needs.



The relationship between domestic abuse and mental health is bidirectional, with research suggesting that those experiencing abuse are at a greater risk of mental health conditions and that having a mental health condition makes one more vulnerable to abuse[1]. Those with diagnosed conditions such as depression, anxiety (etc.) are more likely to be victims of domestic abuse[2].

Language

Choosing language carefully is important and shows service users that you are sensitive to their needs. Certain language can cause offence and may also be inaccurate in its use.

Avoid statements such as, 'is a psycho' or 'a depressive' instead try using 'a person who has experienced…' or 'has a diagnosis of…' is 'currently experiencing…' or 'is being treated for…'.

We sometimes will see in the media headlines such as 'the mentally ill', 'a person suffering from' 'a sufferer', a 'victim' or 'the afflicted' instead try 'mental health patients' or 'people with mental health problems'.

We also need to be aware of how we describe behaviours. Violent or angry behaviour is often referred to as going 'psycho' which inaccurately conflates behaviour with a mental health problem.

Whilst many people will class their mental illness as a problem or difficulty and will be comfortable with those terms, it is also important to recognise that people living with a diagnosis for the rest of their life may find these terms unduly negative and disempowering. It's important to be led by your client.

The barriers to disclosure

Many victims and survivors with mental ill-health will experience barriers when considering disclosing domestic abuse. These can include;

Recognising abuse

Recognising and naming abuse within a relationship is challenging for anyone, but for someone with a mental health problem, it may be even more difficult. The perpetrator may convince their partner that the problem is 'in their head' or that they are suffering from paranoia or confusion. Victim/survivors may have problems with their memory which makes it harder to see a pattern of coercive control. The perpetrator may also having a caring role, which may create uncertainty for victim/survivors over what is care and what is control.

Minimisation

Victim/survivors may anticipate that a disclosure of domestic abuse will **not be taken seriously** by professionals**.** Especially when there has been failure by professionals to respond to signs of abuse previously. Many will have been living with the domestic abuse for a number of years before disclosing, whilst simultaneously engaging with professionals regarding their mental health condition. The dominance of the medical diagnostic and treatment model often means professionals focus on mental health symptoms, rather than exploring underlying factors, such as domestic abuse.

[1] Devries, K.M., Mak, J.Y.B., Loraine, J., Child, J.C., Falder, G., Petzold, M. … & Astbury, J.(2013). Intimate partner violence and incident depressive symptoms and suicide attempts: A systematic review of longitudinal studies.

[2] Trevillion, K., Oram, S., Feder, G., Howard, L. M., (2012) Experiences of Domestic Violence and Mental Disorders: A Systematic Review and Meta-Analysis. PLoS ONE 7(12): e51740. https://doi.org/10.1371/journal.pone.0051740

Fear of not being believed

Victim/survivors with mental health needs are often fearful that agencies will judge them, or will assume they are not telling the truth. Perpetrators will often disguise their abuse, and victim/survivors may have a recorded history of mental ill-health with additional concerns regarding substance misuse, self-harming behaviour, suicide attempts, and/or periods of psychosis or depression, which may make it difficult for the client to feel being believed is likely.

Abusive tactics

Perpetrators of domestic abuse may use their partner's mental health problems as a tool to isolate and further abuse. For example they may threaten their partner with sectioning, they may interfere with medication and/or disrupt attempts to seek help and support.

Substance use

Many people attempt to manage domestic abuse and symptoms of their mental illness alone, which can lead to further **psychological distress**. They may find unhealthy ways to cope with these symptoms, such as using substances to self medicate which can worsen their situation, heighten their risk and increase the barriers to accessing support.

Fear of coping alone

For many there is a fear of **consequence**, particularly regarding perpetrators in a caring role. Victim/survivors may have additional concerns regarding their ability to care for themselves or any dependents. This is increased when the perpetrator has been part of their mental health recovery and is seen as a protective factor by other professionals/agencies. This fear can be intensified by perpetrators telling them that they will not be able to cope alone.

Self-blame

Studies suggest that **self-blame** is exacerbated when the victim/survivor has mental health problems as they may view this as part of their own involvement in provoking the abuse.

Shame

To engage with domestic abuse services for many clients may mean **multiple disclosures**; domestic abuse, mental ill health, substance use, etc. The stigma that surrounds these issues, can mean that survivors feel shame and worry that they will be judged. For some, expectations linked to 'honour' placed upon them by family or community, can make disclosure very difficult and even a risk to their safety.

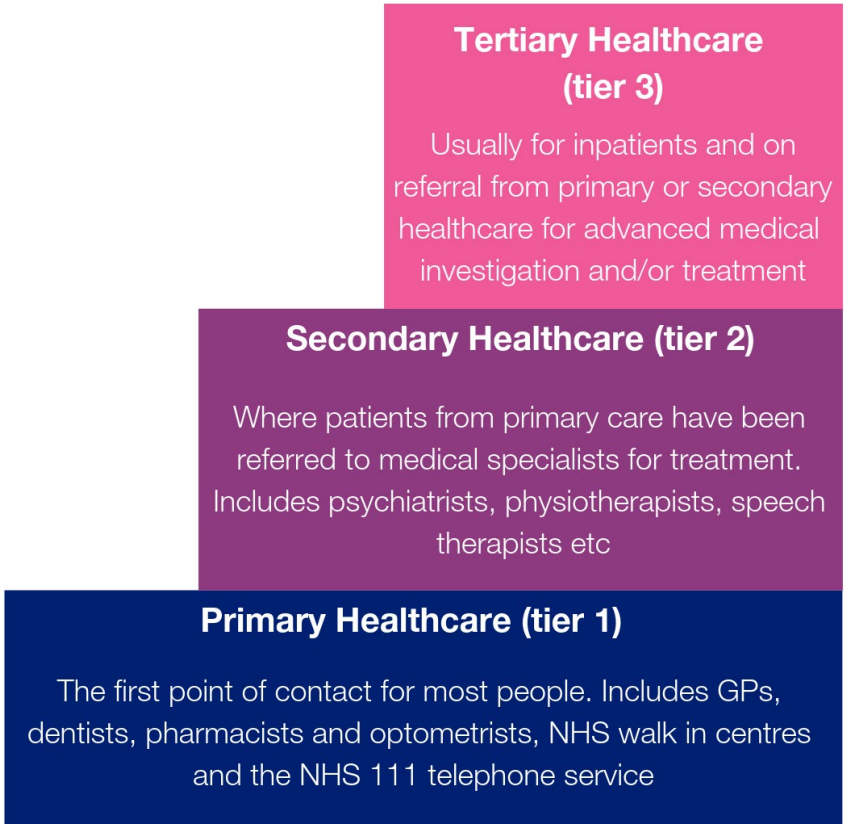
The impact of mental ill-health

Many clients are **isolated** due to their mental ill-health, for example not feeling able to leave the house, struggling to talk on the phone, not being able to remember appointments. Being able to engage with domestic abuse services is often very difficult. It is important that services are pro-active and avoid rigid policies, such as three contact attempts before case closure, which can increase the barriers for those with complex needs.

Mental Health Services: Structure

The difference between primary and secondary care

There are generally 3 different levels/tiers when referring to the health system:



What is a mental health trust?

Mental health trusts provide health and social care services for people with mental health problems. Many NHS trusts have merged over the past couple of years and may now be governed by a foundation trust, which provides a mental health service.

How to access mental health services

Mental health services are free under the NHS, generally you will need a referral from your GP to be able to access them. There are some services that allow people to self-refer, these will include substance misuse services and some psychological therapy services.

GP role within mental health

GPs will assess the individual's circumstances and offer appropriate advice or provide treatment and offer long term care and support. They will ask about the person's mental and physical health and may make a diagnosis. If you are supporting your clients with these appointments, it is vital that they can be honest and give as much detail as they can about how they are feeling and what their symptoms are. This will help the GP decide how to proceed. A GP could give advice on things like sleep or stress, prescribe medication, make a referral to a talking therapy service, or to a specialist mental health team. The GP should not usually prescribe antipsychotic medication unless they have had advice from a psychiatrist.

Diagnosis

In order to diagnose a mental health problem, doctors will look at the individual's symptoms (feelings, behaviours and physical symptoms), how long they have been experiencing them and the impact they are having on their life.

To do this they will ask about mood, thoughts and behaviours, this may be done through questionnaires or forms. The diagnosis will be based on the answers given and what has been described. i.e. if the doctor is informed the individual has been experiencing low mood, low energy and a lack of interest in usual activities for more than two weeks, they may give a diagnosis of depression. If the symptoms change it might be that over time a different diagnosis is given.

Having a diagnosis does not necessarily mean that the individual is unwell currently. They could have a diagnosis of a mental health problem but, at the moment be able to manage it and function well at work and at home. Equally, they might not have a particular diagnosis, but still be finding things very difficult. Everyone's experience is different and can change at different times.

For common problems such as depression and anxiety, the GP may be able to give a diagnosis after one or two appointments. For less common problems there will need to be a referral to a mental health specialist, such as a psychiatrist, and they may want to see the individual over a longer period of time before making a diagnosis.

For some people, receiving a diagnosis can be a positive experience. They may feel relieved they can put a name to what's wrong, and it can help them with their doctor to discuss what kind of treatment might work best for them. However, a lot of people, including some doctors and psychiatrists, feel this medical model of diagnosis and treatment is not enough. For example, the individual might feel that the diagnosis they're given doesn't fully fit their experiences, or that it's simplistic and puts them in a box. Other factors, such as the individual's background, lifestyle and other personal circumstances may be just as important in understanding what they're experiencing and working out how best to help them feel better.

Some survivors feel that their symptoms of trauma following abuse have been missed by doctors and that consequently they have been given an inaccurate diagnosis. Idva/Idaas can support their clients by helping them provide their GP with key information that will improve the response their GP can give.

A diagnosis does not have to shape a person's entire life and may come to be a relatively minor part of their identity. 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 then.

What is a Community Mental Health Team (CMHT)?

If a higher level of support is required, the GP will make a referral to the Community Mental Health Team (CMHT). CMHTs are secondary care services. They may also be called the Community Recovery Team or the Assessment and Brief Treatment Team. Health and social care professionals work in the CMHT. How they operate will depend on each mental health trust. CMHTs are for people aged between18 and 65. There are different mental health teams for other age groups; Child and Adolescent Mental Health Services (CAMHS), for people under 18 years old, and Older Adult Mental Health Teams, for people who are over 65. There are also specialist CMHTs, crisis teams (for people experiencing a mental health crisis), Assertive Outreach Teams (for people with complex mental health needs), and Early Intervention Teams (for people experiencing their first episode of psychosis).

What is sectioning?

Being 'sectioned' is the term sometimes used when someone is detained under the Mental Health Act 1983 (MHA). The MHA is the law which can allow someone to be admitted, detained and treated in hospital against their will. The MHA will only be considered if someone was very unwell and all other options such as community support and/or voluntary hospital admission are not available/appropriate.

The length of time a person can be detained will depend on the type of mental health condition they have and the circumstances at the time.

- Section 2 (assessment) of the MHA is for up to 28 days and often used to make a diagnosis, consider if treatment is needed and how this may affect the persons health.
- Section 3 (treatment) of the MHA is for up to 6 months and used for treatment of a mental health condition and the person would not receive this treatment unless they were detained. This section can be renewed for a further 6 months and then annually.
- Section 4 of the MHA is an emergency application for detention for up to 72 hours.

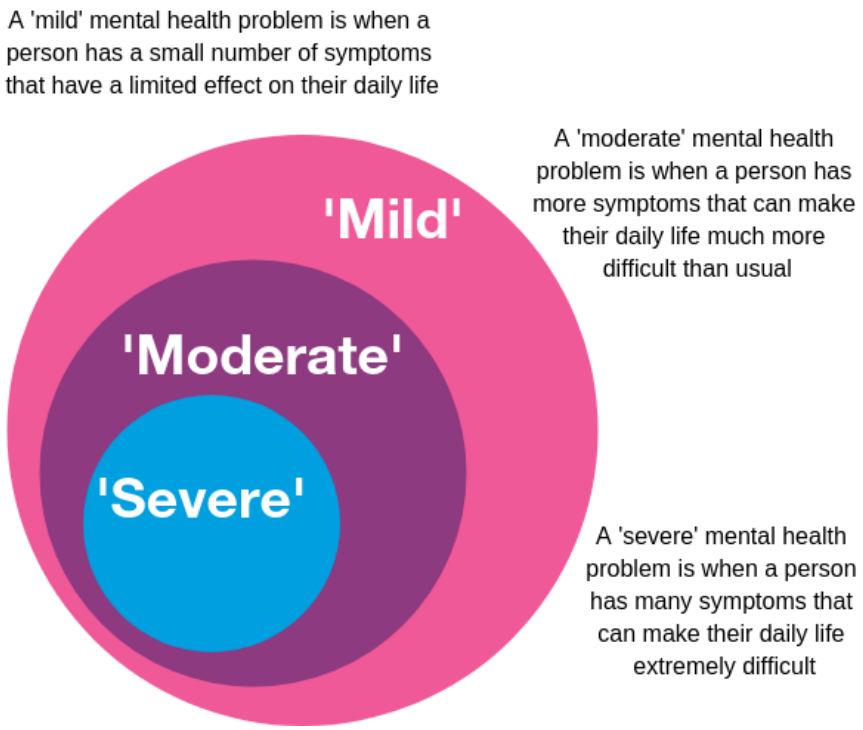
In order to detain someone under section 2 or 3 there needs to an approved mental health professional (AMHP) usually a social worker, mental health nurse, psychologist or occupational therapist and two doctors, one of which will be specially certified (section 12 approved) as having particular experience in assessment of treatment of mental illness.

Common mental health problems

Common mental health problems include depression and anxiety disorders such as generalised anxiety disorder, panic disorder, obsessive-compulsive disorder (OCD) and post-traumatic stress disorder (PTSD). Other common mental health problems include phobias about a specific thing (such as spiders) or situations (such as being embarrassed in front of other people). These mental health problems are called 'common' because combined they affect more people than other mental health problems (up to 15% of people at any one time in the UK). Some people may have more than one mental health problem (such as depression and anxiety)[3]. We recommend Mind for more comprehensive information on symptoms, cause and treatment options.

Levels of mental health

The terms mild, moderate and severe are often used to describe different levels of mental health problems:



[3] NICE (2011). Common mental health disorders | Guidance and guidelines | NICE.

A person may experience different levels at different times.

Depression

The main symptoms are feeling 'low' and losing pleasure in things that were once enjoyable. These symptoms may be combined with others, such as feeling tearful, irritable or tired most of the time, changes in appetite, and problems with sleep, concentration and memory. People with depression typically have lots of negative thoughts and feelings of guilt and worthlessness; they often criticise themselves and lack confidence[4]. They may also experience physical aches and pains with no obvious cause, and some may carry out self-harming or suicidal behaviour. Domestic abuse is the most common cause of depression amongst women; abused women are three times more likely to experience depression than non-abused women[5]. A person who is down or unhappy is not the same as someone experiencing clinical depression.

Generalised anxiety disorder

The main symptoms are having a number of different worries that are excessive and out of proportion to a particular situation and having difficulty in controlling one's worries. A person with generalised anxiety disorder (GAD) may also feel irritable and have physical symptoms such as restlessness, feeling easily tired, and having tense muscles. They may also have trouble concentrating or sleeping[6]. Because there are lots of possible symptoms of anxiety this can be quite a broad diagnosis, meaning that the problems you experience with GAD might be quite different from another person's experiences.

Panic disorder

The main symptoms are having regular or frequent panic attacks without a clear cause or trigger. Experiencing panic disorder can mean that you feel constantly afraid of having another panic attack, to the point that this fear itself can trigger panic attacks[7]. A panic attack may happen because of a particular situation (something that the person fears or wants to avoid), or it may have no obvious cause. People who have panic attacks often change their behaviour as a consequence of the attack, which may develop into phobias such as agoraphobia (a fear of being in places or situations that are difficult to escape from)[8]

Obsessive-compulsive disorder

Obsessive-compulsive disorder (OCD) is an anxiety disorder that has two main parts: obsessions and compulsions.

The main symptoms of obsessions are having unwelcome thoughts, images or impulses that keep coming into the mind and are difficult to get rid of. Common obsessions include being afraid of dirt and germs, worrying that something is not safe (such as an electrical appliance), wanting to have things in a particular order, and thoughts and fears of harming someone else.

Compulsions are strong feelings that the person must carry out or repeat certain physical acts or mental processes to reduce the anxiety caused by the obsession. Common compulsions include excessive washing and cleaning, checking things repeatedly, keeping objects that other people might throw away, and repeating acts, words or numbers in a pattern.

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[4] 7. NICE (2011) CG123.

[5] Trevillion, K., Oram, S., Feder, G., Howard, L. M., (2012) Experiences of Domestic Violence and Mental Disorders: A Systematic Review and Meta-Analysis. PLoS ONE 7(12): e51740. https://doi.org/10.1371/journal.pone.0051740

[6] NICE (2011) CG123

[7] MIND

[8] NICE (2011) CG123

Post-traumatic stress disorder

Post-traumatic stress disorder (PTSD) is a type of anxiety disorder which you may develop after being involved in, or witnessing, traumatic events. One of the most common symptoms of PTSD is having repeated and intrusive distressing memories of the event. There may also be a feeling of reliving the event through flashbacks or nightmares. There can also be physical reactions, such as shaking and sweating.

About one third of adults in England report having experienced at least one traumatic event in their lifetime. Rates were similar for both men (31.5%) and women (31.2%)[9].

Complex PTSD or CPTSD is a fairly new term linked to specific types of trauma such as domestic and sexual abuse. People with CPTSD experience PTSD but with additional symptoms. They are particularly likely to experience an 'emotional flashback'; a re-living of the intense feelings (fear, shame, sadness or despair) that they felt at the time of the original trauma. Not all GPs may be familiar with the term complex PTSD.

About self-harm and suicide

If a person is experiencing low mood they might use self-harming behaviours to cope with the difficult feelings. Although this might make them feel better in the short term, self-harm can be very dangerous and can make the individual feel a lot worse in the long term.

When a person is feeling really low and hopeless, they might find themselves thinking about suicide. Whether they're only thinking about the idea, or actually considering a plan to end their life, these thoughts can feel difficult to control and very frightening. One in five adults has considered taking their own life at some point[10]. It is estimated that every day almost 30 women attempt suicide as a result of experiencing domestic abuse, and every week three women take their own lives.

If you're worried about an individual acting on their thoughts of suicide, you can call an ambulance (999), or take them straight to A&E. There are various free helplines that are also available for the individual such as the Samaritans on 116 123.

You should ensure that you receive training on handling emergency calls, including calls from someone suicidal.

If someone lets you know that they are experiencing difficult thoughts and feelings, it's common to feel like you don't know what to do or say, but you don't need any special training to show someone you care about them. Often just being there for someone and doing small things can be really valuable.

- ***Listen***. Simply giving someone space to talk, and listening to how they're feeling, can be really helpful in itself. If they're finding it difficult, let them know that you're there when they are ready.
- ***Offer reassurance***. Seeking help can feel lonely and sometimes scary. You can reassure

[9] Fear, N.T., Bridges, S., Hatch, S., Hawkins, V., & Wessely, S. (2016). Chapter 4: Post-traumatic stress disorder. In S. McManus, P. Bebbington, R. Jenkins, & T. Brugha (Eds.), Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014. Leeds: NHS Digital.

[10] Stansfeld, S., Clark, C., Bebbington, P., King, M., Jenkins, R., & Hinchliffe, S. (2016). Chapter 2: Common mental disorders. In S. McManus, P. Bebbington, R. Jenkins, & T. Brugha (Eds.), Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014. Leeds: NHS Digital.

someone by letting them know that they are not alone, and that you will be there to help.

- ***Stay calm***. Even though it might be upsetting to hear that someone is experiencing distress, try to stay calm. This will help them feel calmer too. Show them that they can talk to you openly without upsetting you.
- ***Be patient***. You might want to know more details about their thoughts and feelings, or want them to get help immediately. But it's important to let them set the pace for seeking support themselves.
- ***Try not to make assumptions***. Your perspective might be useful to your client but try not to assume that you already know what may have caused their feelings, or what will help.

Best Practice

NICE Guidelines

National Institute for Clinical Excellence (NICE) guidelines are evidence-based recommendations for health and care in England. They recommend how healthcare professionals should care for people with specific conditions and can cover any aspect of a condition that may include recommendations about providing information and advice, prevention, diagnosis, treatment and longer-term management. You can access NICE guidelines at www.nice.org.uk/guidance

What is trauma informed practice?

Trauma informed practice builds on the foundation of awareness, understanding and responsiveness to the impact of traumatic events in the lives of both service users and professionals. Experience of psychological trauma is ubiquitous, and impacts on all areas of human functioning, including physical, emotional, social and spiritual. Trauma-informed practice means treating a whole person, taking into account past trauma and the resulting coping mechanisms when attempting to understand behaviors.

Reflections for Practice

Working with clients with mental ill-health or complex needs can raise issues for Idvas/Idaas and it is vital that these issues are acknowledged. The following practice points may be useful, as well as making yourself aware of the local and national services that are able to provide specific support and guidance. There are some useful links at the end of this guidance.

Within your service or project:

- Think about how you present your service; what can you do to make it easier for people with mental health problems to engage?
- Consider having a dedicated Idva/Idaa for clients with mental ill-health/complex needs.
- Consider other specialist services or groups you can link in with, take referrals from and offer training to. This not only offers a proactive response for clients but also increases opportunities for engagement. It is not always best for a survivor to have another worker; in some instances it is preferable for Idva/Idaas to support another practitioner who is already engaged with the survivor.
- Aim to represent the diversity of those accessing your services, through use of posters, literature, websites, etc.
- Be clear what services you provide to clients with mental ill-health. If your project cannot

provide a service e.g. your refuge cannot take clients with complex needs, be sure to have clear referral pathways to other organisations that do.

- Ensure you have sufficient training and resources to provide a proactive service to people with mental ill-health, rather than relying on the assumption that you will 'treat everyone equally'.
- Monitor your service's data carefully. Use the data related to mental health to create strategies for improving services and to evidence need for specific future resource.

Within your own practice:

- Attend training such as the Mental Health First Aid course. This will improve your understanding of mental ill-health and enable you to respond effectively - and manage your own mental health whilst working in a demanding and often stressful role.
- Utilise the information provided in this guidance to enhance your professional judgement during risk assessment work and to consider whether your client has additional needs and/or vulnerabilities, such as alcohol and drug use which are commonly used to manage symptoms of mental ill-health.
- Think about the language you use when enquiring about a client's experience of mental ill-health.
- Build relationships with your local GP surgeries. GPs are the gateway to mental health services and it's important that they have a good understanding of how domestic abuse can impact upon mental health. SafeLives have produced a toolkit for GPs. Kings College London have produced this free online resource for health settings for health settings
- Read AVA's complicated matters guide, this is a useful toolkit that clearly sets out the issues of both mental health and substance misuse in relation to domestic abuse.
- If you are supporting a client with a mental health diagnosis, it is possible you may need to disclose this when liaising with other services. Ensure that you have discussed this fully with the client and have their consent, and that they understand the implications of your agency's confidentiality policy.
- Challenge the linking of abusive behaviour to a mental health condition. Studies regularly tell us that people with a mental health condition are more likely to be victims of violence rather than perpetrators.
- Be aware of the implications of stigma beyond the client's experience of domestic abuse. For example, securing emergency accommodation in a hostel may provide security from their abuser, but the victim may face abuse from other tenants if they are identified as having a mental health condition.
- Be mindful of the impact that other people's trauma can have on your own mental health, be aware of vicarious trauma and have regular supervision/case management.

Useful Links

Anxiety UK is a charity providing support if you've been diagnosed with an anxiety condition. 03444 775 774 (Mon to Fri, 9.30am to 5.30pm). www.anxietyuk.org.uk

AVA is a national organisation working to end all forms of violence against women and girls. www.avaproject.org.uk

Bipolar UK is a charity helping people living with manic depression or bipolar disorder. www.bipolaruk.org.uk
CALM - Is the Campaign Against Living Miserably, for men aged 15 to 35. 0800 58 58 58 (daily, 5pm to midnight). www.thecalmzone.net

Mind is a mental health charity in England and Wales. Mind offers information and advice to people with mental health problems and lobbies government and local authorities on their behalf. www.mind.org.uk

NHS www.nhs.uk

NICE www.nice.org.uk/guidance

No Panic is a charity offering support for sufferers of panic attacks and obsessive compulsive disorder (OCD). Offers courses to help overcome your phobia/OCD. 0844 967 4848 (daily, 10am to 10pm). www.nopanic.org.uk

OCD Action offers support for people with OCD. Includes information on treatment and online resources. 0845 390 6232 (Mon to Fri, 9.30am to 5pm). www.ocdaction.org.uk

PAPYRUS is a young suicide prevention society. HOPElineUK 0800 068 4141 (Mon to Fri,10am to 5pm & 7 to 10pm. Weekends 2 to 5pm) www.papyrus-uk.org

Place2be is a children's mental health charity. providing school-based support and in-depth. training programmes to improve the emotional. wellbeing of pupils, families, teachers and school staff. www.place2be.org.uk

Rethink mental illness is a charity that challenges attitudes and changes lives. www.rethink.org

Samaritans confidential support for people experiencing feelings of distress or despair. They can be contacted by phone: 116 123 (free 24-hour helpline). www.samaritans.org.uk

Sane is a leading UK mental health charity improving quality of life for anyone affected by mental illness - including family friends and carers. www.sane.org.uk

Time to change is a mental health campaign in England, launched in 2007 with the objective of reducing mental health-related stigma and discrimination. www.time-to-change.org.uk

Young minds is a leading charity committed to improving the emotional wellbeing and mental health of children and young people. www.youngminds.org.uk

Recommended reading

AVA (Against Violence and Abuse) (2018). **Complicated Matters: A toolkit addressing domestic and sexual violence, substance use and mental ill-health.** [online] https://avaproject.org.uk/resources/complicated-matters/ [accessed 17th January 2019)

Ferrari, G., Agnew-Davies, R., Bailey, J., Howard, L., Howarth, E., Peters, T. J., Sardinha, L., & Feder, G.S. (2016). **Domestic violence and mental health: A cross-sectional survey of women seeking help from domestic violence support services**. Global Health Action, 9:1, 29890, DOI: 10.3402/gha.v9.29890.

Trevillion, K., Oram, S., Feder, G., Howard, L. M., (2012) **Experiences of Domestic Violence and Mental Disorders: A Systematic Review and Meta-Analysis**. PLoS ONE 7(12): e51740. https://doi.org/10.1371/journal.pone.0051740

Agenda (2016). **Joining the dots: The combined burden of violence, abuse and poverty in the lives of women**. [online] https://www.dmss.co.uk/pdfs/Joining-The-Dots-Report.pdf [accessed January 17th 2019)

With thanks to Amber Canham.