Whole Lives Scotland

Area 1:
Domestic abuse and mental health service provision in Renfrewshire

COMMUNITY FUND

SafeLives Ending domestic abuse

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http://www.safelives.org.uk/policy-evidence/whole-lives-improving-response-domestic-abuse-scotland

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Introduction

About SafeLives

We are SafeLives, the UK-wide charity dedicated to ending domestic abuse, for everyone and for good.

We work with organisations across the UK to transform the response to domestic abuse. We want what you would want for your best friend. We listen to survivors, putting their voices at the heart of our thinking. We look at the whole picture for each individual and family to get the right help at the right time to make families everywhere safe and well. And we challenge perpetrators to change, asking 'why doesn't he stop?' rather than 'why doesn't she leave?' This applies whatever the gender of the victim or perpetrator and whatever the nature of their relationship.

Every year, nearly 130,000 people in Scotland experience domestic abuse. There are over 9,000 people at risk of being murdered or seriously harmed; over 12,000 children live in these households. For every person being abused, there is someone else responsible for that abuse: the perpetrator. And all too often, children are in the home and living with the impact. Domestic abuse affects us all; it thrives on being hidden behind closed doors. We must make it everybody's business.

Together we can end domestic abuse. Forever. For everyone.

Since 2005, SafeLives has worked with organisations across the UK to transform the response to domestic abuse. In Scotland, we currently deliver three programmes supported by a team of associates who provide additional expertise to our work.

Marac Development: We support the implementation of the Marac process, to promote a best practice, risk-led response to domestic abuse, by providing training, helpdesk support and through the development of Scotland specific resources and tools.

Training & Development: We create bespoke learning packages about domestic abuse and coercive control for a wide range of organisations including Crown Office & Procurator Fiscal Service, NHS Health Scotland and Wheatley Housing. We developed and deliver Domestic Abuse Matters Scotland in partnership with Police Scotland to support implementation of the Domestic Abuse (Scotland) Act 2018.

Whole Lives Scotland: Following our 2017 research report, *Whole Lives*[1], the National Lottery Community Fund in Scotland awarded SafeLives funding to carry out a three-year project working with four Violence Against Women Partnerships (VAWPs) in different local authority areas to:

- Support local services to maximise their impact in terms of accessibility, practice, multi-agency working and victim/survivor experience
- Establish strong, locally relevant evidence bases that have national significance
- Build the case for a more ambitious, deep-rooted, improved response to domestic abuse in Scotland in the longer term
- Amplify the voices of victims/survivors across Scotland

In conjunction with each VAWP, a focus is identified - victim/survivors for whom barriers to support access may be exacerbated. Through on-site data collection and consultation, SafeLives builds a picture of local domestic abuse provision and pathways to support. The research and corresponding thematic report provide a foundation from which the SafeLives Engagement Lead creates a bespoke practice response to any gaps and needs identified. Renfrewshire is the first area to participate in the Whole Lives project.

The National Lottery Community Fund

Thanks goes to our funder, The National Lottery Community Fund, a non-departmental public body and distributor of National Lottery funding. Their work is divided into five portfolios, covering projects across England, Northern Ireland, Wales and Scotland, and the UK as a whole.

Research Approach

Whole Lives research objectives

- Amplify the voice of victims/survivors across Scotland through consultation
- Identify potential improvements to local partnership working
- Highlight strengths and gaps in local practice
- Assist services to use their data and evidence more effectively

We partnered with Renfrewshire's Gender-Based Violence (GBV) Strategy Group in this work, who took the decision to focus on victims/survivors with mental health needs through their involvement in Whole Lives. This choice reflects their commitment to deliver a coordinated response to vulnerable groups who face additional barriers to service access, as outlined in their GBV strategy[2]. Added consideration was given to addiction throughout this research with the acknowledgement that it can often be closely linked to poor mental health. Adopting a whole family approach, we also sought to identify any specific barriers for victims/survivors who are parents. Whilst we considered these issues concurrently at points throughout the work, it should be noted that the focus of the research was on mental health; all the victims/survivors we consulted with had mental health needs, but not necessarily addictions and not all were parents.

Research questions

1. What are the pathways to support in Renfrewshire and what are the barriers?

   - How do victims/survivors with mental health needs access support and what are the specific barriers?

2. What are the strengths in provision in Renfrewshire and where can improvements be made?

   - How are victims/survivors with mental health needs supported and how could this be enhanced?

Research activities

Consultation with professionals

- Practitioner/stakeholder online survey

A survey was sent out to all Violence Against Women & Girls (VAWG) services, as well as services within Renfrewshire Council and Renfrewshire Health & Social Care Partnership (HSCP). The GBV Strategy Group assisted in the promotion of the survey to a range of other multi-agency professionals, including those within third sector non-domestic abuse agencies. Content focused on training and competency on domestic abuse, views on multi-agency work, and identifying barriers to service access. Eighty-two practitioners responded, including a range of domestic abuse professionals and non-domestic abuse professionals.

Domestic abuse professionals	15
Domestic abuse services	5
Children & families social work	4
Police	2
Sexual abuse	1
Criminal justice social work	1
Other	2

Non-DA professionals	67
Community mental health	18
Children & families social work	11
Addiction	9
Health	5
Education – secondary	4
Health visiting / FNP	4
Criminal justice social work	4
Adult social work	3
Education – primary	1
Other	8

- Multi-agency focus groups

Two focus groups with professionals were held. One involved 11 practitioners from a range of services including: specialist domestic abuse, secondary mental health, third sector mental health, adult social work, children & families social work, addiction and the Family Nurse Partnership. The second involved six service managers from domestic abuse services, social work, a Renfrewshire Council education support service, and mental health and addiction services. Two SafeLives facilitators asked questions about barriers to service access and provision in the area for victims/survivors with mental health needs.

- Interviews with practitioners/stakeholders

Two semi-structured interviews were conducted with a domestic abuse practitioner from within Renfrewshire Council and a strategic lead from within Renfrewshire HSCP.

- Mapping of service provision

The Engagement Lead met with stakeholder agencies and used a mapping tool to record service provision and information on referral pathways in the area.

Consultation with victims/survivors

- Focus group

The SafeLives Engagement Lead liaised with domestic abuse services to recruit six victims/survivors of domestic abuse with mental health needs and ensure appropriate support was in place. All participants were no longer in abusive relationships and had accessed a range of services including each of the three local domestic abuse services and various primary and secondary health agencies. We worked with Wise Women[i], a Glasgow-based women's organisation, to co-facilitate the focus group.

- Survivor survey

The Whole Lives survivor survey was promoted locally in Renfrewshire before its national launch in October. As the survey remains open at the time of writing, the results have not been included in this report. Renfrewshire will receive a report of local findings from the survey in 2020.

A note on victim/survivor involvement

Authentic voice is at the heart of SafeLives' work; we employ an Authentic Voice Coordinator and use a toolkit to inform our work and ensure a considered ethical process is followed when consulting with victims/survivors. Wise Women delivered an empowerment session prior to the focus group. Participants were then invited to a co-production group to influence the practice recommendations and toolkit being developed for Renfrewshire.

An important part of the consultation process was checking language. The conversations that took place have directly informed the thematic report and recommendations. It was agreed that 'victim/survivor' best reflected the differing experiences of recovery, and 'mental illness' and 'poor mental health' rather than 'issues/problems' were preferred. Our co-production group also felt that using 'client' represented a more equal dynamic than 'service user'.

Use of local performance management data

Some analysis of locally available data on domestic abuse was carried out as part of the research, including: Equally Safe performance monitoring reports, 2018 'snapshot' data from Women & Children First, HSCP audit data from health visiting and community mental health services, and local Marac data.

Data collection across VAWG services in Renfrewshire is mixed. Some gather data on additional needs at intake to their services, such as mental health and substance misuse, and some do not. Domestic abuse services are not using the same outcomes measurement systems so outcomes across agencies are not comparable. Due to the limited outcomes measurement data available, it has not been possible

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[i] http://www.wisewomen.org.uk/

to conduct bespoke analysis on pathways to services for clients with mental health needs and their outcomes following domestic abuse interventions.

The *Whole Lives*[1] report from 2017 pooled Scottish domestic abuse data from various sources, including three domestic abuse services piloting the Insights outcomes measurement tool developed by SafeLives[ii]. The demographic and abuse profile of victims/survivors in the relatively small Scottish dataset[iii] was similar to the larger Insights dataset incorporating services from England and Wales. Considering these similarities, the current England and Wales dataset[iv] has been used at points throughout this report to help understand the likely picture in Scotland, where no equivalent Scottish data was available.

Structure of this report

The Research Context section of the report provides a summary of research related to the needs of victims/survivors of domestic abuse with additional needs, particularly mental ill health. The report then splits research findings into three sections. Section 1 reports findings on pathways to support in Renfrewshire and barriers for victims/survivors with mental health needs. Section 2 outlines findings on strengths in local provision and gaps for victims/survivors with mental health needs. Section 3 summarises findings relating to victims/survivors who have children - these have been separated out with the acknowledgement that they apply to only some victim/survivors who are parents.

Practitoner and victim/survivor insight is merged throughout the findings sections, which are organised by key themes. The voice of local victims/survivors captured through our consultation feature strongly in this report in quotes and diagrams. Throughout the report, we refer to specialist domestic abuse professionals as 'DA practitioners/professionals', and all other participating professionals as 'non-DA professionals' unless a more specific term is used, such as mental health practitioner. Occasionally, we refer to VAWG services. This is an overall umbrella term used where relevant with the acknowledgement that some specialist domestic abuse services provide other gender-based violence services, though our focus is on domestic abuse provision in this work.

Key research findings are highlighted at the start of each section. The report concludes with recommendations for Renfrewshire's GBV Strategy Group and local domestic abuse services which stem directly from the findings. Additional practice points are highlighted alongside the findings throughout for further consideration by our partners in Renfrewshire's GBV Strategy Group, who will receive a toolkit of the resources and guidance outlined in the recommendation section, plus implementation support from the SafeLives' Engagement Lead.

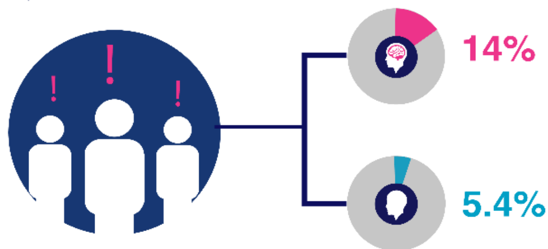
[ii] http://www.safelives.org.uk/practice-support/resources-domestic-abuse-and-idva-service-managers/insights

[iii] 226 cases across three services

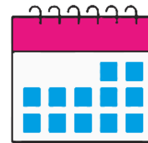
[iv] Specifically, SafeLives Insights dataset 2019, 8288 cases opened and 5024 cases closed from January 2016 through September 2019. Split to compare individuals with mental health needs to those without.

Research Context

People with mental health needs were more likely to experience abuse from multiple perpetrators compared to those without



SafeLives Insights dataset 2019[10]



People with mental health needs experienced abuse for longer before getting support (3 years 6 months v 3 years)

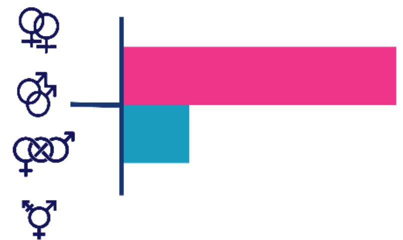
SafeLives Insights dataset 2019[10]

There is a strong association between mental ill health and domestic abuse. One UK study showed that victims/survivors of domestic abuse have a three-fold risk of depressive disorders, four-fold risk of anxiety, and seven-fold risk of post-traumatic stress disorder (PTSD)[3]. Two in five victim/survivors entering services using the SafeLives Insights outcomes measurement tool had mental health needs at intake[4].

Around one-in-eight suicides and suicide attempts by women in the UK are due to domestic abuse[5]. And about 30% of female psychiatric in-patients and 33% of female psychiatric outpatients have experienced domestic abuse[6]. Research also suggests that exposure to multiple forms of abuse, or abuse from multiple people, is more strongly associated with mental ill health[7-9].

The bidirectional relationship between domestic abuse and mental ill health means that poor mental health is a consequence of domestic abuse[11] but also that existing mental ill health may make individuals more vulnerable to abuse[12].

A larger proportion of victims with mental health needs were LGBT+ compared to those without (**4.0%** v **1.2%**)



SafeLives Insights dataset 2019[10]

Some individuals who use abuse seek to exploit the additional vulnerabilities that can accompany mental ill health, for example threats of institutionalisation or having children removed[13]. People already facing discrimination in society, such as LGBT+ people particularly impacted by stigma which can hinder access to services[14].

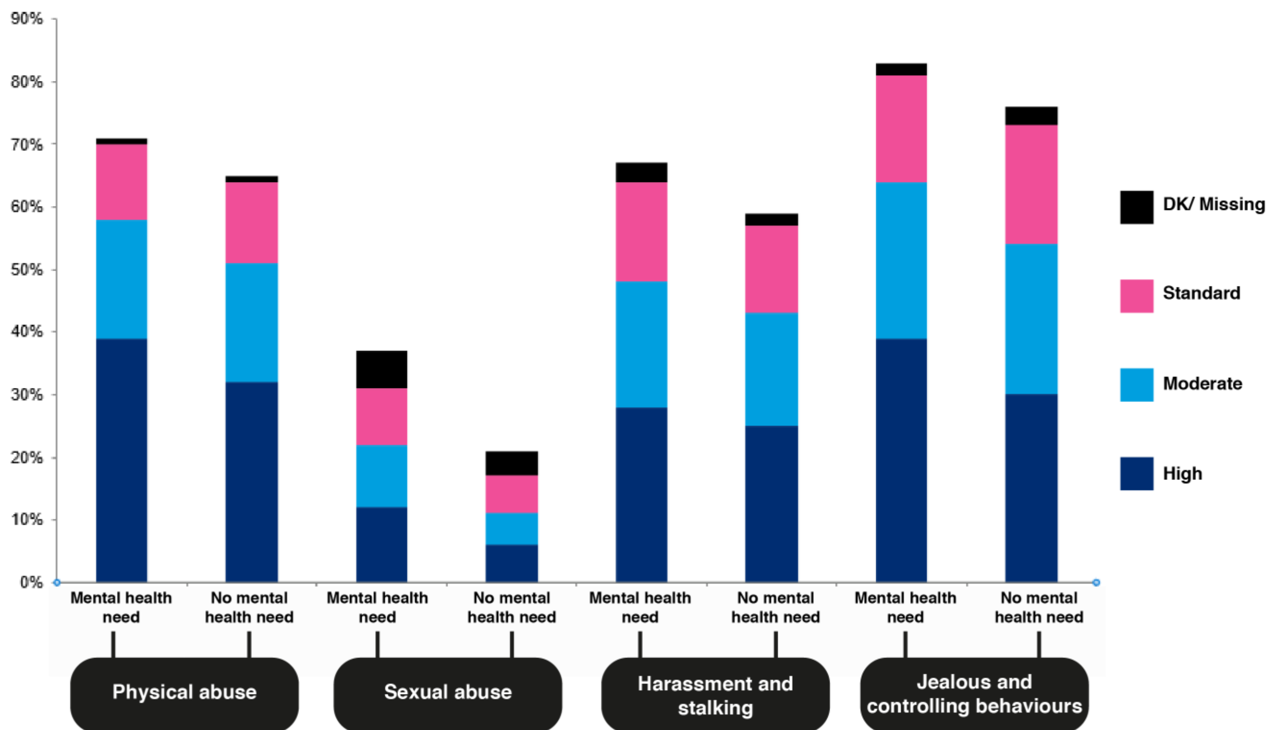
1 in 3 children accessing domestic abuse services had a concern identified around their mental health

Half of these children were experiencing low mood and half were experiencing anxiety.
1 in 4 had problems sleeping.

SafeLives *Whole Lives* 2017[1]

It is known that some victims/survivors hide their mental health needs for fear of discrimination and perceived consequences, such as losing their children[15]. Domestic abuse impacts the whole family and children living in homes where domestic abuse is happening have a higher rate of mental ill health than those who do not[16-18].

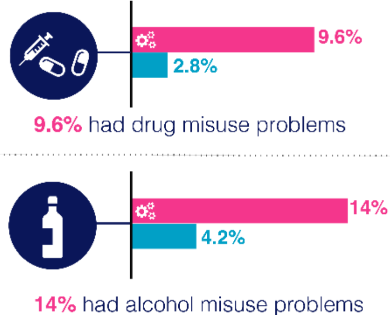
Poor mental health is one of many associated impacts victims/survivors of domestic abuse might experience and often these needs overlap. Insights data also shows that victims/survivors with mental health needs experience multiple disadvantage but are also more like to experience each type of abuse, and at a higher level of risk compared to those who do not have mental health needs (see graph overleaf).



SafeLives Insights dataset 2019[10]

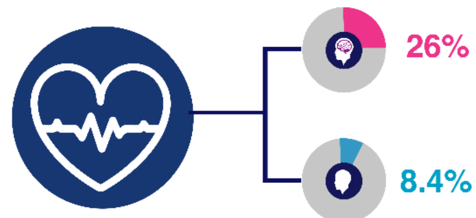
Despite evidence on the interrelatedness of needs, we know that services are not always well-equipped to respond to victims/survivors with multiple needs. This is notably the case where 'dual diagnosis'[19 20] is concerned, despite knowledge that substance misuse is sometimes a way of coping with unmet mental health needs and abuse[21].

Victims with mental health needs were more likely to have problems with drug and alcohol use:



(Compared to victims without mental health needs)
SafeLives Insights dataset 2019[10]

Victim/survivors with mental health needs were more likely to also have physical health needs



(Compared to victims without mental health needs)
SafeLives Insights dataset 2019[10]

Data from England & Wales shows that victims/survivors with mental health needs were no more likely to be referred to domestic abuse services by health agencies compared to those without (6.3% v 6.2%)[10]. Victims/survivors with mental health needs were less likely (1.5% v 2.4%) to be referred by hospital emergency departments though more likely (5.4% v 3.0%) to have visited one in the 12 months before accessing a service[10]. Unsurprisingly, they were more likely to be referred by mental health services (2.4% v 0.4%)[10].

For a more extensive discussion about domestic abuse and mental health and corresponding research references, see the SafeLives Spotlight and policy report, *Safe and Well*[22].

Domestic abuse & mental health policy

Equally Safe[23] is Scotland's strategy to prevent and eradicate violence against women and girls. The third of its four priority areas focusses on the provision of early and effective interventions that prevent violence and maximise safety and wellbeing. Here, the strategy recognises the breadth of support needs

victims/survivors and their families can have, highlighting the importance of diverse cross-sector provision with explicit mention of mental health services.

The ‘where, how and when’ of provision is critical to priority three; this is also at the heart of the Whole Lives Scotland project. Some UK research has highlighted low levels of enquiry among psychiatric service users[24], which the Scottish Government’s focus on sensitive routine enquiry aims to combat. *Equally Safe* calls for ‘an integrated system of mainstream, specialist and third sector services capable of delivering a coherent and consistent response across a diverse range of needs’ particularly highlighting the position of women and children with complex needs and those at additional risk of discrimination.

A 2016 review of mental health services in Scotland[25] reported a general positive direction over the previous ten years, including the impact of specialist trauma services. However regionally the picture was variable, with poor outcomes found for vulnerable groups.

Victim/survivors with a mental health need were 3.5 times more likely to have experienced 4 or more Adverse Childhood Experiences compared to those without

SafeLives Insights dataset 2019[10]

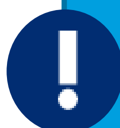
The vision within the *Mental Health Strategy 2017-2027*[26] is ‘a Scotland where people can get the right help at the right time, expect recovery, and fully enjoy their rights, free from discrimination and stigma’. It focuses on achieving parity between mental and physical health and acknowledges the impact of Adverse Childhood Experiences (ACEs), within which domestic abuse features.

The importance of trauma-informed responses to gender-based violence and corresponding mental ill health is becoming more and more widely acknowledged[15], though a report from the Agenda Alliance found trauma-informed mental health services for women are rare in the UK[27]. In Scotland, the *National Trauma Skills and Knowledge Framework* outlined in the *Mental Health Strategy* is now underway with NHS Education for Scotland[28].

In August 2018, the Scottish Government published the *Suicide prevention action plan: every life matters*[29] report, aiming to prevent suicide in Scotland and ensuring support is available to those contemplating suicide and all those affected. The report acknowledges that certain factors raise the risk of suicide, including ACEs and later-life traumas. This reflects the research highlighting suicide risk for victims/survivors of domestic abuse[5].

Renfrewshire Area Profile

Scotland



3% people experienced partner abuse in last 12 months –
3.6% women & **2.3%** men

(SCJS Partner Abuse 2016-2018[V])

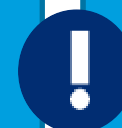
59,541 incidents
44% including a crime or offence
110 incidents per 10,000 population

(Scottish Government, police data 2017-2018)

3211 Marac cases heard
21 cases per 10,000 adult females
20% repeat rate
6.5% BME (15% UK)
0.8% LGBT, 2.8% disability

(SafeLives Marac data, 12 months to July 2019)

Renfrewshire



Estimated female victims each year: **3,000**

Estimated male victims each year: **1,800**[V]

2,132 incidents
41% including a crime or offence
121 incidents per 10,000 population

(Scottish Government, police data 2017-2018)

150 Marac cases heard
20 cases per 10,000 adult females
25% repeat rate
3.3% BME (5% in local population)
2.0% LGBT, 8.7% disability

(SafeLives Marac data, 12 months to July 2019)

[V] Scottish Crime & Justice Survey splits out partner abuse prevalence estimates by age (Table 6.07(i)a). Estimate for Renfrewshire calculated using SCJS Table 6.07(i)a estimates along with the local Renfrewshire population as given in National Records of Scotland 2018 (table mid-year-pop-est-18-time-series-1). Figures were rounded to nearest 50.

Findings

Pathways to specialist domestic abuse support in Renfrewshire

Key findings

- Renfrewshire's multi-agency GBV training programme is equipping professionals to identify domestic abuse and respond confidently. However, there is need for a greater awareness of the links between mental health needs and domestic abuse across services, and work to be done with GPs on enquiring about abuse.
- Victims/survivors with multiple needs including mental ill health feel bounced between agencies. Services sometimes struggle to respond appropriately when multiple needs exist together, and resource limitations can limit their ability to offer the right support at the critical point when need, readiness and engagement align.
- Frontline professionals would benefit from a greater understanding of local mental health and domestic abuse provision, including thresholds and criteria. Victims/survivors also need to know what services are available to help them.

Practice recommendations

- See Practice Recommendation 1: Mental Health Idaa
- See Practice Recommendation 2: Pathway

Other practice points

- GBV Strategy Group: Continue to promote sensitive routine enquiry across sectors and support GPs to respond, see SafeLives' GP Pathfinder guidance[vii]
- Mental health services: Embed discussions around relationships into ongoing case reviews to create more opportunities for disclosure
- GBV Strategy Group: Focus on engaging third sector agencies in GBV training programme

Identifying domestic abuse

A multi-agency GBV training programme is in place in Renfrewshire organised by the subgroup of the GBV Strategy Group which aims to educate professionals on the impact of domestic abuse and equip them to identify it. The practitioner survey indicated wide coverage with room to target third sector agencies, more respondents from within the third sector having not received domestic abuse training.

Practitioner survey – Key finding

Three-quarters of non-DA professionals had received specific domestic abuse training in their current roles

Perhaps reflecting the effectiveness of this programme, most of the 67 non-DA professionals answering the survey were confident they understood the impact of domestic abuse on victims/survivors (82%), including coercive control (79%), as well as on their children (88%). Practitioner confidence was much lower when it came to use of the SafeLives Dash Risk Checklist[viii] to assess the risk posed to victims/survivors, with just one third of respondents confident using it, and a third not at all confident.

[vii] http://www.safelives.org.uk/sites/default/files/resources/Pathfinder%20GP%20practice%20briefing.pdf (Created for NHS England but includes relevant general guidance)

[viii] http://safelives.org.uk/sites/default/files/resources/SafeLives%27%20Dash%20Risk%20Checklist%20%E2%80%93%20Scottish%20Version.pdf

SafeLives Dash Risk Checklist training was only incorporated in the overall training delivery more recently, through a SafeLives train the trainer event, so this may reflect the lesser coverage it has gained compared to the overall awareness training.

Linked to the multi-agency training programme, Renfrewshire HSCP delivers a programme of training around sensitive routine enquiry (SRE) to health agencies. Latest audit data on SRE in health visiting and mental health services from February 2019 demonstrated a significant increase in the use of SRE as means of identifying domestic abuse.

Practitioner survey – Key finding

Three quarters of non-DA professionals said routine enquiry about domestic abuse is happening in their agencies

The majority of non-DA professionals answering the survey felt confident identifying domestic abuse (75%), talking to people about it (80%), and were aware of local domestic abuse services to refer to (70%). Almost all respondents working within addiction, health visiting and community mental health services said routine enquiry is happening. Also, importantly, most felt there is a clear procedure in place to follow SRE. The Health Improvement team have worked to ensure SRE is backed up through clinical supervision structures within key HSCP services, with service leads supporting staff to make onward referrals to domestic abuse services.

Referral routes to specialist domestic abuse support

Figure 1 below shows the relative proportions of adult domestic abuse referrals from different sectors to specialist VAWG services in Renfrewshire in the year through March 2019[ix]. For information on domestic abuse provision in Renfrewshire, see Appendix 1. Whilst overall the police are the largest referrer (43%), they accounted for 96% of referrals to ASSIST in this time period due to their specific criteria working with clients going through criminal justice processes.

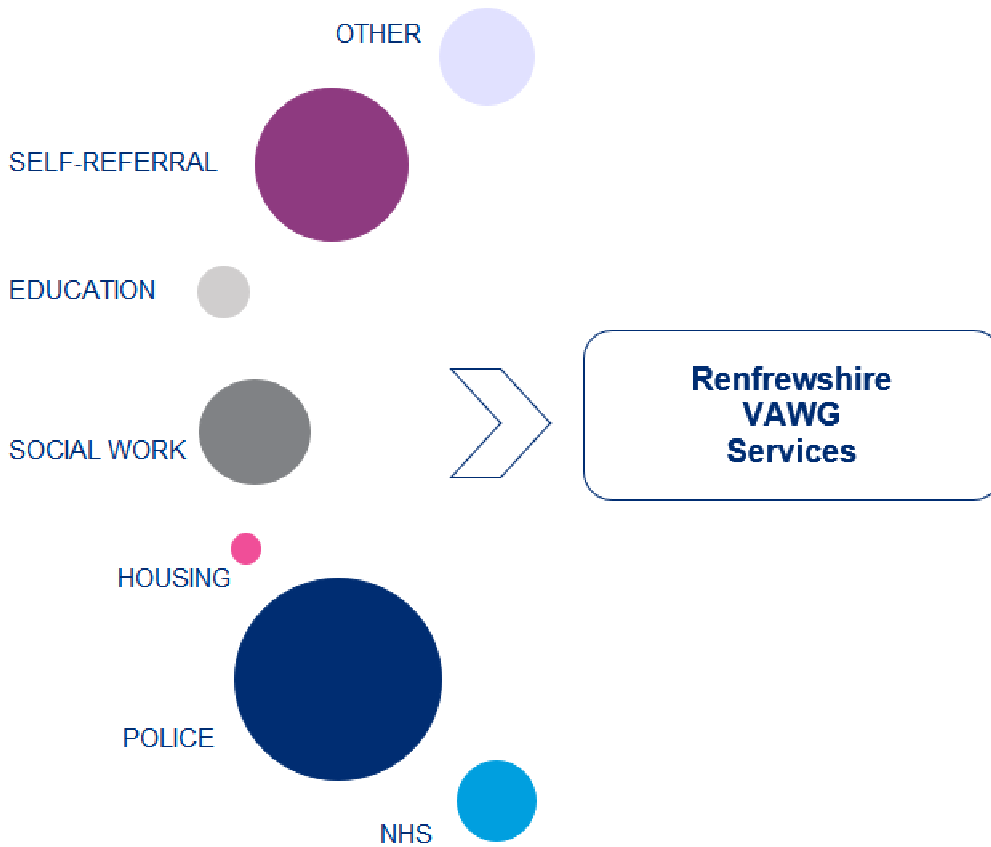


Figure 1: Domestic abuse referral routes to services within the VAWG sector for victims/survivors of domestic abuse aged 16+

[ix] 862 total adult domestic abuse referrals to VAWG services according to Equally Safe monitoring returns. This refers to referrals into services, a greater total number of individuals will have received support over the period.

Police referrals to Women & Children First (WCF) and Renfrewshire Women's Aid (RWA) are substantially lower, as shown in Figures 2 and 3.

Figure 2: Women & Children First - Domestic abuse referral sources (aged 16+)

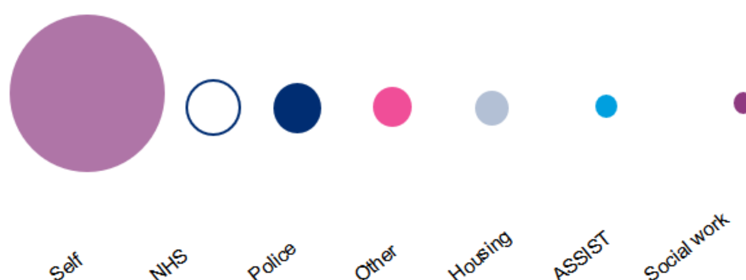


Figure 3: Renfrewshire Women's Aid - Domestic abuse referral sources (aged 16+)

Between July 2018 and June 2019, 150 cases were referred to Renfrewshire's Marac[x], half the number SafeLives would expect to see based on population and prevalence calculations[xi]. This does equate to a 63% increase compared to the same period in the previous year, which may be related to targeted Marac awareness raising and training being delivered in the area. It is worth noting that referral numbers nationally are below the recommended level, which can in part be explained by under-reporting of domestic abuse, as well as a lack of identification by Marac agencies.

Referrals to Renfrewshire's Marac come largely from the local Idaa[xii] services (ASSIST, WCF, RWA), a considerably higher percentage (71%) than the average for Scottish Maracs (26%)[30]. Just one in seven referrals came from the police (14%), much lower than the Scottish average (53%). The remaining referrals came from a range of services and, compared to the Scottish average, there were relatively high referral rates from health (4.7% v 1.1%) and addiction services (2.0% v 0.2%) The practitioner survey highlighted that multi-agency practitioners had a good awareness of their local Marac, but these referral figures may suggest there is more to do to increase agency referrals to Marac in line with prevalence.

Practitioner survey – Key finding

Three quarters of non-DA professionals had heard of Marac and one in five had directly referred

HSCP audit and practitioner survey data tells us that practitioners are confident identifying domestic abuse and SRE is happening within community mental health and health visiting services. Yet Renfrewshire's Equally Safe data shows that a quarter (24%) of referrals to domestic abuse services are

[x] Multi Agency Risk Assessment Conference – a multi-agency meeting where information is shared on the highest risk domestic abuse cases in the area. Attended by Police, Idaa services and key statutory and voluntary sector agencies.

[xi] 40 per 10,000 adult females. See http://www.safelives.org.uk/node/521 for some information on SafeLives Marac data and estimates

[xii] Idaa: Independent Domestic Abuse Advocate. Idaa training in Scotland is co-delivered by SafeLives, Scottish Women's Aid and ASSIST. See Appendix 2 for full definition.

self-referrals and overall health referrals are relatively low (7%). HSCP audit reports on SRE highlighted that when community mental health services, as one example, ask about domestic abuse, follow-on actions were not frequently recorded. Where actions were recorded, signposting clients to self-refer was quite common. Further consideration of the referral pathways that follow identification of domestic abuse may be beneficial. SafeLives' *Whole Lives* report of 2017 showed that self-referrals to Scottish domestic abuse services were relatively high (31%). We will explore pathways to support for victims/survivors who self-refer throughout the project with particular reference to data from the national survivor survey.

Barriers to service access

Consultation with victims/survivors and professionals provided rich detail on a number of barriers that could prevent or delay victims/survivors from accessing specialist domestic abuse support. Inevitably, some of the barriers identified apply widely to many victims/survivors, regardless of additional needs. The following discussion will outline these barriers and emphasise those that are exacerbated for victims/survivors with poor mental health.

Figure 4, below, shows which barriers were selected by the largest percentage of respondents to the practitioner survey (colours indicate proportion of respondents).

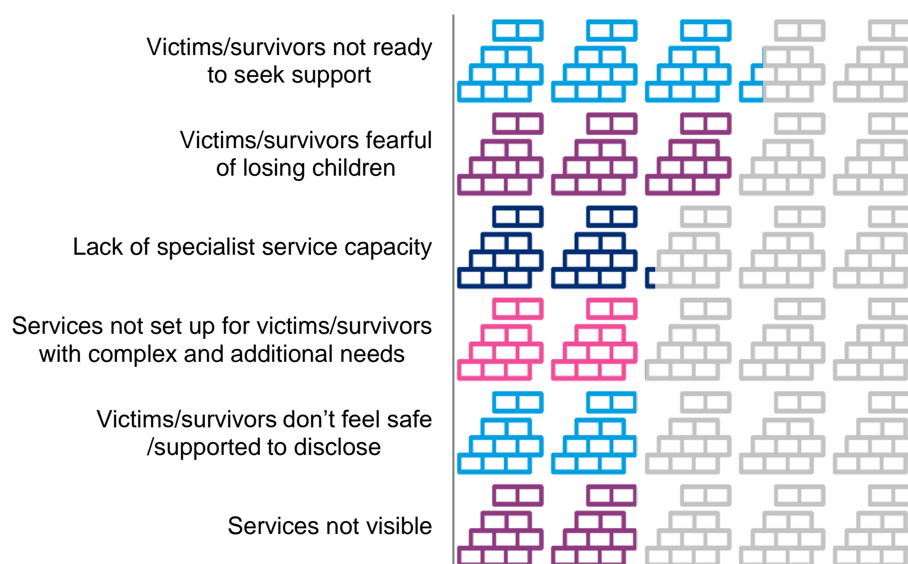


Figure 4: Top barriers to accessing domestic abuse services identified by proportion of practitioner survey respondents

Readiness – people and systems

The most common barrier identified by professionals was readiness to seek support, with two thirds stating this was key. Victims/survivors reflected on the knowledge they needed to see that they were experiencing abuse, particularly concerning coercive control. In focus groups, practitioners also discussed the process of victims/survivors coming to recognise their experience as abuse.

While readiness involves individuals recognising abuse to some extent and being able to work with services to address it, it does not just apply to victims/survivors. Managers highlighted the potential mismatch between client readiness and service availability. Service capacity was also highlighted by two in five practitioner survey respondents (Figure 4). There was a sense that there are missed moments of opportunity where need and engagement align due to a lack of service capacity.

"Then we're talking about the length of time it...takes...[to] engage and build trust and begin to work on the issues. And as we're doing that, there's this never-ending supply, unfortunately, of other women who are coming forward, and the best thing that we can do is just do the risk assessment and find out who's at that… crisis point, which means all those other ones… are just not getting a service, at the minute – and that's lingering for a long period of time." (Domestic Abuse Service Manager)

Frontline practitioners discussed preventative work to be done across society to raise awareness of domestic abuse and educate people early on about healthy relationships. The sense was that building awareness would reduce some of the barriers identified relating to individual readiness.

Specific barriers linked to mental health

Readiness to seek support was identified as the main barrier to service access by mental health practitioners answering the survey, more so than respondents from other sectors. For mental health services, providing clinical support to victims/survivors who are not ready to recognise their experience as abuse is a challenge. Some complex cases were discussed in focus groups where careful planning had been implemented as workers were unable to address the domestic abuse, despite it having been identified, in order to maintain client engagement in mental health treatment.

"We have to weigh up that risk, but the risk is we'd actually rather see her once a week than not have any contact at all." (Mental health practitioner)

Whilst clients with mental health needs are perceived as engaging sporadically, the system was described as too slow with momentum lost when victims/survivors are ready to make changes due to issues such as service waiting times and thresholds.

"Then the momentum for actually doing something there – in the crisis, in the moment – is gone because it's taken too long, and the person goes back." (Practitioner)

Asking and disclosing

Two in five practitioners considered victims/survivors not feeling safe or supported to disclose as a major barrier to access (see Figure 4). A lack of timely and appropriate questioning was discussed by victims/survivors, largely in relation to GPs. The isolation and normalisation of abuse in day-to-day life make timely questioning all the more essential to victims/survivors.

Fear was an inhibitor for many; fear of the perpetrator, of being judged and of losing their children. One survivor described how only through becoming 'numb' to her fears could she ask for help and leave.

"I just left numb, just went and took the wee 'un as if he was going to school and went for the train. I planned it to be there, but I left numb. I wasn't thinking about money, benefits or nothing, I was just thinking I need to get myself out of this life." (Survivor)

Specific barriers linked to mental health

For victims/survivors with mental health needs, it's particularly important that professionals can identify symptoms of mental ill health as potential indicators of abuse. An overly medicalised response to mental ill health by GPs was highlighted as potentially delaying access to appropriate support.

"Especially with the symptoms and the behaviours that I was displaying. I think that should have been a red flag for some of the agencies that I was engaging with." (Survivor)

Practitioners discussed how a 'double stigma' intensifies fear of disclosure for victims/survivors when mental health and/or addiction are present alongside domestic abuse. Some institutions, such as the courts, reinforce this.

"There's a concern there that if you're experiencing a mental health problem, and you start to disclose maybe something that's been going at home, that because... you know... if you've been a bit psychotic or whatever, that you're going to be judged –that's not actually what's been happening to you, but it's more or less in your mind." (Practitioner)

Furthermore, whilst psychological abuse can cause all victims/survivors to doubt their capabilities and ability to make decisions, poor mental health can exacerbate this, leading victims/survivors to doubt their perceptions of the abuse or manage the reality of it as a strategy to keep themselves safe.

'It's my mental health condition that's causing the chaos' (Practitioner quoting survivor)

Practitioner survey – Key finding	**Fear** of services, **difficulties engaging** with services and **waiting lists** or **physical access** issues were the most common barriers highlighted for victims/survivors with mental health needs

Unravelling multiple needs

When victims/survivors have multiple needs, such as mental ill health and addiction, it can be challenging for services to identify the best place to start with support, and the right service to work with an individual. Victims/survivors have their own priorities which can sometimes clash with service expectations. Practitioners acknowledged that the way services are structured, and a lack of coordination, can lead to victims/survivors 'falling through the cracks', as victims/survivors termed it.

"It can be very difficult, I mean, there's drugs and addiction, and domestic violence and then mental health issues in the mix together, and trying to pull that apart and actually have that conversation with somebody, it can be really difficult to know where to start with that." (Practitioner)

A tension between different protocols and waiting times for services heightens this.

"When you're answering the telephone in first crisis…it's about, you know, well, I could refer you to this, but you don't fit that criteria, and you… sometimes you get stuck between the Mental Health and addiction and people just fall through, you know, they get passed from pillar to post." (Practitioner)

Whilst waiting times are an issue for any victim/survivor trying to access a service, the impact on existing mental health was clear in some victim/survivor accounts.

"Well it felt they all kinda palmed you off to each other. The police, they had different protocol, and if you've got children it comes hand-in-hand that the social worker will assess the situation…So, the social worker comes out and they do an assessment and then you don't hear about the assessment for about two weeks. So, on top of leaving an abusive situation, you're like a cat on a hot tin roof waiting for somebody to come up in a white van and take your bairns away. Then the police provided a CID about historical domestic abuse...And with the best will in the world you've got a wee woman coming out and sitting with you...and she's wanting to go delve right into the past and you're not emotionally prepared for that…you're then waiting another six weeks for them to come out and start making any kind of support." (Survivor)

For frontline practitioners, the timing of attempting an intervention was especially important, and building relationships was imperative in facilitating disclosures about abuse. This was also discussed in survey responses, with some mental health workers highlighting the importance of making discussions about relationships and domestic abuse a regular part of ongoing assessments, creating opportunities for disclosure when patients are less unwell.

Professionals discussed a need for greater awareness of routes into domestic abuse and mental health services. Not all focus group participants were clear on the role of Idaas and how to access them, and survey responses also called for improved awareness of services, particularly third sector services. Some clarity on mental health terminology such as 'capacity' could be beneficial for domestic abuse practitioners; there was some disparity between domestic abuse practitioners' consideration of victims' capacity to keep themselves safe and the technical term used by mental health practitioners.

"So, it becomes an absolute minefield, and you're just like… I don't know where to phone, I don't know who to suggest to my client, we just don't know the thresholds and capacities for each different aspect." (Practitioner)

See Figure 5 on page 18 for an overview of all barriers identified by victims/survivors in their focus group, as well as enablers that assisted them to find support.

Pathways to specialist domestic abuse support – summary

Consultation with professionals revealed that Renfrewshire's multi-agency GBV training programme appears to be having a positive impact on professionals' ability to identify domestic abuse and respond confidently. However, there is need for a greater awareness of the links between mental health needs and domestic abuse across services. In particular, victims/survivors felt there is work to be done with GPs so they can identify domestic abuse more effectively.

Practitioners identified survivor readiness to seek support as a potential barrier to service access. Consultation revealed this to be influenced by fear, stigma, access to knowledge about abuse and isolation. Mental ill health can exacerbate stigma and fear around professional involvement. However, readiness also applies to services; service capacity and thresholds impacts on their ability to offer timely interventions.

Victims/survivors with multiple needs described feeling bounced between agencies which mirrored professional feedback on systemic challenges in unpicking multiple needs. Sometimes professionals do not have adequate information about available options for victims/survivors coming into contact with their services.

Victim/survivor experiences seeking support

Individual		Interpersonal		Community		Society	
Enablers	**Barriers**	**Enablers**	**Barriers**	**Enablers**	**Barriers**	**Enablers**	**Barriers**
Knowing it is abuse	Self-blame/ doubt	Support network – family	Isolation from family & friends	Agency awareness of abuse & identification	Unhelpful professional attitudes	Wide awareness and understanding of domestic abuse	Stigma around: domestic abuse, mental health, class
Saying it out loud	Abuse becomes normal	Connecting with other victims/ survivors	Fear of losing children	Understanding, flexible services	Not seeing beyond mental health symptoms (GP)	Adequately funded services	Attitudes towards mothers
Moments of realisation	Fear	Knowing there's support for children & wider family	Perpetrator manipulation re children	Positive professional attitudes	Inappropriate questioning		
Knowing what services do	Perceived lack of 'strength'	Peer support	Wider family not equipped to help	Timely questioning	Not being asked at all		
Only telling story once	Lack of trust in services		Services not talking to family support	Wraparound support for mental health	Too many agencies with different processes		
	Not knowing about services			One coordinating worker	Professionals following rigid protocol		
	Feeling bounced around			Communication between agencies	Waiting times		
	Repeating story			Technology – access to information	Lack of gendered understanding		

Figure 5: Enablers and barriers to accessing specialist domestic abuse support for victims/survivors with mental health needs

Specialist domestic abuse provision in Renfrewshire

Key findings

- Renfrewshire has a well-established range of specialist provision for victims/survivors of domestic abuse. Overall, professionals described efforts at multi-agency work in the area positively.
- Domestic abuse professionals are working with large numbers of individuals with mental health needs and are not currently receiving specific mental health training. Not all specialist domestic abuse services assess and record additional needs at intake.
- There is a gap in provision for individuals with lower level and trauma-related mental health conditions that do not meet the threshold for community mental health services.
- The intersection between domestic abuse and mental health, and the complexity of need of some victims/survivors with mental ill health, means that a greater flexibility in referral processes and more collaboration between domestic abuse and mental health services could benefit victims/survivors with mental health needs.

Practice recommendations

- ➢ See Practice Recommendation 1: Mental Health Idaa
- ➢ See Practice Recommendation 3: Training
- ➢ See Practice Recommendation 4: Toolkit

Other practice points

- ➢ GBV Strategy Group: Support the development of complex needs working forums – the 'GBV breakfast' – to build collaborative work between agencies.
- ➢ GBV Strategy Group: See evaluation of SafeLives' One Front Door[xiii] in England for example of a whole system approach to identifying and addressing needs in a collaborative way.

To understand how victims/survivors experience domestic abuse provision in Renfrewshire, we consulted with local women who experienced mental ill health alongside domestic abuse. We partnered with Wise Women and used their stages model – endure, manage, walk away – to map out victim/survivor needs throughout their journey, and their ongoing needs in recovery, as shown in Figure 6.

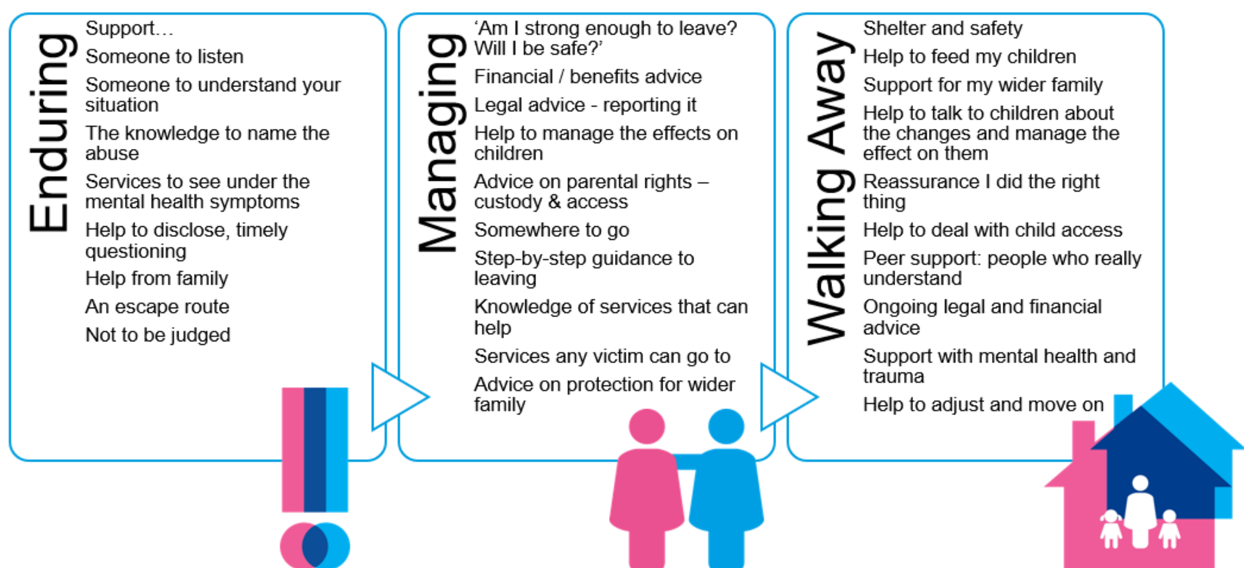


Figure 6: Survivor needs identified during Wise Women consultation

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xiii http://www.safelives.org.uk/one-front-door

Victims/survivors in Renfrewshire have a choice of services across the statutory and third sector. Domestic abuse agencies provide a wide range of direct interventions from refuge to therapeutic groupwork, court support and advocacy. There is a commitment to consider the impact of domestic abuse on the whole family, with well-established children and young people services available and recovery-focussed work. Up until recently, Renfrewshire had two perpetrator programmes: the court-mandated Up2You programme delivered by criminal justice social work, and Connected Dads, a Barnardo's project working with under 25-year-old fathers. In early 2019, Barnardo's funding came to an end.

In their focus group, victims/survivors shared largely positive experiences of specialist domestic abuse support services. It should be noted that victims/survivors were recruited to participate in the group through these services; nonetheless, they discussed how much they valued the proactive approach of domestic abuse workers and their ability to advocate on their behalf when needed.

"They were so supportive. They had obviously seen all different areas of abuse…I didn't have to over explain myself. They got me." (Survivor)

Victims/survivors' comments about their experiences of interventions from domestic abuse practitioners, as well as from other agencies, provided a clear sense of the attributes and approaches they valued in professional responses (see page 21, Figure 7).

Improving support for victims and survivors with mental health needs

A more holistic response

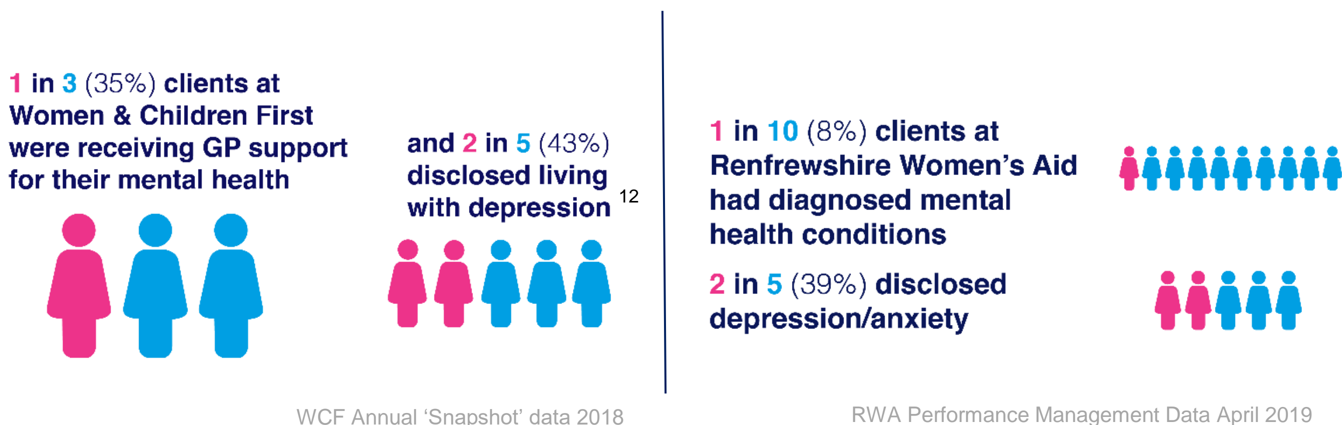
The prevalence of mental ill health among domestic abuse victims/survivors is high, indicating why a holistic offer of mental health support alongside support to address domestic abuse is important. But there is also evidence that receiving mental health support improves survivor outcomes across other areas.

SafeLives Insights dataset 2019[10]

Figure 7: What survivor focus group participants wanted in their interactions with agencies and professionals

In focus groups, cross-sector practitioners acknowledged the need to work with victims/survivors with multiple needs in a holistic and person-centred way, highlighting the links between trauma, addiction and mental ill health in their discussions. However, specialist domestic abuse services do not all assess for and record mental health and addiction at intake, and the level of detail on referrals varies. A lack of established onwards referral pathways for victim/survivors with mental health needs was linked to this.

"A lot of staff might feel apprehensive about actually even engaging in that conversation, because they don't know where it goes after that – 'if I ask the question, then what do I do?' So, that's a real challenge for staff." (Domestic abuse Service Manager)



WCF Annual 'Snapshot' data 2018

RWA Performance Management Data April 2019

The client data that is available indicates that domestic abuse services are working with a substantial proportion of victims/survivors with mental health needs. Mental Health First Aid training has had some professional uptake in the area and will be more available going forward in a new modular form. However, there was a sense from managers that domestic abuse practitioners are not fully confident around mental health. This was supported by survey responses.

Practitioner survey – Key finding

13 out of 15 domestic abuse practitioners considered themselves either somewhat or moderately confident supporting victims/survivors with mental health needs

10 out of 15 had not had mental health training in their current roles

Cross-sector service managers acknowledged that many of the kinds of cases where mental health is a factor were not meeting the thresholds of secondary mental health services and that there is a multi-agency 'trauma gap' in provision for adult victims/survivors of domestic abuse, and for children.

"…if you're at the… high level, high tariff and you've got a diagnosable mental health problem or you're really, really chaotic ... then there are services there, but it's when … you're on the cusp" (Service Manager)

Services need time to deliver trauma-informed approaches; managers highlighted the need to work at a slower pace with clients with mental health needs and with more flexibility, which mirrors victim/survivor feedback (see Figure 7).

Practitioner survey – Key finding

Improving the response to victims/survivors with mental health needs

1. Mental health / DA training for services working with victims/survivors
2. More joint work between DA and mental health services
3. Improved awareness of local service provision
4. Funding and resources

To deliver effective holistic support, resourcing is vital to frontline practitioners. Age-inclusive services were discussed, with a gap in provision noted for young people aged 16-18 with mental health needs. The need for perpetrator change programmes and more Idaas was highlighted.

‘Bridged’ services

In general, practitioners responding to the survey felt positive about multi-agency work in the area. Seven out of ten agreed or strongly agreed that agencies work well to respond to victims/survivors of domestic abuse and their children. Marac was highlighted as an important feature of multi-agency collaboration on the most complex cases in the area by participants in focus groups. Practitioners commented positively about the referral process to Marac in the survey and the outcomes they had experienced.

Collectively, survey respondents felt the least decided about whether multi-agency working was effective when it came to perpetrators: only one in five agreed that it was going well, with most practitioners undecided. This may indicate a lack of awareness around the local plan for this work following the recent loss of provision.

Practitioner survey – Key finding

Practitioner confidence was lower on responding to perpetrators compared to other areas of practice: two in five were moderately or completely confident

However, there was a sense that collaborative working arrangements between domestic abuse and mental health services could be improved. For victims/survivors, a lack of coordination between domestic abuse and mental health services could be challenging, resulting in their having to relay the same information on multiple occasions. One domestic abuse service manager called for a ‘bridge’ between domestic abuse and community mental health services to facilitate more collaborative ways of working.

“I think we actually need to make a conscious effort to build a bigger bridge between our mental health services… ‘Let’s create something where we can sit round a table – at the very least – and talk about these complicated cases…’” (Domestic Abuse Service Manager)

Domestic abuse professionals discussed the potential decline in mental health when victims/survivors start to address domestic abuse. This highlights why joint or flexible working arrangements for victims/survivors with mental health needs is important. Whilst poor mental health is a factor in many domestic abuse cases, there was a sense among domestic abuse professionals that systemic issues were leading to them working with a high level of complexity in clients that they were not equipped for. One manager discussed cases where individuals were signposted to them after being ‘screened out’ of mental health services. They described times when victims/survivors were referred to their services when their mental health was still very unstable or when they were not ready to address domestic abuse.

“It would appear that a woman who discloses that they are or were a victim of DA during the Sensitive Routine Enquiry stage of a mental health referral to CMH team will automatically be considered for an onward referral to a domestic abuse specialist service. However sometimes it would seem that there has been little consideration given to whether the woman wants or is able to look at the DA issues. Following our assessment it is clear that her main issue at present is her poor mental health. We have had to change the way we work with women to ensure we offer safe support. In some cases, however, where the mental health issue is so prevalent we cannot work with her safely and we have no option but to refer her back to her GP to make another referral to CMH.” (Domestic Abuse Service Manager)

For some victims/survivors, where there is a history of poor mental health or overlapping needs, a more flexible referral process between the services or a system of joint working could counter some of these issues.

“So, I feel like there needs to be a kind of go between somewhere, where if you had experience of domestic abuse and poor mental health you can get a combined appropriate support...if the mental health was deemed at that particular point to take priority, that could happen. If it was domestic abuse that could happen, but you weren’t going between services.” (HSCP Lead)

Victims/survivors explicitly stated that the one thing that would have made the biggest difference to them in their journey would be having one worker to coordinate their case from the outset and link them with other agencies when necessary. Especially during a period of particularly poor mental health, the

uncoordinated involvement of multiple agencies could be overwhelming. While domestic abuse practitioners were discussed as providing coordination to a point, and in one particular situation offering protection from a feeling of bombardment, this was not always the case.

"I had eight people in the house one day. I had two social workers, I had the police and then…two folk from the domestic unit…and they were all just crammed in and… it was bad. Could there not just be one person?" (Survivor)

Professionals also discussed the idea of one service or a coordinating worker who could apply the type of holistic and flexible way of working with higher levels of mental health need, but also integrate different systems of support.

Specialist domestic abuse provision - summary

Domestic abuse professionals are working with large numbers of individuals with mental health needs and are not currently receiving specific mental health training. Furthermore, not all domestic abuse services assess and record additional needs at service intake.

There is a gap in provision for individuals with lower level and trauma-related mental health conditions that do not meet the threshold for community mental health services. There is a close intersection between domestic abuse and mental health and some victims/survivors accessing domestic abuse services have complex mental health needs. This means a greater flexibility in referral processes and more collaboration between domestic abuse and mental health services could benefit victims/survivors.

Victims and survivors with children

Key findings

- Renfrewshire has a well-established range of provision for children who have experienced domestic abuse. As with adult provision, resources for cross-sector agencies to respond to children who have experienced trauma as a result of domestic abuse are sometimes limited and would be beneficial.
- There remains work to do to break down the fear non-abusive parents sometimes have around service involvement, which victim/survivor and professional feedback shows still works as a barrier to engagement with domestic abuse support. This is not a problem unique to Renfrewshire and the implementation of Safe & Together shows that movement is happening to address this.

Practice points

- ➢ The continued roll out and embedding of Safe & Together will enhance the opportunity for victims/survivors with children to feel they can speak without fear of stigma and engage with agencies.

Both WCF and RWA have long-established projects for children and young people that ensure the importance of the impact of domestic abuse on the whole family is recognised (see Appendix 1). It is also important to highlight the work carried out by other non-DA organisations within Renfrewshire. Paisley Threads, a Barnardo's project, works with young mothers under 25 and includes input on healthy relationships, domestic abuse and wider GBV. Home School Link staff, based in schools, often work directly with those experiencing domestic abuse as well as signposting on to specialist domestic abuse services. Families First is a multi-agency service, working with families that have young children, on issues such as health, home life, and isolation and often respond to domestic abuse. All agencies mentioned co-facilitate CEDAR (see Appendix 1), enhancing the skills necessary to work with victims/survivors.

The Safe & Together model, introduced to Renfrewshire at its 2016 Child Protection Conference, connects this provision. The perpetrator pattern-based, child-centred, survivor strengths model shifts focus to children's interests and maintains that the perpetrator parent be held to the same parenting standards as the parent who is victim of the abuse. The aim is for this model to be embedded as an approach to GBV across all services in Renfrewshire reflecting national roll out across Scotland.

Barriers to service access

Three in five practitioner survey respondents highlighted fear of losing children as a major barrier which could prevent or delay victims/survivors accessing domestic abuse services. This applies whether or not mental health needs are a factor. In focus groups, some discussed the measures that have been taken to try to break down this barrier, reframing the 'failure to protect' narrative in line with the Safe & Together approach.

The victims/survivors in the focus group who had children were clear that fear of consequences in terms of children's services involvement, and ultimately losing their children, was a barrier in approaching and engaging with services for support to address domestic abuse.

"I genuinely think that that's every mother's fear, and I don't know, I'm just speaking for myself but I think that was a big barrier which stopped me from getting any kind of support was the fear that they were going to take my daughter away." (Survivor)

Some managers also discussed another concern, that there are less options when victims/survivors do not have children. This reflects Scottish Insights data included in the *Whole Lives* report of 2017 that showed two thirds of women accessing domestic abuse services had children, a higher proportion than those with dependent children in the general population[1]. This may indicate v ictims/survivors without children are under-represented in services.

Specific barriers linked to mental health

Practitioners discussed how victims/survivors with mental health needs, already facing a level of stigma when attempting to access services, experience further barriers where they have children and fear children's services involvement. It was recognised that perpetrators can exert some control through this fear.

"She was constantly told that she was a useless mother because she'd significant mental health problems." (Practitioner)

The multi-agency 'trauma gap' in mental health provision highlighted by managers also applied to children's provision.

"…a lot of the children that come to CAMHS have got trauma as a result of domestic abuse they've witnessed. And they tend not to get a service, and often it's really… quite damaging, because… usually the mother is trying to cope with a child who's really, really emotionally distressed, and that has already been through something that's really emotionally distressing herself, and they're not getting the mental health support. And there's a gap – a gap in services there." (Service Manager)

An effective trauma-informed response to children involves all agencies and the community. Trauma-informed practice training would support practitioners to work effectively with children who have experienced domestic abuse. Attendees discussed the need for culture change across all sectors and a coordinated approach to managing distress in traumatised adults and children.

"For those children …to thrive, they need everyone… yes, it is about specialist support to those children, but it's about how they're responded to in the home, and how they're responded to in school." (Service Manager)

Victims/survivors with children – summary

Renfrewshire has a well-established range of provision for children who have experienced domestic abuse. Agencies we consulted with recognised the wide-reaching impact of trauma on children who have experienced domestic abuse; there is a need for resourcing to respond to the cross-sector 'trauma gap' in provision.

There remains work to do to break down the fear non-abusive parents sometimes have around service involvement, which survivor and professional feedback shows can still work as a barrier to engagement with specialist domestic abuse support. This is not a problem unique to Renfrewshire and the implementation of Safe & Together shows that movement is happening to address this.

Recommendations

Based on the research findings, we are making four practice recommendations (pages 28-31) for consideration by Renfrewshire's GBV Strategy Group and local domestic abuse services. All recommendations have been co-produced with victims/survivors in Renfrewshire. We are also making some suggestions linked to data and to incorporating survivor voice in service development (page 32). A package of practice tools will be provided to follow this report.

We know that our findings and recommendations will have value to other local authority areas and to practitioners across Scotland. In year 3 (2020-2021) of the Whole Lives project we will work to amplify local findings, speaking to change makers at a national level to showcase and embed best practice based on lived experience and robust evidence.

1. Recruit a Mental Health Independent Domestic Abuse Advocate (MH Idaa)

- **A medical professional with an Idaa qualification, co-located within a community mental health setting**
- **Carries limited caseload supporting those with a high level of need, with the ability to be flexible within limits of referral criteria**
- **Joint work with domestic abuse services offering training, guidance as well as direct client support including Marac**
- **Raise awareness of domestic abuse and its impact with mental health services through organisational advocacy**

We heard: Victims/survivors with multiple needs, including mental ill health, can feel like they are bounced around services. There are difficulties balancing victim/survivor need, engagement and service capacity to respond, leading to missed opportunities. There is a need for a more open-door approach to mental health services for clients with higher level needs who require more flexible responses.

We think a Mental Health Idaa will:

Help victims/survivors navigate what can be complex pathways between services, advocate on their behalf to ensure that they get the right support at the right time and where appropriate make a case for quicker intervention.

Work intensively with the people who require it most, in a flexible, needs and risk-led way, thus reducing the demand on domestic abuse services. By working closely with the Marac process they will ensure that there are robust risk reduction activities carried out, including safety planning and signposting.

Support other practitioners, both externally and internally, by offering guidance and information, reducing 'silos' and promoting joined up collaborative working.

How to make the MH Idaa work:

Recruit mental health qualified professional with reference to the suggested job description co-created with victims/survivors	Enrol professional on Idaa course
Locate within mental health service and set up outreach to domestic abuse organisations and addiction services	Ensure stable funding of role to maximise impact

2. Pathway – linking domestic abuse and mental health services

- **Document outlining services available in Renfrewshire with information on who can refer and the best way to make a referral**
- **Clarifies service thresholds and expected waiting times**
- **Maps Idaa provision (including Mental Health Idaa and how to access for clients with higher levels of need)**
- **Closure and engagement procedures specified**

We heard: Staff across Renfrewshire are committed and passionate, keen to support victims/survivors in the best way possible. There can be confusion over service structures and access and differences in use of terminology between organisations. Domestic abuse services do not always gather information on additional needs at service intake.

We think the pathway will:

Give a clear picture of the range of services, both statutory and third sector, that are available within Renfrewshire with advice on the type of support and interventions offered, including how to refer directly to the MH Idaa post.

Provide information on current thresholds and waiting lists, meaning that victims/survivors can be supported with the right information and realistic outcomes. Staff will know the best way to make referrals and what they can expect.

Ensure that practitioners can support clients who many not be able to engage due to trauma or circumstance by being aware of organisational engagement policies and advocate on their behalf.

How to make the pathway work:

Create in conjunction with local agencies & victims/survivors	Integrate into existing GBV training & include in induction materials
Mixed media release (email/online/print)	Make available to wider networks of professionals including GPs, third sector agencies and Education
Agree mechanism with agencies to ensure it is kept updated	

3. Training - supporting victims/ survivors with mental health needs

- **Developed specifically for domestic abuse professionals**
- **Links mental health-related theory with current best practice**
- **Includes use of appropriate language and terminology**
- **Centred on trauma-informed working approaches**
- **Considers staff as victims/survivors as well as Vicarious Trauma**

We heard: There is a multi-agency 'trauma gap' in Renfrewshire. Domestic abuse practitioners are working with a high number of clients who present with poor mental health, often linked to trauma caused by abuse, who may not meet thresholds for secondary mental health services. Domestic abuse practitioners do not always receive specific mental health training and can sometimes feel overwhelmed by the complexity of need some clients have.

We think mental health training for domestic abuse professionals will:

Support domestic abuse practitioners to work with those clients who present with poor mental health and do not require crisis intervention or mental health service input, using a trauma informed approach and evidence-based interventions.

Ensure that staff are aware of definitions, thresholds and local services and feel more confident in navigating pathways to support. Highlight existing good practice and be supported by the toolkit.

Help practitioners to recognise and understand vicarious trauma and know where to go for help.

How to make the training work:

Developed by mental health and domestic abuse experts, using survivor feedback	1 day supported by Mental Health Idaa/local experts for capacity building/local knowledge
Link to NHS National Trauma Training Framework	Refers to toolkit and pathway
Targeted for those working directly with domestic abuse	Ensure it sits within existing GBV calendar

4. Practice toolkit - working with victims/ survivors with mental health needs

- **Complements the mental health training package with guidance on the impact of domestic abuse on mental health, victim/survivor needs at different stages of their journey, barriers to service access and best working practice including trauma-informed approaches**
- **Glossary of terminology relating to mental health included**
- **Information on evidence-based interventions available in the local area and mental health service structures**
- **Sample case management templates to support data collection**

We heard: Staff across Renfrewshire are committed and passionate, keen to support victims/survivors in the best way possible. There can be confusion over service structures and access and differences in use of terminology between organisations. Domestic abuse services do not always gather information on additional needs at service intake.

We think the practice toolkit for domestic abuse professionals will:

Provide frontline staff with guidance on the impact of domestic abuse and mental health, highlighting barriers and best practice to support them in their role. It will also provide guidance for new staff and reinforce learning from the mental health training.

Give relevant and up-to-date information on language, service structures and terminology helping to avoid confusion when working across agencies and sectors.

Sample case management documentation will support services to record information at intake, such as additional needs around mental health and substance use, which can help evidence impact at case closure.

How to make it work:

Create in conjunction with local agencies & victims/survivors	Integrate into existing GBV training and new practitioner materials
Mixed media release (email/online/print)	Make available to wider networks of professionals including GPs, third sector agencies and Education
Build on new mental health/domestic abuse training content and reference pathway	Agree review process within agencies to update when required

Recommendations - voice

- SafeLives recommends having a strong victim/survivor voice present through any development work carried out. Potential ways to ensure this happens could include inviting people with lived experience to input to the GBV Strategy Group or creating a small multi-agency Survivor Steering Group to advise on activities. This should include, where possible, children to ensure that all voices are heard and the impact of domestic abuse on the whole family is recognised. The 'RISE' group within WCF is an excellent model of good practice demonstrating the importance of listening to young people.
- It is important to recognise that some staff will also have experienced domestic abuse and may want to be part of any victim/survivor led development work. Consideration should be taken with regards to anonymity, ongoing consent and publications.
- Any new services should follow the Scottish Approach to Service Design, which seeks to ensure that 'the citizen is at the heart of processes that may impact them'.

Recommendations - data

- Good data is at the heart of good service provision. Capturing in-depth demographic and needs information at intake can assist in targeted outreach to groups not accessing services. Outcomes data brings insight into good practice based on service outcomes for victims/survivors.
- Renfrewshire services record intake data and outcomes at case closure in different ways. VAWG services across Scotland are submitting some referral and outcomes data for Equally Safe monitoring returns. The different ways referrals and outcomes are recorded by services have posed some challenges to this process.
- Renfrewshire could benefit from use of an outcomes measurement tool across its VAWG provision to allow for more streamlined data collection for Equally Safe reporting. The Exit Form included within the Case Management Pack that will be provided to Renfrewshire could be used to support more robust capturing of closure outcomes.
- For an example of outcomes measurement reporting, see Appendix 3.

Appendix 1: Specialist domestic abuse services in Renfrewshire

Up 2 You

Court-mandated domestic abuse perpetrator programme delivered one-to-one by Criminal Justice Social Work. Support by Idaa trained staff is provided for partners where required.

Women & Children First

Multi-agency partnership organisation based within Children and Families Social Work supporting anyone impacted by GBV, including domestic and sexual abuse. Staff deliver practical and therapeutic support on a one-to-one and group basis with workers from Rape Crisis Glasgow and Clyde co-located in the service. The Reconnections team within WCF offer recovery work including CEDAR (Children Experiencing Domestic Abuse Recovery), a concurrent 12 week groupwork programme for mothers and children with a psychoeducational approach to repair relationships damaged by abuse. Idaa trained.

Children 1st

Co-located within WCF Reconnections, delivering therapeutic one-to-one support for children, family support and group work activities.

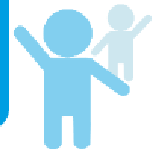
ASSIST

Specialist domestic abuse advocacy service supporting victims/survivors throughout their involvement with the criminal justice system, to reduce risk and improve safety. Support mostly provided via telephone. Idaa trained.

Renfrewshire Women's Aid

Providing refuge for women fleeing domestic abuse, as well as support, information and advocacy to anyone who has experienced domestic abuse. This can be face-to-face or telephone based and group work is also provided. Idaa trained.

Children's worker available offering dedicated service to support those in refuge, providing follow-on support and one-to-one in schools.



Appendix 2: Joint definition of Idaa

The following definition was jointly decided by SafeLives, Scottish Women's Aid and ASSIST, who co-deliver Idaa training in Scotland.

The main purpose of Independent Domestic Abuse Advocates (Idaa) is to address the safety of victims at high risk of harm from intimate partners or ex-partners to secure their safety and the safety of their children. In some services, particularly specialist black and minority ethnic (BME) services they may also work with clients who are at risk from extended family members. Serving as a victim's primary point of contact, Idaas normally work with their clients from the point of crisis to assess the level of risk, discuss the range of suitable options and develop safety plans.

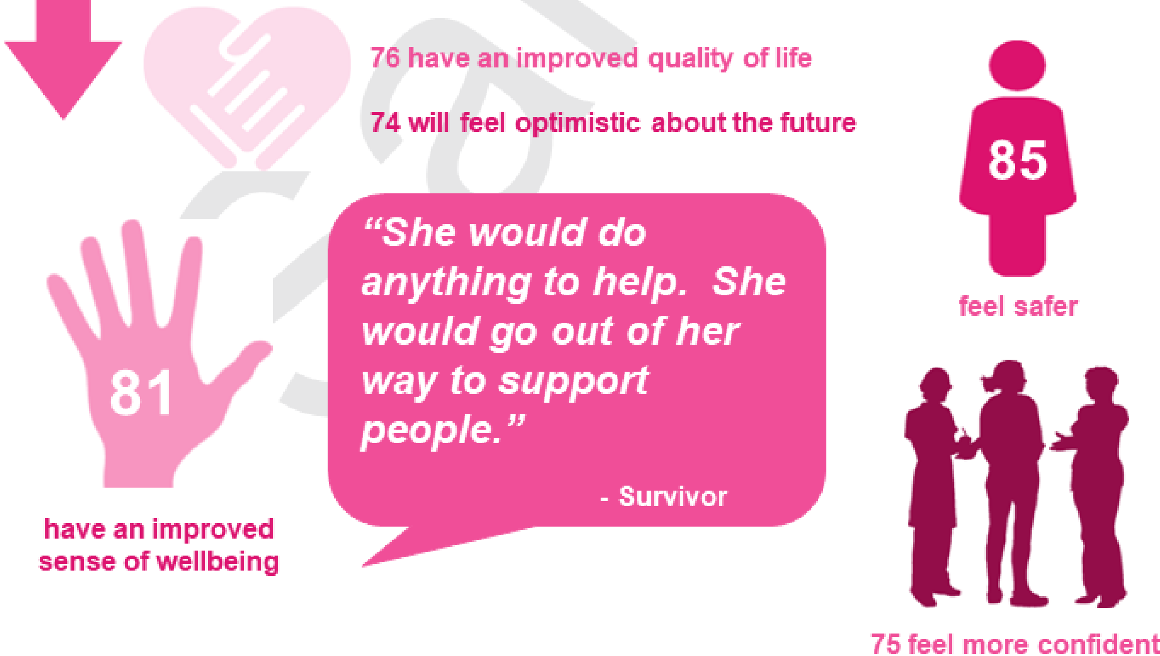
They are proactive in implementing the plans which address immediate safety, including practical steps to protect their clients and their children, as well as longer-term solutions. These plans will include actions from the Marac as well as sanctions and remedies available through the criminal and civil courts, housing options and services available through other organisations. Idaas work over the short to medium-term to put clients on the path to long-term safety. They receive specialist training and hold an SQA qualification. Since they work with the highest risk cases, Idaas are most effective as part of an Idaa service and within a multi-agency framework. The Idaa's role in all multi-agency settings is to keep the client's perspective and safety at the centre of proceedings.

Idaas will sit within a spectrum of domestic abuse organisations, and their specific role is to take on the intensive high risk-led work at the beginning of the client's journey. Once that risk is managed to point where the client is no longer high risk, the Idaa will refer on to other domestic abuse services to meet their long-term safety and support needs.

Appendix 3: Example outcomes measurement report

Domestic Abuse Service

If a service were to support 100 people across the year…



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