LINKS

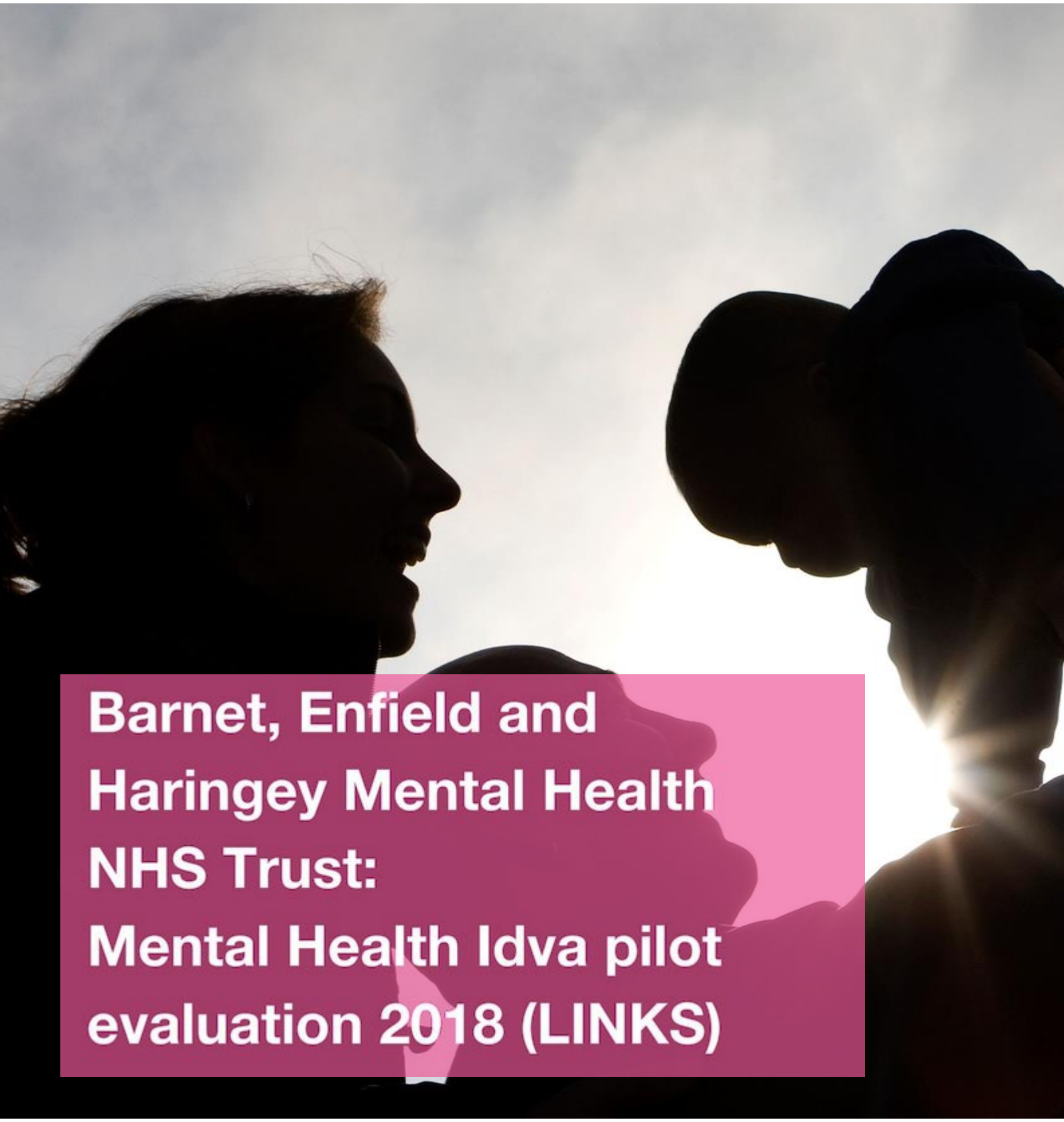
Towards a better response to domestic violence & abuse in mental health

Barnet, Enfield and Haringey NHS Mental Health NHS Trust

A University Teaching Trust

SafeLives Ending domestic abuse

solace women's aid



Barnet, Enfield and Haringey Mental Health NHS Trust: Mental Health Idva pilot evaluation 2018 (LINKS)

About SafeLives

We are a UK charity dedicated to ending domestic abuse, for good. We combine insight from services, survivors and statistics to support people to become safe, well and rebuild their lives. Since 2005, SafeLives has worked with organisations across the country to transform the response to domestic abuse. Last year alone, over 70,000 adults and 120,000 children received dedicated support from interventions designed with partners in the sector.

No one should live in fear. It is not acceptable, not inevitable, and together – we can make it stop.

Every year, over two million people in the UK experience domestic abuse. 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.

SafeLives
Suite 2a
Whitefriars
Lewins Mead
Bristol
BS1 2NT
T: 0117 403 3220
E: info@safelives.org.uk
www.safelives.org.uk

Registered Charity Number: 1106864

Ending domestic abuse

"[Domestic abuse] can trigger mental health problems, and it can also exacerbate mental health problems that already exist."

BEH-MHT staff member

"I found this training very important and helpful in understanding the impact of domestic abuse and how to support service users."

BEH-MHT staff member

"I think it will help save lives, because there are a lot of people who have died [as a result of domestic abuse]."

BEH-MHT staff member

Contents

Context

In August 2016, Barnet Enfield and Haringey Mental Health Trust (BEH-MHT) applied to NHS England for a grant for a pilot project to explore and improve responses to domestic abuse within the mental health services environment. There were a very low level of (Multi Agency Risk Assessment Conference) Marac referrals from mental health services, indicating a need to improve staff awareness and knowledge about domestic abuse and a requirement to improve staff confidence in responding to disclosures of domestic abuse.

To address this, BEH-MHT proposed trialling a 12-month placement of a specialist domestic abuse practitioner - a trained Independent Domestic Violence Advisor (Idva) able to carry out the role of the advocate-educator within mental health services. It was hoped that the trial would lead to an improvement of safety for BEH-MHT patients who disclosed domestic abuse through better risk assessments, increased referrals to specialist services, promotion of recovery and more holistic treatment. BEH-MHT's application was successful and the result was the pilot known as the LINKS project.

BEH-MHT serves three boroughs of Barnet, Enfield and Haringey. For the purposes of the pilot a decision was made to locate the Idva in Barnet to work with the mental health team for that borough. This decision was made based on the rationale that Barnet had strong DVA support services and would be able to support the project.

BEH-MHT were motivated to seek funding from NHS England for the LINKS project because of an understanding of the potential opportunities to support victims of domestic abuse earlier that joint-working practices between domestic abuse and mental health services[1] and co-location in hospital Trusts[2] presented. The LINKS study was informed by the King's College London *LARA study*, which piloted an intervention comprising: (1) domestic abuse training for mental health professionals and (2) a direct referral pathway to mental-health trained Idva advocate-educators, who provided advocacy to mental health service users experiencing domestic abuse. The *LARA study* resulted in increased identification and referral of domestic abuse by mental health professionals; significant improvements in mental health professionals' knowledge, attitudes and behaviours towards domestic violence, and significant reductions in service users' experience of abuse and improvements in their quality of life. This research suggests that joint-working partnerships between mental health and domestic violence sectors can improve health outcomes for service users experiencing domestic violence. SafeLives' *A Cry for Health* research report (2016) found that co-locating Idva services in hospitals helped to increase identification and referral of domestic abuse victims to the service, thereby increasing victim safety as well as access to other forms of specialist support including drug and alcohol and mental health teams. In this way, victims are offered a complete package of support. The research also found that locating a specialist support service within a health setting facilitated disclosures of domestic abuse to a trusted health professional at an earlier stage in the relationship. The research estimated that 10,000 victims at highest risk of harm from domestic abuse who are unable to access help through the criminal justice system could be supported each year through an improved health care pathway.

The LINKS pilot was a partnership between BEH-MHT, Solace Women's Aid, King's College London and SafeLives. Barnet CCG also supported the project. BEH-MHT seconded a member of staff from Solace Women's Aid, the local specialist domestic abuse service provider, to be the co-located domestic abuse professional with BEH-MHT staff in Barnet. Key members of the partnership formed a working group to manage and lead the pilot project. King's College London provided advice about the implementation of the LINKS pilot, based on their learning's from the LARA study and other work on the identification and response of mental health services to domestic violence.

SafeLives was commissioned to evaluate the efficacy of the LINKS pilot. We are very grateful to all of the BEH-MHT staff, Solace Women's Aid staff and victims of domestic abuse who participated in this evaluation. A majority of those who we spoke to were very willing to share information and expertise which has helped us immensely in drawing together a myriad of detail.

[1] Trevillion, K., Byford, S., Cary, M., Rose, D., Oram, S., Feder, G., Agnew-Davies, R. and Howard, L. M. (2014), Linking abuse and recovery through advocacy: an observational study in '*Epidemiology and Psychiatric Sciences*', Vol. 23(1):pp.99-113.

[2] SafeLives (2016), A cry for health: Why we must invest in domestic abuse services in hospitals.

Executive Summary

Domestic abuse is defined by the UK government as 'any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, psychological, physical, sexual, financial and emotional abuse. Domestic abuse is a major, complex social issue which cost the UK an estimated £15.7 billion in 2008[3]. This section outlines:

- the evidence for the LINKS pilot
- the context of domestic abuse in Barnet
- the baseline for BEH-MHT's response to domestic abuse prior to the LINKS pilot
- the impact of the LINKS pilot
- our recommendations for next steps.

The evidence for the LINKS pilot

We know that domestic abuse affects mental health negatively and is associated with a range of mental health problems[4]. It is estimated that every day, almost 30 women attempt suicide as a result of experiencing domestic abuse and every week 3 women take their own lives. Additionally, around 30% of female psychiatric in-patients and 33% of female psychiatric outpatients have experienced domestic abuse[5]. Despite the research evidencing the link between domestic abuse and mental health, mental health services do not routinely enquire about domestic abuse[6] and there are very low levels of Marac (Multi-Agency Risk Assessment Conference) referrals from mental health services. In addition, the dominance of the biomedical model and the stigma of mental health problems have been shown to impede effective responses to domestic abuse experienced by mental health service users[7]. These findings indicate a need to improve mental health staff awareness and confidence in responding to disclosures of domestic violence and abuse (DVA), as well as an understanding of policies and referral pathways.

The LINKS pilot was commissioned to test whether locating a specialist domestic abuse Idva advocate-educator within mental health services in Barnet NHS Trust would help to increase understanding of domestic abuse and identification of domestic abuse victims/survivors. The pilot was funded by NHS England and was a partnership between Barnet, Enfield and Haringey Mental Health NHS Trust (BEH-MHT), Solace Women's Aid, SafeLives and King's College London.

The LINKS pilot co-located a specialist domestic abuse Idva advocate-educator at two of BEH-MHT's sites– Edgware Community Hospital and Barnet Hospital. Both these sites have some in-patient wards however most of the Idva support focused on working with the community mental health teams. Most effective successful models of support are based on co-location and becoming embedded within the site. The Idva was responsible for providing domestic violence training to Barnet staff working for BEH-MHT, giving ongoing support for health professionals, receiving referrals from Barnet staff in BEH-MHT and providing a proactive and culturally sensitive support service for female and male psychiatric in-patients over 16 years of age who are experiencing domestic abuse. The Idva was in post from January 2017 until January 2018.

The aims of the LINKS pilot were:

- To increase the identification of BEH-MHT patients who are experiencing domestic abuse

3 Sylvia Walby (2009) The cost of domestic violence: up-date 2009
4 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*
5 Oram, S., Trevillion, K., Feder, G. & Howard, L.M. (2013) Prevalence of Experiences of Domestic Violence among Psychiatric Patients: systematic review. *British Journal of Psychiatry*. Vol. 202: 94-99
6 Nyame, S., Howard, L.M., Feder, G., Trevillion, K. (2013) A Survey of Mental Health Professionals' Knowledge, Attitudes and Preparedness to Respond to Domestic Violence. *Journal of Mental Health*. Vol. 22(6):536-543
7 Trevillion, K., Hughes, B., Feder, G., Borschmann, R., Oram, S., & Howard, L. M. (2014). Disclosure of domestic violence in mental health settings: A qualitative meta-synthesis. *International Review of Psychiatry.* Vol. 26(4): 430-444

- To increase referrals for BEH-MHT patients in to specialist domestic abuse services
- To increase awareness, knowledge and confidence of BEH-MHT staff in responding to domestic abuse.

SafeLives' role was to evaluate the efficacy of the LINKS pilot in meeting those aims.

The context of domestic abuse in Barnet

The LINKS pilot was delivered at the Barnet sites of BEH-MHT. The majority of BEH-MHT's services for Barnet are delivered at Edgware Community Hospital or Barnet Hospital.

Barnet demographics

Barnet is the largest borough in London by population, with an estimated 379,700 residents in 2015. Its population is continuing to grow. It has a large older population which is expected to increase by over 33% by 2030. This has consequences for how the local population experiences domestic abuse and how commissioners should seek to respond to domestic abuse. SafeLives research[8] shows that on average, older victims experience abuse for twice as long before seeking help as those aged under 61 and nearly half have a disability. The abuse is also more likely to be perpetrated by an adult family member or intimate partner than those 60 and under.

Barnet has a diverse population, with BME residents making up 43.6% of the total Barnet population. Judaism is the second most common religion practised in Barnet after Christianity, and there is a Jewish-specific domestic abuse service within the borough.

Barnet is amongst the 50% most deprived local authorities in England, but compares favourably against other local authorities in London .[9]

Prevalence of domestic abuse in Barnet

Based on the Crime Survey for England and Wales, we estimate that 64,000 Barnet adult residents have experienced domestic abuse at some point since the age of 16. We estimate that 17,000 adult residents experienced domestic abuse in the past year.

Approximately 21 cases per 10,000 adult females in the Barnet population have their cases heard at Marac [10] – half of SafeLives recommended level of 40 per 10,000. This indicates a serious underreporting of domestic abuse.

The baseline for BEH-MHT's response to domestic abuse

We looked at BEH-MHT's baseline domestic abuse data in order to be able to measure the effect of the LINKS pilot. Unfortunately we were unable to gain an accurate understanding of the annual number of patients using .mental health services in Barnet. This means that we have not been able to calculate the number of disclosures we would expect to see in mental health services in Barnet. Across the UK as a whole there were 1.5 million attendances at hospitals for Adult Mental Illness in 2016-2017.[11] Between November 2017-January 2018 NHS statistics show that there were 3745 people in contact with adult mental health services in Barnet CCG. Obviously this covers all mental health services in Barnet, rather than just the two sites the Idva was located within, but it gives an idea of the level of patient numbers seen over a recent three month period.[12]

Patient disclosures

[8] SafeLives (2016), Spotlight 1: Older people and domestic abuse
[9] DCLG 2015), Summary report of the 2015 Index of Multiple Deprivation
[10] From SafeLives' Marac Quarterly data, unpublished.
[11] https://digital.nhs.uk/media/34230/Hospital-Outpatient-Activity-2016-17-All-attendances/default/hosp-epis-stat-outp-all-atte-2016-17-tab
[1212] https://digital.nhs.uk/catalogue/PUB30262

Between April 2016 and April 2017, patient disclosures of domestic abuse were not consistently recorded on the Trust's case management system, Rio. During that time there were 2201 disclosures of domestic abuse logged by staff across the whole of BEH-MHT, but we could not identify which site (e.g.) or borough those disclosures were made. This made the creation of a baseline difficult. Moreover, only 56% of disclosures had 'evidence for domestic abuse' checked on Rio the case management system suggesting that staff failed to log basic the basic information which led to the disclosure. BEH-MHT's Domestic Violence and Abuse Policy states that "information regarding domestic violence and abuse must be recorded in the health records. This includes if routine enquiry questions were asked or were not at the time."[13]

.

Referrals to specialist domestic abuse services

Prior to the LINKS study, BEH-MHT had a referral pathway which sought to ensure that patients who disclosed domestic abuse would be referred to local domestic abuse provider, Solace Women's Aid. Between January 2016 and January 2017, there were just 5 referrals to Solace Women's Aid from BEH-MHT (Barnet) which represented 1% of all referrals of domestic abuse clients they received in that year. However, because we do not have access to the total number of patients seen in BEH-MHT, we can't calculate whether this percentage of referrals is an accurate reflection of the caseload we would expect Solace Women's Aid to see.

Within BEH-MHT's Domestic Abuse Policy, the referral pathway to Solace Women's Aid is unclear. It states that BEH-MHT's "staff responsibility is to provide support and information on local and national support agencies and help-lines, to enable individuals to make a decision on what to do next."[14]. While Solace Women's Aid number is provided, it is not specified as the main provider of domestic abuse services for patients identified in BEH-MHT. Instead staff are given a plethora of contact numbers at local and national level to choose from. It should be noted however that the BEH-MHT Domestic Abuse Policy is intended for use across the entire trust and is not Barnet specific.

Staff approaches to domestic abuse

We examined existing staff approaches towards domestic abuse by conducting an online survey, which 18% of Barnet staff completed. This is a low response rate despite proactive measures to increase the response rate. Given the relatively low numbers involved, there may be self-selecting bias.

Staff members indicated reasonably high levels of confidence about domestic abuse in general and dealing with disclosures in particular, although the majority did not routinely ask patients about domestic abuse. Staff members clearly had positive intentions about domestic abuse, as every staff member surveyed agreed that they had a responsibility to help victims of domestic abuse. Worryingly, 60% of staff said they hadn't received any domestic abuse training, despite the fact that training on domestic abuse in BEH-MHT's DVA Policy is specified as mandatory.[15]

The majority of staff members felt that they had a good level of knowledge about how to help domestic abuse victims on a practical level, although the free text answers indicated that in reality this knowledge was often very patchy.

The majority of staff had appropriate attitudes towards domestic abuse (for example, accepting that domestic abuse does not have to be physical) but again the free text responses showed that many staff lacked nuance in their understanding. For example, when asked about how they would identify a victim of domestic abuse, the majority of respondents' answers focused on physical indications.

The impact of the LINKS pilot

SafeLives found that the LINKS project was successful in meeting these aims and recommend overleaf ways to strengthen its effectiveness.

[13] Domestic Violence and Abuse Policy, Version 3, November 2015, pg 23
[14] Domestic Violence and Abuse Policy, Version 3, November 2015, pg 14
[15] Domestic Violence and Abuse Policy, Version 3, November 2015, pg 7

Referrals to Solace Women's Aid

Over the period of the pilot, there has been a 660% increase in referrals from patients at BEH-MHT to Solace Women's Aid from 5 during January 2016 - January 2017 to 38 from January 2017 – January 2018. This is a strong increase and a testament to the work of staff within the Trust and Solace Women's Aid.

Impact of training on staff awareness and identification of domestic abuse

A core aim of the project was to increase staff awareness of domestic abuse and confidence to identify abuse for their patients through mandatory training for all BEH-MHT staff on the two Barnet-based hospital sites. The training was delivered by the Mental Health Idva. Unfortunately during the pilot, there was a staff restructure which impacted on the Trust's ability to ensure that the mandatory training was made compulsory for all staff in practice. This was compounded by the BEH-MHT mandatory recording matrix which covers the whole trust and not just one borough. The Mental Health Idva trained 164 people for both domestic abuse training sessions and a further 48 people completed the first session only, out of a total of 454 members of staff.

The feedback on the training showed that staff had increased their understanding, knowledge and confidence on every parameter measured. The greatest change in understanding in the first session of training was that staff felt more confident recording disclosures on the Rio case management system (70%), as well as being more confident to ask about domestic abuse (61%) and said increased knowledge of referral pathways (63%). This is a particularly welcome finding given the very poor recording of disclosures prior to the start of the pilot. The written feedback indicated that the majority of respondents felt that refresher training would be beneficial.

Staff experiences of the LINKS project

We evaluated staff experiences of the LINKS project through interviews with a few individual members of staff and through an online survey which mirrored the survey conducted before the pilot began. We examined how the LINKS project had impacted on staff attitudes, confidence and knowledge of domestic abuse.

The interviews indicated that the training helped staff understanding of domestic abuse, which impacted on how they would respond to victims of domestic abuse in practice. Staff felt that training had equipped them to identify potential signs of perpetrators of domestic abuse and increased their confidence in their own ability to spot signs of abuse. Staff members particularly appreciated that the training was focused on practical support that staff could consider for their own patients.

The post-pilot survey was completed by 25 participants, whereas the pre-pilot survey was completed by 82 participants. It is also worth noting that only 36% of respondents had attend the LINKS training, so it is difficult to assess the impact of the training based on their answers.
One of the issues raised by staff was how difficult they found it recording information in Rio. They also raised concerns about poor sharing of information cross-border.

Reflections on training from the Mental Health Idva

The Mental Health Idva found that training was best delivered across mixed groups rather than at team meetings. She found that the hierarchical nature of the NHS meant that junior colleagues felt unable to challenge senior colleagues about inappropriate attitudes towards domestic abuse, whereas mixed groups had better discussions.

The Mental Health Idva found that her caseload tended to focus on historic cases of domestic abuse or low- or medium-risk cases rather than high-risk, crisis intervention.

Recommendations

1. A longer, multi-site evaluation of Mental Health Idva should be considered

While this pilot showed early evidence of the impact of locating a Mental Health Idva within a Mental Health Trust setting particularly in terms of increased referrals and knowledge of staff, the duration of the pilot was too short to collect enough data to evidence substantial impact in terms of increased

safety of victims, and the lack of mandatory training for all staff affected the efficacy of the pilot. A longer, multi-site evaluation of Mental Health Idva could provide a more significant evidence base to support the wider roll-out of this new category of domestic abuse professional. Importantly, survivor voice should also be included in any evaluation which was not possible in such a small scale project such as this.

2. Ensure that staff training in domestic abuse is mandatory

Although this recommendation was always intended to be incorporated into the pilot, this was not delivered in practice. Any future pilots or interventions which locate specialist domestic abuse workers in mental health settings should ensure that all staff receive mandatory training, as part of the pilot. . All staff in BEHMHT receive DVA training at corporate induction and this has been in place for the last three years. Despite this 60% of staff said they hadn't had any domestic abuse training. This suggests that the staff responding to this question had been in post for longer than three years or that the training delivered at corporate induction is insufficient to provide them with a detailed understanding of domestic abuse.

3. Review domestic abuse policies and clarify referral pathways to specialist domestic abuse services

The current BEH-MHT domestic abuse policy does not have a clear referral pathway for staff to use if they identify a victim of domestic abuse, or elicit a disclosure after routine enquiry. In the absence of a dedicated specialist domestic abuse worker within the hospital setting (such as the MH Idva), the Trust should ensure their current pathways are reviewed to ensure there is no confusion about where victims of domestic abuse should be referred. Numbers of disclosures and subsequent referrals to domestic abuse services should also be regularly monitored to ensure that the domestic abuse policy is working in practice. The Rio case management system should be reviewed to ensure it is simple to record information around disclosures, evidence for domestic abuse and actions taken to refer patients to specialist support.

4. Ensure Mental Health IDVA's work is within a co-located hospital team and receives clinical supervision

The feedback from the Mental Health Idva in this evaluation, and in SafeLives' previous Cry for Health research, suggests that locating a specialist domestic abuse worker within a co-located hospital team as well as ensuring they receive clinical supervision will help to improve wellbeing and work culture in addition to the supervision received from a specialist domestic abuse service. Mental Health IIDVA's also need to be visible within the health setting so that mental health staff feel able to approach them and to ensure their service is continually advertised.

5. Two year minimum contracts for Mental Health IDVA's

The project should be based on a two-year minimum contract due to the pace of change within the NHS. Staff awareness of the project had started to increase by the end of the project, but this occurred too close to the end date for the impact to be fully felt.

6. Provide top up domestic abuse training for staff

This was a unanimous request from the staff who participated in the in-depth training. Training needs to include information about challenging myths and stereotypes about domestic abuse victims and perpetrators, coercive and controlling behaviour, as well as a focus on the links between mental health and domestic abuse. In Barnet, in particular, training should cover how older victims of domestic abuse and victims from different cultural backgrounds might find it harder to access services. Training should also be delivered in mixed groups, rather than in teams to avoid more junior staff feeling that they can't challenge senior staff.

7. Advertise the service clearly

Only 60% of staff surveyed by the end of the pilot were aware of the LINKS project. Clear advertising of services provided by the Mental Health Idva and better communication internally would increase impact.

8. Referral routes for perpetrators of domestic abuse

It was out of the scope of the project to provide support for perpetrators of domestic abuse. However, there was a demand for a specialist service that understood the needs of those with mental health conditions. As 25% of those identified as being a victim of domestic abuse are also identified as perpetrators of abuse, the help and support they receive needs to be tailored to their experiences.

9. Mental Health IDVA'sneed to have experience in dealing with cases of historic abuse and trauma-informed responses to support patients

Due to the cohort of patients in a mental health setting, the Idva found that many of her clients had experienced historical domestic abuse and therefore needed floating or therapeutic support which is different from the types of crisis interventions that IIDVAs usually provide.

Section 1: Introduction

This section sets out why the pilot was needed. It presents the evidence on the links between domestic abuse and mental health and explains other research on effective interventions. This section defines the pilot proposal by explaining the aims of the pilot, describing the job description of the Mental Health Idva and explaining how SafeLives will evaluate the efficacy of the pilot.

This section includes:

- Evidence for the pilot
- Pilot proposal.

1.1 Evidence for pilot

An estimated 1.9 million adults aged 16 to 59 years old experienced domestic abuse in the last year[16] (1.2 million women, 713,000 men). A recent report by Agenda[17] evidences the association between domestic abuse and mental health issues. It found that 54% of women experiencing sexual and physical abuse – and 36% experiencing extensive physical violence – meet the diagnostic criteria for at least one common mental disorder. In addition, a systematic review of the associations between domestic abuse and mental disorders identified a high prevalence and increased likelihood of victimisation among women across all diagnostic categories[18].

There are numerous studies that evidence the devastating consequences that domestic abuse has on the mental health of victims of abuse. SafeLives data[19] shows that 40% of victims at the highest-risk of serious harm or murder report having mental health issues. The consequences include anxiety, depression, suicidal behaviour, low self-esteem, inability to trust others, flashbacks, sleep disturbances and emotional detachment. People with mental health problems may also be more vulnerable to experiencing domestic abuse compared to people without mental health problems[20].

It is estimated[21] that every day almost 30 women attempt suicide as a result of experiencing domestic abuse and every week three women take their own lives. In addition, around 30% of female psychiatric in-patients and 33% of female psychiatric outpatients have experienced domestic abuse [22].

SafeLives' research on disabled people victims of domestic abuse[23] found that disabled women are twice as likely to experience abuse than non-disabled women, they typically experience abuse for a longer period of time before accessing support, and are significantly unrepresented in Marac cases, indicating a need to improve staff awareness and staff confidence in responding to disclosures of domestic violence and abuse (DVA). Despite the research evidencing the link between domestic abuse and mental health, mental health services do not routinely enquire about domestic abuse[24] and there are very low levels of Marac (Multi-Agency Risk Assessment Conference) referrals from mental health services – currently 1% according to SafeLives' latest quarterly Marac data.[25] In addition, the dominance of the biomedical model and the stigma of mental health problems have been shown to impede effective responses to domestic abuse experienced by mental health service users[26].

---

[16] Crime Survey for England and Wales, 2017.
[17] Scott S. and McManus (2016), Hidden Hurt: Violence Abuse and Disadvantage in the lives of women
[18] 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*
[19] SafeLives (2015), Getting it right first time, policy report.
[20] Khalifeh, H., Oram, S., Trevillion, K., Johnson, S. & Howard, L.M. (2015). Recent intimate partner violence among people with chronic mental illness: Findings from a national cross-sectional survey. The British Journal of Psychiatry, 207, 207–212. doi:10.1192/bjp.bp.114.144899
[21] Walby, S. and Allen, J. (2004), Domestic violence, sexual assault and stalking: Findings from the British Crime Survey. London: Home Office.
[22] Oram, S., Trevillion, K., Feder, G. & Howard, L.M. (2013) Prevalence of Experiences of Domestic Violence among Psychiatric Patients: systematic review. *British Journal of Psychiatry*. Vol. 202: 94-99
[23] SafeLives (2017), Disabled survivors too: Disabled people and domestic abuse
24 Nyame, S., Howard, L.M., Feder, G., Trevillion, K. (2013) A Survey of Mental Health Professionals' Knowledge, Attitudes and Preparedness to Respond to Domestic Violence. *Journal of Mental Health*. Vol. 22(6):536-543
[25] Unpublished
26 Trevillion, K., Hughes, B., Feder, G., Borschmann, R., Oram, S., & Howard, L. M. (2014). Disclosure of domestic violence in mental health settings: A qualitative meta-synthesis. *International Review of Psychiatry.* Vol. 26(4): 430-444

A pilot controlled study by Trevillion et al (2014)[27], known as the LARA study, assessed the feasibility of a multi-faceted domestic violence intervention comprising: (1) domestic abuse training for mental health professionals and (2) a direct referral pathway to mental-health trained IDVAs, who provided advocacy to mental health service users experiencing domestic abuse. The *LARA study* resulted in increased identification and referral of domestic abuse by mental health professionals; significant improvements in mental health professionals' knowledge, attitudes and behaviours towards domestic violence, and significant reductions in service users' experience of abuse and improvements in their quality of life. This research suggests that joint-working partnerships between mental health and domestic violence sectors can improve health outcomes for service users experiencing domestic violence..

1.2 Pilot proposal

1.2.1 Aims of the pilot

The objective of the pilot was to enhance the safety of BEH-MHT patients by improving staff knowledge of domestic violence and abuse and internal referral pathways. Specifically, the pilot's aims were:

- To increase the identification of BEH-MHT patients that are experiencing domestic abuse
- To increase referrals for BEH-MHT patients in to specialist domestic abuse services
- To increase awareness, knowledge and confidence of BEH-MHT staff in responding to domestic abuse.

The pilot's scope was limited to staff and patients accessing the Barnet sites of the Trust – Edgware Community Hospital and Barnet Hospital.

1.2.2 Job description

The Trust seconded a member of staff from the local specialist domestic abuse service provider Solace Women's Aid, a partner in the pilot. The staff member was recruited as a 'Mental Health Hospital-based Idva and Domestic Abuse Trainer'. For the purposes of this report, she is a 'Mental Health Idva'. The Mental Health Idva was in post from January 2017 until January 2018. The Mental Health Idva was based at Edgware Hospital with the community mental health teams for four days a week and was at the Solace Women's Aid site for one day a week, although she was able to be flexible about location when the need arose.

The Mental Health Idva was responsible for providing training to Barnet staff working for BEH-MHT, giving ongoing support for health professionals, and providing a proactive and culturally sensitive support service for women and men over 16 years of age who are experiencing domestic abuse who were referred by Barnet staff in BEH-MHT.

The job description included the following expectations, but was not limited to:

- To support ongoing training for health professionals based in Barnet from BEH-MHT to increase their understanding, identification and response to domestic abuse.
- To promote awareness of the experiences and needs of women and men living with or experiencing abuse, particularly in relation to their mental health.
- To encourage health professionals to ask women and men about their experience of abuse and respond, record, safety check and refer to Solace Women's Aid or other appropriate specialist services.
- To build and maintain effective relationships with general practice teams and agencies in the borough.
- To carry out DASH risk assessments[28] in a timely manner and refer high risk cases to Marac.

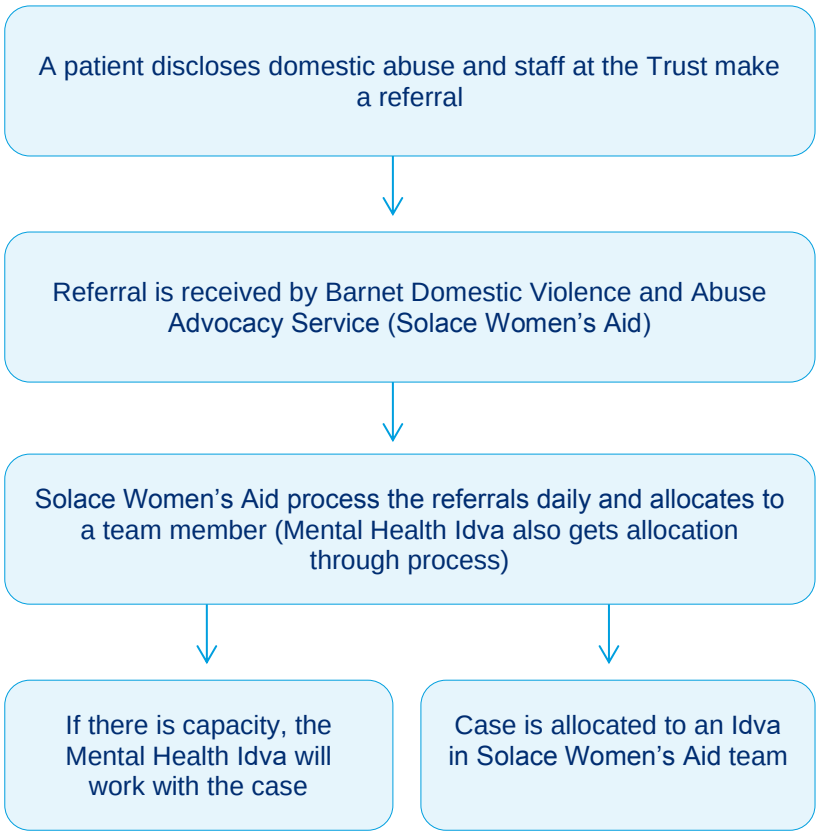
[27] Trevillion, K., Byford, S., Cary, M., Rose, D., Oram, S., Feder, G., Agnew-Davies, R. and Howard, L. M. (2014), Linking abuse and recovery through advocacy: an observational study in '*Epidemiology and Psychiatric Sciences'*, Vol. 23(1):pp.99-113.

[28] http://safelives.org.uk/sites/default/files/resources/Dash%20for%20IDVAs%20FINAL.pdf

- To work with survivors referred to the MH Idva to agree safety and support plans working to reduce risk and meet identified needs including through making referrals to other services to keep them and their children safe.
- To provide an effective and well managed casework service working to targets agreed in the safety and support plan and to act as an advocate for survivors keeping their safety at the centre of all coordinated and community based responses.
- To advocate on behalf of service users with external agencies where appropriate.
- To attend case review meetings and effectively communicate across both teams.
- To keep and maintain accurate and confidential records of all work undertaken.

The introduction of the Mental Health Idva did not create a new referral pathway into services. Referrals to the Mental Health Idva were made by staff on an ad hoc basis. Referrals were intended to be informal to facilitate a greater number of discussions with staff about how to approach patients who disclose domestic abuse. Once a patient had been discussed with the Mental Health Idva, she would typically include the patient as part of her caseload. This means that there are likely to have been some patients who were referred directly to Solace Women's Aid as part of BEH-MHT's domestic abuse pathway who were supported by another Idva at Solace Women's Aid as opposed to the Mental Health Idva co-located with Barnet community mental health teams.

Table 1.2.2: Pathway for referring BEH-MHT service users to local domestic abuse services



1.2.3 Evaluation plan

SafeLives developed an evaluation plan to measure the success of achieving each stated aim of the project. The evaluation is a mixed methods approach, including specialist domestic abuse referral analysis, interviews with BEH-MHT staff and calculating the prevalence of domestic abuse in the area.

Objective	Evaluative approach
To increase the identification of BEH-MHT patients that are experiencing domestic abuse	• Comparison against baseline of patients flagged • Analysis and estimation of DVA • Patient/Victim consultation
To increase referrals for BEH-MHT patients into specialist	• Comparison against baseline of patients referred to

domestic abuse services	DVA services • Analysis of referral demographics • Interviews with advocate-educator
To increase awareness knowledge and confidence of BEH-MHT staff in responding to domestic abuse	• Pre- and post-pilot staff interviews across BEH-MHT • Pre- and post-pilot mass attitudinal survey to staff across BEH-MHT • Review of training impact

Due to the complex nature of the cases and vulnerability of the clients at the time of the evaluation, we did not conduct service user interviews in this pilot. However, we would recommend that service user consultation is included for any future expansion of the service.

All participants in the interviews were given a consent form to read and sign ahead of participating. No identifiable information was collected about staff or any patients in this evaluation. They were able to withdraw their consent at any time during the interview and were free to leave. They did not have to answer any questions that made them feel uncomfortable. It was also made clear to participants that although the interview was anonymous, if any information that suggested they, or someone they knew, was at severe risk of harm we would need to pass on safeguarding concerns to the relevant person in the Trust. However, this was not necessary in any of our interviews.

Section 2: Local need

Any effective intervention at a local level must be rooted in the needs of the local community. As the LINKS project was delivered at the Barnet sites of BEH-MHT, we sought to understand the picture in Barnet. Most of these services BEH-MHT provides to Barnet residents are based across two sites: Edgware Community Hospital and Barnet Hospital. We examined the local needs of Barnet in order to understand how the overarching LINKS project would address those needs and to ensure that the project was as responsive as possible to local characteristics.

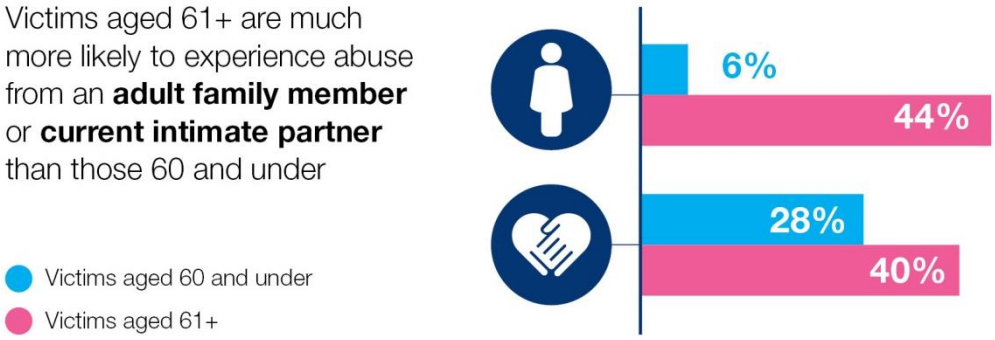
This section includes:

- an overview of the demographics of Barnet
- an analysis of the prevalence of domestic abuse in Barnet

2.1 Demographics of Barnet

Barnet is amongst the 50% most deprived local authorities in England, but compares favourably against other local authorities in London[29]. Barnet is the second-largest borough in London with a population of approximately 379,700 and is continuing to grow.

It has a large older population, with 13.3% of the population being 65 or older. The number of people aged 65 and over is projected to increase by 34.5% by 2030, over three times more than other age groups. The large older population has consequences for tackling domestic abuse in the borough. SafeLives research[30] shows that on average, older victims experience abuse for twice as long before seeking help as those aged below 61years and nearly half have a disability. The abuse is also more likely to be perpetrated by an adult family member or intimate partner than those aged 60 and under. Locally, there has been an increased awareness of the impact of domestic abuse on the older population due to age being a factor in recent Domestic Homicide Reviews (DHR).[31]



Barnet has a diverse population, with BME residents making up 43.6% of the total Barnet population. Christianity is the largest religion (41.2%); the next most common religions are Judaism (15.2%) and Islam (10.3%).[32] The proportion of residents who identify as Jewish is the largest in England and there is currently a Jewish specific domestic abuse service in the borough. Commissioners of services in health must be mindful of the diverse needs of patients in the borough so that health professionals can identify and refer patients on to services that they feel comfortable engaging with.

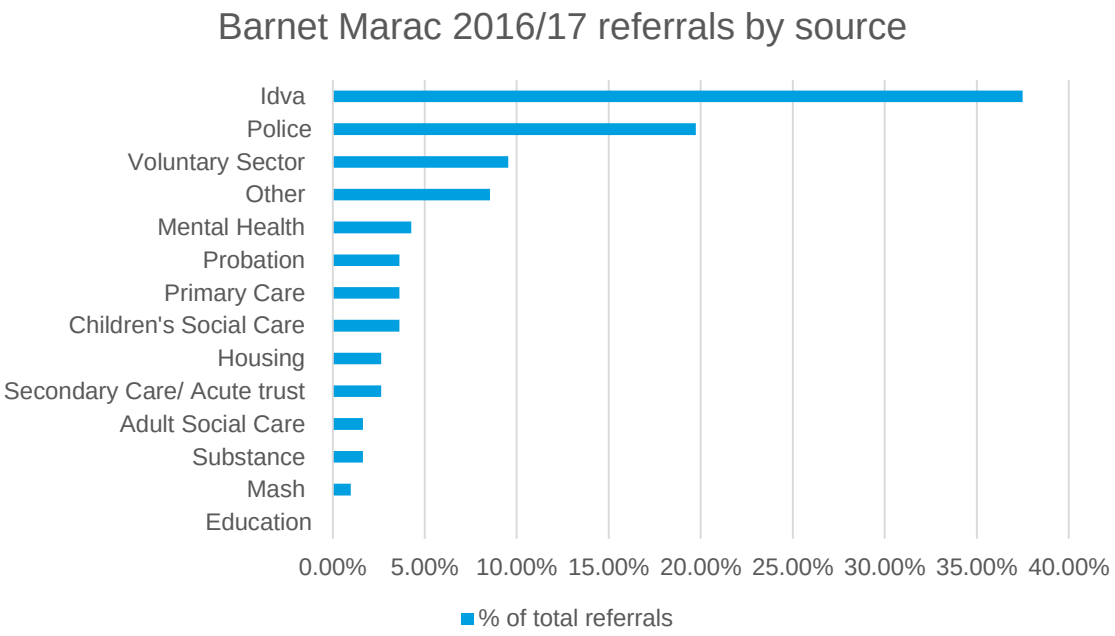
[29] DCLG (2015), Summary report of the 2015 Index of Multiple Deprivation
[30] SafeLives (2016), Safe Later Lives: Older people and domestic abuse
[31] One example is the Domestic Homicide Review published by Herefordshire Council in March 2017 – found here https://www.herefordshire.gov.uk/downloads/file/8550/domestic_homicide_review_02_executive_summary_march_2017
[32] Barnet Joint Strategic Needs Assessment (2015)

2.2 Prevalence of domestic abuse in Barnet

By cross-referencing Barnet's population statistics with the Crime Survey for England and Wales[33], we can estimate the prevalence of domestic abuse in Barnet. We estimate that 64,000 Barnet adult residents have experienced domestic abuse at some point since the age of 16. We estimate that 17,000 adult residents experienced domestic abuse in the past year.

Recent Marac data from Barnet (October 2016 to September 2017) shows that there are only 21 cases per 10,000 adult females in the population who have their cases heard at the Marac. This is nearly half of the SafeLives recommended level (40 per 10,000), which is significantly lower than expected. This means that identification of victims in Barnet at the highest risk of serious harm or murder is poor and victims are failing to receive the specialist Idva support they need to get safe.

Referral routes into Marac contrast with the national picture but are typical for a London borough. In Barnet only 20% of referrals into the Marac come from police. SafeLives expects this to be much higher, between 60 and 75%. However, the Metropolitan police area on average represents 31% of total referrals into Marac.



We can also see from this graph that referrals from mental health services in Barnet make up 4.3% of the total – higher than a number of other statutory services, including acute and primary care.

[33] Crime Survey England Wales supplementary tables year ending March 2017

Section 3: BEH-MHT baseline response to domestic abuse

In this section, we review BEH-MHT's baseline response to domestic abuse. It is crucial to have a good understanding of BEH-MHT's response prior to the LINKS pilot in order to assess the impact of the pilot.

We examined the following factors in order to establish BEH-MHT's baseline:

- Patient demographics
- Referrals to Solace Women's Aid
- Staff attitudes towards domestic abuse.

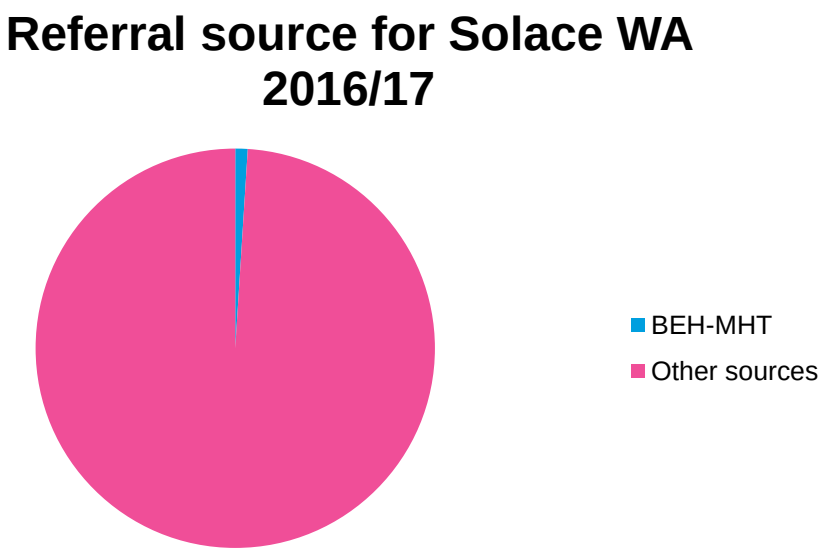
3.1 Patient demographics

We were able to extract demographic information for the patient population from the BEH-MHT Rio case management system. However, as the system is Trust-wide across Barnet, Enfield and Haringey, we were unable to obtain specific information for Barnet only.

Between April 2016 and April 2017, there were 2201 disclosures of domestic abuse recorded on Rio. Of these, only 56% had 'evidence for domestic abuse' checked. There were 550 people who had disclosed domestic abuse who were also assessed as a perpetrator on the system. This represents 25% of those who have disclosed abuse. It reveals the complex nature of domestic abuse and mental health and the difficulties of identifying primary perpetrators, a factor that was later explored by staff in their training session.

3.2 Referrals to Solace Women's Aid pre-pilot

Between January 2016 and January 2017, referrals to Solace from Barnet, Enfield and Haringey Mental Health Trust represented just 1% of all referrals of people requiring support to the service for the year. There were a total of 5 referrals 2016 – 2017.



3.3 Staff attitudes towards domestic abuse pre-pilot

SafeLives conducted a survey of all staff in the trust at the beginning of the pilot. The survey was hosted online on Wufoo and was open between 23 January 2017 and 3 March 2017. There were 82 participants, which is roughly 18% of Barnet staff.

The survey was designed to test the attitudes towards domestic abuse among Barnet staff in the Trust, as well as their knowledge and their confidence in dealing with patients who may be experiencing domestic abuse. We also asked participants to identify the referral pathways that are in place for patients who are victims of domestic abuse, how they would identify victims of domestic abuse and how they would assess their risk level. The response received by patients depends on staff attitudes towards domestic abuse which may be influenced by myths and stereotypes prevalent in society, leading to potentially unsafe and risky decisions being taken, or not taken.

3.3.1 Participants' profile

Of the 82 participants, 54 were women and 28 were men. Most participants had worked in mental health for over 10 years (74%), 10% had worked in mental health for 5-10 years and 16% for fewer than 5 years.

3.3.2 Staff knowledge of domestic abuse

We asked a series of questions to determine the level of knowledge and confidence among Barnet BEH-MHT staff in domestic abuse. There was a reasonably high level of participants who were confident that they have a good understanding of domestic abuse (21% strongly agree, agree 65%).

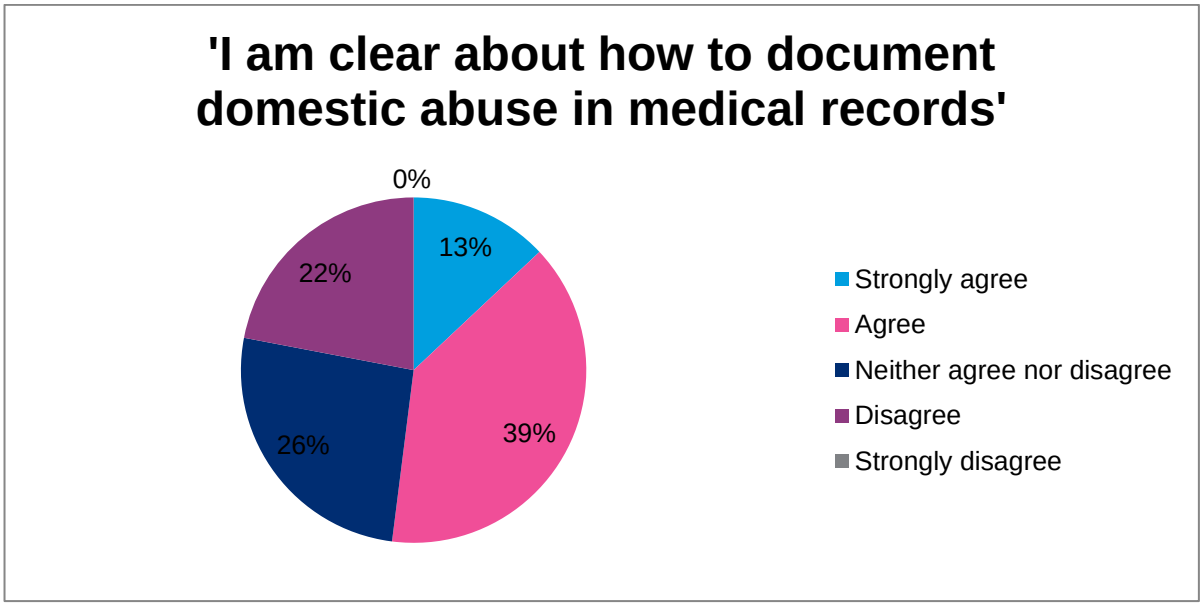
We also asked whether they routinely asked patients about domestic abuse, in line with BEH-MHT Trust policy. Only 42% agreed or strongly agreed that they did which is concerning as medical professionals working in mental health settings should be routinely asking patients about domestic abuse to encourage disclosures. We asked if they were confident to talk about domestic abuse and a high number of participants reported that they were (agree 50%, 24% strongly agree). However, there is clearly a discrepancy between how confident staff say they are about asking and their propensity to routinely ask about domestic abuse.

If staff did receive a disclosure, we wanted to ensure that they felt equipped to deal with it. A majority of staff said that they were (57% agree, 21% strongly agree) but many of the free text responses showed a more mixed picture, particularly in terms of their knowledge of the referral pathways and how to identify a victim of domestic abuse.

The Trust must ensure that staff have the right tools and clear referral pathways in order to give effective help and support to their patients. Once again there was a difference in staff perception of their abilities and the actuality of staff practice. Nearly two thirds of staff (59%) believed that the referral pathways were clear if a patient discloses domestic abuse. However, we asked participants to identify the pathways for victims and there was some confusion around the organisations that could provide support. Additionally, over a quarter (28%) did not answer the question and selected neither agree nor disagree.

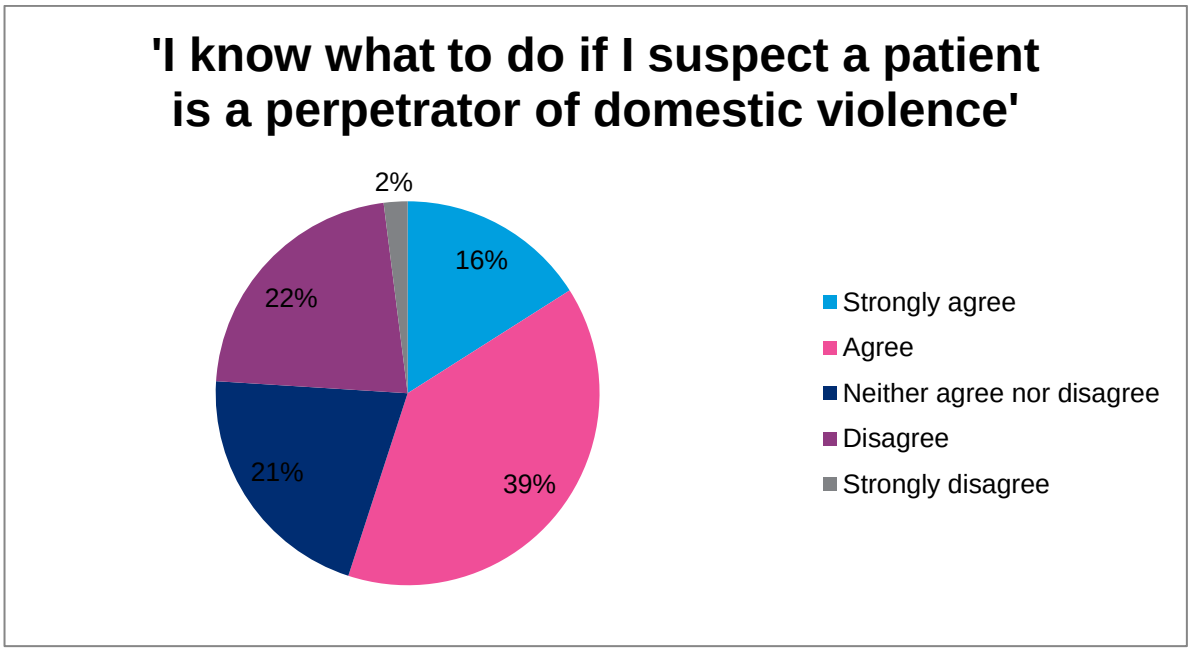
We asked whether staff agreed that they had a responsibility to help victims of domestic abuse get support. Not a single staff member disagreed with this statement, which is positive. We also wanted to know how staff would work with victims of domestic abuse on a practical level. We asked if they were confident assessing the safety needs of a victim of domestic abuse and 58% agreed or strongly agreed. However, 21% disagreed or strongly disagreed which is a significant amount. We asked participants if they could then demonstrate how they would assess the safety needs. The answers were not thorough and many did not respond which shows they were unsure how to assess the safety needs of patients.

We asked staff if they knew how to document domestic abuse in medical records, using the Rio database system. The question is crucial as a patient's history is accessed by various staff members and is a way for them to identify victims of abuse. It is incredibly important that this is being recorded correctly. The survey response identified issues with staff not using the casework system (Rio) correctly: 22% disagreed that they knew how to document domestic abuse, 39% agreed, 13% strongly agreed and over a quarter (26%) neither agreed nor disagreed.



We wanted to know if there was anything preventing them from asking about domestic abuse. One statement was 'I worry that patients will get offended if I ask them if they are a victim of domestic abuse'. The majority of participants disagreed (50%) or strongly disagreed (13%) which is a sign that they are confident to ask and not concerned about causing offence. However, 26% did not agree or disagree, which suggests they did not know how to answer.

Lastly, we wanted to know if staff knew what to do if they suspected a patient was a perpetrator of domestic abuse. Nearly one quarter of participants disagreed (22%); the answer to this question revealed that staff needed more support to work with and identify perpetrators of domestic abuse. The pilot identified the need to address perpetrators in addition to victims due to the complex nature of domestic abuse and mental health.



3.3.3 Staff attitudes towards domestic abuse

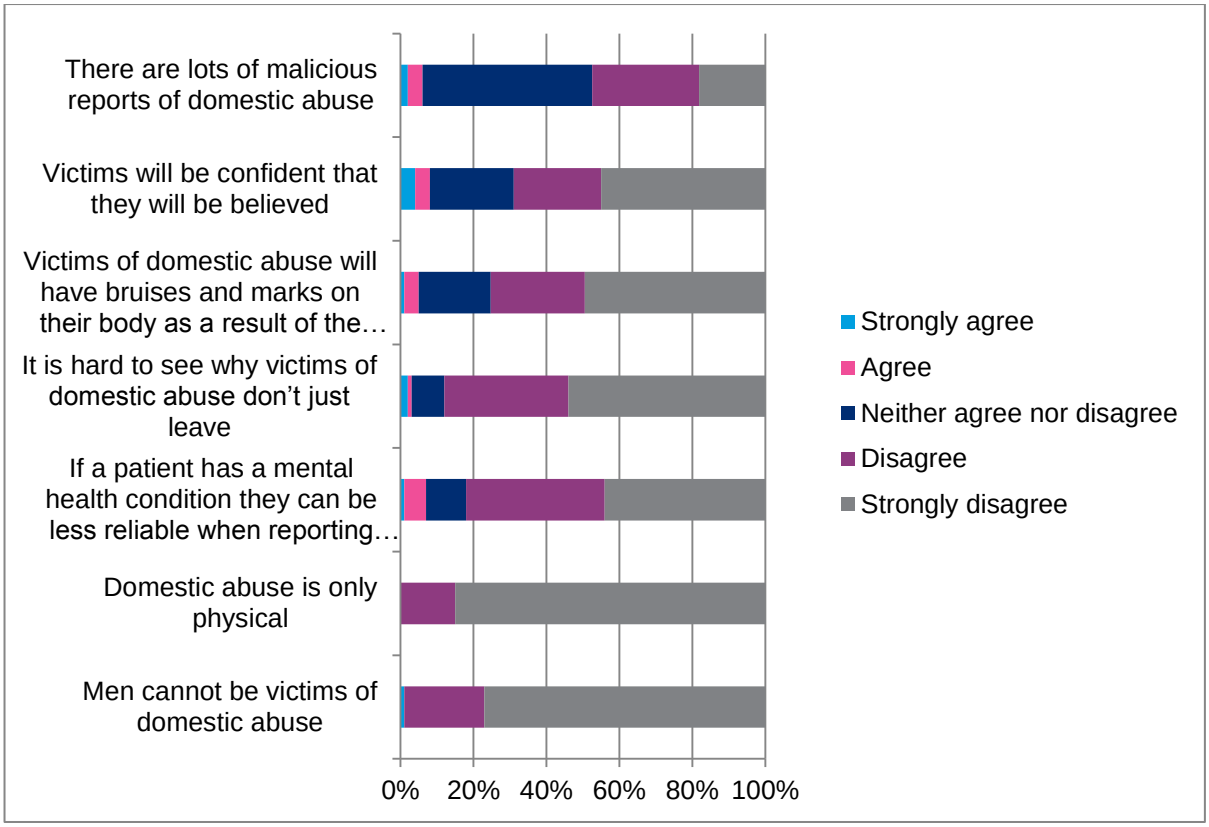
We showed participants a series of statements to assess the attitudes towards domestic abuse among Barnet BEH-MHT staff. The full breakdown of attitudes is shown in chart 3.3.3a below; however, there were a few results that stood out.

We asked questions to determine general awareness of domestic abuse among staff. Most participants strongly disagreed with the statement that 'men cannot be victims of domestic abuse' (77%) and only one participant said they strongly agreed with the statement. Apart from that response, staff members were able to identify that domestic abuse happens to both men and women. They were also able to identify that domestic abuse is not just physical (100%). However, when we later asked how staff members would identify domestic abuse and a number of participants used physical indicators such as bruises as a way to detect abuse in a service user.

We asked questions to determine staff attitudes towards the relationship between mental health and domestic abuse. We wanted to know if there were any biased attitudes towards patients with mental health conditions who experienced domestic abuse. Most participants disagreed (38%) or strongly disagreed (44%) with the statement, 'if a patient has a mental health condition they can be less reliable when reporting abuse'. However, a small minority agreed (6%) or strongly agreed (1%), which reveals that some education around domestic abuse and mental health stereotyping should be carried out.

We asked if there were lots of malicious reports of domestic abuse and ostensibly the results looked good. However, 46% of participants did not answer the question which suggests they were not confident to answer the question with a definite answer. In addition, this question had the highest number of people neither agreeing nor disagreeing.

Chart 3.3.3a: Staff attitudes towards domestic abuse



3.3.4 Training and domestic abuse experience

In addition to testing the general attitudes towards domestic abuse, we wanted to test whether the knowledge and confidence questions we asked (e.g. 'I feel confident assessing the safety needs of a victim of domestic abuse') were demonstrated in practice.

Staff may have answered that they were confident that the referral pathways were clear in the trust, - indeed 59% 'agreed' and 'strongly agreed' with the statement. However, asking staff to identify referral pathways revealed that some participants were using referral pathways not in line with the recommended pathways put forward by the Trust.

Firstly, we asked staff if the Trust had a domestic abuse policy. While 77% correctly answered that there was one, 20% responded that they 'don't know' and 3% incorrectly answered 'no'.

To test participants' knowledge of referral pathways, we asked 'what referral pathways are in place for referring victims of domestic abuse to specialist services?' Although the most common answers refer to the correct procedures, there were 82 responses to the survey and only 25 of those included a reference to Solace Women's Aid which provides the specialist domestic abuse services in Barnet. The profile of Solace Women's Aid as a source of advice and service provision should be raised during future training and within the Trust's domestic abuse and violence policy. The most common responses were Solace (30%), safeguarding (29%), Marac (28%) and Police (15%). 13% of respondents indicated that they were unsure. This roughly corresponded to the 12% who disagreed that the referral pathways were clear.

The full answers we received showed a high level of variance between staff members in their understanding of the referral pathways. These responses include one participant who appeared to copy and paste the referral process from the staff intranet page, which shows that at least the staff member knows where to locate the necessary information. Another participant answered that as they were new to Barnet they did not know the referral pathway; however, the mandatory 'new starter' domestic abuse awareness training should include this. Other responses mentioned discussing it with a manager, referring to Solace and reporting domestic abuse to the police, social services or the GP.

We also asked participants how they would identify a victim of domestic abuse and assess their risk level. Although there are a number of ways to identify domestic abuse, the most common themes were observation, physical signs of domestic abuse, the patients' history and an interview tool. There were a few responses which revealed a level of uncertainty among staff on what they should be doing when they had safeguarding concerns.

Although some staff identified the DASH as a tool to identify the risk faced, not all staff will be trained to use the DASH and it is unsurprising that it was not the primary tool to assess risk. However, a minority of responses identified the tool they would use to identify risk instead of choosing to focus on how they would identify a victim of domestic abuse.

The pilot introduced specific mandatory training for Barnet staff in domestic abuse, delivered by the Mental Health Idva. To inform training, we asked staff whether they had received domestic abuse training, whether that training was mandatory and what form that training took.

The majority of participants (60%) stated that they had not received any domestic abuse training. This perception may be incorrect; for the past three years, all new starters receive safeguarding training, which includes a module on domestic abuse, as part of their mandatory corporate induction. Current staff members are required to update their safeguarding training every three years, which again includes a module on domestic abuse. This possibly inflated perception of a lack of domestic abuse training may indicate that staff members feel that the domestic abuse training modules are not sufficiently extensive to qualify as appropriate domestic abuse training for their roles.

This supports the earlier observation that 60% of staff involved in the project had not received mandatory DVA training in that a high proportion (74%) have worked for the trust for over ten years

3.3.4 Conclusions

Overall, the perceptions of domestic abuse and attitudes towards people who experience domestic abuse and violence were positive. There were few areas of concern in terms of attitudes towards victims of domestic abuse but it was positive that so many participants felt a responsibility towards helping patients who are victims of domestic abuse.

Section 4: Pilot impact

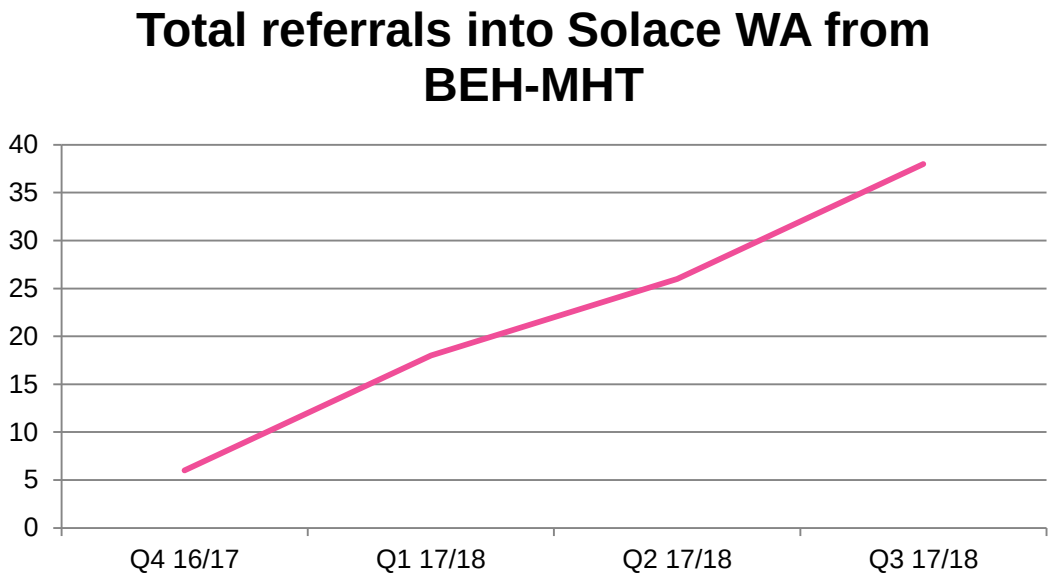
In this section, we evaluate the effect of the LINKS pilot on BEH-MHT's response to domestic abuse.

We examined the following factors in order to establish the impact of the LINKS pilot:

- Referrals to Solace Women's Aid
- Training impact
- Staff experiences of the LINKS project
- Experience of the Mental Health IIDVA.

4.1 Referrals to Solace Women's Aid post-pilot

Over the period of the pilot, there has been a 660% increase in referrals to Solace Women's Aid from the Trust. The Trust increased the number of referrals from 5 referrals in 2016/17 to 38 referrals in the same time period a year later. This is a substantial amount and a testament to the work of staff within the Trust and Solace Women's Aid.



4.2 Training impact

A key element of delivering the aims of the project was to increase staff awareness of domestic abuse and confidence to identify abuse for their patients. The training was delivered by the Idva in two three-hour sessions. The contents of the two training sessions are given below:

Session 1 Survivor Focussed

- What is DVA?
- The links between DVA and MH.
- How can we identify DVA?
- Best Practice: Response and Referral Pathways
- Looking at Risk & Marac

Session 2 Perpetrator Focussed

- Focus point (older adults or young people)
- Perpetrator presentation
- Referral pathways for perpetrators
- Safety Planning

4.2.1 Numbers trained

During the pilot, there was a staff restructure. The most accurate staffing numbers were sent by the Trust in January 2017, so this is what the calculations are based on. There was a total of 454 staff members, including management and CAMHS (Child and Adolescent Mental Health Services) based in Barnet within BEH-MHT. The Idva trained 164 staff for both sessions and a further 48 staff who completed the first session alone. Over one third of staff will have completed the training offered in the pilot (36%). Though the training was considered mandatory and contributed towards Safeguarding Level 3, unfortunately the Idva found it challenging to get all teams signed up for training.

4.2.2 Training observation

As part of the evaluation of the training, SafeLives observed the same group in parts 1 and 2 of their training over a two month period. The group consisted of staff from community outreach, psychologists from psychology hub, the personality disorder team and Hendon Magistrates' Court.

In the first session, it was clear that there was a mixed level of understanding of domestic abuse among the group. For example, one person asked what the acronym 'VAWG' meant, while another gave a full description of domestic abuse. The Mental Health Idva presented research and statistics around prevalence and cost of domestic abuse to the staff. Staff members were surprised at both the cost of domestic abuse to statutory services and the average length of time and occurrence of abuse before a victim seeks help.

> ***'If you loved me you would'***
> A group member, giving an example of how a perpetrator of abuse may coerce their partner to have sex

The group was split into teams which then focused on different types of abuse, including physical, psychological and sexual abuse. They were then asked to give various examples of how this type of abuse will present and what practitioners should be aware of. There was a good understanding of all types of abuse and one member of the group identified that children's services could be used as a weapon by perpetrators.

Barnet has comparatively low domestic abuse disclosures and the group was asked to explore why that may be. They managed to identify the cultural barriers that may exist for Jewish women but were unable to speculate further. The group argued that deprivation was low in the borough therefore that may be a contributing factor. Despite the experience of the team and the population in Barnet, they did not identify age and the issues around older populations of victims of domestic abuse not disclosing.

One practitioner in the room gave the example of a patient whose family and partner called the police on her on a regular basis which resulted in her being sectioned. She felt that by listening to the family, rather than the patient, services were colluding with the perpetrators. She also argued that being repeatedly in contact with the police aggravated the victim's mental health conditions and therefore it became a cycle of abuse and mental health crisis.

One of the final activities of the training session was to say whether a series of statements were true or false. There was disagreement among the team regarding the statement 'some people are just attracted to abusive people'. One person from the psychology hub said that they agreed with the statement because ' [her] experience working in field and listening to why people chose their partner, familiarity, sense of safety, protector, dominant male [proves it to be true]'. According to theIDVA, this is a statement that often causes debate among the staff, with a clear difference in approach between the psychologists and the psychiatrists in the room.

The second session was held just over one month later, with the same group of people. They were asked to identify how their patients would show non-physical signs of domestic abuse. These were some of their suggestions:

- Missing appointments or never coming alone
- No friends
- Body language
- Discrepancy in their stories or how they describe their emotions

- Change in the way they dress or being more conservative

'You're just crazy'
Group member, providing an example of how a perpetrator of domestic abuse may use their partner's mental health to perpetrate abuse

As the aim of the pilot was to increase identification of abuse for patients in a mental health trust, the training explored the relationship between domestic abuse and mental health. Staff members were asked why domestic abuse may impact on someone's mental health. They said that abuse impacts on patients' ability to cope, encourages negative thoughts and attacks their self-identity. They also recognised that partners may gaslight their victims, minimise their abusive behaviour or act as the interpreter for the victim and therefore act as a barrier for them getting further support.

Staff members were also asked to name some barriers to victims of getting support. This part of the training was implemented to increase practitioners' awareness of barriers while they attempted to identify domestic abuse among their patients. Staff said barriers to support included:

- Lack of information or knowledge of services
- Scared of being judged
- Fear of the abuser finding out that they had told someone
- Fear of the police, perhaps due to a bad experience with them in the past
- The pressures on the NHS mean that the length of appointments may prevent disclosures due to lack of time to explore the potential that there is abuse in a relationship

'You're so difficult to manage'
Group member, providing an example of how a perpetrator of domestic abuse may excuse their own behaviour to the victim

Overall, the group already had a good understanding of domestic abuse, which was demonstrated in the first session. However, the second training session linked domestic abuse and mental health and provided clarity on how to identify both victims and perpetrators of domestic abuse among their patient population. It was clear that there needs to be more work around understanding the impact of domestic abuse among the older population as they represent a significant section of the Barnet population and featured in the most recent domestic homicide reviews in the borough.

4.2.3 Training feedback

The Mental Health Idva collected feedback data at each of the sessions, asking participants to rate their knowledge of domestic abuse before and after the training. There were 134 session 1 evaluation forms completed and 94 session 2 evaluation forms completed.

Table 4.2.3a: Session 1 feedback, average scores (rounded)

Question	Pre-training score	Post-training score	% Change
Knowledge of domestic abuse	6	9	56%
Knowledge of associated health consequences	6	8	52%
Able to ask about domestic abuse	5	8	61%
Confidence to deal with and respond to domestic abuse	5	8	55%
Ability to assess immediate risk	6	8	41%
Knowledge of how to record on Rio	5	9	70%
Knowledge of referral pathways	5	9	63%

The greatest change in the first session was their understanding of how to record safeguarding concerns on Rio (70%), something that was also identified as an issue in the interviews with staff members. Staff also felt more confident to ask about domestic abuse (61%) and their knowledge of referral pathways increased (63%). This is very positive as those two factors result in improved outcomes for victims of domestic abuse.

In addition to the scores, staff also gave the following feedback:

- *"I found this training very important and helpful in understanding the impact of domestic abuse and how to support service users."*
- *"Very explorative and elaborate."*
- *"Highly informative and important, trainer also included thoughtful and startling statistics."*
- *"Informative course and good overall learning opportunity, much appreciated."*
- *"Very interesting and useful session.*

The highest improvement of knowledge in the second session was an understanding of referral pathways for perpetrators (94%). The LINKS project board identified that appropriate referral pathways for perpetrators are equally important to pathways for victims early on in the pilot. As 25% of those identified as being a victim of domestic abuse are also identified as perpetrators of abuse, the help and support they get needs to be tailored to their experiences.

Table 4.2.3b: Session 2 feedback, average scores (rounded)

Question	Pre-training score	Post-training score	% Change
Knowledge of domestic abuse and violence	6	8	39%
Able to ask about domestic abuse	6	9	47%
Confidence to deal with and respond to disclosures	6	8	42%
Ability to safety plan	5	8	54%
Ability to identify perpetrators	5	8	52%
Knowledge of referral pathways for perpetrators	4	8	94%

The staff members' feedback for the second session contained the following themes:

- The training was informative
- A refresher training in the future would be useful
- The training is necessary for everyone in a healthcare setting
- The training was comprehensive
- Those who attended the training gained confidence

One of the written pieces of feedback said that the training was 'too basic for a professional team' and suggested one topic that should be covered is 'what ways can the 'victim' take responsibility for abuse?'. This suggests that although the training may have been considered too basic, the fundamental principles that were taught had not been taken on board in this case.

4.3 Staff experience of the LINKS project

There were two sources that informed our evaluation of the impact of the pilot on staff attitudes and behaviour towards victims of domestic abuse. We conducted interviews with 5 members of staff after the pilot had launched but before they had attended training. We also sent out an all staff email to those based in Barnet to assess the impact of the pilot on the attitudes and behaviour of staff, similar to the one we conducted at the beginning of the pilot.

4.3.1 Pre-pilot interviews

Once staff had signed up to training, the Mental Health Idva emailed to ask whether they would consider being part of the evaluation and have two in depth interviews, one before their training and one after. We had 5 interviews with staff before they had attended training but only 3 post-training interviews as some chose not to complete the evaluation.

We interviewed a peer support community engagement worker, a senior social worker, a GP link-worker, an associate mental health worker and a staff member from administration.

> ***'Staff who see clients should be confident about the subject… just to provide a better service, really'***

We wanted to establish the level of understanding the participants had of domestic abuse, and asked them to define it in their own words. They said the following:

- It can be physical, actually hitting people or kicking them, attempting to strangle them; using physical force against someone. Or it can be psychological, and that can involve things like putting the person down, criticising them all the time and calling them names; undermining them and isolating them from family and friends.
- A bit of safeguarding… a number of different abuses. You know, in the home environment, from one adult to another; including physical abuse, emotional abuse, sexual abuse and financial abuse.
- It depends on culture, ethnicity, religion, you have to use your common sense… the men downplay it, especially if the perpetrator is female.
- It happens at home! It's kind of abuse, any kind of abuse… financial, sexual, physical, emotional – like psychological- or it can be neglect.
- If you are in a relationship or a family member or whatever and they are trying to maintain power or control over you. And that can be through either sexual, or physical or emotional abuse.

Overall, the interviewees were able to define domestic abuse and raised the different ways it can be perpetrated. However, later in the interview there were some interesting descriptions of abuse or description of stories that revealed that in some cases it may not be taken seriously.

> ***'Hitting your husband over the head with a wooden spoon because he's tried to take some food – I don't know – is that domestic violence? It becomes quite… grey at times.'***

The interviewees had varied experiences of directly working with victims of domestic abuse. The GP link-worker in his experience of working in mental health had worked with LGBT and refugee women who were victims of domestic abuse and therefore was able to identify the complex issues surrounding the cases. Additionally, for those that had experience with patients, it was often regarding historic abuse rather than ongoing abuse. This is a theme throughout the pilot, as many of the referrals to the Idva concerned historic abuse. This is important as the needs of the victims were different.

> ***'[Domestic abuse] can trigger mental health problems, and it can also exacerbate mental health problems that already exist.'***

The interviewees were able to identify that domestic abuse may present differently in different patients. A number of interviewees recognised that their patients may be more vulnerable because of their diagnosed conditions. There were some concerns that it is confusing to know which route to use when trying to get a service user linked to support because there are a lot of signposting options.

> ***'We know there are big challenges in the older population, and there is a big issue with domestic violence.'***

The participants' experiences of training on how to identify and respond to domestic abuse was varied. Overall, none of the participants had had any recent training on the issue and if they did it was covered briefly in induction. Many of those who had training said it was part of safeguarding training, with a focus on safeguarding children and not specific to domestic abuse.

'I might find it easier to talk to men [about domestic abuse]… I may find it to sensitive and would hesitate to ask.'

Participants were asked what prevents people from disclosing domestic abuse. These were some of the reasons they provided:

- Embarrassment or shame 'especially if they are male'
- Worried about the disclosure getting back to the partner
- Fear that they will be made to report to the police
- Fear of consequences for any children they may have and social services involvement
- Fear that they may have to stay at the hospital for longer or be in services for a longer period of time

In the earlier stages of developing the questions for staff, we consulted with the steering group who raised concerns about staff use of the case management system, Rio. Therefore, we asked the staff how they used the system to manage safeguarding concerns. None of the staff were confident using Rio. They expressed concern that the current templates are difficult to use and discourage people from using them properly. This results in inconsistencies in how data is recorded on Rio, which is bad for service users as the safeguarding systems may not always be used.

'It is difficult when a client is a perpetrator because they are vulnerable but they are causing people more distress or problems. They are not exempt from the law.'

One staff member expressed frustration about the way referrals are made for clients who they suspect are perpetrators of abuse. Once the referral has been made, the case is no longer in 'their hands' and they don't find out the outcome. There were also concerns raised about inter-borough working and communication when Barnet clients are perpetrating abuse to a victim in another borough and liaising between different local authorities and health areas.

We asked staff members what their expectations were of the training they were going to receive. Overall staff members were excited to go on the training. They said they wanted to:

- Become more confident
- Be given statistics around how frequently domestic abuse happens
- Learn how to talk to people if they disclose domestic abuse
- Ensure they follow the correct procedure
- Find services that they can be referred to

'I can talk to [the Mental Health Idva] casually, I can listen to her conversations, I can learn from that as well.'

Finally, we asked staff whether there were any obstacles that could prevent the pilot from being successful. Staff identified that there may be 'training fatigue' which could prevent people from engaging in the training and signing up despite it being mandatory training for all Barnet staff. One participant said that for the project to be successful there had to be commitment from the Trust to the project. They asked whether the project would be more than one year and whether there would be continuity. Another participant said that their experience of witnessing staff with service users is that their attitudes can be a barrier as they had seen staff downplay or blame victims for their abuse.

4.3.2 Post-pilot interviews

'My colleagues have referred cases to [the Mental Health Idva] and found it useful'

We had two participants drop out of the interviews once they had completed their training. Therefore we only conducted three interviews of staff members who had completed training.

'Now I know a lot more about what classifies as domestic abuse'

We asked staff if their definition of domestic abuse has changed since we last spoke. All of them agreed that it had become more broad, enhanced and that the training made them realise how much behaviour is included under domestic abuse. The training changed how they defined domestic abuse which had an impact on how they would respond to a patient experiencing domestic abuse. Staff reported feeling more comfortable encouraging disclosures in a safe manner – for example, asking patients if they would prefer to be alone. Additionally, after understanding the impact that domestic abuse has on children, participants said they would be especially aware of any warning signs for domestic abuse if there were children involved.

> ***'I think without the training, probably my approach would have been different.'***

We asked participants to tell us what they had learned on the training and whether it has changed the way they worked with perpetrators of abuse. They said the training had equipped them to identify potential signs that a client is either with or is a perpetrator of domestic abuse. This included:

- Unwilling to let the partner speak
- Interrupting when their partner speaks
- Contradicting their partner if they tried to talk
- Physical signs such as bruises
- Emotional evidence such as the person seeming frightened or withdrawn

> ***'[the LINKS project] is good because it has helped raise awareness, and how domestic abuse works'***

Following the training, one staff member identified abusive behaviour from the partner of their client. They noticed that the client's partner was withholding money and identified this behaviour as financial abuse. They reported that the training made them aware of what to look for when working with service users. All staff members said that they had increased confidence in their ability to identify domestic abuse.

> ***'I think it will help save lives, because there are a lot of people who have died [as a result of domestic abuse].'***

We asked them again what they believed the role of a health professional is if they suspect a service user is a victim of domestic abuse. All of them said that they would identify the abuse, offer support and signpost to services including Solace Women's Aid and the Mental Health Idva based in the hospital.

The staff gave positive feedback regarding the training and the content of the two sessions. They particularly liked that there was practical advice on what to do if they were with a client who was experiencing domestic abuse. There was a request for more information regarding LGBT relationships, child to parent abuse and abuse against older people.

> ***'We just need to remember to ask the question'***

Finally, we asked them if there was any feedback they would like to give commissioners. All participants requested refresher training. They also made the following suggestions:

- Training should be mandatory and routine
- The system to report domestic abuse is currently badly designed
- It is really helpful to see the Mental Health Idva physically present in the Trust and for her to be easily contactable

4.3.3 Post-pilot questionnaire

SafeLives conducted a survey of all staff in the Trust at the end of the pilot. The survey was hosted online on SurveyMonkey and was open between 16 January 2018 and 19 February 2018. There were 25 participants, which is roughly 6% of Barnet staff. 60% of respondents were female and 40% were male. The following areas of work were represented: management, adult acute services, early intervention services, memory services, primary link working team, community services and social work.

The post-pilot survey was designed to test the impact of the pilot on the confidence, attitudes and knowledge of domestic abuse among Barnet staff in the Trust. The post-pilot survey had a number of limitations. The survey sample size was less than a third of the pre-pilot, meaning direct comparisons are difficult to make. A possible reason for the low response rate may be that the Mental Health Idva contract ended in January 2018, which reduced staff awareness and motivation. Furthermore, only 9 respondents (36%) attended the LINKS training who answered the post-pilot survey and only a further 5 respondents (56% in total) were aware of the LINKS project. As discussed in earlier sections, the training was intended to be mandatory but due to staff restructures no mechanism was put in place to ensure all staff attended both sessions. It is therefore difficult to assess the longer-term difference the training made to staff attitudes and knowledge.

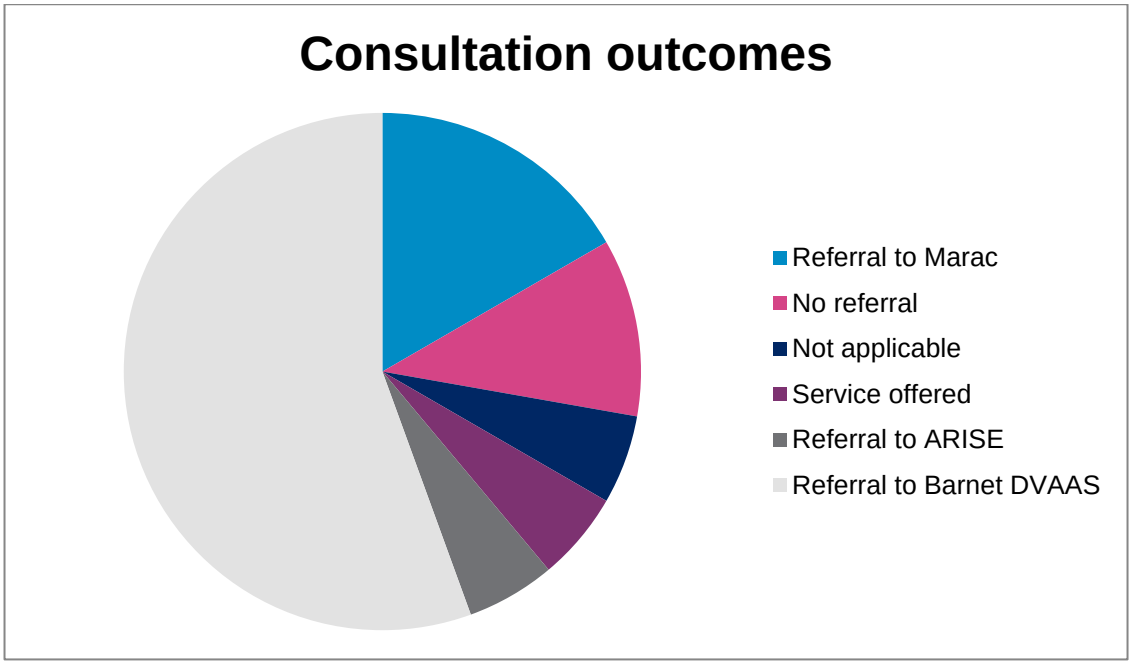
Respondents were asked how the LINKS training could have been improved. The feedback from the 9 respondents was overwhelmingly positive. The most common suggestion was for regular refresher sessions or follow-up learning of some kind, indicating that staff who attended found the training valuable.

4.4 Experience of the Mental Health Idva

4.4.1 Consultations

In addition to the training and the cases allocated through the Solace Women's Aid model (chart 1.2.2a), the Mental Health Idva was able to consult on cases throughout the year. Between February 2017 and December 2017 she advised on 45 cases. There was no recorded outcome for 25 consultations, however once these had been removed 53% of consultations resulted in a referral into the Solace Women's Aid service.

Chart 4.4.1a: Outcome of consultations



4.4.2 Interview with the Mental Health Idva

There were two interviews with the Mental Health Idva, one at the beginning of the project and one at the end. A number of different themes were discussed during the interviews, including the hierarchies that exist in the NHS, the caseload and her struggle to get people to attend the training.

At first, the pace of change was challenging for the Mental Health Idva, '*it moved slower*' than she had hoped so she felt redundant at the beginning of the job until training started. At the beginning, she delivered some training to staff in their team meetings, being flexible so as many people as possible received the training. However, by the end of the pilot she said if she were to start the pilot again, she would not deliver any training in team meetings. This was due to the hierarchies in the NHS which resulted in psychiatrists and doctors not being challenged on their attitudes and behaviours by junior

colleagues. Therefore, mixed groups had greater debate and discussion of the issues in the training sessions.

> ***'[If the training] had been coming from a fellow psychologist or psychiatrist the training may have developed in different ways and been more interesting.'***

At the beginning of the pilot, the Mental Health Idva was concerned that there was a lack of engagement from clinicians. This issue persisted throughout the pilot. Upon reflection, the Idva thought it would be useful to have a session with just psychologists or consultants. This was because she felt that there were two different schools of thought around perpetrating behaviour of those with mental health conditions and a fellow psychologist was better placed to challenge those opinions. She gave an example where a psychologist said the behaviour of a case study of a perpetrator with a personality disorder was because of the illness. However, a psychiatrist challenged them in the room and argued that although the behaviour may be linked with the disorder, the perpetrator is able to manage other behaviours associated with the disorder so they can control perpetrating behaviour and take responsibility for their actions.

> ***'Sometimes because of intellectual superiority my opinion was not valued so much.'***

The Mental Health IDVA's work with clients moved very quickly away from crisis intervention. This is due to the fact that many of the clients had experienced abuse historically; therefore the support they needed was more likely to be therapeutic or floating support.

> ***'The type of support I have been offering has potentially been more long-term engagement.'***

For future projects, she advised that the Mental Health Idva needs to be strict around the number of training sessions they delivered per week in order to manage casework better. The type of work itself was different from her previous Idva experience outside of a mental health setting. She felt that it took three times longer to do a single piece of work with a service user in the mental health setting than outside of it. This was due to the service user requiring more management, the complexity of cases and because of other services outside of mental health. Her maximum caseload was supposed to be ten, however, she found herself never having a caseload below that number.

The Mental Health Idva changed the way she delivered her training, following feedback from her first few sessions. Staff at the Trust requested that they wanted to know how to identify domestic abuse. Staff that we spoke with in the training said that this was something they really valued. The Idva reported that there were several training sessions where people did not turn up or dropped out last minute which affected the effectiveness of the training and the dynamic of the group. Overall, she felt that the training feedback was generally good. There were a few members of staff she felt did not need the training at the level at which it was delivered, but no more than ten.

> ***'[One staff member] said that 'some people actively seek abuse.'***

The Mental Health Idva did not feel as though she was embedded in the Trust by the end of the project. The first few months were slow and she was not part of a team so did not have team meetings or a group of people that were her colleagues in the Trust. She felt that around half of staff knew about the LINKS project, but that those who were aware asked for her advice and trusted her judgement. Clinical supervision and careful caseload management would be important for any replication of the project as she felt that she would not be able to continue in her role past the end of January even if the project had received the funding. This is because the intensity and quantity of the casework could lead to burn out.

> ***'The service users 'take over your life' and have to be managed more. When I have service users that require a lot of work, I speak to them every day. There is not a day when that does not happen. There is a sense of urgency with them which is not necessarily based on risk but is based on risk in terms of them to themselves which is a totally different***

thing to manage. And you've got to take anything they're saying seriously and then when you are dealing with… yes you can assess someone for suicidal ideation but if they have impulsivity as a part of the mental health condition… you can just never tell.'

Section 5: Conclusion and recommendations

The LINKS project had the following aims at its outset:

- To increase the identification of BEH-MHT patients who are experiencing domestic abuse
- To increase referrals for BEH-MHT patients in to specialist domestic abuse services
- To increase awareness, knowledge and confidence of BEH-MHT staff in responding to domestic abuse.

SafeLives found that the LINKS project was successful in meeting these aims and recommend below ways to strengthen its effectiveness.

5.1 Conclusion

5.1.1 Delivery of the LINKS project

The delivery of the pilot experienced a significant obstacle. All BEH-MHT staff in Barnet were intended to receive mandatory domestic abuse training from the Mental Health Idva as part of the pilot. This approach was calculated to embed domestic abuse learning. It was understood that a 100% participation rate would be achieved through making the training mandatory and having it be part of core safeguarding training. Due to a restructure which occurred during the pilot, training was not made mandatory in practice. The Mental Health Idva trained 36% of Barnet staff fully, with a further 11% completing the first training session only. It is our professional judgement that the low levels of training affected the efficacy of the pilot.

In addition there was an office move for Barnet staff based at Edgware Community Hospital, which further disrupted training and moved staff away from the location where the Mental Health Idva was based.

5.1.2 Effectiveness of the LINKS project

The LINKS project was highly successful in its aim to increase the identification and referral of service users into specialist services. Solace Women's Aid saw a **660%** (six hundred and sixty per cent) increase in referrals into the service from BEH-MHT.

There are positive indicators that the LINKS project improved the awareness, knowledge and confidence of the BEH-MHT staff who attended the training. As discussed above, the training element of the LINKS pilot was not completed for the majority of staff at the Trust. Interviews with staff who attended training indicated that training had deepened their understanding of domestic abuse and positively influenced how staff responded to victims and perpetrators of domestic abuse.

However, it is difficult to corroborate the interview response evidence with the post-pilot survey data so this conclusion can only be tentative. The post-pilot survey was completed by 25 participants, whereas the pre-pilot survey was completed by 82 participants. We found that responses in the post-pilot survey tended to be more extreme with more people 'strongly agreeing' or 'strongly disagreeing'. This may be because only the staff members who felt most passionately about domestic abuse answered the survey. It is also worth noting that only 36% of respondents had attend the LINKS training, so it is difficult to assess the impact of the training based on their answers.

The project was shortlisted in the 'Innovations in mental health' category in the HSJ Awards 2017.[34]

[34] https://awards.hsj.co.uk/

5.2 Recommendations

A longer, multi-site evaluation of Mental Health Idva should be considered
While this pilot showed early evidence of the impact of locating a Mental Health Idva within a Mental Health Trust setting particularly in terms of increased referrals and knowledge of staff. The duration of the pilot was too short to collect enough data to evidence substantial impact in terms of increased safety of victims, and the lack of mandatory training for staff affected the efficacy of the pilot. A longer, multi-site evaluation of Mental Health Idva could provide a more significant evidence base to support the wider roll-out of this new category of domestic abuse professional. Importantly, survivor voice should also be included in any evaluation which was not possible in such a small scale project such as this.

Ensure that staff training in domestic abuse is mandatory
Although this recommendation was always intended to be incorporated into the pilot, this was not delivered in practice. Any future pilots or interventions which locate specialist domestic abuse workers in mental health settings should ensure that all staff receive mandatory training, as part of the pilot. . All staff in BEHMHT receive DVA training at corporate induction and this has been in place for the last three years. 60% of staff said they hadn't had any domestic abuse training. This suggests that the staff responding to this question had been in post for longer than three years or that the training delivered at corporate induction is insufficient to provide them with a detailed understanding of domestic abuse

Review policies on domestic abuse and clarify referral pathways to specialist domestic abuse services
The current BEH-MHT domestic abuse policy does not have a clear referral pathway for staff to use if they identify a victim of domestic abuse, or elicit a disclosure after routine enquiry. In the absence of a dedicated specialist domestic abuse worker within the hospital setting (such as the MH Idva), the Trust should ensure their current pathways are reviewed to ensure there is no confusion about where victims of domestic abuse should be referred. Numbers of disclosures and subsequent referrals to domestic abuse services should also be regularly monitored to ensure that the domestic abuse policy is working in practice. The Rio case management system should be reviewed to ensure it is simple to record information around disclosures, evidence for domestic abuse and actions taken to refer patients to specialist support.

Ensure Mental Health Idvas work within a co-located hospital team and receive clinical supervision
The feedback from the Mental Health Idva in this evaluation, and in SafeLives' previous Cry for Health research, suggests that locating a specialist domestic abuse worker within a co-located hospital team as well as ensuring they receive clinical supervision will help to improve wellbeing and work culture in addition to the supervision received from a specialist domestic abuse service. Mental Health Idva also need to be visible within the health setting so that hospital and community staff feel able to approach them and to ensure their service is continually advertised.

Two year minimum contracts for Mental Health Idva
The project should be based on a two-year minimum contract due to the pace of change within the NHS. Staff awareness of the project had started to increase by the end of the project, but this occurred too close to the end date for the impact to be fully felt.

Provide top up domestic abuse training for staff
This was a unanimous request from the staff who participated in the in-depth training. Training needs to include information about challenging myths and stereotypes about domestic abuse victims and perpetrators, coercive and controlling behaviour, as well as a focus on the links between mental health and domestic abuse. In Barnet, in particular, training should cover how older victims of domestic abuse and victims from different cultural backgrounds might find it harder to access services. Training should also be delivered in mixed groups, rather than in teams to avoid more junior staff feeling that they are unable to contribute in front of senior staff.

Better advertising of the service
Approximately 58% of staff surveyed by the end of the pilot were aware of the LINKS project. There needs to be better advertisement of services that the Idva provides and better communication internally.

Referral routes for perpetrators of domestic abuse
It was out of the scope of this pilot to provide support for perpetrators of domestic abuse. However, there was a demand for a specialist service that understood the needs of those with mental health conditions. As 25% of those identified as being a victim of domestic abuse are also identified as perpetrators of abuse, the help and support they receive needs to be tailored to their experiences.

Mental Health IIDVAs need to have experience in dealing with cases of historic abuse and trauma-informed responses to support patients
Due to the cohort of patients in a mental health setting, the Idva found that many of her clients had experienced historical domestic abuse and therefore needed floating or therapeutic support which is different from the types of crisis interventions that Idva usually provide.

Acknowledgments and thanks to the LINKS project group:

Ruth Vines – Head of Safeguarding BEH-MHT

Dr Kylee Trevillion – Kings College London

Heather Wilson –Safeguarding Adult Lead Barnet CCG

Gillian Robinson –Senior Practitioner Barnet

Sharon Thompson- Service Manager BEH-MHT

Senay Dur – Senior Manger Solace Women's Aid

Ana Popovic – Idva Solace Women's Aid

Appendix: SafeLives Team

The SafeLives team who worked on this project included the following:

Sonal Shenai, Head of Consultancy

Sonal leads teams of SafeLives experts in reviewing and strengthening local responses to domestic abuse across the country. Her consultancy clients to date have included Gentoo Group, Cambridgeshire Constabulary, Hampshire Constabulary, the Police & Crime Commissioner for South Wales, the Police & Crime Commissioner for Cheshire, Comic Relief and St Helens Council. Her projects include creating commissioning strategies on domestic abuse, delivering domestic abuse action plans for police forces, reviews to support the local Marac response and researching the role of technology in the lives of victims of domestic abuse and the practitioners who help them. Sonal is also the national lead for SafeLives Tech vs Abuse projects and innovative One Front Door programme to integrate the response to child safeguarding and domestic abuse. As a former strategy consultant, Sonal helped to launch new ventures and deliver major change programmes in large, complex organisations. Sonal is a Trustee at London's poverty charity The Childhood Trust.

Danielle Mcleod, Senior Consultant

Danielle has significant experience working in the context of local government focusing on transforming partnership responses to domestic abuse and violence against women and girls. Having worked across five local authority areas before joining SafeLives she is experienced in developing cross-organisational strategies within an envelope of evidence based practice. She is experienced in the Domestic Homicide Review process having written a local protocol as well as sitting on a number of panels. At SafeLives, she has delivered a number of projects including a sub-regional strategy on domestic abuse, review of a West Midlands domestic abuse strategy and review of a South East domestic abuse triage team. Danielle is a Trustee at AVA (Against Violence and Abuse) as well as her local domestic abuse service.

Annabel Edmonds, Consultant

Annabel provides financial and analytical support to SafeLives consultancy. She has extensive experience of partnership working with local authorities, housing providers and the police. She qualified as a lawyer before starting her career in frontline services, working primarily with rough sleepers and female survivors of sexual abuse and trauma. At SafeLives, Annabel has worked on a number of projects across a wide array of topics including employers' response to domestic abuse, technological training for domestic abuse practitioners and raising awareness of domestic abuse in a mental health setting. She is highly skilled in both data analysis and advocacy. Annabel is a listening volunteer at her local Samaritans branch where she has also led a mentoring programme for trainee Samaritans.

Samantha Jury-Dada, Consultant

Samantha has now left SafeLives for a new role but provided design and research to this project. She has provided expert analysis and led focus groups with victims of abuse, interviewed practitioners and health professionals and designed evaluation strategies to test hypotheses to improve the response to domestic abuse. She has a criminal justice background and a BSc in Social Policy with Government from the London School of Economics. She has worked in number of roles in Parliament, local government and politics. She is experienced in a wide variety of research methods, both quantitative and qualitative and demonstrated these skills in her research into student perceptions of police rape prevention campaigns and as Report Editor for research led by Baroness Tessa Jowell and Baroness Doreen Lawrence into the use of Stop and Search by the Metropolitan Police.