Spotlight Report #SafeAndWell

Safe and Well:
Mental health and domestic abuse

May 2019

SafeLives

Ending domestic abuse

Contents

Key findings:

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i   A definition of trauma-informed practices can be found in the 'Definitions' section of this report.

About SafeLives

We are a UK charity dedicated to ending domestic abuse, for everyone and for good. We combine insight from services, survivors and data 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 we estimate over 65,000 victims at risk of murder or serious harm received co-ordinated support from interventions created by SafeLives and our partners, along with more than 85,000 children. Increasingly, we are also working in partnership to support and challenge perpetrators to change.

We want what you would want for your best friend

✓ **Action taken before someone harms or is harmed**

✓ **Harmful behaviours identified and stopped**

✓ **Safety increased for all those at risk**

✓ **People able to live the lives they want after abuse has happened**
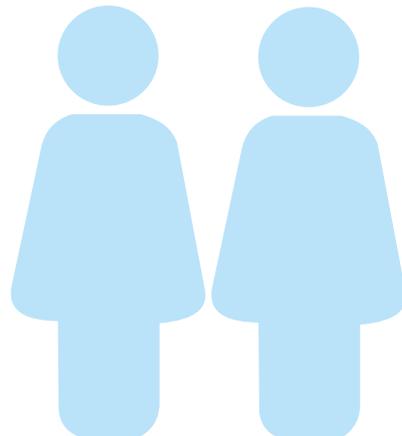
About SafeLives' Insights service

Insights is a tool that enables domestic abuse services to better understand the impact of their work and who is accessing their service. Frontline practitioners collect information about the people they support and submit it to SafeLives for analysis and benchmarking against national comparators. This helps to identify gaps, tailor interventions and support to meet the needs of clients and to evidence the impact of support on safety and wellbeing. Insights is designed for services supporting adults and children who have experienced or are experiencing domestic abuse, both as victim/survivors and those who perpetrate abuse. You can find out more about Insights on our website.

About the Spotlights series

This report will focus on victims and survivors of domestic abuse who experience mental health difficulties. We recognise there is a broad spectrum of severity and types of mental health problems, the impact of which will vary between individuals. The relationship between experiencing domestic abuse and mental health will also be different for each person. However, in compiling this Spotlight series we found commonalities; common barriers, concerns and gaps. This report aims to highlight some of these common issues, whilst also illuminating interventions and initiatives aimed at specific groups of people.

This report is part of our 'Spotlight' series which focus on how some victims and survivors of domestic abuse are hidden from services or/and have unmet needs, and proposes recommendations for both practitioners and policymakers. The series brings together survivors, practitioners, academics and charities, and provides a platform for sharing good practice, new initiatives and the latest research. The series is available online to enable the material to be seen by a wide audience.

We would like to thank all the practitioners, professionals and academics who participated in this Spotlight. In particular, AVA, our expert partner for the project, and The Royal College of Psychiatrists who provided their expertise when reviewing this policy report.

Most of all, we would like to thank the survivors who spoke so honestly and bravely about their experiences. Without your insight, this report would not be possible.
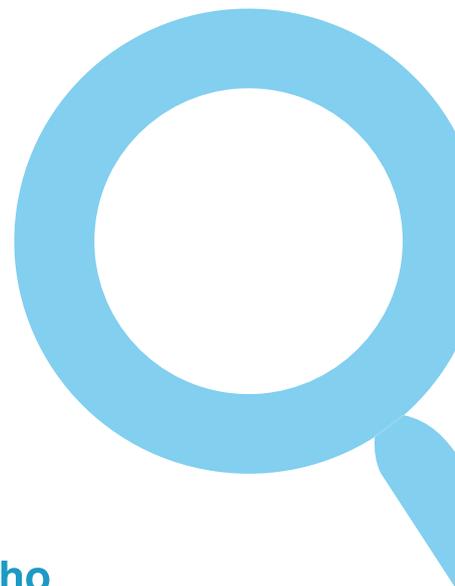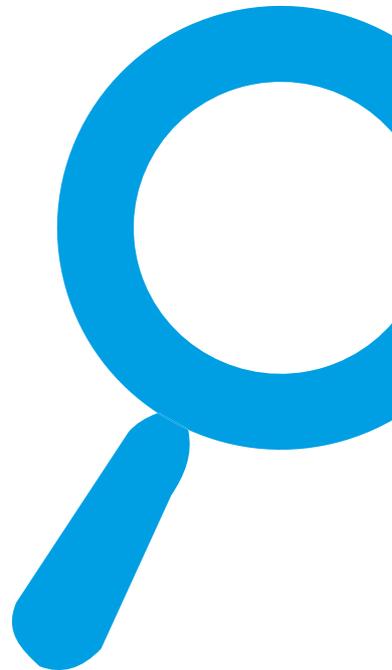
Definitions

Definition of Domestic Abuse (DA)

In England and Wales the cross-Government definition of domestic violence and abuse is[1]:

"Any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members, regardless of gender or sexuality. The abuse can encompass, but is not limited to, psychological, physical, sexual, financial and emotional.

Controlling behaviour is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim."[ii]

In Scotland, the definition of domestic abuse as used by the Scottish Government is[2]:

"Any form of physical, verbal, sexual, psychological or financial abuse which might amount to criminal conduct and which takes place within the context of a relationship. The relationship will be between partners (married, cohabiting, civil partnership or otherwise) or ex-partners. The abuse can be committed in the home or elsewhere including online"

In Northern Ireland, the definition of domestic abuse as set out by the Northern Ireland Government is[3]:

"Threatening, controlling, coercive behaviour, violence or abuse (psychological, virtual, physical, verbal, sexual, financial or emotional) inflicted on anyone (irrespective of age, ethnicity, religion, gender, gender identity, sexual orientation or any form of disability) by a current or former partner or family member"

Domestic abuse sector terminology

Idva/Idaa - Independent domestic violence advisor, or Independent domestic abuse advocate in Scotland. This is a specialist worker who supports a victim of domestic abuse. The Idva/Idaa will support the victim with safety planning and help them to navigate the different agencies involved, including acting as the victim's advocate at Marac.

Ypva - Young people's violence advisor. This is a specialist worker who is trained to support young people aged between 13-18 who are experiencing domestic abuse. Some Ypvas work with young people who have harmed a current or former partner, or adult family member. And some Ypvas are also trained to support young people affected by so-called 'honour' based violence, forced marriage, Child Sexual Exploitation, and gang violence.

Marac - Multi-agency risk assessment conference. A Marac is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, health, adult and children's social care, housing practitioners, Idvas/Idaas, probation and other specialists from the statutory and voluntary sectors including substance misuse. After sharing relevant and proportionate information they have about the situation of a victim of domestic abuse, representatives discuss options for increasing the safety of the victim and turn these into a co-ordinated action plan.

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ii   In January 2019 the Government launched the 'Transforming the Response to Domestic Abuse. Consultation Response and Draft Bill'. This draft bill proposes introducing a new statutory definition of domestic abuse, which includes economic abuse as one example of the type of abuse victims' experience.

Mental health terminology

Diagnoses - Whilst most UK health professionals agree on a similar set of clinical diagnoses for mental health problems, many people will be experiencing mental ill health without a professional diagnosis. This report aims to be inclusive of people both with and without a diagnosis. Details on specific types of mental health problems can be found on the mental health charity Mind's website.

Severity - The National Institute for Health and Care Excellence (NICE) website defines different severity levels of mental health problems[4]:

"A *mild* mental health problem is when a person has a small number of symptoms that have a limited effect on their daily life.

A *moderate* mental health problem is when a person has more symptoms that can make their daily life much more difficult than usual.

A *severe* mental health problem is when a person has many symptoms that can make their daily life extremely difficult."

We recognise that these definitions are somewhat subjective and fluid; a person could be experiencing different severity levels at different times. This report will aim to be reflective of the shared issues, barriers and recommendations for people with mental health problems of all severity levels.

Trauma-informed practice - Trauma informed practice builds on the foundation of awareness, understanding and responsiveness to the impact of traumatic events in the lives of both service users and professionals. Definitions of a trauma-informed practice vary, however, it is widely cited to be based on a paradigm shift from thinking *"What is wrong with you?"* to considering *"What happened to you?"[5]*. Menschner and Maul (2016) state that this involves[6]:

- "Realising the widespread impact of trauma and understanding potential paths for recovery;
- Recognising the signs and symptoms of trauma in individual clients, families, and staff;
- Integrating knowledge about trauma into policies, procedures, and practices; and
- Seeking to actively resist re-traumatisation"

A detailed outline of the principles of trauma-informed approaches have been explored in an article by Sweeny, Filson, Kennedy, Collinson, & Gillard (2018)[7]. However, "rather than being a specific service or set of rules, trauma-informed approaches are a process of organisational change aiming to create environments and relationships that promote recovery and prevent re-traumatisation" (Sweeny et al. 2018, p.323).

A note on language

Many different terms are used to describe people's experiences of mental ill health such as 'mental health problems', 'mental health issues', 'mental health difficulties' and 'poor mental health'. We recognise that different people will feel certain phrases helpful, whilst others will feel they have negative connotations. In an attempt to represent the broad spectrum of people experiencing mental health problems, we have used different terms interchangeably throughout this report. This is in line with guidance from the mental health charity Mind. We have sought to avoid terms commonly known to cause offence, as outlined by 'time-to-change'. We keep our use of language under close review and welcome any feedback for improvements.

Mental health and domestic abuse

People with mental health needs were **more likely to have experienced each type of abuse, particularly sexual abuse**:

Physical Abuse
58%
55%

Jelous and controlling
81%
78%

Harrassment and stalking
66%
63%

Sexual Abuse
27%
19%
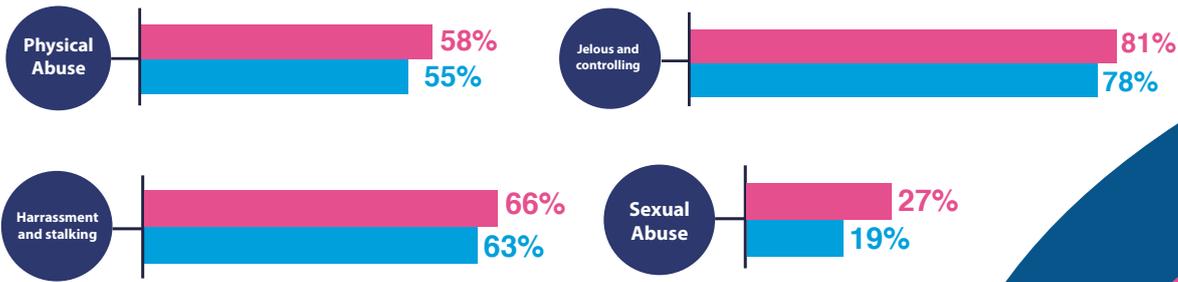
A larger proportion of victims with mental health needs were LGBT compared to those without (**3%** v **1%**)
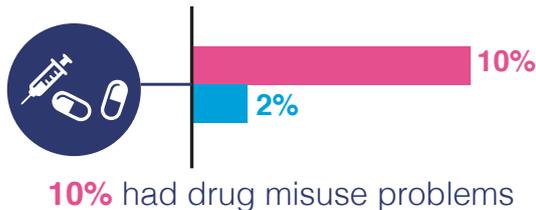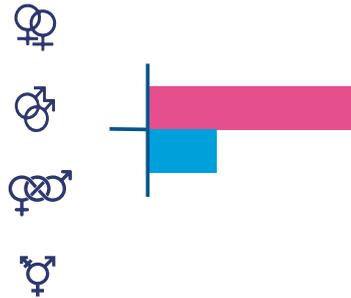
10% had drug misuse problems
10%
2%

Victims with mental health needs were **more likely to have problems with drug and alcohol use:**
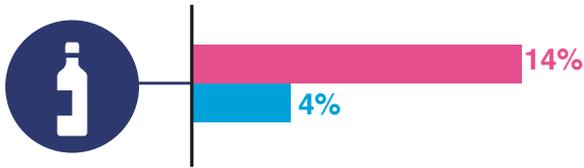
14% had alcohol misuse problems
14%
4%

66%

54%

£ £ £
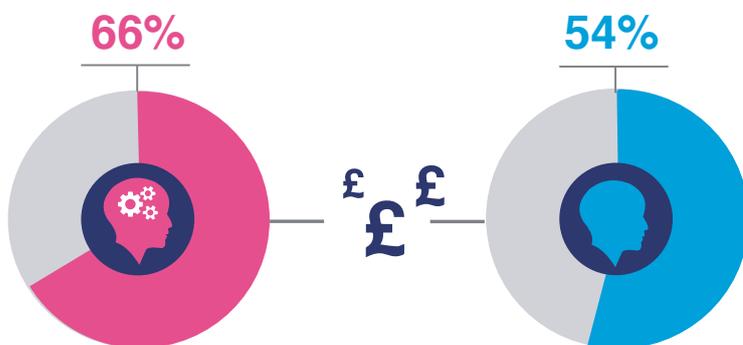
Victims with mental health needs were **more likely to be in financial difficulty:** 66% were struggling to pay for essentials or could pay for essentials with nothing left,

Of the individuals who had attempted to leave the perpetrator, **those with mental health needs had attempted to leave more times on average** compared to those without mental health needs (3 times compared to 2.1)

People with mental health needs had also visited their GP and A&E more times on average compared to those without. (GP: 5.9 times compared to 3.8 times. A&E: 1.5 times compared to 1.2 times)

57%

35%
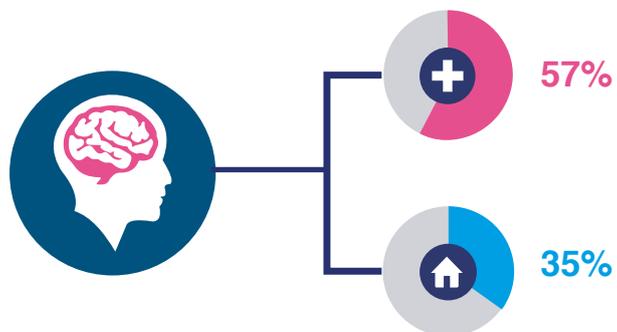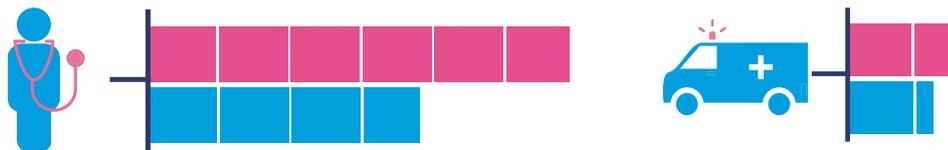
Victims identified in hospital were more likely to disclose mental health needs (57%) than victims identified in community based services (35%)
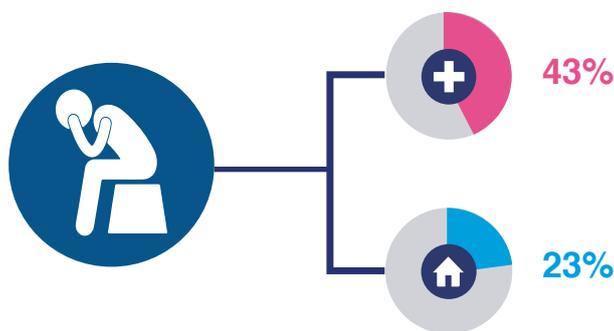
43%

23%

Nearly twice as many hospital-based victim/survivors had self-harmed or planned/attempted suicide (43%) than those in community services (23%)

Victims of domestic abuse with mental health needs were **more likely to have visited their GP and A&E** before accessing support for the abuse:

83%

60%

GP

22%

15%
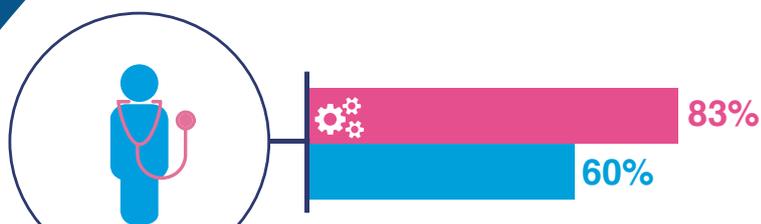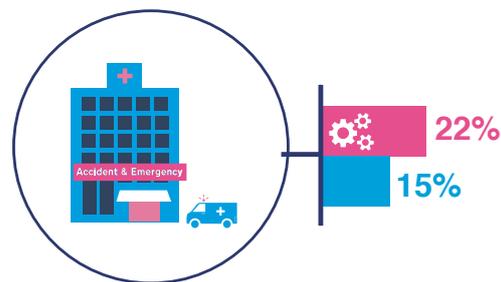
A&E
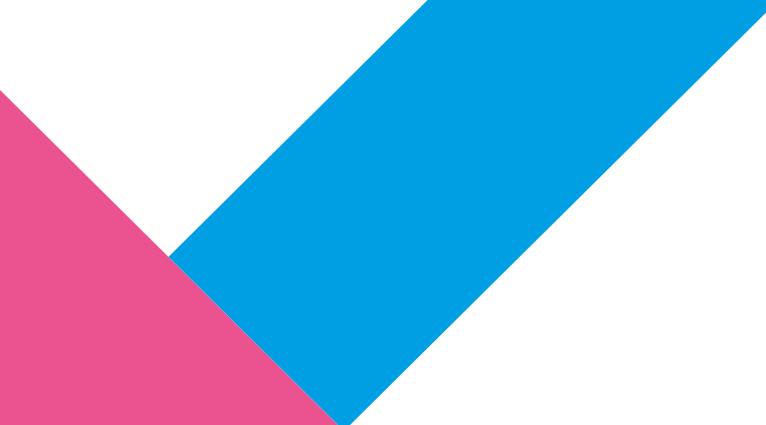
Executive Summary

There is a link between domestic abuse and mental health problems
Mental health problems are a common consequence of experiencing domestic abuse[8], both for adults and children. And, having mental health issues can render a person more vulnerable to abuse[9]. It is therefore perhaps unsurprising that a significant proportion of people accessing mental health services have experienced abuse[10],[11]. **Despite these strong associations, domestic abuse is often going undetected within mental health services[12],[13] and domestic abuse services are not always able to support people with mental health problems.**

Mental health professionals should be trained to respond to domestic abuse
Many mental health practitioners have not been equipped with the necessary skills and support to respond appropriately to domestic abuse. A Freedom of Information request in 2011-12 to Mental Health Trusts in England found the majority either had inadequate or no training in domestic abuse[14]. Consequently, despite many mental health professionals being aware of the strong link between abuse and mental health, they are often lacking the confidence and skills to enquire and respond to disclosures appropriately[15]. **Opportunities are therefore frequently being missed to refer victims and survivors on to specialist support at the earliest opportunity, and those perpetrating abuse on to appropriate interventions.**

We must respond to the mental health needs of those perpetrating abuse
Although most people with mental health needs will never be violent[16], evidence suggests having mental health problems is a risk factor for perpetrating domestic abuse[17],[18]. Mental ill health is never an excuse for perpetration of abuse, but building an understanding of the mental health needs of perpetrators can help services develop more effective interventions[19]. **Interventions aimed at targeting violent behaviour are less likely to be effective if mental health needs are ignored[20].**

Victims and survivors with mental health needs face barriers to support

Mental health services have been particularly impacted by austerity in the UK, leading to a lack of services and long waiting times[21]. Victims and survivors with mental health problems also face barriers accessing many other vital services due to strict eligibility criteria or not being able to engage in the way services require. **Such barriers are too often leading to people being bounced around different services, having to constantly re-tell their story.** Once in contact with professionals, some survivors are fearful they will be treated less favourably as a result of having mental health issues. For parents, this can include a fear that their children will be removed if they disclose mental ill health. This can lead to a tendency to hide mental health problems, preventing many victims accessing the mental health support they need[22].

Victims and survivors can have complex and interrelated needs

At the time of accessing specialist domestic abuse support, victims and survivors with mental health needs are experiencing some of the highest levels of risk and multiple disadvantage - as SafeLives Insights data shows below. For some groups of survivors, these experiences are even more acute, as we will discuss later in this report.[iii]

Survivors with mental health needs are more likely to be experiencing higher levels of abuse and multiple disadvantage
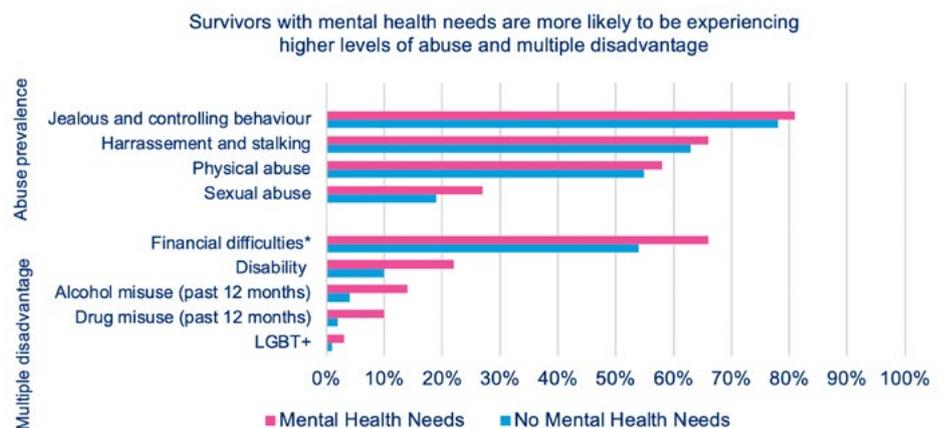
Although there is an awareness of the complex and interrelated needs of those with mental ill health, many services are unequipped to support them. For instance, few services exist which can care for people with a 'dual diagnosis' (having both mental health and substance misuse issues)[23],[24]. This is despite research showing substances are often used as a form of 'self-medication' for unmet mental health needs[25] and as a way of coping with abuse[26]. **It is important to recognise that mental health problems can create additional vulnerabilities that people perpetrating abuse may seek to exploit**, such as threats of institutionalisation, withholding medication, threats to have children taken away, or to 'out' their mental health problems to family and friends[27].

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iii   Financial difficulties defined as 'Struggling to pay for essentials' or 'Can pay for essentials but nothing left after'.

Victims, survivors and perpetrators need trauma-informed approaches

The link between gender-based violence, trauma and poor mental health is well-documented, however a report from the Agenda Alliance found trauma-informed[iv] mental health services in the UK for women are rare[28]. The importance of trauma-informed approaches extends beyond mental health services; all professionals working with victim/survivors with mental ill health should be trained in these approaches. It is also vital that services for people perpetrating abuse are trauma-informed, in order to deliver the most effective behaviour changing interventions. Projects such as 'Refuge for All' show how working with trauma-informed principles can reduce barriers to safety: the number of women refused admission because of mental health needs fell from 6% to 0.06%[29]. For many victims and survivors, however, refuge will not be the most appropriate or preferred option, and many refuges are unable to provide the intensive support needed for people with more severe and complex mental health problems. **It is thus vital that trauma-informed community and health-based services are also made available.**

The Health sector must improve its response to domestic abuse

Inadequate progress by the UK Government and NHS leaders to invest in integrating a domestic abuse response into the health sector is prolonging the period in which victims have no support, and those perpetrating abuse are left free to continue unchallenged. A 2019 report by the Home Office estimated the cost of the emotional and physical harm suffered by victims was £47 billion[v]; 71% of the total estimated cost (£66 billion) of domestic abuse in England and Wales in 2016/17[30]. The majority of the £47 billion cost of harm was attributed to emotional harm, not physical. **A more effective health response to domestic abuse and mental health is thus fundamental not only for the safety and wellbeing of victims and survivors, but also from a health and societal cost perspective.**

A Freedom of Information request in 2011-12 found only three of the 50 Mental Health Trusts in England that responded had a domestic and sexual violence strategy[14]. It is vital that Trusts improve their response to victim/survivors of domestic abuse, and to those perpetrating the abuse. Encouragingly there are already projects which have successfully done so, for instance AVA's PRIMH (Promoting Recovery in Mental Health) intervention14. Practice recommendations from such projects should be used by all Trusts and mental health professional regulatory associations to improve their response to and guidelines on domestic abuse. This will help ensure we eliminate the 'postcode lottery' of appropriate support and - for those who use abuse - appropriate challenge to change.

SafeLives Insights data showed that, in the 12 months prior to accessing specialist support, victims and survivors with mental health needs were more likely to have visited their GP (83%) and A&E (22%), compared to those without mental health needs (GP, 60%; A&E, 15%). However, the

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iv   A definition of trauma-informed practices can be found in the 'Definitions' section of this report.
v   The £47 billion calculation accounts for quality adjusted life years based on victims living with abuse for an average of three years before getting effective help. A worked example is given in the Home Office report, section 3.3. (Pages 2

health response to domestic abuse is often inadequate. **The majority of GPs receive no or little training in domestic abuse, and within hospitals there is typically no one trained to deal with disclosures.**

SafeLives' Cry for Health report in 2012 revealed that hospital-based Idvas (Idaas in Scotland) are more likely to engage survivors who discourse mental health problems (57%), compared to community-based Idvas (35%)[35]. Implementing national programmes (such as IRIS) within GP practices for training, support and referral pathways along with hospital-based Idvas/Idaas are essential to ensure survivors receive a timely and appropriate response, and those perpetrating abuse are challenged at the earliest opportunity. Work is ongoing by The University of Bristol to determine the appropriate identification and referral methods that health professionals should use for patients who perpetrate domestic abuse[31].

Domestic abuse practitioners should have access to mental health training

The mental health needs of survivors, and those perpetrating abuse, are often not being appropriately addressed. Reasons for this include long waiting times, and mental health services offering low intensity support, and/or being inappropriate for people experiencing or perpetrating abuse. Domestic abuse workers are frequently identifying mental health needs and, in the absence of mental health services to refer people onto, are often proving low level psychological support despite not being funded for training in providing such interventions. In his Spotlights podcast, Professor Gene Feder discussed the success of the Psychological Advocacy Towards Healing (PATH) project which trained domestic abuse workers to deliver psychological interventions[32]. **Extending such programmes which integrate domestic abuse and mental health support will help improve the response to survivors with mental health issues.**

We need a whole society response

Both mental health and domestic abuse continue to be stigmatised issues within society; creating potential double discrimination and barriers to speaking out. There are many organisations who regularly come into contact with victim/survivors and perpetrators with mental health problems, yet often fall short of providing an adequate response. Domestic abuse should be recognised as a public health issue with strategies, policies and resources in place to tackle it. Crucially, we need to help individuals recognise what abuse is and encourage them to access support at the earliest opportunity. Public awareness-raising campaigns are vital to highlight the interrelated issues of domestic abuse and mental ill health. These should be co-created with child and adult survivors and focus on the need for attitude and behaviour change amongst those who use, or who are at risk of using abuse. Making it clear that behaviours of those perpetrating abuse are not acceptable will help victims recognise domestic abuse and seek out help. Central to all campaigns must be elevating the voices of victims and survivors with a diverse range of lived experiences.

Recommendations

Victims, survivors and perpetrators of domestic abuse who have mental health difficulties need services with an understanding of their experiences, needs and trauma. These must also be understood by those funding, commissioning and shaping domestic abuse services. Below are our recommendations for change, which stem from the findings outlined in this report:

Recommendations for governments

1. **The Departments of Health and Social Care** in each nation, plus their public health partners (e.g. Public Health England, Public Health Wales, or the national equivalent) should acknowledge the strong links between domestic abuse (DA) and mental health in their strategies and frame domestic abuse as an urgent public health matter. They should contribute to increasing public awareness of its prevalence and dynamics, making reference to the links between DA and mental health in victim/survivors and those perpetrating abuse. Public awareness campaigns should be co-created with child and adult survivors, and focus on the need to change attitudes and behaviours amongst those causing harm.

2. **The Department for Health and Social Care (DHSC) and the Care Quality Commission (CQC) (or national equivalents)** should track every Trust's performance on domestic abuse. NICE (The National Institute for Health and Care Excellence) has already developed standards for how different types of NHS services should spot and respond to domestic abuse[33]. The DHSC and CQC should require trusts to report back on how they are performing on those standards.

3. **Central and local governments** should ensure funding is available for the following services, which local commissioners should provide:

   - In addition to recommendation 14, in depth training for mental health professionals to identify and respond to DA – for victim/survivors and those perpetrating abuse.

- Training, support and referral programmes (e.g. IRIS) for GP practices to improve their identification and response to DA. There is strong evidence that this investment will save NHS money[34]. The Department of Health should give thought to how this can be incentivised, for example through Care Quality Commission frameworks.

- Training and clear referral pathways for other health professionals who regularly come into contact with victim/survivors and perpetrators of DA, such as nurses, to identify and respond to DA with an awareness of its links to mental health. Training should be tailored to the specific health profession.

- Training for DA workers to deliver psychological interventions (e.g. PATH programme[32]).

- Hospital-based Idvas/Idaas within all hospitals, preferably with mental health expertise. There is strong evidence that this investment will save the NHS money in the short to medium term[35].

- Trauma-informed care for all (adult and child) victims and survivors of domestic abuse (DA).

- Specialist mental health DA workers within DA services. Such workers should be equipped to support people with complex needs (such as having a dual diagnosis of mental health and substance misuse issues).

- Increased resources for Child and Adolescent Mental Health Services (CAMHS) to meet the needs of children who've lived / are living through domestic abuse.

- Perpetrator programmes which – as needed - use trauma-informed approaches and have access to a mental health advisor.

The UK Government's refreshed National Statement of Expectations should reflect this, and the **Domestic Abuse Commissioner** (for England and Wales) should hold the UK Government to account for delivery. **The Royal Colleges** and associated professional bodies should include and promote the proposed training above within their programmes of continuing professional development.

4. **Each Government department in the UK and devolved Governments** should invest in training of its associated frontline workers to ensure that they can identify and respond appropriately to victim/survivors and perpetrators with mental health needs. The DA training envisaged in the recent government report 'Transforming the Response to Domestic Abuse: Consultation Response and Draft Bill' (e.g. for police, judiciary, Job Centre Plus agents) should reflect this[36].

5. **The Department for Education** in each nation should ensure guidance on Relationships and Sex Education (RSE) (or the national equivalent) in schools includes age appropriate information about domestic abuse (DA) and its impact on mental health. This content should be developed or approved by domestic abuse experts. Greater investment is needed than currently proposed in England to deliver the new RSE curriculum to ensure teachers are adequately trained on sensitive topics, know how to handle disclosures from pupils with clear safeguarding processes, and that schools can bring in expert external partners where necessary. School Governors should be offered training in DA, allowing them to appropriately monitor schools' polices and response to DA.

6. **The Domestic Abuse Commissioner** must ensure they recognise and respond to the links between domestic abuse and other adverse experiences and effects, including the impact on individuals' mental health and mental ill health being a risk factor for perpetration. They should hold local leaders to account for delivering support and interventions for victim/survivors and perpetrators with multiple needs (including mental health) and all levels of risk.

Recommendations for multi-agency partnerships and forums

7. **Multi-agency forums** (e.g. Marac, MAPPA) should ensure their membership always includes a mental health representative who is supported and equipped to provide active participation with expert insights.

8. **Multi-agency forums** (e.g. Marac, MAPPA) need to ensure they have an effective approach to managing risk when there are multiple concerns and complexities, such as domestic abuse, mental ill health and substance misuse issues. It is crucial that information about the mental health of both victims and those perpetrating abuse is used to enhance risk assessment and inform actions. Members should be aware of local mental health services and their links with local domestic abuse services and perpetrator programmes.

9. **Local multi-agency training strategies** should embed an understanding of the relationship between mental health problems and domestic abuse in victim/survivors and those perpetrating abuse, including the risk dynamic where both parties have mental health difficulties. Training should include the message that whilst mental ill health can increase the risk and volatility of those perpetrating abuse, this does not take away any responsibility for their behaviour.

Mental health and domestic abuse

10. Multi-agency strategic and governance groups should ensure multi-agency forums are accurately recording (and reporting in their returns to SafeLives) the number of disabled victim/survivors and perpetrators being discussed at Marac.

Recommendations for domestic abuse services and mental health services (statutory, voluntary and private)

11. Domestic abuse services and mental health services should work closely together and ensure clear referral routes are established. Mental health services should have training in domestic abuse (DA), and DA services should have training in mental health. Training for DA workers should include guidance on appropriate language to use around mental health (online guidance can be found within SafeLives' Mental Health Idvas/Idaas practice briefing[37]). If possible, DA services should have a specialist mental health worker within the team, and mental health services should have a specialist DA worker.

12. Perpetrator programmes and mental health services should work closely together and implement training programmes and clear referral pathways between services. Perpetrator caseworkers should be trained to understand how service users' mental health problems could impact their ability to change their behaviour, and their risk to self and others. Perpetrator programmes should have a mental health specialist to consult on mental health cases.

13. Domestic abuse services should consider additional needs and vulnerabilities during risk assessments which are more likely to affect people with mental ill health. For instance, the increased likelihood of substance misuse, homelessness, children being removed, and exploitation from their abuser and others (explored in chapter 3). They should also consider how certain groups of victims are more vulnerable to mental health problems (such as LGBT+ and disabled people).

14. All Mental Health Trusts should provide domestic abuse training as part of their mandatory safeguarding training, to ensure every practitioner has a basic awareness of domestic abuse.

15. Mental health services should use the LARA-VP online resource to improve their identification and response to domestic abuse[38].

16. Mental Health Trusts and non-statutory mental health associations should review their current strategy and ensure it sufficiently covers a response to victim/survivors (both adults and children) and perpetrators of domestic abuse. The strategy should be based around providing trauma-informed care. The Women's Mental Health Taskforce includes guidance on introducing trauma-informed approaches[28]. Given the strong links between mental health and domestic abuse, Mental Health Trusts should be investing in domestic abuse specialists.

17. Mental Health Trusts, non-statutory mental health associations and mental health services must ensure they have a clear description of the role and responsibilities of a mental health representative within multi-agency forums, such as Maracs (or national equivalents). Training should be readily available for mental health practitioners, ensuring they feel comfortable and confident in their role. SafeLives Marac toolkit for mental health services provides guidance around the role of a mental health practitioner within Marac[39].

Recommendations for everyone

18. All organisations in a position to identify domestic abuse (adult and children victim/survivors and perpetrators) should review their training protocols and ensure staff are aware of the associations between mental health issues and domestic abuse, and have appropriate responses to victim/survivors and those perpetrating abuse. In particular, this report highlights the important role of the police, child and adult social care, schools and non-government organisations such as housing providers. Training programmes should include an understanding of how aspects of identity (e.g. sexuality, gender, age, race, disability) can create additional barriers, and that certain groups are more vulnerable to mental health problems (for example LGBT+ and disabled people).

19. All services which come into contact with victim/survivors and perpetrators of domestic abuse should assess whether their response is trauma-informed. The Women's Mental Health Taskforce report contains useful guidance on trauma-informed working[28].

20. Domestic abuse services, mental health services, other health services, and commissioners should ensure victim/survivor groups, who are asked to feed into commissioning decisions or help shape service provision, are inclusive of those with mental ill health - including those with severe and chronic conditions.

Mental health and domestic abuse

21. All employers have a duty of care to support their staff. They should therefore have an understanding of the relationship between mental health and domestic abuse, and the potential impact on work performance. They should have appropriate policies and processes in place to support staff and respond appropriately to victim/survivors, and to those perpetrating abuse. Employers should access training in domestic abuse[40], and use freely available online toolkits[41].

We need to have a whole picture response to domestic abuse. SafeLives' strategy, 'The Whole Picture', outlines a framework for a whole picture approach to end domestic abuse, for everyone and for good[42].

Introduction

Our seventh Spotlight brought together practitioners, academics and survivors with expertise in the links between domestic abuse and mental health problems. This report will draw on evidence gathered during the series, as well as wider related literature and SafeLives' research projects including Insights datasets[vi], Cry for Health research[vii], Every Story Matters survey[viii], Psychological Violence study[ix], and the Drive project[x] in partnership with Respect and Social Finance.

Research suggests there is a bidirectional relationship between domestic abuse and mental ill health; experiencing domestic abuse often leads to mental health problems[8] and having mental ill health can make a person more vulnerable to abuse[9]. Mental health needs are also a risk factor for abuse perpetration[17,18]. It is therefore vital that we seek to understand how these two issues intersect, and where improvements to support and interventions can be made.

Whilst it is important that non-medical practitioners always encourage service users to access their GP for a mental health assessment, we recognise that many victim/survivors, and those perpetrating abuse, are managing their mental health problems outside of primary care. For this reason, unless the research or practice advice requires more specificity, this report will talk about mental health inclusive of those with and without a diagnosis.

The majority of people accessing mental health support in the UK go through statutory (NHS) mental health services. However, a

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significant proportion will choose to access non-statutory support, such as private therapists/counsellors or voluntary services (e.g. via BACP and BPC accredited counsellors, or through mental health charities such as Mind). Although this report focuses on statutory health services (due to the higher proportion of people accessing them), the majority of the highlighted issues, barriers and recommendations will be applicable to non-statutory health services and their professional regulatory bodies and associations.

Due to the wide scope of the topic the report will focus on six key findings which arose from evidence within the Spotlight series. The evidence is used to make recommendations for change, which we believe are necessary to improve the response to people with mental health problems who are experiencing or perpetrating domestic abuse.

I suffered the abuse for over 15 years, it's nearly six years ago now and the effects still give me problems in day to day life especially with new relationships or friendships. I suffer anxiety because of it all and have been on medication for it for a long time.

Survivor, Respondent to Psychological Violence survey
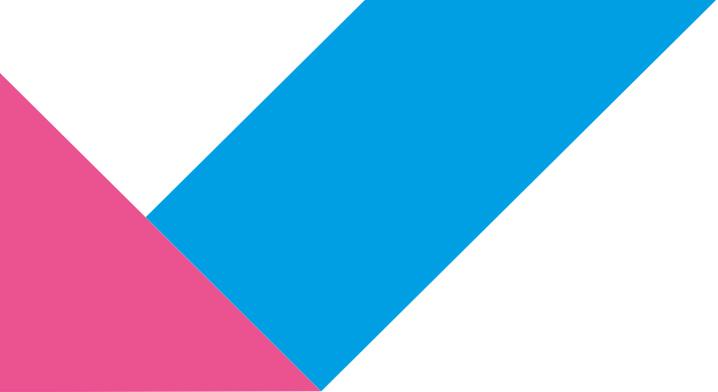
Policy context: support for people with mental health difficulties across the UK

In recent years there has been considerable progress across the UK in improving the support for people with mental health difficulties. However, as this Spotlight series has shown, too many victim/survivors and perpetrators of domestic abuse with mental health needs continue to face barriers in accessing support and interventions. For those that do gain access, the support they receive is often not appropriate:

> **I saw this psychiatrist…He [referring to the psychiatrist] said "I'm really sorry...you need to put the lid on this can of worms."…That really destroyed me.**
>
> *Survivor (as quoted in Trevllion et al., 2012, p.330[43])*

Health policy is devolved to the Governments of Scotland, Wales and Northern Ireland, with different health and care inspectorates in each country. The mental health policy context in each country will therefore be explored separately.

England

In February 2016, the independent Mental Health Taskforce published the national strategy to mental health; the 'Five Year Forward View for Mental Health for the NHS England'[44]. This sets out three main areas of improvements: making it easier for everyone to access high quality services; bringing mental health care and physical health care together; and, promoting good mental health and prevention. The Taskforce recommendations were accepted within The House of Commons briefing paper on 'Mental Health policy in England', and the Government committed £1billion by 2020/21 to support their implementation[45]. In 2017, NHS England published the 'One Year On' report highlighting successes of the strategy so far, such as meeting waiting times standards[46].

However, the report also acknowledged there remains a lot to improve. For instance, despite waiting time standards being met, contributors to this Spotlight highlighted that long waiting times continue to be a barrier for victim/survivors getting appropriate timely support for their mental health needs. Health Education England's 'Stepping forward to 2020/21: The mental health workforce plan for England'[47] sets out the workforce plan required to deliver the transformation within the 'Five Year Forward View'. In July 2018, the Care Quality Commission published 'The state of care in mental health services 2014 to 2017,' which outlined the results of an inspection of mental health services in England[48]. They found 25% of NHS core services were rated as 'requires improvement', and 1% as 'inadequate'. The report presented a picture of variation in quality and access across the country. This 'postcode lottery' of appropriate support was highlighted by our Spotlight contributors.

Despite some progress in policies aiming to improve mental health support, the legacy of previous legislation continues to have a detrimental impact. A report from the charity Agenda outlines how the Mental Health Act 1983 (which allows for patients to be detained and treated against their will) is detrimental to the wellbeing of women and girls, especially to those who have experienced trauma such as domestic abuse[49].

In response to the rising rates of detention and the disproportionate use of the Mental Health Act 1983 among people from black and minority ethnic (BAME) populations, the Government-commissioned the 'Final report of the Independent Review of the Mental Health Act 1983'[50]. This made recommendations including: minimising the number of people being held against their will, strengthening the rights, dignity and wellbeing of people in extremely vulnerable situations, and dealing with racial inequality. The recent 'Mental Health Units (Use of Force) Act 2018'[51], which aims to reduce the use of restraint in mental health settings, is therefore a welcomed change. However, whilst these changes are important, Paul Farmer (Chief Executive from the charity Mind) explained that "detentions will only reduce when people have access to quality, culturally relevant and timely care so fewer end up in a mental health crisis"[52].

Scotland

In the 'Mental Health Strategy for Scotland: 2012 – 2015' the Scottish Government committed to better support the identification and response to trauma[53]. A few years later, 'The Mental Health (Scotland) Act 2015' aimed to help improve access to treatment for people with mental disorders[54]. A 2016 review of mental health services in Scotland reported a general positive direction over the previous ten years, including the impact of specialist trauma services[55]. However regionally the picture was variable, with poor outcomes found for vulnerable groups.

The vision within the 'Mental Health Strategy 2017 – 2027' is "a Scotland where people can get the right help at the right time, expect recovery, and fully enjoy their rights, free from discrimination and stigma"[56]. Similar to England's 'Five year forward view plan', it focuses on achieving parity between mental and physical health. It acknowledges the impact of Adverse Childhood Experiences (ACEs) and sets out the plan to develop a National Trauma Skills and Knowledge Framework. In August 2018, the Scottish Government published the 'Suicide prevention action plan: every life matters' report, aiming to prevent suicide in Scotland and ensuring support is available to those contemplating suicide and all those affected[57]. The report acknowledges that certain factors raise the risk of suicide, including ACEs and later-life traumas.

Wales

In December 2010, 'The Mental Health (Wales) Measure 2010' was passed to improve support for people with mental health problems in Wales[58]. Following this, the Welsh Government published the 'Together for Mental Health' strategy, which aimed to improve the lives of people using mental health services, their carers and families[59]. Compared to the rest of the UK, the Welsh strategy seems more progressive in its response to domestic abuse as it specifically acknowledges the priority of ensuring those working within mental health services are trained to understand how domestic abuse and sexual violence can affect people's mental health[60]. It explains this will be achieved through health boards using the 'The National Training Framework on violence against women, domestic abuse and sexual violence'[61]. Such a framework is missing from the mental health strategies within England, Scotland and Northern Ireland.

The 2017 review of adult community mental health services in Wales concluded that services provided safe and effective care with a high service user satisfaction[62]. In 2018 the Welsh Government published a progress report on the 'Together for Mental Health (2016 – 2019)' strategy[63]. Progress included identifying the needs of people frequently visiting emergency departments, 26 week waiting time standards, and £5.5 million for psychological therapies. The report made explicit reference to being committed to protecting and supporting victims and survivors of domestic abuse with the 'Violence Against Women and Domestic Abuse National Training Framework' being implemented across health boards.

Northern Ireland

Mental Health service reform in Northern Ireland over the past decade has been guided by the 'Bamford Review [of Mental Health and Learning Disability]'[64]. In 2014, two new Regional Mental Health Care Pathways to improve services for those with mental ill health were launched. Firstly, the 'Regional Mental Health Care Pathway: You in Mind' which focused on treatment and care needs being person-centred and recovery-focused. Secondly, the 'Personality Disorder Care Pathway', which outlined the care available for people with a Personality Disorder. In November 2014, a monitoring report on the Bamford Review suggested that 'good progress' had been made[65].

In October 2016, the Department of Health Northern Ireland published the 'Health and Wellbeing 2026: Delivering Together'; a 10-year strategy to transform health and social care[66]. Similar to other UK countries, it highlighted the need for parity between mental and physical health as well as plans to expand services to deal with past traumas. In 2017 the Northern Ireland Assembly published the 'Mental Health in Northern Ireland' paper, which found that stigma and access to services were the main reasons people in Northern Ireland were not seeking help. Whilst the paper acknowledges traumatic past events can be a cause of mental illnesses, there was no specific mention of domestic or sexual abuse.

In September 2016, The Northern Ireland Department of Health published a draft strategy on suicide prevention called 'Protect Life 2'[67]. The aim of this is to reduce the suicide rate in Northern Ireland including the differential rates between the most and least deprived areas. The draft strategy acknowledges that certain risk factors leave people more vulnerable to suicide, including those who have experienced abuse and conflict such as domestic violence and sexual violence.

UK Government response to health and domestic abuse

Despite the well-evidenced links between domestic abuse and ill-health - both mental and physical health - there continues to be insufficient leadership in the UK Government and NHS to improve the health sector's response to domestic abuse. The physical and emotional harm incurred by victims and survivors of domestic abuse is estimated to be £47 billion; the biggest component of the total estimated £66 billion cost of domestic abuse in England in Wales[30]. We welcome the Government's intention to produce a four-year plan to raise awareness of domestic abuse amongst NHS staff, but this must be complemented by investments in specialist domestic abuse workers across the health sector. SafeLives' response to the government's Domestic Abuse Bill outlined the need for greater engagement from the Department of Health and the NHS: "By stepping up its response, the NHS stands to save itself money, transform the domestic abuse response and significantly reduce harm to individuals, families and wider society" (p.3)[68].
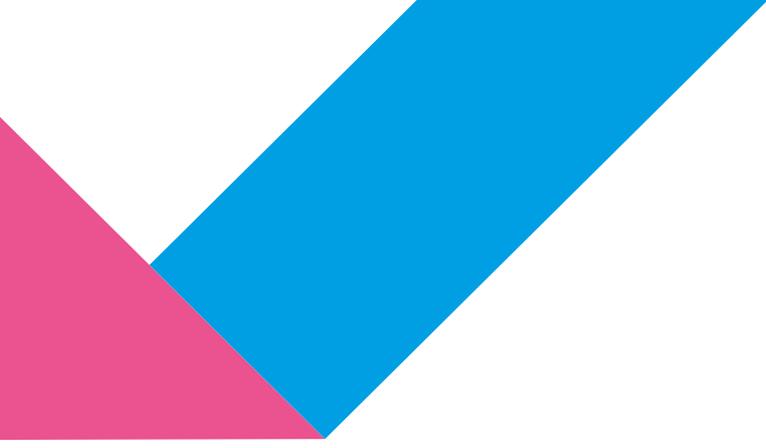
Key Findings

1. There is a strong association between having mental health problems and being a victim of domestic abuse. Mental ill health is also a risk factor for abuse perpetration

Mental health problems amongst victims and survivors

There are higher rates of domestic abuse amongst people who have mental health problems compared to those who don't[69]. Research supports the existence of a bidirectional relationship; domestic abuse can lead to mental health difficulties[8], and having mental ill health can render people more vulnerable to domestic abuse[9]. SafeLives Insights Idva 2017-18 dataset showed that 42% of people accessing support from a domestic abuse service had mental health problems in the past 12 months, and 17% had planned or attempted suicide[70]. However, SafeLives Cry for Health report revealed higher levels of mental health needs amongst victim/survivors within hospital settings (57%), compared to those within community-based domestic abuse services (35%)[35]. Nearly twice as many hospital-based victim/survivors had self-harmed or planned/attempted suicide than those in community services (43% compared to 23% respectively). This higher disclosure rate of mental health needs in hospitals is likely due to the setting being focused on health and wellbeing, instead of on criminal justice. This could suggest that levels of mental health problems amongst victim/survivors are being underreported within community-based services, or/and that there are differences in the needs of people accessing different services.

SafeLives' previous Spotlights series found mental health problems are more prevalent and severe amongst certain groups of victims and survivors. As shown in the below graphs, those identifying as LGBT+ and those who have a disability are more likely to have mental health needs at the point of accessing domestic abuse services. The 'Honour'-based violence (HBV) and forced marriage Spotlight series also highlighted that victim/survivors of HBV are especially vulnerable to self-harm and suicide.

LGBT+ and Disabled survivors are more likely to have mental health problems

	LGBT+	Non-LGBT+
Mental health problems (past 12 months)	51%	38%
Planned/attempted suicide (ever)	28%	15%

	Disabled	Non-disabled
Mental health problems (past 12 months)	56%	33%
Planned/attempted suicide (ever)	22%	11%
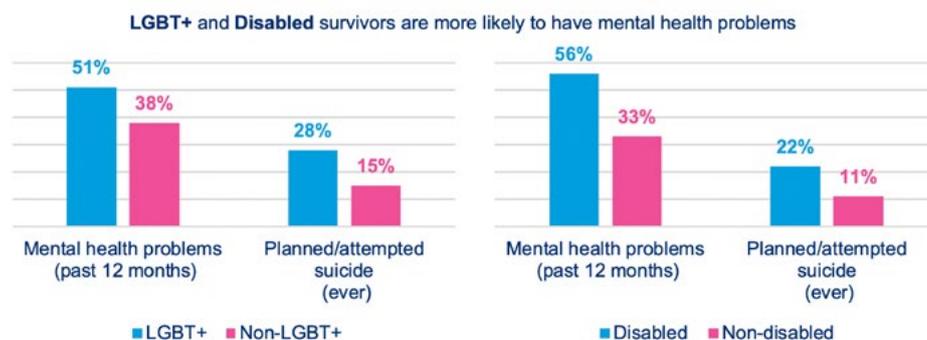
Many contributors to this Spotlight series discussed the strong links between mental health problems and experiences of violence and abuse. For instance, in her Spotlights blog Donna Covey (CEO of AVA) reported domestic abuse as the most common cause of depression amongst women. For some victims and survivors their mental health problems may have preceded experiences of domestic abuse, with the abuse then likely to intensify them. Whereas others may view their mental health problems as a 'reaction to' or 'symptom of' their abusive experiences[71].

The link between domestic abuse and mental health is strongly supported by academic research[72]. A literature review found the prevalence of recent[xi] domestic abuse in women with severe mental illnesses ranged from 15-22%[73]. Survivors of domestic abuse have been found to be at greater risk of having a diagnosed mental health condition: a three-fold risk of depressive disorders, four-fold risk of anxiety, and seven-fold risk of post-traumatic stress disorder (PTSD)[69]. The impact of domestic abuse on a person's mental health tragically leads to an increased risk of suicide[74]. SafeLives 'Cry for Health' report explained that "we are more likely to hear that two women a week are killed by a current or ex-partner in England and Wales, but it is estimated many more take their own lives as a result of domestic abuse: every day almost 30 women attempt suicide as a result of experiencing domestic abuse, and every week three women take their own lives" (p.41)[35].

I was having constant obsessive suicidal thoughts…I got to a point where I didn't think I could cope anymore and I didn't understand why it was happening when I had been so stable for so long.

Kathryn, survivor

Research indicates that the impact of traumatic experiences is cumulative; the more one is exposed to, the greater the mental health impact[75]; the more frequent and severe the abuse, the greater the chance of developing severe mental health issues. In her Spotlights podcast, Dr Kylee Trevillion (Women's Mental Health Department at Kings College) reported that people with chronic and severe mental health concerns often present with more serious and frequent injuries. Exposure to multiple forms of violence and abuse or/and abuse from multiple people has been found to be more strongly associated with mental health problems[76,77,78,79]. In one study female victims who had experienced three forms of abuse (physical, sexual, emotional) were four times more likely to report symptoms of mental ill health compared to those reporting one type of abuse[77]. Practitioners and researchers must consider the mental health impact from different and multiple types of abuse; not doing so risks the relationship between domestic abuse and mental ill health being misinterpreted and/or underestimated.

Compared to other forms of domestic abuse there is a relative lack of research on the mental health impact of *psychological* violence[74,80]. Of the research which does exist, psychological abuse has been found to be strongly and independently associated with mental ill health including an increased likelihood of depression, anxiety and post-traumatic stress symptoms[80,81], and suicide ideation[74,82]. In SafeLives' Psychological Violence[xii] study when survivors were asked about the impact of non-physical abuse, many reported a negative impact on their mental health, including 88% feeling 'emotionally withdrawn or shut down' and almost half (47%) having suicidal thoughts. Furthermore, over a quarter (29%) reported they had a disability, long-term illness or health condition which limited their day-to-day activities. Of those 29%, three-quarters (75%) said they did not have the disability, illness or condition before the abusive relationship. Although this data cannot confirm cause and effect, many survivors felt their mental health difficulties developed as a result of the abuse.

This is the form of abuse [psychological] that still haunts me to this day, almost twenty years later. It has impacted my long-term mental health, ability to trust people and have healthy relationships. I was a teenager then and my experience of being gaslighted, manipulated, controlled and emotionally beaten down destroyed me

Survivor, Respondent to Psychological Violence survey

Given the evidence for such strong associations between mental health problems and domestic abuse, it is perhaps unsurprising that a high proportion of people in mental health services are experiencing, or have experienced, domestic abuse[10]. A study with psychiatric patients in London found that 69% of women and 49% of men had experiences of domestic violence, compared to the general population control groups of women at 33% and men at 17%[11].

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xii   Psychological Violence in this study was defined as all non-physical abuse.

Mental health and domestic abuse

Children and young people

There are also strong links between mental health problems in children and young people who are living in, or have previously lived in, a household with domestic abuse. Recent research suggests the importance of moving away from the passive framing of children as merely 'witnesses' to abuse, towards them 'experiencing' abuse as direct victims/survivors[83]. This was highlighted in Shakti's Spotlights podcast:

> **So many people say children 'witness' or 'are exposed to' domestic abuse, but I feel that completely diminishes our experiences. A child in that environment is not passively observing everything that's going on. The abuse in my home affected every aspect of my life.**
>
> *Shakti[xiii], survivor*

Reframing how we see children as *direct* victim/survivors, brings the mental health impact into sharper focus. Children growing up with domestic abuse have a higher rate of mental ill health compared to those who don't[84,85,86]. In the SafeLives National Dataset on children and young people in domestic abuse services, 21% were experiencing anxiety or depression and 33% said they felt unhappy[87]. In SafeLives' Every Story Matters survey with survivors, mental health issues of children living with domestic abuse was a common theme amongst responses[88]:

> **My children have all been affected by the domestic abuse. They are very dependent on me even now and their coping strategies are badly affected at times of stress. I think we still have a long way to go and it will affect them for the rest of their lives. They have all suffered with anxiety/panic attacks. They have all needed long term counselling and the counsellors have been very shocked by what they have been through.**
>
> *Survivor, Respondent to Every Story Matters survey*

Children and young people's presentation of mental health problems will not always look the same with some coping strategies being less well-recognised[86,89]. Kathryn (survivor) explained in her Spotlight podcast that as she presented as a typical hardworking overachieving child, nobody had any concerns. Whereas, concerns were raised for her brother as he became involved in drugs and crime. Whilst professionals will have protocols for acting on concerns, it is important to be aware that not all children will externalise trauma in ways we anticipate (e.g. acts of aggression, substance misuse, and absenteeism).

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xiii   Name has been changed to protect survivor's identity.

Mental ill health is a risk factor for perpetration

Having mental health problems does not cause people to perpetrate abuse; the majority of people with mental health needs have never and will never be violent[16]. However, research indicates that mental health problems are a risk factor for perpetrating domestic abuse[17,18]. One UK study found 16% of men visiting their GP with symptoms of anxiety or/ and depression demonstrated behaviours linked to domestic abuse[90]. The prevalence of mental health needs have been found to be significantly higher for individuals who perpetrate abusive behaviours compared to the general population or to those who have not disclosed abusive behaviour[91,92,93,94]. The Drive pilot, run by SafeLives in partnership with Respect and Social Finance, seeks to challenge and disrupt the behaviour of high-harm perpetrators. The year two evaluation of Drive, carried out by The University of Bristol, reported that 27% of service users at case closure had mental health needs[95]. However, there was a significant amount of unknown data in this analysis so these figures may be an underestimate. SafeLives internal analysis[xiv] of Drive data with contact only cases found that 42% of service users had a diagnosed mental health condition. The most common of which were depression (38%), anxiety disorders (31%) and personality disorders (24%), and over a third (35%) had planned or attempted suicide. Compared to general population statistics these levels are incredibly high – estimates of around one in six (17%) adults in England in the past week have experienced a common mental health problem, and around 5% have experienced suicidal thoughts/attempts in the past year[96].

They've succeeded because… like I said when I started with them I just wanted to end it. Now, you know, that's not even a thought that ever came to mind, and I just want to keep bettering myself now.

Drive Service User (as quoted in Drive Year 2 Evaluation[95])

Research on domestic homicides supports there being high levels of mental health problems amongst those perpetrating abuse. Along with other risk factors, research has found mental health needs are associated with increased risk of domestic homicides[97,98,99]. In one study on domestic homicides in England and Wales, 40% of perpetrators had suicidal ideation/attempts or had self-harmed prior to the incident[97]. Statistics presented on mental health problems amongst those who perpetrate domestic abuse vary dramatically. Not everyone who commits domestic abuse will have a mental health need, and different groups of those who perpetrate will present with higher needs than others.

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xiv   SafeLives internal analysis of Drive data looked at contact only cases opened during year two of the Drive pilot and that had closed; 130 total cases (unpublished). Levels of mental health needs found in this analysis are higher than in the published Year 2 Evaluation report. This is likely because the internal analysis only looked at cases where contact was made with the service user (SU) as case managers are unlikely to know the same level of detail in cases where there was no contact.

Certain types of mental illness have been associated with increased likelihood of perpetrating different abuse types[18]. In one study, those with panic disorders were significantly more likely to perpetrate physical aggression, whereas those with social phobias more likely to perpetrate sexual abuse[92]. The year two evaluation of Drive found that those with multiple needs (which included mental health) had the highest levels of harassment and stalking and jealousy and control behaviours[95]. Although such evidence suggests there could be an association between different mental health problems and perpetration of certain abuse types, there is a significant lack of research on this area so findings should be considered with caution.

Considering mental health is a risk factor for perpetration, research on the mental health needs of people perpetrating abuse is still very limited. Understandably most research has focused on the needs of victims and survivors. However, we must also develop an understanding of perpetrators' needs to ensure they are taking responsibility for their behaviour; in turn reducing the risk to victims[90]. Research into the relationship between mental health and perpetration must be undertaken carefully. We must balance the risk of increased stigma towards those with mental health issues against the benefits of an improved understanding and risk management (as will be explored in the next chapter).

Overall, given the current evidence for strong links between domestic abuse and mental health problems, it is vital that mental health professionals feel confident in enquiring and responding to disclosures - both from victims and from those perpetrating abuse. Unfortunately, this is too often not the case, as the next chapter will explore.

2. Despite the strong associations, domestic abuse often goes undetected within mental health services – and domestic abuse services are not always equipped to support mental health problems.

Mental health services are often not equipped to respond appropriately to domestic abuse

Despite the high co-occurrence of domestic abuse and mental health problems, domestic abuse is often going undetected in mental health services; research estimates just 10-30% of cases are identified[12,13.] Although many mental health professionals are aware of links with domestic abuse, many mental health services are ill equipped to enquire about abuse and respond appropriately to disclosures from victim/ survivors, and from those perpetrating abuse.

Low levels of enquiry

Levels of enquiry are low; a UK study found only 15% of mental health professionals routinely asked psychiatric services users about domestic abuse[100]. Common barriers to enquiring include a perceived absence of expertise, a lack of a strong therapeutic relationship, time constraints, the presence of partners, and fear of offending or re-traumatising[13]. In her Spotlights blog, Donna Covey explained that some mental health professionals do not see enquiring about domestic abuse as part of their role. This is also evidenced in qualitative research with practitioners:

> **I think so many things are coming under the role of psychiatry to sort out when actually they are not mental health problems…suppose I struggle a bit with us taking on things that aren't mental health problems…perhaps we should be directing people elsewhere.**

> *Psychiatrist (as quoted in Rose et al., 2011[15])*

Asking about domestic abuse will lead to earlier disclosures, in turn leading to quicker support and access to safety. Mental health professionals should be trained to feel confident in enquiring about abuse with an understanding of how it can affect one's mental health. Survivors tell us that being asked sensitively and directly is more comfortable than disclosing to a practitioner who has not tried to broach the subject[101]. Kathryn Lake (Mental Health Community Nurse) explained in her Spotlights blog that even if professionals have misread the situation and there is no abuse present, this is unlikely to damage the therapeutic relationship. Instead, it demonstrates positive regard for the patient's wellbeing and situation. However, research suggests that routine enquiry can have adverse consequences if professionals are not appropriately trained in responding to disclosures[102]. Domestic abuse policies and training programmes should therefore be in place before routine enquiry is introduced[101,103].

Lack of training

In her podcast, Dr Kylee Trevillion explained that people who have experienced abuse often feel more confident disclosing to health professionals compared to the police and other services. Yet a UK study showed only 27% of mental health professionals provided information to psychiatric services users following disclosures of abuse[100]. Sarah Hughes (Mental Health Coordinator at Standing Together) reported in her Spotlights blog that although many mental health practitioners understand the link between domestic abuse and mental ill health, they are often not equipped with the skills and tools to respond appropriately, with a lack of training being a major factor. This is echoed in a Freedom of Information (FOI) request to Mental Health Trusts in England which found, of the 50 trusts that responded, only 34 reported staff were required to learn about domestic and sexual violence, and in 30 of these cases this consisted of a short session within mandatory safeguarding training[14]. Research has found mental health professionals reporting 'low' or 'very low' levels of knowledge regarding domestic and sexual violence, along with a lack of skills and confidence in enquiring about and exploring abuse[14]. Whilst some practitioners find it easier to enquire about perpetration - as this aligns with routine risk assessments – they also report a significant lack of training in how to respond to perpetrators[14]. It is unacceptable that people perpetrating domestic abuse are not receiving a proper response to change their behaviour and be held to account at the earliest opportunity.

Poor experiences of service users

Not providing quality domestic abuse training for mental health professionals risks interventions offered to victim/survivors being ineffective, or potentially distressing[43]. Dr Katherine Pitt explained this in her Spotlights blog:

Psychological support which fails to acknowledge the abuse can be ineffective. Worse, it risks implying that the distress experienced has an intrinsic rather than extrinsic cause. Couples or family therapy can lead to re-traumatisation and [can] be dangerous.

Dr Katherine Pitt, GP and DVA researcher at The University of Bristol

Research with victim/survivors has found that whilst some have had positive experiences with mental health services, others describe responses as patronising, blaming and accusatory - mirroring the dynamics of their abusive relationship[14,71].

Another potential problem arising from a lack of adequate training is the risk of misdiagnosis. Agenda's report on 'The Women's Mental Health Taskforce (2018)' highlighted the tendency for women with Complex Post Traumatic Stress Disorder (PTSD) to be wrongly diagnosed, such as with Borderline Personality Disorder (BPD)[28]. Complex PTSD relates to experiencing multiple traumatic events, such as repeated domestic abuse incidents (compared to PTSD which relates to a single traumatic event). Failing to recognise this distinction can lead to people not receiving appropriate treatment, further compounding their mental health issues. Furthermore, BPD is a particularly stigmatised and misunderstood condition which can lead to additional barriers to support[104,105]. Complex PTSD has only recently been introduced as a diagnostic category so awareness may be limited amongst professionals. The website of the mental health charity MIND contains useful guidance on Complex PTSD[106].

Victim/survivors with severe mental health problems, or people experiencing a crisis, may end up in hospital inpatient facilities (either voluntary or sectioned[xv]). When in these settings they may experience re-traumatising events such as physical restraint, seclusion and physical assault[49,107,108,109]. Research by the charity Agenda reported that almost one in five women and girls have been physically restrained in facilities within Mental Health Trusts in England[110], and 32 women died following restraint over a five-year period[111]. The recently passed 'The Mental Health Units (Use of Force) Act 2018'[51], which aims to reduce physical restraint in mental health settings, is therefore much needed and welcomed[112].

Treating symptoms not the cause

Dr Kylee Trevillion explained that part of the problem is many mental health services continue to be based around the medical model. This focuses on identifying and treating presenting symptoms, rather than exploring underlying factors. Concerns about this approach were echoed in interviews with mental health professionals and survivors in London mental health services:

xv   If someone is assessed and judged to be at risk of harming themselves or others, they can be detained under a section of the Mental Health Act 1983 (in England and Wales).

> **There was never…talking about it, it was just "these are for your depression, these are sleeping tablets."…Again, you know, more tablets…"here's a Valium to calm you down"… but that's it.**
>
> *Survivor (as quoted in Trevellion et al. 2012, p.332[43])*

It is vital that mental health services move towards incorporating more trauma-informed approaches within their work (as will be explored in chapter 4).

Domestic abuse strategies in Mental Health Trusts

Training and support for mental health practitioners need to sit within a framework of a trust-wide strategy for domestic abuse. However, a Freedom of Information (FOI) request in 2011-2012 to Mental Health Trusts in England found only three of the 50 Trusts that responded had a domestic and sexual violence strategy[14]. Another FOI in 2016 found, of the 37 Trusts which responded, only one had a strategy for providing gender-specific services to women[113]. Jessica Southgate (Policy Manager at Agenda) discussed this research in her Spotlights podcast, stating that the results showed no focus on women and no strategic recognition of the relationship between abuse and mental health. However, it is important to acknowledge that within the research a few Trusts did have comprehensive policies on domestic abuse and one, a specific women's mental health plan. This illustrates that incorporating domestic abuse into mental health care planning is possible. A commitment at all levels of a Trust to a strategy will help develop a culture in which good practice is not just established consistently, but also maintained. Mental Health professionals will be routinely working with victim/survivors, and also those perpetrating abuse. The success of any mental health treatment will be heavily undermined if the risk and impact of abuse is not fully recognised. We advocate for Mental Health Trusts to examine their current approach to domestic abuse and seek ways of improving their response. This Spotlight found excellent examples of this already happening, as will be explored later in this report (Chapter 5).

Support for children and young people

Children and young people experiencing domestic abuse face particular barriers to receiving support for their mental health. SafeLives' Insights dataset on children in domestic abuse services found that despite 21% of children at intake having depression and/or anxiety, only 12% of total cases had involvement from Child and Adolescent Mental Health Services (CAMHS). Frontline domestic abuse and children's social care practitioners describe extremely high thresholds and extensive waiting lists for CAMHS, as well as some reluctance to view domestic abuse related trauma as a mental health need. A report by the Education Policy Institute on CAMHS in England found almost one in four children were

rejected from accessing services in 2017/18[114]. The most common reason being that their condition was 'not serious enough' to meet the eligibility criteria. The report raised specific concerns for those whose needs fell under different services (e.g. mental health and domestic abuse), as they often ended up being pushed between agencies. Concern about the capacity of CAMHS has been echoed in recent media attention around the issue[115].

In SafeLives' Every Story Matters survey, many survivors highlighted the importance of mental health support to better protect children[88]. However, Susie Hay explained in her Spotlights blog that even if children manage to access support, professionals are not always making the link between domestic abuse and mental health problems:

Domestic violence and abuse and the associated trauma had touched the lives of over 80% of my clients in one form or another. However, this was rarely the identified issue, event or reason for being referred into the counselling room.

Susie Hay, Child and Adolescent Psychotherapist

It is vital that children and young people have access to timely and appropriate mental health support, to mitigate both the immediate and long-term psychological impact of experiencing domestic abuse.

Mental health problems can become a barrier to support within domestic abuse, and wider, services.

Domestic abuse workers are frequently identifying mental health needs, but due to a lack of mental health services to refer people onto, they are often providing low level psychological support - despite not being funded for training in such interventions. In his Spotlights podcast, Professor Gene Feder discussed the success of the Psychological Advocacy Towards Healing (PATH) project which trained domestic abuse workers to deliver psychological interventions[32]. Domestic abuse and mental health support must be delivered in a more integrated way, for adult and children victim/survivors, and also for those perpetrating abuse. Chapter 5 explores interventions which have delivered such integrated approaches.

There are both positives and negatives of obtaining a mental health diagnosis. For many people a diagnosis can help them understand what is happening and it can provide eligibility for certain treatments. However, a diagnosis can also create barriers to services. The 'The No Woman Turned Away' project reported 'mental health needs' as the third most common reason for refusal to a refuge[116]. There are inevitable difficulties responding to people with mental health needs within refuges as they have limited space and resources to provide intensive support - especially given funding cuts which have led to more generic services[117]. Refuges meet the immediate need for safety for some survivors, and

they should be funded to have resources in place to support people with mental health difficulties. However, there must also be funding for mental health support for those who stay within their own home or other accommodation. This includes health-based Idva/Idaa services - as found in SafeLives' Cry for Health report[35] - and community-based Idva and outreach services.

Victims and survivors sometimes fear being treated less favourably by professionals as a result of having a diagnosed mental health condition. For instance, some report feeling the police being uninterested in their story about abuse after hearing they had mental health problems[43]. In her podcast, Shakti (survivor) described how she avoided a diagnosis as she worried it would affect how GPs treated her in the future. Cases discussed within SafeLives' National Scrutiny Panel (NSP)[xvi] on Mental Health showed examples of professionals casting doubt on disclosures of abuse based on an opinion that disclosures could be symptomatic of a mental health condition[118]. Panel members also highlighted that when both the victim and perpetrator had mental health problems, perpetrators appeared to be held less accountable. Fear of not being believed by professionals is a prominent barrier to disclosure for victims with mental ill health. It is crucial that information about the mental health of both survivors and perpetrators is used to enhance risk assessment and inform actions. When professional opinion and judgements are voiced, they should be made clear and distinguished from factual information sharing. Careful mental health assessments are vital, but mental health problems of either party should never be used as evidence that abuse is trivial or excusable.

NSP members also reported that having mental health problems too often leads to people being 'bounced around' different services[118]; a process where traumatised people are being asked to repeatedly re-tell their story.

When I did get seen by IAPT they went through the whole assessment and then at the end said I wasn't suitable...I really couldn't believe that I was being told after pretty much a year of being assessed multiple times by different NHS mental health teams that there was nothing they could do for me.

Kathryn, survivor

The mental health needs of people perpetrating abuse must be considered for effective interventions.

Research suggests that interventions aimed at targeting violent behaviour will only be marginally effective if mental health needs are ignored[20]. Yet those who perpetrate domestic abuse are often not receiving support for their mental health problems. A study on UK domestic homicides found that only 30% of those with symptoms of mental illness at the time

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xvi   SafeLives National Scrutiny Panel (NSP) on Mental Health was a multi-agency review of Marac cases involving victims at high risk and/or perpetrators of domestic abuse where mental health was a significant factor, hosted by the Home Office (October 2018).

of the offence had been in contact with mental health services in the year before the homicide[99]. The year two evaluation of Drive indicated that service users with mental health needs often had high levels of engagement to the intervention, with access to support (in a variety of areas including mental health) being a powerful lever to engagement[95].

Drive caseworkers reported some service users using their mental ill health to reduce their level of responsibility[95]. This is unacceptable. Having mental health needs is never an excuse for perpetration of abuse. However, building an understanding of the mental health needs of those perpetrating abuse can help services develop more effective interventions. Jonathan Fowler explained this in his Spotlights blog:

While mental health issues may complicate the work we do, or in some cases mean that we cannot work with a particular client, they never remove our focus on how the men we work with can more effectively take responsibility for their behaviour. If there appear to be mental health issues, I am interested in how they impact on a client's ability to take responsibility.

Jonathan Fowler, Mental Health Advisor for the Drive programme

In SafeLives' Every Story Matters survey with survivors, 73% agreed that mental health support for those perpetrating abuse was a good idea[88]. Survivor voice must be central to informing how we work. There is a clear need to hold perpetrators to account for their abusive behaviour whilst also addressing their mental health and other complex needs. This will help create sustainable change and reduce repeat perpetration.

3. Survivors with mental health problems are more likely to be experiencing multiple disadvantage. And perpetrators with mental health needs are more likely to have higher additional needs.

When abuse intersects with other aspects of a person's situation, such as mental ill health and other forms of disadvantage, it becomes increasingly hard for people to become sustainably safe. SafeLives Insights data revealed that, at the time of accessing specialist support, survivors with mental health needs are experiencing some of the highest levels of risk and multiple disadvantage. For instance, they are more likely to have experienced each type of abuse, particularly sexual abuse.

Survivors with mental health needs are more likely to have experienced each abuse type

	Physical abuse	Sexual abuse	Harrassement and stalking	Jealous and controlling behaviour
Mental Health Needs	58%	27%	66%	81%
No Mental Health Needs	55%	19%	63%	78%

■ Mental Health Needs   ■ No Mental Health Needs
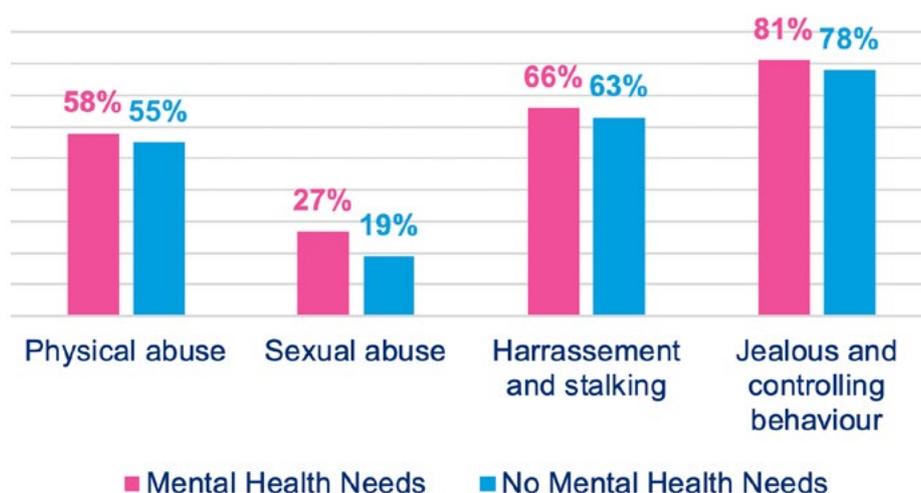
We also know from previous Spotlight series that the likelihood of abuse prevalence and severity increases in certain groups. For instance, SafeLives' LGBT+ Spotlight found the prevalence of all abuse types amongst LGBT+ survivors was higher than those not identifying as LGBT+. And the Disability Spotlight reported that survivors with a disability are more likely to suffer severe and frequent abuse over longer periods of time, compared to those without a disability. It is vital that professionals consider how the intersection of mental ill health with aspects of one's identity - such as their sexuality, gender, disability, age, and race – can increase the likelihood of severe experiences.

The intersection of identity and needs can lead to individuals being affected by different systems of discrimination. SafeLives Insights data found a higher proportion of survivors with mental health needs identified as LGBT+ (3% vs. 1% without). Yet, Dr Kylee Trevillion highlighted that transgender people are typically underrepresented in mental health services and within the research literature. People with mental health problems who identify as LGBT+ are likely to face additional disadvantages due to their sexuality and/or gender identity – as explored in SafeLives LGBT+ Spotlight. Practitioners must consider how multiple needs might interact to fuel disadvantage if left unsupported.

This Spotlight series highlighted the importance of applying an intersectional lens when supporting people with mental health issues who are experiencing so called 'honour'-based abuse (HBA). Dr Savin Bapir-Tardy (Counselling Psychologist in IKWRO[xvii]) explained in her podcast that mental ill health is often a taboo within communities where HBA occurs. This can lead to victim/survivors feeling they have to hide their mental ill health, which can increase risk and barriers to support. The taboo can be so great that victims are forced to leave their families and communities, as highlighted in Asha Iqbal's Spotlights blog:

xvii   IKWRO: Iranian & Kurdish Womens Rights

Unfortunately, severe mental health problems can sometimes be associated with either black magic or the 'Jinn'; supernatural and sometimes demonic beings. People brush severe mental health problems under the carpet so a lack of understanding and education about mental health creates further barriers.

Asha Iqbal, mental health campaigner and founder of Generation Reform

HBA is associated with many wider vulnerabilities and barriers (as explored in SafeLives Spotlight on HBV and Forced Marriage). It is vital that practitioners consider how these can intersect and impact on one's mental health.

SafeLives Insights data showed that a higher proportion of individuals with mental health needs had a disability (22% vs. 10% without). Mental health conditions can be classified as a disability in line with the Equality Act (2010) definition[xviii]. Not every person with mental health issues may feel the term 'disabled' is appropriate for them, and thus may not use this language. However, it is vital that structurally, mental health disabilities are framed as equally important and potentially as debilitating as physical health disabilities. SafeLives NSP highlighted the importance of accurately recording the number of disabled survivors and perpetrators being discussed at Marac. Yet SafeLives' previous Spotlights series on Disabled people found almost one in five Maracs (18%) are not recording disability referrals.

Substance misuse

Insights data revealed that survivors with mental health needs are much more likely to have substance misuse issues.

Survivors with mental health needs are more likey to have substance misuse issues

	Drug misuse (past 12 months)	Alcohol misuse (past 12 months)
Mental Health Needs	10%	14%
No Mental Health Needs	2%	4%

■ Mental Health Needs   ■ No Mental Health Needs

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xviii   Equality Act (2010) definition of a disability: "A physical or mental impairment that has a 'substantial' and 'long-term' adverse effect on your ability to carry out normal day-to-day activities".

Mental health and domestic abuse

A report by Agenda found women who had experienced extensive physical abuse or coercion from a partner were six times more likely to be dependent on drugs, compared to those with little experience of violence and abuse[119]. Although causal pathways are inconclusive, it is largely recognised that for many, substances are used as a coping mechanism following abuse and trauma[26,120]. In AVA's 'Jumping through hoops' report, one survivor explained how "when mental health treatment starts, it's easier to cope with addiction as you don't need to self-medicate" (p.5)[23]. Despite the well-documented comorbidity of mental ill health and substance misuse, many services are not equipped to support people presenting with both issues (typically known as 'dual diagnosis')[14,24]. This lack of support for dual diagnoses means too many people are being bounced between services, leading to a feeling of being "batted from pillar to post" (Sharpen, 2018, p.5)[23].

Increased risk of financial issues and homelessness

Insights data showed survivors with mental health needs are more likely to have financial difficulties; two thirds (66%) were either struggling to pay for essentials or could pay for essentials but with nothing left over, compared to 54% of those without mental health needs. AVA's 'Breaking Down the Barriers' report explained how cuts to public services and incomes have particularly affected certain groups of people, including lone mothers, BAMER women and those with disabilities[22]. Co-occurring mental health and financial difficulties can greatly increase the risk of homelessness. Louisa Steel (Housing First and Homelessness coordinator at STADV) explained in her Spotlights blog that without appropriate mental health support, survivors are more likely to self-medicate, become unable to work and manage benefits; in turn increasing their risk of eviction.

I developed very long term (still suffering) mental illnesses which significantly affect my day to day life. I am left with massive debts. I have lost my driving license due to the ill health which restricts my mobility. I cannot work at the moment due to my mental illnesses.

Survivor, Respondent to Psychological Violence survey

Inequalities for people with complex needs such as mental ill health are well-known; the Government Domestic Abuse Fund made specific provision for specialist services to appoint Complex Needs Workers within refuges[121]. It would be hugely valuable if this funding were to be extended to all refuges throughout the UK, as well as within community-based services for the many survivors for whom refuge is not appropriate.

Parenting

Women with mental ill health and other forms of multiple disadvantage are at greater risk of having their children removed. This can lead to internalised feelings of shame and guilt, in turn exacerbating mental health issues. In Dr Kylee Trevillion's podcast she explained that many mothers are concerned services will question their parenting capabilities if they disclose mental health problems. Similarly, SafeLives' National Scrutiny Panel (NSP) on Mental Health reported the tendency for women to hide mental health difficulties for fear of their children being removed[118]. AVA's 'Breaking Down the Barriers' report explained that this can result in women only coming to the attention of statutory services when they have reached crisis point[22]. NSP attendees also highlighted inconsistencies with how risk can be perceived in terms of parenting capability, with the mental ill health of a mother given a greater risk weighting than that of the abusive father. Professionals must consider how they can reduce such inconsistencies and barriers to disclosures of mental health.

Vulnerability to exploitation

Having mental health problems can create additional vulnerabilities which abusers may seek to exploit. For instance, threats of institutionalisation/ sectioning, withholding medication/treatments, threats to have children taken away, or to 'out' problems to friends, colleagues and family[27]. Abusers may also attempt to undermine the victim's credibility, aiming to misdirect professionals to view their presentation as symptomatic of a mental health condition rather than as an indicator of abuse.

> **We see that abusers may often tell people when they've got mental health problems that this is just all in your head and this isn't really happening and you're unwell. And so they [the victim] start to really question whether this is happening.**
>
> *Dr Kylee Trevillion, Women's Mental Health Department at Kings College*

Mental health issues can also increase vulnerability to wider exploitation and abuse from others. For example, SafeLives' National Scrutiny Panel noted the increase risk of 'cuckooing'; the targeting of vulnerable people whose homes are taken over for the purposes of drug use and other forms of criminal behaviour[118].

In AVA's 'Breaking Down the Barriers' report, they found that services are often failing to make connections between abuse and other forms of disadvantage[22]. It is vital that services work collaboratively, instead of in silos, in order to provide holistic support for all survivors - what SafeLives terms a whole person, whole picture approach[42]. Access to regular training from specialist organisations (such as AVA[122]) can help professionals understand and respond to survivors' multiple and intersecting needs. It is important to recognise that a certain need

- finding somewhere to live, stopping using substances, access to children, immigration status - can be more of an immediate concern over dealing with mental health problems or/and the abuse. Some people may not be ready or able to receive support until more their immediate concern/s have been addressed.

Complex needs amongst those perpetrating abuse

SafeLives' internal analysis of Drive data of high-harm perpetrators found having a mental health need was associated with higher additional needs - especially around employment, training and education – compared to service users without mental health needs[xix].

Drive service users with mental health needs were more likely to have additional needs

Additional need	Drive service user with mental health needs	Drive service user without mental health needs
Employment, training and education	75%	38%
Social and community	68%	63%
Purposeful activity	64%	42%
Self-identity	52%	15%
Children, family and parenting	43%	42%
Drug, alcohol and addiction	43%	25%
Housing	30%	10%
Physical health	23%	17%
Financial	16%	8%

■ Drive service user with mental health needs   ■ Drive service user without mental health needs

A study on Domestic Homicide Reviews found high levels of substance abuse and/or mental health issues amongst individuals committing domestic homicides[97]. However, research on the needs of people perpetrating abuse remains limited. By recognising and understanding the multiple needs of perpetrators, caseworkers can support their clients in creating the stability and space to take responsibility and address their abusive behaviours.

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xix   In 38 cases (of the 130) it was unknown whether the service user had a mental health need. These were excluded.

4. A range of trauma-informed services must be available for survivors - and for those perpetrating abuse where these are required as part of appropriate challenge and support.

What is a trauma-informed approach and why is it needed?

Despite the well documented link between gender-based violence, trauma and poor mental health, a recent report from Agenda concluded that "this link is rarely reflected in the support available to women with mental health problems – with trauma-informed services rare" (p.4)[28]. As discussed in Chapter 2, extreme distress is often treated simply as a symptom of mental illness, rather than as a coping mechanism in response to past or current traumas[7]. People with current or past experiences of domestic abuse need access to holistic, trauma-informed support[116].

A trauma-informed approach recognises how exposure to trauma can affect one's neurological[xx], biological, psychological and social development[123]. It is moving away from '*What is wrong with you?*' to considering '*What happened to you?*'[5]. It also takes into account wider intersectional issues such as racism, sexism, homophobia, ageism, and poverty[5]. A recurring theme within this Spotlight was the importance for all professionals working with survivors to be trained in trauma-informed approaches, as Jo Sharpen explained in her Spotlights blog:

> **Past experiences of trauma and complex needs can sometimes lead to conditioned behaviours, which serve as a psychological defence or coping strategy for women, but may feel very difficult to understand for an untrained worker.**

> *Jo Sharpen, Policy Manager, AVA*

Studies exploring the effectiveness of trauma-informed approaches have found reductions in mental ill health symptoms, improvements in coping skills, and reductions in restraint and seclusion in mental health services[124]. In AVA's 'Breaking Down the Barriers' report, survivors reported that services which understood and responded to their experiences of trauma were vital to their safety and recovery[22]. Trauma-informed approaches are also important when working with children and young people, as was explored in SafeLives' previous Spotlight on Young People.

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xx   NHS Lanarkshire released a useful animation which explains the impact of trauma on the brain (made by mediaco-op).

Adopting a trauma-informed approach will help professionals understand the impact mental health issues can have on one's ability to engage with a service. Jo Sharpen discussed how people with mental health problems can find attending appointments particularly overwhelming and frightening. Yet attendees at SafeLives' National Scrutiny Panel (NSP) reported instances of service users with mental health issues who missed appointments being too quickly labelled as 'failed to engage'[118]. This language places the responsibility solely upon the person to attend services as they are offered, rather than acknowledging that services may need to adapt their approach. Non-engagement needs to be viewed as a potential symptom of poor mental health, trauma and/or complex needs, instead of simply a refusal to access a service.

A gender-informed approach takes into account and responds to the lives and experiences of women[28]. For instance, some women may find it distressing to be supported by a male worker. Seeking to avoid triggers and re-traumatisation is a key principle of trauma-informed working. Gender-informed services need to be available for those who would prefer options such as self-selecting staff's gender and women-only spaces. The Women's Mental Health Taskforce have developed a set of principles intended to be used by providers, practitioners and commissioners to ensure women have access to trauma- and gender-informed support[28].

Access to a range of trauma-informed support options

Both accommodation-based and community-based services can and should adopt a trauma informed approach. In Donna Covey's blog she highlighted the 'Refuge for All' project, by Solace Women's Aid and AVA, which created Psychologically Informed Environments (PIE) within refuges. This led to many positive outcomes including fewer women being refused admission because of their mental health needs; falling from 6% to 0.06%[29]. In Amber Canham's Spotlight blog she discussed the positive impact of introducing a Mental Health Idva into a community-based service who was trained in using trauma-informed approaches:

> **We talk to service users about trauma; the short- and long-term impacts and the way adverse childhood experiences (ACEs) can feed into trauma. Once they have this understanding, they are then in a better position to process their own experiences.**

> *Amber Canham, Social worker and Idva*

Despite examples of good practice in trauma-informed approaches, Donna explained that unfortunately these are being overshadowed by cuts to such specialist services, a shift to generic provision, and an underfunded voluntary sector. Survivors with mental health needs will encounter many different services; it is essential that they all operate within a trauma-informed framework. Implementing trauma-informed approaches could help enable commissioners and health services meet

national policy recommendations[5]. For instance, 'The NHS Long Term Plan (2018)[125]' promises trauma-informed care, and many elements of trauma-informed support are included within the 'Five Year Forward View for Mental Health' in England[44], the 'Transforming Psychological Trauma' framework in Scotland[126], and in 'Public Health Wales' (2015) with their focus on Adverse Childhood Experiences (ACEs)[127].

Trauma-informed and trauma-responsive interventions for people perpetrating abuse.

Perpetration of domestic abuse has been linked with higher rates of past traumatic experiences. One study found that 77% of men who had perpetrated abuse had been exposed to previous traumas, with 62% reporting multiple traumatic exposures[128]. Research on Adverse Child Experience (ACEs) has found that traumatic childhood events are associated with increased likelihood of perpetration of abuse[129,130] and mental ill health[131]. Within the Drive cohort of high-harm perpetrators, of those that reported experiencing domestic abuse as a child, 63% had mental health needs, compared to 30% amongst those who did not report childhood domestic abuse.
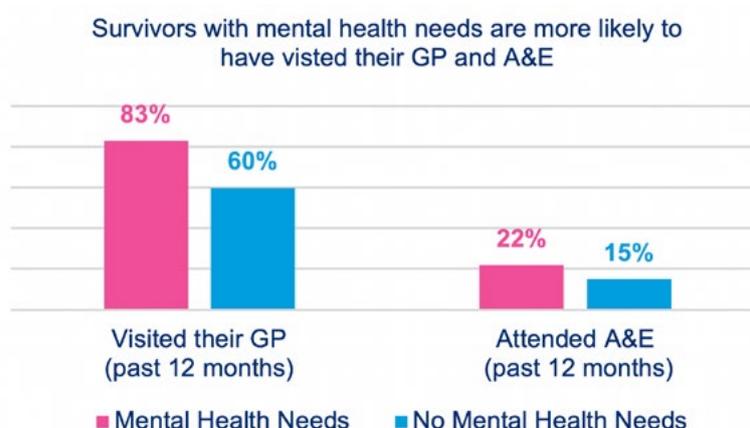
Traumatic experiences are never an excuse for perpetrating abuse. Nor will mental health support ever be the entirety of the response needed to stop someone's harmful behaviour. The majority of people who have been exposed to trauma never go on to cause harm. Instead, a trauma-informed approach for those perpetrating abuse means understanding how past traumas may impact on their behaviour and ability to engage in behaviour change work. Frontline staff working with perpetrators should receive training on the effects of trauma as part of a comprehensive approach to challenging and supporting someone to change. It is likely that some service users will experience barriers to engagement in one-size-fits-all programmes, due to their psychological or emotional difficulties. Services must then be trauma-responsive whereby they consider tailored, flexible interventions to reduce barriers to engagement. The Year 2 Evaluation of the Drive programme highlighted that reflecting on past traumas can help service users recognise the impact of their abusive behaviour on others[95]. The report acknowledged the risk of perpetrators developing a 'victim' mentality whereby they regard themselves as the primary victim. However, it concluded that discussing past traumas can help build trust with caseworkers; allowing them to take service users through more challenging behaviour-changing activities.

I have been able to develop an understanding of my emotions and how they are part of me but also how they impact upon those around me. I have to manage these emotions on an hourly/daily basis but by knowing what they are and working through the consequences of my actions I can make better choices for myself and the people around me.

Drive Service User

5. Inadequate progress by the UK Government and NHS leaders to drive integration of domestic abuse into the Health sector is prolonging the period in which victims have no support, and perpetrators are left free to continue unchallenged.

People experiencing domestic abuse frequently access health services before they reach specialist support[35], but this is particularly common amongst those with mental health issues, as SafeLives Insights data shows:

Survivors with mental health needs are more likely to have visted their GP and A&E

83% — 60% Visited their GP (past 12 months)

22% — 15% Attended A&E (past 12 months)

■ Mental Health Needs   ■ No Mental Health Needs

Insights data also revealed that survivors with mental health needs are visiting their GP *more frequently;* an average of **5.9 times** within the 12 months prior to accessing support, compared to 3.8 times for those without mental health needs, and 3.2 times for the general population within English GP practices[132]. Despite this, Insights data showed that only 5% of referrals to Idva services came from Health[70].

Many victims are frequently visiting their GP with mental health issues or/ and attending A&E for acute mental health episodes. The annual mental health cost alone of domestic abuse to Health services was estimated at £176 million in England and Wales in 2001[133]. However, this figure is likely to be an underestimate as information about the use of public services as a result of domestic abuse is not systemically collected. A Home Office report estimated the cost of the emotional and physical harm suffered by victims was £47 billion in England and Wales in 2016/17; accounting for 71% of the total estimated cost of domestic abuse (£66 billion)[30]. The majority of this £47 billion cost of harm was attributed to emotional harm, not physical. An effective Health response to domestic abuse and mental health is therefore not only fundamental for the safety and wellbeing

of victims and survivors, but also from a health cost perspective. The importance of the Health response to domestic abuse is recognised in NICE guidelines[33], however, implementation of these guidelines is inconsistent. Failures of the UK Government and NHS leaders to invest in integrating domestic abuse into the health sector is prolonging the period in which victims and survivors have no support, and those perpetrating abuse are left free to continue unchallenged.

Training GPs in identifying and responding to domestic abuse

Despite the frequency of victims attending their GP, many GPs receive little or no training in domestic abuse. This finding led to the development of the IRIS (Identification & Referral to Improve Safety) programme. IRIS offers training, education and support to GPs alongside enhanced referral pathways into specialist domestic abuse support[134]. It aims to increase the identification of abuse, improve the response to disclosures, and increase referrals to specialist services. An advocate educator within a local specialist domestic abuse service works with a local clinical lead to co-deliver the training programme. The advocate educator also provides advocacy to the referred victims. GP practices where IRIS was in operation recorded substantially more disclosures of abuse, and referrals to specialist services[135]. In her Spotlights blog, Medina Johnson (Chief Executive of IRISi) highlighted that 66% of the women referred through IRIS self-reported mental health issues. Following engagement with the programme, Medina explained there were significant improvements in their mental health: 83% felt better able to cope, 85% felt more confident and 81% felt optimistic about their future. The importance of GPs being trained to identify all forms of domestic abuse was highlighted by survivors in SafeLives' Every Story Matters survey[88]:

My GP should have spotted the signs ages ago. I even did a course of therapy for anxiety and that therapist definitely should have said something. I didn't know about things like coercive control and gas lighting. I thought abuse was only hitting. They should have known though. If it hadn't been for an extremely well informed (about abuse) receptionist at my GPs surgery, my children and I would still be living through that hell.

Survivor, Respondent to Every Story Matters survey

It is also essential that GPs understand the links between mental health issues and those who perpetrate abuse, and are trained to identify and respond appropriately with clear referral pathways into perpetrator interventions. All GP practices should be funded to have a domestic abuse training, support and referral programme (such as IRIS) to improve their identification of domestic abuse and increase referrals to specialist services. SafeLives also has online guidance for GPs on responding to domestic abuse. However, such guidance should be used alongside, not instead of, face-to-face training. To ensure coverage across England

and Wales, one domestic abuse specialist per 25 surgeries is needed – costing an estimated £24.75 million[68]. An academic study found this would produce net 'societal cost savings' of £37 per woman registered in general practices in the UK per year[34]. However, we must recognise that training and referral pathways on their own are unlikely to change practice; funding must also be available to resource specialist services so that GPs (and other professionals) are able to refer people onto appropriate support and interventions.

Embedding domestic abuse specialists within hospitals

GPs are only one part of the necessary Health response. Given those with mental health needs are more likely to attend A&E, an effective hospital response is also vital. SafeLives' Cry for Health report called for every hospital in England and Wales to have a full time specialist domestic abuse worker[35]. Compared to a control group of community-based Idvas, having hospital-based Idvas led to: more referrals to specialist support services, faster identification of vulnerable 'hidden' groups of victims, and quicker links with specialist services[35]. The report found that a higher proportion of the hospital-based victim population disclosed mental health needs (57%), compared to 35% of community-based victims. Furthermore, nearly twice as many hospital-based victims had self-harmed or planned/attempted suicide compared to those in community settings (43% compared to 23%). This high level of mental health needs within hospital settings was highlighted in the Spotlights blog by Linsey, a hospital Idva, who stated that within the first month of being a hospital Idva, 90% the people in her caseload had complex mental health issues.

High disclosures of mental health problems are likely in part due to the healthcare setting being seen as confidential and focused on wellbeing, rather than on criminal justice issues. Such volume of disclosures warrants the recruitment of hospital-based Idvas with knowledge and experience in mental health[35]. Hospitals are a prime place in which people choose to disclose abuse, but without someone to immediately pick up that referral, as a hospital-based Idva would do, Health professionals are limited in their response[35]. Based on 2012 data within the Cry for Health report[35], SafeLives estimated that two specialist domestic abuse workers based in every hospital in England and Wales would have an upfront cost of £15.7 million, but would generate a net saving of £16.4 million (a saving of £1,000 per patient) through decreased use of acute care[68].

Improving the domestic abuse response within Mental Health Trusts

A recurring theme in this Spotlight was the need for Mental Health Trusts to improve their approach to domestic abuse. Many Spotlight contributors discussed what a good response would look like, elements of which are outlined in Box 1. Trusts which have implemented such responses have seen positive outcomes. For instance, the PRIMH (Promoting recovery in mental health) project delivered by AVA led to significant increases in staff knowledge of enquiring and responding to domestic and sexual violence[14].

Given a significant proportion of victim/survivors and perpetrators will be accessing non-statutory mental health support, it is important that private therapists/counsellors and voluntary services consider how the recommendations (as outlined in Box 1) relate to their service provision. Mental health professional regulatory bodies and associations should ensure their guidelines for members reflect these good practices.

Box 1: Good practice overview within a Mental Health Trust

Key elements of a good response to domestic abuse within a Mental Health Trust, as discussed throughout this Spotlight series:

- **Clear policies and protocols for enquiring about and responding to abuse, both for victims and perpetrators.**

- **Developing close links with specialist services and multi-agencies, with clear protocols for information sharing between agencies.**

- **Training on domestic abuse e.g. from local domestic abuse services or/and specialist organisations such as AVA.**

- **Establishing clear referral pathways to support and interventions for victims, and for perpetrators.**

- **Coordinated commissioning pathways across agencies.**

- **Clear documentation of abusive experiences within case notes.**

- **Having a specific women's mental health strategy.**

- **Providing trauma- and gender-informed care.**

- **Operational and strategic level changes.**

- **Co-producing policies and practice with people with lived experience.**

- **Reducing the use of re-traumatising experiences within inpatient facilities*, such as physical restraint and seclusion.**

- **Promoting the message that domestic and sexual violence is 'core business' within the Trust.**

*For inpatient mental health facilities run by an NHS Hospital Trust, the Trust should apply the same good practices as outlined here.

Another essential role of mental health professionals is their attendance at multi-agency meetings such as Marac. SafeLives' National Scrutiny Panel (NSP) on mental health stressed the importance of active participation where information on mental health is shared in a meaningful and detailed way[118]. Panel members gave examples of where this was not always happening, such as vague case notes being read out verbatim without offering expert analysis and explanations. In her Spotlights blog, Alison Eley highlighted the important role of mental health practitioners in a Marac:

Mental health staff shouldn't feel intimidated or doubt their role, as they can have so much to contribute to the action planning. And most importantly, they can help ensure victims/survivors access services they may desperately need.

Alison Eley, Named Nurse for Safeguarding Children, Domestic Abuse and Marac lead

Attendees of SafeLives NSP reported on the risk dynamic of relationships where both parties have mental health difficulties. Wanting to access help for their partner's mental health can become a key driver for victims' disclosure. Marac (and other multi-agency) processes present an opportunity for professionals to action plan around both the victim's and perpetrator's mental health needs. SafeLives Marac toolkit for mental health services provides information and guidance for their role within a Marac[39].

Integrating domestic abuse and mental health support

Improvements are needed to ensure the mental health needs of victims and survivors are being met, and that those using abuse with mental health problems are identified and provided with appropriate referral to challenge and support them to change. There are often long waiting times for mental health support[136] and many mental health services - when eventually accessed - are not appropriate for people experiencing or perpetrating abuse (explored in Chapter 2). Furthermore, although domestic abuse services are often identifying mental health needs, they are not typically trained in providing psychological interventions (explored in Chapter 2). If given appropriate training, support and funding, domestic abuse services could be well placed to deliver or co-deliver psychological support. Recent research suggests this approach could lead to significant improvements for the mental health of survivors[32] (see Case study 1 in Box 2).

Whilst there is no expectation for domestic abuse workers to become experts in mental health, domestic abuse and mental health support must be delivered in a more integrated way. This should involve mental health training for domestic abuse workers, which could include: providing low intensity psychological interventions, training mental health practitioners in domestic abuse, and developing closer links and clear referral pathways between mental health and domestic abuse services. Examples of projects which

have successfully implemented these responses are outlined in Box 2. Models of training which create opportunities for frontline practitioners from both domestic abuse and mental health services to come together are recommended, as this will encourage services to discuss and learn how best to cooperate. As was explored in Chapter 4, it is important that training programmes are trauma-informed -such as AVA's courses on domestic abuse and mental health[137].

When developing interventions, we should be mindful that people have a right to be self-governing in terms of how their mental health needs are attended to. Rather than a service intervention happening to people, they should be educated to make informed choices about their direction of care. This was highlighted in the podcast with Collette:

> **Some of the key things she [the psychiatrist] said were about putting me in the driving seat of any care plans, about them listening to my concerns, what I wanted and what I needed and taking the lead from me. I just remember how respected and listened to I felt. And that's just everything we talk about in terms of being a good Idva; empowering and supportive.**

> *Collette, Senior Knowledge Hub Advisor, SafeLives*

When integrating mental health and domestic abuse support we must ensure we improve the response to those perpetrating abuse. The Year 2 Evaluation report of Drive suggests that accessing community mental health support at an earlier stage could reduce the likelihood of abuse being perpetrated in the future[95]. Within Drive's multi-agency support working, the most prevalent agency was mental health (20% of cases). Drive case managers work closely with mental health services, and aim to build therapeutic relationships with service users. This allows for better risk management and helps build a foundation for meaningful behaviour change work. Such work requires caseworkers to have an understanding of the presentation and risks associated with different mental health problems. Perpetrator programmes should therefore have a mental health specialist to consult on cases involving mental health issues and help deliver training, guidance and protocols surrounding mental health. Within multi-agency forums (such as Marac and MAPPA), it is vital that members are aware of local perpetrator provision and their links with mental health services. Caseworkers working with people perpetrating abuse should be sharing information on their mental health state within multi-agency meetings, ensuring a full picture of needs and risk for the whole family is presented.

Box 2: Projects improving the response between mental health and domestic abuse

Case study (1): Psychological Advocacy Towards Healing (PATH)[32]

This involved training domestic abuse advocates, supervised by a psychologist, to deliver mental health interventions. Results showed greater improvements in the mental health of women in the PATH intervention group compared to the control group (usual domestic abuse advocacy). Survivors involved in the study described benefits such as a better understanding of the impact of domestic abuse, increased self-confidence, and improved coping strategies.

Case study (2): Linking abuse and recovery through advocacy for Victims and Perpetrators (LARA-VP)

This involved reciprocal training between mental health and domestic abuse services, as well as introducing direct referral pathways to domestic violence support for psychiatric service users. The project led to improvements in mental health practitioners' knowledge, attitudes and behaviour surrounding domestic abuse, as well as improved outcomes for service users. Following its success, King College London released an online resource to help mental health services identify and respond to abuse.

Case study (3): LINKS pilot

This involved co-locating a Mental Health Idva within a Mental Health Trust. The Idva provided advocacy and training to mental health staff, as well as direct support to psychiatric patients who were victims of domestic abuse. The pilot ran for 12 months, during which there was a 660% increase in referrals to local specialist domestic abuse services from the Trust, and an increase in staff's understanding, knowledge and confidence surrounding domestic abuse.

Other projects

- The Big Lottery funded Mental Health Idva post within NDADA

- In Cambridgeshire and Peterborough, Idvas receiving a three-day Mental Health First Aid course, and the employment of 'Mental Health Pathfinders' (CPNs)

- The AVA and Solace Women's Aid Psychologically Informed Environments (PIEs) in refuges

- For Baby's Sake; practitioners work therapeutically with pregnant mothers and abusive fathers.

- WomansTrust; provides free therapy for female survivors of domestic abuse

Mental health support for children and young people experiencing domestic abuse

Due to the high thresholds and long waiting lists for CAMHS (as outlined in Chapter 2), many children and young people are left waiting whilst their mental health deteriorates; potentially resulting in a crisis, or voluntary organisations, including domestic abuse services, filling the gaps. This can place domestic abuse practitioners in the difficult position of managing levels of mental health problems that they are not appropriately trained or qualified for. It is evident that CAMHS need significant investment to meet the demand for services. This must include CAMHS practitioners being trained and supported to understand how domestic abuse impacts on the mental health of children and young people. It must not be assumed that CAMHS practitioners will understand coercive control, but this understanding is crucial for both working with the child and communicating with parents. We see potential for the commissioning of specially trained mental health Young People's Violence and Abuse Advisors (Ypvas) - who could offer interventions to children and young people with lower level mental health support needs; taking some pressure off CAMHS and reducing the trauma of children having to repeat their stories.

When developing domestic abuse training for CAMHS, the negative impacts of other adverse childhood experiences (ACEs) should be considered. Attendees of SafeLives National Scrutiny Panel aired concerns that ACEs can be poorly applied in a fatalistic way; resulting in children being limited to the low aspirations set for them[118]. However, we believe if used correctly - where ACEs assessments are linked to support and prevention - then the theory and data behind the ACEs approach could offer significant value. There is opportunity for colleagues in England, Scotland and Northern Ireland to learn from early progress in Wales.

The Health Pathfinder Project is a consortium of domestic abuse specialists working together to improve the response to domestic abuse in acute hospital trusts, mental health trusts and GP practices. Pathfinder aims to reduce inconsistencies in the health response to domestic abuse, improve awareness and understanding, and create best practice in supporting people experiencing domestic abuse. An effective joined-up response between health, domestic abuse and mental health services is undoubtedly vital for the safety and wellbeing for all victims and survivors with mental health difficulties. However, as Medina Johnson explained in her blog, they are only part of the puzzle. Many other services, organisations and wider society must also seek to improve their understanding and response to domestic abuse and mental health – as the next chapter will explore.

6. Greater awareness of the relationship between domestic abuse and mental health within all organisations and the public will help people get the support they need faster.

Domestic abuse and mental ill health are both stigmatised issues, making it particularly difficult for those affected by both to speak out about their experiences. We must improve our understanding and response to these strongly interrelated issues across the whole of society. The importance of a 'Whole Society' approach is a key element of SafeLives' The Whole Picture strategy to 'end domestic abuse, for everyone and for good'[42]. Many different agencies have a role to play in different ways, however there are some overarching recommendations which all should adopt. These include: increasing staff awareness of domestic abuse and mental health and how they intersect via training from specialists, creating clear referral pathways to services, and engaging with multi-agency meetings (such as Marac) where appropriate. The roles of some key agencies are outlined below, but the full extent of these are outside the scope of this report.

Police

The HMICFRS[xxi] report 'Picking up the Pieces' highlighted that the police are frequently supporting people with complex mental health issues[138]. Yet as most officers do not have the required skills, many people in mental health crisis are not getting the support they need. The report references that a large proportion of women with mental health problems are experiencing domestic abuse. Given the police are frequently responding to mental health crises amongst people experiencing or perpetrating domestic abuse, it is essential that they understand how the two issues intersect and are trained to respond appropriately – both to victims, and to those perpetrating the abuse.

Police officers need to be trained by experts in domestic abuse and mental health. Whilst we welcome the proposal within the government's draft Domestic Abuse Bill to roll out the 'Domestic Abuse (DA) Matters' police training programme[36], there needs to be sufficient funding to support all police forces across England and Wales, as has already been implemented in Scotland. We also welcome the recommendation within the 'Picking up the Pieces' report for police forces to invest in

xxi HMICFRS (Her Majesty's Inspectorate of Constabulary and Fire & Rescue Service)

high quality expert mental health training. Domestic abuse and mental health training programmes should ensure to reference how these two issues often intersect. The police should be at the frontline of responding to those perpetrating abuse. They should therefore understand the prevalence and presentation of mental health issues amongst perpetrators, as well as how abusers can sometimes exploit the mental ill health of victims (as explored in chapter 3).

Housing providers

As explored in SafeLives' Spotlight on Homelessness, housing providers play a vital role in responding to domestic abuse and their response must incorporate provisions for people with mental health difficulties. All survivors – but especially those with mental ill health and other complex needs – require more than just a 'roof over their heads', as Louisa Steele explained in her Spotlights blog:

A survivor of domestic abuse with mental health issues, struggling though trauma, stigma and fear might need someone to help them open their post if they are too scared to, to chase their care co-ordinator, to manage their housing benefit claim, and to be that positive relationship and source of emotional support that can make all the difference.

Louisa Steele, Housing First and Homelessness coordinator, Standing Together

Alternative housing arrangements for survivors with mental health issues are needed to ensure they have access to appropriate accommodation and support. An example of an innovative approach is the supported housing 'Shared Lives Plus' scheme. Following a thorough assessment and matching process, an individual moves into a carer's home, becoming part of their family and community[139]. Historically working with people with learning disabilities or mental health issues, the scheme has recently been developed in conjunction with SafeLives for survivors of domestic abuse[140].

Children's social care

Ofsted's annual report in 2016/17 stated domestic abuse was the most common factor in the lives of children in need of social care services[141]. Yet feedback from those working within the profession, and those working alongside, suggests there is a lack of quality training on domestic abuse and mental health. The importance of better domestic abuse training for children's social care was highlighted by many survivors in SafeLives' Every Story Matters survey[88]. A case analysis of domestic homicide reviews found women are often held accountable for safeguarding their children, whilst perpetrators remain invisible[142]. An environment which holds victims accountable for the harm they are

experiencing is unlikely to encourage social workers to consider mental health problems as symptomatic of abuse. Parental mental ill health must of course be appropriately assessed, but this should be alongside an analysis of how coercive control can create or exacerbate mental health issues. Not doing so creates a double disadvantage where both domestic abuse and mental ill health are viewed as detrimental to parental capacity. A parent experiencing abuse and mental health difficulties must be given the appropriate support and opportunities to demonstrate their capabilities. SafeLives is currently developing a pilot training programme for children's social workers on coercive control to ensure they are effectively identifying and responding to all types of domestic abuse. This will be a 'culture change programme', aiming to change the culture of children's social care teams from the strategic leads to frontline workers and safeguarding call handlers.

Adult social care

In SafeLives' National Scrutiny Panel (NSP) on mental health, attendees highlighted the responsibility Adult Social Care (ASC) have regarding safeguarding adults with mental ill health who are experiencing or perpetrating domestic abuse, but emphasised that in practice ASC are often absent from Maracs. Concerns were raised of ASC deferring to mental health or voluntary services to manage risk, yet these services may not recognise safeguarding issues or undertake necessary enquiries. The 'Adult Safeguarding and Domestic Abuse' guide (2015) recognises the association between domestic abuse and mental illness, but states clearer strategic and practice links are needed between agencies[143]. It is crucial that ASC are active partners in multi-agency processes (such as Marac), but more work is needed to ensure clarity of their role. The SafeLives ASC Marac toolkit provides information to support ASC representatives[144].

Education in schools

A significant proportion of children and young people in schools will be experiencing domestic abuse[145], with many developing mental health issues as a result (as explored in Chapter 1). Yet Ofsted's Joint Targeted Area Inspections (JTAI) report in 2017 found there was a variable response to domestic abuse within schools[146].

> **The only professionals I came into contact with were at school, but I don't think most of them realised what was going on, and none of them ever spoke to me about my home life.**
>
> *Shakti, survivor*

In SafeLives' Every Story Matters survey, when survivors were asked what they thought needed to happen to better protect and support children from domestic abuse, many highlighted the need for improved support and education within schools[88]. It is vital that a 'whole school'

approach is taken where all staff feel confident in spotting the signs of domestic abuse and respond appropriately. One example of improved referrals into schools is 'Operation Encompass'. This requires the police to inform a child's school about a domestic abuse incident before the school day starts the next day[147]. It aims to ensure a rapid response from schools around safeguarding and support. The Operation Encompass team is currently considering how best to ensure this is more than just a phone call; that the school is equipped to act appropriately on the information they receive.

Another critical part of a school's role is Relationships and Sex Education (RSE), due to be implemented in England as standard from September 2020. In SafeLives' Every Story Matters survey, when survivors were asked what they thought could help people understand domestic abuse, 'Education in schools' was highlighted by over half of respondents[88]. The government's current guidance on RSE states that 'children should know the concepts of, and laws relating to, sexual consent, sexual exploitation, abuse, grooming, coercion, and harassment'[148]. There is currently limited detail on exactly how this will be approached, but it is important that it contains information on the intersection of domestic abuse and other traumatic experiences with mental health problems. Although the levels of funding proposed to deliver RSE increased from 1 to 1.5 days of training for one teacher in every key stage, we are concerned this is still inadequate to deliver quality RSE.

Employers

All employers have a duty of care to support their staff. They should therefore have an understanding of the relationship between mental health and domestic abuse, and the potential impact on work performance[149]. Employers should have policies and processes in place to support staff experiencing domestic abuse, as well as an appropriate response to those perpetrating abuse. Although there has been some progress around mental health support within the workplace[xxii], the response to domestic abuse remains limited. Research estimates just 5% of UK organisations have a specific policy or guidelines on the issue[150]. In SafeLives' Every Story Matters survey survivors highlighted the importance of education and training within the workplace to help people understand domestic abuse[88], and some explained the positive impact of reaching out to their colleagues:

Someone I worked with had been in an abusive relationship in the past and saw what was happening and gave me advice and supported me and gave me the strength to eventually leave.

Survivor, Respondent to Every Story Matters survey

xxii   Mental health toolkits for employers such as: Business in the Community and Public Health's 'Mental Health toolkit for employers' and Mental Health Foundation's 'Managing Health in the Workplace'.
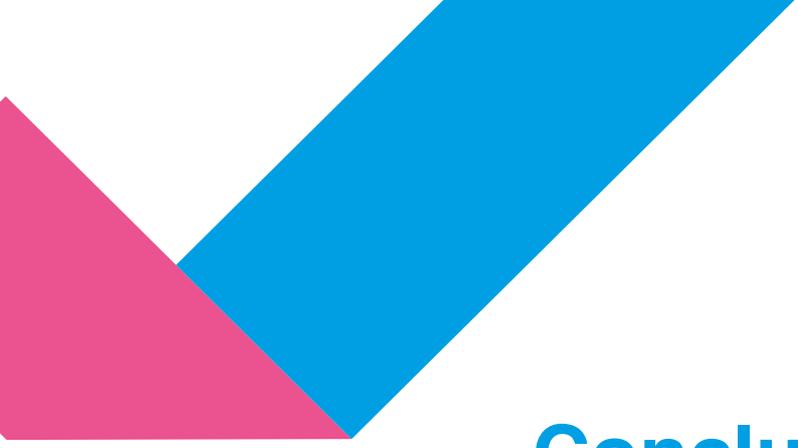
Mental health and domestic abuse

Public Health England (PHE) and Business in the Community (BitC) published an online toolkit in July 2018 to help employers support workers affected by domestic abuse[151]. The toolkit states that issues covered within their mental health toolkit are interrelated. SafeLives' online Employer's Guidance[152] also provides advice to employers on responding to domestic abuse[xxiii].

Whole society

It is time for domestic abuse to be recognised as a public health issue - both for mental and physical health - with strategies, policies and resources in place to tackle it across all services and organisations. Crucially, we need to help individuals recognise what abuse is and encourage them to access support at the earliest opportunity. Public awareness-raising campaigns are vital to highlight the interrelated issues of domestic abuse and mental ill health. In SafeLives' Every Story Matters survey many survivors highlighted the importance of public awareness and media campaigns to help people understand domestic abuse[88]. These should be co-created with child and adult survivors and focus on the need for attitude and behaviour change amongst those who use, or who are at risk of using abuse. Making it clear that the behaviour of those perpetrating abuse is not acceptable will help victims recognise abuse and seek out help.

Central to all campaigns must be elevating the voices of those with lived experience. We need to be mindful that those with the most severe and chronic mental health problems are often the least represented at the table. Opportunities must be created which allow people with a diverse range of experiences, issues and identities to speak out and help co-develop services and policies.

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xxiii   SafeLives' employers' guidance was developed in the context of the NHS for the Department of Health, however we feel the majority of the content is relatable to all employers.

Conclusion

Domestic abuse often has a severe and long-lasting impact on one's mental health - both for adults and children. Given that a significant proportion of people attending mental health services have had experience of domestic abuse, it is vital that mental health professionals are identifying abuse and responding appropriately. Mental health services (statutory, voluntary and private) must provide training on domestic abuse to ensure all practitioners are skilled and confident in their response to victim/survivors, and to those perpetrating abuse. This training should form part of a wider strategy within each Mental Health Trust which considers key drivers for mental ill health, including exploitative and abusive experiences. Mental health professional regulatory bodies and associations should also ensure their guidelines for members reflect good practice. All mental health services must start viewing domestic abuse as 'core business'.

Too often, mental health issues are a barrier to accessing services. Increased funding for specialist mental health support within domestic abuse services is vital to ensure people with mental health problems - including those with severe and complex needs - are being supported. The tendency for those with mental ill health to be 'bounced around' different services - frequently having to re-tell their traumatising story - must be reduced. For parents, fear of their children being removed can be a barrier to seeking support for mental health difficulties. And for some victims, fear of not being believed by professionals because of mental ill health can prevent them disclosing abuse. All professionals who come into contact with victims and survivors must ensure they are not doubting disclosures based on someone having a mental health condition.

Although the majority of people with mental health problems will never be abusive, research suggests having a mental health need is a risk factor. Understanding the mental health of those perpetrating abuse can help services develop more effective interventions and reduce barriers to engagement. Too often those perpetrating abuse are not getting an appropriate response. This is unacceptable. It is dangerous for people using abuse to be left without an effective intervention and free to continue causing harm unchallenged. Any mental health response must be provided as part of a carefully coordinated process of supporting and challenging someone to change.

We must recognise that survivors with mental health issues are at increased risk of multiple disadvantage. Perpetrators with mental health needs are also more likely to have higher additional needs. Access to regular training from specialist organisations (e.g. in substance misuse, HBV, LGBT+, and disability) must therefore be available to domestic abuse and mental health professionals. Having an awareness of people's interrelated issues and needs should form part of professionals providing trauma-informed care, which must also be reflected in the commissioning and funding of services.

Improving the health response to domestic abuse is fundamental to the safety and wellbeing of victims with mental health problems. Mental health and domestic abuse services - including those working with survivors and those perpetrating abuse - must work closely together with training and referral programmes between services being funded nationally. We must recognise the responsibility GPs and hospitals have in responding to domestic abuse. With many victims and perpetrators of abuse frequently visiting their GP with mental health issues, it is essential that GPs are aware of the relationship between abuse and mental health. This can be achieved by GPs being funded for training, support and referral pathway programmes on domestic abuse (such as IRIS). Furthermore, all hospitals should be funded to have full-time hospital-based Idvas/Idaas, ensuring someone with the necessary expertise is available to respond to those who disclose in hospitals - many of whom will have mental health needs. The NHS stands to save millions by investing in identifying and responding to domestic abuse sooner. It is in turn essential that funding is made available to resource specialist services so that health professionals can refer the whole family onto appropriate support and interventions.

Finally, we must raise awareness of the relationship between domestic abuse and mental health problems across the whole of the society. Organisations should ensure they have an appropriate response to these frequently interrelated issues – both to victim/survivors, and to those perpetrating abuse. The public narrative of what it means to be experiencing domestic abuse and mental ill health must reflect the stories of survivors with lived experience. We must therefore ensure opportunities are created for people with diverse identities and experiences - including those with a range of mental health problems - to tell their own stories. This will help highlight where improvements are needed, as well as encouraging others in similar situations to seek out support.

There's also a lot of stigma and shame that we might see across people with the experiences of domestic violence. But there is that potentially double discrimination of the concern that they, because of their mental health needs, they may not be believed in their narratives.

Dr Kylee Trevillion, Women's Mental Health Department at Kings College

Appendix: about the data

Insights

The method of data collection for Insights places a number of limitations on the conclusions we can draw from the data, as set out below. Care has been taken to use this data alongside other sources of information when producing the findings set out in this report.

Sample Size
The dataset used within this report represents 9,974 people entering services, 4,308 of whom were identified as having mental health needs. This was defined as caseworkers reporting them having mental health problems in the 12 months prior to accessing the service.

Cases
Insights data is collected from victim/survivors at the point at which they are accessing services. This means it is not representative of people who are not accessing services.

Data collection
Data collection is completed at two points on the client journey within a support service: intake and exit. Data is anonymous and only collected from people who consent to their data being used for monitoring and research purposes.

The Insights data used in this report is collected by 50 services using the SafeLives Insights tool during the reporting period (May 2016 to April 2017). This means that the nature (e.g. support offered) and location of services will not be representative of all domestic abuse services nationally.

Every Story Matters

Every Story Matters was an online survey carried out by SafeLives to gather survivors' views and experiences, in order to contribute to the government's consultation to improve the response to domestic abuse.

Sample and data collection
Survivors of domestic abuse anonymously completed the online survey between April to November 2018. The sample was self-selecting; it was open to the general public and distributed via SafeLives social media outlets. A total of 428 survivors responded. Not all survivors answered every question thus statistics used throughout this report are based on a maximum of 428 respondents.

Data analysis

The majority of the survey data used within this report are based on responses from open ended qualitative questions. Responses to these questions were analysed using content analysis which involves organising responses into themes and then quantifying them.

Psychological Violence study

The Psychological Violence study aimed to explore the nature and consequences of psychological violence through survivor surveys, interviews, focus groups and practitioner surveys. All data included in this report came from the survivor survey - details of which are outlined below.

Sample and data collection

Survivors of intimate partner violence (IPV) anonymously completed the online survey between April to May 2018. The sample was self-selecting; it was open to the general public and distributed via SafeLives social media outlets. A total of 371 survivors responded. Not all survivors answered every question so statistics used throughout this report are based on a *maximum* of 371 respondents.

Data analysis

The survey included a mixture of quantitative and open ended qualitative questions. All statistics used within this report come from quantitative questions, and all survivor quotes from open ended questions.

Interpretation of results

For the purpose of this study 'Psychological Violence' was specified to refer to all non-physical violence. Results involving the impact to the survivor cannot therefore distinguish what form, or combination, of violence has had the effect.

Endnotes

1   Strickland, P., & Allen, G. (2018). House of Commons Library. Domestic Violence in England and Wales. Retrieved from http://researchbriefings.files.parliament.uk/documents/SN06337/SN06337.pdf

2   Scottish Government. (2018). Domestic abuse in Scotland: 2017 - 2018 statistics. Retrieved from https://www.gov.scot/publications/domestic-abuse-recorded-police-scotland-2017-18/

3   Northern Ireland Government. (2016). Stopping Domestic and Sexual Violence and Abuse in Northern Ireland. A Seven Year Strategy. Retrieved from https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/stopping-domestic-sexual-violence-ni.pdf

4   Common mental health problems. (2011). Retrieved from https://www.nice.org.uk/guidance/cg123/ifp/chapter/common-mental-health-problems

5   Sweeney, A., Filson, B., Kennedy, A., Collinson, L., & Gillard, S. (2018). A paradigm shift: Relationships in trauma-informed mental health services. BJPsych Advances, 24: 319–333. DOI:10.1192/bja.2018.29.

6   Menschner, C., & Maul, A. (2016). Key Ingredients for Successful Trauma-Informed Care Implementation. Issue Brief. Princeton, NJ: Robert Wood Johnson Foundation, Center for Health Care Strategies. Retrieved from http://www.chcs.org/media/ATC_whitepaper_040616.pdf

7   Sweeney, A., Filson, B., Kennedy, A., Collinson, L., & Gillard, S. (2018). A paradigm shift: relationships in trauma-informed mental health services. BJPsych advances, 24(5), 319–333. DOI:10.1192/bja.2018.29

8   Oram, S., Khalifeh, H., & Howard, L.M. (2016). Violence against women and mental health. The Lancet Psychiatry, 4 (2): 159-170. https://DOI.org/10.1016/S2215-0366(16)30261-9

9   Devries, K.M., Mak, J.Y., Bacchus, L.J., Child, J.C., Falder, G., Petzold, M., & Watts, C.H. (2013). Intimate partner violence and incident depressive symptoms and suicide attempts: A systematic review of longitudinal studies. PLoS Med 10(5): e1001439. DOI:10.1371/journal.pmed.1001439

10   Howard, L.M., Trevillion, K., Khalifeh, H., Woodall, A., Agnew-Davies, R., & Feder, G. (2010). Domestic violence and severe psychiatric disorders: prevalence and interventions. Psychol Med; 40(6): 881–93. DOI: 10.1017/S0033291709991589.

11   Khalifeh, H., Moran, P., Borschmann, R., Dean, K., Hart, C., Hogg, J., Osborn, D., Johnson, S., & Howard, L. M. (2014). Domestic and sexual violence against patients with severe mental illness. Psychological medicine, 45(4): 875-86. DOI: 10.1017/S0033291714001962.

12   Howard, L.M., Trevillion, K., & Agnew-Davies, R. (2010). Domestic violence and mental health. International Review of Psychiatry; 22(5): 525-34. DOI: 10.3109/09540261.2010.512283.

13   Trevillion, K., Corker, E., Capron, L.E. & Oram S. (2016). Improving mental health service responses to domestic violence and abuse. International Review of Psychiatry, 28 (5): 423-432. DOI: 10.1080/09540261.2016.1201053.

14   Oram, S., Capron, L., & Trevillion, K. (2016). Promoting Recovery in Mental Health: Final Evaluation Report. London: King's College London. Retrieved from https://avaproject.org.uk/wp/wp-content/uploads/2017/01/PRIMH-Evaluation-Full-Report-1.pdf.

15   Rose, D., Trevillion, K., Woodall, A., Morgan, C., Feder, G., & Howard, L. (2011). Barriers and facilitators of disclosures of domestic violence by mental health service users: Qualitative study. British Journal of Psychiatry, 198(3): 189-194. DOI:10.1192/bjp.bp.109.072389f

16   Van Dorn, R., Volavka, J., & Johnson, N. (2012). Mental disorder and violence: is there a relationship beyond substance use? Social Psychiatry & Psychiatric Epidemiology, 47: 487–503. DOI: 10.1007/s00127-011-0356-x

17   Reingle, J. M., Jennings, W. G., Connell, N., M., Businelle, M. S., & Chartier K. (2014). On the pervasiveness of event-specific alcohol use, general substance use, and mental health problems as risk factors for intimate partner violence. Journal of Interpersonal Violence, 29(16):2951–2970. DOI: 10.1177/0886260514527172

18   Breet, E., Seedat, S., & Kagee, A. (2016). Posttraumatic Stress Disorder and Depression in Men and Women Who Perpetrate Intimate Partner Violence. Journal of Interpersonal Violence, 34(10), 2181-2198. Retrieved from https://DOI.org/10.1177/0886260516660297

19   Fowler, J. (2018). The impact of mental health on the response to perpetrators of domestic abuse. Retrieved from http://www.safelives.org.uk/practice_blog/mental_health_of_perpetrators

20   Rhodes, K. V., Houry, D., Cerulli, C., Straus, H., Kaslow, N. J., & McNutt, L. A. (2009). Intimate partner violence and comorbid mental health conditions among urban male patients. Annals of family medicine, 7(1), 47-55. DOI: 10.1370/afm.936

21   Cummins, I. (2018). The Impact of Austerity on Mental Health Service Provision: A UK Perspective. International journal of environmental research and public health, 15(6), 1145. DOI:10.3390/ijerph15061145

22   AVA. (2019). Breaking Down the Barriers. Retrieved from https://avaproject.org.uk/wp/wp-content/uploads/2019/02/Breaking-down-the-Barriers-full-report-.pdf

23   Sharpen, J. (2018). Jumping through hoops: How are coordinated responses to multiple disadvantage meeting the needs of women? Retrieved from https://avaproject.org.uk/wp/wp-content/uploads/2018/09/Jumping-Through-Hoops_report_FINAL_SINGLE-PAGES.pdf

24   Hughes, L. (2015). The NHS is failing people with mental health and substance use problems. Retrieved from https://www.theguardian.com/healthcare-network/2015/dec/09/substance-use-mental-health-nhs-failing

25   Harris, K. M., & Edlund, M. J. (2005). Self-medication of mental health problems: new evidence from a national survey. Health services research, 40(1), 117-34. DOI: 10.1111/j.1475-6773.2005.00345.x

26   Humphreys, C., Regan, L., River, D., & Thiara, R. (2005). Domestic Violence and Substance Use: Tackling Complexity. The British Journal of Social Work, 35(8), 1303-1320. Retrieved from http://www.jstor.org/stable/23720558

27   Bashall, R. (2016). Recognising and supporting disabled victims of domestic abuse. Retrieved from http://safelives.org.uk/practice_blog/recognising-and-supporting-disabled-victims-domestic-abuse

28   The Women's Mental Health Taskforce. (2018). Agenda & The Department of Health & Social care. Retrieved from https://weareagenda.org/wp-content/uploads/2018/12/The_Womens_Mental_Health_Taskforce_-_final_report1.pdf

29   AVA & Solace Women's Aid. (2017). Peace of Mind: An Evaluation of the Refuge Access for All Project. Retrieved from https://avaproject.org.uk/wp/wp-content/uploads/2017/11/Peace-of-Mind-Evaluation-for-Refuge-Acess-for-All-Project-1.pdf

30   Oliver, R., Alexander, B., Roe, S., & Wlasny, M. (2019). The economic and social costs of domestic abuse. Home Office. Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/772180/horr107.pdf

31   University of Bristol. REPROVIDE. Retrieved from http://www.bristol.ac.uk/primaryhealthcare/researchthemes/reprovide/

32   Ferrari, G., Feder, G., Agnew-Davies, R., Bailey, J. E., Hollinghurst, S., Howard, L., Howarth, E., Sardinha, L., Sharp, D., & Peters, T. J. (2018). Psychological advocacy towards healing (PATH): A randomized controlled trial of a psychological intervention in a domestic violence service setting. PloS one, 13(11), e0205485. DOI:10.1371/journal.pone.0205485

33   Domestic violence and abuse. (2016). https://www.nice.org.uk/guidance/qs116

34   Devine, A., Spencer, A., Eldridge, S., Norman, R. & Feder, G. (2012). Cost-effectiveness of Identification and Referral to Improve Safety (IRIS), a domestic violence training and support programme for primary care: a modelling study based on a randomised controlled trial. BMJ Open;2:e001008. DOI: 10.1136/bmjopen-2012-001008.

35   SafeLives. (2016). A Cry for Health: Why we must invest in domestic abuse services in hospitals. Retrieved from http://www.safelives.org.uk/sites/default/files/resources/SAFJ4993_Themis_report_WEBcorrect.pdf

36   HM Government. (2019). Transforming the Response to Domestic Abuse: Consultation Response and Draft Bill. Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/772202/CCS1218158068-Web_Accessible.pdf

37   SafeLives. (2019). Frontline practice briefing: mental health. Retrieved from http://safelives.org.uk/sites/default/files/resources/Practice%20briefing%20-%20mental%20health.pdf

38   LARA-VP Manual. Retrieved from https://www.kcl.ac.uk/ioppn/depts/hspr/research/ceph/wmh/lara-vp-download-form

39   SafeLives. (2015). Marac toolkit for mental health. Retrieved from http://www.safelives.org.uk/node/548

40   SafeLives. Domestic abuse training for employers. Retrieved from http://www.safelives.org.uk/knowledge-hub/resources-employers/training

41   Business in the community. (2018). Domestic abuse: a toolkit for employers. Retrieved from https://www.bitc.org.uk/sites/default/files/bitc_phe_domestic_abuse_toolkit.pdf

42   SafeLives. (2018). The Whole Picture. Our strategy to end domestic abuse, for good. Retrieved from http://www.safelives.org.uk/sites/default/files/resources/The%20Whole%20Picture%20-%20SafeLives%27%20Strategy.pdf

43   Trevillion, K., Howard, L.M., Morgan, C., Feder, G., Woodall, A., & Rose, D. (2012). The response of mental health services to domestic violence: a qualitative study of service users' and professionals experiences. Journal of the American Psychiatric Nurses Association, 18: 326–336. DOI: 10.1177/1078390312459747.

44   NHS England. (2016). The five year forward view for mental health. Retrieved from https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

45   Parkin, E. (2018). Mental health policy in England. House of Commons Library. Retrieved from http://researchbriefings.files.parliament.uk/documents/CBP-7547/CBP-7547.pdf

46   NHS. (2017). Five year forward view for mental health: one year on. Retrieved from https://www.england.nhs.uk/wp-content/uploads/2017/03/fyfv-mh-one-year-on.pdf

47   Health Education England. (2017). Stepping forward to 2020/21: The mental health workforce plan for England. Retrieved from https://www.hee.nhs.uk/sites/default/files/documents/Stepping%20forward%20to%20202021%20-%20The%20mental%20health%20workforce%20plan%20for%20england.pdf

48   The Care Quality Commission. (2017). The state of care in mental health services 2014 to 2017. Retrieved from https://www.cqc.org.uk/sites/default/files/20170720_stateofmh_report.pdf

49   Agenda. (2018). Women in Crisis: How women and girls are being failed by the Mental Health Act. Retrieved from https://weareagenda.org/wp-content/uploads/2018/08/Women-in-Crisis-Agenda-report-.pdf

50   Department of Health and Social Care. (2018). Modernising the Mental Health Act – final report from the independent review. Retrieved from https://www.gov.uk/government/publications/modernising-the-mental-health-act-final-report-from-the-independent-review

51   Mental Health Units (Use of Force) Act 2018. Retrieved from http://www.legislation.gov.uk/ukpga/2018/27/contents/enacted/data.htm

52   Farmer, P. (2018). Mental Health Act review recommendations published. Retrieved from https://www.mind.org.uk/news-campaigns/news/mental-health-act-review-recommendations-published/#.XBqAt2j7TIU

53   Scottish Government. (2012). Retrieved from https://www.gov.scot/publications/mental-health-strategy-scotland-2012-2015/

54   Scottish Government. Mental Health (Scotland) Act 2015 - Key provisions. Retrieved from https://www2.gov.scot/Topics/Health/Services/Mental-Health/Law/2015Act-provisions

55   Scottish Government, Mental Health Foundation, Voices of Experience (VOX), & Healthcare Improvement Scotland. (2016). A Review of Mental Health Services in Scotland: Perspectives and Experiences of Service Users, Carers and Professionals Retrieved from https://www.mentalhealth.org.uk/publications/review-mental-health-services-scotland

56   Scottish Government. (2017). Mental Health Strategy: 2017-2027. Retrieved from https://www.gov.scot/publications/mental-health-strategy-2017-2027/

57   Scottish Government. (2018). Suicide prevention action plan: every life matters. Retrieved from https://www.gov.scot/publications/scotlands-suicide-prevention-action-plan-life-matters/

58   Welsh Assembly Government. (2011). Mental Health (Wales) Measure 2010. Implementing the Mental Health (Wales) Measure 2010. Guidance for Local Health Boards and Local Authorities. Retrieved from http://www.mentalhealthlaw.co.uk/media/Implementing_the_Mental_Health_(Wales)_Measure_2010.pdf

59   Welsh Government. (2012). Together for Mental Health. A Strategy for Mental Health and Wellbeing in Wales. Retrieved from https://gov.wales/together-mental-health-our-mental-health-strategy

60   Welsh Government. (2016). Together for Mental Health. Delivery Plan 2016-19. Retrieved from https://gweddill.gov.wales/docs/dhss/publications/161026easy-read-delivery-planen.pdf

61   Welsh Government. (2016). The National Training Framework on violence against women, domestic abuse and sexual violence: Statutory guidance under section 15 of the Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015 and section 60 of the Government of Wales Act 2006. Retrieved from http://www.assembly.wales/laid%20documents/sub-ld10514/sub-ld10514-e.pdf

62   Healthcare Inspectorate Wales. (2018). Joint HIW & CIW National Review of Adult Community Mental Health Services: Inspection visit to (announced): The Links Community Mental Health Team (CMHT), Cardiff and Vale University Health Board/Cardiff Council. Retrieved from http://hiw.org.uk/docs/hiw/inspectionreports/180329thelinksen.pdf

63   Welsh Government. (2018). Together for Mental Health. Delivery Plan 2016-19. Progress Report: October 2016-March 2018. Retrieved from https://gweddill.gov.wales/docs/dhss/publications/180627mentalhealth-progressen.pdf

64   Northern Ireland, Department of Health. Bamford Review of Mental Health and Learning Disability. Retrieved from https://www.health-ni.gov.uk/articles/bamford-review-mental-health-and-learning-disability

65   The Department of Health, Social Services and Public Safety. (2014). Retrieved from https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/delivering-bamford-vision-action-plan.pdf

66   Northern Ireland, Department of Health. (2016). Health and Wellbeing 2026 - Delivering Together. Retrieved from https://www.health-ni.gov.uk/publications/health-and-wellbeing-2026-delivering-together

67   Northern Ireland, Department of Health. (2016). Protect Life 2: a draft strategy for suicide prevention in the north of Ireland. Retrieved from https://www.health-ni.gov.uk/sites/default/files/consultations/health/protect-life-2-consultation.pdf

68   SafeLives. (2019). Our Alternative White Paper on Domestic Abuse. Retrieved from http://safelives.org.uk/sites/default/files/resources/Our%20Alternative%20White%20Paper%20on%20Domestic%20Abuse.pdf

69   Trevillion, K., Oram, S., Feder, G., & Howard, L.M. (2012). Experiences of domestic violence and mental disorders: a systematic review and meta-analysis. PloS one; 7(12): e51740. DOI: 10.1371/journal.pone.0051740

70   SafeLives. (2018). Insights Idva England and Wales dataset 2017-18 Adult independent domestic violence advisor (Idva) Services Retrieved from http://www.safelives.org.uk/sites/default/files/resources/Insights%20Idva%20national%20dataset%2012%20months%20to%20April%202018.pdf.

71   Humphreys, C., & Thiara, R. (2003). Mental health and domestic violence: "I call it symptoms of abuse." The British Journal of Social Work, 33 (2): 209–226. Retrieved from https://DOI.org/10.1093/bjsw/33.2.209

72   NatCen Social Research, DMSS Research, & the Child and Women Abuse Studies Unit at London Metropolitan University. (2015). Violence, abuse and mental health in England. Population patterns. Responding effectively to violence and abuse (REVA project) Briefing 1. Retrieved from https://www.dmss.co.uk/pdfs/REVA-Brief1-Population-patterns-FINAL-071015.pdf

73   Khalifeh, H., Oram, S., Osborn, D., Howard, L. M., & Johnson, S. (2016). Recent physical and sexual violence against adults with severe mental illness: a systematic review and meta-analysis. International review of psychiatry, 28(5), 433-451. DOI: 10.1080/09540261.2016.1223608

74   Martín-Baena, D., Mayoral, O., Talavera, M., & Montero, I. (2018). The link between violence and suicidal behaviour among female university students in Spain. Journal of School Violence, 1-10. DOI: 10.1080/15388220.2018.1453823

75   Shevlin, M., Houston, J. E., Dorahy, M. J., & Adamson, G. (2007). Cumulative traumas and psychosis: an analysis of the national comorbidity survey and the British Psychiatric Morbidity Survey. Schizophrenia bulletin, 34(1), 193-9. DOI: 10.1093/schbul/sbm069

76   Margolin, G., Vickerman, K.A., Oliver, P.H., & Gordis, E.B. (2010). Violence exposure in multiple interpersonal domains: cumulative and differential effects. J Adolesc Health.;47(2):198–205. doi:10.1016/j.jadohealth.2010.01.020

77   Simmons, J., Wijma, B., & Swahnberg, K. (2015). Lifetime co-occurrence of violence victimisation and symptoms of psychological ill health: a cross-sectional study of Swedish male and female clinical and population samples. BMC public health, 15(1), 979. DOI: 10.1186/s12889-015-2311-3.

78   Messman-Moore, T.L., Long, P.J., & Siegfried, N.J. (2000). The revictimization of child sexual abuse survivors: an examination of the adjustment of college women with child sexual abuse, adult sexual assault, and adult physical abuse. Child Maltreat, 5(1):18–27.

79   Romito, P., & Grass, M. (2007). Does violence affect one gender more than the other? The mental health impact of violence among male and female university students. Soc Sci Med, 65(6):1222–34. doi:10.1016/j.socscimed.2007.05.017

80   Começanha, R., Basto-Pereira, M., & Maia, A. (2017). Clinically speaking, psychological abuse matters. Comprehensive psychiatry, 73, 120-126. https://DOI.org/10.1016/j.comppsych.2016.11.015

81   Lövestad, S., Löve, J., Vaez, M., & Krantz, G. (2017). Prevalence of intimate partner violence and its association with symptoms of depression; a cross-sectional study based on a female population sample in Sweden. BMC public health, 17(1), 335. DOI: 10.1186/s12889-017-4222-y.

82   Pico-Alfonso, M.A., Garcia-Linares, M.I., Celda-Navarro, N., Blasco-Ros, C., Echeburúa, E., & Martinez, M. The impact of physical, psychological, and sexual intimate male partner violence on women's mental health: depressive symptoms, posttraumatic stress disorder, state anxiety, and suicide. J Womens Health. 2006; 5: 599–611. DOI: 10.1089/jwh.2006.15.599

  Callaghan, J. E. M., Alexander, J. H., Sixsmith, J., & Fellin, L. C. (2018). Beyond "Witnessing": Children's Experiences of Coercive Control in Domestic Violence and Abuse. Journal of Interpersonal Violence, 33(10), 1551–1581. https://DOI.org/10.1177/0886260515618946

83   Callaghan, J. E. M., Alexander, J. H., Sixsmith, J., & Fellin, L. C. (2018). Beyond "Witnessing": Children's Experiences of Coercive Control in Domestic Violence and Abuse. Journal of Interpersonal Violence, 33(10), 1551–1581. https://DOI.org/10.1177/0886260515618946

84   Brandon, M., & Lewis, A. (1996). Significant harm and children's experiences of domestic violence. Child and Family Social Work, 1, 33–42. DOI:10.1111/j.1365-2206.1996.tb00005.x

85   Meltzer, H., Doos, L., Vostanis, P., Ford, T., & Goodman, R. (2009). The mental health of children who witness domestic violence. Child & Family Social Work, 14, 491-501. DOI:10.1111/j.1365-2206.2009.00633.

86   Fantuzzo, J. W. & Mohr, W.K. (1999). Prevalence and Effects of Child Exposure to Domestic Violence. The Future of Children, 9 (3), 21-32. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/10777998

87   Safelives. (2018). Children's Insights England and Wales dataset 2015-18 Specialist children's domestic abuse services. Retrieved from http://www.safelives.org.uk/sites/default/files/resources/Children%27s%20Insights%20national%20dataset%2036%20months%20to%20April%202018.pdf

88   SafeLives. (2018). Every Story Matters survey. (data unpublished)

89   Osofsky, J. (1999). The Impact of Violence on Children. The Future of Children, 9(3), 33-49. DOI:10.2307/1602780

90   Hester, M., Ferrari, G., Jones, S., Williamson, E., Bacchus, L., Peters,. T., & Feder, G. (2015) Occurrence and impact of negative behaviour, including domestic violence and abuse, in men attending UK primary care health clinics: a cross-sectional survey. BMJ Open 5:e007141. DOI: 10.1136/bmjopen-2014-007141

91   Oriel, K. A., & Fleming, M. F. (1998). Screening men for partner violence in a primary care setting: a new strategy for detecting domestic violence. J Fam Pract, 46(6): 493–8. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/9638114

92   Shorey, R. C., Febres, J., Brasfield, H., & Stuart, G. L. (2012). The prevalence of mental health problems in men arrested for domestic violence, Journal of Family Violence, 27(8), 741-748. DOI: 10.1007/s10896-012-9463-z

93   Askeland, I. R., & Heir, T. (2014). Psychiatric disorders among men voluntarily in treatment for violent behaviour: a cross-sectional study, BMJOpen, 4(4), e004485. Retrieved from http://dx.DOI.org/10.1136/bmjopen-2013-004485

94   Okuda, M., Olfson, M., Wang, S., Rubio, J. M., Xu, Y., & Blanco, C. (2015). Correlates of intimate partner violence perpetration: Results from a National Epidemiologic Survey, Journal of Traumatic Stress, 28(1), 49-56. DOI: 10.1002/jts.21986.

95   Hester, M., Eisenstadt, N., Jones, C., Magnus., L., Morgan, K., & Bates, L. (2019). Evaluation of Year 2 of the Drive Project – A Pilot to Address High Risk Perpetrators of Domestic Abuse. Retrieved from http://driveproject.org.uk/wp-content/uploads/2019/01/Drive-Year-2-UoB-Evaluation-Report.pdf

96   McManus, S., Bebbington, P., Jenkins, R., & Brugha, T. (eds.) (2016). Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014. Leeds: NHS Digital. Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/556596/apms-2014-full-rpt.pdf

97   Bridger, E., Strang, H., Parkinson, J., & Sherman, L. W. (2017). Intimate Partner Homicide in England and Wales 2011-2013: Pathways to Prediction from Multi-agency Domestic Homicide Reviews, Cambridge Journal of Evidence-Based Policing, 1(2-3), 93-104. Retrieved from https://DOI.org/10.1007/s41887-017-0013-z

98   Dawson, M., & Piscitelli, A. (2017). Risk factors in domestic homicides: Identifying common clusters in the Canadian context. Journal of interpersonal violence. 1-12. DOI: 10.1177/0886260517729404

99   Oram, S., Flynn, S. M., Shaw, J., Appleby, L., & Howard, L. M. (2013). Mental illness and domestic homicide: a population-based descriptive study, Psychiatric Services (Washington, D. C.), 64(10), 1006-1011. DOI: 10.1176/appi.ps.201200484.

100   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; 22(6): 536-43. DOI: 10.3109/09638237.2013.841871.

101   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; 26(4): 430-44. DOI: 10.3109/09540261.2014.924095.

102   Bacchus, L.J., Bewley, S., Torres Vitolas, C., Aston, G., Jordan, P., & Murray, S.F. (2010). Evaluation of a domestic violence intervention in the maternity and sexual health services of a UK hospital. Reproductive Health Matters, 18, 147–157. DOI: 10.1016/S0968-8080(10)36526-8.

103   World Health Organization. (2013). Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines. Geneva: World Health Organization. Retrieved from https://www.who.int/reproductivehealth/publications/violence/9789241548595/en/

104   Living with Borderline Personality Disorder. The experience of people with the diagnosis, families and services in Scotland. (2018). The Mental Welfare Commission for Scotland. Retrieved from https://www.mwcscot.org.uk/media/431592/bpd_report_final.pdf

105   Aviram, R.B., Brodsky, B.S., & Stanley, B. (2006). Borderline personality disorder, stigma, and treatment implications. Harv Rev Psychiatry; 14(5):249–56. DOI: 10.1080/10673220600975121

106   MIND. (2017). What is complex PTSD? Retrieved from https://www.mind.org.uk/information-support/types-of-mental-health-problems/post-traumatic-stress-disorder-ptsd/complex-ptsd/#.XJtYMFX7SUk

107   Frueh, B.C., Knapp, R.G., Cusack, K.J, Grubaugh, A.L, Sauvageot, J.A, Cousins, V.C., Yim, E., Robins, C.S., Monnier, J., & Hiers, T.G. (2005). Patients' reports of traumatic or harmful experiences within the psychiatric setting. Psychiatr Serv. 56(9):1123-1133. DOI:10.1176/appi.ps.56.9.1123

108   Cusack, P., Cusack, F.P., McAndrews, S., McKeown, M., & Duxbury, J. (2018). An integrative review exploring the physical and psychological harm inherent in using restraint in mental health inpatient settings. International Journal of Mental Health Nursing, 27: 1162–76. DOI: 10.1111/inm.12432.

109   Örmon, K., Hörberg, U. (2017). The unnecessary suffering and abuse caused by healthcare professionals needs to stop: a study regarding experiences of abuse among female patients in a general psychiatric setting. Clinical Nursing Studies, 5: 59–64. DOI: 10.5430/cns.v5n4p59

110   Agenda. (2017). Agenda briefing on the use of restraint against women and girls. Retrieved from https://weareagenda.org/wp-content/uploads/2017/03/Restraint-FOI-research-briefing-FINAL1.pdf

111   Agenda. (2018). 32 women die after being restrained – new Agenda research. Retrieved from https://weareagenda.org/32-women-die-after-being-restrained-new-agenda-research/

112   Agenda. (2018). Bill to reduce restraint becomes law – thank you. Retrieved from https://weareagenda.org/bill-to-reduce-restraint-becomes-law/

113   Agenda. (2016). Agenda mental health gender responsiveness briefing. Retrieved from https://weareagenda.org/wp-content/uploads/2016/11/Mental-health-briefing-FINAL.pdf

114   Crenna-Jennings, W., & Hutchinson, J. (2018). Access to children and young people's mental health services – 2018. Retrieved from https://epi.org.uk/wp-content/uploads/2018/10/EPI_Access-to-CAMHS-2018.pdf

115   Child mental health: Camhs 'not fit for purpose. (2018). Retrieved from https://www.bbc.co.uk/news/health-45607313

116   Smith, K., & Miles, C. (2017). Nowhere To Turn. Findings from the first year of the No Woman Turned Away project. Women's Aid. Retrieved from https://1q7dqy2unor827bqjls0c4rn-wpengine.netdna-ssl.com/wp-content/uploads/2017/07/NWTA-Full-report.pdf

117   Grierson, J. (2018). Council funding for women's refuges cut by nearly £7m since 2010. Retrieved from https://www.theguardian.com/society/2018/mar/23/council-funding-womens-refuges-cut-since-2010-england-wales-scotland

118   SafeLives. (2018). Guidance for multi-agency meetings: Mental Health. Retrieved from http://safelives.org.uk/sites/default/files/resources/Mental%20health%20NSP%20report.pdf

119   Scott, S., & McManus, S. (2016). Hidden Hurt. Violence, abuse and disadvantage in the lives of women. Retrieved from https://weareagenda.org/wp-content/uploads/2015/11/Hidden-Hurt-full-report1.pdf

120   Humphreys, C., Thiara., R. K., & Regan, L. (2005) Domestic violence and substance use: overlapping issues in separate services?. Greater London Authority. Retrieved from https://minerva-access.unimelb.edu.au/handle/11343/34849

121   Domestic Abuse Fund, 2018 to 2020: prospectus. (2018). Retrieved from https://www.gov.uk/government/publications/domestic-abuse-fund-2018-to-2020-prospectus

122   AVA. Training for organisations. Retrieved from https://avaproject.org.uk/in-house-training/

123   Paterson, B. (2014), "Mainstreaming trauma", paper presented at the Psychological Trauma Informed Care Conference, Stirling University, Stirling, 4 June, available at: www.stir.ac.uk/media/schools/nursing/documents/Trauma14-Patersonmainstreaming-trauma-workshop.pdf

124   Sweeney, A., Clement, S., Filson, B. & Kennedy, A. (2016) Trauma-informed mental healthcare in the UK: what is it and how can we further its development? Mental Health Review Journal, 21: 174–92. Retrieved from https://DOI.org/10.1108/MHRJ-01-2015-0006

125   The NHS Long Term Plan. (2019). Retrieved from https://www.longtermplan.nhs.uk/wp-content/uploads/2019/01/nhs-long-term-plan.pdf

126   Scottish Government. (2017). Transforming Psychological Trauma: A Knowledge and Skills Framework for the Scottish Workforce. Retrieved from https://www.nes.scot.nhs.uk/media/3971582/nationaltraumatrainingframework.pdf

127   Public Health Wales. Retrieved from http://www.wales.nhs.uk/sitesplus/888/page/88504

128   Semiatin, J. N., Torres, S., LaMotte, A. D., Portnoy, G. A., & Murphy, C. M. (2016). Trauma exposure, PTSD symptoms, and presenting clinical problems among male perpetrators of intimate partner violence. Psychology of Violence, 7(1), 91-100. Retrieved from http://dx.DOI.org/10.1037/vio0000041

129   Ehrensaft, M. K., Cohen, P., Brown, J., Smailes, E., Chen, H., & Johnson, J. G. (2003). Intergenerational transmission of partner violence: A 20-year prospective study, Journal of Consulting and Clinical Psychology, 71(4), 741-753. Retrieved from http://dx.DOI.org/10.1037/0022-006X.71.4.741

130   Miller, E., Breslau, J., Chung, W-J. J., Green, J. G., McLaughlin, K. A., & Kessler, R. C. (2011). Adverse childhood experiences and risk of physical violence in dating relationships, Journal of Epidemiology and Community Health, 65(11), 1006-1013. DOI: 10.1136/jech.2009.105429

131   Hughes, K., Bellis, M. A., Hardcastle, K. A., Sethi, D., Butchart, A., Mikton, C., Jones, L., & Dunne, M. P. (2017). The effect of multiple adverse childhood experiences on health: a systematic review and meta-analysis, The Lancet, 2(8), 356-366. DOI: https://DOI.org/10.1016/S2468-2667(17)30118-4

132   Hobbs, F. D. R., Bankhead, C., Mukhtar, T., Stevens, S., & Perera-Salazar, R. (2016). Clinical workload in UK primary care: a retrospective analysis of 100 million consultations in England, 2007–14. Lancet, 387(10035):2323–30. DOI:10.1016/S0140-6736(16)00620-6

133   Walby, S. (2004). The Cost of Domestic Violence. Women and Equality Unit. Retrieved from https://paladinservice.co.uk/wp-content/uploads/2013/07/cost_of_dv_research_summary-Walby-2004.pdf

134   IRIS - Identification and Referral to Improve Safety. Retrieved from http://www.irisdomesticviolence.org.uk/iris/

135   Feder, G., Agnew-Davies, R., Baird, K., Dunne, D., Eldridge, S., Griffiths, C., Gregory, A., Howell, A., Johnson, M., Ramsay, J., Rutterford, C., & Sharp, D. (2011). Identification and Referral to Improve Safety (IRIS) of women experiencing domestic violence with a primary care training and support programme: a cluster randomised controlled trial. Lancet, 11: 1–8. DOI:10.1016/S0140-6736(11)61179-

136   Campbell, D. (2018). Delays in NHS mental health treatment 'ruining lives'. Retrieved from https://www.theguardian.com/society/2018/oct/09/mental-health-patients-waiting-nhs-treatment-delays

137   AVA. Trauma Informed Practice: A Course for Frontline Workers (CPD Accredited). Retrieved from https://avaproject.org.uk/in-house-training/trauma-informed-practice-frontline-cpd-accredited/

138   HMICFRS. (2018). Policing and Mental Health. Picking Up the Pieces. Retrieved from https://www.justiceinspectorates.gov.uk/hmicfrs/wp-content/uploads/policing-and-mental-health-picking-up-the-pieces.pdf

139   https://sharedlivesplus.org.uk/about-shared-lives-plus

140   More housing and support options for survivors of domestic abuse - Shared Lives Plus and SafeLives testing new model. (2018). Retrieved from https://sharedlivesplus.org.uk/news/item/558-more-housing-and-support-options-for-survivors-of-domestic-abuse-shared-lives-plus-and-safelives-testing-new-model

141   The Annual Report of Her Majesty's Chief Inspector of Education, Children's Services and Skills 2016/17. (2017). Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/666871/Ofsted_Annual_Report_2016-17_Accessible.pdf

142   The Annual Report of Her Majesty's Chief Inspector of Education, Children's Services and Skills 2016/17. (2017). Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/666871/Ofsted_Annual_Report_2016-17_Accessible.pdf

143   Adult safeguarding and domestic abuse – a guide to support practitioners and managers. (2015). Retrieved from https://www.local.gov.uk/sites/default/files/documents/adult-safeguarding-and-do-cfe.pdf

144   SafeLives. (2015). Marac toolkit for adult services. Retrieved from http://www.safelives.org.uk/node/554

145   SafeLives Insights national briefing on children living with domestic abuse. (2017). Retrieved from http://www.safelives.org.uk/insights-national-briefing-children

146   The multi-agency response to children living with domestic abuse. (2017). Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/680671/JTAI_domestic_abuse_18_Sept_2017.pdf

147   https://www.operationencompass.org/

148   Relationships Education, Relationships and Sex Education, and Health Education in England Government consultation response. (2019). Retrieved from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/780768/Government_Response_to_RSE_Consultation.pdf

149   Jacob, S. (2019). The difference a truly supportive employer can make. Retrieved from http://safelives.org.uk/policy_blog/difference-truly-supportive-employer-can-make

150   Domestic Violence and Abuse: Working together to transform responses in the workplace. (2017). Retrieved from https://www.vodafone.com/content/dam/vodafone-images/foundation/55376_Vodafone_domestic_violence_report_AW5_V2.pdf

151   Domestic abuse: a toolkit for employers. (2018). Retrieved from https://wellbeing.bitc.org.uk/sites/default/files/kcfinder/files/bitc_phe_domestic_abuse_toolkit.pdf

152   SafeLives. Responding to colleagues experiencing domestic abuse: Practical guidance for line managers, Human Resources and Employee Assistance Programmes. Retrieved from http://www.safelives.org.uk/sites/default/files/resources/DV%20Employer%27s%20guidance%20FINAL%20Update%203%20-%20SafeLives%20rebranded.pdf