Promising Practices

Mental Health Trust responses to domestic violence

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Contents

Summary

- There are 56 Mental Health Trusts in England. 51 Trusts responded to FOI request 1; only 43 responded to FOI request 2.

- Only five Mental Health Trusts have, or are in the processing of developing, a domestic violence strategy. In response to a request for *strategies* relating to domestic violence, 19 Trusts returned a related *policy*.

- 71% of Trusts require staff to learn about domestic violence. The availability of training ranges from a 30 minute presentation during induction safeguarding training to whole- and multiple-day training programmes in a small number of Trusts.

- Domestic violence is viewed first and foremost as a safeguarding issue in all Trusts, with Trusts most commonly including domestic violence within safeguarding policies.

- Seven Trusts have a standalone domestic violence policy, and 15 Trusts cover domestic violence in safeguarding policies and a range of protocols specific to domestic violence.

- The content of policy directives relating to domestic violence varies greatly. The most commonly covered topics are confidentiality and record keeping, however these issues usually related to more general safeguarding concerns rather than being specific to domestic violence.

- Relatively little guidance is provided about routine enquiry (30% of Trust policies) and risk assessment (53%) and again this is often generic advice rather than in particular relation to domestic violence.

- Only three Trusts refer explicitly to supporting survivors to recover from their experiences of abuse.

- 79% of Trusts state they have a policy of routinely enquiring about domestic violence.

- 64% of Trusts could not provide data about the number of MARAC referrals made in the last 12 months.

- Of the 14 Trusts which provided MARAC referral data, only one Trust made more than 10 referrals in a 12 month period.

- Five Trusts employ someone to provide specialist support to victims of domestic or sexual violence. Only three Trusts offer specialist groups for victims of domestic violence. 45% of Trusts refer service users to specialist psychology services for therapeutic support around experiences of abuse.

Introduction

The links between experiences of trauma and psychological distress are well understood, with much research having been undertaken to explore the mental health sequelae to experiencing abuse in childhood, being the victim of sexual assault and rape, or witnessing violence in conflict settings (Golding, 1999; Harold and Howarth, 2004; Rees *et al*, 2011: Tanielian and Jaycox, 2008). In terms of domestic violence, the last decade has seen a significant growth in the understanding of survivors' mental health problems being a "symptom of abuse" (Humphreys and Thiara, 2003). Female survivors of domestic violence experience markedly higher levels of depression, anxiety, eating disorders, self-harming and suicidal ideation than the general female population (Campbell, 2002; Dutton *et al*, 2005; Howard *et al*, 2010a).

Sexual violence from an intimate partner is particularly traumatic, with survivors being five times more likely to attempt suicide than women who are subject only to physical and/or psychological abuse (McFarlane *et al*, 2005). Often seen as less significant, psychological abuse can be equally, if not more so, detrimental to the survivor's mental health as physical violence: psychological abuse can be more strongly associated with post-traumatic stress disorder (PTSD) than physical violence (Taft *et al*, 2005, cited in Howard *et al*, 2010a). Experiencing abuse on multiple occasions throughout one's life or being the victim of more than one form of abuse also increases the risk of mental illness and comorbidity (Howard *et a*l, 2010a; Rees *et al*, 2011).

Unsurprisingly, reported rates of lifetime experiences of domestic violence among psychiatric patients is higher than the general population, with a recent systematic review estimating the median prevalence for any lifetime partner violence was 29.8% among female inpatients and 33% among female outpatients (Oram *et al*, in press). Despite the high prevalence of domestic violence in the lives of the people who use mental health services, experiences of abuse are not routinely enquired about (Howard *et al*, 2010b). Furthermore, practice-based evidence collated through the Stella Project Mental Health Initiative, a three-year project funded by the Department of Health to look at models of supporting survivors who have mental health and/or substance use problems, suggests that neither the links between experiences of abuse and service users' current mental health problems nor the risk of further abuse are routinely assessed within mental health services in England. This research was completed to ascertain what Mental Health Trusts in England are currently doing to address domestic violence and to identify areas of good practice.

Research aims and methodology

Aims

Through the Stella Project Mental Health Initiative, contact has been made with three Mental Health Trusts, which has provided a useful insight into how Mental Health Trusts are currently addressing domestic violence. This piece of research sought to develop a broader picture of the present responsiveness of Mental Health Trusts in relation to domestic violence.

The aims of the project are to:

- identify what policies and procedures are routinely in place to support staff in dealing with cases of domestic violence;
- learn more about what support is offered to survivors of domestic violence;
- identify and publicise examples of good practice; and
- highlight the need for a more holistic approach to tackling domestic violence within Trusts.

Overall, we hope that this report can provide a template for how Mental Health Trusts can continue to improve their responses to both victims and perpetrators who are also affected by mental illness.

Methodology

Under the Freedom of Information Act 2000, AVA contacted all 56 mental health Trusts in England with two Freedom of Information (FOI) requests between July 2011 and August 2012. The first request pertained to policies and procedures relating to domestic violence; the second request was for information about specialist services delivered within the Trusts for survivors of domestic violence. A full copy of both FOI requests can be found in appendices A and B.

Request	No. of Trusts
FOI Request 1: policies and procedures	51 (91%)
FOI Request 2: types of available support	42 (77%)

Figure 1: FOI request response rate

Public bodies are required to respond to Freedom of Information requests within 20 working days of being received. Eventually 51 mental health Trusts replied to the first FOI request; a substantial number only responded after a reminder. At the time of publication, 43 Trusts had replied to the second request, again some only replied after receiving a reminder letter.

Findings

In this section, we report on the findings of the two FOI requests. The data has been organised into the following subsections:

- **Leadership** – who leads on domestic violence within Trusts and how
- **Staff development** – accessibility of domestic violence training
- **Policies and procedures** – an analysis of key documents relating to domestic violence
- **Routine enquiry** – stated policies about screening for domestic violence
- **Engagement with MARACs** – numbers of MARAC referrals
- **Specialist support** – provision of practical and emotional support within Trusts

> ***A note about numbers***
> As the data collected pertains to two FOI requests with a respective response rate of 51 and 43 Trusts, the figures in the report total 51 or 43. In some cases, Trusts did not answer all the questions in the FOI request, thus some totals are smaller.

Leadership

Violence and abuse is a relatively new issue for Mental Health Trusts to address in a systematic fashion. In 2006, the National Mental Health Development Unit (NMHDU) launched a two-year pilot to introduce routine enquiry about abuse (with a focus on childhood sexual abuse) into mental health services. Trusts were required to identify a Senior Violence and Abuse lead, e.g. Deputy Chief Executive, Director of Nursing or Medical Director. This was in recognition that strong leadership at senior and middle management levels was important in driving the project forward (NHS Confederation, 2008). Following the pilot, the programme was rolled out nationally, with the aim of all Trusts identifying a lead officer for violence and abuse.

As part of this research, information specifically about domestic violence leads was gathered from a search of all Trust websites and from the 51 responses to our FOI request. Altogether, details of at least one individual who acts as a domestic violence lead and/or Multi-Agency Risk Assessment Conference (MARAC) representative were collected for 35 Trusts. From the available data about lead officers, it is clear that domestic violence is firmly situated and led by safeguarding officials – from named safeguarding nurses who have responsibilities for domestic violence up to Directors who have executive responsibility for safeguarding across the Trusts.

As part of the FOI request, Trusts were further asked to provide both policies and strategies relating to domestic violence. In contrast to a policy that essentially denotes a set of principles about a subject, a strategy is designed to incorporate a plan of action to drive forward the process of improving practice in a systematic way.

Unfortunately, in response to the question of whether they have a domestic violence strategy, only five (11%) of the 42 Trusts who replied to this question have either a strategy or are in the process of writing one. Seven Trusts are party to their local multi-agency or health partnership domestic violence strategy. Twenty seven Trusts appear not to have a specific domestic violence strategy: six responded negatively to the question and 19 Trusts sent policies which outline their approach

to tackling domestic violence rather than a strategy.

Type of strategy	No. of Trusts
Domestic violence strategy	5
Local authority strategy	5
Health partnership strategy	2
No strategy *(Policy submitted instead)*	27 *(19)*

Figure 2: Strategic direction in Trusts

From the information gathered, it remains unclear how many Trusts have strong leadership and a clear direction for tackling domestic violence. The overwhelming lack of specific strategies for addressing domestic violence is potentially concerning. Whilst it may be possible that domestic violence is well embedded within strategic frameworks for safeguarding within some Trusts, it is possible that other Trusts may have no formal plan for addressing domestic violence. Furthermore, inclusion within a safeguarding strategy may limit the range of activities undertaken, with the focus being on securing physical safety and a lesser - or possibly no - emphasis on supporting emotional recovery from experiences of abuse.

Staff development

Training is vital to creation of a workforce that is confident to talk to service users about domestic violence, and is skilled to respond appropriately to disclosures, including how to prioritise the safety of victims and their children following a disclosure. Mental health practitioners should, however, also be particularly knowledgeable about the ways in domestic violence can impact on the victim's psychological wellbeing and how experiencing domestic violence can impede a person's ability to recover from mental illness. As part of our FOI request, we asked Trusts i) if staff were mandated to attend training about domestic violence, ii) if any domestic violence training is delivered internally, and ii) about any external domestic violence training opportunities.

Of the 48 Trusts that provided any information about training, 34 (71%) clearly stated that staff are required to learn about domestic violence as part of safeguarding training. Four Trusts said there are no specific requirements on staff to know about domestic violence, although it should be noted that they meant there is no requirement to attend specific domestic violence training but it is included in safeguarding training. Ten Trusts did not answer the question.

Figure 3: Domestic violence training requirements in Mental Health Trusts

In terms of delivering domestic violence training internally, seven Trusts do not provide specific training internally. Six Trusts include domestic violence within the safeguarding section of their induction training that all staff must attend. The sessions range from 30 minutes to 2.5

hours. 24 Trusts include domestic violence in other safeguarding children and adults training. In a small number of Trusts domestic violence is referred to in all safeguarding training, but more commonly it is only referred to in level 2 and 3 training which is usually limited to staff who work directly with children and young people or designated safeguarding officers.

Eight further Trusts deliver additional domestic violence training. Three Trusts have MARAC briefing sessions, and two Trusts provide training specifically about children and/or for staff in children's services. One Trust provides a half-day training session but did not clarify the content. Only two Trusts who run longer courses: a three-day domestic violence course each year (Mersey Care Healthcare Trust) and a one-day course in partnership with a local domestic violence service (Nottinghamshire NHS Healthcare Trust).

Staff who have a particular interest in domestic violence are often directed to external training opportunities. Unfortunately, 21 Trusts (44%) did not provide any information about external domestic violence training. Whilst this does not mean training is not available, it does point to a lack of knowledge and easily accessible information about local training.

Of the 27 Trusts who submitted information about local training providers, 15 referred to Local Children or Adult Safeguarding Boards (LCSB or LSAB), and nine to local authority training (which could also be LSCB/LSAB). Only two Trusts noted training delivered by local specialist organisations such as Women's Aid.

With regard to external training, there is also a vast difference between Trusts stating that staff have access to local domestic violence training and staff being released by managers to attend said training. Mental health practitioners are required to attend a large number of mandatory training sessions in addition to safeguarding. This means that in many cases staff cannot released to attend additional training; this is particularly true of services in which staff have to provide duty cover at all times the service is open. Evidence from four Trusts which AVA and colleagues have worked with highlights that when external partners are commissioned to deliver to Trusts, even on site, it can be poorly attended.

It is certainly promising that staff in over two thirds of Trusts already have some level of domestic violence awareness training. In a small number of Trusts (6), this may however be limited to only half an hour of information that primarily focuses on safeguarding procedures in cases of identified or suspected domestic violence. Furthermore, the evidence suggests an almost exclusive emphasis within Trusts of domestic violence being a safeguarding issue, and tailoring training opportunities accordingly. Whilst victim safety must be a priority, it is unclear if staff receive any training which prepares them to engage with victims of historic abuse, with those who are not at current risk of harm, or to deal with the long-term impact of domestic violence on the victim's physical and emotional wellbeing.

Policies and procedures

Whilst an analysis of policy documents cannot be relied upon to give a completely accurate picture of frontline practice, it can provide an insight into the position of an

issue like domestic violence within an organisation as well as the importance attached to it. Furthermore, as policies frequently also incorporate practice guidance for an issue, they also reveal what staff are expected to do in certain situation. The FOI requests therefore asked for copies of all policies relating domestic violence. The policy analysis comprised two stages:

1) policy formation – do Trusts have a stand-alone domestic violence, and to what extent have Trusts adopted a violence against women approach?

2) policy content – are key issues such as routine enquiry, risk assessment and referral pathways included?

The findings follow this structure and are set out below in three sub-sections: policy formation, awareness of violence against women and girls (VAWG), and policy content.

❖ Policy formation

In response to our request for any policies relating to domestic violence, Trusts sent a varying selection of policy and procedural documents. Four Trusts did not provide any documentation.

The majority of Trusts, unsurprisingly, include domestic violence within existing child and adult safeguarding policies. Of the 46 Trusts that provided policies, 21 (46%) only incorporate domestic violence into safeguarding policies. Encouragingly, 15 Trusts (33%) submitted child and/or adult safeguarding policies as well as specific domestic violence policies or protocols. Seven Trusts (15%) only provided a stand-alone domestic violence policy, but it is possible they also reference domestic violence in safeguarding policies that they did not submit. Three Trusts (6%) make no explicit reference to domestic violence in the policies that they indicated are the primary guiding document for dealing with this issue.

Policy type	No. of Trusts
Domestic violence included in safeguarding policies	21
Stand-alone domestic violence policy	7
Stand-alone policy and inclusion in safeguarding policies	15
No mention of domestic violence in safeguarding policies	3

Figure 4: Domestic violence policy formation

The inclusion of domestic violence in safeguarding policies is often considered preferable to having a stand-alone policy. The most commonly cited benefit of incorporating domestic and sexual violence into an existing safeguarding policy is the strategic importance of safeguarding policies. This, in turn, raises the profile of domestic and sexual violence and aides practitioners' access to guidance on responding to abuse.

The variation between safeguarding policies, however, provides cause for concern about this approach. In some cases, for example, some Trusts make a single reference to domestic violence in their safeguarding policies and others provide no guidance for staff on how to respond to this specific type of abuse. Of the 21 Trusts that include domestic violence in safeguarding policies, the majority (62%; n=13) make less than 10 references to domestic violence in the whole document. Eight policies include

more comprehensive sections on responding to disclosures of abuse with more than 10 references to domestic violence.

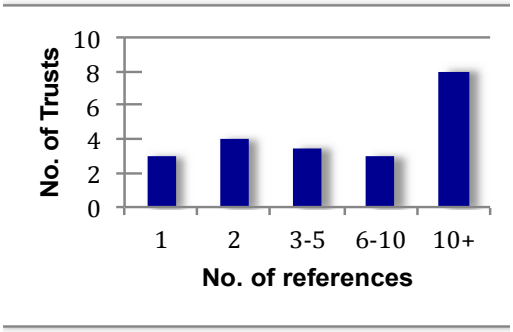

Figure 5: Number of references to domestic violence in safeguarding policies

There was also wide variation among the documents that were included in the stand-alone policy category, The Trusts which submitted solely the stand-alone policy all produced documents which aim to address victimisation and perpetration of abuse by service users, and in some also by staff.

Of the 15 Trusts that supplied safeguarding policies and other domestic violence specific documents, six policies (40%) had a human resources focus outlining procedures for dealing with staff who are victims or perpetrators of domestic violence. Interestingly, in each case the staff policies were more comprehensive and provided a wider range of options for supporting victims of all risk levels than the policies aimed at service users. Several other Trusts submitted MARAC protocols or local information protocols as a stand-alone domestic violence policy, neither of which provides comprehensive guidance on dealing with cases of domestic violence.

Further analysis of the policy content can be found on p.11.

❖ Awareness of violence against women

Recent years have seen an increased awareness of the overlap between various forms of violence and abuse that are most commonly experienced by women, such as domestic violence, sexual violence, forced marriage, honour-based violence and female genital mutilation. In light of this, at both the national and local level, efforts to tackle domestic violence are being superseded by policies and strategies to address violence against women and girls (VAWG).

As within the general population, users of mental health services could be victims of all forms of VAWG. It is important that Mental Health Trusts are aware of the ways in which their service users are at risk of abuse – not only domestic violence, but also sexual violence, forced marriage and honour-based violence. An analysis of all policies submitted by 43 Mental Health Trusts in response to the FOI request revealed mixed results.

Encouragingly, only 21% (n=9) of Trusts refer solely to domestic violence, with the majority (70%; n=30) of Trusts referencing both domestic and sexual violence in their respective policies. The inclusion of sexual violence may reflect the awareness of high prevalence rates of childhood sexual abuse among users of mental health services, either from general knowledge or as a result of the Department of Health's programme in 2006-8 to introduce routine enquiry about experiences of abuse to services users on the Care Programme Approach (NHS Confederation, 2008). No Trust has a specific VAWG policy, however four Trusts refer to VAWG and two Trusts referred to specific forms of VAWG, i.e. forced marriage and honour-based violence within their safeguarding children policies.

Policy focus	No. of Trusts
Domestic violence only	9
Domestic and sexual violence	30
Violence against women and girls	6

Figure 6: Policy focus in Mental Health Trusts

Interestingly, where there is a section on domestic violence within a safeguarding policy or there is standalone policy, each Trust makes it clear that domestic violence is a gendered issue, with almost all stating the figure that 90% of domestic violence is perpetrated by men towards women. At the same time, they do not explicitly highlight how domestic violence is related to other forms of VAWG.

The limited recognition of domestic violence as a form of VAWG within safeguarding policies may lie in the fact that safeguarding is seen as a gender-neutral issue, with policies drafted accordingly. The most commonly used definition of abuse is taken from 'No Secrets: guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse' (Department of Health, 2000):

"Abuse may consist of a single act or repeated acts. It may be physical, verbal, or psychological, it may be an act of neglect or an omission to act or it may occur when a vulnerable person is persuaded to enter into a financial or sexual transaction to which he or she has not consented, or cannot consent"

Safeguarding policies also usually state that abuse can be perpetrated by a partner, family member, carer, etc. In this way, the definition does cover many aspects of domestic violence. Some Trusts also include domestic violence as an additional type of abuse, but for the most part the generic abuse definition is the only definition provided and, as already demonstrated, the vast majority of safeguarding policies do not place domestic violence within a context of VAWG.

❖ Policy content

Most Trusts submitted a range of policies, usually comprising a combination of safeguarding adult and children policies, and domestic violence policies and protocols where available. In a small number of cases (3), Trusts provided alternative policies for example on managing violent behaviour within services supposedly to demonstrate their approach to dealing with perpetrators of domestic violence.

The policy content analysis was completed by Trust policy formation type: 21 safeguarding policies which include reference to domestic violence; 7 stand-alone policies; and the combined safeguarding and domestic violence policies which were submitted by 15 Trusts.

Content analysis criteria

AVA reviewed all policies with regard to several key components that Mental Health Trusts should ideally seek to incorporate into policies relating to domestic violence:

1. **Awareness raising activities**: leaflets and brochures about domestic violence should be displayed and easily accessible to staff and service users
2. **Routine enquiry**: all service users should be routinely screened for experiences of abuse
3. **Risk assessment**: staff should have guidance on how to assess for and respond to risks specifically relating to domestic violence
4. **Recovery plan:** within care plans, staff should include actions to reduce the risk of physical harm from others as well as addressing the psychological impact of abuse
5. **Working with perpetrators**: mental health services will come into contact with perpetrators of abuse and staff should have clear guidance on how to respond to disclosures of abusive behaviour
6. **Human resources**: policies should include information about supporting staff members who experience domestic violence as well as dealing with employees who perpetrate abuse.
7. **Record keeping**: accurate records of disclosures of abuse and subsequent actions should be maintained to allow for monitoring and identification of areas for further improvements
8. **Confidentiality**: staff should be aware of when to maintain confidentiality to increase victim safety as well as the need to breach confidentiality and/or share information in certain situations.
9. **Referral pathways**: clear pathways to relevant protection and support services can improve staff confidence in asking about domestic violence (Holly and Horvath, 2012).

All the policies received incorporate varying levels of practice guidance alongside policy statements. It is important to note that staff may have access to further guidance from local safeguarding boards or domestic violence fora which were not submitted in response to the FOI request. Nonetheless, the policies provided do offer an insight into practice within mental health services in addressing domestic violence.

In terms of policy coverage, two issues stand out as key priorities: confidentiality and record keeping. 35 Trusts (67%) refer to confidentiality, with 100% (n=21) of Trusts that only submitted safeguarding children and/or adult policies include clear guidance on limits of confidentiality. With regard to record keeping, 29 Trusts (57%) detail procedures for documenting information relating to abuse. Again, this issue is addressed most consistently within safeguarding policies. 19 out of 21 Trusts (90%) who provided only safeguarding policies include a section on record keeping with a primary focus on preserving evidence of physical abuse through the use, for example, of body maps.

Another area which is widely covered in safeguarding policies is support for staff. This tends to take one of two approaches:

1) advice for staff on how to cope with cases of abuse towards children or vulnerable adults, and

2) procedures for dealing with allegations of abuse by staff members towards service users.

11 Trusts (52%) that supplied only generic safeguarding policies include this type of information in their policies. Of the 15 Trusts that submitted a combination of policies, nine (60%) include information about human resources. Of those nine, six policies are specifically about supporting staff who are victims of abuse or who perpetrate domestic violence. Only a handful of Trusts (including Merseycare and Northumberland, Tyne and Wear) address both service user and staff experiences of abuse in one policy. More typically, information on how to respond to service users who may experience abuse is held in safeguarding policies whilst information about responding to staff disclosures of abuse are held in separate human resources policies.

Working with perpetrators of abuse is also addressed more commonly within human resourcing policies, although to a much lesser degree: only nine Trusts in total (21% of Trusts that submitted policies which referenced domestic violence at least once) explicitly refer to perpetrators of abuse.

Dealing with service users who are aggressive or abusive towards other service users (not necessarily with whom they are in a relationship) or staff is covered briefly in safeguarding adult policies. The topic is more fully addressed in 'managing aggressive behaviour' policies but again the focus is more on protecting service users, staff and further the general public. Only human resource policies were found to include information more specifically about working with perpetrators of domestic violence.

It may therefore be preferable for Trusts to have a single domestic violence policy which covers both service users and staff who either experience or perpetrate abuse. Much of the information, resources and referral pathways are the same for service users and staff; links to relevant safeguarding policies and procedures relating to service users could be included. This would reduce duplication of information and encourage a more seamless approach to domestic violence across each organisation.

Risk assessment is another topic common to both safeguarding and domestic violence policies. Overall, 23 Trusts (53%) include a section on risk assessment. Ten of these, however, only cover more generic risk assessment within their safeguarding children and/or adult policies. Where domestic violence-related risk is referenced, most often the only further information provided is about the local Independent Domestic Violence Advisor (IDVA) and the process for referring to the Multi Agency Risk Assessment Conferences (MARACs). Nottinghamshire Healthcare NHS Trust offers a useful three stage guide to risk assessment: 1) making a decision in an emergency situation, 2) completing the DASH RIC[1], and 3) multi-agency responses such as the MARAC. The DASH RIC is attached as an appendix to the policy. Whilst this is comparatively comprehensive when viewed next to other Trust policies, there is still a need to provide more information about key risk factors facing victims who access domestic violence services as well as referral pathways for victims of all risk levels.

[1] The DASH RIC (Domestic Abuse Stalking and Harassment Risk Identification Checklist) is the standard domestic violence risk assessment tool used in England areas and is used to ascertain eligibility for the MARAC.

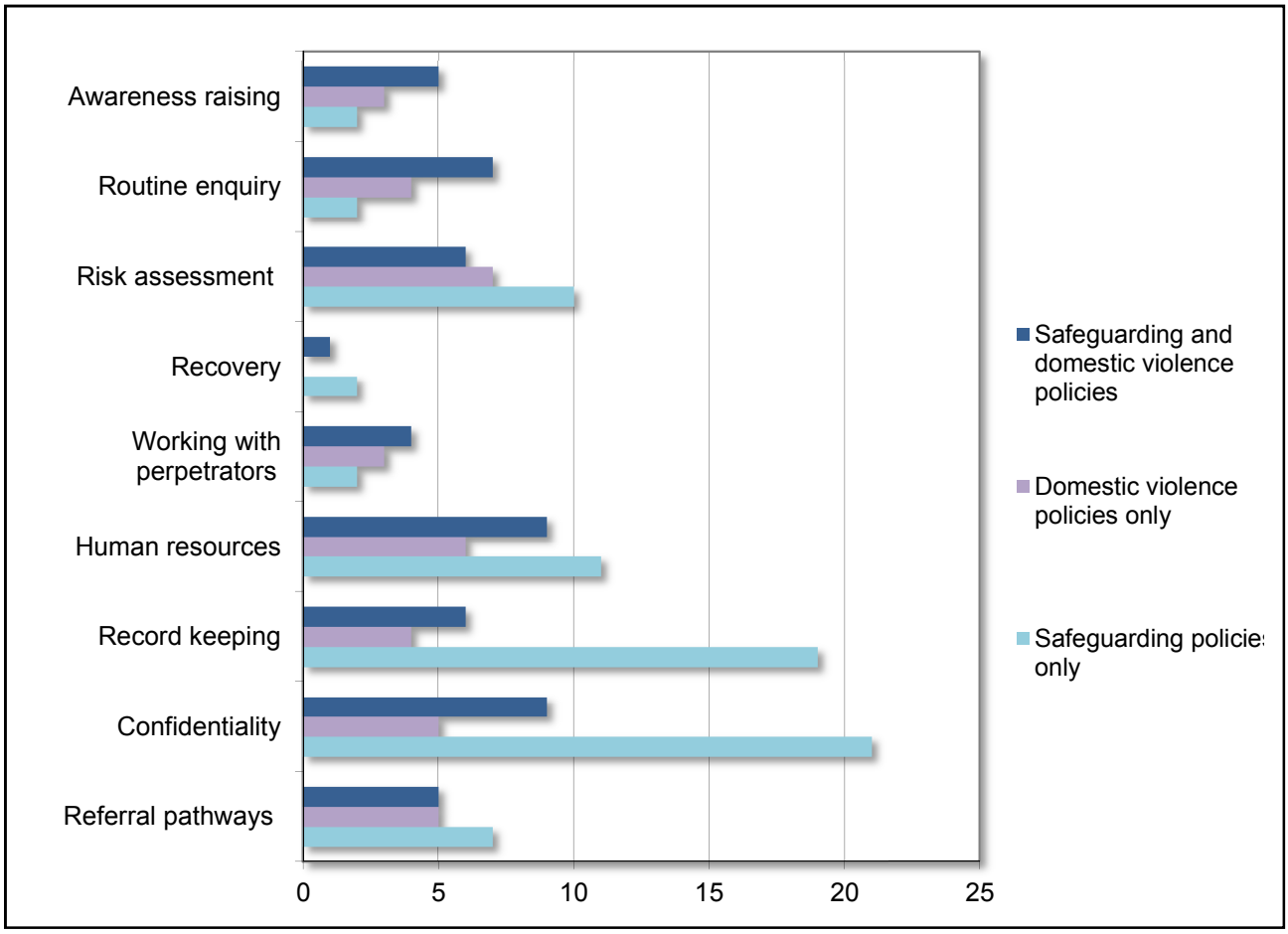

Figure 7: Content of Mental Health Trust safeguarding and domestic violence policies

Safeguarding policies tend to offer clear pathways for dealing with case of abuse towards children and vulnerable adults, which reflects the increasingly well embedded processes within most Trusts for responding to these types of abuse cases. The referral pathways included in these policies are however, generic. They do not, for example, include MARAC as a referral pathway for very high risk victims. Adapting safeguarding referral pathways to include the MARAC would be useful in raising awareness about domestic violence. Furthermore, it may also encourage staff to refer directly to the MARAC rather than always contacting the safeguarding team for initial advice. As such, this could reduce the burden on the safeguarding team in each Trust.

Stand-alone domestic violence policies tend to provide more information about a variety of referral pathways, i.e. not only those catering to victims at very high risk. This is important considering the majority of victims that use mental health services will have experienced domestic violence in the past and/or may not be at high risk.

It should be reiterated at this point that a Trust's safeguarding or domestic violence policy may not be the only source of information about domestic violence that staff are able to access. Nonetheless, as a key guiding document, it still advisable for safeguarding and/or domestic violence services to include details of a range of referral pathways that meet the needs of a greater number of service users.

Two issues that receive woefully little attention within safeguarding policies are awareness raising and routine enquiry. This is particularly problematic as both activities mark the beginning of the disclosure process. Without sufficient support to encourage disclosures of abuse, staff will have little need for subsequent guidance on risk assessment and referral pathways.

Overall, ten Trusts (23%) mention the need to display posters or leaflets about domestic violence within services. Of these ten, this information is covered in two general safeguarding policies and eight stand-alone domestic violence policies.

The lack of guidance on how to ask service users about experiences of abuse is of greater concern. Whilst 13 Trusts (30%) refer to routine enquiry, in many cases it is in relation to enquiring about general safeguarding concerns rather than specific questions about domestic violence. Furthermore, most commonly no guidance is given about routine screening questions but rather the focus is on what action to take only as and when it comes to light that abuse may be taking place. Similarly, only three Trusts (7%) offer staff any guidance on how to respond to disclosures – from (quite literally) what to say if someone discloses to how to support victims to decide what they would like to do and frequently asked questions.

How to ask about and respond to disclosures of domestic violence is a key concern for many health practitioners, including mental health (McLindon and Harms, 2011; Rose *et al*, 2011). It is therefore imperative that staff have clear guidance. It may, again, be the case that staff have access to the relevant guidance but Trusts chose not to include this in their FOI response. On the other hand, this may further strengthen the argument for a template domestic violence policy that includes practice guidance about how to effectively screen for domestic violence.

A final disappointing but unsurprising finding relates to the concept of recovery from experiences of abuse. The content of all policies was reviewed to identify actions that promoted victims' emotional or psychological recovery from domestic violence. Only three Trusts (7%) make explicit reference to recovery within any of the policies submitted. Whilst one might not expect safeguarding policies to focus on long-term psychological recovery, in the absence of any other policy directive or guidance on domestic violence, this is a glaring gap in the framework for supporting victims.

In conclusion, in terms of policy content, it is evident that a very clear template for safeguarding adult policies has been made available: most of the policies reviewed are very similar in structure and content. A similar template is needed for domestic violence. At present there are vastly varying policy provisions for domestic violence within Mental Health Trusts, and only a handful of Trusts provide staff with clear guidance on how to deal with domestic violence in their practice.

Routine enquiry

Whilst the efficacy of routinely screening for domestic violence has been called into question (Ramsay *et al*, 2002), routine enquiry about experiences of abuse has been part of the Department of Health policy agenda for almost a decade (DoH, 2003). This policy was further reinforced by revised guidance (DoH, 2008) on the Care Programme Approach (CPA) which

applies to all mental health services. The CPA Guidance provided clear recommendations for how to ask about abuse (with the focus on childhood sexual abuse) within the family/social history section of mental health assessments:

"Have you experienced physical, sexual or emotional abuse at any time in your life?"

In response, staff are asked to tick whether the person said yes (and then give brief details of the disclosure), made no disclosure or whether the question was not ask (and the reason why). Fifteen Mental Health Trusts piloted the new question between 2006 and 2008, followed by a region-by-region rollout from 2008 supported by the National Policy Implementation Team at the (now defunct) National Mental Health Development Unit (NMHDU). To assess the sustained extent of the rollout since 2008, we asked all Trusts whether they have a policy of routinely enquiring about either domestic violence or abuse more generally. Unsurprisingly, the majority of Trusts (79%; n=35) that responded to the question have some policy of asking about abuse. Five Trusts (11%) do not have such a policy, three (7%) did not reply to the question and for one Trust which is a commissioning organisation, the question did not apply.

Of the 35 Trusts that have a policy of asking about abuse or domestic violence, 26 (59%) said they have a policy of asking all service users specifically about domestic violence, and a further four (9%) ask a more general question about abuse.

It is, however, possible that the Trusts which state they ask especially about domestic violence, mean they do this by asking the generic abuse question (which includes abuse in child- or adulthood) and that domestic violence in particular may not be identified.

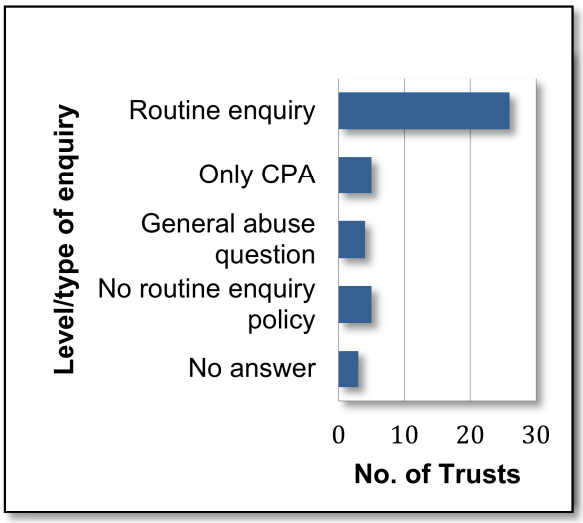

Figure 8: Routine enquiry within Mental Health Trusts

Five Trusts (11%) only ask service users on the Care Programme Approach (CPA) about domestic violence. CPA relates to service users who have multiple and complex needs which require care coordination, so in the Trusts that only routinely enquire about abuse under CPA, many service users who have slightly less complex needs may not be asked. Furthermore, it also possible some of the 26 Trusts who stated they ask specifically about domestic violence, may only actually ask the generic abuse question of those service users on CPA but this was not clarified in their FOI response.

It is also worth reiterating that staff have the option of not asking the question about abuse. In many cases it may be appropriate to refrain from asking, for example if someone is very distressed or is accompanied by their partner. However, research Rose *et al*, 2010: Trevillion *et al*, 2012) alongside anecdotal evidence from working with and training mental health professionals suggests that sometimes the option not to ask the question is used because staff lack the confidence to routinely enquire about domestic violence,

or even about abuse more generally. From our initial question about routine enquiry, it is clear that further research is needed to evaluate the extent to which the NMHDU rollout of the CPA routine enquiry about abuse has been implemented. In order to develop an accurate picture of the levels of routine enquiry, this will require not only an analysis of policy and procedural documents, but also auditing of clinical files to see whether service users are being asked, and where they are not, what reason is given.

Engagement with multi-agency risk assessment conferences (MARACs)

Multi-agency risk assessment conferences (MARACs) are now commonplace across England and Wales. MARACs are meetings where information about victims of domestic violence who are at high risk of serious harm or murder is shared between a wide range of local agencies, including mental health services. As people with mental health problems are more vulnerable to abuse (Howard *et al*, 2010b) and the DASH Risk Identification Checklist, which is used to assess whether a victim meets the MARAC threshold, includes three mental health related risk factors (victim's feelings of depression and suicide, and whether the perpetrator has had any recent mental health/drug problems or whether they have threatened/attempted suicide), it might be anticipated that mental health services would have a strong relationship with their local MARAC in order to safeguard vulnerable service users.

Research shows that adult mental health services do regularly attend their local MARAC, with 70% of MARACs recording a representative attending at least half of all meetings (Steel *et al*, 2011). Disappointingly, Child and Adolescent Mental Health Services attend at least half of all meetings in only 22% of MARACs (ibid). Whilst this means that adult mental health services are engaging with MARACs and will be party to information about service users who are at risk of being abused or perpetrating abuse, this data does not reveal if or how mental health services are identifying victims of domestic violence. As such, for our research all Trusts were asked to provide details of the number of MARAC referrals they made within the last year.

The response rate to this question was remarkable, in that it was the lowest out of all the questions asked. Of the 51 Trusts who replied to the FOI request, 32 (64%) did not provide the information. 11 Trusts (22%) did not answer the question; 21 Trusts (42%) were not able to provide the data because it is not recorded centrally. Five of these Trusts stated that collecting the information would take longer than the 18 hours which FOI officers are limited to spending on each requests.

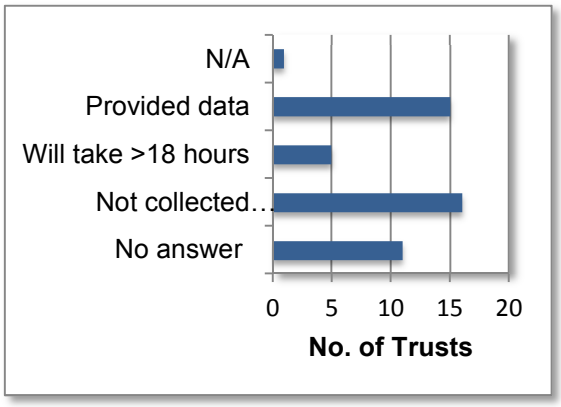

Figure 9: MARAC referral data availability

The lack of centrally collected and easily accessible data about MARAC referrals potentially suggests a lack of strategic leadership around the issue of domestic violence. Considering the heavy focus on safeguarding victims of domestic violence

within Mental Health Trust policy and practice, one might assume Trusts would want to monitor referrals to the MARAC – widely understood as the key forum for reducing the risk of serious harm to victims. It is quite surprising that this information is not more readily available, particularly considering how many Trusts have a single MARAC representative.

In total, less than a third of Trusts (30%; n=15) submitted data about the number of MARAC referrals they had made in a 12 month period[2]. The numbers of referrals are notably low. Of the 50 Trusts that responded to the FOI request, only one (2%) made more than 10 referrals to their local MARAC over a 12 month period. One Trust that reported making no referrals to their MARAC further noted that staff had completed the DASH Risk Identification Checklist on two occasions in the past year but neither case met the MARAC. This is surprising considering Mental Health Trusts (including the aforementioned Trust) frequently employ upwards of 1,000 staff and support tens of thousands of patients each year.

There are several reasons for the low number of MARAC referrals by Mental Health Trusts. Firstly, the figures may reflect the general trend of most MARAC referrals being made by the police and Independent Domestic Violence Advisors (IDVAs). Based on data received through the FOI requests, the number of MARAC referrals by Mental Health Trusts are comparable with those by other agencies such as education and housing. Secondly, as one Trust noted, victims identified in some services will routinely be referred to the IDVA who will then complete a full risk assessment and refer onto the MARAC if required. In this case, greater numbers of service users are being identified as experiencing abuse and being referred to the MARAC than this research project was able to capture.

It also, however, possible that the low MARAC referral rate reflects similarly low rates of enquiry about domestic violence, and/or low knowledge of the MARAC process. Finally, this research did not ask about referrals to other domestic violence services to which many service users may have been directed.

No. of referrals	No. of Trusts
0	4
1	2
4	3
5	1
6.5	1
9	1
10	1
135	1

Figure 10: Number of MARAC referrals per Trust

As such, there is clearly a need for further exploration of referral rates to the MARAC and other domestic violence services. Monitoring referral rates is not a benign exercise: referrals patterns are a potential indicator that staff are asking about domestic violence. Furthermore, they may point towards services and practitioners having created an environment and an approach that encourages disclosures and that beyond screening, appropriate follow-

[2] The FOI request asked for data from the last 12 months, but several Trusts provide the most recent annual data collected which ranged from August 2010 to July 2012.

on action is being taken. As such, it is vital that Trusts start to systematically monitor domestic violence-related referrals.

Provision of practical and therapeutic support

Considering the extent to which experiences of abuse are a common feature in the lives of many mental health service users, we used the FOI request to establish levels of support available within mental health services to address these specific issues.

Overall, the level of specialist support for survivors of domestic violence is relatively low. In terms of delivering practical and emotional support specifically to victims of domestic and sexual violence, only five Trusts out of the 43 who responded to FOI request reported employing staff to carry out this role.

The roles of the five specialist workers varies greatly:

- Lincolnshire Partnership NHS Foundation Trusts manages the local Sexual Assault Referral Centre and through this contract directly employs specialist staff;

- Central and North West London NHS Foundation Trust provides a psychologist for the local Haven (specialist centre for people who have been raped or sexually assaulted);

- Dudley and Walsall Mental Health Partnership NHS Trust employ 1.5 (FTE) workers to provide practical and emotional support to victims of domestic and sexual violence;

- Norfolk and Suffolk NHS Foundation Trust employs a domestic violence/safeguarding officer to provide support to staff who are affected by domestic violence; and

- Barnet, Enfield and Haringey Mental Health Trust employ a specialist domestic violence health visitor.

As would be expected, access to therapeutic services is greater than to practical support. In terms of individual therapy, the majority of Trusts (86%; n=36) who replied can refer survivors to either generic psychological services (40%; n=17) or to see a trauma specialist (45%; n=19). Therapeutic group interventions specifically for survivors of abuse are less numerous. Of the 43 Trusts that replied, 29 (67%) do not run specialist groups; ten of these Trusts noted that they do offer generic group therapy which may include information or support around experiences of abuse. Six Trusts (14%) have groups specifically for survivors of childhood sexual abuse and only three (7%) offer group therapy to survivors of domestic violence.

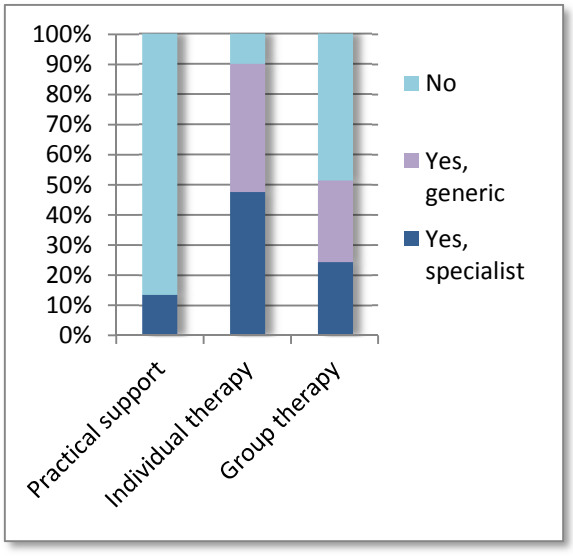

Figure 11: Types of support available to domestic and sexual violence survivors

In conclusion, there is limited specialist support for survivors of domestic violence within mental health services. Many Trusts

noted that generic staff – social workers, nurses and psychologists – routinely support survivors around their experiences of abuse. Taking into consideration the overall limits to training, policy support and guidance around domestic violence, this is somewhat concerning. Whilst it may be argued that survivors of abuse should be referred to specialist external agencies for both practical and therapeutic support, there is also a case to be made that large organisations such as Mental Health Trusts should develop greater internal resources, including access to a range of specialist support, in order to not only protect vulnerable survivors of domestic violence but also to promote their recovery from abuse.

Recommendations

- Further research is needed into the most effective ways of developing strategic leadership for domestic violence within Mental Health Trusts. Whilst embedding domestic violence within existing safeguarding frameworks is seen by many as a way of mainstreaming and promoting awareness of domestic violence, this can lead to a polarised approach to domestic violence which does not take into account the holistic needs of survivors of both current and historic abuse.

- Each Mental Health Trust should draft a stand-alone domestic violence strategy, outlining their commitments to improving responses within their own organisations and in partnership with relevant statutory and voluntary agencies. Being a signatory of a local multi-agency strategy is insufficient for driving forward internal organisational change.

- The Department of Health should provide a template policy for responding to domestic and sexual violence within Mental Health Trusts. Policies should include practice guidance on responding to survivors and perpetrators of abuse who are either service users or staff members. Guidance should go beyond the existing focus of safeguarding vulnerable service users from risk of further harm to take a more holistic approach.

- Safeguarding referrals pathways should be amended to include information about local MARAC procedures. Along with more comprehensive stand-alone guidance on domestic violence, this may encourage staff to refer directly to the MARAC and reduce the number of queries to safeguarding teams.

- Mental Health Trusts should consider increasing access to training about domestic violence, as well as expanding the curriculum to include information outside of what is relevant to safeguarding victims.

- Further research is needed into the rates of routine enquiry about domestic violence within mental health services. This should comprise an analysis of policies and protocols as well as auditing of clinical files to identify where staff are asking, and when not, what reasons are given. Trusts can then use this data to address any barriers to routine enquiry which are highlighted.

- Individual Trusts should monitor rates of referring victims of domestic violence to external agencies, including MARACs. This will enable Trusts to monitor not only levels of disclosures of but also effective responses to domestic violence.

- Consideration should be given to jointly funding specialist workers, such as independent domestic violence advisors, to be based within Mental Health Trusts.

Bibliography

Campbell, J. (2002) “Health consequences of intimate partner violence”, *The Lancet*, 359 (9314), 1131–1136

Department of Health (2000) *No Secrets: guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse* (London: Department of Health)

Department of Health (2003) *Gender and Women's Mental Health Implementation Guidance, Section 8, Violence and Abuse* (London: Department of Health)

Department of Health (2008) *Refocusing the Care Programme Approach Policy and Positive Practice Guidance* (London: Department of Health)

Dutton, M.A., Kaltman, S., Goodman, L.A., Weinfurt, K. and Vankos N. (2005), “Patterns of intimate partner violence: correlates and outcomes”, *Violence and Victims,* 20*,* pp. 483-497

Golding, J. (1999) “Intimate partner violence as a risk factor for mental disorders: a meta-analysis”, *Journal of Family Violence*, 14(2), 99-132

Harold, G. and Howarth, E. (2004) “How Marital Conflict and Violence Affects Children: Theory, Research and Future Directions” in M. Calder, G. Harold and E. Howarth (eds) *Children Living with Domestic Violence: Towards a Framework of Assessment and Intervention* (Russell House Publishing)

Herman, J. (2001) *Trauma and recovery: From domestic abuse to political terror* (New York: Rivers Oram/Pandora)

Hien, D., Cohen, L. and Campbell, A. (2005) “Is traumatic stress a vulnerability factor for women with substance use disorders?”, *Clinical Psychology Review*, 25, 813-823

Holly, J, and Horvath, M.A.H. (2012) “A question of commitment – improving practitioner responses to domestic and sexual violence, problematic substance use and mental ill-health”, *Advances in Dual Diagnosis*, 5(2), pp59-67

Howard, L.M., Trevillion, K. and Agnew-Davies, R. (2010a) “Domestic violence and mental health”, *International Review of Psychiatry*, 22(5), 525-534

Howard, L.M., Trevillion, K., Khalifeh, H., Woodall, A., Agnew-Davies, R, and Feder, G. (2010b) “Domestic violence and severe psychiatric disorders: prevalence and interventions”, *Psychological Medicine*, 40, 881-893

Humphreys, C. and Thiara, R. (2003) “Mental Health and Domestic Violence: ‘I Call it Symptoms of Abuse’”, *The British Journal of Social Work*, 33(2), 209-226

Humphreys, C. and Regan, L. (2005) *Domestic Violence and Substance Use: Overlapping Issues in Separate Services, Final Report*, (London: Greater London Authority and the Home Office)

Kaysen, D., Dillworth, T.M., Simpson, T., Waldrop, A., Larimer, M.E. and Resick, P. (2007) “Domestic violence and alcohol use: Trauma-related symptoms and motives for drinking”, *Addictive Behaviours*, 32, 1272-1283

McFarlane, J., Malecha, A., Gist, J., Watson, K., Batten, E., Hall, I. and Smith, S. (2005) "Intimate Partner Sexual Assault Against Women and Associated Victim Substance Use, Suicidality, And Risk Factors For Femicide", *Issues in Mental Health Nursing*, 26(9), pp.953 - 967

McLindon, E. and Harms, L. (2011) "Listening to mental health workers' experiences: Factors influencing their work with women who disclose sexual assault", *International Journal of Mental Health Nursing*, 22, 2-11

NHS Confederation (2008) *Implementing national policy on violence and abuse*, Briefing number 162 (London: NHS Confederation)

Oram, S., Trevillion, K., Feder, G. and Howard, L.M. (In Press) "Systematic review of the prevalence of domestic violence victimisation amongst psychiatric patients" *British Journal of Psychiatry*

Ramsay, J., Richardson, J., Carter, H., Davidson, L. and Feder, G. (2002) "Should health professionals screen women for domestic violence? Systematic review", *British Medical Journal*, 325: 314

Rees, S., Silove, D., Chey, T., Ivancic, L., Steel, Z., Creamer, M., Teesson, M., Bryant, R., McFarlane, A.C., Mills, K.L., Slade, T., Carragher, N., O'Donnell, M and Forbes, D. (2011). "Lifetime Prevalence of Gender-Based Violence in Women and the Relationship With Mental Disorders and Psychosocial Function", *Journal of the American Medical Association*, 306(5), 512-521

Rose, D., Trevillion, K., Woodall, A., Morgan, C., Feder, G. and Howard, L. (2011) "Barriers and facilitators of disclosures of domestic violence by mental health service users: qualitative study", *British Journal of Psychiatry*, 198, pp.189-194

Steel, N., Blakeborough, L. and Nicholas, S. (2011) *Supporting high-risk victims of domestic violence: a review of Multi-Agency Risk Assessment Conferences (MARACs),* Home Office Research Report 55 (Summary), (London: Home Office)

Tanielian, T. and Jaycox, L. (eds.) (2008) *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery* (Santa Monica, CA: RAND Corporation)

Trevillion, K., Howard, L., Morgan, C., Feder, G., Woodall, A. and 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*, DOI: 10.1177/107839031245974

Appendix A: Freedom of Information Request 1

(Date)

By email to:

Dear Sir or Madam,

My name is (insert name here) and I am working for AVA (Against Violence and Abuse). We have been funded by the Department of Health to look at models of responding to survivors and perpetrators of domestic and sexual violence who are also affected by mental ill-health and/or problematic substance use.

As part of our three-year project, we are contacting all mental health Trusts in England to find out what systems are already in place to respond to victims and perpetrators of domestic violence and sexual abuse, and whether there is any support that we might be able to offer you.

I have a few questions I was hoping you could help me with as follows:

a. **What policies and procedures do you have in place for responding to domestic violence?**
b. **Would it be possible to have a copy of your safeguarding and/or domestic violence policy as we are trying to gather examples of best practice and this would be a really useful addition to our resources?**
c. **Do staff routinely ask about domestic violence?**
d. **What domestic violence training do you run for staff?**
e. **Is the Trust represented on the local MARAC (Multi Agency Risk Assessment Conference)? If yes, who is the Trust representative (and what is their name and email address)? Could you please let me know how many referrals the Trust has made to the MARAC in the last year?**
f. **My last question - Would you like any information about AVA? As a second-tier organisation, our role is to provide support and advice to agencies like yourself on responding to domestic violence. We offer a wide range of services including running service user consultations and mapping exercises, support in developing policies and procedures, delivering training and facilitating multiagency work.**

We understand that you are required to respond within 20 working days to this request. We look forward to hearing from you soon.

Yours sincerely

Appendix B: Freedom of Information Request 2

(Date)

By email to:

Dear Sir or Madam,

My name is (insert name here) and I am working for AVA (Against Violence and Abuse). We are a national second-tier domestic and sexual violence; we do not deliver frontline services but provide training and consultancy support to agencies that do come into contact with survivors or perpetrators of abuse.

We have been funded by the Department of Health to look at models of responding to survivors and perpetrators of domestic and sexual violence who are also affected by mental ill-health and/or problematic substance use. As part of our three-year project, we are contacting all mental health Trusts in England to request the following information:

a) **Do you employ any staff to specifically provide practical or emotional support to victims of domestic and sexual violence?**

b) **Do you provide any individual therapeutic support to victims of domestic and sexual violence specifically to address their experiences of abuse (e.g. trauma counselling)?**

c) **Do you provide any group therapeutic support to services users who are victims of domestic and sexual violence specifically to address their experiences of abuse?**

d) **Does the organisation have a strategy for addressing domestic or sexual violence? If so, please could you provide a copy.**

I look forward to receiving your response via email at (insert email address) by (20 working days from date of letter).

Yours sincerely

Appendix C: Mental Health Trusts that completed FOI requests

Trust	FOI Request 1	FOI Request 2
2gether NHS Foundation Trust	x	
5 Boroughs Partnership NHS Foundation Trust	x	x
Avon and Wiltshire Mental Health Partnership NHS Trust	x	x
Barnet, Enfield and Haringey Mental Health Trust	x	x
Berkshire Healthcare NHS Foundation Trust	x	x
Birmingham and Solihull Mental Health Foundation Trust	x	x
Black Country Partnership NHS Foundation Trust	x	
Bradford District Care Trust	x	x
Calderstones Partnership NHS Foundation Trust		
Cambridgeshire and Peterborough NHS Foundation Trust	x	x
Camden and Islington NHS Foundation Trust	x	
Central and North West London NHS Foundation Trust	x	x
Cheshire and Wirral Partnership NHS Foundation Trusts	x	x
Cornwall Partnership NHS Foundation Trust	x	x
Coventry and Warwickshire Partnership NHS Trust	x	x
Cumbria Partnership NHS Foundation Trust	x	x
Derbyshire Healthcare NHS Foundation Trust	x	x
Devon Partnership NHS Trust	x	x
Dorset Healthcare University NHS Foundation Trust	x	x
Dudley Walsall Mental Health Partnership NHS Trust	x	x
East London NHS Foundation Trust	x	x
Greater Manchester West Mental Health NHS Foundation Trust	x	x
Hertfordshire Partnership NHS Foundation Trust	x	x
Humber NHS Foundation Trust	x	x
Kent and Medway NHS and Social Care Partnership Trust	x	x
Leeds and York Partnership NHS Foundation Trust	x	x
Leicestershire Partnership NHS Trust	x	x
Lincolnshire Partnership NHS Foundation Trust	x	x
Manchester Mental Health and Social Care Trust	x	x
Mersey Care NHS Trust	x	x
Norfolk and Suffolk NHS Foundation Trust	x	x
Norfolk and Waverley Mental Health NHS Foundation Trust	x	
North East London NHS Foundation Trust	x	x
North Essex Partnership NHS Foundation Trust		
North Staffordshire Combined Healthcare NHS Trust	x	x
Northamptonshire Healthcare NHS Foundation Trust		
Northumberland, Tyne and Wear NHS Foundation Trust	x	x
Nottinghamshire Healthcare NHS Trust	x	x
Oxford Health NHS Trust	x	x
Oxfordshire Learning Disability NHS Trust	*Do not provide mental health services*	
Oxleas NHS Foundation Trust	x	
Pennine Care NHS Foundation Trust	x	x
Rotherham, Doncaster and South Humber Mental Health NHS Foundation Trust	x	x

Sheffield Health and Social Care NHS Foundation Trust	x	x
Somerset Partnership NHS Foundation Trust	x	*Delayed*
South Essex Partnership University NHS Foundation Trust	x	
South London and Maudsley NHS Foundation Trust	x	x
South Staffordshire Healthcare NHS Foundation Trust	x	x
South West London and St George's Mental Health NHS Trust	x	x
South West Yorkshire Partnership NHS Foundation Trust	x	x
Southern Health NHS Foundation Trust	x	
Surrey and Borders Partnership NHS Foundation Trust	x	x
Sussex Partnership NHS Foundation Trust	x	x
Tavistock and Portman NHS Foundation Trust		
Tees, Esk and Wear Valleys NHS Foundation Trust	x	
West London Mental Health NHS Trust	x	
TOTAL	**51 out of 56 Trusts**	**43 out of 56 Trusts**