

# **Complicated Matters:**

**A toolkit addressing  
domestic and  
sexual violence,  
substance use and  
mental ill-health**



# AVA Toolkit

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# Acknowledgements

## **Complicated matters: a toolkit addressing domestic and sexual violence, substance use and mental ill-health**

is the culmination of the Stella Project Mental Health Initiative. The Initiative, a three year project funded by the Department of Health, aimed to improve responses to survivors and perpetrators of domestic and sexual violence who are also affected by substance use and/or mental health problems.

The greatest steer for this project and the toolkit has come from **survivors' voices\***. There is nothing more powerful than sitting in a room with survivors telling you of their experiences – of abuse, of trauma, of not understanding why they felt the way they did, of seeing no other way to cope than by having a drink or using drugs. They also tell you of their experiences of being turned away from services, being told to 'get themselves together', not being believed when they have told professionals what has happened to them.

Over the past three years, survivors have told us that ultimately all they want is to **be treated like a human being**. This toolkit is therefore

a tribute to human spirit, to the resourcefulness and resilience of all the survivors who generously shared their time, their experiences and their expertise to make this toolkit what it is. Thank you.

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Jennifer Holly  
Author

*\*All the survivor's voices quoted in  
the toolkit have been taken from  
Treat me like a human being, like  
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of the Stella Project Mental Health  
Initiative Survivor Consultation. The  
full report can be accessed from  
<http://tinyurl.com/c32557t>.*

# Foreword

Gene Feder



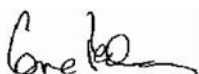
The experience of domestic or sexual violence can lead to mental health problems and substance abuse. In turn, people struggling

with mental health problems and substance abuse are more vulnerable to further violence. Yet, in undergraduate medical education, the relationship between violence or trauma, mental health conditions and drug/alcohol abuse is rarely discussed. Nor is the clinical competence to respond appropriately to the intersection of these three problems developed in the course of most postgraduate medical education. This is particularly problematic for general practitioners, the clinicians with most contact with the population, including people struggling with long-standing depression or alcoholism stemming from current or past abuse. That domestic or sexual abuse may well be hidden if the GP does not ask about it,

undermining efforts to address the mental health or substance abuse problem, ignorant of the trauma that drives them.

This comprehensive, lucidly written toolkit cannot compensate for the relative neglect of these issues in medical education, but it will help GPs and other generalists address the needs of patients who have experienced domestic or sexual abuse and present with mental health or substance abuse problems. By integrating the views of patients, the expertise of professionals and the evidence on effective management, the toolkit, with an accompanying e-learning package, is an innovative resource, particularly for primary health and social care. Its minimum standards of practice are a benchmark for clinicians and other professionals caring for survivors of domestic and sexual violence. The key features of an appropriate response are well articulated under accessibility, policies and procedures, safety, routine enquiry and assessment, treatment and support, and survivor involvement. These form the basis for a compassionate response

tailored to the needs of patients, a principle that should run through the whole of health and social care.

A handwritten signature in black ink, appearing to read 'Gene Feder', is positioned above the text. The signature is fluid and cursive, with a long horizontal stroke at the end.

Gene Feder  
Professor of Primary Care,  
University of Bristol

Chair of the NICE Domestic Violence  
programme development group

Chair of the WHO Intimate Partner  
Violence guideline development  
group

# Foreword

Louise Howard



We all tend to work in silos and focus on the areas we are most familiar with, but this is not always helpful to our service users or ourselves.

This toolkit provides a bridge across three areas - domestic and sexual violence, problematic substance use and mental ill-health - which often co-exist for service users but currently are not comprehensively addressed by the practitioners in each sector. Our research has confirmed that mental health service users have a high prevalence of a history of experiences of domestic and sexual violence and this is particularly the case for women. We have also found that domestic and sexual violence impacts on mental health problems across the diagnostic spectrum, including depression and anxiety, eating disorders, substance misuse and psychosis. Unfortunately we have also found that mental health professionals continue to have

significant gaps in their knowledge of, and fail to respond to, their clients' experiences of domestic and sexual violence, despite policy guidance. Similarly, there is evidence that the domestic and sexual violence sector are not always responding to the specific needs of people with mental ill-health and substance use problems.

This toolkit is therefore to be welcomed. It provides clear guidance to professionals interacting with clients affected by all three issues, so that practitioners in the domestic and sexual violence sector, substance misuse services and mental health services (including primary care) can deepen their understanding of these three inter-linked areas. The toolkit provides practical advice on how to understand the client's issues, ask about their experiences in a sensitive non-judgemental way, find out what their needs are while prioritising safety, consider the needs of the family, and promote recovery. But overall the focus is in articulating key principles that should underpin any intervention. These principles, developed in

consultation with survivors, are: to treat people like human beings, treat people with respect, be empathic and compassionate, value people's insight into their own situation and what will help them, and be patient and flexible.

I do hope this toolkit will be widely used so that it can facilitate practitioners engaging more effectively with survivors and promoting their safety and recovery.

A handwritten signature in black ink, appearing to read 'L Howard'.

Louise M Howard

Professor in Women's Mental Health,  
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# Section 1

## Introduction

# Section 1

# Introduction

## 1. Background

### 1.1 The Stella Project Mental Health Initiative

AVA is a national organisation working to end all forms of violence against women and girls. As a second tier service, our service users are other agencies that develop policies around, and/or provide services to women, children and men who experience or perpetrate different forms of violence against women and girls.

In our fifteen year history, as AVA and formerly the Greater London Domestic Violence Project (GLDVP), we have positioned ourselves as an expert on the overlapping issues of domestic and sexual violence, substance use and mental ill-health.

The Stella Project was born out of discussions in 2002 between the GLDVP and the Greater London Alcohol and Drug Alliance (GLADA) which identified gaps in the provision for both survivors and perpetrators of domestic violence who also used substances problematically. The GLDVP and then AVA have been

funded ever since to support service providers and promote joint working between the domestic violence and substance treatment sectors.

In 2003 and 2005 GLDVP hosted Round Table discussions on mental health and domestic violence, bringing together both sectors. They developed a common understanding of the issues, shared goals for training, plans for effective service provision and drafted key messages and minimum standards.

Recognising the links between all three issues, in 2010 the Stella Project brought both strands of work together through the Stella Project Mental Health Initiative. This three year project, funded by the Department of Health, has supported a range of services in Bristol, Nottingham and the London Borough of Hounslow to develop more effective, joined-up responses to survivors and perpetrators of domestic and sexual violence who are also affected by substance use and/or mental ill-health.

## 1.2 The toolkit

“Complicated matters: a toolkit addressing domestic and sexual violence, substance use and mental ill-health” is one of two major new resources stemming from the Stella Project Mental Health Initiative; the second is an e-learning programme of the same name which is freely accessible here: <http://elearning.avaproject.org.uk/>

The content for both the toolkit and e-learning programme is drawn from:

- consultation with survivors;
- recommendations from frontline practitioners, service managers and academic experts; and
- a review of the relevant available literature, good practice guidelines and toolkits.

## 2. The toolkit

### 2.1 Who should use this toolkit

This toolkit is designed for any

practitioner who works with survivors of domestic and sexual violence who are also affected by substance use and/or mental ill-health, and their families.

Not all individuals who have experiences of domestic and sexual violence, problematic substance use or mental ill-health will need or want to be referred to specialist support. It is therefore essential that all practitioners have an awareness of the issues affecting this client group and a basic understanding of how to work with them.

The toolkit will be useful to practitioners who have time-limited interactions with survivors, perpetrators or their children, as well as those who provide longer-term interventions.

### 2.2 How to use the toolkit

The toolkit is designed to be used as a reference source rather than to be read cover to cover in one sitting. You might refer to a certain section when you are working with an individual or family affected by these three issues.

# Section 1

The toolkit is divided into sections to help you find the information that you need quickly. Each section stands alone but there are common themes.

If you need more information, appendix H outlines additional sources of information and advice.

To check your understanding of the information provided in the toolkit, you can complete the “Complicated Matters” e-learning programme (<http://elearning.avaproject.org.uk/>). On successful completion of the programme you will be able to print out a certificate of completion.

## 2.3 What is the purpose of the toolkit

Domestic and sexual violence, problematic substance use and mental ill-health are three issues that often co-exist. And when they do, things can become complicated. This toolkit is designed to ‘uncomplicate’ matters by raising your awareness about how the three issues interlink and reflecting on the most effective ways to engage with individuals and families who are affected by these issues.

To this aim, the toolkit provides information on:

- The links between experiences of domestic and sexual violence, problematic substance use and mental ill-health
- ways to encourage survivors to engage with services
- how to meet survivors’ needs
- ways to increase safety for survivors and their children
- holding perpetrators accountable for their own violent and abusive behaviour
- developing a holistic approach based on partnerships and integrated work
- practical, adaptable tools which enable organisations to improve policy and practice

## A question of gender

Throughout this toolkit, we have attempted to be as gender neutral as possible in that we have not automatically assumed that all survivors are female or that all perpetrators are male.

In some instances however, we have not been gender neutral. This is mostly because we know that domestic and sexual violence is indeed a gendered issue. For example, we know that leaving a violent relationship is extremely dangerous for heterosexual women. However, the evidence does not suggest that the same is true for men so it would be misleading to state that leaving is a particularly dangerous time for all survivors.

We have also been gendered when presenting research findings that derive from studies that have only focused on female victims / male perpetrators or referring to gender-specific services such as domestic violence perpetrator programmes.

Finally, in some instances, to reduce cumbersome grammatical constructs, we have referred to survivors as female and perpetrators as male in recognition of the fact that this is true in the overwhelming majority of cases. However, this is not meant to imply that this is always the case.

## 3. Definitions

### 3.1 Domestic and sexual violence

This toolkit concerns **domestic and sexual violence**. We use the term 'violence' rather than 'abuse'. The terms are interchangeable.

The current cross-Government definition of **domestic violence** is:

“Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse:

- psychological
- physical
- sexual
- financial
- emotional

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“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.”

*This definition, which is not a legal definition, includes so called ‘honour’ based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.*

The above definition describes the behaviours that constitute domestic violence. However it is important to also understand the motivation of perpetrators which is **to have power and control over the survivor.**

Domestic violence towards people under 16 is generally as child abuse.

Whatever form it takes, domestic violence is rarely a one-off incident: In 35% of households where a first assault has occurred, the second occurs within five weeks.<sup>1</sup> Violence typically escalates in severity and frequency over time.<sup>2</sup> 32% of women experiencing domestic violence are abused at least four times, with an average number of 20 incidents.<sup>3</sup> As such,

**domestic violence is a pattern of abusive and controlling behaviour through which the abuser seeks power over their victim.**

An analysis of ten separate domestic violence prevalence studies by the Council of Europe (2002) showed consistent findings: one in four women experience domestic violence during their lifetime and between 6 - 10% of women experience domestic violence in any given year<sup>4</sup>. These figures are reflected by British Crime Survey data which has also found that, on average, two women a week are murdered by a partner or ex-partner.

**Sexual violence** can happen to children and adults, and may be perpetrated by a family member,

partner, friend, acquaintance or stranger. 1 in 5 women (aged 16-59) has experienced some form of sexual violence since the age of 16, with most women being attacked or abused by someone they know. 54% of rapes, for example, are perpetrated by an intimate (ex-) partner, and 29% by other known individual.<sup>5</sup>

*“Sexual violence can affect anyone. Despite stereotypes involving strangers jumping out from behind bushes, most people are assaulted by someone they know, including partners, family members and acquaintances. Sexual violence is frightening, degrading and humiliating and can have a significant and long-term impact.”<sup>6</sup>*

The Sexual Offences Act 2003 covers a range of sexual offences, including (but not limited to):

- **Rape:** Using the penis to penetrate the vagina, anus or mouth of another person, without their consent
- **Assault by penetration:** Penetrating the vagina or anus of another person, using a body

part (e.g. a finger) or anything else (e.g. a bottle), where they do not consent and the penetration is sexual

- **Sexual assault:** Touching someone sexually, without their consent
- **Causing a person to engage in sexual activity without their consent,** e.g. forcing someone to masturbate themselves
- **Administering a substance with intent:** Administering a substance to another person, where they do not consent to taking the substance and the intention is to stupefy or overpower that person to engage in sexual activity
- **Sexual activity with a child:** it is an offence for a person aged 18 or over to engage in sexual touching of a child aged under 16
- **Paying for sexual services of a child**
- **Causing, inciting or controlling prostitution** for gain, for yourself or a third party

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- **Trafficking** into, within or out of the UK

Under the Act, any sexual activity between a care worker and a person with a mental disorder is prohibited whilst that relationship of care continues. It applies to people working on both a paid and voluntary basis. The laws apply whether or not the victim appears to consent, and whether or not they have the legal capacity to consent.

## Victim or survivor?

The most important time to reflect on our terminology is when working with victims/survivors - how do they refer to themselves? For some, acknowledging that you have survived is important and can also recognise their strength and creativity in doing so. For others, being called a survivor is patronising and denies their victimisation and struggle to cope with the aftermath of violence and abuse.

## 3.2 Problematic substance use

Problematic substance use is defined in different ways by different

organisations, depending on the context in which it is being talked about. The NHS National Institute for Health and Clinical Excellence (NICE) refers to “substance misuse” and describes it as “intoxication by – or regular excessive consumption of and/or dependence on – psychoactive substances, leading to social, psychological, physical or legal problems. It includes problematic use of both legal and illegal drugs (including alcohol when used in combination with other substances).”

AVA’s Stella Project delivers a programme of work around the ways problematic substance use overlaps with domestic and sexual violence. For this reason, we use a wider definition that recognises the ways in which problematic substance use doesn’t just impact on the user, but can also impact on their family, children, friends and community:

### “Problematic substance use

is the use of substances (such as illegal drugs, prescription medicines or alcohol) in such a way that results in harm to the individual user or to the wider community. The range of harms includes problems



for physical health, psychological health, violence, financial problems, family problems or social problems.”

### 3.3 Mental ill-health

Mental health is about what we think and feel, and how we behave. The 2010 Department of Health report, *Confident Communities, Brighter Futures: A framework for developing wellbeing*, defines good mental health as ‘a state of wellbeing in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community’.<sup>7</sup>

Conversely, many people will experience times of mental *ill*-health that affects their daily life, relationships or physical health. Some mental health problems are well-known, such as depression and anxiety. The most commonly diagnosed forms are depression, anxiety, obsessive compulsive disorder (OCD), phobias, bipolar disorder (formerly known as manic depression), schizophrenia, personality disorders and eating disorders. Domestic and sexual violence is also commonly

associated with survivors experiencing post-traumatic stress disorder. Common behaviours and symptoms associated with mental health problems include self-harm, suicidal thoughts and panic attacks.

The Diagnostic and Statistical Manual, now in its fourth edition, is the major text that mental health professionals refer to for classification or diagnosis of mental distress. It categorises mental health problems in terms of mental disorder, defined as:

‘A mental disorder is a clinically significant pattern of thinking, feeling and/or behaving that is associated with distress or impairment’

In this course we talk about **mental ill-health** or **mental health problems** rather than disorders.

### 3.4 Dual diagnosis

A dual diagnosis commonly refers to co-existing mental health and substance use problems.

We refrain from using this term in the toolkit as it fails to recognise that people affected by problematic substance use and mental ill-health

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often have many other needs, both medical and social.

However, it is important for practitioners to be aware that clients who have severe concurrent mental health AND substance use problems may be able to access specialist services which can deal with these issues.

In many cases, however, survivors will not meet the thresholds, and having a label such as 'dual diagnosis' can impact negatively on survivors.

## 3.5 Complex needs, a toxic trio and the trilogy of risk

The past few years has seen an increased awareness of the frequency with which domestic and sexual violence, substance use and mental ill-health co-exist, particularly in the context of safeguarding children and young people.

Various terms have been coined to describe the concurrent experience of these three issues, including survivors having complex needs. We refrain from using this term in the toolkit as it is yet another label

which is used to exclude survivors from services. Furthermore, any combination of needs may be complex, not just substance use and mental health.

We also do not use the terms 'toxic trio' or 'trilogy of risk' which can suggest that the survivor is toxic or is the main source of risk, and thus does not hold the perpetrator to account for his abusive behaviour.

## 4. Key messages

There are a number of key messages which run through the toolkit. Some are for practitioners; others are for practitioners to pass onto survivors, perpetrators or their children.

### For practitioners:

- **You probably already have many skills** that can be used to support survivors who are also affected by substance use and mental ill-health. A non-judgemental approach, a listening ear, access to information and the ability to empower others are all key.

- **We are working with human beings.**

People who have combined experiences of domestic and sexual violence, mental ill-health and problematic substance often only come to the attention of services when the difficulties become so problematic that an intervention is needed. By this point, we can end up working with people who are traumatised, who use coping strategies which we consider dangerous or unhelpful, who are seemingly stuck at a certain point in their life. They can be some of the most challenging and frustrating clients we work with, so remembering where they have come from and that they still deserve our support is vital.

- **Women are more at risk of violence and abuse than men.**

45% of women in the UK will experience domestic or sexual violence in their lifetime. By comparison, 17% of men will experience at least one incident of threat, force, financial or emotional abuse and 2% have been sexually victimised since the age of 16.<sup>8</sup>

- **Every survivor is an individual.**

Many survivors of domestic and sexual violence will remain anonymous. They may be experiencing mental ill-health as a result of their experiences but are coping, or appear to be coping. Their coping strategies may include the use of many different substances, all of which may remain hidden. Survivors come from all parts of society and all walks of life. As you cannot tell who is or isn't a survivor, who is or isn't struggling with their mental health, and who is or isn't using medication, drugs or alcohol to manage, don't make assumptions about who needs support.

*"[There is a] real sense that you need to present yourself as vulnerable in order to get any support; if you present strong and well, the response is different than if you were a mess, crying and sobbing and weak – you have to almost dumb down to get anywhere, to get an effective response"*

Survivor's voice

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- **Survivors may be marginalised in more than one way.**

In addition to the stigma of experiencing abuse, having mental health problems and/or using drugs and alcohol problematically, your service users may experience additional discrimination if, for example, they are from BAMER (Black, Asian, Minority Ethnic and Refugee) communities, are disabled, or are LGBT (lesbian, gay, bisexual or transgender) which can compound difficulties in accessing support.

- **Work in partnership.** Working collaboratively will reduce your workload, increase your confidence, improve the outcomes for survivors and children and reduce the risk of their repeat victimisation.

- **Keeping a record is important.** Records can be important in legal proceedings, including Domestic Violence Homicide Reviews, as well as in supporting survivors and children to access legal, housing and welfare rights.

## For practitioners and survivors:

- **“I believe you”.** It is important to acknowledge that a service user has disclosed abuse and that you believe what they have said.

- **“You are not alone”.** All three issues are commonplace. Violence against women has affected almost 1 in 2 women in the UK.<sup>9</sup> The majority of survivors will experience some type of psychological or emotional response to the trauma, and using prescribed medication, alcohol or other substances is a common coping strategy.

- **Experiences of domestic and sexual violence, mental ill-health and substance use are frequently interlinked.**

Domestic violence and other abuse is the most common cause of depression and other mental health difficulties in women, and results in self-harm and suicide rates among survivors which are at least four times higher than the general female population.<sup>10</sup> Overall, women who have experienced at least one form of gender-based violence<sup>11</sup> are at least three times more likely to be substance dependent

than women who have not been affected by gender-based violence.<sup>12</sup>

- **“You are not to blame”** for the violence. Discussing mental health without acknowledging the impact of violence can increase a victim’s feelings of blame, and fails to hold her abuser(s) accountable.
- **Acknowledge survivors’ strengths.** Your clients have many strengths to build upon; it will have taken much courage and resourcefulness to have survived this far.
- **Safety is a priority.** If someone is currently in contact with an abuser, she may well be at risk of further harm if the abuser knows they have disclosed, are accessing services or (in the case of domestic violence) try to leave the relationship. Some victims may want to stay with their partner, for example, if he is the carer or if they believe it will increase their safety from others. In either case, do not force victims to leave, as this increases the risk of serious harm or death, but encourage her to complete a safety plan to keep herself as safe as possible.
- **A whole person approach is vital.** Ignoring drug, alcohol or mental health problems can leave a survivor less able to manage her safety or change her circumstances. Conversely, if you do not address her safety needs or how the abuse has impacted on the survivor, attempting to address her mental health or substance use will be less effective.
- **Support is available.** Survivors should be provided with information about support options and be enabled to decide what happens next. Survivors are the experts on what they need.
- **Think family.** A survivor’s parenting abilities may be affected by all three issues, so her children’s safety and well-being must be taken into consideration. The greatest risk of harm, however, comes from the perpetrator. Any non-abusing parent should be supported to improve their skills and confidence in looking after their children, and not blamed for ‘failing to keep the perpetrator away’.

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- **Recovery is possible.** People do recover from mental ill-health, problematic substance use, and from abuse.

## For practitioners and perpetrators:

- **Domestic violence is a range of abuse** (not just physical) which is an attempt to control and manipulate a partner or ex-partner.
- **Domestic violence is not acceptable.**
- **Perpetrators are responsible for their violence;** survivors are not to blame for the violence they experience.
- Experiencing mental health issues or substance use problems is **no excuse for perpetrating domestic violence.**
- **Addressing a perpetrator's mental health or drug/alcohol use alone will not reduce their abusive behaviour.** Even if treatment is able to reduce the severity of the violence it does not address the complex dynamics

of and power and control which underpin domestic violence. Therefore, work which specifically addresses such dynamics should accompany a care or treatment plan.

## 5. The AVA approach

### 5.1 Our values

Regardless of which survivor we are working with, or what intervention we offer, we need to think first and foremost about the values we bring to our work:

- Treat people like human beings
- Treat people with respect
- Be empathic and compassionate
- Value people's insight into their own situation and what will help them
- Be patient and flexible

With this as our starting point, there is a greater chance that survivors who have mental health and/or substance use problems will feel able to engage with our services.

## 5.2 The model for working the survivors

This toolkit is based on a simple model for supporting survivors of domestic and sexual violence who are also affected by substance use and/or mental ill-health:

Step 1	Understand the issues
Step 2	Ask the questions
Step 3	Find out what the person needs
Step 4	Prioritise safety
Step 5	Think family
Step 6	Hold the perpetrator accountable

## 5.3 Minimum standards of practice

### Accessibility

- Survivors should not be denied services due to issues with domestic or sexual violence, substance use or mental ill-health.
- Survivors require a non-judgemental and safe environment that generates trust.

- Women-only and women-led services must be available to all female survivors who wish to access them, whenever possible.

- Services need to be accessible to all potential clients and work to meet the diverse needs of all potential clients. This includes provision for children, as well as disability access and access to interpreters where relevant.

- Survivors should be supported in their role as mothers, e.g. by providing childcare.

### Policies and procedures

- Agencies should have clear policies addressing domestic and sexual violence, substance use and mental ill-health.
- Early detection of relevant issues can provide a survivor with greater safety and options. Services may find it beneficial to carry out routine questioning for all three issues after receiving training.
- Be clear about confidentiality boundaries at all times. Where information needs to be shared, always seek the survivor's

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consent. Whether or not you act with her consent, share information safely.

- Ensure that information is available about how to access help. Make information about domestic violence, substance use and mental health services accessible.
- Keep records of enquiries, disclosures and actions.
- Network to improve cross-sector understanding, collaboration, training and referrals.

## Safety

- ALWAYS make safety the priority.
- Survivors MUST NOT be sent back to a place of danger, or where violence occurred, against their will.

## Routine enquiry and assessment

- Provide service users with the means to talk alone, safely and confidentially.
- Always validate survivors' experiences when they disclose.

- Recognising and naming abusive behaviour can be a powerful intervention in itself.
- In terms of domestic violence, do not blame the victim but hold the perpetrator accountable for their own behaviour.
- Acknowledge wherever possible that experiences of trauma can have an impact on the survivor's mental health and that substance use is a common coping strategy. Normalising what might be a very scary experience for survivors can be very helpful.
- Survivors often experience inappropriate labelling that can be damaging to their self-esteem as well as give rise to stigma and further abuse. When referring to survivors, use non-judgemental and non-stigmatising language at all times.

## Treatment and support

- Treatment should not depend on a woman's current level of safety or the status of her relationship. Support should never be withheld from a survivor at risk of harm.



- Survivors are supported to make choices about their own lives and to take control of decisions.
- A 'menu' of different interventions and approaches is available so that women can choose different interventions at different times depending on their needs. The principle of choice is itself empowering.
- Couple and family counselling is unsafe for women experiencing domestic violence.
- Mental health services should not provide medication (except on a very short-term basis) without offering counselling and referral to advocacy.
- Survivors may leave a relationship several times before the break is permanent. They may also relapse more than once in terms of substance use or mental health. These are all common experiences and survivors should be supported through this, rather than criticised or excluded.

## **Survivor involvement**

- Survivors should be genuinely involved in the assessment and care planning process.
- Survivors need to be consulted about the interventions they find supportive and effective.



# Section 2

Getting the  
whole picture

# Section 2

## Getting the whole picture

### Section outline

This section provides an overview of the links between experiences of domestic and sexual violence, mental ill-health and substance use. Our starting point is an understanding of domestic and sexual violence as being traumatic events that survivors respond to and cope with in many different ways.

1. What is trauma?
2. Trauma responses
3. Trauma and the brain
4. Trauma and mental ill-health
5. Post-traumatic stress disorder
6. Managing trauma responses
7. Substance use as a coping mechanism

### 1. What is trauma?

Experiencing a traumatic event, either in childhood or as an adult, is

a common starting point for mental ill-health and substance use.

The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (2004) defines trauma as a situation whereby someone has:

*“experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.”*

Bessel van der Kolk, a professor of psychiatry at Boston University School of Medicine and an expert in post-traumatic stress, defines trauma as **“an inescapably stressful event that overwhelms people’s coping mechanisms”**.<sup>1</sup>

When understood in this way, it becomes clear that traumatic events are commonplace in our world:

- Domestic violence – according to the British Crime Survey, 1.2 million women and 800,000 men experienced domestic violence in 2010/11.

- Rape and sexual assault – 19 per cent of women and two per cent of men in England and Wales have been sexually assaulted or raped, or someone has attempted to sexually assault or rape them.<sup>2</sup>
- Reports of child abuse and neglect – approximately one quarter of all young adults have been severely maltreated, sexually abused and/or witnessed domestic violence as a child.<sup>3</sup>
- Violent crime – there were an estimated 2.2 million incidents of violent crime in England and Wales in 2010/11.<sup>4</sup>
- Car accidents – in 2011 the police in England, Scotland and Wales recorded 203,950 car accidents that involved someone being injured. This includes 23,122 people sustaining serious injuries and 1,901 being killed.<sup>5</sup>
- Death of a parent - around 53 children and young people under the age of 16 are bereaved of a mother or father every day in the UK. <sup>6</sup>
- Combat – according to the Ministry of Defence,<sup>7</sup> over 9,000 military personnel are currently on active duty in Afghanistan alone. Many will experience trauma.

In addition to describing what typifies a traumatic event, some definitions also refer to the feelings of **“intense fear, helpless[ness], or horror”<sup>8</sup>** and **“life-threatening powerlessness”<sup>9</sup>** which can accompany the experience of trauma.

The idea of trauma as an event that makes someone feel helpless and powerless is key to understanding how survivors of domestic and sexual violence may think and behave.

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## Spread the word

As well as developing a solid understanding of trauma and the links with mental ill-health and problematic substance use, it is really important that we enable survivors to understand what is happening to them.

Psycho-educational work is commonplace in many settings now, and is the cornerstone of trauma work. Survivors often do not see the link between their own experiences of trauma and the difficulties they have with their mental health or substance use. Responses to trauma such as flashbacks and dissociation can also give rise to fear as well as self-blame if survivors do not understand why their minds and bodies work in certain ways.

Women's Aid, Rape Crisis, Mind and the Mental Health Foundation all provide information about common responses to experiences of domestic violence, sexual violence and trauma which survivors may find useful.

AVA's toolkit, Sane Responses, also offers succinct information about the links between domestic violence

and each of the most common mental health problems and practical guidance for domestic violence and mental health workers on how to address these issues. Information about all these resources can be found in appendix H.

## 2. Trauma responses

There is no standard pattern in how people react to the extreme stress of traumatic experiences such as domestic and sexual violence. Some people will respond immediately, whilst others may have a delayed reaction. The length of time needed to recover also varies – some people may recover quickly and others will experience the negative effects of trauma over months or years.

There are, however, a wide range of commonly recognised emotional, physical, cognitive, behavioural and interpersonal responses to domestic and sexual violence.

### 2.1 Emotional

Experiencing domestic and sexual violence can give rise to many different feelings:

- Anger, rage, aggression
- Guilt, shame
- Difficulties in regulating emotions
- Fear, preoccupation with danger
- Numb, detached from feelings
- Sadness
- Depression, hopelessness
- Anxiety
- Powerlessness
- Fear of dependency

## 2.2 Physical

The physical impact of trauma includes injuries and other acute health problems directly related to the trauma as well as the long term impact of traumatic stress on the body.

**Acute health problems:** from repeated physical assaults, sexual assaults and rape; sexually transmitted diseases and pregnancy; injuries from self-harming behaviour or attempted

suicide; other accidental injuries due to high tolerance of pain resulting from disconnection to body.

**Stress-related problems:** sleep disturbance, gastrointestinal problems (IBS), migraines, chronic fatigue syndrome, impaired immune system, chronic pelvic pain, somatisation disorder (multiple, on-going physical complaints of no distinguishable cause), eating difficulties, asthma.

All physical problems may be exacerbated by a lack of access to medical care.

## 2.3 Cognitive

Experiencing trauma can lead to changes in survivors' mental processing, i.e. the way they receive, transmit and operate on information. These types of changes are called cognitive responses and include:

- Difficulties concentrating and maintaining attention
- Problems with planning, making decisions, taking action

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- Differing levels of dissociation, from 'spaciness' to complete detachments and disconnection
- Identity disturbance – derealisation (the world seems unreal), depersonalisation (I am unreal; living in a dream-like state), fragmented sense of self (no clear sense of identity)
- Intrusive memories – flashbacks and nightmares
- Fragmented memory, problems with recall of events and information, amnesia of parts of the trauma
- Panic attacks and exaggerated startle responses
- Phobias, obsessive compulsive behaviour
- Self-blame, self-doubt, low self-esteem and lack of confidence
- Rumination, worry cycle
- Loss of meaning and apathy
- Minimisation and denial

## 2.4 Behavioural

How we think and feel can influence our behaviour. Survivors often behave in ways that might seem unhealthy or even dangerous, but are often ways of coping with how they are feeling inside, or externalising their feelings and thoughts:

- Self-harming
- Suicidal ideation and attempts
- Alcohol and drug use
- Eating disturbances
- Irritability, impatience, impulsive and aggressive behaviour, anti-social behaviour
- Hypersensitive to the environment
- Risky sexual behaviour, sexual acting out, compromised sexuality
- Fiercely independent, reject help, hostile and resistant to interventions
- Loss of interest in activities



## 2.5 Interpersonal

Trauma is known to affect how survivors relate to others; this is particularly true when the trauma has been caused by another person rather than a natural disaster. The survivor may respond to trauma with:

- Withdrawal from others, from their community
- Isolation, sense of alienation
- Difficulties with trust
- Problems relating to others, impaired mentalisation
- Difficulties with power and control
- Lack of interpersonal boundaries, lack of assertiveness in relationships
- Issues with intimacy, sexual problems
- Intolerance
- Angry outbursts
- Expectation of rejection

## Incongruence and betrayal

Traumatic experiences have been referred to as being abnormal life events, i.e. outside our normal expectations of life and in contrast with what we believed in, knew or had experienced beforehand. For many survivors this contrast, or incongruence, can be the most difficult part and take the longest to come to terms with. Even survivors of long-term abuse can still be shocked by incidents of violence. Similarly, being violated by someone you should be able to trust – a parent, a relative or a partner – can evoke a strong sense of betrayal which can lead to severe trauma responses.

## 3. Trauma and mental ill-health

Responses to trauma often manifest themselves, and are diagnosed, as mental health problems. There is a growing evidence base to suggest a clear association, and further a potential causal relationship, between experiences of trauma, particularly being the victim of violence, and poorer mental health:<sup>10</sup>

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- 56% of women experiencing domestic violence are diagnosed with a psychiatric disorder.<sup>11</sup>
- Rates of depression for survivors of domestic violence are around four times as high as the rates for non-abused women.<sup>12</sup>
- Research in the US has found that 30% of rape victims report experiencing at least one episode of major depression in their lives compared with only 10% of women who have never been affected by violent crime.<sup>13</sup>
- In one study, the rate of lifetime depression among childhood rape survivors was 52% compared to 27% among non-victims.<sup>14</sup>
- On average, at least two thirds of domestic violence survivors and women who have experienced sexual violence in childhood and/or as an adult report suffering from anxiety and a third have panic attacks.<sup>15</sup>
- Survivors of domestic violence are much more likely to experience post-traumatic stress disorder (PTSD) than people involved in serious car accidents.<sup>16</sup>
- One third of women attending A&E for self-harming have experiences of domestic violence.<sup>17</sup>
- Women who have experienced domestic or sexual violence are around four times more likely to think about suicide compared with the general female population.<sup>18</sup>
- Victims of domestic violence who experience sexual violence are five times more likely to attempt suicide than those who have not.<sup>19</sup>
- Survivors of childhood sexual abuse have also been shown to be at greater risk of problem alcohol use and eating disorders later in life.<sup>20</sup>
- Research has also found that the more abuse you experience, the greater the impact on your mental well-being.<sup>21</sup>

Sadly, however, mental health problems are often diagnosed without knowledge of or reference to any trauma. The dominant medical model of understanding mental distress means this connection frequently remains obscured and survivors are pathologised for the way they respond to trauma.

**Not taking into account experiences of trauma when assessing and treating mental health problems** can leave victims at risk of further harm from a perpetrator, as well as result in less effective interventions to manage their mental health.

## 4. Post-traumatic stress disorder

In addition to experiencing higher rates of depression and anxiety than the general population, survivors of domestic and sexual violence are also more likely to experience post-traumatic stress disorder (PTSD).

### 4.1 What is post-traumatic stress disorder?

Almost all people who go through a traumatic event will respond in some way to their experience. This reaction is typical of normal, healthy people who suffer from trauma involving physical injury or threat. About 30% of people who experience trauma will also experience PTSD.<sup>22</sup>

The diagnostic criteria for PTSD are:

- **Intrusion or flashbacks:** Recurring, distressing re-experiencing of past trauma in memories, dreams or reliving the abuse, as if it was happening all over again.
- **Avoidance** of memories, feelings or conversations associated with the trauma or general **numbing** (unable to remember important aspects of the abuse; loss of interest or involvement in life; feeling flat, empty, pessimistic about a future).
- **Arousal:** including difficulty falling or staying asleep; irritability or anger; difficulty concentrating; hyper-vigilance (being overly watchful); startled easily (jumpy).

In order to meet the clinical diagnosis of PTSD, these reactions must last for more than a month and cause significant distress or affect the person's ability to cope day to day.

In its presentation, PTSD appears to be quite cyclical, with patterns of alternating arousal and avoidance. As the cycle of PTSD continues

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and becomes chronic, avoidance and withdrawal gain prominence, whilst symptoms of arousal and hypervigilance subside. As this happens, survivors may be given diagnoses of depression or somatisation disorder, amongst other things, and the role of trauma in the individual's presenting symptoms may be ignored.<sup>23</sup>

## 4.2 Rates of PTSD

For women and children, trauma that results from violence within intimate relationships can lead to more pronounced responses than traumatic events which are natural disasters or accidents:

- On average, 64% of abused women have PTSD, significantly more than lifetime prevalence of under 26% in the general population.<sup>24</sup>
- Reported rates of PTSD among rape survivors vary from approximately 30% to 65%, with the US National Women's Study reporting that almost one third of all rape victims develop PTSD.<sup>25</sup>
- In one study, women who reported childhood sexual abuse were five

times more likely to be diagnosed with PTSD compared with non-victims.<sup>26</sup> Another study showed that the lifetime rate of a PTSD diagnosis was over three times greater among women who were raped in childhood compared with non-victimised women.<sup>27</sup>

- Research has found that survivors of domestic violence who were stalked or harassed by their (ex-)partner are twice as likely to experience hyperarousal symptoms than those were not.<sup>28</sup>
- Studies estimate that around 20% of military personnel who have seen combat experience PTSD.<sup>29</sup>
- It is estimated that less than 10% of survivors of serious car accidents develop post-traumatic stress symptoms.<sup>30</sup>

## 4.3 Complex PTSD

While post-traumatic stress is a normal and common reaction to violent crime and abuse involving threat of injury, not everyone experiences the same consequences: in type, severity, duration or frequency.

The following factors make a PTSD reaction especially severe, or more long-lasting:

- The trauma is caused by humans rather than by a natural disaster.
- The trauma was caused by a person known to the victim, rather than a stranger.
- The experience is personal and individual, rather than shared by many.
- There is continued contact with the perpetrator.
- The trauma being repeated rather than an isolated incident.
- The trauma occurs in a previously safe environment.
- There has been rape or sexual violence.
- There is little sympathetic social support.
- There is a history of previous abuse or violation e.g. in childhood.

Most of these factors apply to women experiencing domestic and sexual violence, so their post-traumatic stress reaction is likely to be more severe and to last longer. In particular, many women **remain in on-going danger**, experience **multiple incidents** of abuse as well as **secondary victimisation** through negative reactions from others. Many women are also effectively exiled from their communities, which further undermines their identity and support.

Judith Herman<sup>31</sup> believes domestic violence is more likely to be followed by complex PTSD and that it creates a spectrum of conditions rather than a single problem. **Complex PTSD** includes:

- Difficulties regulating emotion, including explosive anger or inability to feel anger, self-harm or suicidal ideas or behaviours, inhibited sexuality, persistent uneasiness.
- Changes in consciousness including loss of memory, numbing, feeling a sense of unreality, constantly thinking about the abuse, intrusive memories, flashbacks.

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- Changes in view of self, including a sense of helplessness, shame, guilt, a sense of defilement/ violation or stigma, and complete difference from others (aloneness, feeling inhuman, belief no one can understand).
- Altered perception of perpetrator, including preoccupation with relationship, belief in their omnipresence and omnipotence, trauma-induced gratitude or dependency, sense of supernatural relationship and taking on the abuser's belief system.
- Altered relationships including isolation, difficulty in intimate or close relationships, distrust, repeated failures of self-protection, search for rescuer.
- Altered belief system, altered faith, hopelessness, despair.

## 4.4 Borderline personality disorders

The symptoms mentioned above largely mirror the diagnostic criteria for borderline personality disorder. There is increasing recognition

within the field of mental health about the overlaps between these two diagnoses and how complex trauma stress may be misdiagnosed as borderline personality disorder.

Historically, the diagnosis of a borderline personality disorder has been stigmatising and also controversial, as it implies that an individual's personality is flawed. Individuals with these symptoms often find it difficult to engage with services and treatment and thus have a reputation for being problematic to treat.

Research has shown, however, that borderline personality disorder diagnoses are common among survivors of childhood sexual trauma who have been most severely impacted, such as those in high secure psychiatric hospitals.<sup>32</sup>

Multiple studies highlight the association between child abuse, including sexual, and borderline personality diagnoses, with some reporting over 90% of people diagnosed having suffered from some form of childhood abuse.<sup>33</sup> Childhood sexual trauma is also associated with other personality disorders, although individuals with

a borderline personality disorder report higher rates of sexual abuse compared with those with other personality disorder diagnoses.<sup>34</sup>

Borderline personality disorders are often diagnosed alongside other mental health problems, including depression, substance use, eating disorders and other personality disorders. There is evidence of high rates (60-70%) of co-morbid borderline personality disorders and PTSD.<sup>35</sup>

Whilst there is no definitive answer about the cause of borderline personality disorders, it is important to remember the association with experiences of trauma. This can inform how we respond to individuals who have the diagnosis and the treatment they are offered.

## 5. Trauma and the brain

There is increasing understanding about how the brain responds to life-threatening situations, and also manages and is impacted by trauma. This knowledge can provide some insight into some of the trauma responses that survivors display.

By including information about the impact of trauma on the brain, we do not wish to suggest all mental health problems have a biological cause. For survivors who may feel negatively about themselves for acting in a certain way, however, it can be beneficial to understand how the brain functions in the face of (repeated) threat.

### 5.1 Fight, flight, freeze, flop, friend

The amygdala is the part of the brain that is primarily focused on threats to safety. All information that enters the brain is scanned by the amygdala to detect any potential threat to our survival.

When the amygdala detects a potential source of harm, it responds incredibly fast, takes over the functioning of the brain and instinctively triggers our 'fight or flight response'.

Since coining the term 'fight or flight', researchers have noted three further automatic responses to extreme stress or threat: freeze, flop and friend.<sup>36</sup> It is important that survivors are aware that freezing, flopping, or befriending an attacker

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can be instinctive responses and no less 'natural' than fighting or fleeing.

As the amygdala is geared towards immediate survival, it chooses the response that mostly likely means the individual remains alive and safe. If a strategy is successful, it will be reinforced in the brain and more likely to be used in future.

This means that survivors may become habituated to responding to threats in a way that may not seem appropriate. Furthermore, because the activation of the amygdala also reduces activity in other parts of the brain that are responsible for analysing and acting upon information, survivors of domestic and sexual violence may become even more dependent on the reflexive responses of the amygdala.<sup>37</sup>

When we face very real dangers to our physical survival, the 'fight and flight response' is invaluable. When all situations involving extreme stress trigger similar responses, survivors' long-term well-being can be sacrificed for immediate survival.

## 5.2 Heightened sensitivity to threat

It is understandable to most that survivors of domestic and sexual violence may be particularly vigilant and aware of potential threat for some time after their experience(s) of trauma. For some survivors, this heightened sensitivity may become chronic – either because of a very real on-going threat, or also as a result of how trauma impacts on the brain.

Trauma, particularly in childhood, can dramatically increase the number of stimuli that our bodies perceive as stressors. Survivors can experience a gradual lowering of the threshold for stimulation, meaning that they are increasingly sensitive to all kinds of stimuli that may be completely unrelated to the original trauma. This increased sensitivity, called 'kindling', can be a result of certain pathways in the brain, including the amygdala, becoming sensitised and starting to fire spontaneously, sometimes even without an external stimulus.



## 5.3 Cognitive functioning

In a 'fight or flight' state, the amygdala temporarily takes over the management of the brain. In doing so, other parts of the brain shut down which inhibits the cognitive processes that are needed for processing information, planning and taking action.

In cases of repeated trauma, or where survivors experience chronic activation of the amygdala and other systems that respond to stress, this may provide an explanation (at least partially) for the noted difficulties some survivors have with what is called 'self-regulation'. This refers to the internal organising functions that are essential to problem solving, processing information, communication skills, and further higher levels of processing such as strategic planning and abstract reasoning. Impaired self-regulation is considered by some to be the most-far reaching effect of trauma,<sup>38</sup> and goes some way to explain why survivors may struggle to make decisions or plan and carry out actions.

## 5.4 Impact on memory

Survivors of domestic and sexual violence can struggle with memories of traumatic experiences – either they cannot recall, cannot recall clearly or keep recalling the event. This can be, at least partially, a result of how the brain is affected by trauma.

When triggered, the amygdala sends out distress signals to the thalamus, which responds by releasing stress hormones such as adrenaline. High levels of hormones, like adrenaline, can stop the hippocampus – a part of the brain that processes memories – from working properly. This can be similar to the hippocampus 'blowing a fuse', meaning that memories of the trauma cannot be processed, which in turn causes flashbacks and nightmares. If the stress goes away and the adrenaline levels return to normal, the brain is able to repair the damage. The memories can be processed and the flashbacks and nightmares will gradually subside.

The impaired functioning of the hippocampus and the prefrontal cortex may also explain why trauma-based memories as vague,

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fragmented and disorganised in terms of time.

## 6. Using substances to cope

How do you cope with stress, anxiety, feeling low, after a hard day at work, after an argument with your manager, your partner or your children?

We all have strategies for regulating our sense of inner and outer security. We may avoid the issue, deny what's going on, we may minimise the urgency or importance of the matter, we may become defensive, angry or find fault with others as a type of attacking strategy. Some of us may hurt or attack ourselves – we may punish ourselves internally in our head, physically in the gym, by not eating properly or by injuring ourselves.

And, of course, we may use substances, including alcohol, prescribed medication and other drugs. Survivors of domestic and sexual violence do exactly the same to manage their responses to the trauma they have experienced.

## 6.1 Substance use in the UK

'Substances' are used widely in our society. Most adults in the UK use the stimulant caffeine, through consuming drinks such as tea, coffee and soft drinks, and foods such as chocolate.

Over a quarter of adults in the UK consume alcohol in a way that is potentially or actually harmful to their health, and 4% of adults are dependent on alcohol.<sup>39</sup>

Over a third (36.3%) of the population will use illicit drugs at least once in their lifetime, with 3.4% becoming drug dependent.<sup>40</sup> Cannabis is the most commonly used illicit drug in England.

## 6.2 Survivors' use of substances

Rates of substance use among survivors of domestic and sexual violence are considerably higher than in the general population:

- Women survivors of childhood sexual abuse are three times more likely to use drugs and/or alcohol problematically than women who have not been abused.<sup>41</sup>

- The prevalence of childhood sexual abuse amongst problematic substance users is around twice as high as in the general population.<sup>42</sup>
- A US study of ‘female alcoholic patients’ found that two thirds of women had suffered partner abuse in the previous 12 months.<sup>43</sup>
- Another US study reports that 60% of women accessing drug or alcohol services reported current or past domestic abuse.<sup>44</sup>
- 25-75% of people who have survived abusive or violent traumatic experiences report problematic alcohol use, compared with 10-30% of people who experience accident-, illness-, or disaster-related trauma.<sup>45</sup>
- Compared with adolescents who have not been sexually assaulted, adolescent sexual assault victims are 4.5 times more likely to experience alcohol abuse or dependence, four times more likely to experience marijuana abuse or dependence, and nine times more likely to experience hard drug abuse or dependence.<sup>46</sup>

## 6.3 Self-medication

The co-existence of mental health and substance use problems, often referred to as ‘dual diagnosis’, is relatively common. Three-quarters (74.5%) of users of drug services reported experiencing any type of mental health problems, and it is estimated that a third of mental health service users have a substance use problem.<sup>47</sup>

There is some consensus that mental health problems often precede substance use, and that many people use different substances to manage the symptoms of mental ill-health. In terms of managing trauma responses, substances are used in different ways.

One of the main difficulties with trauma responses is that they frequently fall outside what is called the ‘window of tolerance’,<sup>48</sup> a zone of emotional arousal that is optimal for well-being and effective functioning.

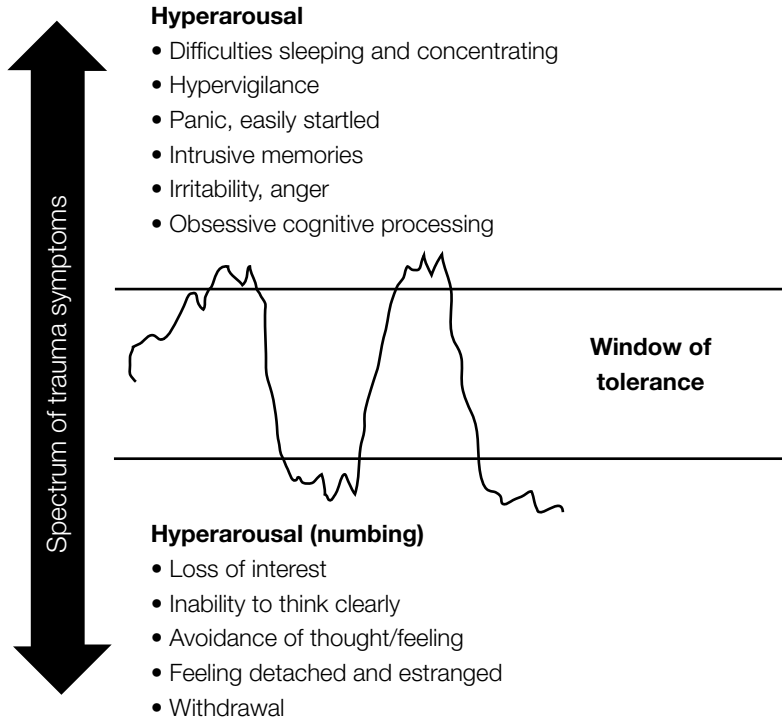
# Section 2

People who have been affected by a traumatic event can experience too much arousal (hyperarousal) or too little arousal (hypoarousal) and often oscillate between these two extremes (see figure 1).<sup>49</sup>

**Depressants** (such as alcohol, cannabis, heroin and other opiates, benzodiazepines) can be effective, at least in the short-

term, in managing **hyperarousal**. Depressants slow down the central nervous system and suppress neural activity in the brain. As such they mirror the symptoms of numbing. For people who have experienced trauma and are unable spontaneously dissociate, they may use alcohol or other depressants to achieve this effect. Depressants may also enable survivors to function by

Figure 1 - Window of tolerance



dampening down anxiety, reducing sensitivity to stimuli, and helping (temporarily) with sleep.

*“Research on survivors of domestic violence found that two-thirds experienced problematic substance use as a consequence of the abuse. The primary reasons given were to dull the physical and emotional pain of physical violence, to escape reality and to simply survive the abuse.”* <sup>50</sup>

Depressants may also help manage painful and overwhelming feelings such as sadness, fear and shame. People who have experienced trauma, particularly in childhood and adolescence, may not be able to self-soothe, i.e. calm themselves down and regulate their emotions. They may take depressants to cope with these emotions or to shut them out for a short time.

Conversely, **stimulants** (cocaine, speed/amphetamines, crystal meth, ecstasy) may be used by people experiencing **hypoarousal**. Stimulants speed up the central nervous system and increase activity in the brain, so therefore may be useful to survivors who suffer from

depression or feeling completely numb or flat.

People with PTSD can also have trouble experiencing pleasure engaging in ordinary tasks, have difficulty staying focused until a job is finished, and often find it difficult collaborating with others in situations that require maintaining multiple perspectives. Using stimulants can help someone focus and increase pleasure in activities.

## 6.4 The problem with problematic substance use

*“There is no doubt that alcohol misuse is associated with a wide range of problems, including physical health problems such as cancer and heart disease; offending behaviours, not least domestic violence; suicide and deliberate self-harm; child abuse and child neglect; mental health problems which co-exist with alcohol misuse; and social problems such as homelessness.”* <sup>51</sup>

In the short term, substances can help reduce feelings of being ‘wound up’ and may temporarily decrease the frequency and severity

# Section 2

of frightening nightmares. It may also, however, increase irritability and hypervigilance. Research shows that alcohol use, particularly heavy alcohol consumption, can result in the chronic activation of stress responses that mirror trauma responses and thus increase psychological distress rather than reducing it.<sup>52</sup>

Alcohol consumption can also impede a survivor's ability to manage future stressful life events. Research has shown that stressful situations are more strongly associated with depressive symptoms among heavy drinkers than in moderate drinkers.<sup>53</sup>

Experiencing post-traumatic stress and problematic substance use can also lead to other psychological problems. Research has found that women who have been diagnosed with PTSD and a substance use disorder appear to present with a more severe clinical profile than those with only one diagnosis. They are more likely to use cocaine and opiates (rather than alcohol and cannabis which are more widely used) and report extremely high rates of co-morbid (co-existing) anxiety and mood disorders.<sup>54</sup>

Both substance use and mental health problems (regardless of the cause) are also, for various reasons, further associated with physical ill-health, unemployment, poverty, homelessness and vulnerability to further abuse:

- Serious mental illness influences the likelihood of being in unsafe environments, and increases vulnerability to violent victimisation.<sup>55</sup>
- Multiple studies with female substance users demonstrate high rates of partner violence, physical assault and stranger rape; the majority of women diagnosed with problematic substance use and PTSD are even more vulnerable to repeated violence and abuse throughout their lives.<sup>56</sup>
- Describing the incidence and experience of rape among women in residential drug treatment, Teets found that 73% of women in her study had experienced sexual trauma, and that these traumas could be classified into five categories: raped while in the context of using, while too high to resist, while prostituting, by a significant other, and by a family

member.<sup>57</sup> 35% of the rapists were described as friends of the survivor with whom they had been using drugs.

- Homeless women, including those living in hostels and sleeping rough, are vulnerable to physical violence from family members, acquaintances, as well as other homeless people and the general public. They also frequently report sexual assault, most commonly perpetrated by someone know to them.<sup>58</sup>
- Substance use is commonplace among women involved in prostitution: in one study 87% of women interviewed used heroin.<sup>59</sup> More than half the women involved in prostitution, both on- and off-street, have been raped or seriously assaulted and at least 75% have been physically assaulted by a pimp or punter.<sup>60</sup>

Experiencing domestic and sexual violence, mental ill-health and/or problematic substance use can leave survivors in a cycle of being vulnerable and victimised, which can lead to increased problems with their mental well-being and increased use of substances to cope.

*"If you come across someone who has no understanding of any of it, it makes you feel like a piece of shit, it puts you back to square one"*

Survivor's voice





# Section 3

It doesn't  
hurt to ask

# Section 3

## It doesn't hurt to ask

### Section outline

“Asking the question” – whether it be about domestic and sexual violence, substance use or mental health – does not happen in isolation. People need encouragement to disclose and disclosures need to be followed by action. There is no point in routinely enquiring if there is no action afterwards. In fact, research shows that certainly in the case of domestic violence, asking and taking no action can be more detrimental than not asking at all.<sup>1</sup>

The process for enabling and responding appropriately to disclosures of all kinds is as follows:

1. Understand why people may not disclose
2. Set the scene
3. Create the right environment
4. Ask the question
5. Listen
6. Respond appropriately
7. Develop an empowering relationship
8. Offer immediate practical support

### 1. Barriers to disclosing

*“The barriers to disclosing experiences of abuse are vast. I don't think we can really appreciate how difficult it is for any survivor, let alone those with mental health and/or substance use problems who experience more stigma, more judgement, more disbelief, more difficulties accessing services and for whom there are more complex consequences to disclosing, to tell someone sitting opposite them about what might feel like a huge, shameful secret.”<sup>2</sup>*

Asking about domestic violence, sexual abuse, mental health or substance use often generates anxiety among professionals.

There are fears of causing offence, opening a Pandora's box, not knowing what to do next, reacting in the wrong way, and so the list goes on<sup>3</sup>. These are legitimate concerns, but ones that must be overcome as survivors of abuse who are experiencing problems with their mental health and/or substance use may find it very difficult to disclose in the absence of direct questioning because they:

- Are not sure of not being sure of what to say, how to start the conversation.
- Fear being judged, being stigmatised or, particularly for survivors, not being believed.
- Are concerned about 'what happens next'. Will Social Services become involved? What will I be asked to do? Will I have to move to a refuge/go into rehab? All could be scary prospects.
- Feel ashamed or embarrassed, self-blame, not feeling worthy of help and support.

In challenging our own concerns about "asking the question", it can be helpful to remember that:

1. **Survivors don't mind being asked.** Research with women in healthcare settings has found that the vast majority of survivors do not mind being asked about experiences of abuse.<sup>4</sup> They always have the choice not to disclose if they don't feel ready or comfortable.
2. **Survivors often want to be asked** because they don't know how to start the conversation themselves.
3. **Asking about an issue can generate the survivor's confidence and trust** in a worker's ability to deal with an issue.
4. **You may be the only person to ask** - never assume that someone else has asked or will in the future. We all have a part to play in supporting vulnerable people to get the help they need.

# Section 3

## The case for routine enquiry

In its guidance on routine enquiry for health professionals, the Department of Health highlighted a number of possible indicators of domestic violence (see annex A for the complete list). These indicators include missing appointments, non-compliance with treatment, unexplained injuries, symptoms of mental health distress – all of which are commonplace amongst users of drug, alcohol and mental health services.

**As such, the Stella Project strongly recommends that substance use and mental health services routinely ask clients about experiences of domestic and sexual violence.**

## 2. Setting the scene

Encouraging and enabling someone to talk about issues that are affecting them but which they might feel embarrassed or ashamed about starts the moment they walk through our door.

- How do service users know that you might be able to help them with experiences of domestic and sexual violence, problematic substance use, mental ill-health? Is it evident that these are issues you care about? Do you display posters in reception or the toilets? Are there discreet leaflets which people can take away with them?
- Do service users feel comfortable? Are you able to offer them a worker of the same gender, ethnicity, etc.? Is there privacy? Will you be overheard or interrupted? Are children present who would be distressed, even if they know the situation? Can you both understand each other or do you need an interpreter? If you have an interpreter, is the service user comfortable with them (are they part of the service user's community or wider family network?) and will they maintain confidentiality?
- Before asking any questions, also establish whether it is safe. Ask yourself, 'Will my intervention leave this patient in greater safety or danger?' This is particularly true for asking about and intervening in cases of current domestic

violence – if you cannot speak to the service user alone, do not ask in front of her partner who may be the perpetrator.

- Be clear about confidentiality. Have you explained the limits to your ability to maintain confidentiality? Have you stated explicitly that a survivor's engagement with services will never be discussed with her partner?

Addressing these points within your practice and your service is the first step in creating an environment which will support survivors to disclose experiences of abuse, problematic substance use and/or mental ill-health.

### 3. Creating the right environment

*"You don't want to have to tell someone that you're an alcoholic, or a drug addict, or that your husband beats you up. Because it makes you feel crap, like you're worthless."*

Survivor's voice

Many survivors, particularly those who have problems with substance use and/or mental health, routinely experience stigma from others, are marginalised by both society and services, and understandably have very low self-esteem. They often report not feeling listened to or respected.

So the next step to creating an environment that enables disclosure is building rapport with a survivor. This is important regardless of the nature and length of the interaction we have: if you are a nurse in A&E, a GP, a social worker or a substance misuse worker, you can aide disclosures of domestic and sexual violence, problematic substance use and mental ill-health by showing that you are focussed and attentive:

- greet someone by using their name
- face the person you are speaking to and sit up straight or lean forward slightly to show your attentiveness through body language
- have an 'open' face by gently smiling

# Section 3

- make and maintain eye contact (limit this to about 60% of the time to avoid someone feeling uncomfortable)
- demonstrate you are focussed – if someone interrupts your conversation, ask them to come back later, do not answer a ringing telephone, etc.
- listen to what is being said rather than focussing on writing it down (that means, wherever possible, put away your paperwork or switch off your laptop/computer and focus on the person facing you)
- be clear about how much time you are able to spend with the survivor at this point in time, but avoid making someone feel rushed by talking about running late, cutting an appointment short (it might be better to rearrange for another day if you do not have enough time today to really pay attention) or repeatedly saying “we don’t have time today, but next time...”.

These might seem like very small measures, but working to create the right environment and good

communication skills can make a world of difference to people who are affected by violence and abuse, substance use and/or mental ill-health, who might otherwise not feel listened to or worthy of our support.

*“My GP just seems concerned with time and getting me out before the next appointment. He just wanted to put me on anti-depressants instead of trying to get to the root of the problem [sexual abuse]. I was just given anti-depressants and told ‘come back and see me in 6 months’.”*

Survivor’s voice

## 4. Asking the question

How do you ask someone if they have experienced abuse? If they are struggling with their mental health? If they have ever used a whole range of different substances, any of them problematically? The exact wording of our questions is crucial as they can, unintentionally, convey judgement. Conversely, they can also communicate important messages.

## 4.1 Framing the question

Where possible and appropriate, start by framing the question by explaining why you are asking. For example:

*“We know that many of our service users also have experiences of being hurt or frightened by a partner or family member/sometimes struggle with how they feel/use alcohol, medication or other drugs to manage, so we ask everyone about these issues.”*

Or

*“Because we care about your well-being, we also would like to find out if you have ever been hurt or frightened by your partner or a family member/if you or anyone else in your home uses alcohol, prescribed medication or any other drugs/if there are times when emotionally you don’t feel well. We ask everyone this because we want everyone to be safe as possible. This will help us to provide the best support.”*

Explaining why you are asking is useful, particularly when talking to people who may be mistrustful and query the motives behind your questions.

## 4.2 Introductory question

You might use a more generic introductory question such as:

- How are things at home?
- How are things with your partner?
- How are you feeling?
- How are you managing at the moment?

But don’t stop here! Service users are not mind-readers and so may not realise the subtext of your question.

## 4.3 Direct questioning

Ask a more direct question. In doing so:

### **Avoid terms people might not understand**

– including domestic violence, sexual violence, problematic substance use, mental health problem or diagnosis

### **Use questions which people relate to more easily, seem less frightening or judgemental:**

# Section 3

## *For domestic violence*

How do you and your partner work out arguments? Do arguments ever result in you feeling put down or bad about yourself? Do arguments ever result in hitting, kicking or pushing? Has anyone ever made you feel frightened or scared at home? Do you ever feel controlled by your partner?

N.B. If you notice an injury, rather than asking how it happened, ask “Who hurt you?”

## *For sexual violence*

Has anyone ever made you do things sexually that you weren't comfortable with or hurt you? Do you feel like you have to have sex with your partner even when you don't want to?

## *For mental health*

How are you doing at the moment? How are you feeling in yourself? You seem a bit down/upset/frustrated. How are things?

## *For substance use*

Do you take any medication prescribed by a doctor? Have you used drugs other than those required for medical reasons? How much alcohol do you drink each week?

## **If you are aware that the service user has been affected by at least one of the issues,**

ask questions that make the link between all three issues as this can reduce the risk of appearing judgemental, shows you understand the links and also raises the survivor's awareness of how these issues are interlinked. For example:

*“Being hurt by a partner doesn't just cause physical injury but also emotional or psychological harm. The effects of living with violence and abuse can cause women to feel depressed, anxious or ill. Have you noticed changes in the way you feel?”*

*“Some people feel depressed, suicidal, traumatised or mentally distressed after being abused or attacked. Some people use alcohol and drugs to manage the physical and the emotional pain....have your experiences led you to feel this way or do anything specific to cope?”*

*“Some people find alcohol and drugs help them cope with how they are feeling – do you use anything to help you manage your situation or what you been through?”*



*Has your partner ever made you feel you had to use drugs or alcohol?*

### *Follow-up questions*

At this point you may wish to ask some further questions to get an idea of the extent of the problem and to identify any immediate risks that should be dealt with. Sample questions can be found in annex B.

## 5. Active Listening

*"It's hard enough trying to get your voice heard at the best of times. When you've used drugs or when you've worked on the streets, it's impossible. Once you're labelled, that's it"*

Survivor's voice

Active listening means **fully attending** to the other person, to gain as deep an **understanding** as possible of not only the words being spoken, but also the thoughts and feelings underlying those words.

However brilliant the questioning, the insights, the interpretations and the strategies of the practitioner, they will **all be wasted** if s/he has

not listened fully and attentively to the survivor. Research has found that nurses who focus on the individual they are talking to or the content of what is being said, rather than prioritising taking action are more able to engage survivors.<sup>5</sup>

Active listening helps establish rapport and build trust, it helps client to disclose their feelings, and helps to gather information. Listening is a vital part of effective communication. Furthermore, sometimes being empathically listened to is the **ONLY** thing that the client needs.

Active listening seems like a simple concept to grasp yet people often fail to listen to one another. It is the active process of paying undivided attention to what the client is saying and what they are **not** saying. You can do this by:

- Listening to and understanding the client's verbal messages
- Noticing non-verbal behaviours — posture, expressions, movement, tone of voice
- Listening to the context — the whole person in the context of their situation in life

# Section 3

- Suspending your judgement or evaluations
- Resisting distractions i.e. your thoughts, imaginations, noise, views, people
- Avoiding “rehearsing”, i.e. thinking what you should say BEFORE the client finishes)
- Allowing the client to express her own ideas without imposing your own.

*“I went to my doctor for help from violence; he didn't refer us anywhere. Doctors just don't listen. Hospitals and doctors never ever help, they don't let you talk, they didn't examine me or ask me anything after he'd been violent, they just gave me pills”*

Survivor's voice

## **BE CLEAR!**

There is another acronym that we can use to remember these responding skills. It is known as ‘CLEAR’ and stands for the following:

**Clarify** what you say. Explain your point clearly so that the client can understand.

**Listen** to your client and show them you are listening by giving them attention and not getting distracted while they are talking.

**Encourage** the client to speak freely by asking open-ended questions.

**Acknowledge** what your client is saying. Let them feel that what they say is important and valuable, or that it was okay for them to talk to you.

**Reflect and repeat** what the client said to increase your understanding.

*"Asking for help is the most difficult thing you can ever do. And when you do that, you just want someone to say, "Look, it's not your fault, and we're going to get you some help, and you are not this worthless human being, you do deserve to live, you deserve to be a mother, you deserve to be happy, you don't deserve this man smacking you round the face every time he has a drink, you know what I mean? That's the first thing you need, then practical help. But what you really need is for someone to treat you like you're worth something, you're not just something out of the gutter."*

Survivor's voice

## 6. Helpful responses

How we respond to a disclosure is as important as how we ask the questions. In an era of lengthy assessment forms and short appointments, it can be easy to just tick a box when someone discloses and move on. This can be detrimental to a survivor who already feels unheard, dismissed and not believed.

Each of the following statements acknowledges the survivor's disclosure, can make the survivor feel listened to and shows that these issues are important to you.

- **Thank you for telling me**  
– remember that disclosing experiences of abuse, substance use problems and mental ill-health can be scary for the survivor.
- **What you have described is not uncommon** – or a similar statement which communicates to the survivor that they are not alone. It can be useful to know a few statistics, e.g. 1 in 3 women will experience domestic or sexual violence in their lifetime; 1 in 4 people will have difficulties with their mental health at some point in their life.
- **You are not to blame for the violence or abuse** – hold the perpetrator accountable for his own behaviour. No one deserves to be abused. The use of violence is never an appropriate way to communicate within a relationship. Whatever 'justifications' are given for 'provocation' of violence, there are more effective and acceptable ways to resolve problems.

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- **You have the right to feel the way you do** – there is no right or wrong way to feel about experiencing abuse, and living with abuse can have a major impact on your mental health.
- **We all have different coping strategies for managing difficult situations or feelings** – acknowledge and validate how a survivor has coped up to now, even if their strategy is potentially problematic, such as heavy substance use or forms of self-harm that are less easily controlled.
- **Your safety and wellbeing is my priority** – highlight that the survivor might be at risk, either from others or in relation to their substance use and mental ill-health.
- **You have the right to be safe and get support** – all survivors, regardless of whether they have problems with substance use and/or mental ill-health, have the right to be safe.

## 7. Developing an empowering relationship

The two major goals in assisting survivors of domestic and sexual violence who are also affected by problematic substance use and/or mental ill-health are:

- to establish a supportive and empowering relationship
- to deal with any practical issues

Achieving the first goal will make it easier to engage the client and therefore work on the second goal.

You can build a positive relationship with a survivor by:

- **Listening.** Show you are listening by nodding occasionally, smile and use other facial expressions, and encourage her to keep talking with small verbal comments like ‘yes’, ‘uh-huh’ and ‘mmm’.
- **Being interested in what she has to say.** Use active listening skills such as reflecting back what has been said (for example, “Sounds like you are saying...” or “I can see that...”) and asking questions to clarify what has been said.

- **Being respectful.** Allow the survivor to finish speaking before asking more questions, and don't interrupt with counter arguments. Treat the person in the way that you would like to be treated.
- **Showing empathy.** In addition to being reflective and respectful, be empathic by imaging what it might be like to be in the other person's shoes ("I can imagine you might feel..." or "I can understand why you might be feeling...").
- **Making her the expert of what she needs.** Do not assume what a survivor might need based on how they appear; for example, someone who looks strong may need a lot of support. Do not assume which issue someone wants to deal with first, but let them tell you what their priorities are.

*"If you present strong and well, the response is different than if you were a mess, crying and sobbing and weak – you have to almost dumb down to get anywhere, to get an effective response"*

Survivor's voice

Assessing how supportive or how empowering you need to be depends largely on the physical and emotional state of the woman. As a general principle, it is better to encourage her to make her own decisions and take action for herself wherever possible. If you do things for her that she could do herself, you are denying her the opportunity to take charge of her own life. Furthermore, pushing her into actions which she is hesitant to pursue will add to her powerlessness. However, some situations will require you to be more supportive than in others especially if the woman is emotionally or physically incapable of helping herself.

# Section 3

## 8. Immediate practical support

In terms of offering immediate practical support:

- 1. Prioritise safety as the foundation for any intervention.** Help with a harm reduction or safety plan, whether it is in relation to abuse, substance use or mental ill-health. Identify what risks are present and how the survivor can best manage these.
- 2. Respect confidentiality and privacy.** If someone is currently experiencing abuse, or has not told their family/friends about their situation in relation to substance use or mental health, it is vital to gain permission to contact the survivor at home and to respect their wish not to be contacted outside of your appointment. Recognise the real dangers that may be created if confidentiality is breached and the perpetrator is alerted. Only send letters if you are sure she will open them. If you phone, ask immediately if it is safe to talk and whether her partner is there. Suggest a code if need be.
- 3. Be realistic.** Help her to assess the strengths and weaknesses of her situation without being overly optimistic or unduly pessimistic so that she can develop a realistic understanding of her situation. Help her to determine goals and plans of action. Help her to reinforce a positive self-image. Your support and encouragement could be an invaluable resource.
- 4. Explain her options.** Keep up to date on relevant local resources so that you can provide information about services. Do not provide definitive solutions, but explain what help or support is available and, wherever possible, spend time with the survivor to help them decide for themselves what they want to do. Signpost or refer on, but only with the survivor's consent.

**DON'T** expect her to make binding decisions in a hurry: Many women say that they wish to stay with their partner and that they only want the violence to stop. This decision-making process can be assisted by your patient, long term support and encouragement. It may take years for a survivor to make the final decision to leave.

5. **Keep a record.** Write down what she tells you, with as much details as possible and avoiding judgment. Use the survivor's words and avoid summarising. All notes should be written during the session with the client, agreed by the client, and signed and dated. It is possible that these case notes may be used for legal purposes in the future, and thus will be beneficial for the client should they wish to pursue the abuse through legal channels. These records will be stored with the agency. The client should be offered the option of receiving a copy. However, it is important to advise clients that it may not be safe to keep records at home or on their person as they may be discovered by the perpetrator. Any documentation will include

the record of the routine inquiry, the client responses (including types of abuse experienced with examples given by the client and any context). The worker's response including discussion of options and information giving, risk assessment, any injuries that have been noted, any referrals made, any safety plans, and scheduled follow-up appointments.

6. **Look after your own safety and wellbeing.** Don't put yourself or your colleagues at risk in a potentially dangerous situation.





# Section 4

Meeting survivors'  
needs

# Section 4

## Meeting Survivors' needs

### Section outline

It can be difficult to know where to start when supporting someone who has experiences of domestic violence, sexual violence, problematic substance use and mental ill-health. The majority of survivors will have multiple needs that vary between individuals and will change with time and circumstances.

This section describes what survivors identify as their greatest needs, with an emphasis on **how** professionals offer support rather than the actual areas of assistance services can provide. Following these steps should encourage survivors to engage with services so that their needs can be met:

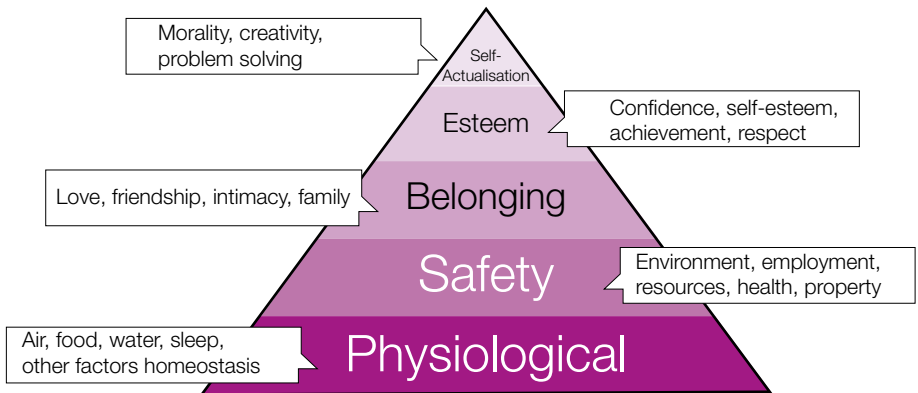
1. Understand the survivor's perspective
2. Treat survivors with humanity and respect
3. Enable survivors to develop life management skills
4. Promote safety and security
5. Support survivors to lead a healthy and active life
6. Consider long-term recovery options

## 1. The survivor's perspective

There are many models and theories about human needs. Maslow's Hierarchy of Need is one of the most well-known. According to

Maslow, humans are motivated to satisfy a range of needs, starting with physiological needs (air, food, water) through to feeling a sense of belonging (a result of friendships, family, intimacy, etc.) and self-actualisation.

Figure 2 - Maslow's hierarchy of need.



The advent of outcomes- or results-based service delivery has led to the development of different needs assessment and supporting planning tools that tend to focus on varying aspects of a client's life:

typically physical health, mental health, housing, finances, social networks, education/training and employment, living skills, substance use and offending.

# Section 4

People who have been affected by domestic and sexual violence, problematic substance use and/or mental ill-health have similar physical, emotional and social needs to those outlined above. However, there is often a level of complexity in supporting this group of survivors as many needs require attention at the same time, and the problems are more severe.

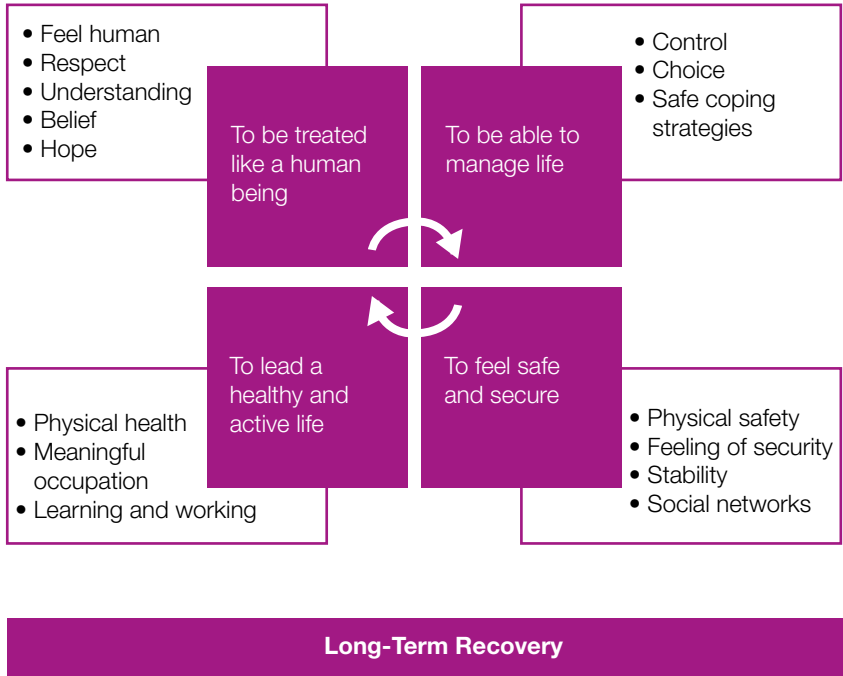
Violence, substance use and mental ill-health can all lead to homelessness, poorer physical health, and leave survivors vulnerable to further abuse. Trauma responses may be compounded by additional events such as having a child removed, losing touch with family and friends, being imprisoned/sectioned, being involved in prostitution. Substance use may worsen mental health problems. Research has found, for example, that women experiencing PTSD and substance use problems have extremely high rates of co-morbid diagnoses of other disorders such as depression and anxiety. They are more likely to use 'harder' drugs such as cocaine and opiates than women who experience either PTSD or substance use problems.<sup>1</sup>

The consultation with survivors that was completed as part of the Stella Project Mental Health Initiative found that there are five areas of need that practitioners and services should address: being treated like a human being, being able to manage life, feeling safe and secure, leading a healthy and active life, and being able to recover in the long-term (see figure 3 for more detail).

The first two segments – treating someone like a human and being able to manage life – refer more to how practitioners behave towards survivors with additional experiences. Meeting these needs is critical in promoting engagement with services so that other needs can be met.

Each of the sections also fits in with broadly accepted principles/values that underpin models of recovery that have been established within substance use and mental health services in the UK and US. As such, the following information provides an overview of the building blocks for recovery which we can all offer survivors.

Figure 3 - Overview of survivors' needs



# Section 4

## 2. “Treat me like a human being”

*“The basic essence of it is that you are worth treating. By the time I got to that point it was like I can’t live with drink, I can’t live without drink, I’ve completely screwed up my whole life, my children’s life, I’m a horrible mother, nobody loves me, every one I go out with wants to beat the shit out of me, so where does that leave me? I’m nothing. And that’s how I felt.”*

Survivor’s voice

### 2.1 Humanity and respect

Experiencing domestic and sexual violence, problems with drug or alcohol use and/or mental ill-health often leads to feelings of self-blame, self-loathing and self-doubt. In addition to how they feel and think about themselves, survivors may also face a lack of understanding and thus stigma. They may have a strong sense of isolation and alienation.

Research with people who have experienced problems with their mental health have found that

stigma and discrimination are rife, with the vast majority reporting that stigma has had a negative impact on their lives and stopped them from doing things they want or need to do.<sup>2</sup> Similarly, a 2010 survey by the UK Drug Policy Commissioning found that 22% of people think that those affected by problematic drug use don’t deserve sympathy.<sup>3</sup>

People who are affected by all three issues are likely to experience multiple discrimination, with women who have problems with substance use and/or mental health reporting significantly higher levels of stigma – either as individuals or as mothers.<sup>4</sup>

As such, survivors of domestic and sexual violence who are also affected by substance use or mental ill-health state **their most fundamental need is to be treated like a human being.**<sup>5</sup>

This means you should:

- 1) Treat survivors with respect.
- 2) Take time to listen.
- 3) Validate their thoughts and feelings.

- 4) Show understanding of how abuse, mental ill-health and substance use are often linked.
- 5) Do not judge survivors for how they might think, feel or act.
- 6) 'Go the extra mile' to show that these survivors are worth helping.

Research<sup>6</sup> emerging from the Troubled Families programme of work has drawn similar conclusions: "Families...want to feel that they are treated as a human being, that they are listened to, and...believe the workers are dedicated to helping them and 'going the extra mile'"

Another important message from people who are affected by these three issues is for professionals to view service users as individuals in their own right, rather than solely as a person with a mental illness, a person in recovery or as a victim or survivor.<sup>7</sup>

*"I love being able to talk to my keyworker about EastEnders. It's like I'm not just a recovering addict, I am a human being and there is something in my life other than staying in recovery"*

Survivor's voice

## 2.2 Understanding change

Making change in life is difficult. For survivors of domestic and sexual violence who are also affected by substance use and mental ill-health, addressing each issue will often take time and require on-going support through periods of well-being and crises of different kinds.

For professionals the slow pace of change can be frustrating, particularly when it appears to be the client who is reluctant to change or take action. Understanding the process of change, and being able to anticipate some of the difficulties that survivors may come across can be useful in managing our frustrations and expectations of clients.

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## 2.2.1 Stages of Change Model

Prochaska and DiClemente's Stages of Change (see figure 4) arose out of research into how people stop smoking, but can also be helpful in understanding the journey survivors of abuse who also experience drug, alcohol or mental health problems take. There are six stages:

**Pre-contemplation.** The individual does not see themselves as having a problem and are unlikely to take action. Raising awareness is helpful at this stage.

**Contemplation.** People become more aware of the personal consequences of their situation and spend time thinking about the problem. Providing a space to talk and reflect can be useful.

**Preparation.** The individual has made a commitment to make change. Professionals can have a huge impact on this stage by providing service users with full information – the positives and the possible negatives – to ensure they are best prepared to deal with the hurdles ahead.

**Action.** Professionals often skip to this stage, encouraging clients

to make change when they have not yet decided action is needed or prepared sufficiently. Wherever possible, survivors should not be forced to make change without sufficient preparation. In some cases, for example where children are involved or a woman is being sexually exploited, immediate action may be needed and practitioners should be aware of how this may impact on the client's ability to maintain the change.

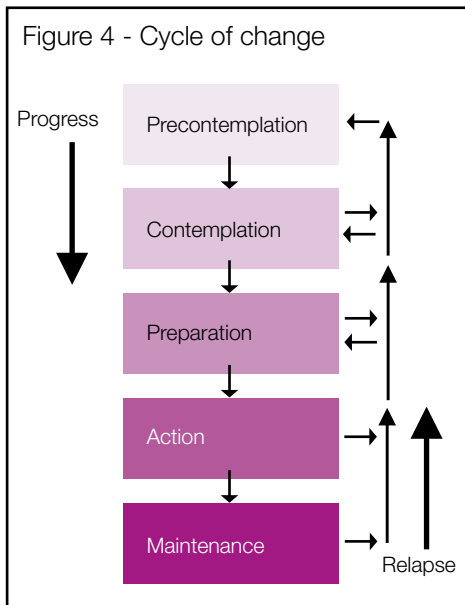
**Maintenance.** There is a vast array of factors that can make maintenance, i.e. not returning to the previous situation, very difficult. At this stage, enabling the person to identify short-term benefits or to use short-term rewards can help sustain motivation and promote self-confidence. They may also need support to anticipate situations which may trigger a relapse and to prepare coping strategies.

**Relapse.** Relapsing at least once is far more common than not relapsing at all. As practitioners, we should support service users to avoid labelling themselves as failures but help them to understand why they had a drink or used, returned to an abuser, or why mental health



problems come back. In this way, relapse can be a learning experience and an opportunity to grow stronger and consider strategies for avoiding relapse in future.

Change can come in many different forms, from acknowledging the abuse or that the substance use is problematic to leaving an abusive relationship and entering treatment for substance use. Supporting a survivor to move between any two stages is excellent progress; if a survivor does not take immediate action this should not be seen as a failure.

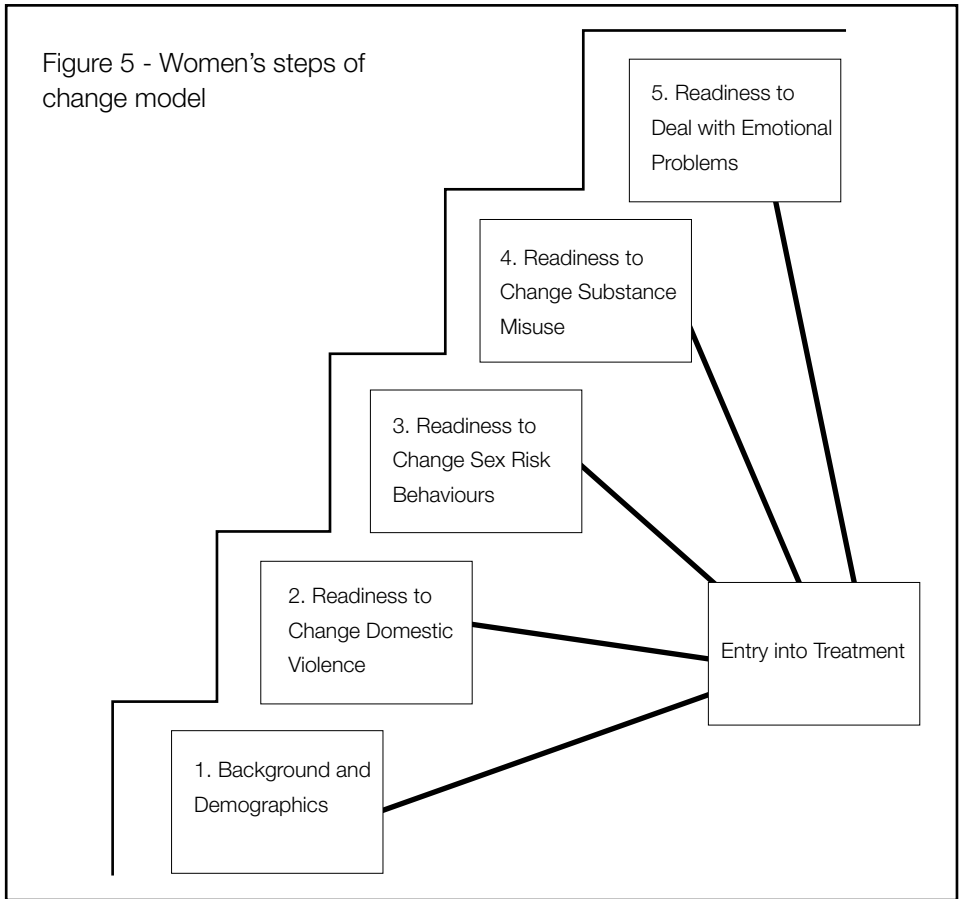


## 2.2.2 Women's Steps of Change Model

Professionals often ask what issue to address first. Depending on who you are asking, you will get a different answer. Practitioners may give varied answers depending on their training and theoretical beliefs. Survivors will have differing opinions which reflect their individual circumstances and needs – which issue is causing the most acute problems, which can you most easily get help for, what are the consequences of asking for help with each problem?

Limited research on the order in which survivors may approach issues such as domestic violence, substance use and mental ill-health has led to the creation of the Women's Steps of Change model (see figure 5). This model proposes that the help-seeking behaviour of women with substance use problems may reflect a hierarchy of readiness to change based on the urgency or immediacy of their treatment issues. For example, their study suggests that some women may be ready to make changes in their exposure to domestic violence or in sexual risk-taking behaviour before they are ready to change their substance use behaviour.

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## 2.3 Have belief and hope

Survivors and professionals alike can become frustrated when change or improvements don't come easily. For people who already feel hopeless or powerless because

of abuse, mental health problems or substance use, it is particularly important for professionals to have:

**Belief in the client.** For people lacking in self-efficacy (belief in their own ability to complete a task), it

is important to show that we have belief that they can make change in their life. You can demonstrate belief in someone by:

- telling them you believe them
- offering encouragement
- highlighting their strengths and resources
- acknowledging how they coped until now
- being realistic about what someone can achieve and not setting them up to fail by overwhelming them with tasks
- having patience, particularly when things go wrong
- not giving up - be persistent with other agencies to get things done

**Hope for the future.** We can suggest we have hope that the survivor's situation can improve as well as teaching them to have hope themselves. Learned hopefulness is the process of learning and utilising problem-solving skills and the achievement of perceived or actual control. Increasing perceived control

(self-efficacy) helps individuals cope with stress and improves the likelihood of solving future problems effectively, which in turn generates more hope. A belief in one's self-efficacy and possessing problem solving skills are core components of resilience in an individual.<sup>8</sup> Engendering hope and building resilience are seen as key contributors to enabling people to recover from mental ill-health.<sup>9</sup>

Survivors who are affected by substance use and/or mental ill-health may need more positive and hopeful assurances than other survivors. Research has shown that problematic drinking can undermine the psychological benefits of positive life events.<sup>10</sup> Similarly, a survivor with depression may not glean hope for the future because one positive thing happens.

*"People do not understand the consequences of not letting go. If you do not let go, your life is never going to change. That person will ruin your life forever and it will never ever change. Letting go is the bravest thing in the world. Let go and never look back."*

Survivor's voice

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## 3. Life management skills

Being able to manage in life centres around the three Cs: **control**, **choice**, safe **coping** strategies.

In turn, research has shown that having a sense of control, developing safe coping mechanisms and the skills to make safe and healthy choices is also paramount to individual empowerment.<sup>11</sup>

### 3.1 Control and choice

Trauma, substance use and mental ill-health are experiences that can leave an individual feeling helpless and powerless: unable to control the occurrence of the traumatic event, to regulate trauma responses, to manage urges to use drugs or alcohol, to control how they are feeling emotionally or psychologically.

Establishing control (perceived or actual) over any aspect of our life – developing a routine for getting the children to school on time, managing money, making telephone calls, deciding when to have appointments – builds our **self-efficacy** or the belief that we are competent and able to achieve tasks. Increased self-efficacy can

lead to a greater sense of control, which is understood to have a direct effect on improving an individual's mental and physical health.<sup>12</sup>

Being given choice is central to developing a sense of control. Being responsible for making decisions enables people to learn to trust themselves (when the outcome is positive) and to learn from mistakes (when the outcome is negative). As professionals, therefore, we should encourage clients to develop control in their life by supporting them to make decisions and complete manageable tasks for themselves.

*"I had the overwhelming feeling that the worker would not suggest something I wasn't capable of doing; she took care of the essential needs like food and clothes first before talking about AA and meetings"*

Survivor's voice

### 3.2 Coping strategies

Being able to cope with flashbacks, cravings, strong emotions and everyday stressors is also key to promoting a feeling of control.

For professionals, we should **acknowledge** how someone has coped thus far and **identify**, where needed, safer coping strategies.

There is a tendency to pathologise women who are affected by abuse, substance use and mental ill-health,<sup>13</sup> rather than understanding how the experiences may be interlinked and that substance use is often used as a coping mechanism.

Whilst research on survivors' resilience is limited, the available literature and practice-based evidence demonstrates that women who experience multiple negative life experiences are in fact more resilient and resourceful than other groups of vulnerable people.<sup>14</sup>

Survivors of domestic violence, for example, will probably have tried many strategies for managing the abuser's behaviour, from calling the police to complying or fighting back. They may also have tried to cope with the abuse by minimizing what is happening, denying the reality of their situation or dissociating during physical or sexual assaults. They may have managed the impact on their physical and emotional well-being by drinking alcohol, misusing

prescribed medication, self-harming or attempting suicide.

As some coping strategies can be potentially dangerous or harmful, it is important that professionals acknowledge the ways in which survivors managed their situation (often successfully, in the short-term) as well as highlighting the potential risks and identifying safer coping mechanisms, where needed.

New coping strategies could involve writing a safety plan with a survivor currently in an abusive situation, practicing grouping exercises and mindfulness to manage anxiety or craving, or identifying activities to let out anger safely such as punching pillows. More information about safer coping strategies can be found in section 5.4.

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## 4. Safety and security

Being the victim of trauma rocks your belief in the world as being an inherently safe place. Certainly in terms of domestic violence, perpetrators create an environment which is steeped in fear and is indeed unsafe for the survivor and their children in many instances. Experiencing abuse, as well as problematic substance use and mental ill-health, also increases the risk of being harmed in future.

Reestablishing someone's sense of safety and security requires a multi-faceted approach which addresses i) their environment, ii) their physical safety, and iii) their emotional stability.<sup>15</sup> The key needs to address are:

- **Harm minimisation.** Supporting someone to identify safe strategies for dealing with difficult emotions and situations can make them feel more secure in themselves. The first step is raising their awareness about what danger they are in, for example exploitation from others, or possible risks of problematic substance use or self-harming.
- **Promote stability.** People affected by abuse, substance use and mental ill-health may have lived with years of chaos and uncertainty which makes the world feel unsafe. Professionals can provide stability by developing consistent, bounded relationships with clients and helping to create routines in their lives.
- **Enable trust.** Consistency is also completely bound up with trust. Survivors of domestic and sexual violence have often had their trust violated by someone close to them. People with experiences of substance use or mental ill-health may also find it difficult to trust others. Survivors are more likely to engage with professionals who they can trust.
- **Living environment.** As a basic need, survivors require somewhere safe to live, and this should be addressed as a priority. This may include finding accommodation, applying for a non-molestation order from the court to stop an abuser from contacting the survivor, or offering other safety measures such as a personal alarm or additional security on the property. See overleaf for more information about housing.

### What engenders trust?<sup>16</sup>

- 1) Being treated like a human being.
- 2) Being listened to and understood.
- 3) Not being overwhelmed with suggestions of things to do that the survivor isn't ready for.
- 4) Not being judged.
- 5) Not being treated as though you are crazy.
- 6) Names and stories being remembered so information doesn't have to be repeated.
- 7) Workers completing actions on the survivor's behalf as agreed.

*"You've got walk-in centres, I don't want to go to a walk-in centre, I want to see someone who understand what's happening"*  
Survivor's voice

- **Peer support.** Domestic and sexual violence, substance use and mental ill-health can leave an individual feeling very isolated and alone in their experiences. Building a network of support, including people who have similar experiences, can be highly beneficial. The decreased isolation and ability to get support from others means someone is more able to leave an abusive partner (or less likely to return) and/or may have more success in addressing their substance use or mental health problems. Furthermore, being part of a family, social network or community can provide a sense of safety.

- **Boundaries.** At the same time as supporting survivors to develop a support network, it is important to remember that people who have experienced their own boundaries being violated may also need support to establish and maintain boundaries within new interpersonal relationships.

Further information about addressing safety issues can be found in section 5, *Keeping Safe*.

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## Housing

Having somewhere to live is undoubtedly very important. For survivors who have drug, alcohol and mental health problems, accommodation is important because it can provide:

1) a place of safety. Professionals should, however, be aware that mixed sex hostels and B&Bs do pose risks to survivors' safety, particularly women. Women routinely report experiencing violence, abuse and exploitation within these settings and so, wherever possible, should be offered single-sex accommodation in a safe setting.

2) a sense of control. Research<sup>17</sup> has found that women affected by multiple issues such as domestic and sexual violence, substance use and mental ill-health yearn for a 'place of their own' over which they have control – control over what to put in the accommodation, how to arrange their own belongings, who to let in, if they let anyone in.

Therefore, where survivors are able to live independently, self-

contained accommodation should be provided along with sufficient support to ensure people do not feel completely isolated:

*"When they discharged me homeless [from hospital], I was in a flat, it was really bare so of course I tried to hang myself. I didn't know where the shops were, I was totally lost. I don't know [the area] very well. It's better in the hostel with people around...[although] there's people on heroin in the hostel, really bad drugs at times, people begging at times. Moving to women's hostel where I can cook for myself before moving into own flat."*

Survivor's voice

## What works?

### The Chrysalis Project

The Chrysalis Project - a partnership between London Borough of Lambeth, St Mungo's and Commonweal Housing - provides housing and support for women who are homeless and have high support needs, including substance use, mental ill-health and experiences of trauma, abuse and sexual exploitation.



There are three phases of accommodation and support within the Chrysalis Project, each tailored to the needs of clients at the different stages of their recovery:

**1) Security, stability and intensive support.** Secure supported accommodation is provided in an 18 bed St Mungo's hostel. Intensive support, including counselling from specially trained psychotherapists, is provided to enable women to address enduring problems such as substance use and mental health problems as well as traumatic experiences.

**2) Moving towards independence.** Clients move into a St Mungo's semi-independent project to help them to develop skills to live independently, such as cooking, budgeting and engaging with local services.

**3) Living in the community.** The women are given a tenancy in one of seven one bedroom flats in South London. The accommodation is well maintained, furnished to a high

standard and is designed to boost the women's self esteem and act as a motivator for further change.

An independent evaluation of the project found women have been supported to reduce their substance use, improve their mental health and live more safely. The project has helped women to avoid having their children taken into care, and supported women to re-establish connections with family. Several women have become economically more active, and all ten women who have been accommodated in phase three have maintained tenancies.

For more information, please see <http://tinyurl.com/bvwx9eu>.

# Section 4

## 5. A healthy and active life

### 5.1 Being healthy

Domestic and sexual violence, problematic substance use and mental ill-health are all associated with poor physical health.

#### Types of health problems

**Injuries from:** physical assault, sexual violence, administering drugs, self-harming

**Neglect:** direct neglect by abuse, not being allowed to care for self, self-neglect due to low self-esteem, substance use, etc.

**Long-term conditions:** impaired immune system, heart disease, liver and kidney problems, respiratory disease, gastrointestinal disorders, various cancers are associated with all three issues

The long-term health conditions associated with trauma, in particular, have been linked in part to chronically high levels of stress hormones, such as adrenaline

and cortisol, in the body. Elevated cortisol levels, for example, are associated with an increased risk of obesity, diabetes, gastrointestinal problems and heart disease.<sup>18</sup>

As such, survivors may need access to health services to address acute injuries as well as for treatment for long-term conditions. A range of health services are available and professionals should ensure information about national and local services are easily available in their place of work:

- Accident and Emergency (A&E) department
- Minor injury unit (where available) for non-life threatening complaints. Minor injury units cannot deal with overdoses, alcohol and mental health problems.
- Walk-in centres (where available) for non-life threatening complaints. Walk-in centres are also accessible for people who are not registered with a GP, although survivors with substance use or mental health problems may be reluctant to attend as you are likely to see a different professional each time.

- NHS Direct (0845 46 47) or NHS 111 (where available) for advice on the telephone 24 hours a day. This service is run by nurses and people calling with non-urgent queries may be called back at a later time.
- GP surgery and out of hours service. The local GP surgery can provide a range of health services, including being the first port of call for someone who is experiencing mental distress.

Alternative approaches to managing stress and aiding relaxation are used variably throughout services for people affected by domestic and sexual violence, substance use and mental ill-health. Substance use and sexual violence services, in particular, are more likely to promote activities such as acupuncture, reiki, different types of massage and aromatherapy to help clients to feel both emotionally more resilient and physically better. More information about alternative therapies can be found on p.85.

## 5.2 Being active

The need to be **active and occupied** is consistently reported by survivors, particularly those who are also affected by substance use and mental ill-health. Being active, meeting other people and usefully occupying your time can create a sense of purpose and build self-esteem.

Whilst it may not always be possible to find meaningful ways to fill time when someone is in an abusive relationship, is heavily using or in crisis mentally, it is important to find out how survivors want to spend their time. It is often in periods of 'calm' after a crisis where boredom and restlessness can set in.

Boredom can be a trigger for substance use, as can loneliness, so having lots of things to do can be very important for people who have recently reduced their substance use, or stopped altogether.

For people who experience mental ill-health, long periods of inactivity can exacerbate symptoms. Boredom and loneliness, for example, can make depression and anxiety worse.

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*“The evenings [in the refuge] were when I really struggled. If they know someone has mental health issues, they need to make sure there’s stuff for them, not just bring them in and do nothing”.*

Survivor’s voice

## 6. Long-term recovery

Recovery is a much talked about subject and is central to the delivery of most drug, alcohol and mental health services. It is also a key concept within sexual violence services such as Rape Crisis.

The Government’s mental health strategy, *No health without mental health*, for example, incorporates recovery as one of the six objectives. Recovery is described as:

*“More people who develop mental health problems will have a good quality of life – greater ability to manage their own lives, stronger social relationships, a greater sense of purpose, the skills they need for living and working, improved chances in education, better*

*employment rates, and a suitable and stable place to live.”<sup>19</sup>*

Similarly, models of substance use recovery look at freedom from substances, reduction in offending, improved health and well-being, stable accommodation, improved employment opportunities and stronger social networks.<sup>20</sup>

*“The word recovery isn’t just about drugs, it’s a way of life, it’s recovering from [domestic violence], it’s a cycle of trying to get out”*

Survivor’s voice

### 6.1 Principles of recovery

As outlined already in this section, survivors’ main needs revolve around how they are treated by others and the extent to which they can regain control of their lives.

These are also the building blocks for recovery:<sup>21</sup>

- Being treated with dignity and respect
- Being seen as an individual, not just as an illness, a survivor, an addict or as someone in recovery

- Having hope and someone to believe in you
- Having the opportunity and support to make sense of what is happening or has happened in your life and to validate how you feel

*“Research has demonstrated that it is not the traumatic events in our lives that determine resiliency so much as how we make sense of those events that determine our ability to experience resiliency”<sup>22</sup>*

- Having control and being supported to make decisions about one’s life
- Developing trust in others through relationships with consistent, caring and empathic people – professionals, peers, friends and family.

## 6.2 Models of recovery

As domestic and sexual violence, substance use and mental ill-health are so interlinked, it is important for practitioners to consider an integrated approach which

recognises that the ways in which dealing with one issue can escalate risk in other areas of the survivor’s life. For example:

- Addressing experiences of trauma, for example in leaving an abusive situation or participating in psychological therapy, can result in a decline in mental health.
- Where alcohol or drugs are used as self-medication or a way to cope with trauma responses, the risk of suicide and self-harm can increase in the short-term when people begin to address the substance use.<sup>23</sup>
- Changing patterns of drug or alcohol use can lead to an increased risk of domestic violence if the victim appears to gain control of their life.

A core principle of supporting people through their recovery therefore is safety.

In prioritising survivors’ safety, models of recovery from trauma, problematic substance use and mental ill-health all have a broadly similar framework:

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**1) Assessment of presenting problem.** Severity of mental health problems, extent of substance use, future risk of being abused may be considered

**2) Crisis intervention and management.** This could include fleeing an abusive partner or being hospitalised due to a mental health crisis (see section 6 for more information).

## What works? Seeking Safety

Seeking Safety is a therapeutic model of addressing the dual issues of PTSD and substance abuse, recognising that dealing with either issue in isolation could lead to a worsening of the other issue. The author has created a manual covering 25 topics (including asking for help, setting boundaries, healing your anger, coping with triggers, grounding) that can be conducted in any order and in both group and individual settings. The core principle is to enable sufferers to be and feel safer – to be able to manage both the symptoms of PTSD and their substance use. The Seeking Safety manual is very user-friendly, with clear guidance for practitioners and handouts for survivors. Repeated reviews of the model have yielded positive outcomes for survivors. The manual can be ordered from [www.seekingsafety.org](http://www.seekingsafety.org).

**3) Stabilisation.** In different settings, this may include the use of medication to manage symptoms of mental health, reducing alcohol or drug use so that the individual can engage with services, or building up a survivor's internal resources so that they are more able to manage trauma responses (see section 5 for more information).

**4) Long-term interventions.** Long-term care plans may include medication, psychological therapies, support with practical matters such as housing, finances and employment and building support networks.

The rest of this section looks at different longer-term options (primarily therapeutic) available to help survivors deal with experiences of trauma, problematic substance use and mental health problems.

## 6.3 Long-term interventions

A wide range of medical, psychological and psychoeducational interventions are used in stabilising and then supporting individuals to address substance use and mental health problems, as well as in enabling survivors to process and recover from experiences of violence and abuse.

### NICE

The National Institute of Clinical Excellence (NICE) writes guidance for health professionals on a range of issues including PTSD, depression, drug and alcohol treatment and dual diagnosis. Their recommendations are based on careful research to find what works, but they exclude methods that have not been rigorously studied within the health sector. Guidance can be accessed at [www.nice.org.uk](http://www.nice.org.uk).

The most common options you will come across are detailed below (in alphabetical order):

### Abstinence (from substances)

An approach adopted by some drug and alcohol services, abstinence means completely refraining from the use of drugs or alcohol. Organisations such as Alcoholics and Narcotics Anonymous require abstinence as part of their self-help ethos.

### Behaviour therapy

Aims to change behaviour by focusing on what the person does and teaching new skills. It is concerned with what people do, rather than thoughts or feelings, which are often influenced by actions. It may include learning ways of reducing anxiety or confronting feared situations (but not ones which are really dangerous). Clients may keep diaries and practice 'homework'. It is particularly good for anxiety or phobia and is usually short term (weekly sessions over not more than three months).

### Body-oriented therapies

In relation to trauma, body therapies primarily relate to either:

- Complementary therapies such as massage, shiatsu and reiki that encourage survivors to reconnect with and honour their bodies.

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- Somatic experiencing and/or sensorimotor therapy that helps survivors to recognise and process trauma-related bodily sensations and memories. More information is on p.41-44 and p.91-92.

## What works?

### Women and Girls Network

Women and Girls Network (WGN) is a free, women-only services providing a holistic response to women and girls who have experienced, or are at risk of, gendered violence. Women who receive individual counselling sessions are also offered six weeks of body therapies (aromatherapy massage and shiatsu). This aspect of the service particularly acknowledges the impact of violence on the body, and this can impact on the survivor's ability to heal. Body therapies offers an opportunity to reconnect and develop a positive relationship with the body and to build trust in others within a safe environment. Find out more at [www.wgn.org.uk](http://www.wgn.org.uk).

### Cognitive Analytic Therapy (CAT)

The therapist and client work together aiming to understand

how problems arose. Clients may find their usual ways of coping make difficulties worse, and will discuss with their therapist ways to improve things, using their own strengths and resources. Diagrams and written outlines of old patterns and new insights are made to help the client develop their understanding and skills. CAT uses some cognitive principles (using the client's thoughts and observations of their experiences and behaviour) and some analytic principles (including exploring unconscious or unacknowledged issues and relationship patterns). It is usually offered 1:1 for sixteen hourly meetings. See [www.acat.me.uk](http://www.acat.me.uk) for more information.

### Cognitive-behavioural therapy (CBT)

CBT can help a survivor to process and evaluate their thoughts and feelings about a trauma. While CBT does not treat the physiological effects of trauma, it can be helpful when used in addition to a body-based therapy such as somatic experiencing or EMDR. CBT approaches are also used in substance use treatment services to help recognise, avoid and cope with triggers or relapses in their substance use. The Increasing



Access to Psychological Therapies (IAPT) programme has increased access to CBT in recent years – ask your GP for more details.

### Cognitive restructuring

Cognitive restructuring teaches people how to recognise and control unhelpful thoughts and replace them with calming, more helpful thoughts. AVA's mental health toolkit, Sane Responses, includes examples of cognitive restructuring techniques and can be downloaded from the Toolkit section of the AVA website ([www.avaproject.org.uk](http://www.avaproject.org.uk)).

### Complementary therapies

Common complementary or 'alternative' therapies include:

- Acupuncture: the Chinese system of healing by inserting fine needles into the body. It can increase the body's release of natural pain killers and have positive effects on the nervous system. Also used in substance use services to manage urges to use drugs or alcohol
- Aromatherapy: the use of concentrated plant oils to treat emotional or physical conditions through massage, bath water or a room vaporiser
- Creative therapies: art, drama and music therapy can help expression of feelings, provide insight and reduce isolation
- Herbal medicine: using one or more herbs, to relieve symptoms and treat the cause of a condition
- Homeopathy: taking tiny, highly diluted quantities of substances that create similar symptoms to the condition suffered, which can promote the body's self-healing efforts
- Self-development courses: local colleges and domestic violence outreach groups run short courses on self-development e.g. assertion, social skills and self-defence
- Yoga: designed to achieve balance between body, mind and spirit by encouraging flexibility, posture, improved breathing and blood flow.

The British Complementary Medicine Association ([www.bcma.co.uk](http://www.bcma.co.uk)) covers over 75 therapies and holds a directory of therapists.

# Section 4

## Counselling

Person Centred, Rogerian or Humanistic approaches to counselling all provide space to examine current and past issues with a counsellor as a non-judgemental listener. The client is seen as the expert with their own answers, and the counsellor a supportive listener who does not give advice. It is not structured or directed by the counsellor, which can be very supportive in cases of domestic violence but has not been shown to help in processing trauma. Counsellors may be located with a GP practice, in private practice or in voluntary organisations such as Rape Crisis. All counsellors should be accredited - check the British Association for Counselling and Psychotherapy ([www.bacp.co.uk](http://www.bacp.co.uk)) or British Psychological Society ([www.bps.co.uk](http://www.bps.co.uk)) for accreditation and for counsellors specialising in abuse or trauma.

## What works? Nottinghamshire Rape Crisis Centre

Nottinghamshire Rape Crisis Centre (NRCC) offers a holistic and person-centred counselling to women in Nottinghamshire who have experienced sexual violence. Person-centred counselling can assist an individual through stages of deepening experiential awareness and acceptance of self. The very nature of the approach means the therapeutic work undertaken avoids the possibility of reinforcing the trauma and fosters post traumatic growth and healing in terms of feeling more empowered, more able to exercise control, stronger sense of self, development of healthy coping strategies and improved quality of life. The client's emotional safety and well-being is paramount. Women who have used NRCC report feeling greater acceptance and healing: *"My difficulties have melted away – I can cope with anything now. I am no longer over-powered, just empowered."* For information about Rape Crisis Centre in England and Wales, visit [www.rapecrisis.org.uk](http://www.rapecrisis.org.uk).

### Couples and family therapy

Couples and family therapy are based on the understanding that many problems arise in relationships and problems are often not one person's alone. Both types of therapy are common within mental health and substance use services, and survivors may request couple or family therapy as a first step to remedy the problems with their partner, **but these approaches are not recommended if domestic violence is a current issue as it can increase the danger faced by the survivor and any children.** Relate, the largest provider of relationship counselling in England, has produced guidance which clearly states that in cases of domestic violence, counselling should not be offered to the couple jointly, but each partner should be seen separately. The full guidance can be downloaded here: <http://tinyurl.com/cwcsu3q>.

### Detoxification

Stabilisation of drug and alcohol use may begin with detoxification. For substance use problems such as alcohol that have significant withdrawal effects, detox may take place in a residential service. In in-patient services, medication may be

prescribed to alleviate painful side effects of withdrawal and monitor the service user's health. Mild to moderate withdrawal as well as non-medical detox may happen in the community.

### Dialectical behaviour therapy (DBT)

DBT was developed from cognitive behaviour therapy (CBT) in order to meet the emotional needs of people diagnosed with a borderline personality disorder. DBT aims to help people recognise and accept their emotions, and then teaches people to manage their emotions more effectively and find safer ways to manage with stress and difficult emotions in future.

### Eye Movement Desensitization and Reprocessing (EMDR)

EMDR incorporates elements of cognitive-behavioral therapy with eye movements or other forms of rhythmic, left-right stimulation. These back-and-forth eye movements are thought to work by "unfreezing" traumatic memories, allowing you to resolve them.

### Gestalt therapy

An 'experiential' approach, emphasising bodily feelings and emotions in understanding people's

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experience. It can be individual or group therapy. The client and therapist typically focus on 'unfinished' past experiences which have left lingering feelings or distress about the person or event. The therapist may suggest experiments to obtain closure, such as having an imaginary conversation with a person or writing them a letter (that may not be sent).

## Harm minimisation

Harm minimisation accepts that some people will choose to use drugs and alcohol and some of those people will develop problems with their substance use. It is an approach that aims to reduce the adverse health, social and economic consequences of alcohol and other drugs by minimising the harms and hazards of drug use for both the community and the individual. This approach does not require abstinence.

## Medication

Medication is the most common form of treatment for mental distress; it is also used in some types of drug and alcohol detoxification. Medication can relieve some symptoms of mental ill-

health and make life easier but is not likely to resolve the problems when taken alone and is most effective when combined with other kinds of support. If misused, medication can cause its own additional problems. Common groups of medication are:

- **Anti-anxiety drugs** also known as anxiolytics or minor tranquillisers. Includes Benzodiazepines which can help people feel calm and relax in the short term but can cause dependency if used over time (longer than a month). Used to treat anxiety and sleeping difficulties.
- **Antidepressants** used in the treatment of depression, anxiety, obsessive-compulsive disorder and pain.
- **Antipsychotics** used in the treatment of psychosis (including schizophrenia) to reduce the distress caused by hallucinations and delusions. Sometimes called Neuroleptics or major tranquillisers. Some examples include haloperidol and chlorpromazine. Newer forms have fewer side-effects.

- **Depot medication** taking prescribed medication, usually antipsychotics, by injection (usually given by a Community Psychiatric Nurse), which releases the drug slowly over several weeks and prevents the need to take tablets regularly.
- **Mood stabilisers** used to control mood swings in Bipolar Disorder. The most common are Lithium and Carbamazepine.
- **Sleeping tablets** designed to help people sleep. Sometimes called hypnotics. Useful in the short term but can cause dependency; use over months or years should be avoided. Over-the-counter sleeping remedies can contain antihistamines (used to treat hay fever and colds) which may cause drowsiness well into the next morning.

Leaflets about all the aforementioned types of medication, how they are used and the potential side effects can be downloaded from the Royal College Psychiatrists website:

<http://www.rcpsych.ac.uk/expertadvice/atozindex.aspx>

### Motivational interviewing (MI)

MI is a directive, service user-centred counselling style for eliciting behaviour change by helping service users to explore and resolve ambivalence. It is primarily used in drug and alcohol services in the UK. Compared with non-directive counselling, it is more focused and goal-directed. The examination and resolution of ambivalence is its central purpose, and the counsellor is intentionally directive in pursuing this goal.

### Multi-systemic therapy (MST)

MST is a family and community-based therapy, often used for young people with complex problems. There is increasing use of MST with CAMHS (Child and Adolescent Mental Health Services) and in social services to deal with families who experience multiple problems. The relationships between family members are seen as the cause of problems rather than individuals and carries the same warning as other types of family therapy that this is not appropriate in cases of domestic violence as the therapy can be used by the perpetrator to further abuse the survivor and manipulate services.

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## Opioid substitution therapy/ methadone replacement therapy

People who are dependent on opioids (heroin) may be prescribed methadone as a replacement. Methadone is a synthetic opiate manufactured for use as a painkiller, and has similar effects to heroin but doesn't deliver the same degree of buzz or high as heroin. Prescriptions may need to be collected on a daily basis, particularly if the service user's drug use is chaotic. Methadone is partly prescribed to break the cycle of offending often associated with using heroin and to help users to reduce their use. Prescribing services are usually run in partnership between a GP surgery and a specialist drugs service.

## Psychoanalysis and psychodynamic counselling

Psychoanalysis originated with the theories of Sigmund Freud. In a session, the client talks about thoughts, feelings, dreams and memories and the therapist listens, sometimes commenting on the client's patterns of thinking and behaving, with the goal of raising self-awareness.

The psychodynamic counselling approach (counselling based on

the analytical approach) generally focuses on working with the inner world of the client, the unconscious and the client's past experiences. This approach can be unhelpful where there is domestic violence because:

- A focus on the past may mean that the cause of trauma – domestic violence – may not be acknowledged or understood.
- This approach may fail to recognise the perpetrator's behaviour.
- It may fail to recognise the strengths and resources of the woman which have helped her cope.
- It may create a risk to a woman's safety unless risk assessments are conducted and the reality of real danger is understood and incorporated.

## Somatic experiencing and sensorimotor therapy

Somatic and sensorimotor therapy recognises the impact of trauma on the survivor's nervous system, brain and hormones. It builds on psychotherapeutic approaches to

integrating thoughts and emotions to include concentrating on what's happening in the body, getting in touch and releasing trauma-related energy and tension.

### Trauma therapy

The treatment of trauma usually involves different therapeutic approaches that:

- Build the survivor's resources so that they have some control over hyper- and hypoarousal and are able to manage strong emotion which may arise during therapy
- Decondition traumatic memories and responses
- Process and integrate events and memories of traumatic events
- Help to discharge pent-up trauma-related energy
- Build or rebuild the ability to trust other people

### What works? LifeWorks

Since 2008, St Mungo's LifeWorks programme has provided face-to-face psychotherapy to around 200 service users regardless of their mental health diagnosis, including psychosis and personality disorders, or active substance use. Of the LifeWorks clients willing to share their history, 66% had histories of chronic trauma including sexual, emotional and/or physical abuse as children and high levels of early loss of primary caregiver. 24% had been in care and 43% had been in prison.

Clients are offered up to 25 weekly sessions, 50 minutes each, of individual psychodynamic psychotherapy. These are 'client led', with clients talking about emotional issues (such as relationship breakdown and bereavement), rather than 'needs led' (talking about substance use and non-engagement with services).

Evaluation of the LifeWorks project has found that:

- 75% of clients showed an improvement in mental well-being

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- Impact on a wide range of health and social outcomes :e.g. increased uptake of appropriate health treatment, reduced use of emergency services, and 42% of LifeWorks clients were in employment or training placements by the end of the therapy
- Higher take-up and completion rates and more recovery outcomes than the IAPT programme (Improving Access to Psychological Therapies) despite working with chronically excluded adults with complex needs.

For more information, see <http://tinyurl.com/cpte2mn>.







# Section 5

Keeping safe

# Section 5

# Keeping Safe

## Section outline

Safety is a much broader concept than just being physically safe. It is also a very subjective experience of security this is informed by both our internal world and the external environment.

This section provides an overview of the steps through which practitioners can promote survivors' safety and security:

1. Understand different aspects of safety - internal, relational and external

2. Assess risk

3. Use risk management systems

4. Support survivors to keep themselves safe

## 1. What is safety?

People who live with violence and abuse, problematic substance use and/or mental ill-health face a range of threats to their safety, from internal and external sources.

As professionals, we tend to look at certain areas of risk:

- Domestic and sexual violence services tend to focus on keeping survivors safe from the person who has abused them;
- Drug and alcohol services concern themselves primarily with the health and social risks, including involvement in crime associated with problematic substance use;
- Mental health services focus on protecting service users from themselves and from perpetrating harm towards others; and
- Children's services' central aim is to protect children and young people from harm.

In this section, we will consider a more holistic approach to increasing survivor safety. Based on Judith Herman's model of working with people affected by trauma<sup>1</sup>, this approach addresses three types of risks: internal, relational and external.

Unless survivors are supported to manage the internal risks and are protected from external threats, they

Internal	<ul style="list-style-type: none"> <li>• How we might harm ourselves</li> </ul>
Relational	<ul style="list-style-type: none"> <li>• How we relate to others</li> <li>• How our actions may affect how others relate to us</li> </ul>
External	<ul style="list-style-type: none"> <li>• How we are vulnerable to deliberate harm by others</li> </ul>

will not feel safe and may continually revert back to pre-existing defensive, risk-taking, negative protective strategies. This will not only place them at continued risk of harm, but will also limit their ability to engage with services and make any meaningful progress.

As professionals, we need to be aware of what makes our service users feel safe: if we act in ways that make clients feel vulnerable this can contribute towards a decline in their well-being and can lead to a crisis.

We also need to ensure the safety and well-being of all service users. Sometimes, therefore, we need to carry out a risk assessment as part of the referral process into services, such as refuges. This is a more appropriate approach to managing referrals than blanket policies to include or exclude certain groups

of clients, for example survivors who have been diagnosed with a borderline personality disorder. The information in this section and the assessment questions in appendix B provides an outline of what risks to assess and how.

## 1.1 Internal safety

Experiences of violence and abuse, problematic substance use and mental ill-health can, among many other things, leave an individual feeling powerless. As well as feeling unable to control the outside environment, they may also struggle to manage their own internal emotional world.

### 1.1.1 Risks to internal safety

There are different ways in which survivors may experience difficulties:

- **Intense emotional distress.**

As outlined in section 2, there

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is a clear association between experiencing abuse and mental distress. Domestic and sexual violence has been shown to lead to anxiety, mood disorders, post-traumatic stress disorder, phobias and compulsive disorders. Similarly, people who use drugs and alcohol problematically are at increased risk of common mental health problems such as depression and anxiety. Due to continued stigma, survivors with substance use and/or mental health problems may also feel shame as well as anger about the way they are treated by others, including the agencies that are meant to help and protect them.

- **Regulating emotions.** Following trauma, more primal parts of the brain that only detect threat can become more active. This can make it difficult to regulate intensity of emotions and/or using problem-solving skills to manage emotions. Furthermore, chronic and persistent stress inhibits the effectiveness of stress responses. Over time, increasingly minor reminders of trauma can trigger full-blown stress reactions.

- **Inability to self-soothe.**

When the survival response (fight, flight, freeze) is activated, stress hormones like cortisol are released. This can reduce production of serotonin (responsible for self-soothing and calming abilities) and dopamine (involved in judgment and impulse control).

*“At the time it looked like I was just messing up inside. If I hadn't done anything, I think I would just have blown up...gone mad. It's like your head was full of so much, you wanted something to calm you down.”*

Survivor's voice

- **Unsafe coping strategies.**

Survivors will manage problems regulating emotions in different ways. Some coping strategies, for example substance use, self-harm and multiple suicide attempts, can, however, pose a risk to the survivor's safety and well-being:

- Substance use can help to regulate states of arousal, to avoid traumatic memories or difficult emotions. Risks include physical damage from intravenous

use; long-term health problems; overdose; increased rates of depression, anxiety, paranoia; associated with higher rates of self-harm and suicide.<sup>2</sup>

- In the absence of fully functioning problem-solving skills and the ability to self-soothe, some survivors may self-harm. Self-harming can, amongst other things, help someone as a means of expressing anger or other feelings that can be difficult to verbalise or managing intrusive thoughts (see appendix F for more reasons why people self-harm). Conversely, self-harm can lead to worsening feelings of guilt, shame and self-esteem. Risks to physical health include infection, damage to tendons and nerves from cutting, life-threatening problems such as blood loss if arteries are cut.
- The research findings differ but abused women are at least four times more likely to attempt suicide, and one third of all female suicide attempts can be attributed to current or past experience of domestic violence.<sup>3</sup> Aside from the obvious danger of death, suicide attempts can be seriously detrimental to an individual's

long-term physical health, if they survive. They may have to live with varying levels of disability, scarring and disfigurement. Asphyxiation can cause brain damage; paracetamol poisoning is a major cause of acute liver failure. NICE guidelines on self-harm note that people who have survived a medically serious suicide attempt are more likely to have poorer outcomes in terms of life expectancy.<sup>4</sup>

### 1.1.2 Managing internal risks

In addressing survivors' internal safety, professionals should:

1. **assess** the level of risk. For more information, see pp.108-113.
2. **consider** utilising risk management systems, including contacting mental health services about someone who is actively suicidal or is at risk of causing themselves serious physical injury through self-harming (more information on p.113).
3. **support** survivors to keep themselves safe by learning to manage emotions and to adopt safer coping strategies. For more information, see p.118 onwards.

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## What works? Survive and Thrive<sup>5</sup>

Survive and Thrive is a psycho-educational treatment for complex trauma which is currently being delivered in several parts of Scotland. The programme aims to help survivors of trauma to manage their responses in a safe way.

## 1.2 Relational safety

Professionals who work with people affected by abuse, problematic substance use and mental ill-health often report feeling confused and frustrated about how some survivors behave and the ways in which they seemingly put themselves in situations which increase their vulnerability. Many of these behaviours are trauma responses that professionals are not always aware of or recognise as such.

These behaviours often include the ways in which survivors relate to others – how they behave towards and communicate with other people. As such, we refer to this as **relational safety**.

### 1.2.1 Risks to relational safety

#### *Sensitivity to potential threat*

Survivors of domestic and sexual violence, including people who experienced abuse in childhood, can develop a long-term sensitivity to potential threat, and over time there can be a continually lowering of the threshold for sensitivity and activation of the protective devices such as the fight or flight response. As such, survivors may appear to always be ready to respond to a threat, and may seem to overreact to seemingly minor triggers. This is a basic survival mechanism. In addition to being hyperaroused and overly sensitive to potential threats, survivors may also anticipate rejection (as has often been the case in the past) and so respond to situations in ways that reflect this expectation.

#### *Directing anger towards others*

Women and girls feel anger as a natural reaction to violence. Survivors may feel anger towards the abuser, but also feel angry at people who condoned or ignored the violence, did not protect them as children and about the injustice of being advised to stay or return to a dangerous situation.



Anger is, however, a particularly problematic emotion in our society, especially for a woman or girl. Many learn that 'nice' girls don't raise their voices - they are supposed to just cry or cope. A woman might also learn to hide anger because her abuser 'would give her something to be really angry about' or because she is determined not to 'sink to his level'. As girls grow up, or women encounter violence, they become prevented from natural expression of their feelings – and then may begin to suffer from suppressing or over-controlling their emotions.

As result, some survivors may express anger in ways that are unhealthy, and even risky:

- Some survivors may misdirect the anger they feel toward their abuser to safer targets: children, family, friends, and professionals who may trigger issues of power and control.
- Women may feel like they are 'a walking volcano' and be frightened of snapping at the slightest thing.
- A survivor may be frightened, hurt, upset by or judgmental about other people's display of emotions but be unaware of her own.

- Anger may be turned in on the survivor, in guilt, self-blame, depression or in physical symptoms

### *Use of violence*

Some survivors may use violence themselves. In the face of being assaulted either physically or sexually, survivors may instinctively use violence to protect themselves (the 'fight' response to threat).

Survivors may have also learnt that violence is an answer to many problems. Survivors may use violence to disperse anger, hurt or frustration, or to provoke people so they retaliate.

People, particularly those who have experienced abuse in childhood or repeatedly in adulthood, may also adopt the world view that there are winners or losers, and choose to be on the winning side by using violence to beat an attacker or in pre-empting a possible threat.

More information about survivors' use of violence can be found on p178.

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Whilst it is useful to understand why survivors use violence, it is equally important that people know violence is NEVER acceptable and should not be condoned. Using violence can increase the risk of further harm.

## *Sexual acting out*

There are many possible reasons for survivors to 'act out sexually'. When someone is sexually assaulted, there is a feeling of helplessness and acting out can be a way of regaining control. The survivor may feel they are damaged, worthless and do not deserve better. Some survivors, particularly children and young people, may have been taught that sex is "all they are good for".

Research has also found that physical abuse is associated with significantly higher rates of disinhibition in female survivors than in male survivors who use stimulants.<sup>6</sup>

## *Lack of interpersonal boundaries*

Do you know survivors who:

- Speak at an intimate level when they first meet someone?
- Fall in love with anyone who reaches out to them?
- Don't notice when someone displays inappropriate behaviour or invades their personal boundaries?
- Accept food or gifts that they don't want?
- Allow someone to take as much as they can from them?
- Let others direct their life?

These are all possible signs of not being able to manage boundaries with other people. People who have not mastered the use of boundaries tend to be more susceptible to the influences and control of others.

Experiencing abuse, particularly in childhood, can lead to problems with boundaries by, amongst other things:

- **disrupting the sense of self.** We need a clear sense of self to be able to separate our own thoughts and feelings from those of others; this helps us to then communicate our needs and desires to others. When the sense of self has been disrupted it can be more difficult to protect oneself from being manipulated by or enmeshed with others.
- **causing uncertainty about where boundaries should lie.** In situations where a person's rights are not upheld and where they do not necessarily matter unless they are useful for the perpetrator's needs, it can be difficult for the survivor to understand that they have the right to control how they are treated.
- **making the survivor feel responsible for other people's happiness.** Survivors are often blamed for the abuser's behaviour and can come to blame themselves. Survivors can respond to the pain, guilt and anger of being responsible for another person's behaviour by trying endlessly to rescue the abuser from the negative consequences of their behaviour. Some survivors

may only get positive attention when they show compassion to the abuser.

- **leaving the survivor believing there is no use in trying to refuse people.** Someone who has been repeatedly abused can have their 'no' disregarded so many times that they no longer expect their 'no' to be heard anymore. Some people may even stop saying 'no' altogether as they expect that it does not matter anyway.

Difficulties in managing boundaries generally play out in three ways:

### 1) **developing rigid boundaries.**

Survivors may learn that rigid and inflexible boundaries might be the way to handle their relationships with other people. They wall themselves off in their relationships as a way of protecting their emotional selves, and, as a consequence, will, probably find it difficult to form lasting close interpersonal bonds with others in adulthood as they are still trying to individuate from their parents.

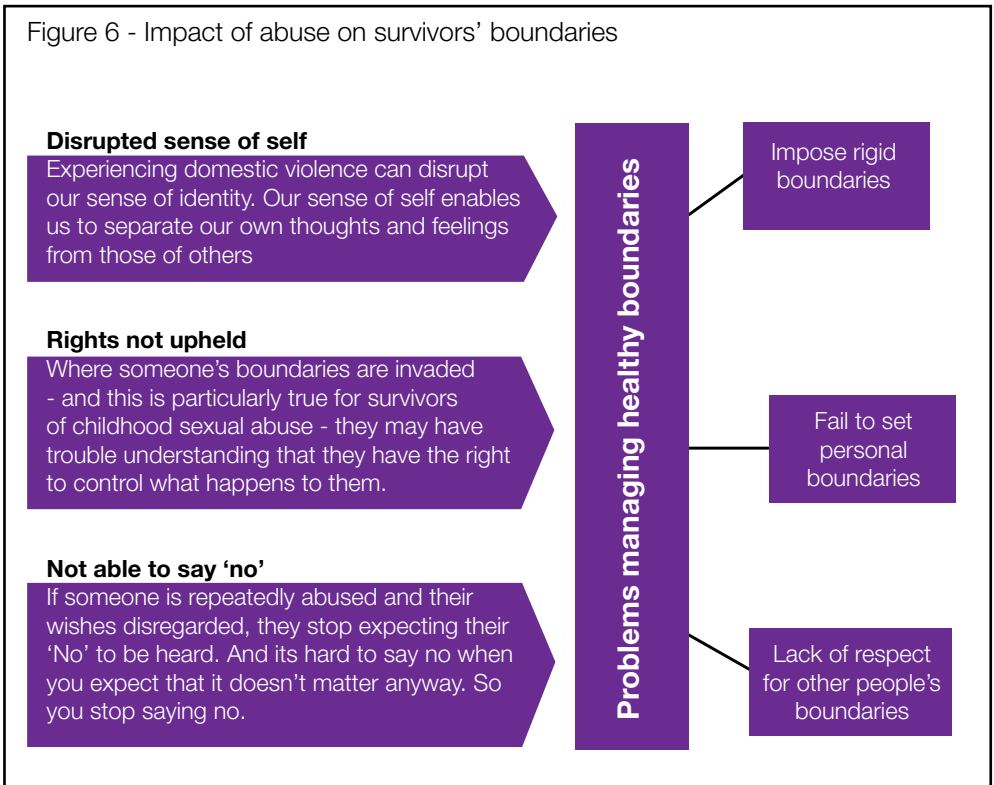
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## 2) failing to set boundaries.

People who have experienced abuse, particularly if repeated, can become desensitized to feeling betrayed. Survivors may not feel strong emotions when someone acts against them or against their wishes. They may

stop being able to sense in themselves what feels right or wrong. For survivors who use alcohol or drugs, substance use can exacerbate the difficulties in setting boundaries as inhibitions can be lowered.

Figure 6 - Impact of abuse on survivors' boundaries



**3) failing to respect other people's boundaries.** Having been denied the right to have a 'no', survivors may not recognise when other people say 'no'.

### 1.2.2 Managing relational safety

Practitioners can increase survivors' relational safety in several ways:

- raise survivors' own awareness about their responses to threat (in cases where the response is disproportionate to the risk) and the risks associated with directing anger at others, using violence and acting out sexually.
- depending on the service, address anger management and other risky behaviours or refer to a partner organisation for specialist support.
- model acceptable behaviour and maintain clear and consistent boundaries.

The last point is particularly important for survivors of domestic and sexual violence, who may lack any other stable attachment figures. Professionals often become so focused on completing practical tasks and overlook the importance

of the stable and consistent relationship they can offer survivors.

Professionals do report difficulties in developing bounded and consistent working relationships with survivors of domestic and sexual violence.<sup>7</sup> For example,

- It is easy to become too close to survivors when you work with them for a long time. No matter what your role is, the contact you have with survivors must stay within professional limits.
- If a worker placates/makes allowances for them on account of them being abused, they are not learning to put boundaries in their proper places.
- Survivors may seek and reject attention and a close relationship with workers, which can cause the worker to feel rejected. In this situation, a worker may unknowingly respond by rejecting the service user or working 'harder' to win the survivor's approval and attention.

Therefore, professionals working with survivors of domestic and sexual violence, particularly those

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also affected by substance use and mental ill-health, are at risk of being treated in a way that crosses their personal boundaries. For that reason it's very important, when in a relationship with a survivor to:

- Set the boundaries early and clearly
- Stay alert and continuously maintain boundaries
- Be consistent

This approach can keep you safe but also provide a vital, safe attachment for survivors regardless of your role.

The Department of Health has produced guidance on relational safety. Whilst primarily aimed at managing the safety on psychiatric wards, much of the information is relevant to other residential settings, such as refuges, hostels, or community project where the same service users meet frequently. The guidance can be downloaded here: <http://www.rcpsych.ac.uk/pdf/Relational%20Security%20Handbook.pdf>.

## 1.3 External safety

People who have been affected by domestic and sexual violence, substance use and mental ill-health are also at risk of further abuse and exploitation by individuals who specifically target them because of their possible vulnerabilities:

- difficulties with boundaries and being assertive
- low self-esteem due to experiences of abuse, substance use and mental ill-health, as well as the stigma attached to these issues
- often isolated from friends/family and society more generally
- open to perpetrators who pretend to be a friend, to care about and about the victim or who are very charming at the beginning
- victims are more likely to blame themselves for abuse, or be made to think it is their fault
- people who have substance use or mental health problems are less likely to be believed when they report abuse

### Domestic Violence

As already noted, perpetrators will use victims' substance use or mental health problems to abuse them. For example, verbal insults such as 'junkie' or 'nutter', controlling finances because victim is not 'capable' or might use for drugs, make victim believe they are to blame for perpetrator's behaviour. A full list of abusive behaviours relating to the victim's substance use or mental health problems can be found in appendix G.

### Sexual violence and exploitation

Sexual violence is most often perpetrated by someone known to the victim, including their parents. Because of their vulnerabilities, people with mental health problems and learning difficulties may also be coerced by a partner or friend into having sex with other people. This is called sexual exploitation. Sexual violence and exploitation is also common among people who use substances, e.g. sexual services can be used to pay for drugs.

## Abuse

### Mate crime

Learning disabilities, mental ill-health and substance use all leaves people vulnerable to exploitation by others, which is called 'mate crime' by some. This can be someone borrowing a person's mobile phone and using all the credit, friends turning up on benefit's day to go to the pub or for a party with the victim paying for everyone, befriending someone to use their flat to deal or use drugs. A user-friendly guide to mate crime can be found on the ARC website: <http://arcuk.org.uk/safetynet/files/2012/08/Friend-or-Fake-Booklet.pdf>.

### Hate crime

People with learning disabilities or mental health problems may also experience hate crime. This can include neighbours calling the person names, children throwing stones at their house, people hassling or threatening the individual. Domestic and sexual violence can also be considered hate crimes.

Survivors with drug, alcohol or mental health problems are vulnerable to different types of abuse: domestic violence, sexual violence and exploitation, mate crime and hate crime. See above for more detail.

In cases where survivors are at risk of harm from others, practitioners should complete the appropriate

risk assessment (see p110) and give immediate consideration to contacting the police, MARAC (Multi-agency risk assessment conference) or adult safeguarding teams. Further information about the MARAC and safeguarding procedures can be found on p.114 onwards.

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## 2 Risk assessment

### 2.1 Approaches to risk assessment

Risk assessments are completed to identify the likelihood of a negative event occurring, how soon it might occur and the severity of any outcomes. Assessments consider a range of risk factors, i.e. a personal characteristic or circumstance that is linked to a negative event and that either causes or facilitates the event to occur. Risk factors are either:

- **Static**, i.e. unchangeable, such as a history of child abuse or suicide attempts.
- **Dynamic**, i.e. those that change over time, e.g. misuse of alcohol. Dynamic factors can be aspects of the individual or aspects of their environment and social context, such as the attitudes of their carers or social deprivation. Because they are changeable, these factors are more amenable to management.

As risk can change – sometimes over very short timescales – the most effective risk assessments are

based on structured professional judgment and are completed in conjunction with the survivor. Risk assessments should formally be reviewed regularly, but also as is needed. This also guards against a ‘tick box’ mentality in completing risk assessment forms.

Good practice across violence risk management, substance use and mental health promotes an approach to risk assessment whereby practitioners make a judgment about risk on the basis of:

- an assessment of clearly defined factors derived from research;
- professional experience and knowledge of the service user; and
- the service user’s own view of their experience, and that of their carer (where safe and appropriate)

Where appropriate and possible, risk assessment should be completed with the input from other members in a team, service or from other relevant agencies. Information about domestic and sexual violence, substance use and mental health



can be complex with fragmented information shared across several different services. Joint information sharing and development of a risk management strategy are far more effective and prevents you, as a lone worker or agency, carrying the sole responsibility for survivor (and their children's) safety.

## 2.2 Assessing risk

If a service user discloses domestic and sexual violence, substance use and/or mental ill-health, a key 'next step' is to assess the risk of immediate harm they face from others or pose to themselves. When considering levels of risk, you should consider the most common risk factors (outlined in this section) and, where appropriate complete the relevant standardised assessment tools (details in 2.3.2). In each case, you may prefer to do this with a partner agency that specialises in that area, for example complete the DASH RIC with an IDVA (independent domestic violence adviser).

### 2.2.1 Common risk factors

If you are in the process of needs assessment and support/care planning with survivors of domestic and sexual violence who are also affected by substance use and/or mental ill-health, professionals should – at a minimum – consider the following key risk factors:

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## Internal

Physical disability / illness

Diagnosed/undiagnosed mental health problems

Current mental state-hallucinations; severe paranoia, anxiety, panic attacks; insomnia

Ability to manage emotional distress

Self-harm

Suicide-high levels of intention/plans

Self-neglect

Substance use - overdose, lost memory or consciousness as a result of substance use; unsafe using, e.g. sharing injecting materials; poly drug use; physical dependence; who supplies substances (abusers?)

## Relational

Sensitive to danger - sees everyone as potential threat, reactions to triggers

Unsafe sexual practices; sexually 'acting out'

Use of violence and aggression against others

Communication skills- unable to express needs

Relating to others - inability to understand others' perspective, to connect with others

Boundaries - unable to set and maintain boundaries in relationships with others; lack ability to say 'no'

Parenting capacity - unable to meet basic parental responsibilities and needs of dependent children

## External

Isolation - social, cultural, lack of engagement with services

Major life stressors - homelessness, bereavement, unemployment, pregnancy or recently given birth

Stated abuse from 'friends' acquaintances, neighbours

Sexual exploitation - involvement in prostitution or other forms of exploitation

Recent sexual assault or rape - key risk factors for mental health, self-harm, suicide as well as for further harm and murder (if perpetrator is known to victim)

Domestic violence - key risk factors are controlling behaviours, escalating abuse, isolation, recent separation, stalking and harassment, threats to kill, attempts to strangle/drown/ suffocate, pregnancy

Sample questions for identifying and assessing internal, relational and external risk factors can be found in appendix B.

### 2.2.2 Risk assessment tools

Most agencies now complete extensive risk assessments with all new service users and follow up with regular reviews. Depending on where you work, you may have access to standardised tools for identifying and assessing risk. The most commonly used tools are listed below and can be found on appendix B onwards along with sample questions which may help to identify major safety risks.

#### *Domestic violence*

- DASH RIC (Domestic Abuse, Stalking and Harassment Risk Identification Checklist) – used to identify very high risk victims and as a threshold for MARACs (for more information about MARACs, see p.114)
- Barnardo's Domestic Violence Risk Identification Flow Chart – primarily designed to assess risk for children and teenagers witnessing domestic violence.

#### *Sexual violence and exploitation*

Sexual violence is not risk assessed like domestic violence is. However, if the survivor is in, or has been in, a relationship with the perpetrator, or still has contact with him, it may be relevant to follow domestic violence risk assessment procedures. This is because sexual assault and rape are uniquely associated with:

- Homicide (both of the abuser killing the survivor, and for the survivor killing their abuser)
- Strangulation
- Threats by abuser to kill survivor and/or her children
- Abuse during pregnancy
- Perpetrator suicidality

For children at risk of sexual exploitation, practitioners should use the SERA model for assessing risk.

#### *Substance use*

- AUDIT (Alcohol Use Disorders Identification Test) is a brief self-report questionnaire developed by the World Health Organisation to identify people whose alcohol consumption has become

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hazardous or harmful to their health.

- APQ (Alcohol Problem Questionnaire)
- SADQ (Severe Alcohol Dependence Questionnaire)
- DUST (Drug Use Screening Tool) can be used to identify young people and adults who might benefit from being referred to a substance use agency

## *Mental health*

- CORE (Clinical Outcomes of Routine Evaluation)
- The Sainsbury Centre for Mental Health Clinical Risk Management manual. Not strictly an assessment tool but a useful guide to risk management in mental health.
- START (Short-term Assessment of Risk and Treatability)

### 2.2.3 Limitations of risk assessment

Due to the fluidity of risk, risk assessments are not foolproof and they only give an indication of risk at a particular point in time. The level of

risk that someone is at may change as soon as they leave your office.

Risk assessments are only as good as the information provided. In terms of domestic violence, survivor assessment of danger is the most reliable indicator of risk. If she feels he will be violent again, chances are that he will.<sup>8</sup> However, you should be aware that survivors often minimise the risk as a way of coping or in denial/hope that the perpetrator will not be violent again. Practice-based evidence shows that professionals who have not been trained to complete the DASH risk identification checklist generally identify 4-6 fewer risk indicators than trained professionals.

Furthermore, survivors may not disclose substance use or mental health (or the extent of the problems) for fear of children being removed, being judged, not being able to access refuge services, etc. This again points to the need to work in partnership with other organisations to gather as much information as possible to inform risk assessment and support planning.

Risk assessment in cases of dual diagnosis, i.e. when the person is affected by substance use and mental ill-health, is also highly problematic. There is a risk that serious mental illness may go unrecognised or untreated when there is coexisting substance misuse, as sometimes psychotic symptoms and challenging behaviour will be attributed solely to the substance use.<sup>9</sup> Conversely, drug and alcohol use may be masked by mental health problems.

As all three issues – abuse, substance use and mental ill-health – are interlinked and can increase the risk of harm related to each other, for example:

- People who misuse substances have an increased risk of a mental health relapse.<sup>10</sup>
- Using drugs or alcohol when feeling desperate or in a crisis greatly increases the risk of unintentionally committing suicide or causing serious physical damage through self-harming as substances can effect a person's judgement.<sup>11</sup>

- Alcohol use is associated with an increased risk of a perpetrator of domestic violence physically assaulting their partner.<sup>xi</sup>
- A survivor's use of substances may increase with a return to their partner<sup>12</sup> or increased episodes of violence.
- A survivor's mental health may deteriorate if they become isolated when moving to a new area to flee an abusive partner.

### 3. Use risk management systems

Once a risk assessment has been completed, it is vital that the appropriate action is taken. In deciding what to do next to manage the identified risks, professionals should share any concerns with their line manager rather than making decisions alone. Similarly, due to the multiple needs this client group has, a multi-agency approach may be required. There are two key parallel and interlinking risk management systems to be aware of:

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## Multi-Agency Risk Assessment Conference (MARAC)

MARACs are meetings where information about victims of domestic abuse who are at high risk of further harm is shared between local agencies. By bringing agencies together, a coordinated safety plan can be devised to support the victim.

## Safeguarding Adult Procedures

Where the victim of abuse is considered to be a 'vulnerable adult', professionals should contact their local safeguarding adult team. A safeguarding alert will be raised and trigger a multi-agency risk assessment and safeguarding plan. The plan may include a referral to the MARAC.

### 3.1 Multi-agency risk assessment conferences

Multi-agency risk assessment conferences (MARACs) exist in most local authorities across England and Wales. You can find out about your nearest MARAC by contacting your local Domestic Violence or Violence Against Women Co-ordinator or the nearest Community Safety Unit based with the police.

The role of the MARAC is to facilitate, monitor and evaluate effective information-sharing to enable appropriate actions to be taken to increase public safety. The aims are:

- To share information in order to increase the safety, health and well-being of high risk survivors. By sharing information, agencies get a better picture of victims' situations and so develop

responses that are tailored to the needs and goals of individual survivors and their children. More information about legal provisions for, and limitations on, information-sharing can be found on p.217.

- To determine whether the perpetrator poses a significant risk to any particular individual or to the general community and to reduce this risk through a jointly constructed risk management plan.
- To reduce repeat victimisation within a multi-agency context.
- To improve agency accountability and responses to domestic violence.
- To improve support for staff involved in high risk domestic violence cases.

The survivor does not attend the meeting, nor does the perpetrator, or the Crown Prosecution Service. The victim is usually informed that their situation will be discussed by the MARAC, unless doing so would jeopardise the survivor's safety.

The MARAC would usually be chaired by an officer from either the police or probation services. This is normally someone with the rank of Detective Inspector or equivalent.

On average the MARAC will spend about 10 minutes per case. This does underline that the responsibility to take appropriate actions rests with individual agencies; it is not transferred to the MARAC. Therefore, those attending the MARAC should have the authority within their agencies to prioritise the actions that arise from the MARAC and to be able to make an immediate commitment of resources to those actions.

### 3.2 Adult safeguarding procedures

If your client is considered to be 'vulnerable', you may consider referring the case to your local adult safeguarding team.

According to the Department of Health's guidance on safeguarding, *No Secrets*,<sup>12</sup> an adult is deemed vulnerable if "he or she is or may be in need of community care services by reason of mental or other disability, age or illness; and who is

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or may be unable to take care of his or herself, or unable to protect him or herself against significant harm or exploitation".<sup>13</sup>

Generally, adult safeguarding teams follows this procedure, which include specific timeframes:

**1) Alert.** Immediate action to safeguard anyone at immediate risk

**N.B. Whilst the following process is in place for the most serious cases, it is worth noting that most cases will not proceed past the 'alert' stage.**

**2) Referral** (same working day). Information about the concern placed into a multiagency context

**3) Decision** (end of same day as referral made). Are the 'Safeguarding Adults' procedures appropriate to address the concern?

**4) Strategy meeting** (within five working days). A multi-agency plan for assessing risk and addressing immediate protection needs is formulated

**5) Safeguarding assessment** (within four weeks of referral). Information about the concern is collected, including from the survivor, and may also include a criminal or disciplinary investigation

**6) Case conference/ safeguarding plan** (within four weeks of assessment being completed). A multi-agency response to the risk of abuse is created and implemented.

**7) Review** (within six months for first review and thereafter yearly).

The Social Care Institute for Excellence (SCIE) have produced clear guidance on dealing with adult safeguarding concerns in cases where the client does and does not have capacity. These guidelines can be found in appendix D.

Full details of the adult safeguarding referral and assessment process can also be found on the SCIE website:

<http://www.scie.org.uk/publications/adultsafeguardinglondon/index.asp>



### 3.3 Confidentiality and consent

You do not need the service user's consent to refer to the MARAC or Adult Safeguarding, although in both cases it is highly preferable. At the very least, referrals should be made with the survivor's knowledge.

*"In the absence of serious crime, and of significant risks to third parties, competent adults retain the right to make decisions about how they wish to direct their lives. Neglecting or violating these decision-making rights, even where the intentions are to protect the individual, can itself amount to a form of abuse."*<sup>14</sup>

If consent is not obtained to share information in a safeguarding matter or where a survivor of domestic violence is at high risk of further harm, there are several considerations to be made about sharing information without consent.

Sharing information without consent may be legitimate where there is an overriding public interest such as in preventing crime, or where

the 'vital interests' of an individual are affected and he or she does not have capacity or is unable give consent. In the latter case, this can include cases where a vulnerable adult is at risk from abuse.

When deciding whether someone has mental capacity, professionals have to consider if the person has an impairment to the functioning of the mind or brain, and an inability to make decisions. A person is deemed to be unable to make decisions if they cannot:

- understand or retain the information relevant to the decision,
- weigh up the information to make the decision, or
- communicate the decision.

Even where a person lacks capacity they should be involved as much as possible in discussions, so that their best interests are maintained, and the least restrictive options in any situation should be sought.

Similarly, even if a survivor does not consent to be referred to the MARAC or Adult Safeguarding

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Team, it is still best practice to tell your service user this is what you are doing and update them on any progress.

## 4. Supporting survivors to keep themselves safe

### 4.1 Safety planning

Safety planning is a common feature of working with survivors of both domestic and sexual violence. Safety planning is used to identify ways to manage the risk of further violence or abuse from others.

The key principles of safety planning are:

- Keep the responsibility for the abuse explicitly with the perpetrator.
- Provide consistency and continuity.
- Never assume you know what is best for victims; they know their situation and the risks better than you do.

- Recognise that victims will already be employing safety strategies, though they may not name them; recognise, validate and build on what they are already doing. Explore which strategies are effective and helpful, and which may not be so helpful but could be adapted.
- Do not suggest or support anything that colludes with the abuse.
- Risk is dynamic (always changing) and so safety planning needs to be an on-going discussion as situations change.

It is also essential to think about the difference between 'safe from' (violence, threats of violence, etc.) and 'safe to' (engage with services, develop friendships, study, work, etc.) to ensure that both needs are met effectively.

Figure 7 - Safety planning



Safety plans for domestic violence should cover actions to keep safe in a relationship, at the point of leaving and once a relationship has ended. Where a survivor has problems with drugs, alcohol or their mental health, you should consider:

- Substance use and mental health problems can make it difficult for survivors to assess the severity of the abuse they are experiencing.
- Is the plan realistic? Can the survivor implement the plan when they're intoxicated or unwell?
- Can you include changes to patterns of substance use that may increase safety? For example, using at times of day that their partner is unlikely to be around.
- Does the plan incorporate strategies to promote access to substance treatment or mental health services?
- What response might survivors receive from services, the police, etc. when they make calls under the influence of alcohol/drugs or when they are unwell? What previous contact have they had with services (including the police) relating to their substance use or mental health?
- If considering leaving – where will they get their supply of drugs? Do they need emergency prescribing?

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Do they have sufficient prescribed psychiatric medication? How easily can they arrange a prescription with a new mental health team?

Full guidance for creating a safety plan for survivors affected by substance use and/or mental health problems can be found in appendix E.

Where someone has experienced sexual violence by their partner or outside of a relationship but by someone known to them, safety plans should consider how to stay safe after the assault and may include a number of the points on the domestic violence safety plan.

## 4.2 Safer coping strategies

Once practical safety plans have been made, developing a sense of internal safety can be helpful for survivors of domestic and sexual violence. In some cases, survivors will need specialist support to re-establish internal safety, for example cognitive behavioural therapy, psychotherapy or drug/alcohol treatment. Information about the commonly available therapies can be found on pp.85-94.

In the absence of specialist support or trauma therapy, or for service users who do not want to go down that route, a wide range of practitioners (including you!) need to be able to support survivors to manage trauma responses themselves. Developing safer ways to manage a survivor's emotional world can even form part of a formal safety plan.

Supporting someone at this stage can include:

### Understanding and managing emotions

- Does the survivor understand what is happening? Give information about domestic and sexual violence, common trauma responses and coping mechanisms
- Does she know what she is feeling? Survivors may need help to clarify and label their feelings
- Does she feel in control of her emotions? Common triggers for becoming overwhelmed with emotion are flashbacks, reminders of the trauma, and HALT (being hungry, angry, lonely and tired).

### Making existing coping strategies as safe as possible

- All coping strategies should be acknowledged for fulfilling their purpose, which is to aid survival. For example, see appendix F for information about how self-harm is used as a coping strategy by some survivors.
- Survivors should not be 'forbidden' from using unsafe coping mechanisms as this could lead to them hiding their behaviour and increases the risk of harm. Instead, listen, acknowledge the survivor's pain, their efforts to survive and make all coping mechanisms safe to discuss.
- Provide information about harm minimisation techniques and incorporate into the survivor's safety plan. Substance treatment and mental health services can provide details of recognised harm minimisation techniques.

### Implementing new strategies

- Whilst tolerating unsafe coping strategies, as professionals, our job is to devise, evaluate and persuade the survivor to adopt an alternative way of coping; one that offers less immediate relief,

but does not trap the person in a diminished quality of life.

- Create clear plans of what to do if feeling overwhelmed, including who can help. This might include calling the Samaritans, the National Domestic Violence Helpline, Rape Crisis, national and local sexual violence helplines, Saneline. Details of all these services can be found in appendix H.
- Consider ways to self-soothe such as grounding, mindfulness and breathing. The Australian National Drug and Alcohol Research Centre has published a useful self-help leaflet about managing trauma responses and substance use. This leaflet can be downloaded from <http://tinyurl.com/d8u734e>.
- Explore other means to manage feelings: writing, drawing, exercising, hitting cushions.

Lifesigns (Self-Injury Guidance & Network Support) has a great website with guidance and information for people at the point when they feel like self-harming. Useful ways of managing urges to self-harm can be found here: <http://www.lifesigns.org.uk/help/read-this-first>.

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The National Self Harm Network also has a comprehensive list of ways for someone to distract themselves from the urge to self-harm. Many of the activities on the list may also be useful for people coping with urges to use alcohol or drugs or for people who are affected by anxiety, acute distress (including suicidal thoughts) or dissociation – the techniques can help the person focus on the world around them. You can access the list here: <http://www.nshn.co.uk/downloads/Distractions.pdf>.

## What works? Sane Responses

AVA's toolkit on domestic violence and mental health, *Sane Responses*, includes detailed information about specific mental health problems commonly associated with domestic and sexual violence.

The toolkit provides concrete advice on This includes how to:

- respond to survivors who are self-harming or feel suicidal
- how to address difficult emotions and negative thoughts
- support survivors to manage symptoms of PTSD (flashbacks, emotional numbing, anxiety and fear)

Sane Responses can be downloaded or ordered from [www.avaproject.org.uk](http://www.avaproject.org.uk).







# **Section 6**

In times of crisis

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# In times of crisis

## Section outline

This section provides an outline of how to deal with a range of crisis situations that survivors of domestic and sexual violence who are also affected by problematic substance use and/or mental ill-health may experience. The procedure for managing crises is:

1. Be prepared - understand what crises may occur
2. Apply key principles of crisis management
3. Support survivors to make their own decisions
4. Be aware of relevant procedures for dealing with different crises
5. Work in partnership

## 1. What is crisis?

Crisis is often described as a situation in which a person is confronted with a critical incident or stressful event that is perceived as overwhelming despite the use of traditional problem-solving and coping strategies.

*“When (my own) resources are stretched to the point of breaking down...when I am rendered powerless by circumstances to engage with my own well being”*  
Mental health service user’s experience of crisis<sup>1</sup>

Crises can take shape differently:

**Developmental:** life-transition events such as the birth of child or retirement

**Situational:** e.g. sexual assault, divorce, car accident

**Existential:** inner conflicts and anxieties including despair that one’s life is meaningless, regret about not achieving one’s own life ambitions

**Environmental:** natural or man-made disasters

**Psychiatric:** mental health problems that can affect coping mechanisms

**Medical:** a newly diagnosed medical condition or an exacerbation of a current medical problem

In this section we will consider how to respond to survivors of abuse who have mental health or substance use problems when they are in crisis, particularly those relating to situational, existential and psychiatric causes.

## 1.1 Types of crisis

Survivors of domestic and sexual violence who are also affected by mental health and/or substance use problems may experience a wide range of situations that they perceive as being uncontrollable and beyond their resources to cope. Indeed some events, such as physical assault, may well be out of the survivor's control and they need immediate protection or support.

The types of crises that you might come across include:

- being physically or sexually assaulted
- needing to flee an abusive partner or family member
- a relapse into substance use
- an accidental overdose
- a decline in mental health
- complications relating to self-harming
- suicide attempts
- other serious life events such as having a child removed, miscarriage, losing job, financial difficulties, the death of a friend or family member, being arrested

It is possible that these crises will precipitate one another, e.g. fleeing domestic violence may lead to a decline in mental health, or sexual assault could result in the survivor attempting suicide. Having a child removed could have an impact on the parent's mental well-being and cause a relapse into substance use.

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Relapsing could leave someone more vulnerable to domestic violence.

Thus, in responding to each individual crisis situation, professionals need to be aware of the impact on other parts of the survivor's life.

## 1.2 A never-ending crisis?

Some survivors with mental health and substance use problems can appear to live in a permanent state of chaos and crisis.

It is important to remember that, as described in the previous sections, survivors of domestic and sexual violence who are also affected by problematic substance use and/or mental ill-health may be more likely to:

- 1) Be targeted by others for the purposes of abuse, coercion and exploitation.
- 2) Find themselves in situations which can result in crisis, e.g. by not having strong boundaries, ending up homeless, losing job.
- 3) Be on alert for danger and so perceive other people or their actions as threatening or dangerous and thus may appear to respond in a seemingly disproportionate manner to situations which are not, in fact, threatening.
- 4) Be more isolated with a small social network and little informal support to help manage situations and thus more likely to need intervention by services.
- 5) Have fewer internal resources to manage situations and therefore things escalate to a crisis situation.
- 6) Habitually revert to a trauma response (fight, flight, befriend, freeze, flop) which has previously kept the individual alive in a trauma situation – this response may be activated when faced with all threats or stress, not just traumatic stress. Survivors may treat all threats as an emergency requiring action rather than thought.

## 2. Key principles of crisis management

Crisis management is often broken down into four stages: mitigation or prevention, preparedness, response and recovery.

Clear organisational policies and protocols are important tools that can prepare and guide practitioners through many crisis situations. However, organisations cannot be fully prepared for every possible scenario, so it is vital that practitioners are skilled in responding as effectively as possible in any situation.

Key points to remember in a crisis:

- The initial emphasis should be on ensuring that the survivor is and feels safe and secure. Is the danger still present (including the danger to themselves)? What is the danger? What makes the person feel more vulnerable? Safety is a subjective concept which is specific to an individual (for more information, see section 5).
- All actions should be assessed to ensure that the survivor's safety

is prioritised. When planning, for example, be mindful that family members, friends and carers may present a risk to the survivor and consider whether it is safe to collaborate with them.

- Wherever possible allow the survivor to tell their own story in their own way, in their own time - being listened to and heard is vital at all times.
- Gather the facts about the situation: What, Who, How, When, Where? Do take the survivor seriously – assertions made by people who have been diagnosed with a severe and enduring mental health problem or use drugs or alcohol problematically are often viewed with skepticism.
- Find out what the client needs now. What would help them cope? What support would they like from you?
- Approach work with survivors from a strengths-based approach, and empower them to make their own decisions. Crises are often accompanied by a sense of losing control and survivors should be supported to regain control.

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- Be honest about the type and level of support you can offer at this moment.
- Prepare a plan with the survivor and put it into operation - but be prepared to be flexible as events unfold.
- Take a holistic approach: consider the impact of resolving a crisis on every aspect of the survivor's life. For example, deciding to move to a refuge may make an individual safer from the perpetrator but may lead to a decline in mental health or an increase in substance use.
- Bear in mind that in a crisis, particularly where there is trauma, survivors may not be able to easily plan and make decisions so be patient. You may have to check several times that information has been understood and absorbed.
- Whilst a crisis can be an opportunity for change, be mindful of the consequences of undertaking potentially life-altering changes during a crisis. There may, however, be times when there is no other choice, e.g. fleeing an abusive partner and going to a refuge.
- Do not deal with an emergency alone. Inform your line manager, or another relevant colleague and seek support/guidance as need.
- Where possible, enable access to peer support. Peer support can be vital in reducing a sense of isolation during and after a crisis, and provide hope and reassurance.
- Offer post-crisis support. Crises in themselves are intrinsically traumatic and can impose further trauma on survivors. Once the individual's immediate safety is established, or the crisis has been resolved, make sure survivors have access to on-going support.

## 3. Support survivor decision-making

Experiencing abuse, substance use and mental ill-health can all give rise to feelings of powerlessness and an inability to manage.<sup>2</sup> It is therefore vital – in even in times of crisis – that survivors who have additional difficulties with drugs, alcohol or their mental health are empowered to support themselves and make decisions about their own safety and care.

As professionals, we may not always agree with survivors' decisions – for example, not to report violence to the police, to stay with or return to a violent partner, to risk their tenancy at the refuge by repeatedly using cannabis in their room, to stop taking psychiatric medication, or choosing to self-harm. People have the right, however, to make what others might perceive to be unwise or unsafe decisions.

Practitioners can support survivors to help themselves and to make informed decisions by:

- Ensuring survivors have access to relevant information and are able to understand what options are available to them. You might have to be creative in communicating information as written information is not always accessible. People who are learning disabled, for example, might find it easier to communicate using pictures, video or sign language.
- Giving survivors sufficient time to absorb information, including repeating information, if needed, at different intervals. You might want to consider if there are particular times of the day when a

person's understanding is better, or is there a place where they feel safer or more comfortable to make a decision? It may not be most effective to speak to someone just after they have taken medication that makes them drowsy, or when someone needs to use drugs, such as heroin or crack.

- Providing space for survivors to weigh up the available information to make the decision. This could be taking time to talk to the survivor or arranging support from a trusted friend or relative, or from another professional. You may know of local services that a survivor could contact. Otherwise, you can give details of some of the key national helplines (for full information, see appendix H) where a survivor can talk to someone independently.

### 3.1. Capacity

Whilst there are times when survivors need support to make a decision, there are also occasions when services have to intervene without the survivor's consent. This is primarily the case when someone is unable to make a decision because of the way their mind or

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brain works is affected, for instance, by illness or disability, or the effects of drugs or alcohol.

The Mental Capacity Act 2005 is designed to cover situations where someone is unable to make decisions that keep themselves or others safe. The Act states that someone cannot make a particular decision if they cannot do one or more of the following things:

- understand information given to them,
- retain the information for long enough to be able to make the decision,
- weigh up the information to make the decision and communicate their decision.

Using the Mental Capacity Act should always be seen as a last resort and it is important that survivors who need to be treated under conditions of compulsion get the help that they need. Using the Act does not remove the need for discussion with the service user – even where a person lacks capacity they should be involved as much as possible in discussions, their best

interested should be maintained, and the least restrictive options in any situation should be sought.

Full guidance about the Mental Capacity Act for health and social care staff can be found downloaded on the Ministry of Justice website: <http://www.justice.gov.uk/downloads/protecting-the-vulnerable/mca/opg-603-0409.pdf>.

## 4. Crisis management procedures

### 4.1 Physical or sexual assault

As well as experiences of domestic and sexual violence being associated with increased rates of mental ill-health and problematic substance use, people who have difficulties with drugs, alcohol or mental health are also more likely to experience violence and abuse from others.

Particularly in relation to mental health, Mind has found that around 70% of people with mental health problems experience harassment or victimisation in their local community.<sup>3</sup> This includes on-going bullying and theft, physical



assault, and sexual harassment and assault. Using drugs or alcohol problematically is also associated with higher rates of physical and sexual violence, particularly for women involved in prostitution.<sup>4</sup> It is therefore important that professionals working with this group of survivors are able to respond to physical and sexual violence.

If someone has recently been physically or sexually assaulted, the immediate concerns are:

1. Is the survivor at risk of further harm?
2. Are they physically hurt?

If the survivor is in immediate danger or has serious injuries, call 999.

#### 4.1.1 Involving the police

Deciding whether or not to involve the police is very difficult. Survivors of domestic violence may not wish to call the police, and often only do so as a last resort after repeated attacks. People who have been sexually assaulted by a partner, friend or acquaintance may be ambivalent about calling, for fear

of not being believed or taken seriously.

Some women may be reluctant to call the police if they have previously had contact because of their own problematic substance use, involvement in prostitution or when mentally unwell. Research<sup>5</sup> has found that:

- 36% of people with mental health problems do not report a crime because they do not think they will be believed and 60% of people with mental health problems who report a crime felt that the appropriate authority did not take the incident seriously
- People experiencing mental ill-health or substance use problems are deterred from reporting due to tensions with the police, prior experience of having been arrested, seriousness of crimes being minimized, being directed to mental health or drug services rather than being supported through the criminal justice system, and cases being dropped because the victim is deemed unreliable due to their mental health and/or substance use problems.

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Survivors from Black, Asian, Minority Ethnic or Refugee (BAMER) communities may also fear racism against themselves or the perpetrator or have concerns about their immigration status and the consequences of calling the police.

**Ultimately the decision is entirely up to the survivor and there is no right or wrong decision.**

If a survivor does choose to call the police in an emergency, the police may provide assistance to victims of domestic or sexual violence by:

- Protecting the survivor if the perpetrator is in the vicinity.
  - Reducing the risk of further immediate danger by arresting and removing the perpetrator.
  - Arranging medical assistance if needed.
  - Finding out what happened.
  - Supporting the survivor to access specialist domestic and sexual violence services.
- Arranging transport to a safe place, if the survivor wants this.
- If it is not an emergency, the survivor may still want to contact the police to report the incident:
- Reports can be made to the **police**. It is possible to report anonymously but to investigate, the police will need the survivor's details and information about the offence.
  - In cases of sexual assault, the police may arrange for forensic and medical exams (including tests for sexually transmitted infections and pregnancy) to be done at a **Sexual Assault Referral Centre (SARC)**.
  - Survivors can also self-refer to a **SARC** if they are not sure whether to report. The SARC can store forensic results until a survivor decides to report or not.

Before a forensic examination, survivors of sexual violence should refrain from washing, brushing teeth, eating, drinking, smoking, going to the toilet, changing clothes, or taking any alcohol or drugs except prescribed medication. Doing any of these things could destroy forensic evidence. If the survivor has done any of the things on the list, however, it is possible that there is still forensic evidence to collect as well as injuries that can be documented.

- Survivors of sexual violence or serious domestic violence will either have their statement taken by a police officer or recorded on video.
- If the survivor has received visible injuries, photographs may be taken by the GP, at hospital or a Sexual Assault Referral Centre (SARC). In sexual violence cases a forensic medical examination may also be arranged.
- The police may investigate further before handing the evidence to the Crown Prosecution Service (CPS) who is responsible for deciding whether or not to charge the suspect.

Full information about reporting to the police and the court process for both physical and sexual assault can be found on the Rights of Women website ([www.rightsofwomen.org.uk](http://www.rightsofwomen.org.uk)).

#### 4.1.2 Support options

While the police and CPS do their job, survivors should be reassured that they are not to blame for what happened to them. Information about post-traumatic stress and rape trauma syndrome should be provided.

Rape Trauma Syndrome is a recognised crisis response to rape or sexual assault. Immediately after the assault, survivors may feel shock, denial and disbelief. They may try to carry on as though nothing has happened. In the longer-term they may experience problems sleeping, having nightmares or flashbacks.

Survivors should be reassured again that there is no right or wrong way to feel. Each person responds to domestic and sexual violence in his or her own way.

Survivors should also be given details of their local domestic and sexual violence support services and

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national helplines for further advice on keeping safe and for emotional support. National helplines include the National Domestic Violence Helpline and Rape Crisis Helpline (contact details are in appendix H).

## 4.2 Ending an abusive relationship

Ending an abusive relationship may be the result of some planning, or may happen unexpectedly, for example after a particularly severe physical assault. In either case, the survivor may need to decide if it is safe to stay at home or if they need to move. There are several options that survivors may consider:

- Staying at home.
- Staying with family or friends.
- Finding other temporary accommodation (refuge, local authority accommodation, private rented).

Each of these options is outlined below, including the possible advantages and disadvantages, which may be helpful for a survivor when deciding what to do.

### 4.2.1 Staying at home

Advantages	Disadvantages
Less disruption to children, work, etc.	Perpetrator knows location
Maintains support networks	Perpetrator may be made homeless if ordered by court to leave home
Additional protection measures available, e.g. non-molestation orders	Limited effectiveness of protection measures

If it is safe to do so, some survivors may prefer to remain in their home and arrange for the perpetrator to leave the property. If the perpetrator does not agree to leave, the survivor may need to apply for:

- **An occupation order.** If survivors have a legal right to occupy the property as a joint or sole owner or tenant or are the spouse, ex-spouse or co-habiting partner of the owner or tenant, they can apply to the family courts for an occupation order to exclude the perpetrator from the home. The order is likely to be for a specific period of time, but may also be until a further order is made. The

order may include obligations on the survivor or the perpetrator, for example making repairs to the property or paying the rent/ mortgage.

Once the perpetrator has left the property, there may be other measures the survivor may wish to consider:

- Applying for a **non-molestation order**. A non-molestation order can also be applied for through the family courts and aims to prevent perpetrators from using threatening behaviour, violence or intimidation against survivors of domestic violence. The order will state what the perpetrator is not allowed to do; this commonly includes not being allowed to contact the survivor or come within a certain distance of the survivor, their children, their home, school or place of work. The breach of a non-molestation is a criminal offence which is punishable by up to 5 years in prison.
- There are some restrictions on who can apply for a non-molestation order, namely the applicant and their partner must

be related or associated with each other in certain ways such as living together or having a child together. Where a survivor is being continually threatened or harassed by someone with whom they are not related or associated, they should consider applying for a **restraining order**.

Some survivors may continue to feel at risk even with a non-molestation order or restraining order in place. This is not unreasonable considering that ultimately court orders are a piece of paper that offer little immediate physical protection: perpetrators do breach them.<sup>6</sup>

Equally, other survivors may not wish to apply for an order, may not be able to afford a non-molestation order or the courts may not grant the order. In all cases, survivors should be advised of:

- Local schemes that provide additional security to the property. Many local authorities now operate schemes to install security measures such as fireproof letterboxes, new locks on doors and windows and panic alarms on a property. The schemes are fully funded and therefore are free

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for the survivor, and are open to people living in local authority and housing association properties, as well as privately rented or owned homes. Contact the domestic violence service or housing department for details of the scheme in the local area.

- Requesting a police marker on the property. Where there is a history of domestic violence, or where a survivor is at risk of further violence, the police may agree to mark the survivor's home as requiring a priority response. This means that if the survivor calls the police they should treat the case as being urgent and respond more quickly. Further details of this system should be available from the local domestic violence unit within the police or specialist domestic violence service.
- Creating a safety plan. A safety plan can be useful in identifying and managing risk of further violence and strategies for keeping safe. More information about safety plans can be found on p.118 and in appendix E.

## Getting legal advice

Whilst it is possible to apply for orders by oneself, it can be beneficial to have legal advice. The Law Society (<http://www.lawsociety.org.uk/find-a-solicitor/>) can provide details of local family solicitors; alternatively the local domestic violence service may be able to provide details of family solicitors who have experience of dealing with cases of domestic violence (visit [www.womensaid.org.uk](http://www.womensaid.org.uk) for details of the local domestic violence services). Survivors may be eligible for funding to help with the cost of applying for orders, however this is not guaranteed.

For full information about applying for any of the aforementioned orders, including making the application themselves, survivors should visit [www.rightsofwomen.org.uk](http://www.rightsofwomen.org.uk).

#### 4.2.2 Staying with family and friends

Advantages	Disadvantages
Less disruption to children, work, etc. Maintains support networks Additional protection measures available, e.g. non-molestation orders	Perpetrator knows location Risk of harm to friend/family member Limited effectiveness of protection measures Usually very temporary measure

Staying with family and friends may be the first choice for some survivors, but may not be possible or desirable in many cases. The perpetrator could easily locate the survivor and put pressure on the survivor and her family to return home. In a situation where the friend or family's property becomes overcrowded, survivors may feel even more pressure to move on and/or decide to return home.

#### 4.2.3 Finding alternative temporary accommodation, including refuge

If a survivor is homeless or threatened with homelessness because of the threat or actual perpetration of domestic violence,

the local authority housing department has a legal duty to provide her with advice about finding somewhere else to live. They may also provide a survivor with temporary emergency accommodation: this could be in a refuge, a hostel or B&B, or in the private rented sector. There are advantages and disadvantages to each option and these will vary depending on the individual survivor and her situation.

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Advantages	Disadvantages
Refuge	
<p>Undisclosed address and additional security measures can increase safety</p> <p>Peer support from other survivors</p> <p>Support available from specialist workers</p>	<p>Limited access for survivors with additional needs such as substance use and mental health problems or no recourse to public funds</p> <p>Potential disruption to many aspects of life if relocating to another area</p> <p>Shared living in some refuges</p>
Other temporary accommodation	
<p>Possibly more accessible as wider range of accommodation</p> <p>Less disruption to family life, support networks, job, etc. if able to remain locally</p>	<p>Limited access for survivors with no recourse to public funds, no dependent children, etc.</p> <p>Unsuitable/unsafe accommodation may be offered</p> <p>Specialist support may not be available or offered</p>
Private rented accommodation	
<p>More control over accommodation, e.g. location</p> <p>Fewer restrictions than, for example, in refuge</p> <p>More accessible for survivors, for example, with older male children who may be excluded from refuge, or who have mental health problems</p>	<p>Access to money for deposit</p> <p>May only be able to afford unsuitable or unsafe accommodation</p> <p>Specialist support may not be readily available</p>



Survivors should be able to get advice about their rights to emergency accommodation from local authority housing advice centres or housing options teams. According to the Homelessness Act 2002 guidance, if a person is homeless due to the threat of domestic violence, they are able to approach any local authority for emergency accommodation – **they do not need a local connection.** Survivors should also be advised that they have the same rights to emergency accommodation regardless of their current housing situation, i.e. if they rent their home from the council, private landlord or housing association, or if they own their own home.

The local authority may ask a survivor to apply for a non-molestation order and/or an occupation order so that she can remain in her own home. There is **NO LEGAL REQUIREMENT** to agree to this, and the local authority should still provide the survivor with emergency accommodation. The local authority may require evidence that the person have experienced violence, but should not refuse a survivor temporary accommodation if no evidence is available. The

local authority should also not refuse an application for temporary accommodation on the basis of rent arrears, although they may not rehouse a survivor permanently.

Some survivors may choose to contact refuges directly, rather than going through the local authority. A refuge is a safe house where survivors and their children can live free from abuse. There are over 300 refuges in England and Wales for women and children, and a handful for male victims of domestic violence.

It is possible to find out which refuges have vacancies on any given day by calling the Freephone National 24-hour Domestic Violence Helpline (0808 2000 247), which is run in partnership between Women's Aid and Refuge. Refuges can also be contacted through local domestic violence services (see <http://tinyurl.com/depva4> for an up-to-date list of services), the Police, the Samaritans (08457 90 90 90).

If a survivor calls the National Domestic Violence Helpline, she will most likely be given the telephone numbers for refuges that currently have spaces. The survivor will need

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to call each refuge and speak to a member of staff who will complete a brief needs and risk assessment. Once a space has been offered, staff from the refuge will discuss travel arrangements with the survivor. It is possible that the survivor will not be given the street address until they are near to the refuge to maintain confidentiality.

## **Survivors who have problems with substance use and/or mental ill-health should:**

- Be prepared to be turned away from refuges because of their substance use or mental health problems
- Be truthful, nonetheless, about any additional support needs at the point of referral. Not disclosing drug, alcohol or mental health problems can lead to survivors not receiving adequate support at a difficult time which could leave them at greater risk
- Be aware that ending an abusive relationship and moving into a refuge (or other temporary accommodation) can be very stressful and may lead to increased use or worsening mental health

- Be prepared to potentially experience discrimination from other survivors in the refuge
- There could be a requirement for survivors to engage with local substance use or mental health services

More information about what survivors can expect in a refuge can be found in the Women's Aid Survivor's Handbook (<http://tinyurl.com/c3nsth5>).

### **What works? Manchester Women's Aid**

Manchester Women's Aid (MWA) employs specialist substance use and mental health workers to enable survivors of domestic violence who have drug, alcohol and/or mental health problems to access necessary help and support from MWA.

MWA actively challenges the widely held belief that survivors who have mental health and/or drugs and alcohol problems are 'too risky', 'too high need' or 'too chaotic', particularly for refuge services. The specialist practitioners support generic domestic violence workers

assess clients more effectively and identify possible risks: this reduces concerns about unknown or unmanageable risks amongst generic workers.

Specialist practitioners work with their colleagues to develop risk management and care plans that take into account the effects of different substances and mental health problems. MWA refuges in general adopt a realistic care plan for the client based on cycle of change and what could be achievable at different stage for the clients. The only expectation is that clients engage with the team fully, this does not mean to stop using drugs as for some people this may not be an achievable goal.

Through this joint working approach, staff have been supported to utilise greater holistic knowledge in developing safety plans in creative and meaningful ways, both in community and refuge setting.

Clients have also benefitted from improved relationships with external agencies. For example, clients accessing shared care services at the GP can meet with a domestic violence worker to discuss concerns

about keeping their methadone script or withdrawing from substances in the refuge.

A review of MWA mental health service can be downloaded here: [www.tinyurl.com/cofetgh](http://www.tinyurl.com/cofetgh)

In the long-term, survivors may decide to return home – either to their partner or once the partner has been removed from the property and any additional protection such as a non-molestation order has been put in place. Other survivors will need to find alternative permanent housing.

The provision of emergency temporary accommodation by a local authority does not guarantee long-term housing. If the local authority has reason to believe someone is homeless as a result of domestic violence, or the threat thereof, they should investigate whether they have a duty to provide the person with permanent, or at least more long-term, accommodation.

Each local authority will have policies on how they allocate housing, but in principle if someone is at risk of

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homelessness because of domestic violence, they are eligible for housing (i.e. they reside in England and have no restrictions on their recourse to social housing), and are considered to in priority need (i.e. they live with dependent children, have a physical or learning disability, or mental health problems), the local authority should accept a duty to house them in the long-term.

The Guidance accompanying the Homelessness Act 2002 also specifically notes that people who are vulnerable as a result of domestic violence should be considered for re-housing even if they do not fit into any other category of priority. The local authority should consider the impact of abuse on the survivor's physical and mental health and the impact of on-going abuse or harassment. In practice, however, few survivors who do not have children or any other additional needs are found to be in priority need solely because of the impact of living with domestic violence.

If the survivor has any problems with a homelessness application, it is advisable to seek legal advice from

local housing advice centre, Shelter, Citizen's Advice Bureau or a housing solicitor (details can be found in appendix H).

Similarly, before making any decisions about long-term housing options or signing any documents to relinquish current ownership or tenancy of a property, survivors should consider getting legal advice.

## 4.3 Mental health crises

### 4.3.1 Types of crisis

Mental health crises typically include:

- suicidal behaviour or intention
- panic attacks/extreme anxiety
- psychotic episodes (loss of sense of reality, hallucinations, hearing voices)
- other behaviour that seems out of control or irrational and that is likely to endanger the survivor or others.

People who experienced mental health crises describe it as:<sup>7</sup>

*“Losing control, not thinking rationally your mind tells you one thing your body another. You just want to die”*

*“Feeling on edge, lose touch with people, not in control – not being able to talk”*

*“Can’t describe it- emotional, paranoid, living in a different world”*

Managing mental health crises typically follows this process:

- 1. Promoting self-help.** Is there a crisis plan? What care strategies does the survivor have?
2. If the survivor is not able to manage crisis themselves, **contact other professionals.** This might include mental health professionals already involved, the GP out-of-hours service or the police.
3. GPs, A&E or the police may request mental health services to complete a **formal assessment** of the survivor’s needs and the risk of harm they pose to themselves and others.

**4. Treatment** may take place in the community or in hospital. It may be on a voluntary basis or a survivor may be detained for treatment.

Each stage is set out below.

#### 4.3.2 Self-help and crisis planning

Supporting someone to help themselves when feeling mentally unwell is usually the first course of action. Whilst some people may be feeling unwell for the first time in their lives, many people will have recurring experiences of mental illness and should be encouraged to manage worsening symptoms when it is safe and possible to do so.

A key aspect of self-help is ensuring that people in crisis have someone to talk to: even when a survivor’s thoughts or speech does not appear to be grounded in reality or is obviously delusional, the opportunity to ‘tell one’s story’ can be an important step towards crisis resolution. Being able to talk to someone is reported to be a fundamental need of people at the point of crisis.

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## *Telephone and online support*

Telephone helplines and email support, particularly if they are available 24 hours a day, offer essential support to people experiencing a mental health crisis. The following organisations run helplines (contact details can be found in appendix H:)

- **Samaritans**
- **Mind infoline**
- **Rethink Mental Illness**
- **Hafal** – leading organisation in Wales for people recovering from severe mental illness
- **Bipolar UK**
- **No panic** – support for people affected by panic disorders, phobias, obsessive compulsive disorders and other anxiety disorders
- **beat** – supporting for managing eating disorders

Websites like MIND, Rethink Mental Illness and NHS Direct also provide a lot of up-to-date information about mental health and support options.

Some survivors might choose to access peer support through web-based forums. Whilst forums can be a source of great support, they are not always moderated, i.e. no-one checks what people are writing, so incorrect information might given or people may post offensive or abusive messages. It is best to use moderated and well-known discussions such as the Big White Wall ([www.bigwhitewall.com](http://www.bigwhitewall.com)).

If someone is already in contact with mental health services, they may be able to talk to a crisis team or community mental health team if experiencing a decline in mental well-being. Each team may be able to resolve a crisis either in a single call or support over several days.

## *Crisis planning*

Some people who have existing long-term mental health problems may be able to plan for a crisis. Some survivors may have an informal, personal plan that they share with family or friends as needed, and other survivors who are under the care of mental health services may have a formal crisis management plan in place. In either case, plans should be shared with services, particularly

accommodation-based services such as refuges and hostels, as needed so that staff can be prepared for and support survivors to manage a decline in mental well-being.

Formal crisis planning tools include:

- **Advance statements.** There are different types of statements which vary in terms of legally how binding they are, i.e. some statements may be overridden by a psychiatrist, for example, if the survivor loses capacity (or not able) to make decisions about their treatment. Nonetheless, advance statements should include information about what survivors would like to happen if they become mentally unwell, such as treatment preferences or domestic arrangements.
- **Joint care plans/crisis plans under the Care Programme Approach (CPA).** If the survivor has severe mental health problems, they may agree a crisis plan with their psychiatrist or other mental health professional so that signs of a crisis can be spotted early on and to plan treatment in cases where the survivor loses capacity.

Many survivors will not be under the care of a mental health professional, but other services, such as specialist domestic and sexual violence agencies including refuges, may want to talk to survivors who experience periods of mental ill-health about creating a personal crisis plan. An example crisis plan can be found in appendix C.

Essential information such as the details of someone to be contacted in a crisis and information about care the survivor would like in a crisis can also be written on a crisis card. This card can be kept on the survivor in case of emergencies.

#### 4.3.4 Contact and assessment

Sometimes a woman's mental health issues can be severe and require intervention from mental health professionals. In some cases, women with severe mental health issues may be unable for a time to live independently or care for their children and they may be seen as a danger to themselves or to others.

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In an emergency, survivors can:

- Call the **GP**. In some cases, survivors may have a GP that they have known for some time and who may be able intervene early if the survivor displays signs of worsening mental health. Survivors may find it helpful to speak to their GP in a crisis; otherwise the GP may be able to advise on who to contact next.
- Go to **Accident and Emergency (A&E)**. A&E might be the first point of call in a mental health crisis, particularly if the survivor has hurt themselves physically. As A&E departments can be very busy, and staff have varying levels of knowledge about mental health problems, it can be helpful for someone to accompany the survivor to hospital.
- Call **NHS Direct** (0845 46 47). NHS Direct can provide information and advice about where to get help in an emergency.

If the survivor is in a public place, people nearby or professionals may choose to call the police. Under section 136 of the Mental Health

Act 1983, the **police** have power to remove a person from a public place to a place of safety, e.g. hospital or police station.

Depending on where the survivor is, an assessment may be conducted by a psychiatric liaison team or another local mental health services such as a Crisis Resolution Team. The assessment will be used to ascertain whether the survivor is well enough to stay in the community, possibly with support from a local mental health service, or needs to be admitted into hospital for further assessment and/or treatment.

## 4.3.5 Treatment

Treatment will vary depending on the individual, but may include a combination of medication, psychological support and social care. A care plan will be drawn up, which might include ways of preventing and resolving any future crises. People with multiple, complex needs may be put under the Care Programme Approach (CPA) and a Care Co-ordinator will be appointed to co-ordinate different aspects of the care plan.

## Community-based services

In most cases, survivors will be



supported to resolve the mental health crisis in the community; this can depend on the services available. Mental health services in each area are commissioned individually and can vary in name. For support in crises, a survivor may be referred to:

- home-based crisis or treatment services
- crisis resolution team
- acute home treatment
- rapid response services
- psychiatric emergency services

Services in the community may also differ in configuration but are typically staffed by a Multi-Disciplinary Team (MDT) comprising a psychiatrist, mental health nurses, social workers, occupational therapists and other support workers. The main aim of crisis resolution teams is to provide the most appropriate treatment possible to prevent hospital stays or speed up discharge into the community.

Alternatively, survivors may be referred to:

- a Community Mental Health Team (CMHT), or
- a community-based Assessment Team before moving on to a Recovery Team for longer-term support.

These services often work during office hours and are therefore not set up to deal with mental health crises. However, if survivors are engaged with a CMHT or Recovery Team, they may be able to receive sufficient support, including out of hours, leading up to or during a crisis which means they can manage in the community.

### Residential support

There are two options for residential support during a mental health crisis:

- crisis house
- hospital

Crisis houses, where available, provide intensive short-term support to people so they can manage a mental health crisis outside of hospital. Crisis houses vary greatly and may be staffed by people with an experience of mental ill-health

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and/or be mixed with medical professionals. Depending on the crisis house, survivors may be able to self-refer or may need a referral from a crisis team or the CMHT. Each referral is assessed to ensure the individual fits the criteria for the house and will be able to manage.

Where community support or a crisis house is not available or suitable, some survivors may be admitted onto a psychiatric ward for further assessment, observation and/or treatment. Depending on the structure of inpatient services, a survivor may be admitted onto:

- Psychiatric Intensive Care Unit (PICU) for high-level support if very unwell, or
- an acute inpatient ward.

Some people may choose to be admitted into hospital as they feel safer than at home, often because there is more scope to protect them and others from themselves, but also because hospital can provide structure in life and contact with other people who have similar experiences.

On the negative side, many wards are now locked as they house a mixture of voluntary and sectioned patients. This means voluntary patients can feel more restricted than they would like or need. Patients may also feel less safe where facilities are mixed-sex during the day even if sleeping arrangements are single-sex. Another complaint is that despite the programme of activities, patients can often be left with very little to do which, like in refuges, can exacerbate mental health problems.<sup>9</sup>

Whilst each ward may be slightly different, and patients' needs will vary, the Royal College of Psychiatrists have identified ten standards which are central to providing safe and effective inpatient care.<sup>9</sup>

1. Bed occupancy rates of 85% or less, to enable patients to be admitted in a timely fashion.
2. Maximum of 18 beds per ward.
3. A physical environment that is fit for purpose, including access to fresh air, quiet and private space, single-sex toilets and sleeping areas.

4. The ward is a therapeutic space, providing a programme of activities to promote mental and physical well-being.
5. Proportionate and respectful approach to risk and safety, centring around effective communication and treating patients with dignity and respect.
6. Information-sharing and involvement in care-planning.
7. A recovery-based approach, including links with the community and other agencies.
8. Access to psychological interventions, with at least one psychological intervention a week.
9. Personalised care, with adequate staffing and daily one-on-one contacts.
10. Providing socially and culturally sensitive care.

For full information about community services and hospital-based care, please see Mind's guide to crisis services: (<http://tinyurl.com/bm8nn9f>).

#### 4.3.6 Sectioning and detaining

Most people will agree to treatment or to go to hospital. They are 'informal' patients who cannot be prevented from leaving hospital when they wish and their consent must be given before treatment.

Occasionally, people are not aware that they have a mental health problem or do not want treatment and yet are a risk to themselves and/or other people. **The Mental Health Act 1983** allows people who are diagnosed as mentally ill to be **sectioned** (held under a section of the Act) or **detained** (kept in hospital), assessed (under Section 2, for up to 28 days) and given treatment against their will (Section 3, for up to six months at a time). They are usually detained in their own interests and for their own safety but may be held if they are seen as a risk to others.

If a survivor does not think there is a problem or does not want treatment, there are three professionals who can be contacted:

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## Who is detained?

In 2011/12, there were 48,631 admissions or detentions made under the Mental Health Act in England (this is not necessarily the number of people who were detained under the Act as some people are sectioned more than once within a year). This is a five per cent increase on the previous year's figures.<sup>10</sup>

According to a census<sup>11</sup>, 29% of women inpatients get admitted for assessment under the Mental Health Act. Women from Black Caribbean, Black African and other Black groups were more likely to be detained (56%-62%) when compared with the average of all inpatients. Indian and other Asian women were also more likely to be detained than other groups.

- If the person is in a public place, the police can remove them to a safe place, e.g. the police station or hospital, for initial assessment.
- If the person is in a private space such as at home, the best person to call is the GP or their out-of-hours service. A GP may be able to persuade the survivor to agree to treatment.

- If the person lives alone and is not caring for herself or if she is not being kept 'under proper care and control', an approved mental health professional (AMHP) can apply for a warrant under section 135 of the Act to enter the home.

In order to detain someone, three people must agree: an approved mental health professional (AMHP), a section 12 approved doctor (psychiatrist) and a registered medical practitioner (GP).

## Nearest relatives

The AMHP is obliged to make reasonable efforts to find and inform the survivor's nearest relative (NR) that the person has been detained under section 2. This is even if the survivor does not want her NR involved. If the nearest relative is the perpetrator, the survivor could explain to the AMHP that she prefers to name another next of kin. Conversely, AMHPs should not assume that a partner will be the survivor's NR.

The two doctors must agree that the survivor needs to be in hospital; then the AMHP decides whether to make an application. The AMHP is also responsible for ensuring that the person is taken safely to hospital. The hospital manager, or a designated person, will examine and accept the section papers and then the individual is lawfully detained in hospital.

A survivor should only be detained for as long as is needed to keep themselves and others safe.

Whilst detentions can last up to six months, most people will be released within a few weeks or a couple of months.

Depending on which section of the Mental Health Act 1983 the survivor is detained under, s/he may be able to apply to the person overseeing their care (Responsible Clinician) or Mental Health Act managers in the hospital to be discharged. In other cases, the application may be referred to a tribunal. In either case, a clear plan should be put in place to manage the survivor's transition back to the community.

### **Independent mental health advocates**

Independent mental health advocates (IMHAs) aim to help people detained under the Mental Health Act in England to understand their rights and can, if needed, speak on their behalf. IMHAs have the right to meet the patient in **private**, see the patient's hospital and local authority notes (with the patient's consent) and speak to the **professionals involved** with the patient's care and treatment.

IMHAs have been in place since 2009, and from April 2013 every local authority will have a legal duty to provide an IMHA service, usually managed by a local voluntary sector organisation such as Mind or Rethink Mental Illness. Staff on inpatient wards have a legal duty to tell patients how to contact their local IMHA service, although this does not always happen.

## 4.4 Substance use

Overdosing, complications with withdrawal and relapse are three common risks related to using alcohol, illicit drugs and prescribed medication.

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## 4.4.1 Overdose

Someone may accidentally overdose if they combine different substances, use substances of unknown strength or have a reduced tolerance due to stopping or reducing use. Some survivors may also intentionally take an overdose in an attempt to commit suicide.

Consuming an excessive amount of alcohol, using illicit drugs, or taking prescribed medication for non-medical purposes can cause impaired motor skills, confusion, hallucinations, increased aggression and short-term memory loss.

When more substances are consumed than the body can cope with, the liver, brain or respiratory system may be seriously, even fatally, damaged. Another complication of consuming large amounts of substance is the risk of the user choking on their own vomit if s/he is sick but unable to clear their airways, e.g. after taking heroin or large volumes of alcohol.

Generally, if you suspect someone has overdosed:

- Reassure them you are there and are getting help.
- Immediately call for an ambulance.
- Place them in the recovery position.
- Do NOT encourage or induce vomiting unless directed by a healthcare professional.
- Stay with them until the ambulance arrives.
- If you know what they have taken, tell the ambulance crew.

## 4.4.2 Withdrawal

If survivors decide to reduce or stop using substances, it is important that professionals are aware of possible withdrawal symptoms. This is particularly important for survivors using alcohol and/or tranquilisers as these substances produce the most dangerous withdrawal and should not be stopped suddenly.

Depending on what substances they use, survivors should seek advice from their GP or drug/alcohol services to discuss how to reduce their use and how to manage withdrawal symptoms. If a survivor experiences severe withdrawal symptoms, they should seek

medical attention from a GP or A&E as needed.

### **Common withdrawal symptoms**

include sweating, difficulty breathing, stroke, racing heart, nausea, vomiting, diarrhoea, hallucinations, palpitations, grand mal seizure, delirium tremens (DTs), chest pain and heart attack

#### **4.4.3 Relapse**

Relapsing into substance use may be seen by some survivors (and also some professionals) as a crisis. However, relapse is a very common part of changing behaviour and it is actually more common to relapse than not to. If a survivor relapses, workers should discuss the risk of overdose (due to reduced tolerance), reassure the survivor that they are not a failure and help them understand why they used or drank again.

## **5. Working in partnership**

Supporting people who have experiences of trauma, problematic substance use and/or mental ill-health usually need support from more than one agency. At all times,

it is important that agencies to work in partnership to provide a seamless package of support that enables rather than overwhelms the survivor.

This is particularly true when someone is experiencing a crisis.

Agencies should identify key partners, establish a named contact and clarify referral criteria in advance, to aide the management of a crisis if and when it does occur.

Information about how to find your partners and to overcome some the challenges in partnership working can be found in section 9 of the toolkit.





# Section 7

Supporting  
children and  
families

# Section 7

## Supporting children and families

### Summary

Children and young people living in homes where there is domestic and sexual violence, parental substance use and/or mental ill-health are most likely aware of what is going on and may suffer harm or neglect as a result.

All professionals should therefore know how to identify and respond to concerns of harm to children and young people.

The process for supporting children and young people who are affected by domestic and sexual violence, parental substance use and/or mental ill-health is:

1. Understand how abuse, substance use and mental ill-health affect parenting skills
2. Understand the impact on children and young people
3. Be aware of the child's perspective
4. Consider referring to child safeguarding
5. Promote children's strengths and resilience
6. Work with the whole family

### 1. Impact on parenting

*"Almost three quarters of the children in [the two-yearly overview report of] serious case reviews had been living with past or current domestic violence and/or parental mental ill health and or substance misuse – often in combination."*<sup>1</sup>

Following more than two decades of legislation, research and successive Government guidance on safeguarding children, services supporting adults who have experiences of domestic and sexual violence, substance use and/or mental health problems have become increasingly aware of the needs of their service users' children over the last few years, with the message of 'Think Family' becoming commonplace.

In the majority of families affected by parental mental health or substance use problems or domestic and sexual violence, most children are not at risk of serious harm. Furthermore, the negative effects of growing up with such problems can often be offset with adequate support. This means children do have a good chance of outgrowing their trouble childhood.

This is particularly true where only one issue affects the family.

Major concerns arise when more than one of these problems is present, as is often the case. It is the 'multiplicative' impact of combinations of factors that have

been found to increase the risk of harm to children,<sup>2</sup> with family disharmony and domestic violence posing the greatest risk to children's immediate safety and long-term wellbeing.<sup>3</sup>

## 1.1 Prevalence of potential problems

- Between 250,000 and 350,000 children live with the problem drug users in the UK<sup>4</sup> and a third of adults in drug treatment have child care responsibilities.<sup>5</sup>
- More than 2.6 million children in the UK live with hazardous drinkers, and 705,000 live with a dependent drinker.<sup>6</sup>
- Research suggests that 30% of adults with a mental disorder have dependent children<sup>7</sup> and an estimated 50,000 to 200,000 children and young people in the UK are caring for a parent with a severe mental illness.<sup>8</sup>
- The Department of Health estimates that, every year, 750,000 children witness domestic violence.<sup>9</sup>

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- In households with children where there is domestic violence, the children witness about three-quarters of the abusive incidents, including physical assault, sexual assault and rape.<sup>10</sup>
- It is estimated that there are 120,000 families experiencing multiple problems, including poor mental health, alcohol and drug misuse, and domestic violence, and over a third of these families have children subject to child protection procedures.<sup>11</sup>
- Research has found that in at least half of all child abuse dealt with by children's social care services, families have experienced several difficulties including mental ill-health, problematic substance use and domestic violence.<sup>12</sup>

## 1.2 Common parenting difficulties

Living with violence and abuse can have a direct impact on the non-abusing parent's ability to care for their child(ren). Perpetrators, for example, may disrupt routines in order to maintain control in the household. They may also undermine the non-abusing parent's

confidence in her own parenting skills.

In addition to this the impact of domestic and sexual violence on the survivor's parenting capacity, there are many ways in which substance use and mental ill-health can further limit both the perpetrator's and the non-abusing parent's ability to care for and safeguard their child(ren):

### Difficulties organising day-to-day living

Periods of mental illness and chaotic substance use can result in a lack of routines and planning ahead that makes life inconsistent and unpredictable for children. Children may also experience physical neglect if, for example, parents cannot manage money or finances are used on substances, and food, basic hygiene and utilities are not prioritised. Perpetrators may also purposefully disrupt daily routines as part of the abuse.

### Problems controlling emotions

Parents who struggle to regulate their emotions or experience mood swings as a result of trauma, mental ill-health or substance use, can impact on the ability to be consistently and emotionally available to children. They may also

become pre-occupied with their own feelings and find it difficult to respond to children's needs.

#### Difficulties in interacting with children

Apathy, depression, pre-occupation with substance use, among other things, can impair a parent's ability to play and talk with their child or take an interest in the child's world, which can lead to insecure attachments for the child.

#### Lack of skills/confidence

Parents who are living with an abusive partner (who may actively undermine the non-abusive parent) as well as those who use, drink or struggle with their mental health may feel inadequate or lack confidence in their parenting ability.

#### Disorganised lifestyle

People whose lives are more chaotic may leave children unsupervised and at risk of accidental harm.

#### Recurrent separation

Parents may be separated from their children whilst in inpatient care, drug and alcohol treatment or prison (for example where the mother is involved in crime or prostitution), which can disrupt the continuity of care provided to children.

#### Living with violence and abuse

Withdrawal - some survivors may also cope with domestic and sexual violence by retreating from reality. In this way, survivors may appear very withdrawn from their child and from life. This could lead to aforementioned difficulties with organising life and interacting with children.

#### **Overall, the greatest risk of physical harm comes from parents**

who have a psychotic illness in which the child becomes the focus, and living with domestic violence where 45-70% of children are also directly abused.<sup>13</sup> Parental substance use is more frequently associated with neglect and emotional abuse, although there is also an increased risk of physical or sexual abuse, primarily in relation to the father or father-type figures drinking.<sup>14</sup>

### 1.3 Talking to parents about parenting

As part of the 'Think Family' approach and the drive to identify, protect and support children who are affected by parental substance use, mental ill-health and domestic and sexual violence, services now

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routinely ask service users about any dependent children.

However, parents may be reluctant to disclose substance use or mental health problems, and may go to great lengths to conceal domestic and sexual violence: research with social workers has found that concerns about each of the three issues are routinely not presented at the point of referral to children's services nor identified during at the initial assessment stage.<sup>15</sup>

A key concern for parents, understandably, is that disclosing problems with drugs, alcohol or mental health could lead to children being removed. In addition, survivors of domestic violence may appear uncooperative because they may:

- Blame themselves for the abuse.
- Fear the children being removed.
- Be aware that discussion about domestic violence could increase the risk of further abuse towards the children or themselves.

Furthermore, in the face of abuse allegations, the couple may create a defensive alliance against outside

agencies<sup>16</sup> – perpetrators may encourage the victim to adopt an 'us against the world' viewpoint as a means of maintaining power. As such, interventions should avoid reinforcing this by being clear about whose behaviour is endangering the children.

When talking to a survivor about children, it is therefore important to:

- Ask basic questions about their family situation, such as the names and ages of all children (not only those who are currently in the household).
- Be clear that experiencing domestic violence, substance use problems or mental ill-health does not automatically mean someone is a 'bad' parent. Many people who experience these difficulties manage parenting well and prioritise their children's needs.
- Never blame, in cases of domestic violence, the survivor for failing to protect her children – it is the abuser's violence that puts the children at risk.
- Bear in mind that survivors may minimise or deny the impact of

their own or the perpetrator's behaviour on the children so you may need to raise their awareness.

- Advise the survivor about the limits to confidentiality, and that you may need to inform children's services of cases where a child is living with domestic violence. Let the survivor know if you are willing to advise children's services of positive aspects of the non-abusive parent's care.

When assessing service users' parenting capacity and the potential risk of harm to any children in the household, practitioners should consider:

- if the child has experienced any direct physical or sexual abuse.
- is the child at risk of neglect.
- to what extent the parent plans their substance use or for periods of mental ill-health (where possible).
- what protective factors are in place (more information about this can be found on p.172).

More comprehensive assessment questions about children and parenting capacity can be found on p.249.

If, after the initial or further questions, parents recognise that their parenting capacity has been affected, professionals should ask what parents feel they should be doing differently, what they feel would help them to do this and whose help they would accept. The children's support needs should also be considered and appropriate referrals made.

If you have concerns about significant harm at any stage, follow the procedures on p.163 onwards.

**If you work with perpetrators individually or as part of a family intervention**, you should also talk to them about their parenting ability in relation to any substance use or mental health problems. If you want to talk to perpetrators about the impact of their abusive behaviour on their parenting, be mindful of both the survivor's and child's safety. You can find more information about this in section 8.

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## 2. Impact on children and young people

Whilst not all children living with parental substance use, mental ill-health and domestic and sexual violence will suffer significant harm, research has found that overall these issues often have a significant impact on children's quality of life and increase the risk of problems with physical, emotional and cognitive well-being and behaviour.<sup>17</sup>

The best predictor of adverse long-term effects on children is the co-existence with family disharmony and violence. This is reinforced by the findings from serious case reviews '*...domestic violence, substance use, mental health problems and neglect were frequent factors in the families' background, and it is the combination of these factors which is particularly 'toxic'.*<sup>18</sup>

### 2.1 Common effects

The effect of parental substance use and mental ill-health and/or domestic and sexual violence varies for each child according to many factors including age, gender,

relationships within and outside the family, as well as simply being an individual. Nonetheless, these are some of the most common effects:

#### Physical health

- Foetal damage from use of substances, physical violence, problems relating to maternal stress
- Withdrawal from substances in newborns
- Risk of accidents, injuries and abuse because due to domestic violence, inadequate parental awareness and supervision, left in care of unsuitable/unsafe people, or as a result of living in temporary accommodation<sup>19</sup>
- Physical injuries, sexually transmitted infections and unwanted pregnancies as a result of sexual violence and abuse
- Risk of serious and potentially fatal harm from access to prescribed medication and illicit substances if stored unsafely
- Stunted physical development and poor health as needs not recognized or as a result of neglect



- Psychosomatic illness including headaches, abdominal complaints, asthma, peptic ulcers, rheumatoid arthritis, stuttering, enuresis
- Sleep disturbances, including nightmares

### Emotional and psychological well-being

- Increased rates of depression and anxiety
- Post-traumatic stress disorder – as their own response and also relational, i.e. because of the close relationship with the non-abusing parent<sup>20</sup>
- Difficulties regulating emotions (mood swings, emotional instability, seeming overreaction)
- Difficulties expressing emotions through words or facial expressions, hand gestures, voice tone, etc.
- Possible difficulties understanding how others feel

### Cognitive abilities

- Cognitive and language development and learning may be delayed through parents'

inconsistent, under-stimulating and hostile behaviour

- Fear, anxiety and stress stunt cognitive development and can impair concentration and memory
- Fear and anxiety can prevent children from exploring

### Behaviour

- Witnessing violence and frightening behaviour may result in helplessness; viewing cruelty and aggression may be normalised
- Externalising behaviours, e.g. aggression and anti-social behaviours (especially boys)
- Internalised behaviours, including self-harming and developing eating disorders (particularly girls)
- Substance use and running away as a means of coping with the effects of the parents' problems. Regressive behaviours, e.g. bedwetting by 10 year olds

### Educational and social development

- Inability to concentrate on school, unsupportive environment at home to study, absenteeism from school to protect and/or look after parent

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- Social isolation – embarrassment over parents’ behaviour means ending friendships, need to care for parents/siblings, being bullied

## 2.2 Talking to children about safeguarding concerns

Understanding a situation from a child’s perspective is the first step in supporting children and young people who are living with domestic and sexual violence, parental substance use or mental ill-health. Their experiences may include:

- Secrecy, stigma and shame
- Feeling guilty about their parents’ problems, thinking it’s their fault
- Worrying about their parents becoming ill, being hurt, dying, getting into trouble
- Fears of being separated from their parent(s)
- Fear of being hurt themselves
- Taking on caring responsibilities beyond their age

- Feeling isolated from family, friends, other social groups and networks
- Feeling worthless

*Children are...likely to blame themselves: “I usually, like, watch her [mum] a bit more when she’s feeling depressed. Half the time I don’t realise I’m doing it, but I do.”<sup>21</sup>*

To address these experiences, children need:

- Someone they can trust to talk to.
- Age-appropriate information about what’s happening and why their parent(s) needs help.
- Reassurance that they are not to blame for what has happened and stress that disclosing problems at home will not necessarily lead to the family breaking down and the child having to live somewhere else.
- Contact with other children who are having similar experiences at home.

- Someone who will listen and help them think through their problems rather than just taking responsibility for decisions

Depending on your role, most professionals do not need to ask children specific questions about experiences of abuse (see p.162 for information about dealing with disclosures). Instead, practitioners can talk to children or use creative tools such as play and drawing to gauge a child's feelings towards their parents' substance use, mental ill-health or living with domestic violence.

Questions about where children seek safety, comfort and protection should be asked alongside questions about fears, anxieties and hopes about their parents' behaviour:<sup>22</sup>

- What is it like when their parent(s) is unwell, under the influence of alcohol or drugs or are arguing? What it is like when they are not?
- What do they do when their parent(s) is drinking or taking drugs, is unwell, or when they are arguing? Where do they go?
- Do they have fears, anxieties and hopes about their parent(s)' behaviour?
- What would they most like to be different or stay the same?
- Whom do they think is most affected by the alcohol/drug use, mental ill-health or violence and how can they tell?
- To what extent do the children have caring responsibilities?

### 3. Addressing safeguarding concerns

When working with families affected by domestic and sexual violence, substance use and mental ill-health, it is vital that you are fully aware of your organisation's safeguarding children policy. If you haven't read the policy, or not recently, now might be a good time!

#### 3.1 Safeguarding and significant harm

Some aspects of the effects of parental substance use, mental ill-health and domestic and sexual violence outlined in section 2.1 on

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p.160 can also constitute a form of maltreatment and source of significant harm to children living in households affected by these three issues.

Section 11 of the Children Act 2004 places a duty on key persons and bodies – including local authorities, social care services, NHS services, the police and voluntary organisations who are commissioned to provide service on behalf of any of the bodies listed in section 11 – to make arrangements to safeguard and promote the welfare of children.

The current statutory guidance on safeguarding, *Working Together to Safeguard Children*,<sup>23</sup> defines safeguarding and promoting the welfare of children as:

- protecting children from maltreatment;
- preventing impairment of children's health or development;
- ensuring that children grow up in circumstances consistent with the provision of safe and effective care; and

- taking action to enable all children to have the best outcomes.

The Children Act 1989 underpins the current safeguarding system in England and Wales and includes a number of key provisions:

- Local authorities are charged with the **“duty to investigate**...if they have reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm” (section 47).
- The definition of **harm** is ill-treatment (including sexual abuse and non-physical forms of ill-treatment) or the impairment of health (physical or mental) or development (physical, intellectual, emotional, social or behavioural) (section 31).
- **“Significant”** is not defined in the Act, so courts have to decide for themselves what constitutes “significant harm” in each individual case. Under the Adoption and Children Act 2002, living with and witnessing domestic violence is a source of ‘significant harm’ for children.

- Local authorities have a duty to provide “services for **children in need**, their families and others”. Children are defined as ‘in need’ when they are unlikely to reach or maintain a satisfactory level of health or development, or their health and development will be significantly impaired without the provision of services (section 17).
- Reassure them that they are not to blame.
- Explain or reiterate the limits on confidentiality and ask the child or young person if they want to continue discussing the matter knowing that you might have to tell someone what has been said.

Therefore, if at any time a professional suspects that a child:

- 1) has been or is being maltreated,
- 2) has suffered significant harm or is likely to do so in future, or
- 3) may be a child in need

they should follow their own organisation’s child protection or safeguarding policy and consider referring the case to the local authority children’s social care.

- Not ask leading questions or investigate the claims.
- Make a written record immediately, including, at a minimum, the date and time the allegation was made, who made the allegation, and the nature of the allegation. Record only the facts, preferably in the words used by the person making the allegation. They may form part of a subsequent prosecution or inquiry.
- Discuss the disclosure with another relevant member of staff, for example line manager or the person responsible for safeguarding children in your organisation.

### 3.2 Dealing with disclosures

If a child or young person discloses experiences of harm or abuse, you should:

- Listen carefully and let them know you believe what they have said.

- Where it is safe to do so, discuss your concerns with the parent(s). In cases of domestic violence, the non-abusing parent should

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be approached about concerns to a child's safety in the first instance. Discuss whether to talk to the perpetrator with your manager. Whilst it is important that perpetrators are held accountable, practitioners must also consider the child and survivor's safety first.

- If you decide to refer the family to children's services, try to get the parent's consent or encourage them to make a referral themselves.

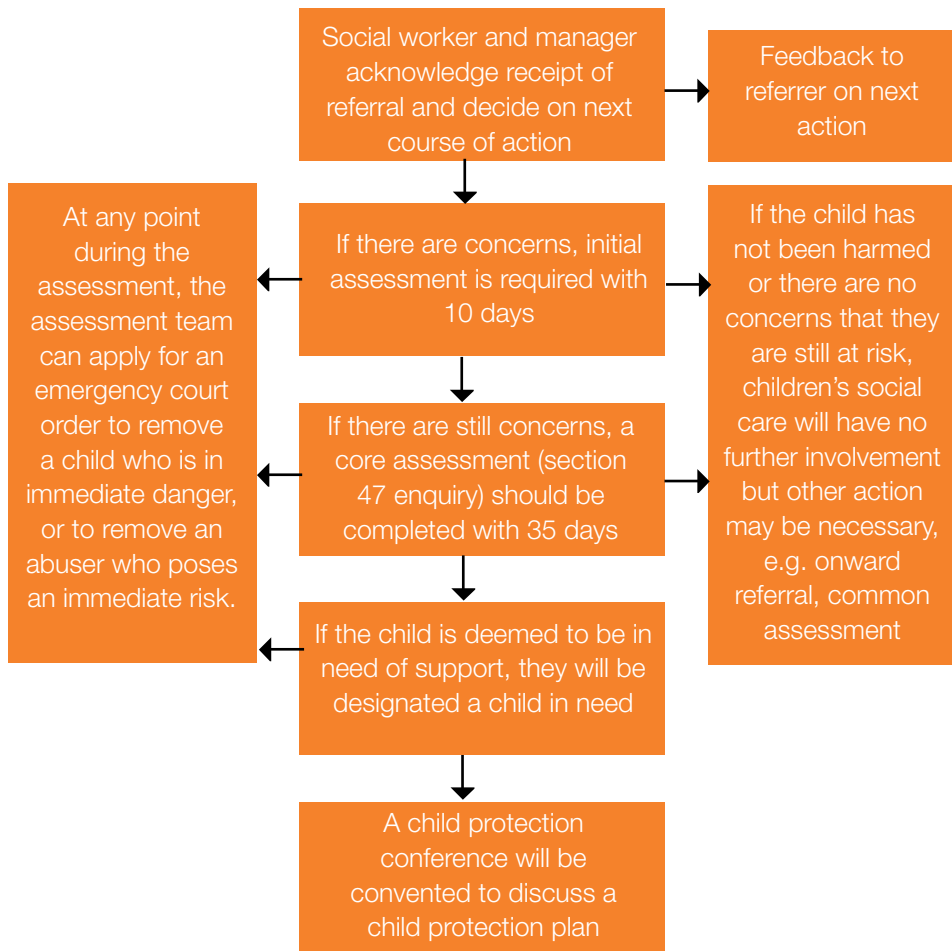
If a parent or a third party discloses information that leads you to have concerns about a child's welfare, or shares their own concerns, you should listen carefully, make an immediate written record and then follow the procedure in the next section.

## 3.3 Local authority safeguarding procedures

Children who are at risk of significant harm should be referred to children's services for assessment. If you are not sure whether the case should be referred, you could discuss with:

- 1) your manager and/or the safeguarding lead for your organisation
- 2) the NSPCC – professionals can call the Helpline (0808 800 5000) for advice
- 3) your local children's services department. Most departments will run a 'duty social worker scheme' where professionals can contact them for informal advice. If you speak to a social worker, you should emphasis your concerns for the child's welfare, rather than allegations of harm or abuse

If you still have concerns, you can refer to children's social care, who will follow this procedure:



More detailed referral pathways can be found in the current statutory guidance, **Working Together to Safeguard Children**, which can be downloaded from <http://tinyurl.com/cx7lcz9>.

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## 3.4 Including children in the safeguarding process

*Working Together to Safeguard Children*, the current statutory safeguarding guidance states that effective safeguarding arrangements should be underpinned by two key principles:

- safeguarding is everyone's responsibility: for services to be effective each professional and organisation should play their full part; and
- a child-centred approach: for services to be effective they should be based on a clear understanding of the needs and views of children.

It is also best practice to inform children, wherever it is safe to do so, of what is happening and that they will be consulted about their wishes for the next steps.

To create a child-centred approach, children have said they need.<sup>24</sup>

- **Vigilance:** to have adults notice when things are troubling them

- **Understanding and action:** to understand what is happening; to be heard and understood; and to have that understanding acted upon

- **Stability:** to be able to develop an on-going stable relationship of trust with those helping them

- **Respect:** to be treated with the expectation that they are competent rather than not

- **Information and engagement:** to be informed about and involved in procedures, decisions, concerns and plans

- **Explanation:** to be informed of the outcome of assessments and decisions and reasons when their views have not met with a positive response

- **Support:** to be provided with support in their own right as well as a member of their family

- **Advocacy:** to be provided with advocacy to assist them in putting forward their views



## Mothers and Fathers

Irrespective of which parental figure is presenting the problem, professionals tend to focus their attention on working with mothers – usually as they are the main caregiver. This can, however, mean that mothers are made to feel responsible for their partner's behaviour and in cases of domestic violence, does not hold perpetrators accountable for their own actions. Workers need to be supported to engage with fathers, including those who do not live in the same household as the children.

In supporting perpetrators who are parents, in addition to the activities above, practitioners should encourage perpetrators to reflect on their behaviour and how it impacts on their children – this is a key motivator for perpetrators seeking help for their behaviour. As always, **prioritise the safety of survivors and the children** and have information about the Respect helpline (details can be found in appendix H) and local perpetrator programmes to hand. More information about working with perpetrators is outlined in section 8.

## 4. Working with the family

Children can rarely be supported in isolation. Working with the whole family, however, can be problematic, particularly when there is domestic violence. Practitioners should always prioritise children's and the non-abusing parent's safety when considering any intervention.

### 4.1 Safety in family work

Work with families affected by substance use, mental ill-health and domestic violence should include both parents wherever possible, rather than focusing on work just with mothers. When dealing with domestic violence, however, engaging both parents must be done in a safe way:

- Always see partners or ex-partners separately, particularly if discussing domestic violence, but also in many cases where long term support is being provided. Ideally, victims and perpetrators should be supported by separate workers to avoid information being shared unintentionally and to reduce opportunities for collusion.

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- Work with partner agencies to increase the survivor's safety and hold the perpetrator to account.
- Be aware that child contact where domestic violence is present can be potentially very dangerous as some fathers may use contact with the children as a route to further abuse them and their mother.<sup>25</sup>
- Reconsider referrals to couples or family therapy to address problems in cases where there is domestic violence.

Many agencies – drug and alcohol treatment, mental health, social services and family support services – raise concerns that excluding couples and family therapy means a significant proportion of clients would not be able to access this type of support.

At this point in time, however, there is insufficient guidance on how to work safely with cases of domestic violence within most couples and family therapy settings.

Working with both a victim and abuser together can be dangerous for the following reasons:

- It is common for the victim to also minimise what is happening to them for fear of the consequences of disclosure and the hope that the relationship can be saved. In this context, such interventions will potentially unwittingly undermine rather than increase the safety of a vulnerable client.<sup>26</sup>
- The work is unlikely to be useful when one partner is fearful about how much they can disclose about the relationship. However skilful the therapist is, they will be unlikely to gain the open and honest thoughts and feelings of a victim while the abuser is in the same room. This can apply equally to the children who may suffer the consequences of speaking openly.
- Reviewing violence and abuse with a couple in a session is not advisable due to the risks of retaliation if the victim discloses abuse.
- The couple have a history with each other which means subtle and exclusive methods of communication – including non-verbal – may have developed which are not discernible to the therapist.

- Research evidence from mediation, couple counselling and court welfare work all tells us that neither women or children fare well in any model which means they have to negotiate their safety in the presence of their abuser. Out of fear for the consequences if they do not, women frequently reach 'agreements' which are not in their best interests.
- Working with domestic violence is a specialist area requiring a high level of understanding of the dynamics of abuse. If a therapist lacks this specialist knowledge, there is the constant danger of colluding with abuse by reinforcing that the perpetration of abuse stems from communication problems between couples or lack of anger management. This sends a message that the victim is somehow to blame for the domestic violence.
- If the victim/survivor has substance use or mental health problems, it is not helpful for more information about the complexity of their problems to be passed on to the abuser. It will only give the abuser more ammunition with which to control his partner.
- It is noteworthy that in at least 20 US states, most of Australia and New Zealand, couple-based interventions are expressly prohibited by law. In Australia, this was in part motivated due to the numbers of women killed by ex-partners when attending or leaving couple-based interventions.<sup>27</sup>

Relate, the leading provider of relationship counselling in England, has developed a model of working with couples where there is a current risk of domestic violence. In this model, the survivor is supported through one-to-one counselling and brief work is also done with the abuser focusing on safety, conveying safe messages about responsibility for abuse and violence, and motivating them to move forward and change their behaviour. They also signpost or refer to domestic violence perpetrator programmes where available.

Relate's guidance on working safely with domestic violence can be found here: <http://tinyurl.com/cwcsu3q>.

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## 4.2 Building children's resilience

Rutter <sup>28</sup> identified the key components of resilience in an individual as:

- A sense of self-esteem and self-confidence
- A belief in one's self-efficacy
- An ability to deal with change and adaptation, and
- A repertoire of social problem-solving approaches

Practitioners working with children who are affected by their parents' substance use, mental ill-health and domestic and sexual violence should work towards putting in place support which achieves the above as well as working individually with the child to:

- Help them feel there are choices in life and they have some control
- Build a sense of self-efficacy – the feeling that they can do things, can cope

- Build self-esteem and confidence by highlighting strengths and resilience
- Develop problem-solving skills
- Deliberately plan for their own adult life to be different from their parents

Practitioners may additionally work with the child and/or the non-abusing parent and wider family to foster more protective factors that can bolster a child's resilience.

*"Protective factors make it more likely that a child can overcome this risk because they provide a more positive setting. Resilience makes this more likely because it equips the child with a set of skills and feelings that enable him (or her) to be forward looking and to bounce back from adversity."* <sup>29</sup>

Established factors that may protect children and young people from the long-term detrimental impact of parental drinking may also apply to living with domestic violence or a parent who is mentally unwell:<sup>30</sup>

- Family cohesion and harmony, i.e. the absence of family conflict, violence or breakdown
- No exposure to drug taking (paraphernalia is kept hidden, use when child is not in home, no exposure with other drugs users/ criminal activity)
- The presence of one consistent and reliable adult
- Close bond with at least one adult carer
- A good wider support network
- Consistent parenting
- Cohesive family unit – the family does things together, family rituals, etc.
- Engaging with school activities – academic and extra-curricular
- Adequate finances
- Deliberate planning for the future

Whilst practitioners can work on these factors with children, the majority either need the input of the parent(s) (e.g. adequate finances)

or would benefit from their co-operation and support.

### 4.3 Support for the non-abusing parent

Ideally, in families affected by substance use, mental ill-health and domestic and sexual violence, the first step is to make the survivor and children as safe as possible by removing the perpetrator from the equation. In reality, however, people's lives are much more complex than this.

You may find yourself supporting a survivor around their parenting whilst they are still in an abusive relationship, or you (or your service) could be working with the whole family – both the survivor and perpetrator – to address their multiple issues.

In all cases, remember that **safety is the priority:**

- Do not speak to couples about domestic violence together, and wherever possible ensure that different workers within the service support the survivor and the perpetrator.

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- Work in partnership with domestic violence services to increase the survivor's safety and hold the perpetrator to account.
- Be aware that child contact where domestic violence is present can be potentially very dangerous as some fathers may use contact with the children as a route to further abuse them and their mother.<sup>31</sup>
- Reconsider referrals to couples or family therapy.

## **Undoing a job well done – how perpetrators might undermine our work**

Practitioners should also bear in mind that efforts to improve the non-abusing parent's skills, to increase their confidence, to build support networks may be undermined by the perpetrator. Any of the aforementioned activities may give the survivor more control over their lives and the perpetrator may feel threatened. The perpetrator may also become more violent or abusive at this point too so putting in safety plans and having close contact with domestic violence services is vital.

Specific support for the non-abusing parent can include:

- Doing all the things you have already read about in the toolkit! It is common knowledge that the best way to support children affected by domestic violence is to support the non-abusing parent.
- Communicate with and involve parents. Parents value professionals who communicate sensitively and involve parents in decision-making and keep them informed.<sup>32</sup>
- Ask about the parent's concerns about their capacity and skills to be a parent. Evidence suggests that parents are able to discuss their own concerns about their parenting when professionals approach them openly and directly.<sup>33</sup> Notice and highlight their own concerns.
- Stress discrepancies between what kind of parent they want to be and what they are actually doing – this can help to identify areas for change, to set goals and motivate the parent.

- Be realistic. Explore how drug, alcohol or mental health problems might stop a parent from improving their parenting skills.
- Stress safety. It may take some time to address all three issues, and in some cases things might not change very much at all. Whilst parents are addressing their substance use or mental ill-health and while domestic violence continues, practitioners should discuss the children's safety – the questions in appendices B and E offer suggestions of the different aspects of children's safety that practitioners should consider.
- Ensure that mothers and carers have access to all benefits to which they are entitled, as well as to local opportunities that will promote their economic security. Focusing on financial strategies can help ensure that women and children are not trapped in violence because of their economic circumstances.
- Provide information about domestic violence, substance use and mental ill-health and discuss the impact they can all have on children. Encourage parents to think about how their own substance use and mental health or the perpetrator's abuse has affected their children.
- Explore parents' negative perceptions of themselves. Remember that perpetrators may have told the non-abusing parent that she is incapable/unfit to be a mother or undermined her parenting.
- Build survivors' self-confidence as a parent. Highlight things they have done well, acknowledge steps they have taken to keep their children safe.
- Set up positive routines, help to get children engaged in activities, support survivors to identify their own interests.
- Work on positive family experiences, for example celebrating birthdays, days out.
- Build self-esteem with small goal-setting.
- Be aware that risk is not a static process and can change rapidly. Missed appointments, drug and

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alcohol relapse, a decline in mental health or disengagement with the service could indicate ongoing experiences of domestic violence.

## **What works? Gender specific alcohol workers**

Until 2012, Nottingham Community Alcohol Teams had gender specific workers. Here they reflect on their work and reasons other areas should continue to employ gender specific workers:

*“Research tells us that our client group do not access mainstream services, they are marginalised and stigmatised. This increases their vulnerability and that of their children, especially those women that are mothers who use substances. So we work with an assertive approach, actively engaging with our clients in a way that services seem to be moving away from. It’s been described as ‘going the extra mile’ with clients. We conduct home visits to enable the clients to engage (otherwise, due to having young child, anxiety, etc, they wouldn’t). We attend the GP, conduct three way appointments with social workers, we support and advocate*

*on our clients’ behalf. We deliver a parenting course specifically for substance using parents to enable them to identify how their use affects their ability to parent their children. This has proved invaluable to some of our parents who believe that by completing this course they have managed to have their children returned to their care.*

*By working in the way that we do, we feel that this enables our client group to work through numerous complex issues with the support of one person that they trust to support, encourage, enable them ultimately to reduce the harm to themselves, their families and the wider community. Our approach is not a quick fix as our clients are sometimes very damaged due to their life experiences and many hours are spent building a rapport to help to prevent the ‘revolving door’ in and out of treatment services with poor outcomes for them and their families. It doesn’t sound like much on paper, but in reality supporting women – who have many other complexities along with substances – takes more time.”*







# **Section 8**

Working with the  
perpetrator

# Section 8

## Working with the perpetrator

### Section overview

Awareness of the need to take a more active role in identifying perpetrators and holding them accountable has increased in recent years. Professionals in many fields work with perpetrators and this section outlines how to work safely with them:

1. Understand who perpetrates violence
2. Be aware of how perpetrators may use the victim's substance use or mental ill-health
3. Hold perpetrators accountable - substance use and mental ill-health are no excuse for abuse
4. Screen for perpetrators
5. Respond appropriately
6. Assess risk
7. Refer on safety
8. Prioritise victim safety

### 1. Who perpetrates violence and abuse?

This section relates primarily to adults who are violent and abusive towards other adults within a context of an intimate partner or family-type relationship.

In addition, section 1.3 incorporates information about child-to-parent violence, of which some perpetrators will be children or young people.

We do not address how to respond to people who abuse children outside of a domestic violence context.

#### 1.1 Men who perpetrate abuse

Domestic and sexual violence is not about a desire to be violent or abusive as such. For the vast majority of perpetrators, they use violence and abuse as a means to exert **power and control** over their partner, family, a friend or acquaintance (the latter specifically in cases of sexual violence<sup>1</sup>).

Within society, the idea of power is very gendered and linked to culturally constructed ideas of how heterosexual men and women should behave and their role in society. Typical gender stereotypes portray men as strong, powerful decision-makers, and women as weaker, emotional homemakers.

Research<sup>2</sup> has found that these beliefs are also strongly held by perpetrators of domestic and sexual violence, who are primarily heterosexual men who perpetrate abuse towards women. Meanings attributed to and expectations associated with gender can also impact on the ways in which professionals approach and respond to perpetrators and survivors.<sup>3</sup>

Although the widely cited figure of 1 in 4 women and 1 in 6 men may suggest both genders experience similar levels of violence, 47% of male victims and 28% of female victims report a single incident. On average, men experience 7 incidents and women 20 incidents of domestic violence per year. 89% of people who suffer four or more domestic violence assaults are women.<sup>4</sup>

Research<sup>5</sup> has shown that men and women use violence in different ways. For example:

- men are more likely to use physical violence, threats and harassment than women, with the violence being more severe
- men are more likely to damage women's property, whilst women damage their own
- men's violence tends to create a context of fear and control compared with women's use of violence

There are many proposed explanations for why men perpetrate domestic violence. Factors associated with domestic violence include abuse in childhood, witnessing domestic violence, experiencing other trauma, anger, depression, substance use and low self-esteem.<sup>5</sup> However, common factors are not causal explanations; their absence does not guarantee domestic violence will not occur. Furthermore, none of these factors are present in the majority of abusers, and the majority of people who experience childhood abuse,

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problems with drugs and alcohol or have depression do not abuse their partners.

## **Never forget – safety first**

Two women a week in England and Wales continue to be murdered by a partner or ex-partner. Many more will be physically hurt (some seriously) as well as suffering emotional and psychological harm.

## **With every intervention involving perpetrators, always:**

1. ask yourself 'Is this going to make the survivor and/or her child(ren) safer?'
2. continually assess and reassess risk – for example, consider how a perpetrator's abusive behaviour may increase on entering drug or alcohol treatment.
3. ensure you share concerns about increased risk to the survivor and/or her child(ren) with the relevant parties, e.g. your line manager, safeguarding lead, MARAC co-ordinator. Do not work alone.

## 1.2 Women who use violence

Whilst the majority of perpetrators are men, you may also come into contact with women who use violence. For various reasons, this is particularly true where one or both partners have problems with drugs, alcohol and mental health. Particularly in relationships where both people drink heavily, violence by both partners is more commonplace. Information about 'bi-directional' violence can be found on p.185.

Whilst a small proportion of women perpetrate violence against a partner in the same way as male perpetrators, research<sup>7</sup> using a range of different methodologies has found that women are less likely to use an on-going pattern of abuse using coercive and controlling behaviours that enable a perpetrator to exert power and induce fear in the survivor.

Instead, many women who disclose hitting a partner are often lashing out or responding in frustration to long-periods of emotional or physical control – commonly referred to as violent resistance to abuse.

Research<sup>8</sup> has found that survivors may also engage in:

- violent self-defence - violence is used for protection in order to prevent or end a violent attack.
- violent retaliation or reaction to abuse – aggression is the product of stress, frustration and disempowerment. There is an accumulation of anger caused by suppression of negative emotions and feelings of powerlessness, whereby violence is used.
- violent self-destructive behaviour - filled with self-blame, guilt and self-hatred, violence is aimed inwards as the individual enacts a cycle of self-destructive behaviour. Problematic alcohol and drug use, suicide attempts and self-harming have been documented amongst this group.

On the whole, women are less likely to initiate violence.<sup>9</sup> Victims of abuse may, however, initiate violence when there is an imminent threat of violence from the abuser.

No violence or abuse can be condoned. If you are working with male or female perpetrators or with a case of bidirectional violence,

ring the Respect Phonenumber (0800 802 4040). The helpline can offer support and help to perpetrators and professionals to clarify patterns of abuse and provide information about relevant services.

### 1.3 Child to parent violence

#### **Between a rock and a hard place**

The information in this section is drawn largely from *Between a rock and a hard place*, a report of research conducted by AVA and Adfam into parents' experience of violence and abuse from children who use drugs or alcohol problematically. The full report can be downloaded from <http://tinyurl.com/c78z6y3>.

There is increasing awareness of the violence and abuse some parents experience from their child(ren), often but not exclusively when either the child or parent has problems with drugs, alcohol or their mental health. As with individuals who perpetrate abuse against a partner, however, the substance use and mental ill-health often masks a sense of entitlement and desire for the child to have power and control over their parent.

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Child to parent violence (CPV) is similar to other types of domestic violence in that:

1. The majority of perpetrators are male, and the majority of survivors are female.
2. Among adolescent perpetrators, research has shown similar negative views of women to adult male perpetrators.
3. The types of abuse includes emotional abuse, financial exploitation, death threats, serious physical assaults with weapons, destruction of property in the home and social isolation caused by emotional manipulation, but an absence of reported sexual violence.
4. In some cases the child has been exposed to domestic violence in the home.
5. Parents have similar feelings to other survivors: long-term worry, fear, profound emotional distress, financial worries, lack of sleep, guilt, feelings of failure and of being (at least partly) to blame.
6. There is a reluctance to name the experience as abuse as it involves acknowledging the painful reality that a loved one is abusive.
7. Knowing what to call CPV and how to conceptualise it can be very problematic for parents. Very few consider it to be domestic violence so most survivors are unlikely to access dedicated domestic violence services.
8. Where the child has drug, alcohol or mental health problems, this is often seen as the cause of the abusive behaviour by both parents and professionals. The parent commonly looks for help for their child rather than protection and support for themselves.
9. There is sense among parents of *“of being passed from agency to agency, of being disbelieved, of having to wait months and months for a service”*. Similarly to other survivors, parents often turn to a trusted friend or the internet for support, at least as a first step, rather than professionals.<sup>10</sup>



*"I can't see him hurt in any way, I've got a very soft spot for him"*

Survivor's voice

In the same way that parents can struggle to identify their child's behaviour as abusive, it can also be difficult for professionals. To increase the identification of child to parent violence, practitioners should:

1. Be aware that not all child to parent violence is perpetrated by people under the age of 18. The majority, in fact, is perpetrated by adult children.
2. Be alert to the possibility that what appears to be normal problematic behaviour of moody teenagers could actually be abusive behaviour by an adolescent perpetrator. In the same way as professionals are encouraged to identify the 'primary aggressor' in cases of domestic violence, with regard to child to parent violence practitioners should consider the extent to which the young person's behaviour is giving him control over the parent and the parent's level of fear.
3. Not assume that parents hold a position of power within a child-parent relationship, and thus misidentify domestic violence and/or who the perpetrator is.
4. Recognise that child to parent violence does happen. Many parents report dismissive and judgemental responses from professionals, as well as from friends and members of the community.<sup>11</sup>
5. Support parents to understand that what is happening is abuse. Child to parent violence involves high levels of emotional abuse which can be difficult to recognise. For example, in cases where the child is drug or alcohol dependent, financial abuse often centres on demands being made for money to buy substances. Often these are reinforced with a threat that the personal safety of the child was at risk if the parents did not provide a certain amount of cash to pay off debts to dealers. It isn't always possible for parents to know whether this was just an excuse used for leverage or if the safety of their loved one really was in danger and this uncertainly is painful in itself.

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When working with parents who are experiencing violence or abuse from their child, it is important to remember that:

1. The perpetrator is responsible for their behaviour. Professionals can be more likely to view the child's behaviour (particularly when they are young) as a direct result of poor parenting and thus hold the parent/survivor responsible for the child/perpetrator's behaviour.
2. The abuse is a manifestation of domestic violence which the perpetrator should address through changed behaviour. Suggestions to improve boundaries and other parenting skills again places responsibility on the parent/survivor and may not be effective.
3. What may appear to be 'lax' parenting and a parent who permits her child to behave outrageously and manipulate her may actually be a mother who is worn down and stressed by living with abuse. Like other survivors of domestic violence, mothers may manage the abuse by not challenging the perpetrator's actions.
4. Child to parent violence occurs disproportionately in single parent families. Providing support to the parent in terms of maximising income, finding stable accommodation and developing support networks may be helpful in strengthening the parent's resources to deal with the violence.
5. Parents, particularly mothers, may be less likely than other survivors to lose contact with the perpetrator. They may also wish to continue carrying out their parenting duties despite the abuse.
6. Even if they did wish to somehow cut off their children, parents do not have the same legal recourse as survivors of domestic violence from an intimate partner.

*"The effect of fear on parenting creates the impression of a 'permissive parent' to the outsider"<sup>12</sup>*

## 1.4 Bi-directional violence

You may come across cases where both partners claim to be victims. In cases where both individuals have used violence against each other, the clarity of what is happening in that relationship can become clouded.

In these circumstances, it is important to remember that domestic violence is a pattern of behaviour comprising various forms of controlling behaviour and not just an individual event.

In most situations, violence and abuse are not perpetrated equally by both parties:

1. In some cases, you will be working with a perpetrator and a survivor that uses violence, and
2. In others, there will be a so-called primary and a secondary aggressor.

Good practice recommends that, wherever possible, practitioners determine who is the primary aggressor<sup>13</sup> in order to make appropriate referrals.

In assessing mutual allegations of domestic violence, practitioners trained in this field will take into consideration:<sup>14</sup>

- **Context, Intent and Effect.**

For example, did the person use violence to induce fear or to protect themselves? And what effect did the violence have?

- **Agency.** i.e. ability to make decisions for oneself. In the context of an abusive relationship, the survivor is less likely to be able to make decisions for themselves and/or the perpetrator will always make the final decision in their own favour.

- **Empathy.** Survivors of domestic violence will empathise with their partner, whilst perpetrators are less likely to empathise and may minimise their partner's feelings.

- **Entitlement.** Linked to a lack of empathy, a sense of entitlement allows someone to assert their will over others (in particular, their partner). This may include particular attitudes towards roles within a relationship or family.

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- **Fear.** If someone is in fear of their partner this is a good indication of an abusive relationship. Fear may be expressed verbally or could be evident in terms of behaviour.

**In many cases, however, practitioners will not have sufficient information about both parties, nor the dynamics within the relationship to be able to reliably determine the direction of abuse.**

Where you are not sure who is the perpetrator and the survivor, or if they are both perpetrators, it is

advisable to contact the Respect Phoneline (0808 802 4040) to clarify dynamics in the relationship.

Alternatively, you can give the number of the Respect Phoneline (see above for number) to both parties. Staff at Respect are trained to screen all calls (using the aforementioned tool) to identify perpetrators and survivors; this is in recognition of the fact that many women (and some men) who contact the service with concerns about their own behaviour are more often survivors who use violence as a form of resistance.

	In coercive control OVER partner/ex, because of own use of violence, abuse, controlling behaviour, threats etc	Under coercive control FROM partner/ex, who has used violence, abuse, controlling behaviour, threats etc
Uses or has used physical or non physical violence against partner/ex →	<b>Perpetrator of intimate partner violence</b>	<b>Victim who has used some form of violent resistance</b>
Experienced or experiencing physical or non physical violence from partner/ex →	<b>Perpetrator whose victim has used some form of violent resistance</b>	<b>Victim of intimate partner violence</b>

Figure 8 - Respect Matrix of use and experience of intimate partner violence (copyright Respect, [www.respect.uk.net](http://www.respect.uk.net))

## 2. Blaming the victim

When partners are abusive, they do not have to use violence to gain power and control over their partner or to instill fear. The Power and Control Wheel (see below) illustrates the many different types of abuse perpetrators use in addition to physical and sexual violence:

A copy of the Power and Control wheel and a fuller list of the perpetrator's actions, specifically where the victim has drug, alcohol and/or mental health problems, can be downloaded and printed from from appendix G



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If the victim has difficulties with their mental health and/or use of substances, this can be used by the perpetrator in many different ways. For example a perpetrator may:

- Isolate the survivor by preventing access to medical services/ medication/drug and alcohol treatment, which exacerbates mental health/substance use problems.
- Damage the survivor's self-esteem by making her feel incompetent because of her mental health or substance use problems; using verbal insults, e.g. she's useless, an unfit mother, crazy, mad, junkie; humiliating her by telling others that she is crazy, mad, a user, an addict.
- Threaten to call social services, the police, have the survivor sectioned.
- Encourage dependence on the perpetrator - telling victim she could not cope on their own, cannot manage money, controlling access to drugs/alcohol, etc.; lying about times/information then saying she appears to get things wrong (proving to self and others

that she can't manage); moving or taking property to cause confusion.

- Deny the abuse by suggesting the survivor has imagined it - "you're hearing/seeing things/ crazy/high/drunk" – caused the injuries themselves when unwell, intoxicated or by self-harming.
- Blame the survivor, e.g. "You drove me to it", "If you weren't such a nightmare to live with, I wouldn't have to behave in this way", "It's for your own good/ safety – you can't cope on your own, manage money/medication, etc."

In terms of blaming the victim, it is important to be aware that:

- Perpetrators may minimise the types of abuse they use ("Well, I didn't hit her") and the impact ("She gives as good as she gets"). Survivors may also minimise the abuse as a coping mechanism or to avoid 'making a fuss'.
- Perpetrators may deny the abuse, its frequency or impact. Survivors may also deny what has happened, again as a

coping strategy or for fear of the consequences, e.g. agency involvement, fear of perpetrator response, fear of social care.

- Perpetrators may blame the survivor, and the survivor may also blame themselves and believe the perpetrator's excuses.

**Perpetrators may also claim to be the victim.** This is particularly true if the police have been involved, they are involved in court proceedings, or where their partner has used violence in self-defence or resistance.

Professionals should be cautious of male service users who report that their partner has used violence against them – be mindful of the context in which the violence was used and the impact on the service user (see p.180 for more information). In many cases, however, you will not have sufficient information to be able assess for yourself if the person is a victim or perpetrator.

All men who report violence and abuse from their partner should be signposted to the Men's Advice Line (see appendix H for details). The

helpline is run by Respect, and staff are trained to screen all callers to identify victims and perpetrators and respond accordingly.

## PROFESSIONAL BLAME

Without sufficient knowledge about domestic violence, professionals may reinforce victim-blaming by:

- Asking the survivor what they did or said to provoke the abuser
- Misdiagnosing genuine fear as irrational anxiety related to mental ill-health or substance use
- Prescribing medication or recommending treatment for substance use to the survivor as a way of changing the perpetrator's behaviour
- Labelling a survivor as challenging/difficult to work with and potentially implying that they must be challenging/difficult to live with.

**Regardless of how challenging someone's behaviour might be, this is NEVER an excuse to use violence and abuse against them.**

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## 3. Holding perpetrators accountable

A fundamental role for all professionals working with perpetrators is to hold them accountable for their behaviour.

In the overwhelming majority of cases of domestic and sexual violence, the perpetrator has control over his actions and chooses to behave in an abusive or violent manner. There are, however, associations with both substance use and mental ill-health that need to be understood in order to avoid colluding with perpetrators.

### 3.1 Substance use as an excuse

There is a strong association between domestic violence and substance use, as well substances figuring in incidents of sexual violence.<sup>15</sup> Findings from a review of British Crime Surveys found 44% of domestic violence perpetrators were under the influence of alcohol and 12% affected by drugs when they committed acts of physical violence.<sup>15</sup> Similarly, an inquiry into homicide convictions found that around half of all people convicted

for murder in England and Wales have a history of problematic alcohol and/or drug use.<sup>16</sup>

Both alcohol and drug use can increase the likelihood and severity of domestic violence, but alcohol appears to be particularly important in escalating existing conflict.<sup>17</sup> Not all people attending alcohol treatment, however, are abusive, nor do the majority of domestic violence incidents take place when the perpetrator was drinking or using drugs.

**This therefore means there is no simple causal relationship between substance use and domestic violence.**

Rather than the physiological effects of alcohol (or other substances) causing someone to be violent solely when intoxicated, survivors consistently report experiencing violence and abuse from their partner when he has not been drinking.<sup>18</sup> Women also report that even when their partners have seemed “uncontrollably drunk” during a physical assault they routinely exhibit the ability to stop the abuse when there is an outside intervention, e.g. children, police.



Substance use is therefore better understood as a 'disinhibitor' which gives a perpetrator the belief that they will not be held accountable or responsible for their behaviour. Galvani<sup>19</sup> terms this 'responsible disinhibition', i.e. that whilst perpetrator may experience some level of disinhibition as an effect of consuming alcohol, they are still responsible for their actions and should be held accountable. See figure 9 on p.187 for more information.

**In addressing perpetrators who use or drink problematically, it is therefore not sufficient to only address their substance use.**

Even if alcohol or drug treatment is able to reduce the severity of the violence, it will not address the many social and cultural factors such as perpetrator's sense of entitlement and attitudes towards women nor the complex dynamics of power and control that underpin domestic violence. Therefore, work that specifically addresses these issues – ideally conducted by appropriately trained staff within the setting of a perpetrator programme – should always accompany a treatment plan.

### 3.2 Mental health as an excuse

Similarly to substance use, the perpetrator's mental health is often cited as a cause of their violent or abusive behaviour.

This belief plays into a common misperception that people who experience mental ill-health are more likely than people without these experiences to be violent. In reality, whilst there is some research suggesting a modest link between mental health problems, such as psychosis and violent conduct, the majority of such crimes are actually associated with drug and alcohol use.<sup>20</sup>

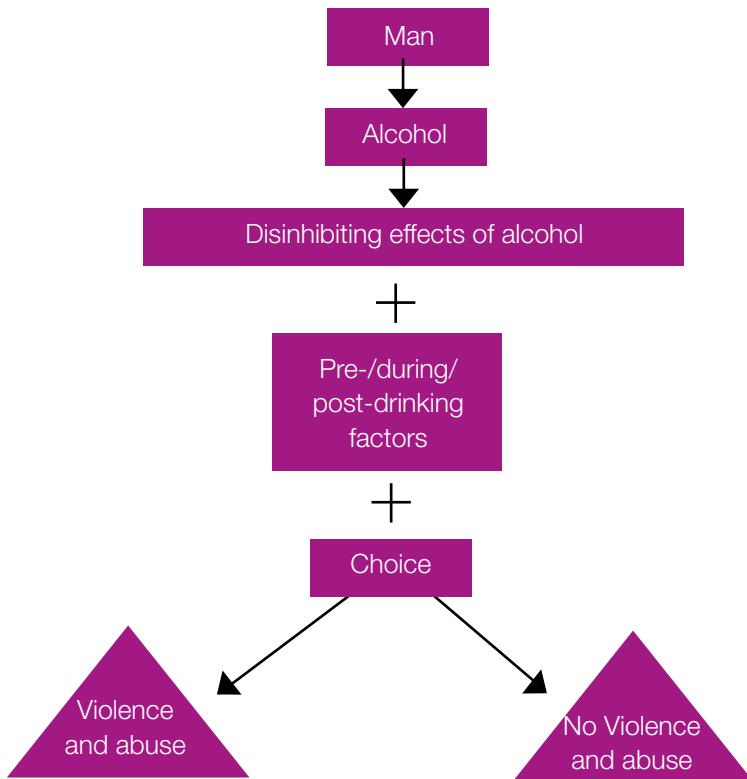
Overall, people who experience problems with their mental health use violence in the same ways as other people who are not mentally unwell.<sup>21</sup>

In terms of domestic violence, research has found that the majority of perpetrators also do not have mental health problems.<sup>20</sup> There are, however, some associations between the two issues:

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- Research<sup>23</sup> has found that just under a quarter of convicted male perpetrators reported being depressed. Practice-based evidence also suggests that perpetrators often approach their GP with symptoms of depression as a first step in seeking help.
- This does not, however, point to a causal link between depression and the perpetration of domestic violence. Conversely, it is more likely that perpetrators feel, at some level, bad about their behaviour or low as a result of the consequences of being abusive.

Figure 9 - Galvani's model of responsible disinhibition



This could include recognising the impact their behaviour has on a partner or children, or if they are arrested for or convicted of domestic violence-related offences.

- Perpetrators use threats or attempts to commit suicide as a means to control their partner. This is not necessarily a sign of mental ill-health. **Depression, self-harming and threats/attempts are, however, established factors in domestic violence murders and should be taken seriously.**
- Research has found that perpetrators frequently display traits of different personality types, with most perpetrators being categorised into anti-social and narcissistic 'typologies'.<sup>24</sup>
- There is a consistent thread, however, between the 'typologies' of **perpetrators holding hostile attitudes to women and having an inflated sense of self rather than low self-esteem.**<sup>25</sup>
- Symptoms associated with some mental health diagnoses mirror behaviours common to many male

perpetrators; this can make it particularly difficult for practitioners to understand the motivations for violence and how to respond.

When working with a perpetrator who also has an established mental health problem, practitioners should bear in mind that:

1. The mental health problem should not be used as an excuse for being abusive. Perpetrators need to be held accountable for their behaviour.
2. Symptoms of mental health problems can exacerbate domestic violence behaviours. Perpetrators who do have a mental health problem are, however, likely to be abusive even when well. Their behaviour should not only be addressed as illness-related violence.
3. A dual diagnosis of mental ill-health and substance use is more likely to increase the risk of violence and abuse
4. Current psychological interventions alone are unlikely to address the complex dynamics centred on power and control

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issues that underlie domestic violence committed by the majority of offenders. In some cases they can reinforce the 'poor me' symptom common to most perpetrators.

5. Alongside specialist support to address abusive and controlling behaviour, some men they may need therapeutic help to deal with emotional and psychological scars associated with childhood or other traumatic experiences (e.g. military).
6. It remains unclear whether adapting treatment to match different 'typologies' of domestic violence offenders has any effect on treatment outcomes.

A perpetrator's mental health problems can play a role in why survivors remain in an abusive relationship. Practitioners may need to address survivors' concerns about who will care for the perpetrator or how he will manage if the relationship were to end.

## 4. Screening for perpetrators

In some settings, such as drug and alcohol and mental health services, clients may already be screened for any violent behaviour. For other professionals, this may be a new area of enquiry.

### 4.1 Reasons to screen for perpetrators

Even if you do not routinely screen for client's violent or abusive behaviour, there may be occasions where it is important to talk to a client about perpetrating domestic or sexual violence:

- Both the client and their partner use your service, and you have a duty of care to the person who may be the victim of abuse.
- Under Section 17 of the Crime and Disorder Act there is a responsibility to take 'reasonable' action to prevent a crime. This includes domestic and sexual violence. Asking your client about their behaviour and exploring motivation to address this may be appropriate.

- Under Article 2 Human Rights Act 1998 public authorities have a duty to protect life and therefore must take positive action to reduce /remove any risks when they are identified.
- At some level most perpetrators are unhappy with their behaviour and this may be an underlying cause or a factor contributing towards states of depression or other mental health problems.
- Your client may express hope that reducing or stopping drinking/ using drugs will result in changes to abusive behaviour.

## 4.2 Ways to approach perpetrators

Perpetrators are unlikely to approach services with a full and honest disclosure about the extent of their abusive behaviours. Instead, a perpetrator is more likely to report other concerns about his relationship or behaviour:

*My wife and I are fighting a lot/need counselling*

*I'm depressed/anxious/stressed/not sleeping/not coping/ not myself  
I'm worried about my rage at work, in the car/street, at the football*

*I need anger management*

*I'm worried about the amount I have started drinking*

Some perpetrators may seek help for their behaviour if their partner threatens to leave them or if the police have involved which could have consequences, e.g. in terms of their employment.

If the person presents with one of these 'mitigating factors', you could approach the conversation in different ways.

If the person indicates that domestic violence is an issue, these are useful questions to ask:

*What worries you most about your behaviour?*

*It sounds like your behaviour can be frightening; does your partner say she is frightened of you?*

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*How have the children been affected?*

*Have you ever felt your behaviour got out of hand? If yes, what happened?*

*Have the police ever been called because of your behaviour?*

If the person discloses using violence or abuse, or even indicates that they might, it is important to give an appropriate response (see below) and collect as much information as possible to assess the level of risk to the survivor and/or her children.

## 5. Appropriate responses

Where someone discloses or alludes to being abusive, you may find the following approaches useful:<sup>26</sup>

1. Give positive feedback where violent or abusive behaviour has been disclosed; be positive about and promote the possibility of change:
2. Name domestic violence and explain it is a range of behaviours, not just physical.
3. Emphasise there is no excuse for the behaviour; encourage perpetrators to think about when they use violence – is it only under the influence of substances or when unwell?

*It sounds like you want to make some changes for your benefit and for your partner/children. What choices do you have? What can you do about it? What help would assist you to make these changes?*

*Acknowledging to yourself and others that you have been abusive in the past is a really important step in making changes. It's not easy as it opens up many emotions that you don't want to feel, so the fact that you are talking to me about this is a really important first step.*

*Change is possible. You are in control over whether you change your behaviour and no-one else. The problem is not you, it's your behaviour.*

*How do you think your bi-polar/ depression/anxiety affects your behaviour? Can you remember being abusive/violent when you were not feeling depressed/anxious?*

*Have you ever hit, kicked or pushed your partner or child when intoxicated? Have you ever harmed or frightened your family when you were sober?*

*How has your partner/child(ren) been affected by your behaviour?*

*What's it like for your partner/ child(ren) being around you when you are at your best, at your worst?*

*Has your partner/child(ren) asked you to change? If yes, in what ways?*

4. Do NOT back him into a corner as this may stop him from talking to you again about his behaviour.
5. Ask him what effects his violence has upon himself and explore if this is how he would like to continue. Be aware that deep down he is somehow unhappy about the abuse.
6. Ask what effect the behaviour has on his children and partner. As well as revealing whether the perpetrator is able empathise with the survivor, this might promote motivation to change:
7. Explore whether the individual shows a desire to change. If not, broach the subject again in future sessions.
8. Where appropriate and safe, you may wish to help your service user to explore the links between the substance use and the abuse – when did the abuse and violence first start, what were the circumstances. Allow him to talk to support analysis of his attitudes, values, insights, defensiveness, powers of self-analysis and commitment to change.
9. Inform the perpetrator of the limits on confidentiality. Your agency could consider including a few sentences in your confidentiality agreement which give permission

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to contact a partner and pass on information to professionals with regards to acts of violence towards a partner or children.

## 6. Assess risk

Similar to working with survivors, following disclosures of abuse by a perpetrator, practitioners are encouraged to ask more direct questions relating to heightened risk factors, for example:

*Have you ever assaulted or threatened your partner with a knife or other weapon?*

*Have you ever grabbed your partner by the throat?*

*Did/has your behaviour change(d) towards your partner during pregnancy?*

*Have you assaulted your partner in front of the children?*

*Do you feel jealous when your partner spends time with other people (e.g. family and friends)? How do you show this?*

*Do you feel unhappy about your partner seeing friends or family - do you ever try to stop her?*

*What has been the worst occasion of violence?*

*Do you feel that your behaviour has got worse?*

Whilst it is not suitable to complete the DASH risk identification checklist with a perpetrator, bear in mind what you know about risk factors relating to domestic violence (p.108 and p.238 for more information). Consider these when deciding whether to inform your line manager or involve other agencies.

**Finally, remember to continually reassess risk.** Risk is not static, and risk levels can change quickly. Remain alert to risk and share information with managers and other agencies as needed. **Do not work in isolation with perpetrators.**



## 7. Refer safely

Similarly to survivors, perpetrators may experience barriers to acknowledging the abuse and seeking help because, for example, of their own sense of shame or fear of the children being removed. They may also deny responsibility for their actions, blame the victim or find ways to justify their behaviour which means they are not open to offers of help to change their behaviour.

Some perpetrators may, however, ask to be referred to specialist support for their behaviour. This could reflect a genuine desire to change or, as is more often the case, the partner has told the perpetrator they must get help 'or I will leave'. As with substance treatment, the most effective intervention takes place if an abuser acknowledges the problem and wishes to change.

If the individual shows any desire to change, they should be referred to a specialist perpetrator service. Professionals and perpetrators can call the Respect Phonenumber (see appendix H for details) for information about local services. The Respect Phonenumber also

provides a clear, non-collusive response to men concerned about their abusive behaviour and advice on short-term strategies to prevent further abuse.

You may also want to consider the following referrals:

1. If you have established any child or adult protection concerns, you may need to refer the case to your **safeguarding lead**.
2. Under Section 17 of the Crime and Disorder Act 1998, there is responsibility to take 'reasonable' action to prevent a crime. If you have concrete information that a crime may be committed, you may need to report this to the **police**.

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## WHAT HAPPENS ON A PERPETRATOR PROGRAMME? IS IT EFFECTIVE?

Perpetrator programmes in England and Wales are predominantly based on the Duluth model of understanding perpetrator's behaviour as being rooted in the perpetrator's desire to have power and control over their partner. As such, the programme:

- Addresses the strong traditional gender stereotypes and negative attitudes towards women that the majority of heterosexual perpetrators hold.<sup>28</sup>
- Uses Cognitive Behavioural Therapy techniques to raise perpetrators' awareness about the level of choice and control they have over their own behaviour.
- Provides guidance on how to deal with conflict and difficult emotions without violence or abuse.
- May offer additional individual support for perpetrators to address issues such as experiences of child abuse and other trauma.

- Should employ a women's safety worker to support victims
- Usually compromise weekly groupwork sessions over a period of approximately six months.

There has not been a systematic review of perpetrator programme in UK as yet. Evaluations from the US suggest that the Duluth model does have a positive impact on perpetration of violence, although other types of abuse may not stop completely.<sup>29</sup>

It is important to remember that perpetrator programmes routinely aim to change long-term held beliefs and well-established patterns of behaviour. In the same way that there is an understanding that drug and alcohol treatment is not always effective first time round, neither are perpetrators programmes. Making long-lasting change takes time (see p.69 for more information on behaviour change).

### 3. **Perpetrator programmes**

are run both by probation (for people convicted of domestic-violence related offences) and in the community. If you have a community programme in your area, you may want to talk to your client about this option. Only refer to perpetrator programmes that are accredited by Respect and provide a women's safety officer. Perpetrators who use drugs and alcohol or who have mental health problems will be assessed as to their suitability for, and ability to participate in the programme. In some cases substance use and mental ill-health may exclude perpetrators from being able to engage in on-going group work but is not always the case.

4. Referrals to **other services**, including for drug, alcohol or mental health problems, may also be appropriate as perpetrators may have concurrent issues that need to be addressed. However, addressing these additional issues rarely affects the perpetrator's use of violence and thus is no substitute for specialist perpetrator services.

### **WARNING!!! DO NOT REFER TO:**

- **Anger management** as this approach fails to account for premeditated controlling behaviours associated with domestic violence and does not specifically address perpetrators' attitudes towards women.
- **Couples or family counselling** because it can add to the belief that victims are somehow to blame for the abuse and may provide a space for perpetrators to reinforce this. It is unlikely to be successful when one partner is fearful of what they can disclose. More information about the risks associated with couples and family counselling can be found on p.169.

## 8. Victim safety

Due to the limited availability of perpetrator programmes, the reality is that in most areas you will not be able to refer perpetrators for specialist support but will have to manage their behaviour and the potential risk of harm to survivors and/or their children with your agency and any relevant multi-agency systems, e.g. MARAC and MAPPA (see glossary for more details).

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## **Remember, survivor safety is the main priority.**

As a professional, there are several things you can do when working with perpetrators that can help towards this:

### **Avoid collusion**

Perpetrators can be very manipulative. You may inadvertently collude with a perpetrator by:

- Inappropriately nodding/smiling as part of active listening.
- Minimising the abuse with words such as ‘just’ and ‘only’. For example, when reflecting back saying “So you just lost it?” or “It was just this once” – particularly if you do not further investigate what happened.
- Copying his words that support his excuses, e.g. “When she kept going on at you, what did you do?”.
- Accepting his account without further investigation/exploration.
- Maintaining confidentiality for him.
- Seeing the perpetrator as a victim

of something else, e.g. stress, abuse in childhood, substance use, mental ill-health, that causes him to use violence and abuse. Whilst it is important to acknowledge that the perpetrator may be experiencing difficulties with such issues and may need support for them, it is never an excuse to be violent or abusive.

- Providing him with information that may put the survivor at risk.

### **Do not work with the perpetrator and the survivor together**

There will be situations where the perpetrator and survivor use the same agencies, for example drug and alcohol, mental health or family support services. In this case, the couple should be seen as individuals by two different workers. This will help avoid collusion.

Where you have contact with both parties, do not share information given to you by the survivor with the perpetrator – do NOT divulge what the survivor has told you about the perpetrator’s behaviour as this could increase the risk of abuse.

DO NOT act as a go-between between the survivor and perpetrator.

### Be mindful of the safety of different interventions

Anger management, couples and family counselling are known to be ineffective and even dangerous in cases of domestic violence (see p.170 for further information). Be alert to the risks of child contact: some perpetrators may use contact with the children as a route to further abuse them and their mother.

### Do not work alone

You should always seek support and advice from your manager if you suspect or identify a perpetrator. Working with support and in partnership is the best way to improve the safety of women and children.

Further to this, domestic violence is a complex crime that requires a multi-agency response. Be aware that the perpetrator may have been discussed at the MARAC or may be subject to MAPPAs. Where you are concerned about a change in the level of risk a perpetrator poses to their partner (or even someone other than their partner), advice must be sought from the community safety team, police public protection team or MAPPAs so that an appropriate safety or protection plan can be activated.

Agencies should have in place clear agreed policies on information-sharing, which advise on the 'need to know'. The rationale for any disclosure without consent, e.g. to prevent harm, should be clearly documented.

### Consider your own safety

It is important to find a balance between challenging the abusive behaviour whilst maintaining the development of the therapeutic relationship and keeping yourself safe. Be especially careful if he is under the influence of alcohol or other substances and do not engage with him about his violence at such times.

### Record what you are doing

It is important to keep detailed records if someone discloses abusive behaviour. Be sure to write down what the perpetrator has said rather than your interpretation of what has happened. This information will enable a continuity of care and may also be helpful in any future legal proceedings. While records are generally confidential, if an individual, especially a child, is at risk of significant harm, this will override any requirement to keep information confidential. You should explain this to the perpetrator.



# **Section 9**

Working in  
partnership

# Section 9

## Working in partnership

### Section overview

In this section we will consider collaborative interventions to support survivors who are also affected by substance use and/or mental health problems.

1. Understand the survivor's perspective
2. Understand different types of partnership working
3. Be aware of challenges to partnership working
4. Identify your partners
5. Establish a partnership
7. Develop effective referral pathways

### 1. Professional overload – a survivor's perspective

Stop for a moment and think about yourself. How many professionals are involved in your life?

Most likely you have a named GP, or at least a particular surgery that you use. If you have children, you might have recently seen a health visitor or a teacher. Some of you will be in touch with primary or secondary mental health services, drug or alcohol support services or maybe you are receiving support from a sexual violence service. Bearing in mind that no-one is immune to experiencing domestic and sexual violence, substance use or mental health problems, it is quite possible that professionals will use some of the same services as their service users.

For many survivors who are also affected by mental health and substance use problems and come into our services, there may be many professionals involved all at one time.

Take Sylvia, for example. She has three children: Sian (9 months), James (3 years) and Paul (8 years). Sylvia separated from the children's father four months ago, after several years of violence and abuse. She has been diagnosed as being bipolar (manic depression) and



having a panic disorder. She also has periods of drinking very heavily.

Who might be involved with Sylvia and her children? The GP? A psychiatrist? Mental health social worker? A children's social worker, health visitor, teachers, child psychologist, family alcohol worker, parenting worker, domestic violence outreach worker, tenancy support officer?? The list goes on and on. Imagine having that many professionals involved in your life! Consider how many appointments Sylvia has each week, how many different people she has to update on what has happened with other professionals and how, if agencies do not work together, she will need to co-ordinate all the support she and her children need.

People who experience multiple difficulties in their lives can feel overwhelmed by the involvement of so many professionals in their lives. However, working collaboratively both within and between agencies, Sylvia's life can be made easier.

## 2. What is partnership working?

*"The essence of partnership is sharing. It is marked by a respect for one another, role divisions, rights to information, accountability, competence, and value accorded to individual input" <sup>1</sup>*

Cooperation, collaboration, teamwork, joint working, partnership working, multi-agency practice, integrated responses are all terms to describe the ways in which professionals and agencies can work together to support survivors and their families.

Partnership working can range from informal sharing of information about a service user (with their consent) between two professionals, to service level agreements between organisations that formalise inter-agency referral pathways.

Working collaboratively can be beneficial for professionals and service users. For clients, effective partnership working is vital in reducing:

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- the number of inappropriate referrals between agencies
- the number of times someone has to 'tell their story'
- the number of appointments with and phone calls/letters from professionals to deal with which can feel overwhelming
- the time and stress of co-ordinating different professionals
- the feeling of being "passed from pillar to post" without getting anywhere
- the likelihood of getting lost in the gaps between services
- better understanding of the client as a whole person and how different parts of their life can impact on the area that you specialise in
- more opportunity to intervene early and prevent crisis from arising or escalating
- greater engagement with service users who feel more supported
- ability to learn from colleagues and see things from a different perspective
- inspire innovation and creativity in the development and delivery of services

*"Every agency has a different form – why can't they all use the same? It's mainly the same information anyway and I just have to say it a million times over."*

Survivors voice

The benefits for professionals are also multiple:

- not feeling alone in supporting clients with complex, intersecting needs

## 3. Challenges to partnership working

Take a moment to think about Sylvia and all the professionals that are working with her family. Whilst there are undoubtedly benefits to everyone working together, in reality this can be quite difficult.

Image Sylvia's alcohol worker, Jane. Each time Jane sees Sylvia, there are more letters from the different

professionals involved with the family, and more appointments to attend. Sylvia often seems confused by it all and can feel overwhelmed at times, which can trigger her drinking. Sylvia and Jane agree for Jane to contact the other agencies and clear up some of the confusion.

Jane may come across a number of difficulties in trying to work together with other professionals:

- Finding the right person, particularly due to frequent changes in staff
- Refusal to share information
- Other professionals being protective of their client
- Feeling threatened - when people's way of working or their identity is threatened, they may feel defensive, experience loss of confidence, emotional stress and be reluctant to collaborate with other professionals
- Different ways of working and models of understanding complex needs.

### **Working across sectors**

Understanding how our partners work is vital to developing strong relationships between agencies. People working in domestic and sexual violence, substance use and mental health services will vary in their working styles and priorities, but in other ways the services can also be similar:

- Safety is key. Domestic violence services focus more on the risk of harm to their service users, whilst substance use and mental health may prioritise service users harming themselves and others.
- Focus on security. Refuges probably will not give their address to you, nor will they usually let male workers from other agencies visit (as anyone could be a perpetrator). Inpatient wards (for mental health) and some drug and alcohol detox units may be locked, so a worker will need to let you in/out.
- Crisis is common. All three sectors with service users whose lives may be chaotic and include frequent crisis – be that an overdose, attempting suicide or being

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seriously assaulted and needing to flee into a refuge. Workers are used to managing in a fast-paced and changing environment.

- Have our own language. Please check the glossary on p.287 if you are not sure what DASH, IDVA, ISVA, MARAC, SARC, CPN, DTTO, or a Section 136 are. Most services today work from a principle of empowering service users and supporting recovery, but substance use and mental health workers are more likely to talk about diagnosis and treatment.
- We are experts. Practitioners develop a wealth of knowledge about the issues they work with most frequently, yet we cannot be expected to know everything. If you do not know something, be direct and ask. Conversely, don't expect colleagues in other services to share your knowledge. Take time to answer their questions – we can all educate and learn from each other.

For frontline workers, much of the difficulty in partnership working comes from a lack of opportunity to meet colleagues in other services, to get to know what they do, how they work and to understand their approach. Professionals work to and often hold on tightly to different models – social care, biomedical, feminist – which can seem completely incompatible. Being able to spend in another service and see how they work can overcome some of these problems.

There may also be differences in terminology (see glossary on p.286 for commonly used terms), in the levels of information professionals are willing to share even with the survivor's consent, and you may be working to different targets or outcomes.

Therefore, there is a need for agencies to develop protocols for working together alongside providing opportunities for professionals to spend time together and learn about each other's services and work.

## 4. Who are your partners?

Before looking at how you can form partnerships, consider who you might form partnerships with. You may already have a directory of local services. If not, it can be a useful idea to make a staff member responsible for collating a list of local services, or nominate 'champions' who are tasked with finding out about certain types of services, for example mental health, drug and alcohol, sexual health, childcare, local doctors, employment services, domestic violence and sexual assault services.

The list will help prepare you for all forms of disclosure, and the process of collecting the information can help build relationships with partner agencies. Take the initiative and instigate the process rather than expecting another organisation to do so.

### Local organisations

Details of relevant national umbrella and membership bodies as well as information on how to find out about local domestic and sexual violence, substance use and mental health services can be found in appendix H.

## 5. Creating integrated responses

Research into the lack of successful integrated approaches to addressing multiple needs<sup>2</sup> routinely suggest taking the following steps to promote collaboration:

- Develop a shared **vision** that all parties involved can agree on and that is interpreted the same way.
- Learn each other's **language** and create shared meanings. 'Risk', for example, evokes different priorities – in substance use services a key risk is drug- or alcohol-related offending; in mental health the main risk is harm to self; for domestic violence the perpetrator is the major risk assessed.
- Enable **relationship building** through regular meetings between agencies, inter-agency visits to get to know partners. Give short presentations about your services at a partner agency's team meeting. Protect staff time to attend multi-agency fora and networking events.

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- Make **communication** between agencies easy by clarifying information sharing and confidentiality protocols (more information on this can be found on p.117) and having a named person to liaise with certain agencies or around particular issues, e.g. nominate a domestic violence champion within a drugs service and vice versa.
- Promote **joint training**. Multi-agency training has been identified as a beneficial way for people to meet each other as well as to teach them about fields that are not their primary specialism. Similarly, training swaps between agencies can be useful in building relationships, particularly when money is tight.
- **Respect** the fact that partner organisations have constraints, responsibilities and outcomes to meet that are not completely the same as yours.
- Address **dissatisfaction and complaints** directly rather than letting them bubble under the surface.

*“We need to formalise partnerships, stop relying on old relationships”<sup>3</sup>*

We often assume partnership working is a formal and time-consuming process, yet making an informal phone call to a service, finding out a named contact and asking for advice and information can be an effective exercise in partnership building.

It is nonetheless important that in addition to enabling professionals to build relationships with colleagues in other agencies, more formal structures are put in place that will withstand changes in staffing:

- **Joint care/support plans.** Survivors with drug, alcohol or mental health problems often require a collaborative response. If a survivor is being supported by more than one worker, can workers come together to devise a joint care plan with the service user? This can cut down on duplication of work, improve information sharing and reduce the chance of professionals working at cross purposes. In such cases consensus about

each professional's roles and responsibilities is needed.

- **Co-locating staff in multi-disciplinary teams** who routinely work together to support service users, such as combined health and social care teams with Community Mental Health Teams.

- **Multi-agency meetings.** MARACs and child protection conferences are examples of a forum where professionals come together to discuss an individual or family who is at risk of harm. It is important that the meetings are not used solely for the purpose of sharing information, but to identify relevant actions for professionals/agencies to take to support and protect the individual. Systems must also be in place to ensure that agreed actions are followed up on.

- **Service level agreements.** If two organisations feel that they would benefit from each other's services a formal written agreement may be developed to clarify roles and responsibilities. A service level agreement should clearly state what services are to be provided and how this will be measured or

ensured. For example, a domestic violence service could offer to run an afternoon of outreach in a mental health service. In order for this to occur, an agreement, inclusive of associated costs, may have to be devised.

#### **What works? Linking abuse and recovery through advocacy <sup>4</sup>**

The LARA (Linking abuse and recovery through advocacy) project is the first pilot domestic violence intervention involving reciprocal training between mental health and domestic violence services, and a direct referral pathway to domestic violence advocacy for psychiatric service users. Between May 2009 and May 2011 five Community Mental Health Teams (CMHTs) in a South London borough participated in a randomized control trial to assess the impact of an integrated response to domestic violence. Two CMHTs offered care as usual to identified survivors of domestic violence. Three CMHTs were provided with 4 hours of domestic violence training, a domestic violence manual for clinicians, a direct referral pathway to domestic violence advocates (seconded to the teams from local

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domestic violence voluntary sector organisations) and an information campaign was run. The domestic violence advocates received 6 hours mental health training. In the three CMHTs that received the training and specialist support, the evaluation found significant improvements in clinicians' domestic violence knowledge, attitudes and behaviours. Service users reported significant reductions in violence and unmet needs at follow-up.

## 6. Information sharing

Confidentiality and limits on information sharing is cited as a key barrier to partnership working. Unfortunately progress towards developing effective multi-agency information-sharing protocols has, overall, been slow,<sup>5</sup> particularly in relation to health.

### 6.1 Reasons to share information

In many instances, agencies will be able to obtain a service user's consent to share information with another service – as part of

the referral process or in jointly supporting a service user. In other cases, you may have to consider sharing personal information, possibly without the individual's consent, because of:

- concerns for the safety of a vulnerable adult, particularly in cases where the person does not have capacity,
- evidence or reasonable cause to believe that a child is suffering, or is at risk of suffering, significant harm, or
- the need to prevent a crime, including acts of domestic and sexual violence, towards a named person.

When considering whether to share information without consent, you must ensure that your decision to share is based on necessity and proportionality "i.e. whether the proposed sharing is likely to make an effective contribution to preventing the risk and whether the public interest in sharing information overrides the interest in maintaining confidentiality".<sup>6</sup>



*“Despite considerable progress in interagency working, often driven by Local Safeguarding Children Boards and multi-agency teams who strive to help children and young people, there remain significant problems in the day-to-day reality of working across organisational boundaries and cultures, sharing information to protect children and a lack of feedback when professionals raise concerns about a child.”<sup>7</sup>*

This does mean that in some cases, particularly if there are no children involved, professionals should not share information or make referrals (even to MARACs) without the survivor’s consent.

It is advisable that agencies develop protocols with partner agencies with whom they need to share personal data. AVA has produced guidance on writing a multi-agency domestic violence information sharing protocol which can be accessed here: <http://tinyurl.com/c28nbvo>.

**Remember** always share information to protect the safety of a survivor and their child(ren). If it is not for this reason, do not share it. Information should not be shared for the sake of sharing information.

## 6.2 What information to share

You should only share sufficient personal information that will enable another agency to work safely to support a survivor and their child(ren). This means balancing the need for survivors not to have to repeat their details over and over again with partner agencies and, in the case of multi-agency fora such as the MARAC, providing sufficient information for agencies to manage risk with the need to respect survivors’ entitlement to privacy. Practitioners should therefore only:

- share personal data on a need to know basis

AND

- share relevant information.

This requires considerable judgement, and will often be specific to the context. At a MARAC, for example, an alcohol worker may choose not to share information about injuries a service user had reported received from falling down the stairs whilst under the influence of alcohol. If, however, during the MARAC, it was reported that the perpetrator’s previous partner had

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suffered a miscarriage as a result of falling down stairs, then details of the current survivor's injuries may need to be shared.

Similarly, the rights of perpetrators need to be upheld, with only relevant information being shared with the purpose of increasing the safety of survivors and their child(ren). Whilst it may not seem necessary or relevant to share information that a perpetrator has entered into a drug treatment programme, drugs workers should be aware that a perpetrator's abusive behaviour may increase as his substance use changes and the survivor may be at greater risk of harm. It could therefore be appropriate to share this information at a MARAC.

More details about information sharing at MARACs is detailed in *Striking the Balance*, the Department of Health's guidance on applying the Caldicott Principles to domestic violence. The document can be accessed from <http://tinyurl.com/cjfyjev>.

## Seven golden rules of information-sharing<sup>8</sup>

1. Remember that the Data Protection Act is not a barrier to sharing information but provides a framework to ensure that personal information about living persons is shared appropriately.
2. Be open and honest with the person (and/or their family where appropriate) from the outset about why, what, how and with whom information will, or could be shared, and seek their agreement, unless it is unsafe or inappropriate to do so.
3. Seek advice if you are in any doubt, without disclosing the identity of the person where possible.
4. Share with consent where appropriate and, where possible, respect the wishes of those who do not consent to share confidential information. You may still share information without consent if, in your judgment, that lack of consent can be overridden in the public interest. You will need to base your judgment on the facts of the case.

5. Consider safety and well-being: Base your information sharing decisions on considerations of the safety and well-being of the person and others who may be affected by their actions.
6. Necessary, proportionate, relevant, accurate, timely and secure: Ensure that the information you share is necessary for the purpose for which you are sharing it, is shared only with those people who need to have it, is accurate and up-to-date, is shared in a timely fashion, and is shared securely.
7. Keep a record of your decision and the reasons for it – whether it is to share information or not. If you decide to share, then record what you have shared, with whom and for what purpose.

## 6.1 How to share information

Sharing personal information is not difficult. What is important is to share information safely. So what does this mean in practice?

- It means encrypting emails if you are sending personal data.
- It means password protecting electronic files that you share so that only the other worker with whom you need to share the information obtains access to it.
- Avoid faxing information whenever possible but if you need to send information by fax take precautions to ensure it does not get intercepted by someone who should not have access to the information.
- When speaking on the telephone, make sure you are not being overheard by someone who does not have a need to know that information. Be careful where you talk about individual cases to ensure you are not overheard.
- Mark post “Personal and Confidential - to be opened by the recipient only”.
- Do you need the consent of individuals in order to share their personal data with another agency?

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- A consent-based approach (i.e. asking the service user) is ideal.

However, there may be occasions when workers need to assess whether sharing information would jeopardise a survivor and their child(ren)'s 'vital interests' (as the law defines it) or if it is in the public interest to share that information (for example, there is a high risk that the perpetrator is about to attack the woman or child or another person). Workers are advised not to seek consent and to share relevant information with relevant partner agencies who have 'a need to know' in these instances.

Support and guidance should be sought from your supervisor/line manager or the Data Controller within your agency if you are unclear on how to proceed.

## 6.1 Dealing with consent

A service user is entitled to withdraw their consent to you sharing their information at any point.

You must tell the service user that they can exercise this right and that, should they do so, you will inform them of any impact on the service they will receive from you.

In the event that an individual:

- withdraws their consent for their personal information to be shared, or:
- wishes to subsequently place/ amend restriction upon the personal information to be shared,

your agency should immediately inform all other agencies who are, or may be, affected by this request and you should record the details of the request on the individual's file.

Where consent is withdrawn, no further personal information should be disclosed unless there are legal reasons for doing so. As before, these may include: a threat to the 'vital interests' of a survivor, their child(ren) or another person or where there is a 'public interest' to share this information. It may also include situations in which the survivor does not have capacity. For information about capacity and consent, see p.117 and p.129.

Remember to inform survivors if you intend to share information about them with other services, even if consent is not forthcoming.

The information in this section was drawn primarily from AVA's Basic Guide to Domestic Violence Information Sharing. The guide can be downloaded from <http://tinyurl.com/cydqe2b>.

## 7. Effective referral procedures

It might seem unnecessary to consider how to make an effective referral but, in practice, many service users report being referred between agencies without knowing why and without sufficient support to contact the second agency or attend the first appointment, which reduces the likelihood that the survivor will engage and get the support they need.

Next time you make a referral, ask yourself the following questions:

- How much do you know you do about the service – what actually do they offer? Is your client likely to meet the referral criteria? What is the referral procedure? Do they have a waiting list?
- Does your client know what the service does and why you are referring them on?
- Is your client okay with you sharing information between the two organisations?
- Have you given the receiving organisation as much information as possible in your referral to minimise the amount of information the client has to repeat?
- Is the client able to go by themselves? Do they have a named contact when they arrive at the meeting place?
- Does the client understand what happens next?

After making a referral, don't forget to follow it up. Find out:

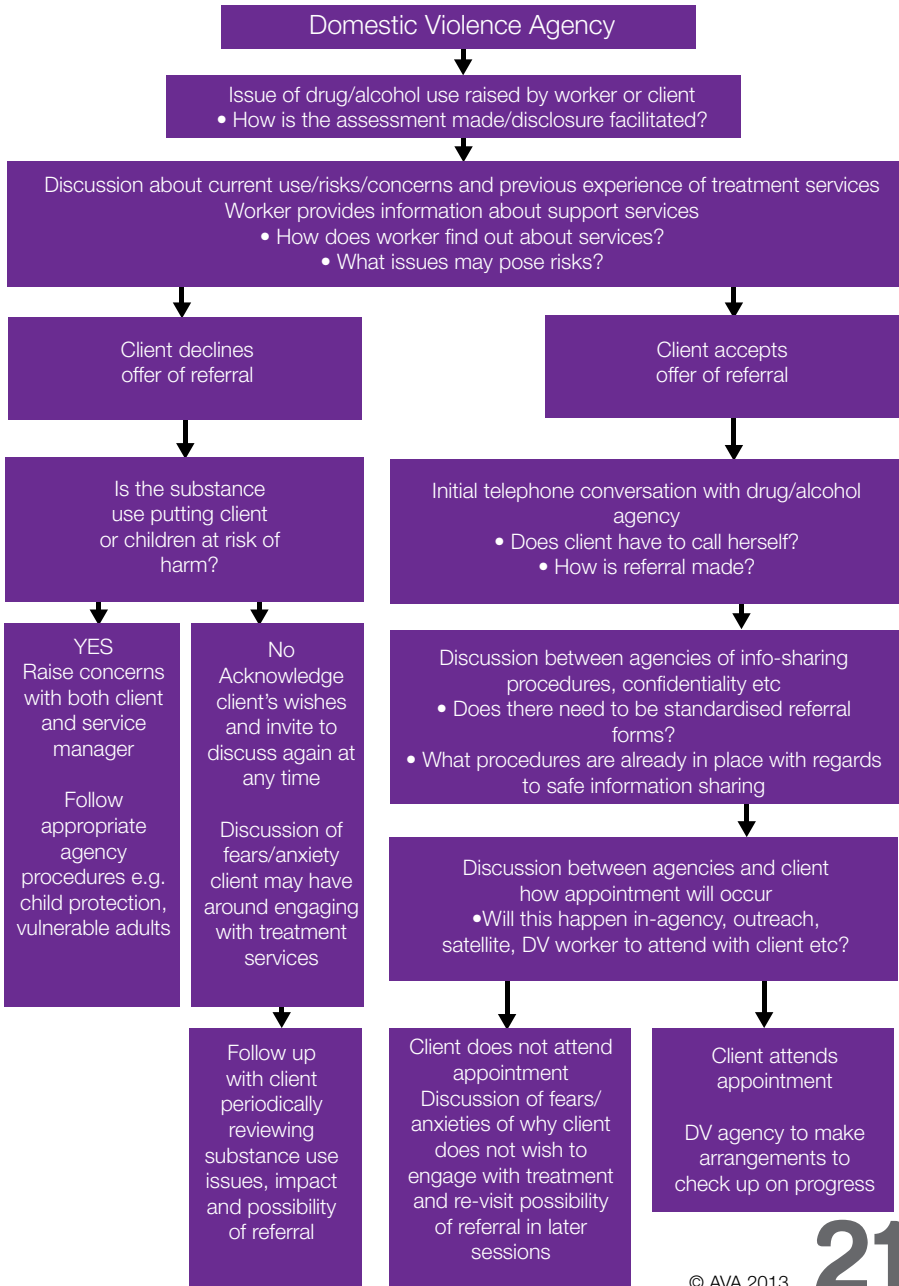
- How did it go? Is your client engaging?
- If not, you might want to speak to the client about why they are not engaging – they could give you useful feedback about the other service, or maybe it just wasn't the right time for the client.

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- If the client does engage, ask for the client's consent to talk to the worker in the partner organisation – find out what are they helping the client with? What are they struggling with? How can you help one another?
- Where possible, organise joint meetings with the client to reduce the number of appointments the client has to attend, to present a united front and reduce the need for duplication of work

A sample referral pathway can be found on p.219 which outlines the process for making a successful referral.

Figure 10 - Sample referral pathway<sup>9</sup>







Equality and diversity

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## Equality and diversity

### 9. Equality and diversity

Survivors of domestic and sexual violence who also have problems with substance use and/or mental ill-health often report in barriers to accessing services. Survivors may, for example, not be able to access some refuges or mental health services if they drink problematically or use drugs.

These difficulties can be compounded by inappropriate reactions to the survivor's identity, including age, gender, ethnicity, culture, class, sexual orientation or ability. Furthermore, each survivor's unique identity will affect her confidence and ability in seeking help, reduce options for support, increase the risks of leaving an abuser or reporting a perpetrator to the police, or otherwise affect the choices which she can make.

By being more aware of these issues, you will be able to make your service more accessible to survivors from many different parts of society. This section provides some guidance on working with survivors of different ages, ethnicity,

ability and sexual orientation, but the information is not exhaustive. Further guidance can be found in appendix H.

#### 9.1 General guidelines for addressing diversity

- Be aware that perpetrators will exploit different characteristics or experiences the survivor has. For example, if the survivor has limited mobility due to being physically disabled, the perpetrator may remove mobility devices that enable independence.
- Remember that a survivor's ethnicity, culture, gender, age, sexual orientation, ability and/or class may affect how and when she seeks help and the type of support she needs.
- Everyone is a unique and multi-faceted individual. Whilst one person's sexuality or ethnicity, for example, is an integral part of how they see themselves and live their life, it may not be the same for the next person. Do not make assumptions about what might be important or relevant to a survivor.

- Remember how much diversity exists within groups of people. ‘Asian’ people, for example, are not a homogenous group. Neither are all lesbians. Viewing people on the basis of one characteristic, such as their gender or sexuality, is simplistic and can perpetuate unhelpful and inaccurate stereotypes.
- Whilst it is important to find out how you can best support and assist a survivor, be careful not to use her as a reference point or learning resource about, for example, her culture or sexuality if this is new to you. If you want to learn more about, for example, survivors who are physically disabled, do your own research or look into training courses.
- Find out whether a survivor wants to be signposted or referred to a specialist organisation or would prefer to access mainstream services. It is possible that she has not told family or friends about her sexual orientation or mental health difficulties and thus does not want to use services specifically aimed at survivors who are lesbian, gay, bisexual or transgender (LGBT) or who have problems with their mental health.
- Think about and ask what is the most suitable format for your communication. Do not assume everyone is literate. You should also consider whether you need to provide information for someone in a different format for example, in large type or on audio tape. You may need to talk through information with some people rather than just hand it to them.
- Survivors who are also affected by substance use and/or mental ill-health and are also, for example, from a minority ethnic group or are physically disabled may need assistance from several different agencies. Special care must be taken to ensure the survivor is not disempowered or overwhelmed by multi-agency involvement.
- Some survivors from the groups referred to in this section may find it difficult to manage the very practical aspects of living away from their partner. Survivors, for example, who do not speak English as their first language, who are illiterate, are learning

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disabled and possibly also older and younger survivors may struggle with managing unfamiliar finances, coping with tenancy agreement regulations, negotiating complex bureaucracies in terms of applying for benefits and housing. Additional on-going support to enable survivors to live independently may be needed.

- Be aware of the Equalities Act 2010. The Act brings together all the legal requirements on equality that private, public and voluntary sector bodies need to follow. The provisions in the Act mean that everyone has the right to be treated fairly at work or when using services. As a service provider, you should be aware what actions you are required to take to prevent discrimination or harassment of employees or service users who have a 'protected characteristic'. These characteristics are: disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief, sexual orientation and age. Full information about the Act and the related Duties can be found on the EHRC (Equality and Human Rights Commission) website: <http://tinyurl.com/37h8yep>.

## 9.2 Improving access to services

The following pages provide information about the main equalities groups: younger and older women, survivors from minority ethnic and cultural groups, survivors who are physically or learning disabled, male survivors and those who define themselves as being lesbian, gay, bisexual or transgender.

As already mentioned, this is not an exhaustive list of guidance, but a starting point. Each survivor is unique and is the best person to explain

### 9.2.1 Survivors of different ages

Women of all ages are abused. Both younger and older women are not always believed or listened to when they speak about their experience of domestic violence. As survivors of different age groups may have differing needs, the information below is split into younger and older women.

#### Younger women

- Young women may experience violence from a partner as well as parents, siblings, family friends, etc.

- They may find it difficult to disclose violence from other family members and may fear the consequences of taking any action.
- Young women may not be used to having access to legal remedies or exercising their rights so may need support to do so.
- Due to limited access to welfare benefits and housing, 16-18 year olds can find it difficult to flee family members or a partner who is abusive. As such, they are at higher risk of running away and thus more vulnerable to sexual exploitation when homeless.
- Young survivors' mental health needs should be assessed by services. Self-harm is most common amongst people between the ages of 11 and 25, with between 1 in 12 and 1 in 15 young people deliberately harming themselves.<sup>1</sup> Young women, in particular, can become trapped in a cycle of self-harming in order to manage trauma responses.
- Young men, by contrast, tend to externalise intrusive thoughts by acting out aggressive patterns

and through involvement in risky activities.

### Older women

- Older women may find it difficult to speak to a younger woman.
- Some older women may feel they have coped with violence so long, it is not worth making difficult changes.
- Some older women may be embarrassed about having put up with the violence for so long and may try to underplay it.
- Older women may experience abuse from a partner who is also their carer. They may fear losing their home, support or independence, especially if institutional care is the only option. Conversely, the survivor may be the perpetrator's carer and may feel a duty to care for him, especially if otherwise he will have to go into a home.
- Older women's mental health needs may not be well recognised. Depression affects one in four people over 65, and one in two people over 85. Women over 75 are more likely to commit suicide than any other group of women.

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- Survivor's mental health problems may be ascribed to getting older, rather than surviving violence or abuse. Perpetrator's abusive behaviour can be masked by mental health problems such as Alzheimer's Disease, which is more common in older people. In cases where an older person develops Alzheimer's and uses violence or aggression, professionals should talk to family members about any history of violence or other types of abuse.
- Older survivors may be drinking, using prescribed medication or illicit drugs in a way that is problematic, but similarly to mental health, this issue may not be recognised or addressed. Professionals should be proactive in asking about levels of substance use.

## 9.2.2 Developing culturally specific services

Domestic and sexual violence happens in every part of society, including among people from different ethnic and cultural backgrounds. Similarly, problematic substance use and mental ill-health is not confined to one social group.

In addition to experiencing domestic and sexual violence, women (and a smaller proportion of men) from ethnic and cultural minorities may also be at risk of other types of violence:

- **So-called honour crimes.** So-called 'honour' crimes stem from the belief that women are the upholders of honour in a family and their behaviour is a mark of family honour. Dishonouring, or bringing shame on, the family is responded to with violence, abuse and sometimes even murder.
- **Forced marriage.** In comparison with arranged marriages, in which both parties agree to the marriage, forced marriage involves one or both parties not consenting to the marriage or consenting under duress.
- **Female genital mutilation (FGM).** FGM is the procedure partially or completely remove the external female genitalia for non-medical reasons. It is most commonly practiced by certain ethnic groups who live mostly in Africa and the Middle East. Due to migration, FGM is now practiced by ethnic minority populations

around the world. It is estimated that around 6,500 girls are at risk of FGM within the UK every year.<sup>2</sup>

All forms of violence can be complicated by multiple family members who collude with or are directly involved in the violence. Survivors from ethnic minority populations, particularly where the perpetrator has links to another country, also have greater fears about child contact and the threat of child abduction.

There is evidence that BAMER survivors might manage responses to abuse and trauma differently than their White British counterparts. Use of alcohol and drugs appears to be lower among Asian, Afro-Caribbean and Traveller women than White British women, although it is on the increase.<sup>3</sup>

Conversely, there is evidence that BAMER women are considerably more likely to self-harm and attempt suicide than White British women and Asian men.<sup>4</sup> South Asian women who self-harm are also less likely than White British women to have a psychiatric disorder, and are more likely to cite marital or family problems as the reason for self-harming.<sup>5</sup>

Whilst individual survivors' experiences of violence and abuse will vary greatly, as will their needs, there are also some similarities in the barriers survivors' from ethnic minorities may experience in accessing support. These are outlined below along with suggestions of how professionals can develop a multi-cultural approach to working with survivors who are affected by substance use and/or mental ill-health.

### Experiences of discrimination

Survivors from ethnic minorities may be wary of involving the police, the legal system, social services or health services because of discrimination and racism within institutions. Research with first and second generation Asian women living in the UK, for example, found that 65% had experienced racial harassment and 35% reported sexual discrimination.<sup>6</sup> Among Travellers there is strong anecdotal evidence of being openly discriminated against and refused access to primary health care on the basis of their surname and address (both of which identified them as Travellers).<sup>7</sup>

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In relation to domestic and sexual violence, this can result in survivors being wary of approaching the police, unsure of their reception, whether they would be treated with respect and fearful of how their partner would be treated by the police and the courts.

## Lack of cultural awareness

A lack of knowledge about different cultures within minority communities can also be a barrier to understanding survivors and ascertaining what they need. Analysis of serious case reviews have highlighted professionals' tendencies to stereotype families from different ethnic or cultural backgrounds, combined with misinterpreting what parents say, can have a negative impact on social work assessments and judgments.<sup>8</sup>

It is therefore very important for professionals to find out more when survivors' behaviour does not match *our* expectations, fit in with *our* cultural norms or does not make sense *to us*. For example, some women may not want to bath when menstruating which means that in accommodation without a shower, a survivor may not wash for a few

days which could be viewed by staff as self-neglect. Alternatively, religious or cultural beliefs may forbid divorce, with divorced women experiencing severe stigma. For some survivors, the stigma of being divorced may outweigh the possible advantages and thus advice to divorce may not be acted upon.

Furthermore, many cultures continue to operate along rigid gender divide. Female survivors may feel uncomfortable talking to men about personal problems, and so a choice of professionals should be offered. This includes GPs, solicitors, social workers, mental health workers and the police.

## Communication

Being able to communicate clearly with professionals is vital for survivors. For survivors who do not speak English as their first language and are not able to communicate clearly in English, professionals should use an interpreter (guidance for working with interpreters is on p.228). Interpreting services should also be made available to people who are deaf or deaf blind (information about national services can be found in appendix H).



All advice and information should be provided in the survivor's first language, wherever possible, and also in a format that is accessible. This means professionals should not assume that someone can read. An estimated 62% of Travellers, for example, are illiterate<sup>9</sup>, and many people who may have learnt to speak English might not be able to read or write well. This includes being able to read letters about appointments, etc. which should be sent and followed up with a telephone call to confirm the person has understood the content of the letter.

### Attitudes towards and treatment of mental ill-health

Sadly there are varying levels of understanding about, and stigma attached to, having mental health problems.

In some groups, for example Traveller communities, there are high levels of stigma and fear around mental health. Stress, anxiety and depression are seen as 'bad nerves' and part of every day life which Travellers may not consider approaching their GP or mental health services for help. 'Mental health' refers to more severe problems such as psychosis.<sup>10</sup>

Survivors of Asian heritage may also be reluctant to speak to a GP about difficulties with their mental health for fearing of bringing shame on the family, not being a "good" Asian wife and mother, and of being considered "pagal" (mad).<sup>11</sup> Similarly to other survivors, Asian survivors may present to their GP with somatic symptoms such as headaches, other aches and pains, feeling constantly tired, low and tense. Practitioners, including GPs, should be aware that these could be symptoms of psychological distress and ask more directly about mental health problems.<sup>12</sup>

Afro-Caribbean people may also be more inclined to manage their mental health themselves and not seek assistance until more acutely unwell. Research<sup>13</sup> has found that Afro-Caribbean people are less inclined to see a GP before presenting as an acute patient to A&E and are more likely to be admitted by the police. Being detained by the police may reflect discrimination and racism, but could also point to Afro-Caribbean people being less likely to access early intervention for mental health difficulties. This could be, in part, because of beliefs about the causes of mental ill-health. A large body of

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research has shown that individuals from different cultures attribute the causes of mental illness to a variety of factors, including curses and spirit possession. If you understand what is happening to be the result of a curse rather than responses to trauma, you are less likely to ask your GP for help.

## Sense of community

Survivors from ethnic and cultural minorities may have people in their community who will support them, including through women's groups. At the same time, strong community connections and the communication that often exist within smaller communities may exacerbate survivors' attempts to protect themselves from domestic or sexual violence, or to get support for mental health/substance use problems.

Due to limited privacy, particularly if sharing accommodation with extended family members, survivors may find it difficult to research support services or attend appointments. Being seen at a GP surgery, for example, may raise suspicions and have negative connotations.<sup>14</sup> There may also be a strong tradition of dealing with

problems within the family or the community, rather than asking for outside help from professionals<sup>15</sup>.

The strong sense of community may also lead to survivors from ethnic or cultural minorities feeling like they have too much to lose by leaving an abusive partner. If a survivor does decide to leave, she may have to leave the whole community, which means losing contact with her culture and way of life.

Professionals therefore need to address survivors' relationships with their community, identify ways in which the community provides support and consider alternative sources of help and assistance.

## Immigration status and recourse to public funds

Migrant women may fear losing their right to stay in this country if they separate from an abusive partner and may have been threatened with this. This can mean that official agencies (not only immigration but also the police and social services) may be seen as particularly threatening to a survivor if her immigration status is insecure. Furthermore, asylum-seeking women and

undocumented migrants are even more marginalised than migrant women generally and even less likely to access services

Most survivors with insecure immigration status have no recourse to public funds. This means they are unable to access state benefits such as housing benefit which pays for temporary accommodation, including refuge. Without access to any money or accommodation away from the perpetrator, survivors without recourse to public funds are among the most vulnerable members of society.

If you are working with a survivor who has no recourse to public funds, contact Rights of Women (details on in appendix H) or the No Recourse To Public Funds Network ([www.nrpfnetwork.org.uk](http://www.nrpfnetwork.org.uk) or 0207 527 7121).

### 9.2.3 Guidelines for working with interpreters

For survivors whose first language is not English, you may need to use an interpreter. Talking about sensitive and emotional issues like violence and abuse, substance misuse and mental ill-health is very difficult to do in a second language.

Below are some guidelines to help you select and use an interpreter:

- Always use a professional interpreter; never use a survivor's partner, child, friends or family member.
- Be sensitive to the fact that for some women, the use of a male interpreter may preclude any discussion of certain subjects so whenever possible, try to use a female interpreter. If, in an emergency, this is not possible don't press for details if you sense a discomfort in talking about sensitive issues. Try to arrange another time when a female interpreter is available.
- Try not to use interpreters from the client's own local area or from community associations to which she, her husband, family or friends may belong. If in doubt, ask.
- Make sure that interpreters sign a confidentiality clause in their contract with you and that they understand the necessity for such precautions.
- Ensure that the interpreters have been trained in issues of domestic

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violence and that they don't have strong beliefs about the 'sanctity of marriage' or that 'outsiders' should not interfere within 'their' community.

- If you regularly use interpreters, include them in any training you may have on domestic violence, substance use or mental health.
- Before any interpreting begins, ensure that language and dialect match between the interpreter and the client.
- During the session, allow time for introductions, pause frequently so that the interpreter can easily remember and translate what you are saying.
- Make sure the interpreter understands that their role is to interpret, not to advise, censor or summarise what either you or she is saying.
- Look at the client and speak directly to them, not the interpreter.

## 9.2.4 Supporting disabled survivors

Disabled survivors are harmed by partners, relatives, carers or

personal assistants and experience additional abuses that use and exploit the impairment, for example threatening to have them institutionalised; controlling disability aides such as wheelchairs or medication; refusing to wash, toilet or feed them; refusing to help them until they consent to sex; making decisions on their behalf without their consent and restricting access to communication aids and their ability to contact others. In relation to people who are learning disabled, abusers are also usually someone involved in the person's care, and the survivor is less likely to disclose the abuse to services.<sup>16</sup>

When supporting survivors of domestic and sexual violence who are disabled, be aware of the powerful myths that determine the way view disabled women.

For example:

- Disabled women are imperfect, dependent, weak and helpless - a crime against them is not of the same magnitude.
- Disabled people do not have partners so cannot be abused by them.

- The survivor needs the aggressor's care and has 'chosen' to remain dependent.
- Disabled people are 'asexual' so would not be sexually exploited, abused or raped.

In fact, there is research evidence that disabled people are at least twice as likely to be abused than non-disabled women.<sup>17</sup>

Key points to bear in mind when supporting survivors who have problems with substance use or mental ill-health and are disabled:

- A disabled woman may feel dependent upon the abuser for 'care' and the home which may have been specially adapted. This makes leaving a very difficult option – she will need information about alternative sources of care.
- She may fear isolation at home, or not wish to live in institutional accommodation. It is important to acknowledge that there are few alternative sources of support.
- She may fear losing her children. This is particularly relevant for parents who are learning disabled.

There is, however, no research that supports the argument that parents who are learning disabled are poor parents, and in a large number of families receiving social care interventions also involve domestic violence and drug/alcohol problems.<sup>18</sup>

- She may feel that a non-disabled person would not understand or empathise. She may wish to have contact with disability groups taking up the issue of violence.
- Accessing services can be more difficult for disabled women. Services may not appreciate women's needs, provide appropriate care or access requirements. Disabled women's experiences should be a mandatory part of any service planning; to exclude them constitutes discrimination.

It is also important to remember that disabled survivors may well have the same responses to trauma as non-disabled survivors and may also use substances to manage. Self-harm among people who are learning disabled, for example, is thought to be quite common.<sup>19</sup>

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Disabled survivors may also be regarded as a vulnerable adult (more information on p.114). In this case, professionals may wish to contact their local safeguarding adults team for advice on what action to take.

## 9.2.4 Supporting male survivors

Men can also be victims of domestic violence at the hands of a female partner and adult children, siblings and carers. Many men may feel embarrassed or ashamed about the abuse they are experiencing, as it does not fit common masculine stereotypes. This may make it difficult for them to disclose the violence and seek appropriate help.

There is limited research and work undertaken on the needs of male victims but what is clear is that it is not appropriate to develop services for male victims as a mirror image of female services. Evidence also suggests there are different support needs for men and this differs between heterosexual and homosexual men.

As with any survivor, it is important to find out what support male survivors would like. More often they seek practical assistance rather than emotional support, but this

may vary. Practitioners working with male victims of domestic violence are encouraged to call the Men's Advice Line (in appendix H) who can provide information about how to screen survivors to ensure they are not perpetrators and can tell you where to signpost or refer male survivors to. They have a new toolkit for working with male survivors, which can be downloaded here: <http://tinyurl.com/ak7ntku>.

Male survivors of sexual violence should be signposted to the nearest SARC (more information in the glossary) and the Survivor's Trust for details of local support (in appendix H).

## 9.2.5 Working with Lesbian, Gay, Bisexual and Transgender communities

Rates of domestic and sexual violence appear to be higher amongst lesbian, gay, bisexual and transgender (LGBT) people than in the heterosexual population. Estimates of prevalence vary, but limited research<sup>20</sup> has found that:

- Similar proportions of lesbians and gay men may have experienced domestic violence from same sex partners, and lesbians have also

experienced domestic violence in earlier relationships with male partners.

- Gay men are significantly more likely to experience physical and sexual violence, while lesbians are much more likely to be affected by emotional and sexual abuse.
- Transgender people are particularly vulnerable to domestic and sexual violence and that both are commonplace but relatively unspoken of within the trans community.

Many experiences of domestic violence are the same regardless of the survivor's sexual orientation or gender identity. There are, however, some differences to be aware of:

- The abuse may be perpetrated by other family members, for example, when someone discloses their sexual orientation or gender identity.
- The perpetrator may use the threat of 'outing' the survivor to their family, friends, colleagues as a means of control. Conversely, survivors may be forced to not out themselves.
- For gay men, there is a higher risk of being infected with HIV if they are unable to negotiate safe sex. Perpetrators may also threaten to reveal their HIV status to others.
- Survivors may be told that abuse is a normal part of same-sex relationships.
- Mental health problems and self-harming is more common among LGBT people, often linked to difficulties in coming to terms with their sexual/gender identity and/or experiencing homo/bi/transphobia.<sup>21</sup> GPs and mental health workers should be aware that these mental health problems may also be responses to the trauma of experiencing domestic and sexual violence.
- There is inconclusive evidence about levels of substance use among LGBT people. There are arguments that substance use is higher due to the central role that bars and clubs can occupy for many LGBT people. An alternative explanation is the impact of homo/bi/transphobia and heterosexism, which may exacerbate the use of alcohol and other substances as a coping mechanism for dealing

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with discrimination. Substance use may also be a strategy for managing trauma responses. Services should be aware of all three possibilities and talk to the survivor about how and why they use.

There are also specific barriers to accessing support for domestic and sexual violence, substance use and mental health which include:

- The need to 'out' oneself to access services or to discuss how violence and abuse is impacting on alcohol, drug or mental health problems
- Real or perceived homo/bi/transphobia (remarks, gestures, verbal and physical abuse and harassment) from service providers.
- Fear that what you say may be used to criticise or condemn all non-heterosexual relationships
- The potential impact of internalised homo/bi/transphobia
- Concerns that the perpetrator will encounter homo/bi/transphobia from police stops survivor reporting abuse
- Unsafe practice in many services due to the fact that staff are unaware that an accompanying 'friend' of a service user could be an abusive partner
- In relation to domestic violence, LGBT survivors may not think the law applies to them
- A lack of appropriate or specialist services (particularly access to crisis housing provision). Broken Rainbow offers support and advice to LGBT survivors. Their details are in appendix H .
- Fear of condemnation and being ostracised from within the LGBT community
- Controlling substance use or remaining abstinent often requires staying away from the drug, alcohol or party 'scene' which the survivors may rely on to meet other LGBT people. This could give rise to fears of isolation and not meeting a new partner/LGBT friends.
- Possible lack of support from family or friends



**Some useful guidelines on LGBT affirmative practice:**

- Develop a comfortable appreciation of your own sexuality and sexual orientation.
- Explore survivors' experiences of oppression with them.
- Help your client to be aware of stereotypes about their sexual orientation and/or gender identity.
- Explore issues, possibility and consequences of "coming out".
- Explore anger and safe ways of expression.
- Depression is very common so work with denial of anger, denial of self-validation and "emotional fatigue" from being invisible and deep hurts caused by homo/bi/transphobia.
- Encourage the survivor to establish a LGBT network system of support, nurturing, care and respect.

- Give messages that are affirming, respectful, valuing and accepting of the survivor's sexual orientation and/or gender identity.
- Desensitise shame and guilt surrounding LGBT thoughts, feelings and behaviours.
- Support consciousness raising efforts.

## Possible indicators of Domestic Violence

Taken from Department of Health (2005). *Responding to domestic abuse: A handbook for health professionals*. London: HMSO

### Appointments

- The survivor makes frequent appointments, but does not present with one particular issue
- Appointments or group sessions are often missed
- Survivor always accompanied by a partner or other family member when attending your agency
- Only presents at a time of crisis
- Non-compliance with treatment or an inability to follow through with plans

### Injuries

- Injuries which seem inconsistent with the explanations of accidental causation (such as falls, or walking into doors etc); injuries to the face, head and neck, chest, breast and abdomen

- Evidence of multiple injuries (e.g. burns, bruises) at different stages of healing
- Minimisation of the extent of injuries, and concealment by clothing
- History of repeated miscarriages, termination of pregnancies/still births or pre-term labour
- Recurrent sexually transmitted infections

### Mental distress

- Presentations as frightened, excessively anxious, depressed or distressed
- History of mental health problems especially depression, PTSD, self-harm and suicide attempts

### Their partner

- Passive or afraid of the partner
- Partner appears aggressive and overly-dominant
- Survivor appears evasive or reluctant to speak or disagree in front of partner

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## Assessment questions

*The following questions are some example of possible questions you might want to ask survivors of domestic and sexual violence who are also affected by substance use and/or mental health problems to ascertain:*

- 1) *whether your services are suitable for them (i.e. can you offer the right level of support and safety?)*
- 2) *whether the survivor may benefit from support from specialist drug, alcohol and/or mental health services*
- 3) *any high risks issues.*

*At the end of each section, there are links to relevant standardised assessment and risk assessment.*

### **Manchester Women's Aid**

Manchester Women's Aid has created a Complex Needs team in order to support survivors of domestic violence who have substance use and/or mental health problems in their refuges or in the community. You can download their assessment form here: <http://tinyurl.com/czwt5on>.

### Section 1 –Domestic violence

- Do you feel safe right now?  
Do you feel safe leaving this meeting/office/going home?
- What do you fear might happen in future? I.e. what types of violence or abuse might happen?
- What threats has the perpetrator made to/about you and/or your children?

There are well known risk factors associated with a high risk of serious harm or death in the future. Some of these risks are:

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Recent separation	Threats to kill	Use of objects/ weapons
Escalation of abuse (frequency or severity)	Threats by the perpetrator to commit suicide	Strangulation, choking, suffocating, drowning
Stalking and harassment	Sexual violence	Excessive jealousy
Isolation from friends/ family	Perpetrator tries to control everything victim does	

*If, when answering the previous questions, the survivor mentions any of these risk factors, practitioners are encouraged to complete the DASH RIC (see below) and/or speak to their manager, safeguarding lead, local domestic violence service to complete the DASH RIC or advice on what to do next.*

- Have you been in touch with any services? Do you have an outreach worker or an IDVA (Independent Domestic Violence Adviser)? Do you know if you have been referred to the MARAC (Multi-Agency Risk Assessment Conference)? Would you like any support around this issue?

## Standard tools

**DASH RIC** (Domestic Abuse, Stalking and Harassment Risk Identification Checklist). Standard risk assessment used by the police, health, children's services and domestic violence agencies in England and Wales. Used to identify very high risk victims of domestic violence who may be referred to the MARAC. <http://tinyurl.com/c456th6>

## **Barnardo's Domestic Violence Risk Identification Flow Chart.**

This primarily designed to assess risk for children and teenagers witnessing domestic violence. <http://tinyurl.com/cmlkpjo>

## Section 2 – Sexual violence

- When did the incident/most recent incident happen?
- Do you need any medical attention? Have you seen a medical professional?
- Would you like to report the incident(s)? It is possible in most areas to have forensic exams completed to collect any evidence a Sexual Assault Referral Centre (SARC) without reporting the assault to the police. Evidence will be kept in case the survivor wishes to report to the police at a later time.
- Do you feel safe at home/work/college/in public?
- Is the perpetrator known to them? He may be a partner, family member, neighbour, colleague, friend or acquaintance.
- Have you spoken to anyone else about what has happened? What would you like to happen now?

## Standard tools

**SERA** model for assessing risk of child sexual exploitation. The SERA model can be found on p.26 of the Derby City Children Abused Through Sexual Exploitation Risk Assessment Tool. <http://tinyurl.com/clqplt9>

## Section 3 – Substance use

- What substance(s) are you using right now? This includes prescribed and over the counter medication, alcohol and other drugs.
- How much do you use?
- Is this usage: occasional/weekly/daily/payday use?
- For prescription and over the counter medication, do you ever use more than instructed to on the package/by GP or pharmacist?
- Do you often drink or use other drugs more than you plan to?
- How much time during the week do you spend obtaining, using, or recovering from the effects of alcohol, other drugs or medication?

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- (In cases of domestic violence)  
How involved is your partner (the perpetrator) in your drug/alcohol use? Did you/do you use or drink together?
  - Sometimes women's partners can control her money or access to substances. Has this happened to you? If a woman answers 'yes', this could mean she is unable to use/drink without him which could make it difficult for some women to leave. For some women leaving may mean going into withdrawal.
  - Since you began using or drinking, have you stopped spending time with family and friends and begun spending more time using alcohol and other drugs or spending more time with people who do?
  - On a scale of 0-10 (0=no problem; 10=significant problems) where
- would you place yourself in relation to whether your drug use/drinking has affected /is affecting your health?
- Has your use of medication or drugs/drinking caused any other problems in the past, or are causing problems now? Do you think your drug use/drinking is causing you a problem? Has anyone else said that your drug use/drinking is problematic?
  - Have you had any arguments or been violent with people other than your partner when affected by alcohol or drugs?
  - Do you have any involvement with the police or the courts in relation to your substance use?
  - Do any of following risk factors apply:

Regular injector	Injecting related virus infection
Chaotic injector (neck or groin)	Serious physical health problems
Unable to inject self ((If a survivor is unable to inject herself, it may be more difficult for her to leave an abusive partner who injects for her)	High risk sexual behaviour – involved in prostitution, other sexual exploitation, unprotected sex
Shared equipment - bongs, pips, spoons	Unintentional overdose
Alcohol dependent/long-term use of benzodiazepines (can include physical dependence which requires close monitoring when reducing use or stopping)	History of accidents or injuries when under influence
History of seizures or DT's (in relation to withdrawing from alcohol)	Needed hospital treatment for accident or injuries

- Have you ever tried to cut down or stop using alcohol, medication or other drugs? Do you do it by yourself or with the help of a service? If you used a service, what was it? When did you last try to change your substance use? If you stopped using/drinking, how long did you manage to stop for?
- Are you currently on a methadone script? What is your dosage? Is it daily pickup/supervised/unsupervised/weekly pickup? (For survivors in supported housing including refuge, methadone

should be collected daily)

- Are you currently in contact with any services or agencies in relation to your substance use? If yes, can you give the name and contact details of current worker(s)? If not, would you like information about local services?

### Standard tools

**AUDIT** (Alcohol Use Disorders Identification Test) - is a brief self-report questionnaire developed by the World Health Organisation

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to identify people whose alcohol consumption has become hazardous or harmful to their health. <http://tinyurl.com/cfbqsmst>

**APQ** (Alcohol Problem Questionnaire) <http://tinyurl.com/cdqtb6>

**DUST** (Drug Use Screening Tool) can be used to identify young people and adults who might benefit from being referred to a substance use agency. <http://tinyurl.com/buuaxux>

**SADQ** (Severe Alcohol Dependence Questionnaire) <http://tinyurl.com/d6ua5wf>

## Section 4 – Mental health

- How are you feeling emotionally right now?
- Do you have any concerns about your health, including how you think or feel inside?
- Do you think your suffering with a particular emotional problem?
- Have you ever been diagnosed or treated for a mental health problem?
- Did you have these feelings or difficulties before you experienced domestic violence/were assaulted or raped? Or did they start then?
- Have you had any help from your doctor, a psychologist, a counselor, or anyone else because of problems with your mental health? Is anyone or any agency supporting you around your mental health now? Do you have a psychiatrist?
- Have you ever been prescribed medication for mental health problems? Are you taking anything now? If yes, what and who has prescribed them? If a survivor has recently moved areas, check how much of their medication they have left and how quickly they need to see a doctor for a new prescription.
- If taking medication, when was your last medication review?
- Do you ever use alcohol or drugs to help manage how you feel or your thoughts? Be aware the using alcohol and drugs is associated with an increased risk of causing serious injury when self-harming and committing suicide.



- Have you ever harmed yourself, e.g. cutting, burning, poisoning, not eating, not caring for yourself? Do you find that it helps you cope? Are you able to care for yourself when you hurt yourself?
- Have you ever felt so bad that you have thought about suicide? What happened?
- Have you ever thought about or been violent towards others?

### Levels of risk

	Self-harm	Suicide	Violence to others
HIGH	Doing it now	Current thoughts with plans and preparation	Now
MEDIUM	Done in the past	Frequent thoughts but no plans or intent	In the past
LOW	Never	No current/ infrequent thoughts	Never

- Have you ever been hospitalised due to mental ill-health? If so what was the date of your last admission?
- How does the way you feel impact on how you function? For example, are you able to go out, buy essential items, cook for yourself, go to work, socialise with others?
- What would help you now with how you are feeling? What would you like to happen now?

### Standard tools

CORE. A short assessment form that is commonly used within mental health and counselling services to measure improvements in service users' mental wellbeing. Can be used to help service users' explain how they are feeling and identify

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risks such as self-harming and suicidal thoughts. <http://tinyurl.com/br4bauz>

Centre for Mental Health Clinical Risk Management. A useful guide to risk management in mental health services. Provides clear information about the common types of risk related to mental ill-health. <http://tinyurl.com/c98mn7u>

## Section 5 – Children

- How many children do you have? How many are dependent? How many live with you? How old are they?
- What effect does drinking or using drugs, your mental health problems or living with domestic violence on your ability to be a parent?
- How do you think your alcohol/drug use or the perpetrator's behaviour has affected your children?
- Do you have regular routines at home, for example getting to school on time, bed times? Is that something you would like help with?
- How do you manage money? Does your drinking or drug use lead to financial problems? Do the children ever have to go without the basics?
- Do the children ever witness you using drugs/drinking or when there is domestic violence?
- In relation to domestic violence, do the children ever try to intervene?
- When you are unwell (mentally), do you ever have thoughts about harming the children?
- When you are drinking or using, are unwell or when there is domestic violence, are the children ever left unsupervised or with unsuitable carers? Who looks after the children when you are not able to?
- What other support do the children have? Do the children have regular contact with a adult/carer who does not use or drink?

- In relation to alcohol or drug use, are children ever taken to places they might be at risk? Or do people come to your home as a place to use drugs or drink problematically?
- Are drugs, drugs works/ paraphernalia, alcohol, medication stored safely and away from children?

## Standard tools

**CAF** (Common Assessment Framework). Used in a range of services to identify children and families who may need additional support. <http://tinyurl.com/cl7fpxv>

This document can be downloaded from <http://tinyurl.com/bu5f2xg>.

# Appendix C

## Personal crisis plan template

Adapted from: Personal Crisis Plan (Advance Directive), created by Mary Ellen Copeland, PO Box 301, W. Dummerston, VT 05357 Phone: (802) 254-2092 e-mail: info@mentalhealthrecovery.com Website: <http://www.mentalhealthrecovery.com>.

*People who experience periods of mental ill-health should be encouraged to plan for times of illness. If the person is in contact with a mental health service, they may already have a personal crisis plan or advance directive. If not, it might be useful for services supporting the person (particularly accommodation-based services) to talk through the following points.*

### Section 1 – What I am unlike when I am unwell

This could include signs that I am starting to feel unwell and also what I want or don't want other people to do when I feel this way.

### Section 2 – Signs I need my supporters to take over

If I have several of the following signs and/or symptoms, my supporters, named in the next section, need to take over responsibility for my care and make decisions in my behalf based on the information in this plan.

### Section 3 – My supporters

- If this plan needs to be activated, I want the following people to take over for me: include name, relationship/connection/contact details and the role or specific tasks for this person.
- I do not want the following people involved in any way in my care or treatment: include name and reason for not wanting involved (optional)
- If my supporters disagree on a course of action to be followed, I would like the dispute to be settled in the following way:

## Section 4- Medication and health care

- Details of GP surgery and named GP, psychiatrist, Community Psychiatric Nurse (CPN), mental health social worker, other mental health professionals, other health professionals, pharmacy and pharmacist
- Details of any medication currently taken, including doses, purpose, when to take medication, and known side effects for individual
- Details of any allergies
- Details of any medications to avoid and reason why

## Section 5 – Treatments and complementary therapy

- If this plan is activated, I would like to use the following treatment and/or complementary therapies: include details of when and how to use the treatment/therapy
- I don't not want the following treatments/complementary therapies wherever possible:

## Section 6 – Home or community care

If possible, follow the following care plan:

## Section 7 – Hospitalisation

- If I need hospitalisation or treatment in a treatment facility, I would prefer the following facilities: include details of facilities, any known contact person, contact details, reasons why this facility is preferred.
- Avoid using the following hospitals or treatment facilities: name and reason why

## Section 8 – Help from others

Please do the following things that would help reduce my uncomfortable feelings, make me more comfortable, and keep me safe.

- I need (name of person) to (task)
- I need (name of person) to (task)
- I need (name of person) to (task)

# Appendix C

Do not do the following. It won't help and it may even make things worse.

## Section 9 – Inactivating the plan

The following signs or actions indicate that my supporters no longer need to use this plan.

**I developed this plan on (date) with the help of (named individuals). Any plan with a more recent date supersedes this one.**

This document can be downloaded from <http://tinyurl.com/cvdav95>

# Appendix D

## Safeguarding adults procedures

Full details of safeguarding adults procedures can be found in the Social Care Institute for Excellence (SCIE) resource, *Protecting adults at risk in London: Good practice resource*, accessible from the SCIE website:

<http://www.scie.org.uk/publications/adultsafeguardinglondon/index.asp>

Where someone is experiencing domestic violence and **has capacity**:

- Take any emergency action necessary.
- Discuss with the person the various options available for addressing the situation.
- Ask the person if they would like to report the matter to the police, and explain the different ways the police may be able to help.
- If the person wants it, report the incident to the police: an investigation will be carried out if a crime has been or may have been committed.
- Consider reporting the incident to the police even if the person does not want to report it, if the risk is seen to be high, if there are public interest or vital interest considerations, or if other people could be at risk from the same person.
- If this, or any other action, is taken against the wishes of the person, consider if the action taken meets the key principle of proportionality, and if the reasons should be fully explained to the person.
- Make a referral to the local authority contact point.
- Instigate an investigation and risk assessment under the procedures if this is what the person wants.
- Agree a protection plan with the adult at risk, if this is what they want.
- Discuss with the adult at risk how they want the person alleged to have caused the harm to change their behaviour.

# Appendix D

- Conduct an additional risk assessment and assessment of need with the adult at risk, and review existing care plans.
- Review any personal budget arrangements that are in place.
- Provide the adult at risk with an advocacy service.
- Conduct a carer's assessment.
- Investigate possible breaches of tenancy agreement or environmental health regulations.
- Make contact with the local community safety team.
- Contact a solicitor regarding possible civil action.
- The relevant organisation should make a referral to the multi-agency risk assessment conference (MARAC) if there is domestic violence and the risk of harm is high.
- If the person says they do not want any action taken and there are no public interest or vital interest considerations, give them

information about where they can get help if they change their mind.

Where someone is experiencing domestic violence and has **NO capacity**:

- Take any emergency action necessary.
- Make a referral to the local authority contact point.
- Bear in mind that even where the person lacks capacity they should be involved as much as possible in discussions, and that the least restrictive options in any situation should be sought.
- Identify who can assist with the person's best interest decisions including the instruction of an independent mental capacity advocate (IMCA).
- Report the incident to the police if a crime has been or may have been committed and it is in the person's best interests.
- Instigate an investigation under safeguarding adults procedures.



- Conduct a risk assessment and assessment of need, and review existing care plans under the care management or care programme approach (CPA).
- Conduct a carer's assessment.
- The relevant organisation should make a referral to MARAC if there is domestic violence and the risk of harm is high.
- Report the incident to the Office of the Public Guardian (OPG) if there is a misuse of power of attorney.
- Report the incident to the Department for Work and Pensions (DWP) if applicable.
- Agree a protection plan with those representing the person's best interests.
- Review the protection plan.

This document can be downloaded from <http://tinyurl.com/c439oah>.

## Safety planning guidance

*For survivors of domestic violence who are affected by substance use and/or mental ill-health.*

### Section 1 – Key principles

- Risk is dynamic (always changing) and so safety planning needs to be an on-going discussion as situations change
- Never assume you know what is best for victims; they know their situation and the risks better than you do
- Recognise that victims will already be employing safety strategies, though they may not name them; recognise, validate and build on what they are already doing. Explore which strategies are effective and helpful, and which may not be so helpful and could be adapted.
- Keep the responsibility for the abuse explicitly with the perpetrator
- Do not suggest or support anything that colludes with the abuse
- Provide consistency and continuity

### Section 2 – What you can do

- Take her identification of danger and risk seriously
- Help her identify areas of increased risk
- Help her identify safer times and locations
- Identify what is working in practice to protect her and her children
- Take time to validate what she is already doing
- Help to develop as wide a range of options as possible, ones that she feels she can use and achieve
- Focus on the options that work best, review and adapt with changing circumstances
- Be willing to suspend safety planning in order to support the survivor and return to it at a later session

- Work within her identified limits, for example, make appointments that she can attend, ensure she is seen alone etc
- Act as advocate with other support services
- Recognise it will take time for her situation to change
- If you left, where could you go?
- Do you ever know in advance when your partner is going to be violent? e.g. after drinking, when they get paid, after relatives visit?
- When you suspect he is going to be violent can you go elsewhere?

### Section 3- General questions to ask

- Can you keep a bag of spare clothes at a friend's or family member's house?
- Are you able to keep copies of any important papers with anyone else? e.g. passport, birth certificates, benefit book?
- Which part of your home do you feel safest in?
- Is there somewhere for your children to go when your partner is being violent and abusive?
- What is the most dangerous part of your house to be in when he is violent?
- Can you begin to save any money independently of your partner?
- When was the most recent incidence of violence or abuse? Frequency, severity, where/when etc.?
- What do you currently do to keep you and your children safe? What works best?
- Do the children know how to contact services or friends/family?
- Who can you tell about the violence – someone who will tell your partner/ex-partner?
- Do you have important phone numbers available e.g. family, friends, refuges, police?

It is also important to help the survivor to focus on the more positive things going on in her life and/or identify ways she could access activities which would help improve confidence, self esteem, emotional well-being, etc.

## Section 4 – Additional considerations and questions about substance use and mental health

### **Issues to consider for safety planning with survivors using substances or who experiences mental ill-health:**

- Some survivors' drug or alcohol use could make it difficult for them to assess the severity of the violence they are experiencing. Their substance use may be 'dulling' both the physical and mental pain they are in.
- Survivors who are using substances or mental health may be too ashamed or embarrassed about their substance use to access services.
- Some women may feel they cannot disclose their substance

use problem or mental health problems for fear of not being given access to refuge accommodation.

- Trust is paramount. Problem drug-using women and those who experience mental ill-health caring for their children fear automatic referral to social services departments, if they disclose.
- Some survivors may have had previous bad experiences with substance misuse/mental health services which may hinder their choice to engage with new services.

For survivors who use drugs or alcohol or have mental health problems, the safety plan should cover the additional risks associated with these needs.

- Is the plan realistic? Can the service user implement the safety plan when they're intoxicated or unwell?
- Consideration of how a survivor's drinking/using may impact on their ability to protect themselves - they are more likely to fight back and receive worse injuries, etc.

- Discussion of harm minimization, e.g. learning to self inject safely, smoking rather than injecting or managing self-harm and suicidal thoughts (local drugs or mental health service, respectively, will be able to provide further details)
  - What provisions are made for children when violence happens, when using/drinking or if the victim becomes mentally unwell?
  - What response might survivors receive from services/police, etc. when they make contact under the influence of alcohol/drugs or when unwell? Survivors may have a history with services, e.g. the police, relating to their substance use and mental health problems.
  - Staying safe when services arrive? Some women see this as a safe opportunity to challenge their partner/become more aggressive themselves when the police are there - this then impacts on them being seen as the aggressor and taken less seriously
  - Does the plan incorporate strategies to promote access to drug/alcohol treatment or mental health services? It can be empowering for a survivor to realise the abuser wants them to remain substance dependent/mentally unwell and to plan for interference with their treatment.
  - If considering leaving partner and needs to relocate, where will they get supply of drugs? Do they need emergency prescribing? Do they have sufficient prescriptions of psychiatric medication? Do they have depot injections? Will they be able to have quick access to necessary medication in new location?
  - Consider vulnerability/safety when entering new relationships if survivor has problems with drugs, alcohol and/or their mental health
- Substance use specific questions:**
- Can you include changes to patterns of substance use that may increase safety? For example, using at times of day that their partner is unlikely to be around.
  - The location of where a survivor goes to use/drink – how does this impact on safety?

- Anticipating partner's substance use – how to keep safer when they have been using/drinking?
- Detox/withdrawal/relapse on the part of the perpetrator can be dangerous times in terms of safety.

## **Mental health specific questions:**

- Awareness of signs of relapse – does the survivor know when they are starting to feel unwell? Do they become more vulnerable to abuse when unwell? In what way?
- If in contact with mental health services, do they have a relapse prevention plan? Can any actions be incorporated into the safety plan?
- Is the abuser their main carer? Is there another (trusted person) who can be contacted by mental health services when survivor is unwell?

When both partners use the same service:

- If a survivor decides to access substance treatment or mental health services, it is advisable that they use a different service

from their partner, especially if the relationship ends.

- Consider altering routes/times if their partner is aware of their attendance at a particular service; use a panic alarms; make sure phone is charged.

## **Section 5 – Types of actions to include**

### **What should a safety plan cover?**

#### *Safety in the relationship*

- Places to avoid when abuse starts (such as the kitchen, where there are many potential weapons).
- People a woman can turn to for help or let know that they are in danger.
- Asking neighbours or friends to call 999 if they hear anything to suggest a woman or her children are in danger.
- Places to hide important phone numbers, such as helpline numbers.
- How to keep the children safe when abuse starts.

- Teaching the children to find safety or get help, perhaps by dialling 999.
- Keeping important personal documents in one place so that they can be taken if a woman needs to leave suddenly.
- Letting someone know about the abuse so that it can be recorded (important for cases that go to court or immigration applications, for example).
- Access to money or credit/debit cards that a woman has perhaps put aside.
- Plans for transport.
- Plans for taking clothes, toiletries and toys for the children.
- Taking any proof of the abuse, such as photos, notes or details of people who know about it.

### **Safety when a relationship is over**

#### **Leaving in an emergency**

- Packing an emergency bag and hiding it in a safe place in case a woman needs to leave in an emergency.
- Plans for who to call and where to go (such as a domestic violence refuge).
- Things to remember to take: documents, medication, keys or a photo of the abuser (useful for serving court documents).
- Access to a phone.
- Contact details for professionals who can advise or give vital support.
- Changing landline and mobile phone numbers.
- How to keep her location secret from her partner if she has left home (by not telling mutual friends where she is, for example).
- Getting a non-molestation or exclusion or a restraining order.
- Plans for talking to any children about the importance of staying safe.
- Asking an employer for help with safety while at work.

# Appendix E

## Section 6 – Items to take in an emergency

**If a service user needs to flee their home, it is useful to take as many of the following items. Survivors should NOT, however, be advised to stay in the home to collect these items if they are at immediate risk of harm.**

- Medication
- Identification – birth certificate, passport, driver's license
- Birth certificates for all children
- Marriage certificate
- Divorce papers
- Tenancy agreement, deeds for any property, rental agreement
- Paperwork relating to benefits
- Money, bank books/cards, credit cards, mortgage papers
- Insurance papers
- Passport(s), Home Office papers, work permits
- Any proof of abuse, notes, tapes, diary, crime reference numbers, names and numbers of professionals who know about the abuse
- Copies of any treatment or care plans
- Phone card, mobile telephone (+ charger) or change for a pay phone
- Medical Cards
- Keys - house/car/office
- Keys to a friend or relative's house
- Children's favourite toys and/or blankets
- Change of clothes for all family members leaving
- Pictures, jewellery, items of sentimental value
- Address book

This document can be downloaded from <http://tinyurl.com/c7w5x3k>.



# Appendix F

## Why do people self-harm

*In the absence of fully functioning problem-solving skills and the ability to self-soothe, some survivors may self-harm to manage their emotional responses.*

Self-harm can help someone to cope as a means of:

- **expressing anger or other feelings** that can be difficult or are not allowed to be verbalized. Way of communicating that something is wrong.
- **regulating distress and anxiety.** Self-harming can reduce tension when it becomes unbearable.
- **regaining control,** having power to make things happen and overcoming terrifying feelings of powerlessness.
- **managing intrusive thoughts.** Survivors may become continually hyperaroused (anxious) and experience flashbacks. Self-harming can help to override intrusive thoughts possibly as a means of focussing on the present.
- **grounding.** Survivors may dissociate to distance themselves from the source of trauma and stress. They may harm themselves during dissociative states, and may hurt as a way to stop dissociation, to regain feelings of being alive and present.
- **distraction.** To escape emotional pain or focus away to make pain more manageable.
- **triggering endorphin production** in the brain. Endorphins are a natural painkiller and reduce anxiety. The natural production of endorphins may be impaired so system may need stimulation.
- **self-punishment** - Self-loathing, negative self image and feelings about themselves; shame, blame, guilt, low self-esteem, self-hatred, feelings of being bad/evil, dirty.
- **self-nurture.** After the physical pain can receive comfort and feel that they deserve to be cared for.
- **Acting out:** a re-enactment of the original trauma and replaces the feelings associated with it.

Traumatic memories leave imprints and cutting may be a way to express those memories.

- **experiences have been denied, minimised, ignored.** Self-harm provides validation of experiences it can be a form of evidence, a testimony. Testifies to the enormity of their experience and a way of remembering events that others may have forgotten or denied. It demonstrates courage, endurance, and pride against the self loathing and shame.
- **deliberate self-harm as a means of influencing others:** In some circumstances harming the self can be a way of communicating distress that is not heeded when communicated in words. At other times self-harm can be a means to influence others, either to care for the person who has harmed or to keep others at a distance.

Often, more than one function may be relevant. For example, cutting the self may serve both to regulate anxiety and to validate the severity of current emotional pain. It is very

important not to make assumptions about the function of a particular episode of self-harm without understanding both the behaviour itself and the person who has harmed.

Often professionals and family members make the mistake of assuming that all episodes of self-harm are about influencing them or other key people in the environment, because the other aspects (reduction of emotional pain, self-validation) are hidden to the outside observer. Because they are experiencing a response to the self-harm, they make the (often mistaken) assumption that the person who has self-harmed intended to make them feel this way. This is not always the case.

This document can be downloaded from <http://tinyurl.com/c3ulnvn>.

# Appendix G

## Power and control wheel-perpetrator behaviours

The Power and Control Wheel depicts the ways in which perpetrators behave to gain power and control over a

partner. Additional actions that perpetrators that specifically relate to the survivor's mental health or substance use are listed below the Power and Control Wheel.



Domestic Abuse Intervention Project, 202 East Superior Street, Duluth, Minnesota 55802, tel: 218-722-2781, website: [www.duluth-model.org](http://www.duluth-model.org)

# Appendix G

## Physical and sexual violence

- Encouraging substance use: introducing substance use, buying substances, administering drugs
- Using physical violence if victim does/doesn't drink/use drugs
- Withholding psychiatric medication or giving overdose of medication
- Refusing to let victim go anywhere alone, say it's for their own safety (e.g. mentally unable to cope, threats of violence from dealers)
- Restraining victim, say it's for own safety (e.g. when mentally unwell)
- Sexual violence when intoxicated or mentally unwell (unable to consent)
- Forcing into prostitution for drugs or drugs money

## Emotional and psychological abuse

- Making victim feel incompetent because of mental health or substance
- Damaging self-esteem with verbal insults, e.g. you're useless, can't do anything, unfit mother, crazy, mad, junkie

- Telling victim s/he is 'crazy' or 'mad'
- Humiliation – telling others s/he is crazy, mad, a user, an addict
- Encouraging dependence - telling victim s/he could not cope on their own
- Lying about times/information then saying s/he appears to get things wrong (proving to self and others that s/he can't manage)
- Moving or taking property to cause confusion

## Minimising, denying and blaming

- "You're overreacting/hysterical/all women are crazy"
- "It didn't happen – you're imagining things/crazy/high"
- "You're hearing/seeing things"
- Destroying property/harming others but saying victim did/imagined it
- "You hit me"
- Blaming injuries on self-harm

- “You drive me to this” – saying the victim caused the abuse with substance use/mental health problems

### Isolation

- Preventing victim from social activity including friends, job, socialising because she is mad, an addict, an embarrassment
- Preventing access to medical services/medication which exacerbates mental health issues
- Preventing attendance at alcohol/drug treatment service or support groups
- Telling victim that family/friends no longer want contact because of substance use/mental health
- Telling other people that victim no longer wants to have contact

### Children

- Telling her she is an incapable mother because of mental health/ substance use problems
- Threatening to use mental health/ substance use to justify the children being ‘taken away’
- Making the children question mental health

- Encouraging children to insult and degrade victim because of mental health/substance use

### Economic abuse

- Telling her that she has lost money, money is missing, taking money etc to make her think she is ‘crazy’
- Suggesting her account of money is incorrect to take control of finances
- Restricting access to money “to stop victim using for drinking/ drugs”
- Taking money for own alcohol/ drugs
- Forcing victim to sell drugs

### Coercion and threats

- Threats of violence if she doesn’t stop being ‘crazy’/drinking/using
- Threaten to contact social care
- Threaten to have her sectioned
- Threaten to tell family/friends/ employer about mental health or substance use problems if not already disclosed

This document can be downloaded from <http://tinyurl.com/bvmchwz>.

## Useful contacts and resources

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Wales who are affected by domestic and sexual violence.

### **Broken Rainbow Helpline**

<http://www.brokenrainbow.org.uk>, 0300 999 5428 (Mon/Thurs, 10am-8pm, Tues/Wed 10am-5pm). Support for lesbian, gay, bisexual and trans people experiencing domestic violence

### **Men's Advice Line**

0808 801 0327 (Monday-Friday 10am-1pm, 2pm-5pm). Support, information and practical advice to men experiencing domestic violence.

## A. Helplines and national organisations

### Domestic and sexual violence

#### Key helplines

##### **Action on Elder Abuse**

0808 808 8141, [www.elderabuse.org.uk](http://www.elderabuse.org.uk) (Monday-Friday, 9am-5pm).

##### **All Wales Domestic Abuse and Sexual Violence Helpline**

0808 801 0800, [www.allwaleshelpline.org.uk](http://www.allwaleshelpline.org.uk) (24 hours). For men and women in

##### **National Domestic Violence Freephone**

0808 2000 247 (24 hours). Support and information for women experiencing domestic violence, their family, friends, colleagues and others calling on their behalf (including professionals).

##### **National Stalking Helpline**

0808 802 0300, [www.stalkinghelpline.org](http://www.stalkinghelpline.org), (Monday, Tuesday, Thursday and Friday from 9.30am to 4.00pm; Wednesday from 1.00pm to 4.00pm). Practical advice and information to anybody who is currently or has previously

been affected by harassment or stalking.

### **Rape Crisis**

0808 802 9999,  
[www.rapecrisis.org.uk](http://www.rapecrisis.org.uk) (midday-2.30pm, 7-9.30pm every day).  
Emotional support and information about local services for women affected by sexual violence.

### **Respect Phonenumber**

0808 802 4040,  
[www.respectphonenumber.org.uk](http://www.respectphonenumber.org.uk)  
(Monday-Friday, 9am-5pm). Offers information and advice to people who are abusive towards their partners and want help to stop.

### **Survivors UK**

0845 122 1201,  
[www.survivorsuk.org](http://www.survivorsuk.org)  
(Monday and Tuesday from 7.00 pm to 9.30 pm; Thursday from 12.00 pm to 2.30 pm). The helpline is for adult men (18 and over) who have experienced childhood sexual abuse or adult sexual assault / rape, as well as their partners and carers.

## National organisations

### **1) Domestic and sexual violence**

**Rape Crisis**, [www.rapecrisis.org.uk](http://www.rapecrisis.org.uk)  
National charity supporting the work of rape crisis centres in England and Wales. Can provide information about local services for women survivors of sexual violence.

### **Refuge**

[www.refuge.org.uk](http://www.refuge.org.uk)  
National charity providing accommodation, advocacy and outreach service for survivors of domestic violence.

### **Survivors UK**

[www.survivorsuk.org](http://www.survivorsuk.org)  
Survivors UK runs a national helpline and provides individual and group support for adult men who have been victims of rape and other sexual violence. Survivors UK is not a helpline for men who have experienced non-sexual violence. The helpline may be able to arrange counselling or a support group if the client lives in the London area. If the client lives outside London, Survivors UK may be able to provide details of an appropriate service outside the London area.

## **The Dyn Project**

[www.dynwales.org/default.asp?contentID=1](http://www.dynwales.org/default.asp?contentID=1),

The Dyn Wales website has general information about domestic abuse and a directory of available services for each local authority in Wales.

The project also offers face-to-face advice, information and support to men who experience domestic abuse within Cardiff. The Dyn Project runs a helpline to support men in Wales experiencing domestic abuse. The helpline is open Monday and Tuesday from 10.00am to 4.00pm; Wednesday from 10.00am to 1.00pm and can be contacted on 0808 801 0321.

## **Women & Girls Network**

[www.wagn.org.uk](http://www.wagn.org.uk)

A pan-London service offering a holistic healing centre, including counselling and body therapies, for women and girls overcoming the experience of violence whether physical, sexual or emotional. They also run a helpline (0207 610 4345) which is open Mon/Fri/Sat (10am-1pm), Tues/Weds (6.30-9.30pm),

## **Women's Aid**

[www.womensaid.org.uk](http://www.womensaid.org.uk)

National charity working to end domestic violence, supporting

over 500 services across the UK. Professionals can call the National Domestic Violence Helpline (0808 2000 247), run jointly with Refuge, for advice and information on supporting clients experiencing domestic violence.

## **2) Other forms of violence against women and girls**

### **Forced Marriage Unit**

[www.fco.gov.uk](http://www.fco.gov.uk), 0207 008 0151 (Monday-Friday, 9am-5.30pm)  
Unit run by the UK Foreign Office, providing confidential advice and assistance to people who are at risk of, or have been, forced into marriage. The Unit can also advise professionals.

### **FORWARD**

[www.forwarduk.org.uk](http://www.forwarduk.org.uk), 0208 960 4000 (Monday-Friday, 9am-6pm). London-based national charity, providing specialist advice on African women's sexual and reproductive health and rights, and with expertise on female genital mutilation.

### **Kalayaan**

[www.kalayaan.org.uk](http://www.kalayaan.org.uk), 01304 203 977 (Monday to Thursday from 9.00am to 5.00pm; Friday from



9.00am to 4.30pm). Kalayaan provides advice, advocacy and support services to migrant domestic workers in the UK. Migrant domestic workers are people who have entered the UK legally with an employer on a domestic worker visa to work in a private household.

### **Karma Nirvana**

[www.karmanirvana.org.uk](http://www.karmanirvana.org.uk), 0800 5999 247 (Honour helpline open 9:30am-9pm). Leeds-based national charity, providing support to survivors of forced marriage and so-called 'honour' based violence.

### **Migrant Helpline**

[www.migranthepline.org.uk](http://www.migranthepline.org.uk), 0207 243 2942 (Monday to Friday from 10.00am to 5.00pm). Migrant Helpline provides support for the victims of human trafficking throughout the UK.

### **NSPCC National Child Trafficking Advice Centre (CTAC)**

0808 800 5000 (Monday-Friday, 9.30am-4.30pm). The NSPCC National Child Trafficking Advice Centre (CTAC) provides support to professionals working with children or young people who may have been trafficked or are at risk of trafficking.

### **Poppy Project, Eaves**

[www.eaves4women.org.uk](http://www.eaves4women.org.uk), 0207 735 2062

Eaves is a London-based charity, but its Poppy Project provides a national accommodation, support and outreach service to victims of trafficking for sexual exploitation and domestic servitude. The Poppy Project has 14 bed spaces for women who need accommodation as part of their support.

### **UK Human Trafficking Centre**

**(UKHTC)** [www.soca.gov.uk/about-soca/about-the-ukhtc](http://www.soca.gov.uk/about-soca/about-the-ukhtc), 0844 778 2406. The UK Human Trafficking Centre (UKHTC) is a multi-agency organisation led by the Serious Organised Crime Agency (SOCA). It works to combat the trafficking of human beings and provide support to victims including taking referrals to the National Referral Mechanism. Further information about trafficking and the National Referral Mechanism can be found on the UKHTC website.

### 3) Women and men involved in prostitution

**CLASH (Central London Action on Street Health)** 020 7734 1794  
HIV and Sexual Health Outreach service in London for male and female sex workers, drug users, homeless, gay and bi-sexual men, groups often marginalised and at risk of HIV and STI.

#### **Dorset Working Women's Project**

07973 235 438  
A HIV and sexual health project targeting women who sell sex in particular those using drugs and alcohol. Twice weekly outreach providing condoms and clean injecting equipment. Information and advice on safer sex and drug use. Home visits to indoor workers. Transport to GUM clinic.

#### **MASH (Manchester Action On Street Health)** <http://www.mash.org.uk>, 0161 202 2022

A sexual health promotion/HIV prevention organisation which provides a service for both street based and sauna based female sex workers and drug users in Greater Manchester. Provides targeted night time service. Harm reduction by supplying users with condoms and

clean injecting equipment.

#### **Streetreach**

[www.streetreach.org.uk](http://www.streetreach.org.uk),  
01302 328396

A confidential service in Doncaster for adults involved in prostitution and for children and young people who are being sexually exploited.

### 4) Black, Asian, minority ethnic and refugee (BAMER) survivors

#### **Al-Aman**

0208 748 2577 / 0208 563 2250  
Arabic speaking service for men and women affected by domestic violence in the London Boroughs of Hammersmith & Fulham, Kensington & Chelsea and Westminster

#### **Ashiana Project**

[www.ashiana.org.uk](http://www.ashiana.org.uk),  
0208 539 0427  
London-based charity, taking referrals nationally. Advice, support and housing for women from the Asian, Turkish & Iranian community experiencing domestic violence.

#### **Chinese Information & Advice Centre**

[www.ciac.co.uk](http://www.ciac.co.uk), 08453 131 868  
London-based national charity,

with a women's support project for Chinese women and families in distress, including domestic violence.

### **Iranian and Kurdish Women's Rights Organisation**

[www.ikwro.org.uk](http://www.ikwro.org.uk), 0207 920 6460  
Provides advice and support to Middle Eastern women and girls living in the UK who are facing honour-based violence, domestic abuse, forced marriage or female genital mutilation

### **Imkaan**

[www.imkaan.org.uk](http://www.imkaan.org.uk),  
0207 250 3933  
Imkaan is a national research and policy project, initiated by Asian women's projects. Imkaan profiles and advocates on behalf of the specialist refuge sector nationally, through accredited training programmes, publications and strategic liaison with government, statutory and community organisations. Information about local violence against women services for BAMER survivors.

### **Jewish Women's Aid**

[www.jwa.org.uk](http://www.jwa.org.uk), 0208 445 8060  
Helpline: 0800 801 0500 (Monday-Thursday, 9:30am-9:30pm).

London-based national charity providing refuge and outreach services for Jewish women and their children affected by domestic violence.

### **Latin American Women's Aid**

[www.lawadv.org.uk](http://www.lawadv.org.uk), 0207 275 0321  
London-based national charity, providing advice, support and temporary accommodation to Latin American women fleeing domestic violence. Staff speak Portuguese and Spanish.

### **Solace Women's Aid (Irish Travellers)**

[www.solacewomensaid.org](http://www.solacewomensaid.org),  
07903 806 161  
London-based charity, which runs a refuge and outreach service for Irish Traveller women.

### **Southall Black Sisters**

[www.southallblacksisters.org.uk](http://www.southallblacksisters.org.uk),  
0208 571 9595  
Specialist campaigning, advice, information, advocacy, practical help and counselling to women experiencing domestic violence, forced marriages, honour crimes and immigration issues. Takes referrals primarily from the London Borough of Ealing but may consider referrals from other boroughs.

## 5) Lesbian, gay, bisexual and transgender survivors

### Broken Rainbow Helpline

<http://www.brokenrainbow.org.uk>, 0300 999 5428 (Mon/Thurs, 10am-8pm, Tues/Wed 10am-5pm). Support for lesbian, gay, bisexual and trans people experiencing domestic violence.

### Galop

[www.galop.org.uk](http://www.galop.org.uk), 0207 704 2040 (Helpline)  
Charity providing advice and support to lesbians, gay men, bisexual and transgender people who have experienced homophobic or transphobic hate crime or violence in the greater London area. They provide support around domestic and sexual violence.

### SOLA (Survivors of Lesbian Abuse)

[solalondon@hotmail.com](mailto:solalondon@hotmail.com), 0207 328 7389  
Support for any woman that has experienced abuse (past or present) from a female partner. Email support is available, and evening phone appointments are available by arrangement. Also has a weekly support group for survivors of rape (women only).

## 6) Older survivors

### Action on Elder Abuse

[www.elderabuse.org.uk](http://www.elderabuse.org.uk), 0808 808 8141 (Helpline). National charity providing advice and information to victims and others who are concerned about or have witnessed abuse of older people.

## 7) Survivors who are disabled

### Respond

[www.respond.org.uk](http://www.respond.org.uk), 0808 808 0700 (Helpline)  
London-based national charity providing psychotherapy and advocacy for people with learning disabilities who have experienced trauma. Independent Sexual Violence Advisor service for people with learning disabilities in inner London who have experienced sexual violence.

### UK Disability Forum

[www.edfwomen.org.uk/abuse.htm](http://www.edfwomen.org.uk/abuse.htm)  
This section of the UK Disability Forum website gives information for disabled women about getting help to tackle violence and abuse.

### **Voice UK**

[www.voiceuk.org.uk](http://www.voiceuk.org.uk),  
0845 122 8695 (Helpline)  
Supports people with learning disabilities who are victims of crime or abuse, their families, carers and professional workers.

### **8) Specialist services for survivors with mental health and/or substance use problems**

#### **Emma Project (Nia)**

[www.niaendingviolence.org.uk](http://www.niaendingviolence.org.uk),  
0207 683 1270  
The Emma Project is London's only refuge for women who are escaping gender violence and who use substances problematically; more than a third of the women who have lived in the refuge have also been exploited through prostitution.

#### **Chrysalis Project (St Mungo's)**

[www.mungos.org](http://www.mungos.org), 0208 762 5500  
Women-only hostel for women with a recent or current experience of trauma, abuse and sexual exploitation and a strong connection to Lambeth (31 beds).

### **DV Plus, Safer Places (Harlow & Broxbourne WA)**

[www.saferplaces.co.uk](http://www.saferplaces.co.uk),  
0845 0177 668  
Specialist refuge in Essex for women with complex needs (6 beds).

### **Northampton Women's Aid**

[www.northamptonwomensaid.org.uk](http://www.northamptonwomensaid.org.uk), 0845 123 2311  
Specialist substance misuse refuge in Northampton (5 units)

### **RISE**

[www.riseuk.org.uk](http://www.riseuk.org.uk), 01273 622 822  
Refuge and community based services in Brighton that can support women with more complex substance use and mental health problems

### **Manchester Women's Aid**

<http://www.manchesterwomensaid.org>, 0161 660 7999  
Employs specialist mental health and substance use workers within a complex families team to support survivors who use substances and/or have mental health problems.

## **Solace Women's Aid**

[www.solacewomensaid.org](http://www.solacewomensaid.org),  
08453 131 868  
Problematic substance use worker provides support and key working for women fleeing domestic violence who use substances.

## **9) Perpetrators**

### **Respect**

[www.respect.uk.net](http://www.respect.uk.net),  
0207 549 0578  
UK membership association for domestic violence perpetrator programmes and associated support services. The Respect Phonenumber (0808 802 4040) offers information and advice to people who are abusive towards their partners and want help to stop. Respect also run the Men's Advice Line (0808 801 0327), for male survivors of domestic violence.

### **Domestic Violence Intervention Project**

[www.dvip.org](http://www.dvip.org),  
0207 633 9181  
Provides perpetrator programmes and partner support services in London to Respect standards.

## **Substance use**

### **Key helplines**

#### **FRANK**

[www.talktofrank.com](http://www.talktofrank.com), 0800 77 66 00 (24hr Helpline), Text 82111.  
Phonenumber run by the Department of Health, providing advice and information on drug and alcohol use to users, their families and friends.

#### **DRINKLINE**

0800 917 8282 (Mon-Fri, 9am-8pm; weekends, 11am-4pm)  
The national alcohol helpline. If you're worried about your own or someone else's drinking, you can call this free helpline, in complete confidence.

## **National organisations**

#### **Addaction**

[www.addaction.org.uk](http://www.addaction.org.uk),  
0207 251 5860  
A leading UK charity working in the field of drug and alcohol treatment. They have over 120 within communities and prisons across England and Wales, including support for young people and families affected by drug and alcohol use.

### **Adfam**

[www.adfam.org.uk](http://www.adfam.org.uk), 0207 553 7640  
National charity working to improve the quality of life for families affected by drug and alcohol use. Adfam run a network of local support groups across the UK.

### **Alcohol Concern**

[www.alcoholconcern.org.uk](http://www.alcoholconcern.org.uk),  
0207 928 7377  
National charity working on problematic alcohol use. They work to reduce the incidence and costs of alcohol-related harm and to increase the range and quality of services available to people with alcohol-related problems.

### **Black Poppy**

[www.blackpoppy.org.uk](http://www.blackpoppy.org.uk)  
A user-run organisation, producing the drug user's health and lifestyle magazine, Black Poppy. BP's website includes a range of drugs information, including information on user groups in the UK.

### **DrugScope and LDAN**

[www.drugscope.org.uk](http://www.drugscope.org.uk) and  
[www.ldan.org.uk](http://www.ldan.org.uk), 0207 234 9730  
National charity working to inform policy development and reduce drug-related risk. They provide quality drug information, promote

effective responses to drug taking, undertake research and provide policy-making advice. DrugScope's London Drug & Alcohol Network (LDAN) provides advice and support to member drug and alcohol agencies in London

### **FRANK**

[www.talktofrank.com](http://www.talktofrank.com),  
0800 77 66 00 (24hr Helpline),  
Text 82111  
Website and phoneline run by the Department of Health, providing advice and information on drug and alcohol use to users, their families and friends. FRANK can provide information on specific treatment services available in your area. Information is particularly aimed at young people, but can be used by people of all ages.

### **Phoenix Futures**

[www.phoenix-futures.org.uk](http://www.phoenix-futures.org.uk),  
0207 234 9740  
A national provider of care and rehabilitation services for people with drug and alcohol problems in the UK in community, prison and residential settings. Also provide residential services where children can stay with their parent(s).

## **RehabOnline**

<http://www.rehab-online.org.uk/>  
Online directory of residential rehabilitation services for adult drug and/or alcohol misusers in England and Wales, run by the NTA. It will give you information about these services, whether you are a member of the public, a professional or a service user.

## **Release**

[www.release.org.uk](http://www.release.org.uk),  
0845 4500 215 (Helpline)  
National charity providing legal services to drug users, including support around housing, debt and welfare problems.

## **Turning Point**

[www.turning-point.co.uk](http://www.turning-point.co.uk),  
0207 481 7600  
020 7481 7600  
A social care organisation working with individuals and their communities across England and Wales in the areas of drug and alcohol misuse, mental health and learning disability.

## **1) Black, Asian, minority ethnic and refugee people**

### **Bro-Sis**

[www.freshwinds.org.uk](http://www.freshwinds.org.uk),  
0121 4156670  
Advice and information, harm reduction information and structured treatment services for people from ethnic minority communities in Birmingham.

### **Ethnic Alcohol Counselling in Hounslow (EACH)**

[www.eachcounselling.org.uk](http://www.eachcounselling.org.uk),  
020 8577 6059  
EACH provides a culturally appropriate counselling and support service to individuals and their families who have been affected by alcohol, drugs and mental health problems in West London.

### **Drug and Alcohol Action Programme**

[www.daap.org.uk](http://www.daap.org.uk)  
A London-based charity, DAAP works with BME communities against addiction and promotes education, community cohesion and service provision. They provide information about alcohol in Polish, Somali, Punjabi, Hindi and Urdu, and information about khat in Somali.



## **Project 8 – Sanctuary Family Support**

toxtethproject@hotmail.com,  
0151 709 8100

An assessment and referral project that supports services in working with BME clients. Acts as a conduit for this group and support them into treatment.

## **2) Lesbian, gay, bisexual and transgender people**

### **Antidote**

[www.thehungerford.org/antidote.asp](http://www.thehungerford.org/antidote.asp), 020 7437 3523

Drugs and alcohol information and support service for LGBT people, based in Soho. Antidote also offers support to organisations working with LGBT clients.

## **Mental health**

### **Key helplines**

#### **beat (beat eating disorders)**

| 0845 634 1414 (for adults)and  
0845 634 7650 (for young people)  
(both helplines open Mon/Weds,  
10.30am-7.30pm; Tues/Thurs/Fri,  
10.30am-6.30pm), [www.b-eat.co.uk](http://www.b-eat.co.uk)

### **Carers Direct**

0808 802 0202 (Monday-Friday,  
9am-8pm; weekends, 11am-4pm)  
Free, confidential information and  
advice for carers.

### **Mind Infoline**

0300 123 3393,  
(Monday-Friday, 9am-6pm),  
[info@mind.org.uk](mailto:info@mind.org.uk)  
Information and advice about mental  
health problems, medication and  
treatment and where to get help

### **No Panic**

0800 138 8889  
(10am-10pm every day),  
[www.nopanic.org.uk](http://www.nopanic.org.uk)  
For people who suffer from panic  
attacks, phobias, obsessive  
compulsive disorders and other  
related anxiety disorders including  
those people who are trying to give  
up tranquillisers

### **Rethink Mental Illness**

#### **Advice Line**

0845 456 0455 (Monday-Friday,  
10am-1pm), [info@rethink.org](mailto:info@rethink.org)  
Provides expert advice and  
information to people with mental  
health problems and those who care  
for them, as well as giving help to  
health professionals, employers and  
staff

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## **Samaritans**

08457 90 90 90 (24-hour helpline),  
jo@samaritans.org  
A listening service for anyone who  
needs to talk or be heard

## **Saneline**

0845 767 8000 (6pm-11pm),  
www.sane.org.uk/what\_we\_do/  
support/helpline  
A national mental health helpline  
providing information and support to  
people with mental health problems  
and those who support them.

## National organisations

### **beat (beat eating disorders)**

www.b-eat.co.uk, 0300 123 3355  
UK's only nationwide organisation  
supporting people affected by eating  
disorders, their family members and  
friends, and campaigning on their  
behalf.

### **Bipolar UK**

www.bipolaruk.org.uk,  
0207 931 6480  
Support and advice for people  
with bipolar disorder (including  
hypomania) and their families and  
friends in England and Wales

## **Carers Trust**

www.carers.org, 0844 800 4361  
Works to improve support, services  
and recognition for anyone living in  
the UK with the challenges of caring,  
unpaid, for a family member or  
friend who is ill, frail, disabled or has  
mental health or addiction problems

## **Emergence**

www.emergenceplus.org.uk,  
admin@emergenceplus.org.uk  
A service user-led organisation  
supporting all people affected  
by personality disorder including  
service users, carers, family and  
friends and professionals.

## **Hafal**

www.hafal.org, 01792 816 600  
The leading organisation in Wales  
working with individuals recovering  
from severe mental health problems  
and their families

## **MIND**

www.mind.org.uk, 020 8519 2122  
A leading organisation working  
in England and Wales providing  
advice and support to empower  
anyone experiencing a mental  
health problem. Also campaigns to  
improve services, raise awareness  
and promote understanding.

### **National Self Harm network**

<http://www.nshn.co.uk/>,  
0800 622 6000

Lead UK charity offering support, advice and advocacy services to people affected by self-harm directly or in a care role

### **No Panic**

[www.nopanic.org.uk](http://www.nopanic.org.uk),  
0800 138 8889

A voluntary charity which helps people who suffer from anxiety-related problems including running a telephone recovery group.

### **Rethink**

[www.rethink.org](http://www.rethink.org), 0300 5000 927

Provide information, advice and support to people affected by mental ill-health. Run mental health services and support groups across England.

### **Samaritans**

[www.samaritans.org](http://www.samaritans.org),  
0208 394 8300

A national charity and the co-ordinating body for the 201 Samaritans branches in the UK, the Republic of Ireland, the Channel Islands and the Isle of Man that provide support to people experiencing emotional distress.

### **Saneline**

[www.sane.org.uk](http://www.sane.org.uk), 0207 375 1002

Practical information, crisis care and emotional support to anybody affected by mental health problems.

### **Together UK**

[www.together-uk.org](http://www.together-uk.org),  
020 7780 7300

Offers a wide variety of support to help people deal with the personal and practical impacts of mental health issues. Services include one-to-one support in the community, supported accommodation, information, advice and advocacy.

### **WISH**

[www.womenatwish.org.uk](http://www.womenatwish.org.uk),  
020 7017 2828

The only national, user-led charity working with women with mental health needs in prison, hospital and the community. It provides independent advocacy, emotional support and practical guidance at all stages of a woman's journey through the Mental Health and Criminal Justice Systems.

# Appendix H

## Children and young people's services

### **Childline**

[www.childline.org.uk](http://www.childline.org.uk), 0800 1111:  
Free 24 hour confidential helpline for children and young people

### **The Hideout**

[www.thehideout.org.uk](http://www.thehideout.org.uk)  
The Hideout is the first national domestic violence website for children and young people. The website has been designed to inform children and young people about domestic violence, help them identify whether it is happening in their home and signpost them to additional support and information.

### **NSPCC**

[www.nspcc.org.uk](http://www.nspcc.org.uk)  
A national charity that works to end cruelty to children. If you're worried about a child's safety or welfare or if you need help or advice, ring the free and confidential helpline (24 hours).

Child Protection Helpline:  
0808 800 5000  
Bengali/Sylheti: 0800 096 7714  
Gujurati: 0800 096 7715  
Hindi: 0800 096 7716  
Punjabi: 0800 096 7717

Urdu: 0800 096 7718  
Asian Helpline Service in English:  
0800 096 7719  
Textphone: 0800 056 0566

### **Reunite**

[www.reunite.org](http://www.reunite.org),  
0116 255 6234 (advice line)  
A national organisation that provides advice, support and information to anyone that has had a child abducted or is in fear of a child being abducted. Assists with international contact issues and legal matters.

### **Runaway Helpline**

[www.runawayhelpline.org](http://www.runawayhelpline.org),  
0808 800 7070  
A freephone helpline for anyone aged 17 or under that has run away or been forced to leave home. Gives confidential advice, makes referrals as appropriate and can help a child or young person to a place of safety. Can also pass a message to family/carers.

## Other

### **Action on Hearing Loss**

0808 808 0123 (Mon-Fri, 9am-5pm), [www.actiononhearingloss.org.uk](http://www.actiononhearingloss.org.uk)  
Information service for deaf and

hard of hearing people, their carers, families and professionals.

### **Citizen's Advice Bureau**

[www.citizensadvice.org.uk](http://www.citizensadvice.org.uk)  
Almost 400 Citizen's Advice Bureaux across England and Wales provide free advice to the general public on a range of issues including welfare benefits, debt, housing and consumer rights.

### **Crisis**

[www.crisis.org.uk](http://www.crisis.org.uk), 0870 011 3335  
Crisis is a national charity that provides services and programmes to empower homeless people. Works with single homeless people.

### **Deaf Blind UK**

0800 132 320 (Mon-Thurs, 9am-5pm; Fri, 9am-4pm),  
[www.deafblind.org.uk](http://www.deafblind.org.uk)  
Information and support, including a befriending service, for people affected by sight and hearing loss.

### **Disability Rights UK**

[www.disabilityrightsuk.org](http://www.disabilityrightsuk.org)  
The leading authority on social security benefits for disabled people, and the website contains regularly updated information about benefits, tax credits and community care.

### **Gingerbread for Lone Parents**

[www.gingerbread.org.uk](http://www.gingerbread.org.uk),  
0800 018 4318 (advice line)  
A national membership organisation providing advice and information for lone parents.

### **Homelessness Link**

[www.homeless.org.uk](http://www.homeless.org.uk),  
0207 960 3010  
Homeless Link is the national membership organisation for frontline homelessness agencies in England.

### **NHS Direct**

[www.nhsdirect.nhs.uk](http://www.nhsdirect.nhs.uk), 0845 46 47  
A 24-hour information and advice over the telephone on any health problem or service. The website has a Mental health section providing advice about what to do if you or someone close to you has a mental health problem

### **NHS Choices**

[www.nhs.uk](http://www.nhs.uk)  
Comprehensive information about NHS services and medical advice

# Appendix H

## **NICE**

[www.nice.org.uk](http://www.nice.org.uk)

NICE, the National Institute for Clinical Excellence, writes guidance for health professionals on a range of issues including PTSD, depression, drug and alcohol treatment and dual diagnosis. Their recommendations are based on careful research to find what works, but they exclude methods that have not been rigorously studied within the health sector. Guidance can be accessed from their website.

## **Relate**

[www.relate.org.uk](http://www.relate.org.uk)

Relate is the largest provider of relationship counselling in England. They have 70 centres across the country. Relate have a clear policy for working with couples affected by domestic violence and will not work with the couple together.

## **RNIB**

0303 123 9999 (Mon-Fri, 8.45am-5.30pm), [www.rnib.org.uk](http://www.rnib.org.uk)

Information and support for anyone with visual impairment and sight problems.

## **Shelter**

[www.shelter.org.uk](http://www.shelter.org.uk), 0808 800 4444

A national organisation providing telephone housing advice and information. Issues include finding accommodation, hostel referrals, housing benefit/rights, illegal eviction, domestic violence and emergency accommodation.

## **National Treatment Agency for Substance Misuse (NTA)**

[www.nta.nhs.uk](http://www.nta.nhs.uk)

An NHS special health authority, working to improve the availability, capacity and effectiveness of drug treatment in England. The NTA provides information and advice about drug treatment to professionals and service users and their families.

## **St Mungos**

[www.mungos.org.uk](http://www.mungos.org.uk)

St Mungos provides accommodation and support to homeless people, mainly in London and across the South of England.

## **Stonewall Housing**

[www.stonewallhousing.org](http://www.stonewallhousing.org),  
0207 359 5767

Provides supported housing, advice and advocacy for the lesbian, gay, bisexual and transgender communities in London.

## **Victim Support**

www.victimsupport.org,  
0845 30 30 900

Offers information and support to victims of crime, whether or not they have reported the crime to the police.

## **B. Local services**

Many of the national organisations listed in section A have local branches or services (for example, Crisis, Mind, Relate, Rethink, St Mungo's, Together UK, Turning Point) or can provide information about services in your area (Rape Crisis, Respect, Women's Aid).

### **There are also two key online search facilities:**

**Helpfinder** | <http://helpfinder.drugscope.org.uk/>  
Helpfinder is DrugScope's database of drug treatment services. It provides contact information and basic service provision details for drug treatment and care services in England, Wales, the Channel Islands and the Isle of Man.

## **HomelessUK**

www.homelessuk.org  
An online search facility with information on over 9,000 services - hostels, day centres and other advice and support services for homeless people and those at risk of homelessness.

Alternatively you can find out about local services and initiatives from various sections of your local authority:

### **Domestic Violence or Violence Against Women**

Co-ordinator  
Most local authority areas have a strategic lead who co-ordinates activities around domestic violence or, more recently violence against women. This may include running the Domestic Violence or Violence Against Women Forum, which is usually attended by a variety of interested parties such as the police, refuge staff and health professionals.

## **MARAC Co-ordinator**

Most areas now have a MARAC (Multi-agency risk assessment conference) that is co-ordinated by someone in the local authority (often in the Community Safety Team) or in the police. The MARAC Co-ordinator can explain how you MARAC works and which agencies are involved.

## **Drug & Alcohol Action Teams (DAATs)**

DAATs are located within councils, and coordinate drug and alcohol service provision in each area. Your local team can provide information on available treatment services, including referral criteria.

## **Safeguarding Boards**

Each local authority has a Local Safeguarding Children's Board and a Safeguarding Adults Board. These Boards oversee activity within the local area to protect, respectively, children and vulnerable adults from harm. You may be able to find out information about local statutory mental health services from the Safeguarding Adults Team with the local authority.

## **Healthwatch**

Local Involvement Networks (LINKs) are gradually being replaced by local Healthwatch organisations to act as an independent consumer champion, gathering and representing the views of the public. You should be able to find out information about local health services from your local Healthwatch. Healthwatch England ([www.healthwatch.co.uk](http://www.healthwatch.co.uk)) holds details for all local groups.

## **Community Voluntary Action Councils**

Usually funded by the local authority and other local statutory agencies, there is a Voluntary Action Council (or a similar body) working in many areas of the country. These groups are run by local groups to support, promote and develop local voluntary and community action. They often hold databases of local voluntary and community groups of all sizes.

## **C. Useful Resources**

### **A literature review on multiple and complex needs**

A comprehensive overview from the Scottish Executive of the available literature on supporting individuals and families affected by multiple



difficulties. <http://tinyurl.com/bpm8463>

### **Bridging To Change, Building Safe Relationships**

Relate guidance on working safely with domestic violence within relationship counselling. <http://tinyurl.com/cwcsu3q>

### **Drug Misuse and Dependence: UK Guidance on Clinical Management**

The Department of Health's guidance on how to assess and manage problematic drug use. <http://tinyurl.com/ccwv2mw>

### **Dual Diagnosis Toolkit: Mental Health and Substance Misuse**

Written by Turning Point, this guidance gives an overview of commonly used substances and mental health problems, along with practical guidance for assessing and managing co-morbid substance use and mental ill-health. <http://tinyurl.com/bwgjgwh>

### **Embracing alcohol, domestic abuse and families – a new approach**

Embrace, a project from Alcohol Concern, worked with alcohol services to improve responses to

domestic violence and encourage workers to 'Think Family'. A range of publications and guidance stemming from the project is available here: <http://tinyurl.com/chlex2d>.

### **Information Sharing: Guidance for Practitioners and Managers**

Full information about how to share information in accordance with relevant legislative frameworks. <http://tinyurl.com/d4nxd5l>

### **Making decisions: A guide for people who work in health and social care**

Guidance from the Office of the Public Guardian on the Mental Capacity Act on how to assess capacity and make decisions in the best interests of individual who lack capacity at a certain time. <http://tinyurl.com/cx43fuf>

### **NICE Guidance on Alcohol Use Disorders**

How to diagnose, assess and manage harmful drinking and alcohol Dependence. <http://tinyurl.com/bwjhvs5>

**No Secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse**

Department of Health guidance on safeguarding adults.  
<http://tinyurl.com/cn5mj5p>

**Protecting adults at risk in London: Good practice resource**

Clear guidance from the Social Care Institute for Excellence on safeguarding adults procedures.  
<http://tinyurl.com/9xvmkle>

**Relational Safety Handbook**

Written originally for staff in psychiatric wards and secure units, this guidance from the Royal College of Psychiatrists may be of interest to workers in any residential setting with adults who may have experienced trauma. <http://tinyurl.com/cydk8g9>

**Responding to domestic abuse: a handbook for health professionals**

The Department of Health's guidance for health professionals on screening for and responding to domestic abuse in clinical practice.  
<http://tinyurl.com/crvyem6>

**Sane Responses: good practice guidance for domestic violence and mental health services**

AVA's toolkit for working with survivors and perpetrators of domestic violence who have mental health problems. <http://tinyurl.com/c6ac52x>

**Stella Project Toolkit: good practice guidance for working with domestic violence, drugs and alcohol**

Produced by AVA (previously the Greater London Domestic Violence Project), this toolkit offers detailed guidance on addressing the overlapping issues of domestic violence and substance use.  
<http://tinyurl.com/bvesbsk>

**“Striking the Balance”**

Practical Guidance on the application of Caldicott Guardian Principles to information sharing in cases of domestic Violence and MARAC referrals. <http://tinyurl.com/cjfyev>

### **The Mind Guide to Crisis Services**

Comprehensive information about statutory services that can be accessed by people experiencing a mental health crisis. <http://tinyurl.com/bm8nn9f>

### **Working together to safeguard children**

Statutory guidance for public services on procedures for protecting children at risk of harm. <http://tinyurl.com/cx7lcz9>

### **Women with complex needs: good practice guidelines and pathways for working with women affected by domestic violence, substance misuse and mental health issues**

Produced by Birmingham Domestic Violence Forum in partnership with local domestic violence, mental health and substance use services. This guidance seeks to support staff in their management of the impact and risks associated with domestic violence, together with their navigation of the specialist provision needed to meet the range and complexity of needs that abuse creates. <http://tinyurl.com/bm3u4ub>

### **Working with Troubled Families: a guide to the evidence and good practice**

Published by the Department for Communities and Local Government, this guide has some clear practical guidance for practitioners supporting families who are multiply disadvantaged. <http://tinyurl.com/d6uskvj>

# Glossary of terms

## **Abstinence**

An approach to drug and alcohol treatment whereby people refrain from the use of any substances, this can even include prescribed medication. Organisations such as Alcoholics and Narcotics Anonymous require abstinence as part of their self-help ethos.

## **Capacity**

Having 'capacity' means being able to make a decision on the basis of relevant information and communicating that decision to others, not necessarily verbally. People can have varying levels of capacity over time, and some people will have the capacity to make some decisions but not others. More information about capacity is on p.129.

**CPA** (Care Programme Approach)  
Approach adopted by mental health services to provide support for people with long term needs for mental health care. A programme can be standard or enhanced (for people with more complex needs) and will include written plans which are reviewed by a named care coordinator.

## **Common Assessment**

### **Framework** (CAF)

Widely used tool for assessing the needs of children at risk of harm. More information on p.124.

### **CPN** (Community Psychiatric Nurse)

CPNs are fully trained staff or charge nurses who have had several years of experience working on psychiatric wards in hospitals. CPNs see people who are living in the community and help with medication, support people through periods of mental ill-health and are an important resource for carers and families.

### **DASH** (Domestic abuse, stalking and harassment)

The DASH (otherwise commonly called the RIC) is a standard risk assessment tool used by the police, children's services and domestic violence services to identify survivors who are at high risk of further violence and abuse.

## **Detention**

Being detained or 'sectioned' means being kept in hospital against your wishes if you are suffering from mental ill-health and pose a risk of harm to yourself or others. Someone

can be detained for assessment and treatment. More information can be found on p.149.

### **Detox**

Detoxification or 'detox' involves stopping using alcohol or substances. Detox can include taking medication to prevent withdrawal symptoms as well as social support. People who want to detox should speak to the GP and/or local drug and alcohol treatment service before stopping as there are potential risks.

### **DTTO/DRR**

Drug Treatment and Testing Orders (DTTO) have been replaced by Drug Rehabilitation Requirements (DRR). This is a community based court order placed on people who are charged with drug related offences. Orders include testing, substitute prescribing (if required), regular drug testing, possible residential rehabilitation and/or attendance at structured day care.

### **Harm minimization/reduction**

Harm minimization is an approach that aims to reduce the adverse health, social and economic consequences of alcohol and other

drugs by minimizing the harms and hazards of drug use for both the community and individual. This approach does not require abstinence.

### **IDVA** (Independent Domestic Violence Advisors)

IDVAs are trained specialists that provide individual advocacy and support to survivors of domestic violence, usually those at highest risk of further harm. IDVAs represent their clients at the multi agency risk assessment conference (MARAC). Contact your council's Community Safety Team for your nearest IDVA service.

### **ISVA** (Independent Sexual Violence Advisors)

ISVAs are victim-focused advocates that work with survivors of recent and historic serious sexual crimes. ISVAs are based in SARC and voluntary sector violence against women services nationally. Contact your council's domestic violence coordinator to find out if there is an ISVA in your area.

### **MAPPA** (Multi-Agency Public Protection Arrangements)

MAPPA refers to the arrangements

put in place to protect the public from serious harm by sexual and violent offenders. They require local criminal justice agencies and other bodies to work in partnership. MAPPA offenders are managed at different levels, with the majority falling under category 1 which requires information sharing but no multi-agency meetings

**MARAC** (Multi Agency Risk Assessment Conference)  
MARACs have been set up in most areas of the country and are usually coordinated by either the local Police Community Safety Unit or Domestic Violence Coordinator. The multi-agency meetings usually meet once a month with the aim of managing the most high risk domestic violence cases. See p.114 for more information.

**Methadone**  
Methadone is a synthetic opiate manufactured for use as a painkiller and is prescribed as a substitute for heroin in the treatment of heroin addiction. It has similar effects to heroin but doesn't deliver the same degree of buzz or high as heroin.

## **Prescribing service**

A prescribing service refers to being prescribed medication (methadone or buprenorphine) as a substitute for heroin. The service is usually run in partnership between a GP surgery and specialist drug service.

**RIC** (Risk identification checklist)  
See DASH

## **Section 136**

Under section 136 of the Mental Health Act 1983, the police have power to remove a person from a public place to a place of safety, e.g. hospital or police station, if they are acting in a way that poses a risk of harm to themselves because of mental ill-health.

**Sectioning**  
See 'detention'

## **Sexual Assault Referral Centres (SARCs)**

There are 24 hour Sexual Assault Referral Centres throughout England, Wales and Scotland, which are specialist centres for people who have been raped or sexually assaulted in the past 12 months. They provide support to recover from the emotional and physical affects of the assault,

including medical care and forensic examination, counselling, psychotherapy, emergency contraception, treatment for STIs and advocacy. For a list of SARCs nationally, see: [www.rapecrisis.org.uk/Referralcentres2.php](http://www.rapecrisis.org.uk/Referralcentres2.php).

### **Shared care**

Shared care is a form of joint working. Drugs workers are (usually) located in GP surgeries and health centres to support GPs and their patients who present asking for help with an opiate dependency e.g. heroin, codeine or over-the-counter opiate painkillers, etc. Shared Care workers work with both GPs and patients to address a patient's dependency through pharmacological and therapeutic interventions

### **DIP (Drug Intervention Programme)**

The DIP is a Government funded crime reduction initiative. DIP workers support their clients through the criminal justice process – from being arrested and testing positive for drug use at the police, through to court. DIP workers encourage people who use drugs and commit crime into treatment.

### **Structured day programme**

Day programmes are common within drug and alcohol treatment services and offer structured non-residential support that usually last for 12 or more weeks and runs Monday to Friday. Day Programmes are a good way for someone to address drug and alcohol issues and still maintain other areas of their life like relationships with their children, education and even paid employment. Service users who are engaged in a day programme have the opportunity to develop new skills, to learn alongside peers through group work and social activities, build new support networks and increase individual confidence level.

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