

## **‘the personal & public cost of domestic violence’ Conference**

**21st November 2013, Maritime Hotel, Bantry**

**Dr. Kylee Trevillion, Institute of Psychiatry, London**

I'd just like to say thank you very much for inviting me to speak today, it's so great to be part of such an important conference, and in such a beautiful setting, I'm not used to seeing such lovely views. It's a real honour to be able to speak to you today and I'm just going to talk about the work that we've been doing in the section of women's mental health at the Institute, looking specifically about the relationship between domestic violence and mental health and the response of mental health services.

Before I start I want to say that most of my slides will be centring on women and women's experiences but I do acknowledge that men can also experience domestic violence but we know that women are more likely to have these experiences and women incur more substantial harms.

We know that people experiencing domestic violence often incur a range of acute and chronic physical and psychological injuries and this can have a result on their health service use. We know that people who are experiencing domestic violence have increased use of health services and they are at greater risk of hospitalisation, particularly for women, they're around three times more likely of a risk for psychiatric hospitalisation. And Nata made reference to Sylvia Walby's work earlier this morning, but the last quantification of the economic cost of domestic violence in England and Wales suggested that it exceeds 1700,000,000 per year for direct medical and mental health care costs.

I'm not going to go into too much detail about the figures themselves but just to show that when you look at the prevalence of domestic violence among health care service users, you can see that there's quite a high proportion of women accessing obstetric and gynaecology services and accident & emergency services who report lifetime experiences of domestic violence. One of our first reviews that we looked at was to try and estimate the prevalence of domestic violence among mental health service users and we found from the data that was out there that these service users report similar if not slightly elevated levels of lifetime abuse compared to the general population.

We then wanted to look in more detail about the relationship between all the different types of mental disorders and domestic violence. So we found that looking across the full diagnostic spectrum for both men and women, there's a high prevalence and increased likelihood of experiencing domestic violence compared to people that don't have a mental disorder. So I've just presented some of the top figures for the data that we've got most information for ([Insert link here to Kylee's Powerpoint Presentation](#)). Depression and anxiety because of the close links with violence have been most researched in this area. And we find women with depression are around 3 times more likely to have

experienced domestic violence in the previous year compared to women without a mental disorder. Those with anxiety are twice as likely to have experienced domestic violence in the past year than women without a mental disorder. Looking at the data for lifetime prevalence of violence, because there wasn't enough data to calculate past year prevalence, we can see that women who have PTSD are over 6 times more likely to experience violence within their lifetime.

We tried to look more closely at the specific relationship and pathways between domestic violence and mental health problems. What we can see from the data is that it's likely to be a bi-directional relationship. So quite understandably, as Annie alluded to, people who experience domestic violence may go on to develop chronic enduring mental health problems but also, people that have chronic mental health problems may be more vulnerable to violence and abuse.

Because we found such a lot of data in this area we were able to do some smaller analysis of specific types of disorders. We found that for men and women with eating disorders they report a high prevalence of lifetime domestic violence. This was quite an interesting paper because a lot of the data around eating disorders within the psychiatrist literature is very much from childhood violence because of when the disorders tend to manifest.

We also looked at violence in pregnancy and found that women who are experiencing violence in pregnancy are around two and a half times more likely to develop post-natal depression than women who are not abused.

So looking at some of the attitudes and behaviours of service users and professionals in the health care setting, we know that people who are experiencing abuse are more frequent attenders of health care services. They report, quite interestingly, a greater willingness to disclose to health professionals than to the police. So health professionals are a very critical point in helping early identification of these experiences. Service users talk quite readily, and this has been looked at across different health service settings, about the importance of staff asking them about domestic violence in helping to start that conversation and facilitating disclosures.

There hasn't been much data done on this but there was a small study done in the UK and one in New Zealand looking at access to mainstream domestic violence services for women who have chronic and severe mental health problems. They found that some of these women can find it very difficult to get access to the services and for the services there is difficulty in having the resources to support these women.

With regards to health professional responses, we looked at the evidence across the globe to see how mental health services currently identify and respond to domestic violence. Sadly it wasn't a great picture. We found that at the moment only between 10 - 30 % of cases are currently picked up by mental health services. There's limited enquiry about domestic violence in current practice, and I don't know if it's a similar picture here, but in 2008 they implemented routine enquiry about history of violence within psychiatric

assessments. But some of the anecdotal evidence when they implemented these things in the States and in New Zealand found that staff, some staff consistently overlooked those questions.

Looking at the experiences of service users, they talk about how when they do disclose to professionals they often feel that the response from the mental services isn't adequate.

So the research that we did within our department, in the area where we work is an inner-city population in London. We wanted to explore the experiences of service users and professionals in addressing domestic violence. So we interviewed 24 mental health service-users, men and women with a range of different mental health diagnoses, it's a qualitative data set so it's not aimed to be representative, but we also interviewed some people who hadn't experienced domestic violence to see what their views were about being asked by staff about experiences of abuse, to see what the acceptability of that is.

We also interviewed 25 professionals across a range of different disciplines, psychiatry, psychology, social work & nursing, to see what their experiences have been of asking about violence and how they respond to disclosures.

Some of the main themes that we found... I'm not going to go into too much detail here but this is just to show you (visually), with regards to looking at barriers and facilitators to disclosure, we found that service users reported considerably more barriers than facilitators to disclosure of domestic violence, with only 3 interviewees who felt they were able to initiate a disclosure without being asked or explored these issues with staff.

The main barriers for service users were to do with the fear of the consequences of the disclosure, so a fear of how that disclosure will be taken and protected, and a fear that that might get back to an abuser and they might suffer further violence. There were also concerns about disruption for family, if they had to up and relocate to another area, the impact that might have on schooling, social networks. A big concern was a fear of social services involvement, and a concern that their parenting capabilities would be called into question because of their mental health problems. They also spoke about the hidden nature of domestic violence and how the sort of subtle coercive behaviours often make it difficult to identify really what's going on. This also arises in the context of when professionals are meeting... about really identifying some of these subtle behaviours.

Again, looking at professionals with their experience of enquiry we can see they report more barriers than facilitators. Staff, largely what they talked about is a lack of knowledge and expertise in this area. A lot of people mentioned that they hadn't received any training about violence and abuse issues in their undergraduate training or post graduate training. They also felt unsure about how to appropriately ask and then what they would do with the disclosure. They talked about not knowing about local and national services, being unclear about referral pathways.

They also spoke about some of the demands in their practice, such as having sufficient time

within initial assessments to explore these issues, and other time constraints. They made reference to fear of consequences as well but in a different context, thinking about their concerns around the fear of offending service users with this enquiry and particularly those that hadn't experienced abuse. But what we found from the service users is that they felt these were really important issues and that there was a need for staff to make an identification about the link between violence and its impact on mental health. So this is something that doesn't seem to be a case for service users.

Then, we looked at the responses of services and how they can support people. Service users spoke about the need for staff to really acknowledge what was happening, to start discussions about the abuse and to be receptive to their disclosures. Both staff and service users in both these areas talked about the dominance of the medical model, and this is the overriding focus on identifying and treating symptoms and doesn't facilitate discussion or exploration of the impact and the things that are going on in people's lives that are contributing to their presentation and to really making those links.

Some service users talked about either perceived or actual discrimination with services, so a fear that their disclosures wouldn't be believed and that they'd be perceived as a manifestation of their illness. And this was the case for some people when they disclosed to staff.

They wanted to know about their options and that was something that they felt that staff just weren't giving them. Then when talking about what would be the routes of referral and follow up support they explained that staff often, although they might mention possible services that they could use and things that they could do, it didn't always follow through that they would receive those. So they wanted greater support in engaging with those services.

Staff talked about the need within mental health services to have greater awareness at an organisational level about issues of violence and abuse and the impact that it has. They felt that it was important to have regular assessment and management of violence, so having key indicators to look at these issues would be of help, to know how to enquire about it and to manage disclosures sensitively.

I found quite interesting, that some of the staff when looking at the differences in reporting requirements, contrasted the child safe-guarding procedures as being very clear, knowing what the responses are, having clear referral pathways and that works in quite direct contrast to adult safe guarding issues where it wasn't clear about what pathways there were or how best to support people. Staff felt that they didn't really have much knowledge of services and they spoke again like service users of the need for continuity of care and making sure that they are supporting people through getting access to specialist services.

So we did some follow-up research by looking at a survey of staff mental health professionals' knowledge, attitudes and behaviours towards domestic violence. We

interviewed 71 psychiatric nurses and 81 psychiatrists. What we found from their practice is, that only 15% routinely ask service users about experiences of domestic violence, 27% didn't feel that they had adequate referral sources or sources of information to pass on to service users. And interestingly, we found that although psychiatrists reported better knowledge about the nature and impact of abuse they didn't feel that they were as ready as nurses to address and manage these issues. So what we infer from this is that when you think about education and training for staff it needs to focus not just on educating people around the nature and impact of abuse but also giving them skills and training about how to ask appropriately and how to manage in a sensitive way, and help to engage people with the right sources. And something that Nata referred to, which I'll come on to soon, is about having a clear referral pathway for people to engage with services.

So based on what we identified from our survey, research and interviews, we developed a small pilot intervention study within the community mental health care teams in our service. We had three teams that received the interventions and two that acted as the comparison condition. The aim of the project was to try and provide training and education to mental health professionals and domestic violence workers to improve their knowledge and confidence in supporting people who experience abuse and have severe mental health problems, and to develop a clear explicit referral pathway to domestic violence advocacy. In the UK, we have independent domestic violence advisors, people that are working in voluntary or third sector organisations, quite often within domestic violence services and this is a system where they have a Home Office accredited training scheme in advocacy. I'll come on to the details of it in a moment but it's about providing practical and emotional support, it's not counselling based but general emotional support and guidance.

So just to give you an idea of how the pilot worked, we seconded two of the independent domestic violence advisors within the local community to become more integrated within the community mental health team. What was interesting is these services had been existing in the same borough for quite a number of years but they hadn't had many links before, in practice. So, if there'd been referrals made there was never any follow up or communication between the two. We had the DV advisors have regular attendance within the teams. They attended staff team meetings, reviewing cases, being there to provide education. And as the intervention continued they ended up doing bi-monthly forums for staff, based around their needs on domestic violence related issues such as honour crime, housing, immigration support, court engagements and generally, helping to really educate staff around these issues. What we hoped that this system would do, would help to inform a reciprocal education between the two services but also lead to increased referrals to the domestic violence agency where the advisors worked.

Part of the intervention was also to train up staff and improve their skills. So at the beginning of the study, which ran over a 2 year period, we had a clinical psychologist who

specialises in domestic violence come and train the staff on how to ask about domestic violence, giving them key prompts, showing them how to document disclosures properly and then we talked them through the clear referral pathway to the advisors. So the staff had a direct mobile contact phone number for both advisors and they would answer those calls within 24 hours. The idea was even if they weren't sure, or if they just wanted to discuss some of those issues, they could get in contact with the advisors.

We also developed a toolkit which had training materials for staff but also a list of local and national organisations in England, key prompts for enquiry, reminding people about how to document properly, and print outs of the referral pathways. And we encouraged staff to put them up in their office space so they could see the referral pathway there.

With regards to what the domestic violence advisors did, the service users that were in the teams receiving the interventions were offered the opportunity to be referred to the advisors and 22 of the 27 service users that we recruited for the study elected to receive support from them. They help service users with risk assessment and planning; so coming back to the MARACs that we referred to earlier, there's an organisation called the 'Coordinated Action Against Domestic Abuse' in the UK and they developed a risk assessment checklist which the advisors complete, it's a way of quantifying the level of risk for women and depending on the score that they get they might be referred to the multi-agency risk assessment conference (MARAC).

What we found from the study is that in the two years before the intervention started, the mental health team had only made two referrals to MARACs in that two year period and by the time this intervention had finished, with the support of the service users there'd been seven referrals. So we know that was making an impact on their practice. They also support people with housing and resettlement and can support people through court proceedings. And they help to just engage them with survivor groups, women's groups and give general education.

So, I'm not going to talk in too much detail, but just from the research perspective what we looked at was to see whether staff knowledge, attitudes and behaviours towards domestic violence changed before and after the intervention. We found that staff reported significant improvements in their knowledge and attitudes and their behaviours in addressing these issues. They felt confident to ask these issues and they knew of clear referral pathways and were actively using them. We had an increase in the number of referrals that were made. For the service users, we looked at improvements for them and we found that those receiving the intervention had a significant reduction in the frequency and severity of violence that they experienced. They reported significant reductions in the level of unmet needs and that's around social, housing and emotional needs. And they reported greater social inclusion.

Because of the small numbers we weren't able to do a direct comparison with the control groups but what we did find by looking at the data from each group was no significant

reductions or changes for those that didn't receive the intervention.

We also did a small costing of this intervention to see what the economic impact of it would be. Unlike Nata, I don't understand the economics of it, so I'm not going to present any of the data in detail but if anyone wants to look in more detail they can read the paper. We found that it was only a small additional cost to have the advocacy intervention running within the teams, and when we looked at service use between those that were receiving the intervention and those that weren't, they were pretty much parallel through the intervention. So we can see that it doesn't seem to lead to a huge amount of additional resources and actually with quite a significant reduction in their needs it would suggest that over the longer-term the initial increase in costs, the minimal costs, would outweigh the continued use of services and need for engagement and support.

Just in summary, what we can see from the data is that mental health services across the globe aren't currently conducive to supporting disclosures, and supporting people who have experienced domestic violence. Staff need to have better education and training. Since we've implemented this study my boss has been sitting on the Department of Health Violence Against Women group and they've managed to implement undergraduate training on domestic violence and violence against women in general within psychiatric training programmes for nurses and doctors. So we see this as being a small step but it's a beginning.

We know that by having clear referral pathways and educating staff about knowing what services are out there and that specialist support has an impact on the support that is offered to service users. Ours is a small study but it might suggest that domestic violence advocacy support is a way of helping to reduce abuse and improve quality of life for people experiencing violence.

Finally just to say that I think we need to have greater collaboration between the two sectors in supporting the needs of service users so they don't end up falling between the gaps. Thank you.