Domestic violence and women's mental health – what do we know, and where are we going?

DR SIAN ORAM

KING'S COLLEGE LONDON

Definitions of domestic violence are often gender neutral…

…but experiences are not.

Defining domestic violence

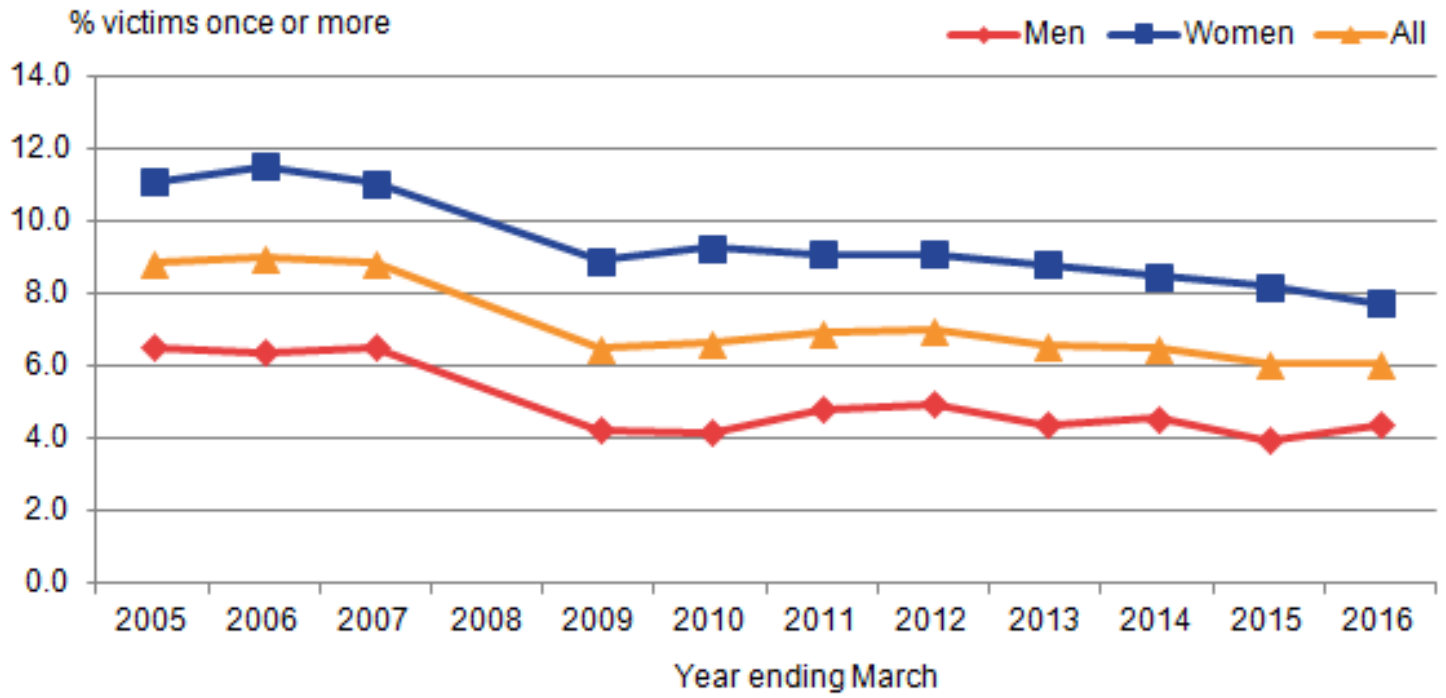
UK Home Office - “Any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between those aged 16 years or over who are, or have been, intimate partners or family members, regardless of gender or sexuality”

An act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten

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.

Prevalence in general population

Past year domestic abuse among adults aged 16-59 in England & Wales



(Office for National Statistics 2016)

The gendered experience of domestic violence

- Lifetime prevalence of isolated acts of domestic violence comparable for men and women

- Women are at greater risk of **repeated, coercive, sexual, or severe physical assault**

(Adapted from Duluth)

The gendered experience of domestic violence

Scale

- Average of 227,000 female victims and 79,000 male victims per year
- Women are 74% of victims of domestic violent crime; 82% of domestic violent crimes are against women.

Frequency

- 80% of high frequency victims (>10 crimes per year) are women
- 48% of domestic violent crime is reported by 4.5% of victims; these victims are women.

Severity

- 77% victims reporting injurious domestic violent crime are women; 91% of injurious domestic violent crimes are against women

(Walby & Towers, 2018, Criminology & Criminal Justice)

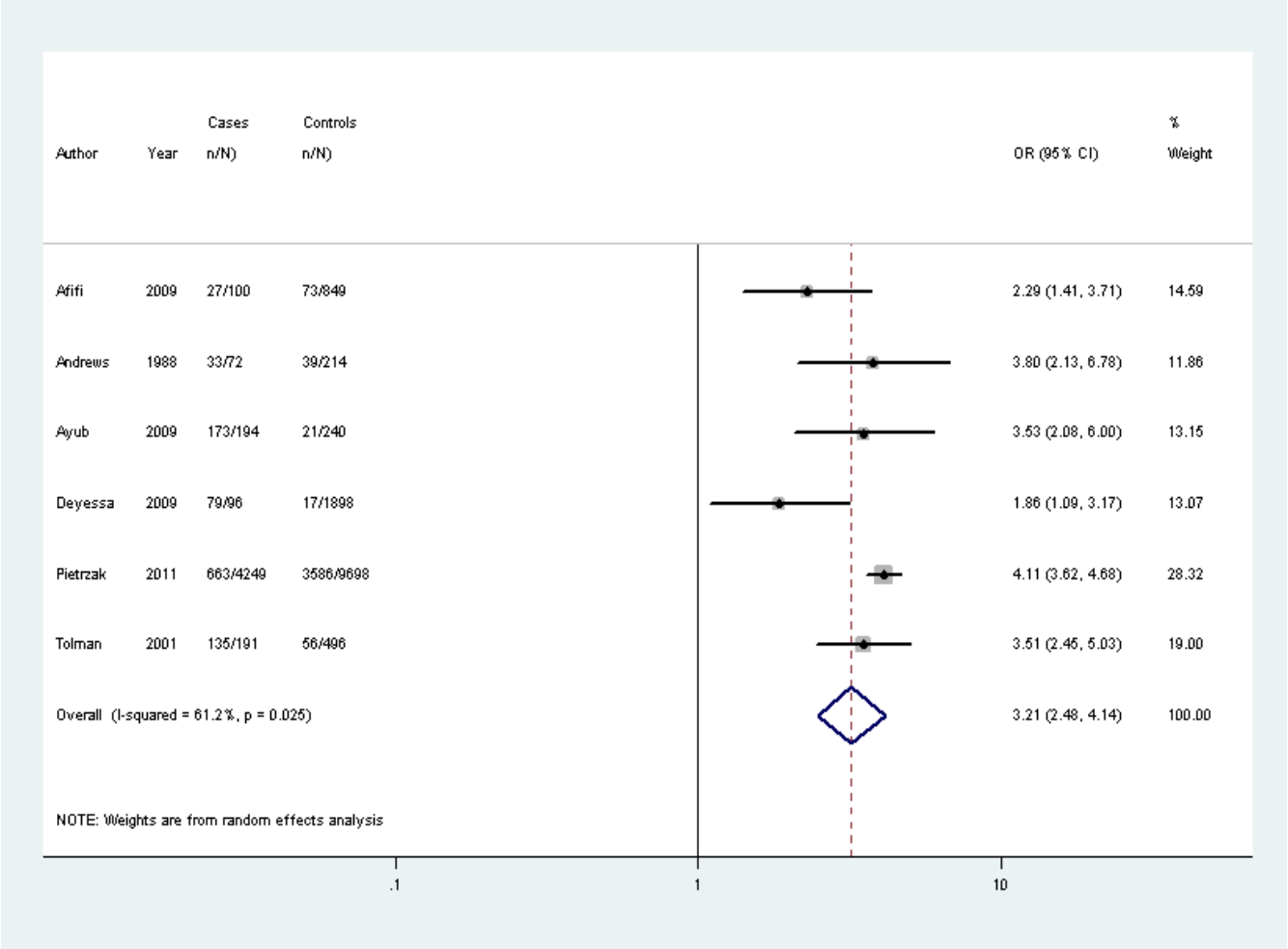
There is a two-way link between domestic violence and mental health problems…

A causal link?

Some points to consider:

- **Strength of association**
- **Temporality** – does the exposure occur before the outcome?
- **Dose-response** – is there a gradient of risk associated with the degree of exposure?
- **Biological plausibility** – the existence of a known or postulated mechanism by which the exposure alters the risk of developing the outcome
- **Consistency** – is the association found using different methods and in different settings?
- **Reversibility**

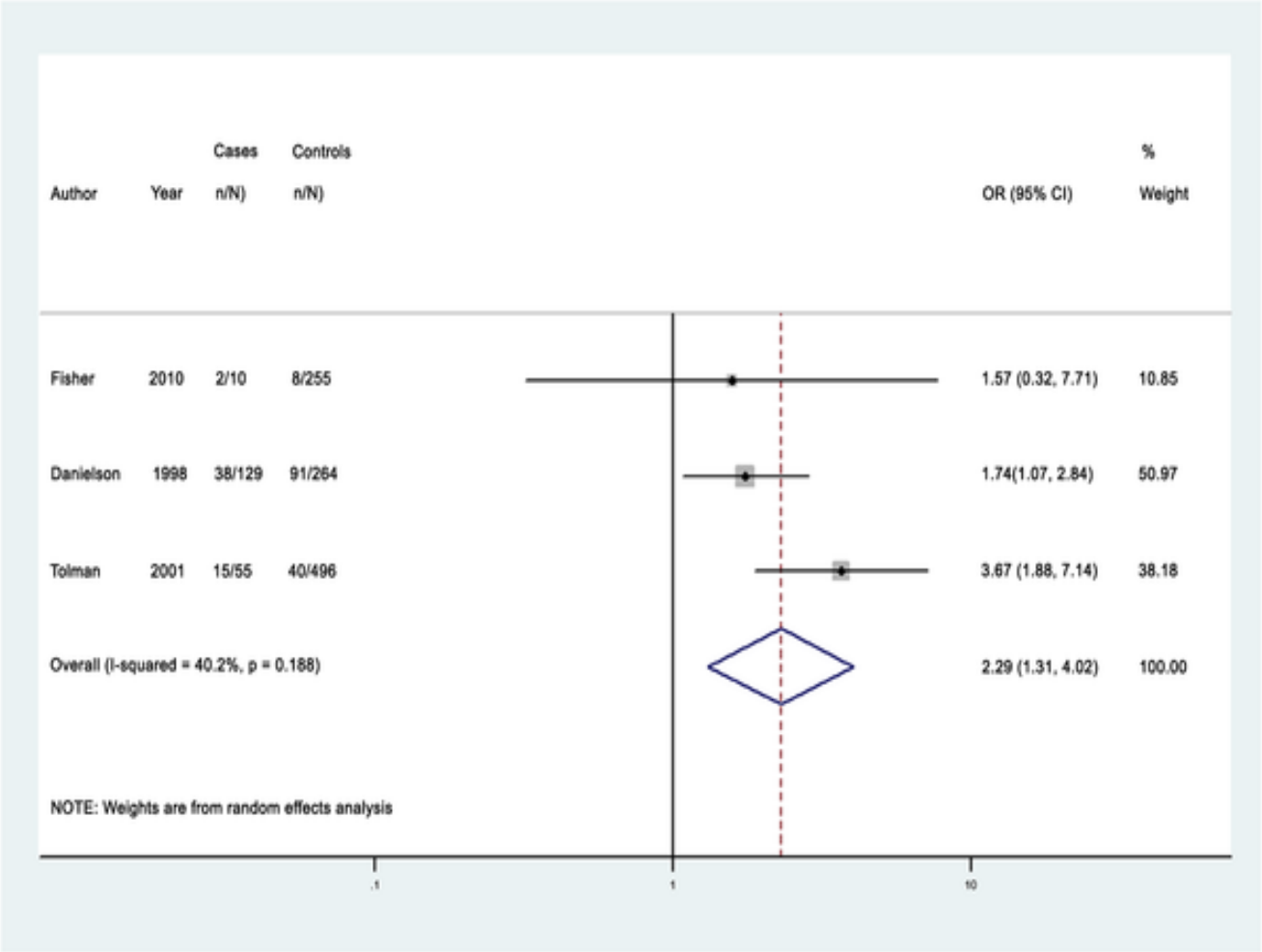
Past year IPV and diagnosed depressive disorders in women



OR 3.21
(95% CI 2.49-4.14)

(*Trevillion, et al. 2012)*

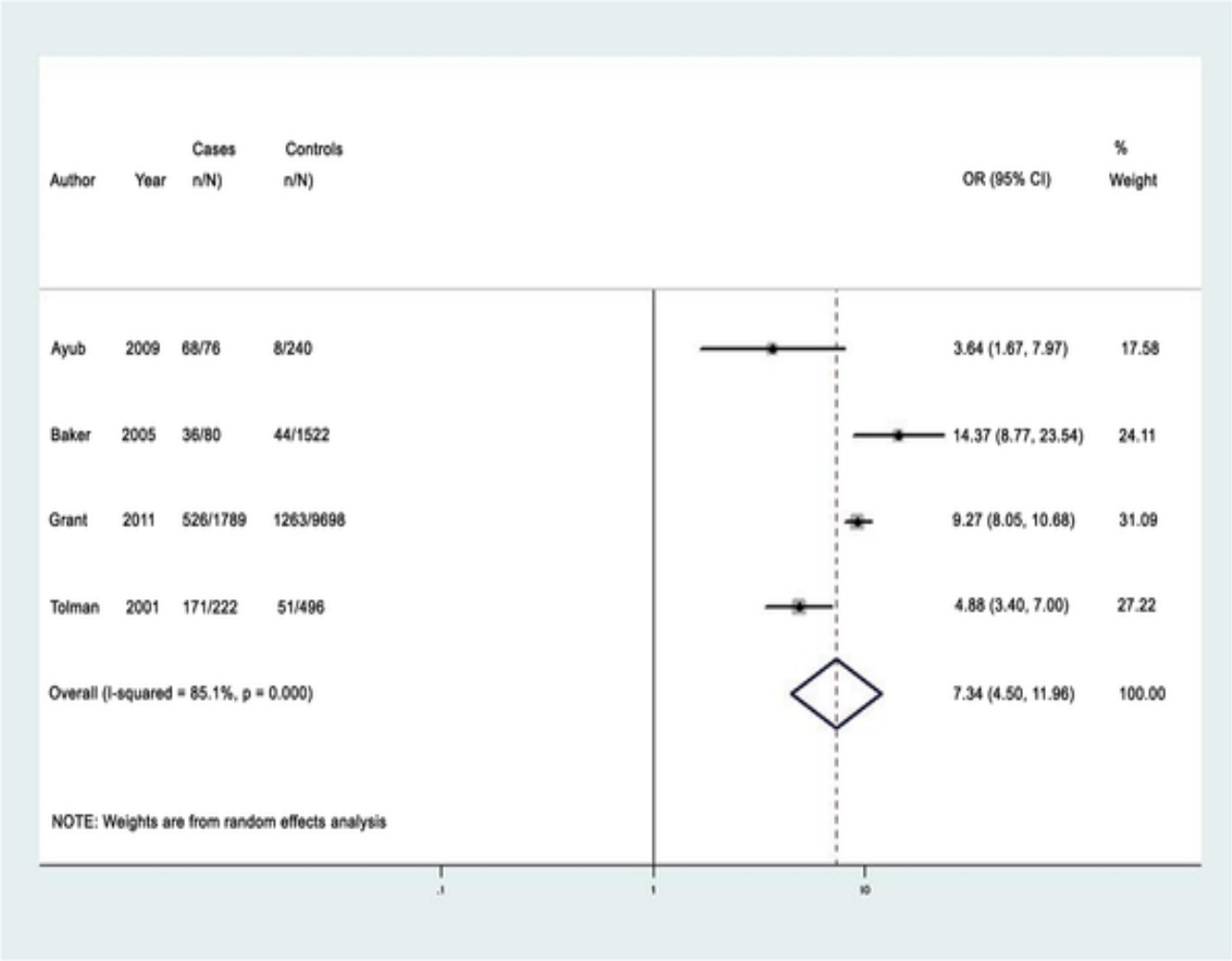
Past year IPV and diagnosed anxiety disorders in women



OR 2.29
(95% CI 1.31-4.02)

(*Trevillion, et al. 2012)*

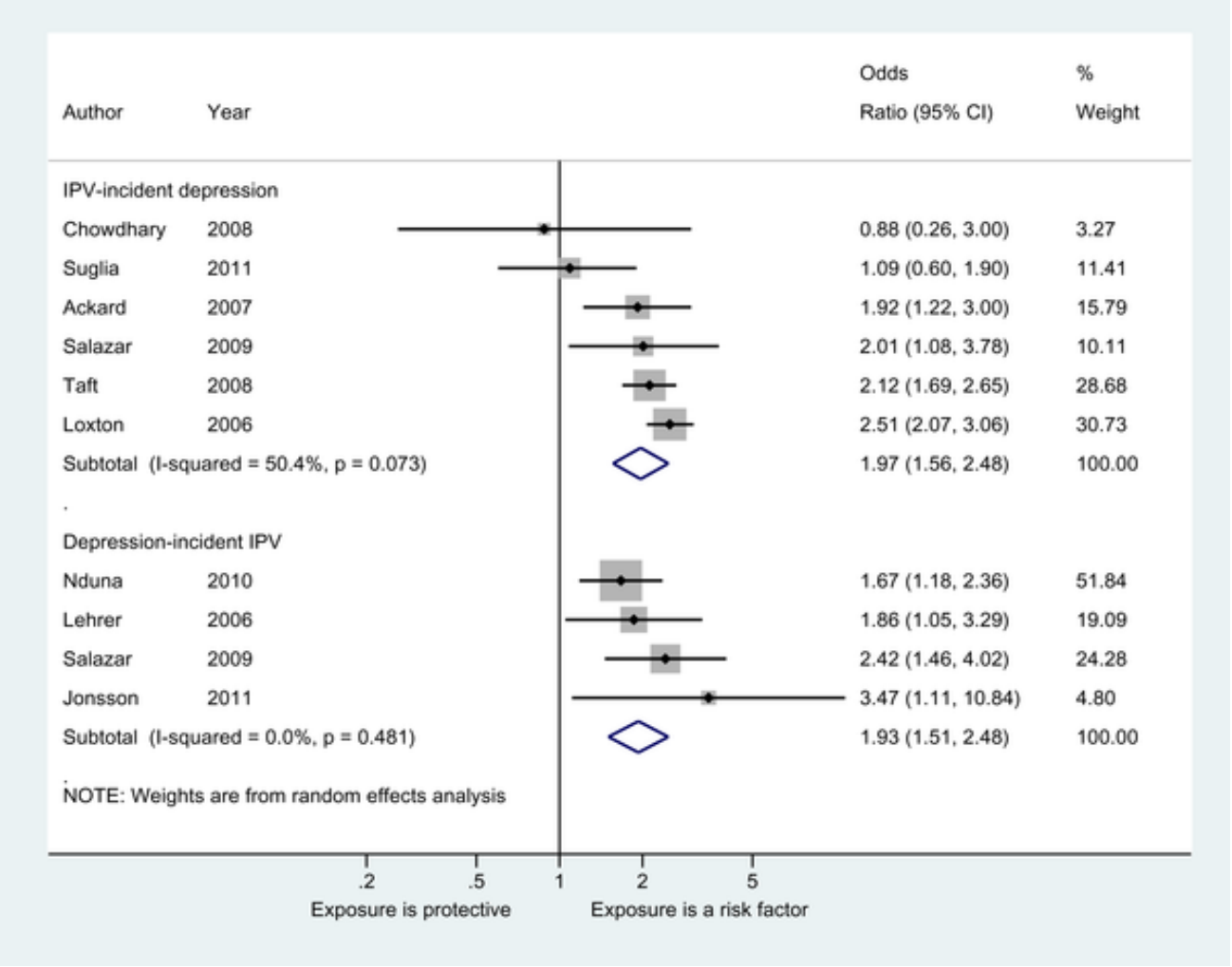
Lifetime IPV and diagnosed PTSD in women



OR 7.34
(95% CI 4.50-11.96)

(*Trevillion, et al. 2012)*

Temporality



IPV → Depression

OR 1.97
(95% CI 1.56-2.48)

Depression → IPV

OR 1.93
(95% CI 1.51-2.48)

Devries et al 2013

Other considerations

- Dose-response - severity of abuse associated with severity of symptoms
- Reversibility - symptoms decrease when abuse stops
- Consistency – similar findings across range of diagnoses, across various country settings, and using different methodologies.

(Golding 1999)

Prevalence of domestic violence is particularly high among mental health service users…

…but service responses are lacking

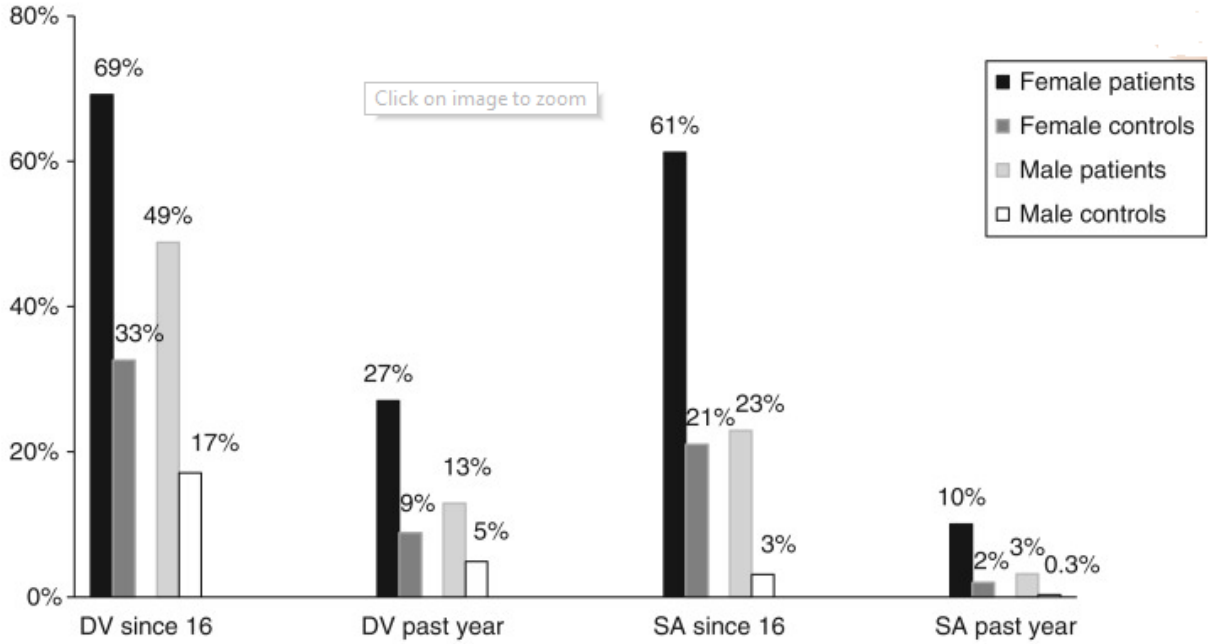
Findings from the Mental Health & Justice survey

Female patients

- Past year DV – 27%
- Past year sexual violence – 10%
- Attempted suicide after serious sexual assault – 53%

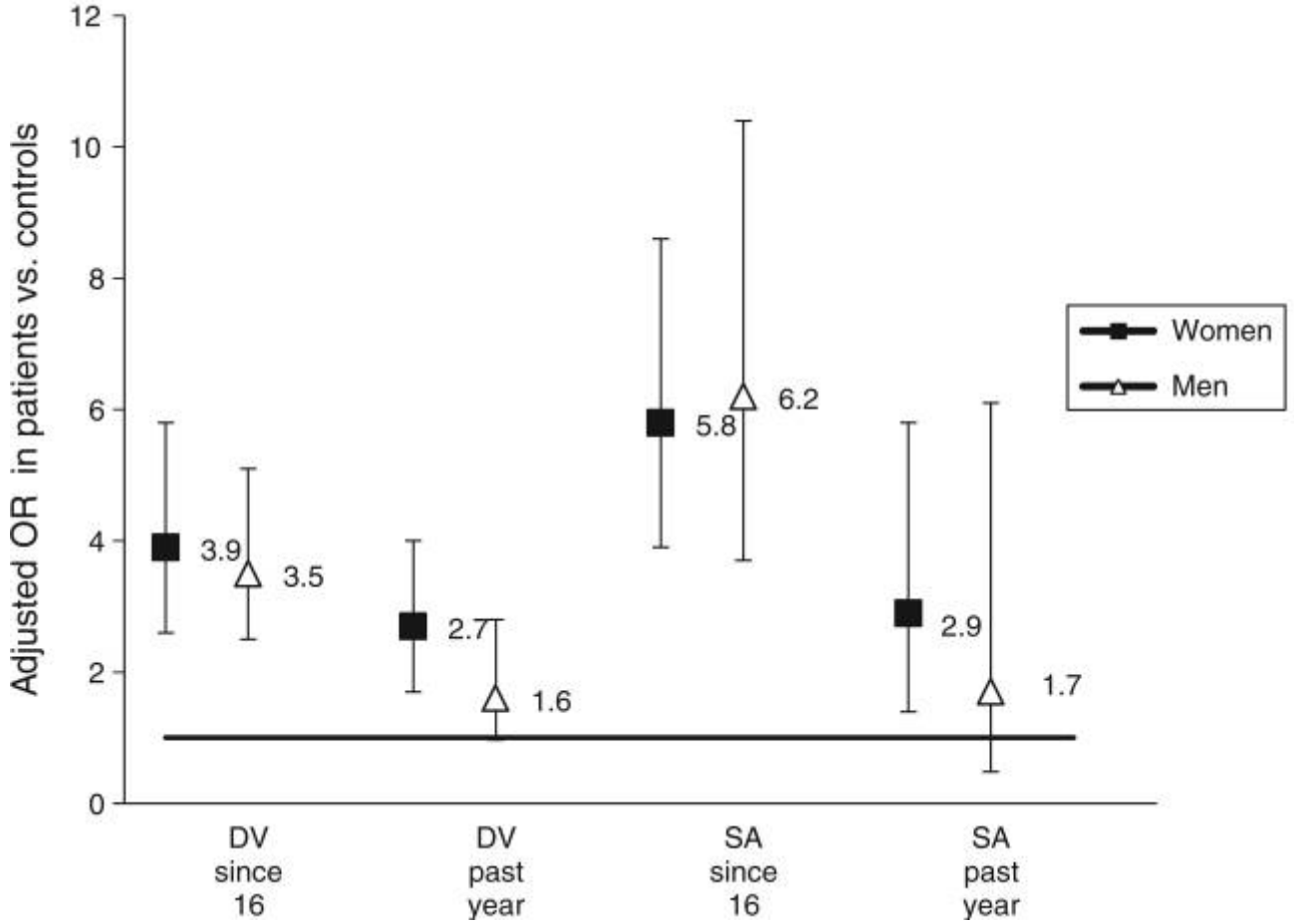
All patients

- Family violence comprised greater proportion of DVA vs. general population (63% vs 35%)



(Khalifeh 2015)

Findings from the Mental Health & Justice survey



(Khalifeh 2015)

Suicide attempts following domestic or sexual violence

	M patients		F patients	
	N	%	N	%
Suicide attempt following:				
Any domestic or sexual violence	91	23.1	106	37.7
Partner violence	56	21.4	73	31.5
Family violence	54	13.0	53	26.4
Sexual violence	32	21.9	74	36.5

(Khalifeh et al 2015)

Barriers to effective responses

Review of rates of DV identification:

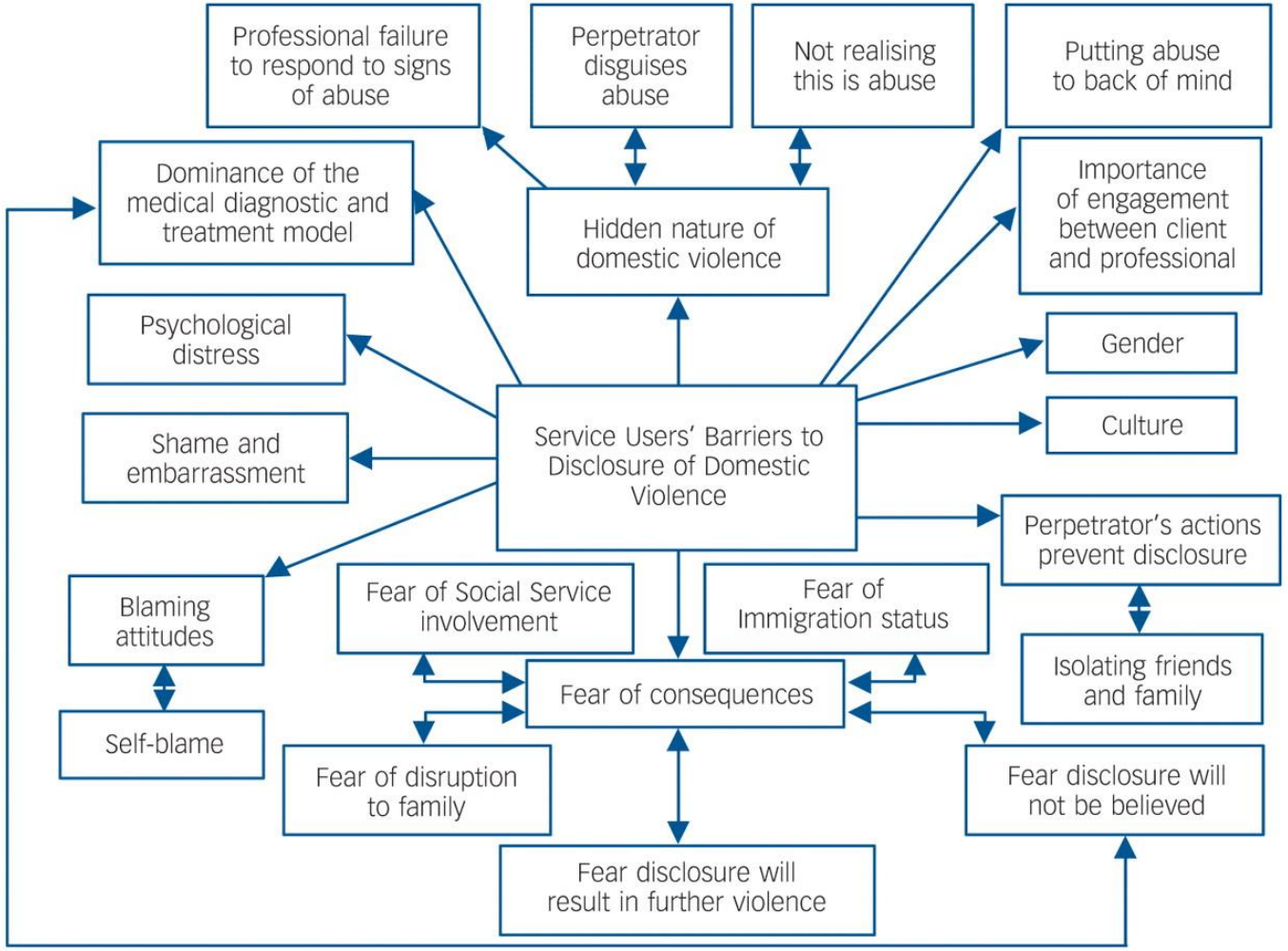
- Low detection rates by mental health professionals (10%-30%)
- Cross-sectional survey of staff in London Mental Health Trust:
  - 15% routinely asked all clients
  - 60% lacked knowledge of support services
  - 27% services lacked referral resources

Survey of domestic violence services:

- National UK survey of 216 refuges found that only 19% of services were able to offer refuge to women with mental health needs
- NZ study of 39 Women's Refuges found high numbers of women denied access because of mental health/substance use problems

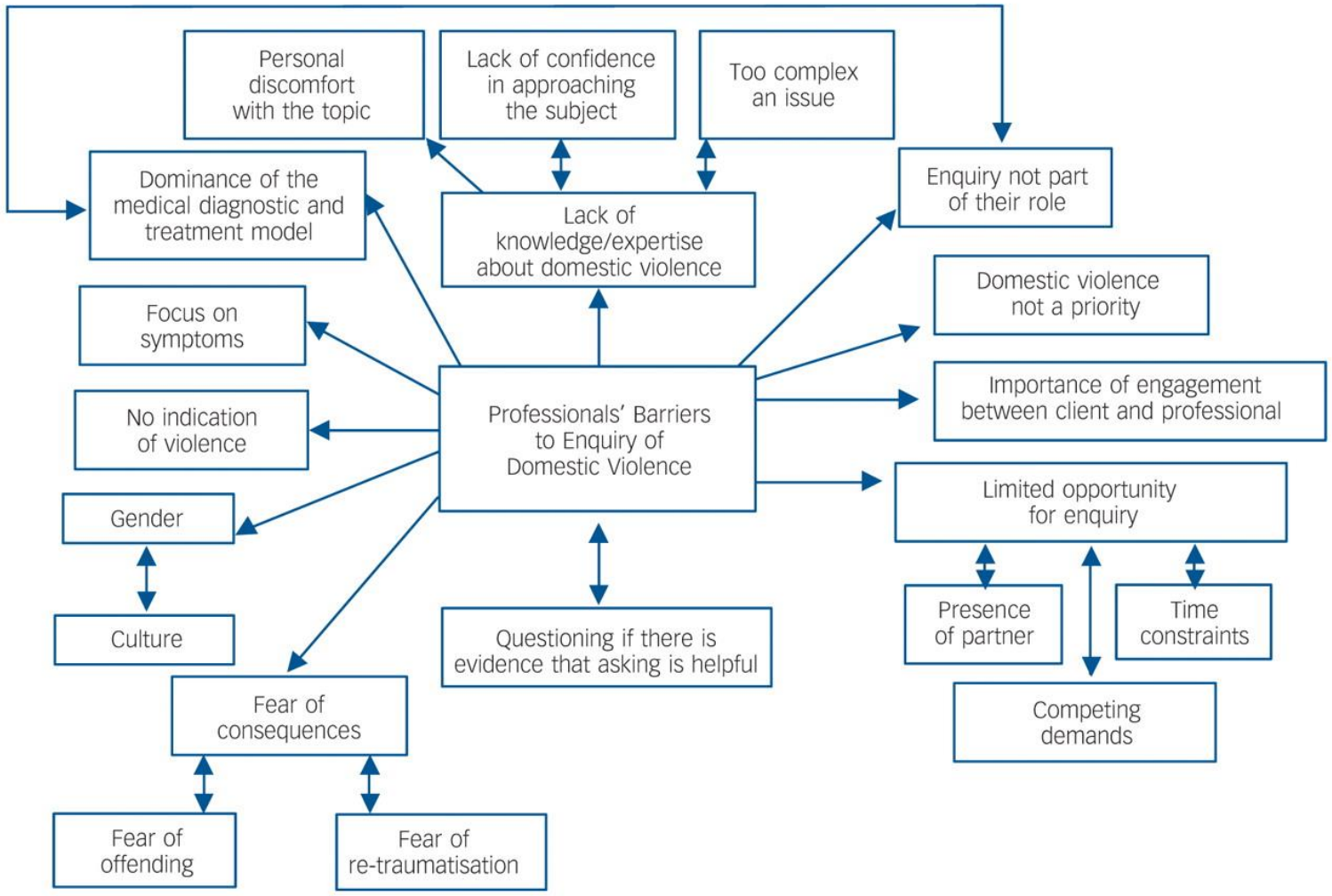
(Nyame 2013; Howard et al 2010; Hager et al 2006; Barron et al 2004)

Barriers to help-seeking



(Rose 2011)

Barriers to identification



(Rose 2011)

Understanding how to improve outcomes is a work in progress…

How should mental health services respond?

- Information in toilets/waiting areas and consulting rooms
- Referral to refuges (some have mental health support workers)
- Initial findings suggest promise for brief interventions, offering info on DV (incl effects) and focusing on:
  - IPV dynamics and safety concerns;
  - Cognitive reframing and skill enhancement;
  - Cultural competence;
  - Social connection; and
  - Individualisation (tailored to individual needs)

(Warshaw, Sullivan, Rivera 2013; Feder et al, 2009; Howard et al, 2010)

How should mental health services respond?

- Psychosocial interventions in perinatal period can reduce DV
- Limited evidence but CBT effective in improving symptoms and self esteem in women who have left abusive relationships
- Domestic violence advocacy for women in community primary care settings:

  ↑ quality of life, safety behaviours and ↓ abuse

- Initial findings suggest advocacy may also be effective in psychiatric settings

(Warshaw, Sullivan, Rivera 2013; Kiely 2010; Feder et al, 2009)

What are “advocacy” interventions?

- Based around models of empowerment,
- Advocates aim to help their clients to understand and make sense of their situations, to achieve goals that they have set, and discuss potential solutions to challenges.
- Common advocacy activities include
  - providing legal, financial, and housing advice;
  - assisting service users to access community resources and interventions;
  - providing ongoing support and informal counselling.
- Cochrane concluded that intensive advocacy (>12 hours) improved everyday life and reduced physical violence for women in domestic violence shelters.

(Rivas 2015).

LARA: A pilot study of integrated domestic violence advocacy

Study:

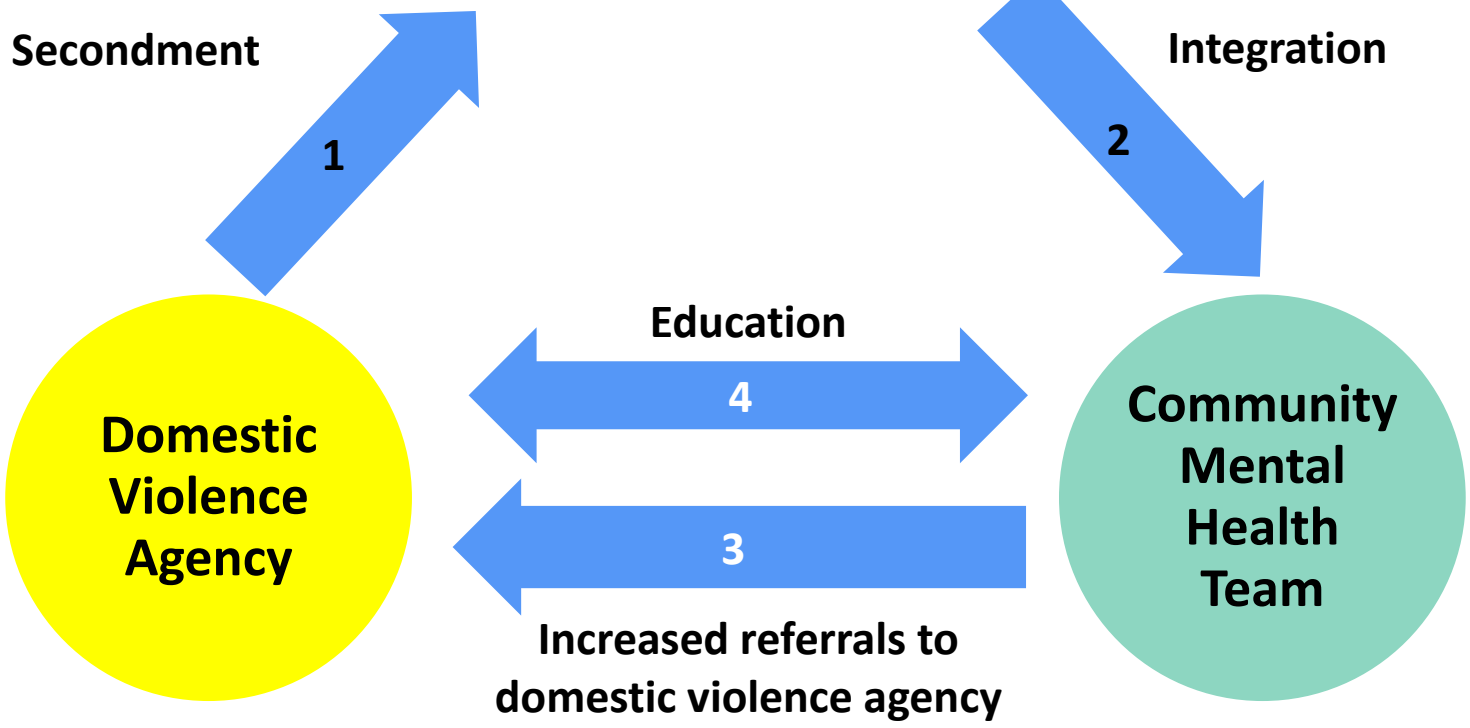
Pilot intervention: domestic violence advocacy for community mental health teams (CMHTs)

Aims:

- Provide training and education to improve knowledge and confidence in responding to needs of service users with DV
- Develop an explicit referral pathway to domestic violence advocacy intervention, via named domestic violence advisors

(Trevillion et al 2014)

LARA Domestic Violence Advisors



(Trevillion et al 2014)

Education and training for clinicians

5 CMHTs in study: 2 control teams (treatment as usual) / 3 intervention teams.

Intervention teams received training and education, including:

- Four hours didactic teaching, experiential exercises
- Domestic Violence Aware toolkit (e.g. strategies for identification and documentation of abuse, details of support services)
- Bi-monthly domestic violence forums - delivered by LARA advisors
- Project advertisements in CMHTs to raise awareness of domestic violence

(Trevillion et al 2014)

Domestic Violence Advocacy for Service Users

7 service users in control teams (treatment as usual) / 27 service users in intervention teams

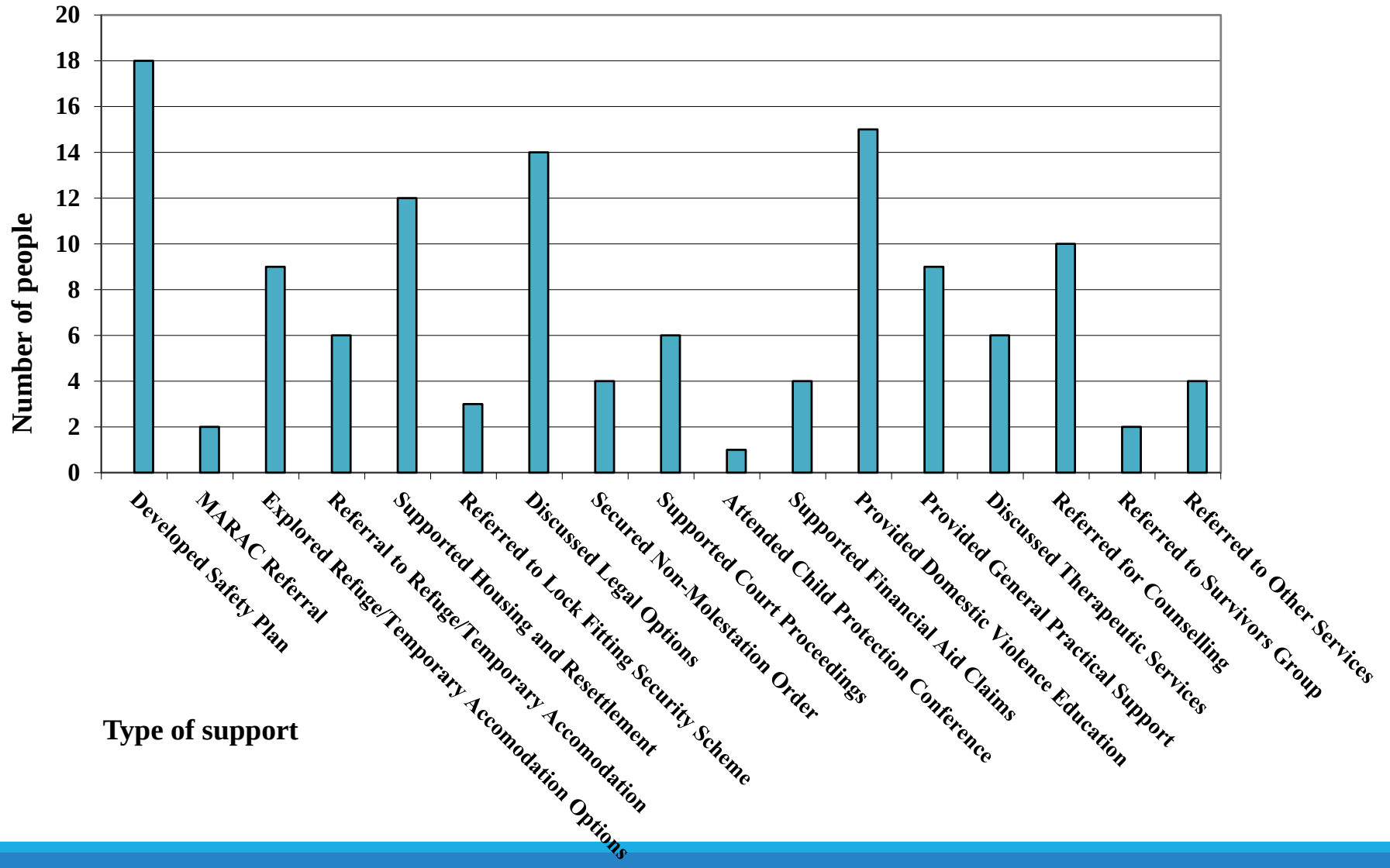
22 of 27 service users in intervention team elected to receive support from trained advisors, including:

- Risk assessment and safety planning
- Support with housing and re-settlement
- Support with court proceedings and victim impact statements
- Referral to other agencies (i.e. MARAC, Victim Support)
- Facilitation of women survivors groups
- General education on domestic violence

→ **Reduction in violence and unmet needs at 6 month follow up**

(Trevillion et al 2014)

Domestic Violence Advocacy received (n=22)



(Trevillion et al 2014)

Moving forwards….

Violence Abuse and Mental Health Network

Understanding, preventing, and reducing the impact of violence and abuse on mental health, by bringing together experts with different ways of thinking about these problems.

Some experts will have personal experience of these issues, others expertise from the work that they do; some will have both.

Key activities incl.

- working with people with lived experience of violence, abuse, and mental health problems to **identify research priorities**;
- awarding small grants through open competitions;
- holding workshops, conferences, lectures, and other events;
- developing online resources to support research;
- working across sectors to improve approaches to measurement

https://www.smartsurvey.co.uk/s/WU1QE/

A survivors' charter

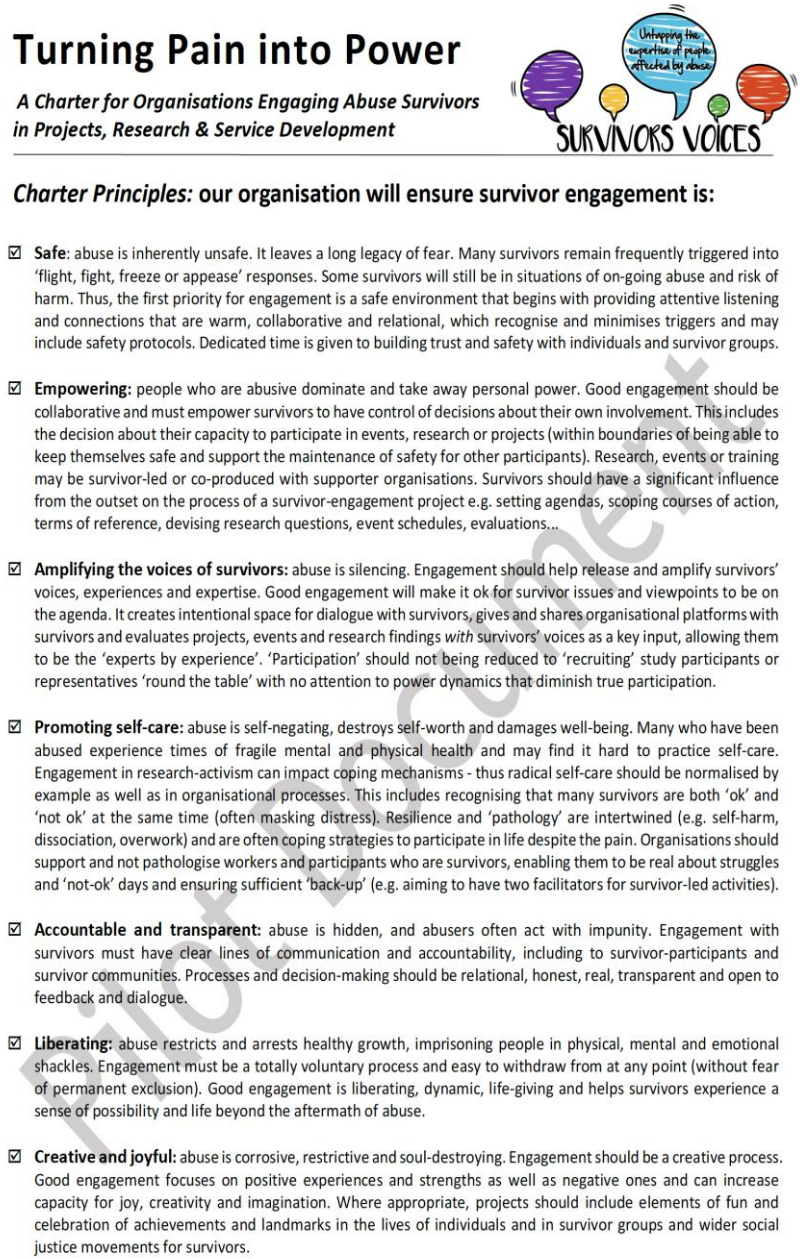
7 principles for good survivor engagement

7 areas of good practice guidance to encourage active, safe and meaningful involvement of abuse survivors in:

- Research
- Development services and projects
- Development of policy and practice standards
- Events, training and conferences.

For: ethics applications, team discussions, checklist, project planning, evaluations…

Pilot document accessible from www.survivorsvoices.org.uk



Turning Pain into Power

A Charter for Organisations Engaging Abuse Survivors in Projects, Research & Service Development

Untapping the expertise of people affected by abuse

SURVIVORS VOICES

***Charter Principles:* our organisation will ensure survivor engagement is:**

☑ **Safe**: abuse is inherently unsafe. It leaves a long legacy of fear. Many survivors remain frequently triggered into 'flight, fight, freeze or appease' responses. Some survivors will still be in situations of on-going abuse and risk of harm. Thus, the first priority for engagement is a safe environment that begins with providing attentive listening and connections that are warm, collaborative and relational, which recognise and minimises triggers and may include safety protocols. Dedicated time is given to building trust and safety with individuals and survivor groups.

☑ **Empowering:** people who are abusive dominate and take away personal power. Good engagement should be collaborative and must empower survivors to have control of decisions about their own involvement. This includes the decision about their capacity to participate in events, research or projects (within boundaries of being able to keep themselves safe and support the maintenance of safety for other participants). Research, events or training may be survivor-led or co-produced with supporter organisations. Survivors should have a significant influence from the outset on the process of a survivor-engagement project e.g. setting agendas, scoping courses of action, terms of reference, devising research questions, event schedules, evaluations…

☑ **Amplifying the voices of survivors:** abuse is silencing. Engagement should help release and amplify survivors' voices, experiences and expertise. Good engagement will make it ok for survivor issues and viewpoints to be on the agenda. It creates intentional space for dialogue with survivors, gives and shares organisational platforms with survivors and evaluates projects, events and research findings *with* survivors' voices as a key input, allowing them to be the 'experts by experience'. 'Participation' should not being reduced to 'recruiting' study participants or representatives 'round the table' with no attention to power dynamics that diminish true participation.

☑ **Promoting self-care:** abuse is self-negating, destroys self-worth and damages well-being. Many who have been abused experience times of fragile mental and physical health and may find it hard to practice self-care. Engagement in research-activism can impact coping mechanisms - thus radical self-care should be normalised by example as well as in organisational processes. This includes recognising that many survivors are both 'ok' and 'not ok' at the same time (often masking distress). Resilience and 'pathology' are intertwined (e.g. self-harm, dissociation, overwork) and are often coping strategies to participate in life despite the pain. Organisations should support and not pathologise workers and participants who are survivors, enabling them to be real about struggles and 'not-ok' days and ensuring sufficient 'back-up' (e.g. aiming to have two facilitators for survivor-led activities).

☑ **Accountable and transparent:** abuse is hidden, and abusers often act with impunity. Engagement with survivors must have clear lines of communication and accountability, including to survivor-participants and survivor communities. Processes and decision-making should be relational, honest, real, transparent and open to feedback and dialogue.

☑ **Liberating:** abuse restricts and arrests healthy growth, imprisoning people in physical, mental and emotional shackles. Engagement must be a totally voluntary process and easy to withdraw from at any point (without fear of permanent exclusion). Good engagement is liberating, dynamic, life-giving and helps survivors experience a sense of possibility and life beyond the aftermath of abuse.

☑ **Creative and joyful:** abuse is corrosive, restrictive and soul-destroying. Engagement should be a creative process. Good engagement focuses on positive experiences and strengths as well as negative ones and can increase capacity for joy, creativity and imagination. Where appropriate, projects should include elements of fun and celebration of achievements and landmarks in the lives of individuals and in survivor groups and wider social justice movements for survivors.

Summary

- Strong and consistent associations between domestic violence and mental illness
- High prevalence of domestic and sexual violence among mental health service users
- DV education and training are necessary to improve clinicians' knowledge and competencies to address DV
- Clear care and referral pathways can assist mental health professionals in supporting the needs of abused service users
- DV advocacy may help reduce abuse, unmet needs and social isolation among mental health service users
- Greater collaboration between mental health and DV sectors may result in improved health outcomes for service users
- It's not trauma-informed, if it's not informed by trauma survivors.

Acknowledgements

LARA and PROVIDE

Roxane Agnew-Davies

Gene Feder

Louise Howard

Kylee Trevillion

Mental Health and Justice study:

Hind Khalifeh

Louise Howard

Paul Moran

Sonia Johnson

David Osborn

Rohan Borschmann

Violence Abuse & Mental Health Network

Louise Howard

George Danezis

Seena Fazel

Alana Harris

Rachel Hewitt

Emma Howarth

Angela Sweeney

Leonie Tanczer

Ravi Thiara

Jude Towers

Sylvia Walby

Survivors Charter
Survivors Voices

Funders

Big Lottery

MRC

NIHR

UKRI

Wellcome Trust