

**A question of commitment – improving practitioner approaches to addressing domestic and sexual violence, problematic substance use and mental ill-health**

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## **Author page**

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## **Abstract**

### *Purpose*

AVA (Against Violence & Abuse) is funded by the Department of Health to deliver the Stella Project Mental Health Initiative. This project aims to develop and implement models of good practice for responding to survivors and perpetrators of abuse who also have a dual diagnosis. Marking the project's halfway point, this article reviews what is already understood to be best practice in this area, presents the initial learning from the project evaluation, and consider the most effective ways of promoting and enabling behaviour change among practitioners.

### *Design/methodology/approach*

The research design for the evaluation is a mixed methods evaluation, drawing on both prospective and retrospective research techniques. The design was developed within an action research framework.

### *Findings*

In line with other research levels of routine enquiry or enquiry about experiences of violence were low amongst staff from all organisations participating in the project. In comparison staff seem somewhat more likely to enquire about substance misuse and mental health issues. Wide variation in attendance at training was found with a complex relationship between training and confidence emerging.

### *Originality/value*

This paper adds to the growing evidence base to suggest that a lot more training, organisational support and research is needed to ensure that professionals who have contact with women who have experienced abuse, have mental health or substance use problems are asking their clients about all three issues, making appropriate referrals and ensuring victims with complex needs having access to protection and support.

**KEY WORDS:** domestic violence, sexual violence, substance use, mental health, best practice

*Article classification:* Research paper

## **Introduction**

It is well-established that experiencing a traumatic event can result in psychological distress, and survivors often use various legal and illicit substances to mediate the symptoms of their distress (Hien, Cohen & Campbell, 2005; Kaysen et al., 2007). However, it is only in the last decade that a solid evidence base has emerged which demonstrates that mental ill-health can be a “symptom of [domestic] abuse” (Humphreys & Thiara, 2003), and highlights the extent to which survivors of domestic and sexual violence often use alcohol, illicit drugs and prescribed medication as a means of coping with the physical and emotional pain of abuse (see, for example, Golding, 1999; Howard, Trevillion & Agnew-Davies, 2010a; Howard et al, 2010b; Humphreys & Reagan, 2005; McLindon & Harms, 2011; Rees et al, 2011). The association between substance use and the perpetration of domestic and sexual violence has also been evidenced (Budd, 2003; Galvani, 2004), and research on perpetration and psychiatric illness is currently underway.

Research on the prevalence of domestic and sexual violence among users of drug and alcohol and mental health services does remain limited. Small-scale studies in the UK and US found between 30% and 75% of female drug and alcohol service users have current or past experiences of violence from a partner (Bury et al, 1999; Powis, Gossop, Payne & Griffiths, 2000; Swan, Farber & Campbell, 2001); 53-63% of couples attending drug and alcohol services report one or more incident of domestic violence within the past year (Klostermann et al, 2010). In terms of mental health, a systematic literature review conducted by Howard et al (2010b) overall higher rates of domestic violence among psychiatric patients than the general population, although the variety of methodologies used in the studies identified means the extent of the increased risk is unclear.

Despite their limitations, the aforementioned studies clearly demonstrate the greater lifetime prevalence of domestic violence among women accessing substance use and mental health services than within the general female population. For those women who are currently in an abusive relationship, there is risk of continued violence. Practice-based evidence from drug, alcohol and mental health workers alongside limited academic research (for example, Gutierrez & Van Puymbroeck, 2006; Call & Nelson, 2007) highlight that victims of child- and adulthood abuse who have additional substance use or mental health problems are also at risk of repeated domestic violence and sexual assault. The risk of further abuse can also hamper a victim’s recovery from mental

illness and/or substance use. Screening for experiences of current and historic abuse, however, is low. Where screening does occur, disclosures of abuse are infrequently incorporated into care planning and referrals to specialist support services are the exception rather than the rule (Howard et al, 2010b).

It is in this context that the Department of Health funded AVA (Against Violence & Abuse) to deliver the Stella Project Mental Health Initiative. AVA is a national charity working to end all forms of violence against women and girls. As a second-tier organisation, we do not provide services directly to victims or perpetrators of abuse, but provide training, advice and support to 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. We also facilitate survivor consultation and act as a hub of information and good practice resources relating to violence against women and girls. Our primary customers are central and local Government as well as police forces, health authorities and voluntary sector organisations across England.

### **Aims**

This article focuses on practitioner responses to the overlapping issues of domestic and sexual violence, problematic substance use and mental illness. As reflects the focal point of the first year of the Stella Project Mental Health Initiative and the primary concerns of the project participants, this article's primary consideration is responding to victims of abuse, rather than perpetrators. We will review what is understood to be best practice, present initial learning from the Stella Project Mental Health Initiative and its evaluation, and consider ways to take this area of work forward.

### **Design**

The Stella Project Mental Health Initiative, which is managed by a project co-ordinator who is employed by AVA, is a three year project which aims to develop and implement effective responses to survivors and perpetrators of domestic and sexual violence who are also affected by problematic substance use and/or mental ill-health. The project is being piloted in twenty organisations/services across three sites: Bristol, London Borough of Hounslow and Nottinghamshire. The project participants comprise voluntary sector domestic and sexual violence organisations, voluntary and statutory community drugs and alcohol services, voluntary and statutory community and residential mental

health services. An independent evaluation of the project is being conducted by Middlesex University, the findings of which are outlined and discussed later in this paper.

The core intervention of the Stella Project Mental Health Initiative is to promote best practice in responding to service users with a mental health and/or substance use problem and have also experienced or perpetrated domestic and sexual violence. Following the English Government's widely publicised programme to deliver intensive support to 'troubled families' (for example, BBC, 2011a, 2011b, 2012a, 2012b) who are so often afflicted by a "toxic trio"<sup>1</sup> (Brandon, Bailey & Belderson; 2010) of domestic violence, substance use and mental ill-health, the question of how to effectively address multiple, co-existing problems has been explored by journalists, researchers and in publications by voluntary sector organisations who work with families who have complex needs (see, for example, Adfam, 2011; Bunting, 2012; Cleaver, Unell & Adgate, 2011; Cuthbert, Rayns and Stanley, 2011; Johnson, 2012; Revolving Doors and Making Every Adult Matter (MEAM), 2011).

Among the aforementioned publications, the Department for Education's second edition of *Children's Needs – Parenting Capacity* (Cleaver, Unell & Adgate, 2011) is notable for its clear presentation of the interaction between domestic violence, substance use and mental ill-health. With an understandable focus on safeguarding children and young people, the authors evidence the ways in which young people living in families with multiple needs are at much higher risk of harm than those who do not. Importantly, they note that, "[a]lthough there is substantial evidence showing that a combination of parental mental illness, learning disability and problem substance misuse increases the risk to children's safety and welfare, *the best predictor of adverse long-term effects on children is the co-existence with family disharmony and violence*" (p. 66; author's emphasis).

The recommendations for improving practice which accompany the Department for Education's report largely mirror existing guidance on supporting survivors of domestic violence, including those who are also affected by problematic substance use and/or mental ill-health (for example, Barron, 2004; Birmingham Violence Against Women Board, 2010; Department of Health, 2010; Stella Project, 2002):

- Screening. Whilst there are differing views about the efficacy of screening in improving outcomes for survivors (Feder et al, 2011; Hien & Ruglass, 2009), there

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<sup>1</sup> It is worth noting that the term "toxic trio" is not universally supported due to the implication that individuals who experience one or more of the issues are "toxic" themselves.

is sufficient evidence that routine enquiry does, at least, result in increased detection rates (Howard et al, 2010b). Considering the barriers which may prevent survivors disclosing experiences of abuse or any additional needs (Rose et al, 2011), it is vital practitioners are 'curious' and proactively enquire about service users' complex needs.

- Information. Both survivors and staff need easy access to information about the range of services available to support survivors' individual needs. Additionally, organisations need to develop clear policies, procedures and referral pathways to provide a supportive framework within which staff can work confidently.
- Partnership work. Collaborative working is a high priority – from conducting assessments with specialists from other agencies to developing holistic packages of care and joint support from multiple workers. Support must enable engagement rather than overwhelming survivors who are, on average, involved with 14 agencies (Stanko, 2000).
- Training. Access to training and education on domestic and sexual violence, problematic substance use and mental health is seen as vital for increasing knowledge and confidence in dealing with these overlapping issues.

In working to promote these areas of best practice, the project co-ordinator is supporting each agency/service to develop and implement new policies and procedures, delivering training and fostering partnership working through multi-agency training programmes, networking events and facilitating communication between agencies.

## **Methods**

The research design for the evaluation is a mixed methods evaluation, drawing on both prospective and retrospective research techniques. The design was developed within an action research framework, hence findings are being fed back to the project on an ongoing basis so problems can be addressed during the course of the evaluation. Data for the evaluation of the Stella Project Mental Health Initiative is being collected pre- and post-intervention, with small amounts of information being gathered in between. The pre-intervention stage was conducted between April and September 2011 and comprised three strands of investigation. Firstly, data about current practice in terms of screening, referrals pathways and partnership working was collated through an online survey for practitioners from voluntary sector domestic and sexual violence organisations, voluntary

and statutory community drugs services, voluntary and statutory community and residential mental health services participating in the project and focus groups with agency leads. The survey was also designed to examine practitioner knowledge, skills and confidence in working with the three issues. All staff from each organisation involved in the project were invited to complete the survey. Overall twenty-nine percent of staff who were invited completed the survey and all organisations had at least one member of staff take part. Service and area leads were invited to take part in the focus groups. One focus group was conducted in each of the three areas. There were between five and eight participants in each focus group and a reasonable mix of representatives from the organisations in each focus group, no agency bias was evident. Secondly, an analysis of organisational policies, procedures and strategies was conducted. Finally, all services were asked to record information about disclosures of domestic violence, sexual violence, mental ill-health and substance use and any relevant referrals. We originally proposed that data should be collected prospectively on a monthly basis from the start of the project until the post-intervention stage from existing agency records in order to provide as complete a picture of referrals as possible. However, it became apparent that given all of the demands on the services involved and the project co-ordinator that this was not feasible. Following consultation with project participants, the project co-ordinator proposed a series of alternatives to the service leads at working group meetings in July 2011. It was agreed that the following strategy would be used. Instead of prospective data collection over the life of the project, retrospective data collection for a four month period of each year of the project is being used. Each agency is completing a spreadsheet giving information about signpostings/referrals which followed disclosures of domestic and sexual violence and/or substance use and mental health problems that were made between January 1<sup>st</sup> and April 31<sup>st</sup> for each year of the project. It is acknowledged that this revised method means that only snapshots of the referrals for each year of the project will be captured but compromise was necessary in order to ensure some data was collected. Therefore there will be three waves of data collection for this element of the evaluation.

### **Preliminary findings**

The preliminary findings of the pre-intervention evaluation suggest that in line with other research (see, for example, Hager, 2006; Howard et al, 2010b; O'Campo, Kirst, Tsamis, Chambers & Ahmad, 2011) levels of routine enquiry or enquiry about experiences of



violence are low amongst staff from all organisations participating in the project, with staff from mental health services being the least likely to ask. In comparison, staff from each sector, i.e. domestic and sexual violence, substance use and mental health, seem somewhat more likely to enquire about substance misuse and mental health issues.

One of the factors which may influence levels of screening is knowledge of the issues and whether practitioners view them as relevant to their client group. Our pre-intervention data shows regional variations in the levels of knowledge; overall, however, there is slightly greater knowledge about all three issues amongst staff from domestic and sexual violence services.

Across all the agencies, attendance at training – a key conduit for increasing knowledge – varied greatly. Encouragingly, less than ten percent of staff overall had received no training on each issue. Unsurprisingly participants have received the most training for the topic in which their organisation specialises. Whilst receiving training typically increases a practitioner's knowledge of a topic, our preliminary findings reveal a more complex relationship between receiving training and increasing confidence in actually dealing with the topic. Many practitioners completing the staff survey reported having received insufficient or just enough training on mental health, yet at the same time reported high levels of confidence in addressing that issue with clients. The same cannot be said about domestic and sexual violence: whilst level of training on this issue were reported, confidence levels were lower.

Further investigation is required into how confidence can be built. Initial discussion with drug and alcohol practitioners participating in the project suggest that mental ill-health is more prevalent among their client group; staff therefore have more experience, and thus confidence, in dealing with clients' mental health problems. A further factor frequently cited during training as boosting confidence is access to clear, reliable referral pathways. From our initial analysis, the mechanisms and pathways for sharing information between organisations and making appropriate referrals appears unnecessarily complex and/or very restrictive, with difficulties in accessing secondary mental health services being the primary complaint among the project participants. This again, then, requires further investigation: confidence levels among practitioners are highest for an issue in which they perceive the greatest problems in accessing appropriate support.

A further dimension of this argument is that knowledge and experience of using referral pathways generates practitioner confidence, rather than the pathways

themselves. Both substance use and mental health workers participating in the project routinely bemoan the lack of refuge accommodation for victims of domestic violence with complex needs, understanding this to be the primary and preferred pathway. Across England there is a definite gap in service provision with only a handful of refuges accepting women who are actively using illicit drugs, are dependent drinkers, or have a psychiatric diagnoses such as borderline personality disorder, bipolar disorder or schizophrenia (Stella Project, forthcoming). Many victims, however, do not choose to move into a refuge. A variety of legal and policy remedies are available, along with broadly accessible community-based support services, which enable many survivors to remain in their own homes or move to alternative, non-refuge accommodation. There is, therefore, reason to argue that an improved pathway into refuge accommodation alone would not necessarily increase practitioner confidence as it is not the desired or required by many victims and is unlikely to be successful in the majority of cases; rather, It is the knowledge of all pathways, in particular that non-refuge support is locally available and more appropriate for many victims, that should heighten practitioner confidence in addressing domestic violence in their practice.

## **Discussion**

In their systematic review of the implementation of domestic and sexual violence screening programmes in health care settings, O'Campo and colleagues (2011) identified the need for training, along with enabling (written protocols and prompts) and reinforcing strategies as pre-requisites for successfully introducing routine enquiry among health professionals. Furthermore, in order to increase not only detection but also referrals rates, evidence from the Identification and Referral to Improve Safety (IRIS) project in the UK also highlights the importance of a combined programme of training, revision of assessment and care planning tools to include prompts to ask about domestic violence, and enhanced access to specialist support through a named advocate who is well known to a service (Feder et al, 2011).

Within the Stella Project Mental Health Initiative, training is a priority. The training programmes are designed to increase knowledge and to address practitioners' multiple concerns about screening for and responding to the different issues (see McLindon & Harms, 2011 and Rose et al, 2011 for a detailed analysis of mental health professionals' concerns around dealing with domestic and sexual violence). The already mentioned complex interactions between training, knowledge and confidence provide many

challenges, not least some practitioners' possible overconfidence without an appropriate knowledge base or experience. This overconfidence could lead to well meaning but ill-informed practitioners doing more harm than good, such as advising victims to leave an abusive relationship without full consideration for her safety. Within training, therefore, we are very clear about practitioners' roles with regard to each issue, and stress the need for working with partner agencies to prioritise service user safety and well-being.

Training does go some way to addressing individual's behaviour and values and beliefs, but as highlighted by O'Campo (2011), the environment in which staff work is another key factor in enabling behaviour change. Paperwork – assessment and case management tools – can be used to provide prompts for staff to ask about domestic and sexual violence, substance use and mental health and include the matters in care planning: such prompts are also indicative of organisational support for staff to address the issues. The preliminary analysis of our pre-intervention findings suggest that the majority of staff from all areas have specific sections of their client records to note information about each issue. A small number of practitioners in each sector, however, are restricted to recording concerns as an 'additional information' note. Where information about the three issues are consigned to 'additional information' sections, it raises two concerns: firstly, that staff may not have dedicated questions on their screening or assessment tools which prompt them to ask service users about experiences of domestic and sexual violence, substance use and mental illness; and secondly, that where disclosures are made, staff are less likely to record information. The evidence base and best-practice suggests that there should be designated spaces to collate information about the issues. We will take this matter forward throughout the project.

A central component of the Stella Project Mental Health Initiative is the development of stronger relationships between organisations to aide and promote partnership working. Whilst evidence shows that projects which offer immediate support, through for example an onsite case manager or coordinator are most effective in increasing screening and referrals (Feder et al, 2011; O'Campo et al, 2011), this model of enhanced partnership is rarely funded. Alternatively, this project focuses on lower intensity partnership work, namely increasing levels of referrals and multi-agency packages of support, and addresses some of the primary structural and individual barriers to implanting these collaborative ventures.

The joint development of clear processes and structures, such as referral pathways, has been identified as a key solution to increasing partnership working (Darlington, Feeney & Rixon, 2005), as well as contributing to staff confidence in addressing complex cases. Such collaborative activities are understood to be most effective when underpinned by inter-agency training and networking events. This approach has been adopted within the Stella Project Mental Health Initiative, with the working group in two sites developing domestic and sexual violence referral pathways, i.e. diagrammatic representations of the process for accessing local support services, for substance use and mental health practitioners. Bringing staff from different agencies together – simply through participation on the local working groups, but also at specific networking events and multi-agency partnership training sessions – aids the implementation of existing and new pathways. Inter-agency training and events are instrumental in overcoming key individual barriers to partnership work, such as a lack of knowledge about partner agencies, stereotyping of other workers, unrealistic expectations of external colleagues' role, and poor communication between agencies (Darlington, Feeney & Rixon, 2005; Glasby & Lester, 2004; Mastache, Mistral, Velleman & Templeton, 2008; Secker & Hill, 2001).

Structurally, the Stella Project Mental Health Initiative reflects the experience of similar projects in that participants cite limited resources (staff time) to contribute to the project, particularly in relation to advancing more time-consuming collaborative work (Glasby & Lester, 2004; Mastache, Mistral, Velleman & Templeton, 2008). A common solution is the engagement of individuals who are committed, ideally senior managers who are in a position to allocate their own and staff resources to the project work. Senior managers are also best located to address a further barrier for individual workers to initiating inter-agency care packages for service users: organisational support (Darlington, Feeney & Rixon, 2005).

Engendering organisation support is integral to the formal “institutionalization” (Mastache, Mistral, Velleman & Templeton, 2008; p.10) of new relationships and practices. In line with similar initiatives to strengthen partnerships between organisations (for example, Glasby & Lester, 2004; Mastache, Mistral, Velleman & Templeton, 2008), a feature of the Stella Project Mental Health Initiative is the tension between the stated desire for partnership working to be formalised and the understanding that inter-agency relationships tend to depend on committed individuals taking a lead and building links informally. As highlighted by other projects to increase collaboration within substance

use and mental health sectors (Glasby & Lester, 2004; Mastache, Mistral, Velleman & Templeton, 2008), the early stages of adopting and integrating new practices into the fabric of a service or agency requires the leadership of an enthusiastic and influential individual. Maintaining relationships and processes, however, involves wider engagement with local political leaders and policymakers who can influence strategic and funding decisions in the long-term. This is the challenge for the second half of the Stella Project Mental Health Initiative.

### **Implications for practitioners and service providers**

There is a growing evidence base to suggest that professionals who have contact with women who have experienced abuse, have mental health or substance use problems should be asking their clients about all three issues, and making appropriate referrals to partner agencies to ensure victims with complex needs having access to protection and support. Practitioners must, however, be supported within their employers to undertake this work. To be most effective, staff need evidence of organisational support through the provision of clear documentation, procedures and referral pathways alongside inter-agency training to promote positive relationships with key partner agencies. Alongside this, senior managers need to engage with local policymaking structures to promote sustained change which will survive the inevitable loss of key actors.

### **Conclusions**

It is often said that child protection has undergone a revolution in the last decade – agencies across the board have acknowledged their role in safeguarding children and young people and clear policies and procedures in place to aid staff who have concerns about a young person's safety or wellbeing. It appears domestic and sexual violence is the next 'frontier' for mental health and substance treatment services. Through the Stella Project Mental Health Initiative, we aim to increase staff knowledge, create supportive organisational environments, and ease inter-agency collaboration in order to build staff confidence in being curious – in asking the necessary questions to identify domestic and sexual violence, substance use and mental health, to understand how these issues have impacted on service users' lives, and to establish what support survivors who have multiple needs want. Based on evidence from other projects, it is clear that change is possible and that best practice change be achieved, it is simply a question of commitment.

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