Section 6

In times of crisis

Section 6

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[1]

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.

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 matter 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 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.

- 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.[2] 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 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

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 themself 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% people with mental health problems experience harassment or victimisation in their local community.[3] 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.[4] 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[5] 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.

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).

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

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. Maintains support networks Additional protection measures available, e.g. non-molestation orders	Perpetrator knows location Perpetrator may be made homeless if ordered by court to leave home 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.[6]

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

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 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 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.

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.

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

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

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/c3nstb5).

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

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

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 they 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:[7]

"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 themself 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 to appear to be ground 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.

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).

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.

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

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.[8]

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.[9]

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:

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.[10]

According to a census[11], 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.

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.