Section 1

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1. Background

1.1 The Stella Project Mental Health Initiative

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

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

The Stella Project was born out of discussions in 2002 between the GLDVP and the Greater London Alcohol and Drug Alliance (GLADA) which identified gaps in the provision for both survivors and perpetrators of domestic violence who also used substances problematically. The GLDVP and then AVA have been funded ever since to support service providers and promote joint working between the domestic violence and substance treatment sectors.

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

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

1.2 The toolkit

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

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

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

2. The toolkit

2.1 Who should use this toolkit

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

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

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

2.2 How to use the toolkit

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

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

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

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

2.3 What is the purpose of the toolkit

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

To this aim, the toolkit provides information on:

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

A question of gender

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

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

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

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

3.1 Domestic and sexual violence

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

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

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

- psychological
- physical
- sexual
- financial
- emotional

"Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

"Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim."

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

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

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

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

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

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

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

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

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

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

- **Rape:** Using the penis to penetrate the vagina, anus or mouth of another person, without their consent
- **Assault by penetration:** Penetrating the vagina or anus of another person, using a body part (e.g. a finger) or anything else (e.g. a bottle), where they do not consent and the penetration is sexual
- **Sexual assault:** Touching someone sexually, without their consent
- **Causing a person to engage in sexual activity without their consent,** e.g. forcing someone to masturbate themselves
- **Administering a substance with intent:** Administering a substance to another person, where they do not consent to taking the substance and the intention is to stupefy or overpower that person to engage in sexual activity
- **Sexual activity with a child:** it is an offence for a person aged 18 or over to engage in sexual touching of a child aged under 16
- **Paying for sexual services of a child**
- **Causing, inciting or controlling prostitution** for gain, for yourself or a third party

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

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

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

3.2 Problematic substance use

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

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

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

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

3.3 Mental ill-health

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

Conversely, many people will experience times of mental *ill-*health that affects their daily life, relationships or physical health. Some mental health problems are well-known, such as depression and anxiety. The most commonly diagnosed forms are depression, anxiety, obsessive compulsive disorder (OCD), phobias, bipolar disorder (formerly known as manic depression), schizophrenia, personality disorders and eating disorders. Domestic and sexual violence is also commonly associated with survivors experiencing post-traumatic stress disorder. Common behaviours and symptoms associated with mental health problems include self-harm, suicidal thoughts and panic attacks.

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

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

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

3.4 Dual diagnosis

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

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

often have many other needs, both medical and social.

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

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

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

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

Various terms have been coined to describe the concurrent experience of these three issues, including survivors having complex needs. We refrain from using this term in the toolkit as it is yet another label which is used to exclude survivors from services. Furthermore, any combination of needs may be complex, not just substance use and mental health.

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

4. Key messages

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

For practitioners:

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

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

- **Women are more at risk of violence and abuse than men.** 45% of women in the UK will experience domestic or sexual violence in their lifetime. By comparison, 17% of men will experience at least one incident of threat, force, financial or emotional abuse and 2% have been sexually victimised since the age of 16.[8]

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

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

Survivor's voice

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

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

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

For practitioners and survivors:

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

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

- **Experiences of domestic and sexual violence, mental ill-health and substance use are frequently interlinked.** Domestic violence and other abuse is the most common cause of depression and other mental health difficulties in women, and results in self-harm and suicide rates among survivors which are at least four times higher than the general female population.[10] Overall, women who have experienced at least one form of gender-based violence[11] are at least three times more likely to be substance dependent

than women who have not been affected by gender-based violence.[12]

- **"You are not to blame"** for the violence. Discussing mental health without acknowledging the impact of violence can increase a victim's feelings of blame, and fails to hold her abuser(s) accountable.

- **Acknowledge survivors' strengths.** Your clients have many strengths to build upon; it will have taken much courage and resourcefulness to have survived this far.

- **Safety is a priority.** If someone is currently in contact with an abuser, she may well be at risk of further harm if the abuser knows they have disclosed, are accessing services or (in the case of domestic violence) try to leave the relationship. Some victims may want to stay with their partner, for example, if he is the carer or if they believe it will increase their safety from others. In either case, do not force victims to leave, as this increases the risk of serious harm or death, but encourage her to complete a safety plan to keep herself as safe as possible.

- **A whole person approach is vital.** Ignoring drug, alcohol or mental health problems can leave a survivor less able to manage her safety or change her circumstances. Conversely, if you do not address her safety needs or how the abuse has impacted on the survivor, attempting to address her mental health or substance use will be less effective.

- **Support is available.** Survivors should be provided with information about support options and be enabled to decide what happens next. Survivors are the experts on what they need.

- **Think family.** A survivor's parenting abilities may be affected by all three issues, so her children's safety and well-being must be taken into consideration. The greatest risk of harm, however, comes from the perpetrator. Any non-abusing parent should be supported to improve their skills and confidence in looking after their children, and not blamed for 'failing to keep the perpetrator away'.

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

For practitioners and perpetrators:

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

5. The AVA approach

5.1 Our values

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

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

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

5.2 The model for working the survivors

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

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

5.3 Minimum standards of practice

Accessibility

- Survivors should not be denied services due to issues with domestic or sexual violence, substance use or mental ill-health.
- Survivors require a non-judgemental and safe environment that generates trust.
- Women-only and women-led services must be available to all female survivors who wish to access them, whenever possible.
- Services need to be accessible to all potential clients and work to meet the diverse needs of all potential clients . This includes provision for children, as well as disability access and access to interpreters where relevant.
- Survivors should supported in their role as mothers, e.g. by providing childcare.

Policies and procedures

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

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

- Ensure that information is available about how to access help. Make information about domestic violence, substance use and mental health services accessible.

- Keep records of enquiries, disclosures and actions.

- Network to improve cross-sector understanding, collaboration, training and referrals.

Safety

- ALWAYS make safety the priority.

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

Routine enquiry and assessment

- Provide service users with the means to talk alone, safely and confidentially.

- Always validate survivors' experiences when they disclose.

- Recognising and naming abusive behaviour can be a powerful intervention in itself.

- In terms of domestic violence, do not blame the victim but hold the perpetrator accountable for their own behaviour.

- Acknowledge wherever possible that experiences of trauma can have an impact on the survivor's mental health and that substance use is a common coping strategy. Normalising what might be a very scary experience for survivors can be very helpful.

- Survivors often experience inappropriate labelling that can be damaging to their self-esteem as well as give rise to stigma and further abuse. When referring to survivors, use non-judgemental and non-stigmatising language at all times.

Treatment and support

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

- Survivors are supported to make choices about their own lives and to take control of decisions.

- A 'menu' of different interventions and approaches is available so that women can choose different interventions at different times depending on their needs. The principle of choice is itself empowering.

- Couple and family counselling is unsafe for women experiencing domestic violence.

- Mental health services should not provide medication (except on a very short-term basis) without offering counselling and referral to advocacy.

- Survivors may leave a relationship several times before the break is permanent. They may also relapse more than once in terms of substance use or mental health. These are all common experiences and survivors should be supported through this, rather than criticised or excluded.

Survivor involvement

- Survivors should be genuinely involved in the assessment and care planning process.

- Survivors need to be consulted about the interventions they find supportive and effective.