Section 5

Keeping safe

Section 5
Keeping Safe

Section outline

Safety is a much broader concept than just being physically safe. It is also a very subjective experience of security this is informed by both our internal world and the external environment.

This section provides an overview of the steps through which practitioners can promote survivors' safety and security:

1. Understand different aspects of safety - internal, relational and external
2. Assess risk
3. Use risk management systems
4. Support survivors to keep themselves safe

1. What is safety?

People who live with violence and abuse, problematic substance use and/or mental ill-health face a range of threats to their safety, from internal and external sources.

As professionals, we tend to look at certain areas of risk:

- Domestic and sexual violence services tend to focus on keeping survivors safe from the person who has abused them;
- Drug and alcohol services concern themselves primarily with the health and social risks, including involvement in crime associated with problematic substance use;
- Mental health services focus on protecting service users from themselves and from perpetrating harm towards others; and
- Children's services' central aim is to protect children and young people from harm.

In this section, we will consider a more holistic approach to increasing survivor safety. Based on Judith Herman's model of working with people affected by trauma[1], this approach addresses three types of risks: internal, relational and external.

Unless survivors are supported to manage the internal risks and are protected from external threats, they

Internal	• How we might harm ourselves
Relational	• How we relate to others • How our actions may affect how others relate to us
External	• How we are vulnerable to deliberate harm by others

will not feel safe and may continually revert back to pre-existing defensive, risk-taking, negative protective strategies. This will not only place them at continued risk of harm, but will also limit their ability to engage with services and make any meaningful progress.

As professionals, we need to be aware of what makes our service users feel safe: if we act in ways that make clients feel vulnerable this can contribute towards a decline in their well-being and can lead to a crisis.

We also need to ensure the safety and well-being of all service users. Sometimes, therefore, we need to carry out a risk assessment as part of the referral process into services, such as refuges. This is a more appropriate approach to managing referrals than blanket policies to include or exclude certain groups of clients, for example survivors who have been diagnosed with a borderline personality disorder. The information in this section and the assessment questions in appendix B provides an outline of what risks to assess and how.

1.1 Internal safety

Experiences of violence and abuse, problematic substance use and mental ill-health can, among many other things, leave an individual feeling powerless. As well as feeling unable to control the outside environment, they may also struggle to manage their own internal emotional world.

1.1.1 Risks to internal safety

There are different ways in which survivors may experience difficulties:

- **Intense emotional distress.** As outlined in section 2, there

is a clear association between experiencing abuse and mental distress. Domestic and sexual violence has been shown to lead to anxiety, mood disorders, post-traumatic stress disorder, phobias and compulsive disorders. Similarly, people who use drugs and alcohol problematically are at increased risk of common mental health problems such as depression and anxiety. Due to continued stigma, survivors with substance use and/or mental health problems may also feel shame as well as anger about they way they are treated by others, including the agencies that are meant to help and protect them.

- **Regulating emotions.** Following trauma, more primal parts of the brain that only detect threat can become more active. This can make it difficult to regulate intensity of emotions and/or using problem-solving skills to manage emotions. Furthermore, chronic and persistent stress inhibits the effectiveness of stress responses. Over time, increasingly minor reminders of trauma can trigger full-blown stress reactions.

- **Inability to self-soothe.** When the survival response (fight, flight, freeze) is activated, stress hormones like cortisol are released. This can reduce production of serotonin (responsible for self-soothing and calming abilities) and dopamine (involved in judgment and impulse control).

"At the time it looked like I was just messing up inside. If I hadn't done anything, I think I would just have blown up…gone mad. It's like your head was full of so much, you wanted something to calm you down."

Survivor's voice

- **Unsafe coping strategies.** Survivors will manage problems regulating emotions in different ways. Some coping strategies, for example substance use, self-harm and multiple suicide attempts, can, however, pose a risk to the survivor's safety and well-being:

- Substance use can help to regulate states of arousal, to avoid traumatic memories or difficult emotions. Risks include physical damage from intravenous

use; long-term health problems; overdose; increased rates of depression, anxiety, paranoia; associated with higher rates of self-harm and suicide.[2]

- In the absence of fully functioning problem-solving skills and the ability to self-soothe, some survivors may self-harm. Self-harming can, amongst other things, help someone as a means of expressing anger or other feelings that can be difficult to verbalise or managing intrusive thoughts (see appendix F for more reasons why people self-harm). Conversely, self-harm can lead to worsening feelings of guilt, shame and self-esteem. Risks to physical health include infection, damage to tendons and nerves from cutting, life-threatening problems such as blood loss if arteries are cut.

- The research findings differ but abused women are at least four times more likely to attempt suicide, and one third of all female suicide attempts can be attributed to current or past experience of domestic violence.[3] Aside from the obvious danger of death, suicide attempts can be seriously detrimental to an individual's long-term physical health, if they survive. They may have to live with varying levels of disability, scarring and disfigurement. Asphyxiation can cause brain damage; paracetamol poisoning is a major cause of acute liver failure. NICE guidelines on self-harm note that people who have survived a medically serious suicide attempt are more likely to have poorer outcomes in terms of life expectancy.[4]

1.1.2 Managing internal risks

In addressing survivors' internal safety, professionals should:

1. **assess** the level of risk. For more information, see pp.108-113.

2. **consider** utilising risk management systems, including contacting mental health services about someone who is actively suicidal or is at risk of causing themselves serious physical injury through self-harming (more information on p.113).

3. **support** survivors to keep themselves safe by learning to manage emotions and to adopt safer coping strategies. For more information, see p.118 onwards.

What works? Survive and Thrive[5]
Survive and Thrive is a psycho-educational treatment for complex trauma which is currently being delivered in several parts of Scotland. The programme aims to help survivors of trauma to manage their responses in a safe way.

1.2 Relational safety

Professionals who work with people affected by abuse, problematic substance use and mental ill-health often report feeling confused and frustrated about how some survivors behave and the ways in which they seemingly put themselves in situations which increase their vulnerability. Many of these behaviours are trauma responses that professionals are not always aware of or recognise as such.

These behaviours often include the ways in which survivors relate to others – how they behave towards and communicate with other people. As such, we refer to this as **relational safety.**

1.2.1 Risks to relational safety

Sensitivity to potential threat
Survivors of domestic and sexual violence, including people who experienced abuse in childhood, can develop a long-term sensitivity to potential threat, and over time there can be a continually lowering of the threshold for sensitivity and activation of the protective devices such as the fight or flight response. As such, survivors may appear to always be ready to respond to a threat, and may seem to overreact to seemingly minor triggers. This is a basic survival mechanism.
In addition to being hyperaroused and overly sensitive to potential threats, survivors may also anticipate rejection (as has often been the case in the past) and so respond to situations in ways that reflect this expectation.

Directing anger towards others
Women and girls feel anger as a natural reaction to violence. Survivors may feel anger towards the abuser, but also feel angry at people who condoned or ignored the violence, did not protect them as children and about the injustice of being advised to stay or return to a dangerous situation.

Anger is, however, a particularly problematic emotion in our society, especially for a woman or girl. Many learn that 'nice' girls don't raise their voices - they are supposed to just cry or cope. A woman might also learn to hide anger because her abuser 'would give her something to be really angry about' or because she is determined not to 'sink to his level'. As girls grow up, or women encounter violence, they become prevented from natural expression of their feelings – and then may begin to suffer from suppressing or over-controlling their emotions.

As result, some survivors may express anger in ways that are unhealthy, and even risky:

- Some survivors may misdirect the anger they feel toward their abuser to safer targets: children, family, friends, and professionals who may trigger issues of power and control.

- Women may feel like they are 'a walking volcano' and be frightened of snapping at the slightest thing.

- A survivor may be frightened, hurt, upset by or judgmental about other people's display of emotions but be unaware of her own.

- Anger may be turned in on the survivor, in guilt, self-blame, depression or in physical symptoms

Use of violence

Some survivors may use violence themselves. In the face of being assaulted either physically or sexually, survivors may instinctively use violence to protect themselves (the 'fight' response to threat).

Survivors may have also learnt that violence is an answer to many problems. Survivors may use violence to disperse anger, hurt or frustration, or to provoke people so they retaliate.

People, particularly those who have experienced abuse in childhood or repeatedly in adulthood, may also adopt the world view that there are winners or losers, and choose to be on the winning side by using violence to beat an attacker or in pre-empting a possible threat.

More information about survivors' use of violence can be found on p178.

Whilst it is useful to understand why survivors use violence, it is equally important that people know violence is NEVER acceptable and should not be condoned. Using violence can increase the risk of further harm.

Sexual acting out

There are many possible reasons for survivors to 'act out sexually'. When someone is sexually assaulted, there is a feeling of helplessness and acting out can be a way of regaining control. The survivor may feel they are damaged, worthless and do not deserve better. Some survivors, particularly children and young people, may have been taught that sex is "all they are good for".

Research has also found that physical abuse is associated with significantly higher rates of disinhibition in female survivors than in male survivors who use stimulants.[6]

Lack of interpersonal boundaries

Do you know survivors who:

- Speak at an intimate level when they first meet someone?
- Fall in love with anyone who reaches out to them?
- Don't notice when someone displays inappropriate behaviour or invades their personal boundaries?
- Accept food or gifts that they don't want?
- Allow someone to take as much as they can from them?
- Let others direct their life?

These are all possible signs of not being able to manage boundaries with other people. People who have not mastered the use of boundaries tend to be more susceptible to the influences and control of others.

Experiencing abuse, particularly in childhood, can lead to problems with boundaries by, amongst other things:

- **disrupting the sense of self.** We need a clear sense of self to be able to separate our own thoughts and feelings from those of others; this helps us to then communicate our needs and desires to others. When the sense of self has been disrupted it can be more difficult to protect oneself from being manipulated by or enmeshed with others.

- **causing uncertainty about where boundaries should lie.** In situations where a person's rights are not upheld and where they do not necessarily matter unless they are useful for the perpetrator's needs, it can be difficult for the survivor to understand that they have the right to control how they are treated.

- **making the survivor feel responsible for other people's happiness.** Survivors are often blamed for the abuser's behaviour and can come to blame themselves. Survivors can respond to the pain, guilt and anger of being responsible for another person's behaviour by trying endlessly to rescue the abuser from the negative consequences of their behaviour. Some survivors may only get positive attention when they show compassion to the abuser.

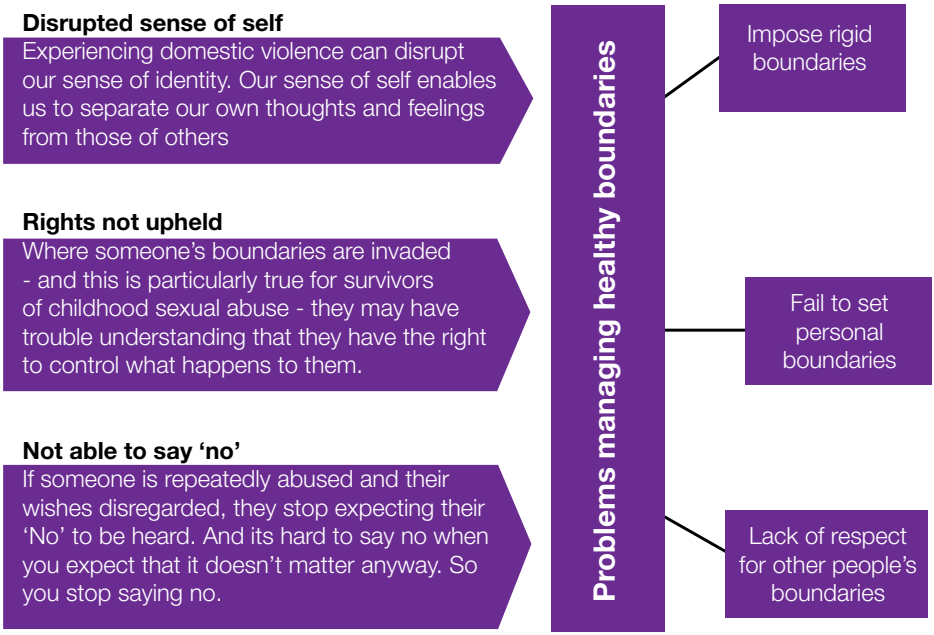
- **leaving the survivor believing there is no use in trying to refuse people.** Someone who has been repeatedly abused can have their 'no' disregarded so many times that they no longer expect their 'no' to be heard anymore. Some people may even stop saying 'no' altogether as they expect that it does not matter anyway.

Difficulties in managing boundaries generally play out in three ways:

1) developing rigid boundaries. Survivors may learn that rigid and inflexible boundaries might be the way to handle their relationships with other people. They wall themselves off in their relationships as a way of protecting their emotional selves, and, as a consequence, will, probably find it difficult to form lasting close interpersonal bonds with others in adulthood as they are still trying to individuate from their parents.

2) failing to set boundaries.
People who have experienced abuse, particularly if repeated, can become desensitized to feeling betrayed. Survivors may not feel strong emotions when someone acts against them or against their wishes. They may stop being able to sense in themselves what feels right or wrong. For survivors who use alcohol or drugs, substance use can exacerbate the difficulties in setting boundaries as inhibitions can be lowered.

Figure 6 - Impact of abuse on survivors' boundaries



3) **failing to respect other people's boundaries.** Having been denied the right to have a 'no', survivors may not recognise when other people say 'no'.

1.2.2 Managing relational safety

Practitioners can increase survivors' relational safety in several ways:

- raise survivors' own awareness about their responses to threat (in cases where the response is disproportionate to the risk) and the risks associated with directing anger at others, using violence and acting out sexually.

- depending on the service, address anger management and other risky behaviours or refer to a partner organisation for specialist support.

- model acceptable behaviour and maintain clear and consistent boundaries.

The last point is particularly important for survivors of domestic and sexual violence, who may lack any other stable attachment figures. Professionals often become so focused on completing practical tasks and overlook the importance of the stable and consistent relationship they can offer survivors.

Professionals do report difficulties in developing boundaried and consistent working relationships with survivors of domestic and sexual violence.[7] For example,

- It is easy to become too close to survivors when you work with them for a long time. No matter what your role is, the contact you have with survivors must stay within professional limits.

- If a worker placates/makes allowances for them on account of them being abused, they are not learning to put boundaries in their proper places.

- Survivors may seek and reject attention and a close relationship with workers, which can cause the worker to feel rejected. In this situation, a worker may unknowingly respond by rejecting the service user or working 'harder' to win the survivor's approval and attention.

Therefore, professionals working with survivors of domestic and sexual violence, particularly those

also affected by substance use and mental ill-health, are at risk of being treated in a way that crosses their personal boundaries. For that reason it's very important, when in a relationship with a survivor to:

- Set the boundaries early and clearly
- Stay alert and continuously maintain boundaries
- Be consistent

This approach can keep you safe but also provide a vital, safe attachment for survivors regardless of your role.

The Department of Health has produced guidance on relational safety. Whilst primarily aimed at managing the safety on psychiatric wards, much of the information is relevant to other residential settings, such as refuges, hostels, or community project where the same service users meet frequently. The guidance can be downloaded here: http://www.rcpsych.ac.uk/pdf/Relational%20Security%20Handbook.pdf.

1.3 External safety

People who have been affected by domestic and sexual violence, substance use and mental ill-health are also at risk of further abuse and exploitation by individuals who specifically target them because of their possible vulnerabilities:

- difficulties with boundaries and being assertive
- low self-esteem due to experiences of abuse, substance use and mental ill-health, as well as the stigma attached to these issues
- often isolated from friends/family and society more generally
- open to perpetrators who pretend to be a friend, to care about and about the victim or who are very charming at the beginning
- victims are more likely to blame themselves for abuse, or be made to think it is their fault
- people who have substance use or mental health problems are less likely to be believed when they report abuse

Domestic Violence

As already noted, perpetrators will use victims' substance use or mental health problems to abuse them. For example, verbal insults such as 'junkie' or 'nutter', controlling finances because victim is not 'capable' or might use for drugs, make victim believe they are to blame for perpetrator's behaviour. A full list of abusive behaviours relating to the victim's substance use or mental health problems can be found in appendix G.

Sexual violence and exploitation

Sexual violence is most often perpetrated by someone known to the victim, including their parents. Because of their vulnerabilities, people with mental health problems and learning difficulties may also be coerced by a partner or friend into having sex with other people. This is called sexual exploitation. Sexual violence and exploitation is also common among people who use substances, e.g. sexual services can be used to pay for drugs.

Abuse

Mate crime

Learning disabilities, mental ill-health and substance use all leaves people vulnerable to exploitation by others, which is called 'mate crime' by some. This can be someone borrowing a person's mobile phone and using all the credit, friends turning up on benefit's day to go to the pub or for a party with the victim paying for everyone, befriending someone to use their flat to deal or use drugs. A user-friendly guide to mate crime can be found on the ARC website: http://arcuk.org.uk/safetynet/files/2012/08/Friend-or-Fake-Booklet.pdf.

Hate crime

People with learning disabilities or mental health problems may also experience hate crime. This can include neighbours calling the person names, children throwing stones at their house, people hassling or threatening the individual. Domestic and sexual violence can also be considered hate crimes.

Survivors with drug, alcohol or mental health problems are vulnerable to different types of abuse: domestic violence, sexual violence and exploitation, mate crime and hate crime. See above for more detail.

In cases where survivors are at risk of harm from others, practitioners should complete the appropriate risk assessment (see p110) and give immediate consideration to contacting the police, MARAC (Multi-agency risk assessment conference) or adult safeguarding teams. Further information about the MARAC and safeguarding procedures can be found on p.114 onwards.

2 Risk assessment

2.1 Approaches to risk assessment

Risk assessments are completed to identify the likelihood of a negative event occurring, how soon it might occur and the severity of any outcomes. Assessments consider a range of risk factors, i.e. a personal characteristic or circumstance that is linked to a negative event and that either causes or facilitates the event to occur. Risk factors are either:

- **Static**, i.e. unchangeable, such as a history of child abuse or suicide attempts.

- **Dynamic**, i.e. those that change over time, e.g. misuse of alcohol. Dynamic factors can be aspects of the individual or aspects of their environment and social context, such as the attitudes of their carers or social deprivation. Because they are changeable, these factors are more amenable to management.

As risk can change – sometimes over very short timescales – the most effective risk assessments are based on structured professional judgment and are completed in conjunction with the survivor. Risk assessments should formally be reviewed regularly, but also as is needed. This also guards against a 'tick box' mentality in completing risk assessment forms.

Good practice across violence risk management, substance use and mental health promotes an approach to risk assessment whereby practitioners make a judgment about risk on the basis of:

- an assessment of clearly defined factors derived from research;

- professional experience and knowledge of the service user; and

- the service user's own view of their experience, and that of their carer (where safe and appropriate)

Where appropriate and possible, risk assessment should be completed with the input from other members in a team, service or from other relevant agencies. Information about domestic and sexual violence, substance use and mental health

can be complex with fragmented information shared across several different services. Joint information sharing and development of a risk management strategy are far more effective and prevents you, as a lone worker or agency, carrying the sole responsibility for survivor (and their children's) safety.

2.2 Assessing risk

If a service user discloses domestic and sexual violence, substance use and/or mental ill-health, a key 'next step' is to assess the risk of immediate harm they face from others or pose to themselves. When considering levels of risk, you should consider the most common risk factors (outlined in this section) and, where appropriate complete the relevant standardised assessment tools (details in 2.3.2). In each case, you may prefer to do this with a partner agency that specialises in that area, for example complete the DASH RIC with an IDVA (independent domestic violence adviser).

2.2.1 Common risk factors

If you are in the process of needs assessment and support/care planning with survivors of domestic and sexual violence who are also affected by substance use and/or mental ill-health, professionals should – at a minimum – consider the following key risk factors:

Internal	Relational	External
Physical disability / illness	Sensitive to danger - sees everyone as potential threat, reactions to triggers	Isolation - social, cultural, lack of engagement with services
Diagnosed/undiagnosed mental health problems	Unsafe sexual practices; sexually 'acting out'	Major life stressors - homelessness, bereavement, unemployment, pregnancy or recently given birth
Current mental state- hallucinations; severe paranoia, anxiety, panic attacks; insomnia	Use of violence and aggression against others	Stated abuse from 'friends' acquaintances, neighbours
Ability to manage emotional distress	Communication skills- unable to express needs	Sexual exploitation - involvement in prostitution or other forms of exploitation
Self-harm	Relating to others - inability to understand others' perspective, to connect with others	Recent sexual assault or rape - key risk factors for mental health, self-harm, suicide as well as for further harm and murder (if perpetrator is known to victim)
Suicide-high levels of intention/plans	Boundaries - unable to set and maintain boundaries in relationships with others; lack ability to say 'no'	Domestic violence - key risk factors are controlling behaviours, escalating abuse, isolation, recent separation, stalking and harassment, threats to kill, attempts to strangle/ drown/ suffocate, pregnancy
Self-neglect	Parenting capacity - unable to meet basic parental responsibilities and needs of dependent children	
Substance use - overdose, lost memory or consciousness as a result of substance use; unsafe using, e.g. sharing injecting materials; poly drug use; physical dependence; who supplies substances (abusers?)		

Sample questions for identifying and assessing internal, relational and external risk factors can be found in appendix B.

2.2.2 Risk assessment tools

Most agencies now complete extensive risk assessments with all new service users and follow up with regular reviews. Depending on where you work, you may have access to standardised tools for identifying and assessing risk. The most commonly used tools are listed below and can be found on appendix B onwards along with sample questions which may help to identify major safety risks.

Domestic violence

- DASH RIC (Domestic Abuse, Stalking and Harassment Risk Identification Checklist) – used to identify very high risk victims and as a threshold for MARACs (for more information about MARACs, see p.114)

- Barnardo's Domestic Violence Risk Identification Flow Chart – primarily designed to assess risk for children and teenagers witnessing domestic violence.

Sexual violence and exploitation

Sexual violence is not risk assessed like domestic violence is. However, if the survivor is in, or has been in, a relationship with the perpetrator, or still has contact with him, it may be relevant to follow domestic violence risk assessment procedures. This is because sexual assault and rape are uniquely associated with:

- Homicide (both of the abuser killing the survivor, and for the survivor killing their abuser)

- Strangulation

- Threats by abuser to kill survivor and/or her children

- Abuse during pregnancy

- Perpetrator suicidality

For children at risk of sexual exploitation, practitioners should use the SERA model for assessing risk.

Substance use

- AUDIT (Alcohol Use Disorders Identification Test) is a brief self-report questionnaire developed by the World Health Organisation to identify people whose alcohol consumption has become

hazardous or harmful to their health.

- APQ (Alcohol Problem Questionnaire)
- SADQ (Severe Alcohol Dependence Questionnaire)
- DUST (Drug Use Screening Tool) can be used to identify young people and adults who might benefit from being referred to a substance use agency

Mental health

- CORE (Clinical Outcomes of Routine Evaluation)
- The Sainsbury Centre for Mental Health Clinical Risk Management manual. Not strictly an assessment tool but a useful guide to risk management in mental health.
- START (Short-term Assessment of Risk and Treatability)

2.2.3 Limitations of risk assessment

Due to the fluidity of risk, risk assessments are not foolproof and they only give an indication of risk at a particular point in time. The level of risk that someone is at may change as soon as they leave your office.

Risk assessments are only as good as the information provided. In terms of domestic violence, survivor assessment of danger is the most reliable indicator of risk. If she feels he will be violent again, chances are that he will.[8] However, you should be aware that survivors often minimise the risk as a way of coping or in denial/hope that the perpetrator will not be violent again. Practice-based evidence shows that professionals who have not been trained to complete the DASH risk identification checklist generally identify 4-6 fewer risk indicators than trained professionals.

Furthermore, survivors may not disclose substance use or mental health (or the extent of the problems) for fear of children being removed, being judged, not being able to access refuge services, etc. This again points to the need to work in partnership with other organisations to gather as much information as possible to inform risk assessment and support planning.

Risk assessment in cases of dual diagnosis, i.e. when the person is affected by substance use and mental ill-health, is also highly problematic. There is a risk that serious mental illness may go unrecognised or untreated when there is coexisting substance misuse, as sometimes psychotic symptoms and challenging behaviour will be attributed solely to the substance use.[9] Conversely, drug and alcohol use may be masked by mental health problems.

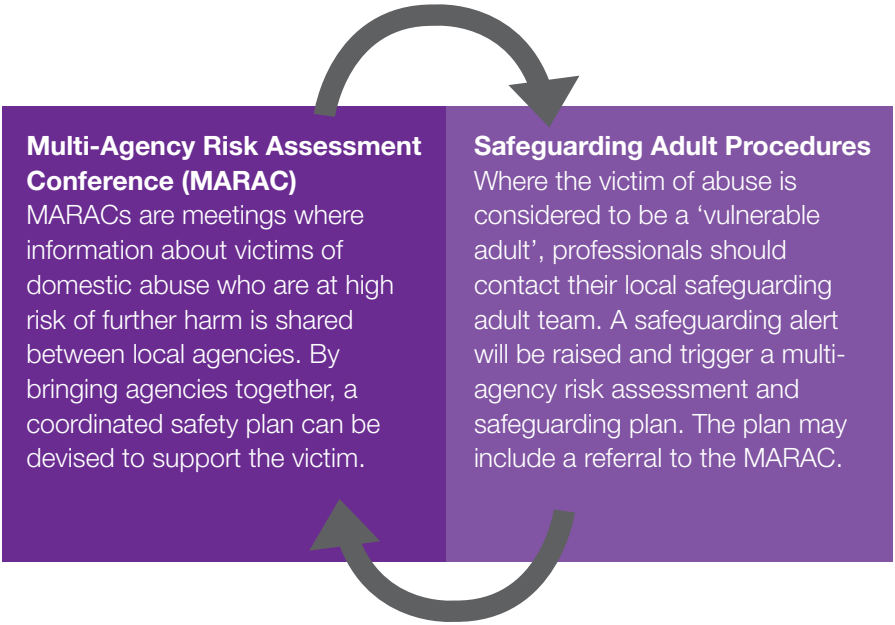
As all three issues – abuse, substance use and mental ill-health – are interlinked and can increase the risk of harm related to each other, for example:

- People who misuse substances have an increased risk of a mental health relapse.[10]
- Using drugs or alcohol when feeling desperate or in a crisis greatly increases the risk of unintentionally committing suicide or causing serious physical damage through self-harming as substances can effect a person's judgement.[11]
- Alcohol use is associated with an increased risk of a perpetrator of domestic violence physically assaulting their partner.[xi]
- A survivor's use of substances may increase with a return to their partner[12] or increased episodes of violence.
- A survivor's mental health may deteriorate if they become isolated when moving to a new area to flee an abusive partner.

3. Use risk management systems

Once a risk assessment has been completed, it is vital that the appropriate action is taken. In deciding what to do next to manage the identified risks, professionals should share any concerns with their line manager rather than making decisions alone. Similarly, due to the multiple needs this client group has, a multi-agency approach may be required. There are two key parallel and interlinking risk management systems to be aware of:

Section 5



3.1 Multi-agency risk assessment conferences

Multi-agency risk assessment conferences (MARACs) exist in most local authorities across England and Wales. You can find out about your nearest MARAC by contacting your local Domestic Violence or Violence Against Women Co-ordinator or the nearest Community Safety Unit based with the police.

The role of the MARAC is to facilitate, monitor and evaluate effective information-sharing to enable appropriate actions to be taken to increase public safety. The aims are:

- To share information in order to increase the safety, health and well-being of high risk survivors. By sharing information, agencies get a better picture of victims' situations and so develop

responses that are tailored to the needs and goals of individual survivors and their children. More information about legal provisions for, and limitations on, information-sharing can be found on p.217.

- To determine whether the perpetrator poses a significant risk to any particular individual or to the general community and to reduce this risk through a jointly constructed risk management plan.

- To reduce repeat victimisation within a multi-agency context.

- To improve agency accountability and responses to domestic violence.

- To improve support for staff involved in high risk domestic violence cases.

The survivor does not attend the meeting, nor does the perpetrator, or the Crown Prosecution Service. The victim is usually informed that their situation will be discussed by the MARAC, unless doing so would jeopardise the survivor's safety.

The MARAC would usually be chaired by an officer from either the police or probation services. This is normally someone with the rank of Detective Inspector or equivalent.

On average the MARAC will spend about 10 minutes per case. This does underline that the responsibility to take appropriate actions rests with individual agencies; it is not transferred to the MARAC. Therefore, those attending the MARAC should have the authority within their agencies to prioritise the actions that arise from the MARAC and to be able to make an immediate commitment of resources to those actions.

3.2 Adult safeguarding procedures

If your client is considered to be 'vulnerable', you may consider referring the case to your local adult safeguarding team.

According to the Department of Health's guidance on safeguarding, *No Secrets,*[12] an adult is deemed vulnerable if "he or she is or may be in need of community care services by reason of mental or other disability, age or illness; and who is

or may be unable to take care of his or herself, or unable to protect him or herself against significant harm or exploitation".[13]

Generally, adult safeguarding teams follows this procedure, which include specific timeframes:

1) **Alert.** Immediate action to safeguard anyone at immediate risk

N.B. Whilst the following process is in place for the most serious cases, it is worth noting that most cases will not proceed past the 'alert' stage.

2) **Referral** (same working day). Information about the concern placed into a multiagency context

3) **Decision** (end of same day as referral made). Are the 'Safeguarding Adults' procedures appropriate to address the concern?

4) **Strategy meeting** (within five working days). A multi-agency plan for assessing risk and addressing immediate protection needs is formulated

5) **Safeguarding assessment** (within four weeks of referral). Information about the concern is collected, including from the survivor, and may also include a criminal or disciplinary investigation

6) **Case conference/ safeguarding plan** (within four weeks of assessment being completed). A multi-agency response to the risk of abuse is created and implemented.

7) **Review** (within six months for first review and thereafter yearly).

The Social Care Institute for Excellence (SCIE) have produced clear guidance on dealing with adult safeguarding concerns in cases where the client does and does not have capacity. These guidelines can be found in appendix D.

Full details of the adult safeguarding referral and assessment process can also be found on the SCIE website:
http://www.scie.org.uk/publications/adultsafeguardinglondon/index.asp

3.3 Confidentiality and consent

You do not need the service user's consent to refer to the MARAC or Adult Safeguarding, although in both cases it is highly preferable. At the very least, referrals should be made with the survivor's knowledge.

"In the absence of serious crime, and of significant risks to third parties, competent adults retain the right to make decisions about how they wish to direct their lives. Neglecting or violating these decision-making rights, even where the intentions are to protect the individual, can itself amount to a form of abuse." [14]

If consent is not obtained to share information in a safeguarding matter or where a survivor of domestic violence is at high risk of further harm, there are several considerations to be made about sharing information without consent.

Sharing information without consent may be legitimate where there is an overriding public interest such as in preventing crime, or where the 'vital interests' of an individual are affected and he or she does not have capacity or is unable give consent. In the latter case, this can include cases where a vulnerable adult is at risk from abuse.

When deciding whether someone has mental capacity, professionals have to consider if the person has an impairment to the functioning of the mind or brain, and an inability to make decisions. A person is deemed to be unable to make decisions if they cannot:

- understand or retain the information relevant to the decision,
- weigh up the information to make the decision, or
- communicate the decision.

Even where a person lacks capacity they should be involved as much as possible in discussions, so that their best interests are maintained, and the least restrictive options in any situation should be sought.

Similarly, even if a survivor does not consent to be referred to the MARAC or Adult Safeguarding

Team, it is still best practice to tell your service user this is what you are doing and update them on any progress.

4. Supporting survivors to keep themselves safe

4.1 Safety planning

Safety planning is a common feature of working with survivors of both domestic and sexual violence. Safety planning is used to identify ways to manage the risk of further violence or abuse from others.

The key principles of safety planning are:

- Keep the responsibility for the abuse explicitly with the perpetrator.
- Provide consistency and continuity.
- Never assume you know what is best for victims; they know their situation and the risks better than you do.
- Recognise that victims will already be employing safety strategies, though they may not name them; recognise, validate and build on what they are already doing. Explore which strategies are effective and helpful, and which may not be so helpful but could be adapted.
- Do not suggest or support anything that colludes with the abuse.
- Risk is dynamic (always changing) and so safety planning needs to be an on-going discussion as situations change.

It is also essential to think about the difference between 'safe from' (violence, threats of violence, etc.) and 'safe to' (engage with services, develop friendships, study, work, etc.) to ensure that both needs are met effectively.

Figure 7 - Safety planning

Safety plans for domestic violence should cover actions to keep safe in a relationship, at the point of leaving and once a relationship has ended. Where a survivor has problems with drugs, alcohol or their mental health, you should consider:

- Substance use and mental health problems can make it difficult for survivors to assess the severity of the abuse they are experiencing.

- Is the plan realistic? Can the survivor implement the plan when they're intoxicated or unwell?

- Can you include changes to patterns of substance use that may increase safety? For example, using at times of day that their partner is unlikely to be around.

- Does the plan incorporate strategies to promote access to substance treatment or mental health services?

- What response might survivors receive from services, the police, etc. when they make calls under the influence of alcohol/drugs or when they are unwell? What previous contact have they had with services (including the police) relating to their substance use or mental health?

- If considering leaving – where will they get their supply of drugs? Do they need emergency prescribing?

Do they have sufficient prescribed psychiatric medication? How easily can they arrange a prescription with a new mental health team?

Full guidance for creating a safety plan for survivors affected by substance use and/or mental health problems can be found in appendix E.

Where someone has experienced sexual violence by their partner or outside of a relationship but by someone known to them, safety plans should consider how to stay safe after the assault and may include a number of the points on the domestic violence safety plan.

4.2 Safer coping strategies

Once practical safety plans have been made, developing a sense of internal safety can be helpful for survivors of domestic and sexual violence. In some cases, survivors will need specialist support to re-establish internal safety, for example cognitive behavioural therapy, psychotherapy or drug/alcohol treatment. Information about the commonly available therapies can be found on pp.85-94.

In the absence of specialist support or trauma therapy, or for service users who do not want to go down that route, a wide range of practitioners (including you!) need to be able to support survivors to manage trauma responses themselves. Developing safer ways to manage a survivor's emotional world can even form part of a formal safety plan.

Supporting someone at this stage can include:

Understanding and managing emotions

- Does the survivor understand what is happening? Give information about domestic and sexual violence, common trauma responses and coping mechanisms

- Does she know what she is feeling? Survivors may need help to clarify and label their feelings

- Does she feel in control of her emotions? Common triggers for becoming overwhelmed with emotion are flashbacks, reminders of the trauma, and HALT (being hungry, angry, lonely and tired).

Making existing coping strategies as safe as possible

- All coping strategies should be acknowledged for fulfilling their purpose, which is to aid survival. For example, see appendix F for information about how self-harm is used as a coping strategy by some survivors.

- Survivors should not be 'forbidden' from using unsafe coping mechanisms as this could lead to them hiding their behaviour and increases the risk of harm. Instead, listen, acknowledge the survivor's pain, their efforts to survive and make all coping mechanisms safe to discuss.

- Provide information about harm minimisation techniques and incorporate into the survivor's safety plan. Substance treatment and mental health services can provide details of recognised harm minimisation techniques.

Implementing new strategies

- Whilst tolerating unsafe coping strategies, as professionals, our job is to devise, evaluate and persuade the survivor to adopt an alternative way of coping; one that offers less immediate relief, but does not trap the person in a diminished quality of life.

- Create clear plans of what to do if feeling overwhelmed, including who can help. This might include calling the Samaritans, the National Domestic Violence Helpline, Rape Crisis, national and local sexual violence helplines, Saneline. Details of all these services can be found in appendix H.

- Consider ways to self-soothe such as grounding, mindfulness and breathing. The Australian National Drug and Alcohol Research Centre has published a useful self-help leaflet about managing trauma responses and substance use. This leaflet can be downloaded from http://tinyurl.com/d8u734e.

- Explore other means to manage feelings: writing, drawing, exercising, hitting cushions.

Lifesigns (Self-Injury Guidance & Network Support) has a great website with guidance and information for people at the point when they feel like self-harming. Useful ways of managing urges to self-harm can be found here: http://www.lifesigns.org.uk/help/read-this-first.

The National Self Harm Network also has a comprehensive list of ways for someone to distract themselves from the urge to self-harm. Many of the activities on the list may also be useful for people coping with urges to use alcohol or drugs or for people who are affected by anxiety, acute distress (including suicidal thoughts) or dissociation – the techniques can help the person focus on the world around them. You can access the list here: http://www.nshn.co.uk/downloads/Distractions.pdf.

What works? Sane Responses

AVA's toolkit on domestic violence and mental health, *Sane Responses*, includes detailed information about specific mental health problems commonly associated with domestic and sexual violence.

The toolkit provides concrete advice on This includes how to:

- respond to survivors who are self-harming or feel suicidal
- how to address difficult emotions and negative thoughts
- support survivors to manage symptoms of PTSD (flashbacks, emotional numbing, anxiety and fear)

Sane Responses can be downloaded or ordered from www.avaproject.org.uk.