The Identification and Response of Psychiatric Services to Domestic Violence

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The Identification and Response of Psychiatric Services to Domestic Violence

Kylee Hutton Trevillion

Thesis submitted to King’s College London

for the degree of Doctor of Philosophy

February 2013

Section of Women’s Mental Health
Health Service and Population Research Department
Institute of Psychiatry
Kings College London
Abstract
Despite a high prevalence of domestic violence among service users, most cases remain undetected by psychiatric services. Moreover, little is known about the attitudes and opinions of service users and clinicians, regarding psychiatric services response to domestic violence. This research comprises three studies that aimed to: (1) systematically review the prevalence of domestic violence among psychiatric service users; (2) systematically review the effectiveness of interventions for psychiatric service users disclosing domestic violence, and (3) qualitatively explore the experiences and expectations of psychiatric service users and clinicians in relation to domestic violence.

Study One: 42 studies were reviewed. Among high-quality studies measuring lifetime partner violence, the pooled prevalence in female inpatients was 37.6% (95% CI 24.3-51) and 31.6% in the one study of males across mixed psychiatric settings.

Study Two: Three studies were reviewed. Insufficient evidence was found to establish the effectiveness of cognitive behavioural therapy or domestic violence advocacy.

Study Three: Semi-structured interviews were conducted with 24 service users and 25 clinicians. Interviews focused on attitudes towards routine enquiry, experiences of being asked/asking about domestic violence, and views on what interventions had been or would be helpful. Overlapping themes among clinicians and service users included the dominance of the medical diagnostic and treatment model and the establishment of specialist services for abused service users. Service user specific themes included unanimous agreement towards routine enquiry, barriers to disclosure (e.g. blaming attitudes, fear of consequences) and clinicians’ assistance with their complex needs. Clinician specific themes included mixed views about the implementation of routine enquiry, barriers to enquiry (e.g. role boundaries, competencies and confidence to address abuse) and the need for improved referral pathways and support at an organisational-level.
The development and implementation of system-level interventions and evidence-based treatments are crucial to improving psychiatric services identification and response to domestic violence.
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Dissemination of Study Results

Refereed Publications


Conference Publications


Glossary

Accident and Emergency (A&E) Department
Hospital department providing emergency care

Care Coordinator
Care Coordinators are qualified mental health workers who are responsible for co-ordinating all aspects of service users’ care in the UK. Care coordinators are usually community psychiatric nurses or mental health social workers but may include psychologists and occupational therapists

Care Programme Approach
The care programme approach (CPA) sets out the way treatment and care is provided to people with severe mental illness. Community mental health services are required to assess the needs of mental health service users, provide them with a written care plan, allocate a care coordinator, and regularly review and update the plan

Domestic Violence
Domestic violence is defined here as: any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults (aged ≥ 16 years) who are or have been intimate partners or family members regardless of gender or sexuality:

1) Lifetime Domestic Violence
   In line with the definition above, lifetime domestic violence is defined as violence or abuse occurring aged 16 years or above

2) Past year Domestic Violence
   Past year domestic violence is defined as violence or abuse occurring in the previous twelve months

Dual Diagnosis Worker
Dual diagnosis workers are situated within Community Mental Health Teams (CMHTs) and provide specialist support to service users and other professionals around managing dual diagnosis (mental health problems and co-morbid drug or alcohol problems)

General Practitioner (GP)
A physician whose practice provides on-going care for medical health problems in people of all ages and often includes referral to specialist services where appropriate. In the UK, GPs act as gatekeepers to secondary health care

Multi-Agency Risk Assessment Conference (MARACs)
MARACs are UK Multi-Agency Risk Assessment Conferences attended by services including the police, Children and Family Social Services and health and housing representatives. MARACs aim to improve the safety of people who are experiencing domestic violence and are at high risk of harm, by developing coordinated action plans, between statutory and voluntary sector organisations

MIND
A mental health charity in England and Wales, which offers advice and information to people with mental health problems. The charity runs campaigns to improve services, raise awareness and promote understanding regarding mental illness
Refuge
A safe house in the community where women experiencing domestic violence can live free from violence

Samaritans
A national charity providing 24 hour helpline support for people experiencing despair, distress or suicidal feelings

Secondary Mental Health/Psychiatric Services
Psychiatric services are secondary or tertiary care specialist services (inpatient, outpatient or community-based) providing psychiatric care and support to people with mental illnesses. Community mental health services had two main configurations within the south London NHS Trust at the time of this research study:

1) Assessment and Brief Treatment
Assessment and Brief Treatment teams are where all new mental health referrals are made. They offer comprehensive assessments and brief interventions for those whose needs can be supported in this way

2) Support and Recovery
Support and Recovery teams provide a service for people who require longer term continuity of engagement, support and treatment

Victim Support
A national charity in England and Wales providing free and confidential help to people who have experienced crime

Vulnerable Adult Protection Procedures
A Department of Health for England policy that seeks to ensure health Trusts implement multi-agency codes of practice to help prevent and tackle abuse of vulnerable adults: defined as individuals “who are 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 him or herself, or unable to protect him or herself against significant harm or exploitation”

Women’s Aid
A national charity working to end domestic violence against women and children. The charity provides 24 hour helpline support, information on housing, welfare, health and legal rights, referral to temporary emergency accommodation, help with the police, emergency services, and support agencies
### Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>A&amp;E</td>
<td>Accident and Emergency</td>
</tr>
<tr>
<td>BAMER</td>
<td>Black, Asian, Minority Ethnic and Refugee</td>
</tr>
<tr>
<td>BCS</td>
<td>British Crime Survey</td>
</tr>
<tr>
<td>CBT</td>
<td>Cognitive Behavioural Therapy</td>
</tr>
<tr>
<td>CI</td>
<td>Confidence Interval</td>
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<tr>
<td>CMHT</td>
<td>Community Mental Health Teams</td>
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<tr>
<td>CPA</td>
<td>Care Programme Approach</td>
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<tr>
<td>DV</td>
<td>Domestic Violence</td>
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<tr>
<td>DoH</td>
<td>Department of Health for England</td>
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<tr>
<td>GP</td>
<td>General Practitioners</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<tr>
<td>HO</td>
<td>UK Home Office</td>
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<tr>
<td>HTA</td>
<td>Health Technology Assessment</td>
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<tr>
<td>IDVA</td>
<td>Independent Domestic Violence Advisor</td>
</tr>
<tr>
<td>LGBT</td>
<td>Lesbian, Gay, Bisexual and Transgender</td>
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<tr>
<td>MARAC</td>
<td>Multi Agency Risk Assessment Conference</td>
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<tr>
<td>MIND</td>
<td>Mental Health Charity</td>
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<tr>
<td>NHS</td>
<td>National Health Service</td>
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<tr>
<td>NICE</td>
<td>National Institute for Health and Clinical Excellence</td>
</tr>
<tr>
<td>NIHR</td>
<td>National Institute for Health Research</td>
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<tr>
<td>OR</td>
<td>Odds Ratio</td>
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<tr>
<td>PTSD</td>
<td>Post-Traumatic Stress Disorder</td>
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<tr>
<td>RR</td>
<td>Risk Ratio</td>
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<tr>
<td>SD</td>
<td>Standard Deviation</td>
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<td>SE</td>
<td>Standard Error</td>
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<tr>
<td>SMI</td>
<td>Severe Mental Illness</td>
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<td>WHO</td>
<td>World Health Organization</td>
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Chapter 1: Introduction

The World Health Organization and the World Bank estimate that violence and injuries contribute to 15% of the worldwide burden of disease (Gosselin, Spiegel, Coughlin, et al., 2009), with violence documented as one of the leading causes of death among people aged 15–44 years (World Health Organization, 2002). Women are more likely to experience domestic violence than violence in any other context (Heise, Ellsberg & Gottemoeller, 1999) and globally it is one of the leading causes of morbidity among women aged 19-44 years (VicHealth, 2005; World Bank, 2009). Consequently, research has predominantly focused on women’s experience of domestic violence and the evidence base regarding the nature and impact of men’s experience of domestic violence remains sparse. Global population-based surveys estimate a prevalence of 10-52% for lifetime physical partner violence and 10-30% for lifetime sexual partner violence among women (Krug, Mercy, Dahlberg, et al., 2002); no such global estimates exist for men. In England and Wales alone 47% of female homicides and 5% of male homicides are perpetrated by a current partner or ex-partner (Smith, Osborne, Lau, et al, 2012).

In addition to injuries, domestic violence is associated with a range of long-term health problems, including chronic pain, gynaecological health problems, alcohol and substance abuse, post-traumatic stress disorder, anxiety and depression (Campbell, 2002; Golding, 1999; Ratner, 1993; Trevillion, Oram, Feder, et al, In Press). Strong and consistent associations have been identified between domestic violence and mental health symptoms and research suggests that domestic violence increases the risk of mental illness (Afifi, MacMillan, Cox, et al, 2009; Bacchus, Mezey & Bewley, 2004; Coker, Davis, Arias, et al, 2002; Kaslow, Thompson, Meadows, et al, 2000; Ludermir, Lewis & Valongueiro, 2010). The ability to determine the direct cause and effect of this relationship is limited, however, due to a paucity of longitudinal studies examining the temporal relationship between mental illness and domestic violence (Trevillion, Oram, Feder, et al, In Press). Research suggests that a complex inter-relationship exists between domestic violence and mental illness: psychiatric illness may be precipitated by abuse, but severe and chronic psychiatric illness can also put people at risk for abuse. Estimates indicate that 30-60% of psychiatric inpatients
experience severe domestic violence in their lifetime (Howard, Trevillion, Khalifeh, et al., 2010).

A paucity of research has been conducted on the nature and impact of domestic violence among people cared for by psychiatric services. However, it is known that domestic violence remains largely undetected by psychiatric services worldwide (Briere & Zaidi, 1989; Chandra, Carey, Carey, et al., 2003; Currier, Barthauer, Begier, et al., 1996; Howard, Trevillion, Khalifeh, et al., 2010; Young, Read, Barker-Collo, et al., 2001). Indeed, clinicians rarely ask service users about domestic violence and often fail to provide sufficient documentation of abuse in medical records (Howard, Trevillion, Khalifeh, et al., 2010). If service users do disclose domestic violence, clinicians frequently fail to incorporate the abuse within treatment plans (Agar, Read & Bush, 2002; Howard, Trevillion & Agnew-Davies, 2010; Klap, Tang, Wells, et al., 2007).

The purpose of the following overview of the literature is to examine current research on domestic violence, with the objectives of: (1) outlining the nature, prevalence and physical and mental health impacts of domestic violence; (2) examining evidence on health services’ identification and response to domestic violence; (3) reviewing evidence on the effectiveness of interventions for domestic violence; and (4) introducing my PhD study, which seeks to address current gaps in the evidence base.
Overview of the Scientific Literature

1.1 Definition of Domestic Violence
In the absence of a single and universally agreed definition, numerous terms have been used to denote what is commonly referred to as ‘domestic violence’ (e.g. wife assault, wife battering, spousal assault, intimate partner violence and domestic abuse). For the purposes of this research study, the UK Home Office definition of domestic violence has been adopted to describe:

“Any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults (aged ≥18 years) who are or have been intimate partners or family members, regardless of gender or sexuality. This includes issues of concern to black and minority ethnic communities such as so called 'honour' based violence, female genital mutilation and forced marriage, and is clear that victims are not confined to one gender or ethnic group” (HomeOffice, 2005, p 7)

The term ‘adults’ was amended to include males and females aged 16 years and above, in light of increasing evidence of a high prevalence of domestic violence among people aged 16-24 years of age (Smith, Osborne, Lau, et al, 2012).

The above definition was selected because it captures the multidimensional nature of domestic violence (e.g. non-physical forms of abuse), and is one of the few descriptions to include violence perpetrated by intimate partners and family members (i.e. mother, father, son, daughter, brother, sister and grandparents; directly-related, in-laws or step-family). The definition does not include specific wording about ‘coercive control’, which is considered by some scholars to be the defining feature of domestic violence (Dutton, 2007; Sanderson, 2008; Stark, 2007); although, the types of behaviours that comprise ‘coercive control’ are contained within this definition (see section 1.2).

Interestingly, in December 2011 the Home Office undertook a public consultation exercise to examine whether the definition should be changed, by lowering the
age range to 16 years and above and including specific wording on coercive control (Home Office, 2011b, p 5). The results of this consultation have just been published and the definition is to be amended to include coercive control (i.e. an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten) and violence or abuse experienced by people aged 16 years and above (Home Office, 2012a).

1.1.1 Terminology
To ensure consistency of terms, the word ‘survivor’ is used when referring to people experiencing domestic violence. This terminology is increasingly used by government agencies, scholars and activists and seeks to challenge early social constructions of “passive victims” (Kelly, 1988, p 159), which attempted to:

“Account for the deviance of battered women who ‘stay’ and shift blame for this behavior by emphasizing their emotionality, and especially their lack of choice” (Dunn, 2005, p 21)

By framing people as ‘survivors’ it supports a re-construction of victims that embodies the “cultural values of strength rather than weakness, and agency instead of passivity” (Dunn, 2005, p 21).

The definition adopted in this study acknowledges that both women and men can be victims of domestic violence. Nevertheless, domestic violence is recognised as a gendered issue, as women are more likely to experience frequent and severe assaults and report greater injuries and fear for their lives compared to men (Finney, 2006).

1.2 Types of Violence
The hidden nature of domestic violence (see Chapter 5 section 5.5.1.3) and the intimate relationship between abuser and survivor means that the violence is generally more frequent and severe than other forms of abuse (Kropp, Hart & Belfrage, 2005). The types of abuse that characterise domestic violence relationships are illustrated below.
1.2.1 Physical Violence
Physical violence can be either controlled or impulsive physical attacks. It incorporates hitting, slapping, punching, shoving, kicking, biting, beating (including beating with objects or weapons and murder), stabbing, shooting, choking, burning, scalding, torture and poisoning. It also consists of physical neglect, including a failure to provide for basic needs (e.g. food and clothing).

Global prevalence estimates of lifetime physical partner violence range from 13-61% among women (World Health Organization, 2005). Estimates from the 2010/2011 British Crime Survey indicate that 6.9% of men and 16.1% of women have experienced physical partner violence since the age of 16 (Smith, Osborne, Lau, et al, 2012).

1.2.2 Sexual Violence
Sexual violence includes rape (forced oral, vaginal or anal penetration with a penis), sexual assault by penetration (forced oral, vaginal or anal penetration with an object), forced sexual acts and forced sex with others, forced prostitution and pornography, cutting or disfiguring of genitalia, refusal to practice safe sex and refusal to adhere to religious prohibitions.

Findings from the 2010/2011 British Crime Survey indicate that 19% of women and 2% of men have experienced sexual assault by an intimate partner since the age of 16 (Smith, Osborne, Lau, et al, 2012).

1.2.3 Financial Abuse
Financial abuse includes prohibiting access to cash and/or credit, by taking absolute control over all finances and financial decisions, refusal to contribute to family incomes and forced engagement in illegal activities (e.g. theft, financial fraud). Financial abuse includes not having sufficient funds for personal necessities (e.g. tampons) and general house-keeping needs (e.g. food, heating). Some abusers may also subsume the role of carer for people with disabilities, in order to gain complete control over finances and prevent access to key resources, including money, medication and transport.
To date, the majority of research on financial abuse has concentrated on abuse of elders (≥ 60 years) (Acierno, Hernandez, Amstadter, et al, 2010; O’Keeffe, Hills, Doyle, et al, 2007). When measured, prevalence estimates for financial abuse are generally not reported separately. For instance, the UK British Crime Survey clusters financial and emotional abuse into a single count and estimates a lifetime prevalence of 26% among women and 17% among men (Walby & Allen, 2004).

1.2.4 Psychological/Emotional Abuse
Psychological and emotional abuse can take the form of both verbal and non-verbal behaviours and is characterised by cruelty and humiliation. It incorporates unremitting criticism, threats of harm, emotional blackmail, degradation, neglectful behaviours (e.g. ignoring signs of distress and pleas for comfort) and cognitive neglect (e.g. restricting social activities). An additional form of emotional abuse is the enforcement of petty rules, which if not adhered to are severely punished.

Evidence suggests that women experience high levels of psychological abuse, with global estimates indicating a mean prevalence of 14% - 78% for lifetime psychological abuse among women (Alhabib, Nur & Jones, 2010). A prevalence of 17.3% has been found for lifetime psychological abuse among men (Coker, Davis, Arias, et al, 2002). Psychological abuse is often seen to precede physical violence, may be as detrimental to survivors’ physical health (Coker, Davis, Arias, et al, 2002) and can result in greater psychiatric morbidity (Follingstad, Rutledge, Berg, et al, 1990; Humphreys & Thiara, 2002; Mechanic, Weaver & Resick, 2008).

1.2.5 Coercive Control
Coercive control comprises a complex pattern of abuse, using power and psychological domination to exert and maintain control over another. It includes financial control (see section 1.2.3), psychological/emotional abuse (see section 1.2.4) and forced social isolation (i.e. isolation from friends, family and other support networks).
It is important to note that survivors of domestic violence are rarely subjected to just one of the behaviours outlined above (Howard, Trevillion & Agnew-Davies, 2010); a finding supported by the research study presented in Chapter 5, which explores the type and severity of abuse experienced by male and female psychiatric service users. Around half of women and a third of men who experience domestic violence report more than one form of abusive behaviour (Coleman, Jansson, Kaiza, et al, 2007).

In an attempt to gain a deeper understanding of the nature of domestic violence among men and women, several scholars have attempted to examine the patterns and characteristics of violence within violent relationships; as outlined below.

1.3 Cycle of Violence

Based on her interviews with over 400 abused women, feminist scholar Lenore Walker (1979) first employed the term ‘cycle of violence’ to explain the three-phase cyclical nature of incidents of domestic violence: (1) the tension-building stage; (2) the acute battering incident, and (3) loving-contrition (Walker, 1979). The cycle usually develops following an initial courtship period, where the abuser is seen to be highly charming, attentive and loving; adopting behaviours that act to bond the woman to the relationship. This is followed by the tension-building stage, a gradual escalation of internal pressure and tension in the abuser, leading them to become increasingly hostile and to act out in ways that cause friction within the relationship (e.g. expressing dissatisfaction, name-calling). As the internal pressure increases, the abuser experiences an “uncontrollable discharge of tensions” (Walker, 1979, p 59) that results in the acute battering incident, characterised by eruptions of physical violence or verbal assaults; it is during this phase that the survivor is most at risk of harm. Once the aggression has been vented it is replaced by loving-contrition, whereby the abuser makes pleas for forgiveness, shows remorse and displays kindness and loving affection. Often abusers profess that they will not act violently again and the woman, who is delighted at the restoration of affection, invariably forgives the abuser and places hope in their ability to change; until the cycle is activated again (Walker, 1979).
Other research with abused women lends support to this three-stage cycle of violence (Evins & Chescheir, 1996; Johnson & Zlotnick, 2010; Sanderson, 2008), which also manifests in post-separation stalking behaviours (Boon & Sheridan, 2008; Coleman, 1997).

Walker adopted the term ‘learned helplessness’ to explain the sequelae of the repetitive cycle of violence and why abused women find it difficult to terminate an abusive relationship (Walker, 1979). The theory of ‘learned helplessness’ was first developed by the psychologist Martin Seligman (1975) to explain why people exposed to uncontrollable aversive events - who learn that their responses and outcomes are independent of each other - develop an expectation that future events will also be uncontrollable. As a result of this learning people frequently display decreased motivation, negative affect and develop coping deficits for future aversive but escapable situations (Seligman, 1975). Walker adapted Seligman’s theory and hypothesised that women’s experience of the non-contingent nature of their attempts to control the violence would, over time, produce a form of ‘learned helplessness’ and passivity; a process which she defined as the ‘battered woman syndrome’ (Walker, 1979; Walker, 1999; Walker, 2009). The ‘battered woman syndrome’ was widely acknowledged and has been introduced within USA, Canadian and UK legal systems as a self-defence claim to explain why abused women kill their abusers rather than leaving them (Rix, 2001; Shaffer, 1997; Stubbs, 1991).

Critiques of the ‘cycle of violence’ model highlight that not all abusive relationships fit this three-stage pathway. For instance, family violence researchers highlight that while some abusive relationships are characterised by continual episodes of violence and high levels of control others comprise infrequent episodes, which do not escalate in frequency and severity over time and are not associated with a general pattern of control (Johnson, 2008; Langhinrichsen-Rohling, 2005). They argue that Walker’s model fails to explore differences in women’s use of violence in abusive relationships (Straus, 2011) (see section 1.4 below). Additionally, other research suggests that it is the intermittency of abuse, as opposed to the predictable and cyclical nature of violence outlined by Walker, that is the major determinant of the sequelae of
abuse (Dutton & Painter, 1993). It is also argued that the static interaction between abuser and survivor in Walker’s model fails to consider changes in relationship patterns and dynamics over time (Fife & Schrager, 2012). Interestingly, Walker’s recent research with female survivors has highlighted that over time there is a change in the duration and occurrence of each of the three ‘cycle of violence’ phases. For instance, she found that as abusive relationships continue women report an increase in tension-building phases and a decrease in loving-contrition phases. Walker’s research suggests that some abusive relationships may be characterised by an absence of tension-building and loving-contrition phases; in these instances women are at an extreme risk of harm (Walker, 2009).

Walker’s ‘battered woman syndrome’ has also received criticisms from some feminist scholars, who argue that this concept perpetuates a stereotypical view of abused women as ‘weak’ and ‘passive’ and fails to explain the full psychological impact of domestic violence (Dunn, 2005; Gondolf & Fisher, 1988; Hoff, 1990). The model is further criticised for its failure to consider the intersectionality of race and gender on women’s experiences of violence (Allard, 1991). Walker’s application of the ‘learned helplessness’ theory as an explanation for the sequelae of abuse has been questioned by its developer, Martin Seligman, who argues that Walker provides little empirical support that women’s responses to abuse are a result of this process (Peterson, Maier & Seligman, 1993). Finally, the ‘battered woman syndrome’ fails to consider evidence that women are at continued risk of post-separation violence (Humphreys & Thiara, 2003b; Thiara, 2010) and are at greatest risk of homicide at the point of, or shortly after, separation (Wilson & Daly, 1993). Therefore, a woman’s decision to remain in an abusive relationship may be a rational decision based on an assessment of the benefits and risks of separation.

1.4 Situational Couple Violence, Intimate Terrorism and Violent Resistance

In response to findings from community-based surveys, family violence researchers have sought to categorise nuances in the nature and severity of
violence perpetrated in intimate relationships. For example, Johnson makes a distinction between ‘situational couple violence’, ‘intimate terrorism’ and ‘violent resistance’ (Johnson, 2008). ‘Situational couple violence’ describes infrequent violence that arises as an intermittent response to occasional conflicts of everyday life; it is not seen to escalate over time and is not associated with a general pattern of control. In contrast, ‘intimate terrorism’ describes a continued pattern of violence, intimidation and control that is characterised by severe and frequent violence; it is seen to escalate over time and comprises one component in a general pattern of coercive control. Finally, ‘violent resistance’ describes violence that is used by one partner in response to the others use of ‘intimate terrorism’ (Johnson, 2008; Johnson, Leone & Xu, 2008). Johnson’s research suggests that there are distinct gender differences in these three forms of violence: ‘intimate terrorism’ and ‘violent resistance’ is largely perpetrated by men against their female partners, whereas ‘situational couple violence’ is seen to be comparable among men and women (Johnson, 2010).

Support for Johnson’s typologies have been found in other research studies, which examine patterns of violence within intimate relationships (Archer, 2000; Frye, Manganello, Campbell, et al, 2006; Graham-Kevan & Archer, 2003; Leone, Johnson, Cohan, et al, 2004; Thiara, 2010). However, detailed examinations of the nature and degree of violence within intimate relationships indicates that controlling behaviours are present within each of the three typologies (Graham-Kevan & Archer, 2008). Moreover, distinct gender differences are seen to be present in the perpetration of mutual violence within the ‘situational couple violence’ typology (Prospero, Dwumah & Ofori-Dua, 2009). Finally, feminist scholars argue that classifications of violence such as these, which focus exclusively on individual and couple dynamics, fail to take in to consideration gender disparities and systems of oppression (e.g. heterosexism, classism, race and religious factors) (Humphreys & Campbell, 2011; Thiara & Gill, 2010a).

Variations between the models of Walker and Johnson may partly reflect differences in the conceptualisation of domestic violence among feminist and family violence scholars (Archer, 2006; DeKeseredy & Dragiewicz, 2009). Family violence scholars situate violence within the context of relationship
conflicts and examine specific behavioural acts of aggression. In contrast, feminist scholars situate violence within the context of power dynamics in relationships and examine the context, impact and consequences of abuse. As will be outlined below, differences in the conceptualisation of domestic violence within epidemiological research contribute to variations in study findings.

1.5 Prevalence of Domestic Violence

Prevalence estimates of domestic violence vary considerably, due to differences in research methodologies, study samples (e.g. community versus clinical samples) and operational definitions of domestic violence; including the time frame assessed for violent experiences (i.e. lifetime versus past year violence), and the type of violent behaviours examined (i.e. physical, sexual, psychological) (Alhabib, Nur & Jones, 2010). Studies employing broader definitions (i.e. physical and non-physical violence) are shown to report higher rates of domestic violence than studies using narrower definitions (i.e. physical violence only) (Feder, Ramsay, Dunne, et al, 2009).

Differences in terminologies of domestic violence among survey instruments also account for variations in estimates (Langhinrichsen-Rohling, 2010). For example, one of the most widely used instruments, the Conflict Tactics Scale (CTS) (Straus, Hamby, Boney-McCoy, et al, 1996; Straus, 1979), examines specific behavioural acts of violence (e.g. slapping, kicking, hitting) arising from relationship conflicts. Research using the CTS has generally reported comparable rates of violence among men and women (Archer, 2000; Archer, 2002), although the CTS has been criticised for ignoring the context, motivations and meanings surrounding violent attacks (Archer, 2006; DeKeseredy, 2011). Interestingly, survey instruments which do examine these contextual issues (e.g. Women’s Experience with Battering Scale (WEB) (Smith, Thornton, DeVellis, et al, 2002)) repeatedly indicate that women are more likely to experience violence than men (Houry, Rhodes, Kemball, et al, 2008) (see Chapter 2 section 2.4.2 for a critique of the CTS scale).

Finally, the method of administration of survey instruments (i.e. researcher administered versus self-complete surveys) affects response rates. Findings
suggest that disclosure of domestic violence is considerably higher for self-completion surveys compared to researcher administered instruments (MacMillan, Wathen, Jamieson, et al, 2006; Walby & Allen, 2004).

1.5.1 Prevalence of Domestic Violence in Community-Based Populations
At present, the majority of prevalence studies focus exclusively on women’s experience of domestic violence. For instance in 2005 the World Health Organization conducted the largest prevalence study to date, which surveyed women’s experience of physical, sexual and psychological partner violence across fifteen sites in ten countries (i.e. Bangladesh, Brazil, Ethiopia, Japan, Peru, Namibia, Samoa, Serbia and Montenegro, Thailand, and the United Republic of Tanzania). Findings from 24,097 women aged 15-49 years identified a lifetime prevalence of 15% - 71% for physical and/or sexual partner violence, with two sites reporting a prevalence of less than 25%, seven sites between 25%-50% and six sites between 50%-75%. Japanese women reported the lowest lifetime prevalence of partner violence and Bangladeshi, Ethiopian, Peruvian and Tanzanian women reported the highest prevalence. For past year partner violence, prevalence estimates ranged from 4%- 54% among women (Garcia-Moreno, Jansen, Ellsberg, et al, 2009). The authors warn that these prevalence figures may underestimate the true extent of violence experienced by women, as conservative definitions of domestic violence were used in order to reflect differing views about violence across the ten countries.

In 2009 Feder et al conducted a comprehensive systematic review of UK community-based studies (published since 1995), assessing the prevalence of physical, sexual and psychological partner violence among women. The review identified five studies that reported a lifetime prevalence of 13%-31% and a past year prevalence of 4.2%-6% among women (Feder, Ramsay, Dunne, et al, 2009). The authors state that the majority of UK prevalence studies focus on violence perpetrated by an intimate partner and overlook abuse perpetrated by other family members. Most studies in the review only reported data on the prevalence of physical violence, even when surveys instruments also collected data on experiences of sexual violence and psychological abuse.
Some large scale surveys, including the UK British Crime Survey (BCS) and the USA National Intimate Partner and Sexual Violence Survey (NISVS), examine both men’s and women’s experience of domestic violence. Findings from these studies often report comparable rates of isolated incidents of domestic violence among men and women (Howard, Trevillion & Agnew-Davies, 2010). For instance, the 2001 BCS sampled 22,463 residents in England and Wales and found that 6% of women and 5% of men had experienced domestic violence, including financial and emotional abuse, in the previous twelve months (Walby & Allen, 2004). It is important to note, however, that these findings may underestimate the true extent of domestic violence because the BCS sampling frame only includes people living in private households. As a consequence, groups that generally report higher rates of domestic violence are excluded, including hospital inpatients, people residing in refuges/hostels and people with no fixed abode (Chandra, Carey, Carey, et al, 2003; Curcio, 1999; Goodman, Dutton & Harris, 1995; Henny, Kidder, Stall, et al, 2007; Heru, Stuart, Rainey, et al, 2006; Stermac & Paradis, 2001). Additionally, the BCS may create a misleading picture of gender symmetry, due to the fact that it measures only the frequency of abusive attacks and not the context in which the attacks occur (Walby & Myhill, 2001). Addressing these issues, Walby and Allen (2004) examined data from the 2001 BCS survey and found that women were more likely to sustain physical and psychological injuries compared to men and 89% of people reporting four or more incidents of domestic violence were women (Walby & Allen, 2004). Similarly, the USA Centers for Disease Control NISVS sampled 16,507 USA residents and found that 36% of women and 29% of men reported partner violence during their lifetime (Black, Basile, Breiding, et al, 2011). When examining the impact of abuse among men and women, however, the NISVS found that women were more likely to sustain physical and psychological injuries compared to men (Black, Basile, Breiding, et al, 2011).

Considerably less research has been conducted on the prevalence of domestic violence among lesbian women and gay men, and a dearth of evidence exists on bisexual and transgender men and women. Preliminary evidence suggests that the prevalence of domestic violence within same-sex relationships is comparable to or slightly higher than within heterosexual relationships (Greenwood, Relf, Huang, 2000).
et al., 2002; Houston & McKirnan, 2007; McClennen, 2005; Rothman, Exner & Baughman, 2011). At present, the extent of domestic violence perpetrated against lesbian, gay, bisexual and transgender (LGBT) people by an opposite-sex partner remains unclear, as most research with LGBT people focuses exclusively on same-sex violence or fails to determine the sex/gender or sexual orientation of perpetrators.

Tucker et al (2004) presented the first USA national estimates of physical and psychological partner violence in same-sex relationships among 117 adolescents participating in the National Longitudinal Study of Adolescent Health (Tucker, Young, Waller, et al., 2004). The authors found that 24% of adolescents experienced domestic violence in the previous eighteen months. Females were significantly more likely than males to experience both types of partner violence, with 15% of males and 26% of females reporting psychological abuse and 9% of males and 13% of females reporting physical violence (Tucker, Young, Waller, et al., 2004). The survey used a validated instrument, the Conflict Tactics Scale (CTS), to measure acts of violence; although the CTS has been criticised for failing to measure the context surrounding violent attacks (see Chapter 2 section 2.4.2), and in its sensitivity for measuring violence severity among same-sex relationships (Regan, Bartholomew, Oram, et al., 2002). The authors also made modifications to the CTS without testing the validity of these changes and these factors may weaken the instrument’s power in detecting cases of domestic violence. Focusing specifically on studies that assess the sexual orientation of men and women, a recent systematic review of USA studies identified a lifetime prevalence of sexual partner violence of 9.5% -57% among gay and bisexual men and 2% -45% among lesbian and bisexual women (Rothman, Exner & Baughman, 2011). The authors note that the failure of studies to determine the gender or sex of perpetrators meant that they could not examine the extent of violence within same-sex relationships compared to opposite-sex relationships (Rothman, Exner & Baughman, 2011). In one of the only USA studies to examine violence perpetrated against transgender people, it was found that among 229 male-to-female and 121 female-to-male transgender people 12% were sexually assaulted and 8% were physically assaulted by a current spouse or partner (Xavier, Honnold & Bradford, 2007). It is important to note that the latter study was not a
representative sample and may not therefore be generalisable to the wider USA transgender population.

In the UK Donovan et al (2006) conducted a survey of domestic violence among 746 men and women in same-sex relationships and found that 40% of women and 35% of men experienced either physical, sexual or psychological abuse in an intimate relationship (Donovan, Hester, Holmes, et al, 2006). Similarly, a UK survey of 3,302 LGBT men and women found that 22% of women and 29% of men had experienced lifetime physical, sexual or psychological abuse by a partner (Henderson, 2003). It is important to note that these studies were not representative samples and as a result may not be generalisable to the wider UK population of people in same-sex relationships or LGBT communities.

The findings above highlight the paucity of representative community- and clinically-based population research on the prevalence and risk of domestic violence among LGBT communities. Initial evidence suggests that LGBT adults and adolescents may be at high risk of experiencing domestic violence, and UK gay, bisexual and transgender men may experience more lifetime abuse than LGBT women. However, the dearth of evidence on the prevalence of domestic violence among non UK and USA LGBT communities, violence perpetrated by opposite-sex partners and experiences of domestic violence among bisexual and transgender people prohibits a full and comprehensive understanding of the nature, extent and potential vulnerabilities to abuse among LGBT communities.

1.5.2 Prevalence of Domestic Violence in Clinical Populations

1.5.2.1 Non-Psychiatric Health Surveys

In 2009 a comprehensive systematic review examined the prevalence of domestic violence among UK women accessing a range of non-psychiatric health services. The review identified eleven studies assessing prevalence of domestic violence among women attending general practices, antenatal and postnatal clinics, accident and emergency services and gynaecology and family planning clinics. The lifetime prevalence of domestic violence across all services ranged from 13%-41% and the past year prevalence from 4%-19.5% among women (Feder, Ramsay, Dunne, et al, 2009). Comparable to general population based surveys,
this review found that most research studies employed relatively narrow definitions of domestic violence, focusing largely on physical violence perpetrated by an intimate partner. The number and content of questions measuring the prevalence of domestic violence was found to vary between studies, and several studies made modifications to instruments without detailing how, if at all, the adapted measures were validated. These factors are likely to reduce both the reliability and comparability of study findings.

A recent systematic review by Alhabib et al (2010) examined the worldwide evidence, published from 1995-2006, on the prevalence of domestic violence among women - excluding pregnant women and women with disabilities - across a range of health settings (e.g. primary care, emergency care, hospital settings, obstetrics/gynaecology clinics). Among primary care and community health settings a mean lifetime prevalence of 37% was identified for physical violence and emotional abuse and a mean lifetime prevalence of 18% for sexual violence; across obstetrics/gynaecology settings the mean lifetime prevalence for physical violence and emotional abuse was 41% and 56% respectively and 35% for sexual violence. Across hospital settings the mean lifetime prevalence for physical violence and emotional abuse was 36% and 38% respectively and 9% for sexual violence. Finally, in emergency care settings the mean lifetime prevalence of physical violence and emotional abuse was 39% and 87% respectively and 20% for sexual violence (Alhabib, Nur & Jones, 2010). The authors observed variations in prevalence estimates both across and within study countries, which partly reflect differences in the type of instruments used to measure domestic violence, and the methods of data collection (face-to-face versus self-complete questionnaires). Although this review appraised the methodological quality of included studies it did not calculate a pooled prevalence of domestic violence across health settings or present separate prevalence estimates by lifetime and past year violence. Furthermore, the review excluded studies on women with human immunodeficiency virus (HIV), women accessing refuges and pregnant women; these particular groups of women have been shown to be at increased risk of experiencing domestic violence (Jewkes, Dunkle, Nduna, et al, 2010; Silverman, Raj, Mucci, et al, 2001). Consequently, these factors limit the ability to generalise findings to all women accessing health services.
To date, the majority of prevalence studies examining domestic violence among male service users have been conducted in emergency care settings. A recent review of prevalence studies in emergency health settings identified a lifetime prevalence of domestic violence of 4.6-22.4% and a past year prevalence of 1-13% among men (Olive, 2007). This review found that the majority of prevalence studies in emergency care settings examined physical violence only and employed different instruments to measure domestic violence, some of which may not have been validated for use with this population. Many studies also excluded male service users with critical illness, injuries or mental health problems and these restrictions are likely to underestimate the true extent of violence experienced by men. As the review did not conduct formal assessments of the methodological quality of studies the ability to extrapolate findings to the wider population of male emergency care service users is limited. This review identified a dearth of evidence on male service users’ experience of sexual violence and/or psychological and emotional abuse.

The findings above indicate that a higher prevalence of domestic violence exists among clinical populations compared to the general population (Alhabib, Nur & Jones, 2010; Feder, Ramsay, Dunne, et al, 2009). However, the majority of prevalence studies conducted to date employ relatively narrow definitions of domestic violence, largely focusing on heterosexual violence perpetrated by an intimate partner or spouse, with a specific focus on acts of physical violence among all female samples.

1.5.2.2 Psychiatric Health Surveys

An international review of prevalence studies by Alhabib et al (2010) indicates that psychiatric service users are at increased risk of experiencing domestic violence compared to primary care service users. The review identified the highest mean prevalence of lifetime physical violence (50%) and the highest mean prevalence of lifetime sexual violence (35%) among women accessing psychiatric services, in comparison to women accessing primary care and non-psychiatric health services. The highest mean lifetime prevalence of psychological abuse (65%-87%) was found among women accessing accident and emergency and
psychiatric clinics (Alhabib, Nur & Jones, 2010). As discussed above, this review did not calculate a pooled prevalence or separate out prevalence estimates by type of psychiatric setting, which precludes an assessment of vulnerabilities to domestic violence across psychiatric services (e.g. inpatient versus outpatient services). Furthermore, the review did not present separate prevalence estimates by lifetime and past year violence. Extending these findings, our narrative review assessed the prevalence of lifetime and past year domestic violence among male and female psychiatric service users by type of psychiatric setting (Howard, Trevillion, Khalifeh, et al, 2010). Prevalence estimates among female psychiatric inpatients ranged from 34%-63% for lifetime domestic violence and 22%-76% for past year domestic violence; among male psychiatric inpatients, estimates ranged from 14%-48% for lifetime domestic violence and 48% for past year violence. A prevalence of lifetime domestic violence for female outpatients ranged from 15%-90% and 19%-86% for past year violence; among male psychiatric outpatients, lifetime prevalence of domestic violence ranged from 0%-13% and 5% for the one study examining past violence in the previous six months (Howard, Trevillion, Khalifeh, et al, 2010). Unlike the review by Alhabib et al, our review did not formally assess the methodological quality of studies.

Although the above reviews summarised the prevalence of domestic violence among male and female psychiatric service users they did not present pooled prevalence estimates. A recent systematic review by Hughes et al (2012) addressed these limitations by making a formal assessment of the methodological quality of studies and by presenting a pooled prevalence of 37.8% (95% CI 17.9-60.2) from three studies measuring past year partner violence among male and female psychiatric service users (Hughes, Bellis, Jones, et al, 2012). This review did not, however, examine adult lifetime experiences of domestic violence and violence perpetrated by non-intimate family members, and failed to present estimates separately by gender and psychiatric setting. Moreover, none of the existing reviews examine unpublished data and these limitations restrict the ability to generalise findings across psychiatric settings.

Further difficulty arises in the calculation of prevalence estimates for domestic violence among psychiatric service users, as several studies fail to distinguish
between domestic and non-domestic violence (i.e. reporting abuse from intimate partners, families, acquaintances and strangers together or failing to specify the perpetrators of abuse) (Ash, Haynes, Braben, et al., 2003; Goodman, Rosenberg, Mueser, et al., 1997; Goodman, Salyers, Mueser, et al., 2001; Jacobson, 1989; Rosenberg, Rosenberg, Wolford, et al., 2000; Shack, Averill, Kopecky, et al., 2004). Similarly the large body of psychiatric literature on violence victimisation - encompassing physical, sexual and emotional abuse regardless of the relationship between survivor and abuser - rarely provides information about specific types and contexts of crime committed against people with mental illness (Maniglio, 2008), although this information may have been collected. These surveys suggest, however, that people in contact with psychiatric services are up to eleven times more likely to experience recent violence compared to the general population (Choe, Teplin & Abram, 2008; Teplin, McClelland, Abram, et al., 2005; Walsh, Moran, Scott, et al., 2003). Yet, as they fail to report the extent to which domestic violence occurs, compared with other forms of violence, it is difficult to estimate the increased risk among psychiatric service users without the investigation of unpublished data in addition to the published reports.

Although existing reviews suggest psychiatric service users experience high levels of domestic violence, an examination of the violence victimisation literature (from which data on domestic violence could potentially be extracted) and pooled prevalence estimates by gender and by type of psychiatric setting has yet to be investigated. Existing reviews either fail to formally assess the methodological quality of included studies (Howard, Trevillion, Khalifeh, et al., 2010) or assign date restrictions to literature searches (Alhabib, Nur & Jones, 2010; Hughes, Bellis, Jones, et al., 2012). Moreover, the majority of reviews do not examine the prevalence of domestic violence among men (Alhabib, Nur & Jones, 2010; Hughes, Bellis, Jones, et al., 2012), despite evidence of an increased risk of violence among male psychiatric service users (Chang, Cluss, Burke, et al., 2011). In response to current gaps in the evidence, Chapter 2 presents a comprehensive systematic review of the prevalence of past year and lifetime domestic violence among male and female psychiatric service users, presenting pooled estimates by gender and type of psychiatric setting.
1.6 Risk Factors

Research on risk factors for domestic violence share similar methodological issues to prevalence research (i.e. variations in methodology, study samples and measurement of violence). The majority of research in this area uses cross-sectional designs; consequently, a direct cause and effect relationship cannot be inferred due to the observational nature of research. Nevertheless, some social and demographic characteristics are shown to be associated with a greater likelihood of experiencing domestic violence; as will be outlined below.

1.6.1 Gender

Although research examining isolated incidents of domestic violence have shown comparable estimates for women and men, women are at a greater risk of experiencing sexual violence, repeated coercive and severe violence (Finney, 2006; Houry, Rhodes, Kemball, et al., 2008) (see section 1.5 for a discussion on findings of gender-symmetry within epidemiological research). Consistent evidence suggests that women are more likely to experience sexual violence from a current or former partner than men (Black, Basile, Breiding, et al., 2011; Smith, Osborne, Lau, et al., 2012; Tjaden, 2000). A cross-sectional study of gender differences in physical and psychological violence among 2,416 men and women aged 16-20 years found that men were more likely to engage in acts of severe physical aggression and women were more likely to incur injuries (i.e. cuts, bruises, black eyes and broken noses) and require medical attention (Muñoz-Rivas, Graña, O'Leary, et al., 2007). Ansara and Hindin (2010) mapped the patterns of physical violence, sexual coercion, psychological abuse and controlling behaviours among 15,416 men and women who participated in the 2004 Canadian General Social Survey study. Their analysis found that men and women were equally likely to experience less severe acts of physical aggression but women were significantly more likely to experience severe and chronic patterns of violence, which involved high levels of fear and injury (Ansara & Hidin, 2010).

A recent comprehensive systematic review found that across all psychiatric disorders women experience a higher prevalence of domestic violence compared to men (Trevillion, Oram, Feder, et al., In Press).
In spite of the above findings, the majority of research in community-based and clinical populations (see Chapter 2) utilise questionnaires that measure isolated incidents of abuse and fail to adequately delineate the severity and chronicity of violence experienced by men and women.

1.6.2 Ethnicity
Research examining differential vulnerabilities to domestic violence across ethnic groups remains inconclusive. Some research findings suggest that black, Asian, minority ethnic and refugee (BAMER) groups are at increased risk of experiencing domestic violence (Caetano, Field, Ramisetty-Mikler, et al, 2005; Houry, Rhodes, Kemball, et al, 2008; Kessler, Molnar, Feurer, et al, 2001; Roberts, Gilman, Breslau, et al, 2011; Thiara, 2006) whilst others do not (Bauer, Rodriguez & Perez-Stable, 2000; Bonomi, Anderson, Cannon, et al, 2009; Krishnan, Hilbert & VanLeeuwen, 2001; Povey, Coleman & Kaiza, 2008). One explanation for the degree of variability of research findings is the tendency of some studies to collapse data from all BAMER groups into a single group to compare against whites; such practices may exaggerate differences between ethnic groups and obscure variations between diverse minority groups (Alhabib, Nur & Jones, 2010; Tjaden & Thoennes, 2000). Prevalence estimates are also seen to be affected by differences in perceptions of violent behaviours among BAMER groups (Sohal, 2011; World Health Organization, 2005).

Differences across BAMER groups have been shown to be mediated by socioeconomic status (Bassuk, Dawson & Huntington, 2006; Rennison & Planty, 2003; Vanhorn, 2002). It is likely therefore that poverty and income are related to increased vulnerabilities to domestic violence among BAMER groups (Grossman & Lundy, 2007; Nixon & Humphreys, 2010).

1.6.3 Age
Although domestic violence occurs across all age groups, several research findings have indicated that people aged between 16 and 24 years of age are at an increased risk of experiencing domestic violence (Catalano, 2007; Kessler, Molnar, Feurer, et al, 2001; Smith, Osborne, Lau, et al, 2012). However, these
findings are not conclusive and other research studies have not found increased rates of violence among younger age groups (Jejeebhoy & Cook, 1997; Wilke & Vinton, 2005).

1.6.4 Socioeconomic Status
Poverty is shown to be a contributory factor for domestic violence, with lower socioeconomic groups around the globe reporting more frequent and severe violence than higher socioeconomic groups (Caballero, Castillo, Ceballo, et al., 2004; Gass, Stein, Williams, et al., 2011; Jewkes, 2002; Ratner, 1993). Incidence rates of domestic violence are seen to rise with socioeconomic deprivation (World Bank, 2012) and high socioeconomic status is found to be a protective factor against abuse (Abramsky, Watts, Garcia-Moreno, et al., 2011).

1.6.5 Childhood Violence and Abuse
Evidence from prospective studies highlight that childhood violence and abuse is associated with an increased risk of domestic violence as an adult (Chen & Raskin White, 2004; Miller, Breslau, Chung, et al., 2011). Analysis of data from a New Zealand birth cohort of over 1,000 young adults found that exposure to inter-parental violence in childhood, including witnessing and experiencing abuse, increased the risk of experiencing and perpetrating psychological partner violence in adulthood (Fergusson, Boden & Horwood, 2008). A representative sample of 543 New York children followed up over a twenty year period found that participants exposed to parental violence experienced an increased risk of adult partner violence, after adjusting for experiences of childhood abuse, harsh parental punishment and conduct disorder (Ehrensaft, Cohen, Brown, et al., 2003). Numerous other research studies have also examined the associations between childhood abuse and future violence in adulthood. However, it is beyond the scope of this research study to undertake a comprehensive review of this literature.

1.6.6 Substance Misuse
Domestic violence has been shown to be closely associated with alcohol and drug misuse (Amaro, Fried, Cabral, et al., 1990; Callanan, 2005; Chang, Shen & Takeuchi, 2009; Klostermann & Fals-Stewart, 2006); although findings are not
always consistent (Boyle & Todd, 2003). A paucity of research has examined the temporal relationship between women’s substance misuse and experiences of abuse (World Health Organization, 2007); yet, a recent longitudinal study found that domestic violence within the first year of marriage was predictive of women’s heavy episodic drinking one year later (Testa, Livingston & Leonard, 2003). It is beyond the scope of this research study to review the substantial literature on the relationship between domestic violence and substance misuse.

1.6.7 Psychiatric Illness
Evidence suggests that men and women with severe mental illness are eleven times more likely to experience past year violence compared to the general population (Teplin, McClelland, Abram, et al, 2005). Few studies have assessed a causal relationship between domestic violence and mental health problems (Briere & Jordan, 2004; Kernic, Holt, Stoner, et al, 2003; Zlotnick, Johnson & Kohn, 2006) but pre-existing psychiatric illness is shown to influence women’s vulnerability to domestic violence (Briere & Jordan, 2004). Furthermore, evidence from prospective studies highlight that mentally ill men and women are at increased risk of domestic violence compared to those without a mental illness (Ehrensaft, Moffitt & Caspi, 2006; Keenan-Miller, Hammen & Brennan, 2007). Indeed, Fergusson et al (2005) analysed data from the Christchurch New Zealand birth cohort, assessing past year domestic violence and mental illness among 828 participants sampled at 25 years of age. They found that depression, anxiety and substance use disorders at 14-21 years of age was significantly associated with domestic violence at 24-25 years of age (Fergusson, Horwood & Ridder, 2005). Our recent systematic review found that men and women with a mental illness are at an increased risk of domestic violence compared to people without a mental illness (Trevillion, Oram, Feder, et al, In Press). Explanations for increased vulnerability to violence include aspects of the illness such as impairments in social functioning in people with schizophrenia (Fitzgerald, de Castalla, Filia, et al, 2005; Goodman, Dutton & Harris, 1997; Honkonen, Henrikson, Koivisto, et al, 2004; Read & Argyle, 1999), use of medication and type of living conditions or co-occurring substance misuse (Briere, Woo, McRae, et al, 1997; Walsh, Moran, Scott, et al, 2003).
As the above findings highlight, certain individuals and groups may have an increased likelihood of experiencing domestic violence; particularly groups with high levels of socioeconomic deprivation (Pickett & Wilkinson, 2009). Nevertheless, it is important to note that no individual or group is insusceptible to domestic violence, which is seen across gender, sexuality, ethnic and religious and socioeconomic groupings. Therefore, an isolated examination of social and demographic vulnerabilities cannot fully explain the myriad factors associated with domestic violence. The ecological model of violence attempts to address these limitations by providing a framework that examines the intersection of factors associated with domestic violence; as outlined below.

1.7 Ecological Framework
The ecological framework of violence consists of four inter-connected levels, which seek to highlight the myriad factors that increase an individual’s likelihood of becoming a survivor and/or perpetrator of violence: (1) Individual-level factors include personal historical factors (i.e. being abused as a child, witnessing parental domestic violence and a history of violent behaviour), and biological factors (i.e. psychological/personality disorder); (2) Relationship-level factors include the influence of familial relationships (i.e. poor parenting practices, marital discord, low socioeconomic status) and peer relationships (i.e. friends that engage in violence); (3) Community-level factors include the contexts in which social relationships occur (i.e. high poverty and high crime areas, high residential mobility and unemployment), and (4) Societal-level factors include social factors that encourage/permit violence (i.e. rapid social changes, gender, social and economic inequalities, cultural norms that support violence) (Heise, 1998) (see Figure 1 below).
As the above illustration highlights, individual, relationship, community and societal factors influence men’s and women’s vulnerability to domestic violence. These factors have significance to this research study, as the findings of Chapter 5 highlight the influence of these factors in shaping service users’ understanding of domestic violence, experiences of disclosure and help-seeking behaviours.

**1.8 Health Impacts Associated with Domestic Violence**

Domestic violence is associated with both short and long term adverse health consequences, which may be present even after the abuse has ceased. Physical injuries as a direct result of violence are common, with more injuries sustained by women than men (Tjaden, 2000). Numerous mental health problems are associated with domestic violence and are seen to be exacerbated by the frequency
and severity of violence experienced (Golding, 1999). The type and severity of physical and mental health impacts are outlined below.

1.8.1 Physical Health Impacts

Domestic violence is associated with a range of physical health impacts including fractures, broken bones, contusions, lacerations, maxillofacial and ocular injuries (Besant-Matthews, 2006; Campbell, 2002; Ellsberg, Jansen, Heise, et al, 2008; Sheridan & Nash, 2007). Physical injuries following choking and strangulation are common, as are internal injuries following physical assaults (Campbell, 2002). A number of chronic health problems are found to be associated with domestic violence, including chronic headaches and chronic back pain, gastrointestinal disorders and abdominal pain (McCaulay, Kern, Kolodner, et al, 1995).

Women experiencing violence in an intimate relationship are more likely to incur acute physical injuries compared to women abused outside of an intimate relationship (Thompson, Simon, Saltzman, et al, 1999). Findings from population-based surveys with women across ten countries indicate that 19-55% of women incur physical injuries following assaults from an intimate partner; with significant associations identified between violence and women’s self-reports of difficulty walking (OR 1.6), pain (OR 1.6) and memory loss (OR 1.8) (Ellsberg, Jansen, Heise, et al, 2008). A recent UK study of 70 female community mental health service users found that 26 (40%) women incurred physical injuries as a direct result of domestic violence (Morgan, Zolese, McNulty, et al, 2010).

Despite the high proportion of injuries sustained during violent assaults, injury is not the most common physical health consequence of domestic violence. In fact, gynaecological problems are shown to be the longest lasting and largest physical health difference between women who are abused and those who are not abused (Campbell, 2002). Specific problems include vaginal bleeding and infection, chronic pelvic pain, urinary tract infections, sexually transmitted infections and human immunodeficiency virus (HIV) (Campbell & Soeken, 1999; Coker, Smith, Bethea, et al, 2000; Jewkes, Sen & Garcia-Moreno, 2002). Recent evidence from the USA and South Africa has demonstrated an increased risk of HIV infection
among women experiencing domestic violence (Jewkes, Dunkle, Nduna, *et al.*, 2010; Sareen, Pagura & Grant, 2009).

A recent review found inconsistent evidence regarding the impact of domestic violence on pregnancy outcomes among women (Feder, Ramsay, Dunne, *et al.*, 2009). Mixed findings were reported in relation to abuse during pregnancy and miscarriage (Boy & Salihu, 2004; Nasir & Hyder, 2003), premature labour (Boy & Salihu, 2004; Jasinski, 2004), the need to undergo operative delivery (i.e. caesarean section) (Boy & Salihu, 2004; Nasir & Hyder, 2003) and kidney infections (Boy & Salihu, 2004; Jasinski, 2004; Nasir & Hyder, 2003). In relation to fetal outcomes, the review found some evidence to suggest that domestic violence during pregnancy is associated with low-birth weight among babies (Boy & Salihu, 2004; Jasinski, 2004; Murphy, Scei, Myhr, *et al.*, 2001).

### 1.8.2 Homicide

The most serious health consequence associated with domestic violence is homicide. Difficulties arise when attempting to measure the extent of domestic violence homicides, as official records may conceal deaths as accidental or attribute them to unknown causes (WHO 2002). Consequently, prevalence estimates are likely to underestimate the true extent of domestic violence related homicides. Evidence suggests that 47% of UK female homicides and 5% of male homicides are perpetrated by a current partner or ex-partner (Smith, Osborne, Lau, *et al.*, 2012). Similar figures are reported worldwide: in Australia, Canada, Israel, South Africa and the United States around 40-70% of female homicides are perpetrated by intimate partners (Krug, Mercy, Dahlberg, *et al.*, 2002). Recent findings from the 2006-2008 UK Confidential Enquiry into Maternal and Child Health found that among 261 mothers who died from any cause 39 (12%) had features of domestic violence and eight of these women were murdered by an intimate partner or spouse (Centre for Maternal and Child Enquiries, 2011).

### 1.8.3 Mental Health Impacts

Domestic violence has a significant effect on the mental health well-being of survivors and has been associated with multiple conditions, including anxiety, depression, post-traumatic stress disorder, substance use disorders, eating
disorders and psychosis (Campbell, 2002; Golding, 1999; Trevillion, Oram, Feder, et al, In Press). In addition, women from BAMER groups who experience abuse report greater suicidal and self-harming behaviours than abused white women (Bhugra & Desai, 2002; Chantler, 2003; Chew-Graham, Bashir, Chantler, et al, 2002; Cooper, Husain, Webb, et al, 2006; Husain, Waheed & Husain, 2006; Siddiqui & Patel, 2010). Evidence suggests a dose-response relationship exists between domestic violence and mental illness: as the severity of violence increases a rise in psychiatric symptoms is observed, conversely, as the severity of violence decreases a reduction in psychiatric symptoms is observed (Golding, 1999). Longitudinal research with separated abused women indicates that severe abuse and high levels of abuse-related stressors contribute to increased depression trajectories (Anderson, Saunders, Mieko, et al, 2003).

In 1999 Jacqueline Golding conducted the most comprehensive systematic review to date on the prevalence and risk of mental illness among women experiencing domestic violence (Golding, 1999). The review identified a weighted mean prevalence of 63.8% for post-traumatic stress disorder (PTSD), 47.6% for depression, 17.9% for suicidality, 18.5% for alcohol abuse and 8.9% for drug abuse among abused women. Women experiencing domestic violence were found to be over three times more likely to suffer from depression (OR 3.8), PTSD (OR 3.7) and suicidality (OR 3.6) and over five times more likely to develop substance abuse problems (OR 5.6) compared to non-abused controls.

Research examining the intersection of race and mental health among women has largely overlooked the experiences and needs of BAMER women. However, the small body of research in this area consistently finds that women from BAMER groups are significantly more likely to report experiences of self-harm, suicidal ideation and suicidal attempts (Bhugra & Desai, 2002; Chantler, 2003; Chew-Graham, Bashir, Chantler, et al, 2002; Cooper, Husain, Webb, et al, 2006; Husain, Waheed & Husain, 2006; Siddiqui & Patel, 2010). In particular, South Asian women report significantly greater self-harming behaviours that white women (Husain, Waheed & Husain, 2006; McKenzie, Bhui, Nanchahal, et al, 2008; Merril & Owens, 1986).
Domestic violence is seen to exacerbate pre-existing mental illness (Howard, Trevillion & Agnew-Davies, 2010). Research over the life-course has shown that prolonged exposure to threatening life events, including domestic violence, is associated with the duration and recurrence of mental disorders (Brown, Harris, Hepworth, et al., 1994; Howard, Trevillion, Khalifeh, et al., 2010). A New Zealand birth cohort of 905 men and women were assessed for the presence of mental illness at ages 18 and 26 years and their experience of partner violence at ages 24 and 26 years (Ehrensaft, Moffitt & Caspi, 2006). The authors found that women involved in a violent relationship at 24 and 26 years had significantly higher rates of major depressive episodes at 18 years, compared to those not in violent relationships. Men involved in violent relationships at 26 years of age also had significantly higher rates of major depressive episodes and anxiety disorders at age 18 years of age. After controlling for pre-existing mental illness, involvement in an abusive relationship at 26 years of age was found to increase women’s risk of generalised anxiety disorder, major depressive episodes and PTSD. No such associations were identified for men (Ehrensaft, Moffitt & Caspi, 2006). Moreover, a cross-sectional survey of 69 male and female psychiatric inpatients experiencing past year domestic violence found that 42 (48%) participants met the criteria for a diagnosis of PTSD as a consequence of the violence (Cascardi, Mueser, DeGiralomo, et al., 1996).

The impact of domestic violence is far reaching and extends to other family members; in particular children and young people, who can rarely be protected from the knowledge that domestic violence is occurring in the home (Humphreys & Stanley, 2006).

1.8.4 Impact on Children’s Health
The first UK national prevalence study of childhood maltreatment among 2,869 young people found that 26% of children had witnessed domestic violence by their parents (Cawson, 2002). Recent estimates indicate that one in seven children and young people under the age of 18 will have lived with domestic violence at some point in their lifetime (Radford, Corral, Bradley, et al., 2011). Evidence suggests that children growing up in a domestically violent situation are 30-60% more likely to experience child abuse (Eddleson, 1999; Hester, Pearson, Harwin,
et al, 2007; Humphreys & Thiara, 2002) and report higher rates of psychological disturbance (McWilliams & McKiernan, 1993).

Over the past decade, several literature reviews have sought to examine the health impacts of children’s exposure to domestic violence; defined as witnessing (i.e. seeing or hearing violent exchanges between parents) and experiencing (i.e. children that are directly abused) domestic violence (Kitzmann, Gaylord, Holt, et al, 2003; Osofsky, 2003; Wolfe, Crooks, Lee, et al, 2003; Yount, DiGirolamo & Ramakrishnan, 2011). For example, Wolfe et al (2003) conducted a meta-analysis of 41 studies and found that children exposed to domestic violence experience more behavioural and psychological problems than non-exposed children (Wolfe, Crooks, Lee, et al, 2003). Kitzmann et al (2003) conducted a meta-analysis of 118 studies and found that children witnessing domestic violence experience an increased risk of psychological, emotional and behavioural problems compared to children not witnessing violence. Furthermore, they found comparable levels of psychological, emotional and behavioural disturbances among children witnessing domestic violence and physically abused children (Kitzmann, Gaylord, Holt, et al, 2003). A more recent meta-analysis identified an association between childhood exposure to domestic violence and trauma symptoms in children (Evans et al 2008).

Prospective data from a USA representative sample of 821 parent-child dyads found that parents’ experience of domestic violence independently increased children’s risk of externalising behavioural problems (e.g. noncompliance, aggression, anti-social behaviour), after controlling for parental history of anti-social behaviour and family violence (Ehrensaft & Cohen, 2011). Evidence from the UK Avon Longitudinal Study of Parents and Children (ALSPAC) birth cohort of 13,617 children and mother dyads found that antenatal domestic violence predicted future behavioural problems in children aged 42 months (OR 1.87); although this was partly mediated by maternal depression (Flach, Leese, Heron, et al, 2011).

It is beyond the scope of this research to review the substantial literature on the health impacts of childhood sexual abuse, which has received considerable
attention in the published literature. Indeed, numerous psychiatric research studies have examined the prevalence and impacts of childhood sexual abuse among psychiatric service users. In contrast, limited research has been conducted on the nature and impact of domestic violence among psychiatric service users, despite evidence that domestic violence has stronger associations with current mental health problems compared to childhood sexual abuse (Coid, Petruckevitch, Chung, et al, 2003; Fergusson, Horwood & Ridder, 2005)

1.9 Addressing the Trauma of Domestic Violence

As outlined above, domestic violence can have a significant detrimental impact on the mental health well-being of survivors and is associated with the onset, duration and recurrence of mental illness (Brown, Harris, Hepworth, et al, 1994). It is essential, therefore, that survivors receive appropriate support to recover from the psychological trauma of abuse.

Existing treatment interventions have generally orientated towards either the socio-political and cultural factors that underpin and reinforce domestic violence, or psychiatric and psychological approaches. The former interventions frame men’s use of violence against women as a result of socially constructed and culturally accepted gender inequalities; treatment focuses on empowering women through validation, celebration of their strengths and in supporting them to make their own decisions (Dutton, 1992; Pence & Paymar, 1986; Prilleltensky, 1994; Stark, 2007). These models traditionally de-emphasise the use of psychiatric and psychological treatments and disapprove of the application of diagnostic labels, due to the propensity of these approaches to pathologise survivors’ experiences of abuse (Burstow, 2003; Gordon, 1988; Lapierre, 2008; McDonald, 2005). However, it is argued that ignoring the psychobiological effects of domestic violence can invalidate survivors’ experiences, minimise the traumatic effects of abuse and hinder appropriate treatment interventions (Dutton & Corvo, 2006; Herman, 1992; Sanderson, 2008; Walker, 2009). In addition, by orientating domestic violence exclusively within a gender inequality framework these models fail to consider other risk factors and social divisions (such as those presented in section 1.6) that perpetuate abuse (Dutton & Corvo, 2006) and to explain
variations in women’s use of violence in intimate relationships (Dasgupta, 2002; Hamberger, Lohr, Bonge, et al, 1997). Therefore, in order to successfully address the effects of domestic violence, interventions should address both psychosocial and psychobiological impacts whilst maintaining an awareness of the dangers of pathologising survivors’ experiences (Humphreys & Thiara, 2003a). It is argued that effective interventions comprise:

“Not only individualised counselling but also the reconnecting of traumatised individuals to their communities and a social movement which continues to bring testimony to their experiences” (Humphreys & Joseph, 2004, p 562)

1.10 Health Costs of Domestic Violence

As highlighted in the previous two sections, people experiencing domestic violence frequently incur a range of acute and chronic injuries as a direct result of violent incidents and in response to the traumatic effects of living in a violent environment (Hamberger & Phelan, 2004). As a result, they display increased use of health services compared to those not abused (MacMillan, Wathen, Jamieson, et al, 2006; Rivara, Anderson, Fishman, et al, 2007; Ulrich, Cain, Sugg, et al, 2003). Consequently, direct medical and mental health costs are estimated to exceed £1,730 million per annum in the UK and approximately $4·1 billion dollars in the USA (Iverson, Resick, Suvak, et al, 2011; Walby, 2009).

Estimates suggest that around two in every five people in contact with GP services, one in every five people in contact with accident and emergency services and as many as six in every ten psychiatric inpatients have experienced domestic violence (Feder, Ramsay, Dunne, et al, 2009; Howard, Trevillion, Khalifeh, et al, 2010). Women experiencing domestic violence are found to have a 50% increased risk of hospitalisation compared to non-abused women, and over three times the increased risk of psychiatric hospitalisation (Kernic, Wolf & Holt, 2000). Interestingly, however, women from BAMER groups are found to be less likely than white women to be assessed by psychiatric services (Cooper, Husain, Webb, et al, 2006) and report unequal access and treatment by mental health services (Chantler, 2003; Chew-Graham, Bashir, Chantler, et al, 2002).
1.11 Response of Health Services to Domestic Violence

In light of the fact that people experiencing domestic violence have increased contact with health services, and report a greater willingness to disclose abuse to health professionals than the police (Yearnshire, 1997), clinicians are ideally placed to identify and respond to domestic violence. Yet, health services in general have been criticised for failing to respond adequately to domestic violence (Taket, Nurse, Smith, et al, 2003). Evidence suggests that clinicians rarely enquire about abuse and service users are reluctant to disclose such experiences in the absence of direct questioning (Howard, Trevillion, Khalifeh, et al, 2010; Klap, Tang, Wells, et al, 2007; Read, van Os, Morrison, et al, 2005).

1.11.1 The Identification and Documentation of Domestic Violence by Health Services

1.11.1.1 Experiences of Primary Care and Non-Psychiatric Health Services

The lack of enquiry about domestic violence has led many health services (particularly USA health services) to implement universal routine enquiry programmes, which seek to improve rates of identification and documentation of abuse. Interestingly, a review of the evidence of these programmes has found inconsistent evidence regarding their effectiveness in improving rates of enquiry and documentation of domestic violence (Garcia-Moreno, 2002; Ramsay, Richardson, Carter, et al, 2002).

One of the more methodologically robust studies used a cluster-randomised controlled trial in five USA primary care clinics (two sites were allocated to the intervention and three to control sites) to assess the effectiveness of a system-level programme, involving skills training and domestic violence questionnaires aimed at improving clinicians’ identification and documentation of abuse. Medical record reviews at nine-months follow-up found no significant differences in rates of identification of domestic violence between intervention and control sites (Thompson, Rivaro, Thompson, et al, 2000); however, the limited number of clinics participating in the study (n=5) and the small number of cases of domestic violence identified between baseline and follow-up (n=131) means that the study may have lacked adequate power to detect clinically meaningful differences.
Studies with longer follow-up periods have shown that sustained improvements in rates of identification of domestic violence, following the implementation of routine enquiry, are difficult to achieve. For instance, an eight year follow-up evaluation of a programme of domestic violence enquiry, implemented within a USA emergency care service, found that initial rates of increased identification were not sustained and had returned to levels similar to that observed prior to the programmes implementation (McLeer & Anwar, 1989).

Despite an increasing focus on interventions to improve rates of identification of domestic violence, limited evidence exists on the effectiveness of enquiry about domestic violence in improving morbidity and mortality outcomes for abused women. In 2004 the USA Preventive Services Task Force conducted a review of the benefits and harm of universal domestic violence enquiry for women and elderly adults in health settings. The review found insufficient evidence that enquiry reduces harm among abused women (Nelson, Nygren, McInerney, et al, 2004). In 2009 the UK Health Technology Assessment (HTA) conducted an update of the evidence and found insufficient evidence on the effectiveness of universal domestic violence enquiry in reducing mortality and morbidity outcomes among abused women (Feder, Ramsay, Dunne, et al, 2009).

A Canadian randomised controlled trial, published subsequent to the UK HTA review, examined the effectiveness of universal domestic violence enquiry in reducing violence and improving quality of life outcomes among abused women. 11 emergency departments, 12 family practices and three obstetrics/gynaecology clinics participated in the study; specific shift patterns were randomised to either enquiry (n=1236 shifts) or no enquiry (n=1207 shifts), with a total of 3,271 women assigned to enquiry and 3,472 assigned to no enquiry. Within shifts allocated to enquiry, women were asked to complete a domestic violence instrument and among those who screened positive for abuse, the instrument was placed in their case file for their treating clinician. Within shifts allocated to no enquiry, women were asked to complete a domestic violence instrument only after they had seen their treating clinician. 14 days after completion of the domestic violence instruments women conducted a baseline interview and further follow-up
interviews at six, 12 and 18 months to examine their experience of violence and quality of life outcomes. At 18 months follow-up, 43% of women in the enquiry group and 41% of women in the no enquiry group were lost to follow-up (women lost to follow-up in the enquiry group reported higher abuse scores than women remaining in the study); when adjusting for losses to follow-up, no significant differences in reduction of violence and quality of life outcomes were found between women in the enquiry group and women in the no enquiry group.

1.11.1.2 Experiences of Psychiatric Services

Findings from the 2002 representative USA National Survey on Drug Use and Health (NSDUH) found that among 7,924 women 536 had experienced domestic violence and these women reported greater unmet needs (19%) for mental health treatment compared with non-abused women (8%). After controlling for socioeconomic status and substance use, women experiencing partner violence were twice as likely to report unmet mental health needs (Lipsky & Caetano, 2007b).

Our recent literature review found that domestic violence is largely under-detected in psychiatric settings internationally; with only 10-30% of recent violence asked about in clinical practice (Howard, Trevillion, Khalifeh, et al, 2010). Rates of enquiry about domestic violence have been shown to be lower in psychiatric settings than primary care and obstetrics/gynaecology settings (Cann, Withnell, Shakesphere, et al, 2001; Klap, Tang, Wells, et al, 2007). Read and Fraser (1998) reviewed the medical records of 100 consecutive inpatient psychiatric admissions, following the introduction of a new admission form that included direct questions about service users’ experiences of violence and abuse. The authors found that the new admission forms were used in 53 of the 100 cases and questions about violence and abuse were asked in just seventeen cases; women who were asked directly about abuse were significantly more likely to disclose physical violence compared to women who were not asked (Read & Fraser, 1998a).

Similar to primary care and non-psychiatric health settings, psychiatric services are increasingly implementing enquiry about domestic violence as part of routine clinical practice. For example, the Department of Health for England (DoH)
recommends that clinical assessments in psychiatric settings incorporate specific questions about service users’ experiences of violence and abuse (Department of Health, 2008). The limited evidence base suggests that rates of enquiry increase following the introduction of direct questions in clinical assessments (Department of Health, 2009; Howard, Trevillion, Khalifeh, et al, 2010); yet, insufficient evidence exists on whether routine enquiry about domestic violence leads to improved outcomes for psychiatric service users.

Current evidence on mental health professionals’ response to service users’ disclosure of domestic violence suggests that clinicians regularly fail to provide sufficient documentation in clients’ medical records and do not incorporate trauma histories in treatment plans (Cascardi, Mueser, DeGiralomo, et al, 1996; Chandra, Carey, Carey, et al, 2003; Eilenberg, Thompson Fullilove, Goldman, et al, 1996; Read & Fraser, 1998b). For example, Read and Fraser (1998) examined the medical records of the first 100 inpatient psychiatric admissions in a calendar year and found that among 32 service users who disclosed abuse only 11 (34%) records documented whether they had previously disclosed or received any treatment for the abuse. Only three records were found to document whether service users had received counselling or psychotherapy and no records provided information on the duration, type or outcome of treatment received. Finally, this study found that 29 (91%) records did not include any mention of clinicians actions in response to disclosures (Read & Fraser, 1998b).

A review of 200 consecutive admissions to a New Zealand community mental health team (CMHT) revealed that only 15 (16%) of the 92 medical records documenting service users’ disclosures of abuse included treatment plans; no records documented whether disclosures of abuse were reported to legal authorities (Agar & Read, 2002). Documentation of any prior disclosures of abuse or abuse-related treatment was found in 30 (33%) of the 92 files and was significantly more likely for cases of childhood sexual abuse compared to adult physical or sexual abuse. The study found that female clinicians were more likely than male clinicians to document abuse and psychiatrists were less likely than nurses, psychologists and social workers to refer service users to counselling or to provide abuse-related therapy within the CMHT. Service users with
schizophrenia, schizoaffective and schizophreniform disorders were less likely than service users with other psychiatric disorders to have the abuse documented in summary formulations or treatment plans (Agar & Read, 2002).

1.11.2 Health Professionals’ Opinions Regarding the Identification and Documentation of Domestic Violence

1.11.2.1 Opinions of Primary Care and Non-Psychiatric Health Professionals

An increasing body of literature has examined primary care and non-psychiatric health professionals’ views on the acceptability of domestic violence enquiry. In 2009 Feder et al carried out a synthesis of this literature and findings across twenty international surveys highlight a considerable amount of heterogeneity about the acceptability of enquiry among clinicians; with figures ranging from 15% to 95% (Feder, Ramsay, Dunne, et al, 2009). The review found that acceptability of domestic violence enquiry was generally higher among USA clinicians, although considerable variation among USA clinicians was found. No consistent association between the type of health setting and clinicians’ acceptability of enquiry was identified (Feder, Ramsay, Dunne, et al, 2009). The reviewers advise caution in interpreting these findings because several studies reported a response rate of less than 50%; low response rates run the risk of inflating rates of acceptability of enquiry among clinicians, as non-respondents may be less likely to consider domestic violence an important clinical issue and to find enquiry acceptable. This review also conducted a comprehensive synthesis of qualitative research studies - four studies conducted in the USA, three in the UK, two in Sweden, one in Australia and one in New Zealand - and found that domestic violence enquiry was acceptable to some health professionals; although some believed that enquiry should be conducted by another professional or designated paraprofessional. The importance of timing, fear of offending service users, and the need for clinical training about domestic violence were also reported (Feder, Ramsay, Dunne, et al, 2009). One limitation of both quantitative and qualitative research on clinicians’ views about enquiry is the underrepresentation of views from male clinicians; the majority of studies identified in this review included female only samples or sampled significantly more female than male clinicians.
1.11.2.2 Opinions of Psychiatric Health Professionals

In 2001 all psychiatrists, psychologists, psychiatric nurses and occupational therapists working for Oxfordshire mental health NHS Trust were approached to participate in a survey assessing their knowledge, attitudes and responses to domestic violence. Among the 61 mental health professionals who participated in the survey 25% felt uncomfortable with asking direct questions about domestic violence, 13% believed domestic violence enquiry could be perceived as offensive to some women and 5% felt there was insufficient time in initial assessments to enquire about service users’ abusive experiences. The survey identified that 5% of mental health professionals had never identified domestic violence in their clinical practice and a third identified one case or less per year; 91% of professionals wanted to receive more training on domestic violence (Cann, Withnell, Shakesphere, et al, 2001).

Despite numerous qualitative studies examining experiences of enquiry of domestic violence among primary care and non-psychiatric health professionals, I am aware of only one study, prior to this research project, which has examined the experiences of mental health professionals. Following a training programme delivered within a large USA health service, focus group interviews were conducted with 39 clinicians. Barriers to enquiry of domestic violence among the six mental health professionals included concerns about the appropriateness of enquiry with intoxicated and psychotic service users, concerns about potential workload priorities following a disclosure of abuse, and time constraints (Minsky-Kelly, Hamberger, Pape, et al, 2005). Chapter 6 presents findings from the first qualitative research study to explore UK mental health professionals’ experience of domestic violence enquiry. This study is timely in the light of increasing policy guidance and the implementation of routine enquiry about abuse within psychiatric settings (Department of Health, 2008; Department of Health, 2009; Department of Health & Care Services Improvement Partnership, 2008).
1.11.3 Service Users’ Opinions Regarding the Identification and Documentation of Domestic Violence

1.11.3.1 Opinions of Primary Care and Non-Psychiatric Service Users

Research suggests that service users are reluctant to disclose experiences of domestic violence in the absence of direct questioning from clinicians (Feder, Hutson, Ramsay, et al., 2006; Kramer, Lorenzon & Mueller, 2004; Plichta & Falik, 2001). As a consequence, many women report delayed help-seeking behaviours, related to concerns about social stigmas, gender roles and children’s well-being, and specifically among immigrant women, concerns about loss of social supports and limited knowledge of resources in host countries (Ahmad, Driver, McNally, et al., 2009; Thiara, 2002; Thiara, 2010).

A recent systematic review of nineteen international surveys, which examined female primary care and non-psychiatric health service users’ views on routine enquiry of domestic violence, identified that most women found it acceptable to be asked about domestic violence by clinicians; rates of acceptability ranged from 35% to 99% across studies (Feder, Ramsay, Dunne, et al., 2009). The review found that rates of acceptability did not vary considerably by type of abuse experienced, by type of services accessed, or type of health care setting; although some women displayed a preference to be asked by a female clinician (Feder, Ramsay, Dunne, et al., 2009). The review also conducted a comprehensive meta-analysis of qualitative research on women’s views of domestic violence enquiry and found that women considered enquiry to be beneficial in encouraging disclosure and help-seeking behaviours. The review examined the expectations and experiences of women when they encounter primary care professionals who ask about a history of domestic violence and found that women wanted professionals to: respond in a compassionate and non-judgemental manner; provide individually tailored support, and show an appreciation of the complexity of violence (Feder, Ramsay, Dunne, et al., 2009). A limitation of these reviews is the exclusion of studies examining male service users’ views on the acceptability of routine enquiry for domestic violence.

In spite of a general acceptance of routine enquiry by service users, a significant number of service users report that clinicians have not asked them directly about
experiences of abuse. For example, a USA nationally representative telephone survey of 4,821 women found that only 7% (n=479) had been asked about domestic violence by a health professional; 46% were asked by primary care clinicians compared to just 24% by secondary mental health clinicians (Klap, Tang, Wells, et al, 2007).

1.11.3.1 Opinions of Psychiatric Service Users

Recent literature reviews have found that in the absence of direct questioning from health professionals, service users are reluctant to disclose experiences of abuse (Howard, Trevillion, Khalifeh, et al, 2010; Klap, Tang, Wells, et al, 2007; Read, van Os, Morrison, et al, 2005). Research with service users has found that the dominance of the medical model may prevent enquiry about domestic violence, as clinicians focus predominantly on diagnosing and treating psychiatric symptoms (Humphreys & Thiara, 2003a). Initial evidence suggests, that psychiatric service users find it acceptable for clinicians to ask about abusive experiences and want clinicians to explore the link between violence and poor health outcomes (McCauley, Yurk, Jenckes, et al, 1998; Morgan, Zolese, McNulty, et al, 2010). To date, no qualitative research study prior to that presented in Chapter 5 has explored in detail psychiatric service users’ experience of disclosure of domestic violence in UK community mental health settings.

In order to enhance the current evidence base in this area, the qualitative research study presented in Chapters 4-7 provides the first detailed exploration of UK community mental health service users’ and clinicians’ views on the acceptability of routine enquiry about domestic violence, experiences of disclosure/enquiry of abuse, and experiences and expectations of services’ response to domestic violence. This research study is the first of its kind to directly compare and contrast the experiences of service users and clinicians.

1.11.4 Interventions to Improve Outcomes for Service Users Experiencing Domestic Violence

1.11.4.1 Evidence from Primary Care and Non-Psychiatric Health Settings

Four recent systematic reviews have examined the effectiveness of interventions in improving outcomes for abused women attending primary care and non-
psychiatric health settings (Ramsay, Carter, Davidson, et al, 2009; Ramsay, Richardson, Carter, et al, 2002; World Health Organization, forthcoming-a; World Health Organization & London School of Hygiene and Tropical Medicine, 2010). Examples of existing interventions include individual and group psychological therapies and advocacy programmes. The methodological quality of many of these studies is low and this limits the strength of evidential support for these interventions. Nevertheless, the reviews have identified sufficient evidence for the effectiveness of some interventions in improving outcomes for women, which will now be presented below.

1.11.4.1.1 Psychological Therapies

A range of individual-psychological interventions have been shown to reduce depressive and post-traumatic stress symptoms and improve self-esteem among abused women (Feder, Ramsay, Dunne, et al, 2009). In particular, two trials developed a cognitive behavioural therapy (CBT) treatment for women with PTSD who were no longer experiencing violence; women with co-morbid substance abuse problems and schizophrenia or bipolar disorder were excluded from participation (Kubany, Hill & Owens, 2003; Kubany, Hill, Owens, et al, 2004). The CBT programme consisted of eight to 11 individual sessions of the following: (1) psycho-education about PTSD (i.e. solution-orientated attitudes and stress management techniques); (2) self-monitoring of maladaptive thoughts and speech; (3) talking about the trauma and exposure homework (e.g. looking at pictures of the abuser, watching movies on domestic violence); and (4) feminist modules on self-advocacy and empowerment strategies (i.e. assertive communication, skills training). Treatment follow-up at three- and six-months identified significant improvements in PTSD diagnosis, symptoms of depression and low self-esteem (Kubany, Hill & Owens, 2003; Kubany, Hill, Owens, et al, 2004). Alongside individual-psychological interventions, several studies have evaluated the effectiveness of group-psychological interventions and report improvements in psychiatric outcomes among women; although these studies possess major methodological limitations (Feder, Ramsay, Dunne, et al, 2009).

It is important to note that existing individual- and group-psychological intervention studies largely exclude women with severe mental illness. As a
consequence, it is not possible to assess the efficacy of these interventions in improving outcomes for women with severe psychiatric symptomatology, who would be cared for by psychiatric services. Current evidence on the effectiveness of psychological interventions cannot be extrapolated to men experiencing domestic violence, to men in contact with psychiatric services and to women still in abusive relationships. Therefore, a recent review concluded that insufficient evidence exists on the effectiveness of group-and individual-psychological interventions in improving outcomes for abused women, particularly among those currently experiencing abuse (Feder, Ramsay, Dunne, et al., 2009).

A well-executed randomised controlled trial published since this review sought to evaluate the efficacy of an integrated multiple risk intervention programme (targeting environmental smoke exposure, cigarette smoking, depression and intimate partner violence) among 913 pregnant African-American women, possessing at least one of the four risk factors, who were receiving antenatal care. The authors developed cognitive behavioural therapy programmes for depression and smoking cessation and an individualised counselling programme (based on feminist empowerment theory) for intimate partner violence; the intervention was delivered over a minimum of four sessions prenatally and up to two sessions postpartum. At follow-up, significant reductions in experiences of intimate partner violence were observed among both groups (p<0.001), but the intervention group reported significantly greater reductions in the number of risks (p<0.05) and greater successful resolution of all risks in the postpartum period compared to controls (p<0.005) (El-Mohandes, Kiely, Joseph, et al., 2008).

1.11.4.1.2 Advocacy Interventions
A forthcoming review conducted by the World Health Organization concludes that sufficient evidence exists for the effectiveness of domestic violence advocacy in reducing partner violence among women who have actively sought help, or are in a refuge (World Health Organization, forthcoming-a). These findings support those of a previous Cochrane review of randomised controlled trials of domestic violence advocacy, which concluded that intensive advocacy (12 hours or more) may decrease physical abuse and improve quality of life; brief advocacy (less than 12 hours) was also shown to increase women’s use of safety behaviours (Ramsay,
Domestic violence advocacy interventions are delivered by advocates whose core role, despite slight variations between studies, is to provide survivors with practical and emotional support (e.g. carry out risk assessments and support safety planning), to provide information (e.g. information on welfare rights, housing options and legal issues) and to signpost to other agencies. Several advocacy interventions are based around the concept of empowerment, which aims to help abused women make sense of the abuse and their responses to it, and supports them in achieving their goals.

Domestic violence advocacy in community and primary care settings can reduce women’s experience of abuse, increase social support, quality of life and use of safety behaviours (Feder, Ramsay, Dunne, et al., 2009). For example, a randomised controlled trial of domestic violence advocacy for pregnant women accessing an urban public antenatal hospital reported significantly less abuse and greater physical functioning at follow-up among women allocated to the intervention; although no differences were observed between intervention and control groups on general health and mental health outcomes (Tiwari, Leung, Leung, et al., 2005). Similarly, a non-randomised parallel group intervention of 132 women attending a USA antenatal clinic found that women receiving brief sessions of domestic violence advocacy reported significantly greater use of resources, improved safety behaviours and reductions in abuse at follow-up, compared to controls (McFarlane, Parker, Soeken, et al., 1998). Within an accident and emergency clinic, a before and after study of domestic violence advocacy identified a significant increase in women’s use of refuge and counselling based services post-intervention (Feighny & Muelleman, 1999).

Despite these promising findings, the number and methodological quality of domestic violence advocacy research in health settings is limited. Furthermore, the ability to generalise findings to men experiencing domestic violence, people currently involved in violent relationships and those experiencing severe mental illness and psychiatric co-morbidity is severely restricted. Indeed, the forthcoming World Health Organization systematic review found insufficient evidence for the effectiveness of domestic violence advocacy in improving mental health outcomes among women (World Health Organization, forthcoming-a). To
date, there are no randomised trials that examine domestic violence advocacy for women or men in contact with psychiatric services (Feder, Ramsay, Dunne, et al, 2009; Howard, Trevillion & Agnew-Davies, 2010).

1.11.4.1.3 Peer-Mentoring Interventions

Recently, an Australian cluster-randomised controlled trial examined the effectiveness of a 12-month mentoring scheme for at risk/abused pregnant and new mothers in 106 primary care clinics (Taft, Small, Hegarty, et al, 2011). The mentoring scheme was delivered by mothers residing in the local community – who received a 13-session training package prior to the study - and comprised emotional and practical support to help women take control over their lives. Over the course of the trial, clinicians referred 215 eligible women to the study (167 women in the intervention clinics and 91 in the control clinics); 174 women were successfully recruited (113 intervention and 61 controls) and 133 women completed the twelve-month intervention (90 intervention and 43 controls); women lost to follow-up were more likely to be severely abused. At one year follow-up, women receiving the intervention reported significantly greater reductions in experiences of abuse (Adjusted Difference= -8.67, range -16.2 to -1.15) compared to women not receiving the intervention (Taft, Small, Hegarty, et al, 2011). However, the low levels of women referred to the study, the greater loss to follow-up of severely abused women and the 2:1 ratio of women recruited in the intervention versus control clinics substantially reduces the power of the study and introduces selection biases. The trial also excluded women with severe mental illness, which limits the ability to extrapolate findings to women with acute psychiatric symptoms.

1.11.4.2 Evidence from Psychiatric Health Settings

The current evidence base on interventions to improve outcomes for psychiatric service users experiencing domestic violence remains sparse (Howard, Trevillion, Khalifeh, et al, 2010). In contrast to several large-scale reviews assessing outcomes for primary care and non-psychiatric service users, no such systematic reviews have examined the evidence base for psychiatric service users. To date, the majority of intervention studies in primary care and non-psychiatric health settings exclude participants with severe mental illness. For instance, a
forthcoming systematic review by the World Health Organization identified nine therapeutic intervention studies that seek to improve mental health outcomes for sexual assault survivors, but almost all of the studies excluded people experiencing severe mental illness and psychiatric co-morbidity (World Health Organization, forthcoming-a). Within the psychiatric literature, an increasing number of trauma-focused interventions have been published that seek to improve outcomes for abused psychiatric service users (Lu, Fite, Kim, et al, 2009; Mueser, Bolton, Carty, et al, 2007; Mueser, Rosenberg, Xie, et al, 2008; Rosenberg, Mueser, Salyers, et al, 2004; Trappler & Newville, 2007); these studies are likely to collect data on outcomes among service users disclosing domestic violence. Therefore, Chapter 3 presents the first comprehensive systematic review on the evidence of interventions in improving outcomes for psychiatric service users disclosing domestic violence.
Overview of the Present Study

1.12 Theoretical Underpinnings of the Study

This study uses a mixed methods design to address current gaps in the evidence base. Mixed methods approaches to social inquiry are increasingly common (Sommer Harrits, 2011) and are reflective of a ‘paradigm shift’ (Morgan, 2007a) away from traditional assumptions about quantitative and qualitative approaches. Briefly, the dominant traditional view posits that quantitative paradigms (i.e. positivism) and qualitative paradigms (i.e. interpretivism) are fundamentally incompatible (e.g. Lincoln & Guba, 1985). Contemporary perspectives, challenge the degree of incompatibility between the main research traditions and reconcile them through the development of new paradigms (e.g. ‘subtle realism’) (e.g. Howe, 2003; Johnson & Onwuegbuzie, 2004; Teddlie & Tashakkori, 2003) (see Chapter 4 section 4.1.1 for a more detailed discussion of these issues). Contemporary paradigmatic assumptions emphasise the connection between epistemological concerns about the nature of knowledge and technical concerns about the methods used to generate knowledge (Morgan, 2007a). Consequently, quantitative and qualitative methods are seen to jointly contribute to the study of social inquiry, by ‘‘examining, explaining, confirming, refuting, and/or enriching information from one approach with that from the other’’ (Carvalho & White, 1997, p 7).

This mixed methods study adopts a subtle realist paradigm (Hammersley, 1992) (see Chapter 4 section 4.1.1 for more details), which provides a solid philosophical foundation for mixed methods research that concentrates on the primary issue of which method best addresses the research question. Quantitative approaches provide the best method for identifying, appraising and evaluating evidence, using methods designed to reduce the likelihood of bias (e.g. quantifying the methodological quality of studies, summarising study effects, conducting meta-analyses). Therefore, quantitative techniques are used to synthesise evidence on the prevalence of and interventions for domestic violence in psychiatric settings (see section 1.13 for further details). Qualitative approaches provide the best method for capturing insider perspectives, using
methods designed to produce an in-depth understanding of perceived meanings, interpretations and behaviours (e.g. conducting semi-structured interviews using open-ended questions, which allow respondents to introduce concepts of importance from the emic aspect). Therefore, qualitative techniques are used to explore the experiences and expectations of psychiatric service users and clinicians in relation to domestic violence (see section 1.13 for further details).

1.13 Study Outline and Aims
This literature review highlights the pervasive nature of domestic violence and identifies it as a serious international health issue. In spite of a growing body of evidence in primary care and non-psychiatric health services, a paucity of research exists on the prevalence of domestic violence, the experiences and expectations of professionals and service users and the efficacy of interventions for domestic violence within psychiatric services. Therefore, the objectives of this research study are as follows:

1) To carry out a systematic review and meta-analysis of studies investigating the prevalence of domestic violence among psychiatric service users

2) To carry out a systematic review of interventions to improve outcomes for male and female psychiatric service users disclosing domestic violence

3) To investigate the experiences of psychiatric service users exploring whether and how they were asked about domestic violence and, if they disclosed, their experiences and expectations of the response of services to domestic violence

4) To investigate factors influencing disclosure of domestic violence by psychiatric service users

5) To investigate the experiences of mental health professionals in asking about domestic violence

6) To investigate factors influencing the response of mental health professionals to service users disclosures of domestic violence.
The following research questions will be addressed:

1) What is the one year and lifetime prevalence of domestic violence among male and female psychiatric service users?

2) What evidence exists on the effectiveness of interventions in improving outcomes for psychiatric service users experiencing domestic violence?

3) What are the facilitators and barriers to enquiry of domestic violence by psychiatric health professionals?

4) What are the facilitators and barriers to disclosure of domestic violence by psychiatric service users?

5) What is the current state of knowledge of domestic violence services among psychiatric service users and professionals?

6) How do psychiatric and domestic violence services respond to domestic violence experienced by psychiatric service users?
Chapter 2: Study One - A Systematic Review and Meta-Analysis of the Prevalence of Domestic Violence among Psychiatric Service Users

2.1 Background

Domestic violence is an international public health problem, associated with substantial physical and psychiatric morbidity. As outlined in Chapter 1, domestic violence is closely associated with mental disorders including anxiety, depression, post-traumatic stress disorder (PTSD) and psychosis (Campbell, 2002; Golding, 1999; Neria, Bromet, Carlson, et al, 2005; Trevillion, Oram, Feder, et al, In Press). Prospective studies have shown that psychiatric disorders can increase vulnerability to domestic violence (Brown, Harris, Hepworth, et al, 1994; Ehrensaft, Moffitt & Caspi, 2006). Severe and chronic psychiatric illness is also seen to increase people’s risk of domestic violence (Howard, Trevillion, Khalifeh, et al, 2010).

Two recent narrative reviews in this area reported a high prevalence of domestic violence among male and female psychiatric service users (Alhabib, Nur & Jones, 2010; Howard, Trevillion, Khalifeh, et al, 2010); although one review failed to critically appraise the quality of studies (Howard, Trevillion, Khalifeh, et al, 2010) and neither presented pooled prevalence estimates (Alhabib, Nur & Jones, 2010; Howard, Trevillion, Khalifeh, et al, 2010). A recent review presented a pooled prevalence of 37.8% (95% CI 17.9-60.2) from three studies measuring past year partner violence among men and women with severe mental illness (Hughes, Bellis, Jones, et al, 2012). However, this review failed to present data separately by gender or psychiatric setting and did not examine lifetime experiences of domestic violence, or violence perpetrated by non-intimate family members. Existing reviews have largely neglected the research literature on violence victimisation among psychiatric service users, from which data on domestic violence could potentially be extracted. For that reason, this systematic review aimed to estimate:
1) The prevalence (lifetime and past year) of domestic violence among male and female psychiatric service users

2) The odds of domestic violence among male and female psychiatric service users compared with non-psychiatric controls

If possible (i.e. if primary studies are not too heterogeneous, too few in number or of too poor quality) a meta-analysis will be carried out to estimate the prevalence and odds of adulthood and past year domestic violence among male and female psychiatric service users.

2.2 Method

2.2.1 Selection Criteria

2.2.1.1 Inclusion Criteria

Studies were eligible for inclusion if they: (1) included male or female psychiatric service users who were 16 years or older; (2) presented the results of peer-reviewed research based on experimental studies (e.g. randomised controlled trials, non-randomised controlled trials, parallel group studies), before and after studies, interrupted time series studies, cohort studies, case-control studies, or cross-sectional studies; and (3) measured the prevalence or odds of lifetime and/or past year domestic violence (or collected data from which these statistics can be calculated). Psychiatric services were defined as secondary or tertiary care specialist services (inpatient, outpatient or community-based) providing psychiatric care and support to people with mental disorders. Domestic violence was defined as “any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members regardless of gender or sexuality” (HomeOffice, 2005, p 7). When the review identified multiple eligible papers from the same study only the paper reporting the largest number of participants, with data of relevance to the objectives of the review, was included.

2.2.1.2 Exclusion Criteria

Studies were not eligible for inclusion if they: (1) included participants who were aged 15 years or younger, and did not provide age-disaggregated data; (2)
included psychiatric service users as part of a broader sample and did not present
disaggregated measures on the prevalence or odds of domestic violence (unless
corresponding authors provided the required information); (3) did not measure the
prevalence (lifetime or past year) and/or odds (i.e., odds ratios, relative risk,
attributable risk) of lifetime or past year domestic violence among psychiatric
service users; (4) included psychiatric service users as part of a broader sample
and did not present disaggregated measures of the prevalence or risk of domestic
violence (unless corresponding authors can provide the required information); (5)
used the following study designs: case studies, case-series and qualitative designs;
or were (6) general discussion papers, conference proceedings, comments/letters
or book chapters and reports.

2.2.2 Search Strategy
The search strategy followed MOOSE (Stroup, Berlin, Morton, et al., 2000) and
PRISMA (Moher, Liberati, Tetzlaff, et al., 2009) reporting guidelines and the
review protocol is registered with the PROSPERO database of systematic reviews
(registration number CRD42011001281). 18 bibliographic databases were
searched from their respective dates of inception to 31st March 2011, using a
combination of Medical Subject Headings (MeSH) and text words (see Box 1 for
a list of the databases). Terms for domestic violence were adapted from published
Cochrane protocols and previous literature reviews (Dalsbo & Johme, 2006;
Friedman & Loue, 2007; Ramsay, Richardson, Carter, et al., 2002). Search terms
for mental disorders were adapted from the National Institute for Health and
Clinical Excellence (NICE) guidelines (National Institute for Health and Clinical
Excellence, 2008) (see Appendix 1 for a full list of search terms). No language
restrictions were used and potentially eligible papers were translated and
assessments conducted using the English translated versions. These searches
were supplemented by citation tracking (i.e. Google Scholar and Web of Science);
hand searches of key journals (i.e. Trauma, Violence and Abuse; Journal of
Traumatic Stress; Violence Against Women); re-examining and updating an
earlier review of violence victimisation among psychiatric populations (Maniglio,
2008), from which data on experiences of domestic violence could potentially be
extracted, and expert recommendations (27 experts were contacted - see Appendix
2 for full details).
### Box 1: Electronic Databases Searched for Systematic Review

| Biomedical databases: Academic Search Complete, BNID, CINAHL, Cochrane, EMBASE, HMIC, MEDLINE, Maternity and Infant Care, PsycINFO, Science Direct, Web of Science (including SCI, SSCI, A&HCI, CPCI-S, CPCI-SSH). |
| Theses and dissertations: DART Europe E Theses Portal, ETHOS, Networked Digital Library of Theses and Dissertations |

#### 2.2.3 Study Selection and Data Extraction

Two reviewers (KT and SO) screened the downloaded titles and abstracts against the inclusion criteria; references were taken forward to the next stage of screening if it was unclear whether they met the inclusion criteria. Two reviewers (KT and SO) then assessed the full text of potentially eligible studies against the inclusion criteria. If it was considered that studies had collected data on the prevalence and odds of domestic violence but had not presented it, authors were contacted for further information.

Data from the included papers were extracted by two reviewers (KT and SO) into an electronic database (see Appendix 3 for a copy of the extraction form). Information was extracted from each study on: (1) the study country, study design, sampling methods and psychiatric setting; (2) demographic characteristics of study samples, and study inclusion/exclusion criteria; (3) methods of assessment of domestic violence (e.g. self-report, case file review), including details on the type of instruments used (e.g. validated, non-validated); (4) type of violence (e.g. physical, sexual, psychological abuse), and type of abusers (e.g. intimate partner, siblings, parents), and (5) type of outcomes (i.e. prevalence and odds of lifetime/past year domestic violence among psychiatric service users). Where possible, outcome measures were extracted separately by gender psychiatric setting and type and severity of violence.

#### 2.2.4 Quality Appraisal

##### 2.2.4.1 Development of the Critical Appraisal Checklist

The quality of included studies was independently appraised by two reviewers (KT and SO), using criteria adapted from the following validated tools:
1) Critical Appraisal Skills Programme Checklists (Public Health Resource Unit, 2006);
2) Quality Index Checklist (Downs & Black, 1998);

Adaptations to the Criteria for Critical Appraisal of Research Articles on Prevalence of Disease (Loney & Chambers, 2000) included incorporating a number of sources on study methodology from the Critical Appraisal Skills Programme Checklists (Public Health Resource Unit, 2006) and sources of confounding and attrition from the Quality Index Checklist (Downs & Black, 1998). The finalised critical appraisal checklist for this review included items assessing study design, representativeness of study samples, blinding and appropriate use of statistical techniques (see Appendix 4 for a copy of the checklist).

2.2.4.2 Appraisal of Studies of High-Quality

Quality scoring, particularly for observational research, is contestable (Greenland & O’Rourke, 2001); however a decision was made to exclude studies with poor methodological quality that threatened the validity of findings. High-quality papers were defined as those that scored ≥50% on questions assessing selection bias. Selection bias was chosen as the primary indicator of high-quality because it examines biases in the representativeness of study samples, selection of controls in case-control studies, characteristics of participants and non-participants, and biases regarding differential loss-to-follow-up in cohort studies. Due to widespread variations in the terminologies used to measure domestic violence (see Chapter 1 section 1.5), assessing quality in relation to measurement biases was not considered to be a good indicator of the methodological strength of studies. A cut off score of 50% was selected as papers scoring below this figure were considered to possess too many biases, which would threaten the validity of findings (e.g. the results would not be representative of the population of interest).

Reviewers compared scores and resolved any disagreements through consensus or with the aid of a third reviewer (LH) before calculating a final appraisal score.
Scores for overall study quality and for questions relating to selection bias and measurement bias are reported for all studies (see Table 1).

2.2.5 Data Analysis

Information on the study design, study sample and definition and measurement of domestic violence were summarised. Prevalence estimates and their standard errors were calculated. For studies in which the required data were not reported, authors were contacted to request the information. Prevalence estimates (lifetime or past year) of domestic violence were calculated separately by gender, type of violence and type of psychiatric setting, where data were available. Odds ratios were not calculated because none of the primary studies included control groups.

Pooled prevalence estimates were calculated (with corresponding 95% confidence intervals) for lifetime and past year domestic violence, broken down by type of psychiatric setting, if estimates were available from three or more high-quality studies. In line with common practice, a minimum of three estimates were required for a meta-analysis (Davey, Turner, Clarke, et al., 2011; Treadwell, Tregear, Reston, et al., 2006). Heterogeneity among studies was estimated using the $I^2$ statistic (associated 95% confidence intervals (CIs) were calculated using the STATA command *heterogi* to conduct a non-central $\chi^2$ based approach) (Higgins & Thompson, 2002). Conventionally, $I^2$ values of 25-50%, 50-75% and $\geq$75% represent “low”, “moderate” and “high” heterogeneity, respectively (Harris, Bradburn, Deeks, *et al.*, 2008; Higgins, Thompson, Deeks, *et al.*, 2003, p 559). If heterogeneity exceeded 50% (i.e. moderate heterogeneity) pooled estimates were based on a random-effects model (DerSimonian & Laird, 1986) otherwise pooled estimates were based on a fixed-effect model (Mantel & Haenszel, 1959).

Summary estimates that included both high- and low-quality papers were calculated in order to assess the impact of excluding low-quality papers. In addition, an examination of the influence of individual studies on summary prevalence estimates was also conducted using influence analyses (i.e. the STATA command *metaninf*), which compute summary estimates omitting one study at a time (Tobias, 1999). Risk of study bias was assessed with funnel plots (Sterne & Harbord, 2004). Due to the small number of eligible studies, statistical tests for funnel plot asymmetry were not appropriate and were confined to visual inspection of the plots. All analyses were conducted in STATA 11.
2.3 Results

The study selection process is presented in Figure 2 below. The literature search yielded 29,707 unique references, of which 28,584 references were excluded following title and abstract screening. Of the 1,123 references that met, or potentially met, the inclusion criteria, 59 (56 dissertations, three journal articles\(^1\)) could not be located. 1,064 full papers were retrieved and assessed and 1,022 were excluded. 42 papers were included in the review: 32 were identified from searches of electronic databases; seven from citation tracking; one from hand searching; zero from re-examining and updating an earlier systematic review on violence victimisation (Maniglio, 2008), and two from expert recommendations. Only one of the 42 included papers was published in a language other than English (i.e. Portuguese) (Ferreira da Silva, 1991). Ten non-English language papers were excluded after screening full text translations\(^2\), most often because they did not measure domestic violence and instead reported on other types of violence.

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\(^1\) The British library was unable to find a supplier for these three articles, which were printed in the Turkiye'de Psikiyatri, Psikiyatri Psikoloji Psikofarmakoloji Dergis, and Revista de Psiquiatria Clinica.

\(^2\) Full text translations of non-English language articles were undertaken by individuals who were fluent in language the article was written in. During the process of translation, translators were asked to document the instrument/measure used to assess domestic violence and to translate, verbatim, the exact phrasing of questions used to explore participants’ experiences of domestic violence.
Figure 2: Flow Diagram of Search Process for a Systematic Review of the Prevalence of Domestic Violence among Psychiatric Service Users

Records identified through database searching: n=41,067

Records identified by alternative sources:
- Hand searches: n=16
- Citation tracking: n=94
- Update and reanalysis of previous review: n=53
- Expert recommendations: n=35

Records after duplicates removed: n=29,707

Records screened: n=29,707

Full-text articles assessed for eligibility: n=1,123

Reasons for exclusion:
- Ineligible publication format: n=25
- Ineligible study design: n=15
- Sample aged less than 16 years of age: n=43
- Sample did not include psychiatric patients: n=567
- Study did not measure domestic violence: n=246
- Prevalence of domestic violence could not be derived: n=95
- Data reported elsewhere: n=31
- Study could not be retrieved: n=59

Studies included in review: n=42
2.3.1 Key Features of Included Papers

42 papers examined the prevalence of domestic violence among psychiatric service users. 36 papers reported on domestic violence perpetrated by an intimate partner only (including seven papers in which the definition was limited to violence perpetrated by a spouse) and six reported on violence perpetrated by an intimate partner or other family member. 32 studies measured lifetime experiences of domestic violence only, seven past year domestic violence only, and three both lifetime and past year experiences of domestic violence. Further details about the instruments used to assess domestic violence and the methods of data collection are provided for each study in Table 1.


Four presented data for emergency psychiatric service users, recruited from the following services: (1) a psychiatric emergency room of a major USA urban medical centre (Briere, Woo, McRae, et al., 1997); (2) a psychiatric emergency room of a major USA urban psychiatric emergency room (Currier & Briere, 2000); (3) two emergency care centres of a large USA, inner-city public hospital

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(Paranjape, Heron & Kaslow, 2006); and (4) a psychiatric emergency clinic within a large USA psychiatric teaching facility (Owens, 2007).

Seven studies were conducted across a range of psychiatric settings and did not provide data disaggregated by service type (Bengtsson-Tops, Markstrom & Lewin, 2005; Chang, Cluss, Burke, et al, 2011; Dienemann, Boyle, Baker, et al, 2000; Ferreira da Silva, 1991; McPherson, Delva & Cranford, 2007; Paranjape, Heron & Kaslow, 2006; Yellowlees & Kaushik, 1994). In five papers it was not clear what type of psychiatric service participants were recruited from (Brown, Cosgrave, Killackey, et al, 2009; Osgood & Manetta, 2000; Tham, Ford & Wilkinson, 1995; Waller, 1991; Weingourt, 1990).

27 studies were conducted with female only samples; one study was conducted with a male only sample. 14 studies included both male and female psychiatric service users, but only nine provided gender-disaggregated data on domestic violence.

2.3.1.1 Pooled Prevalence Estimates

Summary estimates that included both high and low-quality papers were found to be too heterogeneous (≥95%); therefore meta-analysis was restricted to high-quality papers. Due to the limited number of high-quality papers it was only possible to calculate a pooled prevalence for any lifetime partner violence among female psychiatric inpatient samples. Across four papers, the pooled prevalence of any lifetime partner violence was 37.6% (95% CI 24.3-51) among female inpatients, with high heterogeneity I²=79.4% (95% CI 45-92) (see Figure 3 below) (Bryer, Nelson, Miller, et al, 1987; Carlile, 1991; Carmen, Rieker & Mills, 1984; Husain, Anasseril & Harris, 1983). No evidence of publication bias was identified.
Visual inspection of the forest plot and the influence analysis identified an outlier (i.e. Carlile, 1991). Removal of this study from the meta-analysis produced a pooled prevalence of 40% (95% CI 24.6-37.2) with no heterogeneity $I^2=0.0\%$ (95% CI 0-90); the $I^2$ score suggests that all variability in prevalence estimates is due to sampling error within studies and not heterogeneity between studies (see Figure 4 below) (Bryer, Nelson, Miller, et al, 1987; Carmen, Rieker & Mills, 1984; Husain, Anasseril & Harris, 1983).
2.3.2 Psychiatric Inpatients

2.3.2.1 Lifetime Partner Violence (any type)

The prevalence of any (i.e. physical, sexual, psychological) lifetime partner violence ranged from 16.4% to 94.5% among female inpatients and from 18.2% to 48% among male inpatients (see Table 1). Excluding studies that scored <50% on quality appraisal questions relating to selection bias, the median prevalence of lifetime partner violence was 29.8% (IQR 26.1% - 39.2%; range 25.8% - 56%) among female inpatients (Bryer, Nelson, Miller, et al, 1987; Carlile, 1991; Carmen, Rieker & Mills, 1984; Husain, Anasseril & Harris, 1983). No high-quality papers were identified which reported on lifetime partner violence among male psychiatric inpatients.

2.3.2.2 Lifetime Partner Violence (specific types)

2.3.2.2.1 Physical Partner Violence: Seven studies reported on the lifetime prevalence of physical partner violence among psychiatric inpatients (Bryer, Nelson, Miller, et al, 1987; Carlile, 1991; Hudson Scholle, Rost & Golding, 1998; Husain, Anasseril & Harris, 1983; Post, Willett, Franks, et al, 1980; Sansone, Chu
Among high-quality papers, the median prevalence of lifetime physical partner violence was 26.1% (IQR 26% - 41.1%; range 25.8% - 56%) among female inpatients (Bryer, Nelson, Miller, et al, 1987; Carlile, 1991; Husain, Anasseril & Harris, 1983). One low-quality paper presented data for men and reported a lifetime prevalence of physical partner violence of 18.2% (Post, Willett, Franks, et al, 1980).

### Sexual Partner Violence

2.3.2.2 Sexual Partner Violence: One study reported a lifetime prevalence of sexual partner violence of 16.4% among female inpatients; this paper scored <50% on quality appraisal questions relating to selection bias (Chandra, Deepthivarma, Carey, et al, 2003).

### Psychological Partner Violence

2.3.2.3 Psychological Partner Violence: One study reported a lifetime prevalence of psychological partner violence of 94.5% among female inpatients; this paper scored <50% on quality appraisal questions relating to selection bias (Sansone, Chu & Wiederman, 2007).

### Past Year Partner Violence

2.3.2.3 Past Year Partner Violence: Three studies reported on the past year prevalence of physical partner violence among female inpatients, which ranged from 33.3% - 93.2% (Cascardi, Mueser, DeGiralomo, et al, 1996; Heru, Stuart, Rainey, et al, 2006; Weizmann-Henelius, Viemero & Eronen, 2004); none of these studies scored ≥50% on quality appraisal questions relating to selection bias. One high-quality paper reported that the prevalence of past year physical violence among female psychiatric inpatients was 18.2%, but this estimate combined violence from intimate partners and family members (Hudson Scholle, Rost & Golding, 1998).

### Family Violence

2.3.2.4 Family Violence

2.3.2.4.1 Lifetime Family Violence: Two studies reported on the prevalence of lifetime family violence among female inpatients (Bryer, Nelson, Miller, et al, 1987; Chandra, Deepthivarma, Carey, et al, 2003). In the only high-quality study, lifetime prevalence of physical violence by a father was estimated at 9.1%, and 6.1% by a brother among female inpatients (Bryer, Nelson, Miller, et al, 1987).
2.3.2.4.2 Past Year Family Violence: One study of male and female psychiatric inpatients reported the prevalence of past year violence by a family member to be 45.8%; this paper scored <50% on quality appraisal questions relating to selection bias (Cascardi, Mueser, DeGiralomo, et al, 1996).

2.3.3 Psychiatric Outpatients

2.3.3.1 Lifetime Partner Violence (any type)
The prevalence of any (i.e. physical, sexual, psychological) lifetime partner violence ranged from 7.1% - 81.4% among female outpatients and 1.6% - 5.9% among male outpatients (see Table 1). Excluding studies which scored <50% on quality appraisal questions relating to selection bias, the median prevalence of lifetime partner violence was 33% (IQR 20.8% -52.6%; range 14.6% - 81.4%) among females (Carlile, 1991; Herman, 1986; Leithner, Assem-Hilger, Naderer, et al, 2009; Morgan, Zolese, McNulty, et al, 2010). No high-quality papers were identified which reported on partner violence among male psychiatric outpatients.

2.3.3.2 Lifetime Domestic Violence (specific types)


2.3.3.2.2 Sexual Partner Violence: Estimates of the lifetime prevalence of sexual violence among female outpatients were highly variable (Goodman, Dutton & Harris, 1995; Johnston-McCabe, Levi-Minzi, Hasselt, et al, 2011; Leithner, Assem-Hilger, Naderer, et al, 2009; Ramanathan, 1996). In the only high-quality
study, the prevalence of lifetime sexual partner violence among female outpatients was 2.6% (Leithner, Assem-Hilger, Naderer, et al, 2009).

2.3.3.2.3 Psychological Partner Violence: Three studies reported on the lifetime prevalence of psychological violence among female outpatients, which ranged from 9.1% to 71.7% (Leithner, Assem-Hilger, Naderer, et al, 2009; Lipschitz, Kaplan, Sorkenn, et al, 1996; Ramanathan, 1996). Prevalence of lifetime psychological partner violence in the only high-quality study was 9.1% (Leithner, Assem-Hilger, Naderer, et al, 2009).

2.3.3.3 Past Year Partner Violence: Less data were available on past year partner violence. Two high-quality studies assessed past year physical abuse among female outpatients; one reported a prevalence of 15.7% for physical partner violence (Morgan, Zolese, McNulty, et al, 2010), the other reported a prevalence of 11.4% but combined violence from intimate partners and family members (Hudson Scholle, Rost & Golding, 1998).

2.3.3.4 Family Violence
2.3.3.4.1 Past Year Family Violence: One study reported that 4.0% of a mixed sample of male and female psychiatric outpatients had been abused in the past year by a family member; although this study scored <50% on quality appraisal questions relating to selection bias (Bengtsson-Tops & Ehliasson, 2011).

2.3.4 Psychiatric Emergency Department Users
2.3.4.1 Lifetime Partner Violence (any)
The prevalence of any lifetime (i.e. physical, sexual, psychological) domestic violence ranged from 41.9% to 59.7% among female psychiatric emergency department attendees and 8.3% among male attendees (see Table 1). Only one paper scored ≥50% on quality appraisal questions which related to selection bias, this study estimated that the prevalence of lifetime partner violence among female psychiatric emergency department attendees was 59.7% (Owens, 2007). No high-quality papers were identified which reported on domestic violence among male psychiatric emergency department attendees.
2.3.4.2 Past Year Partner Violence (any)
One high-quality study assessed past year experiences of partner violence among female psychiatric emergency department attendees and reported the prevalence of past year physical and sexual violence to be 19.9% and 15.7% respectively (Owens, 2007).

2.3.5 Mixed Psychiatric Settings
2.3.5.1 Lifetime Partner Violence (any)
Seven studies collected data across a range of psychiatric settings (e.g. inpatient, outpatient, community, emergency and forensic mental health services) and did not disaggregate their results according to setting (see Table 1). Excluding studies which scored <50% on quality appraisal questions relating to selection bias, the median prevalence of lifetime partner violence among male and female service users was 25.6% (IQR 20.1% - 44.1%; range 25.6% - 62.6%) (Bengtsson-Tops, Markstrom & Lewin, 2005; Chang, Cluss, Burke, et al, 2011; Yellowlees & Kaushik, 1994). Two high-quality papers reported gender specific prevalence estimates. The first, a large Swedish cross-sectional study attempted to survey all female users of psychiatric inpatient and outpatient services over a one week period about their experiences of violence estimated that 25.6% women had ever experienced violence from a current partner and 23.1% from a previous partner (Bengtsson-Tops, Markstrom & Lewin, 2005). The second, conducted in the USA, estimated that 62.6% of female psychiatric service users had ever experienced partner violence (including 49.6% physical violence and 32.2% sexual violence) (Chang, Cluss, Burke, et al, 2011). The latter study also estimated that 31.6% of male psychiatric service users had experienced partner violence (including 18.4% physical violence and 4.4% sexual violence).

2.3.5.2 Family Violence
2.3.5.2.1 Lifetime Family Violence: One high-quality paper reported that, among male and female service users in mixed psychiatric settings, the prevalence of lifetime violence by a family member was 11.1% (Bengtsson-Tops, Markstrom & Lewin, 2005).
Table 1: Characteristics and Outcomes of Included Studies on the Prevalence of Domestic Violence among Psychiatric Service Users

<table>
<thead>
<tr>
<th>Author and year</th>
<th>Country</th>
<th>Sample</th>
<th>Method</th>
<th>Definition of domestic violence</th>
<th>Results</th>
<th>Quality scores</th>
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<tbody>
<tr>
<td><strong>Psychiatric Inpatient Sample</strong></td>
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<tr>
<td>(Bryer, Nelson, Miller, et al, 1987)</td>
<td>USA</td>
<td>68 female psychiatric inpatients (missing data for 2 participants)</td>
<td>Cross-sectional survey</td>
<td>Violence assessed by self-administered questionnaire using the authors’ questions</td>
<td>Lifetime physical or sexual violence by a spouse, intimate partner, or nuclear family member</td>
<td>Lifetime physical violence: 17/66 (25.8%) females reported physical violence by a spouse or intimate partner, 6/66 (9.1%) females reported physical violence by a father, 4/66 (6.1%) by a brother</td>
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<td>Domestic violence derived from information on age of abuse and perpetrator of violence</td>
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<td>(Disaggregated data on sexual violence by a spouse or intimate partner was not presented)</td>
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<td>Measurement bias: 8/14</td>
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<tr>
<td></td>
<td>South Africa</td>
<td>152 female psychiatric service users (n=64 inpatients, n=88 outpatients)</td>
<td>Cross-sectional survey</td>
<td>Domestic violence assessed during interview using the authors’ questions</td>
<td>Lifetime physical violence by a spouse</td>
<td>36/64 (56%) females reported physical violence by a spouse</td>
</tr>
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<td>(Carlile, 1991)</td>
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<td>Selection bias: 7/14</td>
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<td></td>
<td>Measurement bias: 9/14</td>
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<tr>
<td></td>
<td>USA</td>
<td>188 male and female psychiatric inpatients</td>
<td>Case file review</td>
<td>Domestic violence</td>
<td>Lifetime physical or sexual violence within a marital</td>
<td>41/122 (33.6%) females reported violence by a spouse</td>
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<td>Author and year</td>
<td>Country</td>
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<td>Definition of domestic violence</td>
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<td>Quality scores</td>
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<td>(n=66 males, n=122 females)</td>
<td>assessed on basis of information recorded in case files</td>
<td>relationship</td>
<td>(Data not presented for men)</td>
<td>Selection bias: 7/14, Measurement bias: 6/14</td>
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<tr>
<td>(Cascardi, Mueser, DeGiralomo, et al, 1996)</td>
<td>USA</td>
<td>69 male and female psychiatric inpatients (n=33 males, n=36 females)</td>
<td>Cross-sectional survey, Domestic violence assessed by self-administered questionnaire using the Conflict Tactics Scale</td>
<td>Past year physical violence by an intimate partner or family member</td>
<td>27 (62.8%) of the 43 males and females with an intimate partner reported physical violence</td>
<td>Total score: 26/40, Selection bias: 6/14, Measurement bias: 13/14</td>
</tr>
<tr>
<td>(Chandra, Deepthivarma, Carey, et al, 2003)</td>
<td>India</td>
<td>146 female psychiatric inpatients</td>
<td>Cross-sectional survey, Sexual violence assessed during interview using the Sexual Experiences Survey</td>
<td>Lifetime sexual violence by an intimate partner or a relative</td>
<td>24/146 (16.4%) females reported sexual violence by an intimate partner, 10/146 (6.8%) females reported sexual violence by a relative</td>
<td>Total score: 19/40, Selection bias: 6/14, Measurement bias: 7/14</td>
</tr>
<tr>
<td>(Heru, Stuart, Rainey, et al, 2006)</td>
<td>USA</td>
<td>110 male and female psychiatric inpatients</td>
<td>Cross-sectional survey</td>
<td>Past year physical, sexual or psychological</td>
<td>Past year physical violence: 61/66 (92.4%) females reported physical violence by an intimate</td>
<td>Total score: 26/40</td>
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<td>Author and year</td>
<td>Country</td>
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<td>Definition of domestic violence</td>
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<td>(Hoffman &amp; Toner, 1988)</td>
<td>Canada</td>
<td>50 male and female psychiatric inpatients (n=25 males, n=25 females)</td>
<td>Cross-sectional survey</td>
<td>Lifetime physical, sexual and psychological violence by an intimate partner</td>
<td>19/25 (76%) females reported any violence by an intimate partner</td>
<td>Total score: 24/40</td>
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<td></td>
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<td>Domestic violence assessed during</td>
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<td>12/25 (48%) males reported any violence by an intimate partner</td>
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<td>Selection bias: 6/14</td>
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| (n=44 males, n=66 females) | Domestic violence assessed by self-administered questionnaire using the Revised Conflict Tactics Scale | violence by an intimate partner | | 57/66 (86.4%) females reported severe physical violence | Selection bias: 6/14 |
| | | | | 41/44 (93.2%) males reported physical violence by an intimate partner | Measurement bias: 12/14 |
| | | | | 39/44 (88.6%) males reported severe physical violence | |
| | | | | | |
| Past year sexual violence: | 12/66 (18.2%) females reported sexual violence by an intimate partner | | | 13/44 (29.5%) males reported sexual violence by an intimate partner | |
| | | | | | |
| Past year psychological violence: | 61/66 (92.4%) females reported psychological violence by an intimate partner | | | 36/44 (81.8%) males reported psychological violence by an intimate partner | |
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<th>Author and year</th>
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<th>Definition of domestic violence</th>
<th>Results</th>
<th>Quality scores</th>
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</table>
| (Hudson Scholle, Rost & Golding, 1998) | USA | 317 female householders who screened positive for depression and reported on their use of mental health services in the past year (n=11 reported previous inpatient admission) | Cross-sectional survey | Lifetime and past year physical violence by an intimate partner or family member | *Lifetime physical violence:* 7/11 (63.6%) females reported physical violence by an intimate partner/family member  
*Past year physical violence:* 2/11 (18.2%) females reported physical violence by an intimate partner/family member | Total score: 30/40  
Selection bias: 10/14  
Measurement bias: 11/14 |
| (Husain, Anasseril & Harris, 1983) | USA | 23 female forensic psychiatric service users | Cross-sectional survey | Lifetime physical violence by a spouse | 6/23 (26.1%) females reported physical violence by a spouse. | Total score: 24/40  
Selection bias: 9/14  
Measurement bias: 8/14 |
| (Post, Willett, Franks, et al, 1980) | USA | 60 male and female psychiatric inpatients (n=22 males, n=38 females) | Cross-sectional survey | Lifetime physical violence by an intimate partner | 29/60 (48.3%) males and females reported physical violence by an intimate partner  
25/38 (65.8%) females reported physical violence by an intimate partner | Total score: 18/40  
Selection bias: 6/14  
Measurement bias: 6/14 |
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<th>Author and year</th>
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<th>Sample</th>
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<th>Definition of domestic violence</th>
<th>Results</th>
<th>Quality scores</th>
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</thead>
<tbody>
<tr>
<td>(Sansone, Chu &amp; Wiederman, 2007)</td>
<td>USA</td>
<td>113 female psychiatric inpatients</td>
<td>Cross-sectional survey</td>
<td>Lifetime physical or psychological violence by an intimate partner</td>
<td>4/22 (18.2%) males reported physical violence by an intimate partner</td>
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<td>(missing data for 4 participants)</td>
<td>Domestic violence assessed by self-administered questionnaire using the Sexual Violence Against Women Scale (non-zero score)</td>
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<td>Lifetime physical violence: 91/109 (83.4%) females reported physical violence by an intimate partner</td>
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<td>Lifetime psychological violence: 103/109 (94.5%) females reported psychological violence by an intimate partner</td>
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<td>Total score: 26/40</td>
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<td>Selection bias: 6/14</td>
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<td>Measurement bias: 11/14</td>
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<tr>
<td>(Weizmann-Henelius, Viemero &amp; Eronen, 2004)</td>
<td>Finland</td>
<td>91 female violent incarcerated or hospitalised offenders or community controls</td>
<td>Case control study (cases were female violent offenders incarcerated or hospitalised during a 12 month period and controls were non-offender women recruited from community education or evening courses)</td>
<td>Past year physical and sexual violence by an intimate partner</td>
<td>4/12 (33.3%) females reported any violence by an intimate partner</td>
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<td>Domestic violence assessed during interview using the authors’ questions</td>
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<td>Total score: 23/40</td>
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<td>Selection bias: 5/14</td>
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<td>Measurement bias: 10/14</td>
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<td>(Zanarini, Frankenburg, 2013)</td>
<td>USA</td>
<td>362 male and female psychiatric</td>
<td>Cross-sectional survey</td>
<td>Lifetime physical violence by an intimate partner</td>
<td>108/362 (29.8%) males and females reported physical violence by an intimate partner</td>
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<td>Total score: 27/40</td>
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<td>Author and year</td>
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<td>Reich, et al, 1999)</td>
<td>inpatients (n=83 males, n=279 females)</td>
<td>Adulthood violence assessed during interviews using the Abuse History Interview - domestic violence derived from information on perpetrator of violence</td>
<td>intimate partner</td>
<td>intimate partner</td>
<td>(Data not gender-disaggregated)</td>
<td>Selection bias: 7/14</td>
</tr>
</tbody>
</table>

**Psychiatric Outpatient Sample**

| (Bengtsson-Tops & Ehliasson, 2011) | Sweden | 174 male and female psychiatric outpatients (n=75 males, n=99 females) | Cross-sectional survey | Lifetime and past year physical, sexual or psychological violence by an intimate partner or family member | Lifetime partner violence (any): 9/174 (5.2%) males and females reported any current partner violence<br>27/174 (15.5%) males and females reported any violence by a former partner<br>25/174 (14.4%) males and females reported any violence by a family member<br>7/174 (4.0%) males and females reported any violence by another relative | Total score: 21/40 | Selection bias: 5/14 | Measurement bias: 9/14 |

**Past year violence (any):**<br>9/174 (5.2%) males and females reported any current partner violence
<table>
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<tr>
<th>Author and year</th>
<th>Country</th>
<th>Sample</th>
<th>Method</th>
<th>Definition of domestic violence</th>
<th>Results</th>
<th>Quality scores</th>
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<td>11/174 (6.3%) males and females reported any violence by a former partner</td>
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<td>7/174 (4.0%) males and females reported any violence by a family member</td>
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<td>2/174 (1.1%) males and females reported any violence by another relative</td>
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<td>Past year physical violence:</td>
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<td>7/174 (4.0%) males and females reported current physical partner violence</td>
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<td>6/174 (3.4%) males and females reported physical violence by a former partner</td>
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<td>5/174 (2.9%) males and females reported physical violence by a family member</td>
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<td>1/174 (0.6%) males and females reported physical violence by another relative</td>
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<td>Past year sexual violence:</td>
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<td>2/174 (1.1%) males and females reported current sexual partner violence</td>
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<td>5/174 (2.9%) males and females</td>
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<td>(Carlile, 1991)</td>
<td>South Africa</td>
<td>152 female psychiatric service users (n=88 outpatients, n=64 inpatients)</td>
<td>Cross-sectional survey</td>
<td>Lifetime physical violence by a spouse</td>
<td>38/88 (43%) females reported physical violence by a spouse</td>
<td>Total score: 24/40</td>
</tr>
</tbody>
</table>

**Results**
- **reported sexual violence by a former partner**
  - 3/174 (1.7%) males and females reported sexual violence by a family member
  - 0/174 (0.0%) males and females reported sexual violence by another relative

**Past year psychological violence:**
- **7/174 (4.0%)** males and females reported current psychological partner violence
- **6/174 (3.4%)** males and females reported psychological violence by a former partner
- **5/174 (2.9%)** males and females reported psychological violence by a family member
- **2/174 (1.1%)** males and females reported psychological violence by another relative

(Data not gender-disaggregated)
<table>
<thead>
<tr>
<th>Author and year</th>
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<th>Sample</th>
<th>Method</th>
<th>Definition of domestic violence</th>
<th>Results</th>
<th>Quality scores</th>
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<tbody>
<tr>
<td>(Ford, 2008)</td>
<td>USA</td>
<td>38 female community mental health service users</td>
<td>Cross-sectional survey</td>
<td>Lifetime violence by an intimate partner; type of violence not specified</td>
<td>20/38 (52.6%) females reported any violence by an intimate partner</td>
<td>Measurement bias: 9/14, Total score: 22/40, Selection bias: 4/14</td>
</tr>
<tr>
<td>(Goodman, Dutton &amp; Harris, 1995)</td>
<td>USA</td>
<td>99 episodically homeless female community mental health service users</td>
<td>Cross-sectional survey</td>
<td>Lifetime physical and sexual violence by an intimate partner</td>
<td>Lifetime physical violence: 79/99 (79.8%) females reported physical violence by an intimate partner; Lifetime sexual violence: 40/99 (40.4%) females reported sexual violence by an intimate partner</td>
<td>Total score: 27/40, Selection bias: 5/14, Measurement bias: 12/14</td>
</tr>
<tr>
<td>(Friedman, Loue, Goldman Heaphy, et al, 2011)</td>
<td>USA</td>
<td>53 female community mental health service users</td>
<td>Cross-sectional survey</td>
<td>Lifetime violence (physical, sexual, or threatened) by an intimate partner</td>
<td>36/53 (67.9%) females reported any violence by an intimate partner</td>
<td>Total score: 19/40, Selection bias: 4/14, Measurement bias: 7/14</td>
</tr>
<tr>
<td>(Herman, 1986)</td>
<td>USA</td>
<td>190 psychiatric outpatients (n=85 males, n=105 females)</td>
<td>Case file review</td>
<td>Lifetime physical and sexual violence by a spouse</td>
<td>24/105 (22.9%) females reported any violence by a spouse</td>
<td>Total score: 24/40, Selection bias:</td>
</tr>
<tr>
<td>Author and year</td>
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<td>Sample</td>
<td>Method</td>
<td>Definition of domestic violence</td>
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</table>
| (Hudson Scholle, Rost & Golding, 1998) | USA | 317 female householders screened positive for depression and self-report on past year mental health service use (n=167 reported previous outpatient visits) | Cross-sectional survey | Lifetime and past year physical violence by an intimate partner or family member | Lifetime physical violence: 98/167 (58.7%) females reported physical violence by an intimate partner/family member  
Past year physical violence: 19/167 (11.4%) females reported physical violence by an intimate partner/family member | Selection bias: 10/14  
Measurement bias: 4/14 |
| (Johnston-McCabe, Levi-Minzi, Hasselt, et al, 2011) | USA | 46 deaf and hard of hearing female community mental health service users | Cross-sectional survey | Lifetime physical, sexual or psychological violence by an intimate partner | Lifetime physical violence: 26/46 (56.5%) females reported physical violence by an intimate partner  
Lifetime sexual violence: 12/46 (26.1%) females reported sexual violence by an intimate partner  
Lifetime psychological violence: 33/46 (71.7%) females reported psychological violence by an intimate partner | Selection bias: 3/14  
Measurement bias: 11/14 |
| (Leithner, Assem-Hilger, Naderer, et al, 2013) | Austria | 424 female service users from a women’s Cohort study | Domestic violence | Lifetime physical, sexual and psychological violence | Lifetime violence (any): 62/424 (14.6%) females reported any violence by an intimate partner | Total score: 30/40  
Selection bias: 10/14  
Measurement bias: 11/14 |
<table>
<thead>
<tr>
<th>Author and year</th>
<th>Country</th>
<th>Sample</th>
<th>Method</th>
<th>Definition of domestic violence</th>
<th>Results</th>
<th>Quality scores</th>
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</thead>
<tbody>
<tr>
<td>2009)</td>
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<tr>
<td>(Lipschitz, Kaplan, Sorkenn, et al, 1996)</td>
<td>USA</td>
<td>120 male and female psychiatric outpatients (n=34 males, n=86 females)</td>
<td>Cross-sectional survey</td>
<td>Lifetime physical violence by a spouse or intimate partner</td>
<td>32 /120 (26.7%) males and females reported physical violence by a spouse/intimate partner</td>
<td>Total score: 20/40</td>
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<td>30/86 (34.9%) females reported physical violence by a spouse/intimate partner</td>
<td>Selection bias: 6/14</td>
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<td>2/34 (5.9%) males reported physical violence by a spouse/intimate partner</td>
<td>Measurement bias: 6/14</td>
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<td>Lifetime sexual violence: 11/424 (2.6%) females reported sexual violence by an intimate partner</td>
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<td>Lifetime psychological violence: 44/424 (10.3%) females reported psychological violence by an intimate partner</td>
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<tr>
<td>(Morgan, Zolese, McNulty, et al, 2010)</td>
<td>UK</td>
<td>71 female community mental health service users (missing data for 1 participant)</td>
<td>Cross-sectional survey</td>
<td>Lifetime, past year and during pregnancy physical violence by an intimate partner</td>
<td>42/70 (60.0%) females reported physical violence by an intimate partner</td>
<td>Total score: 32/40</td>
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<td>Selection bias: 12/14</td>
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</table>

Note: The table does not show all the data from the original document. The data is summarised for clarity.
<table>
<thead>
<tr>
<th>Author and year</th>
<th>Country</th>
<th>Sample</th>
<th>Method</th>
<th>Definition of domestic violence</th>
<th>Results</th>
<th>Quality scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Ramanathan, 1996)</td>
<td>India</td>
<td>332 female psychiatric outpatients</td>
<td>Cross-sectional survey</td>
<td>Lifetime physical, sexual or psychological violence by a spouse</td>
<td>Lifetime physical violence: 25/332 (7.5%) females reported physical violence by a spouse; Lifetime sexual violence: 3/332 (0.9%) females reported sexual violence by a spouse; 51/332 (15.4%) females reported psychological violence by a spouse</td>
<td>Total score: 18/40; Selection bias: 5/14; Measurement bias: 9/14</td>
</tr>
<tr>
<td>(Surrey, Swett, Michaels, et al, 1990)</td>
<td>USA</td>
<td>140 female psychiatric outpatients</td>
<td>Cross-sectional survey</td>
<td>Lifetime physical or sexual violence by a spouse</td>
<td>10/140 (7.1%) females reported any violence by a spouse</td>
<td>Total score: 24/40; Selection bias: 6/14</td>
</tr>
</tbody>
</table>

- **Lifetime psychological violence by an intimate partner:**
  - 11/70 (15.7%) females reported physical violence by an intimate partner
  - 14/70 (20%) females reported physical violence by an intimate partner
  - 38/70 (54.3%) females reported threatening behaviour by an intimate partner
  - 57/70 (81.4%) females reported controlling behaviour by an intimate partner

- **Physical violence during pregnancy:**
  - 14/70 (20%) females reported physical violence by an intimate partner

- **Lifetime psychological violence:**
  - 38/70 (54.3%) females reported threatening behaviour by an intimate partner
  - 57/70 (81.4%) females reported controlling behaviour by an intimate partner

**Methodology:**
- Questionnaire using the authors’ questions
- Cross-sectional survey using self-administered instruments
- Domestic violence assessed during interviews; no instrument specified
<table>
<thead>
<tr>
<th>Author and year</th>
<th>Country</th>
<th>Sample</th>
<th>Method</th>
<th>Definition of domestic violence</th>
<th>Results</th>
<th>Quality scores</th>
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</thead>
<tbody>
<tr>
<td>(Swett, Cohen, Surrey, et al, 1991)</td>
<td>USA</td>
<td>189 female psychiatric outpatients</td>
<td>Cross-sectional survey</td>
<td>Violence assessed by self-administered questionnaire using the Life Experiences Questionnaire; domestic violence derived from information on age at abuse and perpetrator of violence</td>
<td>Lifetime physical or sexual violence by a spouse</td>
<td>Measurement bias: 11/14</td>
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<td>17/189 (9.0%) females reported any violence by a spouse</td>
<td>Total score: 22/40</td>
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<td>Selection bias: 6/14</td>
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<td>Measurement bias: 11/14</td>
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<tr>
<td>(Swett, Surrey &amp; Cohen, 1990)</td>
<td>USA</td>
<td>125 male psychiatric outpatients</td>
<td>Cross-sectional survey</td>
<td>Violence assessed by self-administered questionnaire; domestic violence derived from information on age at abuse and</td>
<td>Lifetime physical or sexual violence by an intimate partner</td>
<td>Total score: 21/40</td>
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<td>Lifetime physical violence: 2/125 (1.6%) males reported physical violence by an intimate partner</td>
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<td>Lifetime sexual violence: 0/125 (0.0%) males reported sexual violence by an intimate partner</td>
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<td>Measurement bias: 7/14</td>
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<td>Author and year</td>
<td>Country</td>
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<td>Method</td>
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<td>Quality scores</td>
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<tr>
<td>(Vahip &amp; Doganavsargil, 2006)</td>
<td>Turkey</td>
<td>100 female psychiatric outpatients</td>
<td>Cross-sectional survey</td>
<td>Lifetime physical violence by an intimate partner</td>
<td>62/100 (62%) females reported physical violence by an intimate partner</td>
<td>Total score: 23/40</td>
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<td>Method of assessing domestic violence is unclear, author’s questions used</td>
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<td>Selection bias: 5/14</td>
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<td>Measurement bias: 8/14</td>
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<td>(Briere, Woo, McRae, et al., 1997)</td>
<td>USA</td>
<td>93 female psychiatric emergency room attendees</td>
<td>Case file review</td>
<td>Lifetime physical violence by an intimate partner</td>
<td>39/93 (41.9%) females reported physical violence by an intimate partner</td>
<td>Total score: 19/40</td>
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<td>Domestic violence assessed on basis of information recorded in case files</td>
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<td>Selection bias: 2/14</td>
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<td>Measurement bias: 10/14</td>
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<tr>
<td>(Currier &amp; Briere, 2000)</td>
<td>USA</td>
<td>162 male and female psychiatric emergency room attendees (gender-disaggregated data available for n=84:)</td>
<td>Cross-sectional survey</td>
<td>Lifetime physical violence by a spouse or intimate partner</td>
<td>35/162 (21.6%) male and female emergency department attendees reported physical violence by a spouse/intimate partner</td>
<td>Total score: 16/40</td>
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<tr>
<td></td>
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<td>Domestic violence assessed during interview using the authors’ questions</td>
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<td>Selection bias: 3/14</td>
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<td>Measurement bias: 14/14</td>
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</tbody>
</table>

**Psychiatric emergency department sample**

- **Author and year**: (Briere, Woo, McRae, et al., 1997)
- **Country**: USA
- **Sample**: 93 female psychiatric emergency room attendees
- **Method**: Case file review
- **Definition of domestic violence**: Lifetime physical violence by an intimate partner
- **Results**: 39/93 (41.9%) females reported physical violence by an intimate partner
- **Quality scores**: Total score: 19/40, Selection bias: 2/14, Measurement bias: 10/14

- **Author and year**: (Currier & Briere, 2000)
- **Country**: USA
- **Sample**: 162 male and female psychiatric emergency room attendees (gender-disaggregated data available for n=84:)
- **Method**: Cross-sectional survey
- **Definition of domestic violence**: Lifetime physical violence by a spouse or intimate partner
- **Results**: 35/162 (21.6%) male and female emergency department attendees reported physical violence by a spouse/intimate partner
- **Quality scores**: Total score: 16/40, Selection bias: 3/14, Measurement bias: 14/14
<table>
<thead>
<tr>
<th>Author and year</th>
<th>Country</th>
<th>Sample</th>
<th>Method</th>
<th>Definition of domestic violence</th>
<th>Results</th>
<th>Quality scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Owens, 2007)</td>
<td>USA</td>
<td>216 female psychiatric emergency department attendees</td>
<td>Cross-sectional survey</td>
<td>Lifetime and past year physical and sexual violence by an intimate partner</td>
<td>Lifetime physical violence: 129/216 (59.7%) females reported physical violence by an intimate partner Past year physical violence: 43/216 (19.9%) females reported physical violence by an intimate partner</td>
<td>Selection bias: 10/14 Measurement bias: 10/14</td>
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<td>Lifetime psychological violence by an intimate partner</td>
<td>Lifetime sexual violence: 84/216 (38.9%) females reported sexual violence by an intimate partner Past year sexual violence: 34/216 (15.7%) females reported sexual violence by an intimate partner Lifetime psychological violence: 70/216 (32.5%) females reported psychological violence by an intimate partner</td>
<td>Total score: 29/40</td>
</tr>
<tr>
<td>(Paranjape, Heron &amp; Kaslow, 2006)</td>
<td>USA</td>
<td>153 female hospital service users (n=10 emergency psychiatric care users)</td>
<td>Cross-sectional survey</td>
<td>Lifetime violence (physical, sexual or psychological) by an intimate partner</td>
<td>5/10 (50.0%) females reported any violence by an intimate partner</td>
<td>Total score: 28/40 Selection bias: 5/14</td>
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<tr>
<td>Author and year</td>
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<td>Sample</td>
<td>Method</td>
<td>Definition of domestic violence</td>
<td>Results</td>
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<td>Cross-sectional survey</td>
<td>Domestic violence assessed by self-administered questionnaire using the authors’ questions</td>
<td>Lifetime physical, sexual, psychological or economic abuse by a current/former intimate partner or family member</td>
<td>349/1362 (25.6%) females reported any violence from a current partner</td>
<td>Measurement bias: 13/14</td>
</tr>
<tr>
<td>Bengtsson-Tops, Markstrom &amp; Lewin, 2005</td>
<td>Sweden</td>
<td>1362 female psychiatric inpatients and outpatients</td>
<td>Cross-sectional survey</td>
<td>Domestic violence derived from information on age at abuse and perpetrator</td>
<td>315/1362 (23.1%) females reported any violence from a former partner</td>
<td>Total score: 27/40</td>
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<td>151/1362 (11.1%) females reported any violence from relatives</td>
<td>Selection bias: 11/14</td>
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<td>Measurement bias: 8/14</td>
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<tr>
<td>Chang, Cluss, Burke, et al, 2011</td>
<td>USA</td>
<td>428 male and female psychiatric inpatients, outpatients, and emergency room attendees (n=158 males, n=270 females).</td>
<td>Cross-sectional survey</td>
<td>Lifetime physical, sexual or psychological violence by an intimate partner</td>
<td>Lifetime violence (any): 169/270 (62.6%) females reported any violence by an intimate partner</td>
<td>Total score: 29/40</td>
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<td>Past year physical or sexual violence by an intimate partner</td>
<td>50/158 (31.6%) males reported any violence by an intimate partner</td>
<td>Selection bias: 7/14</td>
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<td>Lifetime physical violence: 134/270 (49.6%) females reported physical violence by an intimate partner</td>
<td>Measurement bias: 12/14</td>
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<td>29/158 (18.4%) males reported physical violence by an intimate partner</td>
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<td>Author and year</td>
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<td>Definition of domestic violence</td>
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<td>Ferreira da</td>
<td>Portugal</td>
<td>40 female service</td>
<td>Cross-sectional</td>
<td>Lifetime sexual violence: 87/270 (32.2%) females reported sexual violence by an intimate partner 7/158 (4.4%) males reported sexual violence by an intimate partner</td>
<td>Lifetime sexual violence: 87/270 (32.2%) females reported sexual violence by an intimate partner 7/158 (4.4%) males reported sexual violence by an intimate partner</td>
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<td>Lifetime psychological violence: 106/270 (39.3%) females reported psychological violence by an intimate partner 42/158 (26.6%) males reported psychological violence by an intimate partner</td>
<td>Lifetime psychological violence: 106/270 (39.3%) females reported psychological violence by an intimate partner 42/158 (26.6%) males reported psychological violence by an intimate partner</td>
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<td>Past year physical violence: 34/270 (12.6%) females reported physical violence by an intimate partner 10/158 (6.3%) males reported physical violence by an intimate partner</td>
<td>Past year physical violence: 34/270 (12.6%) females reported physical violence by an intimate partner 10/158 (6.3%) males reported physical violence by an intimate partner</td>
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<td>Past year sexual violence: 20/270 (7.4%) females reported sexual violence by an intimate partner 4/158 (2.5%) males reported sexual violence by an intimate partner</td>
<td>Past year sexual violence: 20/270 (7.4%) females reported sexual violence by an intimate partner 4/158 (2.5%) males reported sexual violence by an intimate partner</td>
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<td>Total score:</td>
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<tr>
<td>Silva, 1991)</td>
<td></td>
<td>users recruited from a psychiatric day hospital and inpatient unit</td>
<td>survey</td>
<td>Domestic violence assessed during interview using the authors’ questions</td>
<td>physical violence by an intimate partner</td>
<td>16/40</td>
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<td>Selection bias: 4/14</td>
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<td>Measurement bias: 7/14</td>
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<tr>
<td>(Dienemann, Boyle, Baker, et al, 2000)</td>
<td>USA</td>
<td>82 female psychiatric inpatients, outpatients, and members of community support group for people with depression. (missing data for 1 participant)</td>
<td>Cross-sectional survey</td>
<td>Domestic violence assessed during interview using the Abuse Assessment Screen</td>
<td>Lifetime and past year physical and sexual violence by an intimate partner</td>
<td>22/40</td>
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<td>Total score: 22/40</td>
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<td>Selection bias: 3/14</td>
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<td>Measurement bias: 10/14</td>
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<td>Lifetime violence (any): 50/81 (61.0%) females reported any violence by an intimate partner</td>
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<td>Past year violence (any): 11/81 (13.4%) females reported any violence by an intimate partner</td>
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<td>Lifetime physical violence: 30/81 (37.0%) females reported physical violence by an intimate partner</td>
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<td>Past year physical violence: 10/81 (12.2%) females reported physical violence by an intimate partner</td>
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<td>Lifetime sexual violence: 24/81 (29.6%) females reported sexual violence by an intimate partner</td>
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<td>Past year sexual violence: 5/81 (6.2%) females reported sexual violence by an intimate partner</td>
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<tr>
<td>Author and year</td>
<td>Country</td>
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<td>Definition of domestic violence</td>
<td>Results</td>
<td>Quality scores</td>
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<tr>
<td>(McPherson, Delva &amp; Cranford, 2007)</td>
<td>USA</td>
<td>379 female psychiatric inpatients and outpatients</td>
<td>Cohort study (baseline data extracted)</td>
<td>Past year physical violence by an intimate partner</td>
<td>72/379 (19.0%) females reported physical violence by an intimate partner</td>
<td>Total score: 32/40</td>
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<td>Domestic violence assessed during interviews using adapted version of the Conflict Tactics Scale</td>
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<td>Selection bias: 11/14</td>
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<td>Measurement bias: 12/14</td>
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<tr>
<td>(Paranjape, Heron &amp; Kaslow, 2006)</td>
<td>USA</td>
<td>153 female hospital service users (n=49 non-emergency psychiatric care users)</td>
<td>Cross-sectional survey</td>
<td>Lifetime violence (physical, sexual or psychological) by an intimate partner</td>
<td>31/49 (63.3%) female non-emergency psychiatric care users reported any violence by an intimate partner</td>
<td>Total score: 28/40</td>
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<td>Domestic violence assessed during interviews using the Index of Spouse Abuse Physical and Non-Physical subscales</td>
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<td>Selection bias: 5/14</td>
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<td>Measurement bias: 13/14</td>
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<tr>
<td>(Yellowlees &amp; Kaushik, 1994)</td>
<td>Australia</td>
<td>567 male and female service users receiving psychiatric care in community, hospital, and prison</td>
<td>Case file review</td>
<td>Lifetime physical violence by an intimate partner</td>
<td>83/567 (14.6%) males and females reported physical violence by an intimate partner</td>
<td>Total score: 22/40</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Domestic violence assessed on basis of information recorded in case files</td>
<td></td>
<td>(Data not gender-disaggregated)</td>
<td>Selection bias: 9/14</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Measurement bias: 6/14</td>
<td></td>
</tr>
<tr>
<td>Psychiatric Setting Unclear</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Brown, Cosgrave, Killackey, et</td>
<td>Australia</td>
<td>98 male and female youth mental health service users</td>
<td>Cross-sectional survey</td>
<td>Past year physical domestic violence by an intimate partner</td>
<td>6/53 (11.3%) females reported physical violence by an intimate partner</td>
<td>Total score: 27/40</td>
</tr>
<tr>
<td>Author and year</td>
<td>Country</td>
<td>Sample</td>
<td>Method</td>
<td>Definition of domestic violence</td>
<td>Results</td>
<td>Quality scores</td>
</tr>
<tr>
<td>----------------</td>
<td>---------</td>
<td>--------</td>
<td>--------</td>
<td>---------------------------------</td>
<td>---------</td>
<td>----------------</td>
</tr>
<tr>
<td><em>al, 2009</em></td>
<td></td>
<td>(n=45 males, n=53 females)</td>
<td>Domestic violence assessed during interview using Youth Risk Behavior Survey</td>
<td>7/45 (15.6%) males reported physical violence by an intimate partner</td>
<td>Selection bias: 8/14</td>
<td>Measurement bias: 10/14</td>
</tr>
<tr>
<td>(Osgood &amp; Manetta, 2000)</td>
<td>USA</td>
<td>59 female service users from two psychiatric facilities</td>
<td>Case file review Domestic violence assessed during case file review</td>
<td>Lifetime physical or sexual violence by an intimate partner</td>
<td>14/59 (23.7%) females reported any violence by an intimate partner</td>
<td>Total score: 23/40</td>
</tr>
<tr>
<td>(Tham, Ford &amp; Wilkinson, 1995)</td>
<td>UK</td>
<td>184 male and female service users presenting to psychiatric services</td>
<td>Cross-sectional survey Domestic violence assessed during interviews using the authors’ questions</td>
<td>Past year violence by an intimate partner; type of violence not specified</td>
<td>45/184 (24.5%) females reported any violence by an intimate partner (Data not presented for men)</td>
<td>Total score: 19/40</td>
</tr>
<tr>
<td>(Waller, 1991)</td>
<td>UK</td>
<td>67 female service users being treated by psychiatrist for eating disorder</td>
<td>Cross-sectional survey Sexual violence assessed for 1/3 sample by self-administered Sexual Events Questionnaire, for remaining 2/3 assessed during</td>
<td>Lifetime sexual violence by an intimate partner</td>
<td>8/67 (11.9%) females reported sexual violence by an intimate partner</td>
<td>Total score: 18/40</td>
</tr>
<tr>
<td>Author and year</td>
<td>Country</td>
<td>Sample</td>
<td>Method</td>
<td>Definition of domestic violence</td>
<td>Results</td>
<td>Quality scores</td>
</tr>
<tr>
<td>----------------</td>
<td>---------</td>
<td>--------</td>
<td>--------</td>
<td>--------------------------------</td>
<td>---------</td>
<td>----------------</td>
</tr>
<tr>
<td>(Weingourt, 1990)</td>
<td>USA</td>
<td>53 female service users being treated for anxiety or depressive disorder</td>
<td>Cross-sectional survey</td>
<td>Lifetime sexual violence assessed during interviews using the authors’ questions</td>
<td>33/53 (62.2%) females reported sexual violence by an intimate partner</td>
<td>Total score: 22/40</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>treatment interviews - domestic violence derived from information on age at abuse and perpetrator of violence</td>
<td></td>
<td>Selection bias: 5/14</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Measurement bias: 10/14</td>
</tr>
</tbody>
</table>
2.4 Discussion

2.4.1 Key Findings

The findings of this review suggest that male and female psychiatric service users experience a high prevalence of domestic violence. Evidence from high-quality papers identified a median prevalence of 29.8% (IQR 26.1% - 39.2%; range 25.8% - 56%) for any lifetime partner violence among female inpatients (Bryer, Nelson, Miller, et al., 1987; Carlile, 1991; Carmen, Rieker & Mills, 1984; Husain, Anasseril & Harris, 1983) and 33% (IQR 20.8% -52.6%; range 14.6% - 81.4%) for any lifetime partner violence among female outpatients (Carlile, 1991; Herman, 1986; Leithner, Assem-Hilger, Naderer, et al., 2009; Morgan, Zolese, McNulty, et al., 2010). Additionally, a median prevalence of 25.6% (IQR 20.1% - 44.1%; range 25.6% - 62.6%) was found for any lifetime partner violence among male and female service users in mixed psychiatric settings (Bengtsson-Tops, Markstrom & Lewin, 2005; Chang, Cluss, Burke, et al., 2011; Yellowlees & Kaushik, 1994). Only one high-quality paper reported the prevalence of domestic violence among male service users: Chang et al. surveyed service users across a range of psychiatric settings and estimated that 18.4% of males had experienced lifetime physical domestic violence and that 4.4% had experienced lifetime sexual domestic violence (Chang, Cluss, Burke, et al., 2011). These findings align with the literature review presented in Chapter 1, which identified a limited number of papers examining the prevalence of domestic violence among male health service users.

Using data from high-quality papers only (those scoring ≥50% on quality appraisal questions relating to selection bias), a pooled prevalence of 37.6% (95% CI 24.3-51) was calculated for lifetime partner violence among female inpatients. Due to the high heterogeneity observed between studies, caution should be exercised when interpreting this pooled estimate. Visual inspection of the forest plot and an influence analysis identified an outlier (i.e. Carlile, 1991); a revised meta-analysis, with removal of this estimate, eliminated the presence of between-study heterogeneity. In light of the limited number of studies, it was not possible to carry out a meta-regression, which aims to relate the size of pooled estimates to one or more characteristics of the studies (Thompson & Higgins, 2002). Through visual inspection of study characteristics, it was observed that the study identified
as an outlier (i.e. Carlile, 1991) was conducted in a different country to the others; future meta-analyses may therefore benefit from examining the impact of study country on pooled estimates.

The review identified only six studies that examined the prevalence of violence perpetrated by family members and only two of these were high-quality. The high-quality studies reported that 11.1% of a mixed sample of male and female psychiatric outpatients reported family violence (Bengtsson-Tops, Markstrom & Lewin, 2005) and that 9.1% and 6.1% of female inpatients reported lifetime physical violence by a father and brother, respectively (Bryer, Nelson, Miller, et al., 1987). These findings provide some insight into the type of abuses that are commonly perpetrated by family members against people with severe mental illness (Marley & Buila, 2001).

No study included non-psychiatric controls representative of the general population. Thus, although most of the reviewed studies reported higher estimates of the prevalence of domestic violence than have been reported for general population samples (Smith, Osborne, Lau, et al., 2012; Tjaden & Thoennes, 2000), quantifying the extent to which psychiatric populations are more likely to experience domestic violence remains difficult.

2.4.2 Strengths and Limitations
The review employed a comprehensive search strategy following MOOSE (Stroup, Berlin, Morton, et al., 2000) and PRISMA (Moher, Liberati, Tetzlaff, et al., 2009) guidelines. A review protocol was developed and registered prior to the start of any searches (registration number CRD42011001241). No language or lower data restrictions were assigned to any searches. Additionally, two reviewers independently appraised the methodological quality of studies, examining both selection and measurement biases.

A number of methodological and conceptual issues in the studies weaken the prevalence estimates. Indeed, half of the studies were judged to score poorly (<50%) on questions relating to selection bias. Most studies used non-probability sampling and did not provide information on the representativeness of their
samples, the potential impact of non-participation, or study power. These methodological constraints limit the generalisability of findings to the wider psychiatric population who experience domestic violence and as a consequence may not present an accurate estimate of the extent of abuse experienced by service users. Furthermore, few studies reported detailed exclusion criteria or provided information about participants’ primary diagnoses. The most rigorous study identified in this review, which attempted to survey all females attendees of psychiatric inpatient and outpatient services over a one week period, reported that 25.6% had experienced domestic violence from their *current* partner (Bengtsson-Tops, Markstrom & Lewin, 2005). The exclusion of individuals who were not able to give informed consent means that the findings cannot be generalised to the most severely ill service users.

The reliability and comparability of primary studies were limited by the methods of data collection and instruments used to assess domestic violence. Data collection methods varied between studies and included researcher administered questionnaires during face-to-face interviews, self-completed questionnaires, and case file reviews. Face-to-face interviews were used in more than half of the included studies, but this methodology may contribute to an under-detection of violence. Indeed, a randomised controlled trial of screening methods for domestic violence across health settings found that women preferred the use of self-completed questionnaires over face-to-face interviews (MacMillan, Wathen, Jamieson, *et al*, 2006). Despite service users preference for self-complete questionnaires, this form of administration may not adequately capture a comprehensive and detailed picture of the nature and extent of abuse, which can be readily achieved through face-to-face interviewing by researchers. In addition, the ability of researchers to carefully monitor signs of distress and discomfort among participants may be harder to achieve using self-complete versus face-to-face interviewing techniques. Case-file reviews are also likely to underestimate the prevalence of domestic violence experienced by psychiatric service users: the under-detection and poor documentation of domestic violence, even where routine enquiry has been implemented, is well-documented (Howard, Trevillion, Khalifeh, *et al*, 2010; MacMillan, Wathen, Jamieson, *et al*, 2006; Morgan, Zolese,

Studies varied with regards to the instruments used to measure domestic violence. Among studies that employed a validated instrument to detect domestic violence, the most commonly used tool was the Conflict Tactics Scale (CTS) (Straus, Hamby, Boney-McCoy, et al, 1996; Straus, 1979). Authors frequently reported that they made modifications to this and other instruments, which may have adversely affected the instruments validity. Although the CTS is one of the most widely used measures of violence, it has been criticised for measuring acts of violence out of context (i.e. it does not make it clear whether acts of violence were in attack or in defence), for its gender neutrality (i.e. it does not measure the impact, fear or injuries incurred following acts of violence) and for its failure to measure forms of non-physical partner violence (DeKeseredy & Dragiewicz, 2009; Loseke & Kurz, 2005). The revised version of the CTS does, however, incorporate acts of sexual violence (Straus, Hamby, Boney-McCoy, et al, 1996).

The original and revised versions of the CTS have also received criticism for situating acts of violence exclusively within the context of current relationship conflicts, which ignores violence perpetrated by ex-partners (Kimmel, 2002) and control-instigated assaults that do not have their origins in conflict resolution (Archer, 2006; Johnson, 2010; Langhinrichsen-Rohling, 2010). It is argued that these limitations result in a failure of the CTS to adequately measure the full nature, impact and consequences of abuse (DeKeseredy & Dragiewicz, 2009; Kimmel, 2002). Consequently, best-practice recommendations suggest that research should use the CTS in conjunction with other instruments that are designed to elucidate the context, meanings and motives in which violent acts occur (DeKeseredy & Dragiewicz, 2009; Houri, Rhodes, Kemball, et al, 2008).

In eleven papers authors developed their own measures to assess domestic violence and, in a further ten, no details were provided about the instrument used to assess violence. Several studies did not enquire specifically about domestic violence but instead asked participants about their general experiences of violence. Those studies were included in the review if they reported the identity of the abuser and the age at which abuse occurred. Consequently, studies differed
with regards to which forms of violence and specific behaviours were enquired about, which contributed to the observed variation in the prevalence of violence. The limitations of studies outlined above align with limitations of prevalence studies conducted in primary care and non-psychiatric settings (Feder, Ramsay, Dunne, et al, 2009).

2.4.3 Implications of Findings

This review highlights the high prevalence of domestic violence among people using a range of psychiatric services. It draws attention to the lack of high-quality evidence on the prevalence of domestic violence among outpatient and emergency psychiatric populations. Moreover, the review highlights an absence of research comparing psychiatric service users’ risk of domestic violence to that of other clinical populations or to the general population. Further evidence gaps are also apparent. First, despite evidence that emotional abuse is strongly associated with poor health outcomes (Garcia-Moreno, 2009; Pico-Alfonso, 2005), few studies collected data on psychiatric service users’ experiences of psychological violence. Second, few studies included violence from family members within their definition of domestic violence. The prevalence of domestic violence by family members, in the few studies in which it was measured, suggests that family-perpetrated domestic violence may be an issue of relevance for some psychiatric service users. These findings align with those reported in the general population: in 2010/2011, 22% of all homicides in London were domestic related, with the murder of a parent by a son being the most prevalent (Metropolitan Police Authority, 2011). Finally, and despite evidence that suggests that men with severe mental illnesses are at increased risk of violence (Goodman, Salyers, Mueser, et al, 2001; Teplin, McClelland, Abram, et al, 2005), very few studies collected data on the prevalence of domestic violence in male service users. Future research is needed to addresses these limitations, which will result in more accurate estimates of the prevalence and odds of domestic violence among male and female psychiatric service users.

The review findings highlight the need for mental health professionals to be aware of the high prevalence of domestic violence among psychiatric service users and to develop strategies for the appropriate identification and response to domestic
violence. Chapter 8 provides a detailed discussion of the implications of these findings. In light of the under-identification of cases of domestic violence across psychiatric services (Howard, Trevillion, Khalifeh, et al., 2010), research is needed to explore factors that affect clinicians’ awareness and readiness to address abuse in clinical practice. Chapter 6 presents a detailed examination of mental health professionals’ experiences of enquiry of domestic violence and response to psychiatric service users’ disclosure of domestic violence.

Due to the considerable number of psychiatric service users disclosing domestic violence, research would benefit from exploring service users’ views and experiences of the response of psychiatric services to abuse. Chapter 5 presents a detailed examination of psychiatric service users’ experiences and expectations of the response of psychiatric services to domestic violence. Finally, in light of findings that psychiatric service users report considerable vulnerability to domestic violence, secondary mental health services need to identify interventions that are effective in supporting the needs of abused service users. Chapter 3 presents a comprehensive systematic review of the efficacy of interventions in improving outcomes for psychiatric service users disclosing domestic violence.
Chapter 3: Study Two - A Systematic Review of Interventions to Improve Outcomes for Psychiatric Service Users Disclosing Domestic Violence

3.1 Background

Domestic violence is a major public health issue, with many people seeking medical assistance as a direct result of injuries and in response to the traumatic effects of living in a violent environment (Hamberger & Phelan, 2004). Chapter 1 section 1.8 highlights the numerous physical and mental health impacts associated with domestic violence. Evidence suggests that women experiencing domestic violence are three times more likely to undergo psychiatric hospitalisation compared to non-abused women (Kernic, Wolf & Holt, 2000). The systematic review presented in Chapter 2 reported a pooled prevalence of 37.6% (95% CI 24.3-51) for lifetime partner violence among female psychiatric inpatients, and a median prevalence of 33% (IQR 20.8% -52.6%) for lifetime partner violence among female outpatients. The review found one high-quality study for male psychiatric service users, which reported a lifetime prevalence of partner violence of 31.6% across mixed psychiatric settings.

Health service researchers are increasingly focusing their attention on the development of interventions for service users who disclose domestic violence. Two recent comprehensive systematic reviews examined the effectiveness of interventions in improving outcomes for abused women attending primary care and non-psychiatric health settings (Feder, Ramsay, Dunne, et al, 2009; World Health Organization, forthcoming-a). The reviews found some evidence for the effectiveness of domestic violence advocacy interventions - particularly for women who have actively sought help from services - in reducing abuse, increasing social support, quality of life and use of safety behaviours (Feder, Ramsay, Dunne, et al, 2009). Insufficient evidence was found for the effectiveness of advocacy interventions in improving mental health outcomes among abused women (World Health Organization, forthcoming-a).

To my knowledge, no systematic review has examined the efficacy of interventions to improve outcomes for psychiatric service users experiencing
domestic violence. This is particularly noteworthy in light of the results of Chapter 2, which found that male and female psychiatric service users experience high levels of domestic violence. Most interventions in non-psychiatric settings exclude people with severe mental illness and include female only samples (Hegarty, Gunn, O'Doherty, et al., 2010; Joseph, El-Mohandes, Kiely, et al., 2009; Zlotnick, Capezza & Parker, 2011); despite evidence to suggest that men with severe mental illness are at increased risk of violence (Goodman, Salyers, Mueser, et al., 2001; Oram, Trevillion, Feder, et al., In Press; Teplin, McClelland, Abram, et al., 2005). This review aimed to examine:

1) the effectiveness of interventions in improving mental health symptoms, quality of life and use of safety behaviours, and

2) The effectiveness of interventions in reducing the frequency/severity of violence among male and female psychiatric service users disclosing domestic violence.

3.2 Method

3.2.1 Selection Criteria
A preliminary scoping exercise of the literature identified a number of intervention studies aimed at improving outcomes for psychiatric service users who disclose a range of abusive experiences, which may include domestic violence (Mueser, Bolton, Carty, et al., 2007; Mueser, Rosenberg, Xie, et al., 2008; Rosenberg, Mueser, Salyers, et al., 2004; Trappler & Newville, 2007). The ability to examine the effectiveness of these interventions in improving outcomes related to domestic violence is therefore dependent on the number of participants who report domestic violence. It was felt that studies would not be sufficiently representative of the population of interest if less than half of participants reported domestic violence; consequently, studies were only eligible for inclusion in this review when 50% or more of participants reported domestic violence.

3.2.1.1 Conflict of Interest
Prior to describing the methods of this review it is necessary to disclose a conflict of interest. Our research team recently published a paper on an intervention for
psychiatric service users experiencing domestic violence, which meets the eligibility criteria of this review. In order to address the degree of bias that this issue presents, a second reviewer was selected to independently appraise the study quality of all papers included in this review. This process acts as a quality check to ensure the legitimacy of the quality ratings of included papers (Ciliska, Cullum & Marks, 2001).

3.2.1.2 Inclusion Criteria
Studies were eligible for inclusion if they: (1) included male and/or female psychiatric service users who were 16 years or older; (2) included samples where 50% or more of participants disclosed domestic violence; (3) examined the effectiveness of non-pharmacological interventions; (4) presented the results of peer-reviewed research based on experimental studies (e.g. randomised controlled trials, non-randomised controlled trials, parallel group studies) and quasi-experimental studies (e.g. before and after studies, cohort studies, time series studies); (5) measured outcomes on the frequency/severity of violence, use of safety behaviours, mental health symptoms or quality of life outcomes (or collected data from which these statistics can be calculated); (6) reported quantitative comparisons between intervention and control groups or pre-intervention and post-intervention comparisons, and (7) were published in English language.

Psychiatric services were defined as secondary or tertiary care specialist services (inpatient, outpatient or community-based) providing psychiatric care and support to people with mental disorders. When the review identified multiple eligible papers from the same study only the paper reporting the largest number of participants, with data of relevance to the objectives of this review, was included.

3.2.1.3 Exclusion Criteria
Studies were not eligible for inclusion if they: (1) included participants who were aged 15 years or younger, and did not provide appropriate age-disaggregated data; (2) included psychiatric service users as part of a broader sample and did not present disaggregated outcomes (unless corresponding authors were able to provide this information); (3) examined the effectiveness of pharmacological
interventions; (4) were published in non-English language; (5) used the following study designs: case studies, case-series, cross-sectional studies, qualitative designs, or were (6) general discussion papers, conference proceedings, comments/letters or book chapters and reports.

3.2.2 Search Strategy

The search strategy followed PRISMA guidelines (Moher, Liberati, Tetzlaff, et al., 2009) and the review selection criteria and methods of analysis were specified in advance. 19 bibliographic databases were searched from their respective dates of inception to 30th September 2011, using a combination of Medical Subject Headings (MeSH) and text words (see Box 2 for a full list of the databases used). Terms for domestic violence were adapted from published Cochrane protocols and previous literature reviews (Dalsbo & Johme, 2006; Friedman & Loue, 2007; Ramsay, Richardson, Carter, et al., 2002). Search terms for mental disorders were adapted from the National Institute for Health and Clinical Excellence (NICE) guidelines (National Institute for Health and Clinical Excellence, 2008) and search terms for research designs were adapted from the Cochrane Handbook and peer-reviewed reviews (Higgins & Green, 2011; Howard, Trevillion, Khalifeh, et al., 2010; Watson & Richardson, 1999) (see Appendix 5 for a full list of search terms used). These searches were supplemented by citation tracking (i.e. Google Scholar and Web of Science); examination of reference lists of review articles and included studies; hand searches of key journals (i.e. Trauma, Violence and Abuse, Violence Against Women), and expert recommendations (15 experts were contacted – see Appendix 6 for details of experts).

**Box 2: Electronic Databases Searched for Systematic Review**

<table>
<thead>
<tr>
<th>Biomedical databases:</th>
<th>Cochrane Central Register of Controlled Trials (CENTRAL), Database of Abstracts of Reviews of Effects (DARE), Academic Search Complete, BNID, CINAHL, EMBASE, HMIC, MEDLINE, MIDRIS, PsycINFO, Science Direct, Web of Science (including SCI, SSCI, A&amp;HCI, CPCI-S, CPCI-SSH)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theses and dissertations:</td>
<td>DART Europe E Theses Portal, ETHOS, Networked Digital Library of Theses and Dissertations</td>
</tr>
</tbody>
</table>
3.2.3 Study Selection and Data Extraction

One reviewer (KT) screened the downloaded titles and abstracts against the inclusion criteria; references were taken forward to the next stage of screening if it was unclear whether they met the inclusion criteria. The reviewer then assessed the full texts of potentially eligible studies against the inclusion criteria. If it was considered that studies had collected data on the selected outcomes but had not presented it, authors were contacted for further information. Data from included studies were extracted onto electronic forms and ordered into summary tables (see Appendix 7 for a copy of the extraction form). Information was extracted from each study on: (1) the study country, study design and psychiatric setting; (2) demographic characteristics of study samples, and study inclusion/exclusion criteria; (3) methods of assessment of domestic violence; (4) type of intervention (including intervention content, duration and adherence), methods of allocation and characteristics of comparison groups, and (5) type of outcomes assessed (i.e. frequency/severity of violence, safety behaviours, mental health symptoms, quality of life), including details on the measurement of outcomes (see Table 2). Details were also extracted on the theoretical basis of interventions (see Table 3).

3.2.4 Quality Appraisal

3.2.4.1 Development of the Critical Appraisal Checklist

The quality of included studies was independently appraised by two reviewers (KT and CD), using criteria adapted from the following validated tools:

1) Critical Appraisal Skills Programme Checklists (Public Health Resource Unit, 2006);
2) Quality Index Checklist (Downs & Black, 1998);
3) Quality and Assessment Checklist (Jadad, Moore, Carroll, et al, 1996)

Adaptations to these critical appraisal tools included incorporating a number of sources on study methodology from the Critical Appraisal Skills Programme Checklists (Critical Appraisal Skills Programme, 2006); sources of randomisation from the Quality and Assessment Checklist (Jadad, Moore, Carroll, et al, 1996) and sources of confounding and attrition from the Quality Index Checklist (Downs & Black, 1998). The final critical appraisal checklist included items assessing study design, representativeness of study samples, blinding and
appropriate use of statistical techniques (see Appendix 8 for the appraisal checklist).

3.2.4.2 Appraisal of Studies of High-Quality
Reviewers (KT and CD) compared scores and resolved any disagreements through consensus, or with the aid of a third reviewer (LH), before calculating a final appraisal score. Scores for overall study quality, selection bias and measurement bias are reported for all studies (see Table 2). High-quality papers were defined as those that scored $\geq 50\%$ on quality appraisal questions assessing selection bias (see Chapter 2 section 2.2.4.2 for details on how high-quality papers were operationalised).

3.2.5 Data Analysis
Information about the study design and setting, study sample, type of intervention and treatment effects were summarised (see Table 2). Due to the small number of studies and the degree of heterogeneity between studies - in relation to study samples, type of intervention, instruments used to assess outcomes and follow-up periods - a statistical synthesis was not judged to be appropriate. Therefore, a narrative synthesis was conducted (organised by type of intervention), which provides a detailed description of each intervention and its findings, followed by a summary on the effectiveness of the intervention.

3.3 Results
The study selection process is presented in Figure 5 below. The literature search yielded 3,026 unique references, of which 2,906 references were excluded following title and abstract screening; 120 full papers were retrieved and assessed. 117 papers were excluded and three were included in the review (see Table 2). None of the included papers were identified from searches of electronic databases; two were identified from citation tracking and one from expert recommendations.
Figure 5: Flow Diagram of Search Process for a Systematic Review of Interventions for Psychiatric Service Users Disclosing Domestic Violence

Records identified through database searching: n=3,254

Records identified by alternative sources:
- Hand searches: n=8
- Citation tracking: n=63
- Expert recommendations: n=2

Records after duplicates removed: n=3,026

Records screened: n=3,026

Full-text articles assessed for eligibility: n=120

Full-text articles excluded:
- Ineligible publication format: n=2
- Ineligible study design: n=20
- Foreign language: n=1
- Sample did not include psychiatric service users: n=63
- Study did not measure domestic violence: n=13
- Less than 50% of the sample experienced domestic violence: n=5
- Study did not measure eligible outcomes: n=3
- Data reported elsewhere: n=10

Studies included in review: n=3
3.3.1 Key Features of Included Papers

Of the three included studies, two examined only one of the eligible review outcomes (i.e. mental health symptoms) (Frueh, Grubaugh, Cusack, et al, 2009; Lu, Fite, Kim, et al, 2009) and one examined all eligible review outcomes (i.e. mental health symptoms, frequency/severity of abuse, quality of life and safety behaviours) (Trevillion, Byford, Cary, et al, Submitted). Study designs included two pre- and post-intervention studies and one quasi-experimental design. Further details of study characteristics, design, intervention content and treatment effects are provided in Table 2.

Searches identified few high-quality studies that addressed the review questions; only one of the three studies scored ≥50% on quality appraisal questions relating to selection bias (Trevillion, Byford, Cary, et al, Submitted). No randomised controlled trials (i.e. the research methodology least prone to bias in the examination of efficacy of health service interventions) were found. Only one study was developed exclusively for psychiatric service users disclosing domestic violence (Trevillion, Byford, Cary, et al, Submitted). The remaining two interventions were offered to psychiatric service users who disclosed a range of violent experiences, where more than 50% reported domestic violence (Frueh, Grubaugh, Cusack, et al, 2009; Lu, Fite, Kim, et al, 2009).

Two studies were conducted in USA health settings (Frueh, Grubaugh, Cusack, et al, 2009; Lu, Fite, Kim, et al, 2009) and one in UK health settings (Trevillion, Byford, Cary, et al, Submitted). All three studies were conducted in community outpatient services and included a mixed sample of male and female psychiatric service users (Frueh, Grubaugh, Cusack, et al, 2009; Lu, Fite, Kim, et al, 2009; Trevillion, Byford, Cary, et al, Submitted). All studies examined violence perpetrated by an intimate partner or other family member. Two studies measured only lifetime domestic violence (Frueh, Grubaugh, Cusack, et al, 2009; Lu, Fite, Kim, et al, 2009) and one study measured only past year domestic violence (Trevillion, Byford, Cary, et al, Submitted). All studies used pre-validated instruments to measure domestic violence (i.e. Trauma History Questionnaire (THQ) (Green, 1996); Trauma Assessment for Adults (TAA) (Resnick, Falsetti,
Kilpatrick, *et al.*, 1996); the Composite Abuse Scale (CAS)) (Hegarty, Bush & Sheehan, 2005; Hegarty, Sheehan & Schonfeld, 1999) (see Table 2 below).
Table 2: Characteristics and Outcomes of Included Studies on Interventions for Psychiatric Service Users Disclosing Domestic Violence

<table>
<thead>
<tr>
<th>Author(s)</th>
<th>Year of publication and study design</th>
<th>Country and type of setting</th>
<th>Inclusion/exclusion criteria and measurement of DV</th>
<th>Participants</th>
<th>Intervention</th>
<th>Data monitoring periods</th>
<th>Outcome measures</th>
<th>Results</th>
<th>Quality score</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Frueh, Grubaugh, Cusack et al, 2009)</td>
<td>Before and after study</td>
<td>USA</td>
<td>Two CMHTs</td>
<td>Inclusion criteria: (1) Male and female service users (≥ 18 years) receiving care at one of the two CMHTs, with at least bi-weekly contact with a clinician, (2) met DSM-IV diagnostic criteria for PTSD, (3) met the study definition of SMI (i.e. persistent impairment in self-care, work, or social relationships) and a past year history of DSM-IV Axis I diagnosis of schizophrenia or schizoaffective disorder, and (4) ability to provide informed consent</td>
<td>Number recruited: 20 service users (15 females and five males)</td>
<td>An 11 week manualised CBT (exposure-based) intervention for PTSD, comprising:</td>
<td>Baseline, immediate post-intervention, three-months post-intervention</td>
<td>Baseline to three-months post change scores (among 13 treatment completers):</td>
<td>Total score: 29/44</td>
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<td></td>
<td>1) One session of psycho-education (i.e. patterns of expression of chronic PTSD, comorbidity with other Axis I disorders, impact on social functioning and current treatment strategies),</td>
<td></td>
<td>CAPS</td>
<td>CAPS: Mean: 30.62 S.E.: 7.85 t-value: 3.9 (p&lt;0.001)</td>
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<td>2) Two sessions of anxiety management (i.e. training on the management of anxiety and stress levels, including control of panic attacks),</td>
<td></td>
<td>SF-36 mental health</td>
<td>SF-36 mental health:</td>
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<td>3) Seven sessions of</td>
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<td>HAM-A</td>
<td>HAM-A: Mean: 2.38 S.E.: 3.29 t-value: 0.73 (p=0.48)</td>
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<td></td>
<td>HAM-D</td>
<td>HAM-D: Mean: 4.38 S.E.: 3.88</td>
</tr>
<tr>
<td>Author(s) year of publication and study design</td>
<td>Country and type of setting</td>
<td>Inclusion/exclusion criteria and measurement of DV</td>
<td>Participants</td>
<td>Intervention</td>
<td>Data monitoring periods</td>
<td>Outcome measures</td>
<td>Results</td>
<td>Quality score</td>
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<td>alcohol or drug dependence and (2) service users who had a history of psychiatric hospitalization or suicide attempts in the previous two months</td>
<td>The Trauma Assessment for Adults (TAA) was used to assess adult lifetime domestic violence by an intimate partner or family member</td>
<td>social skills and anger management training (i.e. training on how to achieve effective and rewarding social interactions through instruction, modelling, behavioural rehearsal, feedback and reinforcement),</td>
<td>4) Four sessions of trauma issues management (i.e. training to improve communication regarding past traumas with others, as to increase an understanding among family/friends and assume greater control over disclosure and environmental cues),</td>
<td></td>
<td></td>
<td>CGI</td>
<td>t-value: 1.13 (p=0.28)</td>
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<td>CGI:</td>
<td>Mean: -0.15 S.E.: 0.37 t-value: -0.41 (p=0.69)</td>
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<tr>
<td>Author(s) year of publication and study design</td>
<td>Country and type of setting</td>
<td>Inclusion/exclusion criteria and measurement of DV</td>
<td>Participants</td>
<td>Intervention</td>
<td>Data monitoring periods</td>
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<td>5) Eight sessions of exposure therapy (i.e. service users constructed exposure narratives, which were audio-taped and used for homework activities, and discussed service users’ experiences, including difficulties and concerns in creating the narratives), and</td>
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<td>6) Homework activities (e.g. breathing exercises during anxiety management, instruction to listen to audio-taped recording of trauma narrative during exposure therapy)</td>
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<td>The 11 week CBT manual was provided within the context of</td>
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<td>Author(s)</td>
<td>Country and type of setting</td>
<td>Inclusion/exclusion criteria and measurement of DV</td>
<td>Participants</td>
<td>Intervention</td>
<td>Data monitoring periods</td>
<td>Outcome measures</td>
<td>Results</td>
<td>Quality score</td>
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<tr>
<td>(Lu, Fite, Kim, et al, 2009)</td>
<td>USA Two CMHTs Before and after study</td>
<td><em>Inclusion criteria:</em> (1) Male and female service users (aged ≥18 years) currently receiving treatment at one of the two CMHTs, (2) a primary chart diagnosis of major depression, bipolar disorder, schizophrenia, or schizoaffective disorder, (3) meeting state of New Jersey criteria for SMI (i.e. functional disability for a minimum of two years duration), (4) diagnosis of PTSD (confirmed through clinical interview), (5) sufficient fluency in English to participate in treatment and complete assessments, and</td>
<td>Number recruited: 19 service users (11 females and eight males)</td>
<td>A 12 week manualised CBT (non-exposure based) intervention for PTSD, comprising: 1) One session on introduction and orientation (i.e. rationale of treatment components, orientation sheet, development of crisis plan) 2) One session on breathing retraining (i.e. breathing retraining for managing and decreasing anxiety) 3) Two/three sessions on PTSD psycho-education (i.e. information on the nature of PTSD and commonly associated)</td>
<td>Baseline to three-months post-intervention,</td>
<td>Baseline to three-months post change (among 14 treatment completers):</td>
<td>Total score: 30/44</td>
<td>Selection bias: 5/14</td>
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<td>Measurement bias: 15/18</td>
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<tr>
<td>Author(s) year of publication and study design</td>
<td>Country and type of setting</td>
<td>Inclusion/exclusion criteria and measurement of DV</td>
<td>Participants</td>
<td>Intervention</td>
<td>Data monitoring periods</td>
<td>Outcome measures</td>
<td>Results</td>
<td>Quality score</td>
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<tr>
<td>Trevillion, Byford, Cary, et al, Submitted</td>
<td>UK</td>
<td>Inclusion criteria: (1) Male and female service users (≥ 18 years) currently receiving treatment at one of the five CMHTs, (2) experience of</td>
<td>Number recruited: 35 service users (34 females and one male)</td>
<td>A multifaceted domestic violence advocacy intervention, comprising: 1) Four hours domestic violence training</td>
<td>Baseline, three-months post-intervention</td>
<td>Baseline to three-months post change (among 27 service users receiving the intervention):</td>
<td>Total score: 32/44</td>
<td>Selection bias: 7/14</td>
<td></td>
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</table>

Exclusion criteria: (1) any psychiatric hospitalizations or suicide attempts in the previous three months

The Trauma History Questionnaire (THQ) was used to assess adult lifetime domestic violence by an intimate partner or family member

(6) ability to provide informed consent

4) 12 sessions on cognitive restructuring (i.e. developing skills to identify, evaluate and correct/remedy negative thoughts, beliefs and schemas)

5) One session on termination (i.e. reviewing progress and future plans, needs)

The manualised CBT intervention was delivered over a 12 week period, alongside service users’ usual care.

Results:

<table>
<thead>
<tr>
<th>Measure</th>
<th>Mean</th>
<th>SD</th>
<th>p-value</th>
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</thead>
<tbody>
<tr>
<td>PDS</td>
<td>16.50</td>
<td>7.51</td>
<td>0.000</td>
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<tr>
<td>BDI</td>
<td>20.92</td>
<td>14.72</td>
<td>0.03</td>
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<tr>
<td>BPRS</td>
<td>37.83</td>
<td>8.6</td>
<td>0.001</td>
</tr>
<tr>
<td>Author(s) year of publication and study design</td>
<td>Country and type of setting</td>
<td>Inclusion/exclusion criteria and measurement of DV</td>
<td>Participants</td>
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<tr>
<td>domestic violence in past twelve months</td>
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<td>Number receiving intervention that completed treatment: 27 service users (26 women and one man)</td>
<td>2) Domestic violence manual (created by the authors) outlining good practice guidance and local/national domestic violence services</td>
</tr>
<tr>
<td>Exclusion criteria: (1) service users not residing within the study catchment area, (2) service users deemed by clinicians to be too unwell to participate</td>
<td></td>
<td>Number of controls receiving treatment as usual: Seven service users (seven women)</td>
<td>3) Direct referral pathway to domestic violence advocacy for service users experiencing past year domestic violence</td>
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<td>The Composite Abuse Scale (CAS) was used to assess past year experiences of domestic violence</td>
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<td>4)</td>
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</table>

**Data:**
- **Baseline score:**
  - CAS: Median: 32.0 Range: 23.0-44.0
  - MANSA: Median: 3.5 Range: 2.0-4.5

**Follow-up score:**
- CAS: Median: 4.0 Range: 0.0 – 19.0
- MANSA: Median: 4.0 Range: 2.5-4.5
<table>
<thead>
<tr>
<th>Author(s) year of publication and study design</th>
<th>Country and type of setting</th>
<th>Inclusion/exclusion criteria and measurement of DV</th>
<th>Participants</th>
<th>Intervention</th>
<th>Data monitoring periods</th>
<th>Outcome measures</th>
<th>Results</th>
<th>Quality score</th>
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<tbody>
<tr>
<td>groups</td>
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<td>violence advocacy for service users <em>i.e.</em> trained domestic violence advisors provided specialist emotional and practical support, including safety planning and referral to MARACs)</td>
<td>Safety Behavior Scale</td>
<td>Safety behavior scale: Median: 3.7 Range: 3.2-4.2</td>
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<tr>
<td>5) Regular attendance by trained domestic violence advisors at CMHT staff meetings <em>e.g.</em> discuss clinical cases, provide on-going education)</td>
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<td>Social Inclusion scale</td>
<td>Social Inclusion scale: Median: 8.0 Range: 7.0-10.3</td>
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<td>6) Information campaign in CMHTs <em>i.e.</em> posters and leaflets in the waiting room and toilets) highlighting the</td>
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<td>Follow-up score: Median: 8.0 Range: 6.0-10.0</td>
<td>Social Inclusion scale: Baseline score: Median: 41.0 Range: 33.0-48.0</td>
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<tr>
<td>Author(s) year of publication and study design</td>
<td>Country and type of setting</td>
<td>Inclusion/exclusion criteria and measurement of DV</td>
<td>Participants</td>
<td>Intervention</td>
<td>Data monitoring periods</td>
<td>Outcome measures</td>
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<td></td>
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<td>problem of domestic violence and support available</td>
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<td>Advocacy was provided alongside usual care.</td>
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<td>50.0</td>
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</table>

Note: PTSD: Post-traumatic Stress Disorder; CBT: Cognitive Behavioural Therapy; CMHT: Community Mental Health Team; SMI: Severe Mental Illness; MARACs: Multi-Agency Risk Assessment Conference; CAPS: Clinician Administered PTSD Scale; SF-36: Medical Outcomes Study 36-Item Short-Form Health Survey; HAM-A: Hamilton Rating Scale for Anxiety; HAM-D: Hamilton Rating Scale for Depression; CGI: Clinical Global Impressions Scale; PDS: Post-traumatic Diagnostic Scale; BPRS: Brief Psychiatric Rating Scale; BDI: Beck Depression Inventory; CAS: Composite Abuse Scale; MANSA: Manchester Short Assessment of Quality of Life
The type of interventions evaluated were cognitive behavioural therapy (Frueh, Grubaugh, Cusack, et al, 2009; Lu, Fite, Kim, et al, 2009) and domestic violence advocacy (Trevillion, Byford, Cary, et al, Submitted). The theoretical basis of these interventions varied: one study developed a new therapeutic programme, based on a review of the theoretical literature and reflections from clinical practice (Frueh, Grubaugh, Cusack, et al, 2009); the other two adapted pre-tested interventions (Lu, Fite, Kim, et al, 2009; Trevillion, Byford, Cary, et al, Submitted) (see Table 3 below).
Table 3: Theoretical Basis of Studies on Interventions for Psychiatric Service Users Disclosing Domestic Violence

<table>
<thead>
<tr>
<th>Intervention type</th>
<th>Study</th>
<th>Theory Base</th>
<th>Manual</th>
<th>Duration</th>
<th>Format</th>
<th>How was the fidelity of intervention tested</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive Behavioural Therapy (CBT)</td>
<td>Frueh et al (2009)</td>
<td>(1) Based on review of the literature, (2) a previously published intervention on social phobia and PTSD among combat veterans, (3) authors own clinical experience, and (4) a qualitative research study of clinicians and supervisors experiences of CBT therapy in CMHTs</td>
<td>Yes</td>
<td>22 sessions delivered over an 11 week period</td>
<td>Group and individual sessions delivered alongside usual care in CMHTs</td>
<td>To ensure competence and adherence of therapists to the CBT manual all sessions were audio-taped and 20% were independently rated by two clinicians (an inter-rater agreement was calculated using a kappa scale (moderate to perfect agreement was measured from 0.71-1.00 respectively)). Inter-rater scores revealed perfect agreement (k=1.00) Rating forms were developed to determine if the therapist appropriately covered the content of each session and how well they accomplished the relevant tasks for each session. Ratings used a 7-point Likert scale from “good” to “very good”. Average ratings across primary and secondary raters were 6.20 and 6.07, respectively. To assess treatment credibility service users were asked the following four questions, measured on a ten-point rating scale, after the third week of treatment and at post-treatment: (1) How logical the treatment appeared (2) How confident they...</td>
</tr>
<tr>
<td>Domestic Violence Advocacy</td>
<td>Trevillion et al (submitted)</td>
<td>Adaptation of a pre-validated domestic violence advocacy programme for women experiencing domestic violence in primary care settings (Feder, Agnew-Davies, Baird, et al, 2011)</td>
<td>Part manual-based (&lt;i&gt;clinicians were provided with a manual to support their identification and response to service users’ disclosures of domestic violence&lt;/i&gt;)</td>
<td>An average number of nine domestic violence advocacy sessions (i.e. face-to-face and telephone based) were delivered, which were evaluated three-months after commencement of advocacy</td>
<td>Individual sessions delivered alongside usual care in CMHTs</td>
<td>Data were collected on rates of uptake of domestic violence advocacy, the number of advocacy sessions offered to service users’ and their attendance of sessions</td>
</tr>
</tbody>
</table>

| Pre-validated CBT programme for PTSD among people with severe mental illness (Mueser, Rosenberg, Jankowski, et al, 2004) | Yes | 12 sessions delivered over a 12 to 16 week period | Individual sessions delivered alongside usual care in CMHTs | Therapist fidelity was monitored by weekly one-hour group supervision meetings by a supervisor and a co-author of the treatment manual |

Note: PTSD: Post-traumatic Stress Disorder; CBT: Cognitive Behavioural Therapy; CMHT: Community Mental Health Team; SMI: Severe Mental Illness
3.3.2 Effectiveness of Interventions by Type of Therapeutic Model

3.3.2.1 Cognitive Behavioural Therapy (CBT)

Study One: A before and after study in two USA Community Mental Health Teams (CMHTs) examined the effectiveness of an exposure-based manualised CBT intervention for abused service users with PTSD and schizophrenia or schizoaffective disorders (Frueh, Grubaugh, Cusack, et al, 2009). To be eligible for inclusion in the study service users had to meet the following criteria: (1) be 18 years of age or above; (2) be receiving mental health care at one of the two CMHTs (with at least bi-weekly contacts with a clinician); (3) meet the DSM-IV criteria for PTSD (assessed using the Clinician-Administered PTSD scale (Blake, Weathers, Nagy, et al, 1995)), and report lifetime exposure to traumatic events, including domestic violence (assessed using the Trauma Assessment for Adults (TAA) (Resnick, Best, Freedy, et al, 1993)); (4) meet the study definition for severe mental illness (i.e. mental illness resulting in persistent impairment in self-care, work, or social relationships), and have a past year history of DSM-IV Axis I diagnosis of schizophrenia or schizoaffective disorder (assessed using the Mini-International Neuropsychiatric Interview (Sheehan, Lecrubier, Sheehan, et al, 1998)); (5) not meet DSM-IV criteria for current alcohol or drug dependence; (6) not have a history of psychiatric hospitalisation or suicide attempts in the previous two months (Frueh, Grubaugh, Cusack, et al, 2009).

20 service users participated in the intervention (15 women and five men), 14 (70%) of whom reported lifetime domestic violence by an intimate partner or family member. Four therapists, with prior training in CBT and treating individuals with PTSD, were taught to deliver the multi-component manualised CBT intervention. The intervention comprised:

1) One session of psycho-education (i.e. patterns of expression of chronic PTSD, co-morbidity with other Axis I disorders, impact on social functioning and current treatment strategies);

2) Two sessions of anxiety management (i.e. training on the management of anxiety and stress levels, including control of panic attacks);

3) Seven sessions of social skills and anger management training (i.e. training on how to achieve effective and rewarding social interactions through
instruction, modelling, behavioural rehearsal, feedback and reinforcement);

4) Four sessions of trauma issues management (i.e. training to improve communication regarding past traumas with others, as to increase an understanding among family/friends and assume greater control over disclosure and environmental cues);

5) Eight sessions of exposure therapy (i.e. service users constructed exposure narratives, which were audio-taped and used for homework activities, and sessions discussed service users’ experiences, including difficulties and concerns in creating the narratives), and

6) Homework activities (e.g. breathing exercises during anxiety management, instructions to listen to audio-taped recording of trauma narrative during exposure therapy)

The first four components were delivered via a group-therapy format, followed by eight individual-therapy sessions; both group- and individual-therapy sessions were conducted bi-weekly. The 11 week intervention was delivered alongside usual care and all participants continued with their regular course of treatment (e.g. case management, pharmacological treatment) (Frueh, Grubaugh, Cusack, et al, 2009).

Of the 20 service users recruited to the study, 13 completed treatment (i.e. attending ≥70% sessions); treatment completers were significantly more likely to be female (12 women versus one man). Among treatment completers, baseline and three-months post-intervention assessments revealed significant improvements in clinician-assigned ratings of PTSD symptoms (p<0.001) (as measured by the Clinician Administered PTSD scale (Blake, Weathers, Nagy, et al, 1995)). Participants self-assigned ratings of mental health problems (as measured by the Short-Form Health Survey (Ware & Sherbourne, 1992)) were also seen to significantly improve (p<0.001); although, no significant improvements were observed for clinician-assigned ratings of depression and anxiety symptoms (as measured by the Hamilton Rating Scale for Depression and Anxiety (Hamilton, 1959)) (see Table 2).
No adverse events were observed for participants’ involvement in the intervention. In addition, no participants’ psychiatric status was seen to deteriorate significantly during the course of the study. Process measures examined therapists’ adherence to and competence in delivering the manualised intervention: inter-rater reliability revealed perfect agreement regarding therapists’ adherence to the manual (kappa score: k=1.00), and average competence ratings - measured on a seven-point Likert scale from ranging from “good” to “very good” - for effective delivery of the manual (mean scores for primary and secondary raters were 6.20 and 6.07, respectively). Participants reported high levels of treatment credibility and completers showed good session attendance and homework compliance (Frueh, Grubaugh, Cusack, et al, 2009) (see Table 3).

Study Two: A before and after study in two USA CMHTs examined the effectiveness of a trauma-focused (non-exposure based) manualised CBT intervention for abused service users with PTSD and either major depression, bipolar disorder, schizophrenia or schizoaffective disorders (Lu, Fite, Kim, et al, 2009). To be eligible for inclusion in the study service users had to meet the following criteria: (1) be 18 years of age or above; (2) be currently receiving treatment at one of the two CMHTs; (3) have a primary chart diagnosis of major depression, bipolar disorder, schizophrenia, or schizoaffective disorder; (4) meet the state of New Jersey criteria for severe mental illness (i.e. functional disability and minimum of two years duration); (5) have a diagnosis of PTSD (assessed using the Posttraumatic Diagnostic Scale (Foa, Cashman, Jaycox, et al, 1997)), and report lifetime exposure to traumatic events, including domestic violence (assessed using the Trauma History Questionnaire (Green, 1996)); (6) have sufficient fluency in English to participate in treatment and complete assessments; (7) not have a history of psychiatric hospitalisation or suicide attempts in the previous three months, and (8) be able to provide informed consent (Lu, Fite, Kim, et al, 2009).

19 service users (11 women and eight men) participated in the intervention; seven (50%) of whom disclosed lifetime domestic violence by an intimate partner or family member. The manualised CBT intervention was administered by trained clinicians working in the two CMHTs and comprised:
1) One session of introduction and orientation (i.e. rationale of treatment components, orientation sheet, development of crisis plan)

2) One session of breathing retraining (i.e. breathing retraining for managing and decreasing anxiety)

3) Two to three sessions of psycho-education about PTSD (i.e. information on the nature of PTSD and commonly associated impairments)

4) 12 sessions on cognitive restructuring (i.e. developing skills to identify, evaluate and correct/remedy negative thoughts, beliefs and schemas)

5) One final session on termination of therapy (i.e. reviewing progress, future plans/needs). Termination of the therapy is introduced at the first session and re-emphasised in the final five sessions

The 12-16 week intervention was delivered via individual-therapy sessions, alongside usual care, and all participants continued with their regular course of treatment (e.g. case management, psychosocial rehabilitation, pharmacological treatment) (Lu, Fite, Kim, et al, 2009).

Of the 19 service users recruited to the study, 14 (six women and eight men) completed treatment (i.e. attending ≥50% of sessions); no differences in demographic or clinical characteristics were identified between the 14 treatment completers and the five treatment drop-outs. Among treatment completers, three- and six-months post-intervention assessments revealed significant improvements in clinician-assigned ratings of post-traumatic stress symptoms (p<0.0001) (as measured by the Post-traumatic Diagnostic Scale (Foa, Cashman, Jaycox, et al, 1997)), and psychiatric symptoms (p<0.001) (as measured by the Brief Psychiatric Rating Scale (Lukoff, Nuechterlein & Ventura, 1986)). Improvements were also observed for self-assigned ratings of depressive symptoms (p<0.05) (as measured by the Beck Depression Inventory (Beck, Steer & Garbin, 1988)) (see Table 2).

No adverse events were reported as a result of participants’ involvement in the intervention. Therapists’ fidelity was monitored by weekly one-hour group
supervision meetings by a supervisor and a co-author of the treatment manual (Lu, Fite, Kim, et al, 2009) (see Table 3).

In summary, both the exposure based and non-exposure based CBT interventions demonstrated improvements in clinician-assigned ratings of PTSD symptoms among treatment completers. Improvements were demonstrated in service users self-assigned ratings of their mental health problems; although the exposure-based CBT intervention found that improvements were not supported by clinician-assigned ratings of service users’ depression and anxiety symptoms. Neither study included a comparison condition, making it difficult to determine if improvements in outcomes were the direct result of the intervention or simply the result of changes over time, or usual treatment received in CMHTs. These studies scored <50% on quality appraisal questions relating to selection bias, which suggests that samples were not sufficiently representative of the population of interest. The non-exposure based CBT intervention was delivered by CMHT professionals who provided usual mental health care to service users and this may have resulted in social desirability bias regarding service users’ self-reports of depression. Consequently, the effectiveness of cognitive behavioural therapy interventions (both exposure and non-exposure based) remains uncertain and cannot be extrapolated to those still experiencing abuse, those with more acute illness or those who are suicidal.

### 3.3.2.2 Domestic Violence Advocacy

A UK quasi-experimental pilot study implemented a multi-faceted domestic violence intervention within CMHTs over a two year period, which included domestic violence advocacy for psychiatric service users experiencing past year domestic violence (Trevillion, Byford, Cary, et al, Submitted). Five CMHTs were recruited. In order to avoid contamination, cluster non-randomised methods were used to allocate teams that shared the same building to either intervention or control conditions. Three CMHTs received the intervention and two acted as controls (receiving usual care). Due to the pilot nature of the study, no sample size calculations were undertaken. To be eligible for inclusion in the study, service users had to meet the following criteria: (1) be 18 years of age or above; (2) be receiving treatment at one of the five CMHTs; (3) report experiences of
domestic violence in the past twelve months (assessed using the Composite Abuse Scale (Hegarty, Bush & Sheehan, 2005; Hegarty, Sheehan & Schonfeld, 1999)); (4) be residing in the study catchment area, and (5) be deemed by clinicians to be well enough to participate in the study (i.e. capacity to consent, psychiatrically stable, competency to complete structured questionnaires) (Trevillion, Byford, Cary, et al, Submitted).

35 service users participated in the study (34 women and one man); 28 in the intervention group and seven in the comparison group. The multi-faceted intervention comprised:

1) Four hours domestic violence training for mental health professionals (i.e. training to improve their identification, documentation and response to domestic violence),

2) A domestic violence manual for mental health professionals (developed by researchers), which included good practice guidance on how to address domestic violence experienced by service users, and a list of local/national domestic violence services,

3) A direct referral pathway to integrated domestic violence advocacy for service users experiencing past year domestic violence (i.e. referral to a domestic violence advocacy service, via named independent domestic violence advisors (IDVAs)),

4) Provision of integrated domestic violence advocacy for service users (i.e. specialist emotional and practical support, and signposting to relevant support agencies),

5) Regular attendance by trained IDVAs at CMHT staff meetings, to discuss clinical cases and provide clinicians with on-going education about domestic violence, and

6) An information campaign to raise awareness about domestic violence within CMHTs

The intervention was delivered alongside usual care and participants continued with their regular course of treatment (e.g. case management, pharmacological treatment). Service users in the intervention group elected to receive integrated
domestic violence advocacy; delivered by two IDVAs seconded from a local domestic violence service. Advocacy incorporated specialist emotional and practical support, including: safety planning and referral to Multi-Agency Risk Assessment Conferences (MARACs); support with housing and re-settlement; support with court proceedings; facilitation of survivor groups; and general education on domestic violence. Participants in the comparison group received usual care. Mental health professionals in the comparison group were given information on domestic violence services, to pass on to service users who disclosed abuse (Trevillion, Byford, Cary, et al, Submitted).

Of the 35 service users recruited to the study, one female participant in the intervention group was lost to follow-up. Therefore, 27 participants in the intervention group and seven in the comparison group completed three-months follow-up interviews. As the study was not sufficiently powered to detect clinically significant effects of the intervention no statistical tests of association were conducted. At three-months follow-up, the 27 participants who received the intervention reported considerable reductions in frequency and severity of violence (median Composite Abuse Scale (Hegarty, Bush & Sheehan, 2005; Hegarty, Sheehan & Schonfeld, 1999) score pre- and three-months post-intervention 32.0 and 4.0, respectively). Participants also reported improvements in quality of life outcomes (median Manchester Short Assessment of Quality of Life (Priebe, Huxley, Knight, et al, 1999): ‘satisfaction with different life domains’ score pre- and three-months post-intervention 3.5 and 4.0, respectively; ‘satisfaction with life as a whole’ score pre- and three-months post-intervention 3.2 and 3.7, respectively); and perceived social inclusion (median Social Inclusion Scale (Secker, Hacking, Kent, et al, 2007) score pre- and three-months post-intervention 41.0 and 43.0, respectively). No improvements in the use of safety behaviours were observed between baseline and three-months follow-up, as measured by the Safety Behaviour Checklist (McFarlane, Malecha, Gist, et al, 2002) (see Table 2) (Trevillion, Byford, Cary, et al, Submitted).

No adverse events were reported as a result of participants’ involvement in the study, both for those in the intervention and comparison groups. 74% of participants in the intervention group elected to receive domestic violence
advocacy and attended 77% of sessions arranged by IDVAs (see Table 3). Process measures found that the number of clinician referrals to the IDVAs exceeded rates observed prior to commencement of the study. Likewise, rates of referrals to Multi-Agency Risk Assessment Conferences (MARACs) were seen to increase during the study period; seven service users were referred to local MARACs during the study compared to just one referral in the year prior to commencement of the study.

This study was the only one to conduct an economic evaluation. Total costs of the intervention were on average £1,213 per service user. Among intervention and comparison groups, the total cost of service use increased between baseline and follow-up, with slightly greater costs observed in the intervention group (mean difference £962) (Trevillion, Byford, Cary, et al, Submitted).

In summary, this study of domestic violence advocacy demonstrated a reduction in experiences of domestic violence and improvements in perceived social inclusion and quality of life outcomes among service users receiving the intervention. The advocacy intervention was seen to generate only small additional costs compared to treatment as usual. The study scored ≥50% on quality appraisal questions relating to selection bias (see section 3.2.1.1 for details on the appraisal process), which suggests that the sample was characteristic of the overall population of interest. Due to the small sample size of the comparison condition (n=7), no statistical tests of association between groups were conducted. Consequently, the effectiveness of this domestic violence advocacy intervention remains uncertain and cannot be extrapolated to service users with more acute illness or to those experiencing lifetime experiences of domestic violence.

3.4 Discussion
3.4.1 Key Findings
Three studies examined the effectiveness of interventions for male and female CMHT service users disclosing domestic violence. Interventions comprised cognitive behavioural therapy and domestic violence advocacy. Due to the limited number of studies and the heterogeneous nature of these studies (e.g. variations in study samples, types of intervention, types of measurement
instruments, and follow-up periods) it was not possible to numerically pool data. Weaknesses in study design were common, two studies did not include a comparison group (Frueh, Grubaugh, Cusack, et al, 2009; Lu, Fite, Kim, et al, 2009), and due to the pilot nature of all three studies, none were sufficiently powered to estimate clinically significant intervention effects. Consequently, this systematic review found insufficient evidence on whether cognitive behavioural therapy or domestic violence advocacy are effective in improving outcomes (i.e. reducing violence, improving mental health symptoms, quality of life and use of safety behaviours) for psychiatric service users disclosing domestic violence.

Among the included studies, all but one focused exclusively on changes in mental health outcomes among participants (Frueh, Grubaugh, Cusack, et al, 2009; Lu, Fite, Kim, et al, 2009). This finding is interesting in light of the fact that survivors’ of domestic violence experience multiple stressors, alongside psychological trauma, including: mourning the loss of an intimate/familial relationship; a lack of social support; and concerns related to their children (Rose, Trevillion, Woodall, et al, 2011; Sanderson, 2008; Thiara, 2010; Thiara & Roy, 2010). Two of the studies failed to address participants’ safety needs, and the one study that did reported no improved outcomes in participants’ use of safety behaviours at follow-up (Frueh, Grubaugh, Cusack, et al, 2009; Lu, Fite, Kim, et al, 2009; Trevillion, Byford, Cary, et al, Submitted). These findings are notable as survivors are at a high risk of repeated violence and post-separation violence (Thiara, 2010). It is necessary, then, that interventions are developed to directly address the specific needs of people experiencing domestic violence, in a context that “is consistent with battered women’s current needs and will not interfere with their ability to effectively use resources and establish physical safety” (Johnson & Zlotnick, 2010, p 3).

Only one study tested the effectiveness of a domestic violence specific intervention and reported reductions in service users’ experience of abuse, and improvements in social inclusion and quality of life outcomes at three-months follow-up (Trevillion, Byford, Cary, et al, Submitted). These findings are comparable to outcomes reported among domestic violence advocacy interventions in community and primary care settings (Feder, Ramsay, Dunne, et
al, 2009; World Health Organization, forthcoming-a) (see Chapter 1 section 1.11.4.1.2 for more details). However, as this small pilot study did not conduct any statistical tests of association between intervention and control groups, the conclusions that can be drawn on its effectiveness is limited.

The two remaining studies examined the effectiveness of CBT interventions (exposure based and non-exposure based) for service users disclosing a range of abusive experiences (although more than 50% of the sample disclosed domestic violence). As a result, the ability to examine the true effect of these interventions in improving outcomes specific to domestic violence may be weakened. These two interventions were not tailored for service users experiencing recent violence and did not address issues of safety with participants. Both interventions reported improvements in PTSD symptomatology at three- and six-months follow-up among treatment completers. However, as these small pilot studies did not have comparison conditions, it is not possible to draw conclusions on their effectiveness in improving outcomes compared to usual care. Recent evidence from a randomised controlled trial of trauma-focused CBT for 108 CMHT service users with PTSD and a primary diagnosis of schizophrenia, schizoaffective or major mood disorder, found significantly greater improvements in psychiatric symptoms - up to six-months post-intervention - among service users receiving the intervention, compared to controls (Mueser, Rosenberg, Xie, et al, 2008). Yet, only 27 participants in this trial reported adult physical and sexual assault and the authors did not record specific details on participants’ experiences of domestic violence; thereby limiting the ability to assess the effectiveness of this intervention in relation to domestic violence.

The findings above suggest that trauma-focused CBT could be potentially effective in improving outcomes for psychiatric services disclosing domestic violence, although such interventions may need to be tailored to include components that address the specific needs of people experiencing domestic violence (i.e. safety issues).

The studies included in this review suggest that CBT and domestic violence advocacy have no adverse effects, and are generally acceptable to service users.
Only one study conducted an economic evaluation and found that domestic violence advocacy generated a small additional cost in comparison to usual treatment received.

This review identified a lack of evidence on the effectiveness of interventions in improving outcomes for psychiatric service users disclosing domestic violence, which supports findings from our recent literature review (Howard, Trevillion, Khalifeh, et al., 2010). These results highlight the urgent need for improved evidence on the effectiveness of interventions, which ensure the needs of abused psychiatric service users are adequately addressed.

3.4.2 Strengths and Limitations
This review used an inclusive search strategy and followed PRISMA (Moher, Liberati, Tetzlaff, et al., 2009) reporting guidelines. It is perhaps less common for a systematic review to locate a large number of articles and to identify so few as eligible for inclusion. However, the search strategy was made intentionally broad in light of scoping searches, which identified a paucity of material using more restrictive search terms. It was considered preferable to conduct an optimally sensitive search, which would yield some irrelevant material but would be more successful in identifying eligible papers. Due to limited resources, this review was unable to include non-English language papers.

The limited number of studies, and the degree of heterogeneity between studies, means that it was not possible to numerically pool effect sizes. A narrative review of studies was selected, for its strength in reporting diversity and variability among interventions and in clarifying issues that may be of importance for future research.

The review identified a number of methodological and conceptual weaknesses in studies, and two scored <50% on quality appraisal criteria relating to selection bias. All three studies used non-probability sampling methods and did not provide information on the representativeness of their samples. Two studies did not include comparison conditions and none adjusted for potential confounding factors in the analysis of outcomes. Although most studies did not score poorly in
relation to measurement bias, the measurement of domestic violence varied, particularly in relation to the time period assessed (i.e. lifetime versus past year) and the type of instruments used to assess domestic violence (e.g. lifetime exposure to a range of traumatic events versus experiences specifically related to domestic violence).

### 3.4.3 Implications of Findings

The findings of this systematic review emphasise the clear need for further studies, which examine the effectiveness of interventions for psychiatric service users disclosing domestic violence. Randomised controlled trials are necessary and it is essential that future studies seek to address methodological weaknesses of existing study designs (e.g. conducting power calculations and standardising allocation processes for intervention and comparison conditions). Future studies should clearly outline the theoretical basis of interventions and conduct pilot work to test the applicability of interventions in improving outcomes for these vulnerable groups. It would be beneficial for future studies to include a cost-effectiveness analysis of interventions.

In light of the paucity of evidence on interventions in improving outcomes for service users, research is needed to explore how clinicians currently respond to service users’ disclosure of domestic violence. For that reason, Chapters 4-7 present a detailed exploration of clinicians and service users’ experience of the response of psychiatric services to domestic violence.
Chapter 4: Study Three - The Identification and Response of Community Mental Health Services to Domestic Violence: Qualitative Study Methodology

4.1 Introduction

This chapter details how the qualitative research study was conceptualised and conducted. After outlining the philosophical structure underpinning the research, this chapter discusses the study methodology, including sampling strategy and data collection methods. This is followed by a description of the analysis of data, according to the principles of thematic analysis with elements of constant comparative analysis drawn from grounded theory.

4.1.1 Theoretical Assumptions

Before considering the methodological approaches employed in this study, it is necessary to make explicit the theoretical paradigm adopted by the researcher. The theoretical assumptions held by an investigator, guide both the method of collection and analysis of data. Indeed, Guba and Lincoln (1994) argue:

“Questions of method are secondary to questions of paradigm, which we define as the basic belief system or world view that guides the investigator, not only in choices of method but in ontologically and epistemologically fundamental ways” (Guba & Lincoln, 1994, p 105)

The key philosophical questions comprising enquiry paradigms are ontology, epistemology and methodology. Ontological assumptions concern questions about the form and nature of reality and what can be known about it (i.e. What is the nature of the world? What is real? What counts as evidence?). Epistemological assumptions concern questions about the origins of knowledge and how we come to know the world (i.e. What is the relationship between the knower and the known? What role do values play in understanding?). Methodological assumptions concern questions about the principles of demonstration and verification of knowledge (i.e. How can the enquirer go about finding out whether whatever he/she believes can be known?) (Guba & Lincoln, 1994). These three questions are intrinsically connected, as an individual’s view
on the nature of the world (ontology) influences how he/she views the nature of knowledge (epistemology) and this determines his/her view on how knowledge can be acquired (methodology).

Traditionally, quantitative and qualitative research paradigms are purported to be based on fundamentally different ontological and epistemological positions (Maykut & Morehouse, 1994). Quantitative research paradigms are traditionally associated with a realist ontology, which postulates that social phenomena and categories exist independent of human perceptions. Therefore, we can know about mind-independent reality through the observations of patterns (epistemology), which lead to the enumeration of facts about social phenomena (methodology). The study of the social world from a realist perspective is what is generally referred to as positivism; a paradigm that is assumed to be ‘value-free’, whereby researchers are seen to be detached from the phenomena under investigation (Henn, Weinstein & Foard, 2009; May, 1997; Maykut & Morehouse, 1994). In contrast, qualitative research paradigms are traditionally associated with an idealist ontology, which postulates that social phenomena and categories are constructed through human perceptions. Therefore, we cannot know about mind-independent reality and only through studying the meanings that human’s attach to situations (epistemology) can we attempt to uncover the basis of meanings about social phenomena (methodology). The study of the social world from an idealist perspective is what is generally referred to as interpretive; a paradigm that is assumed to be ‘value-laden’, whereby researchers are inseparable from the social phenomena under examination (May, 1997; Maykut & Morehouse, 1994). However, there is a growing consensus that the polarities of these two traditional paradigms are overstated and misrepresentative. As a result, modern paradigms increasingly seek to establish a “mix of, or orientation to, the equally unrealizable polarities” of scientific realism and scientific idealism (Hammersley, 2008, p 47).

My own ontological position is somewhere between the two traditional paradigms and aligns with that of subtle realism. Subtle realism posits that social phenomena exist independent of human interpretations, but because humans are essential components of that reality our knowledge about it cannot be independent.
Consequently, independent social phenomena are not directly observable and are reliant on cultural assumptions, which provide a representation of the underlying reality. As, Hammersley states:

“We can maintain a belief in the existence of phenomena independent of our claims about them, and in their knowability, without assuming that we can have unmediated contact with them and therefore that we can know with certainty whether our knowledge of them is valid or invalid” (Hammersley, 1992, p 50)

Furthermore, in considering how qualitative data is understood within this paradigm Seale (1999) states:

“Subtle realism involves maintaining a view of language as both constructing new worlds and as referring to a reality outside the text, a means of communicating past experience as well as imagining new experience” (Seale, 1999, p 470)

The subtle realist position maintains that as reality exists independent of human knowledge (separation of subject and object) researchers are able to compare the validity of their assertions to underlying social phenomena. However, it stipulates that as researchers’ values are inherent in all phases of the research process and because truth is negotiated through language, cultural symbols and beliefs, objective reality cannot be absolutely determined (Cohen & Crabtree, 2006). Advocates of subtle realism propose that the credibility of research findings in reflecting true assumptions of the world can be strengthened by adhering to the following principles (Adapted from Mays & Pope, 2000):

1) The consistency of the theoretical claims with the empirical data collected
2) The credibility of the account to study participants and readers
3) The degree to which substantive and formal theory is produced
4) The extent to which the description of the culture of the setting provides a basis for competent performance in the culture studied
5) The extent to which the findings are transferable to other settings
6) Reflexivity of the research account (i.e. detailed information of the research process and consideration of the effects of research strategies on the findings).

4.1.2 Research Paradigm
The subtle realist paradigm provides a solid philosophical foundation for mixed methods research, which moves beyond the extreme realist and idealist positions and concentrates on the primary issue of which method best addresses the research question. The methodological rigour of subtle realism can ensure the production of credible and testable knowledge about respondents understanding of domestic violence, health services and health use.

4.2 Researcher Perspective
Since the researcher is the primary “instrument” of data collection and analysis of qualitative research, their beliefs, values and predispositions influence the entire research process (Russell & Kelly, 2002; Stake, 1995). It is essential then that researchers make explicit their perspectives and potential biases and adopt a reflexive approach, which considers how these beliefs/values influence the research.

I am a young, white British female research psychologist who has worked in the field of mental health and violence research for the past six years. I believe that survivors of interpersonal violence frequently incur psychological harm as a direct result of abuse and should receive appropriate therapeutic support for these traumatic experiences (see Chapter 1 section 1.9). As a consequence, I have been active in supporting the provision of therapeutic services for survivors’ of abuse and worked as a trustee for a charitable organisation providing counselling services to survivors of childhood sexual abuse and rape.

My academic orientation focuses on the study of individuals’ minds and behaviours; however, through my research I have become increasingly aware of the inter-connection between psychobiological factors and psychosocial factors in relation to violence and abuse. In seeking to understand the complex nature of
interpersonal violence I have adopted an ecological analysis of situations (see Chapter 1 section 1.7), which explores the intersection of psychological, biological, cultural and socio-political factors in shaping experiences of violence and abuse.

The analysis of service users’ experiences of domestic violence brought up some important questions for me, regarding the social constructions of violence. An examination of the literature highlighted that constructions of violence revolve around issues of culpability, victimisation and what is deemed to be socially appropriate behaviour in specific contexts (Richardson & May, 1999; Stanko, 1990). These different meanings shape our interpretations of the characteristics of people subjected to abuse and the circumstances in which violence occurs. Indeed, these interpretations influence “the processes by which blame and responsibility are attributed to both perpetrator and the victim” (Richardson & May, 1999, p 309). It is argued that constructions of violence are gendered and this facilitates perceptions that some people are more “deserving of violence and less deserving of victim status than are others, on the basis of their ‘behavioural responsibility’ for risk avoidance” (Richardson & May, 1999, p 309). For example, as women commit significantly less violent crimes than men they are more often perceived as ‘victims’ of violence. Conversely, these constructions mean that women are more likely than men to be blamed for experiencing violence, because they are perceived to have made themselves ‘vulnerable’ to abuse (Boonzaier, 2008; Stanko, 1990). The analysis of service user narratives, as presented in Chapter 5 section 5.7.2, suggests that social constructions of violence may also shaped by cultural norms regarding aggressive behaviours (Ramirez, Andreu & Fujihara, 2001). Some service users described how their use of aggressive behaviours in response to conflict led them to understand that they could manage the violence directed at them. As a consequence, they did not perceive that they fit the socially constructed view of a ‘victim’ of domestic violence. Similar views have been expressed by other women who have used violence in an attempt to escape from or to stop an abusive relationship (Miller & Meloy, 2006).
As outlined in Chapter 1, in comparison to women, there is little evidence on the nature, experiences and impact of domestic violence on men. This presented challenges for me, as a woman, with regards to how to interpret, make sense of and understand men’s experiences of abuse. Indeed, although six male service users participated in the study, only two disclosed experiencing domestic violence; consequently my ability to make inferences about men’s experiences of abuse in general was limited. Furthermore, both male respondents reported past histories of perpetrating domestic violence, which does not fit with the traditional perception of a ‘victim’ of domestic violence. Three female respondents also reported perpetrating violence against their intimate partner and the two men’s understanding of their experiences of domestic violence was seen to align with female respondents. For example, one male respondent explained that both he and his partner were emotionally and physically abusive to each other, which he believed was due to the fact that they had both learnt to model the violent behaviours they were exposed to as a child; similar understandings were reported among the three women who disclosed perpetrating violence (see Chapter 5 section 5.7.1.1). The other man described how he was financially exploited by his intimate partner and felt that she had purposefully exploited him because of his vulnerabilities relating to his mental illness; female respondents also reported such examples (see Chapter 5 section 5.7.1.2). In contrast to female respondents, neither of these men reported experiencing considerable physical or psychological injury and did not disclose fear of their abusive partner. Yet, a considerable amount of abuse can occur without causing physical injury and it is argued that men may be socialised not to express fear or vulnerability, particularly in response to violence from a woman (Langhinrichsen-Rohling, 2010).

In addition, a paucity of evidence exists on the intersection between black, Asian, minority ethnic and refugee (BAMER) women’s experience of abuse and mental illness (Southall Black Sisters, 2010; Thiara & Roy, 2010). Initial evidence suggests that BAMER women are at higher risk of experiencing domestic violence and mental illness (Houry, Kemball, Rhodes, et al, 2006; Rodríguez, Valentine, Son, et al, 2009), but often report greater unmet mental health needs in comparison to white women (Rodríguez, Valentine, Son, et al, 2009; Sherbourne, Dwight-Johnson & Klap, 2001). Research suggests that the taboo of mental
illness among BAMER communities means that these women often experience increased stigma and barriers to appropriate medical treatment (Southall Black Sisters, 2010). In view of the limited evidence base, and due to the fact that I am white British woman, it is necessary that I acknowledge my limitations in relation to achieving an in-depth knowledge and understanding of the experiences of BAMER women. In particular, although BAMER women in this study described to me their culturally and ethnically specific perceptions, values and experiences I do not possess a shared frame of reference in which to position these narratives within the wider BAMER cultural framework.

It is important to acknowledge that another qualitative researcher (AW) was involved in this study. We both undertook the development and refinement of study topic guides, the recruitment of participants and conduct of research interviews, and the analysis of interview transcripts. Like me, AW is a young, white, female research psychologist. She is Australian, and has previously worked in child social care. Although it is not possible for me to make explicit AWs perspectives and potential biases, the similarities of our contexts mean that we may share a common frame of reference.

4.3 Study Scope
In Chapter 1, I outlined the current status of knowledge on the identification and response of psychiatric services to domestic violence. This literature review identified a paucity of international evidence on the response of psychiatric services to domestic violence. The majority of research studies employ quantitative techniques to examine the prevalence of domestic violence among psychiatric service users (as synthesised in Chapter 2), and rates of identification and documentation of abuse by mental health professionals. Despite numerous policies advocating routine enquiry of abuse by UK mental health professionals it is not known if this is acceptable to service users and clinicians or how services currently respond to service users’ disclosure of domestic violence.

This qualitative study is the first of its kind to compare and contrast service users’ and professionals’ experiences, understandings and perceptions of domestic
violence. The results of this study help to add depth, richness and an enhanced understanding to existing quantitative research findings.

4.4 Study Aim
The primary aim of this study was to achieve an in-depth understanding of service users’ and professionals’ attitudes towards routine enquiry of domestic violence, their experiences of being asked/asking about abuse and the response received from services.

4.5 Study Site
This research study was conducted within a health locality in the London borough of Southwark, UK. The Southwark Directorate serves a catchment area with a total population of approximately 283,000 people. At the time of the study, the Directorate had four locality mental health team bases, which provided assessment and brief treatment and continuing care for adults of working age (16 to 65 years). The area where this study was conducted has high levels of mental health needs and high levels of deprivation. Within the borough, over 21% of men and 14% of women are unemployed and 70% of residents live in rented accommodation. Twenty-five percent of Southwark’s residents are from minority ethnic communities and 35% of people are under 25 years of age.

4.6 Methodology
4.6.1 Study Design
This study employed a cross-sectional qualitative study design. This design was chosen for its capacity to replicate a fundamental process whereby knowledge about the social world is constructed in normal human interactions (Rorty, 1980).

4.6.1.2 Ethical Approval
This study received ethical approval from the Joint South London and the Maudsley and the Institute of Psychiatry NHS Research Ethics Committee (ref 07/H0807/66) (see Appendix 9).
4.6.2 Study Setting
All interviews with professionals were conducted in private rooms within local CMHTs. The majority of interviews with service users were conducted within private rooms in local CMHTs, unless participants explicitly stated concerns about the location. In these instances, after assessing the level of risk within the participant’s home and if deemed appropriate by their designated care coordinator, interviews were conducted in the participant’s homes (see safety of participants below).

4.6.3 Procedure
Semi-structured interview techniques were employed to allow for the assistance of a strong element of discovery, while maintaining a structure that permits analysis in terms of commonalities (Gillham, 2005).

4.6.3.1 Development of Interview Topic Guides
Topic guides were developed specifically for the study to focus interviews on service users’ and professionals’ attitudes towards routine enquiry of domestic violence, their experiences of being asked/asking about violence, and their views on what interventions had been and would be helpful. Topic guides were chosen to facilitate a systematic assessment of research issues, while still permitting the flexibility to pursue details salient to each respondent (Ritchie & Lewis, 2003).

Myself and other members of the research group, which included expertise in qualitative and social research methodologies, developed and refined initial topic guides for service users and professionals. These guides were then sent for consultation with a reference group consisting of qualitative researchers, including service user researchers, and senior mental health clinicians. Following consultation, myself and another qualitative researcher (AW) refined and amended the topic guides and piloted the revised content and structure of the guides with one another. At this stage, myself and another qualitative researcher (AW) received in-depth training on how to conduct interviews with psychiatric service users experiencing abuse, using role play examples to practice using the topic guides. The training was delivered by a clinical psychologist who specialises in the field of domestic violence (RAD). Finally, my colleague (AW)
and I piloted the topic guides with three psychiatric service users and four mental health professionals. Little revision was required of either topic guide following pilot testing (see final copy of topic guide in Appendix 10).

4.6.4 Sampling Strategy

A purposive sampling strategy was used to recruit community mental health service users and professionals from Southwark. This sampling method was chosen for its ability to increase the likelihood that “variability common in any social phenomenon will be represented in the data” (Maykut & Morehouse, 1994, p. 45).

A purposive sample of psychiatric service users was sought with respect to gender, age, ethnicity, psychiatric diagnosis and experience of domestic violence. The sample included male and female psychiatric service users, in light of evidence of an increased risk of violence perpetrated against men and women with severe mental illness (Silver, Arseneault, Langley, et al., 2005; Teplin, McClelland, Abram, et al., 2005; Walsh, Moran, Scott, et al., 2003). A greater number of women were sampled (18 women versus six men) due to evidence of an increased risk of violence among women with severe mental illness, compared to men with severe mental illness (Khalifeh & Dean, 2010; White, Chafetz, Collins-Bride, et al., 2006). The sampling strategy sought to recruit a range of psychiatric service users of working age (sampled age range: 19-59 years) and with a variety of psychiatric diagnoses, which were reflective of the service user profile of Southwark Community Mental Health Teams (CMHTs). The ethnic groupings of participants were selected to reflect the overall ethnic composition of Southwark residents, as outlined in the 2001 census (Office for National Statistics, 2001). Finally, representations from service users who had and had not experienced domestic violence were sought, in order to more accurately reflect the experiences of the wider population of community mental health service users (see Chapter 5 section 5.2 for demographic details).

With regards to mental health professionals, a purposive sample was sought with respect to gender, age, ethnicity, clinical discipline and number of years qualified. Male and female community mental health professionals from a range of clinical
disciplines (e.g. psychiatry, psychology, social work and nursing) were sought, in
order to more accurately reflect community mental health team compositions

4.6.5 Recruitment of Participants

4.6.5.1 Service Users
Together with another researcher (AW), I recruited a purposive sample of
psychiatric service users via study advertisements placed in CMHTs, voluntary
sector organisations (i.e. Maroons Resource Centre, Castle Resource Centre) and
a local mental health charity newsletter (i.e. MIND). Advertisements invited
service users to contact the researchers for a full description of the study. Care
coordinators (case managers with a background in nursing or social work)
working within local CMHTs were also asked to invite service users to participate
in the study.

Inclusion criteria: male and female service users who were currently in contact, or
had previously been in contact, with Southwark CMHTs. It was not a
requirement for service users to have experienced domestic violence, as the study
sought to elicit views on the acceptability of routine enquiry of abuse among
individuals who had and had not experienced domestic violence.

Exclusion criteria: male and female service users who could not speak English
and those deemed by clinicians to be too unwell to enter the study.

4.6.5.2 Mental Health Professionals
Together with another researcher (AW), I gave several presentations about the
research study to clinicians at local CMHTs. I also contacted team leaders of
local CMHTs and asked them to circulate the study information sheet to
colleagues. Mental health professionals currently working within local CMHTs
were invited to contact researchers for a full description of the study.

Inclusion criteria: male and female mental health professionals currently working
in Southwark CMHTs. No exclusion criteria were applied to mental health
professionals.
4.6.5.3 Obtaining Consent

Service users and professionals who were interested in participation were talked through the participant information sheet by myself and another researcher (AW) (see Appendix 11 for participant information sheet). In line with the study consent procedures, all respondents were provided with a minimum of 24 hours to consider their decision to participate and were informed that they maintained the right to withdraw at any point during the study. All participants who agreed to participate signed a consent form prior to commencement of the interview.

4.6.6 Interview Procedure

Individual semi-structured interviews with service users and professionals were carried out between May and December 2008. Interviews lasted between thirty minutes and an hour and were digitally recorded. I conducted the majority of interviews with service users and another researcher (AW) conducted the majority of interviews with professionals. During the interview process, myself and the other researcher ensured that we both interviewed a sample of service user and professional participants. All interviews were transcribed verbatim and, although transcripts did not include details such as word stresses or intonations, care was taken to ensure that the transcripts were faithful representations of respondents’ speech. Demographic questionnaires were used to gather information about services users and professionals and an interview topic guide (as detailed above) was used to probe, prompt and facilitate flexible questioning styles. A reimbursement fee (£20) was given to service user participants for their time.

As interviews may have contained distressing material for participants, if required and following participants’ consent, care coordinators were contacted to provide further support. Details of local and national domestic violence agencies were provided to all respondents who disclosed domestic violence.

4.6.6.1 Methodological Issues Arising from Interviews with Service Users

In conducting interviews with people experiencing severe mental illness I encountered some methodological challenges. Similar to other qualitative research examining sensitive topics, I found that some respondents displayed reticence in responding to interview questions and became emotionally distressed
when reflecting on their experiences of abuse. In these instances, I actively sought to put respondents at ease by carefully pacing interviews and using sensitive probing techniques, providing positive reinforcement and acknowledging respondents’ distress and asking them if they would like to take a break or move on to another topic. However, I encountered some particular issues unique to research with people with severe mental illness. One of the challenges was finding a means for respondents to reflect on their experiences and to articulate these insights when they displayed impaired communication abilities related to their illness. For example, some respondents’ language moved rapidly from one seemingly unrelated idea to another (flight of ideas), was highly detailed but considerably delayed in reaching its conclusion (circumstantiality) or was characterised by an increased rate of speech (pressure of speech). Some respondents also had difficulties with the acquisition and recall of memories and problems in maintaining focus, which resulted in them forgetting interview questions. Nind (2008) highlights the difficulties for researchers in managing communication impairments among people with disabilities, as respondents may require highly structured support in presenting their views but this may in turn distort their views, due to the nature and phrasing of questions by researchers (Nind, 2008).

Similar methodological concerns have been identified by other qualitative researchers when interviewing respondents with disabilities (Clarke, Lhussier, Minto, et al., 2005; Kirkevold & Bergland, 2007; Moyle, 2002). Interestingly, little consideration has been given to the methods of data collection in research with these vulnerable populations and evidence principally focuses on issues of informed consent and management of confidentiality. Goodley (1998) argues that there cannot be standardised formulae for conducting research on people with disabilities because they are not a homogenous group of people. Nevertheless, he suggests some data collection techniques that may facilitate improved communication and form the basis of shared natural exchanges between respondents and researchers, including a natural interviewing style that includes probing and, on occasion, leading questions (Goodley, 1998).
Finally, the nature of interviews with abused people can sometimes be distressing to the interviewer. Consequently, I had to be aware of issues of transference and counter-transference during interviews and understand how this may have affected me professionally and personally. Alongside supervision and self-monitoring, one of the ways I managed this was through my research writings, which have allowed me to integrate these experiences and discharge any residual emotions. I have also focused on the rewarding aspects of this work, which have been respondents’ feedback that the interview provided them with a cathartic space. Moreover, I feel that my research will make a difference in raising awareness about this issue and may make a positive change to mental health service provision.

4.6.6.2 Safety Procedures

When conducting research with survivors of domestic violence it is essential for researchers to “consider and respond to ethical considerations related to survivors safety and well-being” (Sullivan & Cain, 2004, p 617). A standard operating procedure was developed for this study, detailing ethical and safety considerations of conducting domestic violence research and to record any ethical and safety issues that arose during the course of the project; as outlined below.

A number of safety measures were put in place for the protection of researchers and service users during this study:

1) As researchers may have been at risk of threatening behaviour by abusers or other community members the identity of researchers was protected and pseudonym names were used on all study recruitment material. The mobile telephone number provided for contacting the researchers was used for research purposes only

2) On initial contact respondents were informed that they should not put themselves at any risk by participating in the study. Furthermore, they were advised only to make contact with researchers when they were certain no other person was present who may overhear the conversation

3) Researchers asked participants to specify times when it was safe and unsafe to contact them
4) As there was a risk that telephone conversations may still be overheard by an abuser or another person, an agreement was obtained with respondents on how to manage the situation if conversations were overheard (e.g. they can start discussing safety of electrical appliances in the home). Service users were given the option of the researcher calling them back to save costs and to minimise the chance of the abuser identifying the call on an itemised telephone bill, especially if the call was of a long duration.

5) No indication of the identity of researchers was given immediately to any caller, until the identity of the caller had been established; this was to ensure the protection of service users who may have called earlier and had this call monitored by an abuser.

6) All service users were interviewed alone in private settings, either at their home (following prior risk assessment) or at CMHTs, to ensure that conversations could not be overheard by others. When conducting interviews in home settings, participants were informed that if the abuser or another adult came home during the research process the interview would be terminated and postponed until another secure time.

7) Researchers had access to a mobile phone and screech alarm at all times during interviews and gave details of the interview location to colleagues at their research department.

8) There was no indication that interviews were being held to investigate issues around domestic violence when conducted at CMHTs. Any written information provided to participants gave no indication that the research project was about domestic violence.

4.6.6.3 Issues of Confidentiality
Prior to the start of the interview, service users were informed that if they disclosed information indicating that they or their children were at significant risk of harm the researcher would be obligated to break confidentiality and report this information to appropriate agencies (adhering to the UK Data Protection Act 1998)). All other information remained confidential and, in order to ensure the anonymity of participants, during the transcription process any identifiable
characteristics (e.g. names and addresses) were either omitted or replaced with pseudonyms.

4.6.7 Data Management
Following completion of interviews, all digitally recorded sound files were immediately uploaded to the university secure network and deleted from the portable recorder. Interview transcripts are stored in a locked drawer within the university for the period of time specified by the Joint South London and Maudsley and Institute of Psychiatry NHS Research Ethics Committee study.

4.6.8 Study Feedback
The study consent form asked service users if they wanted to receive feedback about the results of the study. Those who did were asked to name a safe place that the study report could be sent to (e.g. to their care coordinator, to a friend, neighbour or family member). Shortly after the analysis was completed service users who had requested feedback were sent a report of the main findings.

Mental health professionals were also provided with feedback on the results of the study and I gave presentations of the findings at each of the participating CMHTs.

4.7 Analysis
Analysis proceeded from the starting point that the task of the researcher is “one of simultaneously telling the story from the point of view of the research participants, and unpacking that story in some way such that the broader meanings can be elicited” (Green & Thorogood, 2004, p 175).

Two analytical methods were used to analyse the qualitative data: (1) thematic analysis (Attride-Sterling, 2001; Boyatzis, 1998; Braun & Clarke, 2006), which seeks to classify recurring and common themes and to compare and contrast relationships between themes; and (2) constant comparative analysis (Glaser & Strauss, 1967), which seeks to combine thematic coding techniques with the simultaneous comparison of all units of meaning to establish theoretical categories/typologies. These analytical methods facilitate rigorous examination of qualitative data through the exploration of unique nuances in respondents’ narratives (see Box 3 below).
Box 3 – Methods and techniques of analysis of qualitative data using thematic and comparative analytical methods

1. **Development of relevant analysing dimensions**
   a) Thematic coding of interviews
   b) Construction of thematic variables
      - Thematic case comparisons
      - Thematic case contrasts (search for deviant cases)
   c) Computer-assisted indexing and categorisation of themes (NVivo 8)

2. **Grouping cases and analysis of empirical regularities**
   a) Examination of comparable and contrasting thematic cases
   b) Computer-assisted grouping procedures (charting and tabulation of cases)
   c) Conceptualising thematic case attributes
      - Cross tabulation of themes within and between cases
      - Analysis of empirical regularities and irregularities

3. **Analysis of meaningful relationships and type construction**
   a) Comparison of attributes between cases
   b) Search for deviant cases
   c) Development of substantive and formal theories
   d) Test of the construct validity of initial typologies

4. **Characterisation of the constructed types**
   a) Relevant analysis of dimensions and typology attributes
   b) Examination of meaningful relationships
   c) Testing the internal and external heterogeneity of typologies

(Adapted from Kluge, 2000)
4.7.1 Thematic Analysis

4.7.1.1 Familiarisation: Analysis began with familiarisation of the data, which was achieved through transcribing and proofreading of interview transcripts and by repeated readings of finalised transcripts. A proportion of interview transcripts were also read by non-interviewers (DR, LH and GF) in the research group, to facilitate group discussions regarding recurring ideas and emerging hypotheses on relationships within and between codes. These processes were supplemented by memos of my initial thoughts and questions about the data, which were recorded and reviewed throughout the analytical process. The memos facilitated reflections of the data and moved the analysis beyond simple description, by identifying gaps in the data and points for comparison (Charmaz, 2006).

4.7.1.2 Generation of Initial Codes: Intense, open coding of early data was employed to generate an initial coding frame, based on thematic categories rooted in the data. It was not assumed that themes would ‘emerge’ from the data but that interpretive work would be needed to identify them. In line with Boyatzis (1998) assertions, the labels of thematic codes sought to be “meaningful to the phenomenon being studied, clear and concise in communicating the essence of the theme in the fewest possible words and close to the raw data” (Boyatzis, 1998, p31).

Independently of one another, myself and another qualitative researcher (AW) read through each of the professionals’ and services users’ pilot transcripts, examining texts line by line to identify patterns in the data. Separately, we coded the pilot interviews and developed a preliminary coding frame, based on themes identified in the transcripts. Often units of text were given several codes to reflect the multifarious nature of respondents’ narratives. NVivo 8 (2008) was used for indexing material and for retrieval of text chunks pertaining to the same or similar codes (NVivo, 2008). We then came together to compare our preliminary coding frames, examining each of the codes we had created and evaluating reasons for our decisions. Lengthy discussions centred on the appropriateness of each of the codes, and any disagreements were resolved through consensus. Following these discussions, a revised initial coding frame was developed, one for service user
narratives and one for professional narratives. Common and related themes in each of the initial coding frames were developed into tree nodes.

4.7.1.3 Identifying and Reviewing Themes: When coding the remaining interviews, I concentrated on service users’ narratives and the other researcher (AW) concentrated on professionals’ narratives. As service users’ and professionals’ coding frames were expanded and revised, in light of developing themes, each rater kept a record of any amendments made (saved in NVivo8 database) to establish a complete audit trail of the analytical process. Any queries or concerns that individual researchers encountered during the coding process were discussed and agreement was sought on the appropriateness of the code category. The validity of coding frames were checked throughout the process using a number of different methods. First, the appropriateness of each coding frame was checked through progressive iterations and reapplied to earlier transcripts as it developed. Data that did not seem to fit into the coding frame (i.e. deviant cases) was actively sought and multiple coding engaged in by both researchers. At various points during the coding process, inter-coder agreement between the two researchers was sought on independently coded, randomly selected, narratives of professionals and service users. Inter-coder processes continued until over 80% agreement was achieved for service user and professional coding frames. Further inter-coder checks on the appropriateness of coding frames was sought with senior researchers (DR, LH and CM) in the research group. These checks and balances resulted in further revisions and refinements to service user and professional coding frames, thereby increasing the credibility of data analysis (Bryman, 2004; Maykut & Morehouse, 1994).

4.7.1.4 Defining and Refining Themes: Interviews continued until there was a saturation of themes, whereby no new constructs were seen to be emerging. Relationships between and within codes were explored and categories and definitions were revised many times during analysis, in light of developing themes. A deviant case analysis was carried out and codes with similar information were merged. At this point a decision was made to merge the coding frames for professionals and service users, to facilitate analysis within and between cases. The two data sets were merged together and combined by
overlapping themes, or categorised as distinctly separate themes. The merged coding frame was analysed in detail to identify related and unrelated themes and to facilitate the development of more abstract categories based on observed relationships within and between codes and existing theories (see Appendix 12 for final coding frame). Concept maps were developed to represent the data in a visual format. These diagrammatic representations reflect the super-ordinate themes and sub-themes that emerged from the data, following repeated coding and refinement of the framework.

4.7.2 Constant Comparative Analysis
At this point in the analysis, aspects of the constant comparative method (Glaser & Strauss, 1967) were utilised to move the analysis beyond a description of the thematic content of interview transcripts. Constant comparative analysis seeks to connect and integrate thematic categories in such a way that all instances of variation are captured in the emerging theory (Willig, 2008). This method forged inter-connections between codes, through intensive reflection and interpretation of the data, in order to identify formal and substantive themes. A key feature of the analysis was the exploration of relationships of categories, both within and between cases, which allowed for differences and similarities between service users’ and professionals’ narratives to be explored. Furthermore, by comparing categories across cases the analysis seeks to validate concepts according to the overall narrative context (Malterud, 1993).

Analysis within and between cases assisted the development of typologies, which sought to categorise specific case attributes identified in the data. Kluge (2000) states that there are four stages of analysis in the process of type construction (see Figure 6). Researchers using this methodology must ensure that elements within typologies are as similar as possible (internal heterogeneity); and differences between typologies are as strong as possible (external heterogeneity) (Kluge, 2000).
4.7.3 Overview of Analysis

The results of this qualitative study are divided into three chapters:

- Chapter 5 presents results from qualitative interviews with service users;
- Chapter 6 presents results from qualitative interviews with professionals;
- Chapter 7 presents a discussion, which compares and contrasts findings from the qualitative interviews with service users and professionals.
Chapter 5: The Identification and Response of Community Mental Health Services to Domestic Violence: Results from Qualitative Interviews with Service Users

5.1 Introduction
This chapter presents the main findings from qualitative interviews with psychiatric service users. The first section of the chapter details service users’ understanding and experience of domestic violence. The subsequent sections present results from a thematic analysis of: service users’ views on the acceptability of routine enquiry of domestic violence in psychiatric settings; their knowledge of support services; their experience of disclosure, and their experience of the services response to domestic violence. The final section of this chapter will describe and discuss findings from a constant comparative analysis of service user narratives, which identified three distinct typologies of ‘understanding of domestic violence’. These typologies were seen to influence service users’ pathways to and contact with services.

5.2 Demographic Details of Service Users
24 service users were recruited, 18 were female and six were male. Self-ascribed ethnicity was white British (n=12), European (n=1), black Caribbean (n=5), black British (n=1), black African (n=2), Asian (n=1), mixed race (n=1) and Latin American (n=1). The ethnic background of the sample reflected that of the local population as a whole, as identified in the 2001 census (Office for National Statistics, 2001). The mean age of service users was 40.6 (range 19-59, SD 9.27). Clinical diagnoses included bipolar disorder (n=7), depression (n=6), borderline personality disorder (n=1), schizophrenia (n=5), schizo-affective disorder (n=1) and adjustment disorder (n=1), psychoactive substance abuse (n=1) and one case where a diagnosis had not been made.

5.3 Service Users’ Experience of Domestic Violence
All respondents in this sample were psychiatric service users with existing mental health problems. As outlined in Chapter 4, the purposive sampling technique sought to elicit responses from service users who had and had not experienced...
domestic violence. In total, 18 respondents (16 female and two male) disclosed experiences of domestic violence and six did not. The six respondents, four male and two female, who did not report experiences of domestic violence disclosed either perpetrating violence against an intimate partner (n=1) or family member (n=2), experiencing acquaintance violence (n=1) or childhood violence (n=1), or reported no previous experience of violence or abuse (n=1). In total 23 of the 24 service users in this study disclosed some form of violence and abuse (see Table 4 below).
Table 4: Count of Service Users’ Lifetime Experiences of Violence and Abuse

<table>
<thead>
<tr>
<th>Participant ID</th>
<th>Survivor of Childhood Abuse</th>
<th>Survivor of Domestic Violence</th>
<th>Perpetrator of Domestic Violence</th>
<th>Survivor of Acquaintance Violence</th>
<th>Survivor of Stranger Violence</th>
<th>No Experience of Violence or Abuse</th>
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<tbody>
<tr>
<td>SU1</td>
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<td><strong>Total Count</strong></td>
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<td><strong>3</strong></td>
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During qualitative interviews, service users were asked to describe their understanding and experience of domestic violence. Service users’ responses to these questions are provided below. Presentation and discussion of service users’ responses are reported under the questions that were asked. Where a number of respondents gave similar answers, these have been summarised and represented by a quote from one respondent, whose narrative describes the essence of what was said.

5.3.1 Service Users’ Understanding of Domestic Violence

Qualitative interviews began with the researcher informing service users of the study definition of domestic violence and asking them to describe, in their own words, their understanding of this form of abuse.

Several respondents spoke of the significance this definition had in clarifying their understanding of domestic violence “I think that’s really important actually, because to be honest I think one of the things about domestic violence is that you don’t realise. I still find it hard to say I was a victim of domestic abuse, although I suffered in every form imaginable”. Allowing for differences in phrasing, all respondents described domestic violence as incorporating physical and sexual violence and psychological/emotional abuse “domestic violence is abuse of a person...physically, emotionally...sexually” occurring between intimate partners “domestic violence is like...when you are abused by a partner”. Less frequently did respondents identify family members as abusers of domestic violence, although some respondents reported abuse from siblings “I was attacked by my brother a few years ago” and from their abusive partner’s wider family “his family were very controlling of me as well”.

There was a shared understanding among service users who disclosed domestic violence in relation to abusers underlying motivations for violence. Respondents who disclosed domestic violence described how abusers’ pathological jealousy and anger were driving forces behind the violent attacks inflicted upon them:

“It’s like you’ve become an annoyance to them, somebody they have to torture...It’s like you’ve irritated them to the point that they can only do...”
something like that…I would have thought maybe it’s that they don’t like themselves and you just become some kind of projected hate of themselves” (SU22, female, experienced domestic violence)

“He was jealous of me as well because I was very popular” (SU16, female, experienced domestic violence)

Respondents described that a history of witnessing and/or experiencing violence in childhood often resulted in individuals’ modelling these violent behaviours as an adult:

“Domestic violence could be males being beaten in the home, while growing up, making them do and behave a certain way once they've grown up” (SU6, female, experienced domestic violence)

The three male service users who disclosed perpetrating violence against an intimate partner (two of whom also disclosed experiencing domestic violence), and the two respondents (one male and one female) who disclosed perpetrating abuse against their primary caregiver also identified jealousy and anger as contributory factors in encouraging acts of violence:

“Sexually, that can cause problems because if your wife ain't giving you what you want you might start thinking ‘is she seeing someone else?’…Jealous thoughts can have a funny effect on you, because that can cause problems with violence and verbal again” (SU9, male, perpetrated domestic violence)

“I was angry with her because I thought that she wasn’t doing everything she was supposed to be doing…I thought she wanted to take my money…and I was angry with her” (SU7, female, perpetrated domestic violence)

Linked to this, one male abuser described how his heavy use of alcohol exacerbated his use of violence:
“I used to drink and I think that probably didn’t help...yeah drink plays a big part in it...I found out when I used to drink, for some reason, I would get very hot and I couldn’t cope with having too many people around me”

(SU9, male, perpetrated domestic violence)

In contrast, the service user who did not report any experiences of abuse described a different understanding of the motivations for violence. This respondent suggested that domestic violence stems from a lack of shared understanding and communication breakdown within an intimate relationship “I think it’s just basically two people not really connecting together”.

5.3.2 Type of Violence
The 18 respondents who disclosed domestic violence were asked to describe their experiences of abuse. Respondents described the types of abuses perpetrated against them, which can be grouped under the following headings: physical violence, sexual violence, emotional/psychological abuse and financial abuse.

5.3.2.1 Physical Violence
Almost all respondents who reported domestic violence described instances when their abuser had been physically violent. Respondents reported injuries including cuts and bruises “I had black eyes...bleeding nose”, broken bones “my jaw was broken” and internal injuries “I had internal bleeding”. Some respondents reported that abusers were assiduous in controlling where they inflicted physical violence, directing their attacks to parts of the body that would be not seen and therefore remain undetected “I’ve got cuts all over my head, because of course nobody could see it”.

A number of women reported experiencing physical violence during the perinatal period, both during pregnancy “he punched me in the stomach when I was pregnant” and shortly after giving birth “I’d literally just had a miscarriage and I can remember him, from the top landing, just dropping the linen basket full up of washing down at me as I was going down the stairs”.
One woman described how her abuser employed tactics of physical neglect, depriving her of sleep and failing to provide her with basic needs, such as heating:

“He used to turn off the gas during the day when he went out… I couldn’t cook anything I couldn’t put the heating on or anything like that” (SU10, female, experienced domestic violence)

Female service users described how the frequency and severity of physical violence escalated over time: “over five years it became that it wasn’t just every three months it was a few times every week and weapons started to get involved”; often culminating in life threatening attacks “it could have killed me actually, pushing me down the flight of stairs”.

5.3.2.2 Sexual Violence

Many respondents disclosed experiences of sexual violence from an intimate partner “I’ve been raped”. Several respondents also experienced concomitant physical and mental violence:

“He’d be wanting me to have sex with him and because I refused I would either get hit or he’d make sure I would be kept awake” (SU10, female, experienced domestic violence)

Several women disclosed repeated experiences of sexual violence:

“There was sexual abuse as well… he’d come up to bed and disturb my sleep and he would just have sex, without my consent” (SU16, female, experienced domestic violence)

One woman described how her abuser attempted to coerce her in to performing degrading and humiliating sexual acts on an animal:

“I don’t know what you call it, sexual abuse, but that got to the extent where he tried to make me have sex with a dog” (SU17, female, experienced domestic violence)
5.3.2.3 Financial Abuse

Financial abuse was reported by some service users, who described how their abuser would deny them access to key financial resources (i.e. cash or credit cards), “he took my debit card off me six years ago and I had no access to any money” Those who were in employment described how their abuser would expect them to fund everything “I found out afterwards that he used to refer to me as ‘the bank’...he ran up £600 in phone bills” or expected them to hand over the sum of their total income “I’d be left with virtually no money at all. I mean I would go to work and I had no money for food”.

Several respondents described how abusers took total control over their incapacity benefits or exploited the benefits system in order to claim money as a carer, while simultaneously failing to support even their most basic of needs:

“He’d [abuser] applied...for what was then a supplementary benefit for me, so that he could care for me...he was claiming for me, so it meant that he was getting more money to play around with but I didn’t get any sickness benefit” (SU10, female, experienced domestic violence)

One woman, a self-employed business woman, described how her abuser would use threats of physical violence in order to gain control over her financial resources:

“If I was doing a job and he’d say ‘can I come?’ and I’d say ‘it’s on the basis that you’re not earning and you’re just coming along for the ride,’ but then he’d come to my home and get a crash helmet in front of my face and say ‘are you going to give me this money?!’” (SU22, female, experienced domestic violence)

5.3.2.4 Emotional/Psychological Abuse

Emotional and psychological abuse was also widely reported among service users. Abusers were reported to employ tactics including verbal abuse “it was things along lines of ‘you’re useless, you’re pathetic, you can’t do this’”, restriction of movement “he locked me in my room”. A minority of respondents also disclosed
abuse from the family members of their intimate abusers “his [abuser] family was also very controlling of me as well”.

An absence of social networks was reported by a number of service users, who described how their abuser isolated them from friends and family networks:

“It started off with isolation...I’d make friends with people and then he’d [abuser] phone them up and tell them not to call this number again” (SU16 female, experienced domestic violence)

Several respondents also described instances when their abuser was emotionally neglectful, being dismissive and unresponsive to their emotional needs “he kept putting me down, getting me to the point where I thought I needed him and then sort of letting me down again”.

Many respondents also reported emotional manipulation, which was used by abusers to erode their self-esteem:

“You’re always getting told that ‘you’re never going to get no one who loves you like me’ or ‘you are never going to get someone who looks after you like me’...You don’t need to hear that...it knocks your self-esteem” (SU11, female, experienced domestic violence)

Some women also reported occasions when the abuser used threats of physical violence to elicit fear within them:

“There was a great deal of psychological abuse...This particular time he actually came into the bathroom and I was in the bath and he held a live hair dryer over the bath. Everything just seemed to go into slow motion; I wasn’t sure what to do because I thought well ‘if I try and get out of the bath he may just drop it...I’m not going to get out alive’” (SU10, female, experienced domestic violence)
One woman described an occasion when, after informing her partner that she wanted to end the relationship, they used emotional blackmail to try and prevent her from leaving:

“He was threatening to kill himself, to overdose, to inject himself, and you feel…”I don’t want him to kill himself because of me’…it’s really hard”
(SU24, female, experienced domestic violence)

Another woman described how her abusive husband coerced with their children in order that they sided with him:

“He’s coerced with my children and got them on his side… I was invited to a friend’s wedding and I decided to go… He got on side with my eldest daughter and the two of them sat there and said that I wasn’t to go, so in the end I didn’t end up going” (SU16, female, experienced domestic violence)

It is noteworthy that a number of service users described how experiences of emotional and psychological abuse could be more damaging than physical violence:

“I used to see my friends who had that mental abuse thing, always looking over their back and waiting for their man to come in. I think that was more torturous than the bruises… I mean I could look in the mirror and see a black eye but then I could think ‘well tomorrow it will be gone’, but the mental pain it’s like mental stress” (SU11, female, experienced domestic violence)

5.3.2.5 Stalking
Four respondents described being stalked by their abuser either during the relationship or following separation “he became a stalker”. One individual described how her ex-partner had stalked her in an attempt to kidnap their daughter.
One respondent recalled several occasions when her partner would come looking for her when she was visiting friends because they felt she had been out too long:

“He used to come out looking for me. If I was late he’d come roaming the streets looking for me. If I went to friends for coffee or something he’d come out and start looking for me” (SU16, female, experienced domestic violence)

5.3.3 Domestic Violence and Mental Illness

Service users described how having a mental illness influenced their experience of violence in a number of ways. Some respondents described how the experience of severe mental illness rendered them susceptible to abuse by others, who sought to exploit their vulnerabilities:

“Being in the mental health system, once people know, you face a lot of violence. You face a lot of violence physically, sexually, financially, emotionally, psychologically, everything” (SU5, female, experienced domestic violence)

Respondents described instances when abusers sought to exploit existing mental health problems in an attempt to disguise the violence:

“He’d say ‘oh she’s mad, she got all these mental health diagnoses’...and social workers ended up believing him more” (SU14, female, experienced domestic violence)

One service user described how her abuser employed subtle coercive tactics that sought to exacerbate her existing mental illness. As the following illustration highlights, the abuser used deceptive techniques to establish in her a drug dependency:

“I started to have a breakdown...and he obviously knew that and he came round one day and he said ‘oh, try this it might help’ and he produced this little bottle...I didn’t really know what it was and so I took in this drug,
which turned out to be crack cocaine...I was already six weeks into a serious breakdown and then of course I had drug psychosis on top of it”
(SU22, female, experienced domestic violence)

5.3.3.1 Impact of Domestic Violence on Mental Illness
Although not asked directly by the researcher, service users explored the relationship between their experience of domestic violence and mental illness. Six respondents believed their mental illness developed as a direct consequence of their abusive experiences “I think it was actually a contributory cause to me breaking down, if not the main thing”. Five other respondents described how their experience of domestic violence had the effect of worsening existing mental illness “domestic violence makes the mental health worse”.

Several service users described how abusers’ actions to dominate and control every aspect of their lives left them without self-agency and subsequently led to deterioration in their mental state:

“You feel as if you’re trapped. I was in bed for two years or so with depression…I thought ‘well that’s me, I’m trapped’” (SU16, female, experienced domestic violence)

The experience of complete subjugation had the effect of eroding service users’ core sense of self-worth:

“You get to a sort of coping stage…the punches no longer hurt, you’re sort of desensitised to it and you just have some kind of half-life where you exist and you become sort of quite mechanical in what you do…You can’t live it and have any kind of semblance of yourself” (SU22, female, experienced domestic violence)

Many respondents described experiencing long-term psychological effects as a direct result of the violence suffered. They recalled how their mental health continued to deteriorate following separation from the abuser:
“I thought that once I was away I would be so much better but I wasn’t actually, it all just caught up with me and I went into this terrible depression” (SU10, female, experienced domestic violence)

5.3.4 Service Users’ Previous Experience of Violence and Abuse

What is noteworthy from service users’ narratives are how many respondents gave a ‘yes’ response to the interview question “have you been hurt by anyone else?” 13 of the 24 respondents disclosed experiences of childhood abuse “there was some abuse from my childhood”, and 11 of these also disclosed experiences of domestic violence in adulthood.

Ten of the 16 women who disclosed experiences of domestic violence also reported childhood abuse, including witnessing domestic violence “my mum really took some beatings…her face was dismantled, her teeth knocked out, she was strangled. My dad battered her”, experiencing physical “my mum was very violent to me” and/or sexual violence from family members “sexual abuse from my brother”. Six female respondents disclosed abuse from more than one intimate partner “I had about five violent partners” and one woman described abuse from an acquaintance “I was attacked by a man and a woman. They invited me to a party…and they beat me up”. One of the male respondents who disclosed domestic violence also reported childhood abuse “my mum would be very abusive towards me”. Therefore, of the 18 respondents who disclosed domestic violence 12 reported more than one violent relationship during their lifetime (see Table 4 for full details).

As 11 of the 13 respondents reporting childhood abuse also disclosed experiences of domestic violence, it is worthwhile at this stage to explore the experiences of the only two individuals who did not. Like the other 11 respondents, one female respondent took the decision to abscond from the violent childhood home as a young adult; unlike all the other respondents, this respondent had a close family friend who was aware of the violence and had agreed to support her in her decision to relocate to the same area that they resided in. Following relocation, the family friend became a close confidant and took steps to ensure that the respondent was supported. What this individual received, which the other
respondents did not, was a supportive social network. A network with whom she could confide in about her childhood experiences of abuse and who sought to help her live independently and without the risk of further violence. The following illustration describes the respondents understanding of why she did not experience domestic violence in her intimate relationships as an adult:

**Researcher: I wanted to ask you if you’ve ever been hurt by anyone else?**

**Respondent: “No because I won’t take it...I often say ‘don’t even try to bully me because I was bullied by an expert for 18 years and it ain’t going to happen again’” (SU15, female, did not experience domestic violence)**

There was one male respondent who also disclosed experiences of childhood violence but did not report experiences of domestic violence. This respondent reported childhood abuse from their primary caregiver:

“*When I was younger...She [mother] jumped on my head, like properly jumping on my head like it was a football*” (SU4, male, perpetrated domestic violence)

In contrast to the female respondent described above, this male respondent described perpetrating violence against a family member as an adult. He assaulted the primary caregiver who had abused him as a child:

“She [mother] *tried to do it again and I was kind of scared, so I punched her*” (SU4, male, perpetrated domestic violence)

This respondent understood his abusive behaviour to have been the result of feelings of anger, which had manifested during his experience of childhood abuse:

“To me it’s like my mum doesn’t love me anymore and she’s trying to hurt me...It gets me angry...if I get angry I just want to start something” (SU4, male, perpetrated domestic violence)
With this understanding came a realisation that he could overcome these overwhelming feelings of aggression, which had led him to act out violently in the past:

“If I got angry I would just want to beat up the staff [hostel workers] or something but now it’s like I don’t think like that anymore. I want to get along in life and do the things that I want to do” (SU4, male, perpetrated domestic violence)

5.3.5 Summary of Results
Although not all service users had experienced violence, 23 out of the 24 respondents disclosed some experience of abuse during their lifetime. 13 of the 24 respondents disclosed experiences of childhood abuse, either witnessing or being directly abused by family members. 18 respondents disclosed experiences of domestic violence, including physical and sexual violence and psychological/emotional abuse; often these forms of abuse were concomitant. The experiences of service users align with findings from the literature review in Chapter 1, which highlighted that survivors of domestic violence frequently experience more than type of violence. Chapter 8 will explore the implications of the multiple abuse experiences reported by psychiatric service users. Service users talked in detail about their experience of domestic violence and the impact it had on their physical health, with many reporting injuries ranging from bruising and fractures to internal bleeding. In relation to the impact on mental health, several respondents commented that mental illness arose as a direct consequence of the violence suffered and others described how existing mental illnesses were exacerbated by the abuse.

The following sections (5.4-5.6) present findings from a thematic analysis of service users’ narratives and are organised around the main dominant interpretive themes: (1) service users’ views about the acceptability of routine enquiry of domestic violence in psychiatric settings and their knowledge of support services; (2) their experience of disclosure domestic violence; and (3) their experience and expectations of the response of services to domestic violence (see Table 5 below).
### Table 5: Results from a Thematic Analysis of Service Users’ Narratives

<table>
<thead>
<tr>
<th>Super-ordinate theme</th>
<th>Sub-ordinate theme heading</th>
<th>Sub-ordinate theme</th>
<th>Sub-ordinate theme description</th>
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</thead>
<tbody>
<tr>
<td><strong>Acceptability of routine enquiry about DV in psychiatric settings</strong></td>
<td>Routine enquiry increases clinicians’ awareness of DV</td>
<td>Enquiry can support clinicians in recognising the extent of DV experienced by service users</td>
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<tr>
<td></td>
<td>Routine enquiry facilitates disclosure</td>
<td>Enquiry provides an opportunity for service users to disclose DV, which they would not do if not asked directly by clinicians</td>
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<tr>
<td></td>
<td>Routine enquiry assists clinicians’ identification of contributory factors that worsen symptoms</td>
<td>Enquiry can support clinicians in identifying the relationship between DV and poor mental health outcomes</td>
<td></td>
</tr>
<tr>
<td><strong>Barriers to disclosure of DV</strong></td>
<td>Fear of the consequences of disclosure</td>
<td>Fear of reprisals if abuser hears of disclosure; fear disclosure will be dismissed as part of psychiatric symptomatology; fear of Social Services’ involvement and the implications for child custody arrangements; fear of disruption to family life if relocating; fear of implications of disclosure on immigration status</td>
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<tr>
<td></td>
<td>Hidden nature of DV</td>
<td>The subtle coercive behaviours and degree of manipulation used by the abuser inhibits awareness of DV</td>
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<td></td>
<td>Blaming attitudes</td>
<td>Self-blaming attitudes and blaming attitudes of friends/family place responsibility for DV on the survivor</td>
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<td></td>
<td>Putting DV to the back of the mind</td>
<td>The traumatic nature of DV is too painful to think about and is pushed to the back of the mind</td>
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<td></td>
<td>Shame and embarrassment</td>
<td>Feelings of shame and embarrassment for ‘allowing’ themselves to experience DV</td>
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<tr>
<td><strong>Experiences / expectations of services response to disclosures of DV</strong></td>
<td>Acknowledgement and validation of DV</td>
<td>Need for clinicians to openly enquire about DV and to respond to disclosures in a supportive manner</td>
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<td></td>
<td>Discrimination from services</td>
<td>Perceived or actual discrimination towards mental illness when seeking to engage with mainstream services</td>
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<td></td>
<td>Delivery of support</td>
<td>Positive and negative experiences of receiving support for DV. Need to receive additional support for their complex needs</td>
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5.4 Acceptability of Routine Enquiry of Domestic Violence and Knowledge of Support Services: Service Users’ Views

5.4.1 Dominant Themes for Acceptability of Routine Enquiry
The dominant themes in this analysis concern service users’ acceptance of routine enquiry of domestic violence in psychiatric settings. In order to provide a balanced view of service users’ attitudes towards routine enquiry a purposive sample of participants who had (n=18) and had not (n=6) experienced domestic violence were recruited (see Chapter 4 section 4.6.5 for further details). For the purposes of this analysis, all 24 service user respondents are included. The main dominant interpretive theme for service users was an acceptance of routine enquiry of domestic violence by mental health professionals (see Figure 7).
Figure 7: Conceptual Map of the Acceptability of Routine Enquiry of Domestic Violence among Service Users

- Assists professionals in identifying causes of illness
- Identification of vulnerabilities to violence
- Acceptability of Enquiry of Domestic Violence Service Users Views
  - Facilitates Disclosure
  - Increased professional awareness of abuse
5.4.1.1 Routine Enquiry is Acceptable
All service users, including those who did and did not disclose domestic violence were in favour of routine enquiry of domestic violence by mental health professionals. As can be seen from the conceptual map, service users felt clinicians should ask both male and female service users about experiences of abuse:

*Researcher: Do you think staff should ask all clients about domestic violence?*

Respondent: “As a matter of routine I think they should” (SU12, female, experienced domestic violence)

Respondent: “Yeah. If you are in the hospital the Psychiatrist can come and see you...and ask about what happened and how you feel about it” (SU7, female, perpetrated domestic violence)

Respondent: “Yeah...The reason why I say yeah is because from the moment that you recognise something is wrong with your life you can actually do something about it...or maybe just get information about it” (SU20, male, experienced domestic violence)

5.4.1.2 Assists Professionals in Identifying Causes of Illness
As can be seen from the conceptual map, an important sub-theme described by service users was the capacity for routine enquiry to improve mental health professionals’ identification of factors that contribute to current symptomatology:

“Yeah they should, especially with people with mental health problems because the domestic violence makes the mental health worse...So I think they should ask, that’s the first thing they should do” (SU23, female, experienced domestic violence)
“They [professionals] should look into it a bit more to try and find out the reasons; because you can’t just get sick like that for nothing, there’s a cause” (SU16, female, experienced domestic violence)

5.4.1.3 Identification of Vulnerabilities to Violence
This was linked to a belief that enquiry would increase clinicians’ awareness of the vulnerability to violence experienced by people with severe mental illness:

“I feel they should ask people about domestic violence... because being in the mental health system... you face a lot of violence physically, sexually, financially, emotionally, psychologically” (SU5, female, experienced domestic violence)

5.4.1.4 Increases Professionals’ Awareness of Abuse
Service users also described how the implementation of routine enquiry of domestic violence would increase professionals’ awareness of domestic violence:

Researcher: Do you think staff should ask all clients about domestic violence?

Respondent: “Yes... to help them [professionals] understand what you are going through. Then they can help you, so you can get better” (SU4, male, perpetrated domestic violence)

5.4.1.5 Routine Enquiry can Facilitate Disclosure
A related sub-theme concerns the belief that routine enquiry by clinicians would help to facilitate service users’ disclosure of abuse, by bringing the subject out in the open:

“I think sometimes if you’re not asked it can be like a secret that you don’t talk about... You wouldn’t tell someone else unless they asked you a question... I think sometimes it could be just that little, you know, someone asking the question and, you know, you could release a lot of stuff” (SU17, female, experienced domestic violence)
“I think they should ask, because people can tend to bottle things up a lot of the time...Like if they're going through pain or suffering they bottle it up” (SU18, male, did not experience domestic violence)

As the illustrations above highlight, there was a unanimous agreement among service users that mental health professionals should enquire about domestic violence. Overall, service users were seen to be in agreement about the manner and approach with which clinicians should conduct enquiries into domestic violence, although there were some slight variations in views (as outlined below).

5.4.1.6 Direct Enquiry

All but one of the 24 respondents believed that professionals should ask directly about domestic violence:

Researcher: And how do you think people should ask people about domestic violence?

Respondent: Straight out, ‘are you going through domestic?’ ‘Are you suffering from domestic violence?’ (SU6, female, experienced domestic violence)

There was, however, one respondent who did not feel it was necessary for clinicians to ask directly about service users’ experience of domestic violence:

“I think it would come out in the normal discussions that staff have, I don’t think they should pinpoint or highlight it” (SU15, female, did not experience domestic violence)

This female respondent described having a trusting and supportive therapeutic relationship with her clinician, who regularly encouraged her to discuss any worries or concerns she may have. Consequently, she believed that if she was experiencing domestic violence this discussion would arise as a matter of course during one of their regular meetings.
5.4.1.7 Repetitive Enquiry
A related sub-theme describes service users’ suggestion that clinicians should enquire about domestic violence on more than one occasion. Repeated enquiry by clinicians was believed to facilitate disclosures from service users who may not have found the courage to do so when previously asked:

“The woman I was working with said ‘you really need to talk about some of the things that have happened’...At first I was like ‘no I don’t want to speak to anyone,’ but she coaxed me in to it...and she kept saying ‘once you talk to me you’ll feel better, stop clamming up’. Once I let it out I felt so relieved and I wanted to talk again” (SU24, female, experienced domestic violence)

Linked to this, service users described how regular enquiry would allow professionals to be aware of any changes in the level of violence experienced:

Researcher: Is there anything else that you would like staff in particular to do?

Respondent: “Yeah, to monitor and keep in contact with the person...Monitor them and if it gets too much to get them out safely” (SU3, female, experienced domestic violence)

5.4.2 Dominant Themes for Knowledge of Domestic Violence Services
The dominant themes for this analysis concerned knowledge of domestic violence services among psychiatric service users. The dominant interpretive theme for service users was a limited knowledge of domestic violence services.

5.4.2.1 Limited Knowledge
The majority of service users reported a limited knowledge of domestic violence services. Almost all respondents who had accessed health services reported that they were not provided with information on local/national support services for domestic violence:
“I mean I was never told about Women’s Aid while I was in there [hospital], or what other services were available” (SU10, female, experienced domestic violence)

Linked to this, some service users explained how little information they were given about domestic violence services from mental health professionals:

“I didn’t know where to go at all. So I would like them [professionals] to advertise it...Make it obvious where to go and where to get help” (SU3, female, experienced domestic violence)

A related sub-theme describes service users’ concern about the potential for survivors to experience further harm in the absence of knowledge about support services:

“Unless people are aware of what places will help them, then scenarios and situations could get a lot worse” (SU23, female, experienced domestic violence)

Only two respondents described obtaining adequate knowledge of domestic violence services from professionals during the time they were experiencing abuse:

“I went to the police and they gave me a lot of information” (SU16, female, experienced domestic violence)

In the absence of receiving information from psychiatric services, several service users described sourcing information independently of clinicians:

“I must admit I did mine on my own. I just sort of went to the council said ‘I just needed to get out’. I got a solicitor and it was by no means easy, because at the end of the day it is a traumatic time” (SU17, female, experienced domestic violence)
The experience of receiving little or no information on support services from professionals left many service users feeling unsupported. Some women described how a lack of information on domestic violence meant they were unable to identify the behaviours as abusive:

“It’d be better if they [professionals] spoke about domestic violence to their patients, because I wasn’t aware of it...I didn’t realise that I was a victim of domestic violence till I started reading information on it” (SU16, female, experienced domestic violence)

As a consequence, service users discussed the need for improved professional awareness of support services. They also called for greater advertisements about domestic violence across all health settings; some illustrative points follow.

5.4.2.2 Need for Increased Knowledge

Limited knowledge about domestic violence services was reported to be unhelpful and respondents spoke of the importance of increasing awareness of support services within psychiatric services:

“I would like them to advertise it...They should have places where the domestic violence leaflets are put out...that would be helpful” (SU3, female, experienced domestic violence)

“I think they should have cards and information. Leaflets going to all the community mental health teams, all the centres, all the wards” (SU5, female, experienced domestic violence)

One service user spoke of the need for services to make information available within private areas of a service (i.e. consulting rooms), so that service users can safely obtain information without anyone else seeing:

“To go and pick up a leaflet off the wall, for someone who has got domestic violence, they could be thinking inside that someone is seeing
them picking up the leaflets. So if you’ve got a little packet, may be they can’t even take them home to read them, but may be they can read the packets in the park or somewhere else” (SU17, female, experienced domestic violence)

5.4.2.3 Staff Training on Domestic Violence
A related sub-theme concerned service users’ recommendation for increased training for clinicians on how to respond to domestic violence:

“I think that people involved in the mental health profession should have training about domestic violence. They should definitely know what to do with it” (SU20, male, experienced domestic violence)

5.4.3 Summary of Dominant Themes for Acceptability of Enquiry and Knowledge of Services
The findings from this analysis demonstrate that service users are in favour of routine enquiry about domestic violence. Previous studies in primary care and non-psychiatric health services report similar views among service users, regarding the acceptability of routine enquiry of domestic violence in health settings (as outlined in Chapter 1 section 1.11.2.1). Service users in this study suggested that regular enquiry can assist professionals in identifying traumatic life experiences, which contribute to mental health problems. Enquiry was perceived to be instrumental in facilitating disclosure, particularly from service users who may feel shame and embarrassment about their experiences of abuse. During interviews, service users also identified several factors that may hinder disclosure of domestic violence to health professionals and these findings are discussed in the following section (see section 5.5).

Overall, respondents reported limited knowledge of support services for domestic violence and described how little or no information was provided to them by clinicians. Interestingly, as will be outlined in Chapter 6 section 6.4, professionals also reported a limited knowledge of support services and this may partly explain why they did not provide service users with such information. An absence of information about domestic violence made it particularly difficult for service users
to recognise the extent of the violence and to obtain adequate support to secure their safety. In the absence of advertisements about the nature and impact of domestic violence, some service users described being unable to interpret their experiences as abusive and were, therefore, incapable of making a disclosure of domestic violence (a theme explored in greater detail in the subsequent section). The need for increased knowledge of support services among clinicians is perhaps best exemplified by the fact that almost all respondents experienced severe and often life-threatening attacks before they received information on support services from professionals.

Service users described how a limited knowledge of services was particularly unhelpful and left them without the means to access support, during a period in their lives when they felt it was critical to have additional assistance. Notably, only two service users felt they were given adequate information on support services at the time they were experiencing abuse. As a consequence, many service users described having to source information about support services themselves, and this had the effect of exacerbating feelings of isolation and disinterest from services. Chapter 7 provides a detailed discussion of the above findings.
5.5 Service Users’ Disclosure of Domestic Violence in Psychiatric Settings

5.5.1 Dominant Themes for Barriers to Disclosure of Domestic Violence
For the purposes of this analysis, only the 18 service users who disclosed domestic violence will be included. In the absence of direct enquiry by mental health professionals, only two respondents disclosed their experiences of abuse. These behaviours were not seen to be associated with gender, age, or psychiatric diagnosis by were influenced by service users’ ethnicity and immigration status (see section 5.5.1.1.4 and 5.5.1.10 below). The dominant interpretive theme for barriers to disclosure of domestic violence by service users included: a fear of the consequences of disclosure; the hidden nature of domestic violence, and the dominance of the medical diagnostic and treatment model. A number of sub-themes were identified, including: fear of further violence; fear disclosures will not be believed, and clinicians’ failure to respond to signs of abuse (see Figure 8 below).
Figure 8: Conceptual Map of Service Users’ Barriers to Disclosure of Domestic Violence
5.5.1.1 **Fear of Consequences**

As can be seen from the conceptual map above, fear is an important and multifaceted sub-theme for service users when it is an issue of disclosure of domestic violence. A range of themes were identified, including: fear of Social Services involvement; fear that disclosures would not be believed; fear that disclosures would result in further violence; fear of disruption to family life and fear of the consequences of disclosure for immigration status.

5.5.1.1.1 **Fear Disclosure Will Result in Further Violence**

The most commonly reported fear was a threat of further violence, which was often reinforced through direct threats from the abuser:

> “You’re with a partner that threatens you, like ‘if you say anything you will get this and that’...It puts you into a shell...You’re petrified of going to somewhere because they’re threatening” (SU17, female, experienced domestic violence)

5.5.1.1.2 **Fear of Social Services Involvement**

Female service users who had children reported concerns about the involvement of Social Services. Some were fearful that if social workers became aware their children were exposed to violence they would consider it necessary to remove them from their care:

> “I was just scared that if I told them [professionals] about it and what he [abuser] was really like she [daughter] would end up, getting taken into care...so I’d just always minimize it...I really wouldn’t have wanted to say anything if I thought there was the slightest risk that she might get taken into care” (SU12, female, experienced domestic violence)

Some women also raised concerns that professionals would perceive their current mental health problems as indicative of their inability to be the primary caregiver to their children:
“I used to go to the family centre for a visit and they used to say ‘oh he’s got evidence against you to use’...to say ‘oh she’s mad, she got all these mental health diagnoses’ and social workers ended up believing him more” (SU14, female experienced domestic violence)

5.5.1.1.3 Fear of Disruption to Family
A related sub-theme concerned women’s fear about the impact a disclosure could have on their children’s education, and social networks; due to the upheaval associated with relocating to another area when fleeing from domestic violence:

“A lot of people are scared and it puts them off because you’re thinking you’re going to disrupt a whole family. This is what was putting me off” (SU16, female, experienced domestic violence)

5.5.1.1.4 Fear of Consequences for Immigration Status
One respondent, who had recently immigrated to the UK, spoke of her fears about the impact a disclosure could have on her immigration status:

“Sometimes people hide things and I think people take advantage of people because of their status. That’s why most people, when violence comes, they just keep it to themselves...Some people don’t have status in this country and they’re afraid to tell the police” (SU2, female, experienced domestic violence)

5.5.1.1.5 Fear Disclosure Will Not Be Believed
Fear that disclosures would not be believed by professionals was described by some respondents, who were concerned disclosures would be dismissed as a component of their mental illness:

“They [professionals] just blame it on me...‘nothing happened to her, it’s all in her mind’ but I was badly beaten” (SU5, female, experienced domestic violence)
5.5.1.2 Dominance of the Medical Diagnostic and Treatment Model

A related sub-theme (also identified in professional narratives, as described in Chapter 6 section 6.5.1) concerns the dominance of the medical diagnostic and treatment model, which describes the tendency for professionals to concentrate solely on managing mental health symptoms. Service users described the tendency for clinicians to concentrate primarily on managing current symptomatology and to overlook the impact that personal factors have on current mental health well-being:

“They’re [professionals] more interested in your symptoms, your mental health problems. They don’t look into your personal life and I think sometimes they need to do that” (SU16, female, experienced domestic violence)

“It would be ‘well here’s an antidepressant to help you get through...Here’s a tablet to help you sleep. Try eating better.’ There was never any talking about it [abuse]” (SU24, female, experienced domestic violence)

5.5.1.3 Hidden Nature of Domestic Violence

Another important and multi-faceted theme was the hidden nature of the abuse, which was seen to create barriers to disclosure of domestic violence. A range of themes were identified, including: service users’ difficulties in recognising the abuse; abusers actions to disguise the abuse, and professionals’ failure to respond to signs of abuse.

5.5.1.3.1 Not Realising This is Abuse

This theme describes how the subtle coercive nature of the violence and the manipulative actions of the abuser hindered some service users’ ability to recognise the abuse:

“With domestic violence, the way that they [abuser] work is that you’re not supposed to know you’re being abused and you come to believe it” (SU22, female, experienced domestic violence)
It is interesting to note that although almost all of the 16 female respondents who experienced domestic violence described subtle coercive violent behaviours from their abuser, only six women described difficulty in identifying these behaviours as abusive at the time. These six women, in contrast to many other respondents, did not have previous experiences of violence or abuse prior to the domestically violent relationship. A detailed exploration about differences in understanding of domestic violence among service users is described in section 5.7 of this chapter.

5.5.1.3.2 Abuser Disguises Abuse
Several service users also described occasions when abusers would attempt to disguise their use of violence to professionals:

“The other thing with him [abuser] was that as soon as anybody in uniform turned up he was good as gold...He’s got his little halo on ‘nothing to do with me officer, I haven’t done anything’” (SU12, female, experienced domestic violence)

5.5.1.3.3 Professionals’ Failure to Respond to Signs of Abuse
One respondent described how mental health professionals failed to identify signs of violence when making home visits to assess their current mental health status:

“I think they [professionals] need to look in to it a bit more...My first community psychiatric nurse, him [abuser] and my daughter put her out of the house...They should think ‘what’s going on there? There’s something drastically wrong when that’s happening’, but they didn’t” (SU16, female, experienced domestic violence)

5.5.1.4 Blaming Attitudes
A further cluster of sub-themes concerned blame relating to the abuse, including self-blame by service users and blaming attitudes of others. Service users described how abusers would deny their violent behaviour and/or blame them for causing the violence:

“No I couldn’t tell them, I couldn’t face it at the time because they blame
you [abuser] and you think you’ve done wrong, so you can’t talk to people” (SU1, female, experienced domestic violence)

“They’ve got this thing where they [abusers] won’t admit they have the problem...It becomes your problem and you really feel it’s you. The more they hit you...you convince yourself it’s you. I convinced myself ‘look this is the third violent relationship I’ve had, it can’t be them it must be me, it must be something I’m doing wrong’” (SU24, female, experienced domestic violence)

5.5.1.4.1 Self-Blame
The above examples illustrate how abusers’ attempts to relinquish all responsibility for the violence had the effect of fostering self-blaming attitudes among service users. These feelings were often exacerbated by blaming attitudes of family and friends:

“There’s always that victim blame ‘oh she must be weak to put up with it, why did she let it happen?’ Or ‘she doesn’t leave’” (SU14, female, experienced domestic violence)

5.5.1.5 Shame and Embarrassment
Unsurprisingly, the response of friends and family members was linked to feelings of shame and embarrassment:

“I didn’t want to be seen as weaker than anybody else...they would see me as not standing up for myself” (SU14, female, experienced domestic violence)

5.5.1.6 Abusers Actions to Prevent Disclosure
Service users talked about abusers’ actions to prevent disclosure to health professionals, by ensuring that they were present at all health visits and could, therefore, monitor what they discussed with clinicians. The following illustration also highlights how some abusers attempted to discredit any future disclosures, by
seeking to convince health professionals that service users were not of sound mind and judgement:

“*I was taken to the GP. I’d initially gone in to see the GP on my own and he burst in to her office and started telling her ‘oh she’s taken overdoses, she’s done this, she’s done that’*” (SU10, female, experienced domestic violence)

### 5.5.1.6.1 Isolating Friends and Family

Linked to this, service users talked about abusers’ actions to isolate them from friends and family:

“*I’ve been isolated from family and friends…I’d make friends with people and then he’d phone them up and tell them not to call this number again*” (SU16, female, experienced domestic violence)

### 5.5.1.7 Psychological Distress

Some service users described how psychological distress, which arose as a direct consequence of the violence experienced, made disclosures impossible:

“They [professionals] were asking me if I was OK, if anybody was harassing me or if I was being stalked but by then things were getting out of hand and I didn’t even know who to trust or who to talk too, so I locked everything up inside me” (SU5, female, experienced domestic violence)

This level of psychological distress propelled some service users to compartmentalise the violence and place it out of conscious awareness:

“No I couldn’t tell them, I couldn’t face it at the time…I didn’t want to go to victims support because I didn’t want to discuss it…I wanted to forget it, you know, get rid of it” (SU1, female, experienced domestic violence)
5.5.1.8 Putting Abuse to Back of Mind

A related theme describes how some female respondents reported actively avoiding thinking about the abuse and felt it was necessary to put these thoughts to the back of their mind in order for their survival:

“I didn’t want to talk about any violence and I tried to put it to one side and be strong kind of thing” (SU23, female, experienced domestic violence)

5.5.1.9 Gender

Some service users talked about the influence of gender on a willingness to discuss experiences of domestic violence. One male respondent identified this as a key barrier to disclosure:

“I’m a man so I haven’t told them nothing about it…I’d not relay it all to somebody” (SU19, male, did not experience domestic violence)

5.5.1.10 Culture

Culture was also felt to influence disclosure of domestic violence by service users. Some respondents described the impact of cultural attitudes towards gender roles and views about the discussion of intimate relationships in the public domain in shaping decisions to disclose domestic violence:

“The main issue is the women who are covering it up, they’re the ones who are going to be hard to reach. A lot of Muslim Asians are getting abused in certain ways but they’re not going to tell you and you’re not going to see that because it’s against their religion. Even in a West Indian culture it’s a similar thing, Jamaican culture, you know, their men are meant to be superior to the women” (SU11, female, experienced domestic violence)

The themes gender and culture were also found in the data from professionals’ narratives (Chapter 6 section 6.5.1).
5.5.1.11 No Reported Barriers

Only one of the 18 service users did not report any barriers to disclosure of domestic violence, as illustrated below:

Researcher: “At any time that you’ve been to a centre have you ever felt that you couldn’t tell staff anything?”

Respondent: “I don’t think so. I think I’ve always been able to speak about things. I think I’ve always wanted to” (SU23, female, experienced domestic violence)

This respondent was one of 13 service users who also disclosed experiences of childhood abuse but in contrast to the other respondents she received positive early intervention from services. At the time when she was experiencing childhood abuse, child protection services took the decision to temporarily remove her from the violent family home. She was subsequently placed in a children’s home, which she described as a positive experience and during her stay established a good relationship with the staff. When experiencing domestic violence this respondent reflected on her positive experience of input from services as a child and this encouraged her to seek help from services as an adult. Indeed, she took the decision to leave the violent relationship and to return to the supported accommodation unit that she had been placed in as a child:

“I got depressed and I wasn’t happy where I was living...so I thought maybe if I went there, where I’ve got support it would be better...so I got to Scotland and I stayed in the home where I grew up” (SU23, female, experienced domestic violence)

The above illustration highlights how previous positive engagements with services can influence service users’ willingness to seek future assistance. For this respondent, and several others, the importance of engagement between clinicians and service users was considered to be paramount in facilitating disclosures. This theme, along with others is described in detail in the following section.
5.5.2 Dominant Themes for Facilitators to Disclosure of Domestic Violence

The dominant interpretive theme for facilitators to disclosure of domestic violence was the importance of therapeutic engagement between clinicians and service users. A number of sub-themes were identified for factors that can trigger disclosure, including the severity of violence experienced.

5.5.2.1 Importance of Engagement between Service Users and Clinicians

Service users described how a trusting and supportive therapeutic relationship between themselves and clinicians was important in facilitating disclosures and exploration of experiences of abuse:

“Some people might not be able to talk about it but if their social worker is asking them, asking them in a nice way, in a gentle way...making sure that there is good contact between them then one day they will open and say ‘look this is happening to me’” (SU5, female, experienced domestic violence)

Therapeutic engagement is generally conceptualised as something that developed over time, but there was an example of a service user immediately ‘hitting it off’ with a clinician:

“I was having counselling...I did discuss certain things but it's not in detail like when I’ve actually told *name of care coordinator*…He must have been about the only person who has really got a lot out of me, which is terrible because he's got like five pages in like the short time that I met him” (SU11, female, experienced domestic violence)

5.5.2.2 Direct Enquiry

As illustrated in the previous section (see section 5.4), direct enquiry from clinicians about domestic violence was reported to encourage disclosure:

“I feel they should ask because a lot of people don’t come out and tell...If I was asked I would tell them...They [professionals] shouldn’t feel
uncomfortable, they should be asking because some people just suffer in silence” (SU3, female, experienced domestic violence)

5.5.2.3 Triggers Encouraging Disclosure

Service users reported incidents that sought to trigger their disclosure of domestic violence, including the severity of violence experienced and traumatic reminders of abuse; as outlined below.

5.5.2.3.1 Severity of Violence

Severity of violence was an important sub-theme for service users, in relation to triggering disclosures. Almost all service users described that it was the increasingly violent nature of the abuse, making them fearful for their life, which led to a disclosure:

“I left a statement at the police station. I got him nicked because I had internal bleeding” (SU1, female, experienced domestic violence)

Researcher: Have you ever spoken to any health professionals about it?

Respondent: “Yes because I was attacked, I was attacked very badly” (SU5, female, experienced domestic violence)

5.5.2.3.2 Traumatic Reminders

Some service users talked about instances when, following separation from the abuser, they were reminded of the traumatic nature of their experiences and the psychological distress associated with these memories triggered a disclosure:

“Well at the time...there was a bit on the telly; I got a bit depressed actually...Watching it brought back all that happened to me...and I had to go on an antidepressants” (SU1, female, experienced domestic violence)
5.5.3 Summary of Dominant Themes for Barriers and Facilitators to Disclosure

Service users identified several barriers to disclosure of domestic violence; in the absence of direct enquiry only two female respondents disclosed to clinicians at the time they were experiencing abuse. These results support those presented in Chapter 1, which showed that in the absence of direct enquiry from clinicians service users generally do not disclose abuse. Women in this study feared that if they disclosed to health professionals the abuser might come to know this and they could be at increased risk of violence. A fear of Social Services involvement was described by mothers, who raised concerns that their parenting skills may be called in to question in light of their mental health problems. Furthermore, service users described fears that disclosures would be dismissed by services, who would interpret this as part of their current mental health symptomatology.

Abusers’ actions to disguise and minimise their use of violence, to isolate friends/family and to blame respondents for their behaviour fostered a belief among many that they were solely responsible for the abuse. Service users’ mental illness was exploited by some abusers, in an attempt to undermine and discredit any disclosures of abuse that service users may make. It is noteworthy that the subtle coercive nature of domestic violence meant that some service users struggled to recognise the behaviours as abusive. This understanding of domestic violence will be explored in more detail in the final section of this chapter.

Some service users reported that a dominance of the medical diagnostic and treatment model resulted in a lack of opportunity to explore issues of violence and abuse with professionals. This important theme was also highlighted in service users’ descriptions of their experiences and expectations of the response of services to domestic violence (see section 5.6).

A trusting and supportive therapeutic relationship was described as an important factor in facilitating disclosures of domestic violence. Similarly, direct enquiry was considered to be significant in facilitating disclosures and in preventing an escalation in the severity and impact of violence experienced by service users.
5.6 Service Users’ Experiences and Expectations of the Response of Services to Domestic Violence

5.6.1 Dominant Themes for Experiences and Expectations
For the purposes of this analysis, only the 18 respondents who disclosed domestic violence will be included. Three key stages in help-seeking experiences were pinpointed: (1) Identification, including the sub-themes acknowledgement and receptiveness of professionals, and the dominance of the medical diagnostic and treatment model; (2) Engagement and Access, including sub-themes discrimination, support for multiple needs, and knowledge of options; and (3) Service Delivery, including the sub-themes delivering support, multi-agency collaboration, and specialist services.

Thematic analysis identified some variation with regards to service users’ contact and engagement with services; these differences were not seen to be related to gender, age, ethnicity or psychiatric diagnosis. Three of the 18 female respondents decided not to establish contact with formal support services, and the two male respondents described experiencing difficulty in engaging with services. All other respondents described some contact and engagement with formal services, however, their perception of the level of support provided, and the effectiveness of services’ response was seen to differ. The dominant interpretive themes will now be described in detail below (see Figure 9).
Figure 9: Conceptual Map of Service Users’ Experiences and Expectations of Services Response to Domestic Violence

- Acknowledgement and receptiveness
- Dominance of the medical model

Engagement and Access

- Discrimination
- Support for multiple needs
- Knowledge of options

Identification

Service delivery

- Delivering support
- Multi-agency collaboration
- Specialist services
5.6.1.1 Identification of Domestic Violence
5.6.1.1.1 Acknowledgement and Receptiveness

As can be seen from the conceptual map above, the theme acknowledgement and receptiveness describes service users’ experience of clinicians’ recognition of abuse and initial responses to disclosures. Some service users described receiving encouragement from clinicians to discuss their experiences, which provided a supportive therapeutic space in which to explore their feelings and emotions surrounding the abuse:

“The woman [professional] said ‘you really need to talk about some of the things that have happened,’ and I just sort of broke down and let everything out. I felt so relieved when I did…I wanted to talk again when I saw her the next week” (SU24, female, experienced domestic violence)

Many, however, reported that although mental health professionals were aware of their experiences of abuse they did not acknowledge it:

“They [professionals] were all aware that it had happened but they never asked me anything” (SU3, female, experienced domestic violence)

Linked to this, some service users described that professionals were not receptive to their disclosures of abuse and this led them to believe that little support was available:

“I saw this psychiatrist...He [professional] said ‘I'm really sorry...you need to put the lid on this can of worms’...That really destroyed me” (SU17, female, experienced domestic violence)

“It’s not something people want to talk about...I mean I’ve run out of options, because no one wants to listen to me anymore” (SU11, female, experienced domestic violence)

In light of these responses, many service users discussed the importance of receiving validation from clinicians about their experiences of abuse:
“I mean getting validation is very important and recognising that you are being abused and not feeling responsible anymore is huge” (SU22, female, experienced domestic violence)

5.6.1.2 Dominance of the Medical Model
The dominance of the medical model describes service users’ perceptions that clinical assessments have an overriding focus on mental health symptomatology, which consequently ignores the trauma associated with abuse:

“There was never any talking about the abuse. It was just ‘these are for your depression, these are sleeping tablets’...Again, you know, more tablets...‘here’s a valium to calm you down’...but that’s it” (SU24, female, experienced domestic violence)

This theme was also reported with regards to service users’ barriers to disclosure of domestic violence (as highlighted in section 5.5.1).

5.6.1.2 Engagement and Access to Support Services
5.6.1.2.1 Discrimination
As highlighted in the conceptual map, the theme Engagement and Access describes service users’ experiences of gaining access to and engaging successfully with support services. Several service users described how their mental health problems were potentially stigmatising and could lead to discrimination. Some anticipated that they would be refused access from services, because of discriminatory perceptions about severe mental illness, while others described experiencing actual discrimination from services:

“I didn’t mention when I first went to Women’s Aid that I had mental health problems, otherwise they wouldn’t have accepted me” (SU10, female, experienced domestic violence)

“I called the police but because I told them I had a mental health problem they weren’t interested” (SU5, female, experienced domestic violence)
The two male respondents described experiencing discrimination from services when seeking support for domestic violence. They explained that when reporting incidents of violence to the police they were arrested as the sole perpetrators of abuse. They felt that no recognition was given to their experiences of domestic violence:

Researcher: “Those times when you called the police did they give you any advice?”

Respondent: “No…the police, all they do is arrest me…They lock me flipping up”

Researcher: “Even when you called them out?”

Respondent: “If I call them out or not. Yeah, I’ve called them out before and they do the same thing, they lock me up” (SU19, male, experienced domestic violence)

5.6.1.2.2 Support for Multiple Needs
Several service users spoke of the difficulties encountered in accessing services due to the co-occurrence of mental illness and violence:

“The sad irony of it is when you’re really in need of support the thought of being able to go to the benefits office, let alone wanting to, you just can’t when you’re ill. That’s for people who are well” (SU22, female, experienced domestic violence)

“I was told to go to Social Services and to change my benefits…There’s no one that really helps with that side. If you’ve got mental health problems it’s ten times worse because you can’t function properly anyway and having to deal with it [overcoming the abuse] all alone, it’s really, really hard...There should be more places...for that extra support” (SU24, female, experienced domestic violence)
Building on this, some female respondents described difficulties in maintaining adequate support for their mental health needs following relocation to another area, after fleeing from domestic violence:

“I went to register with the GP and was told that they have to get my records sent over, which takes time…You have to wait for the psychiatric team to get in touch with the GP and that takes up to three months…In that time you’re just left to deal with your depression; there’s no support” (SU24, female, experienced domestic violence)

Consequently, they called for services to provide additional support for their multiple needs:

“Just having support that’s the most important thing, because people don’t realise what their options are…They [professionals] need to take it more seriously…If you’re not very well it’s difficult to do these things on your own, and if you’re traumatised as well with domestic violence you need a lot of support” (SU16, female, experienced domestic violence)

“To leave my abuser and to go into a house; I did that all off my own back…If they [other survivors] had someone that they could link up with, like a support worker, to take them to these places…to be a support to that person, that would help them get through it” (SU17, female, experienced domestic violence)

5.6.1.2.3 Knowledge of Options

Service users spoke of the value of receiving information from services about sources of support, which assisted them in identifying their options in responding to the abuse:

“I remember once when I was in A&E, after I’d broken my foot trying to escape from the flat, being given some information about domestic violence…I didn’t disclose the abuse at the time but the doctors and nurses could see it in my face…It was such a turning point for me, reading that information and taking in the aspects of domestic violence…That was
Many service users described that mental health professionals had a limited knowledge of domestic violence services, and in the absence of receiving information from staff they remained unaware of the support available:

“It’s later I found out that, just up the road, they have got a place where women can go if they have been attacked and stuff. They [professionals] didn’t know anything about things like that” (SU5, female, experienced domestic violence)

5.6.1.3 Service Delivery

5.6.1.3.1 Delivering Support

As can be seen from the conceptual map, the theme Service Delivery describes service users’ experience of receiving support from professionals. Some service users described receiving on-going assistance from clinicians in supporting their needs related to the abuse:

“I went to his [abuser’s] community psychiatric nurse and they did help…I did get told what your rights are and was passed on to solicitors and they helped with all that. They were very supportive” (SU3, female, experienced domestic violence)

“My community psychiatric nurse and the psychiatrist stood behind me and stuck up for me and said that actually I was a good mother; because of that we ended up in an arrangement where she [daughter] spent weeks with me and weekends with him…If they’d said that I wasn’t a good mother then I would have lost her completely.” (SU12, female, experienced domestic violence)

Several others spoke of a failure of professionals to deliver on the support that was offered:
“They’ve got all these things in place but it never really materialises in to anything” (SU16, female, experienced domestic violence)

“There to be an understanding that if they [professionals] asked about it they also have to be prepared to offer after care” (SU14, female, experienced domestic violence)

The potential impact of this lack of support in influencing survivors’ decision to return to the abusive relationship was highlighted by some respondents:

“I think there should be more of a support network…You’re told basically to just to get on with it…I can really understand why a lot of women don’t get out, or why a lot of women go back, because there is no support” (SU24, female, experienced domestic violence)

Three female service users who disclosed domestic violence declined assistance from support services. In contrast to the other female respondents, these women described occasions when they had used physical violence against their abusive partner. These actions led the women to conclude that they were able to manage the violent situation and therefore did not require input from formal support services.

“As I said I didn’t see myself as a battered wife, because I fought back…I thought I was tough enough to deal with it” (SU11, female, experienced domestic violence)

5.6.1.3.2 Multi-Agency Collaboration
Some service users also described the need for improved collaboration between domestic violence and psychiatric services, in order to effectively support their mental health and trauma needs:

“When you go into refuges you have to wait for all this paperwork to come through…Until your records arrive they can’t put you down for counselling…You have to wait for the psychiatrist to get in touch with the
GP and that takes up to three months...so they haven’t got any proof of what you’re going through...It’s far too long” (SU24, female, experienced domestic violence)

“I only wish that when I had gone in to hospital they’d said ‘okay, we know what’s going on, we’re going to refer you to domestic violence services and with their help and the mental health teams we’re actually going to help you to find a place away from him.’ That would have been a great help” (SU10, female, experienced domestic violence)

5.6.1.3.3 Specialist Services
Finally, service users spoke of the necessity to develop specialist services that support the specific needs of people experiencing violence and mental illness:

“You need special victims support for people with mental health problems. You don’t need those run of the mill services” (SU5, female, experienced domestic violence)

5.6.2 Summary of Dominant Themes for Experiences and Expectations of Services
Service users reported both positive and negative experiences with regards to the response of services to domestic violence. These experiences are similar to those reported by primary care and non-psychiatric health service users (see Chapter 1 section 1.11.3.1). Service users in this study reported positive experiences, including a response from professionals that acknowledged their experiences of abuse and was receptive to their disclosures. Service users also described the usefulness of receiving on-going support from clinicians. Service users spoke of the need to receive information about domestic violence services and for professionals to facilitate discussions of abuse (the latter theme was also identified earlier in this chapter (see section 5.4). Negative responses from services included the dominance of the medical diagnostic and treatment model, which meant the traumatic nature of service users’ experiences of abuse were overlooked, or were framed solely within a psychiatric medical model. This
theme was also identified by mental health professionals (as will be outlined in Chapter 6 section 6.6.1).

Several service users in this study described experiences of discrimination, including rejecting and blaming attitudes from professionals. The two male service users felt that, during their contact with police services, their experience of domestic violence was ignored entirely. As outlined in the previous section on barriers to disclosure (see section 5.5), dismissive and rejecting attitudes from services may further increase service users’ feelings of self-blame and shame and can have the effect of silencing disclosures. Service users proposed that in order for psychiatric services to improve responses to domestic violence they should seek to establish collaboration with the domestic violence sector. Furthermore, they called for the development of specialist services to ensure that mentally ill people experiencing domestic violence can gain access to support and receive appropriate care. These latter findings align with those reported by mental health professionals (see Chapter 6 section 6.6.1). A detailed discussion of the above findings is presented in Chapter 7.

Interestingly, three women in the sample described physically retaliating against their abuser during periods of violence and this response led them to perceive that they had control over the situation. Consequently, these women did not consider seeking help from services and believed that support from formal services would not be necessary. Explanations for this type of understanding of domestic violence, and others, will be explored in more detail in the following section.
5.7 Service User Typologies of ‘Understanding of Domestic Violence’

5.7.1 Typologies Identified in the Narratives of Service Users

This section presents findings from a constant comparative analysis of the narratives of the 18 service users who disclosed domestic violence. Through detailed analysis, both within and between cases, service users’ willingness to disclose abuse and engage with services was seen to be influenced by their understanding of domestic violence. The dominant interpretive theme identified in service users’ narratives was an ‘understanding of domestic violence’. The analysis revealed distinct categories in relation to service users’ understanding of domestic violence, which for the purposes of this analysis have been classified as separate typologies.

When setting out distinct categories of service users’ understanding of domestic violence there is a danger of homogenising narratives and ascribing to them a degree of coherence that is lacking (Morgan, 2003). However, this form of categorisation allows for the complex experiences of respondents to be summarised and compared in a way that captures all instances of variation within the emerging theory (Willig, 2008); as described below.

Service users in this study described three different types of individual-level understandings of domestic violence, which I have been categorised as follows: (1) accountable, (2) vulnerable, and (3) unknowing. All three typologies were contained within a higher, societal-level category, which I have categorised as: ‘accepting’ (see Appendix 13 for typology tables). The societal-level category was present within each of the three individual-level typologies and was a critical component in shaping respondents’ understanding of domestic violence. This category was seen to transcend personal understandings of domestic violence and instead represents a societal-level of understanding of domestic violence (see Figure 10 below).
Figure 10: Conceptual Map of Service User Typologies of Understanding of Domestic Violence

Societal-Level

Accepting

Individual-Level

Accountable

Vulnerable

Unknowing
What became clear from analysis of service user narratives was the impact of previous experiences of violence in shaping understandings of domestic violence. Some individuals who had experienced previous violence, either as a child or an adult, explored how these experiences rendered them ‘vulnerable’ to further abuse, as they sought attachments with individuals who displayed abusive and exploitative behaviours. A few respondents explored how their experience of childhood abuse led them to externalise violent behaviours, which they subsequently employed in response to conflict within their adult intimate relationships. These respondents described how their own use of violent behaviours in response to conflict made them somewhat ‘accountable’ for the violence. In contrast, those respondents who did not disclose previous experiences of abuse described difficulty in identifying the abusive behaviours perpetrated against them. In the absence of previous experiences of violence, from which to draw comparisons, and in response to the abusers’ subtle coercive behaviours, they described remaining ‘unknowing’ as to the true nature of the violence perpetrated against them (see Table 6 below).
Table 6: Results from a Constant Comparative Analysis of Service Users’ Narratives

<table>
<thead>
<tr>
<th>Super-ordinate theme: Service Users’ Understanding of Domestic Violence (DV)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sub-ordinate theme headings</strong></td>
</tr>
<tr>
<td>Accountable</td>
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<td>Vulnerable</td>
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<td></td>
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<tr>
<td>Unknowing</td>
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<tr>
<td>Social acceptance</td>
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</table>
The three individual-level typologies of understanding of domestic violence were not seen to be related to specific mental health diagnoses, gender, ethnicity or age of participants (see Table 7 below).

### Table 7: Demographic Details of Service Users: Categorised by Service Users’ Understanding of Domestic Violence

<table>
<thead>
<tr>
<th>Typology Characteristics</th>
<th>Accountable (n=4)</th>
<th>Vulnerable (n=8)</th>
<th>Unknowing (n=6)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian, female, adjustment disorder</td>
<td>white British, female, psychoactive substance abuse</td>
<td>white British, female, bipolar disorder</td>
<td></td>
</tr>
<tr>
<td>black British, female, Bipolar disorder</td>
<td>white British, female, bipolar disorder</td>
<td>white British, female, depressive disorder</td>
<td></td>
</tr>
<tr>
<td>black Caribbean, female, depressive disorder</td>
<td>white British, female, borderline personality disorder</td>
<td>white British, female, schizophrenia</td>
<td></td>
</tr>
<tr>
<td>European, male, depressive disorder</td>
<td>white British, female, no diagnosis assigned</td>
<td>white British, female, schizophrenia</td>
<td></td>
</tr>
<tr>
<td></td>
<td>black Caribbean, female, depressive disorder</td>
<td>white British, female, bipolar disorder</td>
<td></td>
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<tr>
<td></td>
<td>black African, female, Bipolar disorder</td>
<td>mixed race, female, depressive disorder</td>
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<tr>
<td></td>
<td>Latin American, female, depressive disorder</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>black Caribbean, male, bipolar disorder</td>
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</tbody>
</table>

This section will describe and discuss each typology in detail and explore their similarities and differences. Discussions will concentrate on how service users’ understanding of domestic violence shaped their willingness to disclose abuse and engage with services.

#### 5.7.1.1 “Both As Bad As Each Other”: Accountable

The four service users in this category (one man and three women) make up some of the 11 respondents reporting both childhood abuse and domestic violence. These respondents described how their modelling of violent behaviours in the childhood home determined the behaviours they used within their adult intimate relationships. These respondents explained how they learnt to model the violent behaviours they were exposed to as a child, which had the effect of fostering a belief that violence was a legitimate response to conflict. Consequently, this belief shaped their understanding of domestic violence and respondents described
how their own use of violence in response to the abuse from their partner led them to conclude that they were equally ‘accountable’:

“Sometimes I would start the fight and then I think to myself ‘is it because my brother used to try to discipline me when I was younger and I felt that was the correct way?’...That it made me think that was the right way, when you are angry or when someone has done something wrong, to smack them” (SU6, female, experienced domestic violence)

“I’ve been on the receiving end of being hit and I’ve also hit someone as well...I think again it came from my own family background...I was quite angry...The person [abuser] used to wind me up quite a lot...Looking back on it, I can’t believe I actually did that” (SU13, female, experienced domestic violence)

Despite this perception, women described experiencing severe physical violence and emotional abuse from their intimate partners:

“I’ve got a scar on the back of my neck where he pushed my head through the kitchen window...We used to argue a lot and it would lead in to fights and I would always end up getting hurt” (SU6, female, experienced domestic violence)

“You’re always getting told that ‘you’re never going to get anyone who loves you like me’ or ‘you are never going to get someone who looks after you like me’...You don’t need to hear that, it knocks your self-esteem...You think ‘who wants me?’...I felt really bad because...the pressure in my life was just too much” (SU11, female, experienced domestic violence)

Service users in this category described how the repetitive nature of their violent experiences (from childhood to adulthood) was critical in shaping their understanding of domestic violence:
“We’ve been around a lot of violence in my life...I’m living in this dirty little circle, which I’m trying to avoid...It’s constantly all the time, and it’s gone from my parents to my relationship, to my children. So, yeah, it’s got to stop” (SU11, female, experienced domestic violence)

The narrative of one female service user in this category described a continual shift in her understanding of domestic violence, with regards to her own use of violence and the violence perpetrated against her. She began by describing herself as equally ‘accountable’ for the violence, because she also engaged in physical violence:

“May be my friends were thinking ‘oh no you are a battered wife.’ No I was not a battered wife, I used to fight him back. So we were both as bad as each other” (SU11, female, experienced domestic violence)

Yet, at other points during the interview she perceived her own response to the violence far less confrontational than previously described:

“I’m not saying some women don’t go around battling men, but I just wasn’t one of those people; maybe I should have been” (SU11, female, experienced domestic violence)

The one male respondent in this category also described a shifting understanding about his experience of violence. His narrative begins by describing how the experience of growing up in a violent environment led him to react violently in response to conflict as an adult:

“I feel like I’m paying the price of my childhood experience from my parents...All this is kind of baggage that manipulates me at the end in to violence. I don’t want it to, and as soon as I realise, which is a split second after it happens, I feel really bad about it” (SU20, male, experienced domestic violence)
A theme unique to the male respondent was a description of how fears of abandonment triggered his violent tendencies in adult intimate relationships:

“I realise now that the way I was dealing with her was wrong...It was very important for her to have her own space and own friends, to be able to go in, and out, and I would perceive that as she wanted to leave me; she wanted to abandon me, so I would try to restrain her” (SU20, male, experienced domestic violence)

The male respondent did identify himself as a survivor of violence and described how both he and his partner acted out violently, because they were re-enacting past traumas experienced in childhood:

“I think that you, kind of, choose your partner to recreate the situation that traumatised you so much as a child...She had a very abusive childhood, so I definitely think that she kind of recreated it, because I wanted none of it, and she was physically abusive towards me...My problem is that I wish I could be better in stressful or difficult situations. Instead, because of my experience of domestic violence during childhood...I am not able to and I need to work it out” (SU20, male, experienced domestic violence)

5.7.1.1.1 Summary of Typology
As was discussed in section 5.6 of this chapter, service users’ use of violence in domestic violence relationships influenced their experience of disclosure and contact with services. The three female respondents in this category shared a perception that they were equally ‘accountable’ for the violence, because they employed violent means in response to conflict. Consequently, they did not view themselves as victimised and did not consider disclosing their experiences, or engaging with services that support abused people.

The male respondent in this category described using violent tendencies in response to conflict which, like the female respondents, he attributed to modelling of violent behaviours witnessed during childhood. Although he explicitly
identified himself as a survivor of violence, something that the female respondents had difficulty doing. The male respondent described that both survivors and abusers are acting out past traumas through conflicts in intimate relationships. Despite this difference in understanding, the male respondent also did not disclose his experiences of abuse and chose not seek support from domestic violence services. One reason for this may have been that during periods of conflict when his partner called out the police he would be arrested as the sole perpetrator of violence (see section 5.6).

5.7.1.2 “I Was Vulnerable”: Vulnerable

The eight service users in this category (seven women and one man) described how their understanding of domestic violence was shaped by their experience of previous violence (including witnessing violence in childhood), mental illness or insecure immigration status. Service users described how these experiences rendered them ‘vulnerable’ to domestic violence, as they were targeted by abusive individuals who sought to exploit these vulnerabilities. These vulnerabilities were felt to be due to personal characteristics (i.e. experience of mental illness) or situational factors (i.e. immigration status), as illustrated below.

Service users in this group, who disclosed childhood abuse, described how these experiences led them to be exposed to situations of increased risk of harm. Service users reporting previous experiences of violence in adulthood (e.g. multiple violent intimate relationships) questioned their strength of character and were concerned that intimate partners may identify and target these insecurities. In relation to service users’ previous experiences of mental illness, many described how certain feelings and behaviours associated with the illness left them ‘vulnerable’ to exploitation by others. Finally, one female respondent described how her experience of insecure immigration status shaped her understanding of domestic violence.

5.7.1.2.1 Previous Experience of Violence

Service users in this category described how their experience of previous violence rendered them ‘vulnerable’ to abuse. Childhood experiences of violence were seen to be critical in shaping respondents’ experiences of domestic violence, in
one of two ways. As young teens, respondents took the decision to either: (1) run away from the childhood home, or (2) leave the childhood home to cohabitate with an intimate partner. The first response (to run away from the family home) was most commonly reported, as service users took the decision to abscond from the family home in an attempt to escape the violence. Alone, and with a lack of material resources and social support, several respondents soon found themselves homeless. Their experience of being homeless, alongside their young age, resulted in an understanding that they were ‘vulnerable’ to exploitation, because the severe privation experienced while homeless led them to form attachment bonds with individuals who sought to exploit their vulnerability:

“I was young, I was homeless, I’d run away from home. I was only in that relationship because I was very vulnerable at that time, and the man knew I was vulnerable” (SU5, female, experienced domestic violence)

“That bad experience that happened to me, while I had run away, I blame it on my mum, because if she had never treated me the way she treated me then I would not have run away” (SU21, female, experienced domestic violence)

Respondents who took the decision to leave the family home and cohabitate with an intimate partner were driven by the same motivations as those exampled above, primarily the need to escape violence within the family home. The naivety of their youth and the strong desire to receive affection (something almost absent in the family home) led them to form close attachments with people who displayed abusive tendencies. As can be seen in the illustrations below, the strong desire to escape the childhood home took precedence over service users’ awareness of the inappropriate behaviours displayed by their intimate partner:

“I think I kind of leant on him [abuser] when I first met him, to get away from my mother...I think I looked at him as a scapegoat...I was just so naïve at the time and I just wanted my own little family and I would have stayed with him forever if he hadn’t started hitting me” (SU23, female, experienced domestic violence)
What is clear from the narratives above is how the experience of trauma in childhood evoked self-protective mechanisms among respondents, which sought to aid survival by seeking security through attachments to others. As was the case in the childhood home, these new attachments soon became characterised by abuse.

Some service users in this category also described how their experience of repeat domestic violence as an adult led them to observe feelings of a weakness of character. This theme was identified in the narratives of several women who believed that their display of physical and emotional weakness encouraged violence from their intimate partner. They perceived that disclosing experiences of previous violence to a new intimate partner might encourage the new partner to use violent behaviours against them:

“I know they’re [abuser] the ones doing it, but I wonder ‘do I reflect myself as weak when I go into the relationship?’ Through the first lot of violence, which was quite bad, has that left a thing with me, whereby when I go in they can see it in the relationship, they can see how weak I am?...There’s no excuse for them hitting you but I think I showed I was weak around him, so he probably thought well I can take advantage of this” (SU24, female, experienced domestic violence)

“I think once you’re a victim in life, by domestic violence, once they know someone has done it, then they will also think they’ve got the right to abuse you” (SU14, female, experienced domestic violence)

5.7.1.2.2 Experience of Mental Illness
Some service users in this category also spoke of how their experience of severe mental illness influenced their understanding of domestic violence. These respondents disclosed a range of psychiatric diagnoses (including clinical depression, bipolar disorder and borderline personality disorder) and described that their experience of mental illness occurred prior to domestic violence. Service users described how their experience of mental illness led them to
understand that they were ‘vulnerable’ to exploitation from family members, acquaintances and the general community:

“Being in the mental health system, once people know, you face a lot of violence…physically, sexually, financially, emotionally, psychologically, everything…Lots of violence goes on with people in the mental health system” (SU5, female, experienced domestic violence)

One respondent reported an absence of social networks, which she felt was influenced by her experience of mental illness. This individual’s experience of social isolation was seen to shape her understanding of domestic violence, as she explored how her overriding desire to secure a social network, regardless of the quality of these relationships, left her ‘vulnerable’ to exploitation:

“He is abusive, but you see the thing is it’s hard to get rid of him because I have borderline personality disorder and I like the company. He’s alright some of the time” (SU14 female, experienced domestic violence)

The male respondent in this category also described an understanding that his experience of mental illness rendered him ‘vulnerable’ to exploitation:

“I said ‘I don’t want anybody living with me; I’m bad to live with at the moment. I’m going through a pain with this mental health thing…I don’t want anybody dragged in to it’ and she wouldn’t go. I had the police called and everything over the year” (SU19, male, experienced domestic violence)

5.7.1.2.3 Immigration Status
The theme of immigration status was reported by only one respondent, as all other respondents were either British citizens or had leave to remain in the country. Nonetheless, the importance of this theme in shaping the understanding of violence warrants exploration. The experience of having an insecure immigration status or status dependent on an individual remaining married may result in an increased risk of violence. For example, an individual may feel unable to disclose
their experiences for fear of deportation. People who are subject to immigration controls have no recourse to public funds and are wholly dependent on their husbands/intimate partners/families. These factors were understood by this female respondent to render them ‘vulnerable’ to the controls exercised by her partner:

“I think people take advantage of you because of your status…When you don’t have status in this country you are afraid to tell the police…And that is what many men do to women; they know they can do things without them going to the police” (SU2, female, experienced domestic violence)

5.7.1.2.4 Summary of Typology
Service users’ understanding of their vulnerability to domestic violence influenced their experience of support from health professionals and other services. These respondents did make contact with services but felt the response they received was often insufficient, as professionals did not facilitate discussions of abuse and failed to adequately respond to disclosures. Many services users in this category, who reported previous experience of violence or mental illness, reported sustained contact with health services over the years; however they felt that the support received largely overlooked their vulnerabilities to violence. This experience led some respondents to feel there was little support available for the trauma associated with abuse.

The male respondent in this category shared similar understandings to females and described a vulnerability to violence because of his experience of mental illness. His narrative described how he felt unable to establish an intimate relationship because of the complex nature of his illness, which he found difficult to manage and described how his experience of illness was exploited. Unlike the female respondents in this section, this man felt unable to disclose his experiences of abuse, citing concerns about his gender identity if he admitted he was a survivor of domestic violence perpetrated by a woman (a theme illustrated in previous sections of this chapter). This reluctance to disclose may have been exacerbated by occasions when his partner called out the police during periods of conflict and arrested him as the sole perpetrator of violence (see section 5.6).
5.7.1.3 “You Don’t Realise You’re Being Abused”: Unknowing

In direct contrast to the ‘accountable’ and ‘vulnerable’ group, the six women in this category did not disclose experiences of abuse prior to domestic violence. Although they disclosed domestic violence from an intimate partner, they were older in age at the time of experiencing such abuse (≥18 years) compared to the other respondents. The majority of women in this category were either married and/or had children with the partner prior to the violence beginning. Therefore, the circumstances in which they first established the intimate relationship and the nature of the relationship as it first developed was distinctly different from the other two groups.

Service users in this category described how their relationships began in a compassionate, loving and non-abusive manner, until the point at which they got married and/or had children. The act of marriage and/or having children further bound these women to the relationship and it was at this stage that the partners first tested their submission, by proceeding to lash out either verbally or physically:

“When I was married he was fine at first and then we our daughter and then he started and it was mainly verbal abuse, things along the lines of ‘you’re useless, you’re pathetic’” (SU12, female, experienced domestic violence)

“It started really at the beginning of marriage. It’s been 26 years now, it’s been a long time” (SU16, female, experienced domestic violence)

One of the six respondents in this group was not married and did not have children with her partner. This respondent described how she became increasingly socially isolated while living in an inner city area, which was geographically distant from her family, and witnessed her close friends leaving the city in preference for a more suburban area. At the time she was also running her own business and this left her with little time to build new social contacts:
“I became very isolated and I didn’t have friends that knew me...People that I was connected with, guys, relationship wise, I didn’t have any common point with, and so I didn’t know their history” (SU22, female, experienced domestic violence)

As illustrated above, her desire to establish close attachments with others led her to enter into a succession of relationships with men whom she knew little about and who displayed abusive behaviours:

“He very quickly became, I mean it was obvious, it was like he hated me...It wasn’t that I particularly liked him...To me it was more about wanting to give love somewhere” (SU22, female, experienced domestic violence)

Her experience of violence was compounded by an existing mental illness and, as she struggled to make sense of these experiences, her partner sought to exploit her vulnerability by using deception to establish within her a drug dependency:

“I started to have a breakdown, which didn’t feel like a breakdown, more like a rite of passage in a way it was very magical, very, almost shamanistic and he obviously knew that...He came round one day and he said ‘oh, try this it might help’ and he produced this little bottle...I didn’t really know what it was, and so I took in this drug which turned out to be crack cocaine” (SU22, female, experienced domestic violence)

Service users in this category described how the subtle coercive nature of domestic violence meant that they did not identify their partner’s behaviours as abusive. Manipulative techniques employed by the abuser to disguise these behaviours resulted in respondents having the perception that they were not experiencing domestic violence:

“The same with the domestic violence, the way that they [abuser] work is that you’re not supposed to know you’re being abused...One of the things about domestic violence is that you don’t realise...You don’t realise you’re
being abused until you’re way down the line” (SU22, female, experienced domestic violence)

“When you’re in it you don’t realise. I wasn’t aware that was domestic violence…It wasn’t till I saw like a phone in on ‘This Morning’ and they were coming up with things and I’m thinking to myself ‘that’s what I was going through’” (SU16, female, experienced domestic violence)

Understandably, abusers manipulative techniques to disguise their use of violence and absolve themselves of blame had the effect of influencing service users’ understanding of their experiences:

“I didn’t realise that I was a victim of domestic violence till I started reading information on it” (SU16, female, experienced domestic violence)

“I still find it hard to say I was a victim of domestic abuse, although I suffered in every form imaginable” (SU22, female, experienced domestic violence)

5.7.1.3.1 Summary of Typology
As identified earlier in this chapter, a lack of awareness among respondents that they were experiencing domestic violence created a barrier to disclosure and contact with services. Indeed, as these women did not recognise the behaviours of their partner to be abusive they did not consider disclosing or contacting support services. Several of these respondents reported contact with health services during the time of abuse, due to physical injuries sustained during attacks, but only one reported receiving information from health professionals about domestic violence; this experience helped her to identify the abuse. For others, recognition of the violence only occurred following media advertisements, discussions with family members or, most commonly, following life threatening incidents of severe violence.

5.7.1.4 “You Just Think It’s Normal Sometimes”: Accepting
Service users in each of the three categories also described how their personal
understanding of domestic violence (i.e. individual-level) was compounded by wider social understandings (i.e. societal-level). Service users discussed how the impact of social attitudes towards the use of violence in intimate relationships shaped their understanding of domestic violence. Examples such as the historical acceptance of domestic violence, gender roles, marital ties and cultural attitudes were cited.

Service users’ individual-level understandings of domestic violence were further influenced by their perception of social attitudes towards the use of violence within intimate relationships. For example, one woman described how her past experience of abuse was shaped by societal views at the time, which promoted the sanctity of marriage and the preservation of marital ties:

“I was married to him, so it was very difficult to get out of the marriage...Once you were married, it was hard in those days to get somewhere to find safety and a refuge” (SU3, female, experienced domestic violence)

As can be seen from the illustration above, this woman’s experience of and response to domestic violence was defined by her understanding of social attitudes toward marriage. Societal tolerance of marital violence, based on the concept of marital privacy, and the absence of formal support systems for abused women meant that she felt there was little alternative but to remain in the violent relationship.

A related sub-theme concerned service users’ description of the historical acceptance of domestic violence within society:

“It’s something that is very ancient, something that was completely accepted in the past. A woman could get beaten up by her husband until say 25-30 years ago, even in this country, and it would be seen by a judge as nothing...At the time I was growing up there was no way that you could even mention it; it was normal, it was accepted. So I think it’s good that
The above illustration highlights how in previous decades domestic violence was considered socially acceptable and was not discussed within the public domain or challenged within legal frameworks. This respondent commented that although greater public awareness exists about the nature, extent and impact of domestic violence, there remains more that society can do to challenge abuse. Interestingly, comments from other respondents suggest that although current socio-political discourses and legal frameworks challenge the acceptability of domestic violence, social attitudes may have remained constant:

“I was next door to his aunt and granddad and then I had his mum and dad on the other side and if I raised my voice, I mean he could hit me and there was no noise, but if we were arguing they’d knock on the door and tell me to shut up shouting because the neighbours could hear” (SU17, female, experienced domestic violence)

Consequently, this woman’s experience of society’s response to domestic violence shaped her understanding of the acceptability of abuse in intimate relationships:

“I think you are very confused. If you haven’t got a straight thing in your mind ‘no this is wrong and this shouldn’t be happening’ and ‘no you’re not going to allow that man to do that to you’. That’s what I lacked…I suppose you just think it's normal sometimes” (SU17, female, experienced domestic violence)

An acceptance of the use of violence within relationships among young people in our society was also echoed by other respondents:

“If they’re going to be abusing you in any way then they’re not loving you are they?...But they [young people] believe...being hit is love...‘If they...
don’t hit me they don’t love me’” (SU11, female, experienced domestic violence)

This theme was further extended by some respondents who explored attitudes towards the use of violence within relationships among different ethnic groups:

“A lot of Muslim Asians maybe getting abused in certain ways... You’re not going to see that because it’s against their religion. Even in a West Indian culture it’s a similar thing, Jamaican culture, their men are meant to be superior to the women” (SU11, female, experienced domestic violence)

A related theme concerned gender roles and an Asian woman explored how changes in social attitudes towards gender roles has impacted on women’s experience of domestic violence; drawing on her own experience of witnessing domestic violence as a child and experiencing it as an adult:

“I was like ‘no this is the twentieth century, I can make more than money than you’. It's not like back in the days when the men used to go to work and you had to stay home and look after siblings and clean the house and wash and they could go and do what they wanted, while you’re being abused, used or whatever” (SU11, female, experienced domestic violence)

The above illustration highlights that women’s gender roles within society have shifted from being constrained to the domestic setting, to being welcomed in the public domain. Consequently, women have greater social freedoms and increased financial independence. These factors shaped this respondent’s understanding of domestic violence and she commented that with greater financial independence women are no longer forced to accept abuse, as they have the resources to escape violence. The above illustration suggests that the ability of women to gain financial independence from their intimate partner may play a role in preventing experiences of domestic violence. However, the following illustration highlights that greater opportunities for financial success may also increase women’s risk of exploitation:
“I think really he saw me as successful business woman, got her own business, her own house, blah, blah, ‘let’s go and have a piece of the pie’” (SU22, female, experienced domestic violence)

Building on the theme of gender roles, the two male respondents who disclosed experiences of domestic violence reported difficulties in disclosing their experiences due to the perception of men’s role in society:

“Well I’m like a man; I haven’t told them [professionals] anything about it...I’ve kept it away from them. It’s nothing to do with them, it’s my problem” (SU19, male, experienced domestic violence)

Furthermore, they described the impact of societal perceptions of male dominance in shaping their willingness to seek support for domestic violence:

“She was running round in the street shouting and the phone rang...I got up and took the phone...they said “where’s *name of partner*, she’s just rung to say she’s been attacked”, I said “who by?” they said “You, obviously, if you’re the only one there”...and I put the phone down, left them to bang on the door...They said “could you let us in please?” I said “I’d rather not...I’ve got nothing to do with it...I didn’t even know she was outside till you rang”. Then they open the door and they go and arrest me” (SU19, male, experienced domestic violence)

5.7.2 Summary of Typologies

There are some clear similarities and differences between the three individual-level typologies, which will now be briefly summarised. All respondents in the ‘accountable’ group and several in the ‘vulnerable’ group disclosed experiences of childhood abuse. However, differences arise between the two groups regarding how these experiences were understood to shape their experiences of domestic violence. The ‘accountable’ group described learning to model and externalise the behaviours witnessed as a child, which were acted out in a physical manner in response to conflict. In contrast, respondents in the ‘vulnerable’ group described internalising their childhood experiences of abuse, which had the effect of altering
their cognitive beliefs regarding relational security and expectations of others. Several respondents also reported a vulnerability to violence but their understanding developed from previous experiences of domestic violence in adulthood, experiences of mental illness and insecure immigration status. Service users in the ‘unknowing’ category did not report previous experiences of violence and described an inability to identify the abuse.

Despite individual variances of understanding, all service users described the impact of societal practices and attitudes towards violence in shaping their understanding of abuse. They explored how patriarchy, gender role socialisation and attitudes that seemingly permit the use of violence in relationships can facilitate an acceptance of domestic violence. A detailed discussion of the above findings is presented in Chapter 7.
Chapter 6: The Identification and Response of Community Mental Health Services to Domestic Violence: Results from Qualitative Interviews with Mental Health Professionals

6.1 Introduction
This chapter presents the main findings from qualitative interviews with mental health professionals. The first section of the chapter details professionals’ understanding and experience of domestic violence perpetrated against service users. This is followed by results from a thematic analysis of: clinicians’ views on the acceptability of routine enquiry of domestic violence in psychiatric settings; their knowledge of support services, and their experience of identifying and responding to domestic violence. The final section of this chapter will describe and discuss findings from a constant comparative analysis of respondents’ narratives, which identified four distinct typologies of ‘perception of professional role’. These typologies were seen to influence professionals’ willingness to explore and respond to domestic violence with service users.

6.2 Demographic Details of Professionals
25 professionals were recruited; 15 were female and ten male. Self-ascribed ethnicity was white British (n=16), white Irish (n=2), black British (n=1), European (n=2), Indian (n=2), Iranian (n=1), Nigerian (n=1). Seven were psychiatrists, three dual diagnosis practitioners (with counselling (2) and nursing (1) backgrounds), one was a team manager (with a social work background), one a community manager, one a psychologist and 12 were care coordinators (with social work (3) and nursing (9) backgrounds). The mean age of professionals was 37 (range 27-58, SD 7.14). The average number of years qualified was 11.7 (range 4-29, SD 6.86).

6.3 Professionals’ Experience and Understanding of Domestic Violence
This section reports the findings of professionals’ understanding of the nature of service users’ experience of domestic violence, as identified in their clinical practice. Presentation and discussion of responses are reported under the
questions that were asked. Where a number of respondents gave similar answers, these have been summarised and represented by a quote from one respondent, whose narrative describes the essence of what was said.

6.3.1 Professionals Experience of the Nature of Domestic Violence among Psychiatric Service Users

Qualitative interviews began with the researcher asking professionals to describe their clinical experience of the nature of domestic violence perpetrated against service users. Professionals recalled cases when service users had been abused and described the type of violence service users had experienced; which can be grouped under the following headings: emotional and psychological abuse, physical violence, sexual violence and financial abuse.

6.3.1.1 Emotional/Psychological Abuse

Almost all professionals recalled examples when service users had experienced emotional and psychological abuse “I think most of the time it would be psychological”; including verbal abuse “he calls her a slag and fat and ugly” and continual criticism “they’re constantly being told that they are not a good person or a bad person”.

Several professionals spoke of abusers’ attempts to erode service users’ self-esteem by undermining their confidence” and through the use of severe controlling behaviours “controlling of activities...what people do, which friends they see, whether they are allowed to have friends, allowed to go out”.

Some professionals described instances when service users’ experience of emotional abuse continued following separation from an abusive partner:

“She came for a referral for depression. She was drinking quite heavily as well. She was only in her early twenties and she had three children under five and the ex-partner was being very verbal towards her, sending her really horrible text messages and threatening her. He doesn’t live with them but he obviously knows where she lives and that came up in the
assessment; she became quite tearful” (P18, female, care coordinator (nursing background))

Abusers were reported to employ verbally abusive tactics to attack service users’ mental illness:

“We’ve got one client at the moment whose partner says that she wouldn’t be any use as a mother because she’s got mental health problems. She’s told that she’s ‘just mad’ and is never going to have a say and she’s gotten into a cycle of thinking that she’s not a valued person” (P15, male, dual diagnosis (counselling background))

One professional recalled how an abuser sought to obtain total control over their client’s mental health care and attempted to prevent them from attending appointments and taking medication:

“I had one client who was telling me that her boyfriend didn’t want her to come and see me and didn’t think she ought to be on medication...She didn’t see that as a form of abuse or control or manipulation” (P2, female, care coordinator (nursing background))

Abusers were also reported to exploit service users’ mental illness, as a means to disguise their abusive behaviours:

“In the end he [abuser] was threatening us, saying ‘something is going to happen to her and it is going to be your fault’...Basically, what we realised was he was going to do something to her and make it look like she did something to herself” (P10, female, care coordinator (nursing background))

6.3.1.2 Physical Violence
A number of professionals recalled service users’ experience of physical violence “I have seen a fair bit of physical abuse”; including slapping and kicking “she’s kicked him”. Professionals also identified a range of injuries inflicted on service
users, including “bruises and cuts”. Severe physical violence was commonly reported, with some of these attacks involving the use of weapons:

“A man who disclosed domestic violence, without much probing, disclosed very serious domestic violence. He’d been stabbed and that’s probably why it’s the first thing that comes to mind, because I was quite taken back by the story” (P23, female, psychiatrist)

One professional recalled a particularly severe physical assault perpetrated against a service user, which had near fatal consequences:

“I’ve got a client...She was beaten up so badly she ended up having a blood clot on her brain” (P10, female, care coordinator (nursing background))

Physical violence in the perinatal period was also reported by some professionals:

“She gave birth prematurely as a result of him beating her up...She was actually found eight hours after giving birth...The [umbilical] cord was still attached and he left her like that...The other client, who disclosed to us after a year, who had first onset of psychosis...she gave birth as a result of him [abuser] beating her up...Although the baby is fine...she was mute for like a month in a ward and she attributes that to him” (P10, female, care coordinator (nursing background))

Two professionals recalled their experience of working with service users who were physically abused by their intimate partner and children:

“A particular case just very recently, which was complicated, was around a female service user...There was an issue amongst the family whereby two children, the two elder sons, were abusing the mother, the mother being the service user...It was compounded by the father’s role...there was a link in terms of him abusing her as well” (P13, male, dual diagnosis (nursing background))
6.3.1.3 Sexual Violence
Several professionals described experiences when service users were sexually abused:

“She got into another relationship, which was abusive and the guy ended up raping her and she ended up having another child” (P10, female, care coordinator (nursing background))

One professional also recalled how a service user was forced into prostitution by their intimate partner:

“Her [service user] partner was actually pimping her as well, so that sort of sexual exploitation and prostitution” (P9, female, care coordinator (social work background))

Some professionals described how service users’ experience of mental illness may render them vulnerable to sexual exploitation:

“I have got quite a few patients who are sexually vulnerable in that they may enter into relationships for provision of money, or a place to live...We’ve recently had a safeguarding adults meeting with one particular lady who said ‘I haven’t got anywhere else to live, I am with my partner basically because I don’t have any entitlements to any benefits. I haven’t got anywhere else to stay, so this relationship suits me at the moment’” (P16, male, psychiatrist)

6.3.1.4 Financial Abuse
Many professionals identified instances when service users had been financially exploited “patients themselves get exploited by other relatives for money”. Professionals described instances when service users’ welfare benefits were taken and key possessions stolen, which were used by some abusers to fund their drug addiction “taking their money...using them for drugs”.

A number of professionals recalled examples when service users were financially exploited using increasingly violent means. One professional explained how physical threats were used by the abuser, in order to gain complete control over their partner’s finances:

“He would also threaten her, with a knife, for her money and literally take her bag, empty the contents of the wallet. Threaten her in the sense of asking for money and buying him presents, asking for big amounts of money, several thousands of pounds” (P7, female, care coordinator (nursing background))

6.3.1.5 Culture
Several professionals explored the impact of culture on service users’ experience of domestic violence. They discussed how cultural views regarding intimate relationships and the use of violence may create a perception that violence in intimate relationships is acceptable:

“A lot of people, like traditional people from Africa...it is an acceptable thing for a woman to be beaten up; that’s how she’s trained” (P10, female, care coordinator (nursing background))

“Some cultures, even regional cultures within Britain, it is almost expected. I come from the north of England, you know, I can remember in my teens being told ‘well there’s nothing wrong in giving your wife a slap if she’s not doing what she’s told’” (P2, female, care coordinator (nursing background))

Professionals also described how cultural attitudes towards discussing domestic issues in the public domain may prevent disclosures from service users; for fear that they might be shunned from their community:

“I think in some cultures it is taboo...wives or partners are not supposed to discuss it with people outside and when they do it’s like they betrayed the family” (P10, female, care coordinator (nursing background))
One professional reflected on her experience of working with a Muslim woman who was shunned from the wider community for leaving her abusive husband:

“I’m thinking about a client where it was kind of complicated by cultural issues as well because she was a Muslim woman...She went through years and years of horrendous physical violence and then actually left her husband...Then because of that she was shunned by her community and she feared meeting people from her ex-husband’s family, because she thought she was still at risk of violence” (P24, female, care coordinator (social work background))

6.3.2 Impact of Domestic Violence on Service Users’ Experience of Mental Illness

Although not asked directly by the researcher, professionals identified a relationship between domestic violence and mental illness. Professionals described their views on how abusive experiences can impact on service users’ mental health well-being and discussed why such abusive experiences occur.

Mental illness was reported to arise as a result of experiences of violence:

“We have assessed people that have been sexually abused but the mental health issues seem to come from that. So that’s why people feel extremely suicidal, due to sexual abuse” (P11, female, care coordinator (nursing background))

Professionals also reported that domestic violence can exacerbate existing mental health symptoms and impede recovery:

“I mean clearly for somebody who’s experiencing some sort of psychotic disorder...who knows what kind of tricks that it’s [the violence] adding to the confusion and paranoia...It may well kind of precipitate a breakdown and inhibit recovery without a doubt” (P22, female, community manager)
Several professionals described how abusers may specifically target psychiatric service users, with the sole purpose of exploiting the vulnerabilities of their mental health (i.e. cognitive impairments):

“I’m thinking about women…They’re more vulnerable because they [abusers] can say ‘you’re mad’…and undermine them…They’re much more vulnerable too, because if they’re not able to communicate because they are mentally ill they’re not perhaps able to tell you what’s happening; because they’re not in touch with reality. So I think there are a lot of extra vulnerabilities for people with mental health problems” (P25, female, care coordinator (nursing background))

In the absence of prompting by the researcher, a number of professionals explored their understanding of the cause of violence perpetrated against service users. A minority of professionals concluded that a lack of understanding about a partner’s/family member’s mental illness, or poor communication skills can lead to abusive behaviours, particularly emotional abuse:

“They [intimate partners] tend to be emotionally abusive because they don’t understand the mental health problems. Or they’re neglectful in the sense that ‘well I don’t want to think about it…it’s very boring for me’…because they don’t understand really and they don’t know what to do, so it’s the avoidance type thing” (P1, female, psychiatrist)

“I think probably the most common would be emotional abuse…Relationships where people are just finding it difficult to communicate in a way that’s healthy. It might be that both partners, it’s a dynamic between both, or it might be that one partner is particularly violent or emotionally abusive and critical” (P17, female psychologist)

Several other professionals explored how psychiatric service users may be vulnerable to experiences of violence and abuse because of their mental illness:

“I think this is very common, where they [service users] are put down a bit
and certainly some of the relatives tend to talk about them as if they are not there...Being belittled and not being respected, I think that’s quite common, being a bit down trodden. I’ve known quite a few patients who have been financially exploited by relatives” (P20, female, psychiatrist)

6.3.3 Summary of Results
Almost all professionals described some experience of identifying cases of domestic violence in their practice and several examples involved frequent and severe violence, including the use of weapons. Professionals explored the damaging physical and mental health effects abuse can have on service users and, similar to service user responses, described how domestic violence can lead to the development of mental illness or exacerbate existing illnesses. Many professionals explored how the experience of mental illness can render people vulnerable to exploitation from family members and intimate partners. They described how abusers may deny their use of violence by blaming service users’ mental illness (i.e. by calling in to question their perception of reality) or exploiting key financial resources, by assuming the role of a carer and obtaining control over their welfare benefits. These examples align with the type of abuses experienced by service users in Chapter 5. Several professionals’ explored the impact of cultural attitudes in influencing service users’ experience of violence and contact with services. These professionals described how cultural attitudes may have the effect of normalising abusive behaviours and consequently discourage people from disclosing experiences of violence. Interestingly, this theme was also reported by service users (see Chapter 5 section 5.7.1.4).

The following three sections will report findings from a thematic analysis of professionals’ experience and understanding of domestic violence in psychiatric settings. Results are organised around the dominant interpretive themes and are presented in the following order: (1) findings from analysis of professionals’ views about routine enquiry and knowledge of support services; (2) findings from analysis of professionals’ experience of enquiry about domestic violence; and (3) findings from professionals’ experiences and expectations of services response to domestic violence (see Table 8 below).
Table 8: Results from the Thematic Analysis of Professionals’ Narratives

<table>
<thead>
<tr>
<th>Super-ordinate theme</th>
<th>Sub-ordinate theme heading</th>
<th>Sub-ordinate theme description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acceptability of routine enquiry about DV in psychiatric settings</td>
<td>• Enquiry is a necessary part of the role of mental health professionals</td>
<td>Most professionals considered DV to be an important mental health issue that should be acknowledged and addressed in psychiatric settings</td>
</tr>
<tr>
<td></td>
<td>• Enquiry is not part of the role of mental health professionals</td>
<td>Few professionals considered DV not to be a mental health issue and believed it was beyond the remit of psychiatric services to address these issues</td>
</tr>
<tr>
<td>Barriers to enquiry of DV</td>
<td>• Limited knowledge and expertise in addressing DV</td>
<td>Professionals did not believe they had sufficient knowledge or expertise to address DV</td>
</tr>
<tr>
<td></td>
<td>• Enquiry of DV is not part of the role of mental health professionals</td>
<td>Some professionals believed that it was not part of their role to address DV experienced by service users</td>
</tr>
<tr>
<td></td>
<td>• Limited opportunities for inquiry</td>
<td>Competing clinical demands, time constraints and presence of partners at assessments prevented opportunities for enquiry</td>
</tr>
<tr>
<td></td>
<td>• Fear of consequences</td>
<td>Professionals were fearful that enquiry would offend some service users; may result in re-traumatisation or a deterioration of symptoms among service users who were acutely unwell</td>
</tr>
<tr>
<td></td>
<td>• No indication of violence</td>
<td>In the absence of clear physical indicators of DV, or direct disclosures from service users, clinicians did not consider enquiring about DV</td>
</tr>
<tr>
<td>Experiences / expectations of responding to service users’ disclosure of DV</td>
<td>• Individual- and organisational-level awareness of DV</td>
<td>Professionals identified a lack of individual- and organisational-level awareness of DV</td>
</tr>
<tr>
<td></td>
<td>• Difficulties in the assessment and management of DV</td>
<td>Professionals spoke of difficulties in assessing and validating DV in the absence of disclosure and in response to service users’ symptomatology</td>
</tr>
<tr>
<td></td>
<td>• Reporting requirements</td>
<td>Professionals reported difficulties in maintaining a supportive therapeutic relationship alongside adhering to and managing the demands of reporting requirements</td>
</tr>
<tr>
<td></td>
<td>• Absence of care referral pathways</td>
<td>Professionals highlighted issues in responding to DV in the absence of clear referral pathways</td>
</tr>
<tr>
<td></td>
<td>• Continuity of care</td>
<td>Professionals encountered difficulties in locating DV services that support people with severe mental illness</td>
</tr>
</tbody>
</table>
6.4 Acceptability of Routine Enquiry of Domestic Violence and Knowledge of Support Services: Professionals’ Views

6.4.1 Dominant Themes for Acceptability of Routine Enquiry
The dominant themes in this analysis concerned mental health professionals’ acceptance of routine enquiry about domestic violence in psychiatric settings. In contrast to service users (see Chapter 5 section 5.4), there was seen to be some variation in professional views of routine enquiry. Although the majority perceived routine enquiry to be acceptable, a small minority did not (see Figure 11 below). Views on acceptability were seen to transcend professionals’ gender, age, ethnicity and clinical discipline and were instead associated with a ‘perception of professional role’. These themes will now be discussed below.
Figure 11: Conceptual Map of the Acceptability of Routine Enquiry of Domestic Violence among Professionals

- Enquiry is necessary part of professional role
- Enquiry is role dependent
- Limited expertise for enquiry
- Domestic violence is an important mental health issue
- Acceptability of Domestic Violence: professional views
- Domestic violence is not a mental health issue
- Enquiry is not part of mental health professionals' role
6.4.1 Domestic Violence is an Important Mental Health Issue
As can be seen from the conceptual map, an important and multi-faceted subtheme for many professionals was the belief that domestic violence is an important health issue that should be addressed in psychiatric settings. Routine enquiry of domestic violence was acceptable for the majority of professionals; although differences were identified in relation to professionals’ implementation of enquiry within their practice.

6.4.1.1 Enquiry is a Necessary Part of Professionals’ Role
Some professionals considered enquiry about service users’ experiences of abuse to be part of their ‘duty of care’ as a mental health clinician:

“I don’t feel afraid to ask about it because at the end of the day you have a duty to care for your clients...Certainly for our client group they are quite difficult to engage...We are probably the only people that they would engage with...You are the only link perhaps they could have to potentially getting other support” (P9, female, care coordinator (social work background))

6.4.1.2 Enquiry is Role Dependent
Linked to this, other professionals admitted that although they considered domestic violence an important health issue they did not routinely ask about it in their clinical practice. These professionals described how their decision to enquire was dependent on the attention their current role placed on identifying experiences of domestic violence among service users:

Researcher: Have you asked or talked about domestic violence with a mental health service user?

Respondent: “I have yes...In the job that I’m doing at the moment, which is perinatal psychiatry...I think there is more awareness about the need to ask about domestic violence...I think prior to this job it was something that I probably didn’t tend to ask about” (P23, female, psychiatrist)
It is noteworthy that these professionals did not report any individual concerns regarding enquiring about service users’ experiences of abuse; although they did not consider enquiring unless they perceived their current role required them to do so.

6.4.1.1.3 Limited Expertise for Enquiry
A related sub-theme described by some professionals was a perception that they did not possess sufficient skills and expertise to routinely enquire about abuse. Nevertheless, they considered domestic violence to be an important health issue:

“Felt untrained, I think is the correct word, in how to address it and I think it is a very important area that is very much overlooked in psychiatric care. We’re treating the after effects of domestic violence...I’ve felt very uncomfortable in knowing how do I address this?”

(P4, male, care coordinator (nursing background))

The above illustrations highlight that although not all professionals have previously asked service users about domestic violence the majority are in favour of implementing routine enquiry in their practice. There were, however, a small minority of professionals who were unconvinced that domestic violence was a mental health issue and consequently questioned the need for routine enquiry; these themes are now discussed below.

6.4.1.2 Routine Enquiry is Not a Mental Health Issue
Four professionals, from different clinical disciplines (three psychiatrists and one psychologist) and with varying years of experience (qualified between six and fifteen years), were unclear about the role of routine enquiry of domestic violence in mental health practice.

6.4.1.2.1 Enquiry is Not Part of Mental Health Professionals’ Role
In contrast to all other respondents, these professionals were unconvinced that domestic violence was a mental health issue and therefore questioned the need for such enquiry:
“Should we be addressing this? Because I think so many things are coming under the role of psychiatry to sort out, when actually they are not mental health problems… So I suppose I struggle a bit with us taking on things that aren’t mental health problems” (P20, female, psychiatrist)

The illustrations above indicate that views on acceptability were associated with a ‘perception of professional role’. For some professionals their perception of the degree of organisational awareness about domestic violence influenced their decision to introduce enquiry. Others questioned whether they possessed the necessary professional competencies to enquire and a small minority did not perceive that it was within their role as a mental health provider to identify service users’ experience of abuse. These perceptions were seen to transcend professionals’ gender, age, ethnicity or clinical discipline.

Another important sub-theme identified by professionals concerned the most appropriate approach to asking about domestic violence. Findings show there were a diversity of views among professionals regarding the most appropriate discourse for enquiry, with an almost equal split between those advocating for direct enquiry and those for indirect enquiry (e.g. through an exploration of general difficulties in service users’ relationships); some illustrative points follow.

**6.4.1.3 Direct Enquiry**

Several professionals spoke of the importance of employing a direct approach when enquiring about domestic violence. This, they felt, would ensure service users were clear about what was being asked of them:

“I am quite a big believer in being quite direct…No point, you know, in asking vague questions that the person doesn’t really know what we are talking about. So, something relatively direct…‘Are you experiencing any kind of violence or anything that you don’t think you should be experiencing?’” (P20, female, psychiatrist)
6.4.1.4 Indirect Enquiry
In contrast, some professionals questioned the appropriateness of asking service users directly about experiences of domestic violence and were concerned that direct questioning might be offensive:

“I think asking a direct question about ‘have you, or do you experience domestic violence?’ would probably have a lot of people running out the door” (P22, female, community manager)

“I think people could possibly be offended by asking [about abuse] outright” (P7, female, care coordinator (nursing background))

Consequently, these professionals felt a more indirect approach to enquiry, by exploring problems in service users’ relationships, would be more suitable:

“I think it should be included but I suppose it’s more about the social history side of things, ‘where do you live?’….‘Are you in a relationship?’ ‘How is that relationship?’ (P4, male, care coordinator (nursing background))

Concerns about the potential for direct enquiry to be emotionally distressing for service users was identified as a barrier to enquiry among professionals and is described in more detail in the following section 6.5.

6.4.1.5 Culture and Language
A related sub-theme described by some professionals concerned the importance of managing service users’ cultural sensitivities and language needs, with regards to asking about domestic violence:

“There’s a whole range of cultural issues that I think would inhibit service users talking about it…language wise…I don’t know how much work we do with interpreters and how would they pick that up? Is it something you can talk about with a third party present?” (P22, female, community manager)
The majority of professionals who were in favour of routine enquiry of domestic violence discussed the value enquiry could have to their professional practice (as outlined below).

6.4.1.6 Enquiry Can Improve Professionals’ Awareness of Domestic Violence
Some professionals believed routine enquiry would assist them in identifying domestic violence, by raising their awareness of the topic:

“The advantages of asking are, well sometimes you just don’t think about it. It might bring up something you hadn’t considered” (P23, female, care coordinator (social work background))

Linked to this, one professional stated that asking about domestic violence could also assist them in the identification of child protection issues:

“I guess we may identify other sort of child protection concerns and be able to intervene there” (P23, female, psychiatrist)

6.4.1.7 Routine Enquiry Can Assist Professionals in Making Appropriate Referrals
Some professionals described that routine enquiry would assist them in helping service users’ access appropriate support for domestic violence:

“You could help them to get help…point them in the right direction. You can support them” (P9, female, care coordinator (social work background))

Linked to this, one professional spoke of the potential for routine enquiry to improve service users’ recovery from mental illness, through appropriate identification and response to domestic violence:

“It ought to be routine practice…part of the whole agenda of recovery and helping people to self-manage…I see our services as helping people to reflect on risk taking, risk issues and to look at ways of best managing
that, including life style issues and other matters” (P12, male, psychiatrist)

6.4.1.8 Routine Enquiry as Part of Risk Assessment
Some professionals felt it was important to enquire about domestic violence when conducting risk assessments, as part of routine clinical practice. The benefit of this, they suggested, would be to identify vulnerabilities to exploitation experienced by service users:

“I think it is pretty crucial to make some sort of assessment with all our clients, about risk both to themselves and to others. When in the context of potential risk to self, one of the issues is about vulnerability and the risk of exploitation. So I would hope that it was part of general good practice” (P12, male, psychiatrist)

6.4.1.9 Routine Enquiry can Reduce Risk of Harm
Linked to this, professionals discussed how the identification of vulnerabilities to abuse could assist them in developing strategies to reduce service users’ risks:

“I suppose the advantages are that you are hopefully reducing the risk and you’re making a safe environment for a person. That would be my immediate kind of thoughts; how do we make this person safe? How do we reduce the risk?” (P19, male, team manager)

6.4.2 Dominant Themes for Knowledge of Domestic Violence Services
The dominant themes for mental health professionals concerned their level of knowledge about domestic violence services. The dominant interpretive themes for professionals were a limited knowledge and some knowledge of domestic violence services.

6.4.2.1 Limited Knowledge
Like service users (see Chapter 5 section 5.4.2), many professionals reported a limited knowledge of domestic violence services:
“I know some service users can go via the housing provider and get some advice...I mean I would be at loss. It’s not an area that I know a lot about to be honest” (P18, female, care coordinator (nursing background))

Linked to this, a dual diagnosis practitioner described the difficulties professionals may experience in identifying and locating domestic violence services:

“I mean Southwark has got so many services but even as a professional it’s very hard to find a specific service” (P15, male, dual diagnosis (counselling background))

6.4.2.2 Some Knowledge

A small number of professionals (one psychiatrist, two care coordinators and a dual diagnosis practitioner) reported good knowledge of domestic violence services:

“I know that there are projects like domestic violence projects....I am aware in that sense that there are services out there specifically geared towards domestic violence, and there are even groups and workshops in which families can attend” (P7, female, care coordinator (nursing background))

Although the majority of professionals disclosed a limited knowledge of support services for domestic violence, several described a willingness to locate information for service users. Many talked about measures they would take to locate domestic violence services on behalf of service users:

“I would be looking at the A-Z book services and I’d be looking on the internet or whatever...So there’s a lot of knowledge out there” (P19, male, team manager)

“Don’t know them off hand but we’ve got the MIND booklet, which is a great little thing...I think we’ve got something in reception as well, sitting
out there, so I am quite good at finding resources from the internet and things” (P15, male, dual diagnosis (counselling background))

6.4.3 Summary of Dominant Themes for Enquiry and Knowledge of Services

These findings highlight that the majority of mental health professionals are in favour of routine enquiry of domestic violence. A small minority, however, question whether enquiry is part of their role as a mental health provider. Analysis of views on acceptability indicated that professional opinions transcended gender, age, ethnicity, clinical discipline and years of experience. Views on enquiry were instead seen to be related to differences in clinicians’ perception of their professional roles in addressing domestic violence. Some professionals perceived that their clinical role obligated them to enquire; others perceived that they lacked the necessary competencies to enquire; some perceived that enquiry was a requirement within their current role, and a small proportion perceived that enquiry was not part of their role as a mental health provider. Findings indicate that some professionals’ implemented enquiry as part of a duty of care, whilst others decision to enquire was dependent on their perception of the organisational focus on domestic violence, and individual competencies in responding to disclosures of abuse.

Variation was also identified with regards to how professionals should enquire about domestic violence, with views split between the need for direct enquiry and indirect enquiry. Professionals who advocated for an indirect approach raised concerns that direct enquiry could cause offence to service users; a theme which also arose during analysis of professionals’ experience of enquiry (as described in the following section). Nevertheless, among those advocating for routine enquiry, the process of asking service users about experiences of domestic violence was believed to help improve professionals’ awareness of abuse, support risk assessment practices and assist them in making appropriate referrals for service users.

Most professionals identified a limited working knowledge of local and national domestic violence services. These findings provide some insight into service users’ descriptions that clinicians often provided them with little or no
information on support services (see Chapter 5 section 5.4.2). A detailed discussion of the above findings is presented in Chapter 7.
6.5 Professionals’ Enquiry of Domestic Violence in Psychiatric Settings

6.5.1 Dominant Themes for Barriers to Enquiry of Domestic Violence
The dominant interpretive theme that emerged for mental health professionals was the implementation of enquiry, with an emphasis on barriers to asking service users about domestic violence. Of the 25 respondents, only six reported that they enquired about domestic violence on occasion. These behaviours were not seen to be associated with gender, age, number of years qualified or professional background. The dominant sub-themes in this data are to do with whether enquiry about domestic violence is part of professionals’ role and concerns about professional competencies and confidence to address abuse (see Figure 12 below).
Figure 12: Conceptual Map of Professionals’ Barriers to Enquiry of Domestic Violence
6.5.1.1 Lack of Knowledge/Expertise about Domestic Violence

As can be seen from the conceptual map above, lack of knowledge and expertise about domestic violence is an important and multi-faceted sub-theme for professionals when it is an issue of enquiry about domestic violence. Several themes were identified, including a lack of confidence in approaching the topic and concerns about the complexity of identifying domestic violence. Many professionals talked of the need for improved clinical competencies and training about domestic violence in order to facilitate enquiry:

“I do think there is a competency issue and a confidence issue in terms of actually feeling able and willing to wade into this…They [professionals] do not know how to go about it, which again relates to their confidence and training” (P12, male, psychiatrist)

Only one professional, a team manager, felt that colleagues in their team had the expertise to identify domestic violence:

“I think the team here are an experienced group…We spend lengthy periods of time working with people over years and encompass a kind of holistic approach, when we would generally be picking up on those signs…So, I mean it would come up in part of the conversation” (P19, male, team manager)

6.5.1.1.1 Lack of Confidence in Approaching the Subject

Several professionals described a lack of confidence in dealing with service users’ experience of domestic violence, because of a perceived lack of expertise and knowledge in responding to abuse:

“People are hesitant because they don’t feel confident…They think that somebody else is better equipped to do it” (P12, male, psychiatrist)

“There is a real lack of information or knowledge, and of course we don’t know anything about housing rights or whatever…If they are already
distressed and whatever it’s really difficult” (P3, female, care coordinator (nursing background))

6.5.1.1.2 Too Complex an Issue
Some professionals also identified concerns about their competence in responding appropriately to the sensitive nature of service users’ experiences of domestic violence:

“I do think it’s a complex issue that people are a bit worried about. I think partly because if they open the can what do they do?” (P22, female, community manager)

6.5.1.1.3 Personal Discomfort with Topic
Linked to this, a few professionals described discomfort in enquiring about a sensitive topic such as domestic violence:

“Personally, I think it is something that’s quite sensitive. I wouldn’t feel comfortable in asking it” (P4, male, care coordinator (nursing background))

One professional considered that routine enquiry about service users’ perpetration of violence was easier to discuss than their experiences of violence:

“It’s easier to ask that question...because you can wrap it up in various different ways...‘Your irritability is a symptom of a particular aspect of mental disorder’. So yeah that’s very easy...‘Have you been violent or intimidating to another person?’ If ticked yes, then you can explore it” (P4, male, care coordinator (nursing background))

Only a small number of experienced clinicians, who had been qualified between 11 and 29 years, described feeling confident to approach the subject of domestic violence:
“I am particularly clued up to look in at bumps and scratches and injuries…I would obviously be aware of people who were rowing in front of me…I would be inclined to ask one or other of them, how safe or unsafe they felt with each other” (P5, male, care coordinator, (social work background))

6.5.1.2 Fear of Consequences
Another important sub-theme was professionals’ concern about how service users would respond to enquiry. Some professionals were worried that service users would be offended if they asked about domestic violence or that discussing these issues might prove traumatising for service users:

“I don’t know at what point you turn around and say ‘have you been a victim of domestic violence?’ I think it has the potential to scare some people off” (P4, male, care coordinator (nursing background))

“I think the disadvantages could be, and perhaps it’s just a myth, is that it would kind of open up a can of worms and create perhaps re-traumatisation for the service user to, you know, delve into those memories” (P14, male, dual diagnosis (counselling background))

Linked to this, one professional described concern about asking service users who are currently in crisis:

“I don’t think in every interview because often when we see mental health service users…they can be quite disturbed…I don’t think that if they are in that disturbed state that it would be appropriate to ask sensitive questions like that” (P23, female, psychiatrist)

6.5.1.3 Limited Opportunity for Enquiry
Another multi-faceted theme outlines professionals’ experience of limited opportunities to explore issues of abuse with service users. Professionals cited competing demands, time constraints and the presence of partners at consultations as hindering enquiry:
“I guess it’s the demands on you to provide all this care, now you have to think about carers and now you have to think about everybody’s risk...It's just getting more and more demands, so sometimes it’s a bit difficult to ask” (P1, female, psychiatrist)

“The problem is of course we’re a short-term team, so sometimes we wouldn’t see someone longer than the actual assessment...Say if they’re going to go off and get psychotherapy...we’ve got to see them first, so we’ve got to get a lot in” (P4, male, care coordinator (nursing background))

“It can be very difficult to ask because quite often my patients bring their partners with them to appointments. So that would make it really difficult” (P20, female, psychiatrist)

6.5.1.4 Dominance of the Medical Diagnostic and Treatment Model
The dominance of the medical diagnostic and treatment model was an important barrier to enquiry among clinicians. Professionals described how the medical model, which focuses predominantly on managing and treating symptoms, may prevent exploration of individual, social and environmental factors that are predictive of illness:

‘It’s not in my list of things that I now have to cover...I suppose my first response is, should we be addressing this? Because I think so many things are coming under the role of psychiatry to sort out when actually they are not mental health problems...I suppose I struggle a bit with us taking on things that aren’t mental health problems...Perhaps we should be directing people elsewhere.’ (P20, female, psychiatrist)

“We focus on the main thing i.e. to try and get them mentally stable...We haven’t actually dealt with the domestic violence” (P10, female, care coordinator (nursing background))
This theme was also identified among service user respondents and is described in detail in Chapter 5, section 5.5.1.

6.5.1.5 Enquiry Not Part of Role
Linked to this, a small minority of professionals questioned whether routine enquiry was part of their role as a mental health provider:

“On the whole it is not seen as the remit of a community mental health team to be dealing with domestic violence unless there are diagnostic mental health problems as well” (P17, female, psychologist)

6.5.1.6 Domestic Violence Not a Priority
A related sub-theme described by some professionals was their concern that the organisational climate was not focused on identifying experiences of domestic violence. Consequently, routine enquiry of domestic violence was not made a priority within the CMHT:

“If it’s...not in the assessment at all...it is something that would easily get missed...I don’t know much about what [name of Mental Health Trust] do in terms of domestic violence as a Trust...I actually don’t even think I’ve ever seen a document that asks about domestic violence as part of an assessment” (P18, female, care coordinator (nursing background))

In contrast, a few professionals considered that the identification of service users’ experiences of domestic violence was a necessary part of their role as a mental health provider:

“Another aspect is they might not see it as their role but, you know, we take a broader view that our role is to help people live healthier life styles” (P12, male, psychiatrist)

The above themes, outlining professionals’ views on the prioritisation of domestic violence in clinical practice and their role in relation to enquiring about abuse was also detected in the previous section (see section 6.4).
6.5.1.7 Questioning the Evidence for Enquiry of Domestic Violence
One psychiatrist questioned the evidence to support routine enquiry of domestic violence in psychiatric settings. He argued that in the absence of strong evidence in support of routine enquiry professionals would not implement it into their clinical practice:

“I think that…you would have to justify it. You would have to demonstrate that there would be some benefit from doing so…I haven’t been persuaded that we should be asking everybody” (P16, male, psychiatrist)

6.5.1.8 No Indication of Violence
Some professionals described that their decision to enquire about domestic violence was dependent on whether service users disclosed difficulties in their relationships or whether they presented with physical indicators of abuse:

“I will ask direct questions about the quality of the relationship between the woman and her partner, and if it’s supportive. If I think that I get positive answers about that and have no suspicion of domestic violence I’d probably stop at that point” (P23, female, psychiatrist)

“Recently I assessed somebody who had been subjected to physical and sexual abuse from her partner; so, yeah, I mean if I’d sense within an interview or an assessment that there is a little hint of any type of abuse then I’d probably investigate into it further. But it’s not something that I’d ask off hand in that sense” (P7, female, care coordinator (nursing background))

6.5.1.9 Gender and Culture
Issues of gender were described by several professionals in relation to barriers to enquiry. The following male member of staff made his ‘excuses’ on the grounds of lack of gender matching:

“I’ve felt very uncomfortable, particularly if it’s women, obviously, in knowing how I address this?...I’ve used my excuses and said perhaps ‘you
need to be assessed by a female member of staff” (P4, male care coordinator, nursing background)

In the following response issues of both gender and culture appear:

“It would be very difficult to ask men…I think women would experience it probably as quite a caring question…There are so many different cultures of patients that I’d need to ask some of the men from some of the cultures, that would be virtually impossible” (P20, female, psychiatrist)

The themes gender and culture were also reported by service users (see Chapter 5 section 5.5.1).

Professionals also identified factors that could facilitate discussion of domestic violence, including the importance of therapeutic engagement. This theme and others will now be discussed below.

6.5.2 Dominant Themes for Facilitators to Enquiry of Domestic Violence
The dominant interpretive theme for facilitators to disclosure of domestic violence by professionals was the importance of therapeutic engagement between service users and professionals. A number of sub-themes were identified that describe factors triggering enquiry of domestic violence, including assessment tools and pre-designed prompting questions.

6.5.2.1 Importance of Engagement between Service Users and Professionals
Like service users (see Chapter 5 section 5.5.2), professionals stressed the importance of a supportive therapeutic engagement in facilitating discussions of domestic violence:

“Professionals need to make a comfortable environment or build up a close enough relationship where the patient actually feels safe enough to actually tell what’s going on” (P13, male, dual diagnosis (nursing background))
Linked to this, professionals discussed the importance of establishing trust within the therapeutic relationship:

“I think it helps if they can feel that they can disclose it in an environment which is non-judgemental. That they can trust that who they are disclosing it too will handle it sensitively and deal with any information appropriately. Otherwise they are going to feel inhibited themselves about divulging any information” (P12, male, psychiatrist)

“You have to build up the relationship, until they feel they can trust you enough to discuss what are very personal intimate things for them” (P2, female, care coordinator (nursing background))

6.5.2.2 Training on Domestic Violence
Several professionals described the significance of domestic violence training in improving clinical competencies regarding asking service users about abusive experiences:

“I think there are probably signs and hints that people give in their assessment or clues that we’re not picking up on. So, it may well be that with more support and training that staff get better equipped at an earlier stage to pick up on those cues” (P22, female, community manager)

“I think staff should be supported via management, training and things like that to be asking these sorts of questions” (P18, female, care coordinator (nursing background))

6.5.2.3 Organisational Awareness of Domestic Violence
Linked to this, organisational policies and procedures were identified as potential triggers to enquiry:

“I usually ask...I want to ask them as part of the assessment...Things like the alcohol strategy for England talks quite a lot about domestic violence hidden within the population of people who drink...So it is something I
always ask about as part of risk” (P15, male, dual diagnosis (counselling background))

6.5.2.4 Following Disclosure from Service Users
Some professionals talked about how service users’ discussions of problems in their close relationships would encourage them to enquire about domestic violence:

“Well generally I see people at home…I mean usually there will be something that will make me want to ask them more…I want to know about their relationship anyway...Usually from asking those kind of questions, if there are problems, something will indicate there’s an issue” (P25, female, care coordinator (nursing background))

6.5.3 Summary of Dominant Themes for Barriers and Facilitators of Enquiry
Mental health professionals identified several barriers to enquiry of domestic violence, including limited opportunities for enquiry, fear of consequences and a lack of confidence and expertise. Professionals described being unable to ask service users about domestic violence because of the presence of partners at meetings, time constraints and competing demands. These issues were compounded among professionals who identified concerns about the consequences enquiry may have on service users (e.g. fears about re-traumatising and offending service users). These findings are similar to the barriers to enquiry reported by primary care and non-psychiatric clinicians; as outlined in Chapter 1 section 1.11.2.1. The dominance of the medical diagnostic and treatment model was an additional barrier to enquiry and professionals explained that the overriding focus in clinical practice was on diagnosing and treating psychiatric symptomatology, to the exclusion of other social, environmental and personal factors that may contribute to current presentation. This theme was also identified by service users as a key barrier to clinical discussions about their experiences of violence (see Chapter 5 section 5.5.1).

An important theme, as highlighted in the previous section on acceptability, was professionals’ perceptions of domestic violence as a mental health issue. Findings
show the majority of professionals identified routine enquiry of domestic violence as an important mental health issue that should be addressed in psychiatric settings; although a small minority did not. Many professionals did not ask service users about their experiences of domestic violence, as they were unsure how to enquire or did not feel identification was a priority in their current clinical role. It is not surprising then that only six professionals had previously asked service users about experiences of abuse. Their decision to do so was not seen to be associated with gender, age, professional background or number of years qualified. It was, however, related to how they perceived their professional role; specifically whether their role as a mental health provider required them to ask (as illustrated in detail in the final section of this chapter).

Professionals considered a supportive therapeutic relationship as a key factor in facilitating enquiry and disclosure of domestic violence. A good level of engagement and trust within the therapeutic relationship was felt to help overcome barriers to enquiry. As outlined in Chapter 5 section 5.5.2, the same facilitators to enquiry and disclosure of domestic violence were reported by service users. Professionals described the value of receiving training on how to ask and how to respond to disclosures of abuse in improving their confidence to enquire. The theme of improved competencies in addressing domestic violence is also identified in the subsequent section. A detailed discussion of the above findings is presented in Chapter 7.
6.6 Professionals’ Experience and Expectations of the Response of Services to Domestic Violence

6.6.1 Dominant Themes for Experiences and Expectations
The dominant interpretive theme for mental health professionals concerned their experiences, both positive and negative, and expectations of services response to service users’ disclosure of domestic violence. Three key stages in experiences of responding to domestic violence were identified: (1) Identification, including sub-themes awareness, assessment and management, and dominance of the medical model; (2) Response and Referral, including sub-themes reporting requirements, referral pathways, skills training, and knowledge of services; and (3) Service Delivery, including sub-themes continuity of care, multi-agency collaboration, and specialist services (see Figure 13 below).
Figure 13: Conceptual Map of Professionals’ Experiences and Expectations of Services Response to Domestic Violence among Service Users

- Awareness
- Assessment and management
- Dominance of the medical model

Response and Referral
- Reporting requirements
- Referral pathways
- Skills training
- Knowledge of services

- Continuity of care
- Multi-agency collaboration
- Specialist services

Identification

Service delivery
6.6.1.1 Identification of Domestic Violence

6.6.1.1.1 Awareness

As can be seen from the conceptual map above, the sub-theme awareness describes how organisational- and individual-level recognition of domestic violence can support professionals in identifying service users’ experience of abuse. Some professionals described a good level of awareness within their individual practice and within the wider organisation:

“It’s something we try to tackle within our team...having team discussions on risk assessment and management, to try to dispel some of the myths, because it ought to be part of routine practice” (P12, male, psychiatrist)

“It’s about being sensitive, showing them that you are available if they want to talk. That you’re not going to judge them and that you’re on their side” (P9, female, care coordinator (social work background))

However, many others described how little organisational awareness existed within their clinical practice:

“I think it’s an area that’s been neglected somewhat in mental health...Some things fall through the cracks and I think with domestic violence, unless you are actually treating an injury in A&E it is one of those things that often falls between the cracks” (P2, female, care coordinator (nursing background))

“There should be a bit more awareness of it” (P18, female, care coordinator (nursing background))

6.6.1.1.2 Assessment and Management

A related sub-theme describes the difficulties professionals encountered in assessing service users’ experience of abuse and managing their disclosures. Some professionals identified problems in supporting service users when the violence is denied, as this can prevent them from intervening and developing strategies to respond to the abuse:
“We all knew there was domestic violence going on but she wouldn’t tell us about it...We were really a bit disempowered...It was very difficult to work with and very frustrating because she would just deny it all the time and we hadn’t actually witnessed anything” (P4, male, care coordinator (social work background))

Others described the complexities of assessing disclosures as real and valid, given service users’ mental health problems. Professionals explored how service users’ psychiatric presentation can make it difficult for them to verify disclosures:

“I can think of probably five or six examples immediately this week, with some service users, whether that’s part of their delusional belief or whether this instance actually happened” (P19, male, team leader)

Several professionals also described concerns about their competencies in managing disclosures of abuse:

“I wouldn’t know how to manage that if it came up and somebody broke down in a session with it...It’s one of those areas that is very delicate and I think you need to know how to approach a service user about that” (P18, female, care coordinator (nursing background))

6.6.1.1.3 Dominance of the Medical Diagnostic and Treatment Model
Another important sub-theme describes professionals’ explanation of the influence of the dominance of the medical and diagnostic treatment model in assisting the identification of domestic violence; this was also a salient theme with regards to professionals’ barriers to implementation of enquiry (as highlighted in section 6.5). Professionals explained how the medical model has an overriding focus on treating presenting symptoms and this often negates discussion of personal and social factors that can influence symptomatology:

“She [service user] got into another relationship, which was abusive...and all the time we [mental health professionals] were concentrating more on her mental health problems...We never ever focused on the things that led
her into that situation”  (P10, female, Care Coordinator (Nursing Background))

6.6.1.2 Response and Referral
The second stage in professionals’ reaction to domestic violence concerns their response and referral following service users’ disclosure of domestic violence (as outlined below).

6.6.1.2.1 Reporting Requirements
The sub-theme reporting requirements describe professionals’ experience of adhering to reporting obligations following service users’ disclosure of abuse. Professionals identified concerns about the impact a referral may have on the therapeutic relationship with service users, particularly with regard to referrals to Children and Families Social Services:

“At what point do you say ‘well actually I’m not able to hold this information, it’s got to be shared for the duty and legal responsibility”’  
(P19, male, team leader)

“I would be saying to a woman ‘I know you don’t want to do something about this, but I’m going to do something about it because you’ve got children in the home’…Often the mothers don’t like that, but Children and Families’ [Social Services] can often tackle the father in ways that we can’t”  
(P4, male, care coordinator (nursing background))

The challenge of acting within the bounds of confidentiality was also highlighted:

“You have to work around confidentiality with the client. It might be that they just want to tell you…where do you go with that?”  
(P19, male, team leader)

Linked to this, professionals explored the value of specific reporting procedures, such as the recent “Vulnerable Adult” procedures. These procedures ensure that health Trusts implement codes of practice to help prevent and tackle the abuse of
vulnerable adults (Department of Health & Home Office, 2000). Within the Trust at which this research took place, all safeguarding adult incidents must be reported both internally (through completion of the Trust incident form) and externally (by informing the local authority Adult Safeguarding Lead). A multi-agency meeting is then held and an investigation process established, based on the nature and severity of the abusive incident and the location of the incident. The local authority then makes a decision whether to proceed with the Adult Protection Investigation (South London and Maudsley NHS Foundation Trust, 2008).

This research revealed mixed views among clinicians who had implemented “Vulnerable Adult” procedures:

“There was a process that we had to go through…and it had police involvement…and various meetings to see how best we could safeguard her [service user]…She’s had a lot of input, of different services, and I think that has helped” (P9, female, care coordinator (social work background))

“They’ve started this new ‘Vulnerable Adults’ thing…In a sense it doesn’t feel very useful…it’s a lot of form filling and meetings…You wouldn’t go out there and say ‘yes, I am going to put my client in to the ‘Vulnerable Adults’ system, because it’s so much work” (P3, female, care coordinator (nursing background))

6.6.1.2.2 Referral Pathways
Another sub-theme describes professionals’ discussion regarding the lack of clear referral pathways for service users who disclose abuse. In the absence of specific referral pathways, many clinicians remained unclear of the most appropriate way to respond to disclosures:

“It would be nice to have contacts…specialist input and support…I think clearer guidelines would be helpful. I think then more professionals might be inclined to look at domestic violence and act on it…It almost feels like
Linked to this, professionals described how, in contrast to child protection guidance, care pathways for adults experiencing domestic violence were unclear, particularly for less severe cases:

“It’s kind of tightening up on having a more clear pathway and guidance for adults I think. I mean obviously if there’s a child involved we are immediately with the children and obviously we are immediately with the police if it’s a really high risk” (P19, male, team leader)

There were mixed views regarding professionals’ experience of referral to domestic violence services. Some professionals reported difficulties in gaining access to services, citing long waiting lists and a reluctance of mainstream services to support people with mental illness:

“I don’t think there are enough services, especially for mental health service users” (P10, female, care coordinator (nursing background))

“Refuge seems to be quite difficult to get into, it’s very busy and not many places are available” (P17, female, psychologist)

Others reported positive processes, with good communication and support between themselves and specialist agencies:

“Domestic violence unit…I have spoken to them for general advice before and they have always been helpful and happy to get involved if necessary” (P19, male, team leader)

6.6.1.2.3 Skills Training
A further sub-theme describes professionals’ concern about their skills and competencies in responding appropriately to disclosures:
“I can help support them but I don’t feel I have the expertise to be able to actually walk them through the process that they need to go through” (P4, male, care coordinator (nursing background))

“It should be part of our training to know more about it...what services are available” (P21, female, psychiatrist)

Linked to this, a few professionals warned against colleagues withdrawing assistance when service users do not act on all of their advice:

“I think it’s important not to withdraw because somebody hasn’t taken up your advice...so they come back to you when it’s happening again...It’s important not to say ‘well I tried and that’s it’, because sometimes it’s quite difficult” (P11, female, care coordinator (nursing background))

6.6.1.2.4 Knowledge of Services
The theme knowledge of services outlines the importance professionals placed on providing service users with information about services:

“Talking to them...and explaining they don’t necessarily have to be alone in this process...Giving information literature...help lines and things that they can just talk to someone if they can’t do it face to face” (P15, male, dual diagnosis (counselling background))

“There is something about the whole system having access and understanding about the impact of domestic violence and where to go for help” (P21, female, psychiatrist)

6.6.1.3 Service Delivery
The third stage in professionals’ response to domestic violence concerns their experience of identifying adequate support services for service users, and ensuring that the support is delivered.
6.6.1.3.1 Continuity of Care
This sub-theme describes professionals’ concern about the consistency of care service users receive from health services. Clinicians explained how the trauma of abuse experienced by service users may not be adequately addressed throughout their contact with health services. As a consequence, this may affect their level of engagement with services:

“Our services aren’t always consistent...so it’s difficult to expect people to commit to a service if the service doesn’t appear to be committed to them really” (P5, male, care coordinator (social work background))

Linked to this, professionals described that although reports of domestic violence may be documented within service users’ medical notes they are often not explored:

“Often they seem to be things that find their way into medical records, just a note of previous violent relationships, but I am not sure they are ever explored in much detail really” (P16, male, psychiatrist)

Additionally, professionals expressed the need for services to ensure that service users receive provision of support following disclosures:

“People need to know that if they are going to report to someone...that there are people who are going to support them”(P16, male, psychiatrist)

6.6.1.3.2 Multi-Agency Collaboration
A related sub-theme, and one also identified by services users (see Chapter 5, section 5.6), explains professionals’ discussion about the need for improved multi-agency collaboration to support psychiatric service users experiencing abuse:

“We should be linking up, working closely in partnership with other agencies and having clear plans in place” (P19, male, team leader)
“We should link up with other services more...My experience was that it was quite fragmented, with all these services involved and everybody had different expertise” (P21, female, psychiatrist)

Professional also spoke of the need to establish improved information sharing practices about service users’ experience of domestic violence:

“I can’t even think that any of the domestic violence stuff has ever been documented in letters or referral letters...No one is sharing information” (P18, female, care coordinator (nursing background))

6.6.1.3.3 Specialist Services
Another sub-theme outlines professionals’ concerns about gaining access to appropriate support services for people with severe mental illness who experience violence. Several professionals identified difficulties in obtaining access to mainstream domestic violence services for psychiatric service users:

“Services that are available are not available for people with mental health illnesses” (P10, female, care coordinator (nursing background))

6.6.1.4 Summary of Dominant Themes for Experiences and Expectations of Services
Three key stages regarding professionals’ response to domestic violence were identified: (1) Identification, (2) Response and Referral, and (3) Service Delivery. With regards to Identification, professionals spoke of the importance of both individual- and organisational-level awareness of domestic violence in supporting the identification of abuse. Difficulties in the assessment and management of domestic violence were reported when service users were seen to deny the violence perpetrated against them. The severity of service users’ psychiatric presentation was also reported to create further difficulties in the assessment of abuse, as professionals sought to verify disclosures as real and valid and not a form of delusion.
In relation to Response and Referral, professionals described the complexities in maintaining a supportive therapeutic relationship whilst adhering to obligatory reporting procedures, particularly regarding child and adult safety issues. Mixed opinions were given regarding protection of “Vulnerable Adults” policies, and professionals identified an absence of clear care referral pathways for domestic violence. Some professionals also discussed limitations, with regards to their professional competencies in responding to service users’ experiences of domestic violence (a theme that is illustrated in detail in the following section).

Service Delivery describes professionals’ call for service users to receive continuity of care from health services and adequate support for the trauma related to abuse, which was often felt to be lacking in practice. Professionals discussed the importance of providing on-going support for service users, both emotionally and practically, and not withdrawing that support if service users do not immediately act on their advice. The need for improved multi-agency collaboration was described as critical in ensuring service users receive adequate support for their experiences of domestic violence. Finally, professionals outlined the potential difficulties experienced in getting service users’ access to mainstream domestic violence services. They explained how mainstream services may refuse to take on service users, on the basis that they do not have the capacity to support their complex needs. As a consequence, professionals called for the development of specialist services to support people with severe mental illness who experience abuse. The latter two findings were also reported by service users, who also believed that improved inter-agency collaboration and the development of specialist service provisions were necessary to improve psychiatric services response to domestic violence (see Chapter 5 section 5.6). A detailed discussion of the above findings is presented in Chapter 7.
6.7 Professional Typologies of ‘Perception of Professional Role’

6.7.1 Typologies Identified in the Narratives of Professionals

This section presents findings from a constant comparative analysis of professional narratives. Through detailed analysis, both within and between cases, clinicians’ experiences of identifying and responding to domestic violence were seen to be influenced by the perception of their professional role. Therefore, the dominant interpretive theme in relation to mental health professionals’ willingness to identify and respond to domestic violence was a ‘perception of professional role’. The analysis revealed distinct categories with regards to professionals’ role perceptions, which for the purposes of this analysis are classified into separate typologies.

As described earlier (see Chapter 5, section 5.7), there are important considerations to be made when categorising the narratives of respondents (Morgan, 2003), to ensure that summaries and comparisons capture all instances of variation within the emerging theory (Willig, 2008).

The professionals in this study described four distinct types of perceptions, which I have categorised as follows: (1) embracing, (2) accepting, (3) ambivalent, and (4) avoidant (see Appendix 14 for the typology tables). Professionals in the ‘embracing’ category were the only ones who perceived that they have an obligation within their professional role to identify and respond to domestic violence. This group of professionals believe that abusive experiences have a considerable impact on service users’ mental health well-being, and they therefore actively seek to explore the topic within their practice. In contrast, professionals in the ‘accepting’ group described how their decision to implement strategies for the assessment of domestic violence was dependent on the degree to which they perceived their current role focused on addressing domestic violence. Although this group of professionals described a general willingness to explore issues of abuse, their experience of doing so was dependent on the perceived level of awareness of domestic violence within the organisation. Professionals in the ‘avoidant’ group perceived that they lack the skills required to identify and respond appropriately to service users’ experience of domestic violence. Finally,
the ‘ambivalent’ group questioned whether domestic violence is a mental health issue and reported feeling unsure whether their role requires them to address this issue with service users (see Table 9 below).
Table 9: Results from a Constant Comparative Analysis of Professionals’ Narratives

<table>
<thead>
<tr>
<th>Super-ordinate theme: Professionals Perception of their Professional Role in Addressing DV</th>
<th>Sub-ordinate theme headings</th>
<th>Sub-ordinate theme description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Embracing</strong></td>
<td>Ten professionals (five women and five men) perceived that they had an obligation to identify and respond to DV among service users, as part of their duty of care as a mental health professional</td>
<td>These professionals actively sought to explore DV with service users on a routine basis.</td>
</tr>
<tr>
<td><strong>Accepting</strong></td>
<td>Six professionals (five women and one man) reported a general willingness to identify and respond to DV, however, their decision to do so was dependent on whether they perceived their current team encouraged them to address these issues</td>
<td>These professionals only sought to explore DV with service users when they perceived their role encouraged them to do so</td>
</tr>
<tr>
<td><strong>Avoidant</strong></td>
<td>Five professionals (three women and two men) considered DV to be an important mental health issue but perceived that they lacked the necessary skills and clinical expertise to identify and respond effectively to DV</td>
<td>These professionals actively avoided exploring issues of DV with service users due to their concerns about their clinical competencies in addressing DV</td>
</tr>
<tr>
<td><strong>Ambivalent</strong></td>
<td>Four professionals (two women and two men) perceived their role was to diagnose and treat the mental health concerns of service users and not that of unrelated social and personal factors, including DV</td>
<td>These professionals did not seek to explore DV with service users, as they perceive such issues to be a non-mental health issue</td>
</tr>
</tbody>
</table>
All four typologies were seen to transcend professionals’ gender, age and ethnicity. The four typologies were found to transcend clinical disciplines (see Table 10 below) and the number of years clinicians had been qualified. These findings have important implications for the implementation of domestic violence protocols by mental health professionals.

Table 10: Demographic Details of Professionals: Categorised by Professionals’ Perception of their Professional Role

<table>
<thead>
<tr>
<th>Typology Characteristics</th>
<th>Embracing (n=10)</th>
<th>Accepting (n=6)</th>
<th>Avoidant (n=5)</th>
<th>Ambivalent (n=4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>social worker (n=3)</td>
<td>community manager (n=1)</td>
<td>psychiatrist (n=1)</td>
<td>psychologist (n=1)</td>
<td></td>
</tr>
<tr>
<td>nurse (n=4)</td>
<td>psychiatrist (n=2)</td>
<td>dual diagnosis practitioner (n=1)</td>
<td>psychiatrist (n=3)</td>
<td></td>
</tr>
<tr>
<td>dual diagnosis practitioner (n=2)</td>
<td>nurse (n=2)</td>
<td>nurse (n=3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>psychiatrist (n=1)</td>
<td>team manager (n=1)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This section will describe and discuss each typology in detail and explore their similarities and differences. Discussions will concentrate on how perceptions of professional role influence clinicians’ views on the role of domestic violence in psychiatric settings, and the response of psychiatric services to domestic violence.

6.7.1.1 Embracing

The ten professionals in this category described experiences of both identifying and supporting service users who disclosed domestic violence. They showed an understanding of the type of violence experienced by service users and the impact this can have on their mental health. Professionals in this group identified a link between mental illness and domestic violence, highlighting how this form of abuse may lead to the development of mental illness or exacerbate existing symptoms.
6.7.1.1 Experience of Identifying and Responding to Domestic Violence

A theme unique to professionals in this category is a perception that they have an “obligation” to respond to domestic violence experienced by service users. They explored how the experience of mental illness can render service users “vulnerable” to exploitation by those close to them and perceived their role as essential to identifying situational factors that may impede service users’ recovery. In practice, they seek to “tease out” experiences of violence and abuse, including observing service users’ verbal and non-verbal responses, as they acknowledge service users will not readily disclose such experiences:

“When you can’t really see anything else then you have to start thinking of what they’re not saying” (P8, male, care coordinator (nursing background))

These professionals are attuned to gender and cultural issues, which may influence service users’ willingness to disclose and discuss experiences of domestic violence. They advocated for clinicians to consider and take steps to mediate gender and cultural factors when identifying and responding to domestic violence. One social worker described how she responded to concerns about a young male service user, which she suspected felt uncomfortable to disclose his experiences of abuse with a woman, by asking a male colleague to talk to him about these experiences:

“I got a male psycho-social therapy practitioner to come in and talk to him [service user], because he just didn’t feel comfortable talking to me about it” (P9, female, care coordinator (social work background))

Professionals in this typology made reference to the social “stigma” of domestic violence and explored how such discriminatory attitudes can influence service users’ willingness to disclose. Some professionals raised concerns about how the stigma of domestic violence may influence referral agencies response to service users:
“If I refer on to a psychologist and say there is domestic violence within this relationship...that will cloud, or potentially could cloud, that person’s view of the service user...That will have an effect on work they try to do” (P13, male, dual diagnosis (nursing background))

6.7.1.1.2 Views on Current Clinical Practices towards Domestic Violence

A common theme among this group of professionals’ concerned frustrations with psychiatric services response to domestic violence. They argued that current mental health practices “gloss over” the subject of domestic violence. Some professionals made reference to examples when service users’ disclosures were dismissed by community mental health teams, because they were perceived to be a symptom of service users’ illness. One professional spoke of her experience in attempting to respond to a service user’s disclosure of domestic violence whilst managing pressures from management, who perceived the disclosure to be symptomatic of mental illness:

“I felt really unsupported by the consultant and the team manager, about whether she’s [service user] telling the truth, because they were saying ‘it’s her mental health problem’...It really was probably the worst bit of practice I’ve seen” (P3, female, care coordinator (nursing background))

Professionals argued that, because domestic violence is not prioritised within psychiatric services, disclosures of violence are commonly dismissed as part of service users’ “social history”. Consequently, experiences of domestic violence are not perceived to require intervention from the mental health team. Professionals also described how some colleagues may expect service users to take sole responsibility for seeking help for the violence.

Professionals in this category discussed how current mental health assessments fail to identify domestic violence among service users. They spoke of the need for psychiatric services to generate a clear discourse about domestic violence, which is implemented in routine practice, organisational procedures and policies:
“Somewhere in our paperwork, like in our CPA system, they should flag up domestic violence...We do risk assessments and it does say risk from others but again I think people talk about risk from the public, rather than family” (P24, female, care coordinator (social work background))

Professionals in this typology raised concerns about an absence of clinical training on domestic violence. They discussed the impact this can have on clinicians’ effectiveness in identifying cases of domestic violence. They called for an increased awareness on the subject of domestic violence in psychiatric settings, on the basis that the majority of clinicians lack the “confidence and knowledge” to address domestic violence. The following illustration explores how clinicians’ lack of competencies in addressing domestic violence can serve to hinder the identification of service users’ experience of domestic violence:

“It’s a huge issue...Just because a practitioner has not been able to, or felt confident enough to ask questions, they don’t know that there’s violence happening” (P15, male, dual diagnosis (counselling background))

Linked to this, professionals explored the value of receiving specific training on domestic violence to improve their responses to service users’ disclosures. They highlighted that clinicians have little knowledge of domestic violence services and this is likely to affect the quality of care they are able to provide service users:

“I don’t know exactly how to deal with it. You’re looking for services and services are not available for people with mental health illnesses, so it’s very difficult” (P10, female, care coordinator (nursing background))

6.7.1.2 Accepting
The six professionals in this category share similar themes with the ‘embracing’ group, in that they identified domestic violence as an important issue, affecting service users’ mental health. They show an understanding of the nature of domestic violence and report some experience of responding to disclosures. In contrast to the ‘embracing’ group, they do not regularly seek to detect service users’ experience of domestic violence in clinical practice.
6.7.1.2.1 Experience of Identifying and Responding to Domestic Violence

Professionals in this category described that their willingness to address domestic violence depends on whether they perceive their role encourages them to explore these issues. They explained that their awareness of domestic violence is determined by how much emphasis they perceive the organisation places on the subject. If they perceive the organisation integrates the topic of domestic violence in routine practice (e.g. via mental health assessments) they will willingly explore these issues with service users. If, however, they perceive these factors are missing they will not explore the subject with service users. The willingness of these clinicians to explore domestic violence was not seen to be dependent on the specific type of job role they held (e.g. care coordinator), but was instead determined by their perception of organisational awareness towards domestic violence. This theme is illustrated in the following quotation from a nursing professional who contrasts her previous role, working in an addiction clinic, with her present role as a nurse in a community mental health team:

“The clinic that we ran was multi-disciplinary...It was kind of everything under one roof...so it would be asked as part of the assessment screen...Here we don’t have it as part of the assessment at all...I know it’s not something that is routinely asked here...If it’s not in the assessment at all...it is something that would probably easily get missed” (P18, female, care coordinator (nursing background))

Professionals in this category spoke of the “complexity” in addressing cases of domestic violence, and felt that the process of responding to domestic violence was often not straight forward. They described how clinicians may develop “frustrations” with regards to adequately supporting service users; particularly in cases where they perceive service users are not taking the necessary steps to leave the violent relationship, or to improve their situation:

“I think people feel quite helpless about domestic violence, if the victim doesn’t get out of the situation. Maybe they also feel angry about it, they
6.7.1.2.2 Views on Current Clinical Practices towards Domestic Violence
As with the ‘embracing’ group, professionals described a limited awareness about the subject of domestic violence within existing psychiatric policies and procedures. They discussed how current mental health assessments fail to include questioning around domestic violence:

“I don’t even think I’ve ever seen a document that asks about domestic violence as part of an assessment” (P18, female, care coordinator (nursing background))

They called for improved knowledge on how to identify cases of domestic violence and proposed that if such measures were introduced clinicians would be encouraged to enquire about domestic violence with service users:

“I think heightened awareness, a better understanding of what to look for...and support around examining relationships...May be exploring that a bit more” (P22, female, community manager)

Professionals described experiencing “frustrations and anxieties” with regards to responding to domestic violence, perceiving it to be “an area that’s been neglected somewhat in mental health”. They also reported a limited knowledge of specialist domestic violence services and, as a consequence, experienced difficulties when seeking to refer service users for support. Based on these experiences, professionals in this typology argued for the need for greater clinical training on domestic violence. They also called for the establishment of regular team discussions and clinical guidance on how to appropriately respond to domestic violence.

6.7.1.3 Avoidant
The five professionals in this category showed some understanding of the nature and impact of domestic violence experienced by service users. Like the
‘embracing’ and ‘accepting’ types, clinicians in the ‘avoidant’ category explored the impact of domestic violence on service users’ mental health. In contrast to the other two groups, these professionals described actively avoiding the subject of domestic violence in clinical practice. Consequently, they reported limited experiences in identifying and responding to domestic violence.

6.7.1.3.1 Experience of Identifying and Responding to Domestic Violence
Professionals in this category reported feeling “untrained” to enquire and respond to domestic violence. As a result, they avoided discussing the topic with service users, both on occasions when they suspected abuse and following service users’ disclosure:

“I’ve always been slightly aware that it’s there, it’s in the room...Sounds awful but I mean I’ve used my excuses” (P4, male, care coordinator (nursing background))

“They’ve [service users] raised it in the assessment but I haven’t gone into the particulars. I haven’t asked them about the nature of it...They’ve said that it has happened, but I haven’t gone into what had happened” (P14, male, dual diagnosis, (counselling background))

Professionals described that, as part of the helping profession, they feel it is important to respond to service users’ disclosures of abuse; however, because they have limited knowledge on the subject they are unclear about how best to respond:

“We feel we very much have to react to this, we’re not just passive listeners and we can’t be...There might be a situation where it's historical and you're just picking up the pieces...There might be a situation where they're telling you ‘no it’s actually happening now’. I think that’s probably where training will come into it...Whether you act on what the person is telling you at the moment and how much you find out” (P1, female, psychiatrist)
Professionals’ uncertainty about how to appropriately respond to domestic violence was further illustrated by some, who raised concerns regarding the amount of focus that should be directed towards discussing issues of abuse with service users:

“I don’t think that should be the focus of the work...I think it’s about...how they [service users] relate to people and how that could be explored, rather than what actually happened” (P14, male, dual diagnosis (counselling background))

6.7.1.3.2 Views on Current Clinical Practices towards Domestic Violence
A common theme among this group of professionals concerned the need for the subject of domestic violence to be “further up the agenda” within current psychiatric practice. These professionals considered domestic violence to be an important mental health issue that should be addressed within clinical practice. However, they did not currently feel they had the competence to identify and respond appropriately. They described a limited awareness about domestic violence and called for greater knowledge and understanding about the subject, including a clear definition of domestic violence. Professionals in this group called for specific training on domestic violence, including an experiential component to improve clinicians’ identification and response to domestic violence. They described how at present there is an absence of discussions about domestic violence within mental health assessments, and advocated for specific policies and procedures on domestic violence.

6.7.1.4 Ambivalent
The four professionals in this category reported some experience of identifying domestic violence among service users, which predominantly occurred following service users’ disclosures. In contrast to the other three groups, these professionals described feeling ambivalent towards addressing domestic violence in their clinical practice. The reason for this is because they remain unconvinced that service users’ experience of abuse is a mental health issue.
6.7.1.4.1 Experience of Identifying and Responding to Domestic Violence

With regards to their clinical experience, professionals in this category described domestic violence as a complex situation, which is “not particularly clear cut”. They described feeling unsure about how to address domestic violence in cases of mutual violence, and when they perceive service users to be “stuck in relationships”. They discussed their observations of the repetitive nature of service users’ experiences of domestic violence and explored the value of addressing factors that render them vulnerable to abuse.

Professionals in this category explained how little focus is given to service users’ experiences of domestic violence in clinical practice and suggested that it is not seen as part of psychiatric services remit:

“On the whole it is not seen as the remit of a community mental health team to be dealing with domestic violence, unless there are diagnostic mental health problems as well” (P17, female, psychologist)

Professionals in this typology questioned whether it is the role of mental health professionals to address domestic violence, which they did not perceive to be a mental health issue:

“I suppose my first response is ‘should we be addressing this?’ Because I think so many things are coming under the role of psychiatry when actually they are not mental health problems…I struggle a bit with us taking on things that aren’t mental health problems” (P20, female, psychiatrist)

Linked to this, one psychiatrist questioned whether there exists clear evidence to suggest mental health professionals should enquire about domestic violence. They concluded that in the absence of good evidence they would not seek to identify such experiences with service users:

“I haven’t been persuaded that we should be asking everybody” (P16, male, psychiatrist)
6.7.1.4.2 Views on Current Clinical Practices towards Domestic Violence

In contrast to the other three typologies, this group of professionals did not call for psychiatric services to implement domestic guidance within clinical assessments and care planning. They also did not propose that domestic violence be incorporated within the mental health agenda, as they did not perceive it to be a mental health issue.

6.7.2 Summary of Typologies

The comparative analysis of professionals’ interviews identified four distinct types of perception of professional roles: (1) embracing, (2) accepting, (3) avoidant and (4) ambivalent. There are some clear similarities and differences between the four different typologies. Professionals in the ‘embracing’ category are the only clinicians who perceive they have a duty of care to explore issues of violence with service users. Consequently, they are the only group who actively seek to identify and explore experiences of domestic violence on a regular basis within their clinical practice. Professionals in the ‘accepting’ group, despite reporting a general willingness to explore the topic of domestic violence, did not regularly do so within their practice. Indeed, their decision to identify and respond to domestic violence is dependent on how much they perceive their current role is focused on addressing this topic. In contrast, the ‘avoidant’ group described an unwillingness to explore issues of domestic violence with service users, because of a limited knowledge and expertise in responding to abuse. As a result, these professionals actively avoided the subject with service users, feeling ill-equipped to identify and respond appropriately.

Despite differences among these three typologies, all of them agreed that domestic violence is an important mental health issue that should be addressed within psychiatric settings. ‘Embracing’ and ‘accepting’ types described frustrations with current psychiatric practices, which were perceived to overlook issues of domestic violence. They called for an increased focus about abuse at an organisational-level across psychiatric services. The ‘accepting’ and ‘avoidant’ groups explored the complexity of managing domestic violence situations and discussed the value of receiving increased knowledge and skills training on how
to respond to abuse cases. They felt it would be particularly useful to receive training around supporting service users who may find it difficult to separate from an abusive relationship, and for those reporting a past history of abuse. Each of the three typologies argued for specific training and education on the topic of domestic violence, which includes experiential training on how to appropriately enquire and respond to service users’ experiences of violence. Further similarities included the need for increased information on the topic of domestic violence and support services, which can support clinicians in providing adequate support to service users.

In direct contrast to the above three groups, the ‘ambivalent’ group remain unconvinced that domestic violence is a mental health issue, and question whether it is part of their role to address this issue. This group of professionals report an unwillingness to explore service users’ experience of domestic violence, which they consider to be beyond the remit of their professional role.

All four types identified that current mental health assessments do not specifically focus on issues related to domestic violence. The ‘embracing’, ‘accepting’ and ‘avoidant’ groups spoke of the need to revise clinical assessments and care plans to include specific questions about domestic violence, which they felt would lead to improved identification by clinicians. The ‘ambivalent’ group argued that if psychiatric services want to encourage routine enquiry about domestic violence they should provide justification for the need to enquire, in order to convince clinicians of the value of increased identification of abuse for their practice. A detailed discussion of the above findings is presented in Chapter 7.
Chapter 7: The Identification and Response of Community Mental Health Services to Domestic Violence: Qualitative Study

Discussion

7.1 Introduction

This is the first study to look at the views of both service users and mental health professionals, in relation to: their experience of enquiry/disclosure of domestic violence; their knowledge of services, and their views on what interventions had been or would be helpful.

Several super-ordinate themes were identified in the narratives of service users and professionals: (1) the acceptability of routine enquiry about domestic violence in psychiatric settings; (2) knowledge of support services; (3) barriers and facilitators to enquiry/disclosure of domestic violence; and (4) experiences and expectations of services’ response to psychiatric service users’ experience of domestic violence. Several overlapping sub-ordinate themes were also identified, including: (1) the dominance of the medical diagnostic and treatment model; (2) the importance of a supportive and trusting therapeutic relationship; (3) the need for improved multi-agency collaboration and specialist services for abused psychiatric service users, and (4) clinical awareness of gender and cultural issues in relation to domestic violence.

This chapter begins with a discussion of super-ordinate and sub-ordinate themes specific to service users and professionals, followed by a discussion of super-ordinate and sub-ordinate over-lapping themes identified among both groups. Study limitations and conclusions then follow.
7.2 Service User Specific Themes: Discussion of Results from a Thematic Analysis

7.2.1 Dominant Interpretive Themes in Service Users’ Narratives
As can be seen from Table 5 in Chapter 5, service user specific themes from the thematic analysis included unanimous agreement about routine enquiry of domestic violence, and barriers to disclosure of domestic violence. With regards to services response to domestic violence, service users valued a response from clinicians that: acknowledged their experiences of abuse, was receptive to their disclosures, and delivered adequate support for their complex needs (as will be discussed below).

7.2.1.1 Service Users’ Acceptability of Routine Enquiry about Domestic Violence in Psychiatric Settings
All male and female service users were in favour of implementing routine enquiry of domestic violence in psychiatric settings, including the six male and female respondents who did not report domestic violence. The ability to generalise these findings to the wider community of psychiatric service users is restricted, however, as only a small purposive sample of service users from one south London borough were sampled. Furthermore, only six of the 24 respondents did not report experiences of domestic violence, and only one reported no previous experience of abuse. The high prevalence of violence in this sample is not unusual when taking in to consideration the findings of Chapter 2, which showed a high prevalence of domestic violence among psychiatric service users. A recent review found that psychiatric service users report more domestic violence than other health service users and the general population (Alhabib, Nur & Jones, 2010). These findings support research in primary care settings, which suggests that female service users are accepting of routine enquiry of domestic violence by clinicians (Boyle & Jones, 2006; Feder, Ramsay, Dunne, et al, 2009). To my knowledge, no systematic assessment of the acceptability of routine enquiry about domestic violence among male service users, in any health setting, has been conducted.
7.2.1.1 Routine Enquiry can Facilitate Disclosure

Service users explained that in the absence of direct enquiry from professionals they would be unlikely to disclose experiences of abuse, which supports international evidence across health settings (Dill, Chu, Grob, et al., 1991; Goodwin, Attiass, McCarty, et al., 1988; Howard & Hunt, 2008; Read, van Os, Morrison, et al., 2005; Richardson & Feder, 1996). Service users described how in the absence of direct enquiry from clinicians they generally ‘bottled up’ their experiences, perceiving them to be a ‘secret’ that should not be discussed. These views may be reflective of service users’ experience of domestic violence, which is often shrouded in secrecy and perpetrated in the private sphere of their homes. Feelings of a need to disguise experiences of abuse may also reflect their understanding of social attitudes towards gender roles, as they question how their experience of violence reflects on the expectations of them as a woman/man or parent. In our society, women are socialised to be the perfect mother, wife, daughter in law, and men to be masculine through the use of dominance and aggression (Gerber, 1991; Seelau & Seelau, 2005). Research with black, Asian, minority ethnic and refugee (BAMER) groups suggests that gender-role conflicts may be further affected by acculturation pressures, racial and ethnic identities and experiences of recent immigration (Canales, 2000; Thiara & Gill, 2010a).

7.2.1.2 Routine Enquiry Assists Clinicians’ Identification of Causes of Illness/ Vulnerabilities to Abuse

Several respondents described how their experience of domestic violence resulted in a deterioration in their mental health, which clinicians failed to identify and explore with them. Other qualitative research has identified similar findings among service users, and scholars warn that medical models run the risk of pathologising the trauma associated with abuse (Humphreys & Thiara, 2003a; Sanderson, 2008). Service users who understood their experiences of domestic violence in terms of their vulnerabilities to exploitation described how direct enquiry would assist professionals in identifying susceptibilities to violence among people with severe mental illness.

The findings of this analysis suggest that a readiness of services to identify issues of violence and abuse, through professional enquiry, can facilitate service users’ disclosures. Conversely, if professionals display a reluctance to generate
discussions of abuse this can act to silence survivors, exacerbate feelings of shame and embarrassment and place survivors at increased risk of harm (Djikanović, Lo Fo Wong, Jansen, *et al.*, 2012; Fanslow & Robinson, 2010; Tabassum N. R., Azim, Bhuiya, *et al.*, 2006). In the absence of direct enquiry from clinicians, most service users in this study only disclosed when the abuse became severe (e.g. hospitalisation following physical assault) and they were fearful for their safety. These findings may be linked to service users’ understanding of domestic violence as a socially accepted phenomenon. Moreover, those who were unable to identify the abuse and those who felt they were able to manage the abuse may have struggled to accurately assess their risk of harm. Evidence suggests delayed disclosure of abuse is common among survivors and can be associated with a perception that abusive behaviours are ‘normal’ and manageable (Djikanović, Lo Fo Wong, Jansen, *et al.*, 2012; Fanslow & Robinson, 2010). The implications of these findings will be explored in Chapter 8.

7.2.1.2 Barriers to Disclosure of Domestic Violence

7.2.1.2.1 Fear of the Consequences of Disclosure

Men and women were afraid of the potential consequences of disclosure of domestic violence to mental health professionals and other professionals (e.g. GPs, social workers, the police). Fear of reprisals from the abuser was an important theme identified in the narratives of service users, including among those who had ended the violent relationship. The latter findings are notable as survivors are shown to be at risk of post-separation violence from their abuser (Humphreys & Thiara, 2003b; Wilson & Daly, 1993). Survey research suggests that men and women abused by their partners are significantly less likely to report abuse to the police, due to fear of reprisals, than people abused by acquaintances (Felson & Pare, 2005).

The findings of this study supports evidence that mental health service users may be reluctant to report abuse due to family loyalties and/or fears about losing custody of their children (Agar, Read & Bush, 2002; Humphreys & Thiara, 2002; McCauley, Yurk, Jenckes, *et al.*, 1998). The dominance of the medical model of mental health has been shown to have negative consequences regarding child contact and child protection proceedings for abused women labelled with mental
health problems (Humphreys & Thiara, 2003a). Research suggests that a significant number of women with severe mental illness - particularly schizophrenic disorders - have children removed from their custody (Hollingsworth, 2004; Howard, Thornicroft, Salmon, et al, 2004; White, Nicholson & Fisher, 1995). In addition, many mothers experiencing domestic violence may lose sole custody of their children, when judges do not believe their children are in danger of harm by abusive fathers. This view contrasts with evidence that 30-60% of men who abuse their partners also abuse their children (Eddleson, 1999; Hester, Pearson, Harwin, et al, 2007; Humphreys & Thiara, 2002), and shows how the justice system makes little connection between male violence and male parenting (Thiara, 2010). In response to joint custody agreements, mothers are forced to continue a relationship with their abuser and this may result in women’s relationships with their children being undermined as part of a wider strategy of abuse (Humphreys, 2006; Thiara, Humphreys, Skamballis, et al, 2006). Child contact arrangements can allow abusers to maintain their damaging presence on the lives of women and children, and permits them to continue to abuse and stalk their partners (Burman & Chantler, 2005; Thiara, 2010; Walker, 2009). Alarmingly, the continuing issues faced by women and children in these situations have frequently been shown to be couched in terms of ‘mother-blaming’ (Jaffe, Lemon & Poisson, 2003; Radford & Hester, 2001; Thiara, Humphreys, Skamballis, et al, 2006; Thiara, 2010).

Legal processes may be used by abusers to continue post-separation violence, with regards to contesting women’s evidence of domestic violence; making counter-allegations of child abuse, and undermining women’s mothering capabilities (Hardesty, 2002; Humphreys & Thiara, 2003b; Thiara, 2010). These issues are compounded among BAMER women, who may be unaware of UK legislation regarding child custody agreements and who may be intimidated by court processes, particularly when it is necessary for them to give evidence through the use of interpreters (Malley-Morrison & Hines, 2007; Thiara, 2010). Research with South Asian women has shown that the failure of courts to understand the complex interplay between personal, family, community and societal dynamics means that their experiences are often inadequately understood and not sufficiently addressed (Thiara, 2010).
Service users in this study described fears relating to the potential disruption caused to their family following disclosure, specifically in relation to the impact of relocation on established social networks and their children’s education. Other research has identified similar fears among mothers experiencing domestic violence (Humphreys & Stanley, 2006). Fear of the consequences of disclosure in relation to insecure immigration status was also reported. Evidence suggests that barriers to disclosure of abuse among immigrant women include: fears around deportation; concerns that abuser(s) will be enlisted as the translator of disclosures, and a fear of the police due to experiences of mistreatment or discrimination in their country of origin (Bent-Goodley, 2007; Gill, 2004; Kasturirangan, Krishnan & Riger, 2004; Lee, 2000).

In light of the findings presented above, non-disclosure can therefore be a very rational decision based on service users’ knowledge of the risks and benefits of disclosure.

7.2.1.2.2 The Hidden Nature of Domestic Violence
Abusers sought to disguise their use of violence from clinicians and to convince service users that their behaviour was not abusive. Service users described how abusers sought to isolate them from friends, family and the wider community. These actions had the effect of increasing the abusers control over them. The abuse dynamic model suggests isolation tactics are employed to make survivors increasingly dependent on abusers, and more susceptible to their distorted perceptions of the world (Horley, 2002; Pence & Paymar, 1986; Sanderson, 2008). Abusers may employ solicitous behaviours in the presence of others by projecting an image of themselves as a charming, adoring and compassionate partner (Sanderson, 2008); this display of emotional concern can be so convincing that health professionals may fail to identify the coercive elements of their behaviour (i.e. the need to be present at all meetings to ensure a disclosure cannot be made). For instance, one woman in this study described how her abusive partner attended her clinical appointments in order to convince the GP that she was extremely mentally unwell and not of sound mind and judgement, thereby invalidating any future disclosures. The Confidential Enquiry into Maternal Deaths has highlighted that the presence of partners at all health assessments may
be indicative of domestic violence (Centre for Maternal and Child Enquires, 2011; Lewis, 2007).

7.2.1.2.3 Blaming Behaviours and Minimisation

One consequence of the abuse dynamics model described above is an erosion of survivors’ identity, values and core beliefs (Horley, 2002). Survivors can become self-loathing and believe that the abuse must somehow be their fault; as the following illustration outlines:

“The enmeshment between abuser and survivor leads to the moulding of the survivor’s identity in which the abuser relinquishes all responsibility for the abuse by projecting this onto the survivor” (Sanderson, 2008, p 68)

Research has shown that abusers frequently deny or minimise their use of violence, seek to deny any responsibility for the violence and place blame directly on to survivors (Blacklock, 2001; Humphreys & Thiara, 2003a). Some service users in this study described how their abuser would blame them for the violence, leading them to conclude that they were responsible for the abuse. This projection of accountability meant that respondents felt unable to disclose to mental health professionals. Feelings of self-blame were exacerbated among some service users, who described how their abuser blamed their mental illness as the cause of the violence. Others described how their abuser would attempt to disguise the violence, by convincing them that it was simply their mental illness that made them think they were being abused.

Some respondents also described that friends/family members held victim-blaming attitudes and put responsibility for ending the abuse solely on them; these findings link closely to service users’ descriptions of social attitudes and practices that condone violence. Such experiences can inhibit help-seeking behaviours and leave survivors at continued risk of harm. For instance, Hegarty and Taft’s (2001) interviews with 20 Australian women explored their experiences of disclosure of domestic violence to GPs and found that self-blaming behaviours left many feeling solely responsible for the abuse, which in turn inhibited their help-seeking behaviours (Hegarty & Taft, 2001).
7.2.1.2.4 Putting the Abuse to the Back of Their Mind

Service users in this study described consciously attempting to put their experiences of abuse to the back of their mind; these strategies acted as a barrier to disclosure. This response can be seen as a form of “psychological escape” (Walker 2009:44) where women implement a range of coping strategies to protect themselves from experiencing the full-blown trauma response (Sanderson, 2008; Walker, 2009). Types of coping strategies include compliance, appeasement, minimisation or denial, dissociation or forgetting (Walker, 2009). Feminist scholars argue that women actively implement these coping strategies as a means to aid their survival (Sanderson, 2008; Walker, 2009). It is important then that clinicians do not interpret these responses as victim-like behaviours, or liken them to traditional conceptualisations of ‘learned helplessness’ (Sanderson, 2008; Walker, 2009). As outlined in Chapter 1 section 1.9, it is important that clinical responses to domestic violence are delivered in an ethical and sensitive manner, which does not attempt to minimise the psychobiological impact of abuse but maintains an awareness of the dangers of pathologising survivors’ experiences.

7.2.1.2.5 Shame and Embarrassment

Service users in this study described difficulty in disclosing that they were experiencing violence, due to feelings of shame and embarrassment. As outlined in Chapter 1 section 1.11.3.1, comparable findings have been found in primary care settings in relation abused women’s shame and embarrassment at identifying themselves as survivors of abuse (Feder, Ramsay, Dunne, et al, 2009). Feelings of shame and embarrassment among respondents in this study were seen to be related to concerns that clinicians would question why they had seemingly ‘permitted’ the violence, by not ending the abusive relationship. These feelings were frequently seen to manifest as a result of social attitudes towards domestic violence, which were perceived to be victim-blaming. The findings suggest that survivors’ understanding of societal attitudes towards the use of violence in intimate/familial relationships affects their willingness to disclose and seek help for domestic violence. Survey research supports these findings, and a study of 161 women, accessing an urban family practice or domestic violence programme, found that 35% reported embarrassment and shame as a barrier to discussing abuse with health professionals (McNutt, Carlson, Gagen, et al, 1999). In relation
to help-seeking, a USA survey of 491 abused women, accessing an urban hospital and four community-based public health clinics, found that feelings of shame and embarrassment acted as a barrier to seeking medical care and assistance from support agencies or counsellors (Fugate, Landis, Riordan, et al., 2005).

The findings of this analysis suggest that, if psychiatric services are made aware of service users’ barriers to disclosure of abuse, they can implement strategies that seek to challenge their fears; address their safety concerns, and support their needs in relation to their children, their immigration status and relocation. By creating an environment that is mindful of the nature, extent and impact of domestic violence and cultural pressures surrounding disclosure psychiatric services can help to raise service users’ awareness of abuse, alleviate feelings of shame and embarrassment, and challenge self-blaming attitudes. The implications of these findings will be explored in Chapter 8.

7.2.1.3 Experiences/Expectations of Services Response to Service Users’ Disclosures of Domestic Violence

7.2.1.3.1 Acknowledgement and Validation for Disclosures from Health Professionals

In relation to the response of services to domestic violence, service users in this study spoke of the need for mental health professionals to openly acknowledge and to facilitate discussions of their experiences of domestic violence. In the absence of direct enquiry several respondents felt unable to initiate disclosures. Several service users described how professionals were dismissive of their disclosures and did not raise the subject again in future clinical meetings. Consequently, service users spoke of the need for professionals to be responsive to their disclosures, and to provide supportive/validating comments. Similar wishes have been reported among female primary care service users who have experienced domestic violence (Feder, Ramsay, Dunne, et al., 2009).

7.2.1.3.2 Discrimination from Services

Some service users in this study described experiencing discrimination from services because of their mental illness. Indeed, one woman explained that she did not disclose her mental illness to a refuge service because she believed that she would be denied support on that basis. A New Zealand survey of 39 women’s
refuges found that over a six month period 179 women were denied access because of mental health and/or substance abuse problems (Hager, 2006). Findings from the UK suggest that as little as 19% of refuges are able to offer space to abused women with mental health problems (Barron, 2004). Additional discrimination is experienced by abused BAMER women, who may encounter racism and marginalisation from mainstream services due to negative racial and ethnic stereotypes (Dasgupta, 2005; Johnson, Bottoff, Browne, et al., 2004; Thiara, 2002; Thiara & Gill, 2010a). These issues are further compounded by the limited provision of specialist services for BAMER women, which support their cultural needs and can address culturally specific domestic violence issues (Thiara, 2002; Wilson, 2010). It is argued that:

“The ways in which women experience violence, the options they have open to them in dealing with that violence and the extent to which they have access to services to help them are all profoundly shaped by the intersection of gender with other dimensions, such as race, ethnicity, class, culture and nationality” (Thiara & Gill, 2010b, p 41)

Based on the findings of this study, survivors’ access to and contact with services is also found to be powerfully shaped by experiences of discrimination in relation to their mental illness, which create additional barriers to engagement and support from services.

The two male respondents in this study described experiencing discrimination from services when seeking support following incidents of violence. They explained how police services arrested them as the sole perpetrators of abuse and gave no consideration to their experiences of abuse. These findings suggests that services may respond to disclosures of domestic violence in different ways depending on the gender of the person disclosing abuse (Richardson & May, 1999). This response is likely to be related to the well-reported evidence base, which shows that women are more likely than men to experience repeated, and severe violence, and that the majority of perpetrators are men (Blacklock, 2001; Mirrlees-Black & Byron, 1999). Nevertheless, services should recognise that men also experience domestic violence and, regardless of the gender of the person
disclosing abuse, should be willing to provide support.

7.2.1.3.3 Delivery of Support

Some service users in this study described receiving on-going support and assistance from professionals in managing their needs related to the abuse. Many others, however, explained that professionals often failed to deliver the support that they suggested was available to them. Research indicates that a lack of support from services can considerably lower the self-esteem of people experiencing abuse (Cascardi & O'Leary, 2005; Mitchell & Hodson, 2004). Respondents in this study, who did not receive adequate support, felt isolated and alone in managing the abuse. One respondent reflected that this may be a reason why some survivors return back to their abuser after they have separated. It is essential that services address the needs of these vulnerable people, by ensuring that they gain access to services, which can support their complex needs, reduce their risk of harm and promote recovery from domestic violence. Research highlights the importance of providing specialist support services for abused BAMER women (Thiara & Roy, 2010), to ensure that they receive adequate support to address issues of safety, and in countering experiences of total isolation from family/community networks (Wilson, 2010).

The findings above show that significant gaps exist in the provision of services for people experiencing severe mental illness and domestic violence. These findings are supported by a recent survey of Mental Health Trusts in England, which found that among 43 trusts only five employed someone to provide specialist support for survivors, only three provided specialist therapeutic group interventions, and under half (45%) of the 43 trusts reported referring survivors to specialist services (Holly, Scalabrino & Woodward, 2012). The stigma and discrimination experienced by people with severe mental illness can act as a significant barrier to receiving adequate support from mainstream services. It is crucial then that services develop strategies to support the complex needs of people experiencing abuse and severe mental illness (as will be explored in Chapter 8).
7.3 Service User Specific Themes: Discussion of Results from a Constant Comparative Analysis

7.3.1 Typologies of Service Users’ Understanding of Domestic Violence
As can be seen from Table 6 in Chapter 5, the constant comparative analysis of service users’ narratives identified three individual-level typologies (i.e. accountable, vulnerable and unknowing), and one societal-level typology (i.e. social acceptance), which shaped their understanding of domestic violence. These typologies were seen to influence service users’ contact and engagement with services.

Typologies of understanding were not seen to be related to service users’ diagnoses, age or ethnicity. Neither were they related to the gender of respondents; although this may reflect the fact that only two of the 18 respondents who disclosed experiences of domestic violence were male.

7.3.1.1 Understanding of Domestic Violence: Accountable
Service users in the ‘accountable’ typology described how their experience of childhood abuse led them to understand acts of violence as an expected outcome during periods of conflict. An understanding that violence witnessed and experienced in childhood is learned and re-enacted as an adult was first raised by the social learning theorist Albert Bandura. He proposed that violence in childhood is learnt, reinforced and then transferred in to adulthood, as a coping response to stress, or as a method of conflict resolution (Bandura, 1973). The data from this study supports Bandura’s assertion.

Service users in this typology described understanding that they were equally accountable for their experiences of domestic violence, as they responded in a physically violent manner during periods of conflict. There is evidence to suggest that high rates of mutual violence exist among couples (Caetano, Vaeth & Ramisetty-Mikler, 2008; Straus, 2011). These findings have led some scholars to seek to categorise differences in patterns of violence within intimate relationships (Holtzworth-Munroe & Stuart, 1994; Johnson, 1995; Langhinrichsen-Rohling, 2005; Stark, 2006) (see Chapter 1 section 1.3-1.4 for more details). Such
categorisations have received criticism for failing to capture the broader relationship and cultural contexts surrounding violence, and in their failure to explain the aetiology and developmental course of violence among couples (Capaldi & Kim, 2007; Oringher & Samuelson, 2011). The findings of this study provide some insight into existing evidence gaps (as outlined below), but further research is needed to provide a comprehensive assessment of the nature and extent of mutual forms of violence within intimate relationships (Capaldi, Shortt, Kim, et al, 2009; Langhinrichsen-Rohling, 2010).

This study found that the experience of mutual violence among female respondents was not comparable between themselves and their male partner. The women in this typology described incurring much greater physical injuries than their male partner, which were seen to increase in severity over time (e.g. injuries requiring medical attention). Despite this, these women reported that they were able to manage the abuse; indeed, they considered that their own use of violence was indicative of their ability to exercise control over the relationship. As a consequence, these women did not consider seeking help from formal support services. This finding is poignant in light of evidence that women who use violence in abusive relationships often experience more severe violence than women who do not, and report equally poor mental health outcomes (Amar, 2007; Swan & Snow, 2003). In comparison, the male service user in this group did not describe incurring significant physical harm or report a growing escalation in the severity of violence perpetrated by his partner. It is important to note, however, that a considerable amount of abuse does not result in physical injury, so classifying domestic violence on this basis may be ineffective in identifying all forms of abusive relationships (Langhinrichsen-Rohling, 2010). Similar to female respondents, the male respondent in this typology did not seek assistance from formal support services; one reason for this may have been that when the police were called out during periods of conflict he was arrested as the sole perpetrator of violence.

As this study included only one male respondent who reported experiences of mutual violence, it is difficult to make generalisations about the nature and impact of this form of violence among men. Evidence from survey research suggests that
women are more likely than men to report their own use of violence within intimate relationships (Dobash & Dobash, 2004), to use violence in retaliation or in self-defence (Amar, 2007) and are less likely than men to initiate an overall pattern of violence in relationships (Capaldi, Shortt, Kim, et al, 2009; Hamberger & Guse, 2002). Future research may benefit from conducting dyadic analyses in order to more accurately determine the frequency, severity and consequences of mutual violence within intimate relationships (Johnson, 2010). It is argued that dyadic analyses can facilitate an understanding of changes in the patterns of violence over time and factors that promote the persistence or desistance of violence (Capaldi & Kim, 2007; Johnson, 2010; Langhinrichsen-Rohling, 2010); such insights would offer specific points of intervention for prevention and treatment efforts (Langhinrichsen-Rohling, 2010).

7.3.1.2 Understanding of Domestic Violence: Vulnerable

Service users in the ‘vulnerable’ typology described an understanding that their experience of previous violence, existing mental illness or immigration status rendered them vulnerable to abuse.

A substantial body of research has examined the impact of childhood abuse (i.e. witnessing parental violence and being abused) on children’s psychological development (Hester, Pearson, Harwin, et al, 2007; Humphreys & Thiara, 2002; Kitzmann, Gaylord, Holt, et al, 2003; Osofsky, 2003). Evidence suggests that childhood trauma impedes the formation of healthy relationships and consequently compels individuals to seek out familiar relational patterns that are characterised by abuse (Cook, Spinazzola, Ford, et al, 2005; Van der Kolk, 2005). The narratives of service users in this typology supports these theories and suggests that childhood abuse disrupts early attachment bonds and results in significant and long-term alterations to an individual’s relational security and expectations of others (Van der Kolk, 2005). Ferguson et al (2005) analysed longitudinal data from a New Zealand birth cohort of 828 young people (437 women and 391 men) and concluded that exposure to childhood abuse significantly increased the risk of experiencing domestic violence in adulthood (Fergusson, Horwood & Ridder, 2005). As discussed in Chapter 5 section 5.3.4, only one of the 16 female respondents who reported childhood abuse did not
experience abuse as an adult. In contrast to the others, this female respondent left the violent home and relocated to an area where a close family friend resided. The family friend provided regular support and assistance and became a close confidant to the respondent. The findings of this study highlight the vulnerabilities to adulthood re-victimisation experienced by people exposed to childhood abuse (Bebbington, Jonas, Brugha, et al., 2011; Dunkle, Jewkes, Brown, et al., 2004; Ehrensaft, Cohen, Brown, et al., 2003; Gomez, 2011; Jirapramukpitak, Harpham & Prince, 2011; Vung & Krantz, 2009); and the benefit of safe, positive role-models in mediating further violence (Humphreys & Stanley, 2006).

Explanations for increased vulnerability to violence among the mentally ill include aspects of the illness, such as impairments in social functioning in people with schizophrenia (Fitzgerald, de Castalla, Filia, et al., 2005; Goodman, Rosenberg, Mueser, et al., 1997; Honkonen, Henrikson, Koivisto, et al., 2004; Read & Argyle, 1999), use of medication and type of living conditions or co-occurring substance misuse (Briere, Woo, McRae, et al., 1997; Walsh, Moran, Scott, et al., 2003). The types of understanding identified by service users in the ‘vulnerable’ typology, regarding vulnerabilities to violence due to mental illness, have been reported in other qualitative research of people with severe mental illness (Dinos, Stevens, Serfaty, et al., 2004). The narratives of service users lend support to findings that the stigma of being labelled with a severe mental illness can result in a reluctance of others to engage with those affected (Corrigan, Backs, Green, et al.). People affected by mental illness may also experience difficulties in establishing and maintaining close relationships, as a direct result of their illness (i.e. delusions, paranoia) (Nicholson, Sweeney & Geller, 1998; Ritsher, Coursey & Farrell, 1997).

Research suggests married immigrant women may experience higher levels of violence compared to unmarried immigrant women, as abusers use their partners’ immigration status as a method of control, or to force them to remain in the relationship (Dutton, Orloff & Aguilar Hass, 2000; Orloff & Kaguyutan, 2002; Thiara & Roy, 2010). The one female UK migrant in this study confirms this finding, as she describes how immigrant women may be at risk of protracted periods of abuse due to fears of the impact that a disclosure of domestic violence
may have on their immigration status. It is argued that traditional gendered stereotypes concerning immigrants, namely the portrayal of female immigrants as purely an accessory to their husbands, has negatively impacted on women’s status within UK immigration controls (Gilroy, 2002). Scholars propose that the discriminatory legacy of UK immigration controls, which were simultaneously gendered and racialised, continues to undermine the position of women within the immigration and asylum sphere today (Dasgupta, 2005; Sharma & Gill, 2010). For example, although abused immigrant women can now apply for permanent UK residency, if their marriage breaks down due to domestic violence, the level of evidentiary support required to prove the abuse remains high (e.g. caution or conviction against their abuser, injunction or non-molestation order or medical report). These stringent evidentiary requirements can prove challenging for immigrant women, who may not know the English language, who may be unaware of their legal rights and who may be kept in isolation by their abuser (Sharma & Gill, 2010). Consequently, making a successful application for residency can prove extremely challenging for abused immigrant women.

Respondents in the ‘vulnerable’ typology reported making contact with services but felt the response they received was often insufficient. They described that professionals failed to facilitate discussions of abuse and to respond adequately to disclosures. These findings lend support to our literature review, which found that mental health professionals rarely ask service users about domestic violence and generally fail to provide sufficient documentation of abuse in medical records (Howard, Trevillion, Khalifeh, et al., 2010). Many of the services users in this typology reported sustained contact with health services, but felt that clinicians had overlooked their vulnerabilities to violence. The respondent with insecure immigration status reported a lack of adequate provision for her needs, which led her to feel unsupported, isolated and without the means to improve her situation. This finding is noteworthy as women from BAMER groups are found to be less likely than white women to be assessed by psychiatric services (Cooper, Husain, Webb, et al., 2006) and report unequal access and treatment by mental health services (Chantler, 2003; Chew-Graham, Bashir, Chantler, et al., 2002; Siddiqui & Patel, 2010). Consequently, scholars call for fairer immigration and welfare systems; improved access to crisis accommodation; long-term housing and mental
health and specialist support services to meet the needs of abused BAMER women (Thiara & Gill, 2010b).

Unlike the female respondents in this typology the male respondent felt unable to discuss his experiences of abuse with clinicians, citing concerns about his gender identity if he admitted he was a survivor of domestic violence perpetrated by a woman. As outlined in Chapter 4 section 4.2, little is known about men’s experience of domestic violence (Cronholm, 2006) and, as this study only included two male respondents who disclosed abuse it is difficult to generalise these findings.

7.3.1.3 Understanding of Domestic Violence: Unknowing
Women in the ‘unknowing’ typology described how the subtle coercive nature of the violence meant that they struggled to identify the behaviours as abusive; as a result they did not seek help for their experiences. This pattern of abuse lends support to theories that suggest male abusers seek to ensnare women during an initial courtship period, by employing charismatic and highly solicitous behaviours, which create deep attachment bonds that entrap women to the relationship (Horley, 2002) (see Chapter 1 section 1.3). This type of behaviour has coined the term ‘the charming man syndrome’ and describes how the use of subtle coercive control, which is masqueraded as love and devotion, seeks to make survivors totally dependent on their abuser; once achieved, this submission is tested by the abuser, who strikes out either verbally or physically (Horley, 2002; Sanderson, 2008). Through the use of intermittent reinforcement of reward and punishment, characterised by episodes of violence and unpredictable gestures of love and affection, survivors become confused about their experiences, which inhibits their identification of the abuse (Horley, 2002; Sanderson, 2008).

7.3.1.4 Understanding of Domestic Violence: Social Acceptance of Domestic Violence
The societal-level typology describes service users’ understanding of socially accepting views about domestic violence. For instance, some service users who disclosed childhood abuse reported an expectation that abuse would always be present within close personal relationships, as this behaviour had been normalised.
and accepted. One woman reflected how she had ‘sabotaged’ healthy relationships with non-abusive men, as she believed she was not worthy of such affection. Research suggests that adults exposed to childhood abuse report a higher acceptance of violence within intimate relationships compared to those not abused as a child (Vung & Krantz, 2009).

Several service users described that although significant improvements had been made in raising societies awareness about nature, extent and impact of domestic violence (e.g. political and legal frameworks that challenge abuse) further changes were necessary to thwart social attitudes/practices that continue to condone violence within close personal relationships. Walker (2009) describes how the “institutionalised acceptance of violence” can have the effect of creating a degree of acceptance about the use of violence in intimate relationships (Walker, 2009, p 12). It is argued that only through the consideration of the intersection of systems of domination based on gender, race, ethnicity, class, culture and nationality can society really address these issues (Thiara & Gill, 2010a).

Service users described that significant improvements had been made with regards to women’s role within society (e.g. improved gender equality, increased financial independence), which can help to protect them from abuse. Despite these positive developments, the dominance of patriarchal control was reported to result in the continuation of women’s vulnerability to abuse. For example, one woman described how her abuser specifically targeted her in order to exploit her financial success as a business woman, by seeking to gain total control over her wages. Other research with abused women supports this finding, and paid employment has been described as a “double edged-sword”, while it provides women with a period of respite from the abusive home, they may neither benefit financially, nor feel less afraid of their abuser (Thiara, 2010, p 159). The relationship between patriarchy and domestic violence has been widely discussed by feminist scholars, who continue to demonstrate ways in which state patriarchy condones men’s use of violence against women (Sanderson, 2008; Thiara & Gill, 2010a; Walker, 2009).
Respondents in this study explored the impact of socio-cultural attitudes and practices in facilitating an acceptance of domestic violence. These findings provide further support for the impact of socialisation in fostering an acceptance of violence within close personal relationships (Andersson, Ho-Foster, Mitchell, et al, 2007). Some respondents in this study spoke of a growing acceptance about the use of violence in intimate relationships among young women and men today. These findings are notable, as a recent UK survey found that among 1,353 young people, aged 13-17 years, one in six girls had experienced severe violence from an intimate partner (Barter, McCarry, Berridge, et al, 2009). A longitudinal study of 1,759 USA adolescents found that an acceptance of prescribed dating violence norms can predict mild and severe forms of dating violence (Foshee, Linder, MacDougall, et al, 2001).

Lastly, respondents described how cultural expectations may create significant barriers for BAMER women in seeking help. This is due to beliefs that domestic issues should remain private, or that as matriarchal figures they should manage family issues without the need of assistance. Other research with abused BAMER women confirms these findings, and their experiences of abuse are shown to be compounded by their dis/location within wider society and their place within families and communities (Bent-Goodley, 2007; Thiara, 2010; Thiara & Gill, 2010a). Low levels of awareness of abuse, fear of the consequences of disclosure and discrimination and racism from services may also prevent abused BAMER women from seeking help (Thiara, 2010). These findings may help to explain why the majority of abused women seeking mental health treatment are Caucasian; with BAMER women more likely to turn to informal sources of support (El-Khoury, Dutton, Goodman, et al, 2004; Flicker, Cerulli, Zhao, et al, 2011).

Results from service users’ understanding of domestic violence lends support to ecological frameworks on the origins of violence, which examine the interplay that exists between personal, situational and socio-cultural factors (World Health Organization, 2012).
7.4 Mental Health Professional Specific Themes

7.4.1 Dominant Interpretive Themes in Professionals’ Narratives
As can be seen in Table 8 Chapter 6, themes specific to professionals included mixed views on routine enquiry in psychiatric settings, and barriers to enquiry about domestic violence. With regards to responding to domestic violence, professionals spoke of the impact of organisational- and individual-level awareness of domestic violence in facilitating the identification of abuse. Discussions also centred on the implications of reporting requirements and referral pathways.

7.4.1.1 Acceptability of Routine Enquiry among Mental Health Professionals
Unlike service users, mental health professionals did not unanimously agree that routine enquiry of domestic violence in psychiatric settings was acceptable; although the majority of professionals felt it was acceptable. As outlined in Chapter 1 section 1.11.2.1, a review of the evidence indicates that a minority of primary care clinicians are also not in favour of implementing routine enquiry of domestic violence (Feder, Ramsay, Dunne, et al., 2009). A recent survey of 15 Mental Health Trusts in England found that although the majority (83%) of mental health professionals were supportive of routine enquiry about abuse, a small minority (8%) were opposed to its implementation (Department of Health, 2009).

Variations in professionals’ perceptions about the acceptability of routine enquiry may provide some insight into evidence that, despite the introduction of questions about abuse within standardised clinical assessments, not all professionals implement enquiry (Read & Fraser, 1998a). In order for mental health professionals to implement questions about abuse within care programme assessments (Department of Health, 2008) they would first benefit from education and training. Such training should challenge views that domestic violence is not a mental health issue and seek to improve professionals’ competencies in addressing abuse.
7.4.1.2 Barriers to Enquiry of Domestic Violence

7.4.1.2.1 Limited Knowledge and Expertise about Domestic Violence

Reasons for non-enquiry cited by professionals in this study also included concerns related to their knowledge and expertise in appropriately identifying and responding to domestic violence. A recent survey of nine Mental Health Trusts in England reported comparable barriers to enquiry of abuse among clinicians working in outpatient and inpatient psychiatric settings (e.g. a lack of staff awareness and training about abuse, and a view that issues of abuse were outside the remit of psychiatric services) (Department of Health, 2007).

A survey of 251 USA clinicians’ barriers to the diagnosis and treatment of post-traumatic stress disorder (PTSD) among people with severe mental illness found that issues of clinical competencies and confidence were associated with the frequency with which service users’ experiences of trauma and PTSD had been discussed, documented and addressed directly in treatment (Salyers, Evans, Bond, et al, 2004). A lack of confidence to enquire about domestic violence has real clinical implications for the care of service users, particularly in relation to managing risk of harm (Morgan, 2007b). Other theories regarding professionals’ barriers to the identification abuse include their own experience of violence and abuse (Gremillion & Kanof, 1996). It is not possible for this research study to examine this theory because interview discussions did not seek to identify professionals’ experience of violence and abuse.

7.4.1.2.2 Enquiry Not Part of Clinical Role

A few professionals in this study questioned whether enquiry was part of their role as a mental health clinician, and one psychiatrist questioned the evidence to support the use of routine enquiry by health professionals. The questions raised by this respondent align with continuing debates in the academic literature about the evidence base to support routine enquiry of domestic violence (Feder, Ramsay, Dunne, et al, 2009; Taket, Wathen & MacMillan, 2004). At present, insufficient evidence exists to prove that universal routine enquiry about domestic violence leads to improved outcomes for abused women (Feder, Ramsay, Dunne, et al, 2009).
7.4.1.2.3 Limited Opportunity for Enquiry

Existing qualitative research that explores health professionals’ experience of identifying and responding to domestic violence indicates that time-limited assessments, workload constraints and a fear of offending service users often prevents exploration of abuse in clinical practice (Feder, Ramsay, Dunne, *et al*., 2009; Minsky-Kelly, Hamberger, Pape, *et al*., 2005; Ramsay, Richardson, Carter, *et al*., 2002). Similarly, professionals in this study described practical examples that prevented them from enquiring, such as competing demands, time constraints and the presence of partners at clinical meetings. The latter finding is noteworthy as clinicians are encouraged, as part of good practice guidelines, to meet with service users on a one-to-one basis at some point in the assessment (Royal College of Psychiatrists, 2002).

Professionals discussed the demands of standardised assessments, which often left them little opportunity to explore other subjects with service users. Indeed, one psychiatrist expressed exasperation that so many recommendations were made by different stakeholders that it was not possible to accommodate them all. One professional reported that clinicians were more comfortable with asking service users if they had ever been violent or had a propensity to commit violence, in comparison to asking them if they had experienced violence, as this was a routine part of mental health risk assessments. The emphasis on the risk of violence committed by people with severe mental illness, rather than on their increased risk of experiencing violence appears to be related to the stigma of mental illness, which Eisenberg (2005) described as turning “the world on its head” (Eisenberg, 2005, p825).

7.4.1.2.4 Fear of Consequences of Enquiry

Several professionals in this study described that they did not ask service users about experiences of abuse, as they were fearful of the consequences of such enquiry. These concerns align with those reported by primary care clinicians (Feder, Ramsay, Dunne, *et al*., 2009; Ramsay, Richardson, Carter, *et al*., 2002). Professionals identified fears that direct enquiry may offend service users, particularly those who had not experienced abuse. Some expressed concerns that asking about experiences of abuse may prove particularly distressing for service
users and create re-traumatisation. The narratives of service users appear to challenge these concerns, as both those who had and had not experienced abuse were accepting of routine enquiry and stated they would not find such questioning harmful or offensive. A small number of professionals also reported concerns regarding asking service users about domestic violence during episodes of psychosis, as they felt that this may worsen symptoms. A survey of 114 mental health professionals’ experience of enquiry of childhood abuse reported comparable findings, and professionals were found to be less likely to ask service users presenting with psychosis (Young, Read, Barker-Collo, et al, 2001).

7.4.1.2.5 No Indicators of Abuse

Some professionals in this study described that in the absence of physical indicators of abuse they might not consider asking service users about domestic violence. This finding is noteworthy, as although people experiencing domestic violence do present to health services with obvious physical injuries they more commonly present with chronic health problems (Hegarty, Hindmarsh & Gilles, 2000). These findings show that clinicians’ assessments of physical indicators of violence are not an effective assessment of risk of harm.

Professionals in this study explained that in the absence of disclosure from service users they may not consider enquiring about experiences of abuse. This finding is interesting as it sits in direct contrast to the findings from service users, which indicate that in the absence of direct enquiry from clinicians they often do not disclose. Comparisons between professionals and service users identified a limited discourse about experiences of abuse during clinical meetings, and lend support to calls for a greater awareness about domestic violence and improved communication between clinicians and service users (Perese, 2007).

Based on the findings from this study, and the current evidence base, it becomes clear that routine enquiry is not a benign intervention and can lead to adverse consequences for service users if clinicians are not adequately trained about abuse. Without sufficient education about the nature and impact of domestic violence, clinicians run the risk of pathologising experiences of abuse. In the absence of previous training on management of routine enquiry and clear
pathways of referral, clinicians may fail to facilitate disclosures of abuse and be unable to provide necessary sources of support for service users. For instance, a recent UK study that implemented a programme of routine enquiry within a maternity service found that some abused women reported breaches of confidentiality by their treating clinicians, who discussed their experiences of abuse in front of family members (Bacchus, Bewley, Vitolas, et al., 2010). Breaches of confidentiality in relation to documentation within medical records were also reported, and one woman was assaulted by her ex-partner after he discovered documentation of abuse within her maternity records (Bacchus, Bewley, Vitolas, et al., 2010).

7.4.1.3 Professionals’ Experiences and Expectations of Responding to Service Users’ Disclosure of Domestic Violence

7.4.1.3.1 Individual-Level and Organisational-Level Awareness of Domestic Violence

With regards to the identification of domestic violence, professionals in this study discussed the impact of individual- and organisational-level awareness in facilitating their recognition of abuse. Although some professionals reported a good level of awareness within their clinical practice many did not, and the majority believed that issues of domestic violence are largely neglected within psychiatric settings. A recent survey of nine Mental Health Trusts in England reported similar views: as only 6% of clinicians felt that their Trust’s response to domestic violence was sufficient and a quarter had never asked service users about experiences of abuse during assessments (Department of Health, 2007).

A study by Allen et al (2007) assessed USA health professionals’ adoption of routine enquiry of domestic violence across 12 different health settings. They found that both individual-level and organisational-level factors influenced professionals’ willingness to enquire about domestic violence. Individual-level factors included professionals’ perception of their knowledge about domestic violence and skills and comfort in addressing the issue. Allen et al found that professionals who held more positive beliefs about the value and appropriateness of asking about domestic violence implemented enquiry more frequently than those who held negative views. Organisational-level factors, including the presence of standardised instruments and procedures for routine enquiry,
documentation of abuse and guidance around safety and intervention procedures were also seen to facilitate routine enquiry (Allen, Lehrner, Mattison, et al, 2007). A detailed description of system-level responses to domestic violence is presented in Chapter 8.

7.4.1.3.2 Assessment and Management of Domestic Violence

Another finding of this study, with regards to identification, concerns clinicians’ difficulties with the assessment and management of domestic violence. Professionals spoke of difficulties in addressing domestic violence when it is denied by service users, and identified concerns with regards to validating some service users’ disclosures in light of their presenting symptomatology. Despite this perception among professionals in this study, there is evidence to suggest that psychiatric service users tend to under-report rather than over-report experiences of violence (Goodman, Thompson, Weinfurt, et al, 1999). Furthermore, evidence suggests that recent and frequent violence is associated with increased symptom severity, including among people experiencing significant intrapsychic and social impairments (Goodman, Dutton & Harris, 1997). It is essential then that this evidence is incorporated into the psychiatric curriculum to ensure that clinicians do not dismiss or underestimate the risk of harm to service users.

7.4.1.3.3 Reporting Requirements

With regards to professionals’ experience of responding to disclosures and making referrals, respondents in this study described the complexities of maintaining a supportive therapeutic relationship, whilst adhering to obligatory reporting procedures (e.g. child and adult safety guidelines). Some professionals also spoke of the potential complexities in managing issues of confidentiality when service users disclose abuse. The difficulties for clinicians in navigating the dual role of helper and reporter have been documented elsewhere (Thompson-Cooper, Fugere & Cormier, 1993). Working within the bounds of confidentiality agreements is common to all health professionals and adhering to such agreements, although challenging, can be managed without necessarily jeopardising the therapeutic alliance. At initial assessments, professionals can be explicit in informing service users about the limits of confidentiality, describing instances when they may be required to break confidentiality, and can reassure
service users that their abuser will not be made aware of disclosures (Royal College of Psychiatrists, 2002). Prior to reporting their concerns, good practice guidance recommends that professionals consult with peers and supervisors about the need to report and the most appropriate approach to take (Brunette & Dean, 2002). This should then be followed by an explanation to service users about their concerns and their obligations to report, whilst providing reassurance that the information will only be passed to reputable organisations (Brunette & Dean, 2002; Department of Health, 2005). This latter point is notable as evidence suggests that mandatory reporting of abuse by clinicians is almost never discussed with service users (Agar & Read, 2002).

Professionals discussed their experiences of adhering to policy guidelines targeted to improve the protection of “Vulnerable Adults” (Department of Health & Home Office, 2000). These policies were considered by some to be over burdensome, due to the requirements of these processes alongside other clinical commitments. This finding may provide some insight into evidence that the adoption of adult protection procedures within mental health practice has been limited to date (Brown & Keating, 1998; Galpin & Parker, 2007). Professionals’ experiences of identifying and responding to abuse in this study suggests that implementation of domestic violence policies in psychiatric settings requires strong organisational support. Klien and Sorra (1996) argue that strong implementation is achieved by: (1) the removal of barriers to implementation; (2) by ensuring employees have the necessary skills to implement policies; and (3) by ensuring employees are provided with incentives for the implementation of policies (Klein & Sorra, 1996).

7.4.1.3.4 Absence of Clear Referral Pathways
This study found that several professionals reported difficulties in responding effectively to the needs of abused service users, in the absence of clear referral pathways. Some professionals contrasted the lack of clarity for referral of adults experiencing abuse to that of children, where there are clear, explicit pathways of referral. A recent survey of nine Mental Health Trusts in England reported comparable findings, and several Trusts raised concerns about lack of resources in supporting the needs of service users experiencing abuse (Department of Health,
2009). The introduction of clear and robust referral pathways for psychiatric service users experiencing domestic violence may increase clinicians’ efficacy in responding to disclosures, and lead to improved outcomes for service users. For instance, Multi-Agency Risk Assessment Conferences (MARACs), which have representation from mental health services, have been seen to improve survivors’ safety and reduce domestic violence re-victimisation (Home Office Violent and Youth Crime Prevention Unit & Research and Analysis Unit, 2011; Robinson, 2004). These findings are particularly notable given the extensive histories of harm and repeated violence experienced among people referred to MARACs.

7.4.1.3.5 Establishing Continuity of Care for Service Users

With regards to referring service users to domestic violence services, professionals in this study reported mixed experiences. Some found it easy to make direct referrals or to contact services for advice and information, while others reported difficulty in getting service users’ access to domestic violence services (e.g. citing long waiting lists, inability of services to take on people with severe mental illness). Research indicates that mainstream domestic violence services may display a reluctance to support abused people with severe mental illness, due to fears about the presentation of illness and its impact on other service users (Barron, 2004; Hager, 2011). In addition, a recent survey compared the experiences of 68 mental health professionals and 56 independent sexual and domestic violence advisors in relation to responding to the needs of people with severe mental illness who have experienced sexual violence. The survey found that both sets of professionals reported difficulties in supporting the complex needs of service users, due to a lack of support services and barriers that the stigma of mental illness creates in relation to securing service users access to support services (Cox, Harvey & Holly, 2012). The two groups wanted to see an increase in the availability of therapeutic resources for survivors, particularly specialist trauma-related therapies, and a streamlining in assessment processes/waiting lists for referrals (Cox, Harvey & Holly, 2012).

Professionals also expressed concern about the consistency of care received from health services and described how service users’ experience of trauma may not be adequately addressed throughout their contact with health services. They
explained that service users’ clinical notes may contain a documentation of abuse but that it may not be raised by clinicians in health appointments. They also suggested that these responses may have a negative impact on service users’ engagement with services. A review of the medical records of 200 community mental health team (CMHT) service users in New Zealand found that professionals often failed to respond to charted documentations of abuse from previous contacts with health services (Agar, Read, Bush 2002).

The findings of this analysis indicate that system-level responses to domestic violence are necessary to improve psychiatric services response to domestic violence. Mental Health Trusts should implement specific policies on domestic violence, which complement existing safeguarding policies, promote organisational-level awareness of abuse, improve clinical competencies in addressing domestic violence and establish clear care referral pathways for service users disclosing abuse. The implications of these findings will be discussed in Chapter 8.
7.5 Professional Specific Themes: Results from a Constant Comparative Analysis

7.5.1 Typologies of Professionals’ Perception of their Professional Role in Addressing Domestic Violence

As shown in Table 9 of Chapter 6, professionals’ narratives identified four distinct typologies (i.e. embracing, accepting, avoidant and ambivalent) with regards to their perception of professional role in identifying and responding to domestic violence. These typologies were seen to influence professionals’ willingness to identify and respond to domestic violence. Professional perceptions were seen to transcend gender, age and ethnicity, clinical discipline and number of years practiced. It is important to note, however, that the small number of social workers (n=3) and psychologists (n=1) sampled may limit the strength of differences observed between clinical disciplines.

As outlined in Chapter 1 section 1.11.3.1, a paucity of research has been conducted on mental health professionals’ experiences of identification and response to domestic violence. Existing research on this topic has yet to examine individual perceptions and motivations that shape clinicians’ willingness to address abuse among service users.

7.5.1.1 Perception of Professional Role: Embracing

Professionals in the ‘embracing’ typology differed from those in the other typologies in relation to their level of comfort in addressing domestic violence. These professionals actively sought to identify service users’ experiences of abuse, and were confident in their abilities to support disclosures from service users. Likewise, a qualitative study of 28 USA primary care clinicians also found that some professionals routinely sought to address domestic violence within their clinical practice (Sugg & Inui, 1992). The study found that these clinicians reported feeling comfortable in asking about domestic violence, validating service users’ experiences, addressing safety issues and in identifying appropriate sources of referral (Sugg & Inui, 1992).
7.5.1.2 Perception of Professional Role: Accepting
Those in the ‘accepting’ typology explained that their decision to address domestic violence was dependent on whether they perceived the organisational climate encouraged them to explore these issues within their clinical role. Allen et al (2007) conducted a study of 209 USA health professionals working in a variety of settings (i.e. general hospital, public and mental health services) and identified that the level of organisational support towards domestic violence determined the frequency with which clinicians enquired about abuse. Indeed, the availability of policies and procedures about domestic violence and team level awareness of abuse promoted clinicians’ behaviours in addressing domestic violence (Allen, Lehrner, Mattison, et al, 2007).

7.5.1.3 Perception of Professional Role: Avoidant
Professionals in the ‘avoidant’ typology did not believe they had the necessary competencies or expertise to address service users’ experiences of domestic violence. Other qualitative research suggests that mental health professionals’ concerns regarding their ability to respond effectively to disclosures of abuse often acts as a barrier to enquiry (Minsky-Kelly, Hamberger, Pape, et al, 2005).

7.5.1.4 Perception of Professional Role: Ambivalent
Professionals in the ‘ambivalent’ typology believed it was beyond the remit of their professional role to address experiences of domestic violence with service users, which were seen to be social pathologies unrelated to mental illness. These perceptions of professional role may provide some insight into why certain clinicians report a reluctance to routinely enquire about domestic violence (Feder, Ramsay, Dunne, et al, 2009; Mezey, 2001; Ramsay, Richardson, Carter, et al, 2002), overlook abuse sections within routine clinical assessments (Read & Fraser, 1998a) and fail to adequately respond to service users’ disclosure of abuse (Howard, Trevillion & Agnew-Davies, 2010).

A review of qualitative research with primary care and non-psychiatric health professionals found that, while many agreed that domestic violence should be addressed by health professionals, others believed it needed to be tackled by other professionals or designated paraprofessionals (Feder, Ramsay, Dunne, et al,
2009). Similar findings have been identified in survey research with clinicians (Feder, Ramsay, Dunne, et al, 2009; Tilden, Schmidt, Limandri, et al, 1994). This study found that variations in mental health professionals’ perceptions of their professional role influenced their views regarding the assessment and management of domestic violence. These findings extend existing research by identifying underlying perceptions that determine clinicians’ behaviours toward domestic violence, and have important implications for innovations aimed at improving psychiatric services response to domestic violence. Results suggest that an awareness of the differences in clinicians’ perception of their professional role in addressing domestic violence, and the implementation of strategies that seek to mediate these variations are crucial in effecting change. The implications of these findings will be discussed in Chapter 8.
7.6 Overlapping Themes among Service Users and Professionals

7.6.1 Dominant Overlapping Themes among Service Users and Professionals
Several important themes were seen to overlap in the narratives of service users and professionals: (1) the dominance of the medical diagnostic and treatment model; (2) the importance of therapeutic engagement between service users and professionals; (3) gender and culture; (4) a limited knowledge of domestic violence services; (5) the need for multi-agency collaboration and specialist services; and (6) clinical training about domestic violence for mental health professionals (as will be outlined below).

7.6.1.1 Dominance of the Medical Diagnostic and Treatment Model
Service users and professionals in this study described how the dominance of the medical model may result in clinicians focusing solely on diagnosing and treating symptoms of mental illness, ignoring social and personal factors that contribute to their symptomatology. Thompson (2001) argues that the dominance of the medical model within mental health services results in an overriding focus on an individual’s mental impairments, which views social processes that might impact on mental health symptoms as secondary to individual pathology (Thompson, 2001). It is argued that the dominance of the medical model can have the effect of pathologising service users’ experiences of abuse and transfer blame to survivors (Hager, 2001). Research exploring women’s experience of health care services when they leave an abusive relationship found that the dominance of the medical model can result in a lack of recognition of trauma, limited provision of trauma services, inappropriate blaming of survivors and a focus on medication over therapeutic support (Humphreys & Thiara, 2003a).

7.6.1.2 Importance of Engagement between Service Users and Professionals
Comparisons between professionals’ and service users’ narratives identified a limited discourse about experiences of domestic violence during clinical meetings. Professionals reported frustrations when they were aware service users had been abused but did not disclose it, and service users reported frustrations when professionals were aware of the abuse but did not enquire. These results suggest the need for specific training that challenges the stigma and secrecy surrounding
domestic violence, increases clinicians’ awareness of the risk of domestic violence among mental health service users and explores effective strategies for enquiry of abuse (Perese, 2007).

Service users and professionals expressed similar ideas about the therapeutic conditions that can facilitate disclosures of abuse. Both believed that a supportive therapeutic relationship was necessary for enquiry and disclosure. These findings have also been reported by female primary care service users experiencing domestic violence (Feder, Ramsay, Dunne, et al, 2009), indicating that this is an important component to effective enquiry. However, research employing validated tools that measure domestic violence suggests that the experience of being asked directly about domestic violence may be sufficient enough to facilitate disclosure, despite service users not having an established relationship with the interviewer (Howard, Trevillion, Khalifeh, et al, 2010; Rose, Trevillion, Woodall, et al, 2011). Likewise, one woman in this study described disclosing her experiences of abuse during the first meeting with her care coordinator, following direct enquiry.

7.6.1.3 Gender and Culture
The influences of gender and culture on disclosure and enquiry of domestic violence were identified as key themes for service users and professionals. With regards to culture, both groups discussed how cultural perceptions may influence survivors’ identification of and willingness to disclose abuse. Cultural attitudes and practices that permit the use of violence within intimate relationships and promote men’s dominance over women are shown to perpetuate women’s vulnerability to abuse (Amoakohene, 2004; Thiara & Gill, 2010a; Walker, 2009; World Health Organization, 2009), and inhibit help-seeking behaviours among abused women, particularly among BAMER women (Morrison, Luchok, Richter, et al, 2006; Sokoloff & Dupont, 2005; Thiara, 2002; Thiara, 2010).

The theme of gender was also highlighted among professionals and service users and both described how perceptions of gender roles may create barriers to disclosure among service users. They discussed how social ideals about male strength and masculinity may have the effect of preventing men from disclosing
their experiences of domestic violence. Professionals explored the influence of gender on the willingness of survivors to disclose abuse to professionals of the opposite sex. One male care coordinator described concern that female survivors, who have been abused by men, may not appreciate being asked about these experiences by a male clinician. Evidence suggests that on the whole women do not report a clinician gender preference for disclosure of domestic violence (McCauley, Yurk, Jenckes, et al, 1998; Rodriguez, Sheldon, Bauer, et al, 2001); although men have been shown to be more likely to disclose same-sex sexual behaviours to male enquirers (Catania, Binson, Canchola, et al, 1996).

The gender and cultural findings identified in this study highlight the need for psychiatric services to be attuned to the effects of domestic violence in the context of gender, race and culture when seeking to identify and respond to domestic violence (Thiara & Gill, 2010a). In particular, services should be mindful that women from BAMER groups report unequal access and treatment by mental health services (Chantler, 2003; Chew-Graham, Bashir, Chantler, et al, 2002). In order to increase cultural and gender sensitive practice among clinicians, the psychiatric curriculum should incorporate specific training on the influences of race, ethnicity and gender identity on experiences of domestic violence (Short, Johnson & Osattin, 1998). Another is through public education campaigns that seek to challenge attitudes, behaviours and cultural norms that perpetuate violence (Garcia-Moreno, 2002; Laing, Toivonen, Irwin, et al, 2010).

7.6.1.4 Limited Knowledge of Domestic Violence Services
Overall, service users and professionals in this study reported a limited knowledge of domestic violence services. Service users described receiving little or no information from professionals following disclosure, and professionals reported feeling ill-equipped to respond to disclosures due to a limited knowledge of sources for referral. Alarmingly, one woman described her frustration that professionals were unaware of a domestic violence service, which was almost adjacent to the community mental health team (CMHT) where she was being treated. A limited knowledge of domestic violence services can leave service users vulnerable to further abuse and exacerbate feelings of isolation. It can also leave service users feeling there is little alternative available, and may explain
why so many respondents only sought help when the violence became severe. Survey research with other survivors of domestic violence suggests that delayed help-seeking behaviours are associated with a lack of knowledge about sources of support (Fugate, Landis, Riordan, et al., 2005). It is crucial then that professionals improve on their knowledge of local and national support services (Taket, Nurse, Smith, et al., 2003). An important observation made by one female respondent, whose partner attended most of her health appointments, was the need for advertisements in private areas of the CMHTs (i.e. toilets and consulting rooms), so that this information could be read without the abuser’s knowledge.

General advertisements about the nature and impact of domestic violence can also be effective in improving service users’ identification of abuse (Garcia-Moreno, 2002). The experiences of respondents in this study suggest that increased advertisements about domestic violence within psychiatric settings may significantly improve service users’ identification of abuse.

7.6.1.5 Multi-Agency Collaboration
In relation to services response to domestic violence, both service users and professionals in this study called for improved multi-agency collaboration between psychiatric and domestic violence services, in order to effectively support the needs of service users experiencing abuse. Results from this study indicate that, although the majority of service users felt unable to confide the abuse to health professionals in the absence of direct enquiry, several of them made contact with police services during incidents of increased violence. Similar barriers to help-seeking were identified among a USA survey of 491 women experiencing past year violence, and women were also seen to be more likely to make contact with police services than medical services (Fugate, Landis, Riordan, et al., 2005). These findings show that greater information sharing between agencies could improve identification of abuse and consequently lead to increased protection for mentally ill individuals at risk of harm.

Service users and professionals described a lack of collaboration between psychiatric services and domestic violence services and called for improved working-partnerships, to improve lines of communication, inter-agency
partnerships and mutual-training among professionals. Traditionally, these two sectors have operated independently of one another, due to differences in the philosophical standpoints of psychiatric (medical model) and domestic violence (social-justice model) services, and in the gendered perspectives of their practices (Humphreys, Regan, River, et al., 2005). Differences in the gender focus of the two sectors, whereby psychiatric services commonly adopt a gender neutral analysis and domestic violence services commonly adopt a gendered analysis, have been found to create a ‘cultural clash’ in working practices (Humphreys, Regan, River, et al., 2005, p 1311). In addition, domestic violence services have traditionally been reluctant to engage with psychiatric services because of their social-justice philosophical standpoint, which views psychiatric symptoms as a direct response to violence that can be resolved through the provision of safety and support (Warshaw, Gugenheim, Moroney, et al., 2003). These divergent viewpoints mean that survivors of domestic violence may struggle to receive adequate support for their mental health and trauma needs (Gorde, Helfrich & Finlayson, 2004). By orientating experiences of abuse purely within a psychiatric model of mental health, services run the risk of pathologising survivors’ experiences (Humphreys & Thiara, 2003a). Equally, by ignoring the psychobiological effects of domestic violence, services run the risk of minimising the traumatic effects of abuse and may hinder access to appropriate treatment (Dutton & Corvo, 2006; Herman, 1992; Sanderson, 2008; Walker, 2009).

Through the development of Multi-Agency Risk Assessment Conferences (MARACs) and “Vulnerable Adults” procedures, inter-agency collaborations are beginning to be established (Home Office Violent and Youth Crime Prevention Unit & Research and Analysis Unit, 2011). Australian examples of ‘mutual information exchange’ programmes between mental health and domestic violence sectors have reported improved practices among professionals, including greater collaborative service provisions and referral information for service users (Morley, 2005).

7.6.1.6 Specialist Provision for Psychiatric Service Users Experiencing Domestic Violence

Both service users and professionals in this research study called for the development of specialist services to support people who have mental health
problems and who experience abuse. Care coordinators experienced difficulty in obtaining access to refuge spaces because of service users’ mental illness. Recent research indicates that a lack of specialist provision exists for survivors of domestic violence who have mental health problems (Howard, Trevillion, Khalifeh, et al., 2010), and mainstream domestic violence services may not be sufficiently resourced to accommodate survivors with a severe mental illness (Barron, 2004; Hager, 2011). These findings are noteworthy, as without specific provision to support the needs of survivors with mental illness, clinicians may make inappropriate referrals that can exacerbate mental illness and put people at increased risk of further violence. Moreover, service users will fail to receive adequate support for their mental health and trauma needs.

7.6.1.7 Clinical Training about Domestic Violence
Service users and professionals in this study spoke of the need for clinicians to receive specific training on domestic violence, in order to address certain deficits in their clinical knowledge. A lack of knowledge and expertise about domestic violence was reported to influence professionals’ identification of abuse and response to service users’ disclosures of abuse. The results of this analysis may shed some light on research findings that even after the introduction of direct questions about abuse on routine clinical assessment forms some clinicians avoid enquiry (Agar, Read & Bush, 2002). This study indicates that professionals’ concern about their competencies in addressing abuse acts as a significant barrier their identification and response to domestic violence. The majority of professionals in this sample had not received specific training on domestic violence. Interestingly, a survey of nine Mental Health Trusts in England found that 35% of mental health professionals had not received any formal training in managing disclosure of abuse by service users (Department of Health, 2007). Professionals in this study called for further education to improve their confidence and expertise in addressing domestic violence, including experiential training that provides practical examples on how to ask about domestic violence and details of local/national domestic violence services. These findings align with those reported among 381 Canadian emergency care professionals, with 85% (n=321) expressing a need for greater training on domestic violence (Mason, Schwartz, Burgess, et al., 2010).
Respondents’ concerns about mental health professionals’ clinical competencies in identifying and responding to domestic violence are noteworthy as on the whole mental health clinicians do not receive specific pre-registration or post-registration training on this topic within the psychiatric curriculum (Hegarty, 2011; Morgan, 2007b). This suggests that with increased training about domestic violence clinicians can become better equipped to identify abuse and make appropriate referrals to support survivors’ recovery. It is essential that domestic violence training programmes incorporate specific components that highlight the complex inter-relationship between mental illness and abuse, in order to educate clinicians who may be unconvinced about the mental health implications of abuse.

There is a paucity of evidence on the effectiveness of domestic violence training interventions in psychiatric settings. Within primary care settings, a recent UK cluster-randomised controlled trial of a multi-faceted programme – including domestic violence training - found positive improvements in clinicians’ identification and referral of women experiencing domestic violence (Feder, Agnew-Davies, Baird, et al, 2011). The trial was implemented within 51 primary care practices (24 practices received the intervention and 24 did not) and intervention practices received the following components: (1) two 2-hour training sessions to improve clinicians response to domestic violence; (2) a named domestic violence advocate educator, who provided on-going support to clinicians in addressing domestic violence; (3) a medical record prompt for routine enquiry of domestic violence (linked to diagnoses including depression, anxiety, irritable bowel syndrome); and (4) a referral pathway to a named domestic violence advocate. At one year follow-up, the 24 practices receiving the intervention displayed increased rates of identification of domestic violence (rate ratio 3.1 [95% CI 2.2–4.3]) and referral to advocacy services (rate ratio 6.4 [95% CI 4.2 – 10.0]) (Feder, Agnew-Davies, Baird, et al, 2011). However, as the study did not collect patient-level data it is not clear whether this intervention led to improved outcomes for service users.

7.6.1.8 Service Users’ and Professionals’ Typologies
Analysis of service users’ and professionals’ typologies suggest that perceptions
of clinical roles and understandings of experiences of domestic violence may influence service user/clinician interactions. Findings suggest that service users’ disclosure of domestic violence may be determined by their treating clinicians’ perception of their professional role. For instance, service users in the ‘unknowing’ typology who struggled to identify their experiences of abuse may have been supported in acknowledging these behaviours if in contact with clinicians in the ‘embracing’ typology, who directly enquire about abuse experiences and actively seek to explore these issues with service users. Alternatively, if respondents in the ‘unknowing’ typology were in contact with clinicians in the ‘avoidant’ typology, who described shying away from discussions of abuse, they may have continued to remain unaware of the violence perpetrated against them. Service users in the ‘accountable’ typology, who did not fully acknowledge the extent of harm perpetrated against them, may have been supported by clinicians in the ‘embracing’ typology in exploring the impact of experiences of abuse on physical and mental health outcomes. Professionals in the ‘ambivalent’ typology, who were unconvinced of their role in addressing domestic violence, may have failed to identify the specific vulnerabilities to violence reported by service users in the ‘vulnerable’ typology.

The degree of support that service users receive following disclosure of abuse may also differ depending on clinicians’ perception of their professional role. For instance, professionals in the ‘embracing’ typology would seek out key resources and explore experiences of abuse within the therapeutic context. Professionals in the ‘avoidant’ and ‘ambivalent’ typologies, however, may fail to incorporate experiences of abuse in service users’ treatment plans. Professionals with ‘accepting’ perceptions of their clinical role in addressing domestic violence may respond to service users’ disclosures of abuse in very different ways, depending on whether they believe the organisational climate of their current team displays an awareness of domestic violence. These findings identify the importance of implementing innovations that seek to address variations in professionals’ perceptions of their professional role, eliminate barriers and provide incentives for routine enquiry, documentation and referrals for service users’ experiences of domestic violence.
7.7 Study Strengths and Limitations

This study examined the experiences of both service users and clinicians to explore how mental health services identify and respond to domestic violence. The study employed semi-structured interview techniques, which were guided by interview schedules developed and piloted in consultation with service users and clinicians. This process helped to ensure that interviews included sensitive methods of enquiry and sufficient prompts to capture the detailed nature of respondents’ experiences. Purposive sampling techniques were employed to obtain a sample of service users and professionals that were clinically and demographically comparable to the local population. No respondents disclosed same-sex domestic violence; therefore it is not possible for this study to make inferences about the abuse experiences of these groups.

Recruitment continued until saturation of themes had been achieved. This process helped to ensure that a detailed and comprehensive picture of service users’ and professionals’ experiences were captured. It is important to note that the research was unable to capture the views of service users and professionals who did not wish to participate in the study and their views may differ from those who agreed to participate.

In order to address elements of subjectivity in the coding and interpretation of data, myself and another researcher (AW) independently coded 20% of professional and service user transcripts, before meeting to compare results and resolve differences. After achieving an 80% inter-rater agreement the results were then cross-checked by senior academics (LH, DR and CM); a deviant case analysis was also conducted to examine the validity of the interpretations. It was not assumed that themes would emerge from the data and that a degree of interpretation was required in identifying them. Consequently, the influence of my presence during collection and analysis has an impact on the overall generalisability of the data (as outlined in Chapter 4 section 4.1 and 4.2). Most notably, as a white British woman I do not possess a shared frame of reference in which to orientate the narratives of BAMER communities within their wider cultural and ethnic frameworks.
Although the demographic characteristics of service users in this study were seen to be reflective of the local population, findings may not be transferable to other settings. The study was conducted in a particular service configuration in south London and in a very socio-economically deprived setting with a high proportion of people from BAMER groups. The ability to extrapolate findings from the analysis of agreement and disparity between mental health professionals should be interpreted with caution, as only a small number of social workers and only one psychologist was included in the sample.

As outlined in Chapter 4 section 4.2, the analysis of service users’ experiences of domestic violence raised some important questions regarding the social constructions of violence (e.g. issues of culpability and victimisation). Namely, how different meanings of violence shape our interpretations of the characteristics of people subjected to abuse and the circumstances in which violence occurs. This was particularly apparent in relation to the analysis of male respondents’ experience of domestic violence, in light of the fact that both male respondents also reported perpetrating abuse and little empirical evidence currently exists on men’s experiences of domestic violence (Cronholm, 2006). The ability to tease out the wider context, motivations and meanings of their experiences was limited within the time constraints of a single semi-structured interview. Other scholars have also identified difficulties in interpreting the experiences of people reporting both domestic violence victimisation and perpetration (Capaldi & Kim, 2007; Johnson, 2010; Langhinrichsen-Rohling, 2010). Future research may therefore benefit from conducting further follow-up interviews with respondents, in order to fully explore the context and meanings that people associate with their experiences of abuse.
7.8 Summary of Findings

Results of the thematic analysis of service users’ narratives highlight the need for improved awareness about the nature, extent and impact of domestic violence within psychiatric services. Health promotion strategies may help to raise service users’ awareness of the extent of abuse and its physical and mental health impacts, and in eliminating feelings of shame and embarrassment. The introduction of routine enquiry about domestic violence can also raise awareness of abuse among service users and clinicians, and facilitate a discourse between clinicians and service users that can promote disclosures. Findings highlight the need for strategies to ensure that people with severe mental illness who experience abuse are able to access mainstream support services and that specific interventions are developed to support the mental health and trauma needs of these vulnerable groups.

Results of the constant comparative analysis of service users’ narratives highlight the potential benefit of implementing campaigns that seek to prevent domestic violence. Primary prevention programmes that seek to: develop safe and nurturing relationships between caregivers and their children; promote social, emotional and behavioural competencies in children, and challenge cultural and social norms supporting violence could be effective in deterring violence and abuse. Secondary prevention measures targeted to support vulnerable groups (e.g. people with histories of abuse, people with severe mental illness and BAMER groups) may be effective in averting experiences of domestic violence re-victimisation. Overall, this analysis has highlighted that individual, familial/peer, community and societal level factors influence service users’ understanding of domestic violence. This finding provides support for the ecological model of violence (see Chapter 1 section 1.7) and suggests that in order to ensure effective responses to domestic violence health services need to adopt an ecological approach within policy and practice.

Results of the thematic analysis of professionals’ narratives highlight the need for organisational strategies that seek to eliminate barriers and introduce incentives to support psychiatric services identification and response to domestic violence. The development of specific policies and procedures for domestic violence, alongside
greater organisational awareness and access to domestic violence resources can assist this process. Clinical training for professionals in how to appropriately identify, document and respond to domestic violence can ensure service users receive adequate support and continuity of care.

Results of the constant comparative analysis of professionals’ narratives identified variations in their perceptions of their professional role, which shaped their views on the assessment and management of domestic violence. The findings highlight the need for system-level strategies that seek to address differences in professionals’ perception of their roles, and to support and promote an improved awareness of domestic violence within psychiatric services. They also highlight the need for clinical training to improve mental health professionals’ competencies in identifying and responding to abuse and in challenging views that experiences of domestic violence are social pathologies that are unrelated to mental illness.

Overlapping themes from the thematic analysis of service users’ and professionals’ narratives highlight the need for psychiatric services to be aware of the dominance of the medical diagnostic and treatment model, and the risk this has in preventing the exploration of issues of abuse. Both service users and professionals discussed the need for psychiatric services to have greater knowledge of local and national support services. The importance of clinical training to improve mental health professionals’ competencies in identifying and responding to domestic violence, and in raising their awareness of gender and cultural sensitivities was also reported. Improved inter-agency collaboration between mental health and domestic violence sectors and the development of specialist services can ensure that service users receive the necessary support for their experiences of abuse and mental illness.

Chapter 8 will discuss in detail the implications of these findings for clinical practice and provides key recommendations to improve the response of psychiatric services to domestic violence.
Chapter 8: Overall Discussion, Conclusions and Implications

8.1 Introduction

The purpose of my PhD study was to establish greater understandings and new insights into the identification and response of psychiatric services to domestic violence. An examination of the existing literature identified a dearth of evidence on the prevalence of domestic violence, the experiences and expectations of professionals and service users, and the efficacy of interventions for domestic violence within psychiatric services. Therefore, I conducted three studies that sought to address these evidence gaps in the following ways:

1) A systematic review on the prevalence of domestic violence in psychiatric settings (see Chapter 2),

2) A systematic review on the effectiveness of interventions for psychiatric service users disclosing domestic violence (see Chapter 3), and

3) A qualitative study of mental health professionals’ and service users’ expectations and experiences of services response to domestic violence (see Chapters 4-7)

Chapter 2 revealed a high prevalence of domestic violence among male and female psychiatric service users. Chapter 3 revealed insufficient evidence for the effectiveness of cognitive behavioural therapy and domestic violence advocacy in improving outcomes for abused psychiatric service users. Finally, Chapters 4-7 revealed that the response of services to psychiatric service users’ experience of domestic violence is limited.

This chapter begins with a discussion of my PhD study findings and its relationship to and implications for academic and policy research. Examination of the implications of these findings for mental health service practice and future research will then be presented; followed by a summary of my reflections about this research study.
8.1.1 Ecological model of violence
A key finding from my PhD study is the interplay of individual, familial/peer, community and societal factors in shaping vulnerabilities to domestic violence among psychiatric service users (as outlined in Chapter 1 section 1.7). At an individual level, risk factors include the presence of mental illness and being directly abused or witnessing abuse as a child. At a familial/peer level, risk factors include poor parenting practices, family stressors, socioeconomic hardship, and friends that engage in violence. Community-level risk factors include the absence of formal and informal social supports, social isolation, unemployment, and the availability and access to community resources (e.g. transportation, shelters/refuges, domestic violence and psychiatric services). Finally, at a societal-level risk factors include gender, ethnic, social and economic inequalities, cultural norms that support violence and incomplete or imprecise health care policies and procedures for domestic violence, which have the effect of increasing an individual’s risk of re-victimisation (Heise, 1998; Little & Kantor, 2002).

As will be outlined below, the three studies of my PhD research show that psychiatric service users are at high risk of domestic violence. Therefore, discussions will highlight the necessity of primary and secondary prevention strategies in addressing individual, familial/peer, community and societal risk factors that condone and perpetuate domestic violence. Focusing specifically on health services, discussions will concentrate on the need for psychiatric services to adopt an ecological analysis of violence, which ensures that clinicians account for the multidimensional factors that shape service users’ experiences of domestic violence and improves their knowledge about how best to intervene and support service users.

8.2 High Prevalence of Domestic Violence is Reported among Male and Female Psychiatric Service Users
The systematic review presented in Chapter 2 highlights that male and female psychiatric service users’ experience a high prevalence of domestic violence. These findings align with existing evidence, which suggests that psychiatric service users disclose a higher prevalence of domestic violence than people

8.2.1 Primary Prevention Strategies
As outlined in Chapter 5, service users frequently reported experiences of childhood abuse (13 (54%) of the 24 service users disclosed childhood abuse). Service users who disclosed childhood abuse described how this influenced their experience of domestic violence in adulthood. Some individuals believed that they had learnt to model the violent behaviours they were exposed to as children. Others described how their desire to abscond from the violent childhood home often resulted in them becoming homeless and establishing relationships with people that sought to exploit their situational and emotional vulnerabilities. These findings support an ecological analysis of violence, which explores the interplay between risk factors such as childhood abuse, poverty, an absence of informal and formal social supports and cultural norms that condone violence in increasing an individual’s vulnerability to domestic violence.

In light of the high proportion of childhood abuse and domestic violence disclosed by psychiatric service users in my study, and numerous other research studies (Cloitre, Tardiff, Marzuk, et al, 1996; Rosenberg, Lu, Mueser, et al, 2007; Surrey, Swett, Michaels, et al, 1990), the development of primary prevention strategies, targeted to reduce individual, familial, community and societal risk factors, may be effective in thwarting child and adulthood experiences of abuse among these vulnerable groups (as will be discussed below).

8.2.1.1 Strategies for the Prevention of Childhood Abuse
A recent literature review examined evidence on the effectiveness of interventions in preventing direct abuse, neglect and exposure to parental domestic violence among children (MacMillan, Wathen, Barlow, et al, 2009). The review found evidence that two family-based home visitation programmes (i.e. Nurse-Family Partnerships and Early Start programmes) are effective in preventing direct abuse and neglect of children within low-income and high risk families. These programmes comprise intensive home-visitation by nurses/social workers who focus on assisting women in improving their prenatal health-related behaviours;
teaching parents sensitive and empathetic care of their children, and improving parents’ economic self-sufficiency. In contrast, a paucity of interventions were found to prevent children’s exposure to parental domestic violence (MacMillan, Wathen, Barlow, et al, 2009; Oleg, Hahn, Crosby, et al, 2005).

8.2.1.2 Strategies for the Prevention of Dating Violence
A review by the World Health Organization examined evidence on the effectiveness of interventions in preventing dating violence and sexual violence among adolescents (World Health Organization & London School of Hygiene and Tropical Medicine, 2010). The review found evidence of the effectiveness of three school-based programmes; comprising education about healthy, non-violent relationships, and teaching to improve communication and conflict resolution skills among adolescents (Foshee, Bauman, Ennett, et al, 2005; Wolfe, Crooks, Jaffe, et al, 2009; Wolfe, Wekerle, Scott, et al, 2003). Despite the success of these interventions in preventing dating violence during adolescence, the absence of longer term follow-up assessments means that it is not possible to examine whether these interventions are effective in preventing domestic violence in adulthood (Wathen & MacMillan, 2003; Whitaker, Morrison, Lindquist, et al, 2006).

8.2.1.3 Strategies for the Prevention of Domestic Violence
The overall effectiveness of adult-based interventions in preventing domestic violence remains uncertain (World Health Organization & London School of Hygiene and Tropical Medicine, 2010). Although there is some evidence that communication and relationship skills training can mitigate violence among adult women and men (Markman, Renick, Floyd, et al, 1993), findings are not consistent (Jewkes, Nduna, Levin, et al, 2008). Initial evidence suggests that interventions aimed at improving women’s economic self-sufficiency and promoting gender empowerment can be successful in preventing domestic violence. For example, a cluster-randomised controlled trial of a microfinance-based intervention, delivered across four South African villages, reported significant reductions in women’s risk of domestic violence at two-years follow-up (Kim, Watts, Hargreaves, et al, 2007). The intervention comprised: (1) a microfinance loan, which provided credit and savings for income-generating
projects, and (2) a ten session empowerment module, including topics on gender roles, domestic violence, and women’s communication skills/leadership. At follow-up, significant reductions in the risk of past year domestic violence (Adjusted RR 0.45 (95% CI 0.23-0.91)) and controlling behaviours from a partner (Adjusted RR 0.80 (95% CI 0.35-1.83)) were found among women receiving the intervention compared to controls (Kim, Watts, Hargreaves, et al, 2007). It is important to note that the findings of Chapter 5 section 5.7 indicate that women’s financial independence, as a protective factor for abuse, may be jeopardised by the dominance of patriarchal control in society.

This section outlines that there is some evidence for the success of interventions in preventing childhood abuse and dating violence among adolescents. However, there is a clear need for further investment in interventions that seek to prevent domestic violence in adulthood, both among the general population and high-risk groups (e.g. psychiatric service users). As outlined by the ecological model, interventions targeted at prevention need to address the multi-dimensional risk factors that increase an individual’s vulnerability to domestic violence. Such prevention efforts need to address not only individual-level structures but also community- and societal-level structures that facilitate abuse.

Alongside primary prevention measures, there is a need for safeguarding strategies that seek to ensure the early identification and treatment of domestic violence (as discussed below).

**8.2.2 Secondary Prevention Strategies**

Findings from Chapter 5 indicate that service users’ experience of mental illness or insecure immigration status can create vulnerabilities to repeat domestic violence re-victimisation. These findings support an ecological analysis of violence, which considers how the intersection of inequalities in relation to gender, race, mental illness and socio-economic status increase an individual’s risk of domestic violence. Chapter 5 section 5.7 underlines that in order to safeguard service users against protracted periods of abuse, clinicians need to distinguish between the types of violence experienced, the motivations of abusers and the cultural contexts in which the violence occurs. These findings emphasise
the need for mental health professionals to conduct detailed safety assessments for people who are experiencing domestic violence, and to provide education on the extent of physical and psychological harms resulting from protracted periods of abuse. Without a careful assessment of the nature of violence experienced, health services run the risk of facilitating self-blaming attitudes among abused people, preventing the identification of abuse and hindering help-seeking behaviours.

8.2.2.1 Non Health-Related Safeguarding Strategies

There is some evidence from international studies that large-scale educational campaigns and home-visitations by police/social workers, following police reports of domestic violence, can reduce prescribed domestic violence norms and promote help-seeking behaviours among survivors (Davis & Taylor, 1997) (Usdin, Scheepers, Goldstein, et al, 2005). Such interventions comprise: (1) media campaigns to increase public awareness of the legal rights of abused people and availability of domestic violence services; (2) media campaigns that challenge social attitudes condoning domestic violence, and (3) the provision of on-the-spot crisis counselling, legal remedies and/or referral to other agencies for people experiencing domestic violence.

Secondary prevention strategies in the UK include the pilot implementation of police-issued Domestic Violence Protection Notices (DVPN) and court-issued Domestic Violence Protection Orders (DVPO). These initiatives require the abuser(s) to vacate the survivor’s residence for a maximum of 28 days, with the aim of securing the survivor’s immediate protection and in supporting their longer-term protection from abuse (Home Office, 2011c). Evaluations of the effectiveness of these pilot measures have yet to be published. Based on the findings of this PhD study - which found that service users do not report abuse due to concerns about relocating/moving from their home - these schemes may be found to encourage help-seeking behaviours among survivors. Other measures include guidance for Crown Prosecution Services to improve their engagement with domestic violence services that specialise in supporting black, Asian, minority ethnic and refugee (BAMER) groups (Home Office, 2011a).
Recent recommendations from the Department of Health in England (DoH) Taskforce on Violence against Women and Girls call for health services to be accessible to the most vulnerable individuals, irrespective of their immigration status (Women’s National Commission, 2010). They also call for services to implement protocols that ensure individuals without recourse to public funds can access adequate support (Women’s National Commission, 2010). Over the past few years, the UK government has made steps to improve the level of assistance provided to abused immigrant women (Sharma & Gill, 2010), and on 1st April 2012 the UK Border Agency introduced the Destitution Domestic Violence (DDV) concession (Home Office, 2012b). This concession allows people experiencing domestic violence, who are subject to the no recourse to public funds rule, to access public funds for a period of three months while they make a claim for indefinite leave to remain (Home Office, 2012b). Additionally, the Department for Work and Pensions have recently implemented an automatic thirteen week deferral period for Jobseeker Allowance claimants who are experiencing domestic violence (Social Security, 2012).

8.2.2.2 Health-Related Safeguarding Strategies

A review of “Vulnerable Adults” alerts and referrals to Adult Safeguarding Leads in England and Wales in 2010 and 2011 revealed that abusers were most frequently family members, and 23% of all referrals were regarding mental health service users (The Health and Social Care Information Centre, 2012). These findings indicate that “Vulnerable Adults” and safeguarding policies can be effective in identifying vulnerabilities to abuse experienced by psychiatric service users. In addition, Multi-Agency Risk Assessment Conferences (MARACs) are shown to improve survivors’ safety and reduce domestic violence re-victimisation (Home Office Violent and Youth Crime Prevention Unit & Research and Analysis Unit, 2011; Pickles & Robinson, 2007). These findings are particularly notable given the extensive histories of harm and identification of high-risk for repeated violence among people referred to MARACs.

In spite of the promising results of existing safeguarding strategies, mental health professionals have reported bottlenecks in referral processes and a duplication of work, when adhering to both “Vulnerable Adults” and MARACs requirements
These findings suggest, then, that adult safeguarding policies may fail to take into account existing organisational policies and practices on the management of harm to service users. Worryingly, the results of Chapter 6 indicate that competing demands and an absence of clear guidance can create barriers to the successful identification and appropriate response of clinicians to domestic violence.

This section underlines the importance of developing and evaluating secondary prevention programmes that address structural inequalities at an individual-, familial/peer-, community- and societal-level, which are seen to increase service users’ vulnerability to domestic violence. In relation to health services, the findings highlight the importance for Trusts in reviewing their current safeguarding and violence and abuse policies, and to rectify any contradictory guidance within clinical practice. Most notably, the results highlight the need for Mental Health Trusts to establish clear procedures for responding to domestic violence in order to safeguard these vulnerable groups.

8.3 Evidence on the Effectiveness of Interventions in Improving Outcomes for Abused Psychiatric Service Users is Limited

As outlined in Chapter 1 section 1.11.4, an increasing number of studies examine the effectiveness of interventions for women disclosing domestic violence in primary care and non-psychiatric health settings. The majority of these interventions exclude male service users and individuals with severe mental illness. As a consequence, findings cannot be extrapolated to people experiencing more acute psychiatric symptoms, who are likely to be supported by secondary mental health services (Howard, Trevillion, Khalifeh, et al, 2010). The results of Chapter 3 highlight a dearth of evidence on interventions for psychiatric service users disclosing domestic violence. All studies included in the review examined the effectiveness of interventions for psychiatric outpatients and therefore findings cannot be extrapolated to inpatient psychiatric service users. In addition, all but one of the studies examined only mental health outcomes among service users and did not address other factors that can perpetuate abuse and impede recovery (e.g.
social isolation, the absence of informal and formal social support, socio-economic hardship).

8.3.1 Need for Interventions to Improve Outcomes for Psychiatric Service Users Disclosing Domestic Violence

The findings above underline the urgent need for domestic violence interventions that consider vulnerabilities to domestic violence experienced by people with severe mental illness, at an individual, familial/peer, community and societal level. In the absence of identification of how these vulnerabilities interact, both within and between the various levels, the efficacy of interventions in improving outcomes for service users is limited. Future health service interventions should therefore seek to address not only the mental health needs of abused service users, but also their needs in relation to parenting skills, economic and housing support, employment, formal and informal social supports and access to community resources. Health service interventions need also to consider whether existing healthcare policies and procedures for domestic violence are sufficient (see section 8.4.1.). Consideration should also be given to political pressures that may inhibit the successful implementation of interventions, such as financial cuts to the sector. Indeed, in the current fiscal climate, and in light of changes to commissioning procedures, health services may experience challenges with regards to investing in the development of domestic violence interventions. Recent guidance from the DoH states that the new local authority Health and Wellbeing Boards will provide a forum for commissioning work on violence against women and children (Department of Health, 2011). The UK Home Office is also currently in the process of developing guidance to assist local authorities in understanding the benefit of investing in violence and abuse services (Home Office, 2011a). Across all health settings, the cost-effectiveness of interventions aimed at reducing exposure to and effects of domestic violence are necessary (Taket, 2012) to support commissioning agreements (Department of Health, 2010a).
8.4 The Identification and Response of Psychiatric Services to Domestic Violence is Limited

Results from Chapter 6 suggest that mental health professionals are often unaware of Trust policies and procedures in relation to domestic violence. Similarly, a UK survey of 685 primary care, obstetrics/gynaecology and mental health professionals found that only three clinicians had used a written protocol for dealing with cases of domestic violence (Cann, Withnell, Shakesphere, et al, 2001). The qualitative study presented in Chapters 5 and 6 found that while mental health professionals have identified cases of domestic violence, they do not routinely ask service users about abuse. Limited enquiry about domestic violence has also been reported within primary care and non-psychiatric health settings (Bradley, Smith, Long, et al, 2002; Brzank, Hellbernd & Maschewsky-Schneider, 2004). Our recent literature review found that only 10-30% of domestic violence cases are currently detected by psychiatric services (Howard, Trevillion, Khalifeh, et al, 2010). Furthermore, a survey of nine Mental Health Trusts in England found that 13-36% of clinicians had never asked female service users about violence and abuse and 17-40% had never asked male service users (Department of Health, 2007).

The results from Chapter 6 indicate that mental health professionals’ experience several barriers to enquiry of domestic violence, including: a lack of knowledge/expertise in addressing abuse; the dominance of the medical diagnostic and treatment model, and competing clinical demands. Similar barriers to disclosure have been reported by primary care and non-psychiatric clinicians (Feder, Ramsay, Dunne, et al, 2009; Hamberger & Phelan, 2004). In spite of these barriers, Chapter 6 found that most professionals believed domestic violence to be an important mental health issue that should receive greater attention within psychiatric services. A finding supported by results from the survey of nine Mental Health Trusts in England, which found that just 6% of clinicians believed their Trust’s response to domestic violence was sufficient and 64% wanted to see improvements in assessment procedures and care planning processes (Department of Health, 2007).
With regards to service users, Chapter 5 found that in the absence of direct enquiry from clinicians many service users only disclose abuse when the violence becomes severe or unmanageable. Findings suggest that service users’ experience several barriers to disclosure of domestic violence, including: a fear of the consequences of disclosure; the hidden nature of domestic violence, and the dominance of the medical diagnostic and treatment model. Chapter 5 found that service users were in favour of the implementation of routine enquiry of domestic violence, which aligns with research conducted with primary care and non-psychiatric service users (see Chapter 1 section 1.11.3). The results from Chapters 5 and 6 indicate that both professionals and service users believe disclosure and enquiry of domestic violence is assisted by routine enquiry.

The results from Chapters 5 and 6 suggest that mental health professionals and service users have a limited knowledge of local/national support services for domestic violence. Furthermore, they identify a lack of clear care referral pathways for service users who disclose domestic violence. It is not surprising, then, that service users and professionals described instances when care was disjointed or had failed to address the trauma associated with abuse. The dominance of the medical diagnostic and treatment model was reported to hinder thorough assessments of domestic violence, and pathways of referral for service users; the latter findings align with other research findings (Humphreys & Thiara, 2003a; Women’s National Commission, 2010). Table 11 (see below) outlines what interventions mental health professionals and service users would like psychiatric services to offer in relation to domestic violence. This is followed by a discussion of the implications of these findings for clinical practice (see section 8.4.1).
### Table 11: Desired Response of Services as Described by Mental Health Service Users and Professionals

<table>
<thead>
<tr>
<th>Stage of Interaction with Mental Health Professional</th>
<th>Desired Response</th>
</tr>
</thead>
</table>
| Before questioning/disclosure of DV                | • Inclusion of leaflets/brochures on DV in CMHTs (i.e. waiting areas, private consulting rooms)  
• Professionals’ knowledge and understanding of DV (e.g. nature/prevalence and impact of DV) |
| Questioning of DV by mental health professionals    | • Direct enquiry of DV  
• Repeat enquiry of DV  
• Sensitive enquiry, exploring prevalence and impact of DV on mental health well-being |
| Immediate response to DV                            | • Acknowledgement of disclosure  
• Supportive/validating responses to disclosures  
• Risk assessment and basic safety planning  
• Exploration of the link between DV and mental illness  
• Discussion of options and provision of information on DV services |
| Subsequent response to DV                           | • On-going emotional support  
• Multi-agency collaboration  
• Support tailored to the needs of people with severe mental illness who experience DV |
With research to suggest that abused people have greater contact with health services than non-abused people (MacMillan, Wathen, Jamieson, et al., 2006; Rivara, Anderson, Fishman, et al., 2007; Ulrich, Cain, Sugg, et al., 2003), psychiatric services must implement strategies to increase their identification and response to domestic violence. Efforts should also concentrate on improving help-seeking behaviours among BAME groups, who are seen to report greater unmet mental health needs than white people (Lipsky & Caetano, 2007a; Lipsky & Caetano, 2007c).

Building on the findings of this PhD study, the following discussion will focus on the specific strategies that psychiatric services should adopt to address domestic violence, which include:

1) Implementation of specific policies and procedures on domestic violence;

2) Implementation of routine enquiry of domestic violence;

3) Training to improve clinicians’ identification and response to domestic violence;

4) Strategies to raise awareness about domestic violence;

5) Continuity of care for service users experiencing domestic violence;

6) Implementation of care referral pathways and the development of inter-agency collaborations, and

7) Development of specialist services.

In order to ensure effective responses, it is critical that health service policy and practice adopts an ecological approach to domestic violence (as will be discussed below).

8.4.1 Policies and Procedures for Domestic Violence

A recent survey of 55 Mental Health Trusts in England found that just 21 Trusts had safeguarding policies which contained information about domestic and sexual violence, and only 15 Trusts had policies specifically for domestic and sexual violence (Holly, Scalabrino & Woodward, 2012). A review of these policies found that there was limited guidance on how to respond to service users’ disclosures of abuse, even in abuse-specific policies, and only three Trusts included guidance on asking about domestic and sexual violence. This survey
also asked Trusts to identify the number of service users referred to MARACs within the previous twelve months. Of the 15 Trusts that responded to this question, five made no referrals, nine made less than ten referrals and only one made more than ten referrals (Holly, Scalabrino & Woodward, 2012). These findings clearly outline the lack of strategic-level provision in relation to the response of psychiatric services to domestic violence. The results may partly explain the difficulties encountered in establishing continuity of care for service users (as outlined in Chapter 6 section 6.6.1.3).

As highlighted in section 8.2.2.2, it is essential that domestic violence specific policies align with and complement existing safeguarding procedures. Chapter 6 found that some professionals contrasted the clear and robust care referral pathways for cases of childhood abuse with the lack of clarity regarding care pathways for adulthood of abuse. Recent guidance from the World Health Organization suggests that it may not always be an efficient use of resources to separate out services for domestic violence and childhood abuse, in light of the high co-morbidity of these two forms of abuse (World Health Organization, 2010). Best practice guidance encourages professionals working within child-protection systems to receive training on domestic violence and for child protection and domestic violence services to establish information sharing practices (Department of Health, 2010b; World Health Organization, 2010).

Through the adoption of specific domestic violence policies and procedures that utilise an ecological approach health services can provide a framework for effective treatment formulations, which acknowledge the interplay of individual, familial, community and societal level risk factors for domestic violence. In addition, specific domestic violence prevention and safeguarding policies/procedures that are aware of risk factors in relation to social divisions, particularly in relation to ethnicity and mental illness, can be effective in challenging social attitudes that condone the use of violence and in promoting clinicians’ education surrounding the identification, assessment and response to domestic violence (Little & Kantor, 2002).
8.4.1.1 Implementation of Policies on Routine Enquiry about Domestic Violence

DoH policy advocates for psychiatric services to acknowledge and address the links between violence and mental illness (Department of Health, 2003). Following a review of mental health assessments and care planning processes the DoH implemented specific questions about service users’ experience of violence and abuse in clinical assessments (Department of Health, 2008). To date, there is limited evidence on the effectiveness of universal routine enquiry in improving rates of identification and documentation by clinicians (Garcia-Moreno, 2002; Thompson, Rivaro, Thompson, et al, 2000), or in improving morbidity and mortality outcomes among service users (Feder, Ramsay, Dunne, et al, 2009). For example, a review of the case files of 200 consecutive admissions to a community mental health team (CMHT) found that in 136 cases clinicians failed to conduct initial assessments, using a new admission form that included specific questions about service users’ experience of abuse (Agar, Read & Bush, 2002).

As outlined at the beginning of this section, mental health professionals report several barriers to routine enquiry of domestic violence. Therefore the implementation of routine enquiry must be supplemented by experiential training, targeted to improve clinicians’ competencies in conducting sensitive enquiry and making appropriate referrals for domestic violence (as discussed below). Educational training components should adopt an ecological analysis of violence, which seeks to challenge negative attitudes, cultural stereotypes and blaming behaviours among clinicians and ensures that clinicians do not make attribution errors regarding the causes of abuse (Little & Kantor, 2002). At an individual level, this analytical approach ensures that clinicians are knowledgeable about the dynamics of abuse and the multi-dimensional risk factors for domestic violence, which can support them in addressing vulnerabilities to abuse experienced by service users. At a familial level, this approach can enable clinicians to conduct comprehensive safety plans for all family members and, at a community level, can facilitate a good working knowledge of services to support people experiencing domestic violence.
8.4.2 Training to Improve Mental Health Professionals’ Identification and Response to Domestic Violence

There is increasing recognition of the need for clinicians to receive training on domestic violence. For instance, the Royal College of Psychiatrists’ policy statement on domestic violence recognises the need for comprehensive clinical training to ensure efficacy of routine enquiry by psychiatrists:

“Psychiatrists need to have a working knowledge of the aetiology, effects and range of interventions available for victims of domestic violence”
(Royal College of Psychiatrists, 2002, p 4)

Similarly, the Royal College of Nursing guidance proposes that in order for all nurses to respond effectively to service users’ disclosures of domestic violence, they need to receive appropriate education and increase their knowledge of sources of referral (Royal College of Nursing, 2000). In spite of these recommendations, a lack of educational resources about the aetiology and effects of violence and abuse have been provided to clinicians to date (Morgan, 2007b).

In 2006 the DoH developed a two year pilot study that sought to enable psychiatric services to address violence and abuse as a core mental health issue (Department of Health & Care Services Improvement Partnership, 2008). Fifteen Mental Health Trusts received one-day training on how to identify and respond appropriately to service users’ disclosures of abuse, and implemented specific questions about abuse in clinical assessments and care planning. The Trusts established practice development forums, which provided guidance and supervision for clinicians in responding to abuse, and implemented strategies to strengthen their partnerships with specialist voluntary organisations (Department of Health, 2009). The study was seen to increase psychiatric services’ awareness of violence and abuse, although this did not always result in changes to clinical practice. For instance, although the implementation of questions of abuse within clinical assessments led to increased rates of enquiry among clinicians, a minority still did not ask service users about abuse. An evaluation of these findings indicated that the absence of enquiry resulted in poorer outcomes for some service users. Furthermore, clinicians frequently reported an absence of specialist
services for psychiatric service users experiencing abuse, which in turn affected the level of support service users received (Department of Health, 2009). Barriers to enquiry of domestic violence results in a failure of clinicians to challenge cultural norms that condone abuse and in support survivors to access key resources that can support their recovery.

It is important to note that the DoH pilot study described above was particularly focused on improving psychiatric services’ identification and response to childhood sexual abuse. Consequently, the effectiveness of these measures in improving the response of psychiatric services to domestic violence remains unclear. Nevertheless, the DoH are in the process of developing specific guidance to incorporate training on domestic violence as a part of a personal development programme for health visitors, and a training module on violence against women and girls for GPs and health professionals who undertake work capability assessments (Home Office, 2011a). Additional consideration is also being given to the development of a universal academic module for frontline health professionals on violence against women and girls (Home Office, 2011a). The results of this PhD study highlight the benefit for healthcare programmes to include education on the ecological model of violence. It is argued that without this understanding that the ability of clinicians to address risk factors and to support the needs of survivors is limited (Peled, Eisikovits, Enosh, et al, 2000).

In light of the findings from Chapter 5, health services would benefit from implementing culturally sensitive services that provide a space for people to either speak in their own language, or through trained interpreters that are not from their local community (Women’s National Commission, 2010). Good practice guidance suggests that to improve cross-cultural communication mental health professionals should use non-psychological terms when asking service users about experiences of abuse (Trevillion, Agnew-Davies & Howard, 2010). It is necessary that BAMER groups have access to specialist services, which can support their cultural needs (e.g. counselling in their mother tongue) and understands culturally specific domestic violence issues (Wilson, 2010). Notably, the UK Home Office is currently undertaking a scoping exercise to identify
specialist service provisions and examples of best practice in supporting BAMER communities experiencing abuse (Home Office, 2011a).

The findings of section 8.4.1 indicate that routine enquiry alone may not improve psychiatric services response to domestic violence and section 8.4.2 highlights that simply raising practice-level awareness of abuse may not be sufficient in itself in changing professionals’ clinical practice. However, sensitive enquiry by appropriately trained clinicians can be critical in ensuring survivors receive timely support. The results from Chapter 6 suggest that clinicians’ perception of their professional role and their knowledge/expertise about abuse affect their willingness to identify and respond to domestic violence. It is essential, then, that clinicians receive specific training about domestic violence, which incorporates the following: training on the ecological model of violence, education on the complex inter-relationship between domestic violence and mental illness; skills training to remove clinicians’ barriers to routine enquiry, and training to improve their competencies in responding to domestic violence. Training programmes must also highlight the importance of documenting disclosures of abuse (Trevillion, Agnew-Davies & Howard, 2010).

8.4.3 Strategies to Raise Awareness about Domestic Violence in Psychiatric Services
Psychiatric services’ implementation of health promotion strategies relating to domestic violence can assist professionals’ and service users’ identification of abuse. A recent report by the World Health Organization recommends that health services integrate messages about violence as part of routine health-promotion activities (World Health Organization, 2010). In addition, the DoH Taskforce on Violence against Women and Girls calls for NHS Trusts to develop health promotion strategies that seek to prevent abuse (Women’s National Commission, 2010). Scholars argue that alongside activities highlighting the housing, legal, social and economic support available to survivors, health promotion strategies need to address the psychological impacts of abuse (Eckermann, 2001).

The findings from Chapter 5 align with calls for the implementation of educational campaigns that identify the nature, extent and consequences of
domestic violence, and promote service users’ identification of abuse (Bates, Hancock & Peterkin, 2001). Health promotion strategies that adopt an ecological analysis of violence would also be beneficial in challenging cultural norms that condone abuse and in promoting service users access to key resources and formal support networks. Such strategies can assist in alleviating feelings of shame and embarrassment among service users, and in promoting gender- and ethnic-sensitive behaviours among clinicians (Östlin, Eckermann, Mishra, et al, 2007). The results of Chapter 5 suggest that advertisements on support services for domestic violence should be implemented within psychiatric services, as they can assist service users in gaining access to appropriate support. It is argued that in order to maximise the effectiveness of health promotion strategies, campaigns should be designed with an understanding of how the causes, manifestations and consequences of abuse differ between men and women (Östlin, Eckermann, Mishra, et al, 2007). The results of my PhD study highlight that further research is also needed to examine these issues among couples that report mutual violence.

It is shown that health promotion strategies can be effective in promoting psychiatric services awareness and readiness to address domestic violence; although their effectiveness in reducing violence among service users remains unclear (Taket, Wathen & MacMillian, 2004). There is a need therefore for additional strategies aimed at increasing psychiatric services’ identification of domestic violence. Strategies that adopt an ecological model of violence can be effective in openly confronting and naming the destruction of domestic violence, in enhancing clinicians’ knowledge of support services and in supporting them to develop clear care referral pathways (as outlined below).

8.4.4 Establishing Continuity of Care

A recent UK survey found that one factor affecting mental health professionals’ ability to respond appropriately to abuse was the issue of service users’ falling “in the gap” between primary and secondary mental health services (Department of Health, 2007, p 6). Similar issues were identified among mental health professionals in this study (see Chapter 6). The findings in Chapter 5 show that although some service users were offered assistance from clinicians, in relation to managing the abuse, their offer of help often did not materialise. These results
underline the need for mainstream domestic violence movements to acknowledge and address inequalities in relation to severe mental illness, which perpetuate psychiatric service users’ vulnerability to domestic violence. Framing domestic violence within an ecological analysis can ensure that the needs of service users are adequately addressed. These findings also highlight the necessity for clinicians in documenting service users’ disclosures of abuse, and in detailing in summary formulations and treatment plans any measures/strategies taken to address abuse. Documentation can ensure that when service users are discharged, or referred to other services, they continue to receive support for their experiences of abuse. Furthermore, it can assist service users in accessing legal and housing support (Trevillion, Agnew-Davies & Howard, 2010).

8.4.5 Establishing Clear Care Referral Pathways

The findings from Chapters 5 and 6 indicate that there is a lack of clear care referral pathways for service users disclosing domestic violence. For this reason, it is necessary that psychiatric services develop and evaluate care referral pathways for domestic violence. Such pathways should involve the domestic violence sector, when appropriate, and should aim to assist service users in increasing their informal and formal social support networks and their access to key resources (Trevillion, Agnew-Davies & Howard, 2010).

As described in Chapter 7 section 7.6.1.7, a recent UK cluster-randomised controlled trial in 51 primary care settings assessed the effectiveness of a complex multi-faceted intervention, which included a referral pathway to a named domestic violence advocate. At one year follow-up a six fold increase in rates of referral to advocacy services was observed among the 24 practices receiving the intervention (rate ratio 6.4 [95% CI 4.2 – 10.0]) (Feder, Agnew-Davies, Baird, et al, 2011). An adaptation of this model within was recently piloted within UK CMHTs and comprised a multi-faceted programme – including a direct referral pathway to an advocacy service (via named domestic violence advisors) – to improve psychiatric services response to domestic violence (see Chapter 3 section 3.3.2.2). The intervention was seen to improve clinicians attitudes, behaviours and response to domestic violence and to reduce service users’ experience of abuse and unmet needs (Trevillion, Byford, Cary, et al, Submitted). These findings provide
preliminary evidence of the benefit of clear care referral pathways in improving health services response to domestic violence. It is necessary that similar intervention studies are developed to test their efficacy in initiating and sustaining improvements regarding the response of services to domestic violence experienced by service users.

8.4.6 Inter-Agency Collaboration

The DoH Taskforce on Violence against Women and Girls recommends that psychiatric services work more closely with third sector services to develop effective care pathways and improved service delivery for service users experiencing abuse (Women’s National Commission, 2010). In light of the current fiscal climate, third sector organisations face on-going challenges to maintain and develop cost-effective services (Department of Health, 2010a). However, the Home Office has committed to invest £3.3 million every year until 2015 to fund Independent Domestic Violence Advocates (IDVAs) and MARAC co-ordinators, who have been shown to improve outcomes for people experiencing domestic violence (Howarth, Stimpson, Barran, et al, 2009). MARACs have also been shown to improve multi-agency working partnerships, and assist organisations in identifying and addressing knowledge gaps (Howarth, Stimpson, Barran, et al, 2009).

Greater inter-agency collaboration can result in mutual education to improve professional competencies and challenge stigmatising views about mental illness and domestic violence (Morley, 2005). These collaborations foster a societal-level response to domestic violence that tackles structural inequalities and situates the needs of psychiatric service users within the mainstream domestic violence movement. By establishing joint working practices between psychiatric and domestic violence services, both the mental health and trauma needs of survivors can be adequately addressed (as will be outlined below).

In the absence of local domestic violence services, the World Health Organization proposes that health Trusts should establish a core group of clinicians, who receive intensive training on violence and abuse. These skilled clinicians can then provide in-house support to colleagues in addressing the needs of abused service
users (World Health Organization, 2010). Such initiatives have been implemented within some European health services (Bacchus, Bewley, Fernandez, et al, 2012). Moreover, the DoH pilot study outlined in section 8.4.2 trained a core group of senior clinicians to deliver: cascade training programmes; in-house support to service users, and supervision to colleagues in responding to violence and abuse (Department of Health & Care Services Improvement Partnership, 2008). Such initiatives have been found to be beneficial to clinicians and recent policy recommendations promote the establishment of ‘clinical champions’ for domestic violence, who can assist their colleagues in addressing the needs of abused service users (Bacchus, Bewley, Fernandez, et al, 2012).

8.4.7 Development of Specialist Services

Findings from a national survey of 216 UK refuges found that just 19% of services were able to offer refuge to women with mental health needs; the majority of services stated that the offer of refuge space was dependent on nature and severity of the woman’s illness (Barron, 2004). The survey found that 40% of refuge workers were often unable to find space for women experiencing severe mental illness. Moreover, 25% of workers had never received training on mental health issues, and just 4% had provided training to all members of staff (Barron, 2004). A survey of 39 New Zealand women’s refuges identified similar difficulties, with regards to obtaining access for women experiencing mental illness and substance misuse problems (Hager, 2006).

As outlined in Chapter 6, mental health professionals reported difficulties in obtaining access to mainstream domestic violence services for abused service users. Chapter 5 found that service users also experienced difficulty in accessing mainstream domestic violence services. These findings underline the need for the development of specialist services for people experiencing domestic violence and severe mental illness. Interestingly, a recent survey examined the working practices of specialist domestic violence services in the UK and Australia, which provide support for women with mental illness and substance misuse problems. The study made several recommendations, regarding how to improve mainstream domestic violence services response to women with mental health/substance misuse needs, including: (1) training mainstream refuge workers in identifying
and managing mental illness/substance misuse problems; (2) appointing mental health/substance misuse support workers, and (3) establishing long-term refuge accommodation for abused women with complex mental health needs (Hager, 2011). The survey concluded that the development of specialist domestic violence services can result in significant reductions in public health costs; due to the fact that women will receive timely and appropriate care that will support them in becoming independent, self-managing members of the community (Hager, 2011). These responses will also ensure that mainstream services give undertake steps to mediate patterns of discrimination and oppression experienced by psychiatric service users.

Recent research activities in the UK are seeking to develop specialised service provisions for people experiencing domestic violence and mental illness (see section 8.4.6). For example, an on-going randomised controlled trial in the UK is examining the effectiveness of a psychological intervention in improving outcomes for women experiencing domestic violence and mental illness. The trial will randomly allocate 250 abused women accessing refuge services to receive either usual care or a psychological advocacy. The intervention is delivered by mainstream refuge workers who have been trained to identify and support women experiencing domestic violence and mental illness (Current Controlled Trials, 2011).

The findings of this section align with research which shows that in order to achieve successful implementation of health innovations it is necessary to create change at the system-level (Bacchus, Bewley, Fernandez, et al, 2012; Munro & Hubbard, 2011; Pawson, 2006). For instance, a recent study of health clinics, hospitals and mental health services found that the degree of organisational-level support for domestic violence determined the frequency with which clinicians enquired about abuse (Allen, Lehrner, Mattison, et al, 2007). A review of European health sector responses to domestic violence concluded that in order to achieve successful implementation of innovations, health services need to establish: senior management-level commitment towards the identification of domestic violence; to implement incentive schemes and flexible training

Building on this approach, scholars such as Munro and Hubbard (2011) call for health services to “go beyond an individual focus and include systemic factors and interactions” in order to improve clinical performance (Munro & Hubbard, 2011, p 727). Their hypothesis is based on a systems theory approach, which posits that social interventions are always “complex systems thrust amidst complex systems” (Pawson, 2006, p 35). Consequently, their success is shaped by several contextual factors:

1) Individual capacities of key actors (i.e. do clinicians have the necessary motivations and competencies to deliver the intervention)

2) Interpersonal working relationships (i.e. are lines of communication between management, administration and front line clinicians supportive of delivery)

3) Institutional setting (i.e. does the organisational culture support the intervention)

4) Infra-structural system (i.e. does the intervention have a political backing, and do sufficient resources exist to ensure effective delivery) (Pawson, 2006).

Based on this theory, to achieve successful implementation of health innovations the organisational climate and the values and needs of its employees must be conducive to its execution. Klein and Sorra (1996) suggest this can be achieved through: the elimination of obstacles; the introduction of incentives, and by ensuring that constructs align with employees’ tasks and duties (Klein & Sorra, 1996). In order for psychiatric services to successfully implement strategies to identify and respond to domestic violence Mental Health Trusts need to achieve the following:
1) Eliminate obstacles (e.g. implementation of organisational policies and procedures, and readily available training/education to improve clinicians’ competencies in addressing domestic violence),

2) Facilitate administration of the strategy (e.g. development of clear care referral pathways, and implementation of questions about service users’ experiences of abuse in clinical assessments),

3) Provide incentives (e.g. accreditation of training programmes, and praise from supervisors/management for clinicians’ implementation of strategies), and

4) Fit the strategy to the needs of professionals (e.g. allowing sufficient time for clinicians to utilise the strategies and to address any concerns they may have about the efficacy of strategies).

Organisational ‘feedback loops’ allow services to learn how innovations are affecting performance and to identify strengths and weaknesses of innovations, which can ensure their continued effectiveness (Munro & Hubbard, 2011, p 730).
8.5 Implications for Mental Health Practice

The findings from my PhD study hold clear implications for mental health practice, with regards to improving the identification and response of psychiatric services to domestic violence:

8.5.1 Strategic-Level Strategies

1) Domestic violence education should be embedded in the national pre-registration and post-registration psychiatric curriculum. Clinicians should receive education on the ecological model of violence, which explores the intersection of individual, familial/peer, community and societal risk factors for domestic violence, and structural inequalities (e.g. gender, class, race, sexuality, mental illness) that increase vulnerabilities to domestic violence among psychiatric service users.

2) Specific domestic violence procedures/policies must be implemented within Mental Health Trusts. Guidance needs to align with and complement existing safeguarding practices, in order to increase system-level awareness of abuse and to remove barriers to implementation.

3) Mental Health Trusts should establish Trust Champions, who receive specialist training on domestic violence and can promote the dissemination of knowledge and education about domestic violence.

4) Improvements in cross-cultural communications and the provision of specialist support for abused service users from BAMER groups are essential to improving help-seeking behaviours and care pathways for these vulnerable groups.

5) The development of clear care referral pathways for domestic violence are critical in ensuring service users receive continuity of care and appropriate support.

6) Service user networks and robust monitoring procedures are necessary to guarantee that psychiatric services are effective in their identification, documentation and referral of domestic violence.

7) Interventions for domestic violence must be individually tailored and sensitive to gender and cultural differences of survivors.
8) Psychiatric services need to support the development of specialist therapeutic interventions and evaluate their effectiveness in improving outcomes for service users who disclose domestic violence

8.5.2 Organisational-Level Strategies
1) Strategies must be implemented which concentrate on promoting an organisational climate with an awareness and readiness to respond to domestic violence. These strategies must remove barriers to implementation, and establish incentives that promote clinicians’ identification and response
2) Information-sharing practices between psychiatric services and other support agencies are critical to ensure that service users receive adequate provision and continuity of care
3) Collaborative working partnerships between psychiatric services and the domestic violence sector can facilitate reciprocal training, improve clinicians’ knowledge of support services and ensure that service users receive adequate support for their mental health and trauma needs
4) Advertisements about the nature and impact of domestic violence, and details on support services are essential in assisting help-seeking behaviours and in creating an organisational climate that is open and willing to address domestic violence

8.5.3 Individual-Level Strategies
1) Mental health professionals should receive experiential training on how to identify, document and respond to domestic violence. Training should consider variations in professionals’ perception of their role in addressing domestic violence and create teaching components that specifically target and reconcile these variations. Training should also aim to: promote an ecological analysis of violence, highlight the relationship between domestic violence and mental illness; identify the acceptability of routine enquiry by service users, and improve cross-cultural communications and issues of gender preference among service users
2) Feedback mechanisms, on-going supervision and re-fresher training are critical in maintaining improvements in clinical competencies
8.6 Future research

8.6.1 Prevalence of Domestic Violence among Psychiatric Service Users
Findings from my study highlight that the majority of prevalence studies in psychiatric settings focus on women’s experience of domestic violence, and violence perpetrated by an intimate partner (see Chapter 2). Consequently, future research is needed to gain a better understanding of the prevalence of domestic violence perpetrated against male psychiatric service users, and the prevalence of violence perpetrated by non-intimate family members. Prevalence studies employing greater methodological rigour for research in psychiatric outpatient settings will assist in facilitating pooled prevalence estimates for domestic violence. In light of findings from Chapter 5, future research efforts should also concentrate on examining the nature of violence within relationships where couples report mutual violence. Better knowledge about the nature, extent and characteristics of abuse in these relationships can assist clinicians in conducting appropriate risk assessments.

8.6.2 Interventions to Improve Outcomes for Psychiatric Service Users

Disclosing Domestic Violence
There is an urgent need for research on interventions to support psychiatric service users disclosing domestic violence. Future studies need to address weaknesses in the study designs of existing research, and randomised controlled trials are required to strengthen evidence on the effectiveness of intervention programmes. The majority of existing studies examine the effectiveness of interventions in improving outcomes for both men and women disclosing abuse. However, many of these interventions seek to improve outcomes for a range of abusive experiences. Consequently, these interventions may not fully address needs specific to experiences of domestic violence. In addition, the majority of existing interventions focus solely on improving mental health outcomes and do not examine other outcomes that may improve morbidity and mortality outcomes for service users, including the frequency and severity of violence, quality of life and use of safety behaviours. Therefore, future research studies should focus on the development of interventions that have an awareness of individual,
familial/peer, community and societal risk factors for domestic violence and seek to support the needs of service users disclosing domestic violence.

A paucity of studies examine interventions for psychiatric service users disclosing domestic violence in psychiatric inpatient settings, thereby limiting the ability to extrapolate findings to service users experiencing more acute psychiatric symptoms. Future research should address these limitations by examining the effectiveness of interventions in psychiatric inpatient settings.

8.6.3 Research Examining Service Users’ and Professionals’ Experiences and Expectations of Psychiatric Services Response to Domestic Violence

Findings from my study highlight the need for a more systematic evaluation of service users’ and professionals’ attitudes towards routine enquiry of domestic violence in psychiatric settings. Survey research on professionals’ and service users’ views regarding routine enquiry of domestic violence is important in light of continued efforts to implement routine enquiry in psychiatric settings. A systematic evaluation of the barriers and facilitators to enquiry/disclosure of domestic violence can assist the identification of key factors that affect successful implementation of domestic violence innovations.

The findings of this PhD study highlight the need for further qualitative research that explores the experiences of mental health professionals in responding to domestic violence. As noted in Chapter 7, this study did not explore professionals own experience of violence and abuse and its potential in shaping their willingness to address domestic violence; these factors have been shown to shape the responses of primary care clinicians. In relation to service users, the findings of this PhD study highlight the need for future research, which explores the experiences and needs of abused BAMER groups, LGBT communities, younger people experiencing abuse (the mean age of service users in this study was 40.6 years) and those reporting recent violence (the majority of service users experienced abuse more than two years prior to being interviewed).

Based on the findings of the constant comparative analysis, future research studies should examine the relationship between clinicians’ perception of their role in
responding to domestic violence and their experience of addressing these issues in clinical practice. An examination of the potential influence of service users’ understanding of domestic violence from an ecological model of violence would also be beneficial in determining help-seeking behaviours, vulnerabilities to abuse and in informing appropriate care pathways for survivors. In light of the barriers and facilitators to enquiry/disclosure of domestic violence identified in my study, the development of training programmes that seek to resolve barriers and promote key facilitators to enquiry would be important in improving psychiatric services identification of abuse.

Most notably, the results from this PhD study underline the urgent need for intervention programmes that seek to address gaps in service provision and establish best practice responses. Initial evidence suggests that system-level interventions can be effective in promoting improved responses to domestic violence in psychiatric settings. However, intervention studies would first benefit from conducting initial scoping exercises to identify barriers and incentives to the implementation of innovations and to incorporate these findings within their intervention model. Interventions need also to develop and implement clear care referral pathways for domestic violence within psychiatric settings.
8.7 Summary and Reflections

This research study has assisted me in recognising the complex interplay of individual, familial/peer, community and societal factors in shaping people’s experience of domestic violence. Most notably, it has challenged my cultural assumptions about how people make sense of their experiences of domestic violence, which moves beyond a primary focus on gender inequalities to include the impact of social divisions, particularly in relation to race and mental illness, which increase an individual’s vulnerability to domestic violence.

Reflecting on the findings of my PhD study, I have come to believe that only through attention to an ecological framework of violence can we enhance our understanding of domestic violence, through the consideration of structural inequalities (e.g. poverty, race, gender, mental illness) that shape peoples’ experiences of abuse. Such an analysis ensures that the experiences of people that are particularly vulnerable to abuse, including people with severe mental illness, are addressed within the mainstream movement against domestic violence. In addition, this framework provides a comprehensive lens in which to centre an individual’s vulnerability to domestic violence within community, cultural and social conventions and practices that may condone or fail to challenge abuse.

This study has highlighted to me the increased vulnerabilities to domestic violence experienced by people with severe mental illness. In spite of these vulnerabilities, however, service users often encounter discrimination when help-seeking and there exists a dearth of evidence-based treatments to support their recovery. Reflecting critically about these findings it becomes clear that existing mainstream domestic violence movements have failed to give consideration to patterns of discrimination and oppression experienced by abused psychiatric service users.

Drawing on this research and my previous work experiences I am reminded of how the failure to acknowledge the trauma of abuse results in such actions being unchallenged, which in turn silences a disclosure from service users and thwarts their recovery from the abuse and improvements in their mental health. I believe that in order to achieve a holistic approach to recovery from trauma, interventions
need to adopt an ecological analysis of violence that addresses both the psychosocial and psychobiological manifestations of abuse. Such interventions examine the intersection of psychobiological, socio-political and cultural factors and the impact of social divisions (e.g. race, gender, mental illness) that shape and constrain an individual’s recovery from abuse.

It is essential that psychiatric services develop and maintain appropriate responses and clear care pathways for domestic violence. With improved identification of domestic violence by psychiatric services comes the need for professionals to be competent in their abilities to respond effectively to service users’ disclosures. Psychiatric services must therefore establish system-level innovations, informed by evidence and good practice examples, aimed at appropriately identifying and responding to domestic violence. Furthermore, at an organisational-level strategies including information campaigns - highlighting the nature and impact of domestic violence - standardised procedures for the assessment and management of abuse (e.g. strategies for enquiry and management of safety), and clear and robust referral pathways are essential to ensuring service users receive appropriate and timely support. At an individual-level, on-going education and training for mental health professionals, including cognitive (i.e. knowledge and beliefs) and behavioural (i.e. skills deficits) components are critical to improve clinicians’ confidence and competency in responding to abuse and to challenge fears of stigmatisation held by service users.

I believe that effective responses to domestic violence by psychiatric services are dependent on meeting the above objectives, which will in turn create an organisational climate that is confidence and competent to adequately address the needs of service users.

Positive policy responses towards domestic violence by health services are complemented by other political movements in this field. For instance, the UK government has recently established a cross-government communication strategy regarding ending violence against women and children (Home Office, 2011a). Furthermore, policy making organisations internationally have started to prepare guidelines on domestic violence. The UK National Institute for Health and
Clinical Excellence has established a guideline development group on the prevention and reduction of domestic violence in health settings (National Institute for Health and Clinical Excellence, 2012). The World Health Organization has established a guideline development group, with the aim of producing practice guidelines for health services in responding to violence against women (World Health Organization, Forthcoming-b). These strategies will be important drivers for improvements in practice.
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World Health Organization & London School of Hygiene and Tropical Medicine (2010) Preventing Intimate Partner and Sexual Violence Against


Appendix 1: Search Terms for Study One

Search terms for MEDLINE, EMBASE, PsycInfo, British Nursing Index, HMIC, Maternity and Infant Care

1. Domestic violence/
2. Family violence/
3. Partner abuse/
4. Partner violence/
5. Spouse abuse/
6. Battered women/
7. ((abus$ OR batter$ OR violen$ OR beat$) adj2 (domestic OR partner$ OR family OR families OR spouse OR woman OR women OR men OR man OR female$ OR male$ OR wife OR wives OR husband$ OR boyfriend$ OR girlfriend$ OR elder$ OR brother$ OR sister$ OR father$ OR mother$ OR daughter$ OR son$ OR carer$).mp.)
8. (domestic adj2 homicid$).mp
9. 1 OR 2 OR 3 OR 4 OR 5 OR 6 OR 7 OR 8
10. Mental disorder/
11. Mental illness/
12. Mental health/
13. Mentally ill persons/
14. (Mental$ adj2 (problem$ OR difficult$ OR disorder$ OR ill$ OR health).mp.)
15. Mental health services/
16. Community Mental Health Services/
17. ((mental OR psychiatrist$ OR psycholog$) adj2 (inpatient$ OR outpatient$ OR hospital$ OR clinic$ OR service$ OR ward$ OR healthcare).mp)
18. Schiz$
19. Psychosis
20. Psychotic
21. Bipolar
22. Depress$
23. Mania OR manic
24. Neurosis OR psychoneurosis
25. Obsessive OR compulsive
26. Personality disorder/ OR anankastic personality disorder/ OR antisocial personality disorder/ OR avoidant personality disorder/ OR borderline personality disorder/ OR compulsive personality disorder/ OR dependent personality disorder/ OR histrionic personality disorder/ OR narcissistic personality disorder/ OR obsessive compulsive personality disorder/ OR paranoid personality disorder/ OR passive-aggressive personality disorder/ OR schizoid personality disorder/ OR schizotypal personality disorder/ OR ((anankastic OR asocial OR antisocial OR avoidant OR borderline OR dependent OR dissocial OR histrionic OR narcissistic OR obsessive OR compulsive OR paranoid OR passive-aggressive OR psychopath$ OR sadist$ OR sadomasochistic OR schizo$ OR sociopath$) adj person$).tw. OR (personality AND disorder$) OR psychopath$.tw OR sociopath$.tw
27. Eating disorders/ OR Anorexia Nervosa/ OR Binge-Eating Disorder/or Bulimia Nervosa/ OR ((anorexi$ OR bulimi$) AND nervosa) OR eating disorder$ OR binge-eat$ OR (binge$ adj eat$) OR (compulsive adj (eat$ or vomit$ or purg$))
28. ((Delusional OR paranoi$ OR mood OR neurotic OR stress OR reactive OR combat OR somatoform OR somatization OR somatisation OR anxiety OR phobic OR obsessive-compulsive OR adjustment OR dissociat$) adj2 disorder$)
29. 10 OR 11 OR 12 OR 13 OR 14 OR 15 OR 16 OR 17 OR 18 OR 19 OR 20 OR 21 OR 22 OR 23 OR 24 OR 25 OR 26 OR 27 OR 28
30. 9 AND 29
Search terms for Web of Science
(Web of Science: SCI Expanded 1970-present; SSCI 1970-present; A&HCI 1975-present; CPCI-S 1990-present; CPCI-SSH 1990-present)

1) "domestic violence" OR "family violence" OR "partner abuse" OR "partner violence" OR "spouse abuse" OR "battered women" OR ((abus$ OR batter$ OR violen$ OR beat$) near/2 (domestic OR partner$ OR family OR families OR spouse OR woman OR women OR man OR man OR female$ OR male$ OR wife OR wives OR husband$ OR boyfriend$ OR girlfriend$ OR elder$ OR brother$ OR sister$ OR father$ OR mother$ OR daughter$ OR son$ OR carer$)) OR "domestic homicide" AND (("mental disorder" OR "mental illness" OR "mental health" OR "mentally ill persons" OR (mental near/2 (problem$ OR difficult$ OR disorder$ OR ill$ OR health)) OR "mental health services" OR "community mental health services")

2) "domestic violence" OR "family violence" OR "partner abuse" OR "partner violence" OR "spouse abuse" OR "battered women" OR ((abus$ OR batter$ OR violen$ OR beat$) near/2 (domestic OR partner$ OR family OR families OR spouse OR woman OR women OR man OR man OR female$ OR male$ OR wife OR wives OR husband$ OR boyfriend$ OR girlfriend$ OR elder$ OR brother$ OR sister$ OR father$ OR mother$ OR daughter$ OR son$ OR carer$)) OR "domestic homicide" AND ((schiz$ OR psychosis OR psychotic OR bipolar OR depress$ OR mania OR manic OR neurosis OR psychoneurosis OR obsessive OR compulsive)

3) "domestic violence" OR "family violence" OR "partner abuse" OR "partner violence" OR "spouse abuse" OR "battered women" OR ((abus$ OR batter$ OR violen$ OR beat$) near/2 (domestic OR partner$ OR family OR families OR spouse OR woman OR women OR man OR man OR female$ OR male$ OR wife OR wives OR husband$ OR boyfriend$ OR girlfriend$ OR elder$ OR brother$ OR sister$ OR father$ OR mother$ OR daughter$ OR son$ OR carer$)) OR "domestic homicide" AND ((paranoid OR passive-aggressive OR psychopath$ OR sadist$ OR sadomasochistic OR schiz$ OR sociopath$) near/1 person$)

4) "domestic violence" OR "family violence" OR "partner abuse" OR "partner violence" OR "spouse abuse" OR "battered women" OR ((abus$ OR batter$ OR violen$ OR beat$) near/2 (domestic OR partner$ OR family OR families OR spouse OR woman OR women OR man OR man OR female$ OR male$ OR wife OR wives OR husband$ OR boyfriend$ OR girlfriend$ OR elder$ OR brother$ OR sister$ OR father$ OR mother$ OR daughter$ OR son$ OR carer$)) OR "domestic homicide" AND (("personality disorder" OR ((anankastic OR asocial OR antisocial OR avoidant OR borderline OR dependent OR dissociate OR histrionic OR narcissistic OR obsessive OR compulsive) near/1 person$))

5) "domestic violence" OR "family violence" OR "partner abuse" OR "partner violence" OR "spouse abuse" OR "battered women" OR ((abus$ OR batter$ OR violen$ OR beat$) near/2 (domestic OR partner$ OR family OR families OR spouse OR woman OR women OR man OR man OR female$ OR male$ OR wife OR wives OR husband$ OR boyfriend$ OR girlfriend$ OR elder$ OR brother$ OR sister$ OR father$ OR mother$ OR daughter$ OR son$ OR carer$)) OR "domestic homicide" AND (("Eating disorders" OR "anorexia nervosa" OR "bulimia nervosa" OR "binge-eating disorder" OR ((anorexia$ OR bulimia) AND nervosa) OR "eating disorder$" OR "binge-eat$" OR (bing$ near/1 eat$) OR (compulsive near/1 (eat$ OR vomit$ OR purg$)))

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7) "domestic violence" OR "family violence" OR "partner abuse" OR "partner violence" OR "spouse abuse" OR "battered women" OR ((abus$ OR batter$ OR violen$ OR beat$) near/2 (domestic OR partner$ OR family OR families OR spouse OR woman OR women OR man OR man OR female$ OR male$ OR wife OR wives OR husband$ OR boyfriend$ OR girlfriend$ OR elder$ OR brother$ OR sister$ OR father$ OR mother$ OR daughter$ OR son$ OR carer$)) OR "domestic homicide" AND ((neurotic OR stress OR reactive OR combat OR somatoform OR somatization OR somatisation OR anxiety OR phobic OR obsessive-compulsive OR adjustment OR dissociat$) near/2 disorder$)

8) "domestic violence" OR "family violence" OR "partner abuse" OR "partner violence" OR "spouse abuse" OR "battered women" OR ((abus$ OR batter$ OR violen$ OR beat$) near/2 (domestic OR partner$ OR family OR families OR spouse OR woman OR women OR man OR man OR female$ OR male$ OR wife OR wives OR husband$ OR boyfriend$ OR girlfriend$ OR elder$ OR brother$ OR sister$ OR father$ OR mother$ OR daughter$ OR son$ OR carer$)) OR "domestic homicide" AND (personality AND disorder$) OR psychopath$ OR sociopath$ OR ((Delusional OR paranoid$ OR mood) near/2 disorder$)

**Search terms for CINAHL (EBSCO)**

1. (domestic violence/ OR family violence/ OR partner abuse/ OR partner violence/ OR spouse abuse/ OR battered women/ OR ((abus$ OR batter$ OR violen$ OR beat$) n2 (domestic OR partner$ OR family OR families OR spouse OR wom?n OR m?n OR female$ OR male$ OR wife OR wives OR husband$ OR boyfriend$ OR girlfriend$ OR elder$ OR brother$ OR sister$ OR father$ OR mother$ OR daughter$ OR son$ OR carer$)) OR (domestic n1 homicide)) AND (mental disorder/ OR mental health/ OR (mental* n2 (problem* OR difficult* OR disorder* OR ill* OR health)) OR mental health services/ OR community mental health services/ OR ((mental OR psychiatr$ OR psycholog*) n2 (inpatient* OR outpatient* OR hospital* OR clinic* OR service* OR ward* OR healthcare)) OR schiz$ OR psychosis OR psychotic OR bipolar OR depress$ OR mania OR manic OR neurosis OR psychoneurosis OR obsessive OR compulsive OR personality disorder/ OR antisocial personality disorder/ OR avoidant personality disorder/ OR borderline personality disorder/ OR compulsive personality disorder/ OR dependent personality disorder/ OR histrionic personality disorder/ OR passive-aggressive personality disorder OR ((anankastic OR asocial OR antisocial OR avoidant OR borderline OR dependent OR dissocial OR histrionic OR narcissistic OR obsessive OR compulsive) n1 person$)) OR Eating disorder/ OR anorexia nervosa/ OR bulimia nervosa/ OR ((anorexi*$ OR bulimi*) AND nervosa) OR "eating disorder*" OR "binge-eat*" OR (bing* n1 eat*) OR (compulsive n1 (eat* or vomit* or purg*)) OR (personality AND disorder*) OR psychopath$ OR sociopath$ OR ((Delusional OR paranoid OR mood OR neurotic OR stress OR reactive OR combat OR somatoform OR somatization OR somatisation OR anxiety OR phobic OR obsessive-compulsive OR adjustment OR dissociat$) n2 disorder$)

**Search terms for IBSS (CSA)**

1. ((KW= domestic violence) OR (KW= family violence) OR (KW= partner abuse) OR (KW= partner violence) OR (KW= spouse abuse) OR (KW= battered women) OR ((abus$ OR batter$ OR violen$ OR beat$) WITHIN 2 (domestic OR partner$ OR family OR families OR spouse OR wom?n OR m?n OR female$ OR male$ OR wife OR wives OR husband$ OR boyfriend$ OR girlfriend$ OR elder$ OR brother$ OR sister$ OR father$ OR mother$ OR daughter$ OR son$ OR carer$)) OR (domestic WITHIN 2 homicide)) AND ((KW= mental disorder) OR (KW= mental illness) OR (KW= mental health) OR (KW= mentally ill persons) OR (KW= mental health services) OR (KW= community mental health services) OR (KW= personality disorder) OR (KW= anankastic personality disorder) OR (KW= antisocial personality disorder) OR (KW= avoidant personality disorder) OR (KW= borderline personality disorder) OR (KW= compulsive personality disorder) OR (KW= dependent personality disorder) OR (KW= paranoid OR mood) WITHIN 2 disorder$)
Search terms for Sociological Abstracts (CSA Illumina)

1. (KW= "domestic violence") OR (KW= "family violence") OR (KW= "partner abuse") OR (KW= "partner violence") OR (KW= "spouse abuse") OR (KW= "battered women") OR ("domestic abus*") OR ("abus* partner") OR ("abus* famili*") OR ("famili* abus") OR ("spouse abus") OR ("abus* spouse") OR ("abus* wom?n") OR ("wom?n abus") OR ("m?n abus") OR ("abus* m?n") OR ("abus* female") OR ("female* abus") OR ("male* abus") OR ("abus* male") OR ("abus* wife") OR ("wife abus") OR ("abus* wives") OR ("abus* husband") OR ("husband abus") OR ("abus* boyfriend") OR ("boyfriend abus") OR ("abus* girlfriend") OR ("girlfriend abus") OR ("abus* elder") OR ("elder* abus") OR ("abus* brother") OR ("brother abus") OR ("abus* sister") OR ("sister* abus") OR ("abus* father") OR ("father* abus") OR ("abus* mother") OR ("mother* abus") OR ("abus* daughter") OR ("daughter* abus") OR ("abus* son") OR ("son* abus") OR ("abus* carer") OR ("carer* abus") OR ("partner batter") OR ("batter* famili") OR ("famili* batter") OR ("spouse batter") OR ("batter* spouse") OR ("batter* wom?n") OR ("wom?n batter") OR ("m?n batter") OR ("batter* female") OR ("female* batter") OR ("male* batter") OR ("batter* male") OR ("batter* wife") OR ("wife batter") OR ("batter* wives") OR ("batter* husband") OR ("husband batter") OR ("batter* boyfriend") OR ("boyfriend batter") OR ("batter* girlfriend") OR ("girlfriend* batter") OR ("batter* elder") OR ("elder* batter") OR ("brother batter") OR ("brother* batter") OR ("sister* batter") OR ("sister* batter") OR ("father* batter") OR ("father* batter") OR ("mother* batter") OR ("mother* batter") OR ("daughter* batter") OR ("daughter* batter") OR ("son* batter") OR ("son* batter") OR ("carer* batter") OR ("carer* batter") OR ("domestic violen") OR ("violen* partner") OR ("partner violen") OR ("violens famili") OR ("famili* violen") OR ("spouse violen") OR ("spouse* violen") OR ("wom?n violen") OR ("wom?n violen") OR ("m?n violen") OR ("m?n violen") OR ("female* violen") OR ("male* violen") OR ("violens* wife") OR ("wife violen") OR ("violens* wife") OR ("husband violen") OR ("husband violen") OR ("violens* father") OR ("father* violen") OR ("violens* mother") OR ("mother* violen") OR ("violen* daughter") OR ("daughter* violen") OR ("violen* son") OR ("son* violen") OR ("violen* carer") OR ("carer* violen") OR ("domestic beat") OR ("beat* partner") OR ("partner beat") OR ("beat* famili")
OR ("famil* beat*") OR ("spouse beat*") OR ("beat* spouse") OR ("beat* wom?n") OR ("wom?n beat*") OR ("m?n beat*") OR ("beat* m?n") OR ("beat* female*") OR ("female* beat*") OR ("male* beat*") OR ("beat* male*") OR ("beat* wife") OR ("wife beat") OR ("beat* wives") OR ("beat* husband") OR ("husband beat") OR ("beat* boyfriend") OR ("boyfriend beat") OR ("beat* girlfriend") OR ("girlfriend beat") OR ("beat* elder") OR ("elder* beat") OR ("beat* brother") OR ("brother beat") OR ("beat* sister") OR ("sister* beat") OR ("beat* father") OR ("father beat") OR ("beat* mother") OR ("mother* beat") OR ("beat* daughter") OR ("daughter* beat") OR ("beat* son") OR ("son* beat") OR ("beat* carer") OR ("carer* beat")

2. (KW= "mental disorder") OR (KW= "mental illness") OR (KW= "mental health") OR (KW= "mentally ill persons") OR (KW= "mental health services") OR (KW= "community mental health services") OR (KW= "personality disorder") OR (KW= "anankastic personality disorder") OR (KW= "antisocial personality disorder") OR (KW= "avoidant personality disorder") OR (KW= "borderline personality disorder") OR (KW= "compulsive personality disorder") OR (KW= "dependent personality disorder") OR (KW= "histrionic personality disorder") OR (KW= "narcissistic personality disorder") OR (KW= "obsessive compulsive personality disorder") OR (KW= "paranoid personality disorder") OR (KW= "passive-aggressive personality disorder") OR (KW= "schizoid personality disorder") OR (KW= "schizotypal personality disorder") OR (KW= "eating disorder") OR (KW= "anorexia nervosa") OR (KW= "bulimia nervosa") OR (KW= "binge-eating disorder") OR (KW= "bulimia nervosa") OR ("anorexic*") OR ("anorexia*") OR ("anorexi*") OR ("anorexia*") OR ("anorexia* nervous") OR (KW= "bulemia nervosa") OR (KW= "eating disorder") OR (KW= "mental inpatient") OR (KW= "mental outpatient") OR (KW= "mental hospital") OR (KW= "mental clinic") OR (KW= "mental service") OR (KW= "mental ward") OR (KW= "mental healthcare") OR (KW= "psychiatr* inpatient") OR (KW= "psychiatr* outpatient") OR (KW= "psychiatr* hospital") OR (KW= "psychiatr* clinic") OR (KW= "psychiatr* service") OR (KW= "psychiatr* ward") OR (KW= "psychiatr* healthcare") OR (KW= "psycholog* inpatient") OR (KW= "psycholog* outpatient") OR (KW= "psycholog* hospital") OR (KW= "psycholog* clinic") OR (KW= "psycholog* service") OR (KW= "psycholog* ward") OR (KW= "psycholog* healthcare") OR (KW= "anankastic person") OR (KW= "asocial person") OR (KW= "antisocial person") OR (KW= "borderline person") OR (KW= "dependent person") OR (KW= "dissocial person") OR (KW= "histrionic person") OR (KW= "narcissistic person") OR (KW= "obsessive person") OR (KW= "compulsive person") OR (KW= "paranoid person") OR (KW= "passive-aggressive person") OR (KW= "psychopath person") OR (KW= "sadist person") OR (KW= "sadomasochistic person") OR (KW= "schizo person") OR (KW= "sociopath person") OR (KW= "bing* eat") OR (KW= "compulsive eat") OR (KW= "compulsive vomit") OR (KW= "compulsive purg") OR (KW= "delusional disorder") OR (KW= "paranoi disorder") OR (KW= "mood disorder") OR (KW= "neurotic disorder") OR (KW= "stress disorder") OR (KW= "reactive disorder") OR (KW= "combat disorder") OR (KW= "somatoform disorder") OR (KW= "somati?ation disorder") OR (KW= "anxiety disorder") OR (KW= "phobic disorder") OR (KW= "obsessive-compulsive disorder") OR (KW= "adjustment disorder") OR (KW= "dissociat* disorder")

Search terms for Applied Social Sciences Index and Abstracts

1. (KW= "domestic violence") OR (KW= "family violence") OR (KW= "partner abuse") OR (KW= "partner violence") OR (KW= "spouse abuse") OR (KW= "battered women") OR ("domestic abus*") OR ("abus* partner") OR ("partner abus*") OR ("abus* famili*") OR ("famili* abus") OR ("spouse abus") OR ("abus* spouse") OR ("abus* wom?n") OR ("wom?n abus") OR ("m?n abus") OR ("abus* m?n") OR ("abus* female") OR ("female* abus") OR ("male* abus") OR ("abus* male") OR ("abus* wife") OR ("wife abus") OR ("abus* wives") OR ("abus* husband") OR ("husband abus") OR ("abus* boyfriend") OR ("boyfriend abus") OR ("abus* girlfriend") OR ("girlfriend abus") OR ("abus* elder") OR ("elder* abus") OR ("abus* brother") OR ("abus* sister") OR ("sister* abus") OR ("abus* father") OR ("father abus") OR ("abus* mother") OR ("mother* abus") OR ("abus* daughter") OR ("daughter* abus") OR ("abus* son") OR ("son* abus") OR ("abus* carer") OR ("carer* abus")
girlfriend* OR ("girlfriend* abus*") OR ("abus* elder*") OR ("elder* abus*") OR ("abus* brother*") OR ("brother abus*") OR ("abus* sister*") OR ("sister* abus*") OR ("abus* father*") OR ("father* abus*") OR ("abus* mother*") OR ("mother* abus*") OR ("abus* daughter*") OR ("daughter* abus*") OR ("abus* son*") OR ("son* abus*") OR ("abus* carer*") OR ("carer* abus*") OR ("batter* partner*") OR ("partner batter*") OR ("batter* famili*") OR ("famili* batter*") OR ("spouse batter*") OR ("batter* spouse") OR ("batter* wom?n") OR ("wom?n batter*") OR ("m?n batter*") OR ("batter* m?n") OR ("batter* female") OR ("female* batter") OR ("male* batter") OR ("batter* male") OR ("batter* wife") OR ("wife batter") OR ("batter* wives") OR ("batter* husband") OR ("husband batter") OR ("batter* boyfriend") OR ("boyfriend batter") OR ("batter* girlfriend") OR ("girlfriend* batter") OR ("batter* elder") OR ("elder* batter") OR ("batter* brother") OR ("brother batter") OR ("batter* sister") OR ("sister* batter") OR ("batter* father") OR ("father* batter") OR ("batter* mother") OR ("mother* batter") OR ("batter* daughter") OR ("daughter* batter") OR ("batter* son") OR ("son* batter") OR ("batter* carer") OR ("carer* batter") OR ("domestic violen*") OR ("violenc partner") OR ("partner violen") OR ("violen* famili") OR ("famili* violen") OR ("spouse violen") OR ("violenc spouse") OR ("violenc wom?n") OR ("wom?n violen") OR ("m?n violen") OR ("violenc male") OR ("violenc female") OR ("female* violen") OR ("male* violen") OR ("violenc wife") OR ("wife violen") OR ("violenc wives") OR ("violenc husband") OR ("husband violen") OR ("violenc boyfriend") OR ("boyfriend violen") OR ("violenc girlfreind") OR ("girlfriend* violen") OR ("violenc elder") OR ("elder* violen") OR ("violenc brother") OR ("brother violen") OR ("violenc sister") OR ("sister* violen") OR ("violenc father") OR ("father* violen") OR ("violenc mother") OR ("mother* violen") OR ("violenc daughter") OR ("daughter* violen") OR ("violenc son") OR ("son* violen") OR ("violenc carer") OR ("carer* violen") OR ("domestic beat") OR ("beat* partner") OR ("partner beat") OR ("famili* beat") OR ("spouse beat") OR ("beat* spouse") OR ("beat* wom?n") OR ("wom?n beat") OR ("m?n beat") OR ("beat* female") OR ("female* beat") OR ("male* beat") OR ("beat* male") OR ("beat* wife") OR ("wife beat") OR ("beat* wives") OR ("beat* husband") OR ("husband beat") OR ("beat* boyfriend") OR ("boyfriend beat") OR ("beat* girlfriend") OR ("girlfriend beat") OR ("beat* elder") OR ("elder* beat") OR ("beat* brother") OR ("brother beat") OR ("beat* sister") OR ("sister* beat") OR ("beat* father") OR ("father* beat") OR ("beat* mother") OR ("mother* beat") OR ("beat* daughter") OR ("daughter* beat") OR ("beat* son") OR ("son* beat") OR ("beat* carer") OR ("carer* beat")

AND

2. (KW= "mental disorder") OR (KW= "mental illness") OR (KW= "mental health") OR (KW= "mentally ill persons") OR (KW= "mental health services") OR (KW= "community mental health services") OR (KW= "personality disorder") OR (KW= "anankastic personality disorder") OR (KW= "antisocial personality disorder") OR (KW= "avoidant personality disorder") OR (KW= "borderline personality disorder") OR (KW= "compulsive personality disorder") OR (KW= "dependent personality disorder") OR (KW= "histrionic personality disorder") OR (KW= "narcissistic personality disorder") OR (KW= "obsessive compulsive personality disorder") OR (KW= "paranoid personality disorder") OR (KW= "passive-aggressive personality disorder") OR (KW= "schizoid personality disorder") OR (KW= "schizotypal personality disorder") OR (KW= "eating disorder") OR (KW= "anorexia nervosa") OR (KW= "bulimia nervosa") OR (KW= "binge-eating disorder") OR (mental* n2 problem) OR (mental* n2 difficult*) OR (mental* n2 disorder) OR (mental* n2 ill*) OR (mental* n2 health) OR schiz* OR psychosis OR psychotic OR bipolar OR depress* OR mania OR manic OR neurosis OR psychoneurosis OR obsessive OR compulsive OR psychopath* OR sociopath* OR (personality AND disorder) OR ((anorexi* OR bulimi*) AND nervosa) OR eating disorder* OR binge-
Search terms for Academic Search Complete (EBSCO)

1. ((DE "FAMILY violence") OR (DE "INTIMATE partner violence") OR (DE "HUSBAND abuse") OR (DE "ABUSED women") OR (DE "ABUSED wives") OR (domestic n1 homicide) OR (domestic abus*)) OR (abus* partner) OR (partner abus*) OR (abus* famili*) OR (fami* abus*) OR (spouse abus*) OR (abus* spouse) OR (abus* wom?n) OR (wom?n abus*) OR (m?n abus*) OR (abus* m?n) OR (abus* female*) OR (female* abus*) OR (male* abus*) OR (abus* male*) OR (abus* wife) OR (wife abus*) OR (abus* wives) OR (abus* husband) OR (husband abus*) OR (abus* boyfriend) OR (boyfriend abus*) OR (abus* girlfriend) OR (girlfriend* abus*) OR (abus* elder) OR (elder* abus*) OR (abus* brother) OR (brother abus*) OR (abus* sister) OR (sister* abus*) OR (abus* father) OR (father* abus*) OR (abus* mother) OR (mother* abus*) OR (abus* daughter) OR (daughter* abus*) OR (son* abus*) OR (son* abus*) OR (abus* carer) OR (carer* abus*) OR (batter* partner) OR (partner batter) OR (batter* famili*) OR (fami* batter) OR (spouse batter) OR (batter* spouse) OR (batter* wom?n) OR (wom?n batter) OR (m?n batter) OR (batter* female) OR (female* batter) OR (male* batter) OR (batter* male) OR (batter* wife) OR (wife batter) OR (batter* wives) OR (batter* husband) OR (husband batter) OR (batter* boyfriend) OR (boyfriend batter) OR (batter* girlfriend) OR (girlfriend* batter) OR (batter* elder) OR (elder* batter) OR (batter* brother) OR (brother batter) OR (batter* sister) OR (sister* batter) OR (batter* father) OR (father* batter) OR (mother* batter) OR (batter* daughter) OR (daughter* batter) OR (son* batter) OR (son* batter) OR (batter* carer) OR (carer* batter) OR (domestic violen*) OR (violien* partner) OR (partner violen*) OR (violien* famili*) OR (fami* violen*) OR (spouse violen*) OR (violien* spouse) OR (wom?n violen*) OR (m?n violen*) OR (violien* m?n) OR (violien* female) OR (female* violen*) OR (male* violen*) OR (violien* male) OR (violien* wife) OR (wife violen*) OR (violien* wives) OR (violien* husband) OR (husband violen*) OR (violien* boyfriend) OR (boyfriend violen*) OR (violien* girlfriend) OR (girlfriend violen*) OR (violien* elder) OR (elder* violen*) OR (violien* brother) OR (brother violen*) OR (violien* sister) OR (sister* violen*) OR (violien* father) OR (father* violen*) OR (violien* mother) OR (mother* violen*) OR (violien* daughter) OR (violien* son) OR (son* violen*) OR (violien* carer*)
Search terms for ETHOS

1. “Domestic violence”
2. “Domestic abuse”
3. “Family violence”
4. “Partner violence”
5. “Partner abuse”
6. “Spouse abuse”
7. “Battered women”
8. “Battered men”
9. “Abusive partner”
10. Mental health
11. Mental disorder
12. Psychiatric
13. Psychological
14. Psychosis
15. Psychotic
16. Schizophrenia OR schizophrenic
17. Bipolar
18. Depressed OR depression
19. Mania OR manic
20. Neurosis OR psychoneurosis
21. Eating disorder OR anorexia OR bulimia
22. Disorder
23. Obsessive
24. Compulsive
25. Post-traumatic
26. (1 OR 2 OR 3 OR 4 OR 5 OR 6 OR 7 OR 8 OR 9) AND (10 OR 11 OR 12 OR 13 OR 14 OR 15 OR 16 OR 17 OR 18 OR 19 OR 20 OR 21 OR 22 OR 23 OR 24 OR 25)= anywhere in text.

**Search terms for NDLTD**

1) ("domestic violence" "domestic abuse" "family violence" "partner abuse" "partner violence" "spouse abuse" "battered women" "battered men" "abusive partner") AND ("mental disorder" "mental illness" "mentally ill" "mental health" "mental problem" "psychiatric inpatient" "psychiatric outpatient" "psychiatric hospital" "psychiatric ward" "psychiatric care" "psychological care")
2) ("domestic violence" "domestic abuse" "family violence" "partner abuse" "partner violence" "spouse abuse" "battered women" "battered men" "abusive partner") AND (Schizophrenia schizophrenic psychosis psychotic bipolar depression depressed depressive mania manic neurosis psychoneurosis obsessive compulsive personality disorder psychopath sociopath “eating disorder” anorexia bulimia)
3) ("domestic violence" "domestic abuse" "family violence" "partner abuse" "partner violence" "spouse abuse" "battered women" "battered men" "abusive partner") AND ("post traumatic stress disorder" PTSD “delusional disorder” “mood disorder” “anxiety disorder” “neurotic disorder” “combat disorder” “somatoform disorder” “dissociative disorder”)

**Search terms for DART**

1) ("domestic violence" OR "domestic abuse" OR "family violence" OR "partner abuse" OR "partner violence" OR "spouse abuse" OR "battered women" OR "battered men" OR "abusive partner") AND ("mental disorder" OR "mental illness" OR "mentally ill" OR "mental health" OR "mental problem" OR "psychiatric inpatient" OR "psychiatric outpatient" OR "psychiatric hospital" OR "psychiatric ward" OR "psychiatric care" OR "psychological care")
2) ("domestic violence" OR "domestic abuse" OR "family violence" OR "partner abuse" OR "partner violence" OR "spouse abuse" OR "battered women" OR "battered men" OR "abusive partner") AND (Schizophrenia OR schizophrenic OR psychosis OR psychotic OR bipolar OR depression OR depressed OR depressive OR mania OR manic OR neurosis OR psychoneurosis OR obsessive OR compulsive OR “personality disorder” OR psychopath OR sociopath OR “eating disorder” OR anorexia OR bulimia)
3) ("domestic violence" "domestic abuse" "family violence" "partner abuse" "partner violence" "spouse abuse" "battered women" "battered men" "abusive partner") AND ("post traumatic stress disorder" OR PTSD OR “delusional disorder” OR “mood disorder” OR “anxiety disorder” OR “neurotic disorder” OR “combat disorder” OR “somatoform disorder” OR “dissociative disorder”)

**Search Terms for Science Direct**
1. Domestic violence/
2. Family violence/
3. Partner abuse/
4. Partner violence/
5. Spouse abuse/
6. Battered women/
7. abuse$ OR batter$ OR violent$ OR beat$ adj domestic OR partner$ OR family OR families OR spouse OR woman OR women OR men OR man OR female$ OR male$ OR wife OR wives OR husband$ OR boyfriend$ OR girlfriend$ OR elder$ OR brother$ OR sister$ OR father$ OR mother$ OR daughter$ OR son$ OR carer$
8. domestic adj homicide
9. 1 OR 2 OR 3 OR 4 OR 5 OR 6 OR 7 OR 8
10. Mental disorder/
11. Mental illness/
12. Mental health/
13. Mentally ill persons/
14. Mental$ adj problem$ OR difficult$ OR disorder$ OR ill$ OR health
15. Mental health services/
16. Community Mental Health Services/
17. mental OR psychiatr$ OR psycholog$ adj inpatient$ OR outpatient$ OR hospital$ OR clinic$ OR service$ OR ward$ OR healthcare
18. Schiz$
19. Psychosis
20. Psychotic
21. Bipolar
22. Depress$
23. Mania OR manic
24. Neurosis OR psychoneurosis
25. Obsessive OR compulsive
26. Personality disorder/ OR anankastic personality disorder/ OR antisocial personality disorder/ OR avoidant personality disorder/ OR borderline personality disorder/ OR compulsive personality disorder/ OR dependent personality disorder/ OR histrionic personality disorder/ OR narcissistic personality disorder/ OR obsessive compulsive personality disorder/ OR paranoid personality disorder/ OR passive-aggressive personality disorder/ OR schizoid personality disorder/ OR schizotypal personality disorder/
27. anankastic OR asocial OR antisocial OR avoidant OR borderline OR dependent OR dissocial OR histrionic OR narcissistic OR obsessive OR compulsive OR paranoid OR passive-aggressive OR psychopath$ OR sadist$ OR sadomasochistic OR schizo$ OR sociopath$ adj person$ OR
28. personality AND disorder$ OR psychopath$ OR sociopath$
29. Eating disorders/ OR Anorexia Nervosa/ OR Binge-Eating Disorder/or Bulimia Nervosa/
30. anorexia$ OR bulimia$ AND nervosa OR eating disorder$ OR binge-eat$ OR bing$ adj eat$ OR compulsive adj eat$ OR vomit$ OR purg$
31. Delusional OR paranoid$ OR mood OR neurotic OR stress OR reactive OR combat OR somatoform OR somatization OR somatisation OR anxiety OR phobic OR obsessive-compulsive OR adjustment
32. dissociat$ adj disorder$
33. 10 OR 11 OR 12 OR 13 OR 14 OR 15 OR 16 OR 17 OR 18 OR 19 OR 20 OR 21 OR 22 OR 23 OR 24 OR 25 OR 26 OR 27 OR 28 OR 29 OR 30 OR 31 OR 32
34. 9 AND 33

Search Terms for JSTOR
1. “Domestic violence” OR “Domestic abuse” OR “Family violence” OR “Partner abuse” OR “Partner violence” OR “Spouse abuse” OR “Battered women” OR “Battered men” OR “Abusive Partner”
2. “Mental disorder” OR “Mental ill*” OR “Mental health” OR “Mentally ill persons” OR “Mental problem&” OR “Mental difficult*” OR “Mental disorder&”
3. ((‘psychiatric inpatient&” OR ”psychiatric outpatient&” OR ”psychiatr* hospital” OR ”psychiatr* ward&” OR ”psychiatric care” OR ”psychological care”))
4. Schiz* OR Psychosis OR Psychotic OR Bipolar OR Depress* OR Mania OR Manic OR Neurosis OR Psychoneurosis OR “Obsessive Disorder” OR “Compulsive Disorder”
5. “Personality Disorder&” OR “Psychopath*” OR “Sociopath*” OR “Eating disorders” OR “Anorexia Nervosa” OR “Bulimia Nervosa” OR “Dissociat* disorders” OR “Post traumatic stress disorder”
6. “Delusional disorder” OR “Mood disorders” OR “Anxiety disorders” OR “Neurotic disorders” OR “Combat disorders” OR “Somat* disorders”

Cochrane Library
1. “Domestic violence” OR “Family violence” OR “Partner abuse” OR “Partner violence” OR “Spouse abuse” OR “Battered women” OR ((abus* OR batter* OR violen* OR beat*) NEAR/2 (domestic OR partner* OR family OR families OR spouse OR wom?n OR m?n OR female OR male OR wife OR wives OR husband OR boyfriend OR girlfriend OR elder OR brother OR sister OR father OR mother OR daughter OR son OR carer)) OR (domestic adj2 homicid*)
2. “Mental disorder” OR “Mental illness” OR “Mental health” OR “Mentally ill persons” OR Mental* NEAR/2 problem OR difficult* OR disorder* OR ill* OR health OR “Mental Health Services” OR “Community Mental Health Services” OR ((mental OR psychiatr* OR psycholog*) NEAR/2 (inpatient OR outpatient OR hospital OR clinic OR service OR ward OR healthcare)) OR Schiz* OR Psychosis OR Psychotic OR Bipolar OR Depress* OR Mania OR Manic OR Neurosis OR Psychoneurosis OR Obsessive OR compulsive
3. 1 AND 2
4. “Personality disorder” OR “anankastic personality disorder” OR “antisocial personality disorder” OR “avoidant personality disorder” OR “borderline personality disorder” OR “compulsive personality disorder” OR “dependent personality disorder” OR “histrionic personality disorder” OR “narcissistic personality disorder” OR “obsessive compulsive personality disorder” OR “paranoid personality disorder” OR “passive-aggressive personality disorder” OR “schizoid personality disorder” OR “schizotypal personality disorder”
5. 1 AND 4
6. ((anankastic OR asocial OR antisocial OR avoidant OR borderline OR dependent OR dissocial OR histrionic OR narcissistic OR obsessive OR compulsive OR paranoid OR passive-aggressive OR psychopath* OR sadist* OR sadomasochistic OR schizo* OR sociopath*) adj person) OR (personality AND disorder*) OR psychopath* OR sociopath* OR “Eating disorders” OR “Anorexia Nervosa” OR “Binge-Eating Disorder” OR “Bulimia Nervosa” OR ((anorexi* OR bulimi*) AND nervosa) OR eating disorder* OR binge-eat* OR (binge* adj eat*) OR (compulsive adj (eat* or vomit* or purg*)) OR ((Delusional OR paranoi* OR mood OR neurotic OR stress OR reactive OR combat OR somatoform OR somatization OR somatisation OR anxiety OR phobic OR obsessive-compulsive OR adjustment OR dissociate*) NEAR/2 disorder*)
7. 1 AND 6
## Appendix 2: Details of Expert Recommendations Sought for
### Study One

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Institution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ann L. Coker</td>
<td>Associate Dean for Research and Professor</td>
<td>Department of Epidemiology, College of Public Health, University of Kentucky, USA</td>
</tr>
<tr>
<td>Ali, Siti Hawa</td>
<td>Associate Professor</td>
<td>Unit Perkembangan Kesihatan Wanita, Pusat Pengajian Sains Perubatan, Universiti Sains Malaysia, Malaysia</td>
</tr>
<tr>
<td>Jacquelyn C. Campbell</td>
<td>Professor and Anna D. Wolf Chair</td>
<td>Department of Community-Public Health, School of Nursing, John Hopkins University, USA</td>
</tr>
<tr>
<td>Padma Bhate-Deosthali</td>
<td>Coordinator</td>
<td>Centre for Enquiry into Health and Allied Themes (CEHAT), Mumbai, India</td>
</tr>
<tr>
<td>Gengli, Zhao</td>
<td>Professor</td>
<td>Women and Child Health Center, Peking University, China</td>
</tr>
<tr>
<td>Kelsey Hegarty</td>
<td>Associate Professor</td>
<td>General Practice and Primary Care Academic Centre, Melbourne Medical School, Australia</td>
</tr>
<tr>
<td>Rachel Jewkes</td>
<td>Professor and Unit Director</td>
<td>Gender and Health Research Unit, Medical Research Council, South Africa</td>
</tr>
<tr>
<td>Ruxana Jina</td>
<td>Specialist</td>
<td>Faculty of Health Sciences, University of the Witwatersrand, Parktown, South Africa</td>
</tr>
<tr>
<td>Joanne Klevens</td>
<td>Epidemiologist</td>
<td>Centers for Disease Control and Prevention, Division of Violence Prevention, Atlanta, USA</td>
</tr>
<tr>
<td>Sylvie Lo Fo Wong</td>
<td>Family Physician and Researcher</td>
<td>Department of Medical Sciences, Radboud University, Department of Family Medicine, Netherlands</td>
</tr>
<tr>
<td>Judith McFarlane</td>
<td>Professor and Parry Nursing Chair in Health Promotion and Disease Prevention</td>
<td>Texas Woman’s University, Texas, USA</td>
</tr>
<tr>
<td>Harriet MacMillan</td>
<td>Professor and David R. Offord Chair in Child Studies</td>
<td>Department of Psychiatry and Behavioural Neurosciences, McMaster University, Ontario, Canada</td>
</tr>
<tr>
<td>Sandra. L. Martin</td>
<td>Associate Dean for Research and Professor</td>
<td>Department of Maternal and Child Health, University of North Carolina at Chapel Hill, USA</td>
</tr>
<tr>
<td>Narayana Reddy Jagadeesh</td>
<td>Associate Professor</td>
<td>Vyddehi Medical College, Bangalore, India</td>
</tr>
<tr>
<td>Ana Flavia Pires Lucas D'Oliveira</td>
<td>Professor</td>
<td>School of Medicine, University of Sao Paulo, Brazil</td>
</tr>
<tr>
<td>Aurora del Rio Zolezzi</td>
<td>Assistant Director General</td>
<td>Department of Gender Equity, Mexico Ministry of Health, Mexico</td>
</tr>
<tr>
<td>Lene Symes</td>
<td>Associate Professor</td>
<td>Texas Woman’s University, Texas, USA</td>
</tr>
<tr>
<td>Laura Sadowski</td>
<td>Associate Professor</td>
<td>Department of Internal Medicine, Rush Medical University, Chicago, USA</td>
</tr>
<tr>
<td>Agnes Tiwari</td>
<td>Professor</td>
<td>School of Nursing, The University of Hong Kong, Hong Kong</td>
</tr>
<tr>
<td>Claudia Garcia-Moreno</td>
<td>World Health Organization Chief for</td>
<td>Department of Reproductive Health and Research, World Health</td>
</tr>
<tr>
<td>Name</td>
<td>Title</td>
<td>Institution</td>
</tr>
<tr>
<td>-----------------------</td>
<td>------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Alessandra C. Guedes</td>
<td>Regional Advisor</td>
<td>Intra-family Violence, Pan American Health Organization, Washington, USA</td>
</tr>
<tr>
<td>John Read</td>
<td>Professor</td>
<td>School of Psychology, University of Auckland, New Zealand</td>
</tr>
<tr>
<td>Charlotte Watts</td>
<td>Professor</td>
<td>Faculty of Public Health and Policy, London School of Hygiene and Tropical Medicine, UK</td>
</tr>
<tr>
<td>Karen Devries</td>
<td>Lecturer</td>
<td>London School of Hygiene and Tropical Medicine, UK</td>
</tr>
<tr>
<td>Louise M. Howard</td>
<td>Professor</td>
<td>Section of Women’s Mental Health, Institute of Psychiatry at King’s College London, UK</td>
</tr>
<tr>
<td>Donna E. Stewart</td>
<td>Professor</td>
<td>Division of Behavioural Sciences and Health, Toronto General Research Institute, Toronto, Canada</td>
</tr>
<tr>
<td>Gene Feder</td>
<td>Professor</td>
<td>Centre for Academic Primary Care, School of Social and Community Medicine, University of Bristol, UK</td>
</tr>
</tbody>
</table>
## Appendix 3: Data Extraction Form for Study One

**Study Type:**

**Author Name:**

**Paper title:**

**Reviewer ID:**

### CHECKLIST

Does the paper meet **each** of the following inclusion criteria?

<table>
<thead>
<tr>
<th>Inclusion criteria</th>
<th>If yes tick box</th>
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</thead>
<tbody>
<tr>
<td>Study is published in a peer-reviewed journal, report, or is a thesis/dissertation.</td>
<td></td>
</tr>
<tr>
<td>Study uses an eligible study design (RCT, non-randomised controlled trial, parallel group study, before and after study, interrupted time series, cohort study, case-control study, cross-sectional study)</td>
<td></td>
</tr>
<tr>
<td>Sample includes participants aged 16 years or older</td>
<td></td>
</tr>
<tr>
<td>Sample includes participants with mental disorders or who are in contact with mental health services</td>
<td></td>
</tr>
<tr>
<td>Study measures adult lifetime or past year domestic violence</td>
<td></td>
</tr>
<tr>
<td>Study results include the prevalence, incidence, odds or risk of domestic violence, or presents data from which these statistics can be calculated</td>
<td></td>
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</tbody>
</table>

If the paper does not meet **all** of the above criteria, please indicate below the reasons why:

<table>
<thead>
<tr>
<th>Exclusion criteria</th>
<th>If yes tick box</th>
</tr>
</thead>
<tbody>
<tr>
<td>Study is published in a book, conference paper, general comment paper, letter, editorial or other non-eligible format.</td>
<td></td>
</tr>
<tr>
<td>Study uses an ineligible study design (single case study, case series analysis, qualitative interview, focus group interviews)</td>
<td></td>
</tr>
<tr>
<td>Sample is aged 15 or younger (or includes participants aged 15 or younger and does not provide appropriately disaggregated data)</td>
<td></td>
</tr>
<tr>
<td>Sample does not include participants who are in contact with mental health services (or does not provide appropriately disaggregated data for mental health service users)</td>
<td></td>
</tr>
<tr>
<td>Study does not measure adult lifetime or past year domestic violence</td>
<td></td>
</tr>
<tr>
<td>Study results do not include the prevalence, incidence, odds or risk of domestic violence and does not present data from which these statistics can be calculated</td>
<td></td>
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</tbody>
</table>

If the paper meets any of the exclusion criteria do not proceed any further.

422
DATA EXTRACTION

Study Design

Please enter the dates of data collection:

<table>
<thead>
<tr>
<th>Year of start of data collection</th>
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</table>

<table>
<thead>
<tr>
<th>Year of end of data collection</th>
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<td></td>
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</table>

Please select the study design:

<table>
<thead>
<tr>
<th>Study Type</th>
<th>If yes tick box(es)</th>
<th>Please specify if required</th>
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</thead>
<tbody>
<tr>
<td>Randomised controlled trial</td>
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</tr>
<tr>
<td>Non-randomised controlled study</td>
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<td>Parallel group studies</td>
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<td>Before and after studies</td>
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<td>Interrupted time series studies</td>
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<td>Cohort Study</td>
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<td>Cross-sectional Study</td>
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<tr>
<td>Other (please specify):</td>
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</table>

Please select the sampling method used in the study:

<table>
<thead>
<tr>
<th>Sampling Method</th>
<th>If yes, tick box(es)</th>
<th>Specify if required</th>
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<td>Random sampling</td>
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<td>Systematic sampling</td>
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<td>Stratified sampling</td>
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<tr>
<td>Convenience sampling</td>
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<td></td>
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<tr>
<td>Matched sampling (please provide details)</td>
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<td></td>
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<tr>
<td>Quota sampling</td>
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<tr>
<td>Other (please specify)</td>
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<tr>
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Study Population

Please enter the country(s) in which the study was conducted:

<table>
<thead>
<tr>
<th>Country(s) in which the study was conducted</th>
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</thead>
<tbody>
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Please enter the number of males and females in the study sample:

<table>
<thead>
<tr>
<th>Sex</th>
<th>N</th>
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<tbody>
<tr>
<td>Males</td>
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<tr>
<td>Females</td>
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Please enter details of the age of the study sample:

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<tr>
<th>Age (yrs)</th>
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<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>Youngest</td>
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<tr>
<td>----------</td>
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</tbody>
</table>

Please select the type of mental health service to which this study relates:

<table>
<thead>
<tr>
<th>Service Type</th>
<th>If yes tick box(es)</th>
<th>Please provide further detail if available</th>
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<tbody>
<tr>
<td>Community mental health services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient mental health services</td>
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<td></td>
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<tr>
<td>Inpatient mental health services</td>
<td></td>
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<tr>
<td>Other (please specify):</td>
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<td></td>
</tr>
<tr>
<td>Not specified</td>
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<td></td>
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</table>

Please enter the study’s inclusion criteria:

Please enter the study’s exclusion criteria:

Please enter information about response rate:

<table>
<thead>
<tr>
<th>Number approached to participate</th>
<th>Number who agreed to participate</th>
<th>Not specified</th>
</tr>
</thead>
</table>

Please enter any comments about response rate:

**Domestic Violence**

Please enter the definition of domestic violence used in the study:

Please select the type of domestic violence measured (tick as many as apply)

<table>
<thead>
<tr>
<th>Type of Domestic Violence</th>
<th>N(%)</th>
<th>Please provide details of severity of violence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical violence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual violence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychological/emotional violence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Financial violence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Domestic homicide</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (please specify):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not specified</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If reported, please enter information about the impact of domestic violence:

Please select the perpetrator/s of reported domestic violence (tick as many as apply)

<table>
<thead>
<tr>
<th>Perpetrator of domestic</th>
<th>If yes</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Violence</td>
<td>Tick Box(es)</td>
<td></td>
</tr>
<tr>
<td>-----------------------------</td>
<td>--------------</td>
<td></td>
</tr>
<tr>
<td>Intimate partner</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent (unspecified)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Father</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sibling (unspecified)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brother</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sister</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child (unspecified)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Son</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Daughter</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (please specify):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not specified</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please select how domestic violence was measured:

<table>
<thead>
<tr>
<th>Measurement of Domestic Violence</th>
<th>If Yes Tick Box(es)</th>
<th>Specify if required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self report (face-to-face or telephone interview)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self report (self-administered questionnaire)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case file review (please state type of records e.g., medical)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (please specify):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not specified</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please select the instrument used to measure domestic violence:

<table>
<thead>
<tr>
<th>Measurement of Domestic Violence</th>
<th>If Yes Tick Box(es)</th>
<th>Specify if Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abusive Behaviour Inventory</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conflict Tactics Scale</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Revised Conflict Tactics Scale</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Composite Abuse Scale</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Index of Psychological Abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Index of Spouse Abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measure of Wife Abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Multi-Dimensional Measure of Emotional Abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Partner Abuse Scale – Physical</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Partner Abuse Scale – Non Physical</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Profile of Psychological Abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychological Maltreatment of Women Inventory</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychological Maltreatment of Women Inventory – Short Form</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safe Dates – Physical Abuse Victimisation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safe Dates – Psychological Abuse Victimisation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Severity of Violence Against Women</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
If data is available, please select the categories of mental disorder recorded for the sample (tick as many as apply and provide further detail if available):

<table>
<thead>
<tr>
<th>Category of Mental Disorder</th>
<th>If yes tick box(es)</th>
<th>Provide further detail if available (e.g., specific diagnostic code)</th>
<th>Please indicate how clinical diagnosis was measured</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenia [F20-21, 295.0-6, 295.8-9]</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Schizoaffective disorder [F25, 295.7]</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paranoid states [297]</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other nonorganic psychoses [F28-F29, 298]</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Persistent and induced delusional disorders [F22, F24]</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute and transient psychotic disorders [F23]</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Manic episode [F30, 296.00-06]</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bipolar affective disorder [F31, 296.40-.89]</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depressive disorder [F32-33, 296.20-296.36, 311]</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Persistent mood affective disorder [F34, 300.04, 301.13]</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other mood affective disorder [F38-39]</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety disorders [F40-42, 300.01-.03, 300.21-300.29]</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute stress reaction [F43, 308.3]</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post traumatic stress disorder [F43.1, 309.81]</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adjustment disorders [F43.2, 309.0-.4, 309.9]</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dissociative disorders [F44, 300.12-.15, 300.6]</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Somatoform disorders F45, 300.11, 300.7-300.81, 307.8]</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other neurotic disorders [F48]</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personality disorders [F60-61, 301.0-301.9]</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (please specify)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not specified:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Please select the criteria against which mental disorder is assessed:

<table>
<thead>
<tr>
<th>Criteria</th>
<th>If yes tick box(es)</th>
<th>Specify if required</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICD-10 (or earlier versions)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DSM-IV (or earlier versions)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not specified</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Does the study include mental health service users with co-morbid substance use?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

Outcomes

Please select whether outcome measures relate to past year or adult lifetime domestic violence (tick as many as apply):

<table>
<thead>
<tr>
<th>Past year domestic violence</th>
<th>Adult lifetime domestic violence</th>
<th>Not specified</th>
</tr>
</thead>
</table>

Please state when domestic violence occurred, in relation to use of mental health service use (tick as many as apply)

<table>
<thead>
<tr>
<th>Before use</th>
<th>Since use</th>
<th>Not specified</th>
</tr>
</thead>
</table>

Please provide details, if reported, of participants’ use of resources in response to experiences of domestic violence (i.e., repeat attendance at health services, any information pertaining to the cost of service use amongst survivors etc.).

Please enter estimates for the following measures of prevalence and risk, if available:

<table>
<thead>
<tr>
<th>Type of Estimate</th>
<th>Estimate</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Past year prevalence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult lifetime prevalence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Incidence (per 1000 per year)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Odds ratio</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adjusted odds ratio (please list the factors adjusted for below)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Absolute risk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attributable risk (risk difference)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk ratio (relative risk)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Population attributable risk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Population attributable fraction</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please enter any notes about these estimates (e.g., are disaggregated prevalence figures available for analysis, were odds ratios adjusted?)

Please enter the following raw data:

<p>| Total number of people included in the analysis |          |
| Total number of people experiencing domestic violence |          |</p>
<table>
<thead>
<tr>
<th>Category</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of people not experiencing domestic violence</td>
<td></td>
</tr>
<tr>
<td>Total number of mental health service users</td>
<td></td>
</tr>
<tr>
<td>Total number of non-mental health service users</td>
<td></td>
</tr>
<tr>
<td>Number of mental health service users experiencing domestic violence</td>
<td></td>
</tr>
<tr>
<td>Number of mental health service users not experiencing domestic violence</td>
<td></td>
</tr>
<tr>
<td>Number of non-mental health service users experiencing domestic violence</td>
<td></td>
</tr>
<tr>
<td>Number of non-mental health service users not experiencing domestic violence</td>
<td></td>
</tr>
<tr>
<td>If reporting incidence, time period (in years)</td>
<td></td>
</tr>
<tr>
<td>If reporting incidence, number of new cases of violent amongst people with a mental disorders</td>
<td></td>
</tr>
<tr>
<td>If reporting incidence, number of new cases of violent amongst people without a mental disorders</td>
<td></td>
</tr>
</tbody>
</table>

** Please repeat the outcomes section if you have further estimates for subgroups**

Please enter any further comments not covered elsewhere:
Appendix 4: Critical Appraisal Checklist for Study One

Appendix 2: Quality Appraisal Instrument

Scoring:
0 – study does not meet criteria/answer question
1 – Study partially meets criteria/gives a partially satisfactory answer to the question
2 – Study fully meets criteria/gives a fully satisfactory answer to the question

<table>
<thead>
<tr>
<th>Part 1: Screening questions</th>
<th>Question</th>
<th>Comments</th>
<th>0</th>
<th>1</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Did the study ask a clearly focused question?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consider:</td>
<td>Is the hypothesis/aim/objective of the study clearly described?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consider:</td>
<td>Is the study question focused in terms of the outcomes considered?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Is the study design appropriate for the research question?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Continue only if score on each of questions 1 and 2 is one or more

<table>
<thead>
<tr>
<th>Part 2: Risk of selection bias</th>
<th>Question</th>
<th>Comments</th>
<th>0</th>
<th>1</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>3a</td>
<td>Is the sampling method appropriate for the research question?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consider:</td>
<td>The sampling method used (i.e. random selection of subjects)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consider:</td>
<td>If applicable, is there appropriate selection of controls?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3b</td>
<td>Are subjects appropriately defined?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consider:</td>
<td>Inclusion/exclusion criteria specified</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consider:</td>
<td>Inclusion/exclusion criteria appropriate</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3c</td>
<td>Is the sample size appropriate?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consider:</td>
<td>Is the sample size justified?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consider:</td>
<td>Were a sufficient number of cases selected?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consider:</td>
<td>If applicable, were a sufficient number of controls selected?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3d</td>
<td>Is the study sample representative of the population of interest?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consider:</td>
<td>Do the authors assess the representativeness of the study sample?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Does the level of non-participation risk introducing bias?

Consider:
- Are key demographic characteristics of non-participants reported and compared against participants?
- Does the study report on the impact of non-participation?
- If applicable, rates of attrition reported

Is the study setting appropriate to the aims of the research? (e.g., setting, location, relevant dates)

Is the method of data collection appropriate for the aims of the research?

**Part 3: Risk of measurement and reporting bias**

<table>
<thead>
<tr>
<th>Question</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>6  Are suitable/standard criteria used for measurement of domestic violence?</td>
<td></td>
</tr>
<tr>
<td>Consider:</td>
<td></td>
</tr>
<tr>
<td>- Criteria of domestic violence was clearly defined</td>
<td></td>
</tr>
<tr>
<td>- Potential for bias of measurement</td>
<td></td>
</tr>
<tr>
<td>- If measures piloted</td>
<td></td>
</tr>
<tr>
<td>- Standardised/pre-validated measures (score 2 points)</td>
<td></td>
</tr>
<tr>
<td>- Researchers developed their own measure (score 1 point)</td>
<td></td>
</tr>
<tr>
<td>- No details of measurement were provided (score 0 point)</td>
<td></td>
</tr>
<tr>
<td>7  Are known confounders accounted for by study design?</td>
<td></td>
</tr>
<tr>
<td>Consider</td>
<td></td>
</tr>
<tr>
<td>- Was consideration of confounding factors accounted for in study design?</td>
<td></td>
</tr>
<tr>
<td>8  Are known confounders accounted for in the analyses?</td>
<td></td>
</tr>
<tr>
<td>9  Are the statistical tests used to assess the main outcomes appropriate?</td>
<td></td>
</tr>
<tr>
<td>Consider:</td>
<td></td>
</tr>
<tr>
<td>- Was there adequate adjustment for confounding in the analyses?</td>
<td></td>
</tr>
<tr>
<td>- Do the analyses adjust for different lengths of follow-up (if</td>
<td></td>
</tr>
</tbody>
</table>
Are the estimates reported with confidence intervals and in detail by sub-group (if applicable)?

Consider:
- Were the findings reported clearly?

Are statistically non-significant results presented?

Are data for relevant variables complete?

### Part 4: Additional questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Comments</th>
<th>0</th>
<th>1</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>11 Was the conduct of the fieldwork appropriate to the study setting?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consider:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Was the allocation of the interviewer/interpreter sensitive to the gender of the participant?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Were fieldworkers trained and supported to work with people who have experienced domestic violence?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12 Were ethical considerations appropriately considered?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consider:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Did researchers obtain informed consent from all participants?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Did researchers take adequate precautions to safeguard participant anonymity and confidentiality?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Did fieldworkers offer information about domestic violence support and referral options to all participants?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Were fieldworkers appropriately trained to deal with participant distress?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13 Do the findings support the conclusions?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14 Are the strengths and weaknesses of the research discussed?</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
Appendix 5: Search Terms for Study Two

Search terms for use in the Ovid Platform (Medline, Embase, PsycInfo and MIDRIS)

1. Domestic violence/
2. Family violence/
3. Partner abuse/
4. Partner violence/
5. Spouse abuse/
6. Battered women/
7. ((abus$ OR batter$ OR violen$ OR beat$) adj2 (domestic OR partner$ OR family OR families OR spouse OR woman OR women OR men OR man OR female$ OR male$ OR wife OR wives OR husband$ OR boyfriend$ OR girlfriend$ OR girlfriend$ OR elder$ OR brother$ OR sister$ OR father$ OR mother$ OR daughter$ OR son$ OR carer$).mp.)
8. (domestic adj5 homicid$).mp
9. 1 OR 2 OR 3 OR 4 OR 5 OR 6 OR 7 OR 8
10. exp animals / not humans.sh.
11. 9 NOT 10
12. Mental disorder/
13. Mental illness/
14. Chronic mental illness/
15. Mental health/
16. Mentally ill persons/
17. (Mental$ adj2 (problem$ OR difficult$ OR disorder$ OR ill$ OR health).mp.)
18. Mental health services/
19. Community Mental Health Services/
20. Community Mental Health Centres/
21. Community Mental Health Centers/
22. ((mental OR psychiatr$ OR psycholog$) adj2 (inpatient$ OR outpatient$ OR hospital$ OR clinic$ OR service$ OR ward$ OR health care).mp)
23. 12 OR 13 OR 14 OR 15 OR 16 OR 17 OR 18 OR 19 OR 20 OR 21 OR 22
24. exp animals / not humans.sh.
25. 23 NOT 24
26. Schiz$
27. Psychosis
28. Psychotic
29. Bipolar
30. Depress$
31. Mania OR manic
32. Neurosis OR psychoneurosis
33. Obsessive OR compulsive
34. Personality disorder/ OR anankastic personality disorder/ OR antisocial personality disorder/ OR avoidant personality disorder/ OR borderline personality disorder/ OR compulsive personality disorder/ OR dependent personality disorder/ OR histrionic personality disorder/ OR narcissistic personality disorder/ OR obsessive compulsive personality disorder/ OR paranoid personality disorder/ OR passive-aggressive personality disorder/ OR schizoid personality disorder/ OR schizotypal personality disorder/ OR ((anankastic OR asocial OR antisocial OR avoidant OR borderline OR dependent OR dissocial OR histrionic OR narcissistic OR obsessive OR compulsive OR paranoid OR passive-aggressive OR psychopath$ OR sadist$ OR sadomasochistic OR schizo$ OR sociopath$) adj person$).tw. OR (personality AND disorder$r) OR psychopath$.tw OR sociopath$.tw

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35. Eating disorders/ OR Anorexia Nervosa/ OR Binge-Eating Disorder/or Bulimia Nervosa/ OR ((anorexi$ OR bulimi$) AND nervosa) OR eating disorder$ OR binge-eat$ OR (bing$ adj eat$) OR (compulsive adj (eat$ or vomit$ or purg$))
36. ((Delusional OR paranoi$ OR mood OR neurotic OR stress OR reactive OR combat OR somatoform OR somatization OR somatisation OR anxiety OR phobic OR obsessive-compulsive OR adjustment OR dissociat$) adj2 disorder$)
37. 26 OR 27 OR 28 OR 29 OR 30 OR 31 OR 32 OR 33 OR 34 OR 35 OR 36
38. exp animals / not humans.sh.
39. 37 NOT 38
40. 25 OR 39
41. 11 AND 40
42. (psychosocial$ adj support$).mp. OR (psychosocial$ adj treatment$).mp. OR (psychosocial$ adj educati$).mp.
44. Psychotherapy/ OR therapy/ OR cognitive therapy/ OR behavi?r therapy/ OR (cognitive adj behavi?r$).mp. OR counselling/
45. 42 OR 43 OR 44
46. exp animals / not humans.sh.
47. 45 NOT 46
48. 41 AND 47
49. Randomi#ed controlled trial$.pt.
50. controlled clinical trial.pt.
51. randomi#ed.ab.
52. clinical trial as topic.sh.
53. randomly.ab.
54. trial.ab.
55. 46 OR 47 OR 48 OR 49 OR 50 OR 51
56. exp animals / not humans.sh.
57. 52 NOT 53
58. Parallel adj group$.tw OR comparative study.sh. OR prospective study.sh. OR (control$ or perspective$ or volunteer$).ti,ab. OR pilot stud$.tw.
59. Case control.tw. OR (cohort adj (study or studies)).tw. OR cohort analy$.tw OR (follow up adj (study or studies)).tw OR time.tw adj series.tw OR Longitudinal.tw OR Retrospective.tw OR prospective.tw.
60. 58 OR 59
61. exp animals / not humans.sh.
62. 60 NOT 61
63. 57 OR 62
64. 48 AND 63

**British Nursing Index Search and HMIC**

1. Domestic violence/
2. Family violence/
3. Partner abuse/
4. Partner violence/
5. Spouse abuse/
6. Battered women/
7. ((abus$ OR batter$ OR violen$ OR beat$) adj2 (domestic OR partner$ OR family OR families OR spouse OR woman OR women OR men OR man OR female$ OR male$ OR wife OR wives OR husband$ OR boyfriend$ OR girlfriend$ OR elder$ OR brother$ OR sister$ OR father$ OR mother$ OR daughter$ OR son$ OR carer$).mp.)
8. (domestic adj5 homicid$).mp
9. 1 OR 2 OR 3 OR 4 OR 5 OR 6 OR 7 OR 8
10. Mental disorder/
11. Mental illness/
12. Chronic mental illness/
13. Mental health/
14. Mentally ill persons/
15. (Mental$ adj2 (problem$ OR difficult$ OR disorder$ OR ill$ OR health).mp.)
16. Mental health services/
17. Community Mental Health Services/
18. Community Mental Health Centres/
19. Community Mental Health Centers/
20. ((mental OR psychiatr$ OR psycholog$) adj2 (inpatient$ OR outpatient$ OR hospital$ OR clinic$ OR service$ OR ward$ OR healthcare).mp)
21. 10 OR 11 OR 12 OR 13 OR 14 OR 15 OR 16 OR 17 OR 18 OR 19 OR 20
22. Schiz$
23. Psychosis
24. Psychotic
25. Bipolar
26. Depress$
27. Mania OR manic
28. Neurosis OR psychoneurosis
29. Obsessive OR compulsive
30. Personality disorder/ OR anankastic personality disorder/ OR antisocial personality disorder/ OR avoidant personality disorder/ OR borderline personality disorder/ OR compulsive personality disorder/ OR dependent personality disorder/ OR histrionic personality disorder/ OR narcissistic personality disorder/ OR obsessive compulsive personality disorder/ OR paranoid personality disorder/ OR passive-aggressive personality disorder/ OR schizoid personality disorder/ OR schizotypal personality disorder/ OR ((anankastic OR asocial OR antisocial OR avoidant OR borderline OR dependent OR dissocial OR histrionic OR narcissistic OR obsessive OR compulsive OR paranoid OR passive-aggressive OR psychopath$ OR sadist$ OR sadomasochistic OR schizo$ OR sociopath$) adj person$).tw. OR (personality AND disorder$) OR psychopath$.tw OR sociopath$_.tw
31. Eating disorders/ OR Anorexia Nervosa/ OR Binge-Eating Disorder/or Bulimia Nervosa/ OR ((anorexi$ OR bulimi$) AND nervosa) OR eating disorder$ OR binge-eat$ OR (bing$ adj eat$) OR (compulsive adj (eat$ or vomit$ or purg$))
32. ((Delusional OR paranoid$ OR mood OR neurotic OR stress OR reactive OR combat OR somatoform OR somatization OR somatisation OR anxiety OR phobic OR obsessive-compulsive OR adjustment OR dissociat$) adj2 disorder$)
33. 22 OR 23 OR 24 OR 25 OR 26 OR 27 OR 28 OR 29 OR 30 OR 31 OR 32
34. 21 OR 33
35. 9 AND 34

Web of Science/ SSCI (via Web of Knowledge platform)
(SCI Expanded 1970-present; SSCI 1970-present; A&HCI 1975-present; CPCI-S 1990-present; CPCI-SSH 1990-present)

1"domestic violence" OR "family violence" OR "partner abuse" OR "partner violence" OR "spouse abuse" OR "battered women" OR ((abus$ OR batter$ OR violen$ OR beat$) near/2 (domestic OR partner$ OR family OR families OR spouse OR woman OR women OR men OR man OR female$ OR male$ OR wife OR wives OR husband$ OR boyfriend$ OR girlfriend$ OR elder$ OR brother$ OR sister$ OR father$ OR mother$ OR daughter$ OR son$ OR carer$)) OR "domestic homicide" AND ("mental disorder" OR "mental illness" OR "mental health" OR "mentally ill persons" OR (mental$ near/2 (problem$ OR difficult$ OR disorder$ OR ill$ OR health)) OR "mental health services" OR "community mental health services")

2"domestic violence" OR "family violence" OR "partner abuse" OR "partner violence" OR "spouse abuse" OR "battered women" OR ((abus$ OR batter$ OR violen$ OR beat$) near/2 (domestic OR partner$ OR family OR families OR spouse OR woman OR women OR men OR man OR female$ OR male$ OR wife OR wives OR husband$ OR boyfriend$ OR girlfriend$ OR elder$ OR brother$ OR sister$ OR father$ OR mother$ OR daughter$ OR son$ OR carer$)) OR "domestic homicide" OR "domestic violence" OR "family violence" OR "partner abuse" OR "partner violence" OR "spouse abuse" OR "battered women" OR ((abus$ OR batter$ OR violen$ OR beat$) near/2 (domestic OR partner$ OR family OR families OR spouse OR woman OR women OR men OR man OR female$ OR male$ OR wife OR wives OR husband$ OR boyfriend$ OR girlfriend$ OR elder$ OR brother$ OR sister$ OR father$ OR mother$ OR daughter$ OR son$ OR carer$)) OR "domestic homicide" AND ("mental disorder" OR "mental illness" OR "mental health" OR "mentally ill persons" OR (mental$ near/2 (problem$ OR difficult$ OR disorder$ OR ill$ OR health)) OR "mental health services" OR "community mental health services")
(personality AND disorder$) OR psychopath$ OR sociopath$ OR ((Delusional OR paranoi$ OR mood) near/2 disorder$)
9 1 OR 2 OR 3 OR 4 OR 5 OR 6 OR 7 OR 8
10 ((psychosocial$ adj support$) OR (psychosocial$ adj treatment$) OR (psychosocial$ adj educati$) OR (psycholog$ adj support$) OR (psycholog$ adj treatment$) OR (psycholog$ adj educati$)) OR ("psychotherapy" OR "therapy" OR "cognitive therapy" OR "behavior therapy" OR "counselling")
11 ((randomi?ed controlled trial$ OR randomi?ed) OR "controlled clinical trial" OR "randomly" OR "trial") OR ((parallel adj group$) OR "comparative study" OR "prospective study" OR (control$ or perspective$ or volunteer$) OR (pilot stud$) OR "case control" OR (cohort adj (study or studies)) OR (cohort analy$) OR (follow up adj (study or studies)) OR (time adj series) OR "Longitudinal" OR "Retrospective" OR "prospective"
12 9 AND 10 AND 11

CINAHL via EBSCO
1. (domestic violence/ OR family violence/ OR partner abuse/ OR partner violence/ OR spouse abuse/ OR battered women/ OR ((abus* OR batter* OR violen* OR beat*) n2 (domestic OR partner* OR family OR families OR spouse OR wom?n OR m?n OR female* OR male* OR wife OR husbands OR boyfriend* OR girlfriend* OR elder* OR brother* OR sister* OR father* OR mother* OR daughter* OR son* OR carer*)) OR (domestic n1 homicide))
2. “Mental Disorders, Chronic” OR “Psychotic Disorders” OR “Adjustment Disorders+” OR “Neurotic Disorders+” OR “Anxiety Disorders+” OR “Personality Disorders” OR “Affective Disorders, Psychotic-+” OR “Paranoid Disorders+” OR “Postpartum psychosis” OR “Schizoaffective disorder” OR “Schizophrenia” OR “Impulse Control Disorders+” OR “Alcohol-Related Disorders+” OR “Substance Abuse+” OR “Bipolar Disorder” OR “Depression+” OR “Stress Disorders, Post-Traumatic” OR “Phobic Disorders+” OR “Obsessive-Compulsive Disorder+” OR “Anxiety Disorders+” OR “Anorexia” OR “Anorexia nervosa” OR “Bulimia” OR “Bulimia Nervosa” OR “Somatoform Disorders+” OR “Dissociative Disorders+”
3. Community Mental Health Services/ OR Mental Health Services/
4. 2 OR 3
5. 1 AND 4
6. ("psychosocial support" OR "psychosocial education" OR "psychological education" OR "psychological support") OR ("psychosocial treatment" OR "psychological treatment”)
7. 5 AND 6

International Bibliography of the Social Sciences (IBSS)/Sociological Abstracts/Applied Social Sciences Index and Abstracts (via CSA)
1. ((KW= domestic violence) OR (KW= family violence) OR (KW= partner abuse) OR (KW= partner violence) OR (KW= spouse abuse) OR (KW= battered women) OR (abus* OR batter* OR violen* OR beat*) WITHIN 2 (domestic OR partner* OR family OR families OR spouse OR wom?n OR m?n OR female* OR male* OR wife OR husbands OR boyfriend* OR girlfriend* OR elder* OR brother* OR sister* OR father* OR mother* OR daughter* OR son* OR carer*)) OR (domestic WITHIN 2 homicide))
2. (mental OR psychiat* OR psycholog*) WITHIN 2 (inpatient* OR outpatient* OR hospital* OR clinic* OR service* OR ward* OR healthcare)) OR (KW= mental health services) OR (KW= community mental health services)
3. (KW= mental disorder) OR (KW= mental illness) OR (KW= mental health) OR (KW= mentally ill persons)
4. (KW= personality disorder) OR (KW= anankastic personality disorder) OR (KW= antisocial personality disorder) OR (KW= avoidant personality disorder) OR
(KW= borderline personality disorder) OR (KW= compulsive personality disorder) OR (KW= dependent personality disorder) OR (KW= histrionic personality disorder) OR (KW= narcissistic personality disorder) OR (KW= obsessive-compulsive personality disorder) OR (KW= paranoid personality disorder) OR (KW= passive-aggressive personality disorder) OR (KW= schizotypal personality disorder) OR (KW= eating disorder) OR (KW= anorexia nervosa) OR (KW= bulimia nervosa) OR (KW= binge-eating disorder) OR OR schiz* OR psychosis OR psychotic OR bipolar OR depress* OR mania OR manic OR neurosis OR psychoneurosis OR obsessive OR compulsive OR ((anankastic OR asocial OR antisocial OR avoidant OR borderline OR dependent OR dissociative OR histrionic OR narcissistic OR obsessive OR compulsive OR paranoid OR passive-aggressive OR psychopath* OR sadist* OR sadomasochistic OR schizo* OR sociopath*) WITHIN 1 person*) OR (personality AND disorder) OR psychopath* OR sociopath* OR ((anorexi* OR bulimi*) AND nervosa) OR eating disorder* OR binge-eat* OR (bing* WITHIN 1 eat*) OR (compulsive WITHIN 1 (eat* OR vomit* OR purg*))) OR ((delusional OR paranoia* OR mood OR neurotic OR stress OR reactive OR combat OR somatoform OR somatisation OR somatization OR anxiety OR phobic OR obsessive-compulsive OR adjustment OR dissociat*)) WITHIN 2 disorder*)

5. 2 OR 3 OR 4

6. 1 AND 5

7. (KW= psychosocial support) OR (KW= psychosocial education) OR (KW= psychological education) OR (KW= psychological support) OR (KW= psychosocial treatment) OR (KW= psychological treatment)

8. 6 AND 7

DART – Europe E-theses Portal

1("domestic violence" OR "domestic abuse" OR "family violence" OR "partner abuse" OR "partner violence" OR "spouse abuse" OR "battered women" OR "battered men" OR "abusive partner") AND ("mental disorder" OR "mental illness" OR "mentally ill" OR "mental health" OR "mental problem" OR "psychiatric inpatient" OR "psychiatric outpatient" OR "psychiatric hospital" OR "psychiatric ward" OR "psychiatric care" OR "psychological care")

2("domestic violence" OR "domestic abuse" OR "family violence" OR "partner abuse" OR "partner violence" OR "spouse abuse" OR "battered women" OR "battered men" OR "abusive partner") AND (Schizophrenia OR schizophrenic OR psychosis OR psychotic OR bipolar OR depression OR depressed OR depressive OR mania OR manic OR neurosis OR psychoneurosis OR obsessive OR compulsive OR "personality disorder" OR psychopath OR sociopath OR "eating disorder" OR anorexia OR bulimia)

3("domestic violence" OR "domestic abuse" OR "family violence" OR "partner abuse" OR "partner violence" OR "spouse abuse" OR "battered women" OR "battered men" OR "abusive partner") AND ("post traumatic stress disorder" OR "PTSD" OR "delusional disorder" OR "mood disorder" OR "anxiety disorder" OR "neurotic disorder" OR "combat disorder" OR "somatoform disorder" OR "dissociative disorder")

Networked Digital Library of Theses and Dissertations (NDLTD)

1("domestic violence" "domestic abuse" "family violence" "partner abuse" "partner violence" "spouse abuse" "battered women" "battered men" "abusive partner") AND ("mental disorder" "mental illness" "mentally ill" "mental health" "mental problem" "psychiatric inpatient" "psychiatric outpatient" "psychiatric hospital" "psychiatric ward" "psychiatric care" "psychological care")

2("domestic violence" "domestic abuse" "family violence" "partner abuse" "partner violence" "spouse abuse" "battered women" "battered men" "abusive partner") AND (Schizophrenia schizophrenic psychosis psychotic bipolar depression depressed 437
depressive mania manic neurosis psychoneurosis obsessive compulsive “personality disorder” psychopath sociopath “eating disorder” anorexia bulimia


Academic Search Complete (via EBSCO)

1. ((DE "FAMILY violence") OR (DE "INTIMATE partner violence") OR (DE "HUSBAND abuse") OR (DE "ABUSED women") OR (DE "ABUSED wives") OR (domestic n1 homicide) OR ("domestic abus*") OR ("abus* partner") OR ("partner abus*") OR ("abus* famili*") OR ("famili* abus*") OR ("spouse abus*") OR ("abus* spouse") OR ("abus* wom?n") OR ("wom?n abus*") OR ("m?n abus*") OR ("abus* m?n") OR ("abus* female") OR ("female* abus*") OR ("male* abus") OR ("abus* male") OR ("abus* wife") OR ("wife abus*") OR ("abus* wives") OR ("abus* husband") OR ("husband abus") OR ("abus* boyfriend") OR ("boyfriend abus") OR ("abus* girlfriend") OR ("girlfriend* abus") OR ("abus* elder") OR ("elder* abus") OR ("abus* brother") OR ("brother abus") OR ("abus* sister") OR ("sister* abus") OR ("abus* father") OR ("father* abus") OR ("abus* mother") OR ("mother* abus") OR ("abus* daughter") OR ("daughter* abus") OR ("abus* son") OR ("son* abus") OR ("abus* carer") OR ("carer* abus") OR ("batis* partner") OR ("partner batis") OR ("batis* famili") OR ("famili* batis") OR ("spouse batis") OR ("batis* spouse") OR ("batis* wom?n") OR ("wom?n batis") OR ("batis* m?n") OR ("batis* female") OR ("batis* male") OR ("batis* wife") OR ("batis* husband") OR ("batis* boyfriend") OR ("batis* girlfriend") OR ("batis* elder") OR ("batis* daughter") OR ("batis* son") OR ("batis* family") OR ("batis* carer") OR ("batis* father") OR ("batis* mother") OR ("batis* daughter") OR ("batis* son") OR ("batis* partner") OR ("batis* family") OR ("batis* carer") OR ("batis* father") OR ("batis* mother") OR ("batis* daughter") OR ("batis* son") OR ("batis* family") OR ("batis* carer") OR ("batis* father") OR ("batis* mother") OR ("batis* daughter") OR ("batis* son") OR ("batis* family") OR ("batis* carer") OR ("batis* father") OR ("batis* mother") OR ("batis* daughter") OR ("batis* son") OR ("batis* family") OR ("batis* carer") OR ("batis* father") OR ("batis* mother") OR ("batis* daughter") OR ("batis* son") OR ("batis* family") OR ("batis* carer") OR ("batis* father") OR ("batis* mother") OR ("batis* daughter") OR ("batis* son") OR ("batis* family") OR ("batis* carer") OR ("batis* father") OR ("batis* mother") OR ("batis* daughter") OR ("batis* son") OR ("batis* family") OR ("batis* carer") OR ("batis* father") OR ("batis* mother") OR ("batis* daughter") OR ("batis* son") OR ("batis* family") OR ("batis* carer") OR ("batis* father") OR ("batis* mother") OR ("batis* daughter") OR ("batis* son") OR ("batis* family") OR ("batis* carer") OR ("batis* father") OR ("batis* mother") OR ("batis* daughter") OR ("batis* son") OR ("batis* family") OR ("batis* carer") OR ("batis* father") OR ("batis* mother") AND ((DE "MENTAL health" OR DE "MENTAL illness" OR DE "MENTALLY ill") OR (DE "MENTAL health") OR (DE "MENTAL illness") OR (DE "MENTALLY ill") OR (DE "MENTAL health") OR (DE "MENTAL illness") OR (DE "MENTALLY ill"))
health services” OR DE "COMMUNITY mental health services”) OR (mental* n2 problem) OR (mental* n2 difficult*) OR (mental* n2 disorder*) OR (mental* n2 ill*) OR (mental* n2 health) OR (mental inpatient*) OR (mental outpatient*) OR (mental hospital*) OR (mental clinic*) OR (mental service*) OR (mental ward*) OR ("mental healthcare") OR (psychiatr* inpatient*) OR (psychiatr* outpatient*) OR (psychiatr* hospital*) OR (psychiatr* clinic*) OR (psychiatr* service*) OR (psychiatr* ward*) OR (psychiatr* healthcare) OR (psycholog* inpatient*) OR (psycholog* outpatient*) OR (psycholog* hospital*) OR (psycholog* clinic*) OR (psycholog* service*) OR (psycholog* ward*) OR (psycholog* healthcare) OR schiz$ OR psychosis OR psychotic OR bipolar OR depress$ OR mania OR manic OR neurosis OR psychoneurosis OR obsessive OR compulsive OR DE "PERSONALITY disorders” OR DE "PSYCHOLOGY, Pathological" OR DE "ANTISOCIAL personality disorders” OR DE "AVOIDANT personality disorder” OR DE "BORDERLINE personality disorder” OR DE "HISTRIONIC personality disorder” OR DE "IMPULSIVE personality” OR DE "MASOCHISM” OR DE "NARCISSISTIC personality disorder” OR DE "PASSIVE-aggressive personality” OR DE "SADISM” OR DE "SCHIZOID personality” OR DE "SCHIZOTYPAL personality disorder”) OR (“anankastic person”) OR (“asocial person”) OR (“antisocial person”) OR (“borderline person”) OR (“dependent person”) OR (“dissocial person”) OR (“histrionic person”) OR (“narcissistic person”) OR (“obsessive person”) OR (“compulsive person”) OR (“paranoid person”) OR (“passive-aggressive person”) OR (“psychopath* person”) OR (“sadist* person”) OR (“sadomasochistic person”) OR (“schizo* person”) OR (“sociopath* person”) OR (“sociopath* personality AND disorder”) OR (EATING disorders” OR DE "ANOREXIA nervosa” OR DE "BULIMIA” OR DE "COMPULSIVE eating") OR (“anorexia nervosa”) OR (“bulimia nervosa”) OR (“bing* eat”) OR (“compulsive eat") OR (“compulsive vomit”) OR (“compulsive purg”) OR (“delusional disorder") OR (“mood disorder") OR (“neurotic disorder") OR (“reactive disorder") OR (“combat disorder") OR (“somatoform disorder") OR (“anxiety disorder") OR (“phobic disorder") OR (“obsessive-compulsive disorder") OR (“adjustment disorder") OR (“dissociat* disorder") AND "PSYCHOLOGICAL treatment” OR DE "PSYCHOLOGICAL support” OR "PSYCHOLOGICAL education” OR DE "PSYCHOSOCIAL treatment” OR DE "PSYCHOSOCIAL support” OR DE "PSYCHOSOCIAL education” OR DE "COUNSELLING” OR DE "ADVOCACY” OR DE "THERAPY”

Science Direct

1. "domestic violence" OR “domestic abuse” OR "partner abuse" OR "partner violence" OR “intimate partner violence” OR "spouse abuse" OR "battered women” OR “battered men”
2. "psych* treatment" OR “psych* support” OR "psych* education" OR "counselling” OR “advocacy” OR "therapy”
3. “randomi?ed controlled trial” OR “randomi?ed” OR "controlled clinical trial” OR "trial” OR “parallel group” OR "comparative study” OR "prospective study” OR “pilot study” OR "case control” OR “cohort study” OR “follow up study” OR “time series” OR "Longitudinal" OR "Retrospective study”
4. 1 AND 2 AND 3
Professionals, Pharmacology, Toxicology and Pharmaceutical Science, Psychology, Social Sciences)

**Cochrane Databases** *(Cochrane Database of Systematic Reviews, Database of Abstracts of Reviews of Effects, Cochrane Central Register of Controlled Trials, Cochrane Methodology Register, Health Technology Assessment Database, NHS Economic Evaluation Database)*

1. "domestic violence" OR "family violence" OR "partner abuse" OR "partner violence" OR "spouse abuse" OR "battered women" OR ((abus$ OR batter$ OR violen$ OR beat$) near/2 (domestic OR partner$ OR family OR families OR spouse OR woman OR women OR men OR man OR male$ OR wife OR wives OR husband$ OR boyfriend$ OR girlfriend$ OR elder$ OR brother$ OR sister$ OR father$ OR mother$ OR daughter$ OR son$ OR carer$)) OR "domestic homicide"
2. ("mental disorder" OR "mental illness" OR "mental health" OR "mentally ill persons" OR (mental$ adj2 (problem$ OR difficult$ OR disorder$ OR ill$ OR health)) OR "mental health services") OR "community mental health services"
3. Schiz$ OR Psychosis OR Psychotic OR Bipolar OR Depress$ OR Mania OR manic OR Neurosis OR psychoneurosis OR Obsessive-compulsive OR Personality disorder OR anankastic personality disorder OR antisocial personality disorder OR avoidant personality disorder OR borderline personality disorder OR compulsive personality disorder OR dependent personality disorder OR histrionic personality disorder OR narcissistic personality disorder OR obsessive compulsive personality disorder OR paranoid personality disorder OR passive-aggressive personality disorder OR schizoid personality disorder OR schizotypal personality disorder OR ((anankastic OR asocial OR antisocial OR avoidant OR borderline OR dependent OR dissocial OR histrionic OR narcissistic OR obsessive OR compulsive OR paranoid OR passive-aggressive OR psychopath$ OR sadist$ OR sadomasochistic OR schizo$ OR sociopath$) adj person$) OR (personality AND disorder$r) OR psychopath$ OR sociopath$
4. "randomi?ed controlled trial" OR "randomi?ed" OR "controlled clinical trial" OR "trial" OR "parallel group" OR "comparative study" OR "prospective study" OR "pilot study" OR "case control" OR "cohort study" OR "follow up study" OR "time series" OR "Longitudinal" OR "Retrospective study"
5. ("psychosocial support" OR "psychosocial education" OR "psychological education" OR "psychological support") OR ("psychosocial treatment" OR "psychological treatment")
6. 1 AND 2 AND 3 AND 4 AND 5

**JSTOR**

1."domestic violence" OR "domestic abuse" OR "family violence" OR "partner abuse" OR "partner violence" OR "intimate partner violence" OR "spouse abuse" OR "battered wom?n" OR "battered m?n")
2("mental disorder" OR "mental illness") OR (mental* ~2 problem OR difficulty OR disorder OR illness OR health) OR ("mental health services" OR "community mental health services")
3("psychosocial support" OR "psychosocial education" OR "psychological education" OR "psychological support") OR ("psychosocial treatment" OR "psychological treatment")

**ETHOS**

1. "Domestic violence" OR "domestic abuse" OR "partner violence" OR "partner abuse" OR "intimate partner violence"
2. "psychological" OR "psychiatric" OR "mental illness" OR "mental disorder" OR "mental health"
3. "schizophrenia" OR "bipolar" OR "depression" OR "Mania" OR "Mood disorder"
   OR "Anxiety disorder" OR “post traumatic stress” OR “Eating disorder”
4. 1 AND 2 OR 3
## Appendix 6: Expert Recommendations Sought for Study Two

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Institution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Michele Cascardi</td>
<td>Professor</td>
<td>Center for Child Advocacy, Montclair State University, New Jersey, USA</td>
</tr>
<tr>
<td>Randy A. Sansone</td>
<td>Professor</td>
<td>Department of Psychiatry and Internal Medicine, Wright State University School of Medicine in Dayton, Ohio USA</td>
</tr>
<tr>
<td>Ghita Weizmann-Henelius</td>
<td>Clinical Psychologist and Adjunct Professor</td>
<td>Vanha Vaasa Hospital, Vaasa, Finland &amp; Department of Psychology Abo Akademi University, Turku, Finland</td>
</tr>
<tr>
<td>Brian Trappler</td>
<td>Associate Clinical Professor</td>
<td>State University of New York, Kingsboro Psychiatric Center, Brooklyn, USA</td>
</tr>
<tr>
<td>Claudia Garcia-Moreno</td>
<td>World Health Organization Chief for Women’s Health</td>
<td>Department of Reproductive Health and Research, World Health Organization, Geneva, Switzerland</td>
</tr>
<tr>
<td>Kim Mueser</td>
<td>Professor</td>
<td>Center for Psychiatric Rehabilitation, Boston University, USA</td>
</tr>
<tr>
<td>Christopher B. Frueh</td>
<td>Director of Clinical Research and Adjunct Professor</td>
<td>The Menninger Clinic, Houston, USA &amp; Menninger Department of Psychiatry &amp; Behavioral Sciences, Baylor College of Medicine, Houston, USA</td>
</tr>
<tr>
<td>Mary Zanarini</td>
<td>Professor</td>
<td>Department of Psychiatry, McLean Hospital, Belmont, USA</td>
</tr>
<tr>
<td>John Coverdale</td>
<td>Professor</td>
<td>Menninger Department of Psychiatry &amp; Behavioral Sciences, Baylor College of Medicine, Houston, USA</td>
</tr>
<tr>
<td>Mark van Ommeren</td>
<td>Technical Officer</td>
<td>Department of Mental Health and Substance Dependence, World Health Organization, Geneva, Switzerland</td>
</tr>
<tr>
<td>Stanley D. Rosenberg</td>
<td>Professor</td>
<td>Department of Psychiatry, Community and Family Medicine, Yale University, New Hampshire, USA</td>
</tr>
<tr>
<td>Weili Lu</td>
<td>Clinical Psychologist and Researcher</td>
<td>Centre for the Study and Promotion of Recovery from Severe Mental Illness, University of Medicine and Dentistry of New Jersey, USA</td>
</tr>
<tr>
<td>Joseph J. Cocozza</td>
<td>Director</td>
<td>National Center for Mental Health and Juvenile Justice, Policy Research Associates, Delaware Avenue, Delmar, USA</td>
</tr>
<tr>
<td>Joseph P. Morrisey</td>
<td>Professor</td>
<td>Department of Psychiatry, University of North Carolina School of Medicine, Chapel Hill, USA</td>
</tr>
<tr>
<td>Emmanuelle R. Peters</td>
<td>Senior Lecturer</td>
<td>Institute of Psychiatry at King’s College London, UK</td>
</tr>
</tbody>
</table>
# Appendix 7: Data Extraction Form for Study Two

**ENDNOTE ID:**

**Study Type:**

**Author Name:**

**Paper title:**

**Reviewer ID:**

## CHECKLIST

Does the paper meet each of the following inclusion criteria?

<table>
<thead>
<tr>
<th>Inclusion criteria</th>
<th>If yes tick box</th>
</tr>
</thead>
<tbody>
<tr>
<td>Study is published in a peer-reviewed journal, thesis or report</td>
<td></td>
</tr>
<tr>
<td>Study uses an eligible study design (randomised controlled trial, non-randomised controlled trial, parallel group study, before and after study, interrupted time series, cohort study, case-control study)</td>
<td></td>
</tr>
<tr>
<td>Sample includes participants aged 16 years or older</td>
<td></td>
</tr>
<tr>
<td>Sample includes participants who have experienced adult lifetime and/or past year domestic violence</td>
<td></td>
</tr>
<tr>
<td>Sample includes participants who are diagnosed with, or screen positive for, mental disorder (as measured using a validated assessment), or are mental health service users.</td>
<td></td>
</tr>
<tr>
<td>Study results include measures of frequency/severity of violence, safety behaviours, mental health symptomatology or quality of life, or collected data from which these outcomes can be calculated</td>
<td></td>
</tr>
</tbody>
</table>

If the paper does not meet all of the above criteria, please indicate below the reasons why:

<table>
<thead>
<tr>
<th>Exclusion criteria</th>
<th>If yes tick box</th>
</tr>
</thead>
<tbody>
<tr>
<td>Study is published as a conference paper, general comment paper, letter, or editorial.</td>
<td></td>
</tr>
<tr>
<td>Study uses an ineligible study design (single case study, qualitative interview, focus group interviews).</td>
<td></td>
</tr>
<tr>
<td>Sample is aged 15 or younger (or includes participants aged 15 or younger and does not provide appropriately disaggregated data)</td>
<td></td>
</tr>
<tr>
<td>Sample does not include participants who are diagnosed/screened for mental disorders or who are mental health service users (or includes these participants but does not provide appropriately disaggregated data)</td>
<td></td>
</tr>
<tr>
<td>Study does not measure adult lifetime or past year domestic violence</td>
<td></td>
</tr>
<tr>
<td>Study results does not measure frequency/severity of violence, safety behaviours, mental health symptomatology or quality of life and the study does not collect data from which these statistics can be calculated</td>
<td></td>
</tr>
</tbody>
</table>

*If the paper meets any of the exclusion criteria do not proceed any further*
DATA EXTRACTION

Study Design

Please enter the dates of data collection:

<table>
<thead>
<tr>
<th>Date of start of intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of end of intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

Please select the study design:

<table>
<thead>
<tr>
<th>Study Type</th>
<th>If yes tick box(es)</th>
<th>Please specify if required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Randomised controlled trial</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-randomised controlled study</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parallel group studies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Before and after studies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interrupted time series studies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (please specify)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please select the sampling method used in the study:

<table>
<thead>
<tr>
<th>Sampling Method</th>
<th>If yes, tick box(es)</th>
<th>Specify if required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Random sampling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Systematic sampling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stratified sampling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Convenience sampling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Matched sampling (please provide details)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quota sampling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (please specify)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not specified</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Study Population

Please enter the country(s) in which the study was conducted:


Please enter the number of males and females in the study sample:

<table>
<thead>
<tr>
<th>Sex</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
<td></td>
</tr>
<tr>
<td>Females</td>
<td></td>
</tr>
<tr>
<td>Not specified</td>
<td></td>
</tr>
</tbody>
</table>

Please enter details of the age of the study sample:

<table>
<thead>
<tr>
<th>Age (yrs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Youngest</td>
</tr>
<tr>
<td>Oldest</td>
</tr>
<tr>
<td>Mean</td>
</tr>
<tr>
<td>Standard deviation</td>
</tr>
<tr>
<td>Not specified</td>
</tr>
</tbody>
</table>
Please select the type of mental health service to which this study relates:

<table>
<thead>
<tr>
<th>Service Type</th>
<th>If yes tick box(es)</th>
<th>Please provide further detail if available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community mental health services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient mental health services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient mental health services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (please specify):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not specified</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please enter the study’s inclusion criteria:

Please enter the study’s exclusion criteria:

Please enter information about response rate:

<table>
<thead>
<tr>
<th>Number approached to participate</th>
<th>Number who agreed to participate</th>
<th>Not specified</th>
</tr>
</thead>
</table>

Please enter any comments about response rate:

Please enter any information about the allocation of participants to study groups:

**Domestic Violence**
Please enter the definition of domestic violence used in the study (including type of violence and perpetrator, if specified):

Please select how domestic violence was measured:

<table>
<thead>
<tr>
<th>Measurement of domestic violence</th>
<th>If yes tick box(es)</th>
<th>Specify if required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self report (face-to-face or telephone interview)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self report (self-administered questionnaire)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case file review (please state type of records e.g., medical)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (please specify):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not specified</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please select the instrument used to measure domestic violence:

<table>
<thead>
<tr>
<th>Measurement of domestic violence</th>
<th>If yes tick box(es)</th>
<th>Specify if required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abusive Behaviour Inventory</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conflict Tactics Scale</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Revised Conflict Tactics Scale</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Composite Abuse Scale</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Category of Mental Disorder</th>
<th>If yes tick box(es)</th>
<th>Provide further detail if available (e.g., specific diagnostic code)</th>
<th>Please indicate how clinical diagnosis was measured</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenia [F20-21, 295.0-6, 295.8-9]</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Schizoaffective disorder [F25, 295.7]</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paranoid states [297]</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other nonorganic psychoses [F28-F29, 298]</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Persistent and induced delusional disorders [F22, F24]</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute and transient psychotic disorders [F23]</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Manic episode [F30, 296.00-.06]</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bipolar affective disorder [F31, 296.40-.89]</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depressive disorder [F32-33, 296.20-296.36, 311]</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Persistent mood affective disorder [F34, 300.04, 301.13]</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Other mood affective disorder
[F38-39]

### Anxiety disorders
[F40-42, 300.01-.03, 300.21-300.29]

### Acute stress reaction
[F43, 308.3]

### Post traumatic stress disorder
[F43.1, 309.81]

### Adjustment disorders
[F43.2, 309.0-.4, 309.9]

### Dissociative disorders
[F44, 300.12-.15, 300.6]

### Somatoform disorders
[F45, 300.11, 300.7-300.81, 307.8]

### Other neurotic disorders
[F48]

### Personality disorders
[F60-61, 301.0-301.9]

### Other (please specify)

### Not specified:

#### Please select the criteria against which mental disorder is assessed:

<table>
<thead>
<tr>
<th>Criteria</th>
<th>If yes tick box(es)</th>
<th>Specify if required</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICD-10 (or earlier versions)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DSM-IV (or earlier versions)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not specified</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Does the study include mental health service users with co-morbid substance use?

- Yes
- No

#### Outcomes

Please select whether outcome measures relate to past year or adult lifetime domestic violence (tick as many as apply):

- Past year domestic violence
- Adult lifetime domestic violence
- Not specified

#### Please enter the measures used to collect frequency/ severity of abuse, mental health symptomatology, safety behaviours and quality of life outcomes:

#### Please enter estimates for the following measures of effect, if available:

<table>
<thead>
<tr>
<th>Type of Estimate</th>
<th>Estimate</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Odds</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Odds ratio</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adjusted odds ratio (please list the factors adjusted for below)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk ratio (relative risk)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attributable risk (risk difference)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------------</td>
<td>--------------------------------</td>
<td></td>
</tr>
<tr>
<td>Standardised mean difference</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Raw mean difference</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Effect size</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please enter any notes about these outcomes (e.g., were odds ratios adjusted?)

Please enter the following raw data:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of people included in the analysis</td>
<td></td>
</tr>
<tr>
<td>Total number of people receiving intervention</td>
<td></td>
</tr>
<tr>
<td>Total number of people not receiving intervention</td>
<td></td>
</tr>
<tr>
<td>Number of outcomes present in intervention group</td>
<td></td>
</tr>
<tr>
<td>Number of outcomes not present in intervention group</td>
<td></td>
</tr>
<tr>
<td>Number of outcomes present in control group</td>
<td></td>
</tr>
<tr>
<td>Number of outcomes not present in control group</td>
<td></td>
</tr>
<tr>
<td>Mean scores and SD of intervention group</td>
<td></td>
</tr>
<tr>
<td>Mean scores and SD of control group</td>
<td></td>
</tr>
</tbody>
</table>

** Please repeat the outcomes section if you have further estimates for subgroups**

Please enter any further comments not covered elsewhere:
### Appendix 8: Critical Appraisal Checklist for Study Two

Please complete part 1 for all study designs and complete the relevant sections for part 2, specific to study design. Score the answer to each question by ticking 0, 1 or 2:
0 – study does not meet criteria/answer question
1 – Study partially meets criteria/gives a partially satisfactory answer to the question
2 – Study fully meets criteria/gives a fully satisfactory answer to the question

<table>
<thead>
<tr>
<th>Part 1</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Screening questions</strong></td>
<td></td>
</tr>
<tr>
<td>Question</td>
<td>Comments</td>
</tr>
<tr>
<td>1</td>
<td>Did the study ask a clearly focused question?</td>
</tr>
<tr>
<td>Consider:</td>
<td>- Is the hypothesis/aim/objective of the study clearly described?</td>
</tr>
<tr>
<td>- Is the study question focused in terms of the outcomes considered?</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Is the study design appropriate for the research question?</td>
</tr>
</tbody>
</table>

**Continue only if score on each of questions 1 and 2 is one or more**

### Detailed questions

**Measurement of risk of selection bias**

<table>
<thead>
<tr>
<th>Detailed questions</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>3a</td>
<td>Is the sampling method appropriate for the research question?</td>
</tr>
<tr>
<td>Consider:</td>
<td>- The sampling method used (i.e. random selection of subjects)</td>
</tr>
<tr>
<td>- If applicable, is there appropriate selection of controls?</td>
<td></td>
</tr>
<tr>
<td>- Were participants in different groups recruited at the same time and from the same population?</td>
<td></td>
</tr>
<tr>
<td>3b</td>
<td>Are subjects appropriately defined?</td>
</tr>
<tr>
<td>Consider:</td>
<td>- Inclusion/exclusion criteria specified</td>
</tr>
<tr>
<td>- Inclusion/exclusion criteria appropriate</td>
<td></td>
</tr>
<tr>
<td>3c</td>
<td>Is the sample size appropriate?</td>
</tr>
<tr>
<td>Consider:</td>
<td>- Is the sample size justified?</td>
</tr>
<tr>
<td>- Were a sufficient number of cases selected?</td>
<td></td>
</tr>
<tr>
<td>- If applicable, were a sufficient number of controls selected?</td>
<td></td>
</tr>
<tr>
<td>3d</td>
<td>Is the study sample representative of the population of interest?</td>
</tr>
<tr>
<td>Consider:</td>
<td>- Do the authors assess the representativeness of the study sample?</td>
</tr>
<tr>
<td>3e</td>
<td>Does the level of non-participation risk introducing bias?</td>
</tr>
<tr>
<td>----</td>
<td>----------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Consider:</td>
</tr>
<tr>
<td></td>
<td>- Are key demographic characteristics of non-participants reported and compared against participants?</td>
</tr>
<tr>
<td></td>
<td>- Does the study report on the impact of non-participation?</td>
</tr>
<tr>
<td></td>
<td>- If applicable, are rates of attrition reported?</td>
</tr>
</tbody>
</table>

| 4  | Is the study setting appropriate to the aims of the research? (e.g. setting, location, relevant dates) |

<table>
<thead>
<tr>
<th>5</th>
<th>Were participants appropriately allocated to intervention and control groups?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Consider:</td>
</tr>
<tr>
<td></td>
<td>- Was the method of allocation described?</td>
</tr>
<tr>
<td></td>
<td>- Were the groups well balanced? Are any differences between groups reported?</td>
</tr>
<tr>
<td></td>
<td>- Was the method used to generate the sequence of randomisation described and appropriate (table of random numbers, computer-generated, etc.)?</td>
</tr>
<tr>
<td></td>
<td>- How were participant allocated to study groups (if applicable)? (i.e. blinding of participants/staff)</td>
</tr>
</tbody>
</table>

### Measurement of risk of reporting bias

<table>
<thead>
<tr>
<th>6a</th>
<th>Are suitable/standard criteria used for measurement of domestic violence?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Consider:</td>
</tr>
<tr>
<td></td>
<td>- Criteria of domestic violence was clearly defined</td>
</tr>
<tr>
<td></td>
<td>- Standardised/pre-validated measures (score 2 points)</td>
</tr>
<tr>
<td></td>
<td>- Researchers developed their own measure (score 1 point)</td>
</tr>
<tr>
<td></td>
<td>- No details of measurement were provided (score 0 point)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>6b</th>
<th>Are suitable/standard criteria used for measurement of outcomes?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Consider:</td>
</tr>
<tr>
<td></td>
<td>- Potential for bias of measurement:</td>
</tr>
<tr>
<td></td>
<td>- Were the main outcome measures used accurate (valid and reliable)?</td>
</tr>
<tr>
<td></td>
<td>- Were participants in all groups followed up similarly?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7a</th>
<th>Are known confounders accounted for by study design?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Consider:</td>
</tr>
<tr>
<td></td>
<td>- Was consideration of confounding factors accounted for in study design?</td>
</tr>
<tr>
<td></td>
<td>Question</td>
</tr>
<tr>
<td>---</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>7b</td>
<td>Are known confounders accounted for in the analyses?</td>
</tr>
<tr>
<td>8</td>
<td>Are the statistical tests used to assess the main outcomes appropriate?</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>9a</td>
<td>Are main effects reported and presented in detail by group (if appropriate)?</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>9b</td>
<td>Are statistically non-significant results presented?</td>
</tr>
<tr>
<td>9c</td>
<td>Are data for relevant variables complete?</td>
</tr>
<tr>
<td>9d</td>
<td>Have all important adverse events that may be a consequence of the intervention been reported?</td>
</tr>
<tr>
<td>10</td>
<td>Was the conduct of the fieldwork appropriate to the study setting?</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Were ethical considerations appropriately considered?</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Calculate total score of part 1 (out of a possible total of 44): ________

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>Do the findings support the conclusions?</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Are the strengths and weaknesses of the research discussed?</td>
<td></td>
</tr>
</tbody>
</table>

**options to all participants?**
- Were fieldworkers appropriately trained to deal with participant distress?
Appendix 9: Ethical Approval Form for Study Three

The Joint South London and Maudsley and The Institute of Psychiatry NHS Research Ethics Committee
South London REC Office (2)
1st Floor, Camberwell Building
94 Denmark Hill
London
SE5 9RS
Telephone: 020 3299 5033
Facsimile: 020 3299 5085

19 November 2007

Dr LM Howard
Senior Lecturer
Institute of Psychiatry
PO29 Health Service and Population Research Department
Institute of Psychiatry, De Crespigny Park
London
SE5 8RS

Dear Dr Howard

Full title of study: The Response of Mental Health Services to Domestic Violence Experienced by Mental Health Service Users

REC reference number: 07/H0807/66

Thank you for your letter of 07 November 2007, responding to the Committee’s request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion
On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

Ethical review of research sites
The Committee has designated this study as exempt from site-specific assessment (SSA). There is no requirement for [other] Local Research Ethics Committees to be informed or for site-specific assessment to be carried out at each site.

Conditions of approval
The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Approved documents
The final list of documents reviewed and approved by the Committee is as follows:

<table>
<thead>
<tr>
<th>Document</th>
<th>Version</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Application</td>
<td>1</td>
<td>24 September 2007</td>
</tr>
<tr>
<td>Investigator CV</td>
<td></td>
<td>25 September 2007</td>
</tr>
<tr>
<td>Protocol</td>
<td>1</td>
<td>08 September 2007</td>
</tr>
<tr>
<td>Covering Letter</td>
<td></td>
<td>10 September 2007</td>
</tr>
<tr>
<td>Peer Review</td>
<td>NIHR</td>
<td>02 August 2007</td>
</tr>
<tr>
<td>Interview Schedules/Topic Guides</td>
<td>1</td>
<td>22 August 2007</td>
</tr>
<tr>
<td>Advertisement</td>
<td>1</td>
<td>28 September 2007</td>
</tr>
<tr>
<td>Participant Information Sheet: For Participants</td>
<td>2</td>
<td>07 November 2007</td>
</tr>
<tr>
<td>Participant Information Sheet: For Staff</td>
<td>2</td>
<td>07 November 2007</td>
</tr>
<tr>
<td>Participant Consent Form: For Participants</td>
<td>2</td>
<td>07 November 2007</td>
</tr>
<tr>
<td>Participant Consent Form: Staff</td>
<td>1</td>
<td>22 August 2007</td>
</tr>
<tr>
<td>Response to Request for Further Information</td>
<td></td>
<td>07 November 2007</td>
</tr>
<tr>
<td>Co Collaborator CV (Dr D Rose)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interview Schedule - Staff</td>
<td>1</td>
<td>22 August 2007</td>
</tr>
<tr>
<td>Changes to Application</td>
<td>2</td>
<td>07 November 2007</td>
</tr>
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**R&D approval**

All researchers and research collaborators who will be participating in the research at NHS sites should apply for R&D approval from the relevant care organisation, if they have not yet done so. R&D approval is required, whether or not the study is exempt from SSA. You should advise researchers and local collaborators accordingly.

Guidance on applying for R&D approval is available from [http://www.rdforum.nhs.uk/rdform.htm](http://www.rdforum.nhs.uk/rdform.htm).

**Statement of compliance**

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.
**After ethical review**

Now that you have completed the application process please visit the National Research Ethics Website > After Review

Here you will find links to the following

a) Providing feedback. You are invited to give your view of the service that you have received from the National Research Ethics Service on the application procedure. If you wish to make your views known please use the feedback form available on the website.

b) Progress Reports. Please refer to the attached Standard conditions of approval by Research Ethics Committees.

c) Safety Reports. Please refer to the attached Standard conditions of approval by Research Ethics Committees.

d) Amendments. Please refer to the attached Standard conditions of approval by Research Ethics Committees.

e) End of Study/Project. Please refer to the attached Standard conditions of approval by Research Ethics Committees.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nationalres.org.uk.

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<th>07/H0807/66</th>
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With the Committee’s best wishes for the success of this project

Yours sincerely

**Tony Eaton,**

**Chair.**

Email: Chris.Ward@kch.nhs.uk

*Enclosures: Standard approval conditions, SL-AC2.*

Copy to: Ms Gill Lambert
Appendix 10: Interview Topic Guides for Study Three

**Topic Guide for Mental Health Service Users**

**Introduction:** Explain study verbally and check participants’ understanding and agreement to participate, including audio taping of interview. Check whether they would like to have a friend or advocate with them.

**Preamble:** We know many people experience domestic violence (sometimes known as domestic abuse) and we know that they may not be asked about their experience of this abuse or asked about their safety. We would like to ask you some questions about whether mental health professionals have asked you about domestic violence and what this was like for you. I want to be sure we are thinking about similar things - what we mean by domestic violence, sometimes called domestic abuse is being abused by another person psychologically, physically, sexually, financially or emotionally, physically, or sexually.

*There are no right or wrong answers to these questions*

1. What is your understanding of what domestic violence is?

2. Have you ever been asked about domestic violence by mental health care professionals such as psychiatrists, care coordinators etc.? If yes, what was your experience of this?
   
   **Probe for:**
   
   By whom?
   
   Did they speak to you about it on more than one occasion?
   
   How did it make you feel?
   
   Nature of the enquiry e.g. sensitively or insensitively asked
   
   Did you feel comfortable being asked by that person?
   
   Did you feel it was a good place to be asked about domestic violence?
   
   Were you hoping or wanting to be asked?
   
   Did anyone else ask you (any other mental health professionals/GP etc)?
   
   Did anyone write down what you said? Who was it?
   
   Have you ever felt like you couldn’t tell the worker anything? If so why?

3. Do you think that staff should ask all clients about domestic violence?

   *If not, why not? If yes, why?*
   
   a) Do you think they should ask only women? Only men? Or women and men?
   
   b) How do you think staff should ask about domestic violence?
   
   c) Do you think staff should ask people if they have ever been violent?

4. What has been your own experience of domestic violence?

   **Probe for:**
   
   By whom?
   
   For how long?
Nature of violence-emotional/physical/sexual/financial/restriction of movement

a) Have you ever been hurt by anyone else?

5. If participant has experienced domestic violence ask:
   Has any health professional ever known that you were experiencing domestic violence?
   Probe for:
   How did they find out? What did they say or do?
   Did they offer help?
   How did you feel about it?

6. When you were going through that was there anyone or anything that helped?

7. If staff know about domestic violence what do you think they should do?
   Probe for:
   What would you want the worker to do?

8. Do you feel mental health professionals have given you adequate choice as to how best to deal with your situation?

9. Is there anything else you can think of that may help people experiencing domestic violence?

10. Have you ever come across services for people who are being hurt by domestic violence?
    If yes, what happened?
    Probe for:
    What was helpful/unhelpful? Did you meet with them?

11. Have you ever been given information about what victims of domestic violence can do or what their rights are?

12. Is there anything else you would like to say about this issue that we haven’t covered?

13. Is there anything else you would like staff to do?

Thank the participant.

Closing note:
“Thank you for sharing your experiences, it’s very courageous of you and it has been a privilege to speak with you.
- How are you doing? How do you feel about it?
- If you would like to speak about this further we can discuss this with your care coordinator.

Domestic violence hotline: 0808 2000 247
Witness: 08454 500 300
Bede House: 020 7237 3881
**Topic Guide for Mental Health Professionals**

**Introduction:** Explain study verbally and check participants’ understanding and agreement to participate, including audio taping of interview. This study is exploring service user and staff attitudes about domestic violence and providing help. The outcome of this will inform the development of an intervention.

I’m interested in your own experiences of working with service users but also your thoughts and opinions of service delivery in general.

**Preamble:** We know many people experience domestic violence (sometimes known as domestic abuse). We would like to ask you some questions about your experience of working with service users who may be experiencing domestic violence. I want to be sure we are thinking about similar things - what we mean by domestic abuse or violence is being abused by another person psychologically, physically, sexually, financially or emotionally.

*There are no right or wrong answers to these questions*

1. Have you ever asked or talked about domestic violence with mental health service users?
   *Probe for:*
   - In what setting?
   - How often?
   - Did you ask the client or did they tell you?
   - How do you ask?
   - Or was there another way you found out?
   - Did you ask if they had discussed this before?

2. Do you think that staff should ask all clients about domestic violence? What would be the advantages and disadvantages of this?
   a. If no, why not? If yes, why?

3. Do you think they should just ask women? Or women and men?

4. What has been your experience of the nature of domestic violence experienced by mental health service users?
   *Probe for*
   - How frequent a problem?
   - By whom?
   - What was the nature of violence - emotional/physical/sexual/financial/restriction of movement?

5. Were children involved in any way? Witnessed violence? Experienced violence?
6. How do you think mental health professionals should address domestic violence?

7. How do you think staff should ask about domestic violence?
8. Do you think staff should ask people if they have ever been violent towards someone else?

9. What do you think has helped mental health service users you have known or you have known about through colleagues who were abused?
   
   Probe for:
   From whom?
   Nature of help?
   What hasn’t helped?

10. Do you know of services for people who are experiencing domestic violence?

11. If yes, have you given this information to clients experiencing domestic violence? Why? Why not?

12. To your knowledge have mental health service users you or colleagues have worked with known about or used services for people who are experiencing domestic violence?

13. Have you ever been given any training or information on the legal, welfare, and housing rights for people experiencing domestic violence?

14. Is there anything you would like to add about how mental health professionals should offer support?

Thank the participant.
The response of mental health services to domestic violence: a study into how mental health services address domestic violence: service users’ information sheet

Participant information sheet
We would like to invite you to take part in a research study which aims to investigate how mental health services respond to mental health service users experiencing domestic violence. Before you decide whether to take part you need to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.

What is the purpose of the study?
We know that mental health service users may suffer from domestic violence but most domestic violence remains undetected by mental health services. We are not sure how best to ask mental health service users about domestic violence or how best to help them if violence is being experienced. The study we would like you to consider participating in will help us investigate how and in what way mental health service users are asked about domestic violence and find out what service users believe would be most helpful for service users who are experiencing domestic violence. This study is a pilot study which will inform the design of a future specific treatment intervention study.

Why Have I Been Invited?
You are a mental health service user who may or may not have experienced domestic violence. We would like to obtain your views on the response of mental health services to domestic violence.

Do I have to take part?
No. It is up to you to decide whether or not to take part. We will describe the study and go through this information sheet, which we will then give to you. We will then ask you to sign a consent form to show you have agreed to take part. If you decide to take part you are still free to withdraw at any time and without giving a reason. This would not affect the standard of care you receive either now or at any time in the future.
What will happen to me if I take part?
If you agree to take part then you will be asked to participate in an interview. The interview will happen at a time that is convenient for you for about 30 minutes to one hour. We will ask you whether and how you have been asked about domestic violence, even if you personally have not ever experienced domestic violence. We will ask your views on being asked about domestic violence. If you have suffered from domestic violence we will ask what sort of help you have found helpful (or not) in the past and what you think would be helpful to mental health service users experiencing domestic violence in the future. We will also ask your views on what you think are the most important and meaningful measures of whether an intervention has been helpful. The interview will be taped for analysis after the meeting. The taped interviews will be written down before the tapes are destroyed. Anonymous quotes from the interviews will be used in reports and publications of the findings but no quotes will be used that could identify you to others. We offer £20 toward your time and any expenses incurred (e.g. travel costs).

What are the possible disadvantages of taking part?
The interview may be distressing as it will focus on questions about domestic violence. At the beginning of the interview you will therefore be asked if there is anyone you would like us to contact for support for you if you do become very distressed.

What if there is a problem?
If you have any concerns about any aspect of the study, you should ask to speak to the researchers who will do their best to answer your questions *number removed*. If you remain unhappy and wish to complain formally, you can do this through the NHS Complaints Procedure. Details can be obtained from the South London and Maudsley NHS Foundation Trust.

Will my taking part in this study be kept confidential?
All information which is collected about you during the course of the research will be kept strictly confidential. The only exception to this confidentiality will be if you disclose information which suggests a risk of serious danger to any person (including yourself), in which case the clinical staff involved in your care will be informed. Any information about you will have your name and address removed so that you cannot be recognised from it. Your care coordinator will be informed that you have taken part in this study unless you state otherwise.

What will happen to the results of the research study?
The results of this stage of this study are likely to be published as a report and may also be published as an academic publication. Copies will be available from [name removed], Health Service and Population Research Department, Institute of Psychiatry. You will not be identified in any presentation of the findings.

Who is organising and funding the research?
The National Institute for Health Research is funding this study and the South London and Maudsley NHS Foundation Trust is sponsoring the study.

Who has reviewed the study?
All research in the NHS is looked at by an independent group of people called a Research Ethics Committee to protect your safety, rights, wellbeing and dignity. This study has been reviewed and given favourable opinion by the Joint South London and Maudsley and the Institute of Psychiatry NHS Research Ethics Committee.

**Contact for further information:** Dr Louise Howard [email removed]
Local agencies that can help people experiencing domestic violence include Bede House 020 7237 3881, and Refuge free-phone helpline: 0808 2000 247.
You will be given one copy of this information sheet to keep with a signed consent form. Thank you for considering taking part in this study.

**CONSENT FORM**

Study number:
**Participant identification number:**

**Title of Project:** The response of mental health services to domestic violence: an investigation into how mental health services address domestic violence experienced by mental health service users

Name of Researcher: Dr Louise Howard

**Please initial box**

1. I confirm that I have read and understand the information sheet dated 7.11.2007 (version 2) for the above study. I have had the opportunity to consider the information, and to ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my legal rights being affected.

3. I agree/do not agree to my care coordinator being informed of my participation in the study.

4. I agree to take part in the above study.

5. I would like to receive feedback on the results of this study.

________________________ ________________ _________ _______
Name of Participant   Date   Signature

_________________________ ________________ ________ ________
Name of Person taking consent Date   Signature
The response of mental health services to domestic violence: an investigation into how mental health services address domestic violence: mental health professionals’ information sheet

Staff information sheet
We would like to invite you to participate in a study which aims to investigate how mental health services respond to mental health service users experiencing domestic violence. Before you decide whether to take part you need to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.

What is the purpose of the study?
Mental health service users are at increased risk of domestic violence but most domestic violence remains undetected by mental health services. It is not known how best to ask mental health service users about domestic violence or how best to help them if violence is being experienced. The study we would like you to consider participating in now will help us to establish the particular difficulties that may be associated with asking mental health service users about domestic violence, and find out from mental health professionals what they believe would be most helpful in helping service users who are experiencing domestic violence. This study is a pilot study which will inform the design of a specific treatment intervention study.

Why Have I Been Invited?
As described above, the views of mental health professionals from different backgrounds are important in establishing how services address domestic violence experienced by mental health service users.

Do I have to take part?
No. It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you can withdraw at any time and without giving a reason. This will have no effect on your employment.

What will happen to me if I take part?
If you agree to take part then you will be asked to participate in an interview. The interview will happen at a time that is convenient for you for about 30 minutes to discuss the issues mentioned above. The interview time will be arranged at a time that will not impact on your availability for the care of patients. You will be interviewed to explore your views about asking service users about domestic
violence, and how you feel service users who are experiencing domestic violence could be best helped. We will also ask what you think are the most meaningful and important ways of deciding whether or not particular interventions have been helpful. The interviews will be audiotaped and the interviews will be written down before the tapes are destroyed. The data will be anonymised. Anonymous quotes from the interviews will be used in reports and publications of the findings but no quotes will be used that could identify you to others.

**Will my taking part in this study be kept confidential?**

All information which is collected about you during the course of the research will be kept strictly confidential.

**What will happen to the results of the research study?**

The results of this stage of this study are likely to be published as a report and may also be published as an academic publication. Copies will be available from the Health Service And Population Research Department, Institute of Psychiatry. You will not be identified in any presentation of the findings from this study.

**Who is organising and funding the research?**

The National Institute for Health Research is funding this study and the South London and Maudsley NHS Foundation Trust is sponsoring the study.

**Who has reviewed the study?**

All research in the NHS is looked at by an independent group of people called a Research Ethics Committee to protect your safety, rights, wellbeing and dignity. This study has been reviewed and given favourable opinion by Joint South London and Maudsley and the Institute of Psychiatry NHS Research Ethics Committee.

**Contact for further information:** Dr Louise Howard

You will be given one copy of the staff information sheet to keep with a signed consent form.

Thank you for considering taking part in this study.
CONSENT FORM

Study number:

Participant identification number:

Title of Project: The response of mental health services to domestic violence: an investigation into how mental health services address domestic violence experienced by mental health service users

Name of Researcher: Dr Louise Howard

1. I confirm that I have read and understand the information sheet dated 22.08.07 (version 1) for the above study and have had the opportunity to ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my legal rights being affected.

3. I agree to take part in the above study.

4. I would like to receive feedback on the results of this study.

__________________________________________  ______________________  ______________________
Name of Participant   Date   Signature

__________________________________________  ______________________  ______________________
Name of Person taking consent   Date   Signature
Appendix 12: Finalised NVivo coding frame for Study Three

Nvivo8 Finalised coding frame (organised by super-ordinate and sub-ordinate themes)

Children

Impact of abuse on children
- Witnesses of abuse
- Children as victims of abuse

Child Protection
- Acting protectingly of children
- Awareness of child protection issues

Losing Children
- Threats by the abuser
- Child Removal

Abusers relationship with children

Coded themes are presented in alphabetical order and not by order of importance
(N.B. Bracketed information refers to the categories that constitute sub-ordinate themes)
Coded themes are presented in alphabetical order and not by order of importance
(N.B. Bracketed information refers to the categories that constitute sub-ordinate themes)
Disclosure of domestic violence

Barriers to disclosure

- Fear of consequences (disclosures not believed, further violence, social services involvement, disruption to family, immigration status)
- Dominance of the medical model
- Hidden nature of DV (not recognising abuse, abuser disguises abuse, professional failure to identify abuse)
- Blaming attitudes (self-blame)
- Gender
- Culture (cultural expectations)
- Abusers actions to prevent disclosure (isolating friends and family)
- Psychological distress
- Shame and embarrassment

Experience of disclosure

- Facilitators to disclosure (concern for children's welfare, enquiry from professionals, severity of violence, time passed since abuse)
- Lack of engagement between client and professional

Barriers to enquiry

- Lack of knowledge and expertise (discomfort with topic, lack of confidence, complexity of DV)
- Dominance of the medical model
- Fear of consequences (offending, re-traumatisation)
- Limited opportunity to enquire (presence of partner, time constraints, competing demands)
- Enquiry not part of professional role
- Domestic violence not a priority
- No indication of violence
- Gender
- Culture
- Questioning evidence for enquiry

Coded themes are presented in alphabetical order and not by order of importance
(N.B. Bracketed information refers to the categories that constitute sub-ordinate themes)
Coded themes are presented in alphabetical order and not by order of importance
(N.B. Bracketed information refers to the categories that constitute sub-ordinate themes)
Routine Enquiry

Opinion of routine enquiry

Sensitivity (determining the right time to ask, teasing out)
Explicit (routine assessment)
Implicit (exploring presenting symptoms and close relationships)
Asking men and women

Asked about domestic violence

Have been asked
Have not been asked

Asking about domestic violence

Have spoken about DV
Have not spoken about DV

Enquiry about perpertation of abuse

Coded themes are presented in alphabetical order and not by order of importance
(N.B. Bracketed information refers to the categories that constitute sub-ordinate themes)
Domestic violence services
- Counselling
- Refuge
- Women's Aid

Non-domestic violence services
- Police
- GPs
- Victim Support
- Social Services
- Solicitors
- Housing Association
- Hospital
- Samaritans
- Substance-misuse services

Knowledge of services
- Staff knowledge (good, limited, no knowledge)
- Service user knowledge (limited, no knowledge)

Coded themes are presented in alphabetical order and not by order of importance
(N.B. Bracketed information refers to the categories that constitute sub-ordinate themes)
Understanding of domestic violence

Service users understanding
- Defining DV (increasing problem)
  - Establishing blame (abuser blames survivor, self-blame)
  - Explanations for DV (acceptability of DV, characteristics of victim, learnt behaviours, motivations, situational stresses)
  - Impact of abuse (on feelings, physical health, mental health, future relationships)
  - Pattern of abuse (hidden nature of DV, responses, ending abuse)
- Recovery

Staff understanding
- Acceptability of DV (cultural influences, defining DV)
- Establishing blame (evidencing abuse)
- Explanations (anger, exploiting vulnerabilities, partner struggles to manage mental illness, situational stresses)
- Impact of abuse (feelings, long-term difficulties, mental illness and DV)
- Pattern of abuse (ending the abuse, frequency and severity of abuse, hidden nature of abuse, multiple abusive relationships)
- Recovery (improving self-esteem, talking about abuse)

Coded themes are presented in alphabetical order and not by order of importance
(N.B. Bracketed information refers to the categories that constitute sub-ordinate themes)
### Appendix 13: Service User Typologies of ‘Understanding of Domestic Violence’ for Study Three

#### Understanding of Domestic Violence: ‘Unknowing’ Types

<table>
<thead>
<tr>
<th>Experience of mental illness</th>
<th>Experience of child abuse</th>
<th>Understanding of DV</th>
<th>Emotional and psychological impact of DV</th>
<th>Barriers to disclosure</th>
<th>Experience of disclosure</th>
<th>Barriers to help seeking</th>
<th>Unhelpful</th>
<th>Needs</th>
<th>Other</th>
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<tbody>
<tr>
<td>Mental illness exacerbated during DV (mental illness and DV lowered self-worth)</td>
<td>None disclosed</td>
<td>Abusers internal anger/self-loathing projected on to survivor</td>
<td>Self-blame</td>
<td>Survivor unaware she was experiencing DV (hidden nature of DV)</td>
<td>Reached crisis point with regards to the impact of abuse on psychological and emotional</td>
<td>Self-blame for abuse (directed by abuser)</td>
<td>Mental health services focused predominately on mental illness</td>
<td>Emotional support</td>
<td>Counselling</td>
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<tr>
<td>Mental illness exacerbated during DV before DV</td>
<td>None disclosed</td>
<td>Survivors need for affection Abusers internal anger/self-loathing projected on to survivor</td>
<td>Self-blame Guilt Fear Attachment to abuser Feeling a “half-person” Exacerbation of mental illness</td>
<td>Survivor unaware she was experiencing DV (hidden nature of DV)</td>
<td>When admitted to A&amp;E, following injury from physical abuse, was provided with information on DV Later disclosed experience to GP (after separation from abuser)</td>
<td>Did not realise it was DV Feeling trapped Self-blame (blamed mental illness for abuse experienced) Shame of mental illness meant she did not seek help for deteriorating mental health</td>
<td>Police response (felt only temporary measure of protection) Unsupportive housing services Negative response from Women’s Aid (refused access)</td>
<td>Definition of DV advertised Information on DV Emotional support Practical support Challenge abusers behaviour (absolve blame)</td>
<td>Abuser exploited illness to the extent that she was unsure what was reality</td>
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- Police response (felt only temporary measure of protection)
- Unsupportive housing services
- Negative response from Women’s Aid (refused access)
- Definition of DV advertised
- Information on DV
- Emotional support
- Practical support
- Challenge abusers behaviour (absolve blame)
- Abuser exploited illness to the extent that she was unsure what was reality
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<td>children</td>
<td>prevent disclosure</td>
<td>health: Disclosed to Refuge</td>
<td>capacity to seek help</td>
<td>temporary measure of protection)</td>
<td>Refuge (no time to talk about DV)</td>
<td>Cost of help-lines</td>
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<td>Self-medicating (post separation)</td>
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<td>Fear of future relationships</td>
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<td>Felt DV caused mental illness</td>
<td>None disclosed</td>
<td>Cowardice of abuser</td>
<td>Self-blame</td>
<td>Survivor unaware she was experiencing DV (hidden nature of DV)</td>
<td>Isolation Self-blame (directed by abuser)</td>
<td>Isolation</td>
<td>Limited response from Victim Support</td>
<td>Emotional support</td>
<td>Regain sense of self</td>
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<td>Abusers pathological jealousy</td>
<td>Anger</td>
<td>Cause of mental illness</td>
<td>Self-blame</td>
<td>Not ready to discuss DV</td>
<td>Dedication</td>
<td>Mental health services focused predominantly on mental illness</td>
<td>Challenge abusers behaviour</td>
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<td>Flashbacks (post separation)</td>
<td>Fear of disruption to family</td>
<td>Putting abuse to the back of their mind</td>
<td>Doctors identified attack as potentially life-threatening.</td>
<td>Isolation</td>
<td>Limited response from Victim Support</td>
<td>Emotional support</td>
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<td>Later disclosed to police</td>
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<td>Felt DV caused</td>
<td>None disclosed</td>
<td>Social constraints</td>
<td>Fear of</td>
<td>Survivor unaware she was experiencing DV (hidden nature of DV)</td>
<td>Reached crisis point</td>
<td>Marital ties Impact of</td>
<td>Police (response)</td>
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<tr>
<td>(Believes mental illness can make people vulnerable to abuse)</td>
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<tr>
<td>Felt DV was the contributing, if not, main reason for mental illness breakdown</td>
<td>None disclosed</td>
<td>Abusers manipulation</td>
<td>Cause of mental illness</td>
<td>Survivor unaware she was experiencing DV (hidden nature of DV) Impact on children (custody) Abuser disguises</td>
<td>Later disclosed to care coordinator (after separation from abuser)</td>
<td>Fear of losing children</td>
<td>Mental health record (stigma of mental illness meant abuse not acknowledged) Mental health services focused predominantly</td>
<td>Emotional support</td>
<td>Went to housing office for support but told she would have to remain in house</td>
</tr>
<tr>
<td>Experience of mental illness</td>
<td>Experience of child abuse</td>
<td>Understanding of DV</td>
<td>Emotional and psychological impact of DV</td>
<td>Barriers to disclosure</td>
<td>Experience of disclosure</td>
<td>Barriers to help seeking</td>
<td>Unhelpful Needs</td>
<td>Other</td>
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<tr>
<td>Felt DV caused mental illness</td>
<td>None disclosed</td>
<td>Abusers pathological jealousy</td>
<td>Fear Psychological distress Cause of mental illness</td>
<td>Survivor unaware she was experiencing DV (hidden nature of DV) Fear of disruption to family Embarrassment of labelling self as experiencing DV</td>
<td>Later disclosed to care coordinator (after separation from abuser)</td>
<td>Did not realise it was DV Feeling trapped Experience of mental illness (limited capacity to seek help) Embarrassment of labelling self as experiencing DV</td>
<td>Mental health services focused predominantly on mental illness Police (offered to change locks but help did not materialise)</td>
<td>Definition of DV advertised Improved professional understanding of DV Practical support Safety Information on nature and impact of DV Talking about DV</td>
<td></td>
</tr>
</tbody>
</table>

Note: In order to protect the anonymity of respondents all research IDs and identifiable characteristics have been omitted from these tables
## Understanding of Domestic Violence: ‘Accountable’ Types

<table>
<thead>
<tr>
<th>Experience of mental illness</th>
<th>Experience of child abuse</th>
<th>Understanding of DV</th>
<th>Emotional and psychological impact of DV</th>
<th>Barriers to disclosure</th>
<th>Experience of disclosure</th>
<th>Barriers to help seeking</th>
<th>Unhelpful</th>
<th>Needs</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental illness exacerbated during DV (sectioned and diagnosed with bipolar when experiencing DV)</td>
<td>Experienced child abuse</td>
<td>Felt they were partly accountable for DV as they had learnt violent behaviours from witnessing or experiencing childhood abuse</td>
<td>Exacerbated mental illness Negative impact on establishing and maintaining future relationships Difficulties in developing attachments with others</td>
<td>Embarrassment of labelling self as experiencing DV</td>
<td>When admitted to hospital, following injury from physical abuse, was referred to DV service Embarrassed when disclosed</td>
<td>Limited awareness of DV behaviours</td>
<td>Nothing reported</td>
<td>Talking Emotional support</td>
<td>Feels she will no longer accept abuse from another person</td>
</tr>
<tr>
<td>Experienced mental illness prior to violent relationship Mental illness exacerbated during DV</td>
<td>Experienced child abuse</td>
<td>Felt they were partly accountable for DV as they had learnt violent behaviours from witnessing or experiencing of childhood abuse Cultural acceptance of violence in intimate and familial</td>
<td>Psychological distress Anger Self-blame Impact on children Negative impact on establishing and maintaining future relationships</td>
<td>Putting abuse to back of mind</td>
<td>Later disclosed to care coordinator (after separation from abuser)</td>
<td>Felt she was able to deal with the situation on her own, talks about the need to be “self-motivated”</td>
<td>Refuge (did not want to leave home and relocate) Negativity in social contacts Response offered from services did not meet needs</td>
<td>Internal strength and courage Social contacts Emotional support Talking about DV Challenge abusers behaviour Support to understand patterns of</td>
<td></td>
</tr>
</tbody>
</table>

As a child received child guidance but did not discuss the violence at home
<table>
<thead>
<tr>
<th>Experience of mental illness</th>
<th>Experience of child abuse</th>
<th>Understanding of DV</th>
<th>Emotional and psychological impact of DV</th>
<th>Barriers to disclosure</th>
<th>Experience of disclosure</th>
<th>Barriers to help seeking</th>
<th>Unhelpful</th>
<th>Needs</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>None reported prior to DV</td>
<td>Experienced child abuse</td>
<td>Felt they were partly accountable for DV as they had learnt violent behaviours from witnessing or experiencing childhood abuse</td>
<td>Anger Cause of mental illness</td>
<td>Putting abuse to back of mind</td>
<td>No disclosure made to professionals</td>
<td>Felt she was able to deal with situation on her own</td>
<td>Unsupported with practical and emotional issues related to abuse (post separation)</td>
<td>Talking about DV Emotional support Information on DV Clinicians understanding of DV Practical support Enquiry Support to understand patterns of re-victimisation</td>
<td></td>
</tr>
<tr>
<td>Experience of mental illness prior to violent relationship</td>
<td>Experienced child abuse</td>
<td>Felt they were partly accountable for DV as they had learnt violent behaviours from witnessing or experiencing</td>
<td>Anger Fear of abandonment</td>
<td>Blaming attitudes Fear of disruption to family</td>
<td>No disclosure made to professionals</td>
<td>Felt he was able to deal with the situation on his own</td>
<td>Police arrested him as sole perpetrator of DV Couple Counselling to maintain relationship and overcome DV</td>
<td>Would like support to re-establish relationship with partner and to have greater contact</td>
<td></td>
</tr>
<tr>
<td>Experience of mental illness</td>
<td>Experience of child abuse</td>
<td>Understanding of DV</td>
<td>Emotional and psychological impact of DV</td>
<td>Barriers to disclosure</td>
<td>Experience of disclosure</td>
<td>Barriers to help seeking</td>
<td>Unhelpful</td>
<td>Needs</td>
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<tr>
<td></td>
<td>childhood abuse</td>
<td>Cultural acceptance of violence in intimate and familial relationships</td>
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</table>

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# Understanding of Domestic Violence: ‘Vulnerable’ Types

<table>
<thead>
<tr>
<th>Experience of mental illness</th>
<th>Experience of child abuse</th>
<th>Understanding of DV</th>
<th>Emotional and psychological impact of DV</th>
<th>Barriers to disclosure</th>
<th>Experience of disclosure</th>
<th>Barriers to help seeking</th>
<th>Unhelpful Needs</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experienced mental illness prior to violent relationship</td>
<td>Experienced child abuse</td>
<td>Survivor felt she had vulnerabilities that were exploited by the abuser</td>
<td>Fear Escalating depression Inability to trust others Self-medicating and flashbacks of abuse (post separation)</td>
<td>No barriers reported (felt ready to talk)</td>
<td>Reached crisis point with regards to the impact of abuse on psychological and emotional health: Disclosed to Social Services</td>
<td>Concerns about relocating family Feeling unsupported in previous contact with services</td>
<td>Cost of help lines Limited opportunity to talk about DV Professionals response to children negative Disclosure not believed (lack of evidence cited)</td>
<td>Advice and emotional support Counselling Support for children Multi-agency collaboratio n between DV and mental health services Challenge abusers behaviour</td>
</tr>
<tr>
<td>Mental illness exacerbated during DV</td>
<td></td>
<td>Survivor felt she had vulnerabilities that were exploited by the abuser Cultural acceptance of violence in intimate and familial relationships</td>
<td></td>
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</tr>
<tr>
<td>Unclear (rarely discussed but was seeking mental health services during DV relationship)</td>
<td>Experienced child abuse</td>
<td>Survivor felt she had vulnerabilities that were exploited by the abuser</td>
<td>Fear Chaos Feeling “stuck” in the relationship Insecure immigration status</td>
<td>Insecure immigration status Limited rapport with health professional Not wanting to discuss problems Fear</td>
<td>Admitted to hospital, following injury from physical abuse, and referred to Social services: Disclosed to Social Services and</td>
<td>Fear of impact on immigration status</td>
<td>Lack of support from services Limited opportunity to talk about DV Unsupported with practical and emotional</td>
<td>Talking about DV Emotional support Professional understandin g of DV Legal sanctions for immigrants experiencing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cultural acceptance of violence in intimate and familial</td>
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</tbody>
</table>

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<table>
<thead>
<tr>
<th>Experience of mental illness</th>
<th>Experience of child abuse</th>
<th>Understanding of DV</th>
<th>Emotional and psychological impact of DV</th>
<th>Barriers to disclosure</th>
<th>Experience of disclosure</th>
<th>Barriers to help seeking</th>
<th>Unhelpful needs</th>
<th>Other needs</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Felt DV caused mental illness</td>
<td>Experience of child abuse</td>
<td>Survivor felt she had vulnerabilities that were exploited by the abuser</td>
<td>Shock</td>
<td>Embarrassment of labelling self as a victim of DV</td>
<td>Reached crisis point with regards to the impact of abuse on psychological and emotional health: Disclosed to care coordinator</td>
<td>Psychologic distress  Professionals focus on mental illness</td>
<td>Mental health services focused predominantly on mental illness  Unsupported with practical and emotional issues post separation</td>
<td>Improved professional to response to disclosure  Emotional and practical support from professionals  Adverts of support services</td>
<td>DV Support helplines</td>
</tr>
<tr>
<td>Experience of mental illness prior to violent relationship  Mental illness exacerbated during DV</td>
<td>Experience of child abuse</td>
<td>Survivor felt she had vulnerabilities that were exploited by the abuser</td>
<td>Fear</td>
<td>Self-blame  Abuser disguises abuse</td>
<td>No disclosure to health professionals but felt they were aware of abuse</td>
<td>Financial and emotional dependency on abuser</td>
<td>Professionals failure to respond to disclosure  Mental health services focused predominantly on mental illness  Stigma of mental illness</td>
<td>Counselling  Emotional support  Adverts of support services  Information on DV Safety support  Legal support</td>
<td>Abuser financially exploited sickness benefit  Feels after violent relationship, sabotaged good relationships as felt undeserving</td>
</tr>
<tr>
<td>Experience of mental illness</td>
<td>Experience of child abuse</td>
<td>Understanding of DV</td>
<td>Emotional and psychological impact of DV</td>
<td>Barriers to disclosure</td>
<td>Experience of disclosure</td>
<td>Barriers to help seeking</td>
<td>Unhelpful Needs</td>
<td>Other</td>
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<tr>
<td>Experiencing mental illness from witnessing or experiencing childhood abuse</td>
<td>and maintaining future relationships</td>
<td>Embarrassment of labelling self as experiencing DV</td>
<td>Reached crisis point with regards to the impact of abuse on psychological and emotional health: Disclosed to Social Services</td>
<td>Social isolation</td>
<td>Blaming attitudes Professionals failure to respond to disclosure Waiting lists for DV services</td>
<td>Counselling Drop in centres Emotional support Legal support</td>
<td>Experience directed from services Feels abuser received more support than she did</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Experience of child abuse</td>
<td></td>
<td>Embarrassment of labelling self as experiencing DV</td>
<td>Reached crisis point with regards to the impact of abuse on psychological and emotional health: Disclosed to Social Services</td>
<td>Social isolation</td>
<td>Blaming attitudes Professionals failure to respond to disclosure Waiting lists for DV services</td>
<td>Counselling Drop in centres Emotional support Legal support</td>
<td>Experience directed from services Feels abuser received more support than she did</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Felt DV caused mental illness</td>
<td>Experience of child abuse</td>
<td>Embarrassment of labelling self as experiencing DV</td>
<td>Reached crisis point with regards to the impact of abuse on psychological and emotional health: Disclosed to Social Services</td>
<td>Social isolation</td>
<td>Blaming attitudes Professionals failure to respond to disclosure Waiting lists for DV services</td>
<td>Counselling Drop in centres Emotional support Legal support</td>
<td>Experience directed from services Feels abuser received more support than she did</td>
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</tr>
<tr>
<td>Experience of mental illness</td>
<td>Experience of child abuse</td>
<td>Understanding of DV</td>
<td>Emotional and psychological impact of DV</td>
<td>Barriers to disclosure</td>
<td>Experience of disclosure</td>
<td>Barriers to help seeking</td>
<td>Unhelpful Needs</td>
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</tr>
<tr>
<td>None disclosed</td>
<td>Survivor felt she had vulnerabilities that were exploited by the abuser</td>
<td>Anger</td>
<td>Embarrassment of labelling self as experiencing DV (related to gender identity) Blaming attitudes Putting abuse to back of mind</td>
<td>Did not disclose</td>
<td>None reported, felt he was able to deal with situation on his own</td>
<td>Police arrested him as sole perpetrator</td>
<td>Couple Counselling</td>
<td>Would like support to re-establish relationship with partner and to have greater contact with their child</td>
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</tbody>
</table>

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## Appendix 14: Professional Typologies of ‘Perception of Professional Role’ for Study Three

### Perception of Professional Role: ‘Embracing’ Types

<table>
<thead>
<tr>
<th>Experience of DV seen in clinical practice</th>
<th>Identification of DV</th>
<th>Organisational approach/awareness of DV</th>
<th>Experience of enquiry of DV</th>
<th>Approach to enquiry</th>
<th>Barriers to enquiry</th>
<th>Response to DV</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial exploitation by children</td>
<td>Home visitations</td>
<td>Current practices are more likely to identify community violence perpetrated against service users</td>
<td>Has asked service users Not something service users readily disclose</td>
<td>Preference to explore quality of relationships (identifying problems and difficulties) Ask men and women</td>
<td>Fear of offending service users but risk worth taking Competing demands</td>
<td>Generate discussions about DV experiences Provide information on support services Referral to DV services (previous referral service user found unhelpful, as services were not understanding of her cultural needs) Encourage reporting (if service user at risk consider reporting requirements) On-going support process (complexity of DV) Improve service users self-esteem (i.e.</td>
<td>Generate discussions about DV experiences Provide information on support services Referral to DV services (previous referral service user found unhelpful, as services were not understanding of her cultural needs) Encourage reporting (if service user at risk consider reporting requirements) On-going support process (complexity of DV) Improve service users self-esteem (i.e.</td>
</tr>
<tr>
<td>Sexual violence</td>
<td>Behaviours of family (describes case of financial exploitation whereby children always had new clothes etc. but mother had no money for heating) Presence of partner at every appointment (if suspect DV will find opportunity to see patient alone and in confidence)</td>
<td>Improved identification of policies on DV Need to generate greater discourse about DV Inclusion of DV enquiry in CPA Need for staff training about DV (improve confidence to identify and respond to DV)</td>
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<tr>
<td>Mutual violence (DV cases often complex)</td>
<td></td>
<td></td>
<td>Has asked service users Not something service users readily disclose</td>
<td>Preference to explore quality of relationships (identifying problems and difficulties) Ask men and women</td>
<td>Fear of offending service users but risk worth taking Competing demands</td>
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</tr>
<tr>
<td>Controlling partners (attending all health appointments)</td>
<td></td>
<td></td>
<td>Has asked service users Not something service users readily disclose</td>
<td>Preference to explore quality of relationships (identifying problems and difficulties) Ask men and women</td>
<td>Fear of offending service users but risk worth taking Competing demands</td>
<td>Generate discussions about DV experiences Provide information on support services Referral to DV services (previous referral service user found unhelpful, as services were not understanding of her cultural needs) Encourage reporting (if service user at risk consider reporting requirements) On-going support process (complexity of DV) Improve service users self-esteem (i.e.</td>
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</tr>
<tr>
<td>Cultural issues (rejection from family and community)</td>
<td></td>
<td></td>
<td>Has asked service users Not something service users readily disclose</td>
<td>Preference to explore quality of relationships (identifying problems and difficulties) Ask men and women</td>
<td>Fear of offending service users but risk worth taking Competing demands</td>
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</tr>
<tr>
<td>Repetitive cycle of DV relationships</td>
<td></td>
<td></td>
<td>Has asked service users Not something service users readily disclose</td>
<td>Preference to explore quality of relationships (identifying problems and difficulties) Ask men and women</td>
<td>Fear of offending service users but risk worth taking Competing demands</td>
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<tr>
<td>Survivors may agree to leave abuser then decide to stay</td>
<td></td>
<td></td>
<td>Has asked service users Not something service users readily disclose</td>
<td>Preference to explore quality of relationships (identifying problems and difficulties) Ask men and women</td>
<td>Fear of offending service users but risk worth taking Competing demands</td>
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</tr>
<tr>
<td>Mentally ill people are vulnerable to DV by those close to them</td>
<td></td>
<td></td>
<td>Has asked service users Not something service users readily disclose</td>
<td>Preference to explore quality of relationships (identifying problems and difficulties) Ask men and women</td>
<td>Fear of offending service users but risk worth taking Competing demands</td>
<td>Generate discussions about DV experiences Provide information on support services Referral to DV services (previous referral service user found unhelpful, as services were not understanding of her cultural needs) Encourage reporting (if service user at risk consider reporting requirements) On-going support process (complexity of DV) Improve service users self-esteem (i.e.</td>
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<tr>
<td>DV impacts on mental health</td>
<td></td>
<td></td>
<td>Has asked service users Not something service users readily disclose</td>
<td>Preference to explore quality of relationships (identifying problems and difficulties) Ask men and women</td>
<td>Fear of offending service users but risk worth taking Competing demands</td>
<td>Generate discussions about DV experiences Provide information on support services Referral to DV services (previous referral service user found unhelpful, as services were not understanding of her cultural needs) Encourage reporting (if service user at risk consider reporting requirements) On-going support process (complexity of DV) Improve service users self-esteem (i.e.</td>
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<tr>
<td>Can lead to development of</td>
<td></td>
<td></td>
<td>Has asked service users Not something service users readily disclose</td>
<td>Preference to explore quality of relationships (identifying problems and difficulties) Ask men and women</td>
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<td>Experience of enquiry of DV</td>
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<tr>
<td>PTSD</td>
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<tr>
<td>Sensitivity of response by clinicians (describes example of a Care Coordinator who attempted to soothe service user by putting their arm around them, this upset the service user)</td>
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<tr>
<td>Controlling behaviours</td>
<td>If service user pregnant explores circumstances around pregnancy (i.e. planned birth, supportive partner)</td>
<td>Mental health team has details of non DV specific services that can be given to service users Need for increased staff awareness of DV</td>
<td>Has asked service users Not something service users readily disclose</td>
<td>Preference to explore quality of relationships (identifying problems and difficulties) Ask men and women If suspect DV explore in semi-structured way (exploring times of conflict etc.)</td>
<td>None identified</td>
<td>Risk assessment of survivor and their children (describes example of case where abuser had attacked a child so the police had to be involved) Initiate adult protection policies Refer to DV and therapeutic support services Improve social support Address repetitive nature of DV relationships</td>
<td>Know of service users who have used DV services but feels most reluctant to acknowledge abuse Not received specific DV training Scope for couple counselling</td>
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<tr>
<td>Experience of DV seen in clinical practice</td>
<td>Identification of DV</td>
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<td>Experience of enquiry of DV</td>
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<td>Barriers to enquiry</td>
<td>Response to DV</td>
<td>Other</td>
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<tr>
<td>fluctuate between violent and loving episodes</td>
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<td>Evidence DV</td>
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<tr>
<td>Repetitive cycle of DV relationships</td>
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<td>Complex situation</td>
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<td>Service users vulnerable to DV and hard for them to communicate problems when ill</td>
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<td>(i.e. separation of family, abuser might be crucial in keeping custody of children)</td>
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<tr>
<td>DV impacts on mental health</td>
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<tr>
<td>Need for affection</td>
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<tr>
<td>Wish to protect abuser (financial constraints, abusers often good fathers)</td>
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| Physical abuse | Physical abuse not frequently observed in practice | Lack of understanding of DV | Lack of knowledge of DV (i.e. what to look for, how to respond) | Focus on risk to carer not service users | Vulnerable adults policy not that helpful in practice | Need for staff training about DV | Has asked service users | Facilitated by good engagement with service users | Service users disclosure of DV dismissed by mental health teams (describes example) | Part of clinical assessment | Preference to ask directly (otherwise cases may be missed) | Dominance of the medical model (unless obvious not likely to be picked up) | Need to explore disclosures and not dismiss as reflective of illness | If children involved follow child protection procedures | Needs proactive response by staff | Need support from colleagues (tried to support) | Used resource books to find services for DV | Not received specific DV training | Lack of continuity of care for service users disclosing DV |
|----------------|-----------------------------------------------|-----------------------------|-------------------------------------------------------------|----------------------------------|---------------------------------------------------------------|-------------------------------|---------------------------------|---------------------------------|-------------------------------------------------------------|---------------------------|----------------------------------|---------------------------------------------------------------|---------------------------------|----------------------------------|---------------------------------|-----------------------------------------------|---------------------------------|-----------------------------------------|

486
<table>
<thead>
<tr>
<th>Experience of DV seen in clinical practice</th>
<th>Identification of DV</th>
<th>Organisational approach/awareness of DV</th>
<th>Experience of enquiry of DV</th>
<th>Approach to enquiry</th>
<th>Barriers to enquiry</th>
<th>Response to DV</th>
<th>Other</th>
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</thead>
<tbody>
<tr>
<td>(improve confidence to identify and respond to DV) Need training on enquiry of DV (useful to have screening tool, easier to ask as part of assessment than to bring up in general conversation) Unsupported by manager in previous DV case Conflict between supporting service user and the line of response by CMHTs</td>
<td>Picking up on signs of DV</td>
<td>Need for increased awareness of DV Vulnerable adults policies now in place (not yet used them for DV case) Staff need training on DV Currently discretion of staff as to asking about DV Need clinical team</td>
<td>Has asked service users Not something service users readily disclose (needs to be teased out) Preference to ask directly (otherwise cases may be missed) Enquiry needs to be sensitive</td>
<td>None identified</td>
<td>Response needs to be individually tailored to each case Clinical team discussions on options for response to DV Referral to police Important to respond, service users should not</td>
<td>service users disclosure and reported to manager who dismissed claims) Unsure how to respond sufficiently Long process (complex nature of DV relationships) Used vulnerable adults policy, not found to be that helpful</td>
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<tr>
<td>Physical abuse Financial abuse DV cases often involve heavy drinking at time of incidents Men and women both experience DV Stigma associated with DV, similar to that which used to be associated with</td>
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<tr>
<td>Picking up on signs of DV</td>
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<td>Response needs to be individually tailored to each case Clinical team discussions on options for response to DV Referral to police Important to respond, service users should not</td>
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<td></td>
<td>Feels renewed police response to DV has encouraged response of other services Some knowledge of DV services</td>
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<tr>
<td>HIV</td>
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<td>discussions on how to enquire/respond to DV</td>
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<td>be left holding it</td>
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<tr>
<td>Hard for some people to leave DV relationships</td>
<td></td>
<td>Inconsistency of mental health services (i.e. staff turnover) influences service users willingness to disclose</td>
<td></td>
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<td></td>
<td>On-going support (need to remain in contact with service users)</td>
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<tr>
<td>Impact on DV on children</td>
<td></td>
<td>Need for standardised DV procedures</td>
<td></td>
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<td></td>
<td>Has received some DV training</td>
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<td></td>
<td>Need consistency of care with service users (found disclosures of abuse became more frequent when seeing service users regularly)</td>
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<tr>
<td>Financial abuse</td>
<td>Intuition of problems through contact with service users (need to explore service users experiences)</td>
<td>Need greater organisational awareness of DV</td>
<td>Has asked service users</td>
<td>Preference to ask directly (otherwise cases may be missed)</td>
<td>None identified</td>
<td>Record disclosures</td>
<td></td>
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<tr>
<td>Emotional and psychological abuse</td>
<td>Cultural issues relating to DV</td>
<td>Greater consideration of DV as a health risk</td>
<td>Facilitated by good engagement with service users</td>
<td>Explores relationships and social situations and how these can impact on mental illness</td>
<td></td>
<td>Display willingness to listen to DV experiences</td>
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<tr>
<td>Controlling behaviours</td>
<td></td>
<td>Inclusion of DV enquiry in CPA</td>
<td>Service users may be fearful of consequences if disclosed</td>
<td>Collaborative working with service user (importance of not taking over</td>
<td></td>
<td>Supports service users in reflecting on experiences</td>
<td></td>
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<tr>
<td>Threats of violence</td>
<td></td>
<td>Mental health service response needs to include greater support for service users (current onus on survivors to seek</td>
<td>Ask men and</td>
<td></td>
<td></td>
<td>Specific immigration issues</td>
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<td>(e.g. abusers may threaten women migrants that if they report the abuse they will be deported)</td>
<td></td>
<td>Important to enquire in</td>
<td></td>
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<td></td>
<td>Not received specific DV training</td>
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<tr>
<td>Cultural issues</td>
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</table>

- **HIV**
  - Hard for some people to leave DV relationships
  - Impact on DV on children

- **Financial abuse**
  - Intuition of problems through contact with service users (need to explore service users experiences)
  - Cultural issues relating to DV

- **Emotional and psychological abuse**
  - Need greater organisational awareness of DV
  - Greater consideration of DV as a health risk
  - Inclusion of DV enquiry in CPA
  - Mental health service response needs to include greater support for service users (current onus on survivors to seek
  - Important to enquire in

- **Controlling behaviours**
  - Threats of violence (e.g. abusers may threaten women migrants that if they report the abuse they will be deported)
  - Cultural issues

- **Barriers to enquiry**
  - Need for standardised DV procedures
  - Inconsistency of mental health services (i.e. staff turnover) influences service users willingness to disclose
  - Need for standardised DV procedures

- **Response to DV**
  - be left holding it
  - On-going support (need to remain in contact with service users)
  - Has received some DV training
  - Need consistency of care with service users (found disclosures of abuse became more frequent when seeing service users regularly)

- **Other**
  - Has received some DV training
  - Need consistency of care with service users (found disclosures of abuse became more frequent when seeing service users regularly)
<table>
<thead>
<tr>
<th>Experience of DV seen in clinical practice</th>
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<th>Response to DV</th>
<th>Other</th>
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</thead>
<tbody>
<tr>
<td>Risk issues linked to DV (i.e. suicide)</td>
<td>help themselves)</td>
<td>women</td>
<td>safe space without partner/family present</td>
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<td>decision process)</td>
<td>Used couple counselling Potential over involvement of services in DV cases where children in the family</td>
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<td>Economic pressures can influence DV</td>
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<td>Survivors may want to remain in relationship</td>
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<tr>
<td>Survivors may not acknowledge behaviours as abusive</td>
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<tr>
<td>DV may be cause of mental illness</td>
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<tr>
<td>Financial abuse</td>
<td>Picking up on signs of DV (i.e. injuries)</td>
<td>Need for improved organisational awareness of DV</td>
<td>Has asked service users</td>
<td>Preference to explore quality of relationships (identifying problems and difficulties)</td>
<td>None identified</td>
<td>Need to secure safety (part of duty of care) Clinical team discussions on options for response to DV Important to provide information on DV (i.e. leaflets) Provide access to support services Encourage climate of openness to</td>
<td>Other</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>Important to identify as service users may not engage with any other service</td>
<td>Lack of staff expertise about DV</td>
<td>Need for engagement in encouraging disclosure</td>
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<tr>
<td>Violence not just from intimate partners but also family members</td>
<td></td>
<td>Care coordinator role often unsupported</td>
<td>Awareness of gender issues (describes case where male service user did not want to disclose to a female, so clinician got a</td>
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<tr>
<td>Many people have experienced previous abuse</td>
<td></td>
<td>Need for greater support for professionals in responding to DV</td>
<td>Enquiry should be sensitive, so as not to offend service users</td>
<td></td>
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<tr>
<td>Survivors reach crisis point regarding abuse (encouraging disclosure)</td>
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<tr>
<td>Some survivors find it easier to disclose</td>
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Limited knowledge of services Not received specific DV training
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<th>Barriers to enquiry</th>
<th>Response to DV</th>
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<tbody>
<tr>
<td>Abusers exploit service users illness</td>
<td>Picking up on signs of DV (i.e. injuries) Following disclosure from service users</td>
<td>Organisational focus almost solely on managing and treating mental health problems Domestic violence not considered a priority Limited provision of support for DV Limited staff enquiry of DV</td>
<td>Has asked service users Need for engagement in encouraging disclosure Understand cultural issues around disclosure of DV</td>
<td>Preference to ask directly (otherwise cases may be missed) Enquiry should be part of routine risk assessment Enquiry should be sensitive, so as not to offend service</td>
<td>None identified</td>
<td>Service users have had good support for mental health problems but little support for DV Provide information on support services (i.e. police) Need to secure safety (i.e. involve police)</td>
<td>Lack of services for people with severe mental illness who have experienced DV (DV services have lack of knowledge in managing mental illness/</td>
</tr>
<tr>
<td>Survivors may not disclose abuse (fear kids will be removed from care) Survivors may deny abuse and its impact on health Some survivors find it easier to disclose than others Survivors may want</td>
<td>Need for access to resources that have expertise in identifying and responding to DV male colleague to enquire</td>
<td>Ask men and women</td>
<td>discuss DV Address trauma related feelings (i.e. anger) Explore and address behaviours employed when ill Used safeguarding adults policy and this included police involvement Considered use of couple counselling</td>
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<tr>
<td>than others (harder for men to disclose) Survivors may want to remain in relationship Social contacts can support separation from abuser Mentally ill people are vulnerable to DV by those close to them</td>
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<tr>
<td>to remain in relationship</td>
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<td>knowledge on how to respond to DV</td>
<td></td>
<td>users</td>
<td></td>
<td>On-going support</td>
<td>limited funding and sessions time-limited)</td>
</tr>
<tr>
<td>Wish to protect abuser</td>
<td></td>
<td>Staff need training about DV (improve confidence to identify and respond to DV)</td>
<td></td>
<td>Consider factors that may influence willingness to disclose (such as marital status, children, age, culture)</td>
<td></td>
<td>Respect service users wishes</td>
<td>Useful to have survivor group for those with mental illness</td>
</tr>
<tr>
<td>Service users mental illness may arise as a result of DV</td>
<td></td>
<td>Need for access to resources that have expertise in identifying and responding to DV</td>
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<td></td>
<td>Instigate child protection plans (continual assessment of risk)</td>
<td>Not received specific DV training</td>
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<td></td>
<td>Inclusion of DV enquiry in CPA (including suggestions on how to respond to disclosures)</td>
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<td>Absence of support for migrants with insecure immigration status (hard to provide adequate support)</td>
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<td>Need for NICE guidance for DV</td>
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<td>Improve service users self-esteem</td>
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<td></td>
<td>Help service users understand the seriousness of DV</td>
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<tr>
<td>Social factors influence DV</td>
<td></td>
<td>During routine assessment (explores risk to self and others, focusing on vulnerabilities)</td>
<td></td>
<td>Preference to ask directly (otherwise cases may be missed)</td>
<td></td>
<td>Investigation of DV using protection and vulnerable adults policies</td>
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<tr>
<td>Service users are vulnerable to DV and hard for them to communicate problems when ill</td>
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<td>Picking up on signs of DV (i.e. service user responses indicate)</td>
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<td>Enquiry should be sensitive, so as not to offend service</td>
<td></td>
<td>Has knowledge of general trauma services but not DV specific services</td>
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<tr>
<td>Many people have experienced previous abuse</td>
<td></td>
<td>Part of mental health team assessment to explore service users social support networks</td>
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<td>None identified</td>
<td></td>
<td>Has received some DV training (but</td>
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<tr>
<td></td>
<td>possible DV)</td>
<td>Need for routine enquiry of DV in clinical assessments</td>
<td>users</td>
<td>Repetitive enquiry</td>
<td>minimise risk)</td>
<td>display willingness to listen to DV experiences (supports service users in reflecting on DV experiences)</td>
<td>would like to receive more)</td>
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<td></td>
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<td>Need for team discussions around risk management</td>
<td>Normalise question, frame it as part of routine enquiry</td>
<td>Ask men and women</td>
<td>Need to evidence DV (obtain information from secondary sources)</td>
<td>Provide individually tailored support</td>
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<tr>
<td>Physical abuse</td>
<td>During routine assessment</td>
<td>Need to implement routine enquiry as part of CPA assessments</td>
<td>Has asked service users (if receiving referral, will request as much information on service user as possible)</td>
<td>Preference to explore quality of relationships (identifying problems and difficulties)</td>
<td>None identified</td>
<td>Risk assessment of survivors and their children (involvement of Social Services)</td>
<td>Staff respond differently to service users when DV identified as an issue</td>
</tr>
<tr>
<td>Emotional and psychological abuse</td>
<td>Colleagues have identified DV and asked for dual diagnosis input</td>
<td>Staff need training about DV (improve confidence to identify and respond to DV)</td>
<td>Exploring relationships (identifying problems and difficulties)</td>
<td>No barriers identified</td>
<td></td>
<td>Explore referral options</td>
<td>Some knowledge of DV services</td>
</tr>
<tr>
<td>Children violent towards parents</td>
<td>Picking up on signs of DV following exploration of service users relationships (i.e. shifts in body movement)</td>
<td>Staff need improved knowledge of DV services</td>
<td>Exploring impact of repetitive cycles of DV</td>
<td></td>
<td></td>
<td>Explore impact of repetitive cycles of DV</td>
<td>Not received specific DV training</td>
</tr>
<tr>
<td>Many survivors have experienced previous abuse</td>
<td>Need for advertisements about DV support services</td>
<td>Useful to identify prevalence of DV in mental health services (highlights extent of problem)</td>
<td>Display willingness to listen to DV experiences (supports service users in reflecting on experiences)</td>
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<td>Consider home visits to assess level of risk</td>
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<tr>
<td>Mentally ill people are vulnerable to DV by those close to them</td>
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<td>Facilitated by good engagement with service users</td>
<td>Referred to psychological services and advice centres (i.e. legal)</td>
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<tr>
<td>If disclosures not handled confidentially survivors could be at risk of further violence</td>
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<td></td>
<td>Uses resource books to identify services for</td>
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<td>Physical abuse</td>
<td>Has asked service users (if receiving referral, will request as much information on service user as possible)</td>
<td>Facilitated by good engagement with service users</td>
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<td>Emotional and psychological abuse</td>
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<td>Exploring impact of repetitive cycles of DV</td>
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<td>Sexual exploitation</td>
<td>Exploring impact of repetitive cycles of DV</td>
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<tr>
<td>Emotional and psychological abuse</td>
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<td>Sexual exploitation</td>
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<td>Identification of DV</td>
<td>Organisational approach/awareness of DV</td>
<td>Experience of enquiry of DV</td>
<td>Approach to enquiry</td>
<td>Barriers to enquiry</td>
<td>Response to DV</td>
<td>Other</td>
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<tr>
<td>Children violent towards parents</td>
<td>suicide risk/perpetration of violence</td>
<td>staff understanding about DV</td>
<td>experiences</td>
<td>Ask men and women</td>
<td></td>
<td>Social Services</td>
<td>Other</td>
</tr>
<tr>
<td>Service users vulnerabilities exploited</td>
<td></td>
<td>Need to improve staff knowledge of DV services</td>
<td>Views assessment of DV as an on-going process</td>
<td></td>
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<tr>
<td>Mental illness and substance misuse problems lead to increased vulnerability to violence (i.e. partner may pimp girlfriend to feed drug habit)</td>
<td></td>
<td>Need for greater use of Adult protection policies</td>
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<tr>
<td>Abusive partners may not understand illness and act out abusively</td>
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<td>Important for DV to be on organisational agenda</td>
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<tr>
<td>Impact of DV on mental health</td>
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<tr>
<td>Survivors may not disclose DV as they may feel abuse is a normal thing</td>
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<tr>
<td>Survivors may deny abuse</td>
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Note: In order to protect the anonymity of respondents all research IDs and identifiable characteristics have been omitted from these tables.
## Perception of professional role: ‘Accepting’ Types

<table>
<thead>
<tr>
<th>Experience of DV seen in clinical practice</th>
<th>Identification of DV</th>
<th>Organisational approach/awareness of DV</th>
<th>Experience of enquiry of DV</th>
<th>Approach to enquiry</th>
<th>Barriers to enquiry</th>
<th>Response to DV</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial exploitation</td>
<td>Home visitations</td>
<td>Organisational focus almost solely on managing and treating mental health problems</td>
<td>Has asked in previous roles (no direct enquiry in current role)</td>
<td>Preference to explore quality of relationships (identifying problems and difficulties)</td>
<td>Dominance of the medical model</td>
<td>Encourage climate of openness to discuss DV</td>
<td>Not received specific DV training</td>
</tr>
<tr>
<td>Abuser rationalises behaviour (i.e. drink, own experience of violence)</td>
<td>Picking up on signs of DV following exploration of service users relationships</td>
<td>Need to generate greater discourse about DV (how this aligns with current policies)</td>
<td>Facilitated by good engagement with service users</td>
<td>Ask men and women</td>
<td>Limited opportunity to enquire (assessments time-limited, service users may never be seen more than once)</td>
<td>Provide information about DV and DV services</td>
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</tr>
<tr>
<td>Growing acceptance of violence among teens</td>
<td></td>
<td>Need for increased staff awareness of DV (subtle DV behaviours may be overlooked)</td>
<td>Understanding of cultural issues around disclosure of DV</td>
<td>Enquiry should be part of routine risk assessment</td>
<td>Staff frustrations (staff reluctance to respond to DV if service users do not appear to be taking their advice)</td>
<td>Referral to support services</td>
<td></td>
</tr>
<tr>
<td>Survivors may not disclose abuse (seen as private issue)</td>
<td></td>
<td>Staff need training on DV enquiry (improve confidence to identify and respond to DV)</td>
<td></td>
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<td></td>
<td>Hard to evidence abuse (could be part of somebody’s delusional belief)</td>
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<tr>
<td>Survivors may blame their mental illness for the abuse perpetrated against them</td>
<td></td>
<td>Need for advertisements about impact of mental illness on family members</td>
<td></td>
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<td></td>
<td>Staff frustrations (staff reluctance to respond to DV if service users do not appear to be taking their advice)</td>
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<tr>
<td>Survivors may want to remain in relationship</td>
<td></td>
<td>Need for advertisements about DV services</td>
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<tr>
<td>Mentally ill people are vulnerable to DV by those close to them</td>
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<td>Staff need awareness</td>
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<tr>
<td>Impact of DV can lower self-esteem</td>
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<tr>
<td>DV has impact on whole family</td>
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Other factors include:

- Growing acceptance of violence among teens
- Survivors may blame their mental illness for the abuse perpetrated against them
- Survivors may want to remain in relationship
- Mentally ill people are vulnerable to DV by those close to them
- Impact of DV can lower self-esteem
- DV has impact on whole family
<table>
<thead>
<tr>
<th>Experience of DV seen in clinical practice</th>
<th>Identification of DV</th>
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<th>Approach to enquiry</th>
<th>Barriers to enquiry</th>
<th>Response to DV</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Survivors may fail to link their experiences of DV to their deteriorating mental health problems</td>
<td>If reports of DV documented in case files Picking up on signs of DV</td>
<td>Low-level mutual violence Men experience DV Mental illness and substance misuse problems lead to increased vulnerability to violence Impact of DV on mental illness Survivors may deny/downplay severity of DV</td>
<td>Staff need training on DV enquiry Need to implement routine enquiry as part of clinical assessments Staff need training about DV (improve confidence to identify and respond to DV)</td>
<td>Has asked in current role (but not in previous roles) No direct enquiry as not part of clinical assessment Facilitated by good engagement with service users</td>
<td>Preference to explore quality of relationships (identifying problems and difficulties) Phrase as routine question Ask men and women Enquiry important but can be unhelpful if staff are unsure of how to respond adequately</td>
<td>Fear of offending service user (timing important, as found in previous A&amp;E role) Limited opportunity to enquire (time constraints)</td>
<td>Unsure how to respond effectively (especially in cases of emotional DV) Assess impact of DV on children Provide information on DV services Referral to support services Clinical team discussions about response to DV Scope to conduct couple counselling</td>
</tr>
<tr>
<td>Physical abuse (in previous A&amp;E role saw several service users with injuries) If service users describe problems in relationships</td>
<td>Staff need training about DV (improve confidence to identify and respond)</td>
<td></td>
<td>Has asked in previous role (in A&amp;E role explored) Preference to explore quality of relationships</td>
<td></td>
<td></td>
<td>Risk assessment of survivors</td>
<td>Limited knowledge of services</td>
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</tbody>
</table>

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<table>
<thead>
<tr>
<th>Experience of DV seen in clinical practice</th>
<th>Identification of DV</th>
<th>Organisational approach/awareness of DV</th>
<th>Experience of enquiry of DV</th>
<th>Approach to enquiry</th>
<th>Barriers to enquiry</th>
<th>Response to DV</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>from DV)</td>
<td>will explore further</td>
<td>to DV)</td>
<td>injuries)</td>
<td>Facilitated by good engagement with service users</td>
<td>(identifying problems and difficulties)</td>
<td>Encourage climate of openness to discuss DV</td>
<td>Not received specific DV training</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>Picking up on signs of DV</td>
<td></td>
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<tr>
<td>Emotional and psychological abuse</td>
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<tr>
<td>Financial abuse</td>
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<tr>
<td>Abusers exploit service users illness</td>
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<tr>
<td>Survivors may not disclose abuse (do not want to report to police)</td>
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<tr>
<td>Mentally ill people are vulnerable to DV by those close to them</td>
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<tr>
<td>Impact of DV on mental illness</td>
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<tr>
<td>Impact of DV on child development</td>
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<tr>
<td>Physical abuse</td>
<td>If reports of DV documented in</td>
<td>Limited organisational</td>
<td>Has asked in previous roles (enquired</td>
<td>Preference to ask directly (otherwise</td>
<td>Lack of knowledge/expertise about the subject of</td>
<td>Unsure how to respond</td>
<td>Need consistency of care with</td>
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<tr>
<td>Emotional and</td>
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</table>

Picking up on signs of DV

Useful if structure in team where service user could continue to be supported for DV if mental health work completed

Facilitated by good engagement with service users

Encourage climate of openness to discuss DV

Discuss impact of DV on children

Provide advice and information on DV support services

Referral to DV services

Provide education about impact of DV

Provide on-going support

Staff frustrations (staff reluctance to respond to DV if service users do not appear to be taking advice)

Not received specific DV training
<table>
<thead>
<tr>
<th>Experience of DV seen in clinical practice</th>
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<th>Experience of enquiry of DV</th>
<th>Approach to enquiry</th>
<th>Barriers to enquiry</th>
<th>Response to DV</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>psychological abuse</td>
<td>case notes</td>
<td>awareness about DV</td>
<td>about DV as part of routine assessment</td>
<td>cases may be missed</td>
<td>domestic violence</td>
<td>effectively</td>
<td></td>
</tr>
<tr>
<td>Survivors experience abuse post-separation</td>
<td></td>
<td>Staff need training about DV (improve confidence to identify and respond to DV)</td>
<td>Considered DV easier to identify in previous role compared to current role</td>
<td>Routinely ask if service user has children</td>
<td>Fear of negative impact on therapeutic relationship</td>
<td>Documentation of abuse</td>
<td></td>
</tr>
<tr>
<td>Many people have experienced previous abuse</td>
<td></td>
<td>Staff need training on DV enquiry</td>
<td>Facilitated by good engagement with service users</td>
<td>Not always appropriate to enquire at first meeting (should be explored at later date)</td>
<td>Presence of partner at health appointments</td>
<td>Provided information on DV support services</td>
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</tr>
<tr>
<td>Survivors may deny/downplay DV</td>
<td></td>
<td>Need to implement routine enquiry as part of clinical assessments</td>
<td>Important to enquire in safe space without partner/family present</td>
<td>Important to enquire in safe space without partner/family present</td>
<td>Limited opportunity to enquire</td>
<td>Need consistency to support survivors</td>
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<td></td>
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<td>Lack of information sharing between agencies</td>
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<td>Provide on-going support</td>
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<td></td>
<td></td>
<td>Need for improved knowledge of support services</td>
<td></td>
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<td></td>
<td>service users (high staff turnover prevents disclosure from service users)</td>
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<td>Limited knowledge of DV services</td>
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<tr>
<td>Physical abuse</td>
<td>Community visits</td>
<td>Limited organisational awareness of DV (need for organisational culture that encourages discussion of DV)</td>
<td>Has asked in previous roles (limited patient contact in current role)</td>
<td>Preference to ask directly (otherwise cases may be missed)</td>
<td>Fear of disrupting therapeutic relationship (if need to break confidentiality due to reporting requirements)</td>
<td>Risk assessment of survivors and their children (referral to children and families Social Services)</td>
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<tr>
<td>Sexual abuse</td>
<td></td>
<td>Need multi-disciplinary response to DV</td>
<td>Repetitive enquiry can be useful</td>
<td>Sensitive approach</td>
<td>Use of adult protection policies</td>
<td>Use of adult protection policies</td>
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<tr>
<td>Financial abuse</td>
<td></td>
<td>Improved links to adult protection policies (not utilised</td>
<td>Facilitated by good engagement with service</td>
<td>Timing of enquiry needs to be judged on individual basis</td>
<td>Recording DV in treatment</td>
<td>Recording DV in treatment</td>
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<tr>
<td>Emotional and psychological abuse</td>
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<td></td>
<td>Limited knowledge of DV services</td>
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<tr>
<td>Carers and children perpetrate DV</td>
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<td></td>
<td>Not received specific DV training</td>
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<tr>
<td>Subtle coercive nature of DV (often hidden)</td>
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<td></td>
<td>Staff need further support in how to deal with and</td>
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<tr>
<td>Many service users</td>
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<tr>
<td>Experience of DV seen in clinical practice</td>
<td>Identification of DV</td>
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<td>Experience of enquiry of DV</td>
<td>Approach to enquiry</td>
<td>Barriers to enquiry</td>
<td>Response to DV</td>
<td>Other</td>
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<tr>
<td>Survivors may deny DV</td>
<td>DV</td>
<td>Development of policies and procedures on DV</td>
<td>Users</td>
<td>Consideration of gender and cultural issues around disclosure</td>
<td>DV cases often complex and outcomes can be slow</td>
<td>DV cases often complex and outcomes can be slow</td>
<td>DV cases often complex and outcomes can be slow</td>
</tr>
<tr>
<td>Survivors may not disclose abuse (do not want to report to police)</td>
<td>DV</td>
<td>Staff need training about DV (improve confidence to identify and respond to DV)</td>
<td>DV</td>
<td>Staff need training about DV (improve confidence to identify and respond to DV)</td>
<td>DV</td>
<td>Staff need training about DV (improve confidence to identify and respond to DV)</td>
<td>DV</td>
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<tr>
<td>DV cases often complex and outcomes can be slow</td>
<td>DV</td>
<td>Need for clear pathway on how to respond to DV (feels staff are competent with enquiry but there are frustrations and anxieties about where to go)</td>
<td>DV</td>
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<td>DV</td>
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<tr>
<td>Survivors may want to remain in relationship</td>
<td>DV</td>
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<td>DV</td>
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<tr>
<td>Mentally ill people are vulnerable to DV by those close to them</td>
<td>DV</td>
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<tr>
<td>Impact of DV on mental health</td>
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Other

- Plan (inter-agency awareness of case and its progress)
- Encourage climate of openness to discuss DV
- Working closely with other agencies
- Provide information and advice on support services
- Generate clinical team discussions of DV cases
- Staff frustrations (staff reluctance to respond to DV if service users do not appear to be taking advice)

Other

- Manage cases of DV
<table>
<thead>
<tr>
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<th>Barriers to enquiry</th>
<th>Response to DV</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical abuse</td>
<td>Picking up on signs of DV (i.e. bruising)</td>
<td>Limited staff knowledge on how to identify and respond to DV</td>
<td>Has asked in previous roles</td>
<td>Preference to explore quality of relationships (identifying problems and difficulties)</td>
<td>Fear of offending service user</td>
<td>Risk assessment of survivors and their children (if children involved refer to Social Services)</td>
<td>Some knowledge of DV services</td>
</tr>
<tr>
<td>Financial abuse</td>
<td>If reports of DV documented in case notes</td>
<td>Staff need training about DV (improve confidence to identify and respond to DV)</td>
<td>Enquiry can facilitate disclosure</td>
<td>Sensitive approach</td>
<td>Ask men and women</td>
<td>Encourage climate of openness to discuss DV</td>
<td>Received some DV training (although not specific to needs of people with severe mental illness)</td>
</tr>
<tr>
<td>Emotional and psychological abuse</td>
<td>Need improved multi-agency responses to DV</td>
<td>DV cases often complex and outcomes can be slow</td>
<td></td>
<td>Repetitive enquiry</td>
<td></td>
<td>Provide information on and referral to services (i.e. police, Social Services)</td>
<td>Feels improved outcomes for DV are dependent on survivors motivation to change and the provision of on-going support and knowledge of support services</td>
</tr>
<tr>
<td>More women experience violence than men</td>
<td>Survivors may deny DV</td>
<td>Survivors may not disclose abuse (do not want to report to police)</td>
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<tr>
<td>Survivors may want to remain in relationship</td>
<td>DV cases often complex and outcomes can be slow</td>
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</table>

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### Perception of Professional Role: ‘Avoidant’ Types

<table>
<thead>
<tr>
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<th>Organisational approach/awareness of DV</th>
<th>Experience of enquiry of DV</th>
<th>Approach to enquiry</th>
<th>Barriers to enquiry</th>
<th>Response to DV</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional and psychological abuse</td>
<td>Following disclosure from service users</td>
<td>Limited organisational awareness of DV</td>
<td>Has not enquired (explores relationships following disclosure from service users, but not in any depth)</td>
<td>Preference to explore quality of relationships (identifying problems and difficulties)</td>
<td>Lack of knowledge and expertise about the subject of DV</td>
<td>Risk assessment of survivors (if necessary report to police)</td>
<td>No knowledge of DV services</td>
</tr>
<tr>
<td>Physical abuse</td>
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<td></td>
<td>Hard to evidence (need for collateral information and to validate disclosure as real)</td>
<td>Not received specific DV training</td>
</tr>
<tr>
<td>Sexual abuse (although most cases related to childhood sexual abuse)</td>
<td></td>
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<td></td>
<td>Different responses required if addressing recent violence versus historical violence</td>
<td>Need consistency of care with service users (high turnover of staff disrupts continuity)</td>
</tr>
<tr>
<td>More women than men experience DV</td>
<td></td>
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<td>Scope for couple counselling</td>
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<tr>
<td>Mothers attempt to protect their children from exposure to DV</td>
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<tr>
<td>People with severe mental illness have complex needs (not just related to DV)</td>
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</tr>
<tr>
<td>Emotional and psychological abuse</td>
<td>Following disclosure from service users (often disclosures)</td>
<td>Limited organisational awareness of DV</td>
<td>DV neglected in mental health settings</td>
<td>Preference to ask directly (otherwise cases may be missed)</td>
<td>Lack of knowledge and expertise about the subject of DV</td>
<td>Risk assessment of survivors and their children (referral to child and family)</td>
<td>Stigma of mental illness becomes overriding focus and</td>
</tr>
<tr>
<td>Physical abuse</td>
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<td>Emotional and psychological abuse</td>
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<td>Identification of DV</td>
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<td>Experience of enquiry of DV</td>
<td>Approach to enquiry</td>
<td>Barriers to enquiry</td>
<td>Response to DV</td>
<td>Other</td>
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<tr>
<td>Controlling behaviours (i.e. controlling who they can and can’t see, total control of finances)</td>
<td>made a long time after incidents occurred</td>
<td>(reluctance across NHS to respond to DV (unless A&amp;E)) Need for clearer guidelines on how to respond to DV Staff need training about DV (improve confidence to identify and respond to DV) Need for improved collaboration with DV services Lack of information sharing between agencies Need for improved multi-agency responses to DV</td>
<td>service users) Facilitated by good engagement with service users</td>
<td>Lack of confidence in approaching the subject Discomfort with topic (difficult subject to discuss) Lack of engagement and rapport with service users Competing demands</td>
<td>Social Services) Encourage climate of openness to discuss DV Referral to DV support services (describes difficulty getting service users access to counselling services) Unsure how to respond effectively Improve service users self-esteem Respect service users choices and decisions</td>
<td>non-psychiatric services may be reluctant to engage with people with severe mental illness Not received specific DV training Some knowledge of DV services but difficulty getting mental health service users access</td>
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<tr>
<td>People with severe mental illness may be so focused on establishing intimate relationships that the quality of these relationships becomes a secondary focus</td>
<td>Have identified DV but not asked or spoken to service users about it</td>
<td>Limited organisational awareness of DV (needs to be further up the agenda)</td>
<td>Has not enquired (avoided even if suspected DV (unsure how to respond)</td>
<td>Preference to explore quality of relationships (identifying problems and difficulties)</td>
<td>Lack of knowledge and expertise about the subject of DV</td>
<td>Unsure how to respond effectively (avoidance of discussion of DV experiences)</td>
<td>No knowledge of DV services Not received specific DV training</td>
</tr>
<tr>
<td>Survivors may want to remain in relationship</td>
<td>Finds it easier to enquire about perpetration than victimisation</td>
<td>Need for clearer guidelines on how to respond to DV</td>
<td>Gender issues (avoided asking women, suggested they speak to someone of same gender as unsure how to enquire)</td>
<td>Phrase as routine question (have key phrases)</td>
<td>Fear of offending service users</td>
<td>Unclear how much information to collect and document</td>
<td></td>
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<tr>
<td>Physical abuse</td>
<td></td>
<td>Need to implement routine enquiry as part of clinical assessment</td>
<td>Staff need training about DV (improve confidence to identify and respond to DV)</td>
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<tr>
<td>Coercive control</td>
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<tr>
<td>Impact of DV on mental illness</td>
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<tr>
<td>Physical abuse</td>
<td>Picking up on signs of DV</td>
<td>Limited organisational awareness of DV</td>
<td>Has not enquired (but acknowledges it is helpful to ask as service users may be frightened or view DV as normal)</td>
<td>Preference to ask directly (otherwise cases may be missed)</td>
<td>Fear of offending service users</td>
<td>Generate clinical team discussions about response to DV</td>
<td>long waiting lists</td>
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<tr>
<td>Sexual abuse</td>
<td>Following service user disclosure</td>
<td>Need to implement routine enquiry as part of clinical assessment</td>
<td></td>
<td>Phrase as routine question</td>
<td>No indication of violence</td>
<td>Referral to DV support services</td>
<td></td>
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<tr>
<td>Psychological and emotional abuse</td>
<td>Staff need training about DV</td>
<td>Staff need training about DV (improve confidence to identify and respond to DV)</td>
<td></td>
<td>Sensitive approach</td>
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<tr>
<td>Majority of DV seen relating to past relationships and not current relationships</td>
<td>Need for improved knowledge of support services</td>
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<td>Generate clinical team discussions about response to DV</td>
<td></td>
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<tr>
<td>Survivors may deny DV (fear of further violence, stigma)</td>
<td>If reports of DV documented in case notes</td>
<td>Need to implement routine enquiry as part of clinical assessment</td>
<td></td>
<td>Phrase as routine question</td>
<td>No indication of violence</td>
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<td>Fear of offending service users</td>
<td>Generate clinical team discussions about response to DV</td>
<td>Sister worked in DV sector so aware of services</td>
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<td>Psychological and emotional abuse</td>
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<td>Need to implement routine enquiry as part of clinical assessment</td>
<td></td>
<td>Phrase as routine question</td>
<td>No indication of violence</td>
<td>Referral to DV support services</td>
<td>Recalls previous government campaign to raise awareness of DV</td>
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<td>Many service users report DV</td>
<td>Staff need training about DV</td>
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<td>Sensitive approach</td>
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<tr>
<td>seen relating to past relationships and not current relationships</td>
<td></td>
<td>about DV (improve confidence to identify and respond to DV) Need for improved knowledge of support services</td>
<td></td>
<td></td>
<td></td>
<td>support services Explore unhealthy relationship patterns Support survivors in re-establishing trust</td>
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<tr>
<td>Survivors may want to remain in relationship</td>
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<tr>
<td>Survivors may display ambivalence about leaving the situation</td>
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Note: In order to protect the anonymity of respondents all research IDs and identifiable characteristics have been omitted from these tables
## Perception of professional role: ‘Ambivalent’ Types

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<thead>
<tr>
<th>Experience of DV seen in clinical practice</th>
<th>Identification of DV</th>
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<th>Experience of enquiry of DV</th>
<th>Approach to enquiry</th>
<th>Barriers to enquiry</th>
<th>Response to DV</th>
<th>Other</th>
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</thead>
<tbody>
<tr>
<td>Emotional and psychological abuse</td>
<td>If reports of DV documented in case notes</td>
<td>Unsure if Trust guidelines exist on DV</td>
<td>Has enquired (explores relationship difficulties)</td>
<td>Preference to explore quality of relationships (unsure if general or specific question should be asked)</td>
<td>Enquiry not part of role</td>
<td>Risk assessment of survivors and their children</td>
<td>Limited knowledge of services</td>
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<tr>
<td>Financial abuse</td>
<td>If service users describe problems in relationships will explore further</td>
<td>Unsure of role of mental health services in responding to DV (feels it medicalises what is often a nonmedical issue)</td>
<td>Important to distinguish between bullying and physical abuse</td>
<td>Do not believe should ask men as they more often report perpetration</td>
<td>Fear of service user disengaging</td>
<td>Hard to intervene with adults as no statutory obligations (often service users do not want to report to police)</td>
<td></td>
</tr>
<tr>
<td>Controlling behaviours (i.e. money, contact with friends)</td>
<td>Process of identification may differ if working with children/teens</td>
<td>Useful to raise awareness about DV</td>
<td></td>
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<td></td>
<td>Leaving it to the survivor to seek help of their own accord</td>
<td>Tackling substance misuse issues</td>
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<td>Mutual violence</td>
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<td></td>
<td>Unclear how to respond to service users that are seemingly stuck in relationships</td>
<td>Consider couple counselling</td>
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<td>Children violent towards parents</td>
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<tr>
<td>Majority of DV seen relating to past relationships and not current relationships</td>
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<tr>
<td>Survivors may not disclose abuse (disclosures usually made by those who have been in DV relationships for a long time)</td>
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<td>If reports of DV documented in</td>
<td>Unsure of role of mental health services in</td>
<td>Has not enquired</td>
<td>Unconvinced if strong evidence for DV enquiry by mental health</td>
<td>Unclear if evidence to support routine</td>
<td>Need to identify aspects of vulnerability to</td>
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<tr>
<td>Sexual abuse</td>
<td></td>
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<td></td>
<td>Sometimes difficult to remove someone</td>
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<td>responding to DV</td>
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<td>professionals</td>
<td>enquiry of DV</td>
<td>DV</td>
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<tr>
<td>Mutual violence</td>
<td></td>
<td>DV enquiry needs to be justified and stand out from other demands</td>
<td></td>
<td></td>
<td>Competing demands</td>
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<td>Majority of DV seen relating to past relationships and not current relationships</td>
<td></td>
<td>If addressing DV mental health services should also focus on abuser and provide them with support</td>
<td></td>
<td></td>
<td>Enquiry not part of their role</td>
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<td>DV cases complex</td>
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<tr>
<td>Mentally ill people are vulnerable to DV by those close to them</td>
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<tr>
<td>Survivors may want to remain in relationship (i.e. loss of housing, financial support)</td>
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<td>Survivors may deny/downplay severity of DV</td>
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<tr>
<td>Emotional and psychological abuse</td>
<td></td>
<td>Unsure if role of mental health services in addressing DV (not has not enquired)</td>
<td>Preference to explore quality of relationships (unsure if)</td>
<td>Competing demands</td>
<td>Enquiry not part of DV to discuss</td>
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<td></td>
<td>Has knowledge of local DV</td>
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<tr>
<td>Experience of DV seen in clinical practice</td>
<td>Identification of DV</td>
<td>Organisational approach/awareness of DV</td>
<td>Experience of enquiry of DV</td>
<td>Approach to enquiry</td>
<td>Barriers to enquiry</td>
<td>Response to DV</td>
<td>Other</td>
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<tr>
<td>Mutual violence</td>
<td>will explore further</td>
<td>seen as the remit of a community mental health team unless there are diagnostic mental health problems as well</td>
<td>general or specific question should be asked</td>
<td>DV enquiry may be more relevant for some service users than others (clinical judgement about who to ask) Ask men and women</td>
<td>of their role</td>
<td>whether service user is appropriate for mental health services Referral to DV services (clinicians role is about gate keeping towards services like refuge) Explore repetitive pattern of DV relationships (why a person stays in DV relationship)</td>
<td>services Useful for staff to receive feedback from services that they have referred service users to for DV issues Not received specific DV training</td>
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<td>Females can be perpetrators of DV</td>
<td>If reports of DV documented in case notes Following service users disclosure</td>
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<tr>
<td>Hard for people with mental health problems to think clearly about situation and how to respond</td>
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<tr>
<td>Emotional and psychological abuse</td>
<td>If reports of DV documented in case notes Following service user disclosure</td>
<td>Limited organisational awareness of DV Unsure if role of CMHT to address DV (struggles with taking on things that are not mental health problems)</td>
<td>Has not enquired</td>
<td>Preference to ask directly (otherwise cases may be missed)</td>
<td>Not part of their role to enquire Domestic violence not a priority Gender and cultural concerns Presence of partner at health appointments Gender</td>
<td>Referral to DV services (need to direct survivors elsewhere) Unsure how to respond effectively</td>
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<td>Financial abuse</td>
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<td>Violence not just from intimate partners but also family members</td>
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<td>Perpetration of DV by mental health service users</td>
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<td>Little experience of responding to DV in practice</td>
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Note: In order to protect the anonymity of respondents all research IDs and identifiable characteristics have been omitted from these tables.