



Finding Safety

Provision of specialised domestic violence and refuge services for women who currently find it difficult to access mainstream services:
disabled women, older women, sex workers and women with mental illness and/or drug and alcohol problems as a result of domestic violence.

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specialised refuges and housing for women

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Purpose

The purpose of this project was to investigate the provision of specialised women's refuge services in Australia and England. This means refuges for women who, because of disability, age, engaging in sex work, mental health or drug and alcohol problems, are unable to access conventional refuge and domestic violence services.

Australia and England are developing services for these women; currently these women have very few options in New Zealand and often nowhere safe to go to escape from domestic violence.

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Thank you to all the women – many of who had not heard of me before this research trip – who welcomed me and generously provided information. My role has been to gather the wisdom of the many amazing women who are providing specialist and extraordinary care to abused women and those who are researching and teaching about this complex subject. Thank you all very much.

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Thank you very much to these people for believing that this work is important and enabling the research to happen.

A note about referencing

Literature has been end-noted into the reference list.
Comments from participants in the research have been footnoted.

A note about language

This report talks about women experiencing mental illness and drug and alcohol abuse. In all cases in this report this is understood to be a response to abuse – the behaviours are often coping strategies or a response to persistent trauma.

The Way Forward: Recommendations To Enhance Service Provision In New Zealand

The following recommendations to ensure non-discriminatory services and evidence informed processes for developing and implementing services to vulnerable clients emerged from this research. These clients currently risk either falling through the gaps or being inappropriately responded to due to lack of knowledge about their circumstances and requirements. All of these recommendations are supported by information from the research.

Violence against women

It is critical that refuge is available to women escaping all forms of violence against women. This includes sexual and domestic violence, underage and forced marriage, FGM¹, violence incurred in sex work and trafficking.

Older women

All mainstream and specialised refuges need to be resourced to house women regardless of age.. There be no upper age limit and no age discrimination. If women require refuge, they require it and should not have to give up their independence and go into institutional care to escape abuse. If older women don't want to be in houses full of small children, refuges need to provide separate accommodation, on site, where older women without children can live and receive services.

Women without children

Separate funding for women and for children is a strategy to ensure that single women receive service and enables specialisation. Where possible, refuges already accommodate women without children. It is important that funding to refuges is linked to women and children separately, so that refuges do not have to turn away women without dependant children because of funding considerations. Separate funding would also allow the development of services specifically for women who don't have dependant children in their care, which would enable some level of specialisation to occur in service provision.

Disabled women

All refuges should have units that are fully accessible and self-contained, with access to communal spaces. These units should also accommodate caregivers/assistants if women require them. This investment is an obligation of government as the funder of refuge services. Currently governments are discriminating against women with disabilities by not providing this service.

Young women

There is a need for supported accommodation for young women escaping abusive family situations. These young women require a more structured and supported environment where they can be encouraged to learn skills related to independent living while accessing legal services and the services that they require to recover from abuse.

¹ Female genital mutilation

Sex Workers

Women working in the sex industry also need refuge to escape domestic violence and violence experienced in their work and refuges need policies to better support them . Specialised and mainstream refuges should develop policies that enable women to keep working until either they leave refuge or decide that they no longer want to work in the sex industry. This could involve agreements about how to keep the refuge address confidential, not bringing clients back etc. Women could also be expected to contribute to their costs from the proceeds of their work.

Specialised refuge services for women with mental health and drug and alcohol problems

This research has demonstrated and strongly recommends that purpose-built, well-funded, refuges for women with mental health and drug and alcohol problems related to domestic violence are developed. Ethically, it is important that refuge and the related healing services are available to those who are most damaged by abuse. From a fiscally responsible perspective, specialised refuges, as described above, will save millions of dollars in long term service provision to women, enabling them to become independent, self managing members of the community rather than long term users of health and social services. It is important that funding for the provision of these services become part of mainstream, on-going mental health or social service funding.

Specialised drug and alcohol and mental health workers to support mainstream refuges

Many more women, with complex problems, could be housed in mainstream refuges if specialised support was available both to the women and the refuge staff. This service can be provided by enabling clusters of refuges to employ staff with clinical expertise and a comprehensive analysis of domestic violence to work alongside the staff and with the clients with complex needs admitted to the refuge.

Housing for women

A critical part of our national domestic violence initiative must be the provision of good quality, affordable housing for women to move into when they are ready to leave refuge. This housing should be for women with or without children. There needs to be two levels of housing provided. The first tier is flats in the community that are administered by refuge to house either women who are unable to live in a communal situation, or those who are almost ready to live independently but who require some level of support to learn to retain a tenancy. The second tier is houses that are administered as part of the social housing stock, that prioritise women who need either to move districts to escape abusive partners or who require housing after refuge. Without the provision of safe housing many women will have no options other than to return to unsafe situations or situations that make them vulnerable to further exploitation.

There is also a need for well-managed women-only communal/transitional housing, such as boarding houses. This would provide a level of safety and support for homeless women and women who for various reasons, including fear of men, find it difficult to maintain tenancies. It would prevent a number of women moving into unsafe relationships for the sake of shelter.

Women-only services

In order to ensure that inpatient services are effective and safe for vulnerable clients, this research recommends that all drug and alcohol and mental health inpatient services must be gender specific, and outpatient units must have women-only components. This does not mean just having separate sleeping areas for inpatient units, it means having separate services for men and women with gender appropriate staff, i.e. female staff for women's units, male staff for men's units. This also applies to the outpatient services by having, for example, separate days for each gender or services for men and women staffed by gender-appropriate staff.

Training

Training programmes are being developed in England and Scotland for social workers, other social service professionals, psychologists, psychiatrists, mental health service staff, substance abuse service staff, health professionals, police, the crown prosecution service, lawyers and judges about the dynamics of domestic violence and the link between domestic violence and mental health problems, PTSD and drug and alcohol abuse.

In New Zealand, very few of these professional groups have training in the dynamics of domestic violence, let alone the relationship between childhood and adult abuse, on going trauma and subsequent mental health problems. If professionals are to respond appropriately to traumatised women it is imperative that this information be a core part of their training and that this knowledge be an ongoing part of professional development.

If professionals had this knowledge it would mean earlier identification of women with trauma responses to domestic violence, a more appropriate response designed to help them, less chance that they would be re-abused by help seeking, and earlier referral to appropriate services.

This research recommends that:

- domestic violence training and training about the mental health effects of domestic violence be incorporated into the initial and ongoing professional development training of all health, legal, therapeutic and social service professionals including psychologists, psychiatrists, mental health and drug and alcohol service staff, judges, lawyers, court staff, police, social workers, therapists and counsellors.
- long-term adequate funding is provided by government to the educational institutions and NGOs that provide this education.

Policies in health and other services to enhance partnership development for women with complex needs

, All services should be encouraged to develop policies about partnership development and memorandums of understanding (MOUs) between services in local areas. If the needs of women with mental health and drug and alcohol problems related to domestic violence are to be understood and constructively responded to, it is critical that partnerships are developed between services to ensure timely effective referral process and responses. These processes would be enhanced by the addition of a service user group being fully incorporated into the consultation and implementation

process for policy and MOUs. This would incorporate the development of better policies in all services (justice, police, health, social services etc) to recognise and respond to women with complex needs.

Funding and support for migrant/minority ethnicity services with specialist expertise

Because of the different cultural understandings of domestic violence and women's right to leave abusive relationships, it is imperative that migrant/minority ethnicity services are funded to have specialist expertise in the dynamics of domestic violence. This is to ensure that services are not colluding with cultural norms that keep women and children trapped in abusive relationships. (See the case study, EACH, Hounslow.)

New service provision initiatives

The IRIS model

The IRIS model involves specific domestic violence/mental health/drug and alcohol training for GPs and other clinic staff, and a dedicated advocate linking a group of GP practices with the local refuges and domestic violence services. The advocate works alongside the practices to respond to disclosures of domestic violence. The role includes the provision of resources for clients and staff. This model could work well in Primary Health Organisations.

IDVA - Independent Domestic Violence Advisors programme

This is a trained domestic violence advocate who focuses on the safety of clients identified by the police as high-risk. These advocates are attached to the police but independent of them. Identified women are given the opportunity for intense work with an IDVA. Research indicates that the key determinant of success is having specialist services on site (with the police), who can respond to a victim within an hour. One of the reasons this is successful is that the advocates work with women while they are open to change. This model is currently part of police practice in the areas where there are Family Safety Teams. This research recommends that Family Safety Teams and FVIERS be fully resourced so that staff can be consistently engaged with the projects and established in every police area.

Research

It is important that funding is provided for research and evaluation to inform the process of service development. Therefore all service contracts should contain sufficient funding for several years of service evaluation.

There also needs to be a pool of research money for pilot projects such as those being developed in the UK.

Research Background

The latest population-based research in New Zealandⁱ indicates that one in three women will experience physical or sexual violence from an intimate partner at least once in their life. There are a range of services that are available to women to help them escape and recover from domestic violence. However, for a number of reasons including funding, training, organisational structures and reliance on volunteers, many women's refuges are still unable to accommodate women who have additional complexities beyond that of domestic violence. Women with drug and alcohol and/or mental health problems, women with physical disabilities that require caregiver support, sex workers, women without dependant children, and those who are over 55 years old are often unable to access refuge and domestic violence services. All of these women – and possibly their children – are trapped in abusive relationships, with all of the attendant long-term effects of experiencing violence.

The effects of domestic violence

There are high rates of injury, physical illness, alcohol and drug abuse, and suicide associated with domestic violence. For many women, higher rates of STIs, including HIV, pregnancy complications and unwanted pregnancies are also consequences of domestic violence.ⁱⁱ

Domestic violence can be a cause of long-term disability. Blindness, deafness, paralysis, damaged limbs and disfiguring injuries caused by burns are examples of the physical disability women suffer.

Each time a woman is shaken hard or hit on the head she risks brain damage – and over time this brain damage can become permanent and disabling.

The strong relationship between domestic violence and the murder of women by their male partners has been named 'femicide' by the United Nations. Nearly two thirds of homicides in New Zealand involve family relationships, and nearly two thirds of those killed are women. Each year the police believe that between 50 - 60% of all murders in New Zealand are men killing their female partners.ⁱⁱⁱ

The mental health effects of domestic violence include:

- suicide - an eight times greater risk than non abused women^{iv}
- substance abuse – a third of abused women will begin abusing substances for a variety of reasons, including being forced to by their abusive partners
- self-harming behaviours including eating disorders
- a variety of mental health problems including anxiety, depression, trauma related illnesses^v and major mental illness diagnoses such as schizophrenia and bi-polar disorder^{vi}. Women are also given diagnoses such as generalised anxiety, obsessive-compulsive disorder, multiple personality and personality disorders.^{vii} These diagnoses are a response to symptoms – not to the cause of the women's trauma.^{viii}

Overall, mental health effects contribute 73% of the total burden of disease (injuries, physical illness and mental health problems) associated with domestic violence.^{ix}

The mental health effects of domestic violence on children

Children who live in an environment where abuse is occurring suffer psychological, sexual and physical abuse, including being killed. They also experience trauma associated with living in an abusive environment, even when not abused themselves. In this situation, children's stability is threatened and this influences their sense of security and ability to survive, which causes them lasting damage.

Both children who experience abuse and those who only witness it have many of the same emotional and behavioural problems, including:

- anxiety, depression, low self-esteem, social withdrawal, hostility, nightmares, disobedience and aggression
- poor school performance
- cognitive functioning problems such as lower verbal and quantitative skills and the development of attitudes supporting the use of violence including lack of empathy
- somatic health complaints and physical problems such as delayed motor skills, speech difficulties and multiple health problems
- passivity, sleep disorders, eating disorders, anxiety, teen pregnancy, suicide and suicide attempts.^x

Childhood exposure to abuse and other adverse experiences is strongly linked to:

- chronic adult health problems, including ischemic heart disease
- cancer
- chronic lung disease
- diabetes, hepatitis, and liver disease
- juvenile offending
- alcohol and drug abuse
- increased risk of later physical and sexual assault
- interpersonal and parenting difficulties^{xi}

Prevalence

Mental illness/drug and alcohol abuse

Currently there are no records kept of women who are experiencing mental health/drug and alcohol problems as a result of domestic violence. This is partly because, until recently, there has been no systematic screening for domestic violence in these services, but also because the mental health effects of intimate partner violence have not been recognised by most health professionals. It is also indicative of the practice of most NZ refuges of excluding women who are – at the first phone assessment - believed to have mental health or substance abuse problems. Research was conducted in 2006 with all of the affiliated refuges in New Zealand. Thirty-nine refuges participated. The results found that, in a six-month period in 2006, two hundred and fifty-seven women, many with children, were denied refuge because of mental illness or drug and alcohol problems.

This research is detailed in appendix two.

Women with physical disabilities

Women with physical disabilities experience higher rates of physical, emotional and sexual abuse than able-bodied women. They are abused by family, friends and paid caregivers. Statistics on prevalence vary depending on the research methodology, but it could be as high as, or higher than, 1 in 2 disabled women (with a slightly lower figure for disabled men).

In addition, as mentioned above, women can become physically disabled by domestic violence – suffering head injuries and becoming physically impaired in a wide range of ways.

As most women's refuges are not accessible there is often nowhere for disabled women to go to find safety from abuse. This is especially difficult for women who require caregiver support for daily needs.

Women with disabilities and mental illness are often not believed when they seek help for abuse – which further increases their vulnerability.

Older women experiencing domestic violence

Many women have experienced domestic violence for many years from their partners yet never accessed help or attempted to use domestic violence services to leave the relationship. Other women experience abuse as they age, either from an ill partner or from older children. All of these women require services and refuge to help them escape abuse. Currently, however, very few, if any, refuges accommodate women over about 55 years and few services work with older women, referring them instead to Age Concern.

Sex Workers

Currently sex workers can access women's refuge and domestic violence services however they usually have to stop working to stay in a refuge. In many New Zealand refuges, if a woman is found to be continuing sex work she is evicted^{xii} – yet sex work may well be related to the abuse that she has experienced. These women may not only be victims of domestic violence from partners, but abused as a result of their work and working environment. These women also require refuge to escape further harm.

Why is there a need to have specific responses for these groups of women?

The primary reason is that it is not equitable to provide a service to only a few women. Refuges do their best to accommodate all women, but they have to manage demand, safety and the complexities of a communal living environment. Also, women with physical disabilities, mental health/substance abuse problems, sex workers and older women are frequently left out of discussions and decisions about domestic violence service provision and information. This is partly because historically they haven't been consulted, but also because they don't easily fit into the services that exist, as they require specialised accommodation, help and support.

Another reason to respond specifically to these groups of women is the ethics of asking women to divulge abuse when there are no services available to help them once they have disclosed.

All over New Zealand, District Health Boards are rolling out screening for family and intimate partner violence throughout all of their services. If women are unable to access refuge or other domestic violence services because of their mental health or substance abuse problems, because existing services are not accessible, or there is an age limit on services, referral will not only not help them, it will further exacerbate their mental health problems and may put them at risk of further violence, as they are refused another avenue of support.^{xiii}

One of the considerations, when deciding whether to put a screening process in place for any health related issue, is to consider the possible harm that could occur as a consequence of that screening. One of the related ethical considerations – as part of the consideration of harm - is whether there are sufficient and appropriate services to respond to the identified health issue. Currently, there are no appropriate and acceptable treatments or services for women who have substance abuse or mental health problems that preclude them from accessing conventional refuge and domestic violence services. Nor are there many accessible refuges or refuges that will house older women. This could, therefore, be construed as causing harm.

The DHB screening is already identifying women who are unable to use the conventional domestic violence services (women's refuge and associated support) because the traumatic stress responses that they have are too complex for staff to accommodate. This problem is only going to increase as screening begins in mental health, disability and older peoples services. *“You can't ask the questions until you know what you're going to do with the answers”*²

In order to ensure that the screening process is ethical and is causing more good to the screened population than harm, this gap in response and service provision will need to be addressed. This research set out to discover how this could be done from a practical, service delivery perspective.

Costs – financial and personal

The ongoing costs to the state, associated with not responding to this issue, include:

- placing and keeping children in foster care or in the care of the state
- ongoing judicial costs related to the family and criminal courts
- the cost of service responses to abused women, for example, CYF, social services, NGO family services
- women and children's ongoing use of mental health and substance abuse services
- rehabilitation and long term care
- personal health services such as A&E and GP services for ongoing physical health problems and problems associated with self harming behaviours

The costs to women and their children include:

- years of life lost because of suicide and homicide

² Dr. Sarah Galvani

- the inappropriate care of women who have been abused and the resulting additional trauma suffered by women as a consequence of this
- the time that women are unable to function without support
- diminished realisation of educational, employment and personal potential
- the long-term effects on the children and wider family, including the perpetuation of intergenerational violence, and a wide range of ongoing health problems for the children as adults.

The Research Project

Homeworks Trust has been advocating for the provision of services for women currently excluded from refuge for ten years. Over this time we have slowly raised awareness of these issues.

Since the production of our teaching resource *He Drove Me Mad*³, awareness of the relationship between mental illness/substance abuse and domestic violence has risen to the stage where people in refuges, domestic violence services, DHBs, NGOs and others are starting to recognise the need for specialised services and think about how these services could be provided.

In March 2011 a booklet was launched as part of the MSD *It's Not OK* campaign that specifically talks about domestic violence and disability. Homeworks Trust was a pivotal part of the consultations and writing of the resource. Dissemination of this booklet will lead to greater awareness of the need for refuge services for women with physical disability who experience abuse.

Why go overseas?

Australia has been working with more complex refuge clients for at least five years, England has been researching solutions and developing services since about 2003. In 2004, I visited England at my own cost and spoke to a number of people who were involved in research, service development and the development of therapeutic practices for women with severe mental health and substance abuse problems related to domestic violence. Several projects were just in their infancy - or still being talked about. Since this time a number of services and refuges have started and some experience has been developed in this field.

While a little of the information that could be used in New Zealand is available on the internet, most is not - it is held by the people who developed the projects and services and who work in them. Hearing first-hand how services have been developed and are actually working - understanding how people are developing and delivering education about these issues - and also gaining understanding about how to bring the different sectors together to work towards collaborative responses, is a useful step towards helping New Zealand take the steps necessary to put new processes in place to ensure that these women no longer miss out on help.

³ *He Drove Me Mad*. A teaching resource about domestic violence and mental illness and women's attempts to find help for themselves and their children. Produced by Homeworks Trust

Method

Visits were made to women's refuges, domestic violence agencies and a number of key people in Australia and England.

The research asked questions about a number of different groups of women. Some of these women can be accommodated in mainstream refuges – others require specific services.

- Older women.
- Disabled women
- Women without dependant children
- Sex workers
- Women with mental health and substance abuse problems

The refuges visited are specialised services that take women with mental health and/or substance abuse problems. The questions asked of each service were:

- The structure of their services - specialised or mainstream, number of staff, qualifications, hours, organisational issues, policies etc.
- Who provides the specialised mental health/drug and alcohol, or care giving services.
- How they are funded.
- How they are managed/governed.
- How the women are referred.
- How they decide who accesses their specialised services.
- Where the women move to after refuge - what other services are there to support the specialised services?
- What the outcomes are for the women who use the service.

The specialist services visited have developed, or are attempting to develop, collaborations with mental health/substance abuse services and they discussed how they went about it; what processes they used and what results they are achieving.

There were also interviews with researchers and teachers, all of whom work at or with universities.

These women are involved in a number of projects including:

- Educating professionals in health and social services to understand and constructively respond to women with mental health/substance abuse problems who are experiencing domestic violence
- Development of specific therapeutic processes to help severely abused women heal from trauma
- Pilot projects educating GPs and providing them with ongoing support to screen and refer
- Developing a training programme for selected refuge workers to enhance their therapeutic abilities

I had already established relationships with some of these women as we have been corresponding about issues. A number of them use the teaching resource developed by Homeworks Trust, consisting of a dramatised DVD, handouts and teaching material.

See Appendix One for a list of agencies, the services they are providing and also the individuals spoken with.

Findings

The English, Scottish and Australian refuges spoken to during the research have a number of generic differences from their sister organisations in NZ. These include:

- higher paid staff to client ratios
- a range of specialised staff alongside the support workers. These include support workers for children and family workers who help women with parenting, custody and relationships with other family members.

In Britain, Ireland and Scotland refuges accommodate women escaping all forms of violence against women. This includes domestic violence, sexual violence, violence experienced during prostitution, female genital mutilation, forced and underage marriage and honour crimes. They accommodate women with and without children. The refuges in NSW also accommodate women with and without children. Therefore mainstream and specialised refuges in these countries were already working with a much wider group of women than those generally accommodated in NZ, which lead to the recognition of the need for specialist services for women with mental health/substance abuse problems and physical disabilities.

This research asked questions about a number of different groups of women. Some of these women are accommodated in mainstream refuges – others require specific services.

Older women

All services that I spoke to accommodated women regardless of age. Many had had women in their 70s and 80s using the service.

Disabled women

Many refuges in England and Scotland have accessible self-contained units within their refuges that can accommodate women with disabilities. These are attached to the communal areas so disabled women can also use the communal facilities and access staff as required. If required, all refuges with accessible units will allow caregivers into the refuge to assist disabled women. In cities with multiple refuges run by one service, some of the houses will accommodate women with disabilities and others won't.

Women without dependant children

While most New Zealand refuges try to accommodate women without dependant children, they prioritise women with children. This is partly because refuge funding comes via CYF (Child, Youth and Family). CYF funding comes with a contractual

obligation to prioritise the rights and needs of children as a first principle of service provision. Because of this, women with older children and women who have lost custody of their children find it harder to access refuge services. Women with disabilities, and those with complex chaotic lives, frequently fall into the category of women without dependant children. The refuges spoken to in the research all accommodated women without dependant children. Some, for example the Nia Project, only accommodated women without children because of the complexity of the issues that women presented with to the service. There was an understanding that women who have mental health and/or drug and alcohol problems as a result of domestic violence will have had children removed or be under threat of removal of children. Therefore the services have specific support workers to help women to keep or regain custody of their children or to regain access to children already adopted out.

Sex Workers

Sex workers are accommodated in refuges in England and Scotland. In specialised refuges – for women with mental health and drug and alcohol problems, they are often able to continue working as long as their work doesn't endanger the security of the refuge. This enables them to work on issues of abuse, mental health and drug and alcohol misuse without having to give up their work and their peer/social group.

Women with mental health and substance abuse problems

Women with mental health and substance abuse problems pose a number of problems to mainstream refuge and domestic violence services. This includes the difficulties these women have living in communal accommodation, the particular problems they bring, the intensity of support required, the need to allow some women to keep using substances while using the services and also the length of time they need to stay in the service in order for real change to be achieved.

By the time many of these women access appropriate domestic violence services they have developed very chaotic lives and find it difficult to sustain tenancies and live within a structured environment. This may be chaotic mental health problems, chaotic substance misuse, or both. Many of them have lost custody of their children and some have had their children placed into permanent adoption. This means all specialist services must have a policy of accommodating women without children.

Women in these situations are often engaged in prostitution, and experiencing additional violence associated with this.

There are three levels of complexity associated with women who have mental health problems relating to their experience of abuse.

- Some have generalised anxiety and depression – this will be many of the women who enter mainstream refuges, as the greatest burden of illness associated with domestic violence is mental health problems including self-harming behaviours such as eating disorders, smoking and substance abuse.^{xiv} *“All women have mental health problems as a result of domestic violence – anxiety, depression, post traumatic stress...some are just more severe”⁴*
- Other women have more severe mental health and/or substance abuse problems that can be managed in specialised refuges in partnership with drug

⁴Celia Hutton, Wimlah Refuge, Katoomba, Blue Mountains

and alcohol and mental health services. These women have some control over themselves and their circumstances and can choose to engage in therapeutic processes.

- Finally there are the most chaotic and damaged women. These are the women “*no-one else will work with*”⁵ These women find it very difficult to engage in any processes and require very specialist refuge support before they can begin to engage in therapeutic work. These are the women that even specialist services find difficult to work with because they have used chaos and change to survive. These women require specialist services with highly qualified staff.

Provision of services

As a result of the research carried out in Australia, England and Scotland, I identified three ways that services can be provided to women with substance abuse/mental health problems related to domestic violence.

1) Women with generalised anxiety and depression related to abuse

Up-skill mainstream refuge workers with basic therapeutic skills.

A training resource, PATH, developed by Dr. Roxane Agnew-Davies, is being trialled in England to up-skill mainstream refuge workers with therapeutic skills that help them to identify mental health problems associated with domestic violence, to provide basic therapy and to equip women with some strategies that they can use to help themselves.

This is a programme that would benefit all women who enter a women’s refuge as anxiety and depression are barriers to women becoming self-sufficient and moving on from abuse. Having support staff who could engage women in basic therapeutic processes would assist women to recover more quickly and more effectively from the experience of abuse and begin to develop strategies for living independently.

“PATH aims to improve outcomes: to support each woman to regain a positive sense of herself, to construct meaning from her experiences, to expand her repertoire of choices and skills, to improve her mental health and to empower her to regain control of her life and future.”^{xv}

See appendix three for more details.

2) Specialised service provision in mainstream refuges for women with substance abuse problems

Appoint drug and alcohol and mental health support workers to work with mainstream refuges and clinical services to support women to actively engage with both services simultaneously.

Currently there are seven specialist drug and alcohol support workers working with refuges and drug and alcohol services in London. They are all accredited alcohol and

⁵ Mairig Tagg, Easterhouse Women’s Aid specialised refuge service, Glasgow

drug clinicians and can provide all of the drug and alcohol services that women require. Most of this work is on a one-to-one basis.

Joan Harrison Support Services for Women in Liverpool, West Sydney, had a 2 year pilot project (2008- 2010) that investigated how collaboration between mental health and domestic violence services could be enhanced and more effective services offered to women who experience both domestic violence and mental health problems.

Both of these services provide “*ongoing case work, counselling, advocacy and generalist support to the women*”^{xvi}. They also work with drug and alcohol and mental health services, providing training and liaison between refuge and clinical services and support women to engage with the services.

The support worker role allows women who would otherwise be unable to engage with domestic violence services to address the cause of their trauma (domestic violence) and the symptoms (mental health problems or drug and alcohol problems) at the same time. By helping women make the link between these two things and find constructive help from appropriate services, women who previously would have been constantly re-traumatised by the responses to their help-seeking behaviour, begin to find a place of safety, understanding and processes to heal.

In order for this model of service to work in New Zealand, refuges will need significantly increased funding. Staffing levels in mainstream refuges would need to be higher to accommodate women with more complex problems, even with specialist support. Paid staff in mainstream refuges in Australia, England and Scotland include support workers, family workers, children’s workers and a range of specialist services. New Zealand would need to provide this level of dedicated funding before refuges have sufficient resource to accommodate and work with women with complex needs.

CASE STUDY

Sim Mandir, Solace Refuges. Specialised, professional drug and alcohol support in mainstream refuges

Sim Mandir, who works with Solace Women’s Refuge, provides an example of the work that drug and alcohol support workers perform. She has a full time position overseen by the manager of the seven Solace refuges. Ms. Mandir’s manager has a background in substance abuse services so she understands the issues. Ms. Mandir has clinical supervision with a drug and alcohol clinical supervisor.

Referrals to Ms. Mandir come from:

- refuges
- self referrals
- Police
- the national domestic violence line
- other advice and housing services

She runs house meetings in mainstream refuges to talk about drug and alcohol use, as

many women are secret users. Women in mainstream refuges are afraid to talk about their substance abuse because they are likely to get evicted if they are using. Once they have disclosed, Ms. Mandir can work with these women to get them help and support.

Individual refuges do the initial domestic violence risk assessment. If the refuges are unsure about accepting a woman because of perceived substance abuse problems they will contact Ms. Mandir to engage her support in housing the woman.

Ms. Mandir meets women the first day they come into refuge and does a brief assessment with them to collect the information that the drug and alcohol services will need to work with them.

She works with about seventeen women a week – ninety over a year (2008 - 2010 statistics.) These women wouldn't have had refuge if they hadn't been supported. All of the women Ms. Mandir supports have substance abuse problems and all the women have also been diagnosed with clinical depression, therefore they all also have mental health support needs.

70% of the women have had their children removed from them prior to contacting refuge.

Ms. Mandir introduces women to the local drug and alcohol services and the local GP and supports them to use these services. Her role is to encourage ongoing contact with the drug and alcohol services.

A critical part of her job is to develop partnerships with services and run training for them. Training is provided for mainstream refuges that take women who misuse substances, to help staff manage and understand the clients and to be able to understand the roles of the drug and alcohol support workers and others who will be working with the women. There is also training for substance abuse services about the needs of clients who have experienced domestic violence.

CASE STUDY

**Joan Harrison Support Services for Women, (JHSS) Liverpool, NSW.
A two-year pilot project. Domestic violence and mental health worker.
Lynn Jennings**

This pilot was set up after research^{xvii} identified that women with domestic violence and mental health needs were 'falling through the cracks'. The research investigated the need for collaborative approaches between domestic violence and mental health organisations and how this could occur. This resulted in the employment of a full time staff member at JHSS who worked directly with people with mental illness and also with mental health services. The service was offered to all women with mental health problems related to domestic violence – not only those with a diagnosis.

JHSS have found that “*nearly every women who walks in the door is using prescribed anti-depressants.*”⁶ This usage is frequently unmonitored so women are still on medication several years after they have been prescribed. Abused women end up in mental health units because of long-term trauma symptoms, long-term depression, self-harming behaviours and suicide attempts.

Ms. Jennings job was first to connect with women either in the mental health inpatient units and community mental health services or anywhere else women with mental health and domestic violence problems had accessed for help, gain their trust and offer them services. She didn’t work with the women in the services, but when they came out. The personal connection was very important, the women felt that Ms. Jennings didn’t think they were mad.

Ms. Jennings worked with women if they decided to leave their abusive relationship or if they stayed. She would help them find accommodation and get legal and other help.

During the pilot, women could be offered accommodation in the JHSS single women’s refuge or into sister services and Ms. Jennings would work alongside them. Since the pilot, women with mental health problems can still come into the refuges but sometimes, during the pilot and now, women who don’t fit refuge criteria go straight to an ‘exit house’ and receive the same support services as women in refuge.

Outcomes included increased cooperation and collaboration between services.

“The activities of the DV&MH worker have improved mental health service providers’ understanding of the impact of domestic violence on women’s mental health; their ability to identify underlying domestic violence in clients of mental health services; and promoted better practice with women who experience the complex interaction of both issues.”^{xviii}

“Outcomes For Women

- The DV&MH service provides practical support, therapeutic interventions and advocacy for a vulnerable group of women with complex needs who, almost certainly in the past, would have “fallen through the gaps” of service provision between the mental health and domestic violence service sectors.
- The service has connected with hard to reach clients – women experiencing complex domestic violence and mental health concerns, younger women, Aboriginal women, and women from culturally and linguistically diverse backgrounds.
- The DV&MH service has created connections with the mental health sector which has allowed identification and easy referral of women in a mental health setting who were experiencing domestic violence. Often, the detected violence had been the underlying cause of the mental health concern or illness. By addressing the violence, the mental health concerns were often alleviated.

⁶ Tracy Phillips, Joan Harrison Support Services for Women, Liverpool, West Sydney

- The impact of the work of the service on women's mental health and their journey away from domestic violence is profound. All of the women interviewed had left the domestic violence and all reported an improvement in their mental health.
- The holistic and feminist approach of the DV&MH worker allowed a connection and trusting relationship to develop between the DV&MH worker and her clients. This in turn led to improved outcomes for the women as they listened to and trusted advice the DV&MH worker provided them with.
- Women's experiences of violence and mental ill health were listened to and validated by the worker, which also enhanced the trusting relationship. Often women had never had this type of validation from a service provider which went a long way to improve their self-esteem, confidence, and health and well-being.^{ix}

3) Specialised refuge services for women with complex mental health and drug and alcohol problems

Long term refuge accommodation for women with complex mental health needs associated with domestic violence.

Specialised services provide safety and support for women with mental health and/or drug and alcohol problems. A specialised service enables women, who are unable to access conventional refuge services, to move into secure accommodation with services that address both their domestic violence issues and the corresponding substance misuse and/or mental health problems without stigma or judgement and with appropriate expertise.

This provides refuge to women who are unable to be managed in mainstream communal refuge services because of the complexity of their problems. The word frequently used to describe these women's lives is chaotic.

Specialised refuges provide a very different service from conventional refuges. While they still maintain the importance of women's choice and autonomy, there is recognition that these women require a period of stability and normalisation before they can address the complex issues that they bring to the service. Therefore, in many of the refuges, the first few months of a woman's stay are spent developing regular routines and helping women to develop ways of living that don't rely on chaos and crisis. This means that women are encouraged to go to bed and get up at regular times, eat meals regularly, and attend appointments on time. This is intensive work for the support workers, who walk along side women, taking them to appointments, getting them up, encouraging eating and compliance with medication etc. Until women have stabilised in this way and started to address some of the issues that brought them to refuge, they are unable to make plans and move forward. Some women are unable to live in refuge with rules and the necessity to engage with other residents.

“The most chaotic women are disassociating, many are hyper-sexualised and many have chaotic drug and alcohol use. These women can't come in to refuge but are housed in 'scatterflats' in the community. It's not just enough to have a roof if you have to obey rules – because these women can't. They need a wrap around service

several times a week – a drop in service.... The volunteers get women up in the morning, get children to school, get women to appointments etc.

Workers will also act as external regulators to help women develop routines when they are in refuge. Refuge workers facilitate house meetings and a drop in service, go to meetings with women and act as their advocates. Women do much better under these circumstances. Their behaviour is the solution to the problems they've been through.”⁷

3a Safety

Specialised refuges need to provide women with both physical and psychological safety. For many women, especially those who have been abused as children and then adults, who have complex trauma problems, safety can be an unknown concept. This means that a critical part of the first and subsequent stages of work with women is helping them identify what physical and psychological safety means generally, then what this could mean in their own lives and then, how they might gain the skills required to keep themselves safe.

“The primary responsibility of domestic violence services is to create safety. Chaotic women don't have any of the tools that they require to recover.”⁸

Part of this process is establishing routine and helping women reconnect with their bodies. Women *“stay in a place of traumatic stress if they are not eating and sleeping routinely...These women are not connected to their bodies at all – neglected children often show this in adult hood. Therefore the women do physical work to release trauma stored in the body – this could just be getting their nails done or having massage – there are two therapists who do this work. Women are given free passes to the gym and other sports centres...”⁹*

3b Post Traumatic Stress Disorder

Virtually all of the women entering a specialised refuge service will have some or all of the symptoms of post traumatic stress syndrome (PTSD). However for most women in a specialised refuge service this is not *post* traumatic stress, but ongoing day-to-day traumatic stress. PTSD is a diagnosis that explains the ongoing trauma related problems that returned service men have, often for many years, after returning from war. The previous name for this was “shell shock”. This diagnosis presumes that the traumatic event is in the past. Yet, for many women who have been living in an abusive relationship, or experiencing ongoing abuse related to sex work or culture, the abuse they experienced hadn't stopped until they came to refuge. Women who require specialised services have often tried for a long time to get help but been prevented by the structure of the services they were accessing, that were unable to accommodate their mental health or drug and alcohol problems. This lack of ability to gain support and safety has further traumatised women and increased the complexity of their support needs.

⁷ Mairig Tagg, Easterhouse Women's Aid

⁸ *ibid*

⁹ *ibid*

In 2002, a study of women leaving refuges in Adelaide found that 45% met the criteria for a diagnosis of PTSD.^{xx}

3c Who accesses specialised services?

Each service spoken to had different criteria, depending on the level of specialisation and their area of expertise.

This ranges from women with moderate mental health problems and/or contained substance abuse problems to women who are so chaotic that no one else will work with them. In some refuges there is the requirement for women to self manage without specialised support within the refuge, others will take women with 24 hour support needs. See appendix one for details.

Most services work with women with more complex behaviour in flats in the community, if they are unable to accommodate them in the refuge.

3d Physical structure of buildings

A refuge for these women needs to have separate, self-contained units for each woman/family. This can be configured like a motel, or apartments in a block, with communal facilities and office space for staff associated with the units. If staff sleep over, there will be sleep over facilities for staff on the premises.

Women who are experiencing a range of complex mental health and drug and alcohol problems need a private space in order to retain their tenancy in a controlled environment. All of the services are designed to ensure maximum safety and there is some form of direct communication between staff and residents in each room. This can be a direct phone line, an intercom or a panic button. Communal spaces are used for shared meals, group work, group recreation etc. For services that house children, the communal spaces include playrooms.

All of the services stressed the importance of having high quality facilities and furnishings. They believe it helps women regain self respect if they feel that they deserve good quality accommodation. *“Why should women who have been treated really badly be treated as second class citizens?”*¹⁰

3e Staffing

In specialised refuges there is generally a high staffing ratio. This includes support workers, family workers, children’s workers if the service takes children, therapists and others.

a) Support workers

These women do the day-to-day refuge support work. They deal with the issues that arise as women work through the problems that brought them to refuge. Support workers have regular (usually) weekly meetings with their assigned residents. This is to set goals and work towards the achievement of goals, monitor progress etc. They also support women with day-to-day requirements. In a specialised refuge this includes much greater support

¹⁰ *ibid*

around normalising behaviours such as going to bed and getting up at a regular time, eating regularly and well and getting to appointments.

- b) Family workers
Whether women have their children with them or not, all of the services have family support workers. This role helps women with parenting, supports women going through court processes for access and custody, helps women with other access and custody issues and helps women find therapy to deal with the grief and guilt of having had children permanently removed. It also helps women reunite and develop healthy relationships with family and friends that she has become estranged from because of domestic violence and the resulting mental health and drug and alcohol problems.
- c) Children's workers
These women individually case manage children, assessing them and ensuring that they have access to schools/preschools and the specialised services that they require after living in houses where they have witnessed/experienced domestic violence plus having a mother with mental health and/or substance abuse problems.
- d) Outreach workers
In some services the staff does outreach as well as in house support, in others there are separate staff for outreach. These staff provide two kinds of support. They support women in the community who are unable to come into the specialised service – or who are working towards refuge but aren't ready to come in - and also women who have been through refuge and are living in the community but who occasionally require help and support – or who want to keep in touch.
- e) Therapists
Some services have therapists on staff; others have therapists who come in once a week or once a month to provide counselling and other services to women.
- f) Staff management and supervision
All services have a manager who manages the service and also does staff supervision. This is a senior practitioner, often with a drug and alcohol or mental health background and extensive domestic violence experience.

The women who work in these services require a high level of experience and are usually highly qualified.

3f Qualifications

In all of the services in Australia, England and Scotland staff have university degrees in human services or equivalent qualifications and/or many years experience in domestic violence and/or social services. Often staff have a mental health or drug and alcohol services background as well as extensive domestic violence services

experience. *“We’re looking for an understanding of violence against women, good communication skills, good listening skills, non-judgemental attitudes.”*¹¹

The staff in these services are working closely with women with multiple trauma and problematic behaviours. They need to have very good boundaries to sustain professional relationships for two years or more. They also need the skills to recognise the manipulative behaviours of many of these women and ensure that neither staff nor residents are played off against each other, creating dissatisfaction and conflict within the houses/organisation.

*“Workers in many services judge chaotic women by their own lives – they don’t understand the difference.”*¹² This means that the women working in specialised refuges must have a very high skill level to understand and work along side the clients in refuge, yet still be able to retain professional boundaries and leave their work behind at the end of the day.

*“One thing the house does, because the women are so chaotic, the staff hold the chaos. The house is a safe place to come home to...”*¹³

3g Providing cover – hours the services are staffed

All services provide 24 hour, seven day a week staff cover.

For some services this means that there are staff in the refuge all of the time. This means that staff sleep over every night and are available all night if required.

Others, with less funding, provide twelve hour a day cover Monday – Friday plus phone cover 24 hours and weekends. This requires one staff member to be rostered on to the phone and available to go out to the refuge overnight or in the weekends if required.

Most services believe that the ideal for specialised services is on-site 24 hours a day, seven day coverage. This would require nine support staff, plus specialised staff.

3h Children

Many of the women in specialised services have had their children removed prior to them making contact with the refuge services. Therefore a number of the specialised services make no provision to house women with children. Some refuges wouldn’t take children because of the risks posed by other residents and if required, would support women with children to find refuge with other services or in separate flats. Others, however, have flats that can accommodate women with and without children. Women’s children can be with family (siblings or parents) or fostered or adopted. Some abusers will have custody of the children.

All of the children who come to refuge with their mothers will have emotional problems related to living with abuse. These children require specialised help and

¹¹ Mairig Tagg, Easterhouse

¹² *ibid*

¹³ Claire Colley, Nia Project

support to help them recover and stabilise so that they can also move on in their lives and not repeat the patterns of their parent's relationship. It is therefore important that all specialised services have children's workers associated with them to work closely with children and that specialised services for children continue to be provided in each geographical area.

3i Services

A range of services is offered in specialised refuges. As mentioned previously, this includes helping women develop routines and achieve day-to-day goals such as doctor's appointments and eating and sleeping regularly. Much of the work is one to one. Some refuges also run groups that have more of an educative function, such as life skills and information about domestic violence.

Providing support services means a variety of things. It includes:

- Risk assessment, "unpacking the issues", and helping women understand domestic violence.
- Work with/about the violence that has occurred
- Safety and risk - what these words mean and how to minimise risk and work towards greater safety
- Addressing mental health issues
- Parenting support for those women who have custody of their children, access to removed children, help with custody disputes and preventing children being removed
- Court support
- Getting legal aid
- Linking with clinical services and making constructive use of these services
- Working with grief
- Working with guilt
- Reconnecting with family and friends
- Skills related to developing and maintaining friendships with other women
- Harm minimisation for those who are using substances
- Understanding and minimising the risk of self-harm
- Life skills including developing new routines, problem solving techniques and conflict resolution
- Self care
- Suicide prevention
- Finding housing
- Resettlement work when it's time for women to leave
- Outreach once they have moved

The work is about changing patterns; focusing on what the client wants to do and helping her identify and make constructive choices that enable her move on in her life. *"This is work from a woman-centred perspective – what women need and the order they need it in. But we have to recognise the need to stabilise first. This is done as a side-by-side process – not pushing from behind."*¹⁴

Support workers must build rapport with women – develop a one-on-one relationship with them. This is a slow process; every day in the refuge is different. Women's

¹⁴ North Ayrshire Women's Aid

lives change on a daily basis so there are a lot of informal conversations. Information comes slowly as women develop trust and relationships with the support workers. *“Small steps towards big steps.”*¹⁵

Some services meet women in mental health or drug and alcohol in-patient units and use this time to develop rapport and trust that enables women to move into the specialised refuge when she leaves the in-patient service.

At North Ayrshire, Women’s Aid staff discussed the need to look at women’s overall health – for example the injuries, long term physical health problems, smoking and skin conditions that result from not having cared for themselves. They had accommodated a woman with inoperable cancer and assisted her to find safety while she dealt with this.

All refuges partner with other services in the community to provide clinical support for women *“The women are encouraged to use other services for their needs – so they already have relationships with other services when they leave. The questions we ask when assessing for this are:*

Can she do it herself?

Can she do it herself with support and advocacy?

*Can she do it herself with support from another service?”*¹⁶

3j Provision of specialised therapeutic services

Many services offer some specialised services in house.

Nia offer a harm minimisation approach to drug use, helping women work towards detoxing. They track women’s use and do daily health and safety checks of rooms to ensure that drugs and drug paraphernalia are locked away and that there are no weapons etc in rooms.

*“If women are using crack, alcohol etc the staff and women have to understand the underlying issues, because of the psychological addiction. In the refuge they chart their use and recognise what’s happening when they use less.... It’s about changing patterns – focusing on what the client wants to do. It’s rarely judgemental. We work on choices. They can never let us down, that’s judgemental.”*¹⁷

A number of services have therapists and/or psychologists on staff or available to the women for regular sessions. While not all women want therapy it can be a constructive tool to help women recognise the cause of their trauma and work to address and reduce it. Counselling is often for PTSD as so many women are suffering from this.

“Mostly these women have an inability to sooth themselves – they are written off as personality disorder – then mental health services won’t touch them. National mental health services might offer 10 or 20 sessions to treat symptoms – they never look at the social and human rights abuses the women have experienced.

¹⁵ Claire Colley, Nia Project

¹⁶ Celia Hutton Wimlah Refuge

¹⁷ Claire Colley, Nia Project

Not all women recover from the inside out – some women need to start with the outside to be safe.

The therapy at Easterhouse isn't about disclosure – it's about integration – many women are not able to disclose – we work very gently with a variety of therapies – e.g. sand therapy. The progress is often internal – it doesn't need words.

People (who don't work with abused women) don't get traumatic bonding. In hostage situations the first thing we say is to form a relationship – it's the safest thing to do – and the best thing to do to prevent worse harm or death. So this is what women do – and it's a very hard bond to break away from because it has been a useful strategy.

Most chaotic women require secure accommodation for up to three months at least – a place where they are safe and have to engage with services. Women's Aid celebrates autonomy and self help – but some women need more – they need the security of a safe place. The autonomy etc is tied up with women's history, the development of refuge services etc – but some women require a different and more secure environment. Many of these women don't even know what we mean by the language we use, because their perspective is so different. So the first part of recovery is to help them understand what is meant by a safe life.

The biggest problem is that chaotic women use chaos to deal with trauma - they get used to hyper-arousal. So when they stop they feel flat and have to learn to manage this and reconceptualise it. This involves learning new behaviours, which is why physical therapy is so important.”¹⁸

3k Rules

In the refuges for very chaotic women, many women have experience of being evicted from mainstream refuges for unacceptable behaviours including mental health problems or substance abuse. Often a specialised refuge is women's last chance so if a woman is able to settle in and abide by the rules she will generally achieve constructive outcomes for herself.

a) Visitors

All refuges have the usual no men rule. Some English and Scottish refuges allow women's female relations to visit – some can even stay overnight. Others have a no visitor policy and women can only meet their friends at least 15 minutes walk away. This is to keep the refuge location safer.

b) Drug use

Different services have different rules about drug use. Refuges that provide services for women with mental health problems may not allow women to use anything other than prescribed medications. Others take women who are using but don't allow use on the premises. Still others allow drug use – but not in the communal areas – and insist that drugs and drug paraphernalia is kept in a locked cupboard in women's rooms. Most services require a

¹⁸ Mairig Tagg, Easterhouse

commitment from women to access drug and alcohol services and make some effort to gain control over their use.

c) Prostitution

Most services accept women who are sex workers. A number allow women to keep working during their stay in refuge, which gives women time to deal with the other issues in their lives before addressing their choice of employment. Some services have rules that prohibit women enticing other residents into sex work.

d) Violence towards other women

Violence is not acceptable between residents or towards staff. The refuges that take very chaotic women said that the only thing that would exclude a woman would be a history of serious violence. Even then they may house the woman in a flat remote from the refuge or work with her in the community.

3l Evictions

A high proportion of the women who access specialised services will have been denied refuge at a mainstream refuge or have been evicted for substance abuse or behaviour that contravenes rules and safety practices.

As noted above, all specialised refuges have rules, however they are very loath to evict women, as they know that they are the last resort for many of them and therefore will work with women to help them live/behave within the rules of the organisation rather than evict them. This is part of the process of helping women develop new, non-chaotic self-management skills. If there is no choice – because they are putting other residents at risk - they will be offered alternative accommodation and the opportunity to continue their recovery through the outreach service.

3m Outreach

Most refuges provide an outreach service. For specialised refuges, outreach enables a number of things, including working with women who:

- are still with the abusive partner
- are too chaotic to live in refuge
- are working towards stabilising so that they can live in refuge
- have been in refuge but still require either intensive or intermittent support and contact

Some refuges have “exit” houses that women can move to after refuge for up to two years while they relearn the skills of independent living and managing a tenancy.

These women require regular contact and support. There are many benefits of exit houses:

- They provide stable tenancies for women who are still fragile while allowing more independence than a refuge situation
- Staff don't have to spend resources finding tenancies that are appropriate until women are more able to participate in the process
- There is a much greater chance of ongoing tenancies being successful after this period of supported adjustment.

Outreach support ensures that women don't feel abandoned by their support services. They still have access to the expertise, relationships and networks that were established in the refuge. This provides greater confidence to re-engage with the community and find alternative means of support including developing relationships with a wider range of services. While women coming out of refuge will be considerably empowered by the therapeutic process of living in a place of safety and support, they may still require advocacy and information to enable them to make good choices and insist on the recognition of their rights.

*“Outreach is available as long as women need it. They can come and go because women can go into crisis at any time...”*¹⁹

Other outreach services can be run by ex-residents of the refuge. For example, associated with North Ayrshire Women's Aid, there is a “Lunch Club” run by ex-residents. This is a non-judgemental activity-based meeting that attracts women currently using refuge and those who have left but want ongoing peer support. Two important success factors for this group are that there is no labelling in the group, for example, junkie or mad woman, and that the meetings are held in the community so they are perceived as normalised women's groups, not specialised therapeutic interventions.

North Ayrshire Women's Aid also make the point that it can be dangerous to work with some women in the community as they are less able to be protected from ongoing abuse by their ex-partners.

At Wimlah, refuge work is 30 – 40% of the work of the staff. The rest is outreach. This includes groups in small towns in the area.

3n Referrals and assessments

Women are referred to specialised services from many places. In some areas drug and alcohol and mental health services refer, in others there is still no awareness of the links between mental health and abuse and therefore no mechanisms for recognising and referring women from these agencies. Referrals often rely on the networks and partnerships that have been developed by the refuges. This means that key referral agencies differ from service to service. However there is a wide range of agencies that can be potentially useful partners in the identification and referral of women requiring specialised refuge services.

Typically referrals come from:

- women themselves
- mainstream refuges in the area
- domestic violence phone lines
- word of mouth

Other referral agencies vary from service to service:

- police – especially domestic violence units and interagency domestic violence response units in the police

¹⁹Celia Hutton, Wimlah Refuge

- A &E (accident and emergency)
- health services
- women's services
- social workers
- family
- housing/homelessness organisations
- sex worker services
- GPs
- mental health services – not commonly – only when very good partnerships have been established
- substance abuse services - not commonly – only when very good partnerships have been established
- midwives/maternity services

All women who want to come into refuge are assessed. In some areas assessments are centralised – for example, a Women's Aid mainstream refuge may do an initial assessment, then, in all cases, specialised refuges will do their own assessment, relevant to the services they supply.

“It's rare to refuse a woman who wants to come in ...after the initial assessment many women don't come because they're too chaotic. If they come into the refuge, work starts immediately.”²⁰

3o Partnerships/relationships with outside services

“...integrated service strategies are badly needed to prevent women with complex needs being excluded from mainstream services and/or each sector failing to address the multiple issues, and therefore to promote safety, health and quality of life.”^{xxi}

An integral part of the therapeutic process of specialised refuges is the relationship with drug and alcohol or mental health services that provide the clinical component of the work.

In order for clinical interventions to be constructive, the partner agencies must understand the need to acknowledge the abuse that has preceded or exacerbated the mental health /substance abuse problems and the necessity to be addressing both issues at the same time – i.e. the importance of working in partnership with domestic violence services.

Some agencies have done this by setting up their own clinical services – for example, Missing Link and EACH Hounslow (see case studies). This means that women accessing these services can work with both issues together while staying in a service that they trust.

Other refuges, while often employing women with clinical skills within their service, support women to use outside agencies for the clinical component of their care. This has varying degrees of success depending on the partnerships that have been developed between the two services and the willingness of the statutory agencies to

²⁰ Claire Colley, Nia Project

engage in learning about the needs of women with severe trauma responses to domestic violence.

Successful partnerships rely on shared understandings of women's pathways towards specialised services, shared goals for service provision and outcomes as well as a desire, from both services, for constructive working relationships.

Central to this is training that helps both partners understand the organisational paradigm of the other and a willingness to overcome barriers to collaborative work. This training and relationship building is not one-off but must be constantly updated and refreshed as new staff are employed.

Joan Harrison Services for Women, in Liverpool, NSW have an MOU with their local mental health service that forms the basis of their relationship. This was negotiated as the specialised service was being developed, meaning that both agencies – domestic violence and mental health - have equal responsibility to make the partnership work. *“A key finding...was that, in the absence of collaboration across the domestic violence and mental health sectors, interventions fail to address the complex interaction of domestic violence and mental health issues, often leaving women in unsafe situations where the mental health issues are exacerbated”^{xxii}*

3p Length of stay

In Australia the length of stay in refuge is three to six months with, at Joan Harrison Support services, a further 18 months in individual flats. In most English and Scottish refuges the length of stay in refuge is 6 months to two years before moving to 'exit' flats. The shorter stays are related to funding – not to the length of time considered necessary for women to stabilise and recover.

“The refuge keeps women until either they are able to manage outside or they have disengaged – so they are kept as long as possible – especially until they can maintain a tenancy.”²¹

Experience and research suggest that women take the first 3-6 months of stay to settle into the house, stabilise routines and start feeling safe enough to engage with the issues that brought them to refuge. Only then are they able to start making plans to change and move on. Celia Hutton at Wimlah talked about research done by the Benevolent Society of Australia that suggests that it takes women who experience domestic violence up to three years of support to stabilise and move on, with many still traumatised ten to fifteen years later. This means outreach services that enable women to engage for years after leaving refuge are very important.

“Understanding the relationship between mental health, drug and alcohol and violence – and starting to heal from this – takes a long time. A year is a tiny amount of time for this journey. Many women will have been abused as a child as well...”²²

²¹ Claire Colley, Nia Project

²² *ibid*

3q Staff supervision

All the services talked to have an on-site senior practitioner to provide supervision for the other staff. This is generally the manager of the service. Supervision is a critical role in a specialised service; to ensure the safety of staff and clients; because of the complexity of the problems that clients present with; the difficult interpersonal issues; and the need for clear boundaries discussed above. Some services also provide staff with clinical supervision from a partner mental health or drug and alcohol organisation.

3r Moving on

As described earlier, a number of the refuges have flats that women can move to when they leave the refuge. They can stay in these for 18 months to 2 years. This enables a stepped leaving process so that women are able to gain some independence and experience managing a tenancy, while not relinquishing support from the service. All of the services provide on going outreach to women after they have left the refuge. This is not time limited so women can use it when they need it and not feel constrained by policies that restrict use.

3s Outcomes

Outcomes are of course variable. They depend on women's level of engagement with the services, the amount of time they are able to stay in refuge and the support agencies that work in partnership with the refuge.

As with all refuges there are some women who are unable to engage and leave after a few days or a few weeks. Some will return to the abuser, others are serial refuge users and are unable to maintain the commitment to change. Refuges see these women not as failures, but an opportunity to work with women to help them develop the skills, confidence and courage to one day return to refuge if they want or need to. These women are encouraged to stay connected via the outreach services until ready to make the long-term commitment to their own healing and wellbeing.

Other women just want to be in a safe place and aren't interested in engaging with either outside services or the services offered within the refuge. These women will not benefit from the specialised services that are available, although having a place of safety will help them make decisions about their life and future, as in any refuge.

A number of women are loath to engage with outside drug and alcohol or mental health services because they are mixed gender. Other women don't want to engage in therapeutic counselling processes for PTSD because it is too difficult to revisit past trauma.

The outcome most common to all the refuges, however, was that once women make a commitment to engaging in the processes offered to them by the service, they tend to stay for as long as possible to take full advantage of the service.

For the women who live in specialised refuges there are a range of benefits, depending on the services offered and the length of stay. Women who are able to engage fully with the therapeutic processes are able to make long-term changes that will be life-changing. This begins with developing an understanding of the relationship between the abuses they have experienced and the subsequent mental

health and drug and alcohol problems. “...a critical part of the recovery depends on each woman locating the problem as the abuse she has sustained, and separating herself as a person from what has been done to her.”^{xxiii} This understanding enables women to take control over substance misuse and/or leads to greatly improved mental health. Women develop self-awareness and understand that “you can’t change people, you can only change yourself”.²³

Women find, after a period of time, that they are able to maintain stable routines and develop strategies to live in a less chaotic manner day to day, so that their lives become more manageable. This enables them to engage with outside support services, maintain tenancies and gain and maintain employment.

Staff provide advocacy and manage “the balance between advocacy and encouraging autonomy.”^{xxiv}

All of these things result in an increase in self-esteem, confidence, self-respect and independence

After learning about safety, warning signs, and what healthy and unhealthy relationships look like, women are better equipped to have healthy relationships and live violence-free lives.

Women who have had children adopted out can sometimes regain contact with them. Others, who have lost custody or access, can regain this. This is very important for women’s ongoing mental health. Women can also gain more confidence in their parenting. It is not only relationships with children that are resurrected. Many women are able to repair relationships with family and friends that have been damaged by the abusive situation and her subsequent chaotic behaviour.

Although women have their own flats within the refuge, interacting with other residents and staff helps women develop better social skills, which help them reintegrate back into their families and communities when they leave the refuge.

Women become more aware of the opportunities available to them in the wider community. Virtually all women who engage with domestic violence services and refuges will leave with more information about their situation, the available services, legal processes and other information that will help them make informed choices about what they want to do, how to do it, and who is available in the community to help them. Some women gain the confidence to engage in education, helping them to develop self-esteem and enhancing their employment prospects.

For women who enter refuge without residency the time in refuge can be used to apply for immigration status.

3t Funding

In Australia, England and Britain, refuges are funded from a variety of sources. Primary funding for many of them comes via Government homeless support funding and from local Government. In the current political climate many specialist services are under threat of withdrawal of funding.

²³ North Ayrshire Women’s Aid

Women in refuge pay weekly rent that is higher than usual rents. This money comes from a housing benefit that they receive from the government.

“Women who work often can’t afford to come into refuge – also women with mortgages often stay home because they can’t afford to pay for two types of accommodation. Some women take sick leave or give up their jobs to come in...it’s getting harder to get grants and funding²⁴.”

CASE STUDY

Next Link, Safe Link and Missing Link. Bristol

This is a multi-agency service that provides women only mental health, domestic violence and sexual violence services. The organisation believes that there must be a holistic approach to women’s lives and has always seen a link between domestic violence, sexual violence and mental illness. There is ongoing consultation with survivors about services, new initiatives and their experience of services.

Missing Link is a women-only mental health service that has been in operation since 1982. It offers services to women with long term or acute mental health needs, providing accommodation as well as support in women’s homes.

Next Link is the domestic violence service that has been operating since 1999. In 1999 it supported 89 women, in 2009 it supported 1001 women.

Safe Link is the sexual violence service. All of the services are supported by a housing service.

The organisation does advocacy work to show the links/relationships between the three issues and women’s position in society.

At first the various parts of the organisation were operating independently but they realised that many of the women had overlapping issues and now the mental health services train the domestic and sexual violence staff and visa versa. This ensures that all sectors understand each other, can pick up issues to refer to each other and can work together with clients. Locating teams in the same building gets over the silo mentality²⁵ and ensures that expertise is shared across teams.

“Because we use a social model we are looking for wider skills in our staff”.²⁶

“We save money for everyone – Court, social services, child services....”²⁷

There are 70 – 80 staff. All staff are trained by the service in core competencies and some go on to other training, for example more intense domestic violence training.

²⁴ Mairig Tagg, Easterhouse

²⁵ ‘silo mentality’ – services operating independently of each-other

²⁶ Carol Metters, Director, Missing Link, Bristol

²⁷ *ibid*

When employing staff, the management look for experience over qualifications – for example, mental health knowledge, an understanding of domestic violence, confidentiality and boundaries. The service employs survivors.

The aim of the service is to help women gain an understanding of the underlying reasons that they feel the way they do - to help them develop insight that helps them go on to form less harmful relationships and live safer lives. For women with mental health problems this means helping women to manage their mental health problems by seeking help early, having a prevention plan and being clear about what helps them stay well.

“Equipping women with tools to go outside and have another go...helping them to do something different”²⁸

Staff costs are 70% of the organisation’s outgoings.

The agency has developed partnerships with a range of outside organisations. They work in a very multi-agency way.

The support offered looks at both emotional and practical support – *“beyond the pathology”*.

They use a social care model. This looks at practicalities:

- education
- economics
- housing
- children’s schooling and support

Missing Link; a women-only mental health service

There is starting to be recognition in mental health services in England that there should be women-only wards and services. Women don’t fare well in psychiatric hospitals – they may become institutionalised and there is a high risk that they will be raped and/or abused. The majority of women go into mental health services as informal patients; they’re not sectioned, so have ended up in hospital by default, but then find it very difficult to leave the system.²⁹

The Crisis House is proving incredibly successful for women already using community-based mental health services and is a safe, effective solution for women needing in-patient care. Women feel safe in a woman only environment and like making their own beds and their own food. They like having responsibility given back to them. The crisis house is a house – women can come and go, so the women are more integrated into the community. This results in women, including sectioned women, doing better and requiring in-patient care for a shorter time. The house makes huge cost savings – the cost is one third of an in-patient psychiatric bed. It’s not medical model, it’s a social care model that works well for women with any form

²⁸ ibid

²⁹ ibid

³⁰ ibid

³¹ ibid

of abuse in their lives. The house developed from 20 years of work by survivors.

While women live in the house staff help them with:

- housing
- benefits
- work
- relationships
- primary health
- confidence
- self esteem

Many women who use the mental health service have domestic and/or sexual violence in their backgrounds so they are introduced to the relevant service – Next Link or Safe Link and leave the crisis house with a crisis prevention plan.

Next Link. Domestic violence service

This service has:

- a large Black/migrant service
- 5 refuges, one specifically for Black and ethnic minority women
- a specialist South Asian service
- counsellors
- training and education
- a forced marriage worker
- dedicated children's workers

The refuges are not staffed 24 hours a day. They are staffed 9 – 5 with on-call staff who will, if necessary, come to the refuge after hours. Average length of stay in the refuge is about 6 months, but can be longer if required. If a woman has no recourse to Government funding it can take up to a year trying to organise her right to stay. These women often have very high needs, including their immigration needs. The refuges can take two women with no funding at any one time.

The refuge staff includes:

- a play worker
- a child worker
- a family worker
- 2 support workers
- dedicated services for Black and ethnic minority women
- south Asian response workers

There is a counsellor attached to the refuges and staff who provide resettlement and tenancy support. The ratio is one staff member to six women, and children have their own support worker. Some women have more intense support needs than others and this is also accommodated - it's not 'one size fits all'. There is also community support, which is based on women's needs. Once the violent partner is no longer living with the woman staff focus on integrating her back into the community and gradually phasing out support.

There are staff engaged with high risk families, in partnership with other agencies in the city. There is also a worker in the police station who picks up domestic violence

incidents and refers to the police high risk interagency team. This position was created to increase referrals and to increase successful prosecution of perpetrators.

There is a crisis response service for women who become homeless because of domestic violence. This helps women access emergency legal help to stay in their own homes or to move to a safe place. Once a woman engages with crisis services she is usually there for about four weeks. The crisis service is staffed 24 hours/7 days a week with a minimum of two people. Women can move to refuge from the crisis service.

If women go through the three services – crisis, safe house and community support, the outcomes are very good and less than 10% of women come back into the service. In 2009, of 105 families worked with in refuge, only 5 women returned to their violent partners.

Domestic violence/mental illness

If safety is the primary concern women will go into refuge, as the refuge staff are all used to managing complex needs. After a period of stabilisation, women will be referred to other services within the organisation. There is one safe house for women without children and the others for families.

The refuge risk assessment includes mental health and drug and alcohol issues. None of the refuges take intravenous drug users who are currently using, as they feel they must consider the safety of everyone in the refuge.

Other Link services:

A housing service that includes:

- support for rough sleepers to get off the streets and regain tenancies
- support for women who have lost tenancies because of mental health problems
- a shared housing scheme to help women stabilise their lives, find alternative ways of managing their lives and moving on into long term secure tenancies
- floating settlement support – a resettlement support service for women moving into new tenancies or wanting to continue existing tenancies, including helping them find voluntary work, training courses and new activities to do during the day. There are also classes in managing money and managing mental health problems.

There is a dedicated self-harm worker as many of the women who use the Link services self-harm.

A counselling service. A counsellor sees women for a set period of time and works closely with other support staff.

Training, recreation, education and employment service. This is a citywide service that “*works with women with mental health needs who require help with finding interesting things to do during the day and to build up confidence and enjoy life.*”³⁰ It also helps women work towards longer sustainable goals.

A support worker who is based in the courts to work with female defendants. In the first seven weeks of the pilot they worked with 60 women. They are looking for permanent funding for this initiative.

A worker who trains local GP practices about domestic violence and provides on-going support. "...getting GPs to ask the question, to think out side the box"³¹ This position has resulted in many referrals.

CASE STUDY: EACH, London

EACH Hounslow started as a drug and alcohol service for black and ethnic minorities (BEM) and has expanded in to a counselling service for; alcohol, drugs, mental health, housing and domestic violence. They operate over eight boroughs of London. The service is open 9-5, and the alcohol service has two late nights.

There are forty staff in total – many are part time. There is wide ethnic representation and many languages are spoken. Staff include:

- counsellors
- psychologists
- a housing team
- 2 directors

All counsellors have diplomas and all counsellors and psychologists are accredited.

EACH use a harm minimisation, person centred approach for all their services. They work to maximise safety.

Services available include home visits, one-to-one counselling and groups. Clients are also referred to other relevant organisations.

For domestic violence, women usually have a maximum of fourteen counselling sessions but if they are high risk this can extend to twenty-one or more. Counselling for alcohol and/or drug use is usually twenty-one sessions, but can also be longer.

EACH run a number of psycho-educational groups about:

- looking after yourself
- your health
- how family members can help people who misuse substances
- how family can help people change

There is a 12-week structured programme for people using alcohol. As the domestic violence programme has developed they have started offering gender specific drug and alcohol groups. These work on both a feminist and an addiction model. Both men and women prefer gender-specific groups. The domestic violence groups run for nine weeks, two hours per week.

EACH has a mental health project for men and women. This consists of seven counselling sessions based in GP services. These counsellors work alongside local

mental health services. The seven-session limit is because of funding restrictions; they would rather provide up to twenty-one.

Staff provide training about domestic violence/substance abuse and forced marriage. This training is offered in-house and also to statutory and voluntary agencies including child protection, social workers, domestic violence workers, midwives and other health staff.

There is a substance misuse worker who works with mainstream refugees across London.

EACH is involved in community engagement projects that seek to address the wider determinants of health in the BME communities.

EACH is developing good partnerships with other health and social services, for example, they work with the domestic violence network and forum, drug and alcohol services and housing.

In each borough there is a senior counsellor or team leader, with counsellors, administration staff and volunteers in every office. Women are referred from a variety of sources, including mental health teams, and women with psychosomatic illness are referred through GP services. From the organisation's counselling and groups they identify women who have domestic violence or mental health problems, including the misuse of prescription drugs.

When a referral comes in there is a full assessment including risk and advocacy needs. Counselling occurs after assessment. If there is risk of violence, women are placed directly into a refuge and EACH liaises with the refuge workers. Sometimes they do telephone counselling until women can engage with services.

There is a lot of fear in minority communities about engaging with services. Once they engage people are okay about one-to-one, but very suspicious of groups and other services.

Domestic violence

The domestic violence service is 5 years old. There are 5 people working in the domestic violence team, none full time.

When the drug and alcohol service was set up staff realised that they needed to work with partners and children, as well as the person abusing substances, because the family is an important part of supporting a person's rehabilitation, so a home visiting service was started. During the home visiting assessment, staff noticed that a lot of the partners of men being counselled for alcohol/drug use were experiencing domestic violence. Women weren't specifically talking about domestic violence, but they were disclosing mental health problems indicative of domestic violence, such as anxiety and depression. After doing research it was discovered that one third of women in the home visitor programme were experiencing domestic violence that was invisible, secretive and stigmatised, so EACH put in a bid for a specialist domestic violence service for Asian and BME women.

At first EACH counsellors weren't experienced in domestic violence. Although most people using drug and alcohol services have histories of perpetrating or experiencing violence EACH only worked with the substance abuse. However, once they had the domestic violence funding, all counsellors had domestic violence training and realised that the teams (substance abuse and domestic violence) had to work together. The organisation recognised gaps in competencies, policies, training and safe practices and now have responded to all of these.

*"It has taken us a while to work in a way that is integrated and competent."*³²

If domestic violence is identified in clients referred for drug and alcohol counselling, staff will start working with the domestic violence, as substance use is recognised as being a coping mechanism. Also, EACH say that abused women are more prone to anxiety and depression. Women are often secret drinkers to cope with these symptoms. EACH are concerned that GPs are putting women on anti-depressants rather than referring them to counselling services.

Asian women often won't leave abusive relationships. They will put up with years of abuse before they'll leave because of gender roles, economic dependency and language barriers. This leads to a higher risk of murder. Also, women won't go to the police because they're perceived as racist and not very helpful.

The first response of an Asian family to domestic violence is to patch it up, to keep the family together, so women are often pressured into couple counselling, the family name being more important than the women's safety. Therefore the assessment for couple counselling needs to be very careful. The counsellors assess the couple together and separately and if there seems to be domestic violence, the service insists that women have separate counselling. That the organisation insists on separate counselling is very important, because if women won't do couple counselling they are often seen by their family and community to have failed – to have broken up the relationship. At first domestic violence was very hidden and secret, but by the end of the fourth year of the project women were disclosing more readily.

The domestic violence advocates will go on supporting women and helping them with domestic violence related issues once they have finished their counselling sessions. They work with women both in and out of violent relationships.

Women are helped to build strength and competence to make a decision. This has to be done with cultural awareness and sensitivity. Very often it is about risk.

Every session is safety planning. Women work on:

- empowerment
- safety
- setting out a core plan that will keep them safe

In the domestic violence service, only women work with women. In drug and alcohol services they have a choice, but all women and men can do same sex work if required. For example, it's easier for men to challenge men about their abusive behaviour. They note that the feminist model doesn't work entirely – because mother-in-laws

³² Sandra Machado, Director, EACH Hounslow

also abuse.

Women are often victimised when using drugs or alcohol or having mental health problems even although there are services to support women and legitimate the abuse. Alcohol doesn't fit culturally into women's role – men can go out and drink and be merry – women can't. If women step out of proscribed gender roles it brings shame to the family and abuse often escalates, while even abusive, substance-using husbands can be perceived as charming and culturally acceptable. These men, with wives who are abusing alcohol or having mental health problems, can end up with custody of the children. If women are sectioned (mental health) then men will always get custody.

Challenges

EACH doesn't have very standardised ways of doing things as the issues are so different from community to community. They have to be sure not to further marginalise people and communities because the host community marginalises them with poverty and exclusion, plus the pressure to succeed. This means that the organisational learning never stops. There are always new communities arriving, and different generations have different issues. The organisation is often working with people who are very conservative, for instance coming straight from a village in Pakistan, so often it's not just counselling, its educating – saying “*that's not right*”³³.

Quite a few clients are older first generation BME women. These women were not born in Britain but came for marriage or work. When older women come to the service many of them have a lot of remorse for not leaving the relationship earlier – a lot of regret about their lives. They often didn't know that there was any help. There is sadness and grief but they don't want to leave because “*it's too late*”. However, after counselling they frequently become more assertive, can assess risk, call police and access services with the help of EACH. Counselling for these women needs to be very different. They often have no language for therapy and think they will be told what to do and then will do it, so therapists have to help them understand what counselling is and how to talk about themselves.

The teams come together to talk about clients, domestic violence and substance abuse, and often work with both partners. Working with both partners in the same service can be a dilemma because “*how much do you challenge an abuser if he hasn't disclosed?*”³⁴ When the service started recognising and responding to domestic violence they had to decide, for example, how to recognise abuse while empowering women and how to challenge the myth that women are home breakers if they disclose domestic violence. To do these things, counsellors have to confront their own beliefs and values to ensure that they can work ethically and challenge people to meet their goals. It's important not to collude – staff members need to be culturally competent so that they can challenge attitudes and behaviours from a religious and cultural basis. This meant a learning and growth for the staff – not just a feminist perspective but looking at the cultural perspective and layering it with a rights perspective. Staff have to ensure that they are “*not colluding with culture*”³⁵, but are looking at the cultural elements that respect women as equal with, and as respected as, men.

³³ Sandra Machado, Director, EACH Hounslow

³⁴ Gayatri Shah, EACH Hounslow, London

³⁵ *ibid*

Key Issues Arising From The Research

Violence against women.

All of the services I spoke to talked about violence against women – not family violence. As described in the results section, violence against women includes sexual violence, violence experienced during prostitution, female genital mutilation, forced and underage marriage and honour crimes, not just domestic violence. The women spoken to believe that it is important to define the gendered nature of violence – that it is predominantly men abusing women. There is also a shared understanding that domestic violence is supported by societal attitudes about men and women's roles and the unequal allocation of power and resources. While domestic violence occurs at all socio-economic levels, there is international evidence that the less access to resources a woman has, the more vulnerable she is to abuse.^{xxv}

The need for women-only services

Many women who have mental health or substance abuse problems have histories of psychological, sexual or physical abuse as children or adults. These women require safe, appropriate services where they will be free from the fear of male harassment and abuse, and can concentrate on becoming well.

If women have experienced – or are experiencing - abuse from men it is inappropriate to expect them to use mixed-gender mental health and drug and alcohol services. There are a number of reasons for this. Women who require inpatient help are vulnerable to the predations of men in these services. Women using mixed-gender services have been:

- raped or coerced into sex by men also in the inpatient unit
- taken out of substance misuse services in the guise of starting intimate relationships and re-addicted by men who want to control them for their own use and/or for prostitution
- further traumatised by the inappropriate behaviours of men in inpatient units or by being forced to be in close proximity with anti-social men
- treated, by male staff, in ways that mirror the power and control behaviours of their abusive partners including, for example, physical restraint, inappropriate medication practices and minimising of their fear and anxiety

If women are in a specialised refuge they can be supported to use mixed-gender services if this is all that is available to them. A number of women, however, will not engage even with this support. Others will stop using mixed-gender services once they leave the refuge as they no longer have a place of safety to return to and the support to manage the gender related, traumatising interactions.

This suggests that inpatient services for substance abuse and mental illness must be gender specific if women are going to benefit. Men may benefit from having women around but it is unethical to use traumatised and damaged women to help men heal at the expense of women's mental health and safety.

Gender specific does not mean having separate sleeping areas with mixed sex communal areas. It means separate units with gender specific staff.



Cartoonist – Jackie Fleming, Liverpool.

Service user involvement in service development

Next Link services “*firmly believe that domestic abuse services should be informed and guided by survivors.*”^{xxvi} They constantly consult with the women and children who use their services about existing and new service provision. Service users are also involved in the recruitment of staff, fundraising and talking to the media.

The Crisis House that was opened in 2009 was a result of several years of work by mental health service users and Missing Link.

Dr. Gill Hague has been involved in research about “*service user participation in domestic violence services and how much the voices of domestic violence survivors are heard in policy and service development.* (She believes) *If services addressing domestic violence are to continue to develop and to effectively meet abused women's needs, then the views of those using them need to be heeded and acted on.*”^{xxvii}

She raises concerns about this process and the need to have policies and processes in place to ensure that consultation is done safely and provides constructive outcomes for the women participating. Barriers to participation, for service users, may include: “*...safety and confidentiality issues; the impacts of poverty, of social class and of cultural imperatives and differences; the silencing and stigmatising effects of domestic violence; the impact of abuse on self-esteem; and personal difficulties in dealing with painful memories and remembered traumas.*”^{xxviii} Other barriers are the behaviours of the professionals engaged in the consultation. Women can be re-victimised and marginalised by professionals who exclude them from decision-making, ignore what they say and don’t adequately support them during the consultation processes.

A guide^{xxix} has been produced that outlines the benefits and processes for consulting with abused women. This is available from the Women's Aid website (see appendix four).

One of the key benefits of consultation is that statutory and voluntary sector services and policy development is "... *'kept on track', and subjected to and able to withstand user scrutiny. Without abused women's voices to provide a 'reality check', official responses can result in 'talking shops' of professionals, or lengthy policy documentation and development which can take much time, but result in little change*"^{xxx}

The Liverpool Joint Forum Women's group is an example of a service enabling the empowerment of women and the integration of women's voices into service development in a safe and supported way. See the case study at the end of this section.

Partnerships

Developing partnerships with drug and alcohol and mental health services was a critical part of the service provision of all specialised refuges. Every specialised refuge required women to seek help from the appropriate clinical services. This meant that partnerships have to be developed for referral paths, to ensure that women's needs and problems would be understood and also to develop collaborative relationships with staff in the services. This had happened with various degrees of success in the various services. Staff felt that part of their jobs was to train their colleagues in the clinical services to understand the issues relating to domestic violence in order to ensure that their clients would be appropriately treated by the services.

Developing MOUs ensures that the relationship between agencies is integrated into policy and procedure and therefore is not person specific.

Partnerships with other services were also developed, including housing, other health and social services and women's organisations.

Volunteers

Virtually none of the specialised services use volunteers. There are some who use them in the office or with children – but only one service uses volunteers with clients. This is because of the complexity of the work with chaotic, abused women. Some services take appropriate students on placement. It's felt that volunteers are inappropriate for a number of reasons - for example, that they:

- want to rescue women, which is an inappropriate response
- don't have good professional boundaries
- are unable to have ongoing education and supervision

Also, for services with limited resources, it's difficult to provide the level of support and mentoring that volunteers require.

That said, however, Glasgow Women's Aid, who work with very chaotic women, use volunteers to work with women in the community. These volunteers do very concentrated work that involves helping a woman get up in the morning, get dressed

and washed and attend any programmes or appointments that she has for the day. This is intensive one-on-one work that couldn't be managed for so many women without the help of these volunteers. This service enables Easterhouse to work with far more women than just those able to be accommodated in the refuge.

Housing for women

Everyone spoken to in the refuge services talked about the difficulties of finding housing for women to move to after refuge. This is also a problem in NZ. Moving out from refuge is, ideally, a two-step process: first into independent flats owned and supported by refuge, and then into safe, affordable and secure tenancies in the community.

A critical part of any national domestic violence initiative must be the provision of good quality affordable housing for women to move into when they are ready to leave refuge. Without this, women either have to return to precarious living conditions which can include moving in with abusive men for shelter, or return to the abuser that they left to enter refuge.

Secure housing is an essential determinant of good mental health, so safe secure housing helps women to stay healthy and refrain from substance abuse.

Suicide

Many of the refuges I spoke to assess for suicide risk at the time of the first assessment and then at other times when it seems to be required. In Northern Ireland, for example, suicide assessment is an ongoing process. Suicide is discussed in refuges and other domestic violence services as part of the normal group work, as it's understood that leaving a violent relationship and moving into a refuge is a vulnerable and risky time for women. Also, suicide prevention services are called in to domestic violence services if workers are concerned about women's behaviour.³⁶

At Glasgow Women's Aid all staff are trained in suicide prevention programmes – they talk about suicide as soon as women come in and make a suicide prevention plan. *“...you need to call it what it is or you don't deal with it. If you don't name it, you can't deal with it, and it's harder to receive help.”*³⁷

Self-harm

Many of the women who enter mainstream and specialised services self-harm in some way. This can be socially acceptable behaviour such as smoking, substance use/misuse or eating disorders or less acceptable behaviours such as cutting and other physical harm. Some women are *“hyper-sexualised”*³⁸ and harm themselves through their sexual behaviours. Most of these self-harming behaviours are manifestations of living with childhood and/or adult abuse and trauma, and therefore need to be addressed in the context of that abuse. Next Link, in Bristol, has a dedicated self-harm worker to help women identify and address these issues. All refuges – and specifically specialised refuges – would benefit from staff with expertise in self-harm.

³⁶ Helen Woods, suicide prevention worker, Belfast, Northern Ireland,

³⁷ Mairig Tagg, Easterhouse Women's Aid

³⁸ *ibid*

“First Aid packs are kept in refuge for women who self-harm and they are taught to ask for them or ask for help if it’s too bad – so working from where women are.”³⁹

Culturally appropriate services

Because of the different cultural competencies required and the different issues faced by minority ethnic groups, it is important to have specialist mental health/substance abuse programmes to support specialist domestic violence services for non-Pakeha women. In New Zealand this would mean continuing to support Maori, Pacific and ethnic minority services to develop not just refuges, but also mental health and drug and alcohol services.

Drug and alcohol services

Jacqui Barron from Women’s Aid national office reported that a problem in drug and alcohol services is that therapeutic processes are often focused on a twelve-step model that seems to be more effective for men than women. She says that the rhetoric of AA and twelve-step models are very off-putting for many women as they are focused solely on the substance abuse and don’t look at any context. Specifically, these models don’t address abuse and abusive partners as a cause of substance abuse. This reinforces the need for gender specific services that address the underlying causes of substance abuse.

Therapeutic responses.

During the conversations with services and individuals, a number of ideas emerged for therapeutic best practice.

1) Training domestic violence support staff in basic therapeutic techniques.

The PATH project (see appendix three) trains domestic violence service advocates and support staff in specific interventions to help women with psychological problems associated with domestic violence. The training is about the recognition of symptoms and behaviours that indicate mental distress, and strategies to help women identify and heal the symptoms.

2) PTSD

Most women will have post-traumatic stress (PTSD) symptoms. The critical thing to remember is that for many women it’s not *post* traumatic stress, it’s current – current recurring trauma and related symptoms. In Glasgow, one study suggested 54% of women in refuge have PTSD, while another reports 70 % of abused women experience ongoing PTSD after domestic violence.⁴⁰

“Many people don’t recognise the complexity of PTSD and that it’s not post – it’s current.”⁴¹

Many women come to refuge directly from abusive relationships. It is well known that even when women leave abusive men, the abusive behaviour doesn’t stop – in fact often it escalates and becomes more lethal and more emotionally damaging. This means that it is important to have therapists associated with specialised refuges who understand trauma and how to work with it constructively.

³⁹ *ibid*

⁴⁰ *ibid*

⁴¹ *ibid*

The therapists and psychologists that were spoken to during this research project insisted that women should not be required to disclose abuse and tell their stories during therapeutic and other interventions, unless the women choose to. They believe that unless it is necessary as part of lodging complaints with the police, or providing evidence for court, retelling stories can re-traumatise women and prevent them moving forward and healing. Therefore they suggest that the focus of therapeutic interventions be on helping women recognise the relationship between abuse and mental health/drug and alcohol problems, what triggers their trauma responses, and strategies and interventions to help them recover.

3) Working with grief

Many of the support workers and others spoken to talked about the importance of working with the grief that women carry. Most of the women who enter a specialised refuge or domestic violence service have loss in their lives. They may be grieving because they have lost custody of their children or because they have lost touch with family and friends. Although the relationship with their partner has been abusive, women still grieve over the loss of their relationship and many will perceive themselves as failures for being unable to make the relationship work. Women also grieve for themselves – for the loss of potential that they feel has occurred by being driven crazy or from years of abusing substances. Many feel the huge waste of having lived in an abusive situation for so long and blame themselves for not having acted sooner. All of these issues must be addressed if women are going to be able to heal and move on to healthy and safe lives.

Policy development

Policy development is essential to ensure that services developed for women with mental health and drug and alcohol problems related to domestic violence are sustainable and based on evidence and best practice guidelines. This requires policy at all levels, including for funding bodies and service providers.

In London, for example, AVA and the Stella Project are working to get all council boroughs to align their processes and partnerships related to domestic violence and substance abuse, and make sure that the issue appears in all strategies – drug and alcohol in domestic violence strategies – domestic violence in drug and alcohol strategies. This includes:

- drug and alcohol coordinators attending the police high risk interagency group meetings
- looking at referral pathways – how drug and alcohol services screen and refer to domestic violence services
- running training to improve these processes
- looking at safe processes for information sharing
- discussion about how services respond if perpetrators and victims are using the same service

These processes are also required with mental health services.

Training

A number of the women spoken to are involved in training various professionals to understand the relationship between domestic violence and mental illness/substance

abuse. Training programmes are being developed and run for social workers, health professionals, psychologists, psychiatrists, mental health service staff, substance abuse service staff, lawyers and judges, police and the crown prosecution service.

Bristol University teaches courses on violence against women at undergraduate and postgraduate levels. They teach their own courses including Public Policy and Domestic Violence Activism and Policy. They also teach papers about violence against women in the Masters of Social Work, Childhood Studies, Family Support Studies and other departments.

London Metropolitan University has a Child and Women's Abuse Unit and a Masters in Violence Against Women.

Research

In order for services to provide appropriate support for women with mental health and substance abuse problems related to domestic violence, there must be a shared understanding of the process that leads to the substance abuse and mental health problems and constructive ways to address this.

The individual women that I spoke to are all experts in these areas and have important contributions to make to the development of a coherent response. A range of research projects are currently being run in England to assess the benefits of various approaches to meeting the needs of women with mental health and drug and alcohol problems related to domestic violence.

See appendix four for a list of research projects that participants are involved in.

CASE STUDY.

Women-only services and service user involvement in service development. Jackie Patiniotis, Joint Forum Women's Group, Liverpool

The Joint Forum is an NGO mental health support service, funded by the Liverpool City Council. The Joint Forum Women's Group is part of a wider mixed gender service for people with mental health problems, helping them engage with services and how services are delivered. Prior to Ms. Patiniotis starting there was no consideration of gender issues.

Ms. Patiniotis came into the position five years ago and noticed there were fewer women than men using the service. She discovered that women didn't/couldn't talk in the mixed gender groups so started a women's group where women felt more comfortable to talk and the service could respond to women's needs. Since inception, the group has met once a month, and on average ten women attend. The meetings are about three hours long with breaks. There are many more than ten women on the mailing list but not all come each time. Women come to meetings when they want to, but have problems maintaining regular attendance - doing things regularly. Each meeting has an agenda and an action plan. Overall, the group is designed to create a sense of community.

The women are from very diverse backgrounds with different levels of understanding of their circumstances and gender issues in society. The group is starting to look at the

social issues that impact on women's mental health and wellbeing. This "*debunks the myth that mental health is in women's heads – it's in fact societies expectations that disable women.*"⁴² This has led to discussion about a gender focus in delivering services.

*"Women either use mental health services or experience mental distress because of domestic violence or other gendered violence and therefore have ongoing mental health problems."*⁴³

Many of the women using mental health services have experienced domestic violence and sexual violence and their experience is that some men who use mental health services are very predatory. "*Women's Aid reports that 70% of women in mental health inpatient units have been raped, abused or experienced domestic violence.*"⁴⁴

Because of this, the group are campaigning for women-only mental health services. They have been campaigning for five years for a women-only day service, as currently all services are mixed-gender. The women are '*raising their voices*' to influence how mental health services are designed and run.

A women-only day service for women with mental health problems, as envisaged by the service user group, would include information about domestic and sexual violence, parenting, therapies, homeless support and would provide drop in, educational courses, and trips.

Ms. Patiniotis has talked to mental health commissioners (funders) about women-only services, including the sexual harassment that goes on in mixed-gender mental health services. The commissioners wanted specific examples and details but the women refused to allow their stories to be told/used. Women only want this information known as part of the bigger issues – there are issues of safety for them in disclosing specific instances.

As a consequence of this discussion, one of the questions that the group has been addressing is how these things are reported in ways that keep women safe. Women are concerned that if they complain (tell their stories) they will lose the service they have because, even if it's not perfect, it's better than no service. They are also scared of how men (service users and staff) might misuse their information.

The women in the group have come up with some strategies/solutions including:

- staff training about sexual harassment and abuse
- posters about sexual harassment
- single-sex groups
- special facilitators in single-sex groups to raise the issues
- a framework to refer to

As a result of the work the women's group has been doing, there is a move to look at a women-only day service. In mental health inpatient services there have been some

⁴² Jackie Patiniotis, Joint Forum Women's Group, Liverpool

⁴³ *ibid*

⁴⁴ *ibid*

women-only wards, but they had male staff. Now, with a change in government policies, women-only is being interpreted as women-only accommodation – not separate wards. The women’s group response is ‘*no – not good enough*’⁴⁵. Women say unless there are women-only wards, men will access the women’s areas. Women-only accommodation doesn’t mean that women are safe, because communal areas are shared. The existing women-only wards are also ‘not good enough’ because of the male staff. Women need female staff because all men scare these women and make them feel more vulnerable. The group is looking at how to address this problem. They have also recognised the need for women-only respite and crisis housing.

*“You can’t ever address mental health unless you address gender”*⁴⁶

One of the successful things the group has done is work with the Liverpool Women’s Resource Centre. This gives more power and credibility to the work they are doing. The women’s group has done research with the Women’s Resource Centre about how women’s organisations can influence government bodies i.e. what opens the locked doors that prevent women-only services being funded and delivered?

The women’s group also makes connections with other women’s organisations, for example, Rape Crisis, and has become involved in wider women’s campaigns such as the campaign against lap dancing and raising the voices of women asylum seekers.

Because the Joint Forum is currently a mixed gender organisation it has been difficult to organise women’s empowerment. Some male service users have been hostile so the women’s group is not discussed in mixed forums. Men say they feel uncomfortable with the idea of women-only services because “*men are victims of women*”⁴⁷. If there are to be women-only services, men say there have to be some male staff. In the past, psychiatric services have silenced users, so the forum was set up to give them a voice, “*but if that voice is oppressive, how is this challenged? In mixed gender groups you have women who have been harmed by men and men who are abusers.*”⁴⁸

Within the women’s group they use research and feminist analysis to make sense of women’s experiences but in the mixed group - a more generic situation – people can “*say really dodgy things and they are difficult to challenge because it’s perceived as silencing the service user. The loudest most dominant voices in mixed groups are men’s...*”⁴⁹

⁴⁵ ibid

⁴⁶ ibid

⁴⁷ ibid

⁴⁸ ibid

⁴⁹ ibid

Appendix One

Organisations and people visited for the research.

Australia

Wimlah Refuge, Katoomba, West Sydney, NSW. This refuge takes women with mental health problems who can care for themselves and their children. There are seven full time staff. Cover is seven days a week, but not 24 hours in the refuge – there is a 24 hour phone with one person on call for nights and weekends. The refuge has four purpose built units. Each one can house a woman and up to six children or they can house three women with children and two single women sharing a unit. Most women stay three - 6 months. Out reach follow up is done for as long as women need it, up to several years if required.

Joan Harrison Support Services, Liverpool, West Sydney, NSW. This refuge takes women with mental health and/or drug and alcohol problems and/or physical disability. This is a seven bed single women's refuge. Some women share rooms. There are eight staff, including outreach staff, not all are full time. One is a psychologist. Women stay for up to 6 months then they move to exit houses where they can stay for up to 18 months after which the out reach support goes on for as long as required. Staff cover is 12 hours a day, 5 days a week with rostered 24 hour cover by phone.

England

Nia Project, London, is a refuge for women with substance abuse problems. This is a specialised service in a residential street that houses 6 women. The refuge does not take women with children. The office is staffed from 8.00 am – 10.00pm every day and after hours there is an emergency on call person. Women can stay for (usually) six – nine months but can stay up to a year. The house has communal facilities but each woman has her own bedroom. There are four full time staff with others coming in for specific purposes such as running groups.

EACH (Ethnic Alcohol Counselling in Hounslow) is an alcohol counselling project in London that also runs a domestic violence service for Asian and ethnic minority women. They offer advice, information, support and counselling for people with alcohol, drug, domestic violence and mental health problems. They have recently launched a resource about domestic violence and mental health. They operate over eight boroughs of London. The service is open nine to five and the alcohol service has two late nights. There are forty staff.

London Women's Aid. This service has a worker who works across London offering extra support to refuges so that they will take women with substance abuse problems. She is a qualified drug and alcohol counsellor who offers services to women and links them to clinical services.

Sutton Women's Aid. London. This is a main-stream refuge that recognises that most women will have mental health problems as a result of abuse. The refuge has seven staff who together make up three and a half full time positions. This is not a 24 hour service. They have one refuge and two second stage houses and work with approximately thirty five women and sixty five children a year.

Next Link, Missing Link, Safe Link, Bristol. This is an integrated service for women that comprises Missing Link a mental health service, Next Link, a domestic violence service and Safe Link sexual violence service. There are between seventy and eighty staff. The domestic violence service has five houses, one specifically for Black and ethnic minority women. Refuges are not 24 hour. Office hours are nine to five with an on call emergency service after hours. In the refuge an average length of stay is about 6 months but can be longer if required. Women often move from crisis services to refuge and engage with the mental health service while in refuge. There is also an inpatient unit.

Joint Forum Women's Group, Liverpool. A women's mental health support and activist group who are addressing women's issues related to the provision of mental health services..

Dr Roxane Agnew Davies - a psychologist who specialises in therapeutic processes to heal severely abused and traumatised women. She has developed three DVD/teaching resources that have just been purchased by the NZ Family Violence Clearing House. Roxane has developed a number of manuals for English domestic violence and refuge services and also for mental health services. She is very active in training and research in England.

Jackie Barron, Women's Aid National Office. Jackie has researched domestic violence and mental illness and has written manuals for Women's Aid about how refuge workers work with women with mental health problems and for mental health services about how to understand and respond to domestic violence. She is involved in ongoing research for Women's Aid.

Karen Bailey, Deputy Director, The Greater London Domestic Violence Project. This project has developed a number of resources and responses for women who have mental health/substance abuse problems associated with domestic violence. It is associated with the Stella Project. The Stella Project works across all 33 London boroughs for positive, sustained improvement in the way services are delivered to survivors, their children and perpetrators of domestic violence affected by problematic substance use.

Dr Sarah Galvani, Principal Research Fellow, Institute of Applied Social Research, University of Bedfordshire. Sarah teaches social work academics about domestic violence and substance abuse and is involved in research.

Dr. Louise Howard, Head of Section of Women's Mental Health, Institute of Psychiatry, Kings Collage, London. Louise teaches psychiatrists about domestic violence and mental illness/substance abuse and is involved in research.

Professor Gill Hague, Professorial Research Fellow, Co-director of Violence Against Women Research Group, University of Bristol. Gill teaches about domestic violence and is involved in encouraging (and doing) research.

Scotland

Glasgow East Women's Aid, Easterhouse. A service that works with women with complex needs. Easterhouse has six staff, two of whom are therapists. The refuge houses five women who stay for an average of a year but can stay for up to two years. As well, the therapists can be working with up to fifteen women in out reach scatter flats. The service is staffed 5 days a week all day. Every member of staff takes time on a roster for evening and weekend call outs. Women can come to refuge with children.

Inverness Women's Aid. A specialist refuge for women with mental health problems, including substance abuse. Women can stay for eighteen months to two years. There is 24 hour staffing. Staff day cover is nine am – nine pm during the week with three people on, one person covers nights and there is one person all the time in the weekends. There are three directors, three administrative staff and ten support staff who work thirty-five hours a week to provide cover. There are twelve fully self contained units in the house including an accessible flat. The house can take twelve women with children.

North Ayrshire Women's Aid in Saltcoat is a refuge for women with mental health and drug and alcohol problems. They have two communal refuges, six cluster flats and four independent flats throughout North Ayrshire. This is space for twenty-four women with children. For the twenty-four beds there are 17.5 workers. There are also three counsellors at the Women's Aid office who work with these women. The refuge is only staffed nine to five but staff are on call 24 hours and weekends. Refuge time is open ended. The longest is a year in this refuge – four to five months is more common but women can then move into the flats for up to eighteen months.

Edinburgh Women's Aid, A specialist refuge for women with mental health problems, including substance abuse. The refuge has six x one-bedroom flats and two x two bedroom flats. For four years they have been operating for 24 hours a day. Until recently a staff member was awake all night. Now the office closes at 10.00 and opens at 8 and a worker sleeps over so emergencies can be responded to. Women can stay for up to two years – the average stay is six months.

Ireland

Helen Woods, Belfast, Northern Ireland. Helen is involved in, among other suicide prevention initiatives, suicide prevention in Women's Refuges.

Appendix Two

New Zealand prevalence research

In a 2006 survey of 39 refuges affiliated to the National Collective of Independent Refuges^{xxxii} questions were asked about the number of women with mental illness and drug and alcohol problems that the refuges had had contact with over a six month period in 2006. This was anecdotal information, as few records are kept of mental health/drug and alcohol status, especially for women who are unable to access refuge because of the pre-admittance process.

During this six-month period, 347 women were accepted into refuges that were identified as having mental health or drug and alcohol problems. The women brought 447 dependant children with them.

Seventy-nine of these 347 women were moved out of refuge because the refuge staff felt either that they were a threat to the other women and children in the refuge or that they – the refuge staff – didn't have the expertise and skills to work appropriately with them. This affected 81 children.

A further 178 women are known to have been denied access to refuge because of mental health and/or substance abuse problems. This is an under-estimate, as most refuges do their screening via phone and don't keep any records of how many women are screened out. It is not known how many children were affected by this.

Outcomes for women asked to leave or denied access to refuge include: going back to the abuser, short term solutions such as moving into caravan parks or with friends and family, living on the streets or going into psychiatric wards or substance abuse services – which means placing children with the abuser or others.

Two hundred and fifty-seven women, many with children, were denied refuge over a six-month period. This indicates an acute need for constructive responses to meet these women's complex needs.

Appendix Three

PATH. Psychological Advocacy Towards Healing; Therapeutic approaches to empower recovery from domestic violence

Dr Roxane Agnew-Davies

C.Psychol, AFBPsS

Overview

This manual is designed for domestic violence advocates who have a special interest in using psychological approaches to support victims who are experiencing or have experienced domestic violence. It is the main source of materials for a 25-day training course to equip advocates to become Specialist Psychological Advocates (SPAs). A psychological approach looks at thoughts, feelings and behaviour, not as a substitute for advocacy but to act in parallel. If we think about any person as having outside and inner worlds, advocacy offers support in the outside world while a psychological approach can help meet needs in the inner world. Both are crucial for self-esteem.

The idea of counselling victims of domestic violence has created heated debate over the last three decades. It has been argued that individual therapy by its very nature pathologises the victim (treats them as if they are the problem) while making the abuser(s) invisible. Of course it would be wrong to do anything other than hold the abuse as the cause of the problems and there are dangers of medicalising a socio-political issue based on gender and power imbalance. However, even though political action is needed and practical help is essential, they do not address the needs for some women to recover their psychological health. Many victims are traumatised by their experiences and just as they need medical help for a physical injury, women have the right to support to reclaim their psychological well-being. We would not deny medical assistance for a woman with a sexually transmitted infection on the grounds that only political action can address sexual exploitation!

Many women have said that the bruises heal, but the mind-games or the way the abuser made them feel still hurts them inside. Research has shown a primary and direct association between experiences of domestic violence and psychological symptoms. For example, Golding's, (1999) meta-analysis of 41 research studies, demonstrated this association in terms of:

- Size: a large association between variables (domestic violence, depression, suicidal thoughts, post-traumatic stress and substance use)
- Consistency: the association holds over different places and different people
- Timing: mental health symptoms generally occur after the onset of violence rather than before
- Gradient: the more severe or frequent the violence, the greater the risk of mental health symptoms
- Experimental: when violence stops, mental health improves and when violence returns, mental health deteriorates.

This manual aims to empower an advocate to understand psychological distress as a consequence of the abuse and to offer support in that context. Goals include:

- crisis support, given that safety and protection are always the priority
- dealing with the acute psychological impacts of domestic violence
- preventing any longer-term damaging effects of abuse.

The first section covers general principles about relating to and empowering a victim of domestic violence. The other chapters give an overview of some common effects of domestic

violence on psychological health, how to identify signs of distress and how to use tools and strategies to help women reclaim their psychological wellbeing.

Each topic is sub-divided into guidance for workers and hand-outs for clients. Each theme is designed to be independent of others, to allow maximum flexibility for women and advocates. Over the course of eight sessions, the SPA will empower a woman to choose the priority topic or focus for each week. The order in which you work on different topics across sessions will vary from client to client. While work on specific topics (such as depression) could extend over several sessions, each topic may also be addressed briefly in the limits of one meeting. The use of the tools will depend on the unique and immediate needs of the client.

Chapter 1

Therapeutic Principles and the Working Relationship

Introduction

The PATH Manual is a practical guide for domestic violence advisors with a special interest in using psychological approaches to support women experiencing or who have experienced domestic violence. It is the handbook for Specialist Psychological Advocates (SPA's). The manual draws on work with over 1000 women as well as on national and international clinical and research literature.

The PATH model is a heuristic framework, a set of assumptions developed through piloting and evaluating psychological services for women escaping domestic violence. These assumptions about the effects of domestic violence and processes of recovery are made without claiming the status of 'truth', theory or the only 'right' method. There are many valid theoretical and technical approaches to supporting women experiencing domestic violence.

Indeed, the approach is eclectic because no single psychotherapy provides an adequate breadth of interventions (Dutton, 1992). The PATH model is primarily cognitive-behavioural but draws from different concepts and strategies in experiential, dynamic, psycho-educational and feminist schools. Theoretical and technical choice increases the chances of finding something to suit a particular woman and her current needs, in service of a more egalitarian relationship and the opportunity for her to regain control.

In each session, ask "What would be the best approach with this woman with this problem in this setting at this time?" (Prochaska, DiClemente & Norcross, 1992)

This stance is consistent with feminist counselling philosophy, which aims to empower the client (Chaplin, 1988; Holiman, 1997) by acknowledging both external, objective reality (including the abuse inflicted) as well as internal, subjective experience.

PATH aims to improve outcomes: to support each woman to regain a positive sense of herself, to construct meaning from her experiences, to expand her repertoire of choices and skills, to improve her mental health and to empower her to regain control of her life and future.

Appendix Four

Research, resources and information recommended by research participants.

Research

1) **Dr. Roxane Agnew-Davies, Director, Domestic Violence Training Ltd.**

Dr. Agnew-Davies has a key role in raising awareness of the needs of women with mental health and substance abuse problems as a result of domestic violence. She is involved as a key person in many of the research projects in England. These include:

IRIS

This was a pilot project that placed advocate/educators into clinical and GP settings to offer professional support and enable better practice and responses to women. This was a randomised control trial taking place in twelve practices each in Bristol and London. There was a 12 month evaluation after the second training in the intervention practices.

The intervention was 2 sessions of training for the GPs and other staff and provision of a simple referral process. Referral is to an advocate who is based in the local refuge. The advocate then follows up with the clinic to tell them what's been done with the woman and what outcomes have occurred. There is one advocate/educator per twenty-five practices. Training was also run with reception staff so that they put up posters, ensure a supply of leaflets and understand the issue that they are being asked to respond to.

As a result of the intervention, 3.5 times more women were identified and recorded as experiencing domestic violence, and twenty-one times more women referred to the advocate (over 200 women). The data was compared with that of twelve non-trained practices. In these control practices, over the same period, 12 women were referred to outside domestic violence services.⁵⁰

Funding has now been provided to roll this project out nationally, so the team are working on implementation. This involves negotiating the dynamics between clinicians and domestic violence services and getting feedback about what works and what doesn't.

PATH model

Dr. Agnew-Davies is currently completing a training manual that will be used to provide refuge workers with basic therapeutic skills to work with severely traumatised women.

She has spent eighteen months training three women as Special Psychological Advocates (SPA) who are domestic violence advocates with the PATH training. They are now looking at how this could be rolled out around the country. The next part of the project is to evaluate how well the PATH model functions compared to

⁵⁰ Dr. Roxane Agnew-Davies

current practice. This will be an eighteen month-two year follow up with an estimated 150 – 200 clients involved with the three SPA.

Perpetrator research

Dr. Agnew-Davies is working with Dr. Miriam Hester and Dr. Emma Wilkinson from Bristol University to run an IRIS model in Bristol for perpetrators. Stage one is to have researchers in waiting rooms with questionnaires. Following this they will train GPs to identify perpetrators and refer them. She is also doing a similar project with Lorraine Bacchus at the London School of Hygiene and Tropical Medicine – with men who have sex with men. This data will be synthesised and will look at the prevalence of perpetrators in health settings.

LARA (Linking Abuse and Recovery) is a similar process/evaluation occurring with community mental health services. This has already had a number of outcomes including a domestic violence/mental illness literature review.

2) Dr. Louise Howard, Head of Section of Women’s mental health – health service and population, Institute of Psychiatry, Kings Collage, London.

Dr. Howard has recently been involved, with Dr Agnew-Davis, in the LARA research (Linking Abuse and Recovery.) This involved qualitative interviews with professionals in mental health services – doctors, social workers, psychiatrists, and psychologists – about if or how they ask about domestic violence.

The next stage was talking to service users about being asked about their experiences. The research found that service users were being discriminated against by the services they interacted with - mental health services, police, child protection, immigration etc.

In a response to this research Dr. Howard is doing training with domestic violence professionals and mental health professionals about each other and their respective roles. This includes training psychiatrists about the dynamics and effects of domestic violence.

3) Dr. Gill Hague. Co-director, Violence Against Women Group, Centre for Gender And Violence Research, Bristol University

The centre has eight staff plus PHD students. They do research in Brazil, Canada, India, Taiwan, China, Libya and Britain. Dr. Marian Hester is the new director. Currently, in Britain they are doing research about:

- Forced marriage
- Government policies and practices
- Same sex relationships
- Black and minority ethnicity women
- Disability
- Young people and dating violence
- Perpetrators
- Journeys to recovery.

There is only a small amount of research about mental health and substance abuse. Currently they are trying to raise money for a big mental health study.

They are doing joint projects with Dr. Jean Fayder and Dr. Agnew-Davis. (IRIS, PATH and LARA)

4) Dr. Sarah Galvani, Principle Research Fellow, Institute of Applied Social Research, University of Bedfordshire, Luton.

Dr. Galvani has been commissioned by SWAP – the higher education academy for social workers - to develop resources for social worker education. In England, social workers are not routinely taught about domestic violence. At the moment there is very little course content guidance other than five key benchmarks and an information sheet about substance abuse and domestic violence that Dr. Galvani has developed.

See appendix four for information about resources and papers available.

Dr. Sarah Galvani is also exploring the importance of intersectorial partnerships to the provision of appropriate services for women with mental health and drug and alcohol problems associated with domestic violence.

Embrace Project

The Embrace Project is a pilot, working to support nine alcohol agencies, through training and consultation, to improve the response to domestic violence and how the agencies work with women and children. The purpose is to challenge the mentality of substance abuse service staff who are trained only to respond to the substance abuse, and encourage them to work more with families and ensure that the services are identifying, and responding to, domestic violence.

There are nine pilot sites where the Embrace Project run events and training and do on-going consultancy. “ *...it’s been a really important learning curve for everyone involved. Initially it was felt that because the alcohol agencies had to apply to be part of the scheme it might be easy – because people said they had policies and procedures in place – but they were ‘running before they could walk’ – it’s not a linear process.*”⁵¹

As in New Zealand, a number of services are starting to screen for domestic violence, however, many of these do not have robust processes in place to respond to disclosures. Therefore the research the Embrace Project has undertaken is developing strategies that can be replicated across substance misuse services across the country. “*You can’t ask the questions until you know what you’re going to do with the answers*”⁵²

This project received three years of lottery funding, and is now in its third year.

“So much good practice is the practitioner’s willingness to engage, reflect, struggle, change practice and procedures. This requires good, committed leadership, who

⁵¹ Dr. Sarah Glavani

⁵² *ibid*

provide strong informed supervision and management. This in turn requires training at manager level."⁵³

EMBRACE have publications and knowledge sets for practitioners about good practice.

ADFAM

Dr. Galvani and Natalie Pallier from ADFAM have a two-year Comic Relief funded project working to support people with drug and alcohol problems. They are researching two groups of family members:

- Children of parents who abuse substances
- Family member support group providers/facilitators – i.e. people from the community who run the support groups – they are peers, mostly well informed, local and grass roots, mostly voluntary, with a few now paid.

First, the researchers went to agencies that work with young people 10 –15 years old, and ran focus groups about healthy and unhealthy relationships and what made people feel happy/unhappy in relationships. The second group – people who run family support groups - were individually interviewed. These people often fall between the gaps of service provision. They are providing a valuable service and should have training and resources offered to them – but don't.

From both groups, views and experiences of the relationship between domestic violence and drug and alcohol abuse were gathered. The "*kids interviewed were quite switched on*"⁵⁴. They knew about healthy and unhealthy relationships and said that substance abuse programmes don't always work, i.e. stopping substance abuse doesn't always stop abuse or help the tension in a family.

6) **Karen Hughes, Violence Prevention, John Moores University, Liverpool**

Dr. Peter Donnelly at the University of Scotland is doing research about government policy making. Specifically, he is asking why some governments are picking up on violence prevention and research work and not others, what is preventing them making policy from the evidence, and finally, what helps the transition into policy and what hinders it?

John Moores University are researching whether having safe houses for women reduces the incidence of violence, as this is not well researched.

⁵³ *ibid*

⁵⁴ *ibid*

Resources and information

Wimlah

- Use Truth or Dare by Star Hawke to help understand the raise of patriarchy.
- The Benevolent Society. <http://www.bensoc.org.au/index.cfm>

Joan Harrison Support Services for women

- Bridging the gap: evaluation of the domestic violence and mental health pilot project. Dr. Lesley Laing and Cherie Toivoven
- http://ses.library.usyd.edu.au/bitstream/2123/6118/1/JHSSW%20_final.pdf
- Homelessness and Criminal Justice Pathways. Eileen Baldry, University of NSW
- Why Australia Needs a Gendered Homeless and Housing Policy. Ludo McFerran
- Towards better Practice; Enhancing collaboration between Women's services and mental health services. University of Sydney

[www.faculty.edfac.usyd.edu.au/projectstowards better practice](http://www.faculty.edfac.usyd.edu.au/projectstowards_better_practice)

Sim Mandir

- The "Effective Freedom" technique – a therapeutic technique for abused women and children.
- Fawcett Society – taking the British Government to Court for always putting women/ violence against women, last on the political agenda.

Karen Bailey

AVA. www.avaproject.org.uk

- Mental health and substance abuse/domestic violence toolkit
- Sample drug policy for refuges
- Innovative Responses report.

Dr. Sarah Galvani

www.swap.ac.uk

- Social worker information
- Resources and publications – put in substance abuse or Dr. Sarah Galvani's name to find the guides and information sheets and look at the links to others including domestic violence.

- Dr. Sarah Galvani and Dr. Cathy Humphries. National Treatment Agency (NTA) for substance abuse. *The impact of domestic violence in engaging and retaining women in treatment.*
- Dr. Sarah Galvani 2006 *Parenting, domestic violence and substance abuse.*
- Alcohol Concern website ctoфт@alcoholconcern.org.uk
- Dr. Sarah Galvani “*Grasping the nettle – Alcohol and domestic violence.*”
- The Embrace Project (on website above). This has publications and knowledge sets for alcohol practitioners about domestic violence. There are also two evaluations about the project
- A report is out, about domestic violence and substance abuse, with a fact sheet (Sarah’s name is on both) on www.adfam.org.uk
- London Drug and Alcohol Network www.lsan.org.uk

Karyn Hughes

www.preventviolence.info

- The series of booklets from the WHO on violence prevention
- Elder Abuse – from a review of the literature there is very little evidence of what prevention initiatives work.
- There is a big question around the role of the media in violence prevention/promotion. There is emerging evidence that video games have a negative effect – but not much evidence of the effects of film and television.
- New report from British NHS “*Responding to Violence and abuse. The NHS response.*” 2010

Jackie Patiniotis

The Joint Forum Women’s group are using ‘The Equality Illusion’ by Kat Banyard as their study text.

Jacqui Barron

www.women’said.org.uk

- SAFE – the Domestic Abuse Quarterly – Women’s Aid Federation, and other publications, policy guidelines and information sheets.
- *Struggle to survive: Challenges for delivering services on mental health, substance misuse and domestic violence* Jackie Barron (2004)
- *Home truths about child sexual abuse: influencing policy and practice: a reader.* Itzin, Catherine ed. London: Routledge, 2000
http://www.nspcc.org.uk/Inform/research/reading_lists/child_protection_wda48855.html

Dr. Gill Hague

- *Professionals by experience: Guide to service user participation and consultation for domestic violence services.* Authors: Gill Hague, Audrey Mullender and Rosemary Aris (2002) www.women'said.org.uk

Dr. Louise Howard

David Fergusson – abortion and mental health, British Journal of Psychiatry

Glasgow Women's Aid

Easterhouse use Mary Beth Williams' book The PTSD Handbook and Judith Herman's book Trauma and Recovery

Inverness Women's Aid

www.actionforchildren.org.uk

<http://www.lltff.com/> guided self-help

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