Maternal Mental Health Alliance

Briefing

Perinatal Mental Health and Domestic Abuse

JANUARY 2023

Background context

Domestic Abuse affects 1 in 4 women in their lifetime. On average 2 women are killed every week in the UK as a result of domestic abuse. Young women are more commonly affected than older women, including by domestic homicide and severe, repeated abuse. Government estimates in 2016 found that domestic abuse costs £77bn per year, 2.3bn of which are costs to health services.

Yet it is rarely seen as a public health priority.

There is something profoundly significant about gendered violence and abuse in the perinatal period.

- Domestic abuse can start in pregnancy and escalate in frequency and severity during pregnancy and the first year after birth, it is estimated that as much as 30% of domestic abuse starts in pregnancy.
- Only around 0.5% of maternity patients are recorded to disclose domestic abuse. During lockdown, this fell to almost 0%.
- Mental health conditions have a well-established link with domestic abuse. 60-70% of women accessing general mental health services have experienced domestic abuse. Women with antenatal and postnatal depression are three times more likely to report experiencing domestic abuse, including during pregnancy, than women without perinatal depression.
- The Domestic Abuse Bill 2021 recognises children affected by domestic abuse as victims in their own right. In 90% of domestic abuse incidents, children were in the same or the next room.
- A recent landmark coroner's inquest highlighted that suicide can also be due to domestic abuse.
- There is increasing evidence of poor birth outcomes, foetal trauma and subsequent negative behavioural outcomes which are long-lasting. Back in 1998, domestic abuse was found to be the leading cause of foetal death.

Perinatal clinical experts, health practitioners, Violence Against Women and Girls (VAWG) specialist organisations and academics have for many years identified and explored issues around domestic abuse. There are examples of exemplary research and practice supporting and safeguarding women, babies and families across the UK and there has been a positive shift towards greater recognition of domestic abuse and its impact on mental health over recent years.

However, it is also widely recognised that this is nowhere near as embedded in services across the perinatal pathway as we might expect, given the prevalence and impact of domestic abuse on new and expectant mothers and babies. Likewise, domestic abuse does not feature as prominently as we might expect in many health policies including perinatal mental health. The NHS England Long Term Plan for Perinatal Mental Health (PMH) places new emphasis on support for partners and fathers with no reference to domestic abuse at all, despite the prevalence which is likely to be under-estimated. Whereas the Scotland Parent and Infant Mental Health Programme Board delivery plan refers directly to expectations to respond to domestic abuse and trauma.

The need to raise awareness and improve our responses in perinatal mental health for women experiencing domestic abuse is becoming ever more urgent in recent years:

- The latest MBRRACE Confidential Enquiry into Maternal Deaths in the UK and Ireland (2018-2020) found that suicide was the leading cause of maternal death in the first postnatal year and domestic abuse was documented in 33% of suicides and 70% of deaths related to substance misuse. However, we also know that the records of many women who have lost their lives to suicide do not include information about whether they were a victim of domestic abuse, so we don't know the true number, which is likely to be higher.
- The pandemic has increased the incidence of domestic abuse, with health visitors reporting soaring rates of abuse[1] and calls to domestic abuse helplines increasing 400% during lockdown. During the first 3 months of lockdown, there were 10 recorded domestic abuse linked deaths during the perinatal period. Four of these were suicides.
- Detection of abuse and facilitating disclosure in mental health and maternity services was already poor prior to the pandemic, with just 0.5% of women accessing maternity services disclosing domestic abuse. During COVID, this fell even further to almost 0%.
- We know that poverty adversely affects mental health and domestic abuse, and as such the cost of living crisis is likely to exacerbate this situation. Funding for specialist VAWG organisations and the Criminal Justice System has fallen since the pandemic.

Improving our responses to make specialist perinatal mental health services, universal services and all essential services trauma-informed cannot wait.

A multi-agency roundtable

On 3rd November 2022, the Maternal Mental Health Alliance hosted an on-line meeting of clinicians, academics, VAWG specialists, health professionals, commissioners, policy makers and people with lived experience; a case study presentation was also delivered by an attendee with lived experience. Our aim was to take stock of what we know about the intersection of perinatal mental health and domestic abuse, including where there are gaps in practice, policy and research. Chaired by Professor Louise Howard, a catalyst and leader in this area of work both as a clinical psychiatrist and academic over the past 30 years, we brought together cross-sector expertise in one place to join forces in campaigning for change.

The speakers and discussions at this meeting demonstrated the drive and energy of those involved in this work. There is a collective commitment to do more to raise awareness, do more to work together and do more learning.

We want to build on the conversation to ensure greater attention to domestic abuse and make sure that awareness runs like a thread through perinatal mental health research, policy and practice. Likewise, to ensure that consideration of the specific risks associated with domestic abuse in the perinatal period run like a thread through all VAWG research, policy and practice.

There are some key learning points to emerge from the presentations and subsequent discussions:

1. Routine Inquiry
2. Recording
3. What Works
4. Barriers.

1. Routine Inquiry

Speakers highlighted that there is a gap in consistent professional enquiry and curiosity about domestic abuse. There is also a gap in knowledge about the role of health professionals and their responsibilities regarding domestic abuse, signs of abuse and links to trauma.

- Despite research showing the vital importance of routine inquiry in facilitating disclosures of domestic abuse among service users, only half of all health professionals noted they felt comfortable asking about domestic abuse.It is interesting to note that we hear similar reluctance for routine inquiry for perinatal mental health issues. There is a risk that many women experience a double disadvantage when experiencing two heavily stigmatised difficulties.
- Concerns about the lack of training on domestic abuse for staff, including how to ask and respond sensitively about experiences of domestic abuse, and a fear among staff that inquiry will be re-traumatising or offensive to service users was reported as barriers to routine inquiry.
- Repeated serious case reviews and domestic homicide reviews highlight the importance of repeated routine inquiry in facilitating disclosure.
- Research also shows that women find it difficult to start a conversation about domestic abuse, in the absence of direct questioning, and want to be asked by health professionals. Women in maternity services, including those who have not experienced domestic abuse, tell us they do not find inquiry to be offensive or re-traumatising.
- The group questioned why there is this lack of confidence among staff, especially given the highly sensitive nature of other routine inquiry questions about women's personal lives during pregnancy and postnatally.
- The good news is that there is a fantastic resource that already exists in the LARA Manual to support professionals in how to ask questions about domestic abuse.

2. Recording

Ensuring that domestic abuse is a mandatory field in health care records including national datasets would drive improvements to routine inquiry and enhance understanding of the prevalence, and association with mental health including during the perinatal period.

There is a relatively recent initiative giving patients the legal right to access their NHS records. Whilst overall this is welcomed, the group highlighted concerns about the risk that perpetrators will gain access to these notes and where disclosures have taken

place, risks to women, babies and children could escalate. There is a need to understand how health professionals across universal services, specialist perinatal mental health teams and beyond are recording disclosures.

3. What Works

There is good evidence for the effectiveness of IDVAs (Independent Domestic Abuse Advisors) - employed by, or seconded to, a range of healthcare settings (e.g. GP surgeries, A&E, gynaecology, mental health services and maternity services) - in improving the health outcomes of service users. There are, however, no current national funding streams for healthcare-based IDVA interventions. As a consequence, the level of IDVA provision in healthcare settings varies across the country and across healthcare services. In addition, funding for healthcare-based IDVAs is often insecure and insufficient. Healthcare services have also identified some issues regarding how to successfully implement IDVAs, including having adequate space for IDVAs to speak to clients confidentially.

More evidence is needed around what healthcare services can do, in particular perinatal health services, to ensure the success of IDVA interventions. With respect to other interventions, there is much less evidence for programmes such as brief domestic abuse advice, short-term counselling and nurse case management in preventing and reducing domestic abuse.

Research currently being carried out by Dr Kylee Trevillion at King's College London (called the RIVA study), looks at how healthcare services can ensure the successful implementation of IDVA programmes, particularly within maternity services contexts. This work will generate guidance for healthcare services and will be extremely useful in informing recommendations to commissioners across perinatal health services, including mental health.

4. Barriers

There are a number of reasons why the existence or impact of domestic abuse on perinatal mental health might not be acknowledged or responded to appropriately:

- The medical model of mental health is still dominant among clinicians and health professionals, and domestic abuse can still be seen as a 'social issue', beyond the scope of mental health treatment.
- A lack of understanding of coercive control means that there are many examples when a perpetrator's behaviour is explained as a symptom of (usually) his own mental health condition and the victim is blamed for this.
- Abusers use stigma around mental ill health as a method of control, and this is exacerbated when abusers take on caring responsibilities or where there are immigration fears (often well justified).
- There are specific barriers for ethnic minority women in obtaining support, due to factors including health professional assumptions about cultural norms and traditions.
- We see a pattern of victim blaming and an onus on the victim to seek help.
- Some health professionals will also have experienced/be experiencing domestic abuse and this could impact how they respond to disclosures and support for survivors. 77% of the NHS workforce are women and given what we know about the prevalence of domestic abuse across society in the UK this is likely to impact a high proportion of the workforce.
- Desensitisation and compassion fatigue are both factors. We know that many professionals are feeling exhausted and disconnected post-COVID.
- Confusion around safeguarding children and safeguarding adults continues to exist in the context of parenting. There is a tendency of the system to require mothers to be 'perfect parents' and the notion of 'failure to protect' from the impact of domestic abuse remains in child protection proceedings.

This list of barriers (not exhaustive) indicates more systemic issues in statutory services, such as patriarchal structures and the burden of judgement on mothers suffering from domestic abuse and mental ill health is often entrenched. This is especially prevalent for disadvantaged groups including those experiencing poverty, discrimination and trauma which can often be manifested in homelessness, addiction, contact with Criminal Justice System (CJS) and social services. Services tell us they are supporting families with increasingly complex needs, including domestic abuse.

For these needs to be met, we require a wide-scale trauma-informed perspective.

Next steps

Our discussions demonstrated the depth of the evidence-based knowledge around what is needed to respond more effectively to the needs of new and expectant mothers, babies and families experiencing domestic abuse. The expertise and high-quality resources which are already used in some places mean there is a strong bedrock from which to build influence across policy and practice.

- Taking a survivor-led approach is vital. Adopting the '7 Pillars for a survivor-led approach to mental health support' by Women's Aid is a good place to start.
- Policies, quality standards, guidelines and competencies must routinely and explicitly highlight the need to be acutely aware of signs of domestic abuse, coercive control and trauma. This is about always having a lens into the possibility that domestic abuse could be a factor in each case.
- Given the prevalence and risks associated with mental health and domestic abuse during the perinatal period, health professionals and those who work in the VAWG sector must have appropriate training to identify and respond empathetically to survivors who feel suicidal and connect them to proper support.
- Widespread and consistent use of the LARA manual can support professionals' routine inquiry and significantly impact outcomes for women and babies.
- Guidance must acknowledge the balance of the needs of partners/co-parents and wider family with the risk of inadvertently facilitating abuse, ignoring or missing cases with potentially devastating consequences for women, babies and families.
- Consideration of lobbying for improved recording systems for domestic abuse to inform national datasets.
- Explore the existing NICE guidelines and review whether there is enough new evidence to suggest they should be updated, particularly regarding the assessment, diagnosis and treatment of complex PTSD for violence against women and girls.

A radical transformation in practice and policy tends to happen when practitioners move towards the boundaries of professional silos and see domestic abuse during the perinatal period as 'Everyone's Business'. This requires closer relationships between domestic abuse specialist organisations and health professionals, with IDVAs ideally embedded within services and the third-sector employers of IDVAs co-funded by health to deliver healthcare-based domestic abuse support.

The MMHA has a role to raise awareness and influence opinion about stigma and discrimination, considering the diversity of our networks. We will continue to explore how best we take on the next steps and work closely with our colleagues to raise awareness, showcase best practices, and improve policy, practice and systems. We look forward to continuing what we have started in 2023.

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Dr Kylee Trevillion
Deputy Director of a national Mental Health Policy Research Unit and Senior Lecturer at Institute of Psychiatry, Psychology & Neuroscience, Kings College London

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Parental MH Lead, Centre for Parent and Child Support, South London and Maudsley NHS Foundation Trust

Isabelle Younane
Head of External Affairs for Women's Aid, leading on Deserve to be Heard campaign to ensure an effective mental health response to survivors of domestic abuse

Angela Broadbridge
VCSE Maternal Mental Health Services Project Manager at Ways to Wellness developing social prescribing support for new mothers

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If you have questions about anything you've read in this briefing, please email laura@maternalmentalhealthalliance.org.


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