

Mental health and domestic homicides: a qualitative analysis of DHR overview reports for STADV

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Mental health and domestic homicides

- Introduction – DVA and mental health
- STADV London DHR Case Analysis and Review report 2020: mental health chapter
- Take-home message for practitioners in the DVA and health sectors
- How healthcare services can respond to DVA safely
- Questions/discussion

DVA experiences and mental health

A **survey** (conducted between 2011 and 2013) of mental health service users from South London and Maudsley (SLAM) and Camden and Islington (Candi) NHS Foundation Trusts found (22):

- **27% of women** had experienced DVA *in the past year* and had three times the odds of past year DVA compared with women in the general population.
- **13% of men** had experienced DVA *in the past year* and had twice the odds of past year DVA compared to men in the general population.
- **69% of women** had ever experienced DVA and had four times the odds of lifetime DVA compared with women in the general population.
- **49% of men** had ever experienced DVA and had four times the odds of lifetime DVA compared with men in the general population.

Yapp et al., LARA-VP: A resource to help mental health professionals identify and respond to Domestic Violence and Abuse (DVA). King's College London, 2018.

Khalifeh, H. et al. (2015). Domestic and sexual violence against patients with severe mental illness. *Psychological medicine*, 45(4), 875-886.

DVA perpetration and mental health

- Men and women who have a mental disorder are at higher risk of experiencing and of perpetrating DA compared to the general population (Trevillion et al 2012; Oram 2013)
- In England and Wales, 20% of convicted perpetrators of IPH and 34% of convicted perpetrators of AFH between 1997 and 2008 had symptoms of mental illness at the time of the offence (Oram 2013b)
- Mental disorder was a factor in 75% of the 33 intimate partner homicides and in all of the 7 familial homicides analysed by the Home Office (Home Office, 2016)
- There is an association between the use of psychoactive substances and perpetration of IPV, though the exact mechanisms involved in this relationship are not yet clear (Choenni, Hammink & van de Mheen, 2015).

DVA perpetration and mental health

- Depression may be a risk factor for aggression (Dutton & Karakanta, 2013), and men who perpetrate intimate partner violence have higher rates of depressive symptoms and PTSD (Rhodes et al., 2009; Machisa & Shamu, 2018)
- Some personality disorders have also been reported among perpetrators of IPV, particularly among those who perpetrate moderate and severe IPV (Sesar, Dodaj & Simic, 2018)
- People with psychosis are at higher risk of perpetrating violence against families and carers (Solomon, Cavanaugh & Gelles, 2005), although the relationship between psychosis and violence is complex (Fazel et al., 2009)

Sir Patrick Stewart: ‘At 80, I’m still in therapy to deal with seeing my mother beaten by my father’

The veteran actor took decades to speak about the domestic abuse he witnessed as a child. He tells Guy Kelly how it still afflicts him today

By Guy Kelly

5 December 2020 • 6:00am



DVA may be a reason for:

Service user:

- Attending late or frequently missing appointments/“non-engagement”.
- Frequent visits with complaints or symptoms that have vague or implausible explanations.
- Inconsistent explanations for injuries, or the person seems evasive or embarrassed.
- Seeming anxious, fearful or passive (particularly in the presence of others).
- Self-harming behaviours.
- Covering the body to hide marks (long sleeves, trousers or scarves).
- Not wanting to receive letters or be contacted at home (post, telephone, email).

Partner or family member:

- Cancels appointments on behalf of the service user.
- Always attends with the service user and never leaves their side.
- Seems to bully or be aggressive or **conversely, over-protective**.
- Is sexually jealous or possessive of the service user.
- Is critical, judgmental or insulting about the service user
- Frequently talks on behalf of the service user and ~~does~~ **does not** consult them.

Yapp et al., LARA-VP: A resource to help mental health professionals identify and respond to Domestic Violence and Abuse (DVA). King's College London, 2018.

Survivors' barriers to disclosure

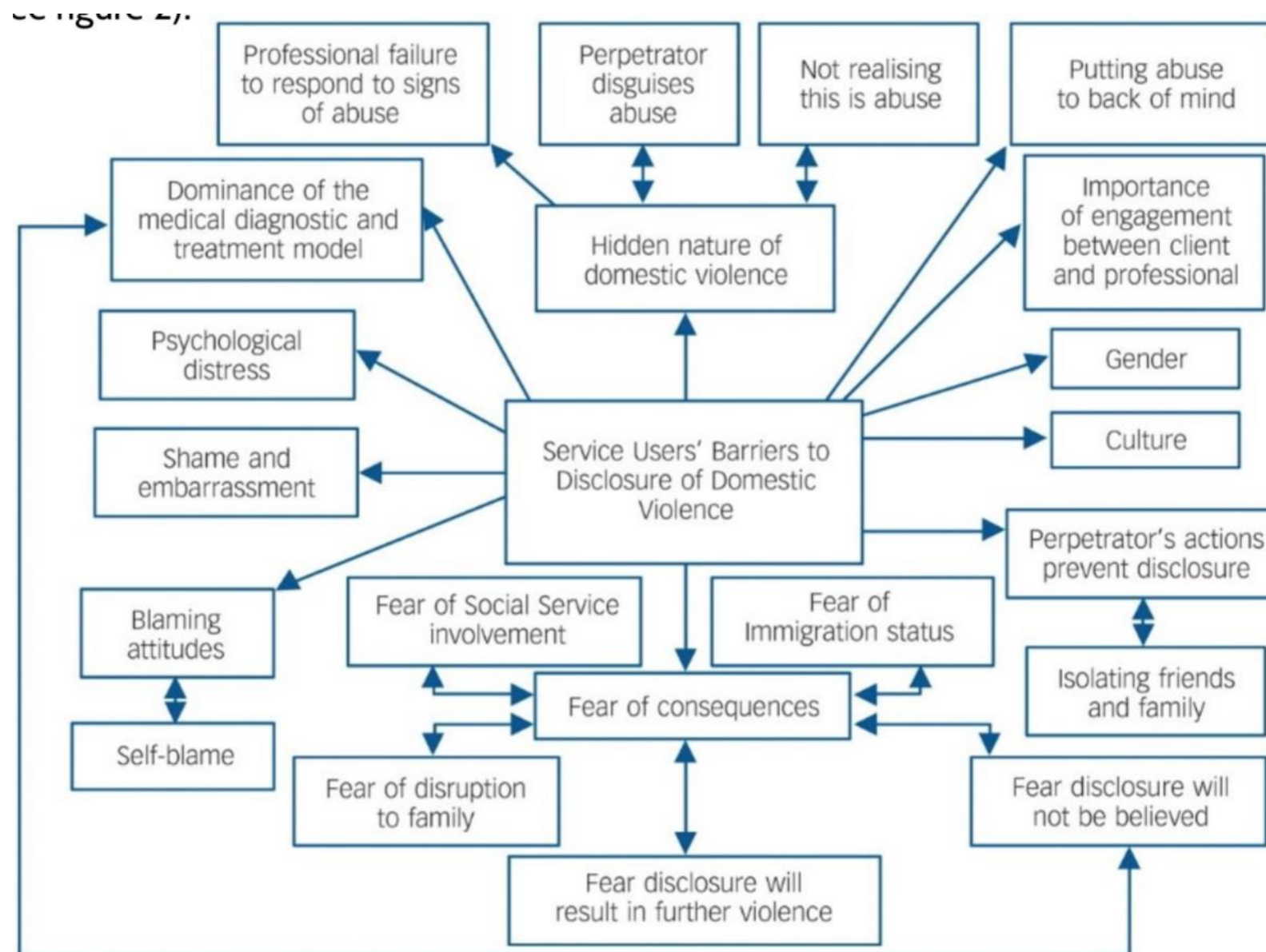


Figure 2. Barriers to disclosure of DVA in mental health services.⁵

From: Rose, D., Trevillion, K., Woodall, A., Morgan, C., Feder, G., & Howard, L. (2011). Barriers and facilitators of disclosures of domestic violence by mental health service users: qualitative study. *The British Journal of Psychiatry*, 198(3), 189-194.

Perpetrators' barriers and facilitators to disclosure

<p><i>Facilitators of disclosure of DVA to healthcare staff and engagement with healthcare</i></p>	<p>Reaching a crisis point or experiencing negative social consequences following abusive behaviour</p> <p>Active listening by healthcare professionals</p> <p>Availability of emotional and practical support (ideally on-site)</p>
<p><i>Barriers to disclosure of DVA to healthcare staff and engagement with healthcare</i></p>	<p>Negative emotions and attitudes towards DVA by perpetrators</p> <p>Lack of recognition of what constitutes DVA</p> <p>Fear of consequences of disclosure</p> <p>Lack of trust in healthcare services' knowledge or expertise in addressing DVA</p>

Calcia, M; Bedi, S.; Lempp H; Howard, ML; Oram, S. (In press). **The healthcare experiences of perpetrators of domestic violence and abuse: a systematic review and meta-synthesis.** BMJ Open, 2021

London DHR Case Analysis and Review

- Report author: Bear Montique
- Mental health chapter (p.68-78)
- Method: qualitative analysis of 10 DHR reports selected by STADV
- Method of analysis: thematic analysis
- Aims: to analyse the responses of healthcare services (any setting or specialty) to victims or perpetrators with mental health problems

DHR	DVA type	Perpetrator mental health problem(s)	Victim mental health problem(s)	Relationship problems* known to healthcare services	Children involved
DHR 1 (RB, Haringey)	IPV (man killed ex-partner)	Depression, suicidal ideation	Depression (historical)	Yes (perpetrator cited separation as trigger to suicidal thoughts; disclosed thoughts to kill ex-partner to mental health services)	No
DHR 2 (Mrs A, Merton)	IPV (man killed long-term partner)	Emotionally unstable personality disorder	N/A	Yes (perpetrator disclosed thoughts to kill ex-partner to mental health services)	No
DHR 3 (Tekia, Waltham Forest)	FV (man killed father-in-law and severely injured wife)	Paranoid schizophrenia	Opiate and cocaine dependence (in treatment)	Yes (DVA between perpetrator and his wife)	Yes (known safeguarding concerns)
DHR 4 (Roger, Barking and Dagenham)	FV (transgender woman killed father)	Agoraphobia, hoarding	Depression associated with multiple sclerosis (historical)	Yes (safeguarding concerns/alert due to suspected financial abuse)	No
DHR 5 (Barbara, Ealing)	IPV (man killed long-term partner and killed himself)	Recurrent depression	Recurrent severe depression	No	No

DHR	DVA type	Perpetrator mental health problem(s)	Victim mental health problem(s)	Relationship problems* known to healthcare services	Children involved
DHR 6 (Charlotte, Hillingdon)	IPV (man killed ex-partner)	Depression, PTSD, 'stress'	N/A	Yes (perpetrator mentioned 'domestic incident'; difficult separation and not seeing children cited as triggers to depression)	Yes
DHR 7 (Rose, Ealing)	IPV (man killed partner)	Schizophrenia, drug-induced psychosis, dissociative personality disorder, IV heroin dependence (historical); alcohol misuse	N/A	No	No
DHR 8 (Agapito, Kingston)	IPV (man killed ex-partner)	Depression, suicide attempt	N/A	Yes (perpetrator cited separation as trigger to suicide attempt; disclosed unauthorised access to ex-partner's emails; made threat to abduct child)	Yes (perpetrator threatened to abduct child)
DHR 9 (Lottie, Hillingdon)	IPV (man killed partner)	Dissocial personality disorder, substance misuse	Personality disorder, depression, self-harm, substance misuse	Yes	Yes (known safeguarding concerns)
DHR 10 (Sophia, Lambeth)	IPV (man killed ex-partner)	N/A	Depression and anxiety	Yes (victim reported that 'domestic hassle' was trigger to anxiety)	Yes (known safeguarding concerns)

Results: perpetrator mental health

- 9/10 perpetrators in the sample had mental health problems
- The mental health diagnoses identified were:
 - depression and/or anxiety disorder (3/10)
 - personality disorder (3/10) (including EUPD and dissocial personality disorder)
 - psychosis (2/10) (including drug-induced psychosis and schizophrenia)
 - agoraphobia (1/10)
 - suicide attempt with no formal psychiatric diagnosis (1/10)
 - One perpetrator (DHR 7) had two diagnoses (dissocial personality disorder and drug-induced psychosis)

Results: perpetrator mental health

- 5/9 perpetrators had reported suicidality to health services prior to the homicide
- 3/9 perpetrators displayed suicidal behaviour or thoughts in the month before the homicide
- 2/9 perpetrators had been suicidal more than one year before the homicide and had disclosed to mental health services that they had thoughts or plans to kill their partners
- 2/10 DHRs (DHR 1 and DHR 8) made recommendations for NHS services to assess risk of harm to families and partners in all patients who present with suicidality

Results: victim mental health and vulnerability

- DHR 4: perpetrator was the victim's carer; she had MH problems and did not receive adequate carers' assessment or support
- DHR 3: the victim was a middle-aged man with addictions, unstable housing and uncertain immigration status
- DHR 9: the victim was a vulnerable woman with depression and personality disorder and a history of DVA and self-harm. Agencies lacked understanding of the effects of coercive control
- In DHR 5 and DHR 10, victims had depression and/or anxiety. They were not asked about DVA, despite one of the victims having disclosed that 'domestic hassle' was a trigger to her anxiety

Results: substance use

- Substance use was present in 3/10 DHR reports in this sample:
 - in DHR 9, both victim and perpetrator used psychoactive substances but did not engage with addiction services. Both were known to mental health services.
 - One perpetrator (DHR 7) misused alcohol. He had been diagnosed with dissocial personality disorder and drug-induced psychosis several years before the homicide. At the time of the homicide, he was experiencing psychotic symptoms (likely induced by medication prescribed for viral hepatitis)
 - One victim (DHR 3) was known to addiction services for heroin and crack cocaine dependence and was engaging well with treatment. There is no indication that his substance use played a role in the homicide.

Inter-agency working

- Agencies often focused on their own area of practice only; there was a lack of effective partnerships between agencies to share information and improve their understanding of the victim and perpetrator
- In DHR 3 and DHR 9, there were significant child protection and mental health concerns, but joint working between mental health and social care was not effective
- In DHR 1 and DHR 8, there were gaps in the information-sharing from mental health services to other agencies.

Inter-agency working

- In DHR 7, the Acute Trust prescribed medication that is associated with risk of serious mental health side effects but did not request historical mental health information from the perpetrator's GP.
- In DHR 4, a there were indicators of neglect and financial abuse which led to a safeguarding alert, but there was no multi-agency strategy meeting or communication with primary care

Carers

- The carer role is associated with a high risk of psychological distress for the carer, known as **caregiver burden**
- The risk is particularly high for carers who live with the person for whom they provide care, and if the carer has mental health problems (Adelman et al., 2014)
- Conflict in the relationship between carer and recipient of care, carer strain, carer history of physical or mental health problems, and carer and care recipient living together have all been identified as risk factors for abuse by carers (Kohn & Verhoek-Oftedahl, 2011)

Carers

- In 2/10 DHRs (DHR 4 and DHR 5) the perpetrators were carers for the victims and were not coping with their role
- DHR 4: neglect and financial abuse
- DHR 5: carer strain was one of the underlying reasons for the perpetrator's low mood and suicidality
- Both cases were associated with perpetrator suicidality in the month before the homicide, and one (DHR 5) was a homicide-suicide.
- In DHR 7, the victim was a carer for the perpetrator

Healthcare services' responses to disclosure of DVA: victims

- In DHR 9, services expected the victim to be proactive about managing the risk to herself.
- There was a lack of understanding of the reasons why the victim may have minimised the impact of DA to professionals.
- In DHR 10, the victim reported to her GP that she was experiencing anxiety and negative thoughts in relation to 'domestic hassle'.
- This was not explored or seen as indicative of domestic abuse.

Healthcare services' responses to disclosure of DVA: perpetrators

- Perpetrators had mentioned relationship difficulties to healthcare services, though often in indirect ways, such as:
 - disclosing separation as a trigger to suicidality
 - having unauthorised access to ex-partner's emails and planning to abduct their child (DHR 8);
 - making 'oblique references' to DA (DHR 9);
 - disclosing injuries due to 'domestic incidents' and depression due to recent separation and loss of contact with their children (DHR 6). Those statements were not explored or shared between agencies.

Risk assessment

- In 5 DHRs, mental health services had not involved the partner when assessing the perpetrator, despite:
 - perpetrators disclosing thoughts to kill their partner (DHR 1; DHR 2)
 - Perpetrators disclosing that relationship difficulties had been the trigger to their mental health difficulties (DHR 8; DHR 6)
 - perpetrator being a carer for their partner (DHR 5).

Risk assessment

- In two DHRs, the risk assessments conducted by mental health services for the perpetrators lacked information or was unreliable due to language barriers
- In DHR 7, the perpetrator had a history of drug-induced psychosis, dissocial personality disorder and violence towards partners (including the victim); information about his mental health was not available to the acute health Trust who was providing a treatment which involved a risk of serious mental health side effects

Mental health treatment and follow-up

- In DHR 3, there was a lack of contingency planning to manage the perpetrator's recurrent disengagement from treatment for psychosis
- In DHR 9, there were insufficient arrangements for housing and mental health follow-up of the perpetrator after release from prison (DA-related offences)
- In DHR 5, the perpetrator had low mood and difficulties in fulfilling his role of carer to his partner after his diagnosis of cancer. His assessment by MH services did not explore the causes of his distress, his role as a carer, or help him manage his distress

Summary

- Mental health symptoms and diagnosis
- Vulnerability
- Substance use
- Inter-agency working
- Caring responsibilities
- Agencies' response to DA
- Risk assessment processes
- Treatment and follow-up for mental disorders

Table 34: Comparison of 2016 and 2019 mental health DHR data

2016 sample	2019 sample
Depression and suicide	Mental health symptoms and diagnosis (includes depression and suicidality among other diagnoses)
Mental health and substance use	Mental health and substance use
Caring responsibilities	Caring responsibilities
Transitions of care	Inter-agency working (includes transitions of care and communications between agencies before transfers or discharges)
Medication	Treatment and follow-up for mental disorders (includes medication and other forms of treatment)
	Vulnerability
	Agencies' response to DA
	Risk assessment processes

Summary

- Healthcare services need to be attentive to the risk of domestic abuse in individuals with mental health problems, as this group is at higher risk of being both survivors and perpetrators of DA
- In more than half of the cases analysed, the victims and/or perpetrators had made disclosures of relationship difficulties to healthcare teams prior to the homicide, often in indirect ways, mentioning arguments, recent separation, disputes about child contact, injuries and psychological difficulties such as depression, anxiety and 'stress' in relation to problems at home
- Disclosures were not seen as indicative of DA or followed up by collateral history

Summary

- Most, but not all, agencies involved with the victims and perpetrators in this sample of DHRs had policies for assessment and management of DA.
- Clear policies for the assessment of suspected or confirmed domestic abuse need to include:
 - guidelines for professionals' recognition of indirect signs of DA
 - safe enquiry about DA experiences or perpetrators
 - response to disclosures of DA
 - local DA agency contacts and referral pathways.
- DA is a complex problem that cannot be effectively address by a single agency or team. Collaboration between agencies, including active information-sharing and joint planning, are essential

Preparing to ask

1. Display information about DVA in the team base

In any mental health setting, people should be able to find information about local or national DVA services, so ask yourself:

- Do you have posters and leaflets providing information about DVA services and sources of help (including helpline numbers) displayed in waiting areas, toilets and/or your consulting room? If not discuss with your team leader so they can be obtained and displayed.
- Is information on sources of support available in a range of formats and locally used languages?

People should not be asked to take away leaflets, cards, or other written information if it may be unsafe to do so. **Make sure that posters and information about experiencing DVA are also accessible to staff. For more information on how to make provisions for staff who have experienced or perpetrated DVA, please refer to [page 35](#) at the end of this resource.**

2. Ensure privacy

It should be part of routine practice to see service users without partners/family members for at least a portion of the consultation. Enquiring about DVA in the presence of a partner or family member may put a person experiencing DVA in danger; this includes any children who may be of comprehending age. If you are finding it difficult to see service users alone, you may find it useful to tell all your service users and the person or people accompanying them that this is just part of routine practice:

"It is routine practice for us to see our service users on their own for a portion of the consultation."

If private enquiry is not possible (e.g. during a home visit) then remember to document that DVA has not yet been assessed.

Preparing to ask

3. Choose an appropriate interpreter if necessary

If an interpreter is needed, make sure to use an independent professional and arrange for someone who is the same gender whenever possible. Interpretation should not be provided by a friend or relative of your service user, or by someone from your service user's local community – this may affect both your service user's ability to disclose and your duty to provide confidential care. If an interpreter could not be accessed in time for a meeting, you may find it useful to use readily available translation services such as [Language Line](#).

4. Be clear about the limits of confidentiality

Before you ask your service users about DVA, you should explain the [limits of confidentiality](#), and ensure that your service user understands these limits. Your goal is to work collaboratively with your service user, and to see how you can empower and support them in the way they want to be supported. Be clear that you will try to obtain your service user's consent before you share any information and that you are working to prioritise your service user's safety.

Yapp et al., LARA-VP: A resource to help mental health professionals identify and respond to Domestic Violence and Abuse (DVA). King's College London, 2018.

Asking about DVA

Your service user may not realise or acknowledge that what they are experiencing is DVA, and your goal is to develop a dialogue about how your service user interacts with those closest to them. Asking specific questions can be easier to understand. You could start by asking an open question, for example:

- *I know that 1 in 4 women/1 in 7 men experience abuse from someone close to them, so I ask everyone if this has ever happened to them. Has anyone close to you ever hurt or frightened you?*
- *How are things with your partner/ex-partner/family?*
- *Are you afraid of anyone close to you?*
- *What happens when you and your partner/expartner/family member argue? What sort of things do you argue about?*
- *Who makes the rules in your household? What happens when you do not obey them?*
- *Does anyone consistently put you down or belittle you?*
- *Do you ever change your behaviour because you're worried about how someone at home might react?*
- *Many people who have these symptoms have been experiencing difficulties in close relationships. Has anyone hurt or upset you?*

Yapp et al., LARA-VP: A resource to help mental health professionals identify and respond to Domestic Violence and Abuse (DVA). King's College London, 2018.

Responding to disclosure

If DVA is disclosed, try and establish the **extent, impact** and **pattern** of the abuse. You could ask:

- *What is the worst that has happened? How did this affect you?*
- *Has the abuse ever resulted in hospitalisation or attendance at an Accident and Emergency department?*
- *Have the police ever been called? Who called them? What happened?*
- *Has anyone ever taken an injunction out against the perpetrator?*
- *Does the perpetrator have a history of convictions/prison for violence (or threats of violence) to partners/family members?*
- *How frequent is the violence or abuse?*

Remember, however, that an absence of a criminal record does not mean that the perpetrator does not pose a risk of harm to their partners, ex-partners, and family members.

Yapp et al., LARA-VP: A resource to help mental health professionals identify and respond to Domestic Violence and Abuse (DVA). King's College London, 2018.

Asking about DVA perpetration

As with people who have experienced DVA, your enquiry should start with open, non-judgemental questions if you hope to elicit a disclosure:

- *Who supports you at home?*
- *Which relationships do you feel are most important to you?*
- *How are things between you and your family? What happens when you argue? Has that ever led to violence?*
- *Has any family member/partner ever said that they feel frightened by you?*
- *Have you ever felt your behaviour get out of hand or violent? What is the worst that has happened?*
- *How do your [insert symptoms here e.g. irritable mood] affect those around you?*
- *What are the effects on those around you when you feel [insert symptoms here e.g. angry]?*
- *Have you ever shouted or smashed anything when you feel [insert symptoms here e.g. angry]?*

Yapp et al., LARA-VP: A resource to help mental health professionals identify and respond to Domestic Violence and Abuse (DVA). King's College London, 2018.

DVA perpetration – risk indicators

When assessing potential risk of ongoing and future harm, key risk factors for repeated and/or escalating abuse include:

- *History of DVA or violence (100);*
- *Use of weapons (102);*
- *Threats to kill (102);*
- *Threats of suicide (107);*
- *Traditional conceptions of masculinity;*
- *Mental health problems; and*
- *Alcohol/substance misuse.*

If a service user has disclosed DVA perpetration, you may also find it helpful to speak to partners/family members/carers to establish the degree of risk, but only if private enquiry is possible and if it is safe to conduct it. Family members and friends often hold vital information about the degree of risk in serious DVA cases (109).

Other factors to assess include any information about a pregnancy or recent separation (102), and whether any children may be involved, including if there are any children present in the household born of previous relationships (102). With help on how to assess risk of DVA perpetration, please see the risk assessment section within this resource. Example risk assessment tools are also provided in appendices.

Yapp et al., LARA-VP: A resource to help mental health professionals identify and respond to Domestic Violence and Abuse (DVA). King's College London, 2018.

Information-sharing

There are several agencies with which you may be required to share information in cases of DVA. These include, but are not limited to:

- **Police** – if a crime has been committed/suspected.
- **Social care** – if a child or vulnerable adult is at risk of harm.
- **Multi-Agency Risk Assessment Conference (MARAC)** – for people experiencing DVA and/or perpetrators.
- **Multi-Agency Public Protection Arrangements (MAPPA)** – for perpetrators who have been convicted of violent and/or sexual offences. This is the process by which the police, probation, and prison services share information with other services to assess and manage risks and protect the public from harm.
- **Multi-Agency Safeguarding Hub (MASH)** – pathway for children who are in need/at risk of harm into social services.

Yapp et al., LARA-VP: A resource to help mental health professionals identify and respond to Domestic Violence and Abuse (DVA). King's College London, 2018.

References and resources

- AVA (Against Violence and Abuse) Domestic abuse during COVID-19: guidance for mental health practitioners:
- <https://avaproject.org.uk/wp-content/uploads/2020/04/FINAL-AVA-Briefing-for-MH-professionals-1.pdf>
- SafeLives Safe and Well: Mental health and domestic abuse: <https://safelives.org.uk/sites/default/files/resources/Spotlight%2007%20-%20Mental%20health%20and%20domestic%20abuse.pdf>
- LARA-VP Online Resource for mental health services: <https://www.kcl.ac.uk/psychology-systems-sciences/research/lara-vp-download-form> (free download)
- Women's Aid safety planning for survivors of DVA: <https://www.womensaid.org.uk/covid-19-coronavirus-safety-advice-for-survivors/>

Thank you!

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