# Section 18 - Therapeutic service provision for Adults affected by domestic and/or sexual abuse in Sheffield

**This section was written in early 2016 and was initially a separate document. A decision was made to include this section in the needs assessment and therefore the section has been updated in light of this.**

**The developments since the original report was written are as follows:-**

- **The section has been presented to the Mental Health Partnership Board and the Mental Health Partnership Network. During this process feedback was given. These comments have been considered and the section amended accordingly.**
- **An Action Plan has been agreed and is now being worked towards to address the recommendations made**
- **VIDA Sheffield have provided up to date information for their service (May 2017)**

## Introduction

One of the themes in *The Sheffield Domestic and Sexual Violence and Abuse Strategy (2014-17)*[1] is to *'ensure good… quality services…are responsive to local need'.* One of the actions was to *'Examine the current offer with regard to therapeutic services in order to consider possible gaps and/or better links between services'.*

The aim of this report is therefore to better understand how effective mental health (MH) and domestic and sexual abuse (DA/SA) services in Sheffield are at identifying, supporting and addressing individuals with a conjunctive MH condition and a current or history of domestic/ sexual abuse situation.

The report reviews current research and national guidance. Local prevalence data is included alongside current activity information. Current commission, training of MH services, policies and there is a summary of the consultations held with stakeholders.

The report provides a services of recommendations for local commissioners, MH services and DA/SA services for consideration.

## The individuals discussed in the report are as follows:-

a. Those who have a pre-existing MH condition prior to the DA/SA situation and has a further negative impact on well-being.
b. Those who have a MH condition diagnosed following a DA / SA situation.
c. Those who are a perpetrator of DA and or SA and accessing MH services

## Current research and reports outline the extent of MH and DA/SA

**Research 1 - suggests that that there are significant connections between MH and sexual and domestic abuse.**

- Domestic abuse has significant psychological consequences for victims, including anxiety, depression, suicidal behaviour, low self-esteem, inability to trust others, flashbacks, sleep disturbances and emotional detachment[2]
- 40% of high-risk victims report having MH issues[3]

[1] Sheffield Domestic and Sexual Violence and Abuse Strategy 2014-17 http://sheffielddact.org.uk/domestic-abuse/resources/local-strategies/
[2] CTC (2014), *Website of the US Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Violence Prevention*.
[3] SafeLives (2015), *Getting it right first time: policy report*. Bristol: SafeLives

- 16% of victims report that they have considered or attempted suicide as a result of the abuse, and 13% report self-harming[4]
- 56% of women experiencing domestic violence are diagnosed with a psychiatric disorder[5]
- Abused women are at least three times more likely to experience depression or anxiety disorders than other women[6].
- 45% of women survivors of domestic abuse reported mental or emotional problems as an effect of the abuse[7].

**<u>Research 2</u> - suggests that <u>individuals with MH conditions are more vulnerable to being a victim</u> of domestic abuse than individuals without a MH condition**[8].

- The Trevillion et al (2012) meta-analysis found the compared to women without MH problems women with;
    - Depressive disorders were around 2 and a ½ times more likely to have experienced domestic violence over their adult lifetime
    - anxiety disorders were over 3 and a ½ times more likely to be a domestic abuse victim;
    - Post-Traumatic Stress Disorder (PTSD) were around 7 times more likely to be a domestic abuse victim.
    - Obsessive Compulsive Disorder (OCD), eating disorders, common MH problems, schizophrenia and bipolar disorder were also at an increased risk of domestic violence.
- Men with all types of mental disorders were at an increased risk of domestic violence, although prevalence estimates for men are lower than those for women[9].

**<u>Research 3</u> - shows that <u>MH</u> services often have service users with a history or are in a current domestic or sexual abuse relationship.**

- Women who use MH services are much more likely to have experienced domestic violence than women in the general population[10].
- Between 30 and 60% of psychiatric in-patients had experienced severe domestic abuse[11].
- A survey of women using MH services in Leeds found that half had experienced domestic violence and a further quarter suffered sexual abuse[12].
- A study of women in contact with community MH teams in south London found that 60% had experienced domestic violence from partners (27% during pregnancy)[13].

**<u>Research 4</u> - shows that <u>perpetrators of domestic and sexual abuse may present to services with a MH condition</u>.**

- Hester et al (2015[14]) suggests there may be a higher likelihood of men who present symptoms of anxiety and depression in primary care who could be the perpetrators or victims of domestic violence and abuse[15].

### 3. A national review of Domestic Homicide Reviews (DHRs) found a high number of incidents with MH present.

[4] SafeLives (2015), *Insights Idva National Dataset 2013-14*. Bristol: SafeLives.
[5] Physical Health Consequences of Physical and Psychological Intimate Partner Violence. Coker, A. et al (2000).
[6] Survivors Handbook, Women's Aid, 2009
[7] Crime Survey of England and Wales, 2015
[8] Trevillion, K. Oram,S., Feder, G., Howard, L, M. *Experiences of domestic violence and mental disorders: A systematic review and meta-analysis* (2012) http://dx.plos.org/10.1371/journal.pone.0051740
[9] Ibid.
[10] Survivors Handbook, Women's Aid, 2009
[11] Howard, L.M., Trevillion, K., Khalifeh, H., Woodall, A., Agnew-Davies, R. and Feder, G. (2010), *Domestic violence and severe psychiatric disorders: prevalence and interventions in 'Psychological Medicine'* (2010), 40, 881-893. Cambridge: Cambridge University Press
[12] Survivors Handbook, Women's Aid, 2009
[13] Morgan (2010) as cited in M Hester, G Ferrari, S K Jones, E Williamson, L J Bacchus, T J Peters, G Feder (2015) Occurrence and impact of negative behaviour, including domestic violence and abuse, in men attending UK primary care health clinics: a cross-sectional survey.
[14] M Hester, G Ferrari, S K Jones, E Williamson, L J Bacchus, T J Peters, G Feder (2015) Occurrence and impact of negative behaviour, including domestic violence and abuse, in men attending UK primary care health clinics: a cross-sectional survey.
[15] Hester el al found that 22.7% (95% CI 20.2% to 24.9%) of men questioned reported ever experiencing negative behaviour (feeling frightened, physically hurt, forced sex, ask permission) from a partner. All negative behaviours were associated with a twofold to threefold increased odds of anxiety and depression symptoms in men experiencing or perpetrating negative behaviours or both.

The 2013 Home Office report '*Domestic Homicide Reviews - Common Themes Identified as Lessons to be Learned*[16] reviewed all DHRs completed nationally between April 2011 and March 2013 and found that a number of cases had *'complex needs'* of which MH was one[17]. Therefore one of the key actions coming out of DHRs has been to better understand the MH services and their approach to DA/SA.

In a number of cases the MH was being treated but the domestic and / or sexual abuse was not always addressed. The report therefore identified a number of issues in MH services including silo working, workers needing a better awareness and understanding of engaging with individuals with complex needs and the need to promote MH representation at Multi-Agency Risk Assessment Conferences (MARAC).'

## 4. National research shows a mixed response to DA/SA in MH services

NICE[18] found that MH services varied in their handing and approach to DA/SA. Of the 51 MH trusts who responded to a questionnaire only 5 had a specific domestic abuse strategy within the service. All had a policy which mentioned domestic abuse but this varied from a separate policy to a few lines in a safeguarding policy. It was found that 35 provided direct domestic abuse training with the majority providing this as part of safeguarding training. The domestic abuse part of the training varied in duration from 30 minutes to 2.5 hours with the exception of two trusts who ran a whole day course.

Howard (2012) found that routine enquiry of DA/SA was the norm in MH services and this *'increases detection[19]'* however even with routine enquiry in place further research the LARA project found '*that MH staff uncovered less than 30% of service users' experiences*[20]*.* The findings suggested that when violence was disclosed professionals were often unsure what to do with the information. Both projects recommended comprehensive training, (how to enquire safely, offer support themselves, and liaise with an organisation specialising in helping survivors of domestic abuse) following the development of referral and care pathways.

## 5. The current National Guidelines on Domestic Abuse include recommendations for MH services

- **National Institute for Health and Care Excellence (NICE) Public Health 'Domestic violence and abuse: multiagency working' (PH Guidance 50)**, published February 2014.

The guidance makes a total of 17 overarching recommendations with 79 individual actions; see Appendix 1 for the full list. 16 recommendations are relevant to local commissioners, managers, trainers, medical professionals and MH and DA/SA workers.

The recommendations pertinent to MH and DA/SA include how commissioners and managers of MH services and DA/SA services should collaborate to ensure both strategies and commissioning align to address both areas. There should be trained professionals in DA/SA in all MH services; there should be an environment in which people are encouraged to disclose their personal situation, a detailed identification/assessment process and clear guidance on Information Sharing. For those who require support, referral systems should be in place to ensure individuals are referred to the most appropriate service to address their DA/SA situation.

One of the key recommendations on MH and DA/SA is recommendation 13 which states that the MH condition should be treated by a MH professional trained in DA/SA:

[16] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/259547/Domestic_homicide_review_-_lessons_learned.pdf
[17] The other complex needs were substance misuse and alcohol misuse.
[18] Health and Social Care responses to domestic violence, Davina James Hanman https://www.nice.org.uk/guidance/ph50/evidence/report-1-current-health-and-social-care-interventions-on-domestic-violence-69195997
[19] Howard. L, M, (2012) *Domestic violence: its relevance to psychiatry Advances in psychiatric treatment* vol. 18, 129–136 doi: 10.1192/apt.bp.110.008110
[20] Prof Louise Howard Making a difference Supporting Victims of Domestic Violence reviewed the Linking Abuse and Recovery through Advocacy (LARA) project assessed the impact of an integrated response to domestic violence. The findings suggested MH professionals often don't discuss experiences of violence with service users, that there may be reluctant to ask questions as they lacked expertise and confidence. http://www.kcl.ac.uk/ioppn/about/difference/4-Supporting-victims-of-domestic-violence.aspx

| Recommendation 13: Provide people who experience domestic violence and abuse and have a mental health condition with evidence-based treatment for that condition | |
|---|---|
| 13.1 | Where people who experience domestic violence and abuse have a mental health condition (either pre-existing or as a consequence of the violence and abuse), provide evidence-based treatment for the condition. |
| 13.2 | Ensure mental health interventions are provided by professionals trained in how to address domestic violence and abuse. Interventions may include psychological therapy (for example, trauma-focused cognitive behavioural therapy), medication and support, in accordance with national guidelines. |
| 13.3 | Ensure any treatment programme includes an ongoing assessment of the risk of further domestic violence and abuse, collaborative safety planning and the offer of a referral to specialist domestic violence and abuse support services. It must also take into account the person's preferences and whether the violence and abuse is ongoing or historic. |

**An audit of the PH50 guidance has not be undertaken by Sheffield Health and Social Care, therefore this report recommends that an audit is undertaken in 2016/17 by SHSC and the outcome including recommendations shared with the SCC and CCG commissioners of MH and domestic and sexual abuse service in Sheffield.**

- **NICE Quality Statement [QS116][21] Domestic violence and abuse, Published date: February 2016**

There are now four quality statements to measure the effectiveness of identification (disclosure), the professional and trained response following the disclosure, of the number of referrals to professional services for DA/SA support following disclosure and the final measure reviews disclosure and referral for perpetrators.

*Statement 1 - People presenting to frontline staff with indicators of possible domestic violence or abuse are asked about their experiences in a private discussion.*

*Statement 2 - People experiencing domestic violence and abuse receive a response from level 1 or 2 trained staff.*

*Statement 3 - People experiencing domestic violence or abuse are offered referral to specialist support services.*

*Statement 4 - People who disclose that they are perpetrating domestic violence or abuse are offered referral to specialist services.*

Each statement is given a measurable outcome which can be used to understand the current performance against each measure and identify areas for future action (see Appendix 3).

The NICE quality standard acknowledges and supports the overarching themes of the NICE PH50 guidance; of encouraging '*multi -agency partnership working at both an operational and strategic level (as) the most effective approach for addressing domestic violence and abuse. Training and ongoing support from within an organisation are also needed for individual practitioners. Without training in identifying domestic violence and abuse and responding appropriately after disclosure, healthcare professionals may fail to recognise its contribution to a person's condition and to provide effective and safe support.*

- In addition to NICE guidance there is also a widely recognised Domestic Abuse toolkit on MH and DA/SA, **The Against Violence and Abuse (AVA) Stella Project *Complicated Matters Toolkit: Addressing Domestic and Sexual Violence, Substance Use and Mental Ill-Health*[22].** The toolkit aims to improve the professional response to both victims and perpetrators of DA and SA who are also affected by MH and or substance use.

The toolkit recommends:-

- Practitioners have an awareness of the issues affecting this client group and a basic understanding of how to work with them.

[21] http://www.nice.org.uk/guidance/QS116/chapter/List-of-quality-statements
[22] http://www.avaproject.org.uk/our-resources/good-practice-guidance--toolkits/complicated-matters-stella-project-toolkit-and-e-learning-(2013).aspx

- Robust assessment tools and providing opportunities for disclosure.
- Providing information about all support options available (MH services and DA / SA services) to enable the individual to decide what happens next.
- Making a range of interventions and approaches available so individuals can choose different interventions at different times depending on their need.
- Making services available so women who wish to attend without the presence of a man can do so.
- Partnership working provides a seamless package of support.
- Partnership working can vary from informal sharing of information about a service user (with their consent), to service level agreements between organisations that formalise inter-agency referral pathways.

**NICE Guidance PH50, quality standards QS116 and the Stella Toolkit will therefore be used as the measure of success for this report.**

## The Current Sheffield Position

**Local DHRs provide insight into MH and DA/SA, with a number of DHRs having MH issues present.**

MH conditions were present in either the victim or perpetrator in six out of nine reviews (Seven were Domestic homicide reviews and two were serious incidents reviews) completed over the last five years. Therefore the recommendations specific to improving the mental health service disclosure, response and referral pathways in the individual reports and the national DHR report needs to be needed to.

## Therapeutic support available for DA/SA victims in Sheffield

The commissioning of adult therapeutic support in Sheffield is not centralised.

DACT does not currently commission therapeutic services for domestic abuse victims with MH issues. This is an historic commissioning decision and the subsequent commissioning of DA support services has not resulted in specialist therapeutic services being commissioned either as part of the contract or as a separate contract.

This means:-

- The commissioning of therapeutic services in Sheffield is varied. There are number of different commissioners within Sheffield City Council and the CCG funding specialist domestic and/or sexual abuse therapeutic support. These commissioners do not necessarily fund the full therapeutic support service but fund 'part' of a service. For example DACT part fund SRASAC with other funding into the service is also from the Ministry of Justice.
- Public funding (Council and CCG) given to the domestic and sexual abuse therapeutic services are to both generic mental health and to specialists in DA and SA therapeutic services. Some funding is specific to the type of abuse and some is specific to gender and the age of the victim.
- The funding received by specialist therapeutic services in Sheffield is often from a number of funding bodies. Not all get funding from the public sector[23] and funding is received from funds such as the; e.g. Big Lottery, Ministry of Justice and local trusts. Therapeutic support services often provide more than therapeutic support to victims, including support for homelessness and training services.

DACT commissions the high risk IDVA service and the medium and standard DA support services in Sheffield (which provide a wide range of practical and emotional support and advocacy). In addition to this DACT commissions:-

- Specific SA therapeutic services. One to one therapeutic support is provided to females (and male victims from April 2016) of current and historic sexual abuse. There is also a telephone helpline service.
- A citywide helpline for professionals to use as well as the general public.

[23] Taken from the Questionnaire for the Domestic and Sexual Abuse Needs Assessment 2016 and circulated to services attending and the wider circulation list of the Provider Consultation Group 2016

- A DASH risk assessor to support professional to use the DASH assessment tool to refer to MARAC, ascertain if a case is high risk and provide briefings to professions on the service offered.
- A domestic abuse training service. Courses are accessible to any services (including MH services both commissioned by SCC and the CCG and those which are not commissioned). One Accredited course is specifically for 'domestic abuse and MH', and non-accredited training includes Domestic Abuse: signs, risk and referral pathways in Sheffield, Domestic Abuse Risk Assessment: DASH and MARAC for Domestic Abuse Leads and Champions, Safeguarding Children and Young People affected by Domestic Abuse, Young People and Domestic Abuse, Multi Agency Lunchtime Seminars and Refresher Training.

**MH services in Sheffield are in the majority commissioned by the Clinical Commissioning Group.**
The Sheffield Clinical Commissioning Group (CCG) NHS MH Services are commissioned by and offer a range of support and interventions depending on the assessed need of the service user. An initial referral is usually made to the **Improving Access to Psychological Therapies (IAPT)** which is a national therapeutic programme. The CCG contract with SHSC is a national generic contract which makes no reference to DA and SA[24]. IAPT is provided in the community the service offers initial assessment (which includes questions on DA/SA) and evidence based psychological therapies for people suffering mild to moderate depressions, anxiety or stress.

For individuals with more substantial and complex MH needs the **Community Mental Health Team** (CMHT) provide therapeutic support for psychosis, severe depression, personality disorder and PTSD.

A **Specialist Psychotherapy Service** provides consultative healthcare for advanced treatment and assessment on depression, anxiety and PTSD, Obsessive Compulsive Disorder and Personality Disorder.

The CCG also commission **psychotherapy from Sheffield Women's Counselling and Therapy Service (SWCTS)** which provides free, confidential counselling and psychotherapy for women aged 16 and over who have experienced rape or sexual abuse, emotional abuse or neglect, domestic abuse and other forms of trauma.

**Other local services providing specialist domestic and sexual abuse therapeutic support**
There are some locally based services which provide specialised therapeutic support to victims but these are not commissioned by DACT or the CCG. The additional services are as follows (in alphabetical order)[25]:-
- Ashiana
- Roshni
- Young Women's Housing Project
- VIDA Sheffield – Vida have provided a summary of their service during the needs assessment consultation. Vida is a *'specialist provider of therapeutic services to women and girls affected by abuse and trauma – in particular domestic and sexual abuse. We have spent many years developing our Eva service model, in response to the needs of our service users and with reference to NICE guidance. We offer the following forms of therapeutic support: trauma focused CBT, (Eye Movement Desensitisation Reprocessing) EMDR, integrative counselling, PTSD group work programme, psycho-education group work programme (and an) informal crafts based support group[26].*

Further details for these services can be found on the DACT website www.sheffielddact.org.uk and on their own websites.

**Other mental health and therapeutic services in Sheffield**
There are also a number of other mental health and therapeutic organisations working with individuals in Sheffield. Whilst not specialising in Domestic and or sexual abuse these services are in contact with individuals affected by domestic and or sexual abuse and some are represented on the Mental Health

[24] Information requested of and provided by Robert Carter, Senior Commissioning and Contracts Manager at Sheffield CCG (29 February 2016).
[25] Taken from the Questionnaire for the Domestic and Sexual Abuse Needs Assessment 2016 and circulated to services attending and the wider circulation list of the Provider Consultation Group 2016
[26] Vida Sheffield, April 2017 as per the needs assessment consultation and feedback provided by Maureen Storey.

Provider Network[27] that the report has been presented at. Information on activity in these services is very limited[28].

**NICE PH50, recommendation 4 is for the commissioning of an integrated pathway. There is a need for MH and DA/SA commissioners to consult with each other when commissioning to ensure contracts have relevant sections on MH or DA/SA.**

**There is a current gap in male therapeutic service provision in the city for those who are victims of DA, therefore this needs to be reviewed and consideration on how this should be addressed.**

## Current prevalence data and activity in Sheffield

**In Sheffield we find the following:-**

1. **DA and SA Prevalence rates suggest around 26% to 31% of victims in the last 12 months access DA support each year (See Appendices 3 and 4 for the full information).**

- Prevalence estimates (Crime Survey of England and Wales 2015) suggest that between 18,200[29] and 21,700 individuals in Sheffield will have been a victim of domestic abuse in the last year; between 13,200 and 14,500 will be female and 4,800 to 7,600 will be male.
- Prevalence estimates (Crime Survey of England and Wales) suggest that the number of people in Sheffield who have been a victim of any sexual abuse in the last 12 months is between 5,095 and 8,797 of which 3881 to 7410 will be female and 1,041 and 1,387 will be male.
- See Section 3 and Part 2 Sexual Abuse for the full prevalence information.

Using the research figures of the CSEW (cited on page 2 of section 18) which reports that 45% of victims experience mental or emotional problems as an effect of the abuse, then an estimated 9,765 (nearly 10,000) victims per annum in Sheffield may have mental or emotional problems as an effect of the abuse.

- The rates and prevalence figures for any abuse (domestic and sexual) in a person's lifetime are also found in Appendices 3 and 4. These victims would be considered 'historic victims' of abuse and local experts have suggested that often those presenting for therapeutic support, present sometime after the incident or abuse has happened.

We know from activity data that:-

- some but not all of the estimated prevalence who accessed support services (a total of 5,800 victims received domestic abuse support in 2015/16, which is between 26% and 31% of the estimated victims annually based on prevalence figures above)[30] will be in therapeutic support services.

- That some victims will be receiving therapeutic support from specialist mental health and therapeutic services but not in DA/SA support.

- That some will not be in either and are known as 'hidden' victims. Hidden victims maybe experiencing standard or medium risk abuse and do not feel in need of support from specialist services at this current time (for a variety of reasons) and some will be unaware of support available. In addition some will be presenting to other professionals services but not disclosing the abuse.

[27] Melanie Hall, MH Commissioning Manager (August 2015)
[28] Requests for information and to meet with these following services were requested in August 2015; Mind, Share Psychotherapy, Rethink, Syeda, Mums in Needs. Activity was not provided by these services.
[29] The CSEW provides data for prevalence of domestic abuse in the whole population for the ages 16 to 59 years. The two figures provided (the lower and higher range) show the estimate population using two populations for Sheffield. The first is the lower of the two, and uses the Sheffield population for the ages 15 years to 60 years (349,850) which is similar to the CSEW however it does not factor in that older people can be victims too. Whilst there is evidence to suggest that the rate is likely to be lower for the over 65 years population group, the second and higher figure has had the same rates applied but for the population 16 plus (461,150).
[30] 5,377/ total DA + total SA (30,000+7,000) = 14% and 5,377/ total DA + total SA (22,700+5250) = 19%

Based on the research earlier in this section it is likely that a significant number are likely to be presenting to mental health services.

**2. MH – prevalence rates suggest there will be a significant number of individuals with a history or current DA/SA situation referred to and in treatment with MH services.**

- It is estimated that around 25% of the adult population will experience a MH problem[31] and that 17.5% will have a common MH disorder in the course of a year[32].
- The MH Foundation reports that women are more likely than men to have a common MH problem[33] and are almost twice as likely to be diagnosed with anxiety disorders[34].
- The Department of Health (2003) reported that over 50% of women within the MH system are a victim of violence and abuse.
- The standardised rate of access to mental health and learning disability services in Sheffield is 3,595 for every 100,000 population[3536] which is a similar rate to the England average (3,617 to 100,000 populations or 1 in 28).
- 15,470 people were in MH treatment in 2014/15 with an NHS mental health provider.
- 18,685 referrals were made to IAPT in 2014/15 and 7,135 started treatment (46% of the total in MH services)[37]. 51.1% in IAPT treatment had an anxiety and/or stress disorder and of those referred in IAPT 63% were female (11,685) to 37% (7,000) male.

Using this information it is estimated that there are around 81,000 adults in Sheffield with common mental disorder each year. This would equate to 23% of the estimated number who have a common mental disorder.

**If we apply the NHS Department of Health (2003) research (upwards of 50% of all women in MH services have a history of DA /SA) to the number of females accessing the IAPT services in a year, then of the 11,685 females referred to IAPT in 2014/15 upward of 5,842 could have a history of DA /SA.**

This means that MH services will be in contact with a significant number of victims with a current or history of DA/SA although this is likely to be a lower estimate given that the 5,842 excludes total referrals to mental health services (only IAPT is included), male victims (see section on Diversity for the a detailed discussion on male and female abuse and perpetrators (MARAC information and local experts both explain that perpetrators are treated in mental health services but the abuse may not be known).

The additional unknown is the proportion of victims in mental health services who are also receiving some form of domestic abuse support from the commissioned support services and/or from other therapeutic services in Sheffield.

Therefore trained staff, procedures, policies (for the disclosure and subsequent treatment of these individuals) and referral systems to specialist DA/SA are essential. These are in line with recommendations in the PH50 NICE guidance and Stella Project.

## Domestic abuse support activity and referrals to MH/therapeutic services

[31] http://www.mentalhealth.org.uk/help-information/mental-health-statistics
[32] *Sheffield MH Needs Assessment*, UCL Partners Academic Health Science Partnership, January 2015
[33] McManus, S., Meltzer,H., Brugha, T., Bebbington, P., & Jenkins, R. (eds) (2009). *Adult Psychiatric Morbidity in England 2007: results of a household survey. NHS Information Centre for Health and Social Care*. [online] Available at: http://www.hscic.gov.uk/pubs/psychiatricmorbidity07 [Accessed 25 August 2015].
[34] Martin-Merino, E., Ruigomez, A., Wallander, M., Johansson, S. and Garcia-Rodriguez, L. (2009). Prevalence, incidence, morbidity and treatment patterns in a cohort of patients diagnosed with anxiety in UK primary care. Family Practice, 27(1), pp.9-16
[35] MH Bulletin: Annual report 2014/15 using the MH dataset. Published by HSCIC 23 October 2015
[36] The MH Needs Assessment raised the issue that referrals to MH services could be higher, since levels of referrals in Sheffield were lowest of all comparator cities in 2012/13.
[37] *Psychological Therapies, Annual Report on the use of IAPT services - England, 2014-15;* Publication date: November 24, 2015 www.hscic.gov.uk

Support services data provides insight into the proportion of victims with mental health conditions who disclose to them a mental health condition. A total of 5,377 received domestic abuse support in 2014/15[38] and around 26.8% (1,435) stated that they suffered with mental ill-health[39]. We also know that only 17% of the 1,435 with a MH condition[40] (236 individuals)[41] were referred or sign posted for therapeutic support. The difference between the proportion with a condition compared to the proportion referred suggests that some were already receiving therapeutic support, that perhaps more could have been referred or that some were not wanting a referral.

There is a suggestion from this that **perhaps more could be done by DA services to encourage service users to access specialist MH treatment. This is based upon NICE PH50 recommendation 13 that evidenced based MH treatment should be provided for the MH condition and those experiencing DA/SA.**

Furthermore when referrals are observed, the majority (220) were referred or signposted to specific domestic and/or sexual abuse therapeutic service and a minority (16) to MH services. **This could suggest that for those in DA/SA services with a MH condition that these service users want or prefer specific DA/SA therapeutic support. However the NICE PH50, recommendation 13 is that this support is evidence based and delivered by trained professionals.**

## MH services activity and referrals to DA/SA services

It is estimated that around 5,842 female victims are accessing IAPT MH services, which is a similar number to the total accessing support services. Again, it needs to be stated that it is not known what proportion disclose the abuse nor what proportion may be accessing specialist DA and or SA support.

MH services can be accessed directly from a local GP surgery and waiting list information suggests support can be received within 45.5 days[4243].

In 2014/15 there were a total of 54 referrals (47 to medium and standard risk services and 7 into the high risk service). This is less than 1% of the total IAPT referrals. Therefore if we review the estimated MH prevalence figure of 5,842 female victims accessing IAPT, then it is noticeable that there were significantly low numbers of referrals from MH and therapeutic services to domestic abuse and sexual abuse support services. This suggests either, mental health services are working effectively with victims OR that mental health services are not identifying victims, the abuse remains undisclosed and is therefore not acted upon. There is further discussion on this later on in the section.

## Specialist domestic and/or sexual abuse Therapeutic support services

A third insight into victims and therapeutic support is to focus on those victims who are accessing the range of specialist therapeutic support services in Sheffield. These services vary, with some providing counselling for all those referred whilst for some services counselling is a part of what they offer.

- The number accessing the therapeutic services - In 2015/16 there were a total of 607[44] referrals into specialist domestic and or sexual abuse services (which also provide therapeutic support) and a subsequent 473 were taken on to the caseload. The total service activity for Ashiana (358 referrals and 349 onto the caseload), VIDA (168 referrals, 76 caseload), YWHP (81 referrals, 48 caseload).
- The information provided finds that the change in volume on the previous year was varied, with only one service[45] stating it was higher.

[38] Information reported by providers to Sheffield DACT as part of performance management of the high risk, medium and standard risk contracts in 2014/15.
[39] 4,517 standard & medium risk and 860 high risk based on feedback to the minimum dataset.
[40] As recorded on MODUS
[41] MODUS is the DA software used in DA services to record information on all clients.
[42] Psychological Therapies, Annual Report on the use of IAPT services - England, 2014-15; Publication date: November 24, 2015 www.hscic.gov.uk
[43] IAPT waits on average are 32 days, therefore Sheffield is significantly higher than national average (IAPT Psychological Therapies, Annual Report on the use of IAPT services - England, 2014-15; Publication date: November 24, 2015 www.hscic.gov.uk
[44] Taken from the Questionnaire for the Domestic and Sexual Abuse Needs Assessment 2016 and circulated to services attending and the wider circulation list of the Provider Consultation Group 2016
[45] VIDA Sheffield

- The data is limiting as it is unknown what proportion of the 473 were also being supported by another service for their mental health, what proportion are current or historic victims and what proportion are or only receiving therapeutic support from this service (the data includes all on the caseload) and therefore the 473 includes individuals who received therapeutic support and/or support for their practical needs.

Insight into the needs of those accessing the specialist therapeutic services reveals a range of mental health conditions. For example Vida explained that their service users had long term recovery needs related to mental health impacts of domestic and sexual abuse trauma (e.g. depression, anxiety, PTSD and low self-worth). The needs of those accessing YWHP included homelessness, practical support, low confidence, isolation, low self-esteem, depression, anxiety, PTSD and self-harming. It was explained that those accessing the BME services of Ashiana and Roshni had counselling, crisis counselling and emotional support needs.

The data therefore shows that specialist therapeutic support is available for victims of domestic and/or sexual abuse in Sheffield. However the known activity (e.g. waiting lists and the outcomes of the support received) for these services is limiting because there are different funders of these services, varying data requirements, differing outcomes measures and processes in place.

Additional data provided by Vida for the 2017 needs assessment (April 2017) provides insight into the Health and mental health referrals to these therapeutic services

In 2016-17, one in five or 20.5% of referrals into Vida's Eva Therapy service (39 out of 190) were from NHS Practitioners. Of these 39 health referrals, 16% (or 22 of the 39) were referred specifically by mental health workers, including IAPT.

The self-referral data also finds that health or mental health services most often cited as the service which had signposted them - 11% of total referrals (21 out of 190) and representing 44% of all self-referrals (21 out of 48).

The data here raises a couple of points - the first is that referrals are made to the Vida therapeutic service by mental health workers because they offer a 'specialist service above the mental health offer' and therefore the voluntary sector is 'adding value' by offering longer periods of therapy, bespoke therapy and specialist therapy for victims of DA and SA. A second train of thought is that mental health workers may not be confident or not experienced enough to work with a small proportion of the DA and SA victims referred to them and therefore onward referral to the specialist services is made.

What is known is that for a small proportion of the estimated 6,000 to 8,000 accessing mental health support per annum, only a fraction are referred to specialist therapeutic DA and SA services from these services.

The discussion on specialist therapeutic support therefore highlights the following:-

(1) Specialist therapeutic services are providing a specific service to a small proportion of estimated victims per annum - the 473 is less than 5% of the estimated 9,765 (nearly 10,000) victims per annum in Sheffield that may have mental or emotional problems as an effect of the abuse[46].

(2) It is not known whether the therapeutic support provided by these services is in accordance with national NICE guidelines

(3) The outcomes of the specialist therapeutic support are unknown.

(4) It is not known how effectively the services are at working together to best meet the DA and MH needs.

[46] Using the research figures of the CSEW (cited on page 2 of section 18) which reports that 45% of victims experience mental or emotional problems as an effect of the abuse

(5) It is not known whether the victims went to these services first (and therefore did not access the commissioned mental health provision and could therefore have been supported in mental health services) or whether these specialist services meet a specific need for some victims with mental health conditions.

This therefore leads onto discussing the quality of therapeutic support on offer at the mental health service for victims of SA and DA.

One measure of understanding the current effectiveness of MH services at identifying and addressing the DA/SA is to better understand the referrals of high risk individuals to the Sheffield Multi Agency Risk Assessment Conference (MARAC)[47].

## MARAC sample data –Two in five cases to MARAC will have a MH issue, one in four high risk victims to MARAC are likely to have a MH issue and 14% of perpetrators. Only 12% of total cases had an individual in contact with MH services and only 5% of cases were referred to MARAC by MH services.

A sample of the latest 2 months of MARAC minutes[48] found that of the 127 cases a significant proportion 48 or 38% had MH issues. This means two in five cases to MARAC had MH identified. In the 48 cases there were a total of 52 individuals with a MH issue of which 33 were victims (26% of all victims), 19 were perpetrators (or 14% of all perpetrators) and in four cases both the victim and perpetrator had a MH issue. Of the 52 identified with MH conditions, 16 (31%) were in contact with MH services which means the majority (36 individuals or 69%) were not in touch with MH services at the time the MARAC was held. It was found that of the total cases (127) to MARAC only 4% (5 cases) had been referred by MH services (2 the victim had MH issues and 3 the perpetrator had MH issues). This means of the 16 cases in contact with MH services the majority (11 cases) had not been referred by the MH service.

The numbers can be used to provide indicative annual estimates on the volumes of the following:-

- total cases in MARAC with MH issues = around 300
- total cases in MARAC with MH issues with either the victim or the perpetrator in contact with MH services = around 300
- total referred by MH services each year = around 30

**SCC Children, Young People and Families Service – Prevention and Early Invention Service** reviewed 68 individuals who had gone to the Vulnerable Adults Panel during April to June 2015/16[49]. They found that 32 individuals (48% of the total) had poor MH, 22 individuals (33% of the total) had contemplated suicide, 12 individuals (18% of the total) had experienced self-harm and the majority had a conjunctive drug or alcohol problem. Only four (6%) were engaged with MH services. The data was not extrapolated to say whether the VAP individual was the victim of DA / SA or the perpetrator or both.

**It is recommended that MARAC data and referrals from MH services are used as measures of effectiveness.**

### Sheffield Mental Health Services and DA/SA

Sheffield Health and Social Care (SHSC) are the main NHS providers of MH services in Sheffield. They provide community, inpatient treatment including the IAPT citywide service.

### The SHSC Domestic Abuse Policy

The service has a policy for Domestic abuse and it was recently reviewed and updated in late 2015. The policy is available for all workers to access on their intranet system and is promoted to all staff attending

[47] MARAC is a local, multi-agency victim-focussed meeting where information is shared on the highest risk cases of domestic violence and abuse between different statutory and voluntary sector agencies.
[48] Information complied by the MARAC co-ordinator. The data was extracted from minutes to all MARAC meetings held during January and February 2016.
[49] *Sheffield City Council Information re – Vulnerable Adults, August 2015*, Dr. Matt Carnell (Data and Performance) by the SCC Children, Young People and Families Service – Prevention and Early Invention Service shared with Alison Higgins (DACT Domestic Abuse Strategy Manager)

the Safeguarding Training which is internally provided. The policy has used the PH50 Guidance as a crib sheet for the policy's content and it heeds the recommendations in the guidance.

The review process included consulting with the Domestic Abuse Strategy manager, to ensure it best met the needs of all stakeholders. This is encouraging as it suggests good partnership working and good strategic links between the provider and commissioners, including those who do not directly commission their service.

The policy is very detailed; it contains a flowchart showing the disclosure and subsequent referral process that should be undertaken by all staff with all service users to allow for disclosure of DA.

The policy contains information on:-

- A consistent process in place for disclosure, for recording and for referring into services (recommendation 4, NICE PH50).
- A list of signs and indicators to look for in a person who may be in, or have a history of DA.
- How the initial assessment should ask about DA/SA and a subsequent routine enquiry every six months should be undertaken.
- How recording of all incidents reported to a worker should be recorded (system, paper and to the police if necessary) assessment.
- How and when referrals to MARAC should be made (where it is ascertained as high risk) using the DASH assessment, how information should be shared and when signposting to specialist DA services should be undertaken (NICE PH50, recommendation 8).
- Training courses available and the level of training required.

There are named leads for Domestic Abuse in the service that provide advice on cases and support workers to complete the DASH for high risk referrals.

The policy has an accountability and governance structure in place.

However the policy does not….

- Contain a detailed section on perpetrators. It does not explain that the service user may be the perpetrator of DA; it assumes the service user is the victim (given the MARAC information which shows high risk cases have a number of perpetrators with a MH issue) and therefore there is no explicit reference on how to work with an individual once this information is disclosed.
- Explain there is a MARAC Information protocol that SHSC is a signatory to.
- Explicitly explain the situations when information can be shared by the worker in confidence to the IDVA service about their client (recommendation 7).
- Explain multi-agency working with specialist domestic abuse support services also in touch with the individual.
- Explicitly explain risk issues and safety – there is one line about clinical risk training on page 13 of the policy, and how separation from a partner and the risks this may have.
- That asking the service user about DA/SA could be done sooner than the 6 months routine enquiry, if signs of indicator signs are present.
- Does not mention how frequently training on DA should be undertaken.

## Domestic Abuse training for SHSC professionals

**NICE PH50 guidance specifies four levels of training, the four levels are contains in the SHSC policy and there are recognised by the MH service.**

The SHSC safeguarding team lead on Domestic and sexual abuse training. Training in the Trust is provided in a number of forms and dependent on the level and role within the organisation. All staff receives some DA/ SA training as part of their mandatory induction training, all clinical staff receive clinical risk training and all have to attend the SHSC Safeguarding Comprehensive training one day course.

The safeguarding course is comprehensive, has been recently reviewed and has been changed from the old Triple Three course, become a one day rather than half a day course and now includes more details information on DA and SA. This includes how to share information with IDVAs, working together with DA/SA support services and completing the DASH, including on behalf of a victim when a perpetrator has disclosed information to them[50].

There are currently issues with getting all staff to complete the course, due to the nature of the duration of the course and the current high demand for MH services. At present, in February 2016, around 55% of staff has received the Safeguarding training. The current aim of the Safeguarding leads is to ensure 100% of staff have been trained in this Safeguarding course, which is encouraging given the depth of the DA content.

The course content is detailed and is likely to be classified as level two training (NICE PH50, Recommendation 11) as it covers – Disclosure, reporting & recording, referral to safeguarding, referral to MARAC and the MARAC process, information sharing rules, and raising an alert.

For those in a co-ordination role and supervision role attendance on the external training course commissioned by DACT is available. The DACT commissioned domestic abuse training is available citywide for professionals and in 2015/16 a total of 36 individuals have been trained from SHSC. The course is likely to be classified as level three training (NICE PH50, Recommendation 11) as the training includes guidance and a walk through of the DASH risk assessment tool which is only briefly discussed in the level two training.

Given the high likelihood of MH workers treating service users who have a current or historic DA/SA experience it is probably aspirational, but recommended that specialist DA training is made available for all clinical staff and not just the co-ordinators. This is supported following observations made at a Substance misuse and MH training event held at the end of 2015 that suggests more can be done to support MH workers. There was a specific workshop at the event on DHRs. The DHR workshop was well attended and anecdotal feedback was the interest in the DASH; how some had not used a DASH and for some, they had not seen a DASH.

**It is recommended that DACT ask Action (the current providers of DA training) to work with SHSC during 2016/17 to work together on developing a training package that can be delivered in house by SHSC that are in locations and times convenient for staff, that are booked in advance, giving enough time for staff to work around training scheduled and prioritised by SHSC and workers, at a level three.**

Feedback from Eva Rix, training lead on Safeguarding at SHSC supports this, however notes that for some workers there is a need to consolidate the current training they have recently received prior to going into more detail and at a higher level. Therefore she has recommended that the Safeguarding Steering Group is the priority to begin with, as they act as the hub for all DA/SA queries.

Given the time it may take for all staff to receive such training **it is also recommended that a 'trial' of the MH and DA/SA training is held, similar to the MH and Substance misuse workshops held in 2015.**

Where staff from DA services and MH are both present. It would have a dual purpose with DA and SA services having the first session and MH services having the second session. This could be done in a couple of hours but would clarify some initial questions workers have of the different services, the current processes in place, build worker links and provide some extra guidance on the training content.

[50] Information provided to DACT by Eva Rix, Lead for Safeguarding, SHSC

## Consultations[51] with local experts during the course of this report identified the following statements of fact, issues, and risks.

### Statements of Fact

- Not all victims of DA / SA access or want to access support services[52] therefore support and identification in the services they are accessing is a priority.
- The support pathway is accessible and widely publicised widely among partners and to the public.
- Referrals into their services come from a wide range of partners as well as a large proportion of self-referrals.
- Access to services can be gained by contacting a specific service directly or via the helpline which provides a point of access to DA / SA services for both professionals and individuals.
- DA/SA therapeutic service providers refer and signpost their service users to the commissioned DA/SA providers for additional support.
- MH service providers routinely ask their clients questions regarding DA/SA and there is a process to follow based on the outcome given.
- MH services report that most of their service users, where DA/SA is identified, do not want a referral to DA/SA services but want to address the MH.
- SRASAC regularly make referrals to MH services where it is identified that the client requires a more intense and longer-term care for their psychological condition.
- Recognition that generic MH services are not able to meet all the needs of all those who are a victim of DA/SA but neither are the therapeutic services which show referrals to DA/SA support services.
- More people are referred to DA/SA therapeutic services from DA support services than to SHSC MH services.

### Issues

- There are no DA therapeutic services commissioned for male or female victims and the non-commissioned specialist therapeutic support services do not offer services for men. Therefore the only therapeutic support available for male DA victims is via the generic MH services, and these are not explicitly commissioned to provide a specialist service for DA individuals.
- Options should be made available to all and it should be an individual's choice to access multiple services.
- A multi-agency approach is still not happening between MH and DA/SA services consistently and varies by worker.
- A multi-agency approach - Issues with the sharing of information with the IDVA
- It has not been possible to determine the number of service users receiving support from MH services who has disclosed a DA/ SA incident. This is required for NICE QS116 guidelines.
- Communication and liaison between CMHTs and therapeutic services is inconsistent.
- All services are working to high demand and one of the biggest obstacles for them is capacity, with all services having waiting times. This hinders the speed with which people receive support, the time available for partnership working and time to attend training.
- The referral routes are there, but not used as effectively as what they could be.
- Some groups of people are underrepresented at therapy services, e.g., one therapy service highlighted that they don't receive any referrals for women under the age of 25.
- Interpreter costs for BME individuals can be an issue in DA/SA therapeutic services.
- Promotion to raise services' profile with hard to reach groups is hindered when at full capacity.
- Very few cases of SRASAC caseload are current victims of SA; their client base is mainly historic victims. Therefore is there a need to promote the service to current victims?
- Long term funding for the specialist domestic and sexual abuse therapeutic services

[51] James Newcomb, DACT Information & Performance Analyst met with workers from commissioned and non-commissioned services, both DA, SA and MH services.
[52] Sheffield Domestic and Sexual Abuse Needs Analysis 2014

**Risks**

- Feedback from DA/SA services has indicated that the generic MH Services in Sheffield do not carry the specific skills and knowledge to effectively address all the needs of DA/SA victims, with treatment focussed on addressing the presenting psychological condition(s) and is not trauma or abuse specific.
- The level of qualifications and counselling skills of all the services in Sheffield that are providing therapeutic support to victims is unknown.
- The short term and long term effectiveness of the therapeutic service provision based on service user outcomes is not known.
- A multi-agency approach - The crisis plan (MH) and safety plans (DA support) may complement or conflict.
- MH services acknowledge that they cannot always meet all of the needs of the victim.
- Where the service user is not determined to be high risk, the MH service will signpost to DA/SA services but if this is not followed up by the service user they may be at risk.
- If DA/SA is not disclosed the treatment given may put the individual at risk (e.g. give the person tools to assert themselves may put them in a vulnerable position.
- DA disclosed but risk level not ascertained.
- *Not taking into account experiences of trauma when assessing and treating MH problems can leave victims at risk of further harm from a perpetrator, as well as result in less effective interventions to manage their MH[53].*

**The feedback here has been reviewed and considered alongside the other findings in the report and in the recommendations made.**

## Conclusion

The report shows Sheffield has a number of MH and DA/SA therapeutic support services, providing a range of support options in Sheffield for victims of DA/SA with a MH issue. The MH services however are commissioned for MH and not specifically for DA/SA. The report has shown that MH services have a number of DA/SA victims currently in treatment for MH and when research findings are applied; prevalence figures suggest these individuals could be a significant proportion of their client base. It is unknown at present whether DA/SA is identified to its full extent in each individual case but MARAC evidence suggests that when it is disclosed the extent of the risk level is not always ascertained appropriately (e.g. MARAC data shows a number of individuals in touch with MH services who were not referred by the MH service).

The report shows the MH service has a good policy in place which was reviewed in 2015/16 and there are disclosure and referral systems in place for clinicians to refer to DA support services. There are a number of training opportunities for workers on DA/SA and the training programme as part of the Safeguarding training has become more comprehensive in 2015/16. However there is also recognition that training could be more specialist and specific on DA/SA, more workers need to be trained, that a more effective multi-agency working with DA/SA support services is required and there should be more referrals to MARAC from the MH service provider.

The recent NICE guidance on domestic abuse recognises the opportunities for improving the MH response to DA/SA and therefore it is paramount that the training happens and that an audit against the NICE PH50 guidelines is undertaken with a subsequent action plan be put in place.

There is also a need for commissioners to review commissioning contracts to ensure the MH include reference to DA/SA and DA/SA contracts include specifics on MH.

Therefore the report recommends that the majority of cases should be supported by secondary care MH services. The MH services in Sheffield are large, specialist clinically trained and evidenced based MH provision at all levels - community based to inpatient and psychological therapies.

[53] http://www.avaproject.org.uk/our-resources/good-practice-guidance--toolkits/complicated-matters-stella-project-toolkit-and-e-learning-(2013).aspx

Small specialist therapeutic services cannot offer the diversity and range of services that the MH service can to such a larger number of individuals, however it does have to be recognised that for a small minority of individuals it maybe the best option at that time but these services should only be provided by specialist counsellors trained in and using evidenced based therapies.

In times of austerity it is difficult to recommend that there needs to be more specialist provision, particularly when it is unknown what proportion of people in these services could be in generic MH services. Therefore the commissioning of specialist DA/SA services for therapeutic services to work with services users who also have a MH issue should not be made at this time, and should be reviewed once the recommendations have been put into place and measurable outcomes achieved.

Therefore what is required before a decision is made to commission specific therapeutic DA/SA support is to ensure that DA/SA disclosure is encouraged at any time during MH treatment and that there is consistency in workers in their response to disclosure. Clear and thorough policies, good IG guidance, specialist mandatory training which is repeated regularly and the outcomes measured.

The measures of success will be the NICE quality standards QS116 for Domestic abuse and the number of referrals to MARAC from MH services.

## List of Recommendations

**Therapeutic support is available in Sheffield, although not commissioned by DACT for DA, people are accessing support but it is currently unknown whether the support is along national NICE guidelines, whether people go to the most appropriate service first and how effectively the services are at working together to best meet the DA and MH needs. Therefore:-**

**Action - An audit of the PH50 guidance should be undertaken by Sheffield Health and Social Care bin 2016/17 and the outcomes including recommendations shared with the SCC and CCG commissioners of MH and domestic and sexual abuse services in Sheffield.**

**Action - There is a need for MH and DA/SA commissioners to consult with each other when commissioning to ensure contracts have relevant sections on MH or DA/SA (NICE PH50, recommendation 4 is for the commissioning of an integrated pathway).**

**Action - Consider the options for addressing male therapeutic service provision in relation to domestic abuse, which is a current 'gap' in the system.**

**Action - Encourage the formal referral of DA/SA support services users with MH issues to specialist MH treatment. (NICE PH50 recommendation 13)**

**Action - DACT request that Action (the current providers of DA training) work with SHSC during 2016/17 to develop a training package that can be delivered in locations and times convenient for MH staff, that are booked in advance, giving enough time for staff to work around training scheduled and prioritised by SHSC and workers, at the NICE level three, starting first with the Safeguarding Steering Group.**

**Action - A 'launch' of the MH and DA/SA training is held, similar to the MH and Substance misuse workshop held in 2015. Where staff from DA services and MH are both present. It would have a dual purpose with DA and SA services having the first session and MH services having the second session. This could be done in a couple of hours but would clarify some initial questions workers have of the different services, the current processes in place, build worker links and provide some extra guidance on the training content.**

**Action - Monitor the effectiveness of the MH service at addressing MH issues by reviewing MARAC data and measuring against the NICE quality Standards (QS116).**

**Action - Better understand what need there is specifically for specialist DA/SA services that is unable to be undertaken by the current MH service and why.**

**Action – Introduce a therapeutic dataset that can be used by all services providing direct therapeutic support to victims in third sector services. This will build a detailed profile on the number of referrals, the number receiving therapeutic support, the waiting times of the service, the capacity available and the split between DA and SA. Furthermore an understanding of therapeutic service outcomes including the duration of treatment will be built and the qualifications of therapists in the service.**

**Action - Only once the above are completed and there is assurance that there is a specific need for a separate DA service, should consideration of a separate therapeutic service contract be given.**

**The agreed Action plan**

An action and timescale has been agreed between the DACT Domestic Abuse Strategy Manager, Sheffield Health and Social Care and Action. It is expected that all actions will be completed by mid-2017.

At this point, the Action Plan can be reviewed and further consideration of current and future therapeutic service provision and commissioning in Sheffield can be considered.