Lives of quiet desperation - meeting the health and social care needs of mental health patients, experiencing domestic violence, in their care plans

Aidan Cooney M.Sc. (Kings) BSW (UCC) Senior Medical Social Worker

IASW Special Interest Group Adult Mental Social Work – National Conference 03/12/2021

Mental Health & Social Care – Psychiatrist's / Psychologist's views

- Priebe et al (2013) writing in the British Journal of Psychiatry, The future of academic psychiatry may be social. Peter
- Kinderman (2014) argues that in mental health teams needs to stop diagnosing mental illness and prescribing drug treatments. Instead, we need to offer social and psychological interventions.
- Alex Thompson (2016) a liaison psychiatrist in the UK tweeted; as a psychiatrist, if I had the choice between a prescription pad and proper housing, employment, legal support, I'd give up the prescription pad.
- Professor George Szmukler (2020) in critiquing the the mental health act 1983 in UK, spoke about how unmet health and social care needs as a concern for him and those who he has worked with in mental health
- Professor Brendan Kelly (2021) TCD Psychiatry opinion piece in the Medical Independent spoke of mental health patients needing the *The right to treatment, **social care**, and liberty; arguing*

> *There were, however, **clear gaps** in the new legislation, which did not address in detail the process of voluntary admission; did not establish **a minimum standard of care** to which patients were entitled; and did not allow for shorter periods of detention explicitly for assessment purposes.*

Mental Health & Social Care - Feminist Social Work

- Feminist principles are deeply aligned with social work's core values of the importance of relationship, social justice, integrity, and dignity and worth of the person **(Shepard et al, 2016)**
- Feminist bioethics offers critiques of psychiatry and feminist discussions of certain diagnostic categories that disproportionately affect women, but these are concerned with women's issues within psychiatry and how psychiatry has been used to oppress women (Martin, 2001) .
- Martin (2001) argues that feminist bioethics offers a general critique of psychiatry and the rethinking of the practice of psychiatry, regardless of whether the specific instances involved are women's issues.

MH- Social Work	Care Ethics lens of Mental Health Reform			
Philosophy of Social Care -	**Attentiveness**	**Responsibility**	**Competence**	**Responsiveness**
Human Rights	Structural Barriers	Equality	Legally Literacy	Citizenship
Relationship Based	Relationship	Collaboration	Respect	Shared Decision Making
Strengths Based	Helping	Person Centered	A person ability to learn	Community
Safeguarding Adults	Needs	Choices	Advocacy	Personal Outcomes
Trauma informed Care	Experiences	Peer Support & Mutual Self-Help	Empowerment, Safety & Non-Judgmental	Cultural, historical, and gender issues
Disability, Ethnicity and Culture	Exclusion	Inclusion	Equity	Identity

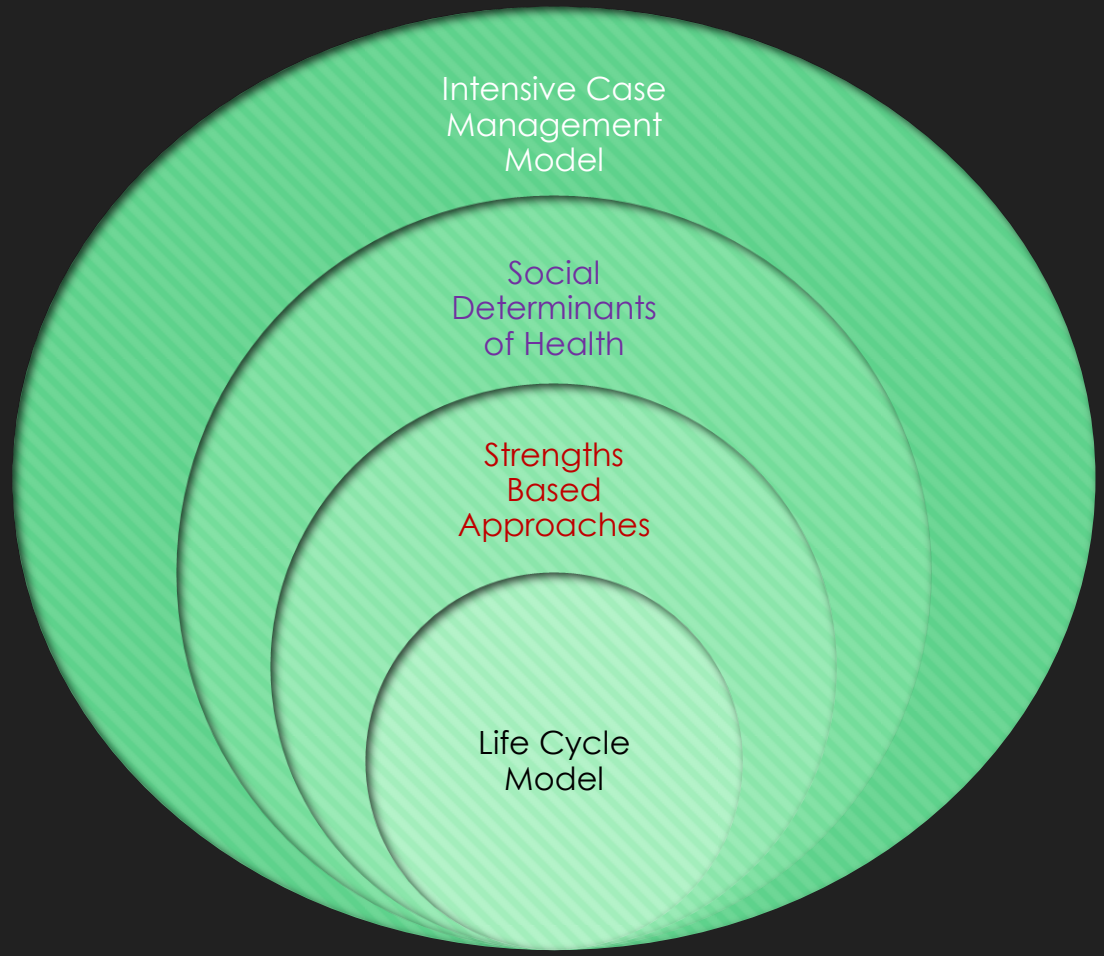
Mental Health & Social Care - Care Planning

- Statutory Instrument No 551; Article 15 & 16 outlines Care Planning in approved centre (2006)
- An individual care plan, as defined by the regulations, is: "*a documented set of goals developed, regularly reviewed and updated by the resident's multi-disciplinary team, so far as practicable in consultation with each resident. The individual care plan shall specify the treatment and care required which shall be in accordance with best practice, shall identify necessary resources and shall specify appropriate goals for the resident. The individual care plan shall be recorded in the one composite set of documentation* (MHC 2009).
- O'Loughlin & O'Neill (2018) assessment of how a patient's needs were identifying needs as a key part of their ICP process identified a number of factors

Confusion between needs and goals **Too many goals listed at one time**	**Resources and person responsible for action not identified**	**Needs which have been identified at the outset are forgotten and disappear from the agenda**
Patient strengths and supports are not included, not recovery focused	Family not included (where patient consents)	ICP focus is too narrow, in-patient focused, symptom relief focused, not inclusive of holistic view of patient, does not extend to a community view
Address nursing and medical domains only	One shoe fits all, tokenism, empty paper exercise	Over reliance on standardized assessments

Mental Health & Social Care – Care Planning
A 'Stepped Care' Approach

- **Slainte Care**
- Health inequalities can result from economic and social inequalities. The impacts of social determinants of health are evident in health outcomes in Ireland. Research shows that a number of chronic illnesses and markers of ill-health are more common among deprived sections of the population
- **Sharing the Vision – Stepped Care Approach**
- This policy recognises the need for a whole-of population, whole-of-government approach to the delivery of mental health services. In adopting this approach, the policy is underpinned by an ecological model which uses a stepped care approach that ensures that the values from Sharing the Vision are preserved throughout.
- A 'stepped care' approach seeks to ensure that each person can access a range of options of varying intensity to match their needs. In other words, there can be a 'stepping up' or a 'stepping down' in accordance with the stage of recovery.
- A stepped approach to care should also help to increase efficiency by 'shifting' constituencies of need towards more of the 'upstream' services, that is, promotion, prevention, early intervention, recovery and participation. Over time, this should reduce the need for more expensive 'downstream' acute and crisis response services. In this context, strategic investment in 'upstream' services should be viewed as an investment rather than a cost.



Mental Health & Social Care – Domestic Violence Case Study

- ***T1 – Patient's reported experiences of domestic violence –***

The abuse was constant and mind games never ending; morning-noon-night. This led to such confusion and be told that it was not right. After a few months I decided to try and stand up for myself but realized very quickly that if I did that, that the abuse would become more severe...

There was emotional control. I just spent years and years trying to get my voice heard but I was still experiencing eh quite a high level of domestic violence, so it was just like being in quick-sand, I could not get my voice heard and because of the brain washing element of domestic violence…

- ***T.2 – Admission was part of the abuse cycle -***

Well, it was my second admission was a direct result of my ex-partner demanding that I was given psychiatric care in the hospital setting. I had no intention or want for that (admission) but I felt that I had to go along with that. I felt backed into a corner, manipulated and I was actually depressed, and I am not saying I was not. But because of that (depression) I could not articulate it or using my voice again...

- ***T.3 – Silencing of the patient in care planning -***

I could not articulate myself ... to tell the professionals I was dealing with in the mental health field, so it is not very clear to them unless they are very specifically trained in domestic violence, so it was very messy / very confusing on say the professional's side and my side and very messy for a long time, which is unfortunate because if there had been somebody with the right level of training then I think I might have avoided a lot of pain...

- ***T.4 – Coercive Control and Discharging -***

When I came back, I was discharged by one of the doctors who happened to say I will talk to my ex-partner, before you go. So, my partner at the time came into talk to him and all of a sudden, when he came out the doctor wanted to talk to me and say no in fact you will be staying and he said I cannot hold you here (Department of Psychiatry), but I do think it is for the best after talking to your partner who said things are very bad, you really are not well and you need to stay...

Social Determinants of Health - Care Planning & DV

- In recent years, a growing understanding of the importance of social determinants of health (SDOH) has driven a flurry of efforts to identify and address health-related social needs in health care settings.
- One novel, national approach to identifying when SDOH influence demand for health care are SDOH-related Z codes when it comes to case management in health and social care settings
- The 5 most utilized Z codes were:
- Z59.0 – Homelessness
- Z60.2 – Problems related to living alone
- Z63.4 – Disappearance and death of family member
- Z63.0 – Problems in relationship with spouse or partner
- Z65.8 – Other specified problems related to psychosocial circumstances,

Other Problems Related to Primary Support Group, including family circumstances (Z63)	
Z.63.0 Problems in relationship with spouse or partner - Interpersonal Violence	50%
Z.63.8 Other specified problems related to primary support group; Family discord NOS: High expressed emotional level within family	50%
Problems Related to Employment and Unemployment (Z56)	
Z56.0 Unemployment, unspecified	**100%**
Problems Related to Housing and Economic Circumstances (Z59)	
Z.59.0 Homelessness	**100%**
Z.59.6 Low Income	**75%**
Problems Related to Social Environment (Z60)	
Z.60 Problems of adjustment to life-cycle transitions	**75%**
Problems Related to Negative Life Events in Childhood (Z61)	
Z.61.2 Altered pattern of family relationships in childhood	50%
Z.61.3 Events resulting in loss of self-esteem in childhood	25%
Z.61.4 Problems related to alleged sexual abuse of child by person within primary support group	**75%**
Z.61.6 Problems related to alleged physical abuse of child	**75%**
Z.61.7 Personal frightening experience in childhood	**75%**
Z.61.8 Other negative life events in childhood	**100%**
Problems related to certain psychosocial circumstances (Z64)	
Z.64.0 Problems related to unwanted pregnancy	75%
Z.64.3 Seeking and accepting behavioural and psychological interventions known to be hazardous and harmful	25%
Problems Related to Other Psychosocial Circumstances (Z65)	
Z.65.0 Conviction in civil and criminal proceedings without imprisonment	**100%**
Z.65.1 Imprisonment and other incarceration	25%
Z.65.2 Problems related to release from prison	25%
Z.65.3 Problems related to other legal circumstances; Arrest, Child custody or support proceedings, Litigation, Prosecution	50%
Z.65.4 Victim of crime and terrorism, Victim of torture	75%
Problems related to lifestyle (Z.72)	
Z.72.1 Alcohol Use	**100%**
Z.72.2 Drug Use	75%
Z.72.5 High-risk sexual behaviour	75%
Personal history of risk-factors, not elsewhere classified (Z.91)	
Z.91.1 Personal history of noncompliance with medical treatment and regimen	**100%**
Z.91.2 Personal history of poor personal hygiene	50%
Z.91.4 Personal history of psychological trauma, not elsewhere classified	50%
Z.91.5 Personal history of self-harm: Parasuicide / Self-poisoning / Suicide attempt	**100%**
Z.91.6 Personal history of other physical trauma	50%

Assessment of Need & Care Planning - DV and Health & Social Care Issues - Intensive Case Management

Camberwell Assessment of Need Mother - Initial Assessment							
Needs		**Patient**		**Staff**		**Intensive Case Management – Strength Based**	
Category	Description	Met	Unmet	Met	Unmet	Pillar of Care	Interventions
Basic	Accommodation		**100%**		**100%**	POC.5- Self-Care & ADL	Referral to Council – Presentation to HAT Link in with Women's Aid and explore housing support options
Functioning	Self-care	50%	**50%**	25%	**75%**	POC.5- Self-Care & ADL	Referral to Occupational Therapy – Functional Assessment Referral to Day Centre – Recovery College
Functioning	Daytime activities	25%	**75%**	25%	**75%**	POC.5- Self-Care & ADL	Referral to Occupational Therapy – Functional Assessment Referral to Day Centre – Recovery College
Health	General Physical health	25%	**75%**	25%	**75%**	POC.1- Physical Health	Referral to Women's Aid – Gender Specific Physical Care Support
Social Care	Information about condition		**100%**		**100%**	POC.2 Mental Health	Review of mental health diagnosis and joint meeting with Consultant
Health	Sleep	25%	**75%**	25%	**75%**	POC.1 Physical Health	Referral to Occupational Therapy – Sleep Hygiene Support Referral to Day Centre – Recovery College – Stress & Anger Management
Health	Psychological distress		**100%**		**100%**	POC.2 Mental Health	Referral to Women's Aid – Trauma Informed Groups Referral to Day Centre – Recovery College – Stress & Anger Management
Health	Safety to self	25%	**75%**	25%	**75%**	POC.4 Problem behaviour	Referral to Women's Aid – Safety Planning and Mental Health Crisis Plan Liaise with Gardai
Health	Safety to child and others	25%	**75%**	25%	**75%**	POC.4 Problem behaviour	Referral to TUSLA - Joint working and shared care planning
Health	Substance Misuse		**100%**		**100%**	POC.3 Drugs & Alcohol	Referral to Drug and Alcohol Services - Dual Diagnosis and MH Crisis Plan
Social Care	Violence and Abuse		**100%**		**100%**	POC.7 Family & Social Network	Referral to Women's Aid – Trauma Informed Groups
Health	Sexual Health	25%	**75%**	25%	**75%**	POC.1 Physical Health	If a referral to Women's Aid – Trauma Informed Groups
Functioning	Practical Demands of Child care	50%	**50%**	50%	**50%**	POC.7 Family & Social Network	If a referral to TUSLA - Joint working and shared care planning
Functioning	Emotional Demands of Childcare	25%	**75%**	25%	**75%**	POC.7 Family & Social Network	If a referral to TUSLA - Joint working and shared care planning Family Talk – Intervention for Parent & Child re: Parental Mental Illness
Social Care	Budgeting	25%	**75%**	25%	**75%**	POC.5 Self-Care & ADL	Referral to Occupational Therapy – Functional Assessment Referral to MABS / NGO – Financial Support
Social Care	Benefits	25%	**75%**	25%	**75%**	POC.5 Self-Care & ADL	Liaise with CWO and advocate for own benefits

Assessment of Need & Care Planning - DV and Health & Social Care Issues - Intensive Case Management

Camberwell Assessment of Need Mother - Assessment Reviews 3 months later							
Needs		Patient		Staff		Intensive Case Management – Strength Based	
Category	Description	**Met**	Unmet	**Met**	Unmet	Pillar of Care	Interventions
Basic	Accommodation	**100%**		**100%**		POC.5- Self-Care & ADL	Working with the Council re: housing with financial support / emergency placement
Functioning	Self-care	**100%**		**100%**		POC.5- Self-Care & ADL	Referral to Occupational Therapy – Functional Assessment Referral to Day Centre – Recovery College
Functioning	Daytime activities	**75%**	25%	**75%**	25%	POC.5- Self-Care & ADL	Attending the Day Centre – Recovery College Occupational Therapy – Interventions being offered
Health	General Physical health	**100%**		**100%**		POC.1- Physical Health	Referral to Women's Aid – Gender Specific Physical Care Support
Social Care	Information about condition	**100%**		**100%**		POC.2 Mental Health	Attended the mental health diagnosis review with the Consultant and reporting clarity around mental health diagnosis
Health	Sleep	**100%**		**100%**		POC.1 Physical Health	Completed Occupational Therapy – Sleep Hygiene Support Attending Day Centre – Recovery College – Stress & Anger Management
Health	Psychological distress	**50%**	50%	**50%**	50%	POC.2 Mental Health	Attending Women's Aid – Trauma Informed Groups Attending Day Centre – Recovery College – Stress & Anger Management
Health	Safety to self	**75%**	25%	**75%**	25%	POC.4 Problem behaviour	A joint Safety Planning and Mental Health Crisis Plan completed and shared with Women's Aid, TUSLA and Mental Health Services
Health	Safety to child and others	**100%**		**100%**		POC.4 Problem behaviour	Referral to TUSLA - Joint working and shared care planning
Health	Substance Misuse	**50%**	50%	**50%**	50%	POC.3 Drugs & Alcohol	Dual Diagnosis and MH Crisis Plan developed with Mental health & Drugs & Alcohol Service and shared with TUSLA / Women's Aid
Social Care	Violence and Abuse	**100%**		**100%**		POC.7 Family & Social Network	Engaged with Women's Aid – Trauma Informed Groups Domestic Violence Orders in place
Health	Sexual Health	**75%**	25%	**75%**	25%	POC.1 Physical Health	If a referral to Women's Aid – Trauma Informed Groups
Functioning	Practical Demands of Child care	**75%**	25%	**75%**	25%	POC.7 Family & Social Network	If a referral to TUSLA - Joint working and shared care planning
Functioning	Emotional Demands of Childcare	**75%**	25%	**75%**	25%	POC.7 Family & Social Network	If a referral to TUSLA - Joint working and shared care planning Family Talk – Intervention for Parent & Child re: Parental Mental Illness
Social Care	Budgeting	**100%**		**100%**		POC.5 Self-Care & ADL	Referral to Occupational Therapy – Functional Assessment Referral to MABS / NGO – Financial Support
Social Care	Benefits	**100%**		**100%**		POC.5 Self-Care & ADL	Liaise with CWO and advocate for own benefits

Mental Health & Social Care – Family Care-Giving & Abuse

- In a study of violence against family members and patients with schizophrenia 32-40% family members assaulted at least 1-2 occasions in previous 12 months (Solomon et al, 2005).
- Family members (in particular spouses, ex-spouses and mothers) are most at risk. If an individual with mental illness becomes violent, family members are most often the victims, especially mothers (Estroff & Zimmer, 1994; Steadman et al., 1998; Straznickas, McNeil, & Binder, 1993).
- Understanding Adult Family Domestic Homicide - HALT Research Team Manchester Metropolitan University (Briefing Paper 2) - Mental Health and Substance/Alcohol Misuse
- Perpetrators (n=26) reported mental health together with substance/alcohol misuse problems. Agencies working with either mental health or substance misuse problems often failed to identify domestic violence and abuse (DVA).
- Perpetrators (n=52) had a history of mental health difficulties and 53.0% (n=35) were reported to have been diagnosed with mental health problems, most frequently psychotic disorders and mood disorders such as depression.
- Perpetrators with mental health difficulties had received support for mental health (n=46). The DHRs described difficulties in engaging them with services.

Mental Health & Social Care – Family Care-Giving & Abuse

- Early studies of mental health and domestic violence in family care-giving relationships were drawn from prison populations.
- Tardiff et al (1985) of mentally ill offenders study reported that approximately 38% of those with mental illness living with their families are assaultive and destructive.
- Studies of forensic patients and their families support and carer burden, identified between 30% and 60% had experienced violence in their relationships prior to index offence (Tsang et al, 2002, Ridley et al 2014).
- In an audit of cases before the Mental Health Review Board in Ireland between 2015 to 2019, we see the prevalence of violence towards a family member – table 2015 – 2019
- A social work survey of the prevalence of Domestic Violence in Family Care-Giving relationships amongst a patients in NFMHS MHIDD service found that 66% of families reported some type of violence in their relationships with the patient prior to the index offence (Cooney et al, 2020)

MHRB Data	2015	2019
Murder	61% of patient's victims, were a family member	This figure decreased to 54%,
Attempted Murder	**57% of the patient's victim's family member/known to the patient**	**This figure increased to 60%**
Assault causing harm/serious bodily harm	35% of the patient's victims were a family member 23% of the patients weren't a family member but were known to the patient	This figure decreased to 19%. This figure decreased to 15%

Mental Health & Social Care - Family Care Giving & Abuse

- **Domestic Violence of Referrals between 2016 & 2018 to a National Forensic Neurodevelopmental Service in Ireland (Cooney, Dr Kearns, Dr Elamin, 2021)**
- A quantitative methodology was used for this study. A survey method was used. The survey was conducted by the MHIDD team. Consultant, Senior Registrar, Registrar.
- A 100 referrals were audited.
- **Audit Outcomes Findings –**

I. 22% of the referrals recorded reference to Domestic Violence in the family in varying degrees.

II. Range of disabilities / global functioning - 19% had a moderate disability and 48% had a mild disability, with 33% unknown or not recorded.

III. The father was recorded as the parent to experience Domestic Violence most in family members; 40%, with mothers 32%.

IV. 33% of those referred where there was reported domestic violence in the referral were living at home at the time of the referral to the NFMHS MHIDD

V. 100% of the referrals to the NFMHS-MHIDD, there was previously unreported domestic violence in the family.

VI. None of the families, in the sample, had sought out an order for their safety and protection under the Domestic Violence legislation

VII. There were no records of any ongoing, or past, safeguarding adult investigations noted in the referrals from the local Mental Health Services to FMHIDD.

Reflective practice issues from this work -

- Theme 1 – Feminist approach to psychiatric services and mental health care planning
- Theme 2 – Sustainable Development Goals and Gender Specific Mental Health Services

  SDG 1 No Poverty / SDG 3 Good Health & Well-Being / SDG 5 Gender Inequalities
- Theme 3 – Social Determinants of Health (SDoH) & Family Focused Mental Health Practice

  Z.63 Other problems related to primary support group, including family circumstances;
- Theme 4 – Restorative justice & Family Focused Mental Health practice
- Theme 5 - Safeguarding Adults & Family Focused Mental Health practice