

# A briefing for commissioners

## What survivors of violence and abuse say about mental health services

Responding effectively to violence and abuse  
(REVA project) Briefing 4

### Summary

Survivors of abuse and violence have identified the following elements that need to be in place if services are to be effective:

- **Routine enquiry occurs** across a wide range of child and adult settings
- **Well-trained** and supported staff are **able to make direct referrals** to specialist services
- **Group and peer support** is available for both male and female survivors
- There is appropriate **crisis provision**,
- Services know about, talk to, and **coordinate** with each other.
- This vision of what good service provision looks like has implications for the types and range of services that get commissioned, and for the details of commissioning specifications. For example, a minimum level of training should be recommended for all staff employed by commissioned services who may have contact with survivors.
- Voluntary sector provision emerged as key in some survivors' recovery. It is recommended that resources are made available locally to these organisations.

# Introduction

The Department of Health publication, *Commissioning services for women and children who have experienced violence or abuse – a guide for health commissioners*, clearly acknowledges that ‘victims of violence or abuse tend to use health services more than average’ and that this is ‘despite often finding it hard to access services’ (Golding and Duggal, 2011: 22). The guidance goes on to state that it is precisely because of this that ‘it is in the NHS interest to identify these women and children, provide opportunities for them to disclose, and provide services [...] to help them improve their physical and mental health’ (ibid). The policy that has been implemented to support this process is known as ‘routine enquiry’ (RE). Since 2003 it has been Department of Health policy that all adult service users should be asked about experiences of violence and abuse in mental health assessments. **However, asking about experiences of abuse and violence is not enough<sup>1</sup>. To be effective the policy of routine enquiry has to be underpinned by the provision of appropriate and effective services for survivors of abuse.** As the commissioning guidance notes, ‘commissioners should be aware of the importance of clear referral pathways, so that health professionals know where and how to refer women

and children to local services’. **For appropriate services to be available, commissioners also need to be aware of the type of services and care pathways that people who have experienced abuse feel are appropriate to meet their needs.** In this briefing we present information drawn from interviews with mental health service users who have experienced domestic and/or sexual violence.

This briefing focusses on the links between experience of abuse and mental health and the implications this has for commissioners to create an effective service landscape. The REVA research included the experience of both male and female service users. Useful guidance focussing on commissioning services specifically for women and girls who have survived violence is also available: see Woman’s Aid and Imkaan, 2014 ‘Successful commissioning: a guide to commissioning services that support women and children survivors of violence’, see [www.womensaid.org.uk](http://www.womensaid.org.uk) for details.

<sup>1</sup> Implementation guidance: mainstreaming gender and women’s mental health. DH, 2003

## The research

### In 2012 the Department of Health funded research on responding effectively to the needs of survivors of violence and abuse.

This project, *Responding effectively to violence and abuse* (REVA) included case-studies of four of the original trusts to implement routine enquiry in order to explore the ongoing implementation of the policy. As part of this research we also conducted in-depth qualitative interviews with 21 survivors of violence and abuse who had used a range of mental health and support services within these trusts<sup>2</sup>. In this briefing we present what they had to say – and what they identified as the key elements of ‘good services’. This is crucial information for commissioners seeking to understand the type of provision that is appropriate for survivors of abuse.

#### About the interviewees

Seventeen interviewees were women and four were men, ranging in age from their early 20s to their early 60s. They had experienced different kinds of violence and abuse both recently and in the past. Three women had experiences of domestic violence as adults while six discussed childhood sexual abuse. The remaining eight women had experienced violence and abuse both as children and as adults. All four men identified as survivors of childhood sexual abuse.

The survivors were recruited through service providers and all had experience of statutory mental health services or support from voluntary agencies, or both. Experiences ranged from minimal contact with NHS mental health services (e.g. those who had mainly been supported by voluntary sector organisations and/or primary care) through to people who had extensive experience of secondary mental health services including acute in-patient care, crisis team interventions, community mental health provision and therapy. Some had accessed specialist support on violence and abuse, such as counselling and group work, provided by both the NHS and the voluntary sector.

---

<sup>2</sup>Participants were purposively sampled to ensure range and diversity of experience and circumstance.

# 02

## Views on services

**The survivors we interviewed had a wide range of experience of service use and had some major concerns about the current nature of mental health services for survivors of abuse. Recurring themes were:**

### **Cuts to services**

Interviewees had commonly experienced a reduction in time and input from mental health professionals and higher thresholds for access to the support they needed. The only support available to some was that provided by voluntary sector services such as Rape Crisis Centres. This provision was generally viewed very positively, however due to funding constraints, these voluntary sector services may have very limited opening hours, and may only be able to see service users for an hour a week; and they are not always equipped to address the severe mental health issues that some were struggling with. Participants therefore sought both increased access to such support (which requires funding) while recognising that for some people such support should be viewed as complementary, rather than as an alternative, to statutory mental health services.

### **Mental health professionals failing to view violence and abuse as a mental health issue**

Survivors commented that some staff – particularly, but not exclusively those working in in-patient services – seemed not to view their experiences of abuse as relevant to their mental health.

#### **‘They see me as being in the wrong place’.**

This is particularly troubling given that the links between abuse and mental health have long been evidenced; for example, research has found high prevalence rates of violent and abusive experiences in both the childhoods and adult lives of mental health service users (Bebbington et al, 2011; Jonas et al, 2010; Bryer et al, 1987; Walker and James, 1992; Wurr and Partridge, 1996). Survivors also consistently noted that the validation they received from their abuse being acknowledged by professionals could be a first step in them seeking help to deal with it.

### **A lack of understanding from staff in primary care**

Many survivors went to GPs for support initially and met with a variable response. Dismissive responses were again felt to be due to a lack of understanding about the links between experiences of abuse and mental health outcomes.

### **Gender stereotyping**

Participants also noted that staff could stereotype them on the basis of gender. Male survivors reported a lack of awareness and support, with men still not being viewed as legitimate victims of abuse. Women still experienced services labelling them as ‘hysterical’ and ‘attention seeking’.

## Experience of services

**Participants described aspects of accessing services, and key components of their care, that they felt had either promoted or undermined their recovery.**

### **Continuity of care (or lack thereof)**

Interviewees described a lack of integration in the support they received. Separate assessment and 'delivery' functions result in mental health services being experienced as disjointed. Some were assessed as having a need for support but then nothing happened, or established a relationship with one person or service and were then moved onto another and had to repeat their stories over and over.

"I saw a [therapist], and he was brilliant, I really opened out to him, and I felt confident, I felt relaxed, I felt I trusted him, and then they turned round and says 'Well he's retired now'.... Then I saw [CPN], she was really good, but then she went. When you have somebody and then they move on, it's quite upsetting, because they know what you're

like, and then you get a bond with them, and then [they're gone]."

### **The difference individual professionals can make**

Every survivor interviewed described the impact of being supported by empathic, committed individuals, whether from the NHS or the voluntary sector. The value of individuals (whatever their discipline and skills) listening, understanding and responding cannot be under-estimated.

"The only time I told of the abuse is when I saw [name of Doctor] and I broke down. It all just flooded out. [He's] been really, really good. He's on the end of the phone if I feel that I need him."

## Support in crisis

Good support in a crisis was described as really important, particularly the availability of respite. One survivor who had access to this (via a Shared Lives service) described it as

**“Wonderful. It’s sometimes better [to be] away from home for a short while.”**

In other instances crisis teams had provided a level of support, kept people going through a crisis and prevented a hospital admission. However, crisis teams were also criticised for having a lot of power to assess an individual as requiring in-patient admission or not – without having detailed knowledge of the client and their needs. They were also criticised for being focused on monitoring medication at the expense of other issues.

These experiences indicate some key components of an effective and responsive service landscape as identified by survivors of abuse: continuity of care; access to statutory and voluntary sector provision; well trained, empathetic staff who understand the relationship between abuse and mental ill health; and the availability of crisis services.

Survivors quite commonly recounted their experience of disclosing abuse at a time of crisis. It was not unusual for these disclosures to be dismissed or set aside as less important than the treatment of immediate symptoms. The issue was not always returned to. There were other examples of people repeatedly asking for help to deal with their experience of abuse and only being offered medication.

# 04

## What do good services look like?

Interviewees also reflected on positive experiences of services. These may be particularly significant for commissioners as they suggest the building blocks for what could be achieved, reflecting what service users themselves report as being useful.

Good services were defined as **'holistic'**, **'integrated'** and **'seamless'**.

"My current CPN has seen me through the psychotherapy and she's let me dictate, almost dictate when I wanted to see her. So when I was having the psychotherapy I'd say, I might need to see you on X day, particularly during the most graphic parts, if that's the right word and, I just thought the fact that she would do that was just incredible."

Good services were also described as those that gave survivors' some genuine control, are not time-limited and manage endings well.

"There seemed to be a fluid relationship between the psychiatrist, CPN and me, so in the times that I didn't see my psychiatrist but I just saw my CPN she would then feedback as to how I was, and I suppose that again gave me a feeling of [...being] supported in the system, and I always had very clear... instructions about the out of hours service and crisis team".

At their best services were able to recognise the importance of survivors' relationships and include non-abusive friends and family so they could be helped to understand the issues and support the individual as well.

"[I appreciated] the flexibility and the fact that they always incorporated [my husband]. He was given the opportunity to come and see somebody, particularly after I revealed what I did reveal to him, he was given the chance to see somebody on his own. And a couple of times we had a meeting all three of us which he found incredibly helpful. And they really helped me with my relationship with my daughter [so] I just repaired my relationship to a level that you wouldn't believe. That's something that I'm really, really grateful for."

Survivors strongly favoured having a range of different types of support and therapy in both statutory services and voluntary agencies. They emphasised that particular therapeutic approaches mattered much less than that the dynamics and impacts of abuse were understood by staff.

"I honestly don't think the model is that important, [...] because I think it is about the relationship with the client and the therapist, or therapy."

Survivor groups were most frequently cited as transformative. Formal therapeutic groups, self-help, drop-ins and psycho-educational groups were each praised for the same core elements: providing safe contact with others and helping them understand the commonality of their experiences; inspiring people with what others had achieved while allowing people to move forward at their own pace, and enabling them to support others and 'give something back.'

"I just belong, this group are very special to me...There was a buddy system when you were new, they watched out for you, they were lovely, they smiled and knew your name and that was enough for me, and I find the same with new service users nowadays."

One man described how after 14 years of seeking help from mental health services for the first time he encountered help that was really helpful in a group setting.

"I wasn't in isolation anymore, I could relate to other people who'd had the same experience, and I think that was the biggest thing. It taught me about trauma. I would not have perceived I was somebody who was dealing with trauma, I didn't understand about things not getting processed and that's why they're going in a continual loop. Or

understanding about this confusion between the present and the past ...flashbacks and that. And everybody was having the same thing. I thought blimey, it's real then, it's not just me [laughs]. ...It's like the approach from people had been[all about] my symptoms, but it was the underlying distress that I needed to deal with ...and I think that was the first time in that group that those roots were actually being tackled."



## A model of support

Interviewees identified five core components of effective **support**:

- 1 Routine enquiry** taking place in primary care, in children's services, in Child and Adolescent Mental Health Services (CAMHS), and in community services – particularly those dealing with drug and alcohol issues.
- 2 Staff in these services having good training and support** and being able to make direct **referrals to specialist services** in both the statutory and voluntary sector.
- 3 Group and peer support** being readily available for male and female survivors of all types of abuse.
- 4 Some non-hospital based crisis/respice** provision available specifically for survivors.
- 5 Services knowing about, talking to, and coordinating** with each other.

Interviewees suggested that having these elements in place could mean many survivors need never become users of secondary mental health services. The REVA research has produced evidence that individuals with multiple experiences of abuse are fifteen times more likely to attempt suicide than the

general population (REVA Briefing No. 1 Scott et al, 2013). If survivors can be helped appropriately from the outset this will save not only the financial cost of many years of intensive service use, but the human cost of wasted years and lives lost.

These five components are therefore core to the model of support that should be created via the commissioning process.

## Implications for commissioners

- 1 The links between experience of violence and abuse and mental health are clear and should be reflected in the commissioning landscape by a) including routine enquiry in commissioning specifications; b) commissioning both specialist services for survivors and mental health services that are sensitive to the needs of survivors; c) encouraging as part of service level agreements joint-working and planned care pathways for individuals. Such an approach is supported by recent NICE guidelines for addressing domestic violence (2014) which emphasised the value of similar approaches as those supported by routine enquiry. <http://www.nice.org.uk/guidance/ph50>
  - 2 It may appear costly to commission a range of different services (both voluntary and statutory) and provide support that is flexible and not time limited. However interviewees' accounts suggest that it was precisely these features which led to the most successful outcomes for them including their reduced reliance on services.
  - 3 The DH guidance on commissioning services for women and children who have experienced abuse recognises that 'health professionals may refer or signpost survivors' to voluntary sector organisations 'without contributing to cost' or without 'engaging in co-ordinated care' (Golding and Duggal, 2011: 17). It is recommended both in the guidance, and here, that resources are made available locally to these organisations that play a vital role in some survivors' recovery process.
  - 4 Training for all staff who come into contact with survivors of abuse is crucial. The way that staff respond to survivors and understand the issues that experience of abuse bring can have a significant impact. A minimum level of training should be recommended for all staff employed by commissioned services who may come into contact with survivors.
- An updated training manual and material for the course 'Asking the question about violence and abuse in mental health assessments', developed for the RE implementation pilot is available at <http://www.e-lfh.org.uk/programmes/domestic-violence-and-abuse/trainer-resources/>
- Public Health England have also recently launched (with the charity AVA) an e-learning course to promote the identification and support of survivors of domestic violence specifically: <http://elearning.avaproject.org.uk/>

# References

Bebbington, P. Jonas S. Kuipers, E. King, M. Cooper, C. Brugha, T. Meltzer, H., McManus, S. Jenkins. R. (2011) Child sexual abuse and psychosis: data from an English National Psychiatric Survey. *British Journal of Psychiatry*, 199; pp 29–37.

Bryer, J. Nelson, B. Miller, J. et al. (1987) Childhood sexual and physical abuse as a factor in adult psychiatric illness. *American Journal of Psychiatry*, 144: 1426–1430.

Golding, N. and Duggal, A. (2011) Commissioning services for women and children who experience violence or abuse – a guide for health commissioners. London: Department of Health, [www.dh.gov.uk/publications](http://www.dh.gov.uk/publications)

Jonas, S. Bebbington, P.E. McManus, S. Meltzer, H. Jenkins, R. Kuipers, E. Cooper, C. King, M. and Brugha, T. (2010) Sexual abuse and psychiatric disorder in England: Results from the 2007 Adult Psychiatric Morbidity Survey. *Psychological Medicine*, 10:1–11.

National Institute for Health and Care Excellence (NICE) (2014) Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively, NICE public health guidance 50: <http://www.nice.org.uk/guidance/ph50>

Scott, S. McNaughton Nicholls, C. (2015) Why asking about abuse matters to service users – Responding effectively to violence and abuse (REVA Briefing 2). [www.natcen.ac.uk/revabriefing2](http://www.natcen.ac.uk/revabriefing2)

Scott, S. Williams, J. Kelly, L. McNaughton Nicholls, C. Lovett, J. and McManus, S. (2013) Violence, abuse and mental health in England (REVA Briefing 1). London, NatCen, [www.natcen.ac.uk/revabriefing1](http://www.natcen.ac.uk/revabriefing1)

Walker, S. and James, H. (1992) Childhood physical and sexual abuse in women: Report from a psychiatric emergency clinic. *Psychiatry in Practice* Spring: 15–18.

Wurr, C.J. and Partridge, I.M. (1996) The prevalence of a history of childhood sexual abuse in an acute adult inpatient population. *Child Abuse & Neglect* 20(9): 867–872.

## This is the fourth of five briefings based on the REVA study:

- **Violence, abuse and mental health in England** (REVA Briefing 1) [www.natcen.ac.uk/revabriefing1](http://www.natcen.ac.uk/revabriefing1)
- **Guidance for Trust managers: Implementing and sustaining routine enquiry about violence and abuse in mental health services** (REVA Briefing 2) [www.natcen.ac.uk/revabriefing2](http://www.natcen.ac.uk/revabriefing2)
- **A briefing for mental health professionals: Why asking about abuse matters to service users** (REVA Briefing 3) [www.natcen.ac.uk/revabriefing3](http://www.natcen.ac.uk/revabriefing3)

- **A briefing for commissioners: What survivors of violence and abuse say about mental health services** (REVA Briefing 4) [www.natcen.ac.uk/revabriefing4](http://www.natcen.ac.uk/revabriefing4)
- **A briefing for service providers and commissioners: Measuring outcomes for survivors of violence and abuse** (REVA Briefing 5) [www.natcen.ac.uk/revabriefing5](http://www.natcen.ac.uk/revabriefing5)

This briefing reports independent research commissioned and funded by the Department of Health Policy Research Programme (Effective Responses to Long-Term Consequences of Violence, Trauma and Abuse, 115/0005). The views expressed are those of the author(s) and not necessarily those of the Department of Health.

**The REVA research was conducted  
by the following team:**

Dr Sara Scott and Dr Jennie Williams

**DMSS Research**

Dr Carol McNaughton Nicholls

**Truth Consulting**

Sally McManus, Ashley Brown  
and Shannon Harvey

**NatCen**

Prof Liz Kelly and Joanne Lovett

**CWASU, London Metropolitan University**

