October 2015

A briefing for mental health professionals

Why asking about abuse matters to service users

Responding effectively to violence and abuse (REVA project) Briefing 3

Summary

- Interviews with users of mental health services found that people are positive about routine enquiry.
- Those who had been asked by a professional about their experience of violence and abuse welcomed this.
- Service users had a number of clear recommendations for service providers about how routine enquiry should be implemented (the policy of asking routinely about experiences of abuse in service user assessments).
  - The question: Should be asked as early as possible
  - With interest and concern (rather than feel like a 'tick box' requirement)
  - More than once (as people may not feel able to respond at first)
  - Of everyone, and
  - Responses to any disclosure should be full, helpful, and followed up with good services, when possible.

Introduction

There are high prevalence rates of violent and abusive experience in both the childhoods and adult lives of mental health service users. Histories of childhood sexual and physical abuse amongst women service users are particularly well documented. Although many of the samples in studies are small, figures of over 50% are not unusual (Palmer et al, 1992; Bryer et al, 1987; Walker and James, 1992; Wurr and Partridge, 1996). In secure settings this figure is even higher (Bland et al, 1999). Studies of severe domestic violence among psychiatric in-patients report lifetime prevalence ranging from 30% to 60% (Golding, 1999; Howard et al. 2010). The REVA study, on which this briefing is based, has also found that people who suffer violence and abuse are much more likely to have a mental disorder, self-harm or attempt suicide than those with little or no experience of this kind (Scott et al, 2013).

Given the prevalence of experiences of abuse among users of adult mental health services it is vitally important that these experiences are identified to ensure appropriate diagnosis, support and referral. 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[1].

Yet actually disclosing experiences of violence and abuse can be very difficult. **Survivors can feel a deep sense of shame and responsibility for the abuse they have experienced – feelings that are often strategically encouraged by their abusers (Clark and Quadara, 2010). These feelings can be compounded by unhelpful responses from professionals when they try to disclose (Imkaanetal, 2014).** And survivors consistently say that disclosure has to be 'at the right time for them', which may be immediately or many years after the abuse (McNaughton Nicholls, 2012).

In this briefing paper we present findings from research funded by the Department of Health Policy Research Programme on responding effectively to the needs of survivors of violence and abuse: the REVA study. The study included specifically asking survivors of violence and abuse about their views on routine enquiry, their experiences of disclosing abuse and their recommendations for how staff should ask clients about abuse.

[1] Implementation guidance: mainstreaming gender and women's mental health. DH, 2003

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Background, methods and sample

In 2006 a two-year initiative was launched to pilot an approach to introducing routine enquiry and embedding it in clinical practice. The pilot involved a total of 15 trusts and its evaluation identified key lessons for effective implementation of routine enquiry in all trusts[2]. In 2012 the Department of Health funded follow-up research on responding effectively to the needs of survivors of violence and abuse (the REVA study) to include case studies of four of the original pilot trusts and explore their implementation and subsequent embedding of routine enquiry[3].

As part of the research we conducted in-depth interviews with 21 survivors of violence and abuse who have used a range of mental health and support services drawn from these trusts. The interviewees were purposively sampled to ensure a range of views and diversity of experiences were included.

Seventeen interviewees were women and four were men, ranging in age from their early 20's to their early 60's. They had experienced different types of violence and abuse both recently and in the past. Three women mainly described experiences of domestic violence as adults while six were mainly survivors of 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. It was not the purpose of the interviews to explore their experience of abuse in any detail. However, the accounts people gave us suggest that the sample of interviewees encompassed the five violence and abuse groups identified in our earlier APMS analysis - sexual abuse as a child, sexual abuse as a child and sometimes as an adult, domestic violence, including very extreme domestic violence such as threats of death, and a fifth group who had experienced multiple and extensive forms of domestic and sexual violence (Scott et al, 2013).

The survivors were recruited through service providers and all had experience of statutory mental health services, support from voluntary agencies, or both. This experience 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. Their experience included specialist support for issues of violence and abuse, such as counselling and group work provided by both the NHS and the voluntary sector. Survivors of domestic violence were the least likely to have used secondary mental health services, and the most likely to have been referred by health professionals directly to specialist agencies in the voluntary sector.

In this briefing paper we outline findings from three key areas of the research with the aim of providing the views of those directly affected: survivors views on routine enquiry; their experiences of being asked about abuse; and their recommendations to professionals to aid sensitive and appropriate enquiry into experiences of abuse.

[2] Scott, S and McNeish, D (2008) Meeting the Needs of Survivors of Abuse: Mental Health Trusts Collaboration Project. Overview of Evaluation findings. Department of Health/ National Institute of Mental Health.

[3] 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. Implementation guidance: mainstreaming gender and women's mental health. DH, 2003

02

Views on routine enquiry

A range of research indicates that most survivors of violence and abuse do not mind, or indeed welcome being asked about a possible abuse history by healthcare professionals. Confirmation comes from studies which have focused on survivors of childhood sexual abuse (Nelson, 2001; Zeitler et al, 2006; Renker et al, 2006) and on those experiencing domestic violence. A systematic review of qualitative studies found that survivors of domestic violence want to be asked by doctors (Feder et al, 2006). Similarly, interviewees in this study were overwhelmingly positive about the policy of routine enquiry:

"I think it's very important... But there's more answers than just 'yes' or 'no'....You need to ask some quite searching questions...and I was always happy to answer them as far as I could at the time. But I could only respond 'yes' when I felt sure and confident in the service... and I look back now and I think 'yeah you were ready', I responded to Dr M because he was a different sort of psychiatrist, the building blocks were in place at that time."

Survivors talked about the consequences of not being asked about their experiences of abuse. **They described feeling as though their experiences were not considered relevant to their mental health, that nobody wanted to hear about them, which suggested that such things were best not spoken of. Not being asked directly about abuse thus encourages people to keep it a secret and makes them more vulnerable to re-victimisation.**

"The biggest problem for me, I think, was nobody asked me. ...so my perception was these things happened in my childhood, and [my mental health] is just as bad now as I was then. It wasn't: 'I might be having trouble because those things have happened'. It just showed how bad I was."

Recent NICE guidelines for addressing domestic violence (2014) have also emphasised the value of similar approaches as those supported by RE. This includes the importance of creating an environment that is enabling for disclosure, ensuring staff are trained to ask about abuse, and also on how to effectively respond if a disclosure is made. See: **http://www.nice.org.uk/guidance/ph50**

03

Experience of being asked about abuse

None of the people interviewed recalled having experienced routine enquiry as part of an initial or follow-up mental health assessment. However, there were accounts of being asked about experiences of violence and abuse by professionals – most often people with whom they had an ongoing relationship. **Those who had been asked by a professional about their experience of violence and abuse welcomed this – even when their immediate response had been to deny such experience. Some wished they had been asked sooner. Others felt that they would have disclosed anyway but that it would have taken them longer to do so.** Some reported having been asked several times before they disclosed. Being asked was felt to be acknowledgement that their experiences were important, gave them permission to talk about their abuse and in some cases enabled the start of a therapeutic process to address its impact. For some survivors being asked was the most important and helpful thing that had happened in services.

"Bless her, I guess she knew the right questions that needed to be asked and it was the first time anybody had ever asked me… [When she asked] I felt sick to my stomach. [And] I thought, 'I'm - I'm going to have to get out of this room.' And then I thought, 'If you go out of this room, that's it. It's… you're never going to be able to go back.' So, I sat there and… then I got this feeling of relief to think that somebody had noticed that there was something very wrong … yeah, a - a feeling of absolute relief to know that I wasn't going to be burdened with it anymore."

Others felt that they first had to be asked to be able to find the language and strength to disclose the abuse they had experienced.

"I don't think I had the words. I don't think I knew how to begin, or what to say, or…yeah, even when I did start to talk about it, it took me a long time to really find the words to tell my story"

One interviewee recalled being asked the question as a life or death issue.

"[If I hadn't been asked then] I think I'd have been in real trouble. I don't think I would be here now."

Some had not waited to be asked but had spontaneously disclosed to a range of mental health and non-mental health professionals, including GPs, nurses, police officers, psychiatrists, psychologists, and, in some cases, to several staff on different occasions. As has been reported in other research, the immediate response from professionals following a disclosure impacts greatly on survivors overall experience (Imkaanetal, 2014). In our research we

found some staff had responded helpfully and/or referred them to specialist help. In other instances, disclosures were not responded to, or were met with an unhelpful response. There were examples of disclosures not being 'heard' e.g. someone telling a member of staff and it never being mentioned again.

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.

"There was no real in-depth discussion. We talked around things but I didn't feel people were getting it. ...I felt I was going there for a snapshot and people were asking me how I'd been over the last two weeks and whether I was suicidal or not... So I felt that I was just being kept an eye on. Are you a risk, are you not a risk? Lots of medication. One person did ask 'is there anything bothering you?'... I said 'well I had this thing in childhood' - I didn't call it abuse or anything. And I remember being incensed because I saw her a few weeks later and she said 'Oh you mentioned so and so, is that still a problem for you or are you all right with that now?'"

Survivors also reported feeling a lot of guilt about not disclosing earlier as well as anger about not being asked. Sometimes following a disclosure they had been able to seek justice and protection for others, as well as therapy for themselves, and this could be enormously healing.

"The police are re-investigating [my abuser]... and that was like a massive sort of change for that to actually happen and just sort of switched things around a bit. And I actually want to be part of society now, whereas before I just.. I was quite happy not properly engaging with it at all".

However, a disclosure that exposes safeguarding issues can have a mixed impact on a survivor. **The consequences of disclosing abuse when children may be at risk can be massive for survivors – they may risk losing their children, home or extended family. This issue highlights the difficult decisions people face when asked if they have experienced abuse.** And it is in this context that we asked survivors for their views about how this question should be asked.

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Asking about abuse and violence: recommendations from survivors

Interviewees had some clear messages for services about when the question should be asked and how people should respond to a disclosure, which we summarise below.

Ask as early as possible

Survivors described missed opportunities when they wanted someone to ask them about their abuse and it didn't happen. They spoke of finally disclosing much later than might have been the case had they been asked sooner, and of having been in contact with a range of services that could have helped but didn't, sometimes over years e.g. with GPs, maternity services and A&E as well as mental health services. They expressed anger that nobody had asked them when they were younger and gratitude when people had. In some cases, people had used mental health services for many years before they felt able to tell someone. One man who had first gone into hospital 20 years ago in his teens described how his then recent abuse was simply ignored.

"All that was treated at that time was the effects... the symptoms. My mum did say to them about [the abuse] and they, they were just like 'oh that's not really an issue', what the issue is is dealing with the mood swings and trying to control those with medication rather than what was causing them."

Ask because you really want to know

Survivors spoke of being assessed by 'tick box' and the difference between that and the expression of real interest and concern.

"I know it was her job, but she didn't come across like that. She came across as though she was... and I think she was genuinely interested in what I said."

Keeping asking the question

Survivors talked about needing to find the courage to disclose and not always having this when the issue was first raised. Being asked a second or third time gave them confidence that their experiences mattered and they would be listened to.

Don't be selective about who you ask

Survivors felt that staff were more likely to ask some people rather than others whether they had been abused. Male survivors believed that staff felt more uncomfortable asking men about abuse. Asian women recounted experiences of not being asked about domestic violence even though they believed what was happening to them was glaringly obvious – similar experiences have also recently been reported in research (Imkaanetal, 2014).

Respond helpfully

People who responded helpfully to a disclosure of violence or abuse took the disclosure seriously, took time to listen, showed that they understood the significance of the abuse and the courage it took to talk about it. Survivors gave many accounts of helpful responses which had made a huge difference to their lives.

"[My CPN] was fantastic because as a victim when you reveal it to, to friends, to professionals you watch their reaction to you, it's very important that they're not overcome with horror. And she, you know... I remember her being just very measured and very calm and she just said, something like 'that's very brave. What you've done is very brave, what you've said it to me'. She was the first person I actually said it out loud to, and it was a very emotional hour or hour and a half. "

Unfortunately, survivors also gave accounts of unhelpful responses where their disclosures were ignored, dismissed or minimised. Examples included a survivor who disclosed abuse to a ward nurse and was told not to talk about it 'because we can't help' and a survivor who was asked by a Psychiatrist 'Have you got over that abuse thing yet?'

Follow up with good services

Survivors recognised that some services do not want to ask about abuse because they do not have specialist support they can offer. This is not a reason not to ask – listening to and acknowledging a survivor's experience is helpful in itself. Working collaboratively with people to find a way forward is much more important than having a pre-prepared treatment or service to offer. However, survivors did express concerns about reduced funding for voluntary sector services, the lack of good specialist support within mental health services and the length of waiting lists. Survivors views on what 'good services' look like is explored in our related briefing paper 4 (see next page for reference).

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This is the third of five briefings based on the REVA study:

- **Violence, abuse and mental health in England** (REVA Briefing 1) 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
- **A briefing for mental health professionals: Why asking about abuse matters to service users** (REVA Briefing 3) 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
- **A briefing for service providers and commissioners: Measuring outcomes for survivors of violence and abuse** (REVA Briefing 5) www.natcen.ac.uk/revabriefing5

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