

## Two Sides of the Same Coin: supporting people who have experienced sexual violence and mental ill-health

June 2013



*"There needs to be more of a joined up approach... It would be helpful if other workers would make themselves available to working with underlying issues instead of avoiding talking about the issues, retreating into labelling, blaming the victim for being 'dependent', etc. Services are sparse, and there needs to be a wider availability, ease of access, and earlier intervention, rather than waiting until people have had 10 different diagnoses, multiple 'treatment' that have failed, violent relationships, children taken into care, etc. This is avoidable with some timely and appropriate help and intervention."*

*Counsellor in a statutory organisation*

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## Introduction

In early 2012, AVA and staff at the Paddington Haven<sup>1</sup> met to discuss how the role of a specialist mental health ISVA (Independent Sexual Violence Advocate) differed from that of a generic ISVA. The conclusion was that survivors of sexual violence who experience mental ill-health present with more complex needs than the service users who do not have the additional mental health problems. As such, this group of service users need more intensive support, and often on a longer-term basis. To test this idea on a wider scale, the two organisations jointly conducted a small scoping exercise with two sets of practitioners – mental health workers and Independent Sexual and/or Domestic Violence Advocates (ISVAs, IDVAs and IDSVAs) – to better understand the extent to which they are currently working with the intersecting issues of sexual violence and mental health, and their skills in this area. After collecting basic data about each respondent's profession, practitioners were asked 15 questions about any relevant training, their confidence levels in supporting this client group, their service user profile, and the ability of the practitioners' organisations to meet the service users' needs.

Two online questionnaires were used: the first for mental health workers asking about their experiences of supporting service users seeking assistance for a mental health problem who have also been affected by sexual violence, and the second for sexual and domestic violence workers about their experiences with survivors of sexual assault and rape who also have problems with mental health. Therefore, in many – but not all – ways, the service users are part of the same population and the questions of the surveys went to the attitude towards and treatment of this specific group by the two different groups of professionals that could be approached by survivors for assistance.

The discrepancies in the results analysed in this report leave much room for speculation, especially because the service users referred to are, in one instance, those with mental health problems that have experienced rape or sexual violence, and in the other instance, those survivors of rape and sexual assault that also have mental health issues. As such, they are potentially very similar groups of service users. Clearly the two groups of professionals view their service users in different ways, which might also translate into varies approach to supporting this client group.

*"...If there is a disclosure made it is validated and explored in terms of immediate safety and safety of others. If we do not offer a service, the woman is given leaflets, phone numbers etc. If she is offered a service, the issues raised at assessment will be explored during her crisis admission. We will work on teaching grounding techniques, trauma skills, support contacting police, referral to other agencies to continue the therapy or to convict the perpetrator..."*

Women's lead and manager of women's service in an NHS trust

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<sup>1</sup> The Haven Paddington is a sexual assault referral centre which offers forensic examinations, medical checks and emotional support to women, men, young people and children who have been raped or sexually assaulted.

## The professionals

### *Mental health*

The survey was circulated widely through AVA's mailing lists and targeted contacts within both statutory and voluntary sector mental health services. In total, 97 mental health practitioners began the survey, and 68 completed it. Of the 68 who completed the survey, 74% of the respondents work for the NHS (n=50) and 10% for other statutory organisations (n=7). Ten per cent are employed by a voluntary sector organisation (n=7) and the remaining 6% did not specify a type of employer (n=4).

A wide range of occupations was reflected among the 68 respondents who completed the survey, with the most common professions being mental health nurses and counsellors but also including service managers and psychiatrists (see figure 1 for full breakdown).

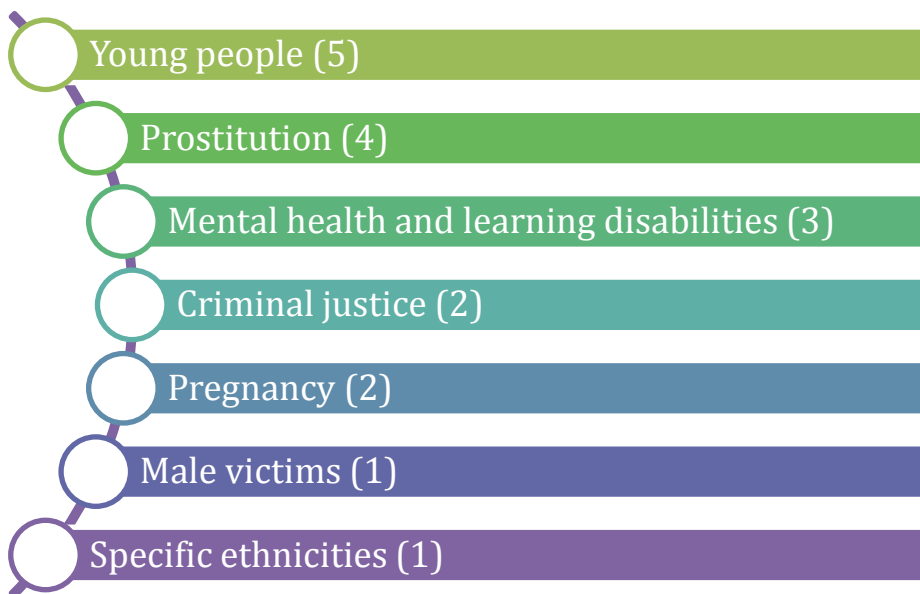
The majority of the practitioners (n=53; 78%) categorised themselves as having some sort of specialisation, including **adults** with mental health issues (n= 29; 43%), **young people** (n=5; 7%), **domestic violence** (n=2; 3%), **learning disabilities** (n=2; 3%), **women** (n=2; 3%) and **other** uncategorised specialisations (n=13; 19%).

### *Sexual and domestic violence*

In relation to sexual and domestic violence workers, 108 individuals began the survey, but only the data from the 56 practitioners who finished the questionnaire was analysed. These 56 practitioners fit into three job titles: 30 (54%) are independent sexual violence advocates (ISVAs); 21 (38%) are independent domestic violence advocates (IDVAs); and 5 (9%) are independent sexual and domestic violence advocates (ISDVAs).



**Figure 1: occupations of mental health practitioners**



**Figure 2: IDVA/ISVA/IDSVA specialisms**

Of the 56 professionals reporting, 21 reported some sort of specialisation within their work and several reported that they had multiple areas of expertise. Other than five workers who specialised in supporting females, other specialisms included young people, mental health and ethnic specific workers (see figure 2 for full details).

All three respondents who specialise in mental health are ISVAs, but only one reported that mental health was their exclusive focus. The other two reported other specialisations in youth, male victims and prostitution, and in youth, prostitution and female victims over 12 years of age.

Sexual and domestic violence practitioners were also asked about their employers. The vast majority (n=49; 88%) work for the voluntary sector, with a further four practitioners (7%) being located in the NHS and three workers (5%) in other statutory organisations. Interestingly, although there might be an expectation that the ISVAs based within the NHS would specialise in mental health or pregnancy, in fact two specialise in supporting young people, one focuses on women involved in prostitution and one on victims using the Criminal Justice System.

### Training and confidence

Whilst it is well established that training does not automatically lead to increased confidence<sup>2</sup>, attending training is a useful conduit for raising awareness about an issue and disseminating information. As such, both surveys included questions about attendance on any sexual violence or mental health (for mental health and sexual/domestic violence practitioners, respectively) training in the past two years, and if so, how many days training they had received in that time and whether they thought this was an adequate amount of training. Subsequently, both groups were asked to quantify their level of confidence when working with service users affected by both issues.

<sup>2</sup> Holly, J. and Horvath, M.A.H. (2012) "A question of commitment – improving practitioner responses to domestic and sexual violence, problematic substance use and mental ill-health", *Advances in Dual Diagnosis*, 5:2, pp.59-67; Holly, J., Scalabrino, R. and Woodward, B. (2012) *Promising Practices: Mental Health Trust responses to domestic violence* (London: AVA)

### *How much is too much training?*

Reported levels of training are distinct between the two sectors in that sexual and domestic violence workers are far more likely to have received mental health training (57%; n=32) in the last two years, compared with mental health practitioners attendance on sexual violence training (28%; n=19).

Of those who had attended, practitioners from both disciplines were most likely to have received either one or four days training. Most striking, however, is that the majority reported one day or less of training about their non-specialist subject over the past two years.

Considering the extent to which sexual violence and mental ill-health co-occur, and thus the number of service users in both sectors who will be affected by the two issues, there might be an expectation that practitioners should have greater access to training to develop their skills and knowledge in supporting this client group.

<i>Mental Health Workers</i>			<i>Sexual &amp; Domestic Violence Workers</i>		
Four days	5	26%	Four days	9	28%
Three days	3	16%	Three days	1	3%
Two days	2	11%	Two days	7	22%
One day	5	26%	One day	11	34%
Half day	3	16%	Half day	4	13%

***Table 1: Number of days of training in the past two years***

### *A note of caution!*

It should be noted that this data should be analysed with some degree of caution, and because the sample sizes are so small, it cannot be treated as infallibly accurate. It is feasible that practitioners who completed the survey did so because of a personal interest in the subject matter and therefore may have sought out higher levels of relevant training than is attended more generally. Similarly, the training which supported the NMH DU pilot of routine enquiry about abuse may have temporarily increased access to sexual violence training within mental health services.

Of the 120 participants that expressed an opinion on the amount of training that they had received:

- 45% think they had had the right amount of training (n=54),
- 55% had too little (n=66), and
- none indicated that they had had too much.

Overall, the picture appears positive, in that almost 50% of respondents have received sufficient training. Broken down by profession, however, it is clear that a greater disparity exists in mental health than sexual violence, with 64% (n=42) mental health practitioners stating a need for more training compared with only 44% (n=24) of sexual and domestic violence workers.

	4 days	3 days	2 days	1 day	Half day	None
<b>Too little</b>	1	0	5	9	3	47
<b>Right amount</b>	11	6	4	6	4	19
<b>Too much</b>	0	0	0	0	0	0

**Table 2: Opinion on amount of training based on number of days of training**

Of those who felt that one day or less of training in the past two years on how to assist service users affected by both issues, of which there were 29, there were several occupations. Fourteen were sexual and domestic violence workers and 15 were mental health workers. More specifically:

The correlation between levels of training and confidence was initially interrogated by cross-referencing the number of days spent in training with opinions about the length of training (see table 2). One might have expected that the data would have shown a trend in which almost all participants in the “half day” group would have felt that they’d received too little training, with ratios evening out or even reversing as the number of days of training increased. To some degree this trend was seen for 1-4 days and for those who had had no training, but in the “half day” group, the majority actually felt that they had received the right amount of training.



**Figure 3: professionals for whom one day's training is sufficient**

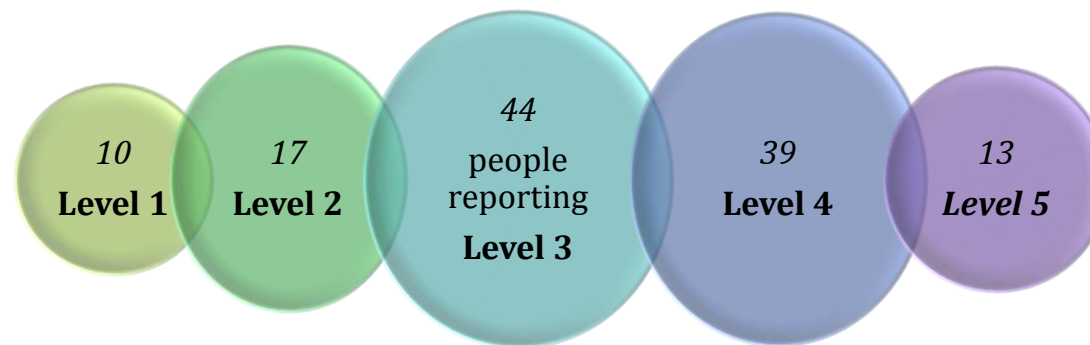


Even taking into consideration that some respondents may have received training more than two years ago, as well as bearing in mind how some people 'learn on the job' and may not see training as vital to knowing about or responding to a certain issue, it is surprising that so many sexual and domestic violence workers felt that one day or less of training in mental health was adequate to assist their clients, as their general service user population is one that is at high risk of psychological problems. It seems less surprising that the team manager in the mental health field should feel that he or she would need less specialised training in sexual violence than those in other positions, but the same cannot generally be said for the therapists, counsellors and social workers that might experience frequent reports of sexual violence and rape from their clients. Without consulting with service users about their experiences of service providers, it is impossible to know whether professionals' perception of the 'right' amount of training equates to implementing best practice – a question for future research.

In contrast, there were six practitioners who felt that two or more days of training on the subject in which they did not specialise was not adequate. This group comprised two mental health nurses and four sexual and domestic violence workers (two ISVAS, one criminal justice IDSVA, and one specialist maternity IDVA). This may indicate that these practitioners encounter a particularly large number of service users with needs relating to both issues, or it may reflect a problem in the focus or the quality of the training that they are receiving.

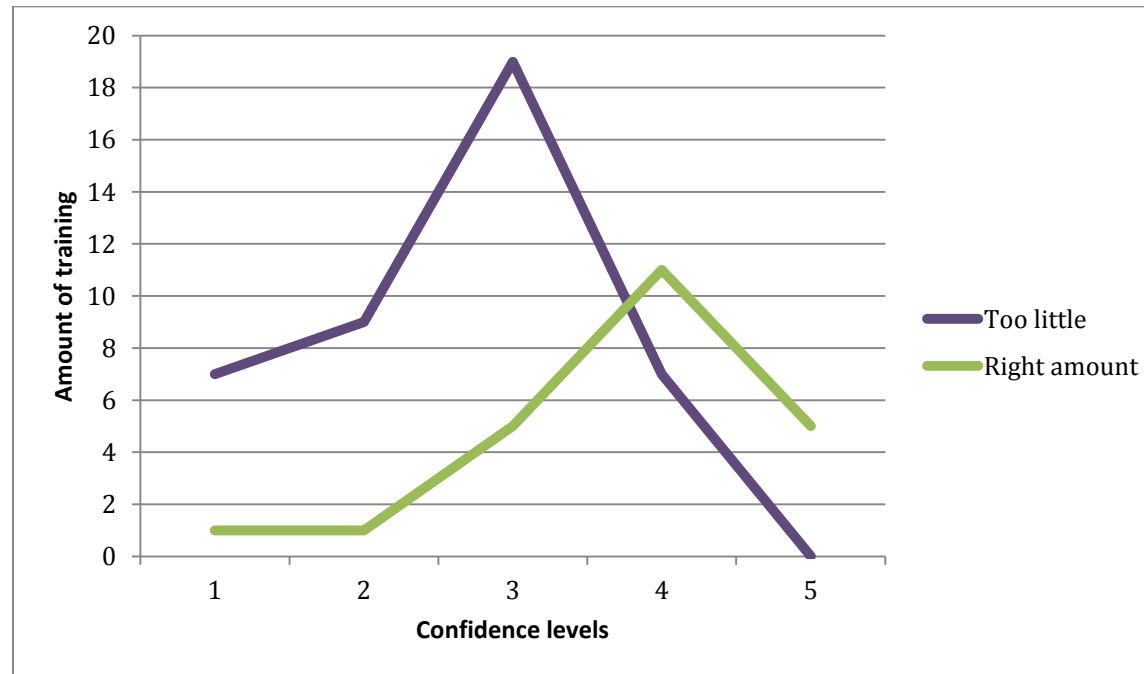
#### *Building confidence*

Following on from questions about levels of training, mental health and sexual/domestic violence workers were asked to rate their confidence levels from 1 to 5 (with 1 being not confident at all and 5 being very confident) when treating clients with experiences with sexual violence and with mental health problems, respectively. Generally similar trends were found within both groups of professionals:



**Figure 4: reported confidence levels**

Overall, comparing confidence levels with the opinions that participants gave in regards to whether they thought they had received an adequate amount of training in the past two years did not yield any unexpected or illogical findings. As figure 5 demonstrates, confidence levels generally rose as the ratio of participants who thought that they had received the right amount of training to those who thought they had had too little increased.



**Figure 5: Amount of training vs. confidence levels**

Several interesting sub-trends did, however, emerge. First, there are a high number of practitioners who felt that they had had too little training whilst almost all reporting moderate confidence levels in supporting clients affected by both issues. Conversely, two practitioners had attended adequate training but still felt low confidence (levels 1 and 2). The first scenario begs the question of where these practitioners' confidence stems from if they do not feel they have learned enough about the issues. In the second scenario, it would be prudent to investigate what else needs to be in place to develop confidence following training. In light of the apparent lack of relationship between the

two variables, there remains uncertainty about where confidence, or lack of confidence, comes from if not from an adequate or inadequate amount of training.

### The service users

Considering the known prevalence of experiences of sexual violence among the psychiatric population and conversely the mental problems which are commonly associated with being sexually assaulted and raped, we sought to establish if similar levels of sexual violence/mental ill-health were reported to practitioners.

### General caseloads

Firstly, respondents were asked for the number of service users on their caseload; this number varied greatly. Mental health workers reported caseloads ranging from one to 927, compared with six to 625 for sexual and domestic violence workers. Table 3 provides a distribution of caseload reported by practitioners separated by sector:

	0	1 to 24	25 to 49	50 to 74	75 to 99	100 to 124	125 to 149	150 to 174	175 to 199	200 to 249	250 to 299	300+
Mental health	9 (14%)	24 (38%)	10 (16%)	0 (0%)	5 (8%)	4 (6%)	5 (8%)	0 (0%)	2 (3%)	0 (0%)	1 (2%)	1 (2%)
Sexual and domestic violence	1 (2%)	6 (11%)	8 (15%)	8 (5%)	7 (13%)	10 (18%)	6 (11%)	2 (4%)	3 (5%)	2 (4%)	0 (0%)	3 (5%)

**Table 3: number of clients on caseload**

There was a marked difference in overall caseloads. The majority of mental health workers had 1-24 clients, but with a mean average of 72. In comparison, the largest group of sexual and domestic violence workers had between 100 and 124 service users, the average being 111. This is a much larger mean than that of the mental health professionals, a fact that might be explained by the difference in interventions provided by the two groups of professionals.

#### **300+**

Four practitioners reported having over 300 clients. This includes two IDVAs with caseloads of 490 and 625 clients, and a domestic violence helpline worker who had spoken to 947 people in one year. The final member of this group was a therapist within the NHS with a caseload of 600 people.

A further striking distinction emerged in relation to rates of reported sexual violence/mental ill-health. Of the 56 mental health professionals that answered this question, 34% of the people on their caseload had reported sexual violence. Conversely, sexual and domestic violence practitioners reported 49% of their caseloads having experienced mental health problems.

#### *Prevalence of reported sexual violence*

The question about levels of reported sexual violence gave rise to a distinct difference between the distributions for the two groups of practitioners. Half of mental health professionals indicated that only 1-19% of their clients had problems with sexual violence, whereas the majority of sexual and domestic professionals (54%) said that the part of their caseload with mental health problems was between 20% and 60%.

	Mental Health Workers	Sexual & Domestic Violence Workers
<b>100%</b>	7 (13%)	3 (6%)
<b>80-99%</b>	3 (5%)	5 (10%)
<b>60-79%</b>	3 (5%)	7 (15%)
<b>40-59%</b>	3 (5%)	14 (29%)
<b>20-39%</b>	12 (21%)	12 (25%)
<b>1-19%</b>	28 (50%)	7 (15%)

A quick note: In Table 4, ranges started at 1% because all of the respondents who answered this question indicated that at least one of their service users in the past year had disclosed an experience of sexual violence or rape. Ranges start at 1% in Table 5, seen below, for the same reasons – all of the sexual and domestic violence professionals who responded indicated that at least one of their clients had a mental health problem.

***Table 4: Percentage of reported sexual violence/mental health by sector***

In interpreting this data, it must be reiterated that the client base that sees each set of practitioners is in many ways the same, so this difference cannot be attributed to differences in population. Alternative possibilities include a tendency for people with both mental health and sexual violence issues to seek help for the sexual violence issues over the mental health issues, the under-identification of sexual violence within mental health services or, alternatively, an over-diagnosis of mental issues by sexual and domestic violence workers.

In a follow-up question about the nature of their clients' situations, 7% of the mental health respondents reported that for the majority of their service users who have experienced sexual violence, the abuse had occurred in childhood, 23% reported that it had happened in adulthood and 70% indicated that assault had happened both in childhood and in adulthood for their clients. The latter figure can be understood in two ways: either that practitioners were reporting that 70% of their service users had experienced abuse at more than point in

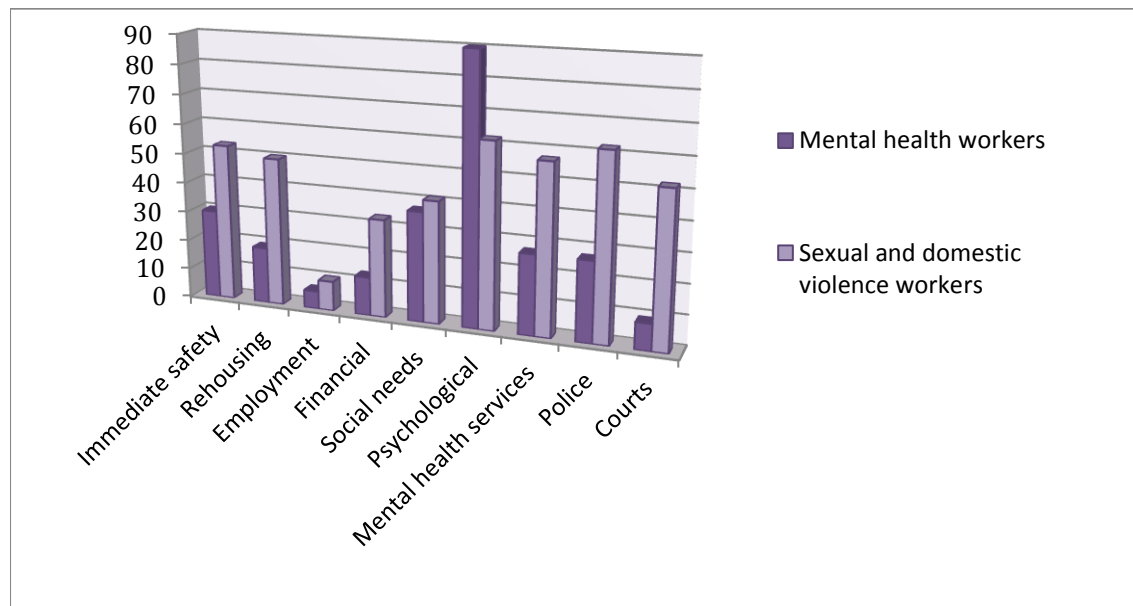
their life, i.e. both in childhood and adulthood, or that across their caseload there are service users who have experienced abuse in childhood *and* service users who have experienced sexual violence as an adult. Most likely, it is a mixture of both. In terms of sexual and domestic violence workers responses to this question, they indicated that on average, 53% of the cases where the service user had a mental health problem, the client had mental illness issues prior to the incident for which they were being seen currently, i.e. that the mental health problem is not related to the current/most recent experience of sexual violence.

### Service users' needs

Both the mental health workers and the sexual and domestic violence workers were asked about their perception of their service users' needs. They were asked to indicate from a list of needs whether they thought each was an important need for this group of service users; the listed needs included immediate safety, rehousing, support with employers and unemployment, financial issues, social needs, psychological and therapeutic needs, access to and liaison with mental health services, reporting or dealing with the police and dealing with the CPS and/or attending court.

### Other needs

Participants were also given the chance to identify other important needs after these choices, but no clear consensus was met in the open-ended portion and so those answers were not included in the analysis.



**Figure 6: Practitioners' perception of service users' needs**

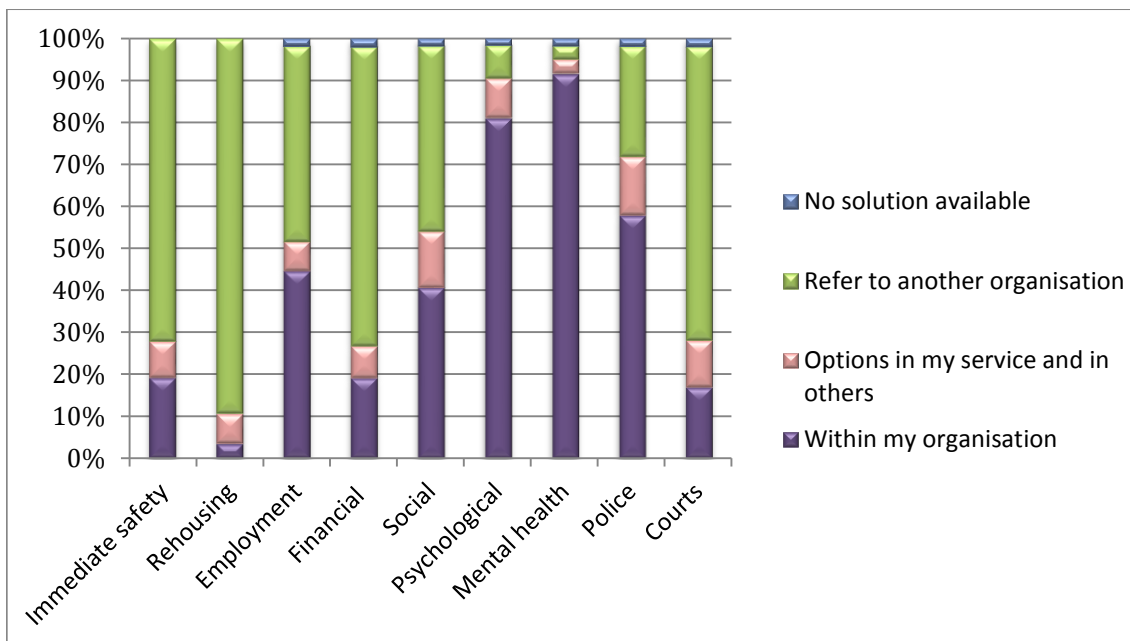
The results of this question (illustrated in figure 6) show a huge discrepancy between what mental health workers and sexual and domestic violence workers viewed as prominent needs. In general, mental health workers were consistently less likely to see each of the needs as important to their client group. The only need that mental health workers exceeded sexual and domestic violence workers in supporting the importance of was psychological and therapeutic needs, which they did by 28%.

Sexual and domestic violence workers overall perceived their service users having a great range of needs rather than a particular focus on one area of need. There was, however, a distinction between types of sexual and domestic violence workers. ISVAs

were most likely to report psychological/therapeutic support as being the most prominent need of their service users with a mental health problem with 25 respondents (83%) indicating that it was an important need. IDVAs were more likely to prioritise immediate safety as the most important issue (n=13; 52%), but IDSVAs were not strongly indicative of one particular need as being the most prominent for their service users. It is understandable that IDVAs, who work the victims at high-risk of domestic violence and whose immediate safety might be at risk, will therefore prioritise this need. In comparison, ISVAs work with sexual violence victims – some of whom may also be experiencing domestic violence, but not all – and for whom addressing immediate safety is not a primary focus of their intervention.

### Meeting service users' needs

Figure 7 shows the percentage that mental health practitioners felt that their organisation could address the previously mentioned needs, or whether they would refer to another organisation or felt that both their organisation and an external service could address it or if there was no solution available. Mental health services, psychological/therapeutic services and dealing with the police were the needs that were most able to be met within the practitioners' organisations (92%, 81% and 58% respectively). In the case of several other needs, the majority of practitioners indicated that they would refer a service user to another organisation if they needed help. These included rehousing (89%), immediate safety (72%), financial needs (71%) and dealing with the courts (70%).

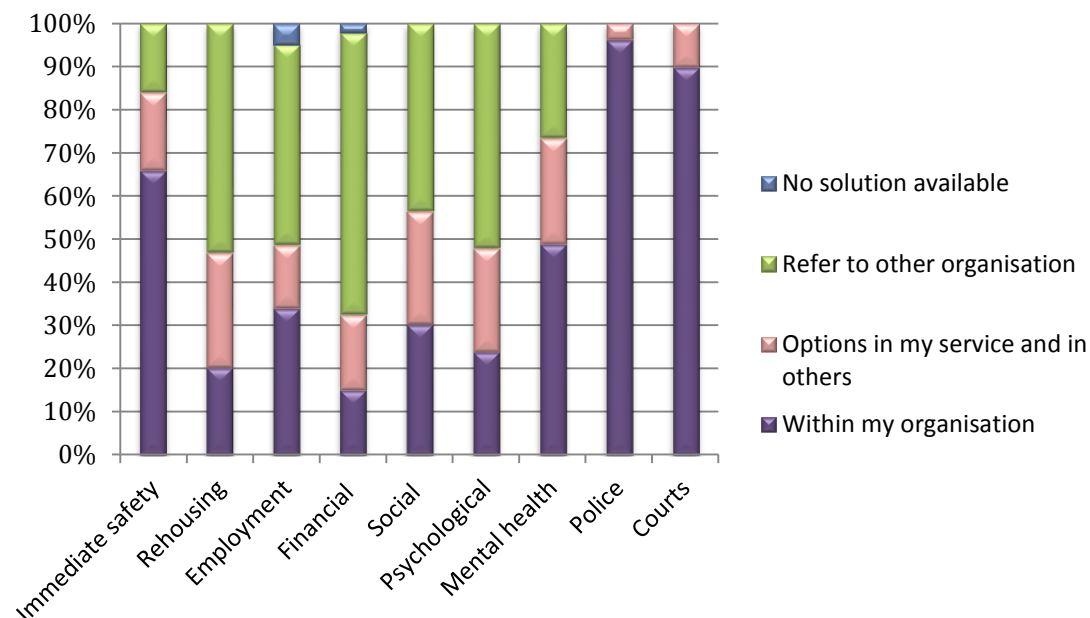


**Note:** It is additionally useful to take the “within my organisation” and the “options in my service and in others” segments of each column in Figure 7 in order to see the percentage of respondents’ organisation that have some sort of solution within their services, even though they might refer the client elsewhere depending on the case. In contrast, grouping the “no solution available” and “refer to another organisation” segments together shows the percentage of organisations that have no solution within their own organisation. The same concept can be applied to Figure 8, “Ability of sexual and domestic violence practitioners to fulfil service users’ needs.”

**Figure 7: Ability of mental health practitioners to fulfil service users' needs**

In seven of the nine areas one person indicated that they had no way to address a need. Certainly it is unfortunate when any of these important needs are not able to be met, but it should be noted that the seven “no solution available” responses were only given by four of the 68 practitioners who responded to this survey, and two of the professionals had no solutions to only two or three of the needs. This indicates that the problem may lie within a few organisations and not necessarily within the whole system. It is also concerning that when asked who would address a need for mental health services, three of the mental health practitioners answered either that there was no solution available within their service (n=1) or that the service user would be referred to another organisation (n=2). The respondent with no solution was a psychological wellbeing practitioner in the NHS and those who would refer elsewhere were a support worker in the NHS and a support worker in a voluntary organisation. Similarly, four mental health practitioners answered that they would refer clients elsewhere for psychological or therapeutic needs and one answered that they had no recourse for this issue. Those who would refer elsewhere included two support workers and one social worker in the NHS and one support worker and an advocate in the voluntary section. A support worker in the NHS indicated that there was no response available to her or him in a situation with psychological or therapeutic needs.

Figure 8 illustrates the perceived ability of IDVAs, ISVAs and IDSVAs to meet the needs of service users who also experience mental ill-health. The majority of the professionals would deal with three particular needs exclusively within their services, namely addressing immediate safety (66%), and dealing with the police (96%) and the Crown Prosecution Service and the courts (90%). Interestingly, all respondents indicated that they had services available within their own organisations for those survivors who needed to deal with the police or with the court system. Other needs, including financial needs (65%), rehousing (53%) and access to psychological and therapeutic services (52%) would usually be dealt with by referring the service user to another organisation.



**Figure 8: Ability of sexual and domestic violence practitioners to fulfil service users' needs**

Despite an indication by a majority of sexual and domestic violence practitioners that psychological/therapeutic support was a major need of service users, just under half of the practitioners (48%) indicated that there were options to deal with that need within their organisations. Of the 52% of these practitioners that would need to refer service users externally to access therapeutic support, there were:

- 13 IDVAs
- 12 ISVAs
- 1 IDSVAs

Overall, the majority of both mental health and sexual/domestic violence practitioners think their services are able meet the needs of service users who are affected by mental ill-health and sexual violence, at least some of the time. Of the 53 mental health practitioners who answered this question, ten thought their organisation assists this client group adequately, three disagreed and 40 reported that their services sometimes met the needs required. Among sexual and domestic violence workers, 15 said their services were adequate, one did not and 37 think that they sometimes assist service users adequately. The distribution is roughly similar between the two groups of professionals and also reflects the data collected on practitioners' perception of service users' needs and the extent to which they can meet these needs within their service or have to refer clients on to other organisations.

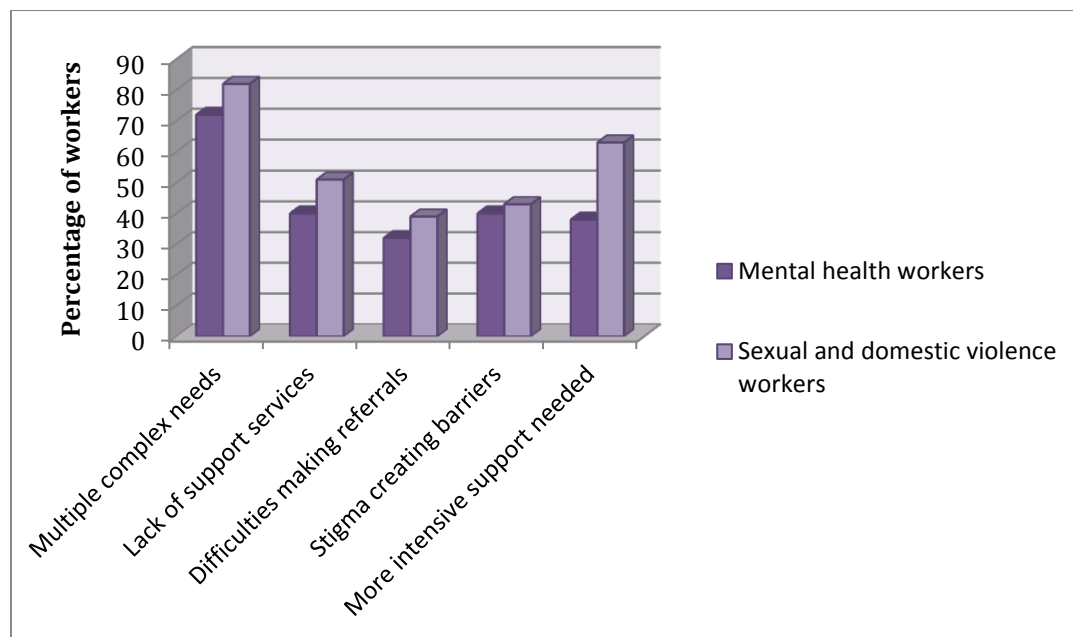
### An easy job?

Whilst practitioners in both sectors overwhelmingly reported being able to meet their clients' needs either within their own organisation or through referrals to other services, the majority also noted that supporting this client group – people affected by both sexual violence and mental ill-health – was more difficult than supporting other client groups. Notably, sexual and domestic violence were far more likely to report additional difficulties in supporting their clients who are also affected by mental ill-health: 90% of IDVAs, ISVAs and IDSVAs think it is somewhat or significantly more difficult to support this client group, compared with only 74% of mental health practitioners.

Difficulty level (in comparison with other clients)	Mental Health Workers	Sexual & Domestic Violence Workers
No more difficult	17 (26%)	5 (10%)
Somewhat more difficult	41 (62%)	36 (69%)
Significantly more difficult	7 (12%)	11 (21%)

**Table 5: Difficulties in supporting people who have experienced sexual violence and mental ill-health**





**Figure 9: reasons for support being more difficult**

Fifty practitioners cited a number of reasons why supporting this client group is more difficult, and in many cases they indicated that there are multiple difficulties: complex needs, lack of support services, difficulties making referrals, stigma that creates barriers in accessing other services and the increased level of support required.

As figure 9 (see left) highlights, mental health practitioners generally noted fewer barriers to supporting this client group than sexual and domestic violence workers. Differences in percentages were not vast, except in that 63% of sexual and domestic violence workers thought that more intensive support was needed compared with only 38% of mental health practitioners.

In conclusion, from the data collected, it would appear that mental health workers perceive themselves and their services as being more able to meet the needs (as they think them to be) of service users who are also survivors of sexual violence compared with sexual and domestic violence workers' self-reported ability to support clients who are mentally unwell. How to interpret this conclusion? One argument could be that people using mental health services (particularly secondary mental health services which were strongly represented among the survey respondents) have quite complex needs. Arranging the additional psychological or therapeutic support, which mental health workers identified as survivors' primary need, is therefore not overly problematic, particularly as this support is usually available within their own organisation. Conversely, sexual and domestic violence workers may work with many survivors with more or less complex needs and thus the service users who also experience mental ill-health are often at the more complex end of the spectrum. In addition, mental health services – particularly secondary services for people with more severe and enduring mental health problems – are more difficult to access due to high thresholds.

### Improving practice

The concluding section of the survey asked practitioners about the ways in which they thought they excel in supporting people who have been affected by sexual violence and mental ill-health, as well as ideas on how their own practice could be improved. Almost 100 practitioners from both sectors indicated several common themes in terms of their ability to work with this client group:

- providing emotional, psychological and therapeutic support (40)
- signposting and referring to helpful organizations (38)
- listening to, valuing and believing the accounts of the service users (35)
- advocating and creating useful partnerships within other organisations (25),
- providing practical support (13)
- providing specific trauma-related support and therapy (7)

*"Allow them to have a voice, be heard, listened to and believed."*

Psychotherapist in the NHS

These six themes were prevalent in the answers provided by both mental health and sexual and domestic violence professionals; however, mental health workers did put more emphasis on their ability to provide emotional and psychological support, and to provide trauma support, while sexual and domestic violence workers often mentioned advocating on behalf of clients and providing practical support as strengths of their organisations.

*"I can give them good 1-2-1 support which puts them at the heart of decision making. I liaise with all services on their behalf where they want this and I can accompany them to meetings and ensure that their voice and their wishes are heard."*

Voluntary sector mental health ISVA

*"I offer emotional support, an opportunity to talk through issues of [sexual violence] and also offer creative workshops... around relaxation, positive change and coping strategies."*

ISVA at a voluntary organisation

Similarly, in terms of improving practice, several common themes emerged across both sectors (see table 6 right) As with the previous question, these six themes were commonly found in the answers of both the mental health workers and the sexual and domestic violence workers and distributions of answers were largely the same, although mental health workers put greater emphasis on the need for therapeutic resources and on the need to streamline the process clients go through.

	No. of responses
<b>Increased training, knowledge and awareness</b>	36
<b>Improvements in referral pathways and increased partnerships with relevant organisations</b>	28
<b>Increased resources, time, money and staff</b>	20
<b>More specialist staff members</b>	15
<b>Availability of therapeutic resources for clients</b>	12
<b>Streamlining assessment processes/reducing waiting times for services</b>	9

**Table 6: What is needed to improve practice**

*"Better understanding from agencies about the role of the ISVA and the benefit to their agency that an ISVA can provide, so that we meet fewer closed doors when trying to access services for clients. More time to do outreach and visit the services to familiarise them with the role perhaps - though getting in there in the first place can be pretty insurmountable..."*

Voluntary sector mental health ISVA

*"A greater understanding of how sexual violence can impact on different clients. I need to be able to demonstrate to the client that I have a reasonable understanding of, and experience in working with, this issue so that they can feel confident in my competence in this area."*

Counsellor in the voluntary sector

*"I would like more training in this area to better support the needs of clients with mental health issues. I would also like to have better communication with mental health services that can be quite difficult to access for clients. Counseling and psychotherapy services usually have a long waiting list and I would like to feel more confident in supporting a client while they are waiting for this assistance, or I would like to be made more aware of other groups that may be able to support a client in the mean time."*

ISVA at a voluntary organisation

## Conclusions and recommendations

- The two groups of practitioners who completed our surveys – sexual violence and mental health workers – arguably work in different locations around the country, in varying settings (i.e. statutory and voluntary sectors) and fulfil a range of professional roles. It could be argued that these reasons offer an explanation for the distinctly different perception of survivors' needs. Nonetheless, in many ways, they have a shared client base – that of people who have experienced sexual violence and mental ill-health. In addressing the needs of this client group, it is evident that greater awareness of all the client's needs – driven by the client's stated wishes rather than practitioners' professional bias is required.
- As highlighted in previous research, further exploration of the association between training and confidence is needed. The lack of a strict correlation between attendance on training and confidence in carrying out the work of supporting people affected by sexual violence and mental ill-health suggest other factors contributing to increased confidence need to be identified to enable organisations to develop an effective workforce.
- Notwithstanding the previous point, the majority of practitioners who responded to the question about how to improve practice reported a need for greater training, knowledge and awareness.
- The rates of sexual violence towards service users that was reported by mental health practitioners, i.e. 50% said that less than 20% of their clients have experienced sexual violence, is surprisingly low. Further research examining rates of routine enquiry about sexual violence is needed to ascertain why this figure is lower than expected – is it due to a lack of screening, the effectiveness of screening which means service users are not disclosing, or another factor?
- Mental health workers overwhelmingly identified psychological or therapeutic support as the primary need for clients who have experienced sexual violence. Whilst accessing therapeutic support may be desirable for some survivors, it is important that professionals are aware of the varying needs that sexual violence survivors may present with and take a holistic approach to assessing need. Sexual violence training for mental health practitioners should reflect this point.
- It is extremely positive to note that almost 100% of respondents reported that their service users' needs can be met either within their own organisation or through a referral to another service. In practice, however, consultations with many people who have experienced sexual violence and mental ill-health routinely highlight the lack of services that are able to meet their needs in a timely fashion, and that they often tire from being passed from pillar to post. Practitioners who completed this survey also noted that a lack of services and long waiting lists were key barriers to effectively supporting this client group.