



# briefing

JUNE 2008

ISSUE 162

## Implementing national policy on violence and abuse

A slow but essential journey

### Key points

- Violence and abuse is a core mental health issue affecting 70% or more of women service users and a significant number of men.
- DH policy is that *all* service users should be asked about abuse in assessments, after appropriate staff training, and that survivors of abuse receive appropriate care.
- 15 mental health trusts have been piloting policy implementation focusing on child sexual abuse.
- The pilot learning outcomes will inform national implementation from November 2008: roll-out of the one-day sexual abuse training and publication of supportive practice guidance.
- This *Briefing* aims to provide you with sufficient information to commit your trust to the national implementation process: initially, to identify a lead officer to liaise with the National Team.

Working with the victims or survivors of violence and abuse, and in particular child sexual abuse, is an important aspect of delivering effective mental health services. It is sensitive and challenging work and, by its very nature, can run the risk of being overlooked and not receiving the attention it deserves.

This *Briefing* outlines the current Department of Health policy on violence and abuse pertaining to adult mental health services; the pilot implementation of this policy under the aegis of the Mental Health Trusts Collaboration Project; the forthcoming national implementation of the pilot process.

It is hoped that this *Briefing* informs you sufficiently to commit your trust to participating in the national implementation process, to better meet the needs of the large numbers of survivors of abuse within your service user population.

### Department of Health policy

Department of Health (DH) policy<sup>1</sup> is that adult mental health services should acknowledge and address the links between violence and abuse and mental ill health, by:

- ensuring staff, once satisfactorily trained, raise issues of violence and abuse routinely and consistently in assessments (both at 'first contact' and at assessment reviews)
- providing appropriate care and support to survivors of abuse through the care programme approach (CPA), subsequent to disclosures.

<sup>1</sup> Implementation guidance: mainstreaming gender and women's mental health. DH, 2003, pertaining to all service users.

The 'building blocks' of the policy are:

- inserting the 'abuse question' into assessment documentation: *"Have you experienced physical, sexual or emotional abuse at any time in your life?"*
- embedding the process in clinical audit procedures
- ensuring sexual safety in inpatient units
- actively involving service users
- providing effective staff support and supervision
- enabling staff, who are survivors of abuse, to access confidential counselling
- working in partnership with the voluntary sector
- establishing opportunities for staff to develop their clinical practice
- developing appropriate care, support and specific therapeutic interventions (where needed) for survivors.

## Background

### Prevalence of abuse

Child sexual, physical and emotional abuse, all forms of domestic abuse and sexual assault or rape (outside the home) are common in society today. Studies indicate that around 50 per cent of women within the mental health system are survivors of child sexual abuse, rising to 70 per cent or more when adult abuse is taken into account (typically, child victims who are re-victimised in adulthood). In secure settings the figure is even higher.<sup>2</sup> Clinical practice indicates that a significant number of men service users have also been victims of abuse.

### Effects of abuse

The effects of child sexual abuse can be a significant contributory factor to all diagnoses and presentations from depression, anxiety, eating and obsessive compulsive disorders and peri-natal mental ill health through to bi-polar disorder, psychosis/schizophrenia, dual diagnosis and personality disorder diagnoses. Whilst post-traumatic stress syndrome is widely recognised as a key effect of the violence and abuse continuum, it cannot be diagnosed as such without an abuse disclosure, hence many service users are misdiagnosed.

### The prevailing mental health context

There is a notable reluctance on the part of mental health professionals of all disciplines to routinely explore service users' experiences of abuse, and to directly affect their healing process if they are a known victim or survivor, particularly of child sexual abuse.

This is largely due to the virtual absence of any reference to violence and abuse in pre-registration and post-registration training. In-service training typically relates to safeguarding children, protecting vulnerable adults and, sometimes, domestic abuse. Furthermore, whilst mental health providers are striving to deliver a 'hope and recovery model', the tendency of individual services is still to prioritise the symptoms and behaviours of their client group over the causes of their mental ill health.

## Pilot implementation

### The Mental Health Trusts Collaboration Project

In 2003, the Gender and Women's Mental Health Programme was established to support service delivery. By 2006 it was apparent that mental

health provider trusts were in general not implementing routine exploration, notwithstanding some pockets of good practice. A lack of easy access to the necessary staff training has worked against implementation. To kickstart the process a national two-year project was established in July 2006: the Mental Health Trusts Collaboration Project (MHTCP).

### Focus on child sexual abuse

Whilst the 'abuse question' relates to all forms of abuse – *"Have you experienced physical, sexual or emotional abuse at any time in your life?"* – pilot implementation has focused on child sexual abuse. This is because:

- staff demonstrate the most reluctance to address this specific form of abuse, not least because they have not been trained to do so
- it is the most significant and damaging cause of service users' long-term reliance on mental health services.

### Commitment of the pilot trusts

All chief executives and boards of the pilot trusts formally signed up to the following principles of the process:

- sexual abuse should be 'core business' for mental health trusts
- it is the clinical responsibility of all practitioners and clinicians
- all members of the multi-disciplinary teams need to attend the one-day sexual abuse training (see page 3).

Each pilot trust identified appropriate personnel to, respectively, be operationally responsible for the process and accountable to the board.

### Pilot trusts

#### First wave process

Eight trusts engaged in the **first wave** which began in July 2006. These were: Barnsley PCT; Camden and Islington Foundation Trust;

<sup>2</sup> *Women's mental health: into the mainstream.* DH, 2002.

## Aims of the pilot process and future national roll-out

- Sexual abuse is embedded as a core mental health issue.
- Routine exploration of sexual, and other, abuse is consistently carried out by all mental health professionals conducting assessments.
- Mental health professionals of all disciplines recognise their clinical responsibility to address sexual, and other, abuse in partnership with service users.
- Adult services users with a history of abuse receive the care, support and therapy they need.
- Every trust has an adequate number of staff with the confidence and skills to provide appropriate support to service users with a history of abuse.

Coventry and Warwickshire Partnership Trust; Devon Partnership Trust; Nottinghamshire Healthcare Trust; Plymouth PCT; Sheffield Care Trust; (West) Sussex Partnership Trust.

### Second wave process

Seven trusts engaged in the **second wave** which began in September 2007. These were: Birmingham and Solihull Mental Health Trust; Dorset Healthcare Foundation Trust; East London Foundation Trust; Kent and Medway NHS and Social Care Partnership Trust; Leicestershire Partnership Trust; Lincolnshire Partnership Trust; Wolverhampton PCT.

### Pilot implementation process

This comprised all the necessary building blocks to embed violence and abuse in service delivery and, in particular, routine exploration in all assessments. The role of the national team has been to emphasise the importance of developing and maintaining all building blocks in tandem, rather than a sole focus on the cascade training; similarly, a qualitative process rather than any prescribed timetable or 'checkbox' approach.

### One-day sexual abuse training

The course objectives are to:

- address staff fears in working with survivors/victims of

violence and abuse, particularly child sexual abuse

- equip staff to routinely explore sexual, and other, abuse in assessments and deal effectively with disclosures

The training is cascaded in each trust by a two-person training team.

### 'Training the trainers'

Trust personnel responsible for cascading the training attended a two-day 'training the trainers' course. On the first day they undertook the one-day course. The second day provided an opportunity to debrief. Detailed manuals were provided.

### Evaluation

For the **first wave**, milestones were agreed for key stages of the pilot process. Year One focused on the efficacy of the 'training the trainers' process and subsequent cascade training. Year Two focused on progress towards embedding violence and abuse in service delivery and, in particular, routine exploration in assessments. For the **second wave**, the efficacy of the 'training the trainers' process and subsequent cascade training were evaluated.

Account was taken of the considerable challenges faced by

mental health providers, such as the impact of restructuring and service reconfiguration, financial constraints, the profligacy of policy directives, conflicting training pressures and time-consuming preparations for foundation status. The effectiveness of the pilot process has been largely due to the considerable commitment, and sheer ingenuity, of key personnel in each of the pilot trusts.

The evaluation will end at the end of June 2008. Summary reports of each stage of the process are available from [liz.mayne@dh.gsi.gov.uk](mailto:liz.mayne@dh.gsi.gov.uk)

### Key outcomes to date

- Both the 'training the trainers' process and the subsequent cascade training process have been effective and significantly increased mental health professionals' confidence in asking 'the question' in assessments.
- Effective implementation of violence and abuse policy, particular in relation to child sexual abuse, is a long-term process requiring significant cultural change.

### Lessons learnt

Key factors that contribute to an effective process are:

- the efficacy of the cascade training, particularly 'trainer authority' and style of delivery
- the early insertion of the 'abuse question' in assessment documentation with attendant clinical audit process
- the strength of leadership at senior management and middle management i.e. ward managers and team leaders driving the process within their individual teams
- the presence of trust-wide champions.

## National implementation

### Preparatory phase

May–October 2008

The aim is to achieve 100 per cent sign-up – to the national implementation process – by all non-pilot mental health provider trusts. For each trust, the preparatory phase has two key components:

- first, designate a **lead officer** to act as the official link with the national team and facilitate the planning process
- identify two **core trainers** to attend the two-day ‘training the trainers’ course to enable them to subsequently cascade the one-day sexual abuse course in-house.

You will shortly receive a formal invitation to participate, co-signed by the National Lead and regional CSIP NIMHE Mental Health Lead. Subsequent engagement will involve some or all of the following, dependent upon the tailored approach required in each region:

- CEO regional mental health provider forums/networks
- follow-up meetings with individual trusts
- specially convened regional working seminars with representative personnel from each trust
- ongoing telephone/face-to-face contact with individual trusts to provide additional advice and support, if and whenever required.

### Implementation phase

November 2008 to March 2009

This will comprise:

- Roll-out of the **one-day sexual abuse training**, initially through a two-day ‘training the trainers’ course for trusts’ training teams, on a regional, rotational basis. Backfill costs will be paid to trusts to

facilitate their core trainers’ attendance at the course. A third day will be held in each region at a later date to provide an opportunity for trusts to discuss progress and problems with the national team.

- DH/NIMHE **practice-based guidance** on how to start embedding routine exploration, outlining ways of effectively establishing building blocks, potential pitfalls, creative solutions to problems that may arise, how to

## Myths and realities

### Myths

- Sexual abuse is *not* a core mental health issue, but is rather the specialist remit of psychological therapies or distinct specialist services.
- It is too sensitive or intrusive a question to be asked routinely in assessments; for example: *“I can judge whether or not the question should be asked in assessment, whether the time is right”... “better to wait until a relationship has been established”... “better not to ask the question, rather wait until a service user discloses when they’re ready.”*
- *“It’s our role to stabilise service users, support them to manage the immediate symptoms of their crisis”* (inpatient services) *“It’s our role to support service users to manage their lives on a day-to-day basis* (community mental health teams)... *not to delve into the past.”*
- Asking ‘the question’ will *“open a can of worms... we haven’t got the resources to respond to, best left closed.”*
- 50 per cent of victims/survivors of child sexual abuse become abusers and, therefore, a significant proportion of victims/survivors in mental health services are also abusers.

### Realities

- This is not a new group of service users; these are people that we are already providing a service for. By exploring a potential history of abuse, we will better understand their presentations, symptoms and behaviours and be able to address them with greater insight.
- Survivors of abuse want to be asked; service users who are not survivors don’t resent being asked ‘the question’.
- Survivors in our care will not *all* disclose a history of abuse when asked ‘the question’. Whilst being relieved that they have, at last, been asked, they may well take some time to decide whether they wish to disclose, to what extent and to whom.
- Survivors have a range of needs in addition to formal therapy; to be asked, listened to and believed is a hugely affirming first step for them. Staff need to be open to learning from survivors, to empower them to dictate the pace of the healing process and enable them to stay safe when most distressed by their experiences of abuse.
- Abuse is already our core business but we could be dealing with it a lot better; our staff could be better supported. The pace of embedding routine exploration will be slow and disclosures will increase gradually, thereby giving time for staff to correspondingly enhance their clinical expertise.

address pockets of resistance and signposting to other useful resources.

- A **clinically-based forum** in each of the eight regions to enable mental health trusts to collaborate and share learning across the pilot and non-pilot trusts.
- National and regional **websites** providing supplementary support and information, to facilitate inter-trust collaboration and shared learning.

### Assessment documentation

It is envisaged that by Autumn 2008 each trust will have included

the ‘abuse question’ in their assessment documentation, as outlined in the assessment and care planning section of *Refocusing the care programme approach* practice guidance (DH, 2008). The national lead or your regional CSIP/NIMHE mental health lead (see page 6 for contact details) would be happy to liaise with trusts’ CPA lead if they have any queries or concerns about this. It will be possible to ascertain progress in this regard through the Autumn 2008 NSF Local Implementation Teams Self-Assessment.

### Links with other mental health services

Whilst national violence and abuse policy is specifically enshrined in adult mental health services, it is equally relevant to *all* other mental health services: CAMHS; specialist services (for example, for those diagnosed with eating disorders; personality disorders; peri-natal mental ill health); services for older people; services for those with learning disabilities – linking through to primary care. All the pilot trusts clearly acknowledge this need, and some have already made inroads into these related services.

### Influencing the pre-registration training of all mental health professionals

This is a crucial element to the national implementation process. Engagement will take place with all the national regulatory bodies and Royal Colleges. In particular, a consortium will be established with a number of leading schools of nursing which are keen to embed violence and abuse, with a particular focus on child sexual abuse, into the curriculum of their pre-registration training.

### Benefits for your trust

- Signing up to the national implementation process has the potential for transforming your mental health services into truly needs-led services for all service users, not only for those who are victims or survivors of abuse.
- The one-day sexual abuse course facilitates practitioners to look beyond the presentations and diagnoses of their client groups; to address the root causes of their mental ill health in addition to supporting them to better manage their day-to-day lives.

### Feedback from the pilot trusts

*“Our experience has been that the training in sexual abuse for front-line teams has increased the confidence of clinical staff and contributed to effective risk management. We know how challenging it is for staff to ask about violence and abuse, and particularly child sexual abuse; acknowledging how difficult this can be has been an issue we have had to face together. We have not shirked this and nor have our training team. We urge all trusts to participate in the national roll-out, and to do so with their eyes fully opened.”*

Wendy Wallace, CEO, Camden and Islington Foundation Trust

*“As an organisation we are committed to providing care based on evidence and what service users want. Studies indicate that at least 50 per cent of women – notwithstanding the significant number of men – within the mental health system are survivors of sexual abuse, and many feel that this is not acknowledged or addressed within the mental healthcare they receive. We are therefore committed to ensuring we invest in staff, through appropriate training, in order to enable them to routinely ask service users the question about experience of sexual, and other, abuse and then ensure we provide care to support the needs of the person who has made the disclosure.”*

Erville Millar, CEO, Kent and Medway NHS and Social Care Partnership NHS Trust

*“This work has been going on in Nottinghamshire Healthcare for some time but this added input is welcome. We had a service user speak very eloquently at our AGM about how liberated she felt at being able to talk about her experience of abuse to a member of staff trained to understand and help her deal with it. She is contributing further to our training programme. This pilot and subsequent work will embed an attitude that is helpful for staff and service users. We need to support people within our services who are survivors of sexual abuse and work with them to improve the efficacy of the care they receive.”*

Clair Chilvers, Chair, Nottinghamshire Healthcare NHS Trust

- It represents an essential contribution to effecting New Ways of Working in building capable teams, implementing CPA guidance and other key trust priorities such as service improvement, suicide prevention and your equalities agenda.
- In the longer term, it has the potential for significant economic benefit; as victims and survivors of abuse are supported in their recovery process, their prior long-term reliance on secondary care will greatly diminish. The best means of producing a reliable cost benefit analysis is currently being explored.

## Conclusion

Committing your trust to the national implementation process may seem daunting; however, it is about embarking on an essential, but slow, journey towards meeting a huge, unmet need. Disclosures of abuse won't suddenly overwhelm your staff, they will build slowly, giving staff time to enhance their capabilities.

The toxic experience of violence and abuse is endemic within our society – and within our service user populations. If we're really serious about conveying hope and supporting both women and men survivors on the road to recovery, addressing the root causes of their mental ill-health is a definite 'must'.

## National implementation of violence and abuse policy

For more information or to discuss any of the issues covered in this *Briefing*, contact the national team or your regional CSIP NIMHE mental health lead as follows:

### National Implementation Team:

Liz Mayne, Implementation Lead, [liz.mayne@dh.gsi.gov.uk](mailto:liz.mayne@dh.gsi.gov.uk), 07785 555712

Chris Holley, Clinical Lead (seconded by South Staffs and Shropshire Healthcare Foundation Trust), [chris.holley@ssh-tr.nhs.uk](mailto:chris.holley@ssh-tr.nhs.uk), 07798 608067

### CSIP NIMHE Mental Health Leads:

Eastern: [susannah.howard@csip.org.uk](mailto:susannah.howard@csip.org.uk)

East Midlands: [dean.repper@eastmidlands.csip.nhs.uk](mailto:dean.repper@eastmidlands.csip.nhs.uk)

London: [fionuala.bonnar@londondevelopmentcentre.org](mailto:fionuala.bonnar@londondevelopmentcentre.org)

North East and Humberside: Jackie Price – email [jmgprice@btinternet.com](mailto:jmgprice@btinternet.com)

North West: [simon.rippon@csip.org.uk](mailto:simon.rippon@csip.org.uk)

South East: [judi.mallalieu@csip.org.uk](mailto:judi.mallalieu@csip.org.uk)

South West: [kate.schneider@csip.org.uk](mailto:kate.schneider@csip.org.uk)

West Midlands: [jenny.dalloway@csip.org.uk](mailto:jenny.dalloway@csip.org.uk)

Yorkshire: Clare Hyde, email [hclarehyde@aol.com](mailto:hclarehyde@aol.com)

## The Mental Health Network

The Mental Health Network was established as part of the NHS Confederation to provide a distinct voice for mental health and learning disability service providers. We work to raise the profile of the issues facing mental health providers and improve the influence of mental health and learning disability members.

The NHS Confederation is the independent membership body for the full range of organisations that make up today's NHS across the UK. Our ambition is excellence for patients, the public and staff by supporting the leadership of today's NHS. As the national voice for NHS leadership, we meet the collective needs of the NHS and address the distinct needs of all parts of the NHS through our networks and forums. The Mental Health Network is one of these.

To find out more about the work of the Mental Health Network, visit [www.nhsconfed.org/mental-health](http://www.nhsconfed.org/mental-health) or email [mentalhealthnetwork@nhsconfed.org](mailto:mentalhealthnetwork@nhsconfed.org)

*Further copies can be obtained from:*

NHS Confederation Publications  
Tel 0870 444 5841 Fax 0870 444 5842  
Email [publications@nhsconfed.org](mailto:publications@nhsconfed.org)  
or visit [www.nhsconfed.org/publications](http://www.nhsconfed.org/publications)

© NHS Confederation 2008. This document may not be reproduced in whole or in part without permission.

Registered Charity no: 1090329

BRI016201