October 2015

Guidance for Trust managers

Implementing and sustaining routine enquiry about violence and abuse in mental health services

Responding effectively to violence and abuse (REVA project) Briefing 2

Summary

- Department of Health policy is that adult service users should be asked about experience of violence and abuse in mental health assessments. This is known as routine enquiry (RE).
- Interviews with service providers found some staff to be reluctant to ask, in part due to lack of confidence in how to respond to disclosure.
- This briefing highlights key recommendations and good practice guidelines for Trust managers, focusing on the need for strategic leadership and commitment; training provision; data collection requirements; knowledge sharing and awareness raising.

Introduction

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]. However, by 2006 it was apparent that mental health provider trusts were not generally implementing the policy and 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 to include case-studies of four of the original pilot trusts to implement routine enquiry (the REVA study). This guidance is based on findings from this study.

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

[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.

01

The evidence base

Why mental health professionals should routinely ask service users whether they have experienced violence or abuse

Mental health service users have often experienced violence and abuse in their lives

There are high prevalence rates of violent and abusive experience in both childhood and adult life amongst users of mental health services. Histories of adulthood sexual and physical abuse amongst women service users are particularly well documented. Although many of the samples in these 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).

Violence and abuse impact on mental health

Recent analysis of the Adult Psychiatric Morbidity Survey (Scott et al, 2013) identified a number of discrete groups of people with distinct patterns of abuse experience and mental health outcomes. One group, representing 1 in 25 of the population, had experienced extensive physical and sexual violence, with an abuse history extending back to childhood. Nearly all members of this group had been assaulted by a partner. Half had been threatened with death. Most had been sexually abused as children and some severely beaten by a parent. Many had also been raped as an adult. Over half the members of this group had a common mental disorder (CMD) such as clinical depression or anxiety - making them five times more likely than those with little experience of abuse to have a CMD. In a further group, characterised by extensive physical violence and coercive control in an adult relationship – and representing 1 in 50 of the population – 37% had a CMD. The mental health implications of domestic violence are clearly considerable, but have received very little attention until now.

The analysis also showed that a wide range of different mental disorders, including screening positive for psychosis, post-traumatic stress disorder (PTSD) and eating disorders, showed strong and consistent associations with violent and abusive experiences. There was also a strong link with having more than one disorder. People in the 'extensive physical and sexual abuse' group were about 15 times more likely than those with little experience of violence and abuse to have three or more mental disorders.

People in all the groups characterised by experiences of violence and abuse were at least five times more likely than those with little experience to have attempted to take their own life. People in the 'extensive physical and sexual group' were 15 times

more likely to have done so. Over half (56%) of people in this group had self-harmed at some time – compared to 10% of those with little experience of violence and abuse. These findings underline the importance of making connections between mental health, suicide attempts and self-harm and people's experiences of violence and abuse.

Mental health services have often failed to take account of people's experiences of violence and abuse

A substantive literature review (Hepworth and McGowan, 2013) recently examined the extent to which mental health professionals enquire about childhood sexual abuse during routine mental health assessments in acute mental health settings. They concluded that while many professionals acknowledged the importance of enquiry, there was little evidence of widespread routine enquiry occurring during mental health assessments.

In one New Zealand study, two-thirds of service users reported sexual, physical or emotional abuse at some point in their lives, but only 20% had been asked about abuse on assessment. The majority (69%) of those who reported abuse believed there was a connection between having been abused and their mental health problems, but few (17%) thought the clinician saw such a connection (Lothian and Read, 2002). In another study the files of 200 users of a community mental health centre revealed that while 46% contained documentation of sexual or physical abuse as children or adults, only a third of treatment plans for abused clients mentioned the abuse and only 22% of the abused clients received abuse-focused therapy (Agar et al, 2002).

Reluctance to ask about abuse amongst some mental health professionals has been highlighted in a number of studies (Goater and Mehan, 1998; Hamberger and Phelan, 2006). The evaluation of the pilot of routine enquiry identified a number of barriers to staff asking the question. Key amongst these were a lack of confidence in how to respond appropriately to a disclosure; fear of causing distress they could not contain ('opening a can of worms and not being able to get the lid back on'); and a lack of specialist services to which people could be referred (Scott and McNeish, 2008).

So research examining how far such experiences are known to mental health professionals, are considered relevant to diagnosis, or go on to be reflected in treatment plans, shows a considerable gap between what research suggests and what clinicians do.

Service users' 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. 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). In a study of domestic violence amongst clients of a community mental health team, 82% regarded routine enquiry as acceptable, but only 24% had ever been asked about domestic violence (Morgan et al, 2010). In a US study of community mental health service users, all service users considered routine enquiry about domestic violence in mental health settings to be acceptable (Trevillion et al, 2012). The 21 survivors interviewed as part of this research were overwhelmingly positive about the policy of routine enquiry – they considered that asking about experiences of violence and abuse was an essential part of assessment and a pre-requisite for appropriate care (Scott et at, 2015).

1.1 Does routine enquiry (RE) work?

As patient disclosure is a prerequisite for clinician engagement with issues of violence and abuse and patients find routine enquiry acceptable, advocating RE with clinical populations amongst whom high levels of violence and abuse have been identified would seem to be uncontroversial. In addition, there is evidence that routine enquiry – defined as 'a question routinely asked of all clients by appropriately trained staff' – undertaken in a range of healthcare settings increases disclosure, referral and take up of specialised support services (Spiby, 2013). This has been confirmed by studies in mental health contexts. A study in ten Australian health care settings, covering antenatal, drug and alcohol and mental health services (Spangaro, 2010) found that 23% (27/120) of women who reported domestic abuse on screening were revealing this for the first time and 35% of those who reported abuse accessed further services.

However, for routine enquiry to be effective it needs to be followed up by interventions that make a positive difference to people's lives. In a review of studies of domestic violence and severe psychiatric disorders, Howard et al (2010) found that although when routine enquiry is introduced into services, detection rates improve, identification of domestic violence is rarely used in treatment planning.

There have been three recent studies of screening programmes in general health care settings where limited interventions have been offered (an information leaflet, brief counselling or a 30 minute appointment with a GP). These programmes resulted in no improved outcomes in quality of life, mental health, or safety planning and behaviours (the WEAVE trial in Australia (Heggarty et al, 2013), and in the US (Klevens et al, 2012) and in Canada (MacMillan et al, 2009). On the basis of such evidence the recently updated external review for the UK National Screening Committee (Spiby, 2013) concluded that: Screening for domestic violence is not recommended because there is insufficient evidence on the benefit of interventions. Comprehensive screening programmes can increase the level of screening (asking about domestic violence) undertaken, disclosure and identification but to date there is no evidence of reduction in level of such violence or positive health outcomes following screening.[...] There is a lack of evidence on effective interventions.

However, the Identification and Referral to Improve Safety (IRIS) study indicated the value of training and support in primary-care practices for increasing identification of women experiencing domestic violence and their referral to specialist services. The study introduced an intervention (training, a prompt in medical records to ask about abuse and a referral pathway and advice from a named domestic violence advocate) to clinicians within 24 practices. Compared to 12 referrals from a control group of 24 practices with no interventions, there were 223 domestic violence referrals from the intervention group (Feder et al, 2011). Recent NICE guidelines for addressing domestic violence (2014) has 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.

Importantly, as Rachel Jewkes has pointed out in The Lancet[3], research on widespread screening does not show a lack of value in asking patients about violence and abuse in circumstances in which it might be directly associated with the presenting complaint or important for clinical intervention - particularly mental health problems. What the research on widespread screening does highlight is that in any context identification is not enough – routine enquiry is only effective if it leads to better support, understanding and quality of life.

[3] The Lancet, Volume 382, Issue 9888, Pages 190 - 191, 20 July 2013

02

The building blocks for effective implementation of RE in mental health trust: findings from the REVA study

In the four case study trusts where RE had been implemented since 2008/9 there was widespread recognition by staff of the importance of knowing if a service user has experienced violence or abuse and an appreciation of the links such experiences can have to mental health. Staff also recognised that experiences of abuse have to be asked about in a sensitive and appropriate way.

The main barrier is staff resistance to asking the question – either asking it at all, or to ask it in some circumstances or of some groups of clients. The main reason for reluctance is lack of confidence in how to respond to any disclosure that follows. The building blocks for effective implementation are therefore those factors which our research suggests have the biggest effect in increasing staff confidence in responding to disclosures.

Strategic Leadership and commitment

The evaluation of the RE pilot (Scott and McNeish, 2008) identified the importance of leadership and managerial support to effective early implementation. The REVA follow up study confirmed that this continues to be essential if RE is to be embedded and that multi-disciplinary leadership - representing nursing alongside psychology/psychotherapy and psychiatry – was most effective. Staff in mental health services identify to varying degrees with both their profession and the (usually multi-disciplinary) team within which they work. They are most likely to embrace new practice which is endorsed both managerially and professionally.

In all four case study trusts overall leadership had been consistently provided by some of the same individuals – even when their substantive roles had changed. In seeking long-term sustainability two trusts had located RE within the remit of the trust Safeguarding lead - with clinical audit and training monitored quarterly by the Safeguarding Committee. Safeguarding teams were seen as providing essential support for RE but it was also recognised that RE should not be seen solely as a safeguarding responsibility but rather as a clinical issue with potential safeguarding implications.

Effective implementation is greatly assisted by two other kinds of leadership. First, that provided by RE 'champions': in the case study trusts these were most often RE trainers who had played a dual role as effective champions of RE within their own services. And second, by team managers who kept RE on the agenda by discussing it in team meetings and supervision, and who themselves modelled good practice in responding appropriately to survivors of violence and abuse. Both managers and champions provided consultation and support and thereby increased staff confidence in their ability to respond helpfully to disclosures.

It is recommended that there should be a designated lead for RE in all trusts and that senior leadership should be provided by a multi-disciplinary team working closely with the trust's Safeguarding Lead.

Training

Training is key to ensuring staff understand the importance of RE and have the confidence to undertake it. Training is particularly important given that pre-registration curricula contain little or no reference to the significance of violence and abuse for mental health. A one-day training workshop *'Asking the question about violence and abuse in mental health assessments'* developed for the RE implementation pilot in 2006 has continued to be delivered on a regular basis in the case study trusts. It was most successful in reaching a critical mass of staff where it had been rolled out to all levels and grades of staff from consultant psychiatrists to healthcare assistants and where it had mandatory status. The importance of the training being mandatory was emphasised by staff:

'by its very nature this is not something a lot of people are going to opt-into. It needs to be automatic for everyone or it just won't happen'.

Views on the RE training were mostly positive. People used terms such as 'useful' and 'empowering', commenting that the training helped them understand why it was important to ask the question and gave them more confidence to do so. There was considerable demand for 'refresher' training as the best way of keeping RE on the agenda.

It was suggested that the workshop materials now required some updating to reflect recent research and that the focus on child sexual abuse should be reduced to enable greater coverage of other forms of violence and abuse.

In one trust, training had been provided for IAPT/PWP workers and the extension of RE into primary care was seen very positively. In other trusts, places had been made available to mental health social workers, health visitors and voluntary sector staff from local refuges, helplines and counselling services[4].

It is recommended that the one-day course is delivered regularly in every trust and that attendance is mandatory for all staff conducting assessments – including staff working with older people and those with learning disabilities - and for all new starters. A half-day update/refresher workshop should be provided and attendance required every three years. Updated workshop materials include a Powerpoint presentation and trainers' manual and can be downloaded from: **http://www.e-lfh.org.uk/programmes/domestic-violence-and-abuse/trainer-resources/**

Including 'the question' in assessment documentation and in Clinical audit

Embedding RE in assessment was seen as one of the original building blocks for the implementation of RE and national guidance from DH advocated the inclusion of a standard question within the Care Planning Assessment in the following form:

"Have you experienced physical, sexual or emotional abuse at any time in your life?"

☐ Yes ☐ None stated ☐ Not asked

If 'Yes', record brief details:

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If question not asked, please state reason:

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Although only about 40% of mental health service users are on CPA, this is the only adult mental health assessment that follows a national standardised format for which it is therefore possible to collect national data.

[4] Public Health England have recently launched a free e-learning course with the national charity AVA- Against Violence and Abuse, to provide free e-learning for all health and social care professionals to enable them identify and support survivors of domestic abuse. The course can be accessed at http://elearning.avaproject.org.uk/

From 2012, Trusts were required to return quarterly figures on how frequently the question was asked to the NHS Information Centre as part of their National Minimum Dataset return. However, a number of Trusts failed to return complete data last year.

Inclusion in CPA assessments and reviews is a minimum requirement. Routine enquiry about violence and abuse should be included in all relevant mental health assessments and it is recommended that trusts review the assessment tools being used across all mental health services (including services such as psychotherapy, eating disorders and learning disability services).

Although in the case study trusts inclusion of a standard question in assessment forms was regarded by staff as an essential pre-requisite for RE being consistently undertaken, there remains some variation in how RE was carried out. All staff used their own judgement concerning when to ask about experiences of violence and abuse – and avoided doing so when someone was very distressed or when another family member was present for example. Many staff always (or nearly always) asked the question using the recommended form of wording:

RE has become routine. It's like asking do you sleep, how's your appetite?

Some varied how they asked about violence and abuse and sometimes used a less direct approach. There were a minority who did not routinely ask. Some had not yet attended the training, others did not ask because, despite the training, they still felt unable to respond helpfully to a disclosure. There were also a few senior staff who resisted the idea that any question should routinely be incorporated into their assessments - preferring to rely on their own professional judgement about whether it was appropriate to ask about experiences of violence and abuse in any particular case. However, others clearly recognised the danger of making assumptions about who the question was relevant to and the importance of asking routinely.

None of the case study trusts had undertaken regular internal auditing of the question so definitive benchmarking is not possible. Audit data covering a three month period in 2012 was supplied by one trust which showed that in 50% of cases it had been recorded that the question had been asked at an assessment or review. Twelve months data in another trust showed that in 83% of assessments it had been recorded whether service users were known to have experienced violence or abuse.

It is recommended that trusts provide the required quarterly data to the national minimum dataset. This data should also be monitored internally. It will allow the identification of teams and services where RE is well embedded and those where further training and support is required. This would enable limited resources to be targeted where they are most needed. In addition, communication of the findings from audit could be used as a behaviour change 'nudge' to encourage individual staff and teams to follow their colleagues and implement RE.

Support for practice development

Routine enquiry will only be sustained if staff feel competent to deal with disclosures of violence and abuse. Our research suggests that, whilst some staff are very confident asking about abuse and violence, others lack knowledge about the dynamics and impacts of violence and abuse on mental health and their confidence is lower in terms of dealing with disclosures from different service users. Asking the question and responding helpfully was often considered more problematic with men, older people and some ethnic minority service users.

Support for practice development through specialist clinical supervision, case consultancy and practice development forums formed one of the original building blocks for the implementation of RE. In one case study trust a quarterly practice development forum brought together 30-40 staff - ranging from consultants to student nurses – with an interest in providing effective support to service users who have experienced various forms of violence and abuse.

See REVA briefing 4 (Scott et al, 2015) for information for staff on dealing with disclosures and NICE guidelines on domestic violence **http://www.nice.org.uk/guidance/ph50**

It is recommended that managers support practice development by addressing RE in team meetings and supervision, and support interested staff to attend forums, conferences or specialist training and encourage the sharing of knowledge gained within their teams. Trusts should have systems in place to offer support to mental health teams in the care of victims and survivors of violence and abuse.

Providing a good practice checklist (see over page) on how to ask about client's experiences of violence and abuse can be a good way of introducing new staff (and reminding experienced staff) of the Trust's commitment to RE and its expectations of staff conducting assessments.

Partnership working with voluntary agencies

Lack of knowledge about support available to survivors of different kinds of violence and abuse is a key barrier to staff asking the question and, conversely, knowing about specialist support available: the staff, services, waiting lists etc. made people feel more confident about asking the question.

Providing the good practice checklist on how to ask about client's experiences of violence and abuse can be a good way of introducing new staff (and reminding experienced staff) of the Trust's commitment to RE and its expectations of staff conducting assessments.

Staff in mental health services tended to have very limited knowledge of services in the voluntary sector. However many recognised that they needed more than the name and phone number of agencies in order to signpost or refer helpfully and to prepare service users for using support in the community or for starting counselling or therapy.

Voluntary sector interviewees in the case study trusts were equally concerned that referral needs to be an appropriate and collaborative process rather than a matter of 'refer and run'. This was considered all the more important because that they were increasingly working with clients with complex needs who would have been in statutory services a few years ago.

Good examples of collaborative working included formal links between statutory and VS agencies, shared training and 'shared care'. For example, one voluntary agency manager described that, 'if someone has disclosed on a ward I'll visit and work with staff to do a risk assessment and organise continuity of care in the community...we'll also try to bridge the gap with emotional support while someone is waiting for therapy'.

It is recommended that relationships between statutory mental health and specialist voluntary agencies are addressed at a strategic level and by raising awareness of VS services amongst NHS staff and Commissioners. Voluntary agencies should be involved in planning for the commissioning of services. PCCs are currently reviewing their victim services and level of need as they take over commissioning victim services, so they need to work closely with VS agencies supporting victims of sexual and domestic violence.

Commissioners of both health and crime related services need to be acutely aware of the links between inter-personal violence, abuse and mental health and the related needs of the population and fund accordingly rather than just on the basis of either criminal justice outcomes or health outcomes. See also: *Commissioning services for women and children who are victims of violence: a guide for health commissioners (Department of Health, 2011) and Securing Excellence in Commissioning Sexual Assault Services for People Who Experience Sexual Violence (NHS England, 2013).*

03

Good practice in asking people whether they have experienced any form of violence or abuse

The following lessons for good practice in implementing RE as part of mental health assessments were highlighted by mental health practitioners interviewed in the case study trusts involved in the REVA study:

- **Ask everyone:** don't try and judge whether the question is appropriate to individuals.
- **Don't worry about people taking offense** or being upset – all the evidence suggests that people don't mind being asked and survivors welcome it.
- **Be flexible about when to ask the question**, whilst being clear that it has to be asked.
- **Don't make false promises** about confidentiality – keep safeguarding in mind and address any current safety issues.
- **Don't rush people** -book extra time if necessary for appointments to complete assessments.
- **Be patient, listen genuinely** and let people tell their story in the way they want to.
- **Take seriously every disclosure** even if the client has a history of false claims.
- **Give a clear message** that violence and abuse should not have happened/should not be happening.
- **If the answer is 'no', don't just tick the box** and move on. Always acknowledge that abuse can be difficult to talk about and that if they ever needed to discuss an abuse issue there are people ready to listen.
- **Re-visit the question** because people will only disclose when they are ready and some people only disclose when trust has been built up.
- **Find out what your Trust can offer survivors** and about local voluntary sector specialist services and how they work so you can signpost clients appropriately.
- **Share disclosures with your team**, and ask for ideas about how to ask the question and respond to it.

References

Agar K, Read J. (2002) What happens when people disclose sexual or physical abuse to staff at a community mental health centre? Int J Ment Health Nurs. Jun 11(2):70-9.

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.

Bland J, Mezey G, Dolan B. (1999) Special women, special needs: a descriptive study of female special hospital patients. Journal for Psychiatry 10(1):34-45.

Department of Health. (2011) Commissioning services for women and children who are victims of violence: a guide for health commissioners **https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215635/dh_125938.pdf**

Feder G, Davies R, Baird K, Dunne D, Eldridge S, Griffiths C, Gregory A, Howell A, Johnson M, Ramsay J, Rutterford C, Sharp D. (2011) Identification and Referral to improve Safety (IRIS) of women experiencing domestic violence with a primary care training and support programme: a cluster randomised controlled trial, The Lancet, vol. 378, No. 9805, P1788 – 1795,

Feder G, Hutson M, Ramsay J, and Taket A R. (2006) Women exposed to intimate partner violence: expectations and experiences when they encounter health care professionals: a meta-analysis of qualitative studies, Archives of Internal Medicine, 166 (1): 22–37.

Hamberger L K, Phelan M B. (2006) Domestic violence screening in medical and mental health care settings: overcoming barriers to screening, identifying, and helping partner violence victims. Journal of Aggression Maltreatment and Trauma, 13 (3/4): 63-102.

Hegarty K, O'Doherty L, Taft A, et al. (2013) Screening and counselling in the primary care setting for women who have experienced intimate partner violence (WEAVE): a cluster randomised controlled trial. Lancet published online April 16. **http://dx.doi.org/10.1016/S0140-6736(13)60052-5.**

Klevens J, Kee R, Trick W, et al. (2012) Effect of screening for partner violence on women's quality of life: a randomized controlled trial. Journal of the American Medical Association 308: 681-689.

MacMillan HL, Wathen CN, Jamieson E, et al. (2009) Screening for intimate partner violence in health care settings: a randomized trial. Journal of the American Medical Association; 302: 493-501.

Goater N, Meehan K. (1998) Detection and awareness of child sexual abuse in adult psychiatry. Psychiatric Bulletin 22(4):211-213

Golding JM. (1999) Intimate partner violence as a risk factor for mental disorders: a meta-analysis. J Fam Violence; 14:99–132

Hepworth I, McGowan L. (2013) Do mental health professionals enquire about childhood sexual abuse during routine mental health assessment in acute mental health settings? A substantive literature review Journal Of Psychiatric And Mental Health Nursing, 20 (6): 473-483

Howard L M, Trevillion K, Khalifeh H, Woodall A, Agnew-Davies R, Feder G (2010) Domestic violence and severe psychiatric disorders: Prevalence and interventions. Psychological Medicine 40 (6): 881-893.

Lothian J, Read J. (2002) Asking about Abuse during Mental Health Assessments: Clients' Views and Experiences. New Zealand Journal of Psychology. 1(2): 98-103.

Morgan J F, Zolese, G, McNulty, J Gebhardt S. (2010) Domestic violence among female psychiatric patients: Cross-sectional survey. The Psychiatrist, 34(11): 461-464.

Nelson S. (2001) Beyond Trauma: Mental Health Care Needs of Women Who Survived Childhood Sexual Abuse, Health in Mind, Edinburgh

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**

NHS England. (2013) Securing Excellence in Commissioning Sexual Assault Services for People Who Experience Sexual Violence **http://www.pcc-cic.org.uk/article/advice-commissioning-sexual-assault-services**

Palmer R, Chaloner D, Oppenheimer R. (1992) Childhood sexual experiences reported by female psychiatric patients. British Journal of Psychiatry 160: 261-265.

Renker PR, Tonkin P. (2006) Women's views of prenatal violence screening: acceptability and confidentiality issues. Obstet Gynecol 2006; 107:348–54.

Scott S, 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. Download the overview report here.

Scott S, McNaughton Nicholls, C. (2015) What survivors of violence and abuse say about mental health services: Responding effectively to violence and abuse (REVA) Briefing 4. **www.natcen.ac.uk/REVAbriefing4**

Scott S, Williams J, Kelly L, McNaughton Nicholls C, Lovett J, McManus S. (2015) Violence, abuse and mental health in England: Responding effectively to violence and abuse (REVA) Briefing 1. London, NatCen. **www.natcen.ac.uk/REVAbriefing1**

Spangaro J M, Zwi A B, Poulos R G, Man W Y N. (2010) Who tells and what happens: disclosure and health service responses to screening for intimate partner violence Health & Social Care In The Community, 18 (6): 671-680

Spiby J. (2013) Screening for Domestic Violence External review against programme appraisal criteria for the UK National Screening Committee (UK NSC) VersionTwo **http://webcache.googleusercontent.com/search?q=cache:EppV2qFgGqUJ:www.screening.nhs.uk/policydb_download.php%3Fdoc%3D283+&cd=5&hl=en&ct=clnk&gl=uk**

Trevillion K, Howard L M, Morgan C, Feder G, Woodall A, Rose D. (2012) The response of mental health services to domestic violence: A qualitative study of service users' and professionals' experiences. Journal of the American Psychiatric Nurses Association, 18(6): 326-336.

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

Wurr CJ, Partridge IM. (1996) The prevalence of a history of childhood sexual abuse in an acute adult inpatient population Child Abuse & Neglect, 20 (9) : 867–872

Zeitler MS, Paine AD, Breitbart V, Rickert VI, Olson C, Stevens L, et al. (2006) Attitudes about intimate partner violence screening among an ethnically diverse sample of young women. J Adolesc Health; 39:119:1–8

This is the second 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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