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Independent Sexual Violence Advisers (ISVAs) in England, Wales and Northern Ireland

A study of impacts, effects, coping mechanisms and effective support systems for people working as ISVAs and ISVA Managers

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1. Executive Summary

1.1 Background

This study is the first of its kind in England, Wales and Northern Ireland and was carried out to gather information about the impact of working as Independent Sexual Violence Advisers (ISVAs) or ISVA Managers. The ISVA role is relatively new, and as such, little is known about this difficult and emotionally charged work. Although some literature looks at the impact of working in the sexual violence field, there is little from England, Wales or Northern Ireland, and even less focused on the direct, ongoing, face-to-face work ISVAs do. This report focuses on the impacts, effects, coping mechanisms and effective support systems for people working as ISVAs and ISVA Managers in supporting victim-survivors of sexual violence across England, Wales and Northern Ireland. Since its introduction in 2005, the ISVA role has been invaluable in providing continuous support to victim-survivors of sexual violence and working to meet their emotional and practical needs during the criminal justice process. As conviction rates are at an all-time low, ISVAs can also provide support to people who may otherwise feel let down by the Criminal Justice System. ISVAs can also support people who do not want to report the crime to the police – helping people at, potentially, the lowest point of their life. This survey focused on providing an overview of the ISVA role (e.g. context they work in, caseloads, supervision and support available) and determining which factors predict the likelihood of experiencing negative and positive impacts as a result of the work they do.

1.2 Method

One hundred and twenty-one ISVAs and ISVA Managers took part in an anonymous online survey. Potential participants were invited to take part using social media posts through a dedicated Facebook group for ISVAs hosted by LimeCulture and through a presentation at the LimeCulture Annual ISVA conference (2020). The survey was divided into three sections:

1. Basic demographic information (including time in the role, highest qualification and area they work in).
2. The type of organisation (NHS, charity, police and environment of the work – alone or part of a team), they were asked about their workload at their organisation, risk levels of clients and how cases are allocated. Additionally, they were asked about the training and supervision available to them.
3. The final part of the survey used established questionnaires to measure aspects of the impact of working as an ISVA and their personal feelings; the CORE 10 to assess psychological distress, the Breslau 7 (for Post-Traumatic Stress Disorder), the Personal Belief in a Just World Scale, Vicarious Trauma Scale, the Brief COPE Inventory (for coping strategies), the Vicarious Resilience Scale, the Conor Davidson Resilience Scale and the Vicarious Trauma Scale.

1.3 Findings

The majority of ISVAs who completed the survey were white females with a university degree or professional qualifications. Many of the ISVAs had worked in another roles with victim-survivors of sexual violence before becoming an ISVA, on average for 8 years. The average time as an ISVA was just under three years. Most ISVAs worked as part of a team and managed high caseloads (the average caseload was 48.29), which were allocated to them using a wide range of criteria, including location, availability and specialism. Just over half of the participants had not received role-specific training before starting work as an ISVA. Almost all participants received regular supervision; monthly individual clinical and management supervision were the most common. Individual clinical supervision was the most highly rated.

ISVAs and ISVA Managers who completed our survey were generally not experiencing PTSD but were experiencing some psychological distress and moderate to high vicarious trauma. Personal belief in a Just World (PBJW) was moderate, and resilience scores are in line with other professionals who work with trauma. The most commonly reported coping mechanisms were positive; the five most frequently used were acceptance, spending time with family and friends, self-distraction, positive reframing and emotional support.

In order to understand if ISVAs' characteristics (e.g., how long they had been ISVAs, their resilience) would predict their experiences of psychological distress and vicarious trauma we conducted statistical tests called regressions. The first regression showed that ISVAs with higher caseloads who are using more coping mechanisms (both positive and negative) are reporting more psychological distress (measured by the CORE-10). This suggests the higher caseloads cause ISVAs to use more coping mechanisms in order to be able to manage the high caseloads but they are still experiencing more psychological distress than ISVAs with lower caseloads who are using fewer coping mechanisms. This shows us that coping mechanisms help, but having a high caseload causes distress. The second regression showed that the longer participants had been in their current role, the longer they had been working in an SV role and the more positive coping mechanisms they used, the more vicarious trauma they had experienced. This shows a cumulative effect of trauma. ISVAs 'pick up' trauma over time both whilst working as ISVAs but also during other work in the SV field. This accumulated trauma leads to them needing to use more coping mechanisms. This suggests that the longer people spend working with clients who have experienced sexual violence, the more likely they are to use positive coping mechanisms but also to experience vicarious trauma. In contrast, resilience (CD-RISC) and PBJW had a negative effect on vicarious trauma meaning the more resilient a person is and more belief in a just world ISVAs had, the less vicarious trauma they experienced. Therefore, resilience and PBJW can protect against vicarious trauma; resilience enables the person to emotionally 'bounce back' from difficult situations and PBJW is an emotional protective factor from witnessing distressing things happening to others.

1.4 Conclusions

This report documents findings from a survey of 121 ISVAs and ISVA Managers conducted between the 5th March 2020 and 30th April 2020. This study was carried out at the time of the

first national lock down as a result of the Covid pandemic. It is worth noting that this may have had an effect on the results of this study. However, given the scarcity of research into the work of ISVAs and ISVA Managers, this audit provides an invaluable insight into the role and the challenges faced. As this is a comparatively new role and the role has had to evolve since its inception, little has been systematically researched on the impact of working as an ISVA or ISVA Manager. The findings from this study have implications for both policy and practice. The present research provides an invaluable insight into the practices of ISVA and ISVA Managers, however, more systematic research is needed to fully understand the impact of working with sexual violence victims. This survey provides a quantitative insight into the effects of working as an ISVA/ISVA Manager and what supports and helps individuals who work in this role.

1.5 Recommendations

Role-specific training – Notably, over half of the ISVAs/ISVA Managers in this study had no specialist training before starting their role. Although many ISVAs/ISVA Managers have had a lot of experience in other roles in the sexual violence field before becoming ISVAs – not all had. Even when they have previous experience, there is no guarantee that this experience means they can fulfil the ISVA role. It is recommended that there is a requirement for a national standard for training in 1st year in the role. The training provided should be accredited, role-specific and high quality. In addition to the initial training, there should be a national standard for annual, role-specific continuing professional development. Time should be allotted to carry out this training and there should be monitoring to ensure it is meeting the needs of the ISVAs. This form of professionalisation would provide consistency across the country and ensure that all victim-survivors experience more parity in the service they receive.

Guidance about supervision – Supervision has been identified as an area of need in previous studies of ISVAs (e.g., LimeCulture, 2018). Best practice for supervision has been established as being from an external provider (Koper, 2009; Tromski-Klingshirn & Davis, 2007). This finding was replicated here, in that not all supervision was considered to be of equal helpfulness. There was a strong preference shown for external clinical supervision. However, there is also an important role for management supervision. Both external clinical supervision and management supervision are essential and offer ISVAs different things. A framework for management and clinical supervision needs to be developed for ISVA services, providing guidance about the function, frequency and form of the different types of supervision. Management supervision provides an invaluable opportunity to ensure that ISVAs are working within their capacity with regards to case load size, and Clinical Supervision provides a safe place for people working in an emotionally demanding job. Best practice guidance is available from the BACP; although this guidance pertains to counselling supervision, it will apply for ISVAs too in many ways (BACP Ethical Framework | Supervision resources). In addition to supervision experience, it would be important for supervisors to have professional experience working with victims of sexual violence. This client population displays unique challenges and considerations, and ISVAs would benefit from their supervisors' understanding of this particular population's needs. It is also important that dual relationships are avoided to ensure conflicts of interest do not occur. This means that the person who

provides clinical supervision for an ISVA should not also be the person who provides counselling to the ISVA's clients and/or should not be a staff member at the same organisation.

In addition to supervision providing a safe place to express the feelings they have from the work they do, it is also important that this relationship is contracted appropriately and that there is a feedback element to it. This is not dissimilar to counselling supervision, where the supervisor has the responsibility to ensure that their supervisee is fit to practice. As part of safeguarding clients, this should also be built into the ISVA's supervision contract. This is not to be seen as punitive but as supportive – if an ISVA is experiencing burnout, the clinical supervisor is likely to be the first person to spot it and be able to sign post for support. This is beneficial to the ISVA as well as their clients.

At a time when services are increasingly being offered online, it would be possible for a national database of ISVA supervisors to be developed. It would also offer an opportunity for ISVAs to be able to find supervisors in their area that are not affiliated with their organisation and whom they may otherwise be unaware of. A national database would allow for checks and minimum qualification requirements to be set.

Routine monitoring of impacts and wellbeing – ISVAs/ISVA Managers who completed the survey reported psychological distress and moderate to high levels of vicarious trauma. Routine monitoring of these impacts should be implemented by organisations providing ISVA services and appropriate support and care should be provided (see recommendation about supervision). Alongside this, a national annual survey of ISVAs would be helpful to provide a more holistic view of ISVA experiences. Linked to this, self-care sessions for ISVAs should be offered. This would provide ISVAs with dedicated time to socialise with other ISVAs from differing organisations, share experiences and focus on self-care and resilience building. For example, with Ministry of Justice Funding. LimeCulture offered 'Coping & Connecting online sessions' during the first stage of the COVID19 pandemic[1]. Feedback from these sessions indicated that almost all of the respondents found it useful to connect with other ISVAs and were planning to recommend the sessions to other ISVAs. Four main benefits of the sessions were identified by the ISVAs: Safe space to reflect and focus; Sharing experiences; Reducing loneliness and isolation; and Facilitated discussion (LimeCulture, 2020). The benefits of these kind of sessions would extend beyond the COVID19 pandemic and we recommend they should become standard practice.

More support for positive coping mechanisms – Linked to the previous recommendation about routine monitoring of impacts and wellbeing, coping mechanisms were found to be fundamental in reducing emotional distress. As such, it would be helpful for positive coping mechanisms to be incorporated into the working lives of ISVAs. Perhaps, organisations can link with local services to offer opportunities for exercise, meditation, emotional support or by offering staff mindfulness apps, such as, Headspace. The self-care sessions proposed in the

[1] 241 ISVAs attended the sessions from 77 different ISVA services and 36 PCC areas; feedback forms were completed by 103 of the ISVAs (LimeCulture, 2020).

previous recommendation would also be beneficial for supporting and developing positive coping mechanisms.

National standards for maximum caseloads – Caseloads were a key factor predicting psychological distress and vicarious trauma amongst ISVAs and ISVA Managers and varied widely (from less than 10 to over 100). Although there are lots of possible reasons for this, such as, ISVA Managers also carrying a caseload, Child ISVAs needing more time with clients and some geographical issues that may mean more travel in certain areas, it could be helpful for there to be a nationally recognised maximum number of clients per ISVA. National standards for caseloads should reduce the number of overwhelmed ISVAs and improve the level, quality, and amount of care they can offer their clients. This approach would also be beneficial for commissioners. However, because of the complexities and differences intrinsic in the ISVA role and the lack of professional standards, it is difficult to set a national client maximum for all ISVAs. Nonetheless, with some further investigation, it would be possible to develop guidelines and role specific caseload caps. Therefore, we recommend that a scoping exercise be conducted to provide recommendations for maximum caseloads and these then be piloted and evaluated. Alternatively, a toolkit or framework could be developed to support ISVA Managers to set maximum caseloads and assist them in managing the capacity of their own teams. Whichever approach is taken, the process will need to carefully consider what strategies can be put in place if ISVAs reach capacity. There is a need to protect clients and ensure that they do not end up being screened out of receiving ISVA support or discharged early in order to keep ISVAs at or below the maximum caseload.

Professional Networks – There is a lack of consistency in ISVA provision which has impacts on the ISVAs and ISVA Managers delivering the services and, ultimately, on the services provided to victims of sexual violence. As the ISVA role is very nuanced and unique, it also requires confidentiality. This means that many ISVAs do not have outlets for discussing their work, therefore, it would be helpful for ISVAs to network with other individuals who perform the same role. Additionally, some ISVAs work in environments where they are the only ISVA or are part of a very small team. This limits the opportunity to learn more about the ISVA role, develop and adopt best practices from other practitioners. As such, it would be helpful for National Professional Networks (which are regularly used in the NHS to bring together professionals for specific illnesses) to be set up for ISVAs, which would provide an opportunity for idea sharing, peer learning and peer support. They could also be extended to ISVA Managers and Commissioners with the purpose of building consistency across different providers, sharing ideas and challenges. These networks could also focus on the development of a template ISVA Service specification or the development of a quality assurance framework that could be used by local commissioners to benchmark their services against each other.

2. Introduction

2.1 Background

Independent Sexual Violence Advisers (ISVAs) are victim-focused advocates who provide emotional and practical support to victims and survivors of rape, sexual assault and current/historical sexual abuse (Lea et al., 2015). They play an important role in providing continued advocacy and impartial information and advice to victims and survivors, regardless of whether they have reported to the police (Home Office, 2017). ISVAs are typically based in Sexual Assault Referral Centres (SARCs), within the NHS, or in voluntary organisations, such as Rape Crisis (Robinson & Hudson, 2011).

The role was originally implemented by the Home Office in 2005/6, in the wake of the success of the similar role, Independent Domestic Violence Advisor (IDVA). IDVAs proved effective in meeting the needs of domestic violence victims at risk of serious harm, working to keep them safe by coordinating with other agencies (Stern, 2010; see Granville & Bridge, 2010, and Howarth et al., 2009, for examples of evidence of the success of IDVAs).

Though there is no nationally recognised definition for the ISVA title; the most recent Home Office guidance (2017) set out the key expectations and responsibilities of the position. However, it is accepted and encouraged that the role will vary case-to-case to suit individual needs. The overarching objective of the ISVA role is to provide victims with impartial information about their options, including but not limited to:

- Reporting to the police
- Accessing specialist support (e.g., pre-trial therapy or counselling)
- Accessing Sexual Assault Referral Centre (SARC) services
- Providing information on or signposting to other related services (health and social care, housing, or benefits, for instance) (Home Office, 2017)

ISVAs provide continuity as an important single point of contact for victims and other agencies that may be involved in the response to sexual violence and have consequently emerged as crucial in guiding victims through this overwhelming process (Home Office, 2017, p.16).

There is an absence of a consistent job description and ISVA roles can be set up, funded, or delivered in different ways (Lea et al., 2015). There may also be different job titles used to describe the work of an ISVA, hence, in response to calls for a more cohesive understanding of the role, the aforementioned Home Office (2017) guidance for ISVA services and commissioners defined seven essential elements of the role to be followed by anyone carrying out work fitting the description above:

- Tailor support to individual needs
- Provide accurate and impartial information

- Provide emotional and practical support
- Provide support before, during and after criminal and civil court proceedings
- Act as a single point of contact
- Ensure the safety of victims, survivors and their dependents
- Provide professional services

The role has been considered a success, and its use is regularly recommended. Baroness Stern's independent review into 'How Rape Complaints are Handled by Public Authorities' (2010), found that the ISVA role is cost-effective, as well as successful in its aim of helping victims, with a huge impact on how victims feel about the process. The role is an intrinsic part of dealing with rape complaints; it is integral to ensuring victims receive a service that operates effectively, hence, Stern's recommendation for it be treated as crucial (Stern, 2010).

More recent evidence upholds the need for specialist ISVA services. Non-specialist agencies (such as statutory mental health services) are not able to provide a targeted response to sexual violence, where specialist ISVA services can respond effectively to the changing individual needs of victims/survivors (Hester & Walker, 2018). Hester and Walker (2018) found that ISVAs' flexible approach was key to shaping the type and level of emotional and practical support to the individual victim. This is reflective of emphasis on case-to-case support in guidelines (e.g., Home Office, 2017). Hester and Walker (2018), also highlighted the role of ISVAs as the 'enabler' (enabling victims to continue their journey to transition to a survivor, by facilitating access to relevant support services); the 'holder' (ISVAs were described as 'holding' victims within the CJS throughout the process in a way that made them feel safe); and the 'mender' (ISVAs may do some mediation work where the impacts of sexual violence can affect a whole family). The work of ISVAs is important, multifaceted and difficult to define; large scale national studies are needed to better understand the role itself and the impact of the challenging work on practitioners.

The ISVA workforce has steadily increased and continues to increase (the Ministry of Justice announced a £3million fund for ISVAs in May 2020, which paid for approximately 95 new ISVAs, and announced £14million in February 2021 which will go on to support ISVAs in 2021-2023). In 2015, Lea and colleagues estimated that 251 ISVAs worked across England and Wales. However, a current and precise figure is difficult to establish. As there is a lack of centrally coordinated regulation, there is no obligation for employing organisations to provide any monitoring information, hence, there is no central register (Lea et al., 2015). LimeCulture (personal communication, 8th January, 2021) now estimate that in 2020-2021 roughly 500-650 ISVAs are working across England and Wales. LimeCulture (personal communication, 12th January, 2021) suggested that the Ministry of Justice estimated that there were approximately 450 FTE ISVAs, but reached this figure by counting those working under PCC commissioners; many of the ISVAs work in un-commissioned services, or some in similar roles (i.e., IDVAs) with sexual violence training and may call themselves ISVAs – a practice that raises some concern over the quality of service. There are currently no restrictions on those given the title of 'ISVA', as well as a lack of responsibility to ensure that professional standards are met when recruiting for an ISVA position (Lea et al., 2015).

Considering the lack of central regulation, some work has been done to inform a cohesive understanding of the role and to provide clearer guidelines for commissioners. In 2015, LimeCulture conducted an audit to gather information on ISVAs and their clients, how the work was being undertaken, the nature of their caseloads, ISVA training and supervision (Lea et al., 2015). This is the only previous large study of ISVAs in England and Wales – important in producing a profile of the ISVAs and their clients, to inform a deeper understanding of the effectiveness of the support provided by ISVAs, and the support and training that ISVAs themselves need. This audit recommended the creation of a national body to provide professional oversight and quality standards of ISVAs.

In 2018, LimeCulture launched the Quality Standards for ISVAs Service, including a detailed document for service providers and commissioners (LimeCulture, 2018), with an accompanying accreditation programme launched in 2019 (LimeCulture, personal communication, 12th April, 2021). As of February 2021, 31 ISVA/CHISVA (Child Independent Sexual Violence Advisor) services have been accredited, with a further 12 working towards accreditation. Other organisations (i.e., Rape Crisis England and Wales, and The Survivors Trust) have their own service standards and there is a lack of consistency and agreement between the different organisations involved. Hester and Walker's (2018) research concluded that there was a danger that the importance of ISVA work could be lost in the practice of local service commissioning. Where roles across the country are formed and funded in different ways, commissioners need to be aware of the actual roles and input of voluntary sector sexual violence services, to avoid a limited focus of statutory services, to the detriment of victims (Hester & Walker, 2018). LimeCulture (2019) publicly stated that it is unacceptable that a postcode lottery determines the quality of service that the victim can access.

Considering the complex and developing nature of the role, and in the interest of providing a consistently professional service, there has also been increased attention on ISVAs themselves, including training, continued professional development and their welfare. Building on existing guidance for SARC staff (e.g., Department of Health, Home Office, & Association of Chief Police Officers, 2009; Lea et al., 2015), the 2017 Home Office guidance promoted that 'ISVAs should have access to ongoing continued professional development' (p.22) to maintain competency, and that ISVAs must have completed accredited training[2].

2.2 Impacts on ISVAs

Very little research has considered the impacts of the role on ISVAs' and ISVA Managers' professional and personal lives. Research with other practitioners who support victims of sexual violence has found they are at heightened risk of developing trauma-like symptoms and other negative impacts due to working in stressful environments, with complex clients, while consistently hearing about traumatic experiences or seeing their effects (e.g., Baird & Jenkins, 2003; Schauben & Frazier, 1995). While ISVAs themselves do not directly hear the details of the cases (apart from in court; Home Office, 2017), there are similarities with the risks faced by other sexual violence professionals, where ISVAs may face excessively high

[2] Accredited training is currently available from: LimeCulture, accredited by NCFE; The Survivors Trust; Rape Crisis England and Wales, delivered by Purple Leaf.

caseloads (e.g., Cunningham, 2003), chronic underfunding and under-resourcing, which have been shown to increase the risks of suffering distressing impacts (Ryan, 2019).

Negative impacts can include vicarious trauma (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995), compassion fatigue (Figley, 1995), burnout (Maslach, 1993), or post-traumatic stress disorder ([PTSD]; e.g., Baird & Jenkins, 2003; Choi, 2011). These can result in disruptive behaviour, emotional, and mental health concerns, including anxiety, depression, sleeplessness, avoidance of social interactions, or hypervigilance (e.g., Rostron & Furlonger, 2017).

An American study that examined vicarious trauma (VT) in trauma social workers found that those with a larger caseload had an increased risk of developing VT (Cunningham, 2003). The effect was exacerbated in the group with a larger proportion of sexual abuse clients (Cunningham, 2003). Literature is inconsistent where a study with sexual assault and domestic violence counsellors, using the same measure of VT, found that a larger caseload reduces the risk of VT (Baird & Jenkins, 2003). Baird and Jenkins (2003) highlighted the length of tenure and the development of positive coping strategies as possible explanations for this.

Positive effects of working with victims-survivors of sexual violence are also common. Recent research with staff at St. Mary's Sexual Assault Referral Centre in Manchester, UK, found that positive emotions are often associated with the meaningfulness of the work and the team spirit between colleagues (Massey et al., 2019). These results are in line with previous work (e.g., Coleman et al., 2018) with various sexual violence professionals, who often benefit from their role. For example, they can experience vicarious and professional growth, compassion satisfaction, gain perspective on life and relationships, or increased confidence and assertiveness.

A study of the psychological distress, resilience, and coping strategies of members of the Faculty of Forensic and Legal Medicine found personal belief in a just world, coping strategies and resilience were useful predictors of psychological distress (measured using the Personal Belief in a Just World Scale, the Connor-Davidson Resilience Scale 25, the Brief Symptom Inventory, and the COPE) (Horvath & Massey, 2018).

A recent review of the literature on vicarious trauma amongst sexual violence professionals (Crivatu et al., in press) found that distressing impacts can be minimised, with positive effects increasing through training, supervision and support from the organisation. Using healthy and adaptive coping mechanisms whilst at work and in private life was also beneficial to overall wellbeing. A qualitative study of frontline staff at a charity-run domestic and sexual violence support service (Splitz Support Service) found that staff emphasized, in their positive experiences of the work, the importance of the nature of their clinical supervision, a positive relationship with their manager, effective caseload management that they were involved in, peer support and specialist training (Dalton, 2019).

In the policy context, recent guidance has indicated a commitment to prioritising staff welfare. Though there still may be a long way to go, Home Office (2017) guidance acknowledges that ISVAs work in emotionally complex and challenging environments and that

remaining aware of staff welfare is central to providing a professional service. It is generally accepted across services that ISVAs should have access to external clinical supervision that is distinct from management supervision. The Home Office's (2017) guidance states:

> *'It is recommended that ISVAs are provided with access to separate clinical and management supervision. Clinical supervision should be used to assess the ISVA's caseload and provide advice and guidance on specific or complex cases. Clinical supervision can help to reduce the risk of serious oversight by an individual in terms of their own personal competencies, and/or health and wellbeing needs.' (p.21)*

This is useful, but, with no overarching regulatory body, there is nothing to ensure all ISVAs receive consistent and effective supervision. However, this was incorporated into LimeCulture's (2018) *Quality Standards for ISVA Services*, which states that it must be ensured that all full-time ISVAs have access to regular clinical supervision of no less than 1.5 hours, every 4-6 weeks

Some work is beginning to consider the welfare needs of ISVAs providing an essential service. Yet, there is a gap in the literature regarding the impacts of the work on ISVAs' lives and what protects against such impacts. It is necessary to understand both how ISVAs and ISVA Managers cope, and how to better support them in order to secure their physical and psychological wellbeing and to improve the quality and consistency of the services they provide to victims and survivors of sexual violence across England, Wales and Northern Ireland.

2.3 Research Aims

The purpose of this research is to expand on the limited previous evidence regarding ISVAs in England, Wales and Northern Ireland. The specific research objectives are to identify:

- The scope and range of the ISVA role, including caseload, the risk profile of clients, longevity in role, training, support and supervision

- ISVAs coping strategies, resilience, personal trauma history, personal belief in a just world vicarious trauma, mental health (anxiety, depression, sleep problems), hopelessness and vicarious resilience

- The research also sought to identify which factors (e.g., caseload, the risk profile of clients, longevity in role, training, support, supervision, coping strategies, resilience, personal trauma history, personal belief in a just world) predict the likelihood of experiencing negative (e.g., vicarious trauma, mental health [anxiety, depression, sleep problems], hopelessness) and positive (e.g., vicarious resilience) impacts for ISVAs and ISVA Managers of working with victim-survivors of sexual violence

- This research will not provide more detailed insights into ISVAs' and ISVA Managers' perceptions of their experiences, strategies for coping and their ideas for what their

organisations can do to support them. Everyone who completed the survey was invited to take part in follow up interviews where these issues were addressed; 35 ISVAs and ISVA Managers were interviewed and the findings will be presented in a forthcoming report (Massey et al., 2021, manuscript in preparation)

3. Method

This study employed a quantitative methods design. An online survey was used as it provides access to a breadth of perspectives across a range of descriptive, behavioural and attitudinal questions.

3.1 Participants

All ISVAs and ISVA Managers in England, Wales and Northern Ireland were eligible to complete the online survey. Advertisements for the survey were posted on social media (Facebook, Twitter and LinkedIn). LimeCulture also placed the advertisement on their website and a Facebook group for ISVAs that they host[3].

One-hundred and ninety-one participants followed the link to the survey, having read a participant information sheet. Most respondents (*n* = 155; 80.6%) agreed to progress and 125 (64.5%) provided informed consent. Four respondents, having provided consent, submitted no further responses. These cases have been removed, leaving a sample of 121, all of whom had completed more than 50% of the survey. The characteristics of the participants (e.g., age, gender, ethnicity, role, and region) can be found in section 4.

3.2 Survey

The online survey was hosted via Qualtrics and was open from 5th March to 30th April 2020. Consent was recorded electronically for all respondents prior to completion of the online survey, and a debriefing sheet was provided at the end of the survey. All participants who completed the survey were invited to take part in follow-up telephone interviews and provided their email addresses (which were stored separately from their survey responses) if they were interested.[4]

The survey comprised of three sections[5]:

[3] There are currently 510 members of the Facebook group.
[4] The findings of the interviews are not included in this report and will be published in due course Massey et al. (2021, manuscript in preparation).
[5] The full survey is available upon request from the authors.

Demographic information

Age, gender, ethnicity, role (ISVA or ISVA Manager), the highest level of qualification, geographical area they work in, length of time in the role, length of time working in the sexual violence field.

Details of their role

Type of organisation they are based in (NHS/Police/Charity etc.), if they worked alone or as part of a team, hours worked per week, type of contract (permanent, fixed-term etc.), caseload, the risk level of clients, how risk level is established, how clients are allocated, specialist training for the role, helpfulness of training, access to supervision, form supervision takes (internal/external, individual/group), frequency of supervision, helpfulness of supervision, other forms of support provided by the employer, support outside of work.

Established questionnaires to measure aspects of the impacts of working as an ISVA, specifically

Personal Belief in a Just World (PBJW; Dalbert, 1999) – Previous research by the authors established that PBJW was the strongest predictor of psychological distress experienced by members of the Faculty of Forensic and Legal Medicine (Horvath & Massey, 2018). The PBJW scale is well established and often-used measure of people's beliefs about the world and the events in it.

The Brief COPE (Carver, 1997) – Coping strategies have been established as a protective factor against developing mental and emotional difficulties in the face of adversity (Bourke & Craun, 2014). The brief cope is not onerous to fill out yet maintains a high level of validity.

Vicarious Trauma Scale (Vrklevski & Franklin, 2008) – This scale was included as the crux of this research is to establish if ISVAs are traumatised by the work they do. This measure differentiates between personal trauma and workplace trauma/trauma from being around people who have been traumatised.

Clinical Outcomes in Routine Evaluation 10 (CORE-10; Beck et al., 2006) – The CORE-10 is a short version of the CORE. It was deemed important to measure distress that fell short of trauma and the CORE is a well-established measure often used in Clinical Psychology. As it was acknowledged that this questionnaire was lengthy and our participants would be filling out this questionnaire for no personal gain, the short version was used to reduce the onerousness of participating.

Breslau 7-Item Scale for Post-Traumatic Stress Disorder (Breslau et al., 1999) – The Breslau 7 Scale is a 7-item, self-reporting scale which screens for post-traumatic stress disorder (PTSD).

Vicarious Resilience Scale (VRS; Killian et al., 2017) – This new scale measures the resilience that comes from working with people who have survived extreme trauma. As this study

investigated the harms that can come from working with traumatised people, it was included to measure the positives that can also come from working with this population.

Conor Davidson Resilience Scale (CD-RISC; Vaishnavi et al., 2007) – This scale measures a person's resilience and natural ability to 'bounce back' from difficult, traumatic or distressing experiences. This scale reports being different from the VRS as it measures a person's resilience regardless of the work they do or the experiences they have.

3.3 Ethics

The study received ethical approval from the Middlesex University Department of Psychology Ethics Committee[6] and the Faculty Ethics Panel of the School of Psychology, Politics, and Sociology at Canterbury Christ Church University[7]. The issue of confidentiality and anonymity is important for ISVAs; it was important to assure participants that it would not be possible to identify them from the data we present in final reports. The survey was anonymous, however, given that certain areas have very few ISVAs – necessary identifying information (to individuals or organisations) was not used.

3.4 Analysis

Statistical Product and Service Solution (SPSS) was used to conduct the data cleaning, coding and quantitative analyses of ISVAs'/ISVA Managers' responses. In addition to descriptive statistics, inferential analyses were used to explore the distributions of categorical variables (e.g., access to supervision and support services, access to role-specific training) and whether it was the same across individual factors (e.g., ISVA and ISVA Manager, length in the current role). Comparative analyses were also conducted to explore how respondents' views and experiences varied according to their demographic characteristics (age, gender, location, ethnicity, whether they are an ISVA or ISVA Manager, their highest level of qualification, geographical area they work in, length of time in the role and the length of time in the sexual violence field), types of supervision received, forms of support provided (both internal and external) and specialist training received for their position. The main outcome variables which served as the focus of the comparative analyses were:

- Amount of trauma and stress found in ISVAs and ISVA Managers
- The support provided by the organisation
- The length in the current role and working within the sexual violence field
- Levels of stress and depression
- Amount of resilience in ISVAs and ISVA Managers

[6] Application number: 12495
[7] Application number: 19-SAS-16E

3.5 Limitations

Limitations do not negate the contribution of this research or the important and unique information it gives us about the effect on ISVAs of the work they do. The limitations of this study provide an important context for the research findings. This study includes 121 ISVAs and ISVA Managers from an estimated 500-650 (LimeCulture, 2021). At best, 24% of ISVAs completed the survey and there is a possibility that there could be distinct differences between the ISVAs who chose to participate in our study and those who did not.

Similarly, while we aimed for and achieved diversity within the sample, few studies can ever truly achieve real randomness or representativeness of the wider group. This was a self-selecting group; the ISVAs who chose to take their time to fill out this lengthy survey did so for a reason which demonstrates some unknown motivation. This could mean our results do not represent the wider community of ISVAs.

Furthermore, while the research elicited a wealth of data that makes a ground-breaking contribution to the research evidence base on this topic, there are some areas in which it raised questions or challenges that are yet to be explained. This is to be expected when researching a previously unstudied area in an under-researched field. However, these important topics must be taken forward in future research if we are to achieve a more thorough understanding of the impacts of working with victim-survivors of sexual violence.

A further limitation of this research is the sample size, which rendered its statistical power limited – particularly for sub-groups (e.g., only 9 male participants were present). The participants in this study are largely a homogenous group with majority identifying as white, British, English speaking, females. This made further analysis by gender, ethnicity, or nationality impossible.

There were some limitations related to the survey which included having to restrict the number of questions asked in order to be mindful of the time it would take participants to complete the survey. Participants who took part in this study were employed in very demanding jobs and were not in any way incentivised to complete the survey. As such, it was deemed important that the survey was as concise as possible. As a result of this, short versions of existing scales were used whenever possible. Despite having restricted the length of the survey, many participants did not complete all questions. It is not possible to know whether this was due to the length of the survey, not wanting to answer certain questions or because they were distracted or called away. However, this resulted in an incomplete data set for some variables.

Some of the findings in this study were unexpected and as yet not fully explained, such as the relatively low levels of trauma. This may be explained in part by the phenomenon found in other studies such as policing, where there is a cultural emphasis on ‘coping with anything’ (Foley & Massey, 2020). This may have led to participants in this study downplaying any distress they experience. It must also be acknowledged that data collection happened in the two weeks leading up to and the first 5 weeks of the first national lockdown in the United Kingdom in 2020. During that time, much of the country and the majority of the participants

in the study shifted from working in person to home working which may have impacted responses, their working day and their feelings about their work. The worldwide pandemic may have also affected the levels of emotional distress they were experiencing as measured by the CORE 10.

4. Participant Demographics

The ISVAs and ISVA Managers who completed this study consisted of 112 females (92.6%) and 9 males (7.4%). Participants ages ranged from 23 to 63 years old; 23-33 (*n* = 47; 38.8%), 34-43 (*n* = 20; 16.5%), 44-53 (*n* = 28; 23.1%) and 54-63 (*n* = 26; 21.5%).

The majority of participants were White British (*n* = 104; 86%), with the remaining identifying as Black British (*n* = 3; 2.5%), Other Black Background (*n* = 1; .8%), Asian British (*n* = 5; 4.1%), Other White Background (*n* = 3; 2.5%), Mixed/Multiple Background (*n* = 4; 3.3%) and Other Ethnic Background (*n* = 1; .8%).

The majority of ISVAs and ISVA Managers stated that English (*n* = 117; 96.7%) was their first language, with the remaining listing: Italian, Portuguese, Punjabi and Spanish as their first languages.

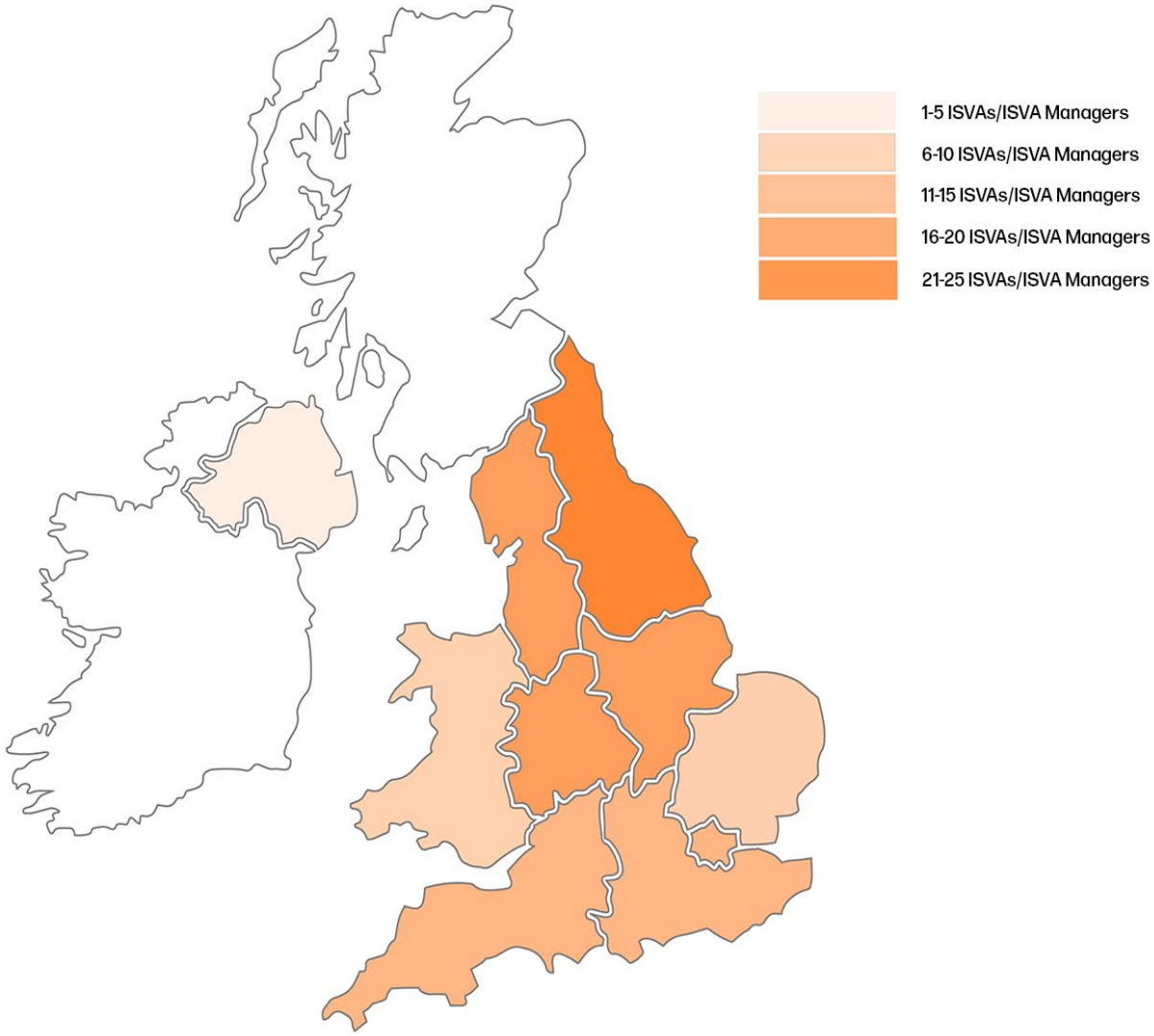
Nearly fifteen percent (14.9%) of the ISVAs and ISVA Managers were fluent in a second language which included (from most to least common):

- Spanish
- English and French
- German, Welsh, Punjabi, Hindi
- Dutch, Mandarin, Italian and Malayalam

In terms of the highest educational qualification obtained, 40.5% (*n*=49) of the participants had a university degree or professional qualification. The next most common educational qualifications were postgraduate degrees (*n* = 29; 24%), diplomas (*n* = 19; 15.7%), A-Levels or Vocational/College qualifications (including BTECs and NVQs) (*n* = 15; 12.4%) and GCSEs or O-Levels (*n* = 8; 6.6%). One participant had no educational qualifications (*n* = 1; 0.8%).

Figure 1 shows that ISVAs and ISVA Managers who took part in the survey worked in all 9 regions of England, Wales and Northern Ireland and were fairly evenly distributed between them.

Figure 1: Distribution of ISVAs/ISVA Managers Across Regions of England, Wales and Northern Ireland



The demographics of the ISVAs and ISVA Managers who took part in this survey are consistent with the audit conducted by Lea and colleagues (2015), although our participants were more evenly distributed across the age groups (half of the ISVAs in Lea et al.'s study were aged between 40-51 years).

5. Descriptive Statistics

5.1 Role, Experience, Service and Employer

Just over half of respondents were non-specialised ISVAs (*n* = 70; 55.6%), with the next most common roles being Children's ISVAs (*n* = 23; 19%) and ISVA Managers (*n* = 22; 17.5%). Only a handful of participants were Independent Sexual and Domestic Violence Advisers (ISDVA) (*n* = 3; 2.4%) and Specialist ISVAs (*n* = 9; 4%)[8]. ISVA Managers reported that they managed between 1-13 ISVAs in their current role, with the average being 5.

The average amount of time spent in their current role was two years and nine months (35 months), with a minimum of 3 months and a maximum of 13 years and two months (*M* = 34.82; *SD* = 29.46). The average amount of time spent in a sexual violence professional role was 8 years (96 months), with a minimum of 3.5 months and a maximum of 32 years (*M* = 96.17; *SD* = 78.51).

Just under three quarters (71.1%) of respondents were employed by charity or non-profit organisations, with the rest employed by the NHS (9.1%), police (5.8%), local authority (1.7%), private company (1.7%), or other (3.3%).

Participants were asked what type of contract they had out of the four options:

- Permanent (*n* = 86; 71.1%)
- Fixed term (*n* = 21; 17.4%)
- Temporary (*n* = 3; 2.5%)
- Other (*n* = 2; 1.7%)

Those that chose the 'other' option stated that they were on maternity cover and on a rolling fixed term contract every 12 months.

In contrast to Lea et al. (2015), where 43% of the ISVAs reported working alone, most respondents in the present survey worked within a team (*n* = 105; 96.3%). Those who had reported that they worked in a team were then asked how many people there were in their ISVA service. The most common size was 3-5 people (*n* = 41; 41.8%), 6-8 people (*n* = 19; 19.4%), 9-11 people (*n* = 16; 16.3%), 1-2 people (*n* = 10; 10.2%), 12-14 people (*n* = 9; 9.2%) and 15-23 people (*n* = 3; 3%).

[8] Respondents who disclosed their specialism stated that they were ISVAs working with clients who had complex needs/multiple disadvantages, learning disabilities, sex workers and historical institutional abuse.

5.2 Case Allocation and Case Loads

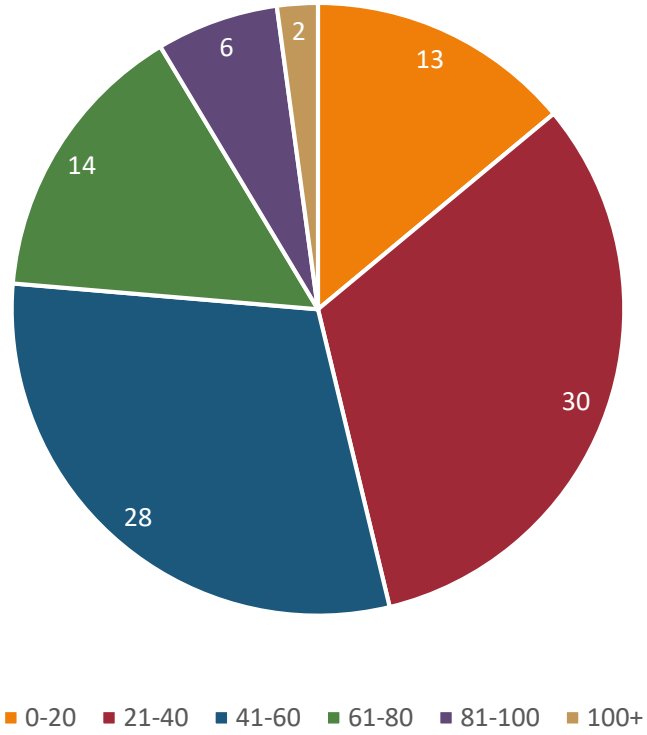
5.2.1 Case allocation

Case allocation for ISVAs differed greatly; we asked them to report every method used by providing multiple choices. Most commonly, ISVAs were allocated cases based on their clients' location (*n* = 45; 31.72%) and their specialism (*n* = 30; 20.7%). However, respondents also reported that cases were allocated to them based on availability (*n* = 29; 20%), randomly (*n* = 18; 12.4%), other (*n* = 12; 10%)[9], by choosing who takes each case (*n* = 9; 6.2%), in a rotation (*n* = 8; 5.5%) and by seniority (*n* = 5; 3.5%). ISVA Managers told us that case allocation was based on clients' location (*n* = 4; 40%), by area of specialism (*n* = 3; 30%), choosing which cases they take on (*n* = 2; 20%) and in a rotation (*n* = 1; 10%).

5.2.2 Caseloads

All ISVAs had a caseload, whereas only 34.8% (*n* = 8) of ISVA Managers had caseloads. Ninety-three participants told us what their current caseload was (we asked for estimations if they did not know exactly). Current caseloads ranged from 10 to 170 (see Figure 2). The mean caseload was 48.29 (*SD* = 27.01). The most common caseloads were in line with Lea et al. (2015), however, there were more ISVAs with higher caseloads in the current survey.

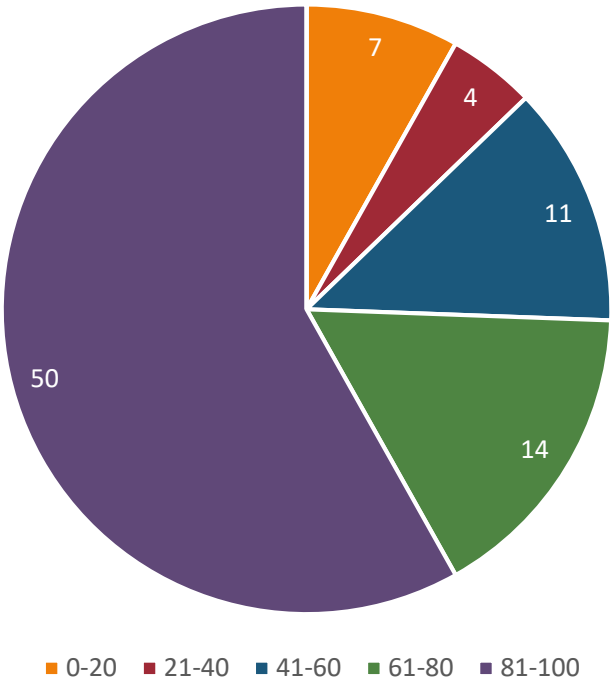
Figure 2: Current Caseloads



[9] 'Other' reasons included by client request, gender and being the only ISVA in the service.

Eighty-six ISVAs also estimated what percentage of their current caseload classed as 'active' – meaning that they provide support for those clients at least once every six weeks. The mean was 76.9% (*SD* = 27.06) of caseloads were classed as 'active'. Because of the wide variation in caseloads and estimates of active caseloads, we created categories. Figure 3 shows that just under two-thirds considered 81-100% of their caseloads 'active'. This is, again, consistent with the previous audit of ISVAs (Lea et al., 2015).

Figure 3: Percentage of Current Caseload Considered 'Active

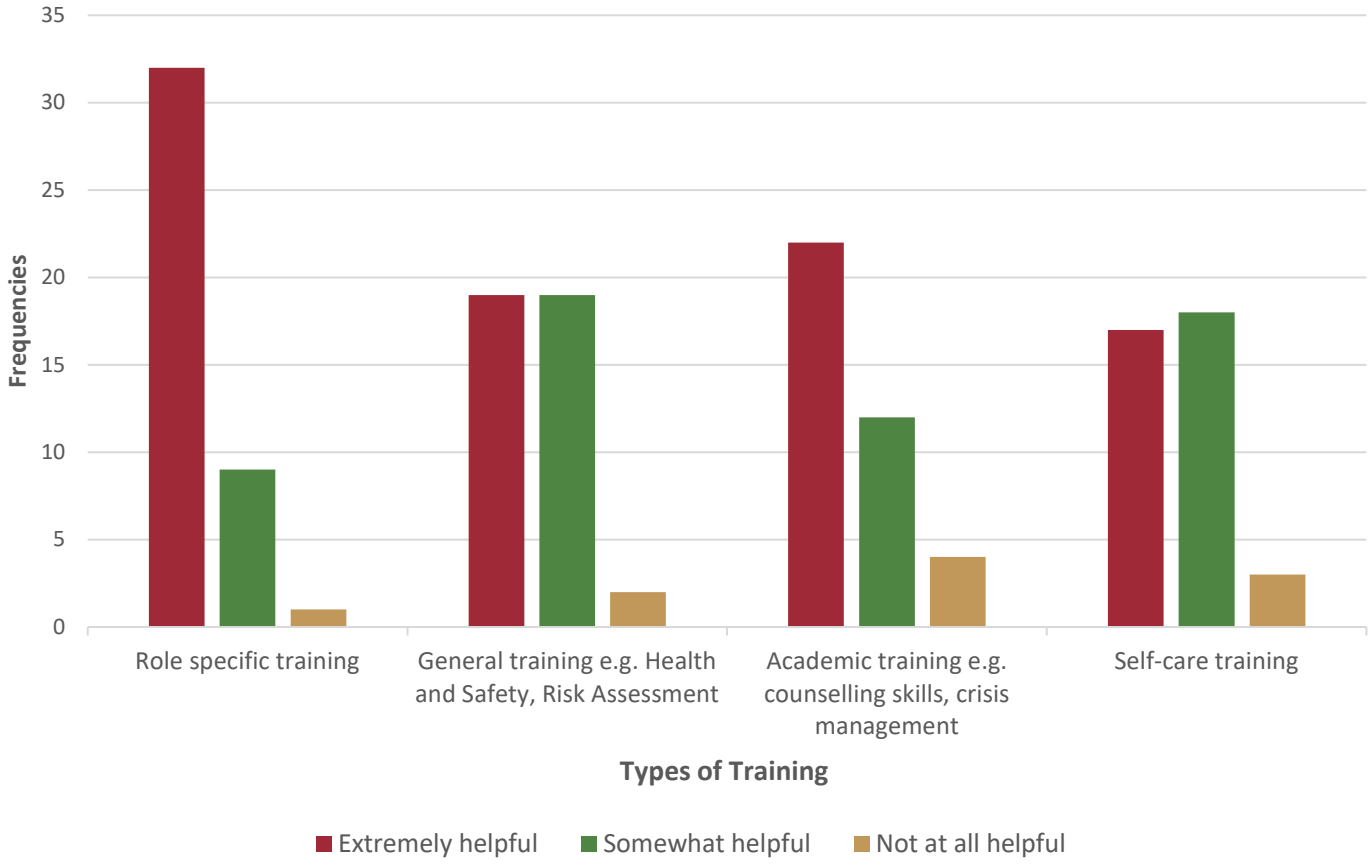


5.3 Training, Supervision and Support

5.3.1 Training (ISVA role specific, helpfulness and compulsory)

Forty-six participants (42.6%) reported that they had received specialist training before starting their current role and 62 participants (57.4%) had not. Respondents rated how helpful they found each training. Figure 4 shows that all kinds of training were considered helpful; no statistically significant differences were found between how helpful the different types of training were considered to be.

Figure 4: How Helpful ISVAs and ISVA Managers Found Different Types of Training They Undertook Before Starting Their Roles



Respondents elaborated on other training which would have been found helpful, if provided by organisations before starting their current role. Their responses were categorised into the following:

- Trauma-related training
- ISVA training/role-related training
- SAS training; crisis mental health training
- Mental health first aid
- BME specific training
- Professional boundaries and children trauma-related training

It was also mentioned that it would have been beneficial to begin formal training sooner in their role.

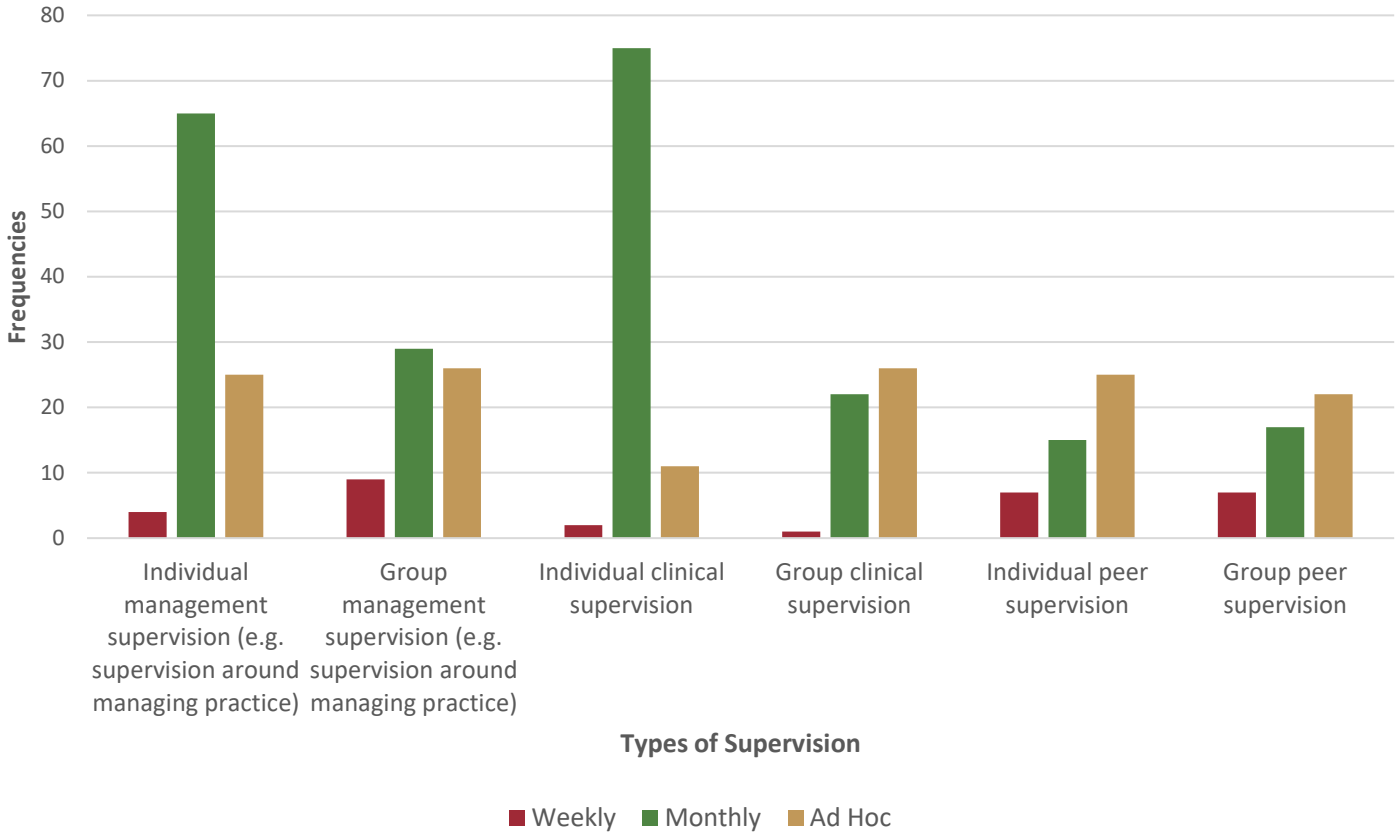
Training received before starting their current ISVA or ISVA Manager role was either compulsory (*n* = 14; 11.6%), optional (*n* = 3; 2.5%) or a mixture of both compulsory and

optional (*n* = 26; 21.5%). Thirty-six respondents (29.8%) were currently engaged in training, sixty-eight (56.2%) respondents were not. The training that respondents were currently engaged in was: LimeCulture (*n* = 8; 26.7%), Train the Trainer (*n* = 2; 6.7%), ISVA training (*n* = 5; 16.7%), on-going independent or in-house training (*n* = 4; 13.3%), SafeLives (*n* = 1; 3.3%) and online training (*n* = 1; 3.3%).

5.3.2 Supervision

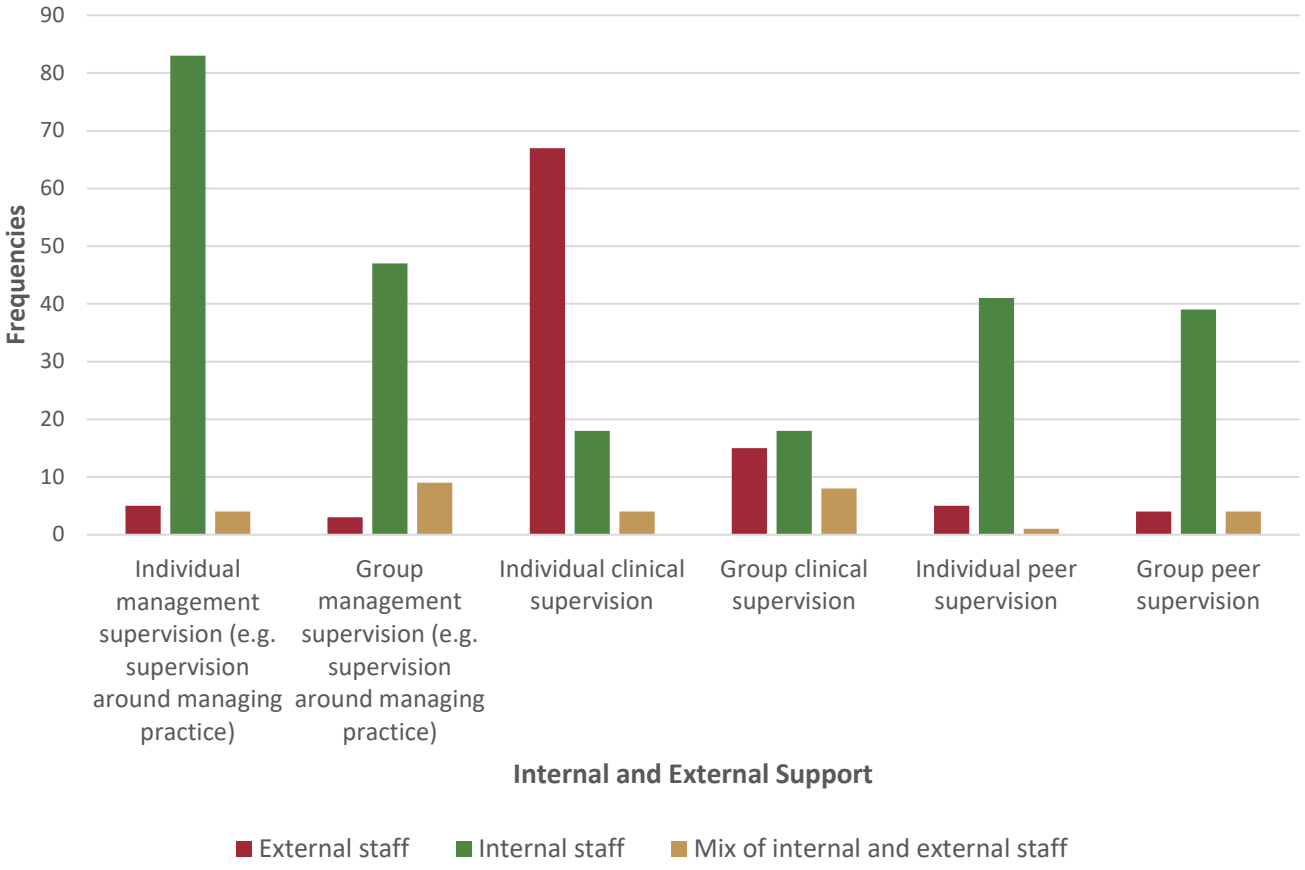
One-hundred and two respondents (96.2%) received supervision as part of their role and four respondents did not receive supervision (3.8%). The type and frequency of supervision are shown in Figure 5. Monthly individual clinical and management supervision were the most common.

Figure 5: Supervision Frequency



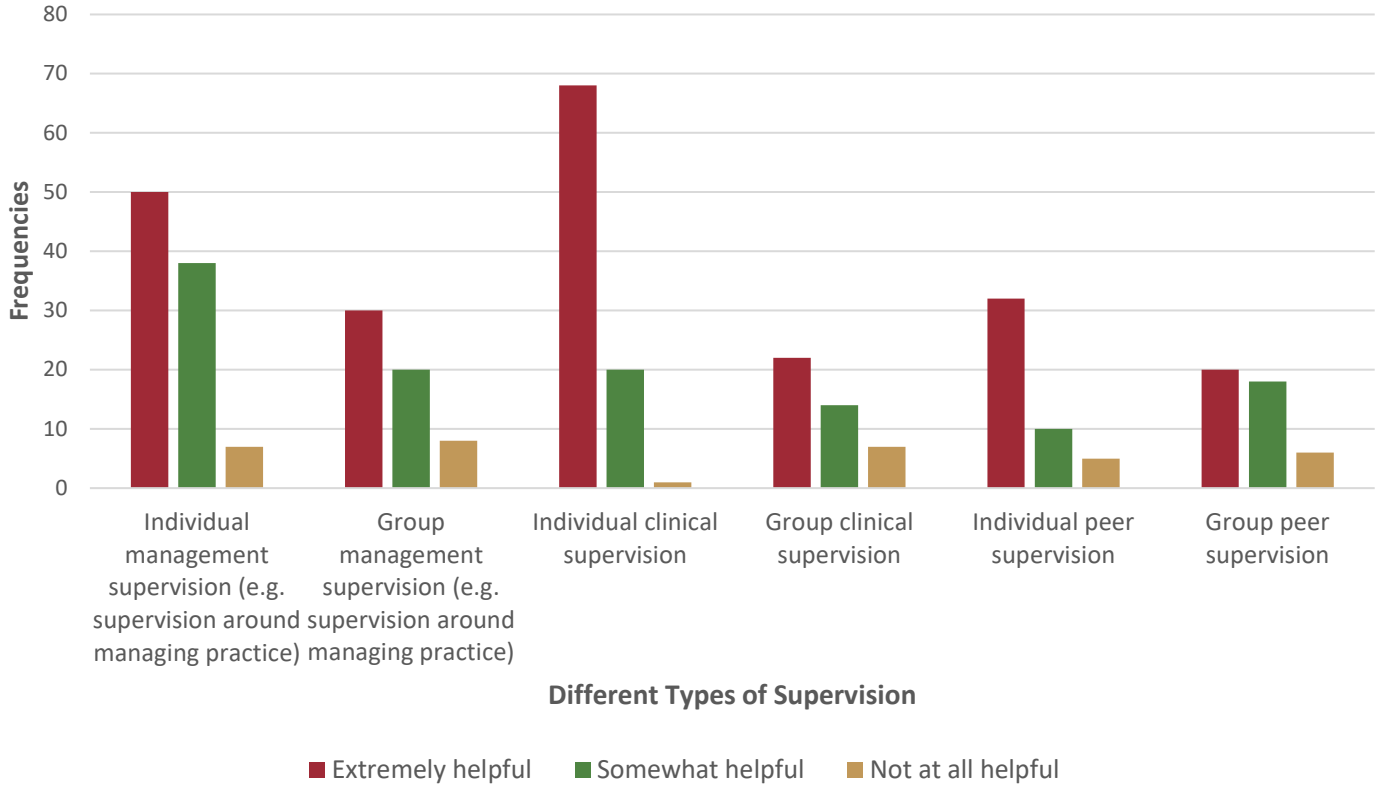
Respondents were asked whether the provided supervision was internal or external to their organisation. Figure 6 shows that, as expected, the majority of management supervision is provided internally. Clinical supervision, most commonly, comes from an external provider – this approach is considered to be best practice by many researchers (e.g., Koper, 2009; Tromski-Klingshirn & Davis, 2007) and is recommended by professional bodies such as the British Association for Counselling and Psychotherapy (https://www.bacp.co.uk/).

Figure 6: Internal or External Staff Providing Support



Respondents rated how helpful they found each supervision type that they received. Figure 7 shows that all forms of supervision were generally considered helpful, but individual clinical supervision stands out as being most highly rated and group supervision being deemed the least helpful.

Figure 7: How Helpful ISVAs Found Different Types of Supervision



5.3.3 Support available from employers

ISVAs and ISVA Managers were asked to indicate whether their employer offered other support services (not supervision); 61 (58.7%) reported that they did, 26 (25%) reported that they did not, 17 (16.3%) were not sure and 22 participants did not answer the question. From the other forms of support listed, respondents indicated that they were offered:

- Impromptu support sessions or open-door policies for talks after difficult sessions (*n* = 41; 31.1%)
- Employee assistance programmes (*n* = 29; 22%)
- Staff wellbeing events (*n* = 26; 19.7%)
- Staff away days (*n* = 23; 17.4%)
- Discussion groups (*n* = 13; 9.8%)

Fourteen 'other' responses were provided and were further coded into peer group (*n* = 3), counselling (*n* = 2), helplines such as trauma-specific helplines or NHS run helplines (*n* = 2), debriefing (*n* = 2) and occupational health (*n* = 1).

ISVAs and ISVA Managers reported that they received support external to work from the following sources:

- Family (*n* = 83; 21.5%)
- Friends (*n* = 75; 19.4%)
- Exercise (*n* = 62; 16.1%
- Hobbies (*n* = 56; 14.2%)
- Socialising (*n* = 54; 13.7%)
- Pets (*n* = 52; 13.5%)
- Counselling (*n* = 7; 1.8%)
- Religious/spiritual affiliations (*n* = 6; 1.6%)[10]

6. Scales

Table 1 shows the mean scores, standard deviations, ranges and alphas for the scales. All scales, apart from the CORE-10, meet the generally acceptable alpha level for use (0.7; Taber, 2018). The Core-10 is 0.68 and just below the acceptable alpha level; in light of this, we used the scale for analysis but approach the interpretation of findings with caution. Further details about the properties of the scales including distribution, skewness and kurtosis can be found in the Appendix from 10.1 to 10.7.

[10] Participants were allowed to pick more than one of the options given which is why the total is more than the participant pool.

Table 1

Mean Scores, Standard Deviations, Ranges and Alphas for the Scales and their Sub-scales

Measure	*n*	Mean (SD)	Possible Range	Observed Range	α
Breslau 7 (PTSD) (7 items)	97	2.05 (2.21)	0-7	0-7	.83
Vicarious Trauma Scale (8 items)	89	37.10 (8.08)	8-56	19-53	.79
Clinical Outcomes in Routine Evaluation (10 items)	91	23.06 (5.01)	0-40	0-28	.68
Problems (6 items)		5.70 (4.28)	0-24	0-18	
Functioning (3 items)		7.30 (1.85)	0-12	0-12	
Risk (1 item)		.07 (.36)	0-4	0-3	
Personal Belief in a Just World (7 items)	95	21.58 (5.16)	7-42	14-35	.77
COPE Inventory (42 items)	87	84.35 (17.01)	42-168	42-119	.90
Original Scale (27 items)		57.14 (12.26)	27-108	27-84	
Additional Items (15 items)		27.33 (6.07)	15-60	15-42	
Positive Coping (26 items)		59.74 (12.40)	26-104	26-84	
Negative Coping (16 items)		24.70 (7.18)	16-64	16-47	
Vicarious Resilience Scale (27 items)	82	78.45 (21.08)	0-135	14-130	.94
Connor-Davidson Resilience Scale (25 items)	95	73.35 (11.39)	0-100	41-96	.90

**Not all participants answered every question so n's are provided for each scale and sub-scale*

6.1 PTSD, Psychological Distress and Vicarious Trauma

The scores on the scales reported in Table 1 show that the ISVAs and ISVA Managers who completed our survey were not generally experiencing PTSD (a score of 4 or more indicates PTSD on the Breslau 7). This contrasts with recently conducted studies of police officers, who show levels of PTSD many times higher than the general population (Foley et al., personal communication, 18th February, 2019). Scores on the CORE10 (our measure of psychological distress) are generally in the clinical range (a cut-off of 10/11 is recommended where ten is in the non-clinical range), suggesting that the majority of ISVAs were experiencing some

psychological distress. The mean scores on the VTS are in line with previous studies with professionals who are exposed to trauma – for example, lawyers and mental health professionals (Maguire & Byrne, 2017), correctional staff and forensic mental health staff (Newman et al., 2019). Aparicio and colleagues (2013) have suggested total scores can be grouped into three categories to represent low (8-28), moderate (29-42) and high (43-56) levels of vicarious trauma symptoms. Most ISVAs had moderate or high vicarious trauma (*n*=57, 64% and *n*=19, 21.3%, respectively) which is, again, in line with previous studies with similar groups of professionals (Aparicio et al., 2013; Maguire & Byrne, 2017; Newman et al., 2019).

6.2 PBJW, Resilience and Coping Mechanisms

Personal Belief in a Just World was moderate, with a slight positive skew towards a strong belief in a just world. This is expected in a group of people who have chosen to do a stressful job and who show minimal signs of psychological distress. Previous research has found that belief in a just world is a good predictor of psychological wellbeing (Be'gue & Bastounis, 2003; Dalbert, 1999; Lipkus et al., 1996; Sutton & Douglas, 2005), and has been shown to act as a buffer against negative events and may foster good mental health (Dalbert, 2001, 2002; Jiang et al., 2015; Otto et al., 2006).

For both resilience scales, higher scores indicate greater resilience. The mean resilience scores on the CD-RISC, for the participants in this study are lower than the expected scores in general population samples; for example, the US general population score, on average, 80.7 (Connor & Davidson, 2003). However, these scores are in line with the limited number of previous studies on other professionals who work with trauma (Lee et al., 2014; Sen et al., 2010; Stevens et al., 2010). Also, the distribution of scores was skewed toward the participants being resilient – with two-thirds of participants scoring 70 or more and only two participants scoring less than 50 (the mid-point on the scale). The scale we used to measure vicarious resilience (VRS) was only recently developed (Killian et al., 2017) and, as a result, has not been used in many other studies. Reynolds (2020) sampled a wide range of professionals who work with clients who have experienced trauma in the USA and found a mean score on the VRS of 95.5. The score in the present study was nearly 17 scale points lower. The inclusion criteria for participation in the Reynolds study were that practitioners:

1. Had worked with clients individually in case management, counselling, or psychotherapeutic context for at least 45 minutes per week.
2. Identify clients as dealing with issues related to trauma within the working relationship.

The contact with clients that the Reynolds (2020) participants had was far greater than the ISVAs in the present study, which may explain the higher vicarious resilience scores in that sample.

The most reported coping mechanisms being used were positive. The five most frequently used were acceptance, spending time with family and friends, self-distraction, positive

reframing and emotional support. The most common negative coping mechanisms ISVAs reported using were self-blame and substance use, however, it is noted that even these were rarely used.

Table 2 shows the correlations between the scales. The first thing to note in Table 2 is that all the significant correlations are weak, except for the positive association between the overall and sub-scales of the COPE (which are predictably strong[11]). There are two moderate positive correlations between the overall COPE scale and the CORE10 and the COPE (Neg.) subscale and CORE10.

This suggests that participants use more coping mechanisms and more negative coping mechanisms when they experience more psychological distress.

Table 2

Kendall's Tau-b Correlation Coefficient Analysis of All Scales

Scales	BS7	CD-RISC	VRS	VTS	PBJWS	CORE10	COPE	COPE (Pos.)	Cope (Neg.)
BS7	1.00	--							
CD-RISC	.24**	1.00	--						
VRS	.16	.27**	1.00	--					
VTS	-.10	-.30**	.25**	1.00	--				
PBJWS	.04	.00	.12	.02	1.00	--			
CORE10	-.20*	-.14	-.07	.29**	.12	1.00	--		
COPE	-.11	-.16*	-.04	.28**	.14	.49**	1.00	--	
COPE (Pos.)	-.03	-.06	.02	.24**	.09	.33**	.76**	1.00	--
Cope (Neg.)	-.18*	-.26**	-.17*	.29**	.12	.50**	.63**	.37**	1.00

*Correlation is significant at the .01 level (2-tailed)

**Correlation is significant at the .05 level (2-tailed)

Coping mechanisms are similar, albeit weakly, positively correlated with vicarious trauma – meaning more coping mechanisms are used when participants are more traumatised. There are weak significant negative correlations in Table 2.

[11] As the COPE is a measure of coping mechanisms, it would be expected to correlate within itself: the use of 1 coping mechanism would be likely to predict the use of other coping mechanisms. This would be expected if an individual was feeling they need some help to manage their emotions or stress.

Which suggests that the more negative coping mechanisms participants used, the less resilient they were and that the more vicarious trauma participants had experienced, the less vicarious resilience they had.

This shows that people who have less internal resilience use coping mechanisms (and sometimes negative coping mechanisms); added to this, the less resilient they are the more likely they are to show signs of trauma.

6.3 Similarities Between the Two Resilience Scales

Due to the similarities in the Vicarious Resilience Scale (VRS) and Conor Davidson Resilience Scale (CD-RISC), we standardised the scales using a formula (see Appendix 10.8). By standardising the scales, participants' scores were between 0 to 1.0. Additionally, we removed responses from participants who did not complete both scales so that the total responses were the same (n = 80). Findings showed that after standardising the scales, both the VRS and CD-RISC had almost identical means, standard deviations, skewness and kurtosis, which indicates that they are measuring the same thing. As a result, we only used the CD-RISC in all subsequent analysis.

6.4 Predicting Psychological Distress and Vicarious Trauma

In order to understand if ISVAs' characteristics (e.g., how long they had been ISVAs, their resilience) would predict their experiences of psychological distress and vicarious trauma, we conducted statistical tests called regressions. First, a stepwise logistic regression was carried out to see if ISVA role length, SV role length, age, PBJWS, current caseload, COPE (positive), COPE (negative) and CD-RISC scores would predict psychological distress (as measured by CORE-10 scores). Using the backwards elimination method[12], it was found that model 6 predicted 51% of the variance in CORE-10 scores, $F(3, 61) = 22.85$, $p < .001$, $R^2 = .53$, $R^2_{Adjusted} = .51$. Table 3 shows the current caseload, positive and negative coping mechanisms predicted CORE-10 scores. This tells us that:

ISVAs with higher caseloads who are using more coping mechanisms (both positive and negative) are reporting more psychological distress (measured by the CORE-10).

This suggests the higher caseloads are causing ISVAs to use more coping mechanisms in order to be able to manage the high caseloads, but they are still experiencing more psychological distress than ISVAs with lower caseloads (who are using fewer coping mechanisms). This shows us that coping mechanisms help, but having a high caseload causes distress. The other variables that were entered into the regression (e.g., ISVA role length, SV role length, age, PBJW and CD-RISC) did not affect the psychological distress ISVAs experienced.

[12] Using this method all of the predictor variables (e.g., ISVA role length) are entered into the model and are then deleted one at a time if they do not contribute to the outcome variable (e.g., CORE-10 scores).

Table 3

The Effect of Current Caseload, Cope (Positive) and Cope (Negative) on the Total Score of CORE-10 Using Multiple Linear Regression with Backward Elimination Selection Procedure

Variable	B	95% CI	Beta
Current Caseload	.11	-.25, .47	.05
Cope (Positive)	.09	.01, .17	.21
Cope (Negative)	.37	.24, .50	.59

Another stepwise logistic regression was carried out to see if ISVA role length, SV role length, age, PBJWS, COPE (positive), COPE (negative) and CD-RISC scores predicted the vicarious trauma (measured by VTS scores) ISVAs experienced. Using the backwards elimination method, it was found that model 4 predicted 34.4% of the variance in VTS scores, $F(5, 57) = 7.49$, $p < .001$, $R^2 = .40$, $R^2_{Adjusted} = .34$. Table 4 shows positive coping mechanisms, current role length, length of time in SV role, CD-RISC and PBJW predicted vicarious trauma. This tells us that:

the longer participants had been in their current role, the longer they had been working in an SV role and the more positive coping mechanisms they used, the more vicarious trauma they had experienced.

This shows a cumulative effect of trauma. ISVAs 'pick up' trauma over time both whilst working as ISVAs but also during other work in SV field. This accumulated trauma leads to them needing to use more coping mechanisms. In contrast, resilience (CD-RISC) and PBJW had a negative effect on vicarious trauma meaning:

the more resilient a person is and more belief in a just world ISVAs had, the less vicarious trauma they experienced.

This suggests that the longer people spend working with clients who have experienced sexual violence, the more likely they are to use positive coping mechanisms, but also to experience vicarious trauma. In addition, resilience and PBJW can protect against vicarious trauma; resilience enables the person to emotionally 'bounce back' from difficult situations and PBJW is an emotional protective factor from witnessing distressing things happening to others.

Table 4
The Effect of CD-RISC, PBJWS, Cope (Positive), Current Role Length and Role Length in SV on the Total Score of CORE-10 Using Multiple Linear Regression with Backward Elimination Selection Procedure

Variable	B	95% CI	Beta
CD-RISC	-.41	-.56, -.25	-.59
PBJWS	-.20	-.52, .12	-.14
Cope (Positive)	.20	.05, .35	.28
Current Role Length	.04	-.04, .12	.12
SV Role Length	.02	-.01, .04	.15

7. Conclusions

This report documents findings from a survey of 121 ISVAs and ISVA Managers conducted between 5th March 2020 and 30th April 2020. Given the scarcity of research into the work of ISVAs and ISVA Managers, this audit provides a deeper insight into the role and the challenges faced. As this is a comparatively new role and the role has had to evolve since its inception, little has been systematically researched on the impact of working as an ISVA or an ISVA Manager. The findings from this study have implications for both policy and practice. The present research provides an invaluable insight into the practices of ISVAs and ISVA Managers. However, more systematic research is needed to fully understand the impact of working with sexual violence victims. This survey provides a quantitative insight into the effects of working as an ISVA or ISVA Manager and what supports and helps individuals who work in this role.

8. Recommendations

Role-specific training – Notably, over half of the ISVAs/ISVA Managers in this study had no specialist training before starting their role. Although many ISVAs/ISVA Managers have had a lot of experience in other roles in the sexual violence field before becoming ISVAs – not all had. Even when they have previous experience, there is no guarantee that this experience

means they can fulfil the ISVA role. It is recommended that there is a requirement for a national standard for training in 1st year in the role. The training provided should be accredited, role-specific and high quality. In addition to the initial training, there should be a national standard for annual, role-specific continuing professional development. Time should be allotted to carry out this training and there should be monitoring to ensure it is meeting the needs of the ISVAs. This form of professionalisation would provide consistency across the country and ensure that all victim-survivors experience more parity in the service they receive.

Guidance about supervision – Supervision has been identified as an area of need in previous studies of ISVAs (e.g., LimeCulture, 2018). Best practice for supervision has been established as being from an external provider (Koper, 2009; Tromski-Klingshirn & Davis, 2007). This finding was replicated here, in that not all supervision was considered to be of equal helpfulness. There was a strong preference shown for external clinical supervision. However, there is also an important role for management supervision. Both external clinical supervision and management supervision are essential and offer ISVAs different things. A framework for management and clinical supervision needs to be developed for ISVA services, providing guidance about the function, frequency and form of the different types of supervision. Management supervision provides an invaluable opportunity to ensure that ISVAs are working within their capacity with regards to case load size, and Clinical Supervision provides a safe place for people working in an emotionally demanding job. Best practice guidance is available from the BACP; although this guidance pertains to counselling supervision, it will apply for ISVAs too in many ways (BACP Ethical Framework | Supervision resources). In addition to supervision experience, it would be important for supervisors to have professional experience working with victims of sexual violence. This client population displays unique challenges and considerations, and ISVAs would benefit from their supervisors' understanding of this particular population's needs. It is also important that dual relationships are avoided to ensure conflicts of interest do not occur. This means that the person who provides clinical supervision for an ISVA should not also be the person who provides counselling to the ISVA's clients and/or should not be a staff member at the same organisation.

In addition to supervision providing a safe place to express the feelings they have from the work they do, it is also important that this relationship is contracted appropriately and that there is a feedback element to it. This is not dissimilar to counselling supervision, where the supervisor has the responsibility to ensure that their supervisee is fit to practice. As part of safeguarding clients, this should also be built into the ISVA's supervision contract. This is not to be seen as punitive but as supportive – if an ISVA is experiencing burnout, the clinical supervisor is likely to be the first person to spot it and be able to sign post for support. This is beneficial to the ISVA as well as their clients.

At a time when services are increasingly being offered online, it would be possible for a national database of ISVA supervisors to be developed. It would also offer an opportunity for ISVAs to be able to find supervisors in their area that are not affiliated with their organisation and whom they may otherwise be unaware of. A national database would allow for checks and minimum qualification requirements to be set.

Routine monitoring of impacts and wellbeing – ISVAs/ISVA Managers who completed the survey reported psychological distress and moderate to high levels of vicarious trauma. Routine monitoring of these impacts should be implemented by organisations providing ISVA services and appropriate support and care should be provided (see recommendation about supervision). Alongside this, a national annual survey of ISVAs would be helpful to provide a more holistic view of ISVA experiences. Linked to this, self-care sessions for ISVAs should be offered. This would provide ISVAs with dedicated time to socialise with other ISVAs from differing organisations, share experiences and focus on self-care and resilience building. For example, with Ministry of Justice Funding. LimeCulture offered 'Coping & Connecting online sessions' during the first stage of the COVID19 pandemic[13]. Feedback from these sessions indicated that almost all of the respondents found it useful to connect with other ISVAs and were planning to recommend the sessions to other ISVAs. Four main benefits of the sessions were identified by the ISVAs: Safe space to reflect and focus; Sharing experiences; Reducing loneliness and isolation; and Facilitated discussion (LimeCulture, 2020). The benefits of these kind of sessions would extend beyond the COVID19 pandemic and we recommend they should become standard practice.

More support for positive coping mechanisms – Linked to the previous recommendation about routine monitoring of impacts and wellbeing, coping mechanisms were found to be fundamental in reducing emotional distress. As such, it would be helpful for positive coping mechanisms to be incorporated into the working lives of ISVAs. Perhaps, organisations can link with local services to offer opportunities for exercise, meditation, emotional support or by offering staff mindfulness apps, such as, Headspace. The self-care sessions proposed in the previous recommendation would also be beneficial for supporting and developing positive coping mechanisms.

National standards for maximum caseloads – Caseloads were a key factor predicting psychological distress and vicarious trauma amongst ISVAs and ISVA Managers and varied widely (from less than 10 to over 100). Although there are lots of possible reasons for this, such as, ISVA Managers also carrying a caseload, Child ISVAs needing more time with clients and some geographical issues that may mean more travel in certain areas, it could be helpful for there to be a nationally recognised maximum number of clients per ISVA. National standards for caseloads should reduce the number of overwhelmed ISVAs and improve the level, quality, and amount of care they can offer their clients. This approach would also be beneficial for commissioners. However, because of the complexities and differences intrinsic in the ISVA role and the lack of professional standards, it is difficult to set a national client maximum for all ISVAs. Nonetheless, with some further investigation, it would be possible to develop guidelines and role specific caseload caps. Therefore, we recommend that a scoping exercise be conducted to provide recommendations for maximum caseloads and these then be piloted and evaluated. Alternatively, a toolkit or framework could be developed to support ISVA Managers to set maximum caseloads and assist them in managing the capacity of their own teams. Whichever approach is taken, the process will need to carefully consider what

[13] 241 ISVAs attended the sessions from 77 different ISVA services and 36 PCC areas; feedback forms were completed by 103 of the ISVAs (LimeCulture, 2020).

strategies can be put in place if ISVAs reach capacity. There is a need to protect clients and ensure that they do not end up being screened out of receiving ISVA support or discharged early in order to keep ISVAs at or below the maximum caseload.

Professional Networks – There is a lack of consistency in ISVA provision which has impacts on the ISVAs and ISVA Managers delivering the services and, ultimately, on the services provided to victims of sexual violence. As the ISVA role is very nuanced and unique, it also requires confidentiality. This means that many ISVAs do not have outlets for discussing their work, therefore, it would be helpful for ISVAs to network with other individuals who perform the same role. Additionally, some ISVAs work in environments where they are the only ISVA or are part of a very small team. This limits the opportunity to learn more about the ISVA role, develop and adopt best practices from other practitioners. As such, it would be helpful for National Professional Networks (which are regularly used in the NHS to bring together professionals for specific illnesses) to be set up for ISVAs, which would provide an opportunity for idea sharing, peer learning and peer support. They could also be extended to ISVA Managers and Commissioners with the purpose of building consistency across different providers, sharing ideas and challenges. These networks could also focus on the development of a template ISVA Service specification or the development of a quality assurance framework that could be used by local commissioners to benchmark their services against each other.

9. References

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10. Appendix

10.1 Breslau 7-Item Scale for Post-Traumatic Stress Disorder (Breslau et al., 1999)

The Breslau 7 Scale is a 7-item, self-reporting scale which screens for post-traumatic stress disorder (PTSD). A score of 4 or greater on this scale indicates positive cases of PTSD with a sensitivity of 80%, specificity of 97%, the positive predictive value of 71% and negative predictive value of 98% (Breslau et al., 1999). Participants (n = 97) reported either 'yes' or 'no' for the 7 items. The minimum score was 0 and the maximum 7, with an average of 2.05 (SE = .21). The Cronbach's alpha for the Breslau 7 Scale was α = .83 which indicated adequate internal consistency. The Breslau 7 Scale was non-normally distributed, showing a slight positive skew, with a skewness of .78 (SE = .25) and kurtosis of -.59 (SE = .49).

10.2 Personal Beliefs in a Just World Scale (Dalbert, 1999)

The Personal Beliefs in a Just World Scale (PBJWS) is a self-reporting, 7-item scale which explores the predisposition and conceptualisation of one's view towards a just world. Participants (n = 95) rated each statement using a 6-point Likert scale, from 'strongly agree' to 'strongly disagree'. The minimum score was 14 and the maximum 35, with a mean score of 21.58 (SE = 5.16). The Cronbach's alpha for the PBJWS was α = .77 which indicated adequate internal consistency. The PBJWS was non-normally distributed, showing a slight positive skew, with a skewness of .62 (SE = .25) and kurtosis of .01 (SE = .49).

10.3 Vicarious Trauma Scale (Vrklevski & Franklin, 2008)

The Vicarious Trauma Scale (VTS) is a self-reporting, 8-item scale which explores the presence and severity of vicarious trauma whilst working with victims of trauma. The scores can range from 8 to 56, with a higher score indicating higher levels of distress. Participants (n = 89) rated each statement using a 7-point Likert scale, from 'strongly disagree' to 'strongly agree'. The minimum score was 19 and the maximum 53, with an average of 37.1 (SE = 8.08). The Cronbach's alpha for the VTS was α = .79 which indicated adequate internal consistency. The VTS was non-normally distributed, showing a slight negative skew, with skewness of -.02 (SE = .26) and kurtosis of .51 (SE = .51).

10.4 Clinical Outcomes in Routine Evaluation (CORE-10; Beck et al., 2006)

The Clinical Outcomes in Routine Evaluation (Core-10) is a self-reporting, 10-item scale which explores anxiety (2 items), depression (2 items), trauma (1 item), functioning (3 items – a day to day, close relationships and social relationships), physical problems (1 item) and risk to self (1 item). The minimum score for the CORE-10 would be 0 and the maximum would be 40.

Participants (*n* = 91) rated each statement using a 5-point Likert scale, from 'not at all' to 'most or all the time'. The minimum score was 10 and the maximum 38, with an average of 23.06 (*SE* = 5.01). The Cronbach's alpha for the CORE-10 was α = .68 which indicated adequate internal consistency. The CORE-10 was non-normally distributed, showing a slight positive skew, with a skewness of .49 (*SE* = .25) and kurtosis of .58 (*SE* = .50).

10.5 COPE Inventory – Amended Version (Carver, 1997)

The COPE Inventory is a self-reporting, 10-item scale which explores coping mechanisms used in stressful/traumatic experiences, split into two sub-categories: positive and negative. Participants (*n* = 87) rated each statement, using a 4-point Likert scale, from 'I don't do this at all' to 'I do this a lot'. The minimum score was 42 and the maximum 119, with an average of 84.35 (*SE* = 17.01). The Cronbach's alpha for the COPE Inventory is α = .90 which indicated adequate internal consistency. The COPE Inventory was non-normally distributed, showing a slight positive skew, with skewness of -.16 (*SE* = .26) and kurtosis of -.44 (*SE* = .51).

10.6 Vicarious Resilience Scale (Killian et al., 2017)

The Vicarious Resilience Scale (VRS) is a self-reporting, 27-item scale which explores resilience whilst working with clients who have survived severe trauma, attitudes and experiences. Participants (*n* = 82) rated each statement, using a 5-point Likert scale, from 'did not experience this' to 'experienced this to a very great degree'. The minimum score was 14 and the maximum 130, with an average of 78.45 (*SE* = 21.08). The Cronbach's alpha for the VRS is α = .94 which indicated adequate internal consistency. The VRS was normally distributed with skewness of -.51 (*SE* = .27) and kurtosis of -.91 (*SE* = .53).

10.7 Conor Davidson Resilience Scale (CD-RISC; Vaishnavi et al., 2007)

The Conor Davidson Resilience Scale (CD-RISC) is a self-reporting, 25-item scale which explores resilience, attitudes and experiences within the last month. The maximum score is 100, with a higher score indicating that the person is more resilient. Participants (*n* = 95) rated each statement using a 4-point Likert scale, from 'not true at all' to 'true nearly all the time'. The minimum score was 41 and the maximum 96, with a mean of 73.35 (*SE* = 11.39). The Cronbach's alpha for the CD-RISC was α = .90 which indicated adequate internal consistency. The CD-RISC was normally distributed with skewness of -.30 (*SE* = .25) and kurtosis of -.15 (*SE* = .49).

10.8 Formulae used for standardising the scales

$$Y = \frac{Xi - \text{Min}\,(X)}{\text{Max}\,(X) - \text{Min}\,(X)}$$

Xi = Participant Score

Min (*X*) = Minimum Score

Max (*X*) = Maximum Score