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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

Executive Summary

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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.