MENTAL HEALTH TRUSTS COLLABORATION PROJECT

Meeting the needs of survivors of abuse

OVERVIEW OF EVALUATION FINDINGS

SEPTEMBER 2006 TO JULY 2008

Di McNeish and Sara Scott
DMSS Research & Consultancy
www.dmss.co.uk

CONTENTS

ACKNOWLEDGEMENTS

This evaluation would not have been possible without the active participation of the staff, managers and services users in the pilot trusts who gave generously of their time to participate in interviews and complete questionnaires.

Our particular thanks to:

The DH/NIMHE National Team, Liz Mayne and Chris Holley, and the sexual abuse teams and trainers in wave one trusts:

Joanne Tandy and Jennie Beattie, Barnsley Primary Care Trust
Shirley McNicholas, Alan Jones, Tina Purcell and Pippa Stallworthy, Camden and Islington Foundation Trust
Terri Warr, Martin Hunwicks and Cate Dandridge, Devon Partnership Trust
Maureen Tomeny and Jane Thorpe, Nottinghamshire Health Care NHS Trust
Lori Coulson and Heather Morfett, Plymouth Primary Care Trust
Teresa Hagan, Paul Firth, Linda Wilkinson, Kim Parker and Andreas Weichselbraun, Sheffield Health and Social Care NHS Foundation Trust
Allison Anderson and Mel Baird, Sussex Partnership NHS Trust
Penny Greenaway, Peter Rook, Sue Smith and Natalie Willetts, Coventry and Warwickshire Partnership NHS Trust.

Thanks also to members of the Clinical Reference Group who provided invaluable advice on the evaluation:

Michael Clark (Chair), Gill Aitken, Kay Toon and Clare Shaw.

PREFACE

I have great pleasure in introducing this report to you: The Mental Health Trusts Collaboration Project (MHTCP) has taken the pilot trusts on an impressive journey - to establish enquiry into violence and abuse as a routine aspect of adult mental health assessments and provide timely and appropriate care to victims/survivors of abuse through care planning processes.

At the outset it seemed an ambitious initiative given the limited resources at trusts' disposal, the competing demands on their time and staff anxiety about the changes in individual clinical practice the pilot process implied. Chief Executives and Trust Boards were prepared to trust senior leads, frontline management and the sexual abuse teams who sustained the process. They have been tireless champions of the principle that addressing violence and abuse should be core business for mental health services, the clinical responsibility of all members of the multi-disciplinary team. All the pilot trusts are continuing the process although the pilot phase has come to an end.

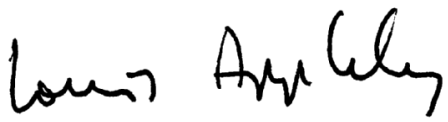
The findings of the evaluation, contained in this report, clearly indicate :

- that changes to clinical practice are achievable and can be replicated by other trusts;
- that the provision of adequate training provides firm foundations for change in culture and practice;
- important messages to inform future national replication.

These messages include the importance of credible trainers; leadership by senior and frontline management and experienced clinicians; staff access to support and supervision, when needed, from practitioners with specific expertise in child sexual abuse; insertion of the abuse question in assessment documentation as described in the (recently published) CPA Guidance.

At this stage, the focus is on enlisting the commitment of all mental health provider trusts. Currently, in six of the eight NIMHE regions, trusts are coming forward to designate a lead officer for liaison purposes.

The key message from the evaluation of the pilot is that establishing routine abuse enquiry is challenging for organisations and clinical staff but can be done. We need to change over the question from *"What is wrong with this person?"* to *"What has happened to this person?*".



Professor Louis Appleby
National Director of Mental Health for England

OVERVIEW OF EVALUATION FINDINGS

SECTION ONE: INTRODUCTION

1.1 Background

The Mental Health Trusts Collaboration Project (MHTCP) commenced in July 2006 as a two-year pilot. It had its origins in the Department of Health's Mainstreaming Gender and Women's Mental Health Implementation Guidance[1] which states the need:

- To acknowledge and address the links between violence and abuse and mental health in the delivery of mental health services in inpatient and community settings and, most importantly:
- *Once satisfactorily trained,* to ensure that staff raise issues of violence and abuse routinely and consistently in assessment and care planning with *all* service users.

The MHTCP has had a particular focus on meeting the needs of adult survivors of child sexual abuse. This is in recognition of the extent of such abuse amongst users of mental health services, and the particular need to increase the knowledge and confidence of all mental health professionals in this area[2].

1.2 The pilot trusts

Eight mental health provider trusts were included in the first wave of the pilot with a second wave of seven trusts joining in September 2007[3]. Each wave one trust has had a **sexual abuse team (SAT)**, usually consisting of two people with some formally agreed dedicated time[4]. It was recommended that the teams initially identify a pilot area in their trust comprising of around 70 to 80 multi-disciplinary staff, generally representing a full care pathway[5], to enable adaptations to be made before implementing the process more widely.

Pilot trusts have been supported by a **National Team**: Liz Mayne, Project Director, responsible for project management/joint monitoring with individual pilot trusts and Chris Holley, Clinical Lead, who supported the SATs through the training process and with related clinical issues.

1.3 The evaluation

The independent evaluators[6] were appointed in September 2006 and worked with the National Team and an expert reference group to articulate the specific outcomes and milestones *(see Section 3 Achievement of Milestones)* the MHTCP was aiming to achieve. The **outcomes** were:

- Sexual abuse is embedded as a core mental health issue.
- There is routine exploration of physical, emotional and sexual abuse by all mental health professionals conducting assessments.

- Adult service users with a history of abuse receive the support, care and therapy that they need.
- Every trust has an adequate number of staff with the confidence and skills to provide appropriate support to service users with a history of abuse.
- Joint working with service users/survivors is embedded as a core principle.

The evaluation has been based on a **theory of change model** which emphasises a collaborative and formative approach to evaluation and the 'journey' of interventions in local trusts aimed at achieving change over time. Therefore the evaluation team identified milestones over the two-year period of the evaluation, which would indicate that the initiative was on course to achieve its longer-term outcomes. These were assessed primarily through qualitative methods. This approach *(described in more detail in the appendix)* enabled the evaluators to provide regular feedback to the National Team, and individual trusts on the progress of the pilot and to inform its ongoing development

The evaluators worked with the National Team to articulate the following theory of change underlying the initiative:

- Many users of mental health services have past experience of violence and abuse which has a significant impact on their mental health.
- Addressing the needs of survivors has to start with exploration of sexual, and other, abuse in assessments and then provision of support, care and therapy needed.
- This can be achieved by developing staff skills and capacity to consistently carry out routine exploration and provide appropriate follow up support.
- Practice improvement can, in turn, be achieved through a number of 'building blocks' including training, supervision and support, forging links with specialist services in the voluntary sector and establishing Sexual Abuse Practice Development Forums.
- Collaboration across trusts to share ways of working will add value to the process.

SECTION TWO: BUILDING BLOCKS OF THE INITIATIVE

About the building blocks

The building blocks for this initiative were derived from the Gender and Women's Mental Health Implementation Guidance. It was believed that for routine exploration to be implemented, each trust needed to have the following in place:

- ***Training for staff*** to give them the knowledge and confidence required to routinely ask about violence and abuse as part of adult mental health assessments, and respond appropriately to disclosures.

- ***The inclusion of 'the question'*** ("*Have you experienced physical, sexual or emotional abuse at any tine in your life?")* in assessment documentation and arrangements for audit of routine exploration.
- Opportunities for staff to enhance their ***clinical expertise*** including access to a Practice Development Forum and specialist support and supervision.
- Partnership working with relevant ***voluntary sector*** agencies.
- The availability of formal ***therapeutic interventions***.

Much of the work of the sexual abuse teams in wave one trusts focused on developing these with some variation of emphasis according to the local context. A condition of becoming a wave two trust was that core building blocks were already in place i.e. that trusts had good supervision arrangements, well-established relationships with other agencies and plans to insert 'the question' into assessment paperwork.

The evaluation focused on assessing the progress of trusts in developing these building blocks and identifying what factors have been significant in contributing to successful implementation.

Building block 1: One-day training course on sexual abuse

As part of this initiative, pilot trusts were required to deliver a one-day course focusing on sexual abuse, based on one developed over many years in Staffordshire[7]. Sexual abuse teams and additional trainers from the wave one trusts received a two day training course in September 2006: Day One was a demonstration of the course they would be required to deliver in their own trusts with a follow-up day to equip them to do so. Trainers from wave two trusts received a similar two-day course in September 2007.

The ***aims*** of the course were:

- To address staff fears in working with survivors/victims of violence and abuse, particularly child sexual abuse.
- To equip staff to routinely and consistently explore violence and abuse in assessments and respond appropriately to disclosures.

An evaluator observed a delivery of one course in each trust. The cascade training was also evaluated through the administration of a standard post-course questionnaire, around 50 of which were analysed by the evaluators for each trust. The observations and feedback from participants and trainers in wave one informed some revisions to the course provided to the wave two trusts.

For this pilot initiative to be evaluated, it was important for SATs to deliver the training with a good degree of consistency (though they were encouraged to use their own case material to illustrate key points wherever possible). The evaluators' observations confirmed that SATs were complying in delivering a consistent core curriculum. Following the initial pilot period, most SATs made

minor amendments to make the training 'their own' without undermining the core messages.

Progress and impact of training

By December 2007 the sexual abuse teams across all wave one trusts had been successful in delivering the training to the target groups of multi-disciplinary staff in their pilot areas. In the main these were qualified staff with some responsibility for assessment. However all SATs recognised that non-qualified staff with significant levels of patient contact (e.g. health care assistants) also required a degree of knowledge and awareness and some SATs extended access to their courses accordingly. Where a specific set of pilot teams had been identified (in six of the eight trusts), almost all staff in those teams had received the training. By June 2008, all SATs had trained the majority of their target groups of staff in adult mental health services.

Evidence from an analysis of 462 post-course questionnaires showed that, across all wave one trusts, 89% of respondents said that the training had increased their knowledge relevant to working with survivors of sexual abuse, and 82% said that it had increased their confidence in undertaking routine exploration.

Interviews with staff carried out six to eight months after the training began[8] confirmed that the training had contributed to an increased awareness of sexual abuse as a mental health issue and the importance of routine exploration. Feedback on the training was positive with 84% of trainees responding "*yes"* or "*mostly"* to the statement "*the training has provided the information I need to conduct routine exploration in my workplace"*.

Key messages for effective training

The ingredients of effective training are:

Organisational commitment so that staff know that it is important to attend. This can best be achieved by including the course as part of mandatory training. Continued reiteration by senior managers and clinical leaders of the organisation's commitment is also important.

Clarity of 'message' so that participants leave feeling completely clear about what is expected of them.

Confident delivery of evidence-based information combined with some opportunity for sharing experience - so that participants both learn something new and have their own expertise valued.

Good preparation and planning so that participants feel that they are in 'safe hands'; **administrative support** is crucial in this regard ideally provided by the trust's training department or equivalent.

Credible trainers who combine recognised clinical experience of working with abuse issues and training skills.

Useful **strategies** employed by SATs have included:

- initially delivering the course to a team known to them who can provide honest feedback;
- ensuring familiarity with the trainers' notes in advance of each delivery;
- playing to the strengths of each trainer in terms of delivering particular parts of the course;
- integrating their own case material and practice experience;
- having new trainers 'sit in' on a number of courses before starting to deliver it themselves.

Building block 2: Recording and auditing 'the question'

However good the training, if the question is not in the assessment forms used by practitioners, then routine exploration is less likely to happen. A key element of establishing routine exploration, therefore, is embedding the question - *'Have you experienced physical, sexual or emotional abuse at any time in your life?'* - in assessment documentation. This has been a challenge in most trusts. By December 2007 several trusts had incorporated 'the question' into some assessment documentation but only one had integrated it into their e-CPA documentation.

The main difficulty was that without a trust-wide directive, most sexual abuse teams had to rely on individual teams inserting the question into their own paperwork. While this was often discussed in the training, there was no explicit requirement of team/ward managers to ensure it occurred and it was often deferred – particularly in teams with continuing concerns about routine exploration.

In February 2008, **DH CPA Guidance** was issued with the inclusion of the abuse question. This has clearly been of critical importance; by June 2008 all wave one trusts had either inserted 'the question' in their assessment documentation or had plans to do so.

Inserting the abuse question in assessment documentation is an important step. However, at present, there remain inconsistencies in where 'the question' is located and whether it uses the exact recommended wording. In addition, many service users do not reach the threshold for secondary care, notably those being assessed by Primary Care or Access teams. Interviewees commented that it remains likely that assessments will continue to vary with no guarantee that they will all include the question about violence and abuse.

Clinical audit is the primary tool for ongoing monitoring and many sexual abuse teams had early discussions with trust audit teams to try to generate data on whether the question was being asked. However, by June 2008, the majority of pilot trusts had not yet reached the stage of auditing the extent to

which the question was being asked across the organisation. The exception to this was Devon which was the first of the pilot trusts to insert 'the question' into the e-CPA.

Key Messages for recording and auditing routine exploration

Crucial elements of establishing and sustaining routine exploration are:

- ensuring that '**the question' is in assessment paperwork** prior to staff receiving the training, so that there is a trigger for it to be asked at every assessment;
- **using the wording and positioning as recommended in the CPA Guidance** for all mental health assessments in secondary care;
- giving consideration to the inclusion of 'the question' in referral assessments i.e. 'first contact' or screening assessments;
- having plans in place to **audit implementation.**

Building block 3: Support for staff to enhance their clinical expertise

3.1 Specialist case consultancy

A core component of this building block is the availability of specialist case consultancy being provided by those with expertise in sexual abuse to enable practitioners, following disclosures, to develop their confidence and skills in follow-up work with survivors of abuse.

Sexual abuse teams had limited capacity to provide specialist consultation themselves (though most offered this to some degree). Most teams, therefore, aimed to identify staff with expertise willing to provide this, mostly on an informal basis. One trust established a locality-based clinical support team of individuals offering consultation and advice and another was setting up a network of specialist supervision groups.

3.2 Practice development forums

It was envisaged that the creation of practice development forums would provide an arena for staff learning, practice development and informal supervision - related to working with survivors of sexual abuse across disciplines and agencies. Most sexual abuse teams, therefore, set up one or more such forums in their trusts and some have proved to be useful vehicles for professional development beyond the one-day training course. In trusts where forums have been successfully sustained over time, there is usually a committed group of people who take responsibility for maintaining an interesting agenda and promoting meetings widely. However, whilst in some trusts the forum has been well attended, in several others attendance has been disappointing.

Factors identified as ***barriers*** were:

- information about the forum not getting through to staff;
- competing demands on staff time;
- staff shortages leading to difficulties in releasing staff;
- long distances to travel in many trusts.

Forums can be resource-intensive to plan and organise and, where take-up remains low, they are unlikely to be successful as a vehicle for *widespread* practice development. If this is their primary objective, it may be more appropriate to pursue alternative options such as quarterly seminars, an annual event or link in with existing meetings or fora.

3.3 Clinical supervision

Although not specifically included as one of the building blocks, it is widely recognised that regular clinical supervision is fundamental to safe professional practice in mental health services. Interviews, with a variety of staff across the pilot trusts, highlighted variable arrangements for clinical supervision and the priority afforded to it. In several trusts arrangements were ad hoc with staff expected to identify their own supervisor. It was frequently stated that it was supposed to happen but often did not.

The perceived relevance of clinical supervision seemed to be linked to individual and team understandings of their role i.e. those who saw their role as undertaking therapeutic work (in its broadest sense) valued clinical supervision. Those that routinely worked with abuse issues generally had supervision adequate to support this work. Others did not perceive the need for it; their primary concern was where they could refer survivors to, rather than where they could refer themselves to receive any help they needed to provide support directly.

This variable culture and practice relating to clinical supervision is likely to prevail in most trusts and will impact on staff's willingness to seek more specialist case consultation. The lesson to be drawn from the pilots is - not that there is no need for further specialist support or supervision but - that, in the early stages, it is likely to be under-utilised and may need to be 'sold' to staff by their managers as they begin to conduct routine exploration. This may be particularly true in teams where there is no culture of external supervisory support.

Key messages for effective staff development and support

- Specialist case consultation needs to be available for all staff providing ongoing support for survivors.

- Individuals with appropriate expertise need to be identified and allocated the time to provide this consultation.

- Specialist case consultation should be in addition to, not a substitute for, regular clinical supervision.

- Where arrangements for clinical supervision are weak, the take-up of specialist support is also likely to be low and may require additional encouragement.

- Practice development forums can be an effective means of developing staff expertise as well as building inter-agency working. They require commitment, persistence and active promotion.

- Where practice development forums are not practicable, trusts need to find alternative means of providing regular professional development opportunities and inter-agency networking.

Building block 4: Partnership working with the voluntary sector

A key premise of the MHTCP was that responding to the mental health needs of survivors of sexual, and other, abuse is a core responsibility of mental health services. However it was recognised that the voluntary sector play a crucial role in supporting survivors. Over many years voluntary organisations (many of which are user-led) have developed significant knowledge and expertise. As well as providing specialist support, they also offer service users a choice of provision outside the mental health system. Partnership working with the voluntary sector was therefore identified as a key building block of the initiative.

Pilot trusts varied in their relationships with the voluntary sector according to a range of contextual factors:

- The number of relevant agencies operating within the trust area (for example, (West) Sussex had almost none).
- Previous history of established relationships; some sexual abuse team members had been working closely with particular agencies over many years. For example a SAT member in Plymouth was located within a voluntary agency.
- The funding context; in some areas key voluntary agencies were under threat of losing their funding.
- The limited capacity of small agencies to participate in partnership working.

Most SATs invested time in mapping voluntary sector services within their area and making contact. In some trusts (for example Nottinghamshire), particular voluntary agencies had been involved from the outset of the pilot as part of steering groups, which had helped to build very strong links. In several others, practice development forums have provided a means of developing inter-agency communication, with voluntary agencies playing a key role as co-

facilitators in some areas. Other examples of joint working include the co-production of information (e.g. leaflets) for both survivors and staff.

Key messages for partnership working with the voluntary sector

Partnership working is more likely to be successful where:

- relevant voluntary organisations are involved from the outset;
- there is an understanding of the capacity and funding arrangements for the voluntary sector;
- the importance of service users having the choice to use voluntary sector services is reflected in commissioning plans;
- time is taken to develop relationships;
- voluntary agency expertise is utilised in a variety of ways e.g. through steering groups, practice development forums, joint training and resource development.

Building block 5: Developing specialist therapeutic interventions

A key principle of the MHTCP is that providing support to survivors of abuse is integral to the role of adult mental health services, and that the majority of professional staff have the necessary skills to offer immediate and ongoing support following disclosure. It has always been understood that survivors have a range of needs which may or may not, at some stage, include specialist therapeutic input. Therefore the expansion of trust-based specialist therapeutic input is not regarded as a prerequisite for routine exploration.

It is fully acknowledged that, in instances where survivors do require formal therapeutic interventions, this can be provided via three main routes:

- increasing the therapeutic expertise of practitioners in multi-disciplinary teams;
- increasing access to specialist in-house provision e.g. Psychology Services and group-work;
- developing some external specialist therapeutic provision e.g. by increasing access to voluntary sector provision through appropriate commissioning arrangements.

A recurring theme of staff feedback throughout the evaluation has been anxiety about the limited availability of specialist therapeutic input, where this is required. In some cases this concern clearly impacted on staff's willingness to routinely ask about abuse.

Sexual abuse teams approached this building block in a variety of ways according to local need. Most have created opportunities for individual practitioners to develop their skills. Some have identified additional sources of funding to boost the capacity of existing therapeutic services (for example, in Nottinghamshire the SAT successfully bid for time-limited funds to extend therapeutic input provided by psychologists). Some have developed new group-work: For example, in Plymouth the SAT has established a new psycho-educational group for survivors; in Devon the SAT is working closely with an established group-work programme (SAGE) to expand their capacity to provide therapeutic groups.

So far pilot trusts have identified the need to work with commissioners on increasing support to survivors but this is an area needing further development.

Key messages for developing specialist therapeutic interventions

Trusts need to have a strategy in place for responding to the needs of survivors post-disclosure. This should include:

- increasing the capacity (both time and skills) of all practitioners to provide therapeutic support;
- ensuring clear pathways for survivor access to psychological services;
- developing additional group-work for survivors based on 'tried and tested' models;
- building the service needs of survivors into commissioning plans.

Building block 6: Management leadership and support

This was not originally identified as a separate building block but the importance of management and clinical leadership and support has been recognised - by the National Team and sexual abuse teams - throughout the pilot process. At the outset an operational lead, to manage the pilot process, and a senior management lead, to be accountable to the board, was identified by each trust.

The evaluation has confirmed that having senior management 'sign up' is crucial for the implementation of routine exploration and the improvement of support to service users with a history of abuse. The Trust's Board and Executive need to be committed to abuse being 'core business' for adult mental health services. Having an **accountable senior manager** can ensure that support for survivors is integrated into business planning and the links are made with other developments. This level of senior leadership needs to be sustained and regularly communicated and demonstrated in the Trust.

The active engagement of **front-line managers** is also important. These managers shape the culture and practice of their teams. All teams are likely to include those who are sceptical of the value of routine exploration, or staff who are personally uncomfortable with working with abuse issues. Without the active support of ward managers/team leaders, these individuals are far less likely to be won over.

Almost all team managers interviewed for the evaluation were supportive of the introduction of routine exploration in principle. However the extent to which they were actively promoting and managing its introduction was variable, with only a few taking a very proactive stance. The pilot trusts relied heavily on the **peer influence** of SAT members who lacked sufficient time to fully involve frontline managers and follow-up implementation issues with them post-training.

The role of the SATs in pilot trusts has been a critical factor in keeping routine exploration of the agenda - by providing peer-leadership, motivation, enthusiasm and sheer determination.

Key messages for management leadership and support

Management and clinical leadership, at both senior and front-line management levels, are crucial. Important steps to ensuring this are:

- getting **trust board and executive sign up** to the principles of abuse being 'core business' and routinely communicating this across the organisation;
- having a **senior lead** to integrate it with business planning and performance management;
- **briefing and supporting front line managers,** such as team leaders and ward managers, to take responsibility for implementation in their teams;
- having **experienced clinicians** taking a lead in the implementation.

SECTION THREE: ACHIEVEMENT OF MILESTONES

Achieving the ambitious outcomes of the initiative is a long-term goal, not realistically achievable or measurable within a two-year pilot. Therefore a theory of change model was applied to establish the milestones that the pilot trusts would need to reach by June 2008: To provide convincing evidence that significant progress was being made towards the long-term outcomes. In this section we report on each of these milestones.

Milestone 1: Each trust has a significantly greater reservoir of staff with skills and confidence in addressing sexual abuse issues.

The evidence from this evaluation shows that the MHTCP has contributed to an increase in staff's confidence and skills in addressing sexual abuse issues

in the participating trusts. A final stage of interviews conducted in each wave one trust[9] during May and June 2008, combined with a follow-up postal/e-questionnaire to a sample of staff who had completed the training[10], suggested that the MHTCP, particularly the training, has had an impact on staff confidence and skills.

86% of questionnaire respondents rated themselves either confident or very confident to carry out routine exploration. 63% of questionnaire respondents said they required no further training in order to undertake routine exploration.

However questionnaire responses and observations from interviewees suggest that there is still a need, for some staff, for further training and support in responding to disclosures and providing ongoing support to survivors. As a clinical team lead commented:

> *Individuals need to know what to do in response to a positive answer. Asking is one thing, responding is something entirely different.*

A service user's testimony

Following this training, at my CPA review, my care co-ordinator asked me all the abuse questions now included in our CPA forms. Although he thought he had probably covered this ground already, he used the questions to check this. He is much more confident now in talking about abuse with me and so much more sensitive and empathic. He gives me time and really listens and actually thanks me for talking with him about things that are so painful. He makes a point of saying that he hasn't experienced abuse himself and that he can't imagine how he'd have coped with what happened to me - he has a lot of respect and admiration for how I've coped now he has a better understanding of the impact of sexual abuse.

The training also helped him understand some of the problems within my relationship with him and we have been able to address them. As a result, our relationship is more trusting and I've been able to progress hugely in the way I'm learning and trying out ways of relating with him that I can then transfer to other relationships. This training has definitely benefited my mental health care and my personal life.

Milestone 2: Sexual, and other, abuse is recognised as 'core business' for all adult mental health professionals, managers and other relevant trust personnel.

By June 2008 nearly all managers and sexual abuse teams interviewed expressed the view that sexual, and other, abuse was more generally accepted as 'core business'. They reported that abuse was now widely acknowledged as impacting on people's mental health and that there was a

greater awareness of the number of service users affected. This increased awareness was not necessarily reflected in practice change; most interviewees suggested that this varied, though several people highlighted an overall trend in mental health services towards taking a more holistic view of service users' needs:

> *We need to develop 'mindful practitioners' but have to be aware that this is beginning a revolution in mental health services - it's not confined to this issue.*

Interviewees commented that as well as 'new ways of working', there is a range of other drivers for change including the safeguarding agenda, equalities and increasing access to psychological therapies (IAPT). While some argued that the sheer scale of current change in mental health services was increasing resistance to a new culture, others suggested that a general climate of change made it easier to take on new ideas.

Milestone 3: Routine exploration (i.e. asking 'the question') of sexual, and other, abuse is either established trust-wide or sufficiently embedded that the process will continue after the pilot period has ceased.

By June 2008, evidence from the follow-up questionnaire suggested that, while a small number of clinicians remained opposed to Department of Health policy on conducting routine exploration (8% of respondents), the majority (83%) were supportive. Of those who conducted assessments:

- half said that they 'always' asked about violence and abuse;
- a further 35% said they 'mostly' did so;
- 86% said they were using the recommended wording or similar.

This, very positive, finding supports the perceptions of interviewees that 'the question' is being asked more routinely. So far quantitative evidence from clinical audit is only available from one trust (Devon) but initial findings from this indicate that the question was being asked in a relatively high proportion (45%) of assessments at a point where the training had yet to reach all staff[11].

However, as long as a there is a minority of staff conducting assessments who are not routinely asking about abuse, the experience of this service user is likely to be replicated:

> *I went to my GP cos I thought I was going mad. I went to a counsellor through the GP. It took a while to say about abuse because I wasn't asked. I got details about [the group] and eventually got around to contacting – but it took about three years in all. I should have been asked – it would have been easier. (Service user)*

Interviews with multi-disciplinary teams who had received the training identified several concerns expressed by staff in pilot trusts, which are very likely to be raised as other trusts implement routine exploration.

A summary of recurring staff concerns about asking 'the question'

Who should ask 'the question': Some staff in both in-patient and some community settings described their role as primarily establishing and maintaining the stability of their clients rather than 'delving into their past'. There can be an assumption that asking 'the question' is someone else's responsibility, especially when assessments are carried out by more than one clinician; these responsibilities need to be made clear.

When to ask 'the question': The evaluation found differences in practice and understanding as to whether routine exploration should be incorporated in initial assessment, risk assessment and/or assessment reviews. Trusts need to be clear about their expectations.

When not to ask 'the question': There was widespread agreement that it was inappropriate to ask 'the question' when a client was severely disturbed or distressed; neither would it be appropriate to ask in the presence of someone who might have been involved in the abuse. In these circumstances it is not clear at what point 'the question' will get asked. There needs to be an agreed process for completing the assessment to include 'the question' at an appropriate time.

***How to ask 'the question'*:** For some staff, the recommended question feels too direct and interrogatory and they prefer to explore the issue more gradually. In some cases, this less direct approach will achieve the same ends. However it is important to ensure that staff are not being so indirect as to avoiding using the term sexual abuse entirely.

Safeguarding Children and Adults: Concerns about safeguarding children and adults tend to generate anxiety and can deter people from asking the question. Trusts need to ensure that staff have readily available access to support and advice on their responsibilities.

Milestone 4: Trusts have capacity to provide the necessary support to those who disclose abuse in terms of the ability to provide immediate and ongoing support following disclosure; the growth of expertise among staff; the development of appropriate specialist therapeutic interventions.

The evaluation suggests that there is a good degree of confidence that staff are able to ask 'the question' about violence and abuse and provide appropriate support immediately after disclosure:

> *The training 'does what it says on the tin' and has helped increase the adequacy of immediate response. It's hard to know beyond that.*

However not all staff see it as their role to provide ongoing support and, if they do, may not feel sufficiently skilled to provide it.

> *As a care manager undertaking assessments I have no difficulty in routinely asking about sexual abuse, but feel I lack training and knowledge to know what and where to go with the information.*

Some teams clearly do provide such support as part of their overall work but this is not a universal approach. It is clear that many staff, within both in-patient and community based settings, continue to regard the provision of ongoing support to survivors as a task for specialist services whether in the voluntary sector or by psychology services within their trusts.

There is still a gap between the common perception that survivors, certainly of sexual abuse, need to be referred to a specialist abuse service, and the MHTCP assertion that providing support to survivors is 'core business' that all staff should be able to undertake. These different understandings are likely to be encountered by most trusts as they introduce routine exploration. Clarifying the kinds of support staff are expected to provide and the particular role of specialist services (voluntary and statutory), where these exist, is fundamental to ensuring that service users receive a consistent response.

There is some optimisim that 'new ways of working' and other policy drivers will equip staff with the time and the skills required to make therapeutic approaches more widely available:

> *There's no new capacity but new services will have more capacity to respond. 'New ways of working' will give staff time to deliver talking therapies and there are new job descriptions to allow this.*

However there is still a fairly widely held view that the lack of resources for specialist therapeutic support remains a serious problem. Sexual abuse teams have contributed to the development of therapeutic support via new groups or the identification of additional funding. There remains, though, a serious concern in several trusts about the security of funding for specialist voluntary sector services.

Milestone 5: Trusts have effective arrangements for working with other agencies including those from the voluntary and community sector and there are sustainable practice networks across trusts.

Local partnership working

Most sexual abuse teams developed positive links with relevant voluntary agencies and, in some trusts, the voluntary sector was involved in the pilot process from the start. The evaluation found that voluntary sector services were much valued by adult mental health staff where they were available.

The views of relevant voluntary agencies operating in the catchment areas of wave one trusts were sought by questionnaire between September and

December 2007. Nine of the 12 agencies responding to the questionnaire stated that their organisation agreed, in principle, with Department of Health policy on routine exploration, though they were concerned about the availability of follow-up support. Voluntary agencies reported a variety of contact with their local SAT and eight of the 12 had attended a Practice Development Forum. Some expressed disappointment that there had not been greater engagement.

In addition to forging links with the voluntary sector, SATs all committed time to networking with statutory sector partners including the Police and Children's Services, and developing relationships with relevant internal partners such as their Safeguarding Leads. Practice development forums were established in most pilot trusts and several SATs reported a benefit being the development of improved communication with other agencies.

The national collaborative

Sexual abuse teams and trust managers were very positive about their involvement in the national collaborative, and were particularly clear about the local impact of being involved in a DH-led initiative. Almost all interviewees greatly valued the support available from the National Team and the ongoing evaluation. Despite concerns about the lack of national resources attached to the pilot, several trusts expressed a willingness to share their learning more widely.

> *In the current NHS climate where people feel they have no power, being part of something bigger makes you feel you have some clout. Seeing the CPA guidance was a real buzz – seeing evidence that we've had an influence.*

However, the potential 'added value' of participation in a national collaborative has not been exploited as fully as originally hoped; there has been relatively little active exchange of learning between the trusts involved in the pilot. The main reasons for this have been the time constraints on SATs resulting in them prioritising work within their own trusts and their immediate work plans. Trusts are also relatively autonomous and few of those involved had experience of cross-trust collaboration and its benefits.

Milestone 6: There is evidence of sustainability in each trust including the adoption of key sexual abuse team functions into mainstream funding and an ongoing programme of high quality cascade training.

By June 2008 all wave one pilot trusts had plans for sustaining the work initiated by the MHTCP. Most envisaged some ongoing role for the sexual abuse team, generally including the continuation of training. Their plans were based on a recognition that implementation is still at an early stage and, in order for it to be sustained, there is a continuing need for a sexual abuse team or equivalent to focus on developing staff skills. A couple of trusts had identified funding to maintain and develop the SAT to provide an ongoing leadership role. Other trusts were embedding this role within other functions

such as their Safeguarding Leads. Others were still at the stage of identifying potential resources.

The inclusion of 'the question' in the CPA guidance has been a crucial factor in giving people confidence that routine exploration will continue:

> *Now it's DH policy and in the paperwork, and the training is now mandatory, so it will get asked….The 'ball has started rolling' and will keep going with a bit of a push from supportive clinicians and survivors.*

4. CONCLUSION

The evaluation findings summarised in this report provide evidence that the pilot trusts participating in the Mental Health Trusts Collaboration Project have achieved the milestones set out in the project's outcomes framework. Furthermore the 'theory of change', on which the MHTCP was premised, has been shown to be valid. This suggests that, if other trusts take similar steps to develop the building blocks in line with the pilot experience, there are good grounds to believe that routine exploration can be successfully implemented nationally.

Appendix: Methodology

The evaluation of the Mental Health Trusts Collaboration Project was conceived as a piece of action research using a theory of change approach, the findings of which would inform the development of the project throughout the pilot period. It was therefore designed in four stages:

Stage 1: Preparatory work

This involved identification of the MHTCP theory of change and ultimate outcomes in collaboration with the DH/NIMHE National Team responsible for the initiative, and development of an evaluation framework incorporating milestones (interim outcomes) at intervals of the pilot period (March 07, August 07 and June 08). Data collection methods were designed to access evidence in relation to each set of milestones.

Stage 2: National training

The national training of pilot trusts' sexual abuse teams and trainers was evaluated using a questionnaire completed by course participants prior to the training on Day 1; a questionnaire completed by participants at the end of the training on Day 2; contemporaneous observation notes taken by the evaluators throughout the training.

The pre-course questionnaire asked a series of questions to elicit participants' views on:

- their trusts' current provision for survivors of sexual abuse;
- their understanding of routine exploration and its anticipated impact on services in their trust;
- pre-course levels of knowledge of sexual abuse and confidence in delivering the cascade training;
- their expectations in relation to the training, the collaborative and practice development forums.

The post-course questionnaire was designed both to obtain information on participants' satisfaction with the training they had received and to repeat some of the questions asked in the pre-course questionnaire; to gauge whether there was a change in people's self ratings of knowledge and confidence in delivering the cascade training.

Stage 3: Cascade training

This stage of the evaluation focused on the initial implementation of the project across the trusts, particularly the cascade training provided to staff in the trusts' pilot sites. It reported on early evaluation findings for eight of the nine pilot trusts recruited to this project. The ninth experienced problems in implementing the cascade training and was not included in the evaluation.

The evaluators observed one training day, delivered by the SAT and/or additional trainers, in each of the pilot trusts during the initial delivery period

(February to June 2007). This was usually the sixth or seventh session delivered. The evaluators used an observation checklist and took contemporaneous notes during the sessions

A post-training questionnaire was administered to all participants attending training courses across the pilot trusts. A sample of 462 questionnaires was obtained - representing around three-quarters of the total number of staff scheduled to receive training as part of the pilot phase i.e. 60 questionnaires from each trust. Most trusts had identified a pilot site consisting of an average of 75 staff and delivered their initial courses largely, although not exclusively, to these staff. The post-course questionnaire was designed both to obtain information on participants' satisfaction with the training they had received, and to gauge people's self-ratings of knowledge and confidence particularly with regard to carrying out routine exploration.

Interviews were conducted with the SAT members in each trust between February and June 2007. In some cases they were joined by the senior manager with responsibility for the initiative for part of the interview. Interviews were 90 minutes to two hours in length. A standard topic guide was used for these interviews. Some interviews were tape recorded, in others contemporaneous notes were taken, usually by the second evaluator.

The two 'up-country' and 'down-country' implementation group meetings which took place during the time period were attended by the evaluators and contemporaneous notes were taken. Copies of the presentations used in training and other materials supplied to participants were collected by the evaluators.

Stage 4: Early implementation

From September to December 2007 the evaluation team conducted the fourth stage of the MHTCP evaluation focusing on the introduction of routine exploration in participating mental health trusts' pilot sites. This stage of the evaluation was concerned with the learning to be extracted from the initial experience of implementation of routine exploration, and to assess the progress of trusts against the interim milestones as set out in the outcomes framework for the MHTCP.

Visits were made to each trust approximately six to eight months from the start of their cascade training: individual interviews were conducted with managers/team leaders (due to problems of availability during visits six of these were telephone interviews) and face-to-face interviews and/or focus groups were conducted with staff who had received training and had begun to implement routine exploration. The former were approximately an hour in length and the latter 30 to 40 minutes. We obtained feedback from:

- ward managers/charge nurses of in-patient wards/units;
- team leaders of community teams;
- a range of both in-patient and community based staff conducting assessments.

A total of 86 staff participated in interviews/focus groups. A standard topic guide was used for interviews and focus groups. All participating staff received an information sheet and consent form at the outset of interviews/focus groups or by e-mail in advance of a telephone interview.

This stage of the evaluation also included gathering the views of voluntary sector organisations working with survivors of violence and abuse located in participating trusts. Sexual abuse team members provided details of key contacts in their local voluntary sector identified as likely to be willing to participate in the evaluation. Seven of the trusts provided contact details for a total of 26 voluntary agencies. A questionnaire was sent to these in September 2007. The questionnaire focused on: organisations' knowledge of the collaborative; contact with the SAT to date (including through the Sexual Abuse Practice Development Forums; any immediate impacts/issues arising for organisations and/or their service users.

12 completed questionnaires and one additional letter from a survivors' group were returned. The two SATs who did not supply contact details were Barnsley and West Sussex who, at that stage, identified themselves as piloting routine exploration in areas where no relevant voluntary agencies were operating.

Stage 5: Progress towards the final milestones

The fifth and final stage of data collection for the MHTCP evaluation took place in May and June 2008. This focused on the progress of trusts towards the final milestones set out in the outcomes framework for the MHTCP, their plans for sustaining the work beyond the pilot and lessons learned from the experience of the pilot process that could inform the national roll-out.

Visits were made to each of the wave 1 pilot trusts and interviews conducted with members of the SAT and other key individuals, identified by the SAT as having had a significant input into the pilot and/or its future implementation. This included senior managers in all trusts and service user representatives in three trusts. Interviews were conducted using a topic guide designed to elicit views on the progress of the initiative and plans for future sustainability.

This stage of the evaluation also gathered a final tranche of information from a sample of staff in each trust who had undergone the sexual abuse training. This sample was generated from post-course evaluation questionnaires participants had completed after they had received the cascade training. The questionnaire had included a question about participants' willingness to take part in further evaluation. Those that had agreed and supplied their contact details were sent a follow-up questionnaire either by email or by post. The questionnaire was designed primarily to gauge the extent to which staff who had received the training were routinely asking about violence and abuse as part of their assessments. 479 questionnaires were sent out and 158 were returned, a good response rate (for a postal/e-questionnaire) of 33% across the trusts.

Notes

1 Mainstreaming Gender and Women's Mental Health Implementation Guidance, Department of Health, 2003, Section 8.1 (pertaining to all service users); this initiative gave equal recognition to the needs of men as well as women as service users and survivors of violence and abuse.

2 An audit of staff knowledge and confidence in working with sexual abuse issues was conducted across the pilot trusts during 2007 by Penny Stafford of Walkerhill Consultancy (produced in July 2007). This provided further evidence of the need for further training and support for staff in this area.

3 The eight trusts involved in Wave 1 were Barnsley PCT, Camden & Islington Foundation Trust, Coventry & Warwickshire Partnership Trust, Devon Partnership Trust, Nottinghamshire Healthcare Trust, Plymouth PCT, Sheffield Health and Social Care Trust, (West) Sussex Partnership Trust. The second wave trusts were Birmingham and Solihull Mental Health Trust, Dorset Healthcare Foundation Trust, East London Foundation Trust, Kent & Medway NHS & Social Partnership Trust, Leicestershire Partnership Trust, Lincolnshire Partnership Trust and Wolverhampton PCT.

4 The composition of the sexual abuse team varied between trusts, as did the amount of dedicated time, which ranged from 1.5 to 3 person days per week.

5 For example, the CMHT, crisis intervention, early intervention, assertive outreach and in-patient staff within a particular geographical area. In two trusts a broader approach was taken and training provided to staff across the whole trust.

6 The evaluation of the pilot by Di McNeish and Sara Scott of DMSS Research & Consultancy has encompassed: the national training provided to sexual abuse teams and core trainers and the subsequent cascade training carried out in both waves of pilot trusts. The extent to which routine exploration of violence and abuse has been implemented, and the progress of trusts against the milestones set out in the outcomes framework for the MHTCP, relates to wave one only. At each stage, reports have been provided to highlight any learning for future development available at www.dmss.co.uk.

7 The one day training course was originally developed by Chris Holley, Nurse Consultant in Sexual Abuse, South Staffordshire and Shropshire NHS Foundation Trust informed by the work of Carolyn Ainscough (deceased) and Kay Toon. This original course has been delivered in Staffordshire since 1990.

8 The evaluators visited each wave one trust between September and December 2007 and conducted interviews and/or focus groups with staff, who had received training between six and eight months previously and had begun to implement routine exploration. A separate report on this stage of fieldwork was issued in May 2008.

9 During May and June 2008 the evaluators carried out a final set of interviews with members of the sexual abuse team in each wave one trust and other key individuals identified by the sexual abuse team as having had a significant input into the pilot and/or its future implementation. A separate report on this stage of fieldwork was issued in September 2008.

10 The above stage of the evaluation included a questionnaire to a sample of staff across the wave one trusts. This sample was generated from post-course evaluation forms participants had completed as part of their cascade training, which included a question about participants' willingness to take part in further evaluation. Those that had agreed and supplied their contact details were sent a follow-up questionnaire, either by email or by post, designed primarily to gauge the extent to which staff who have received the training are routinely asking about violence and abuse as part of their assessments. 479 questionnaires were sent out and 158 were returned, a response rate of 33 % across the trusts.

11 E-CPA audit in Devon between 31 Nov 2007 and 18 Mar 2008 found that, from a total of 4018 opportunities (trust-wide), routine enquiry was competed with 1819 people (45%). Emotional abuse was disclosed by 918 people (23%); 506 (55%) of whom wanted to do work on this experience; physical abuse was disclosed by 706 people (18%), 374 (53%) of whom wanted to do work on this experience; sexual abuse was disclosed by 603 people (15%) 407 (68%) of whom wanted to do work on this experience.