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Final report of the Responding Effectively to Violence and Abuse (REVA) project

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1. Executive Summary

Background

There are high prevalence rates of violent and abusive experience in both childhood and adult life amongst users of mental health services; yet mental health services have often failed to take account of people's experiences of violence and abuse.

The first step in responding effectively to survivors of violence and abuse is to identify them and to that end it has been Department of Health policy since 2003 that a question about experiences of violence and abuse is included in all adult mental health assessments. However, the implementation of routine enquiry across Trusts and services has been patchy, and it is recognised that for routine enquiry to be useful it needs to be followed up by interventions that make a positive difference to people's lives.

In relation to the general population little is known about the patterns and interrelationships of different kinds of abusive experience, the implications of these for mental health and other outcomes, and the levels of unmet need for support that might exist.

This study was designed to explore these issues through three linked strands of investigation:

First, it uses data from the 2007 Adult Psychiatric Morbidity Survey (APMS) to explore different patterns of experience of violence and abuse amongst women and men across the life-course and the relationship between these and mental health and wellbeing outcomes. We used a statistical approach called latent class analysis (LCA) to derive a typology of people according to their lifetime experience of violence and abuse.

Second, it follows up Department of Health (DH) policy on routine enquiry 10 years on from its introduction - returning to four of the original pilot trusts to conduct qualitative case study research to explore in depth the lessons that could be extracted from their experience. The case studies consisted of interviews with senior and strategic managers, secondary and primary care practitioners involved in the implementation of routine enquiry (RE) and service providers from the voluntary sector. Service users who had experienced interpersonal violence and abuse were also interviewed and their views on effective responses and services explored.

Third, the study has incorporated the collaborative development of an outcomes tool which enables services to measure outcomes which are meaningful to, and desired by, survivors of violence and abuse (known as 'survivors' throughout) themselves. We conducted an initial audit of existing relevant outcome measures; consulted extensively with survivors and service providers on an outcomes framework; used cognitive interviews to refine a draft tool and piloted it in seven voluntary sector and NHS services.

Patients and members of the public have been actively involved from the outset and at every stage of the study through extensive consultation and membership of a reference network.

Findings

Strand One – APMS analysis

Latent class analysis of APMS data identified that while three-quarters of the population have little experience of violence and abuse in their lives, the remaining quarter is made up of five groups with distinct patterns of abuse experience. The two groups that experience the poorest outcomes are those with the most extensive experiences of violence and abuse. The prevalence of mental illness among people in both these groups is extremely high: over half (53%) of those experiencing extensive abuse as adults and children have a common mental disorder.

This research confirms in an adult population the strong impacts of 'poly-victimisation' which David Finkelhor (2008) has identified in children and adolescents and suggests that the compounding effects of different experiences of abuse may continue across the life-course.

Importantly, it also identifies a high level of mental health difficulties among those survivors who had suffered the most extensive partner violence (but who had mostly not experienced other kinds of abuse). The mental health consequences of partner violence have previously received little clinical or research attention.

Strand Two – Routine enquiry and effective services

The two key findings concerning routine enquiry about experience of violence and abuse as part of mental health assessment are:

1. Routine enquiry is acceptable to, and considered desirable by, survivors.
2. Routine enquiry can be effectively embedded in practice where there is adequate training, managerial and clinical support; it is included in documentation and clinical audit, and it is regarded as an integral aspect of safeguarding.

Survivors emphasised that not being asked about their experiences of abuse suggested that it was not considered relevant to their mental health, that they should continue to keep it a secret and that a consequence of not being asked could be greater vulnerability to re-victimisation. They felt that effective services to address the long-term consequences of violence and abuse were those that gave survivors some genuine control, were integrated or well-coordinated, not time-limited and managed endings well. While favouring having a range of kinds of support available in voluntary and statutory services – including some non-hospital based provision for respite/crisis - it was survivor groups which were most frequently cited as transformative.

Strand Three – Outcomes for survivors
Practitioners and service users collaborated in the development of a tool designed to measure survivor outcomes that would be meaningful to survivors themselves. Completion rates of the tool were high and providers and users agreed it was clear, accessible and relevant to their experiences of the impacts of violence and abuse. Survivors appreciated the need to provide information and valued the chance to see that they had made positive changes.

Service users participating in the pilot experienced marked changes across many measures between completion of the first and second forms, particularly in relation to their awareness of available support, feelings about the abuse, sense of control over their lives, and in their health and wellbeing.

Key recommendations

In relation to routine enquiry and the provision of effective, accessible services which address the long-term consequences of violence and abuse it is not further research but further implementation activity that is required. RE can be effectively embedded but it requires commitment from NHS England, Clinical Commissioning Groups and Health Education England; leadership within trusts and some mandatory provision for training.

In the longer term it requires the incorporation of these issues into the core curriculum of pre-registration training for all mental health professionals. In addition the views of survivors on effective services should be taken into account and their expertise, alongside that of specialist voluntary agencies, should be utilised by involving them in planning for the commissioning of services.

In relation to further research the APMS is an excellent vehicle for tracking changes over time – in terms of abuse experience, use of services and outcomes. Data from APMS 2014 will be publicly available for analysis from 2016 and it is recommended that the latent class analysis is repeated, to check that the abuse and violence typology is confirmed and that a sample is drawn for qualitative follow-up of men and women in the two extensive abuse groups. Such follow-up would enable the comprehensive profiling of group membership and analysis of the nature of the relationships between particular patterns and accumulations of abuse experience and outcomes in terms of health, well-being and use of services.

2. Study Aims

The aims of the study were:

1. To identify the prevalence of different types of abuse and violence experienced in childhood and adulthood and how these cluster together; understand the associations between past abuse and current health, mental health, service use and other factors and to develop a typology of different groups of survivors. To achieve this through latent class analysis of data from the Adult Psychiatric Morbidity Survey (APMS).

2. To identify what works in implementing routine enquiry about experience of violence and abuse in adult mental health assessments, how this gets embedded in practice and the experience and views of service users.

3. To ascertain how experience of violence and abuse impacts on the use of health and support services and what makes these helpful/unhelpful in meeting survivors' needs and helping them towards positive outcomes.

4. To develop an outcomes tool, relevant to services working with survivors in both voluntary and NHS settings, which is grounded in user and practice experience as well as in research evidence.

3. Policy background

There are high prevalence rates of violent and abusive experience in both childhood and adult life amongst users of mental health services. Histories of childhood sexual and physical abuse amongst women service users are particularly well documented. Although many of the samples in these studies are small, figures of around or over 50% are not unusual (e.g. Palmer et al, 1992 (sample of 115 women psychiatric inpatients); Wurr and Partridge, 1996 (sample of 120 psychiatric inpatients)). In secure settings this figure is even higher (Bland et al, 1999). Studies of severe domestic violence among psychiatric in-patients report lifetime prevalence ranging from 30% to 60% (Golding, 1999; Howard et al, 2010).

Mental health services have often failed to take account of people's experiences of violence and abuse. A substantive literature review (Hepworth and McGowan, 2013) has recently examined the extent to which mental health professionals enquire about childhood sexual abuse during routine mental health assessments in acute mental health settings. They concluded that while many professionals acknowledged the importance of enquiry, there was little evidence of widespread routine enquiry occurring during mental health assessments.

In one study, two-thirds of service users reported sexual, physical or emotional abuse at some point in their lives, but only 20% had been asked about abuse on assessment. The majority (69%) of those who reported abuse believed there was a connection between having been abused and their mental health problems, but few (17%) thought the clinician saw such a connection (Lothian and Read, 2002). In another study the files of 200 users of a community mental health centre revealed that while 46% contained documentation of sexual or physical abuse as children or adults, only a third of treatment plans for abused clients mentioned the abuse and only 22% of the abused clients received abuse-focused therapy (Agar et al, 2002). Reluctance to ask about abuse amongst some mental health professionals has been highlighted in a number of studies (Goater and Mehan, 1998; Hamberger and Phelan, 2006).

Routine enquiry in England

It has long been recognised that experiences of violence and abuse impact on people's mental health, but the responses of mental health services to survivors of violence and abuse have been extremely variable. A smattering of individuals at all levels of service provision (from health care assistants to consultants) have recognised the relevance of violence and abuse to their patients' distress, sought out information and training for themselves and provided excellent support to their clients. And since the 1980s a few specialist services have developed with a focus on the treatment of complex trauma, the sequelae of child sexual abuse or providing a women's therapy service. However, there was no strategic NHS response to evidence of the large numbers of survivors of violence and abuse with mental health needs, or already using mental health services, until the development of the Women's

Mental Health Strategy (2002) and the accompanying guidance. The strategy recognised the centrality of effectively addressing the long-term consequences of violence and abuse – and designated this as 'core business' for mental health services. Subsequent action in the form of a national pilot and roll-out was based on the following theory of change:

> *'The first step in responding effectively to survivors of violence and abuse is to sensitively identify them. If service users are routinely asked about their experiences of violence and abuse as part of mental health assessments by suitably trained staff they will often disclose and the support and treatment they receive is likely to be more helpful than hitherto. At the same time, increased disclosure will encourage the commissioning and development of more specialist services and better co-ordination with VS services. Staff resistance to routine enquiry is based on fear of not being able to respond adequately to disclosures and can be overcome by the provision of training and support alongside strategic leadership, required recording and clinical audit.'*

Evaluation of the pilot confirmed the hypothesis that routine enquiry could be effectively introduced and embedded by these means (Scott and McNeish, 2008).

Since then the landscape of policy, commissioning and provision has developed in a variety of directions providing new opportunities and challenges to the provision of effective mental health service responses to survivors of violence and abuse. However, important policy imperatives for all in the NHS are to address health inequalities and operate within the framework of the Equality Act 2010 (Department of Health, 2011c). As our analysis of APMS data makes clear: survivors of extensive violence and abuse are likely to be multiply disadvantaged in terms of a wide range of socio-economic and health measures. Addressing their needs should therefore be central to services fulfilling their equality duties.

Service users' views on routine enquiry

A range of research indicates that most survivors of violence and abuse do not mind, or indeed welcome being asked about a possible abuse history. Confirmation comes from studies which have focused on survivors of childhood sexual abuse (Nelson, 2001; Zeitler et al, 2006; Renker et al, 2006) and on those experiencing domestic violence. A systematic review of qualitative studies found that survivors of domestic violence want to be asked by doctors (Feder et al, 2006). In a study of domestic violence amongst clients of a community mental health team, 82% regarded routine enquiry as acceptable, but only 24% had ever been questioned (Morgan et al, 2010). In a US study of community mental health service users, all service users considered routine enquiry about domestic violence in mental health settings to be acceptable (Trevillion et al, 2012).

Does routine enquiry work?

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

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

There have been three recent studies of screening programmes in general health care settings where limited interventions have been offered (an information leaflet, brief counselling or a 30 minute appointment with a GP). There was little evidence found that these programmes resulted in improved outcomes for women experiencing domestic violence (the WEAVE trial in Australia (Hegarty et al, 2013), in the US (Klevens et al, 2012) and in Canada (MacMillan et al, 2009). A Cochrane Review (Taft et al, 2013) concluded that: 'As there is an absence of evidence of long-term benefit for women, there is insufficient evidence to justify universal screening in healthcare settings'. On the basis of such evidence the recently updated external review for the UK National Screening Committee (Spiby, 2013) concluded that:

> *Screening for domestic violence is not recommended because there is insufficient evidence on the benefit of interventions. Comprehensive screening programmes can increase the level of screening (asking about domestic violence) undertaken, disclosure and identification but to date there is no evidence of reduction in level of such violence or positive health outcomes following screening.[…] There is a lack of evidence on effective interventions.*

Importantly, as Rachel Jewkes (2013) has pointed out in The Lancet, this research on widespread screening does not show a lack of value in asking patients about violence and abuse in circumstances in which it might be directly associated with the presenting complaint, or important for clinical intervention - particularly mental health problems. Our APMS analysis for strand one of this study clearly demonstrates that this is a population highly vulnerable to abuse experiences which have direct relevance to service response, and that while there is limited evidence that screening in universal

services is effective/cost effective routine enquiry in mental health services is clearly appropriate. However, what the research on widespread screening does highlight is that in any context, identification is not enough – routine enquiry is only effective if it leads to better support, understanding and quality of life.

The Identification and Referral to Improve Safety (IRIS) study has indicated the value of training and support in primary-care practices to increase identification of women experiencing domestic violence and their referral to specialist services. Recognising that many clinicians lack training in identifying and responding to domestic violence, the study introduced an intervention (training, a prompt in medical records to ask about abuse and a referral pathway and advice from a named domestic violence advocate) to 24 practices. Comparing outcomes to a control group of 24 practices where no intervention had been applied, there were 223 domestic violence referrals made one year later from the practices subject to the intervention, and just 12 referrals from the control groups practices (Feder et al, 2011).

Recent NICE guidelines for addressing domestic violence (2014) have also emphasised the value of similar approaches as those supported by RE. This includes the importance of creating an environment that is enabling for disclosure, ensuring staff are trained to ask about abuse, and also on how to effectively respond if a disclosure is made.

Measuring outcomes

Concern to effectively assess the outcomes of treatment and service use has increased in recent years (see the NHS Outcomes Framework, Department of Health, 2011b) – and it is widely recognised that in terms of mental health, outcomes that are important to patients should be reflected in outcome measures. Patient Reported Outcome Measures (PROMS) for services addressing violence and abuse of women and girls were included in the Department of Health (2011a) Guide for Commissioners.

The development of an outcome-focused commissioning framework specifically for VAWG services was recommended in the Alberti review (2010), and Patient Reported Outcome Measures (PROMS) for services addressing violence and abuse of women and girls were included in the Department of Health (2011a) Guide for Commissioners. Despite this, aside from the work of second-tier organisations like Women's Aid, Imkaan (see Women's Aid & Imkaan, 2014) and Rape Crisis England and Wales (2013), many specialist violence and abuse support services are not well equipped to evidence how their clients benefit from their services. For example, almost three quarters of agencies that responded to a survey conducted on behalf of the Survivors Trust[1] said that they used an 'in-house' system to evaluate client outcomes, with many describing this as 'ad-hoc' and 'in need of development' (Survivors Trust & Consult, 2010: 64).

[1] The Survivors Trust (TST) is a national umbrella agency for more than 135 specialist rape, sexual violence and childhood sexual abuse support organisations throughout the UK and Ireland.

Third sector organisations in particular need to demonstrate their effectiveness in the context of competitive commissioning (Harlock, 2013). However, cuts to already under-resourced services in the violence against women and girls (VAWG) sector have made it difficult for many, especially smaller services, to develop meaningful measurement frameworks or to fully engage in commissioning processes (Callanan et al, 2012; Women's Aid & Imkaan, 2014).

Responding effectively to violence and abuse (REVA)

This study represents a follow-up of Department of Health (DH) policy on routine enquiry in adult mental health assessment 10 years on from its introduction. In addition to returning to four of the original pilot Trusts to explore in depth the lessons that could be extracted from their experience, this study incorporates two other related strands of enquiry.

It uses data from the Adult Psychiatric Morbidity Study (APMS) to explore different patterns of experience of violence and abuse amongst women and men across the life-course and the relationship between these and mental health and wellbeing outcomes. In doing so it provides new and important messages for commissioners, trust managers, those responsible for the training of mental health professionals and for public health.

The study also incorporates the collaborative development of an outcomes tool which enables services to measure outcomes which are meaningful to, and desired by, survivors themselves and also gathers feedback on those aspects of provision which are known to be most important to providing an effective response.

4. Methods

The study consisted of 3 strands, detailed below:

Strand 1- Secondary analysis of the Adult Psychiatric Morbidity Study

The first strand of the research comprised analysis of data from the Department of Health funded Adult Psychiatric Morbidity Survey (APMS). APMS is the only representative, national, community-based data source to use clinical assessments to generate rates of treated and untreated psychiatric disorder in England. APMS 2007 included detailed interviews with 7,400 men and women aged 16 and over from across England. Participants were asked about their:

- Lifetime experience of different types of violence and abuse
- Current mental health
- Current social and economic circumstances
- Use of health and community mental health services.

The dataset was examined to see how the English population can be divided into groups with distinct profiles of abuse and violence, and how these groups go on to have very different mental health outcomes and service use needs.

We used a statistical approach called latent class analysis (LCA) to derive a typology of people according to their lifetime experience of violence and abuse. LCA is a modelling technique that identifies groups in a population that share a similar profile according to the characteristics entered into the model. The approach is widely used in market and consumer research to segment populations into distinct groups. The advantage of using LCA to analyse APMS is that it enabled analysis that segmented groups by clusters of similar experiences or characteristics. Rather than look at experiences singularly – for example the characteristics of those who have experienced one type of abuse such as child sexual abuse, the analysis created a meaningful typology of clusters of experiences.

As a next step the research team had to assess the typology that had emerged from the analysis and assign these groups meaningful labels based on the shared clusters of characteristics or experiences they represented. The findings from this strand are presented later in this report.

Further information about the analytical approach can be found in Appendices A, B and C.

Strand 2 – In-depth interviews with professionals and service users in four case study trusts

The second strand involved qualitative case study research in four NHS trusts, where 'routine enquiry' about experience of violence and abuse has been incorporated in mental health assessments. They were selected from Trusts involved in the original pilot of RE that appeared to have been relatively successful in embedding RE. The case studies consisted of interviews with senior and strategic managers, secondary and primary care practitioners, involved in the implementation of RE, and service providers from the voluntary sector. Interviews with people who had accessed mental health services and had experienced interpersonal violence and abuse were also conducted in each case study area.

Rationale

A number of features of this component of the research made it ideally suited to qualitative methods. Qualitative approaches can provide a rich and detailed understanding of complex and contextual issues such as how policies are implemented in practice and the range of factors which enable or constrain a policy in becoming embedded (Robson, 2011; Ritchie and Ormston, 2014). Exploring a sensitive research topic and appropriately interviewing survivors of violence and abuse was also facilitated by a qualitative approach, as it permits responsivity and flexibility to the individual needs and circumstances of participants (Lewis and McNaughton Nicholls, 2014).

A case study design was chosen for this strand of the research in order to provide an in-depth, comprehensive and contextualised understanding of the implementation of routine enquiry and the influence of environmental and other factors on the process through which it had been successfully embedded. Case study research is particularly associated with qualitative methods, whereby a phenomenon or issue (here routine enquiry) is studied in context (Cresswell, 2013), and in detail (Bryman, 2012), taking into account multiple relevant perspectives (Lewis and McNaughton Nicholls, 2014) to build up rich, layered understanding *in situ.*

Here, case studies were also designed to enable comparison between different trusts, by ensuring that a similar profile of statutory and voluntary services and participants were included in each case. There was some variation in the composition of the samples in order to capture local differences in the nature of service provision.

Sample design & recruitment

Qualitative research is not concerned with measurement but with mapping experiences, views and implementations (Ritchie and Ormston, 2014). Qualitative approaches to research involve the inclusion of fewer people in the sample, but delve more deeply into particular contexts, than quantitative research (Baker and Edwards, 2012). Qualitative research is designed to generate understanding of how and why people perceive, interpret, and act as they do. The probability sampling techniques used for quantitative studies are rarely appropriate when conducting qualitative research (Holloway and

Wheeler, 2010). Rather, the aim of purposive sampling, typically adopted in qualitative studies (Mason, 2002) is to develop a sample that is symbolically (as opposed to statistically) representative of the parent population, ensuring representation of key characteristics (Bryman, 2012).

Purposive sampling involves the identification of important criteria (characteristics, experiences, etc.) that might influence an individual's views or experiences. Selection is based on the researcher's practical knowledge of the research area, the available literature and evidence from the study itself. All of the relevant criteria should be identified and the aim is to ensure the sample encapsulates the relevant range and diversity of criteria - characteristics and experiences - to be symbolically representative of the broader parent population that the study sample is drawn (Ritchie et al, 2014).

Purposive sampling techniques should be applied to the selection of each component of the study sample – from the case study sites selected, to individual participants within study sites.

The question of appropriate sample size within qualitative research has long been a subject of debate; and in essence the response to this is 'it depends' (Baker and Edwards, 2012). It depends on the focus of the study, population in focus, and practical issues such as scope, access and timetable (Flick, 2012). Though some methodologists note that qualitative studies tend to have a sample size of under 50 participants (Creswell, 2013; Ragin, 2012), where multiple case study sites are included, the sample can become much larger, as in this study.

Sampling case studies

Here the rationale in selecting case studies was to enable detailed exploration of *what works* in implementing 'routine enquiry' and how this gets embedded in practice. The research was therefore conducted in four NHS trusts that were known to have made progress in implementing and sustaining routine enquiry in order to identify best practice and lessons learned. Four trusts were felt to enable adequate comparison between sites without developing an unnecessarily large sample overall.

To select the case study sites, the first stage involved 'scoping' interviews with senior managers from each of the 8 original RE pilot sites and a desk based review of available evidence regarding the implementation of RE from NHS Information Centre data[2]. This scoping stage led to the selection of four trusts that evidenced good progress in implementing RE, and that also represented variation in terms of trust structure, geographical location and size (to ensure representation of criteria that could influence difference in implementation of RE such as size of trust, nature of governance, and which department holds responsibility for RE).

[2] This review identified that the data returns to the minimum dataset for the first quarter in which returns had been required were extremely patchy and unfit for purpose. The analysis we undertook was shared with the NHS Information Centre (now the Health and Social Care Information Centre).

The rationale for selecting individual interviewees within each case study trust was then to ensure range and diversity of coverage across key criteria such as:

- Type of NHS or voluntary sector service working within (CMHT, Crisis Team, specialist eating disorder etc.)
- Level of experience and seniority within service
- Length of time elapsed since completing the RE training
- Demographical characteristics such as gender and ethnicity.

Sampling criteria were chosen because they were expected to be important in understanding the range of attitudes, views and experiences of 'routine enquiry', and in enabling exploration of the research questions. The stages of fieldwork are summarised below:

Scoping interviews
At the first stage of each case study, semi-structured scoping interviews were conducted with strategic staff members who had a key role implementing and embedding routine enquiry. One or two strategic interviews were conducted per site. These were used to map the service landscape within each trust, and select a relevant range of services to include within the case study interview sample[3]. Practitioners from these services were then invited to take part in an in-depth interview.

Practitioners
The next stage involved in-depth interviews with practitioners. As with all research it was important to ensure participants understood they were under no obligation to take part and could provide their informed consent to do so (Webster et al, 2014).

NHS practitioners who took part in interviews were recruited through the managers of different purposively selected services, with contact first made via the strategic lead interviewed at the initial stage. Service managers that agreed to assist with the research were asked to introduce and explain the study to practitioners and to provide them with information (leaflets/letters) making clear that participation was voluntary. They could then directly contact the research team and arrange an interview. Practitioners working in the voluntary sector were recruited using a similar approach, making initial contact with service managers.

[3] The introduction of routine enquiry was intended to cover all 'adult mental health services'. The emphasis for implementation was on adult inpatient, community and specialist teams. In some Trusts it has been extended to include older people and learning disability teams. Since 2005 IAPT services have developed across the country and are not currently required to include a question about violence and abuse in their assessments – although some teams are apparently doing so.

Sampling participants
A total of 108 practitioners were interviewed across the four case study sites for the main fieldwork stage. Quotas were set prior to recruitment to ensure that at each case study site participants with relevant characteristics were included (Ritchie et al, 2014). The sample was monitored during fieldwork and steps taken to boost diversity where this was lacking, such as including additional services. In order to explore how routine enquiry was operating in different environments participants were recruited from across a diverse range of services available in each case study trust.

It was expected that practitioners' views and experiences of routine enquiry may be affected by their role and seniority. Interviewees were therefore selected to ensure a range of roles and responsibilities and different positions of seniority were included in the research sample.

Additionally, interviewees were purposively selected on the basis of demographics such as gender and ethnicity. This was in order to achieve a balanced sample and assess the extent to which these characteristics may have influenced perceptions of how and to whom practitioners 'asked the question'.

Of the 108 practitioners who participated in the research 89 were women and 19 were men. This is likely to be indicative of the profile of people working in relevant services, which also included some services primarily/exclusively for female survivors of violence and abuse. The majority of participants were white. However, some diversity with respect to ethnicity was achieved across the sample. Detailed information about the samples can be found in Appendix D.

Service users: including people with experience of violence and abuse
To understand more about experiences of accessing and engaging with services, including being asked about experiences of abuse and violence, a sample of service users were interviewed in each site. These participants were recruited and interviewed at second waves of case study fieldwork, working closely with the statutory and voluntary organisations that had participated in the research to appropriately identify and make contact with their service users. The research team have extensive experience of working with survivors of abuse, and are acutely aware of the importance of ensuring their participation in research is enabled sensitively.

Gatekeepers from within organisations supporting survivors were asked to approach a small number of service users, who they believed would not find the study an unwelcome intrusion and who had capacity to consent to participation. The 'trusted gatekeeper' explained the research to them, making clear the voluntary nature of participation, and asked those who were interested for written consent to pass their contact details to the research team. A member of the research team then contacted these individuals to provide further information, and to arrange an interview if they agreed to take part.

Survivor sample A total of 23 survivors were interviewed. The interviewees were selected to represent diversity across types and clusters of abuse experienced, type of services accessed, and demographical characteristics such as gender, age and ethnicity. These were identified by the researchers are important criteria that could influence survivors' views and experiences of accessing services. Nineteen interviewees were women and four were men ranging in age from their early 20's to their early 60's.

They had experienced different kinds of violence and abuse both recently and in the past:

- Five women mainly described experiences of domestic violence as adults, while seven were mainly survivors of childhood sexual abuse.

- The remaining seven women had experienced violence and abuse both as children and as adults.

- All four men identified as survivors of childhood sexual abuse.

It was not the purpose of the interviews to explore their experience of abuse in detail. However, the accounts participants gave suggested that the interviewees encompassed the violence and abuse groups identified in our APMS analysis (see section below for findings) – which included sexual abuse as a child; sexual abuse as a child and sometimes as an adult; domestic violence; very extensive domestic violence such as threats of death and choking; and multiple and extensive forms of both domestic and sexual violence (Scott et al, 2013).

The survivors all had experience of accessing statutory mental health services and support from voluntary agencies, or both. These experiences ranged from minimal contact with NHS mental health services (e.g. those who had mainly been supported by voluntary sector organisations and/or primary care) through to people who had extensive experience of secondary mental health services including acute in-patient care, crisis team interventions, community mental health provision and therapy. Their experience included specialist support for issues of violence and abuse, such as counselling and group work provided by both the NHS and the voluntary sector. Survivors of domestic violence included in the research were the least likely to have used secondary mental health services, and the most likely to have been referred by health professionals directly to specialist agencies in the voluntary sector.

Conduct of fieldwork

Practitioners

Interviews lasted up to 1.5 hours and were conducted using a topic guide to help ensure consistency of coverage across participants (Marshall and Rossman, 2011). This listed key themes to be covered rather than prescribing precise questions to be asked of participants. The research team used the guides in a way that was responsive and tailored to individual experiences. This meant that the topics covered and the order in which they were

discussed varied. This was essential to gathering rich and detailed data and in minimising harm to participants, particularly survivors. Interviews were audio recorded and transcribed verbatim with the permission of participants.

Interviews with NHS practitioners were conducted face-to-face or by telephone depending on the preferences of the participant.
Interviews covered four main areas:

- understanding the service the participant worked in and how they came into contact with or supported survivors of violence and abuse;
- exploring views and experiences of whether and how routine enquiry had become embedded in service delivery;
- their own personal process of implementing routine enquiry in an assessment setting; and,
- mapping the availability of appropriate services for survivors and exploring views on the adequacy of these services in meeting the needs of survivors once they had been identified.

Interviews with voluntary sector staff were conducted face-to-face or by telephone, depending on their preference. These staff tended to have less direct involvement or awareness of routine enquiry. The interviews therefore focussed on:

- the type of work with survivors they undertook in the local area;
- the referral mechanisms between them and NHS services;
- their views on the concept of routine enquiry and,
- mapping available services in their area.

Service users with experience of violence and abuse
Interviews with survivors of violence and abuse lasted up to two hours and were conducted in a private, comfortable location chosen by the participant. Interviews with survivors took a free-flowing narrative approach (Riessman, 2008) focusing on their life experiences, including experiences of disclosing abuse, accessing services and outcomes of this. Interviews also included exploring survivors' attitudes, views and experiences of routine enquiry. The interviews were undertaken by highly experienced staff, who worked at the pace of the participant.

A copy of the topic guides for NHS practitioners and survivors is included in Appendices E and F.

Data analysis
A total of 140 participants were interviewed during the case study research (scoping, practitioner and service user interviews) which produced a considerable quantity of data. The interview data from each case study site was managed using the 'Framework' approach (Spencer et al, 2014) widely used in medical and health research (Gale et al, 2013).

The first stage in the process was the creation of an analytical framework – a hierarchy of themes and sub-themes. The framework was developed by the research team after they had reviewed transcripts and field notes to identify key topics relevant to the research questions. An analytical framework was

then developed and a series of matrices drawn up, each relating to a different thematic issue. The columns in each matrix represented the key sub-themes or topics and the rows represented individual participants. Data from each transcript were then summarised into the appropriate cells.

This approach is supported in the software package NVivo 10, developed by QSR International in partnership with NatCen.[4] This software enabled the summarised data to be linked to the verbatim transcript, and meant that each part of every transcript that related to a particular theme was noted, ordered and accessible.

The final analytic stage involved working through the charted data, drawing out the range of experiences and views, identifying similarities and differences and interrogating the data to seek to explain emergent patterns and findings (Spencer et al, 2014). The data could easily be compared across groups (i.e. by case study site or by type of service participants represent). Interviews with service users were managed and analysed using the same process but a different thematic framework, developed to encapsulate the very different accounts provided in the interviews.

Verbatim interview quotations are provided in this report to highlight themes and findings.

Generalisation and limitations

Generalisation in qualitative research – that is whether findings are applicable beyond the sample and context of the study itself – is important. However criteria for understanding qualitative generalisability is often misunderstood (Altheide and Johnson, 2011).

This misunderstanding may in part be due to different types of generalisation being applied to qualitative findings. Empirical generalisation (or 'external validity') refers to findings being applicable beyond the immediate setting or sample (Polit and Beck, 2010). Theoretical generalisation involves building theoretical propositions or concepts that have wider, or even universal, application (Polit and Beck, 2010).

Although the findings presented in this report could have theoretical implications, the research was empirically driven. A key concern of the research team was designing and applying a research process that led to empirically generalisable findings that addressed the research objectives. This was particularly in relation to understanding how to successfully implement RE, and understanding survivors' needs and experiences.

Criteria within the design that can support confidence in the empirical generalisability of qualitative research includes:

- Adequate sampling, ensuring important criteria is identified and the sample is of adequate size and profile to represent this - justification of sample size and profile has been outlined in this chapter.

[4] http://www.qsrinternational.com/support_faqs_detail.aspx?view=1057

- Consistent and in-depth data collection – here the team were fully briefed and worked closely together to ensure key issues were explored and probed in a non-leading manner (Yeo et al, 2014) at each interview.
- Systematic and comprehensive analysis - here supported by the framework approach.
- Interpretations and findings well supported by the data – the findings presented have developed from the data, with illustrative examples from quotes and case studies given throughout.

We can therefore assert the findings have empirical generalisability. However, as for any piece of research there are limitations, and it is important that these are acknowledged. The sample was selected to obtain range and diversity of experiences across key dimensions outlined above. We acknowledge however that future research on the issue, if it aimed to explore factors that have inhibited progress implementing RE, could focus on different sites, such as those known to have made less progress in embedding routine enquiry.

Additional research with service users who have direct experience of routine enquiry, shortly after it has occurred, would also be valuable as participants within this sample had limited recall of being 'asked the question' themselves. Indeed further qualitative research to understand the experiences and needs of each 'abuse group' identified by the latent class analysis would also be valuable. There was not scope to do so within this project but a future qualitative and quantitative segmentation study could provide meaningful understanding of the needs and characteristics of each group.

Within a dynamic, complex and changing policy landscape of the NHS it is also important to acknowledge that recommendations stemming from this research may have to adapt to changing contexts to be feasibly implemented. Despite these limitations, the diversity of practitioners and survivors taking part enabled the research team to fully explore and gain an in-depth understanding of experiences of embedding routine enquiry from a range of different vantage points and across different trusts.

Strand 3 - Development of an outcome framework for survivors of violence and abuse

An outcome measure is "a measure of change, the difference from one point in time (usually before an intervention) to another point in time (usually following an intervention)" (Kendal cited in Department of Health, 2011a: 48). The term PROMS (Patient Reported Outcome Measures) is commonly used in the health sector to denote measures that capture information on the effectiveness of services from the perspective of patients themselves (Department of Health, 2011a).

Approach to developing the tool

Although a range of physical and mental health complaints can be issues for survivors of violence and abuse, traditional health outcome measures are of limited utility where service users' key concerns are immediate safety and protection (particularly in the case of domestic or honour-based violence), practical issues like managing work or childcare in the aftermath, or under the continued threat of violence, or restoring a sense of self or trust in others. Recent research with Rape Crisis Centres (Westmarland & Alderson, 2013) found that professionals working in the field saw existing generic outcome measures and tools as both overly detailed and failing to address the wide range of impacts violence and abuse has on survivors. Strand 3 of the REVA project therefore involved developing an outcomes framework to reflect and monitor the work of specialist violence and abuse support services more accurately than existing measurement tools. In doing this, we built upon work underway in the specialist women's voluntary and health sectors and consulted with a range of individuals and organisations through the REVA reference network.

Before developing our draft outcomes framework we conducted an audit of existing relevant outcome measures[5]. We also consulted with the project reference network, which included service users and specialist violence and abuse service providers, including those for black and minority ethnic women and for male survivors. In addition, we asked a number of interviewees participating in Strand 2 of the REVA research about their views on the outcomes they thought important to measure, and the types of assessments they had had to complete. The draft outcomes tool was refined through cognitive interviews with six survivors and three staff members, who were recruited through agencies that had assisted with this earlier strand of the research. The interviews explored the language used and whether the themes included in the outcomes tool adequately reflected interviewees' experiences of the impacts of violence and abuse in their own lives and their use of services. The feedback provided led to some changes in the wording, ordering and layout of the outcomes tool. We refer to this as the Supporting Survivors Outcomes (SSO) tool in the remainder of the report.

The SSO tool also builds on a number of the measures within the CORE tool and other outcome frameworks (for example, the PROMS for Violence Against Women and Girls (VAWG) services included in the Department of Health (2011a) Guide for Commissioners). However, it differs from its closest equivalents by incorporating measures that go beyond the diagnostic and clinical, and seeks to encompass the multiple impacts experiences of violence and abuse can have on daily functioning as well as physical, mental and emotional wellbeing. We also sought to develop a tool that could be suitable for non-therapeutic services such as those providing advocacy and outreach. Our aim was for the measures to be suitable for use in a range of types of

[5] These included current measures for DH and other government departments, Clinical Outcomes in Routine Evaluation (CORE), the Warwick-Edinburgh Mental Well-being Scale (WEMWBS), Rape Crisis Federation of England's Take Back Control tool, the Outcomes Star, and outcome measures for several local authority VAW strategies, among others.

services addressing various forms of violence and abuse located in both the voluntary and statutory sectors.

The SSO is grounded in service user and practice expertise, and research evidence. The tool, which is divided into two sections, fits on four sides of A4, comprising a total of 34 simply worded items and a small number of open-ended questions. Part 1 of the form, subtitled 'How are you feeling and how are you doing?', consists of 28 items answered on a five-point Likert scale ranging from 'never' to 'all the time' and concludes with three open-ended questions. The majority of items are framed 'positively' and cover six broad domains: feeling in control; health and wellbeing; relationships with others; safety; access to support; and feelings about the violence/abuse. Part 2, 'How are we doing?', comprises nine items regarding the survivors' experience of the service provided. These are again answered on a five-point Likert scale ranging from 'strongly agree' to 'strongly disagree'. This is followed by six items where respondents rate how helpful particular aspects of the service have been, if they have accessed them, and the form concludes with two open-ended questions. In both parts of the form, respondents are asked to provide answers based on how they have felt in the past two weeks.

Pilot

The outcomes tool was piloted in seven services (six voluntary sector, one statutory) located across four NHS Trust areas in September 2013-June 2014. Services were instructed to pilot the tool for either three- or six-month periods depending on the typical length of their contact with service users and when they were recruited to the pilot. Pilot services included those providing individual counselling, group work, practical and emotional support or a combination of these for survivors of domestic violence and sexual violence, including childhood sexual abuse and sexual exploitation. One was a specialist provider for BME women and one was a specialist service for male survivors. Services piloting for a three-month period invited service users to complete the outcomes form twice – once within the first four weeks of contact and three months after initial contact. It was intended that those piloting over a six-month period would invite service users to complete a third form six months after initial contact. However, in practice only the first follow-up forms were completed within the timescale of the project.

At the conclusion of the pilot, the final stages of refining the outcomes tool involved conducting follow-up interviews with nine service users and six staff who had taken part in the pilot about their views of the tool and the process of completing it. The Project Reference Network was also involved in reviewing the modified tool and proposing final revisions.

Sample

Overall, 29 service users and 13 staff across the pilot services took part in completing the forms, with 24 of these service users completing a follow-up form. One additional service user decided not to complete the form at an early stage, and it has not been included in the analysis. Follow-up forms were completed between seven and 14 weeks after the first form, with an average gap of ten weeks. Staff administering the forms kept a log of how the

process had worked in practice at each point of completion, noting any concerns or benefits that arose for either themselves or the participant. These were completed in 20 cases.

The sample of service users completing outcomes forms comprised 24 women and five men[6]. The majority were white British; four of the women were Asian. A small number (n=8) described their religious faith: three Muslim, three Spiritualist, one Church of England and one atheist. Participants ranged in age from 18 to 63; the mean age was 37 years old. They were fairly evenly distributed in terms of the type of violence they had experienced: ten were survivors of sexual abuse as child, nine of sexual violence as an adult, nine of violence from a current/ex-partner and one of sexual exploitation (multiple responses, based on n=21 cases where known). Eight had experienced two or more different forms of abuse. The type of support accessed across the pilot services included primarily counselling/therapy (n=10) and practical/emotional support (n=7), as well as pre-group therapy (n=5), support groups (n=4) and outreach (n=1) (multiple responses, based on n=22 cases where data provided).

Data analysis

Data from the outcomes forms and the service user profile from the log forms were analysed using SPSS. Basic frequencies were conducted of the sample profile and baseline responses. For the 20 cases where two outcomes forms were completed, percentage changes between first and second completion were calculated for each item. All interviews were transcribed and responses to these and the qualitative sections of the log forms were coded thematically.

Research Ethics

Research ethics committee approval

Ethical approval for this study was obtained from the Social Care Research Ethics Committee. Approval for Strand 2 (**12/IEC08/0020**) was obtained in May 2012 and for Strand 3 (**13/IEC08/00/17**) in May 2013. Priorities for ethical consideration in the conduct of this research included:

Informed consent

In any research it is important that informed consent to participate is obtained, but especially so when the research includes populations who may feel obligated to participate such as professionals and potentially vulnerable populations. The consent process is dynamic – agreeing to take part at one point in the recruitment process should not be taken to infer consent at later stages. During this project we were sensitive to the dynamic nature of consent, and wanted to ensure that participants understood taking part was voluntary and felt under no obligation. This was particularly important when recruiting survivors, for whom their abuse may have involved coercion from the perpetrator. Trusted gatekeepers already working with survivors made the first approach, were briefed regarding this and asked to communicate clearly

[6] Reported statistics referring to changes the outcome tool measured do not include the male participants. Due to operational constraints it was not possible for the pilot agency to provide the data.

that participation was entirely voluntary. This was also communicated via written documentation. At the point of setting up and conducting the interview this was reiterated by the researcher and at each stage participants were given the option to 'opt out' if they did not wish to take part.

It was also important practitioners did not feel obliged to take part, and again this was made clear in written and verbal communication by researchers at each stage of the interview process.

All participants were provided with verbal and/ or written information including: who the research was being conducted for; what the research interview would include; how the information they gave would be stored, used, reported and destroyed; that the research interview was confidential and anonymous, and crucially, the limits to confidentiality.

Anonymity and confidentiality
Research maintaining the confidentiality and anonymity of research participants is essential and we adhered to industry standards, such as using encrypted recording devices and only allowing named research staff access to personal information. Additional measures taken for this study included:

- Consent was sought at the outset of the research to name case study and pilot sites and discussed with prospective participants. It was explained that contextual information about each site and the success it has had in implementing 'routine enquiry' may be disseminated with the findings. However it was also explained that specific services or individual participants would not be named and that aggregate findings from across the four case study sites would be used when discussing the experiences of different types of services. The pilot services were also drawn from these areas and from the reference network members.

- Given the focus of the research, explicit permission was gained from survivors before any written information about the study was sent to them. A generic information leaflet that did not explicitly discuss the focus of the research was available for participants who said they wanted this. This was to ensure they could be provided with information but it would not inadvertently disclose they had experienced abuse or accessed mental health services if read by someone else, such as a family member.

- Researchers were careful to explain to participants how confidentiality would be maintained when collecting, storing and reporting research data. The exceptions to confidentiality were also carefully outlined before the interview. In the event that disclosure of risk or harm to the participant or another person occurred, researchers would have implemented the NatCen Disclosure Policy and escalated this within the trust and/or to relevant authorities.

Conduct of interviews

In-depth interviews can provide the flexibility to build rapport with the participant, allow the participants to maintain control of the process and feel empowered to tell their story in the way they want to tell it while minimising the psychological risks from taking part in the study (Webster et al, 2014). Most of the interviews were conducted by the authors who are highly experienced and brought specific skills interviewing potentially vulnerable populations. We were alert to indications of distress or discomfort. Rather than terminate an interview should this occur – essentially silencing a participant and taking away their control of the situation – we would suggest a break, check if they wished to proceed, and ensure they were comfortable doing do or ask them if they would prefer to end the interview.

5. Details of patient and public involvement

Patients and members of the public have been actively involved in this study from the outset. The original idea for the study was discussed with survivor-led organisations at the pre-funding stage and the proposal built on previous research undertaken by members of the team in which service users and survivor led organisations had been involved as advisors, stakeholders and participants. Strand 2 of the project was built upon the earlier evaluation of the introduction of routine enquiry as part of adult mental health assessments in England – an evaluation in which service users were key informants (Scott and McNeish, 2008). Strand 3 was designed on the basis of prior Voluntary Community Sector (VCS) led outcomes development work.

The research team have considerable experience of working collaboratively with survivor-led organisations and in real partnership with service users. Four of the collaborators have direct experience of delivering services for survivors of sexual and domestic violence in addition to conducting research. They brought to the project a range of pre-existing relationships that helped the study get off the ground quickly. Umbrella organisations working in the fields of domestic and sexual violence indicated their interest in the project from the outset. These included: Women's Aid Federation England and Rape Crisis Federation England and Wales and the Survivors' Trust (all organisations in which survivors/service users are actively involved). Representatives from these organisations, alongside those from smaller organisations representing survivors of violence and abuse (including those providing services for male survivors), and researchers were successfully recruited as members of a reference network for the project (see appendix G for list of members). A third of network places were reserved for survivors/service users.

This network has been an important element in the development of the study at all stages. Three face-to-face meetings have been held with reference groups members during the project. At these we have introduced emerging findings and obtained feedback which has then been incorporated in the next stages. Members have provided invaluable commentary and critique of approaches, methods and outputs. They have contributed their thinking, shared their networks, facilitated access to organisations and individuals and aided dissemination of the findings. Most particularly members of the network have ensured that the research findings were clearly expressed and accessible to professionals and survivors/service users and highly relevant to both audiences. They will continue to support the final dissemination stages of the project pending review of this report.

Strand 2 of the project also involved service users as key informants on the implementation, meaning and impact of routine enquiry in mental health services and on what constitutes effective mental health (MH) service provision.

Strand 3 has involved service users at every stage in the development and piloting of an outcomes tool: from identification of the outcomes that were

meaningful to them, through cognitive testing and piloting a tool to providing detailed feedback on the experience of the tool in their own recovery process.

6. How the work addressed equality and diversity issues

This work is centrally concerned with equality issues. Interpersonal violence and abuse involve the abuse of power and differentially impact upon women and girls. However, this study recognised that the feminist origins of much contemporary concern over violence and abuse had helped generate considerably greater knowledge about female experience, and has consequently been concerned to involve men and include male experiences at all levels of the study. We have made every effort – and had considerable success – in including representatives of services working with male survivors in the reference network, in consultations on, and piloting of, the outcomes tool and as service user interviewees.

Each strand of the study has addressed ethnic diversity in terms of: using APMS data which is based on a representative community sample and enables analysis by ethnic group; sampling to include representative diversity among staff and service users in the four case study trusts; designing interview topic guides which addressed issues of cultural difference in relation to interpersonal violence and the discussion thereof; involving services working with ethnically diverse survivors in piloting the outcomes tool.

Strand 1 analyses have provided an evidence base relevant to a wide range of diversity issues. The results demonstrate social and economic inequalities associated with abuse and violence exposure and highlight the need for resources to be targeted towards the greater need in more deprived neighbourhoods. As a large, high quality, probability sample national survey, kitemarked as National Statistics, APMS is a robust source of data for profiling a range of types of inequality. It should be noted, however, that as a survey of people living in private households, some of the very most disadvantaged in society would have been excluded from the sampling frame: people living in insecure housing or who are homeless, and those in offender or other residential institutional settings such as care homes. It should also be noted that while the survey was designed to be straightforward to complete, those with severe cognitive impairment or learning disability would not have been able to participate.

7. Key findings and their policy relevance

Strand 1 findings

Three quarters of the population have little experience of violence and abuse in their lives. The remaining quarter is made up of five groups with distinct patterns of abuse experience. The groups differed from each other in terms of their mental and physical health and economic and social wellbeing. Poverty, disability, poor health and health risk behaviours are much more common among groups characterised by violence and abuse.

The two groups that experience the poorest outcomes are those with the most extensive experiences of violence and abuse. One of these groups, representing 1 in 50 of the population, is made up of those who have suffered the most extensive physical violence and coercive control by a partner (in terms of severity and frequency) and the other, representing 1 in 25 of the population, is composed of those who have experienced extensive abuse in both childhood and adulthood – often including sexual abuse as a child, violence by a partner and rape as adults. The prevalence of mental illness among people in both these groups is extremely high: over half (53%) of those experiencing extensive abuse as adults and children have a common mental disorder and nearly a third (29%) had attempted suicide (compared with 2% of those who have experienced little violence or abuse).

There is a high level of unmet mental health need among survivors of extensive violence and abuse which needs to be addressed. (Despite being 15 times more likely to have three or more mental disorders they were only four times more likely to discuss their mental health with a GP.)

What is new about these findings compared to previous research into the relationship between violence, abuse and mental health is that they make clear that it is particular patterns of experience which have the strongest impacts on adult mental health and wellbeing. There are two key findings:

1. The identification of the group of survivors with the poorest outcomes being those with the most extensive experience of abuse as children and adults. This finding confirms in an adult population the strong impacts of ‘poly-victimisation’ which Finkelhor (2008) has identified in children and adolescents, and suggests that the compounding effects of different experiences of abuse may continue across the life-course.

2. The identification of a high level of mental health difficulties among those survivors who had suffered the most extensive partner violence (but had mostly not experienced other kinds of abuse). While the mental health impacts of some other forms of violence and abuse (particularly child sexual abuse) have previously been recognised, there has been little research on the long-term mental health consequences of domestic violence.

The implications of these findings for MH policy and practice are profound. They clearly evidence the necessity for an understanding of the impacts of violence and abuse to underpin the commissioning of services and the training of MH staff. The key implication of these findings is that addressing the long-term consequences of violence, trauma and abuse should be regarded as 'core business' for mental health provision and that routine enquiry about experiences of violence and abuse would be appropriate in a population with such high prevalence rates. The specific policy implications are that:

- Health Education England should develop a strategy to ensure that all current and future MH staff receive adequate training and support for responding effectively to survivors of violence and abuse. This should includeworking with the Royal Colleges and the Universities to ensure that all pre-registration training includes coverage of these issues proportionate to the numbers of survivors of abuse likely to be amongst students' future patients.

- NHS England commissioning assurance should include routine enquiry in clinical commissioning. In turn, Clinical Commissioning Groups should require Trusts to deliver mandatory training for all staff conducting assessments to support routine enquiry about patients' experience of violence and abuse (see Strand 2 implications).

- Mental health teams should designate a violence and abuse lead to receive specialist training to enable them to support other staff in direct work, signpost and refer appropriately to specialist services and act as the link with such services and with the Trust Safeguarding lead.

- Public Health England and local authorities should note the clear links between the experience of extensive abuse and disability, alcohol and drug dependency and smoking.

- DH should recognise through the National Suicide Prevention Strategy the strong link between extensive experience of violence and abuse and suicide attempts. This analysis shows that suicide attempts are 15 times more likely among people who have experienced extensive violence and abuse.

Strand 2 findings

The two key findings concerning routine enquiry about experience of violence and abuse as part of mental health assessment are:

1. Routine enquiry is acceptable to and considered desirable by survivors.

2. Routine enquiry can be effectively embedded in practice where:

    - There is strategic leadership and commitment;

    - Overall responsibility for implementation is allocated to someone; with sufficient authority and local responsibility is delegated to managers and clinical leads in each service;

    - It is regarded as an integral aspect of safeguarding;

    - 'The question' is included in all relevant assessment documentation and in clinical audit;

    - Adequate training is provided;

    - Staff have access to specialist advice and supervision when required.

The policy implications of these findings are that:

- Health Education England build on and disseminate the DH commission of the re-design and updating of training materials for a one-day course to support staff in undertaking routine enquiry.

- Monitor and NHS Trust Development Authority remind NHS Trusts that it is DH policy that…'once adequately trained all staff conducting mental health assessments ask about experiences of violence and abuse in mental health assessments'. This can be achieved by comprehensive dissemination of REVA Briefing 2.

- Clinical Commissioning Groups require their provider mental health services not currently providing mandatory training to support RE.

- The Mental Health Minimum Dataset (now the Mental Health and Learning Disability Dataset) asks Trusts to report how often the question about experiences of violence and abuse is included in assessments. Their response should be designated as mandatory rather than required.

- Commissioners should be reminded of DH guidance on commissioning services for women and children who have experienced violence and abuse (2011). They should be alerted to the fact that while over 80% of those adults who have experienced the most extensive violence and

abuse (with the most severe impacts on mental health) are women, 20% are men, and services to meet their needs are also required in accordance with Equality Act duties. Good commissioning practice can be supported by comprehensive distribution of REVA Briefing 4.

- The principles of RE align perfectly with recent NICE guidelines focusing on how health services, social care and organisations they work with can respond effectively to domestic violence and abuse. This alignment should be made explicit, as the successful implementation of RE as a policy would naturally support the implementation of NICE recommendations. A requirement to implement RE could also be embedded in national outcomes frameworks, given the associated potential increase in identification and referrals (Feder et al, 2011) that could lead to improved health outcomes across a range of dimensions.

Strand 3 findings

- On the whole, services responded positively to piloting the SSO tool. Problems in recruiting participants experienced by a minority of pilot services were largely linked to funding and capacity pressures, which in some cases affected levels of staff engagement with the process and ability to provide data.

- There was wide agreement among both service providers and service users taking part in the pilot that the outcome measures and format of the SSO tool were clear and accessible. Service users agreed that they captured a range of elements that resonated with their experiences of the impacts of violence and abuse.

- Completion rates among participants were extremely high across all measures, suggesting that overall the measures were clearly worded and not overly intrusive.

- The measures included were broadly relevant across service types and user groups.

- A flexible approach to completion is beneficial, and service users often welcomed the option to have assistance. However, as the SSO tool was often completed in or immediately pre/post sessions, sometimes cutting into support time, the resource implications for managing this process do need to be factored into use on a wider scale.

- Service user participants in the pilot experienced changes across many measures between completion of the first and second forms, particularly in relation to their awareness of available support, feelings about the abuse and sense of control over their lives, as well as in their assessments of their health and well-being.

- For service users, gaining a sense of this change and improvement was valued extremely highly.

- The pilot services scored extremely highly across the majority of measures relating to service quality.

- For some services participating in the pilot, there were overlaps between the SSO and existing monitoring tools.

The policy implications of these findings are:

- Resources and capacity for outcome measurement must be built into service schedules, as otherwise this takes time away from sessions, which may be time-limited.

- Effective implementation of a consistent outcome framework will require buy in and support from senior policy and operational levels. DH and PHE should identify and agree a relevant framework and invest in the development and roll-out.

- The role and value of using the outcome measure tool for both service providers and service users must be clearly communicated to ensure engagement in the process. This could be further enhanced by the development of practical tools and technology that supports the use of SSO, such as a dashboard and reporting templates.

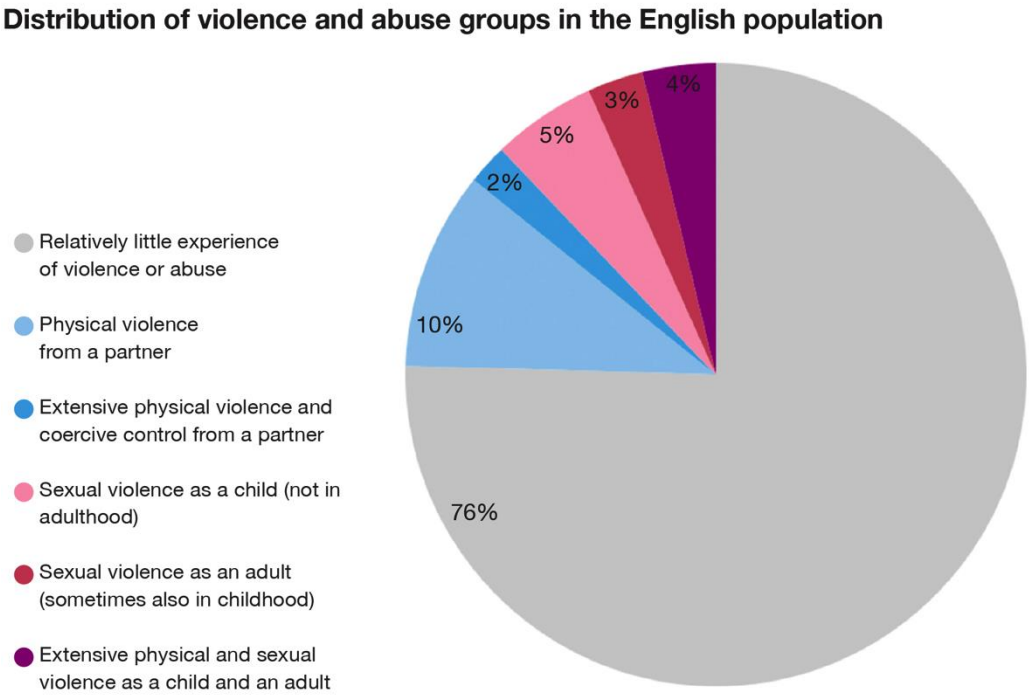
- Service users appreciate the need for information and the chance to be heard. A feedback loop should be built into service standards whether there is a recognised outcome framework in place or not.

- Streamlining the outcomes form process by integrating the measures with Core Outcome Measure (CORE-OM) or other existing monitoring/outcomes tools would lessen the burden of additional form filling.

8. Results

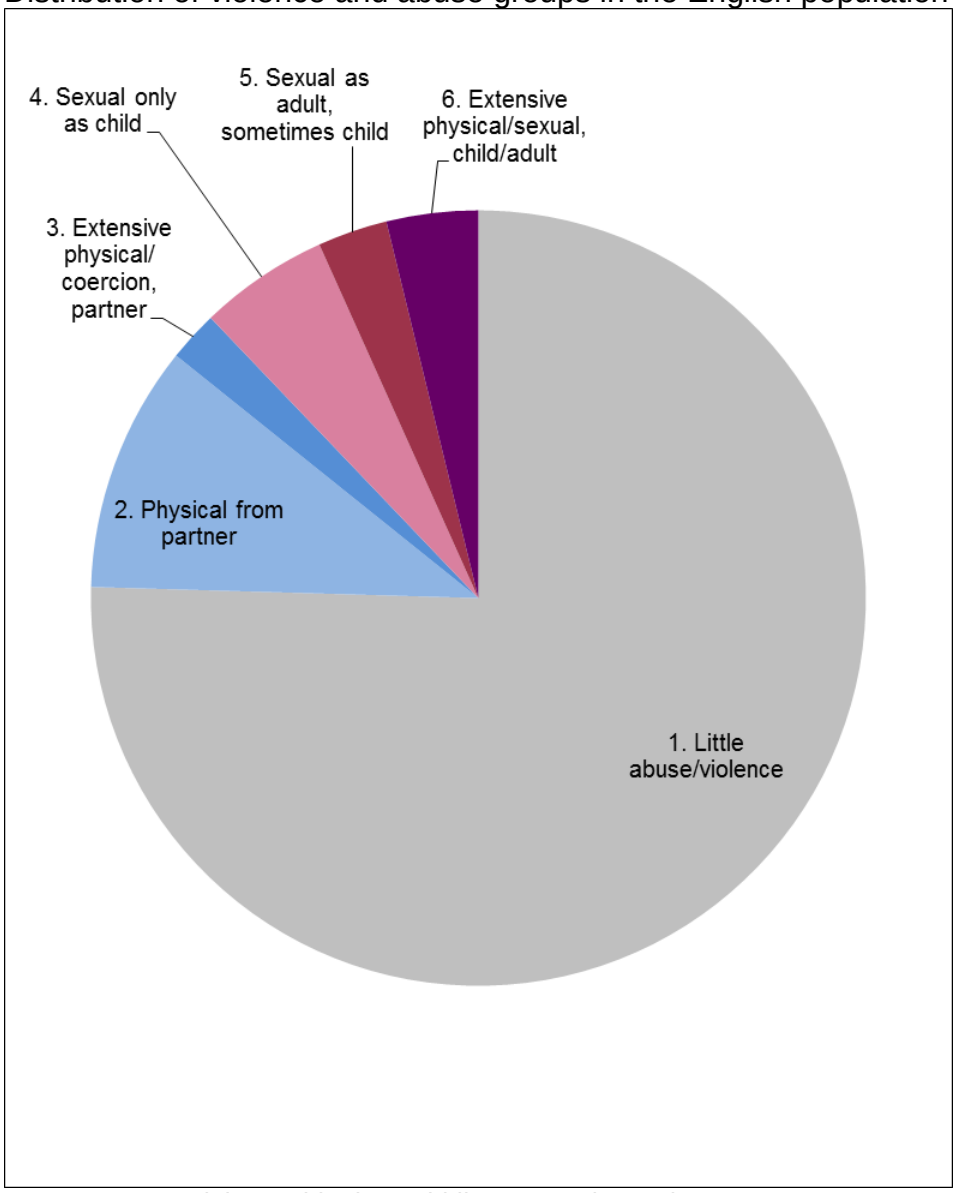
Findings from strand 1: APMS analysis

The first strand of research involved secondary analysis of the APMS dataset. From this we found that the population can be divided into six different profiles based on lifetime experience of a wide range of different types of abuse and violence. We were also able to explore other outcomes associated with these difference abuse experiences.



Data source: Adult Psychiatric Morbidity Survey (APMS) 2007

Distribution of violence and abuse groups in the English population



Data source: Adult Psychiatric Morbidity Survey (APMS) 2007

Group 1: Relatively little experience of violence or abuse
Three quarters (76%) of the population belonged to this group and had relatively little experience of any of the types of abusive experience asked about. However, even in this group, 3% had been prevented by a partner from seeing friends and family, and 2% had household finances withheld. Fourteen per cent reported some experience of having been bullied.

Group 2: Physical violence from a partner
One in ten (10%) belonged to this group. 81% of whom had been 'pinned down, slapped, pushed' by a partner, and 61% had been 'kicked, bit, hit'. There was some evidence of coercive control. For example, a third (33%) had been prevented from seeing friends/family and 39% were threatened with hurt. However, sexual abuse and the more 'severe' types of physical abuse (choking, use of weapon, threatening to kill) were rarely reported by members of this group.

Group 3: Extensive physical violence from a partner
One in fifty (2%) were assigned to this group. 81% of people in this group had been threatened with death and 53% had weapons used against them. Almost all had been ‘pinned down, slapped, pushed’ and ‘kicked, bit, hit’ by a partner, and two-thirds (65%) had also been choked. They had experienced high levels of coercive control. However, members of this group had experienced very little sexual violence.

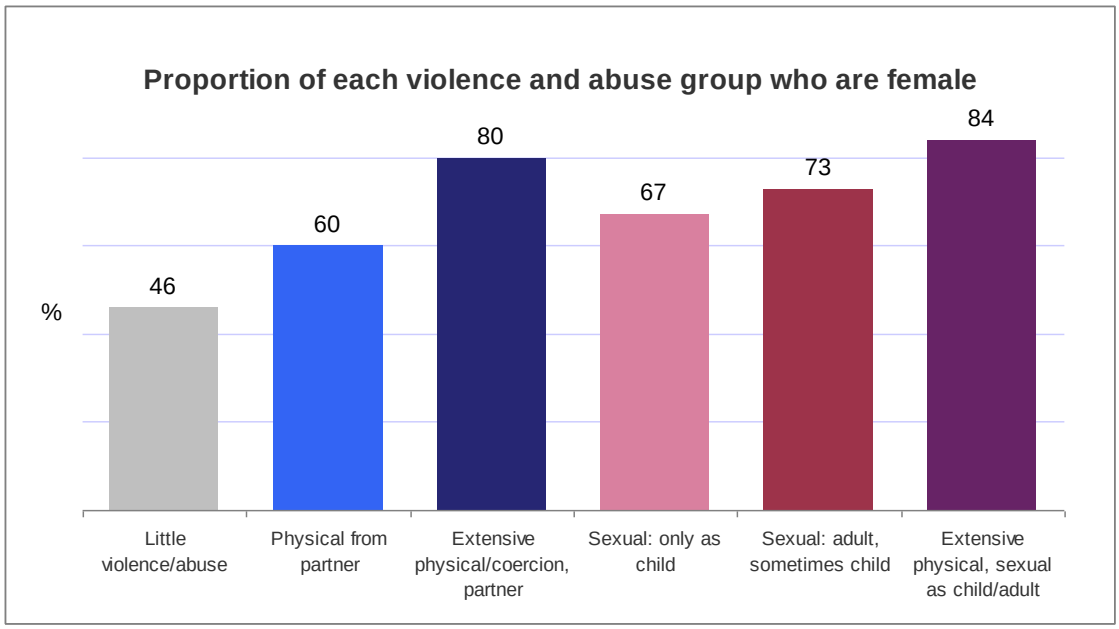
Group 4: Sexual violence as a child (not in adulthood)
One in twenty (5%) belonged to this group. 85% had been ‘talked to in a sexual way' and 66% had been touched sexually as a child. 13% had experienced non-consensual sex in childhood. 13% of people in this group had been beaten by a parent. Although almost half had experienced non-consensual sexual talk in adulthood, few had experienced abusive sexual contact as an adult.

Group 5: Sexual violence as an adult (and sometimes also in childhood)
Three per cent of the population was in this group. The abusive experiences that defined this group were almost entirely sexual. Virtually all (99%) had experienced non-consensual sexual touching as an adult, and almost a third had non-consensual intercourse in adulthood (30%). Childhood sexual abuse was also evident in this group: half had been 'talked to in a sexual way' and 40% had been touched sexually as a child.

Group 6: Extensive physical and sexual violence as adult and child
One in twenty-five (4%) of the population was in this group. Almost all had been ‘pinned down, slapped, pushed’, as well as ‘kicked, bit, hit’ by a partner, and had experienced high levels of coercive control. In addition, they had suffered very high levels of severe sexual violence: 38% had non-consensual sex in adulthood and 23% had experienced this as a child.

Profiles of the six groups

Sex, age and ethnicity
Women were more likely than men to be in every abuse group, especially those groups where such experiences were most extensive. 84% of those in the ‘extensive physical and sexual violence’ group were women. However, men were present in every group. The people most likely to be in a group characterised by violence and abuse were divorced women aged 35 to 54.



Data source: Adult Psychiatric Morbidity Survey (APMS) 2007

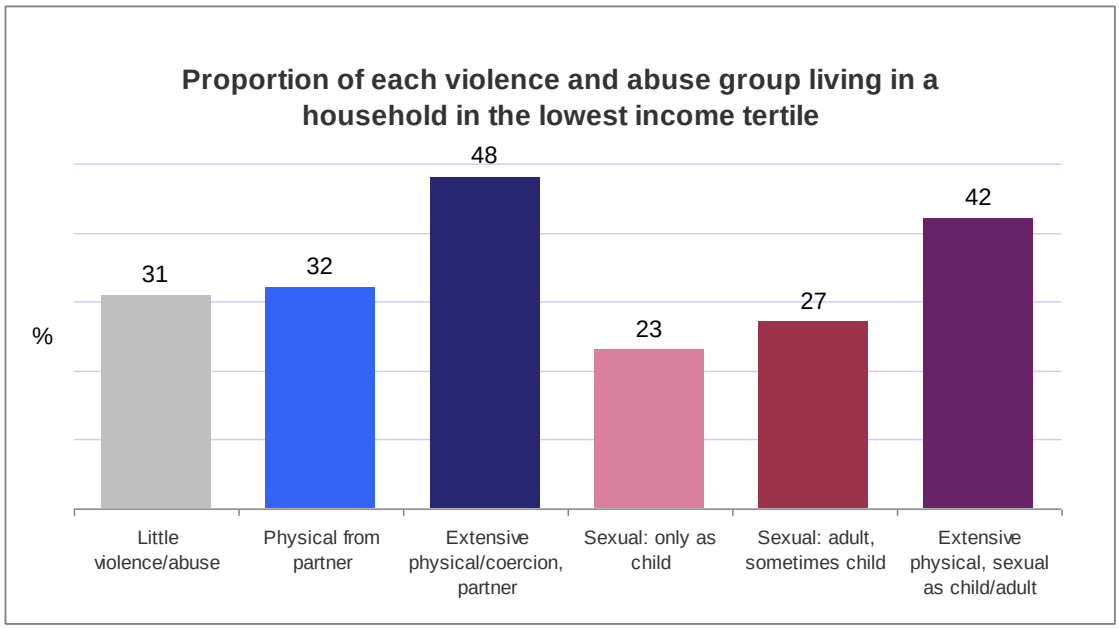
Divorced and separated people were overrepresented in groups characterised by extensive violence and abuse, and older people (and the widowed) were overrepresented in the 'little violence or abuse' group. The low prevalence of older people in the groups characterised by violence and abuse may be partly due to under reporting of violence by this age group.

In terms of ethnicity, white people were overrepresented in one of the two physical violence only groups, and black people were overrepresented in the 'extensive physical and sexual violence' group.

Socio-economic profile

Extensive experience of violence and abuse was more common among people with a lower household income, a low level of educational qualification (GCSE or equivalent) and living in rented households, in the most deprived neighbourhoods. However, this pattern did not hold for all groups characterised by violence and abuse. Having a degree, for example, was associated with being in one of the two sexual violence only groups.

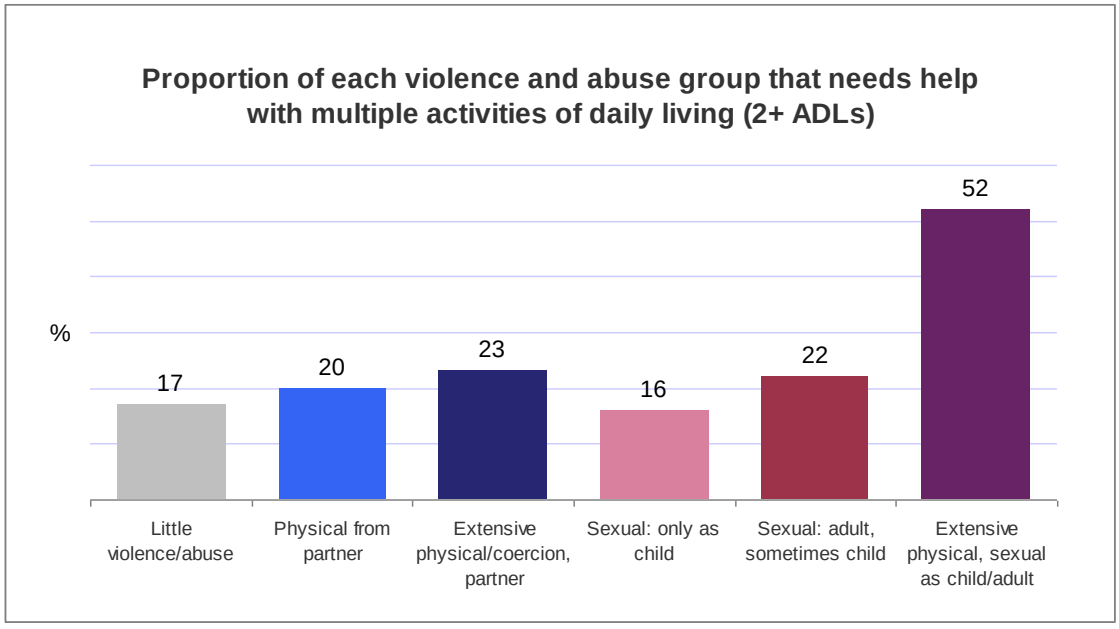
While there were associations between socio-economic factors and abuse and violence, what was even more pronounced was the fact that violence and abuse are experienced in all socio-economic groups. For example, 29% of people with extensive experience of physical and sexual abuse live in the third of households with the highest income.



Data source: Adult Psychiatric Morbidity Survey (APMS) 2007

Health, wellbeing and disability

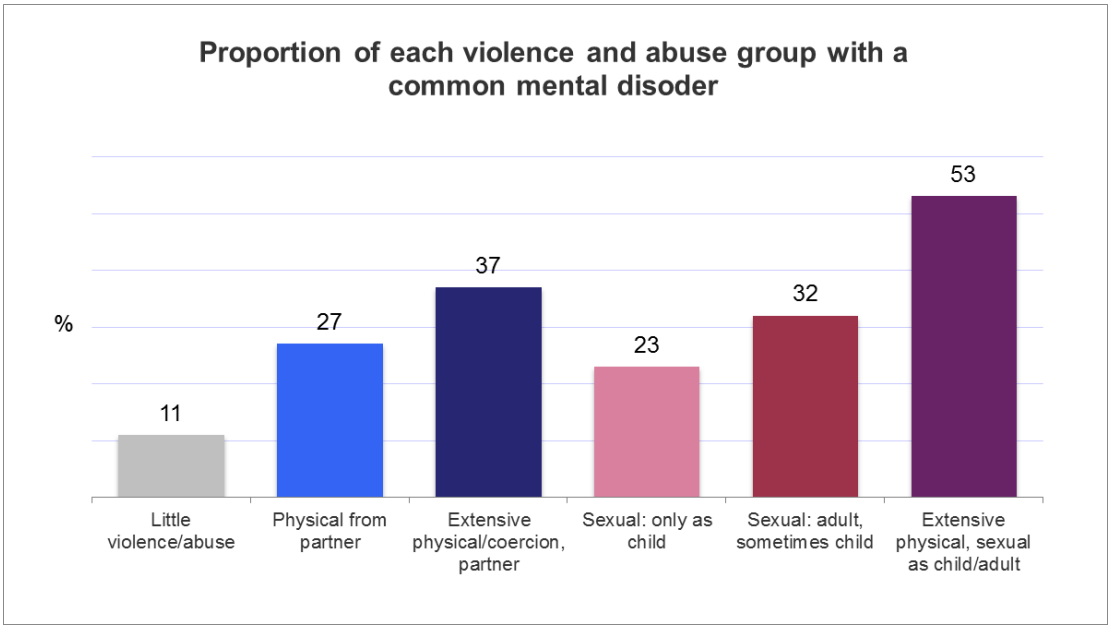
Violence and abuse were strongly and consistently associated with poor health and disability. People in the two groups characterised by extensive violence and abuse were most likely to describe their health as 'fair' or 'poor'. People in all the violence and abuse groups were less likely to regard themselves as 'happy' compared with people in the 'little violence or abuse' group. Most violence and abuse groups were associated with people having difficulty with one or more 'activities of daily living' (ADLs provide an indication of disability). People in the five groups characterised by experience of abuse and violence were also more likely to be providing care for someone else due to the other person's ill-health or disability.



Data source: Adult Psychiatric Morbidity Survey (APMS) 2007

Common mental disorders

Violence and abuse are strongly associated with Common Mental Disorders (CMD) such as anxiety or depression. People in the 'extensive physical and sexual' violence group were five times more likely than those with little experience of violence to have a CMD. More than half of this group met the threshold for a CMD.



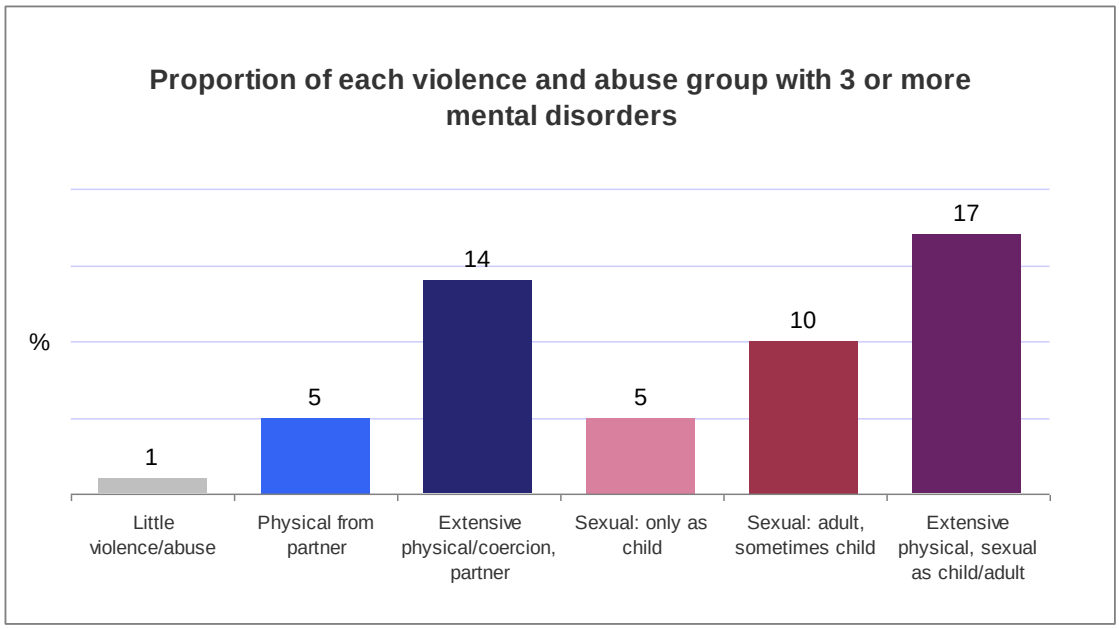
Data source: Adult Psychiatric Morbidity Survey (APMS) 2007

This same pattern held true for individual disorders (such as phobias, depressive disorder and generalised anxiety disorder). Phobias were present in 10% of people in the extensive physical violence group and 14% of people in the extensive physical and sexual group. This compared with a prevalence of 1% among people with few such experiences.

Other mental disorders

Violence and abuse are not just predictive of common mental disorders. A wide range of different mental disorders, including screening positive for psychosis, post-traumatic stress disorder (PTSD) and eating disorders, showed strong and consistent associations with such experiences.

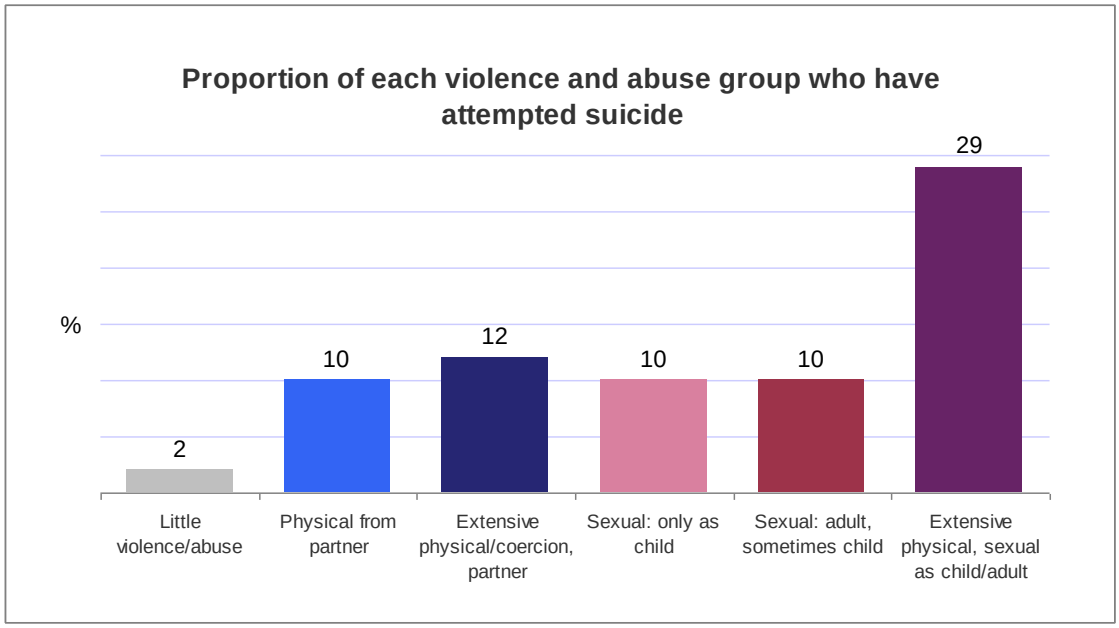
There was also a strong link with having more than one disorder. People in the 'extensive physical and sexual' group were about 15 times more likely than those with little experience of violence and abuse to have three or more disorders present at the time of interview.



Data source: Adult Psychiatric Morbidity Survey (APMS) 2007

Suicide and self-harm

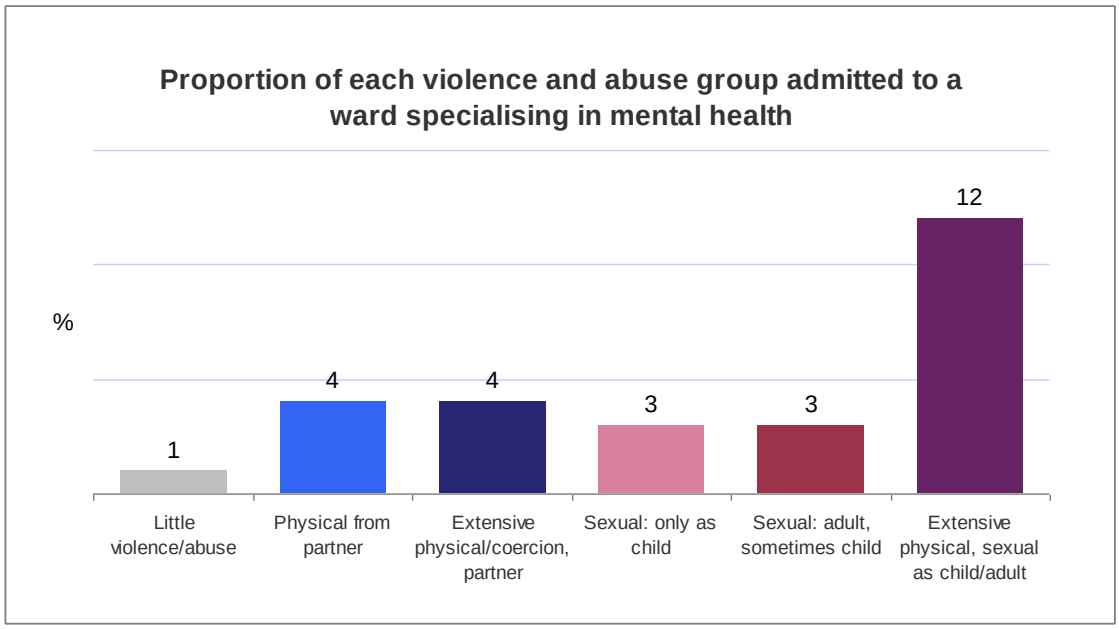
There is a strong association between experience of violence and abuse, and suicidal behaviour. People in all the groups characterised by violence and abuse were at least five times more likely than those with little experience to have attempted to take their own life. People in the 'extensive physical and sexual group' were fifteen times more likely to have done so, and 4% had made an attempt in the last year. 56% of people in this group had self-harmed at some time – compared to 10% of those with little experience of violence and abuse.



Data source: Adult Psychiatric Morbidity Survey (APMS) 2007

Mental health treatment and service use

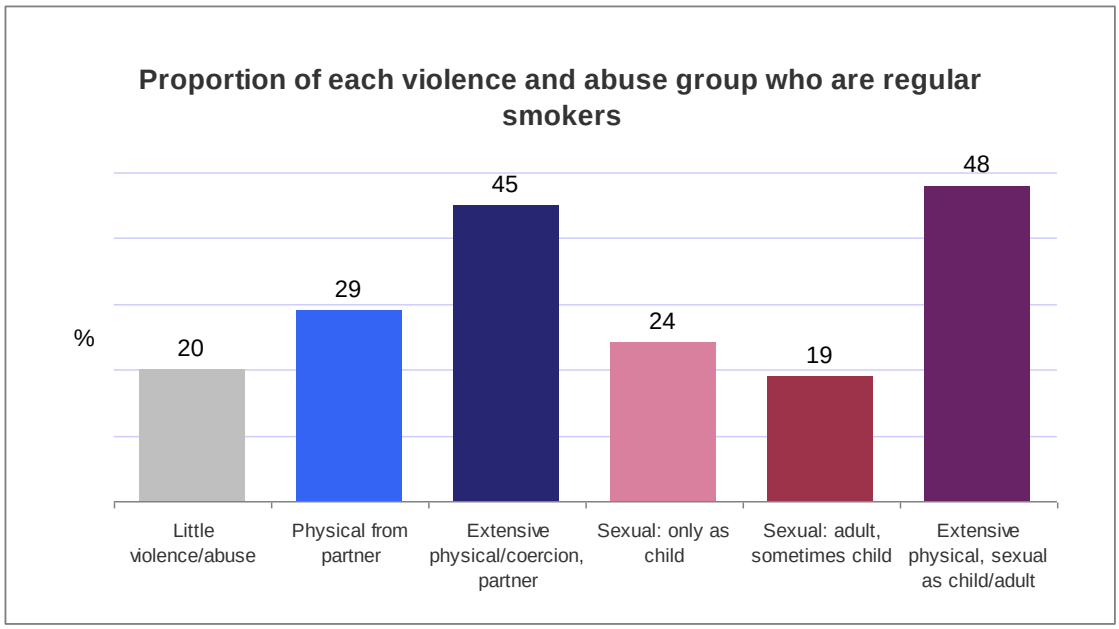
Use of community mental health services was not as common as might be expected given the rates of poor mental health in the violence and abuse groups. Only 10% of people in the 'extensive physical and sexual' group were currently in receipt of a talking therapy, despite more than half this group having a CMD and 16% screening positive for post-traumatic stress disorder. However, 12% of people in the extensive physical and sexual group had been admitted to a unit specialising in mental health. Such high rates of use of secondary health care services may indicate a failure of primary and community care providers to meet the needs of people with experience of violence and abuse.



Data source: Adult Psychiatric Morbidity Survey (APMS) 2007

Health risk behaviours

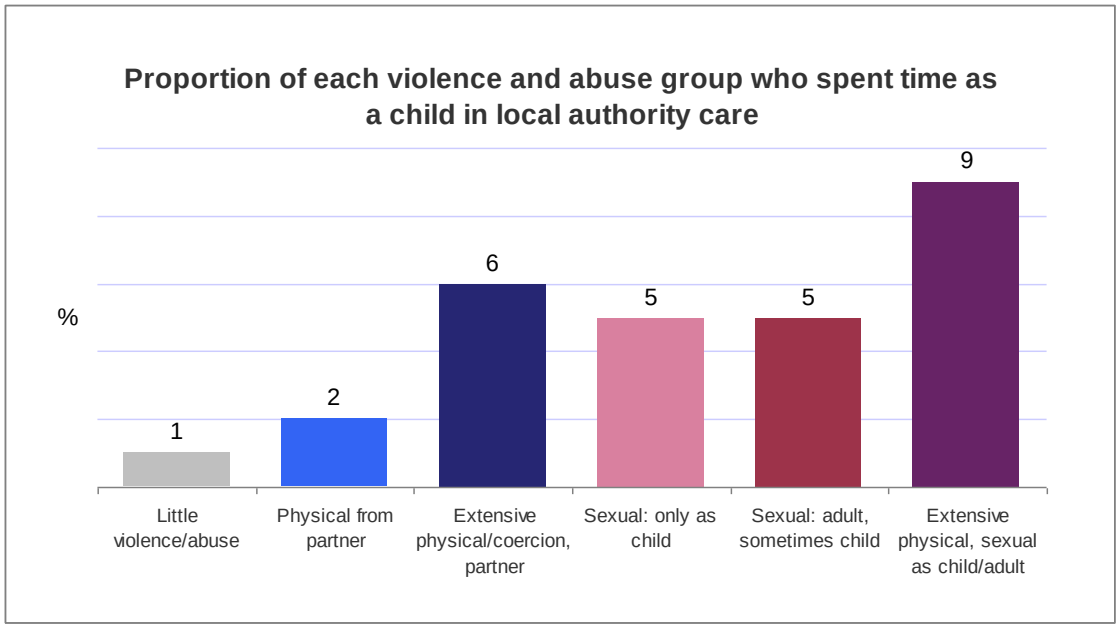
Violence and abuse are strongly associated with a range of health risk behaviours. People in the two groups characterised by extensive violence and abuse were more than twice as likely to be dependent on illegal drugs and to be smokers as those with little such experience. Alcohol dependence was also more common among people in the two 'extensive violence' groups. 38% of people in the 'extensive physical and sexual violence' group had a problematic pattern of alcohol consumption.



Data source: Adult Psychiatric Morbidity Survey (APMS) 2007

Experience in the early years and parenting

People in the two groups characterised by extensive violence and abuse were less likely to have lived with both natural parents to the age of 16. They were more likely to have spent time in an institution or local authority care. We do not know whether the childhood experiences of violence and abuse preceded going into care or happened while they were in care.



Data source: Adult Psychiatric Morbidity Survey (APMS) 2007

People in the groups characterised by physical violence were more likely to have children of their own (compared to those with little experience or in a group characterised by sexual violence only). The impact of domestic violence on children is now widely recognised.

The first strand of the research strongly highlighted the way in which different experiences of abuse and violence could be associated with different outcomes. These strikingly related to increased poor mental health, suicide attempts and self-harm. Abuse and violence is therefore a key business for mental health professionals. In the next stage of the research, having clearly established the importance of RE, we explored the implementation of RE in four Trusts.

Findings from strand 2: The building blocks for effective implementation of RE in mental health trusts

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

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

Strategic leadership and commitment

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

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

Effective implementation is greatly assisted by two other kinds of leadership. First, that provided by RE ‘champions’: in the case study trusts these were most often RE trainers who had played a dual role as effective champions of

RE within their own services. And second, by team managers who kept RE on the agenda by discussing it in team meetings and supervision, and who themselves modelled good practice in responding appropriately to survivors of violence and abuse. Both managers and champions provided consultation and support and thereby increased staff confidence in their ability to respond helpfully to disclosures.

Training

Training is key to ensuring staff understand the importance of RE and have the confidence to undertake it. This finding was supported by recent trials such as IRIS, which found training, alongside interventions, may increase clinicians' referrals to domestic violence advocates (Feder et al, 2011). Training is particularly important given that pre-registration curricula contain little or no reference to the significance of violence and abuse for mental health. A one-day training workshop *Asking the question about violence and abuse in mental health assessments* developed for the RE implementation pilot in 2006 has continued to be delivered on a regular basis in the case study trusts. It was most successful in reaching a critical mass of staff where it had been rolled out to all levels and grades of staff from consultant psychiatrists to healthcare assistants and where it had mandatory status. The importance of the training being mandatory was emphasised by staff: '*by its very nature this is not something a lot of people are going to opt-into. It needs to be automatic for everyone or it just won't happen'.*

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

It was suggested that the training materials now required some updating to reflect recent research and that the focus on child sexual abuse should be reduced to enable greater coverage of other forms of violence and abuse[7].

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

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

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

[7] An updated version of the training materials has been commissioned by DH and will be available to Trusts in Autumn 2014.

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

Yes	*None stated*	*Not asked*

If 'Yes', record brief details:……

If question not asked, please state reason:……..

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

From 2012, Trusts were required to return quarterly figures on how frequently the question was asked to the NHS Information Centre (now the Health and Social Care Information Centre) as part of their Mental Health Minimum Dataset return. However, a number of Trusts failed to return complete data last year.

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

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

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

However, others clearly recognised the danger of making assumptions about who the question was relevant to and the importance of asking routinely.

None of the case study trusts had undertaken regular internal auditing of the question so definitive benchmarking is not possible. Audit data covering a

three month period in 2012 was supplied by one trust which showed that in 50% of cases it had been recorded that the question had been asked at an assessment or review. Twelve months data in another trust showed that in 83% of assessments it had been recorded whether service users were known to have experienced violence or abuse.

Support for practice development

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

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

Partnership working with voluntary agencies

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

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

Voluntary sector interviewees in the case study trusts were equally concerned that referral needs to be an appropriate and collaborative process rather than a matter of 'refer and run'. This was considered all the more important because that they were increasingly working with clients with complex needs who would have been in statutory services a few years ago. Good examples of collaborative working included formal links between statutory and VS agencies, shared training and 'shared care'. For example, one voluntary agency manager described how:

> *'If someone has disclosed on a ward I'll visit and work with staff to do a risk assessment and organise continuity of care in the community…we'll also try to bridge the gap with emotional support while someone is waiting for therapy'.*

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

- Ask everyone: don't try and judge whether the question is appropriate to individuals.

- Don't worry about people taking offense or being upset – all the evidence suggests that people don't mind being asked and survivors welcome it.

- Be flexible about when to ask the question, whilst being clear that it has to be asked.

- Don't make false promises about confidentiality – keep safeguarding in mind and address any current safety issues.

- Don't rush people - book extra time if necessary for appointments to complete assessments.

- Be patient, listen genuinely and let people tell their story in the way they want to.

- Take seriously every disclosure even if the client has a history of false claims.

- Give a clear message that violence and abuse should not have happened/should not be happening.

- If the answer is 'no', don't just tick the box and move on. Always acknowledge that abuse can be difficult to talk about and that if they ever needed to discuss an abuse issue there are people ready to listen.

- Re-visit the question because people will only disclose when they are ready and some people only disclose when trust has been built up.

- Find out what your Trust can offer survivors and about local voluntary sector specialist services and how they work so you can signpost clients appropriately.

- Share disclosures with your team, and ask for ideas about how to ask the question and respond to it.

Findings from strand 2 (cont): Why asking about abuse matters to service users

The findings from strand 1 highlighted that people who suffer violence and abuse are much more likely to have a mental disorder, self-harm or attempt suicide than those with little or no experience of this kind (Scott et al, 2013).

Given the prevalence of experiences of abuse among users of adult mental health services it is vitally important that these experiences are identified to ensure appropriate diagnosis, support and referral. Routine enquiry represents a policy and structure that supports asking about abuse, routinely, in AMHS assessments. The findings from interviews with professionals from strand 2 highlighted the building blocks required for the implementation of routine enquiry as a policy and 'good practice' aimed at practitioners for 'asking the questions'. One of the perceived barriers to implementing routine enquiry is practitioners' reluctance to ask about abuse for fear it may cause more harm than good by opening up the issue of abuse. In this section we present findings from interviews with service users, focussing their experiences of being asked about abuse and views of routine enquiry.

Disclosing experiences of violence and abuse can be very difficult. Survivors can feel a deep sense of shame and responsibility for the abuse they have experienced – feelings that are often strategically encouraged by their abusers (Clark and Quadara, 2010). These feelings can be compounded by unhelpful responses from professionals when they try to disclose it. Survivors consistently say that disclosure has to be 'at the right time for them', which may be immediately or many years after the abuse (McNaughton Nicholls, 2012).

Views on routine enquiry

As outlined in the introduction a range of research indicates that most survivors of violence and abuse do not mind, or indeed welcome being asked about a possible abuse history. Confirmation comes from studies which have focused on survivors of childhood sexual abuse (Nelson, 2001; Zeitler et al, 2006; Renker et al, 2006) and on those experiencing domestic violence. A systematic review of qualitative studies found that survivors of domestic violence want to be asked by doctors (Feder et al, 2006). Similarly, interviewees in this study were overwhelmingly positive about the policy of routine enquiry:

> *"I think it's very important… But there's more answers than just 'yes' or 'no'….You need to ask some quite searching questions…and I was always happy to answer them as far as I could at the time. But I could only respond 'yes' when I felt sure and confident in the service… and I look back now and I think 'yeah you were ready', I responded to Dr M because he was a different sort of psychiatrist, the building blocks were in place at that time."*

In the research survivors talked about the consequences of not being asked about their experiences of abuse. They described feeling as though their experiences were not considered relevant to their mental health, that nobody wanted to hear about them, which suggested that such things were best not spoken of. Not being asked directly about abuse thus encourages people to keep it a secret and makes them more vulnerable to re-victimisation.

> *"The biggest problem for me, I think, was nobody asked me. …so my perception was these things happened in my childhood, and [my*

mental health] is just as bad now as it was then. It wasn't: 'I might be having trouble because those things have happened'. It just showed how bad I was."

Experiences of being asked about abuse

None of the survivors interviewed recalled having experienced routine enquiry as part of an initial or follow-up mental health assessment. However, there were accounts of being asked about experiences of violence and abused by professionals – most often people with whom they had an ongoing relationship. Those who had been asked described being pleased and relieved that this had happened – even when their immediate response had been to deny any such experience. Some wished they had been asked sooner. Others felt that they would have disclosed anyway but that it would have taken them longer to do so. Some reported having been asked several times before they disclosed. Survivors said that being asked the question was an acknowledgement that their experiences were important, gave them permission to talk about their abuse and in some cases enabled the start of a therapeutic process to address its impact. For some survivors being asked was the most important and helpful thing that had happened in services.

"Bless her, I guess she knew the right questions that needed to be asked and it was the first time anybody had ever asked me…. [When she asked] I felt sick to my stomach. [And] I thought, 'I'm - I'm going to have to get out of this room.' And then I thought, 'If you go out of this room, that's it. It's... you're never going to be able to go back.' So, I sat there and … then I got this feeling of relief to think that somebody had noticed that there was something very wrong … yeah, a - a feeling of absolute relief to know that I wasn't going to be burdened with it anymore."

Others felt that they had to be asked to be able to find the language and strength to disclosure the abuse they had experienced.

"*I don't think I had the words. I don't think I knew how to begin, or what to say, or...yeah, even when I did start to talk about it, it took me a long time to really find the words to tell my story"*

One interviewee recalled being asked the question as a life or death issue.

"[If I hadn't been asked then] I think I'd have been in real trouble. I don't think I would be here now."

Some survivors had not waited to be asked but had spontaneously disclosed to a range of mental health, and non-mental health professionals including GPs, nurses, police officers, psychiatrists, psychologists, and, in some cases, to several staff on different occasions. Some staff had responded helpfully and/or referred them to specialist help.

In other instances, disclosures were not responded to, or were met with an unhelpful response. There were examples of disclosures not being 'heard'

e.g. someone telling a member of staff and it never being mentioned again. Survivors quite commonly recounted their experience of disclosing abuse at a time of crisis. It was not unusual for these disclosures to be dismissed or set aside as less important than the treatment of immediate symptoms. The issue was not always returned to. There were other examples of people repeatedly asking for help to deal with their experience of abuse and only being offered medication.

> *"There was no real in-depth discussion. We talked around things but I didn't feel people were getting it. …I felt I was going there for a snapshot and people were asking me how I'd been over the last two weeks and whether I was suicidal or not… So I felt that I was just being kept an eye on. Are you a risk, are you not a risk? Lots of medication. One person did ask 'is there anything bothering you?'… I said 'well I had this thing in childhood' - I didn't call it abuse or anything. And I remember being incensed because I saw her a few weeks later and she said 'Oh you mentioned so and so, is that still a problem for you or are you all right with that now?'"*

Survivors also reported feeling a lot of guilt about not disclosing earlier as well as anger about not being asked. Sometimes following a disclosure they had been able to seek justice and protection for others, as well as therapy for themselves, and this could be enormously healing.

> *"The police are re-investigating [my abuser]… and that was like a massive sort of change for that to actually happen and just sort of switched things around a bit. And I actually wanna be part of society now, whereas before I just. I was quite happy not properly engaging with it at all".*

However, a disclosure that exposes safeguarding issues can have a mixed impact on a survivor. The consequences of disclosing abuse when children may be at risk can be massive for survivors – they may risk losing their children, home or extended family. This issue highlights the difficult decisions people face when asked if they have experienced abuse and it is in this context that we asked survivors for their views about how this question should be asked.

Recommendations from service users: how to ask about abuse

Participants had some clear messages for services about when the question should be asked and how people should respond to a disclosure. These are summarised below.

Ask as early as possible

Survivors described missed opportunities when they wanted someone to ask them about their abuse and it did not happen. They spoke of finally disclosing much later than might have been the case had they been asked sooner, and of having been in contact with a range of services that could have helped but did not, sometimes over years e.g. with GPs, maternity services and A&E as well as mental health services. They expressed anger that nobody had asked

them when they were younger and gratitude when people had. In some cases, people had used mental health services for many years before they felt able to tell someone. One man who had first gone into hospital 20 years ago in his teens described how his then recent abuse was simply ignored.

> *"All that was treated at that time was the effects…the symptoms. My mum did say to them about [the abuse] and they, they were just like 'oh that's not really an issue', what the issue is dealing with the mood swings and trying to control those with medication rather than what was causing them.'*

Ask because you really want to know
Survivors spoke of being assessed by 'tick box' and the difference between that and the expression of real interest and concern.

> *"I know it was her job, but she didn't come across like that. She came across as though she was... and I think she was genuinely interested in what I said."*

Keep asking the question
Survivors talked about needing to find the courage to disclose and not always having this when the issue was first raised. Being asked a second or third time gave them confidence that their experiences mattered and they would be listened to.

Do not be selective about who you ask
Survivors felt that staff were more likely to ask some people rather than others whether they had been abused. Male survivors believed that staff felt more uncomfortable asking men about abuse. Asian women recounted experiences of not being asked about domestic violence even though they believed what was happening to them was glaringly obvious.

Respond helpfully
People who responded helpfully to a disclosure of violence or abuse took the disclosure seriously, took time to listen, showed that they understood the significance of the abuse and the courage it took to talk about it. Survivors gave many accounts of helpful responses which had made a huge difference to their lives.

> *"[My CPN] was fantastic because as a victim when you reveal it to, to friends, to professionals you watch their reaction to you, it's very important that they're not overcome with horror. And she, you know… I remember her being just very measured and very calm and she just said, something like 'that's very brave. What you've done is very brave, what you've said it to me'. She was the first person I actually said it out loud to, and it was a very emotional hour or hour and a half. "*

Unfortunately, survivors also gave accounts of unhelpful responses where their disclosures were ignored, dismissed or minimised. Examples included a

survivor who disclosed abuse to a ward nurse and was told not to talk about it '*because we can't help'* and a survivor who was asked by a Psychiatrist *'Have you got over that abuse thing yet?'*

Follow up with good services
Survivors recognised that some services do not want to ask about abuse because they do not have specialist support they can offer. This is not a reason not to ask – listening to and acknowledging a survivor's experience is helpful in itself. Working collaboratively with people to find a way forward is much more important than having a pre-prepared treatment or service to offer. However, survivors did express concerns about reduced funding for voluntary sector services, the lack of good specialist support within mental health services and the length of waiting lists.

As noted above survivors may be seeking appropriate services following a disclosure; we found from the research with practitioners that a lack of appropriate services for survivors of abuse can inform their reluctance to ask the question. But for appropriate services to be commissioned there is a need to know what they look like, from the point of view of users. This question is addressed below, exploring survivors' experiences of mental health services.

Findings from strand 2 (cont): What do survivors of violence and abuse say about mental health services?

Views of services
The survivors we interviewed had a wide range of experience of service use and had some major concerns about the current nature of mental health services for survivors of abuse. Recurring themes were:

Cuts to services
Interviewees had commonly experienced a reduction in time and input from mental health professionals and higher thresholds for access to the support they needed. The only support available to some was provided by voluntary sector services such as Rape Crisis Centres. This provision was generally viewed very positively, however due to funding constraints, these voluntary sector services may have very limited opening hours, and may only be able to see service users for an hour a week; and they are not always equipped to address the severe mental health issues that some were struggling with. Participants therefore sought both increased access to such support (which requires funding) while recognising that for some people such support should be viewed as complementary, rather than as an alternative, to statutory mental health services.

Mental health professionals failing to view violence and abuse as a mental health issue
Survivors commented that some staff – particularly, but not exclusively those working in in-patient services - seemed not to view their experiences of abuse as relevant to their mental health. '*They see me as being in the wrong place'*.

This is particularly troubling, given that the links between abuse and mental health have long been evidenced; for example, research has found high prevalence rates of violent and abusive experiences in both the childhoods and adult lives of mental health service users (Bebbington et al, 2011; Jonas et al, 2010; Bryer et al, 1987; Walker and James, 1992; Wurr and Partridge, 1996). Survivors also consistently noted that the validation they received from their abuse being acknowledged by professionals could be a first step in them seeking help to deal with it.

A lack of understanding from staff in primary care
Many survivors went to GPs for support initially and were met with a variable response. Dismissive responses were again felt to be due to a lack of understanding about the links between experiences of abuse and mental health outcomes.

Gender stereotyping
Participants also noted that staff could stereotype them on the basis of gender. Male survivors reported a lack of awareness and support; with men still not being viewed as legitimate victims of abuse. Women still experienced services labelling them as '*hysterical'*.

Experience of services
Participants described aspects of accessing services, and key components of their care, that they felt had either promoted or undermined their recovery.

Continuity of care (or the lack thereof)
Interviewees described a lack of integration in the support they received. Separate assessment and 'delivery' functions result in mental health services being experienced as disjointed. Some were assessed as having a need for support but then nothing happened, or established a relationship with one person or service and were then moved onto another and had to repeat their stories over and over. *"I saw a [therapist], and he was brilliant, I really opened out to him, and I felt confident, I felt relaxed, I felt I trusted him, and then they turned round and says 'Well he's retired now'…. Then I saw [CPN], she was really good, but then she went. When you have somebody and then they move on, it's quite upsetting, because they know what you're like, and then you get a bond with them, and then [they're gone]."*

The difference individual professionals can make
Every survivor interviewed described the impact of being supported by empathic, committed individuals, whether from the NHS or the voluntary sector. The value of individuals (whatever their discipline and skills) listening, understanding and responding cannot be under-estimated.

> *"The only time I told of the abuse is when I saw [name of Doctor] and I broke down. It all just flooded out. [He's] been really, really good. He's on the end of the phone if I feel that I need him."*

Support in a crisis
Good support in a crisis was described as really important, particularly the availability of respite. One survivor who had access to this (via a Shared Lives service) described it as "*Wonderful. It's sometimes better [to be] away from home for a short while.*" In other instances, crisis teams had provided a level of support, kept people going through a crisis and prevented a hospital admission. However, crisis teams were also criticised for having a lot of power to assess an individual as requiring in-patient admission or not, – without detailed knowledge of the client and their needs. They were also criticised for being focussed on monitoring medication at the expense of other issues. These experiences indicate some key components of an effective and responsive service landscape. This includes: continuity of care; access to statutory and voluntary sector provision; well trained, empathetic staff who understand the relationship between abuse and mental ill health; and the availability of crisis care.

This research has highlighted what makes a difference for users of services, the interviewees also reflected on positive experiences they have had. These may be particularly significant for commissioners as they suggest the building blocks for what could be achieved, reflecting what service users themselves report as being useful.

What do good services look like?

- Good services were defined by participants as 'holistic', 'integrated' and 'seamless'. e.g. an interviewee described how her CPN had supported her while she was undertaking therapy: *"My current CPN has seen me through the psychotherapy and she's let me dictate, almost dictate, when I wanted to see her. So when I was having the psychotherapy I'd say, I might need to see you on X day, particularly during the most graphic parts, if that's the right word and, I just thought the fact that she would do that was just incredible."*

- Good services were also described as those that gave survivors some genuine control, are not time-limited and manage endings well: *"There seemed to be a fluid relationship between the psychiatrist, CPN and me, so in the times that I didn't see my psychiatrist but I just saw my CPN she would then feedback as to how I was, and I suppose that again gave me a feeling of I was supported in the system, and I always had very clear… instructions of the out of hours service and crisis team".*

- At their best services were able to recognise the importance of survivors' relationships and include non-abusive friends and family so they could be helped to understand the issues and support the individual as well. *"[I appreciated] the flexibility and the fact that they always incorporated [my husband]. He was given the opportunity to come and see somebody, particularly after I revealed what I did reveal to him, he was given the chance to see somebody on his own. And a couple of times we had a meeting all three of us which he found incredibly helpful. And they really helped me with my relationship with*

my daughter [so] I just repaired my relationship to a level that you wouldn't believe. That's something that I'm really, really grateful for."

- Survivors strongly favoured having a range of different kinds of support and therapy in *both* statutory services and voluntary agencies. They emphasised that particular therapeutic approaches mattered much less than that the dynamics and impacts of abuse were understood by staff. *"I honestly don't think the model is that important, [...] because I think it is about the relationship with the client and the therapist, or therapy."*

- Survivor groups were most frequently cited as transformative. Formal therapeutic groups, self-help, drop-ins and psycho-educational groups were each praised for the same core elements: providing safe contact with others and helping them understand the commonality of their experiences; inspiring people with what others had achieved while allowing people to move forward at their own pace, and enabling them to support others and 'give something back.' *"I just belong, this group are very special to me…There was a buddy system when you were new, they watched out for you, they were lovely, they smiled and knew your name and that was enough for me, and I find the same with new service users nowadays."*

One man described how after 14 years of seeking help from mental health services, for the first time, he encountered help that was really helpful in a group setting:

"I wasn't in isolation anymore, I could relate to other people who'd had the same experience, and I think that was the biggest thing. It taught me about trauma. I would not have perceived I was somebody who was dealing with trauma, I didn't understand about things not getting processed and that's why they're going in a continual loop. Or understanding about this confusion between the present and the past …flashbacks and that. And everybody was having the same thing. I thought blimey, it's real then, it's not just me [laughs]. …It's like the approach from people had been my symptoms, but it was the underlying distress was what I needed to deal with …and I think that was the first time in that group that those roots were actually being tackled."

Models of support

We discussed with participants their preferred model of support and outline their suggestions below:

- Routine enquiry taking place in primary care, in children's services, in CAMHS, and in community services - particularly those dealing with drug and alcohol issues.

- Staff in these services having good training and support and being able to make direct referrals to specialist services in both the statutory and voluntary sector.

- Group and peer support being readily available for male and female survivors of all types of abuse.

- Some non-hospital based crisis/respite provision available specifically for survivors.

- Services knowing about, talking to, and coordinating with each other.

These five components could provide a foundation for commissioners to map and understand core components of the service landscape that should be created via the commissioning process.

Interviewees suggested that having these elements in place could mean many survivors need never become users of secondary mental health services.

The REVA research has produced evidence that individuals with multiple experiences of abuse are fifteen times more likely to attempt suicide than the general population (see Chapter 8). If survivors can be helped appropriately from the outset this will save not only the financial cost of many years of intensive service use, but the human cost of wasted years and lives lost.

Of course an important element of commissioning effective services is also the ability to measure the outcomes that they may support. In the final findings section the findings from the pilot of the outcome measure framework (SSO) developed as part of this project are presented.

Findings from strand 3: Pilot of SSO

Participants were given a range of options for completing the SSO forms and were able to choose the mode they were most comfortable with. The majority opted to complete forms either during or immediately before/after sessions with a support worker or other staff member present, although at one service users took the form away to complete. Particularly where participants were receiving counselling, a number of staff noted in the log forms that the forms were completed during sessions, and that this could cut into valuable time. For example, one commented, “We have a limited number of sessions, so there is always a pressure on time” (Staff log form). Previous research (see Fitzpatrick et al, 2006) has shown that the type and amount of assistance provided can influence completion rates, but given the scale of this pilot we were unable to control for whether this led to differences in response. Instead, we left this open for the staff/participants to decide on, whilst ensuring that the mode of completion was recorded in log forms so as to monitor any potential effects.

There was an even split between those who completed the first form by themselves (50%) and those who required some assistance (50%). Assistance included providing clarification about the meaning of questions and how to interpret them, reading the questions out, help with

comprehension for those who did not have English as a first language, or simply offering a supportive presence. The rates for these modes of completion were similar for the second form. No apparent effects were noted in relation to the different completion modes. This suggests that a flexible approach to completion is beneficial, and that the option to have assistance is often welcomed. However, the resource implications for managing this process do need to be factored into wider use.

Completion rates among the 24 participants in the pilot were extremely high across all measures. At first completion, of items 1-28 in Part 1 of the form, there were eight where just one participant (different in each case) failed to answer, and two did not respond to a separate item at second completion. The only exceptions were measures that made reference to children and ability to manage use of alcohol, drugs or prescribed medication, which had been left blank or marked 'not applicable' by respondents (respectively n=9 cases and n=8 cases). Feedback provided by staff in the log forms confirmed that no items caused consistent confusion or misunderstanding. The only two items where it was noted that a small minority of participants queried the meaning were 24: *I have been able to recognise if other people have been behaving abusively* (n=3 cases) and 25: *I have been aware of what options are available to me* (n=2 cases). No participants were reported to have experienced distress as a result of completing the forms. This suggests that, in the main, the measures were clearly worded and not overly intrusive.

Part 1 – How are you feeling and how are you doing?

Participants in the pilot experienced changes across many measures in the SSO tool between completion of the first and second forms. These were most marked in connection with their awareness of available support, their feelings about the abuse and sense of control over their lives. In relation to support, between first and second completion there was: a 49%[8] increase in those who felt able to ask for support most or all of the time; a 44% increase in those who felt able to speak to others about their abuse if they wanted to most or all of the time; and a 36% increase in those who knew what options were available most or all of the time. With regard to coming to terms with their experiences of violence and abuse: there was a 37% increase in those who felt able to recognise if others were behaving abusively; and a 27% increase in those who realised that they were not responsible for the abuse that had happened to them. In terms of regaining control of their lives: 33% more felt in control most or all of the time at the time of completing the second form; 30% more felt able to make their own decisions most or all of the time; and 33% more felt safer most or all of the time. There were also positive shifts in respondents' assessments of their own health and well-being. For example, at the point of second completion, there was a 38% decrease in those who said they felt low, anxious or depressed most or all of the time; a 28% decrease in those who said they had self-harmed some/most of the time; and an increase of 27% in those who had not over- or under-eaten to help them cope. 23.3%

[8] Given the sample size the percentages reported throughout are illustrative and not statistically significant.

of participants also reported that they felt safer from further violence most or all of the time at the point of completing the second form.

Part 2 – How are we doing?

Part 2 of the form deals with respondents' perceptions of the service they have received and includes questions about whether they have been listened to, valued, treated with respect and felt safe. The pilot services scored extremely highly across the majority of these measures, with 78-83% strongly agreeing with the statements on service quality at the point of first completion. 83% strongly agreed with the statement that 'coming to this service has made a positive difference to my life'. When those who 'agreed' were combined with those who 'strongly agreed' these scores reached 100% for seven of the nine measures. The only area where services were rated slightly lower was in relation to the item, 'I have been given choices about the support I receive,' where only 68% strongly agreed. In the log forms support staff attributed this to the fact that funding issues had meant that access to one of their key services had been postponed for a year. At the point of completing the second form, levels of satisfaction had increased further. Here, 85% or more of respondents strongly agreed with all nine items about service quality, with 100% strongly agreeing that the service had made a positive difference to their lives. Completion levels for items 1-9 in Part 2 were also high, with only one participant not completing this section and one item unanswered by an additional respondent.

The final section of Part 2 of the form asks whether respondents have accessed particular forms of provision and, if so, how helpful they have been. These questions saw slightly lower completion levels than other parts of the SSO form, with between one and four respondents not answering this series of questions. This is likely to be due to variations between the pilot services in the types of provision offered, as well as differences in individual circumstance, meaning where a particular service was not available or was not applicable, respondents may have left this blank. This was most notably the case for the item on support with relationships with children. If the SSO tool was adopted by services there could be scope to tailor these items to make them service-relevant. The follow-up questions on how helpful the different types of support had been were also sometimes left blank. Enhancements to the design of the form could be made to encourage greater completion here.

Views and experiences of using the outcomes tool

Of the seven pilot services that committed to undertake piloting the SSO form, most described the experience positively. However, all services experienced significant funding and resource pressures during the pilot, which impacted to varying degrees on their ability to engage service user participants. A manager at one of the pilot services that struggled to recruit participants explained that being over-stretched had meant she was unable to fully engage with the pilot, which had a knock-on effect on how the pilot was received by counsellors and, ultimately, service users. This underlines the importance of staff at all levels being informed about and invested in outcome measurement.

Where asked to participate, the majority of survivors were happy to trial the outcomes tool and no problematic issues arising from completion of the forms were reported. A number of service users described the process as helpful.

> *I think it's really useful because when we read this I find out myself – what I can and what I can't and what is happening – it's useful, it's really useful […] Normally I always think about my kids, my house, other things. When I do this then it gives me a chance to think […] what I am* (Service user follow-up interview).

> *…because they relate to how you do your daily activities or the way you interact with other people, they make you think, it makes you think whether you have actually managed or you haven't, whether there is a problem, there is this kind of problem that you're not aware of, or you're not conscious about, so that was quite reflective, I would say* (Service user follow-up interview).

Accessibility and resonance

Pilot service managers and practitioners administering the forms agreed that the outcome measures and format of the form were clear and accessible. One service manager commented that the direct style of questioning would be particularly helpful when working with younger clients. One staff member commented that "*the questions are well phrased with accessible language and they're laid out in a clear and inviting way*" (service provider log form).

Discussions with service users confirmed that the items were clearly worded and suggested that the range of items on the form captured their experience of the impacts of violence holistically.

> *I think the questions have been selected quite… perfectly, actually, to be honest ... because when you are a victim of domestic violence all aspects of your life – how you do your daily activities, how you interact with other people [are affected], so I think it was quite accurate* (Service user follow-up interview).

> *Your questions obviously go from one to the other because they went from about me looking after myself and depression – it's all part of it. So your questions are quite relevant in that it covered, not just the abuse, it actually covered how I was feeling personally. And it was nice that you fill it in and you can see what it [i.e. the abuse] does to you – it belittles you, it degrades you, you know […] it all goes together – the depression, everything, the belittling, how it affects you with other people* (Service user follow-up interview B/02).

There was also an acceptance among service users that, whilst the forms could be seen as long, there was a rationale behind the range of questions being asked, and the end result was for their benefit.

> *I think because of the issues that it's dealing with, these questions need to be asked, so I think the variety of questions that are asked are necessary in terms of finding out what services are available and obviously how you are […] everything that's been asked is, like, it needs to be asked – everything's there for a reason* (Service user follow-up interview).

Most participants had been in contact with a range of services in addition to the pilot support service and, through this, had completed a range of tools. A number of them commented that the SSO form compared favourably to assessment processes, particularly in statutory agencies.

> *I've done the usual ones within [the service] itself [like Beck's Inventory], those mammoth ones, but this one was nice to do* (Service user follow-up interview).

> *I actually thought it was quite a good form to fill in – because, obviously, I've done different kinds of forms with different agencies and one in particular I did with my midwife and it was a DASH form and I found that a bit too intense, whereas this one was fairly […] straightforward, you don't have to go into detail. Because, you know, with domestic abuse and that you don't want to keep going over and over and over things, so this was kind of a 'nice' form [with the tick boxes] rather than, like, can you expand, can you explain* (Service user follow-up interview).

Showing the process of change

Service users also valued gaining a sense of change and improvement through repeating completion of the form some months later and comparing the results.

> *It makes you think what you were at one time and where you're going now, you know. It's not a bad thing – it shows you're on the way to change. 'Cause it shows me that I've become a lot more stronger person. I wasn't that strong when I first done it* (Service user follow-up interview).

> *And when you see it on paper and you know and you're kind of like ticking the boxes the second time, you're like, 'Wow, I'm in such a better place!' It's a nice feeling and you start to feel like, yeah, you're getting somewhere and you're successful* (Service user follow-up interview).

> *[T]hat was massive for me to see the change. So that was a bonus to see it there on paper and think 'Wow!' So I think that's a good thing with the form that you can look back and see how you have improved* (Service user follow-up interview).

This finding has been replicated in other studies (see, for example, Kelly et al, 2014). For longer term use of the SSO it would be useful to develop a way of visually showing the shifts between first and second completion of the forms.

For service users, part of reflecting on the positive changes they had made involved thinking about the difference the service had made to them. A number of participants commented that the open-ended questions and service-oriented questions in Part 2 of the SSO form gave them the opportunity to acknowledge the help and support they had received.

> *I think the form definitely gives you a chance to say, you know, this service is a good thing for victims of domestic abuse […] Because we don't sit round and talk about how good the service is, you know, the service is there […] So really they don't get no feedback in these sessions, whereas this form obviously allows them to get some kind of feedback and then they can look at the results and kind of like work through what needs to be done and what doesn't need to be done* (Service user follow-up interview).

Relevance across groups and service types

No significant difficulties in understanding the SSO form were reported in relation to participants from the BME women's service, who did have access to a mother tongue support worker where needed. However, the concepts of 'isolation', 'boundaries', 'depression' and 'self-harm' did require further explanation in one case. The question on sexual relationships was problematic for two of the BME women who were Muslims, as said they would not have a sexual relationship outside marriage and had separated from their husbands due to the violence, although both answered it.

There were indications that the outcome measures were of particular use in services offering advocacy, outreach or practical support as they provided a means of initiating discussions about the service user's well-being and salient issues connected to the violence.

> *[It was] a useful starting point for conversations and barometer of what's going on for [service users] now* (Service provider log form).

> *I think it opened up conversations for me and the women that I supported, questions that I probably wouldn't have asked – there was a question about self-harming, and I wouldn't have asked the question like that* (Service provider follow-up interview).

However, counselling services also found this useful:

> *It opened up comments from [the] participant at times which we came back to in our session* (Service provider log form)

> *It was helpful for [service user] to see improvements already made and to help the service participating in this exercise. It was helpful for me to*

see how good [service user] found our service (Service provider log form).

Integrating the measures into existing practice and processes

There were differing opinions between staff at the pilot services on how best to integrate the SSO into their wider practice. This was largely dependent on which existing tools they utilised. Two of the sexual violence services, for example, had a dedicated tool used by their wider network, which overlapped significantly with the SSO form, meaning that use of both forms would be repetitious.

There was a sense among a small number of service providers that the second half of the form was a separate type of form that focused more on service evaluation than outcomes and did not necessarily need to be repeated. Despite this, a number of service providers mentioned specific items on the SSO form that it would be useful to add to their existing evaluation and monitoring forms. One commented:

> *I definitely think that if I incorporated some of your questions in our final feedback form, yours is written much better than ours is* (Service provider follow-up interview).

One service manager, whose service closed at the end of the pilot due to funding pressures, said the type of data the form would have enabled them to gather would have been invaluable for evidencing the value of their work to funders.

> *…if we'd had something like this, obviously to be a better service it's useful, but also for funding. To have quotes like this, you know, so many women strongly agree that…, you know so many per cent of the women have been supported, you know would be really good stuff. And to say if it was a Department of Health approved research questionnaire, that would be really something good. We do use women's quotes in our annual reports and also in our funding applications* (Service provider follow-up interview).

> *I think definitely for funders I think something that specific would be really useful […] I think it gives a much bigger day-to-day picture, really, I think a much more factual picture, really, so that's useful* (Service provider follow-up interview).

Comments from service users participating in the pilot confirmed that the range of outcomes measured in the SSO tool were relevant and captured their experiences of the impacts of violence and abuse. There was a general recognition among participants that violence and abuse affect survivors across multiple domains. This validates our approach to developing a tool that would go beyond traditional health and wellbeing measures. The high completion rates for most items suggest that the language used is broadly accessible.

The pilot indicated that the SSO form was relevant for different groups, including BME women and those who had experienced different forms of violence and abuse, and service provision. No negative experiences were reported by the men's service that piloted the form, but as this service was unable to supply the data at the end of the pilot more development work could be done to test the form with this group.

Practitioners from both counselling and advocacy services found the SSO tool useful, but it was particularly welcomed by advocacy/outreach services because it enabled staff to broach difficult issues in a structured way and ultimately enabled them to gain a greater understanding of their service users' circumstances, needs and changes over time. The SSO form may offer an especially useful tool for smaller services not affiliated to larger second-tier organisations within the sector, or those who have been otherwise unable to engage in the development of suitable monitoring processes to date. The potential for integrating the SSO tool with a service's existing assessment and monitoring processes depends largely upon which tools are currently used. There may be scope for integrating the measures with the Core Outcome Measure (CORE-OM) or similar monitoring/outcomes tools.

9. Conclusions and further research

In relation to routine enquiry and the provision of effective, accessible services which address the long-term consequences of violence and abuse it is not further research but further implementation activity that is required. RE can be effectively embedded but it requires commitment from DH (including sorting out effective audit through the minimum dataset and a commitment to publish results) leadership within trusts, and some mandatory provision for training. In the long term it requires the incorporation of these issues into the core curriculum of pre-registration training for all mental health professionals. It is therefore recommended that:

- Trusts are reminded that it is DH policy that…'once adequately trained, all staff conducting mental health assessments ask about experiences of violence and abuse in mental health assessments'. This can be achieved by comprehensive dissemination of REVA Briefing 2.

- There should be a designated lead for routine enquiry in all Trusts and senior leadership should be provided by a multi-disciplinary team working closely with the trust's Safeguarding Lead. Mental health teams should designate a violence and abuse lead to receive specialist training to enable them to support other staff in direct work, signpost and refer appropriately to specialist services and act as the link with such services and with the Trust Safeguarding lead.

- Health Education England should work with the Royal Colleges and the Universities to develop a strategy to ensure the future training of mental health professionals includes adequate coverage of the impacts of violence and abuse and the delivery of effective responses.

- Monitor and NHS Trust Development Authority notify all Trusts of how to access the revised routine enquiry training materials when published in Autumn 2014 and attach guidance on regular delivery of the one-day course on routine enquiry with attendance mandatory for all staff conducting assessments. A half-day update/refresher workshop should be provided and attendance required every three years.

- The Mental Health Minimum Dataset (now the Mental Health and Learning Disability Dataset) asks Trusts to report how often the question about experiences of violence and abuse is included in assessments. Their response should be designated as mandatory rather than required. This data should also be monitored at Trust level. It will allow the identification of teams and services where RE is well embedded and those where further training and support is required. This would enable limited resources to be targeted where they are most needed. In addition, communication of the findings from audit could be used as a behaviour change 'nudge' to encourage individual staff and teams to follow their colleagues and implement RE.

- Voluntary agencies and survivors themselves should be involved in planning for the commissioning of services. Police and Crime Commissioners (PCC) are currently reviewing their victim services and level of need as they take over commissioning victim services, so they need to work closely with VS agencies supporting victims of sexual and domestic violence. Commissioners of both health and crime related services need to be acutely aware of the links between inter-personal violence, abuse and mental health and the related needs of the population and fund accordingly rather than just on the basis of either criminal justice outcomes or health outcomes (See for example, DoH, 20011; NHS, 2013).

- In relation to the outcomes tool there is development work that would benefit services wishing to use the SSO tool in the future and their service users. Firstly, development of a software tool that could visually represent any change in outcomes would be an invaluable accompaniment to the outcomes form itself. Survivors taking part in the pilot found seeing changes between first and second completion of the SSO tool highly beneficial and motivating. This would also highlight to service providers areas of success and any outstanding needs still to be addressed in their work with individual service users. Secondly, an analysis package for services allowing them to aggregate data from different cases and report on client group level change would enable them to produce useful and usable data, both for funders and service planning/development.

- In relation to further research into patterns of violence and abuse and their relationship to mental health, the APMS is an excellent vehicle for tracking changes over time – in terms of abuse experience, use of services and outcomes. The 2014 APMS includes modules on all these topics, as well as new questions on experience of neglect in childhood and on perpetration of partner abuse in adulthood. Data from APMS 2014 will be publicly available for analysis from 2016 and would be ideally placed for:

    - Tracking trends in prevalence of recent violence and abuse in the English population

    - Replication of the LCA, to check that the abuse and violence typology is evident in other national samples

    - Providing sample for qualitative follow-up, for example, identifying men and women in the two extensive abuse groups. Such follow-up would enable the comprehensive profiling of group membership and analysis of the nature of the relationships between particular patterns and accumulations of abuse experience and outcomes in terms of health, well-being and use of services.

10. Dissemination plans

From the outset this project was designed with effective dissemination in mind, tailoring a range of outputs and channels of communication to reach different audiences. However we are also mindful that the findings are not to be publicised until they have been peer reviewed and finalised with the Department of Health. To this end we have outlined our suggested dissemination plans for findings from strand two and three of the research below – however we also welcome additional suggestions on the most effective and relevant channels for dissemination.

The findings from strand one have already been peer reviewed and the dissemination activity undertaken or planned for strand one is also outlined below.

We intend the core outputs of the project to be five briefing papers for different 'end users' which will contain the findings outlined in this report.

Strand one – dissemination activity
Results have been presented at a number of conferences, selected to reach both a wide and diverse audience covering policy makers and public health and research. Presentations have included:

- Report Launch, House of Lords, 2013
- Public Health England Annual Conference 2013, 2013
- Social Research Association Annual Conference, 2013
- ESRC Health Inequalities Research Network, 2014
- And the forthcoming Association for the Treatment of Abusers Conference, 2014.

Briefing one (findings from strand one) has been emailed to the following in each Trust in England:

- CEO
- Head of training
- Safeguarding Lead
- Violence and Abuse lead (if identified)

And in addition:

- ACPO leads
- MPs offices

Briefing one is also available on the study website. Finally, a paper of results from strand one is currently in preparation for submission initially to the British Journal of Psychiatry.

Strand two and three – Planned dissemination activity
Four additional briefing papers have been developed, containing findings presented in this report. These include:

Briefing 2 – Implementing and sustaining routine enquiry about violence and abuse in mental health services: Guidance for Trust managers.

Briefing 3 – Why asking about abuse matters to service users: A briefing for mental health professionals.

Briefing 4 – What do survivors of violence and abuse say about mental health services: A briefing for commissioners.

Briefing 5 – Measuring outcomes for survivors of violence and abuse.

Each of these briefings released monthly, following final approval and will be sent to relevant audiences from the list provided above. In addition, specific additional audiences have been identified for each briefing (see below) and findings from different strands will be presented at relevant conferences over the next 12 months.

We also intend to submit at least three articles to peer reviewed journals by the end of 2014 focussing on different aspects of the overall study findings, and are actively exploring with the Department of Health possible uses and development of the outcome measure framework. We plan on developing and submitting articles focussing on different aspects of the findings to the following journals: Feminism and Psychology, International Journal of Child Abuse and Neglect, and The Mental Health Review. We will also submit guest blogs for Discover Society http://www.discoversociety.org/ and the Conversation http://theconversation.com/uk with links to the briefings/project report.

Findings from strand two are also due to be presented as part of a symposium focused on the links between mental health and abuse and violence at the 2014 European Public Health Association Annual Conference in November. We also hope to present the overarching findings at additional conferences such as the Public Health England Annual Conference, and welcome further discussion with Department of Health regarding other suitable outlets and/or

whether our idea to hold an event showcasing findings from projects across the funding programme would be valuable to pursue.

Briefing 2

As well as being made available on our website and sent out to our contact lists (see above), we intend to send this to Heads of psychology, psychotherapy and nursing, IAPT managers, RCN mental health nurses forum and the Royal College of Psychiatry. We also plan to develop and submit an article based on the findings to the Health Services Journal http://www.hsj.co.uk/ .

Briefing 3

As well being available on our website and sent to our mailing list we will develop an article focussing on these findings for Nursing Times http://www.nursingtimes.net/

Briefing 4

This will be sent to all mental health commissioners and Police and Crime Commissioners via the Association of PCCs. We will develop an article and/or guest blog in Mental Health Today based on the finding. http://www.mentalhealthtoday.co.uk/

Briefing 5

This will be sent to all survivor organisations via networks including Survivors' Trust, Rape Crisis England and Wales, Women's Aid Federation, and the network of Sexual Assault Referral Centres.

Our reference group members will also be sent copies of the briefings.

In addition we have also held local area feedback workshops with key staff members involved in the research at each case study Trust; we have also been provided with feedback from mental health professionals in these areas that the research has aided their promotion of routine enquiry within their locality.

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Appendices

Appendix A – Summary of methods (Strand 1)

Latent class analysis (LCA) is a statistical approach widely used to segment populations. It is used in market research analysis to identify different types of consumers and is particularly suitable for research designed to inform social policy, because it identifies real and discrete groups in the population. Rather than a typology being derived from theory and imposed on data, this approach uses software to identify patterns that exist in the population. It is a 'bottom up' rather than 'top down' approach. It should be noted, however, that LCA does have drawbacks. The selection of model (that is, the decision about what number of groups best fits the data), and the labels given to those groups, are somewhat subjective.

Table A1 Types of abuse and violence entered into the LCA modelling
Partner ever prevented you from having fair share of household money
Partner ever stopped you from seeing friends/relatives
Partner ever frightened you, by threatening to hurt you or someone close to you
Partner ever pushed, held or pinned you down or slapped you
Partner ever kicked, bit, or hit you with a fist or something else
Partner ever choked or tried to strangle you
Partner ever threatened you with a weapon
Partner ever threatened to kill you
Partner ever used a weapon against you
Partner ever used some other kind of force against you
Someone talked in sexual way since the age of 16
Someone touched in sexual way without consent since the age of 16
Sexual intercourse without consent since the age of 16
Someone talked in sexual way before the age of 16
Someone touched in sexual way without consent before the age of 16
Sexual intercourse without consent before the age of 16
Severely beaten by parent/step-parent/carer before the age of 16
Ever experienced bullying
Ever experienced violence at work

The 19 variables listed in Table 1 (relating to lifetime experience, including in childhood) were all included on the Adult Psychiatric Morbidity Survey and were entered into the LCA model, with the analytic programme looking for people who shared similar traits. It should be noted that about half of the items related to violence or abuse specifically from a partner. However, the other half spanned a range of experiences including from a parent or carer

and at the workplace. The analysis was run several times, and each time a different number of groups was specified. To decide which model to use (that is, which number of groups best fits the data), the following criteria were considered:

- BIC, AIC and class errors should have a value that is low,
- Entropy (EntR2) should have a value that is high,
- Each group should ideally be large enough to analyse,
- The model should be stable (that is, when moving from a model with k groups to a model with k+1, the new group should be formed from division of old; and there should not be too many respondents with a low probability of belonging to any group),
- The groups in the model should make sense.

The fit statistics for models with between 2 and 8 groups are presented below.

Table A2 Fit statistics for LCA models with 2 to 8 groups specified

	BIC(LL)	AIC(LL)	AIC3(LL)	Class errors	Entrophy2
2 groups	54632.07	54363.81	54402.81	0.0175	0.9023
3 groups	52405.25	51999.43	52058.43	0.0394	0.8432
4 groups	51264.12	50720.73	50799.73	0.0459	0.8386
5 groups	51049.16	50368.20	50467.20	0.0488	0.8360
6 groups	50976.34	50157.81	50276.81	0.0467	0.8517
7 groups	50890.80	49934.71	50073.71	0.0665	0.8073
8 groups	50898.50	49804.84	49963.84	0.0965	0.7494

After reviewing these criteria, the six-group model was felt to fit the data best. The results for this model are presented in this report.

Further methodological detail will available in subsequent publications. For more information about APMS 2007, see the main survey report:http://www.hscic.gov.uk/catalogue/PUB02931/adul-psyc-morb-res-hou-sur-eng-2007-rep.pdf

Appendix B – Profile of the six violence and abuse groups (Strand 1)

Table B1 Socio-demographic profile of the abuse and violence groups

	Violence and abuse group					
	Little violence or abuse	Physical from partner	Extensive physical from partner	Sexual as child only	Sexual as adult	Extensive physical/ sexual as child and adult
Sex	**%**	**%**	**%**	**%**	**%**	**%**
Men	54	40	20	33	27	16
Women	46	60	80	67	73	84
Age group						
16-34	30	31	29	31	37	31
35-54	33	47	49	40	40	52
55-74	27	19	21	26	20	16
75 or more	10	2	2	2	4	1
Marital status						
Married	55	42	38	59	43	34
Cohabiting	9	18	18	11	8	14
Single	22	22	18	20	37	22
Widowed	8	3	5	3	4	4
Divorced	4	12	18	5	5	20
Separated	2	3	4	2	2	6
Ethnic group						
White	90	95	94	90	89	92
Black	3	2	3	3	4	5
South Asian	4	2	1	4	3	1
Other/mixed	3	1	2	3	4	2
Bases	*5414*	*739*	*151*	*388*	*209*	*274*

Data source: APMS 2007.
All variables (except age) were highly significant (p=<0.001) in their association with class membership.

Table B2 Socio-economic profile of the abuse and violence groups						
	Violence and abuse group					
	Little violence or abuse	Physical from partner	Extensive physical from partner	Sexual as child only	Sexual as adult	Extensive physical/ sexual as child and adult
Educational qualifications	**%**	**%**	**%**	**%**	**%**	**%**
Degree	20	23	10	29	32	18
Teaching, HND, nursing	7	8	10	10	5	10
A Level	14	20	14	16	17	15
GCSE or equivalent	27	30	35	26	29	35
Foreign/other	4	1	5	2	3	2
No qualifications	28	18	26	18	14	20
Tenure						
Owner-occupier	73	64	50	71	70	53
Rent or other	27	36	50	29	30	47
Equalized household income						
Highest third (>=£29,826)	36	40	25	41	38	29
Middle third (>=£14,057, <£29,826)	33	28	27	36	35	29
Lowest third (<£14,057)	31	32	48	23	27	42
Index of Multiple Deprivation						
0.59->8.35 (least deprived)	20	17	12	19	21	15
8.35->13.72	22	21	19	23	23	20
13.72->21.16	20	20	14	20	22	16
21.16->34.21	19	20	20	20	14	20
34.21->86.36 (most deprived)	19	22	35	18	21	30
Bases	*5414*	*739*	*151*	*388*	*209*	*274*

Data source: APMS 2007.
All variables (except IMD and income) were highly significantly ($p<0.001$) associated with class membership.
IMD and income were significant, except with $p=0.031$ and 0.005 respectively.

Table B3	General health, disability and wellbeing profile of the abuse and violence groups					
	Violence and abuse group					
	Little violence or abuse	Physical from partner	Extensive physical from partner	Sexual as child only	Sexual as adult	Extensive physical/ sexual as child and adult
Health in general	**%**	**%**	**%**	**%**	**%**	**%**
Excellent / very good	54	53	45	52	51	38
Good	28	27	25	31	28	30
Fair / poor	18	20	30	17	20	32
How happy						
Very happy	43	32	29	34	30	18
Fairly happy	51	57	50	56	57	59
Not too happy	6	12	21	9	13	23
Activities of daily living (ADLs)						
No difficulties	69	65	56	67	60	48
1 difficulty	14	15	21	17	18	20
2 or more difficulties	17	20	23	16	22	52
Provides care due to health or disability						
Carer	23	30	38	29	29	39
Not a carer	77	70	62	71	71	61
Bases	*5411*	*739*	*151*	*388*	*209*	*274*

Data source: APMS 2007.
All variables (except ADLs) significantly associated with class membership ($p<0.001$).
ADLs were significant, but with $p=0.044$.

Table B4	Common mental disorder (CMD) profile of the abuse and violence groups					
	Violence and abuse group					
	Little violence or abuse	Physical from partner	Extensive physical from partner	Sexual as child only	Sexual as adult	Extensive physical/ sexual as child and adult
	%	%	%	%	%	%
Any CMD	**11**	**27**	**37**	**23**	**32**	**53**
Depressive disorder	2	3	8	6	7	13
Mixed anxiety and depression	6	15	14	10	17	21
Generalised anxiety disorder (GAD)	3	7	15	7	9	16
Obsessive compulsive disorder (OCD)	1	2	2	2	4	4
Panic disorder	1	2	4	1	3	5
Phobia	1	3	10	3	4	14
Bases	*5414*	*739*	*151*	*388*	*209*	*274*

Data source: APMS 2007.
All variables highly significantly associated with class membership ($p<0.001$).

Table B5	Profile of other mental disorders in the abuse and violence groups					
	Violence and abuse group					
	Little violence or abuse	Physical from partner	Extensive physical from partner	Sexual as child only	Sexual as adult	Extensive physical/ sexual as child and adult
	%	%	%	%	%	%
Number of disorders						
None	82	63	53	70	61	37
1	13	24	23	18	22	33
2	3	8	10	7	7	13
3 or more	1	5	14	5	10	17
Eating disorder (screen)	1	3	4	4	4	8
ADHD (screen)	6	26	17	13	13	8
Probable psychosis – past year	0	1	2	0	2	2
Borderline personality disorder	0	0	-	3	3	4
Antisocial personality disorder	0	1	2	1	-	2
Autism	1	-	-	1	10	2
PTSD (screen)	2	5	12	4	9	16
Problem gambling	1	1	1	0	1	2
Bases	*5411*	*739*	*151*	*388*	*209*	*274*

Data source: APMS 2007.
All types of disorder (except problem gambling) were significantly associated with class membership.
Please note that the number of people identified with some low prevalence disorders is small and results should be treated with some caution.

Table B6	Suicidal and self-harm behaviour profile of the abuse and violence groups					
	Violence and abuse group					
	Little violence or abuse	Physical from partner	Extensive physical from partner	Sexual as child only	Sexual as adult	Extensive physical/ sexual as child and adult
	%	%	%	%	%	%
Thought about killing self - in past week	0	1	4	1	1	5
Thought about killing self - in past year	2	8	13	8	13	17
Thought about killing self - ever	8	26	36	26	35	49
Suicide attempt - in past year	0	1	3	1	2	4
Suicide attempt - ever	2	10	12	10	10	29
Self-harm without suicidal intent - ever	10	31	40	36	41	56
Bases	*5414*	*739*	*151*	*388*	*209*	*274*

Data source: APMS 2007.
All variables were highly significantly associated with class membership ($p<0.001$).

Table B7	Mental health treatment and service use profile of the abuse and violence groups					
	Violence and abuse group					
	Little violence or abuse	Physical from partner	Extensive physical from partner	Sexual as child only	Sexual as adult	Extensive physical/ sexual as child and adult
	%	%	%	%	%	%
Ever stayed on ward specialising in mental health	1	4	4	3	3	12
Having psychotherapy, psychoanalysis	0	2	3	2	2	2
Receiving any medication, treatment or counselling						
- no treatment	95	88	82	89	88	75
- medication only	4	7	12	6	7	15
- counselling only	1	3	3	3	2	4
- both medication and counselling	1	2	3	2	3	7
Community care service use	6	8	13	11	8	15
Day care service use	4	4	7	8	4	9
Secondary health care service for mental health reason	8	19	26	16	18	34
GP in last 2 weeks for mental health reason	2	3	3	4	4	7
Bases	*5414*	*739*	*151*	*388*	*209*	*274*

Data source: APMS 2007.
All variables were highly significantly associated with class membership ($p<0.001$).

Table B8 Health risk behaviours of the abuse and violence groups						
	Violence and abuse group					
	Little violence or abuse	Physical from partner	Extensive physical from partner	Sexual as child only	Sexual as adult	Extensive physical/ sexual as child and adult
	%	%	%	%	%	%
Smokes 7 or more cigarettes per week	20	29	45	24	19	48
Drink problem – Audit score of 8 or more	23	32	25	26	25	38
Illicit drug use – ever	21	41	35	40	37	50
Illicit drug use – past year	8	15	15	13	10	22
Drug dependent	3	6	10	5	4	11
BMI group						
Less than 18.5	2	3	4	1	5	3
18.5 to less than 25	45	45	36	52	49	42
25 to less than 30	36	32	34	28	29	28
30 or more	17	21	25	19	16	27
Bases	*5414*	*739*	*151*	*388*	*209*	*274*

Data source: APMS 2007.
All variables (except BMI group) were highly significantly associated with class membership.

Table B9	Family and relationships profile of the abuse and violence groups					
	Violence and abuse group					
	Little violence or abuse	Physical from partner	Extensive physical from partner	Sexual as child only	Sexual as adult	Extensive physical/ sexual as child and adult
	%	%	%	%	%	%
Lived with both natural parents to age 16	83	77	63	77	70	64
Spent time in any institution before age 16	2	4	8	6	5	8
Ever in local authority care	1	2	6	5	5	9
Have children of own	67	71	88	69	56	76
Number of children natural parent of:						
1	24	25	16	21	27	19
2-3	64	61	60	67	61	63
4 or more	12	14	24	12	12	19
Bases	*5414*	*739*	*151*	*388*	*209*	*274*

Data source: APMS 2007.
All variables (except number of children) were highly significantly associated with class membership.

Appendix C – Strand 1 Methodological detail

About latent class analysis

Latent class analysis (LCA) is a statistical technique for finding subtypes of related cases (latent classes) from multivariate categorical data. The analysis fits a model to the data that (a) identifies a given number of latent classes, and (b) generates probabilities, for each respondent, of their being in each class (one probability per class). Respondents are then assigned to the class for which they have the highest probability. In this way, as with cluster analysis, it divides individual cases in a dataset into discrete non-overlapping groups.

Applied to the APMS dataset, LCA allows us to investigate whether there are discrete groups of people who share recognisable combinations of types of abuse and violence. Once groups such as these are found, the analysis generates a probability for each respondent of their being in each class and assigns them to the class for which they have the highest probability of membership. Once this is done it is straightforward to relate membership of each class to respondents' answers to these and other survey questions.

The data was modelled using the package Latent GOLD. A typical analysis involved fitting several models with different numbers of classes. It was then possible to write SPSS syntax to compare different models – for example to compare a model containing five classes with one containing six. This allowed us to identify the most useful model.

Modelling the data

Nineteen binary variables were derived and used as input to the LCA. They each defined the presence/absence of one the following events:

- Partner ever prevented you from having fair share of household money
- Partner ever stopped you from seeing friends/relatives
- Partner ever frightened you, by threatening to hurt you or someone close to you
- Partner ever pushed, held or pinned you down or slapped you
- Partner ever kicked, bit, or hit you with a fist or something else
- Partner ever choked or tried to strangle you
- Partner ever threatened you with a weapon

- Partner ever threatened to kill you
- Partner ever used a weapon against you
- Partner ever used some other kind of force against you
- Someone talked in sexual way since the age of 16
- Someone touched in sexual way without consent since the age of 16
- Sexual intercourse without consent since the age of 16
- Someone talked in sexual way before the age of 16
- Someone touched in sexual way without consent before the age of 16
- Sexual intercourse without consent before the age of 16
- Severely beaten by parent/step-parent/carer before the age of 16
- Ever experienced bullying
- Ever experienced violence at work

As is common with survey data and low prevalence events, the dataset is sparse. That is, there are many possible combinations of responses but only 7,400 respondents, the majority of whom do not have experience of abuse and violence. Therefore only a minority of the possible response patterns is attained. A consequence of this is that many of the standard test statistics produced by LCA packages to evaluate and compare models with different number of classes are not fully valid with this type of dataset. We therefore draw on a wider range of criteria in choosing the number of classes for our final model. The same approach was taken to examine psychiatric comorbidity in this dataset.

Identifying the number of classes

As part of a latent class analysis we need to identify the number of classes. In practice, it is unlikely that there will be a single ‘correct’ model so it is usual to consider a range of possible models containing different numbers of classes and choose the most appropriate using some specified criteria.

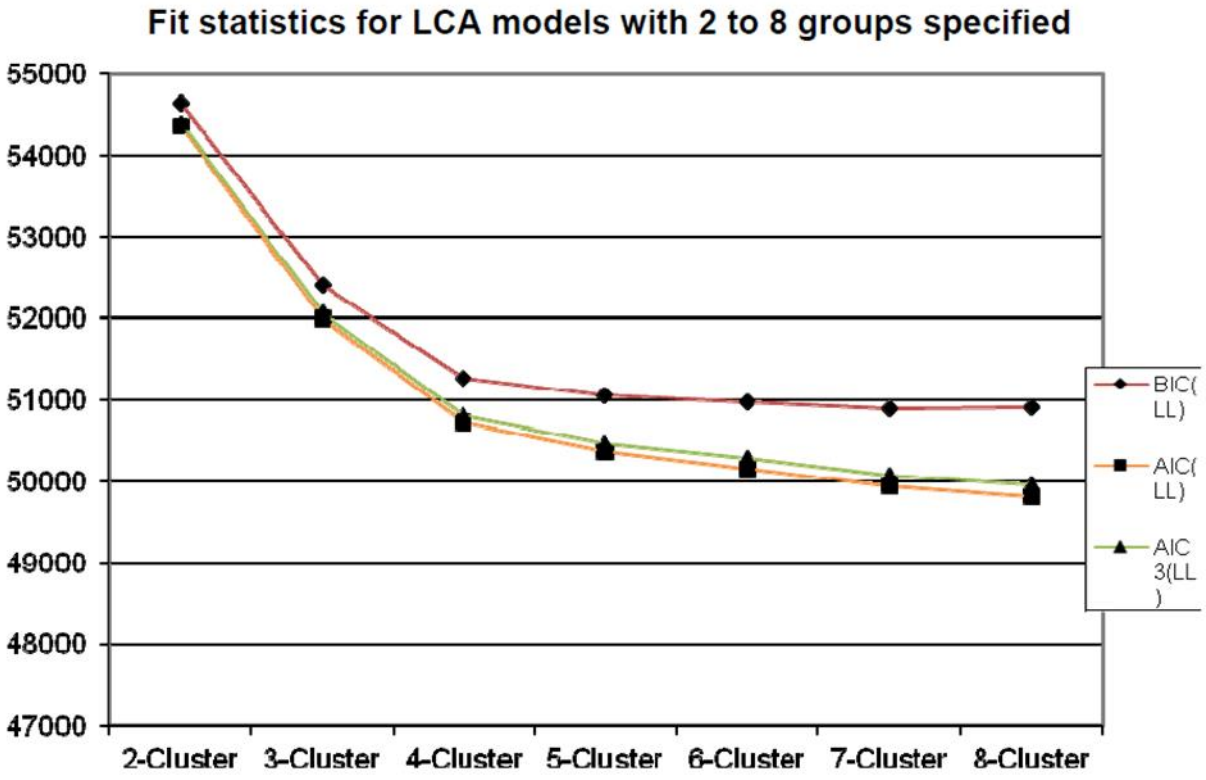
A general approach to statistical model fitting is to try to balance the fit and the parsimony of a model – generally if two models fit a dataset equally well the one with fewer parameters will be chosen. Under this principle, in LCA, if a model with k+1 classes fits the data just as well as one with k classes the k-class model will be chosen.

LCA software packages such as Latent GOLD provide analysts with statistics to help in the choice of the correct number of classes in the data. In particular

it provides several goodness-of-fit statistics to help decide on an appropriate model; a formal hypothesis test can also be performed to see if a k+1-class model is an improvement on a k-class model.

However, as mentioned above the p-values calculated by the package are not valid when analysing a dataset as sparse as the APMS data. Furthermore, the size of the dataset (15 variables) is large enough to mean that the significance tests might not be very powerful. Even when classes display a large difference on one or two variables the overall significance test will be found to be "not significant" if the classes are similar on the other variables. This means that rather than choosing a model on the basis of the p-values obtained from a formal hypothesis test, we used a more informal method of assessment.

First, Latent GOLD was used to fit models with varying numbers of classes, in this case those with between two and eight classes. Goodness-of-fit statistics were then examined for each of the models. These statistics allowed us to rule out certain models as having too poor a fit to be considered, and also gave an approximate upper limit for the number of classes that needed to be considered.



The choice between these was then made on the basis of several other considerations:

- The most important of these was interpretability of the classes. A model with k interpretable classes was preferred to one with (k+1) classes where one or more of the classes was not recognisable.

- We assigned respondents to clusters (using modal assignment) and examined how the composition of the clusters changed as we moved from one solution (with k clusters) to the next (k+1 clusters). This allowed us to examine the stability of the models and to understand how new clusters formed and from which clusters in the previous solution.

- We considered the sizes of the clusters. In this case we expected to have two or three relatively small groups comprising those with the most extensive experience of abuse and violence. However, a model with several very small groups would be neither stable nor interpretable.

- We examined membership probabilities, in particular the probability that a respondent belongs to the cluster to which he/she has been assigned. Ideally each individual would have a fitted probability of 1 of being in their assigned group but in reality this figure is lower.

We found that all clusters in all models with up to six clusters were interpretable but once seven clusters was reached, the “new” cluster was not recognisable. We also found that when we looked at the seven-cluster solution, the new cluster which appeared was much less robust than the rest in terms of the average probability of membership. Again this suggested that a six-cluster solution was more appropriate for the data.

When we looked at the change in the composition of cluster membership we found that each successive solution added a new cluster from the remnants of one or more of the previous clusters but apart from this the remaining clusters were relatively stable. The six-cluster solution produced a new cluster (not present in the five cluster solution) which was previously subsumed in another cluster. Where the five cluster solution grouped sexual only experience together, the six cluster solution divided this group into two meaningful groups, one characterised by sexual abusive experiences in childhood only and the other which included sexual abuse in adulthood. For this reason, having ruled out the seven-cluster solution, six clusters was preferred to five.

Classifying individuals and describing classes

Once a working model has been chosen, analysts will usually try to relate membership of each class with the respondent’s answers to each question and thus describe each class.

One method of doing this is to examine the parameter estimates obtained by

the model. Latent GOLD estimates the probability associated with each class for its answers to each question. For example, a member of cluster two (physical violence from a partner) has an 81% probability of having been ‘pinned down, slapped, pushed’ by a partner, whereas a member of cluster one (little experience of abuse and violence) has only a 1% probability of this. Those in both the ‘extensive’ groups (clusters three and six) had a 95% probability. Thus, clusters two, three, and six will be more associated with physical violence than cluster one (four or five).

Another method is to examine the responses rather than the parameters. This method requires respondents to be assigned to their modal class and hence does not take into account the uncertainty concerning class membership. Either of these methods can be used to help describe classes. The first method has the advantage that it does not require that individuals be assigned to clusters. On the other hand, the second method might be preferable as its class labels are based on descriptions of a real sample rather than estimates of parameters (many of which could have quite large standard errors).

We used the first method when comparing the interpretability of solutions with different numbers of classes. However, once we had chosen our final solution we assigned respondents to clusters and treated the resulting variable like any other analysis variable when comparing the characteristics of each cluster. This variable was used in the data tables presented in Appendix B.

It should be acknowledged that LCA does have drawbacks. The selection of model (that is, the decision about what number of groups best fit the data), and the labels given to those groups, are somewhat subjective.

Appendix D - Strand 2 Methodological detail

Table D1: Achieved sample of participants across four case study areas

	Scoping	Practitioners	Survivors
Case study 1	5	27 (14 NHS/ 13 VS)	5
Case study 2	1	20 (18 NHS/ 2VS)	4
Case study 3	2	30 (20 NHS/ 10 VS)	7
Case study 4	1	31(20 NHS/ 11 VS)	7
Total no. participants	*9*	*108*	*23*

Table D2: Achieved sample of NHS mental health services by case study

	Case 1	Case 2	Case 3	Case 4
Mental health inpatient	X	X	X	X
Community mental health	X	X	X	X
Trauma services				X
Psychological Therapies		X	X	X
Personality disorder				X
Depression and anxiety services			X	X
Eating disorder	X	X		X
Learning disability	X		X	X
Rehabilitation services	X			
Older adults	X			
Child and Adolescent Mental Health Service			X	

Table D3: Achieved sample of NHS practitioners by case study area

Table D3: Achieved sample of NHS practitioners by case study area				
	Case 1	**Case 2**	**Case 3**	**Case 4**
Deputy manager/ manager	5	4	1	7
Nursing assistant/ Nurse/ Senior Nurse	6	7	5	5
Psychological Wellbeing Practitioners	0	0	2	1
Therapist/ Psychotherapist/ Psychodynamic therapist	0	0	5	0
Psychologist/ Clinical Psychologist	0	4	2	3
Social worker	0	1		0
Consultant Psychiatrist	0	2	1	1
Health Care Assistant	0	0	1	0
Doctor			1	1
Speech & language therapist/ occupational therapist	2	0	0	0
Other	1	0	4	2
Total	*14*	*18*	*22*	*20*

Table D5: Achieved sample of voluntary sector organisations by case study area			
	Domestic violence and abuse	**Sexual violence and abuse**	**Other services working with survivors**
Case study 1	1	2	1
Case study 2	1	0	0
Case study 3	1	3	0
Case study 4	1	2	1
Total	***4***	***7***	***2***

Appendix E – Strand 2 Topic Guide for NHS practitioners

Responding effectively to the long-term consequences of violence and abuse (REVA)

Service Provider Topic Guide

The study

Researchers should re-familiarise themselves with the aims and objectives of the depth interviews and the circumstance of the interviewee prior to each interview.

Generally the aim of the interview is to:

- explore how the participant's service works with survivors of violence and abuse
- explore their experience of identifying survivors using routine enquiry (RE)
- explore their views on the extent to which RE has been embedded into AMHS
- explore their views of the effective responses once survivors have been identified
- explore their views on the concepts identified as part of the outcome measure work strand
- to discuss possible involvement in the recruitment of survivors for interviews

Guidance for interpretation and use of the topic guide:

The following guide does not contain pre-set questions but rather lists the key themes and sub-themes to be explored with each participant. It does not include follow-up questions like 'why', 'when', 'how', etc. as participants' contributions will be fully explored throughout in order to understand how and why views and experiences have arisen. The order in which issues are addressed and the amount of time spent on different themes will vary between interviews.

Due to the different roles of participants this topic guide is aimed to function in such a way as to cover the range of roles that could be involved in the interviews.

INTRODUCTION

- Introduce researcher(s) and NatCen
- Explain who the research consortium and funding by DH
- Explain research:
    - To explore effective responses to long-term consequences of violence and abuse
        - How survivors of violence and abuse are identified in AMHS using RE
        - What facilitates successful implementation of RE
        - How AMHS and other services effectively respond to survivors' needs
        - Survivors experiences of support services (gathered from survivor interviews)
        - Develop outcome measures and pilot a tool for service development
- Explain the interview will last between 1 - 1.5 hours. The discussion will focus on:
    - Their views and experiences of identifying survivors of violence and abuse using RE

    - Their views and experiences of the factors involved in successful implementation of RE
    - Their views and experiences of effective responses for survivors after identification
- Explain voluntary nature of interview:
    - No right or wrong answers.
    - Participation is voluntary - can have a break or choose not to discuss any issue/answer any question.
- Explain recording, data storage and confidentiality
- Explain that not asking participant for particular cases as examples
- Explain reporting process and that no individual will be identified in the report, but that the trust will be named as the case study area. Data will be destroyed on completion of the research and study findings will be available if interested.
- Check if any questions before we start
- Ask for permission to start recording

START RECORDING

BACKGROUND

Aim: to gather some initial information on the interview respondent, in order to facilitate the rest of the interview.

- Ask to describe current role:
    - role in the service they work and length of time been with service,
    - information about the service in which they work
    - previous experience and training,
    - any specialisms (i.e. sexual abuse)
    - anything else they think is important

HOW SERVICE WORKS WITH SURVIVORS

Aim: to get an overview of participant's role in the care pathway to understand how they work with survivors and at what stage. NB – some information regarding this may have been shared in the background section.

- Ask the participant to explain the service they work in:
    - Type of service (primary care, secondary care, voluntary service)
    - How service users access them – referral routes
    - The process involved when a new service user accesses the service
    - Information they receive about the service user
        - History or just current needs
    - Services/support they provide to service users
    - Case loads

EXPERIENCE OF IDENTIFYING SURVIVORS USING RE

Aim: to get an overview of participant's role in the delivery of RE and their views about it. NB – some information regarding this may have been shared in the background section.

- RE Training
  - Attended/not
  - When
  - View on training
  - Change to practice following

- Ask the participant to explain their involvement in identifying survivors of violence and abuse, probe for:
  - When this takes place (e.g. in initial assessment of service user, in CPA, etc.)
  - Use of structured RE question
  - How they feel about this, own confidence in assessment
  - Appropriateness of using RE
  - Training they have had, ongoing support they have available

- Ask the participant to explain their views and experiences of using RE in identifying survivors of violence and abuse, probe for:
  - How RE is used in the service they work in
  - What works well using RE
  - Situations in which using RE is not appropriate
  - Outcome of RE (are specialist services required/available)

- Staff skills and confidence
  - Appropriate
  - Effective
  - Tendency to refer onto specialist services or address needs themselves

EMBEDDING RE INTO PRACTICE

Aim: to explore how the participant feels RE has been embedded into AMHS, what factors have been important in this and how successful this has been

- Ask the participant to discuss how RE has been embedded
  - Is it part of standardised assessments (initial assessment, CPA, eCPA etc.)
  - Is it used consistently
  - Is it audited
  - Is training provided
    - Frequency
    - Quality
  - Is ongoing support available
    - Specialist practitioners
    - Practice Development Forums

- Ask participant to talk about the factors which have facilitated successful implementation
  - What is essential to have in place
  - What factors help
  - What factors have made it challenging

EFFECTIVE RESPONSES

Aim: to identify what are effective responses once survivor is identified.

- Survivors needs/wants following RE:
    - Specialist service
    - Mainstream AMHS
    - Acknowledge their experience but not act upon it

- Support services available in area (generally)
    - Range of services
    - Who provided by (statutory, voluntary)
    - Adequacy of available services

- Referral process
    - What involved in onward referral
    - Timescale for referral

- Confidence participant has in delivering effective responses
    - What influences this
        - Availability of services
        - Timeliness of referral process
        - Participant experience in area

- Any change in responses/ services available to survivors of violence and abuse since adoption of RE

- What is the perceived value of identifying survivors through RE e.g. increased support, earlier intervention etc.

- Ask the participant to explain their views on how identifying survivors through RE has impacted on the service they provide

Effectiveness:

- Type of service/support work well (for whom, how)
- Types of service/support work less well (for whom, how)
- Types of outcomes indicate an effective response to survivors needs

VIEWS ON OUTCOME MEASURES FOR DEVELOPMENT OF STRAND 3

Aim: to explore participant's views on the concepts identified as part of the outcome tool audit/development process and how they could apply an outcome measurement tool in their own work

- Recap that part of the research is looking at the development of outcome measures and a tool which can be used in a range of AMHS and VS. As part of this would like to explore what they think works well to demonstrate outcomes.

- How do they currently measure outcomes

- What format of tool would be valuable for them (i.e. questionnaire, complete with patient etc.)

- **Introduce the draft outcome tool (provide most recent handout)**

- Ask participant to reflect on these dimensions, questions and process, probe for:
    - Applicability of concepts in their work area
    - Applicability of format to their work (ie would they use it, could they use it)
    - Coverage of issues – anything missing
    - Suggestions for improvement

NEXT STEPS

Aim: to give the participant the opportunity to raise anything that has not been covered already in the interview and to wind down.

- Any other areas of importance to cover/ questions for researcher

STOP RECORDING

- Reassure regarding confidentiality

- Inform respondent of next steps of research and any future involvement

- Discuss the possibility of participant assisting research team to recruit survivors for interviews
    - Recap that also want to talk to survivors as part of the research, ideally those who have experienced RE
    - Discuss possibility of participant helping to recruit survivors using the service they provide

- Check whether participant would like to receive findings from research

- Thank respondent for their time and ensure have research team contact details

Appendix F – Strand 2 Topic Guide for Victims/ survivors of violence and abuse

Responding effectively to the long-term consequences of violence and abuse (REVA)

NIHR_Survivor Topic Guide

The study
Researchers should re-familiarise themselves with the aims and objectives of the depth interviews and the circumstance of the interviewee prior to each interview.

Generally the aim of the interview is to:
- explore the survivor's experience of violence and abuse
- explore how their support needs were identified by AMHS
- map the range of services which they are currently receiving support from, along with their route into these services
- explore their views of the services which they are in contact with
- explore how their current experiences of support services differ from previous experiences
- to identify how current practices and support services could be improved
- explore their views on the concepts identified as part of the outcome measure work strand

It is important to note that the interviews may deal with highly sensitive and upsetting information for the participant. Researchers should allow participants to lead on the discussion and make clear they do not have to answer any question they do not wish to. Probing should be done sensitively. Researchers should also plan time for general chatting at the beginning and end of the interview to create a safe discussion space for participants.

INTRODUCTION

- Introduce researcher(s) and NatCen
- Explain who the research consortium and funded by DH Explain research:
    - To explore effective responses to long-term consequences of violence and abuse, Survivors experiences of support services and develop accurate outcome measures that relate to this.
- Explain the interview will last between 1 - 1.5 hours. The discussion will focus on:
    - How they were referred into/found their current support services, including detail of how their support need was identified
    - Their views of the support they are receiving
    - How their current experience differs from any previous experiences
    - How services could be improved
- Potentially sensitive/distressing to discuss but they are in control of the interview:
    - No right or wrong answers.
    - Participation is voluntary - can have a break or choose not to discuss any issue.
- Explain recording, data storage and confidentiality

- Explain reporting process and that no individual will be identified in the report. Data will be destroyed on completion of the research.
- Check if any questions before we start (remind them they can have a break or stop at any time and only answer questions they wish to)
- Ask for permission to start recording

START RECORDING

BACKGROUND

Aim: to gather some initial information on the interview respondent, in order to facilitate the rest of the interview.

- Ask to describe self- age, what they do with their time, who they live with and anything else they think is important

- Confirm where heard about research
    - Accessing support due to own experiences of violence and abuse
        - Types of support
        - Through which sector (statutory, voluntary)
        - Which support services do they access

IDENTIFICATON OF SUPPORT NEEDS VIA AMHS

Aim: to explore how the respondent was identified as having a support need. Key issue to explore is whether 'routine enquiry' was used within the AMHS and their views on this.

Note: during this discussion the participant may discuss their experience violence or abuse. The interviewer should use their discretion to which point in the interview they discuss this in detail.

Note: this section is particularly relevant for participants who have accessed adult mental health services or have been recruited via one. It may not be relevant for participants recruited via voluntary sector services. Please use as appropriate.

- How did the AMHS identify their need for support
    - Standardised assessment
    - Self- disclosure from respondent
    - Referral

- **Did they ask 'the question'**
    - If they recall this explore in depth
    - Were all experiences covered :

- Views on routine enquiry (if used)
    - Appropriateness of question
    - Timing of being asked/who asked
    - Outcome

- How did the AMHS then respond
    - Perceived skills and knowledge of staff members in ability to respond to disclosed need
    - Involvement of specialist staff with AMHS

QUESTIONS FOR VOL SECTOR PARTICIPANTS:

- How did service identify support needs (self-disclosure)
- Was an assessment undertaken
- Have historical experiences been explored
- Have the participant been referred to other services/support following this

ONWARD REFERRAL

Aim: to identify how the respondent was referred into their current support services.

- Support services available
  - Range of services
  - Who provided by (statutory, voluntary)
  - Adequacy of available services

- Referral process
  - What involved in onward referral
  - Timescale for referral
    - Views of
    - Any delays and why

EXPERIENCE OF VIOLENCE AND ABUSE

Aim: to get an overview of the respondent's experience of violence and abuse. NB- this is not the 'focus' of the interview so let the respondent determine the level of detail which they feel comfortable sharing. This may be covered at earlier stages of the interview – researcher to use their discretion and discuss at the appropriate stage.

EXPLAIN: It would be helpful to be clear about the support needs they have and the different experiences of violence or abuse that may relate to this. Understand this may be difficult so they can take their time and go into as little or as much detail as they like:

- Ask the respondent to summarise their own experiences of violence and abuse, probe for:
  - When took place (i.e. how long ago)
  - Any long term implications/ impacts of their experiences

EXPLAIN: Having discussed their support needs and experiences would now like to explore how the services they access have supported them

USE OF AND VIEWS OF SUPPORT SERVICES

Aim: to explore the range of support services which the respondent is currently engaged with

- Ask the respondent to give an overview of the support services which they are currently receiving as a result of their experiences of violence and abuse.

- For each service accessed probe for:
    - Any further assessment of need
    - Nature of support received
        - Practical
        - Emotional
    - How long been engaged with service
    - Views of service
        - Appropriateness
        - Feel supported
        - Believed
        - Respected
        - Offering the right level of support
        - Nature of relationship with staff
    - Differences between statutory and voluntary services (if applicable)

SERVICE IMPACT/ OUTCOMES AND OVERALL

Aim: to explore respondent views on the services which they have received and the impacts of these services.

- General reflections on support services received
    - What were they seeking/what did they want to change

- Key outcomes / impacts of engagement with services

- Facilitators / barriers to outcomes / impacts being realised

- Suggestions for improvement
    - To assessment/ routine enquiry
    - Availability of appropriate support services
    - Referral to onward support services
    - Support received through services

- Ask respondent to compare current services accessed to any previous services received for these needs
    - Nature of support received
    - Views of service
        - Appropriateness
        - Offering the right level of support
        - Nature of relationship with staff

VIEWS ON CONCEPTS IDENTIFIED IN STRAND 3

Aim: to explore participant's views on the concepts identified as part of the outcome tool audit/development process.
NOTE: Researcher refer to sheet of key concepts and select a few
PROVIDE HANDOUT TO PARTICIPANT

- Recap that part of the research is looking at the development of outcome measures and a tool which can be used in a range of AMHS and VS.

- Introduce the key concepts identified via the audit and those we will focus on in the interview.

Ask participant to reflect on these concepts, probe for:

- Applicability of concepts in their experiences and needs
- Coverage of issues – anything missing
- Suggestions for improvement (language, etc)

NEXT STEPS

Aim: to give the participant the opportunity to raise anything that has not been covered already in the interview and to wind down.

- Any other areas of importance to cover/ questions for researcher

STOP RECORDING

- Reassure regarding confidentiality
- Inform respondent of next steps of research and discuss their willingness for any future involvement
- Complete re-contact consent form is appropriate
- Thank respondent for their time and ensure have research team contact details

Appendix G: Reference Network

Name	Role/ Organisation
Lynda Arkwright	Retired Psychotherapist
Liz Mayne	Mental health advocate (DH Lead for MHTCP on RE 2006-2010).
Shirley McNicholas	Manager, Crisis House Camden
Gary Harkness	Service Manager, MESMAC Yorkshire
Dr Frank Keating	Senior Lecturer in Health and Social Care & MSc in Social Work Programme Director, RHUL
Professor Paul Bebbington	Emeritus Professor of Social and Community Psychiatry, UCL
Professor Louise Howard	Professor in Women's Mental Health, KCL
Duncan Craig	Director, Survivors Manchester
Martyn Sullivan	CEO, Mankind
Heather Morfett	Psychotherapist, NHS Plymouth
Fay Maxted	CEO, The Survivors Trust
Georgina Hoare	Clinical Services Manager, Survivors UK
Dr Ruth Cureton	Trustee, Trauma and Abuse Group
Melanie Goodwin	Trustee, chair and trainer for First Person Plural
Kathryn Livingston	Trustee and trainer for First Person Plural
Hilary McCollum	Campaigner
Nicki Norman	Women's Aid
Davina James Hanman	Director, AVA
Dr Cathy Zimmerman	Senior Lecturer migration, health, vulnerable migrants, labour exploitation gender-based violence, LSHTM
Lee Eggleston	Chair, of Rape Crisis England and Wales
Marianna Tortell	Performance Coordinator, Rape Crisis England and Wales

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