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Routine Enquiry about Adverse Childhood Experiences Implementation pack pilot evaluation (final report)

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Implementation Pack pilot evaluation (final report)

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Contents

Research summary and key considerations

Background

A wealth of research has highlighted strong associations between adverse childhood experiences (ACEs), including child sexual abuse and exploitation (CSAE), and poor health and social outcomes throughout the life course. In England, identifying, addressing and preventing ACEs, in particular CSAE, is high on the political and public agenda. In 2013/14, Lancashire Care NHS Foundation Trust (LCFT) developed a training programme on Routine Enquiry about Adversity in Childhood (REACh) and have since implemented it across various services in England (Box i). As part of a broader suite of work around CSAE, in 2015, UK Government made a commitment to explore the implementation of routine enquiry on childhood adversity (amongst those aged 14+ years) across a range of public services. Subsequently, in 2016 the Department of Health commissioned LCFT to implement a pathfinder project to develop a standalone Implementation Pack to support services in developing, implementing and embedding REACh, and to pilot its use across three services in North West England (pilot sites). In 2017, the Implementation Pack was piloted across a Child and Adolescent Mental Health Service (CAMHS), drug and alcohol service, and sexual violence support service. This report presents key findings from a study that aimed to describe: the development and piloting of the Implementation Pack; practitioner views of the Implementation Pack; and practitioner (and where possible client) views on REACh.

Development of the Implementation Pack

Guided by a project steering group, and consultation with wider stakeholders, the pathfinder project was refined over nine months. During this time, there were substantial changes in the design of the Implementation Pack, including the routine enquiry questionnaire. Thus, whilst it originally focused on CSAE only, it was later amended to also

Box i: The REACh programme

The REACh programme aims to raise awareness amongst professionals about the long-term impacts of ACEs, and support practice change across services (e.g. drug and alcohol, GP practices) to embed REACh within client assessments, using a modified version of the ACE international questionnaire (ACE-IQ; WHO, 2017). The rationale for REACh is to encourage disclosures of ACEs, and support practitioners to respond appropriately and plan client-centred interventions more effectively. REACh includes an intensive package of support, including the REACh team working with a service to: identify their needs (i.e. to be an ACE-informed service only or to also implement REACh); ensure the service/staff are ready to implement REACh (where applicable, prior to implementation); training all relevant staff as required; and where applicable supporting the service/staff in the delivery of REACh (for up to six months post-training). The LCFT REACh programme has been implemented across more than ten services in North West England (McGee et al, 2015).

include other ACEs (recommended by the project steering group due to links between CSAE and other forms of adversity). To accommodate this change, a version of the ACE-IQ (WHO, 2017) was adapted to incorporate additional questions on CSAE, to produce the ACE-CSE questionnaire. Further, it was initially anticipated by LCFT that the pathfinder would follow a 'train the trainer' model, with the REACh team training pilot sites leads and providing them with the knowledge and materials to implement REACh within their service (e.g. staff training materials). However, this was not proceeded with due to concerns around the feasibility and affordability of this approach at national level. Thus, it was decided by the project steering group that the project would involve the development and piloting of a standalone Implementation Pack that services could access and use to implement routine enquiry using the ACE-CSE questionnaire, without additional support. Subsequently, the core components of the Implementation Pack were identified by the REACh team, based on learning from implementing REACh, review of the literature, and project steering group and wider stakeholder consultation.

The Implementation Pack

The pack includes three core components:

- ***The Organisational Readiness Checklist and Action Plan (OR-CAP):*** Designed to enable services to self-assess whether they are ready to safely implement, and effectively embed, routine enquiry using the ACE-CSE questionnaire, and respond appropriately to disclosures. It includes nine categories of assessment, covering: commitment; the assessment pathway; data collection; training and development; safeguarding; on-going support and embedding routine enquiry; supervision support and self-care; information governance; and, quality monitoring and review.
- ***A staff training package:*** Designed to support services in training staff to implement routine enquiry using the ACE-CSE questionnaire. It includes a range of resources: a training facilitator pack including a training guidance manual and training PowerPoint slides; pre-learning materials (available online for the trainer and trainees to access); and, links to videos of role-play scenarios.
- ***The ACE-CSE questionnaire:*** Designed to provide services with a standardised tool and list of questions to use when implementing routine enquiry. It includes: information for practitioners to share with clients about the ACE-CSE and confidentiality; a checklist for practitioners to identify if the client has the capacity and Gillick competency to complete routine enquiry; a consent form for clients; and, the ACE-CSE questions.

Implementation Pack piloting

Prior to being provided with the Implementation Pack, pilot site leads had some awareness of what they were expected to achieve during the pilot and that they would receive some materials (i.e. the Implementation Pack) to support them. Due to delays in the finalisation of the Implementation Pack, the OR-CAP was provided to pilot sites first, followed by the staff training package and ACE-CSE questionnaire a few weeks later. All pilot sites used the OR-CAP to self-assess whether they were ready to safely implement routine enquiry, and

subsequently implemented staff training. There were variations in the delivery and content of training sessions across pilot sites. The training appeared to work best when the trainer had the time to familiarise themselves fully with all the materials, and content from all slides was included. All sessions were delivered by an internal staff member who had knowledge of the work conducted by trainees, and some included a second trainer and/or internal champion of routine enquiry. Both of these aspects appeared to facilitate the training. No training session lasted the recommended six hours (sessions ranged from 1-3 hours). Pilot site leads across two services acknowledged that it would have been better if trainers received more support and guidance, particularly to ensure they had an adequate understanding of the subject matter, and how to implement and embed routine enquiry using the ACE-CSE questionnaire, before delivering training themselves.

Two pilot sites implemented routine enquiries, using the ACE-CSE with a subset of clients (total n=15; see Box ii). However, routine enquiry was not fully implemented or embedded across any pilot site. Reasons for this were multi-faceted, and appeared to centre around three intrinsically linked aspects:

1. The feasibility of implementing REACh (using the ACE-CSE questionnaire) through the use of the standalone Implementation Pack;
2. Staff uncertainties around the rationale, appropriateness and value of REACh (using the ACE-CSE questionnaire) across these types of services; and,
3. Implementation of the pilot within services that were going through an organisational restructure (resulting in changes in the pathfinder leadership team within LCFT, and implementation staff within pilot sites).

Aspects within the pilot sites appear to have influenced the implementation of routine enquiry:

1. ***CAMHS*** were undergoing an organisational restructure during the piloting phase. Trainers were not aware of the available training package included in the Implementation Pack until the week before the first training session was scheduled to be implemented (prior to this they had started to produce their own training materials). The training delivered deviated from the staff training pack provided (leading to gaps in training, particularly around implementing routine enquiry), and trainers acknowledged that trainees might require follow-up sessions, prior to implementing routine enquiry. However, following the training sessions, and subsequent concerns raised by trainees and senior practitioners about

Box ii: Client experience of childhood adversity

The prevalence of ACEs amongst a small sample (n=15) of clients across two pilot sites is presented below. Due to low numbers, figures should be interpreted with caution.

- 1+ ACEs = 100%
- 4+ ACEs = 60%^
- Sexual abuse and/or exploitation = 60%
- Sexual abuse = 60%
- Sexual exploitation = 40%

^ Excluding sexual exploitation.

implementing routine enquiry, a decision was made by senior CAMHS practitioners to cease implementation.

2. Within the ***drug and alcohol service,*** following initial training and implementation of routine enquiry (Phase 1), the service underwent major staffing change where staff (pilot site lead/trainer and trained practitioners) involved at the beginning of the pilot left the service. Subsequently, service priorities primarily focused on the recruitment and integration of new staff and ensuring the continuity of standard service provision (i.e. drug and alcohol support) to existing and new clients. Whilst a new project lead took over and new practitioners were trained (Phase 2), routine enquiry was not implemented, as senior practitioners felt they required more support (i.e. from the REACh team) beyond provision of the Implementation Pack.
3. At the ***sexual violence support service***, enquiries were implemented during the pilot phase with a subset of clients (as it was not deemed appropriate for all clients). However it was not embedded into the service for implementation post-piloting due to concerns around implementation within a service that had limited resources and was commissioned based on outputs (e.g. number of clients seen).

Monitoring of the pilot and where applicable provision of support to pilot sites was the responsibility of LCFT and the REACh programme team. There was little communication between the REACh team and pilot sites during the piloting phase. Progress updates were provided by pilot sites in project steering group meetings, and via email correspondence, with risks formally monitored, and where applicable followed up. Figure i and Table i provide a summary of pilot implementation.

Figure i: Summary of implementation across pilot sites

	Self-assessment (OR-CAP)	Staff training	Enquiries commenced	Enquiry embedded
Drug and alcohol service (phase 1)	✓	✓	✓	X
Drug and alcohol service (phase 2)	?	✓	X	X
Sexual violence support service	✓	✓	✓	X
Child and Adolescent Mental Health Service	?	✓	X	X

Perceptions of the Implementation Pack

- ***OR-CAP:*** Across the three pilot sites there were mixed views on the value and use of the OR-CAP. CAMHS reported that they required more support at an organisational level to adequately self-assess their organisation (using the OR-CAP), complete actions and thus implement routine enquiry successfully. The drug and alcohol service (initially, during Phase 1) felt that the OR-CAP was useful to help them prepare to implement routine

enquiry. However, when they attempted to reintroduce the pilot following staff changes (Phase 2), the OR-CAP was reported as often being too vague to enable the service to assess and prepare their organisation to implement routine enquiry, and they felt that they needed additional support (e.g. from the REACh team). The sexual violence support service did not feel they required the OR-CAP to implement routine enquiry.

- ***Staff training package:*** Across the three pilot sites there were mixed views of the staff training package. Overall, the training slides, facilitator pack and related resources were viewed as useful. The REACh video animation in particular was seen as providing a great overview of the requirement and importance of implementing REACh. Specific concerns focused around the required skill set of the trainer; clarity around the extent of pre-training preparation required by trainers and trainees; and, overuse of PowerPoint. Further, both trainers and trainees noted that the training (pack and sessions) required more focused content on implementing routine enquiry, dealing with disclosures and the support/intervention pathways for clients requiring additional support.

> *"Very little covered on the questions, how to ask and what to do next."*
> Trainee

- **ACE-CSE questionnaire:** For the majority of enquiries implemented as part of the pilot (n=15), practitioners reported feeling comfortable discussing ACEs and CSAE with clients, and believed that their clients also felt comfortable. Correspondingly, clients agreed that: the questions were clear and they understood what was being asked; they felt providing this information was acceptable; it is important that the practitioner understands what happened during their childhood; and the service is a suitable place to enquire. Two-thirds also agreed that they felt comfortable answering the questions. Although this is a small sample size, these findings are corroborated by other research. Despite this, practitioners across all services raised various concerns and queries about the ACE-CSE questionnaire. Using a structured questionnaire to conduct the enquiry was queried and it was felt that this might not be the most appropriate way of eliciting such information, and was not universally appropriate. The risk being that if a process of disclosure is not tailored to the service user, it may lead to disengagement or interruption of processes of disclosure. Practitioners across pilot sites noted that consideration of the timing and the therapeutic way such adversities were raised and addressed was necessary. A number of specific concerns about the questions within the ACE-CSE questionnaire were also raised, particularly around the CSAE questions (e.g. appropriateness of terminology used), whether the questions were appropriate for children, and asking clients how often the childhood adversities had occurred.

> *"Can give a better understanding of your struggles, especially if you are afraid of sharing your experiences with others."*
> Client

> *"It just feels like a questionnaire is an incredibly blunt tool to access what can be an incredibly tricky situation."*
> Pilot site lead

Views on REACh

All pilot sites were supportive of developing ACE-informed services. Where routine enquiry was implemented (15 clients across two services), it was generally viewed as acceptable to practitioners and clients. However, engagement in the pathfinder raised concerns across various practitioners around the rationale and appropriateness of implementing routine enquiry using the ACE-CSE questionnaire, within these types of services. For instance, implementing routine enquiry during the initial assessment was viewed as not being universally appropriate, as it is vital that a good client-practitioner rapport is developed and the client displays signs of resiliency, before exploring such traumas. Conversely, within the sexual violence service enquiring with a client near the end of service provision was considered potentially unethical if further support was required to deal with disclosures (that the service could not offer). Further, when a client is going through the criminal justice process or is experiencing mental health issues, routine enquiry was deemed not appropriate, or potentially risky to the client. Concerns were also raised around enquiring with young people, including potential misinterpretation of the questions posed. To date, the REACh programme has only been implemented with clients aged 18+ years. The REACh team noted that there was little evidence of the reliability and acceptability of using the ACE-IQ with young people, and practitioners raised concerns about this also, along with the unknown impacts it could have on the young person. Significant concerns were raised about identifying ACEs, without the required resources (both within and external to the service) to support the client appropriately. It was noted that both the enquiry and response will need to be tailored depending on the clients age (e.g. adult or child) and if the abuse is current or historic.

Conclusion

Following provision of the Implementation Pack, none of the pilot site services fully implemented REACh using the ACE-CSE questionnaire. A key reason for this was the need to demonstrate a clear theoretical and, or evidenced based rationale for REACh across the targeted services. Variations in piloting of the Implementation Pack, and thus fidelity to the original REACh model may have heightened practitioner concerns around implementation of REACh. Equally however, this pathfinder raises questions around the feasibility of implementing REACh across the target services through the provision and use of the piloted standalone Implementation Pack. A number of changes to the Implementation Pack were also identified (see Appendix 6). Further consideration needs to be given to the complexity of enquiry of this nature, and the support and training needs of both services and staff implementing enquiry. Ensuring a service is ready to implement REACh, prior to implementation of staff training and routine enquiry, is a core prerequisite of the REACh model. One pilot site was unable to prepare their service through provision of the Implementation Pack alone, whilst another appeared to have attempted to implement training within a service that was not fully prepared. Whilst further investigation is needed, this pathfinder suggests that, beyond revision of the Implementation Pack, some services

may need additional support (e.g. from a professional with knowledge of REACh) to assess whether their service is ready to implement REACh, and if so, to do so effectively.

Key considerations for research, policy and practice

- Through both research and practice, further develop understanding of the rationale, process and impact of implementing REACh (using the ACE and ACE-CSE questionnaire) across the targeted services, including:
    - Demonstrating how information identified through REACh can support clients and develop service provision and support pathways.
    - Exploring if and how routine enquiry could be implemented effectively across services (considering whether this will vary by client and service type).

- Further consider the support and training needs of services (and their staff) in implementing REACh, and identify if revisions to the Implementation Pack would allow services to successfully implement REACh, or if additional support would still be required.

- Ensure that any roll-out of the REACh model is documented, monitored and where possible evaluated, with particularly consideration given to the impact (positive and negative) of enquiry on clients (immediate and long-term) and services (including practitioners and service demand).

Table i: Summary of Implementation Pack piloting across the three services

Service	OR-CAP	Staff training	Enquiry implemented	Fidelity	Acceptability	Impact	Sustainability
Drug & alcohol	✓	Phase 1: 1 session (3 hours); group training - 1 trainer, 3 trainees (February). Phase 2: 1 staff training session (ACE-aware) (October).	Phase 1: 10 enquiries across ≈ 8 weeks (data collected centrally in service database). Phase 2: ceased engagement in pilot.	✓ Phase 1 only.	? Phase 1: Some young people found it difficult/chose not to complete. Phase 2: Senior staff concerns about implementing routine enquiry.	? Phase 1: Potential increase in service/ support needs of clients. Phase 1/2: Whole service engaged in becoming ACE-informed.	X Ceased implementation due to concerns about routine enquiry, and ability to implement it using the Implementation Pack alone.
Sexual violence support	✓	3 sessions (1 hour): individual training - 1 trainer, 1 trainee (total 3) (March).	5 enquiries across ≈ 4.5 weeks (data collected on paper forms). Certain clients only*.	✓ However, no specified point of enquiry.	? Staff concerns that it may negatively impact on progress made with client.	? Service level concerns that it will lead to an increase in service/support needs of clients that cannot currently be met by service.	X Will not continue post-pilot. Further exploration required around suitability of enquiry at this type of service.
Child & adolescent mental health	?	5 sessions (2 hours): group training - 2 trainers, approx. 10 trainees (total 40) (March-April).	Not implemented. (System established to store scanned copies of ACE-CSE electronically).	? Completeness of OR-CAP/ alterations to training.	X Staff concerns about use of ACE-CSE questionnaire and routine enquiry with clients in this type of service.	? Staff concerns about potential negative impacts on clients.	X Did not implement routine enquiry. Further exploration required around suitability of enquiry at this type of service.

* Not currently (or in the near future) engaged in criminal justice proceedings and the practitioner perceives the client has a good rapport with them and they are resilient enough to be asked the questions.

1. Introduction

A wealth of research has highlighted strong associations between adverse childhood experiences (ACEs; Box 1), including child sexual abuse and exploitation (CSAE; Box 2), and poor health and social outcomes throughout the life course (Bellis et al, 2014, 2016; Public Health England, 2017; Sneddon et al, 2016). Broader impacts are also placed on society, for example costs to public services through dealing with the impacts of ACEs (e.g. attendance at health services [Bellis et al, 2017]). In the United Kingdom (UK), identifying, addressing and preventing ACEs, in particular CSAE, is high on the political and public agenda (Department of Education, 2015; Department of Health, 2015; HM Government, 2015, 2017; House of Commons, 2018; NHS England, 2015). Whilst various research studies have illustrated the large prevalence of CSAE across the UK (Box 3), a wealth of evidence also suggests that experience of CSAE often goes unreported and unrecognised (Allnock and Miller, 2013; Berelowitz, 2013). Thus, as part of a broader suite of work to identify, address and prevent CSAE, in 2015 the Government made a commitment to explore the implementation of routine enquire about childhood adversity (REACh) across mental health, sexual health and substance misuse services (HM Government, 2015).

Box 1: Adverse childhood experiences (ACEs)

The term ACEs incorporates a wide range of stressful events that children can be exposed to whilst growing up. While the types of adversities defined as ACEs may vary across contexts, typically, they include harms that affect the child directly, such as neglect and physical, verbal and sexual abuse; and harms that affect the environment in which the child lives, including exposure to domestic violence, parental separation or divorce, or living in a home with someone affected by mental illness, substance abuse, or who has been incarcerated. A study across England estimated that 47% of adults have experienced ACEs (Bellis et al, 2014).

In 2013/14, Lancashire Care NHS Foundation Trust (LCFT) developed a training programme on REACh (see Section 2) and have since implemented it across various services in England (McGee et al, 2015). Based on this experience, in 2016 the Department of Health commissioned LCFT to implement a pathfinder project to support the government's commitment. The aim of the pathfinder was to develop a standalone Implementation Pack to support services in developing, implementing and embedding routine enquiry (amongst clients aged 14+ years) about CSAE within the context of broader enquiry about adversity in childhood, and to pilot its use across services. Three services across North West England volunteered to pilot the Implementation Pack including a Child and Adolescent Mental Health Service (CAMHS), drug and alcohol service, and sexual violence support service. Within each service, a senior member of staff (s) was tasked with using the Implementation Pack, and where necessary other resources (e.g. from the REACh team and/or their own

organisation)[1], to implement routine enquiry as soon as was feasible within their organisation, but with the expectation that enquiry will commence within three months of the provision of the Implementation Pack. In January/February 2017, the services were provided with a preliminary Implementation Pack and were tasked with using this resource to develop, implement and embed routine enquiry in their service. The Public Health Institute (PHI), Liverpool John Moores University (LJMU) were commissioned to evaluate the piloting of the Implementation Pack across the three services, including exploration of broader factors that may influence the development, implementation and embedment of REACh.

1.1 Research aim and objectives

The evaluation has the following primary objectives:

1. To describe the development of the Implementation Pack, and the model upon which it is based (i.e. the LCFT REACh training programme).
2. To describe if and how routine enquiry is developed, implemented and embedded across the three services during the pilot.
3. To explore practitioner views on the Implementation Pack.
4. To explore practitioner (and where applicable client) views on REACh.

Box 2: Definitions of child sexual abuse and exploitation

Child sexual abuse: *"Involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse (including via the internet). Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children"* (Berelowitz et al, 2013).

Child sexual exploitation: *"Involves exploitative situations, contexts and relationships where young people (or a third person or persons) receive 'something' (e.g. food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money) as a result of them performing, and/or another or others performing on them, sexual activities. Child sexual exploitation can occur through the use of technology without the child's immediate recognition; for example being persuaded to post sexual images on the internet/mobile phones without immediate payment or gain. In all cases, those exploiting the child/young person have power over them by virtue of their age, gender, intellect, physical strength and/or economic or other resources. Violence, coercion and intimidation are common, involvement in exploitative relationships being characterised in the main by the child or young person's limited availability of choice resulting from their social/economic and/or emotional vulnerability"* (Allnock and Miller, 2013).

[1] Throughout the initial piloting phase, the LCFT REACh programme team were available to support the pilot sites in implementing routine enquiry if necessary.

1.2 Methods

A range of research methods have been implemented to inform this study including:

- Interviews with the Implementation Pack developers and pilot site leads;
- Surveys with practitioners and clients engaged in the pilot;
- Collation of anonymised data collected during the routine enquiries;
- Review of project documentation, including project wide and pilot site materials; and,
- Researcher observations of pilot implementation (i.e. training sessions).

Full details of the methods used are provided in Appendix 1.

Box 3: Estimates of the prevalence of CSAE

- A survey exploring ACEs amongst adults (aged 18-69 years) in England estimated that 7% had experienced child sexual abuse (Bellis et al, 2014).
- In 2015/16, across England and Wales there were 39,813 police-recorded sexual offences where it was known that the victim was under the age of 16 years (Flatley, 2016).
- In 2015/16, the Crime Survey for England and Wales included a new module of questions exploring child abuse. The survey estimated that 7% of adults (aged 16-59 years) across England and Wales had experienced sexual assault during their childhood (i.e. under the age of 16 years), with women four times as likely as men to be a survivor of this form of abuse (Flatley, 2016).
- One UK study has estimated that 4.8% of children aged 11-17 years have experienced contact sexual abuse at some point in their childhood (Radford et al, 2011).
- An inquiry into child sexual exploitation (CSE) in England identified 2,409 child victims of CSE perpetrated by groups (during a 14 month period in 2010/11). In addition the inquiry identified that 16,500 children and young people were at risk of CSE in 2010/11 (Berelowitz, 2012).

2. Development of the Implementation Pack

This section provides a summary of the development of the Implementation Pack based on information collected through interviews with the REACh team and project documentation. It presents an overview of the LCFT REACh programme, the model which the Implementation Pack is based upon, the Implementation Pack content, and concludes with a summary of its development.

2.1 The REACh programme model

The REACh programme was developed by LCFT and aims to raise awareness amongst professionals about the long-term impacts of ACEs, and support practice change across services (e.g. drug and alcohol, GP practices) to embed REACh within client assessments, using a modified version of the ACE international questionnaire (ACE-IQ; WHO, 2017). The rationale for REACh is to encourage disclosures of ACEs, and support practitioners to respond appropriately and plan client-centred interventions more effectively. REACh includes an intensive package of support, including the REACh team working with a service to: identify their needs (i.e. to be an ACE-informed service only/to implement REACh); ensure the service/staff are ready to implement REACh (where applicable, prior to implementation); training all relevant staff as required; and where applicable supporting the service/staff in the delivery of REACh (for up to six months post-training). The LCFT REACh programme has been implemented across more than ten services in North West England (McGee et al, 2015).

REACh is an intensive programme that has five core phases:

> *"Over the years we have worked out a blueprint of what works."*
> REACh team member

1. **Scoping:** working with an organisation to help them understand what REACh is and assess their requirements (e.g. to be an ACE-informed service, and/or implement REACh). The information is used to develop a bespoke REACh programme package that is tailored to meet the organisation's needs.
2. **Organisational readiness (checklist):** used to assess if the service has appropriate processes in place to implement REACh safely. For example, through exploring: the organisation's infrastructure; organisational commitment to being ACE-informed and/or implementing REACh; potential risks; staff training needs; and data collection processes.

> *"From both staff and service users, there are fears about disclosure, from service users they have said, I'm really frightened of the consequences of telling you... but then staff don't want to open a can of worms, so at both ends you've got someone withholding information, and someone else not wanting to ask which causes a kind of logger head in the middle and that's what this whole work [REACh programme] is trying to overcome."*
> REACh team member

3. **Training:** bespoke training for staff so they become ACE-informed, and where relevant have the knowledge, skills and confidence to implement REACh (the length of training can range from a half-day session to two days dependant on requirements).
4. **Follow-up support/monitoring** (over six months)**:** provided to both the organisation and staff members engaged in REACh ensuring REACh is embedded within the service.
5. **Evaluation:** internal evaluation of the process and outcomes of the REACh programme.

The team reported piloting and developing the REACh programme across a range of services, who are likely to be in contact with clients/patients who have experienced ACEs, and who may require more tailored support that may not have been identified through existing assessments. The development of the REACh programme across services has led to: an expansion of the team (number of staff and skill base) and subsequently the available knowledge and support to refine the programme further; and greater opportunity to gather (anecdotal) evidence to explore if, and how, the REACh programme may work across different services. The REACh team reported a number of key lessons that they had learnt. This included: REACh training appears to alleviate practitioner concerns about routine enquiry and potential disclosures; REACh should only be implemented if the organisation and its staff are ready to implement it, and respond to disclosures appropriately; implementation of routine enquiry appears to be feasible when all five key components (see above) are implemented; and, a standalone ACE questionnaire may enhance consistency and comparability of implementation of routine enquiry across clients and services.

> *"REACh is… very much hands on, face to face teamwork. What we are going for is to distil all that learning into a package that can be self-contained, that can be delivered to that team with a set of guidance and materials that they can use to self-train, and also we're using a specific questionnaire, which is the standard ACE with CSE questions added and that's the first time this has happened."*
>
> REACh team member

2.2 Implementation Pack content

The Implementation Pack includes three core components: an Organisation Readiness Checklist and Action Plan (OR-CAP); staff training pack; and the ACE-CSE questionnaire.

2.2.1 Organisational Readiness Checklist and Action Plan (OR-CAP)

Purpose: To enable services to self-evaluate whether they are ready to safely implement, and effectively embed, routine enquiry using the ACE-CSE questionnaire (see below), and respond appropriately to disclosures.

Process of development: The OR-CAP incorporates learning from implementing the REACh programme by the LCFT REACh programme team.

Structure/content: The OR-CAP begins by providing background information on ACEs and associations with health harming behaviours and ill health, and the value of implementing REACh. Following this, the OR-CAP includes nine categories of self-assessment, covering: commitment; the assessment pathway; data collection; training and development; safeguarding; on-going support and embedding routine enquiry; supervision support and self-care; information governance; and, quality monitoring and review. Each section is presented in a similar format (e.g. Appendix 3), including: a description of why the section is important; questions to address and examples of evidence required; and space to record responses, evidence and required actions (where applicable). There is also a section at the end to collate actions, and detail responsible persons and completion dates.

Instructions for use: In line with the REACh programme, the REACh team highlighted that the OR-CAP should be completed, actioned (where required) and reviewed, before an organisation decides if they are ready to implement routine enquiry. Routine enquiry should only be implemented if the organisation: has assessed themselves as having the correct systems and processes in place; is in an appropriate position to implement it (e.g. not implementing other changes; are able to action any required changes to support routine enquiry [e.g. train staff]); and knows how they will implement it (e.g. where in a client's pathway). If an organisation is ready to implement routine enquiry, the next step is to train staff accordingly, incorporating elements from the OR-CAP into the training design, content and delivery (see below).

> *"If we were doing standard REACh historically, we would only have got to the point of training if we had known that the service was set up and ready to do enquiries, safeguarding policies in place, procedures, they have everything ready in case they need to do anything. Supervision available, support for staff, then we do training."*
>
> *"All of this is about making sure practice is embedded across the whole service, it's not just, make sure these questions are asked, it's about what you do next."*
>
> *"You should have decided where routine enquiry goes in a pathway and you wouldn't enquire with someone that only sees someone once. To make sure there is follow up…there are services where routine enquiry isn't appropriate, in a centre for domestic abuse with someone in immediate crisis and hurt for example. But in a refuge, with a case worker and settled, then that's an ideal environment for routine enquiry."*
>
> REACh team members

2.2.2 Staff training package

Purpose: To support services in training their staff to implement routine enquiry using the ACE-CSE questionnaire.

Process of development: The training pack incorporates learning from implementing the REACh programme by the LCFT REACh programme team. The REACh team noted that they recognise that services and staff members may have different training needs. Thus, the pack

covers all aspects that the REACh team believe (based on their prior experience, expertise and knowledge) are required to implement enquiry effectively. A range of new resources were developed to support training delivery (detailed below).

Structure/content: The training pack includes a range of resources: a training facilitator pack including a training guidance manual and training PowerPoint slides; pre-learning materials (available online for the trainer and trainees to access); and links to videos of role-play scenarios, for use during the training session (e.g. routine enquiry with a young person) (Appendix 4).

Instructions for use: The REACh team acknowledged that some elements included in the training package may already be part of existing training within services, and thus may not need to be covered in depth as part of this training, noting that the training can be tailored to the needs of the service and trainees (identified in the OR-CAP). The training is designed as group training, and whilst an individual may complete it independently, this was not advised.

> *"The pack was developed from the learning over the past four years in content, and it was designed in a very specific way. So you might touch a sensitive topic but then move to a less sensitive and a group activity…So you create an evidence base that people believe it's a good thing to do, then you need to help people feel confident to ask, we cover all their fears, why don't practitioners ask? And then why don't clients disclose? Getting them to think about all the barriers. We then move into good practice about routine enquiry and responding."*
>
> *"It can be done quite flexibly, the way we designed it was with a pack of slides and each slide has notes to talk about, things to discuss etc., so they could deliver on a day, but there's no reason why someone couldn't do it on their own, although its better as a group exercise so people can practice, we've put group exercises in there, role plays, they can have a go at doing it, to raise confidence. What I wouldn't like is someone to be forced to go away on their own to do the training as a solo practitioner with no support and go, there you go, you're trained now go get on with it, without a chance to say they are not confident or to practice, there are a lot of suggested group discussions etc."*
>
> REACh team members

2.2.3 ACE-CSE questionnaire

Purpose: To provide services with a standardised tool and list of questions to use when implementing routine enquiry.

Process of development: The ACE-CSE is based on the ACE-IQ and existing list of ACE questions used in previous REACh programmes. Additional questions on CSAE were developed by the REACh team in collaboration with members of the project steering group (e.g. NHS Digital). Questionnaire format and content was discussed with young people, practitioners and other key stakeholders (e.g. national experts on ACEs).

Structure/content: A four page questionnaire including: information for practitioners to share with clients about the ACE-CSE questionnaire and confidentiality; a checklist for practitioners to identify if the client has the capacity and Gillick competency to complete routine enquiry; a consent form for clients; and the ACE-CSE questions (ACE questions followed by more detailed questions on CSAE) (Appendix 5).

Instructions for use: Whilst there are no written instructions on how to use the ACE-CSE questionnaire, a discussion of its use is included in the training pack, accompanied by videos providing examples of how to implement routine enquiry and respond. The ACE-CSE questions are designed to be completed by either the practitioner (through discussion with the client) or the client (i.e. self-complete).

2.3 Implementation Pack development - monitoring and review

> *"…because of our experience of asking about ACE we know that if you have experienced one type of trauma you are more likely to have experienced others…there is an opportunity to open up access to services that might best suit a person's needs."*
>
> REACh team member

At the beginning of the project (early 2016), a local stakeholder event was held to engage key partners in the pathfinder project, particularly practitioners from potential pilot sites. Subsequently, a pathfinder project steering group was established (Box 4). Hosted by LCFT and chaired by the REACh programme lead, the steering group included representatives from: LCFT; each pilot site; local commissioners; the Department of Health; NHS Digital; and NHS England. Through discussion with the project steering group and other key stakeholders[2], the project was further refined over a period of nine months. During this time, there were substantial changes in the design of the Implementation Pack and routine enquiry questionnaire. Thus, whilst the project originally focused on CSAE only, it was later amended to also include other ACEs. One REACh team member noted that this was an important development of the pathfinder, due to the high likelihood that those experiencing CSAE will have also experienced/be experiencing other childhood adversities. Identifying and addressing CSAE alone, without identification and

Box 4: Role of the pathfinder project steering group

The role of the project steering group included:

- Ensuring the successful and timely implementation of the project;
- Providing strategic direction, and overseeing and driving the implementation process;
- Driving the project forward and delivering the outcomes and benefits;
- Identifying potential issues and barriers to the planning and implementation process, assisting in providing solutions, systems and processes to move it forward;
- Ensuring that the project does not adversely affect care quality, safety or outcomes;
- Supporting the communication of the project to staff and stakeholders; and,
- Providing resource and specific commitment to support the Senior Responsible Officer (based within LCFT) who is accountable for project delivery (LCFT, 2016).

[2] E.g. partners with knowledge and/or experience of ACEs/CSAE/routine enquiry.

consideration of other childhood adversities, could thus be a missed opportunity to support clients more effectively. Further, it was felt that exploring a range of ACEs prior to exploring CSAE in detail, would be a more sensitive way to ask the CSAE specific questions. To accommodate this change, a version of the ACE-IQ (already being used as part of the REACh programme, and including questions on sexual abuse; WHO, 2017) was adapted to incorporate additional questions on CSAE (developed by the Department of Health, NHS Digital, REACh team and external advisors). Interviewees noted that developing the new questionnaire (i.e. the ACE-CSE questionnaire) was a complex process. There was a need to ensure the questionnaire would: provide information necessary for local and national stakeholders/practitioners to understand the issues and provide more appropriate and effective support for clients; be comparable to existing research/enquiry about ACEs; and be acceptable to practitioners and clients. The views of field experts and patient groups were consulted and extensive suggestions were made, including changing the structure and wording of the ACE questions. However, questionnaire developers agreed that for the pathfinder project, the ACE specific questions should be similar to the validated ACE-IQ, acknowledging that revisions may be required following the pilot.

> *"It went through many revolutions, we tried to be as inclusive as possible whilst respecting the research, that this [ACE-IQ] is an established tool, we tried to see the views of professionals, service users, experts in the fields."*
>
> REACh team member

Whilst the initial design of the project included a 'train the trainer' model, with the REACh team expecting to train pilot site leads directly (and then provide them with materials to implement REACh within their service), this was not proceeded with due to concerns around the feasibility and affordability of this approach at national level. Further, as the REACh team would not be freely available to support other services implementing routine enquiry, the pathfinder project steering group agreed that the project would involve the development and piloting of a standalone Implementation Pack that services could access and use internally, without additional support[3].

> *"We originally started by planning to do the full REACh model, but then three months in we took a step back and thought that previous policy implementation had struggled because implementation plans were not robust enough, so we decided we wanted to pilot exactly what people would get nationwide."*
>
> REACh team member

To inform the development of the Implementation Pack, the REACh team reported conducting a rapid literature review to identify any existing resources to train practitioners in routine enquiry about ACEs (beyond the REACh programme). Coupled with learning from implementing REACh, (see Section 2.1), and discussion with the project steering group and other stakeholders the core components of the Implementation Pack were identified by the

[3] Although, for the purpose of the pilot, the REACh team would be available to support pilot sites if requested.

REACh team (detailed in Section 2.2). The REACh team described several minimum outcomes they would expect to achieve through piloting of the Implementation Pack:

- To identity if REACh can be implemented and embedded using the Implementation Pack alone (without involvement of the REACh team), and if changes need to be made to the Implementation Pack.
- To implement routine enquiry using the ACE-CSE questionnaire across the three pilot sites, develop ACE-informed services, with data used to: identify the nature and prevalence of childhood adversity across clients; inform client support/treatment plans; and identify service needs.
- Support the development of the REACh programme across England, developing ACE-informed services and building awareness of the nature, extent and impact of ACEs, including CSAE, and develop the evidence base on REACh.

The REACh team expressed a number concerns regarding the piloting of the Implementation Pack including:

- **Timescales:** the pressure placed on pilot sites to implement routine enquiry within a relatively short space of time.
- **Organisational change and capacity:** implementation of the pilot within a service (CAMHS) that was undergoing organisation change (restructure) and another (sexual violence support service) that had limited resources and was commissioned based on outputs (e.g. number of clients seen).
- **Fidelity, dose and reach:** the impact that the project timescales and subsequent pressures to establish routine enquiry within defined deadlines may have on programme fidelity, dose and reach. For example, would this lead to services implementing training and routine enquiry without the necessary systems and processes in place to safely and effectively implement and embed REACh?
- **Effectiveness of the Implementation Pack:** whether the approach being taken as part of the pathfinder, i.e. a standalone Implementation Pack, would have the same (perceived) effect as the original REACh programme model. Critically, it was noted that one of the strengths of the REACh programme model is having a person/team to support a service and practitioners to effectively implement, and embed, the enquiry, ensuring that it's not just a process of asking additional questions, but a whole system change that leads to more effectively support and outcomes for clients. The team were conscious that implementing REACh in a new way and the use of an amended questionnaire, may present a number of unforeseen challenges.

> *"I think that the main issue for me is the impact doing routine enquiry has on the time it takes to do things for services. At what point in their pathway will they ask the questions? Will it impact on number of sessions people can do? If people are paid based on a tariff-based on activity, adding twenty minutes onto your appointment is going to see a significant drop in your output and therefore what you get paid."*
>
> REACh team member

"They also have to provide us with some assurance that things are in place, it's (OR-CAP) a self-assessment essentially but we wouldn't suggest they proceed unless everything on the checklist has been addressed."

"Done (i.e. routine enquiry) badly it could be traumatic, which is why part of the training is about how to do it properly."

REACh team members

Prior to piloting, the REACh team distributed a draft Implementation Pack to various stakeholders (e.g. safeguarding leads, Department of Health, NHS Digital) for review. The review period was short (one week) and limited feedback was received from reviewers. Feedback focused on concerns about the acceptability of routinely enquiring about CSAE specifically; the wording of the CSAE questions[4]; and services having the resources to respond to disclosures, particularly where the client may need access to additional support. Whilst the REACh team reported they would have valued more time for external partners to review the Implementation Pack, they were confident that systems were in place however, to identify and monitor project risks, and implement actions accordingly as part of the project steering group meeting.

[4] No changes were made to the ACE-CSE questions prior to piloting.

3. Implementation Pack piloting

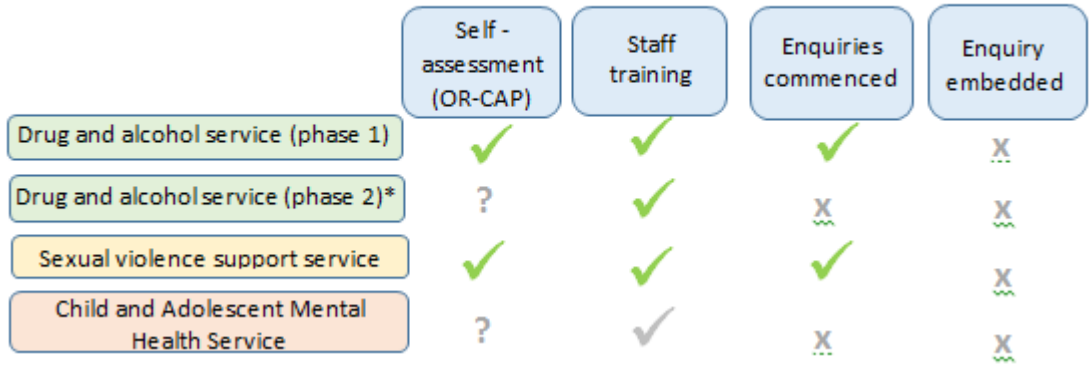
This section provides a summary of the pilot implementation based on information collected through interviews with pilot sites leads, the REACh team and project documentation.

3.1 Overall implementation

Following the review process the Implementation Pack was piloted across the three services. The original intention was for pilot site leads from the three services (members of the project steering group) to receive the full Implementation Pack, and then use this, and where necessary other resources, to develop and implement routine enquiry in their service within three months. In January 2017, the pilot sites were provided with the first part of the Implementation Pack – the OR-CAP, with the training package and ACE-CSE questionnaire provided around four weeks later[5]. In addition, they were requested by LCFT to complete each stage of the Implementation Pack, and thus implement routine enquiry, within a shorter time period than originally anticipated (one-two months), to allow initial learning from the pilot to be obtained before the end of 2016/17 (i.e. when the pathfinder was originally expected to end[6]).

Overall, following engagement in the pathfinder project and provision of the Implementation Pack, no pilot site fully developed, implemented and embedded routine enquiry using the ACE-CSE questionnaire into their service (Figure 1; Table 1).

Figure 1: Summary of implementation across pilot sites



* Following initial training and implementation of routine enquiry (Phase 1) the service underwent major staffing changes, and staff involved at the beginning of the pilot left the service. A number of months later, senior staff attempted to reintroduce routine enquiry into the service (Phase 2).

[5] As they were still being finalised at the point at which the pilot commenced.
[6] In April, the pathfinder was extended until autumn 2017, to allow further learning on the pilot to be obtained.

Table 1: Training provision and delivery across pilot sites

Drug and alcohol service	Sexual violence support service	CAMHS
• 1 * 3 hour group training session • 1 trainer • Total 3 trainees[7] • No pre-training completed • All training pack slides used • Videos not used (technology not available) • Included role play/ detailed discussion about enquiry/ACE-CSE questionnaire	• 3 * 1 hour one-to-one training sessions • 1 trainer • Total 3 trainees • No pre-training completed • All training pack slides used • Videos not used (but video link sent to trainees) • Included role play/ detailed discussion about enquiry/ACE-CSE questionnaire	• 5 * 2-3 hour group training sessions • 2 trainers • ~40-50 trainees • Some trainees accessed pre-training • Subset of training pack slides used • Some videos used (issues around identifying which videos to use when) • Limited role play/detailed discussion about enquiry/ ACE-CSE questionnaire in 1st session (more in following sessions)

3.2 Individual pilot site implementation

3.2.1 Drug and alcohol service

> *"You get to a point where you think, we're actually more ready than we think we are because we've had a lead up, staff who have done this before."*
>
> Pilot site lead

Piloting of the Implementation Pack in the drug and alcohol service is described in two phases below. Following initial training and implementation (Phase 1; up to April 2017), the service underwent major staffing change where staff involved at the beginning of the pilot left the service over a period of three months. Consequently, a new project lead took over and new practitioners were trained (Phase 2).

Phase 1 As part of local contractual requirements, the service had a commitment to implement REACh[8] with clients in 2016/17. Thus to achieve this, and as part of their role as a pilot site, they had begun some preparatory work prior to receiving the OR-CAP. This included developing knowledge amongst managers and staff about the purpose of REACh. A number of staff attended the pathfinder stakeholder event and/or had attended REACh training whilst employed elsewhere. Steps were established to embed REACh through developing organisation commitment and considering how REACh would be implemented (i.e. at what stage in the client pathway, by whom and with which client group). Upon receipt of the OR-CAP, the pilot site lead completed the self-assessment, and were ready to implement training four weeks later (Table 1), with routine enquiry implemented around one-to-two weeks following training. Routine enquiry at this point was implemented amongst clients aged 14-25 years during the initial (or next) assessment (Box 5). However, it was noted that resource issues (i.e. staff shortages) affected the amount of enquiries

[7] Two trainees had previously received REACh training whilst employed at another service.
[8] Using the original REACh ACE tool, not the ACE-CSE tool.

conducted, and there was a backlog of new clients who needed to be assessed. Delays were initially experienced in establishing electronic data capture systems, however this was later rectified, with questions from the ACE-CSE questionnaire incorporated into the services IT system. At this point it was planned to expand routine enquiry to all clients, and train more staff so they were ACE-informed and, where relevant, able to implement routine enquiry. Routine enquiry was a regular agenda item in practitioner and management meetings (reported by the pilot site lead as instrumental in facilitating development and implementation during this phase).

Phase 2 Following the departure of the pilot site lead/trainer and also trained practitioners, service priorities primarily focused on the recruitment and integration of new staff and ensuring the continuity of standard service provision (i.e. drug and alcohol support) to existing and new clients. When service provision was stable and new practitioners were established in their role, in September/October 2017 the service attempted to train staff and implement routine enquiry using just the materials in the Implementation Pack. A senior member of staff took on the role of pilot site lead, setting time and resources aside to support the development and implementation of routine enquiry into the service. While all new practitioners were trained using the staff training pack, due to several concerns, routine enquiry was not implemented (see Section 4). The project lead concluded that going forward the focus would be on becoming an ACE-informed service, and if, at some point in the future, they felt competent and skilled enough to implement routine enquiry, only then would it be implemented.

> *"Yeah so we stopped, I didn't feel as though I was trained enough on this, so, I know quite a lot about ACEs but I'm not au fait with REACh and I wouldn't be confident going in there and doing an enquiry with a young person from the training that I went to and the knowledge that I got, so to train somebody who is newer to the role, I wouldn't have felt confident at all and I guess it's the support behind it that we need."*
>
> *"It's bigger than just once you've got this [the training pack] you can go and deliver it wherever you want."*
>
> Pilot site lead

3.2.2 Sexual violence support service

As part of their engagement in the pathfinder project, the service had initiated some preparatory work prior to receiving the OR-CAP. This included exploring the feasibility of implementing REACh given available

Box 5: Client experience of childhood adversity

The prevalence of ACEs amongst a small sample (total n=15) of clients* across two pilot sites is presented below. Due to low numbers, figures should be interpreted with caution.

- 1+ ACEs = 100%
- 4+ ACEs = 60%^
- Sexual abuse and/or exploitation = 60%
- Sexual abuse = 60%
- Sexual exploitation = 40%

* 66.7% were female; 53.3% were aged 18-30 years. Two enquiries were made with clients aged 16-17 years. All clients were of white ethnicity. ^ Excluding sexual exploitation.
Note: it is not known how many clients refused to participate in routine enquiry.

resources[9], and if and when it would be appropriate to implement REACh within the client pathway. The initial assessment was not deemed appropriate to implement routine enquiry as the client is likely to be in a crisis point, and this was a critical time to develop trust and build client-practitioner rapport. Upon receipt of the OR-CAP, the pilot site lead completed the self-assessment and was ready to implement staff training (see Table 1) within a few weeks, with routine enquiry implemented immediately following the training (Box 5). Enquiries were implemented only with clients who were not (currently or in the near future) going through criminal justice proceedings and only at the point when the practitioner believed it was appropriate (e.g. client displays signs of resiliency and has a good rapport with the practitioner). Whilst routine enquiry had been implemented with certain clients at an appropriate point in their support pathway, it was reported that this would not continue following the conclusion of the pilot[10], due to the service having limited resources and commissioned based on outputs (e.g. number of clients supported).

> *"I can absolutely see the benefits of it for a generic service, for someone going into mental health services as a starting point it's excellent, for us as a small specialist agency I'm not entirely sure it would fit with every client…The only concerns are this onwards referral, leaving people when they were starting to feel better starting to think about this and feeling worse again and then we can't offer anything else."*
>
> Pilot site lead

3.2.3 Child and Adolescent Mental Health Service

As part of their engagement in the pathfinder project, the pilot site leads had prior knowledge of REACh and had initiated some preparatory work prior to receiving the OR-CAP. In particular, identification of where in the service enquiry would be implemented (tiers three and four), and when in the client's pathway (initial assessment or next session). On provision of the OR-CAP, the service was undertaking an organisational restructure, affecting all staff including those tasked with developing and implementing routine enquiry. Various staff within the service have noted that this placed pressure on the service and its ability to pilot the Implementation Pack effectively, particularly within the requested timeframes. However, upon receipt of the OR-CAP, two senior staff members within the service set aside time to complete the self-assessment. A number of actions were identified and, where possible, addressed, with the OR-CAP updated a number of weeks later to reflect changes and/or completed actions (it is not clear from the completed OR-CAP if all actions were completed prior to training implementation).

Following the update of the OR-CAP, five staff training sessions were scheduled (Table 1), with the first session taking place around 11 weeks after receiving the OR-CAP. However, the trainer did not become aware of the available training package until the week before

[9] The service is small with limited resources; most staff are part-time; and the service was commissioned to provide a set number of sessions/level of support to clients.
[10] Within this service, June 2017.

the first training session was scheduled to be implemented (prior to this they had started to produce their own training materials). Within CAMHS, the training pack was modified (slides removed) prior to the first session and between each session. Pilot site leads/trainers noted that the delivery of the training changed as they implemented more sessions, with later sessions including a greater focus on routine enquiry and the ACE-CSE questionnaire (the first session did not focus on routine enquiry until near the end, leaving little time for trainees to explore the ACE-CSE questionnaire and discuss if, and how, they could implement it). Upon reflection, a trainer acknowledged that trainees might require a follow-up session, to allow them an opportunity to cover things not included in other training sessions (e.g. more discussion on routine enquiry and use of the ACE-CSE questionnaire).

Despite the completion of the steps in the OR-CAP and the training of staff, engagement in the pilot was put on hold within this service due to trainee (and subsequently senior management) concerns regarding the purpose and appropriateness of implementing routine enquiry using the ACE-CSE questionnaire with their clients. Senior staff within LCFT held a clinical focus group discussion with practitioners to consider the issues that had arose, and to make recommendations around continuation in the pilot and/or alternative approaches. Following this, it was decided that routine enquiry would not be implemented due to the concerns raised around acceptability and impact on the client (see Section 4 and 5).

3.3 External support and monitoring

> *"We don't know how well it's [the training] being delivered, if the enquires don't go well, we don't know if that was because of how they delivered it."*
>
> REACh team member

Monitoring of the pilot and where applicable provision of support to pilot sites was the responsibility of LCFT (and thus the REACh programme team). Throughout the piloting of the Implementation Pack, there was little communication between the pilot sites and the REACh team. Progress updates were provided by pilot sites in project steering group meetings, and via email correspondence, with risks formally monitored. Across the three pilot sites, during the initial phase of the pilot, only one major risk was identified regarding implementation within CAMHS (see above), which was formally recorded on a risk register and escalated to appropriate senior management members within LCFT. These concerns were further explored, and subsequently the pilot was ceased within this service.

As noted earlier, the approach taken during the pathfinder is different to the usual REACh programme model. Whilst it was the role of LCFT to lead on project monitoring, REACh team members described frustration towards not being able to closely monitor and observe the progress of each pilot site, as they assumed that they could not engage with the sites during implementation and had to wait for feedback on the Implementation Pack until the interim research report was produced (Quigg et al, 2017). This was reported as an on-going concern by members of the REACh team, particularly relating to project fidelity. Questions were raised around if, and how, pilot sites will know they have implemented all aspects of the

Implementation Pack successfully, as no one is there to assess, and if relevant, inform them otherwise.

4. Perceptions of the Implementation Pack

This section provides a summary of views of the Implementation Pack, the training delivered, and the ACE-CSE questionnaire. Information presented is collated from various research methods implemented with pilot site leads, and practitioners and clients who engaged in the pathfinder project.

4.1 OR-CAP

Across the three pilot sites there were mixed views on the usefulness of the OR-CAP:

- **CAMHS** reported that they felt they required more support at an organisational level to self-assess their organisation (using the OR-CAP), complete actions and thus implement routine enquiry successfully. With this service going through an organisational restructure at the time of the piloting, additional organisation support may not have been available, accessible or feasible. Further, upon reflection, pilot sites leads noted that it would have been better to complete the OR-CAP at an earlier stage prior to training implementation (giving themselves and the organisation more time to prepare to implement REACh and staff training).
- **The drug and alcohol service** had mixed views on the OR-CAP. In the initial phase of piloting, they felt that the OR-CAP was useful to help them prepare to implement routine enquiry (and at that time felt that the Implementation Pack was adequate to prepare the service to implement routine enquiry). During this phase, the pilot site lead was someone who had a thorough understanding of ACEs, REACh and what the pathfinder project aimed to achieve, through their regular engagement in the project steering group and pre-pilot discussions with the REACh team. However, in phase 2 when a new project lead took over (who had limited background knowledge on the pathfinder project, REACh and no support from, or discussions with the REACh team [similar to a real world scenario]), it was felt the OR-CAP was sometimes vague in terms of what information was required, and queries were expressed around how it should be completed. The pilot site lead felt that such concerns and questions may have been alleviated in phase 1 due to the additional support/information provided from the REACh team/project steering group, which was not available during the phase 2 stage. Critically, during phase 2, the Implementation Pack alone was not considered sufficient to provide the service with the knowledge, skills and confidence to implement routine enquiry, and that additional support was required (e.g. from the REACh team).
- **The sexual violence support service** did not feel that they required the OR-CAP to implement routine enquiry; the pilot site lead had sole responsibility for managing the service, which they described as already having robust safeguarding procedures in place.

4.2 Staff training package

Across the three pilot sites there were mixed views of the staff training package. Whilst some reported few concerns with the staff training package and expressed that it was adequate to support them to train staff, others reported a number of areas required further clarification and/or development.

> *"The training provided a helpful and informative overview of ACEs and how these can impact on a child's development."*
>
> Trainee

Trainer skill set: A number of general comments were expressed about the knowledge and skills that a trainer should hold prior to implementing the staff training. Critically, staff across two services noted that it would have been better if the trainers across the pilot sites had received more support/guidance in training staff, particularly to ensure they had adequate knowledge of the subject matter and skills in training delivery, before implementing training sessions for others. Suggestions included developing a train the trainer model, an e-learning training module and/or a podcast.

Pre-training preparation (trainers): A number of trainers noted that more clarity was required around the extent of preparation that was required by trainers prior to implementing the training.

Pre-training preparation (trainees): One trainer noted that it should be clearer in the pack that trainees must complete the pre-learning module prior to training attendance. Ensuring trainees were provided with adequate time (from their organisation) to engage with the training, including completing the pre-training module was also noted by a trainee.

Training materials: Both trainers and trainees noted that the training included too much information presented via PowerPoint, and that slides should be made more attractive and less wordy. Generally, both trainers and trainees felt that the REACh video animation provided an excellent and clear overview of the background to, and importance of implementing routine enquiry. Further, it was felt that this could be used with other (non-trained) staff members so they become ACE-informed. One trainer suggested embedding the videos into the training slides, as Wi-Fi is not always accessible and it was not obvious within the pack that online access would be required. During one training session that was observed by researchers, all trainees (~10) in the session noted that the discussion and approach in the video presenting a scenario with a young person was inappropriate, as it appeared to be a

> *"That [REACh video] was fantastic, that would give a really great starting point."*
>
> *"…pack was clear and direct and easy to use. I was happy with the training bit and all of the therapists, it was easy to understand."*
>
> *"A challenge to know how to implement it, the finer details. Unless maybe the person delivering the training has maybe a podcast or some e -learning for them. I think having a face-to-face is useful. Possibly a guru they could phone."*
>
> Trainers

somewhat unengaging approach to have with a young client, which they would not recommend.

Training content:

I. One practitioner noted that focusing discussions with clients around what has happened to them, as opposed to what is wrong with them, is key to identifying trauma and supporting clients more effectively (also raised by the REACh team). It was felt that such nuances may not be clear from the training pack for professional groups who are not specifically trained to support people who have experienced trauma. Further, they noted that training for such professional groups should also focus heavily on understanding what type of client presentation and/or behaviours could be linked to ACEs/trauma. Further, it was suggested by some senior practitioners to train staff in recognising when it is an appropriate time to enquire about ACEs/trauma with a client, and how to make that enquiry helpful to the client and service provision. A perceived lack of evidence on the impact of the enquiry on the client in both the immediate and long term was also noted by another practitioner. Equally, some trainees noted that the training focused too much on research on ACEs and not enough on using routine enquiry as a tool to support clients more effectively. Generally, however, trainees who completed the post-training survey indicated that they felt confident talking to clients about ACEs/CSAE, and responding to disclosures (Box 6).

> *"Covers areas already included in annual safeguarding training - level of audience needs considering."*
>
> *"Very little covered on the questions, how to ask and what to do next."*
>
> Trainees

II. A number of practitioners raised concerns about the lack of guidance in the training pack (and more broadly the Implementation Pack) on what to do following disclosures with regards to: how to respond to the information elicited via the questionnaire; safeguarding issues; and how the information may influence the provision of support (e.g. mental health service provision) (supported by trainees), and the client themselves. Trainees also raised concerns about the lack of identifiable pathways for clients following a disclosure of childhood adversity. Including information in the training on the type of support that may be required by the client and the available intervention/referral pathways was noted by trainees, however they also acknowledged that support may not be available.

III. One trainer felt it was not clear from the training pack that disclosures of current abuse necessitated a safeguarding responsibility to report this, nor was it felt adequate information was provided regarding what these reporting procedures were. It was also felt that there was a lack of information provided on what are the appropriate actions with regard to reporting procedures for cases of historical abuse. A lack of guidance around advising the young person before the routine enquiry about the necessary steps following disclosure of ongoing abuse was also noted. The questionnaire includes a

statement of such for the client to read but it was felt that further guidance was needed for the practitioner to ensure the client fully understood the consequences of such disclosures.

IV. During two sessions observed by researchers, trainees noted that the training content focused too much on policy issues. There was uncertainty around whether the intention was to understand the national prevalence of CSAE, and, or to support clients within the services more effectively, through understanding their experience of childhood adversity and how it may be linked to current health problems. If it was to identify prevalence only, it was not seen as appropriate. Trainees noted some queries about implementing routine enquiry using the ACE-CSE questionnaire that were not covered during the training (and trainers displayed difficulty in answering):
    a. Is it acceptable to alter the wording of the ACE-CSE questionnaire questions for young people?
    b. Can we ask the questions through a broader discussion throughout the assessment or do we have to complete the questionnaire systematically?
    c. Why are we asking these questions, what is the purpose, and who should routine enquiry be implemented with?

V. Finally, some trainees noted that more information was needed on how routine enquiry could be implemented in practice and what the next steps would be to implement routine enquiry within the service. This included, tailoring the ACE-CSE questionnaire, and its presentation within the training, so that it is more specific to service level implementation plans.

Training delivery

I. The amount of time which the training should take was not clear to one trainer. Whilst they acknowledged that it could depend on the audience, they felt there could be more detailed guidelines around this and it should not be left to the trainer to decide. For example there could be guidelines as to the minimum content which must be covered even if staff are already ACE-aware.

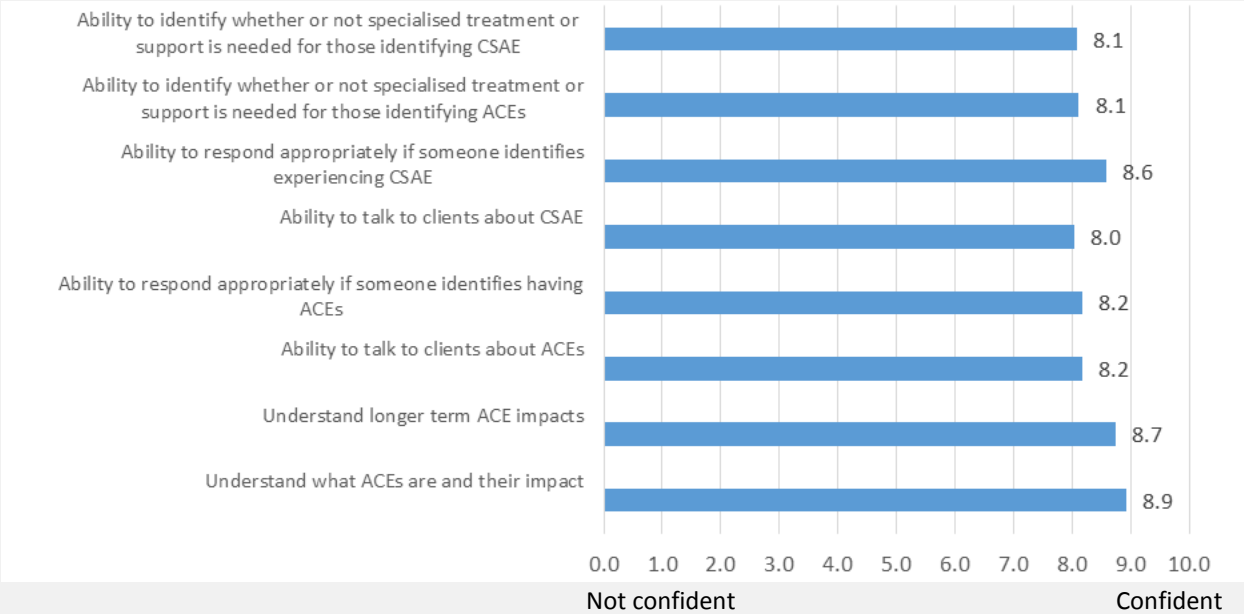
II. Box 6 provides a summary of trainee (n=35) responses to the post-training survey.

Box 6: Trainee (n=35) responses to post-training survey

The majority (80%) of trainees agreed that the training session had met their expectations. Respondents were then asked what they thought (free text) the positive and negative aspects of the training were, if any. Positive responses included: information was presented in a clear/concise way; it developed/affirmed knowledge about ACEs/CSAE and routine enquiry; it facilitated group discussion and reflection about ACEs, routine enquiry and client support/pathways; and, it encouraged staff to implement routine enquiry. Negative responses included: the pitch of the training was not correct (repeat of information from other training); it felt rushed and there was not enough time to cover all training sections adequately; the training location and equipment was not ideal (e.g. too hot/noisy); and, the time out taken to attend the training during a busy schedule at work.

To understand if trainees were ready to implement routine enquiry, respondents were asked to self-rate their confidence (scale: 0 [not confident at all] - 10 [very confident]) on a number of key areas that the training package aimed to address. Overall, all mean scores were above eight, indicating that respondents were confident about: their understanding of ACEs and their impacts, and CSAE specifically; their ability to talk to and respond to clients identifying ACEs and/or CSAE in an appropriate and sensitive way; and their ability to identify whether or not specialised treatment or support is needed for those identifying ACEs and/or CSAE (Figure 2). Respondents were asked to describe (free text) how they thought their participation in the training would influence their current working practices. The key influences that emerged included: having a structured/routine approach for enquiring about childhood adversity; enhancing current practice, with for example, practitioners being more considerate when specific issues arise; enhancing client assessments, leading to a more client tailored recovery plan; the ability to monitor the prevalence of ACEs/CSAE across clients; and, practitioner recognition of the requirement for more clearly defined trauma focused support pathways within the service.

Figure 2: Trainee (n=35) self-rated knowledge and confidence post training, three pilot sites



4.3 ACE-CSE questionnaire

> *"It adds another dimension to my practice in that I will consider, impacts of possible specific events on a child or young person's mental health."*
>
> *"Provides a medium in which to facilitate difficult conversations."*
>
> Trainees

Using a structured questionnaire to conduct the enquiry was queried by some practitioners as it was felt that this might not be the most appropriate way of eliciting such information, and was not universally appropriate. The risk being that if a process of disclosure is not tailored to the service user, it may lead to disengagement or interruption of processes of disclosure. Practitioners across pilot sites noted that consideration of the timing and the therapeutic way such adversities were raised and addressed was necessary. The sexual violence support service pilot lead noted that they felt their client's acceptability of it during the pilot was a result of practitioners adequately explaining the purpose of the enquiry and the questions posed. There were mixed views amongst trainees around whether use of the ACE-CSE questionnaire would have a positive or negative impact on the client-practitioner relationship, particularly around levels of trust. Despite this, some trainees felt that the use of the ACE-CSE questionnaire may encourage clients to disclose ACEs/CSAE in a safe controlled environment, potentially increasing their acceptance of support, as they will have had an opportunity to explore if and how ACEs may have impacted on their life.

> *"I think it has to be an individual approach no matter what the age. If I don't think it is right to ask I don't."*
>
> Practitioner

Previous experience of working within an ACE-informed framework had led one practitioner to conclude that a questionnaire format to enquire about adversities for children and young people was not appropriate. Developing trauma informed services and ensuring those who worked with the children and young people are aware of the things which might trigger disclosures or a discussion of experiences was noted as more important so that practitioners can be attuned to it. Further, suggestions were made around eliciting information in other ways, for example through case files and speaking with parents/other individuals who were familiar with the child/young person. This would enable the key themes of young people's experiences that may be impacting on current health presentations to be teased out and supported. Thus, experiences and exposures would be understood through a slower and evolving therapeutic process and the overarching premise would be being trauma informed.

> *"Hopefully more opening up about those issues and how they have been affected by them."*
>
> *"Unsure how the questionnaire will benefit service users as I believe it is more helpful to integrate questions into therapeutic conversations, although useful reminder of questions."*
>
> Trainees

Specific concerns raised by practitioners regarding questions within the ACE-CSE questionnaire (Appendix 5) are summarised below.

> *"…we still feel there's an issue with this five year thing that I'm not that happy with. I know they put in the extra line underneath about five years younger or the same age but it still kind of minimises, it puts a question into people's heads about why that's an issue."*
> Pilot site lead

- ***Introduction:*** A practitioner noted that when implementing enquiry as part of the pilot, the client found the wording of the introductory statement confusing (i.e. clarity needed around the statement before the age of 18 – is this just before the age of 18 years or up to the age of 18 years?).
- ***Question 10/11:*** One pilot site lead reported that they and other practitioners had a query about the importance of asking about abuse by someone 'at least five years older' (i.e. why is the age gap important/does this infer that abuse by someone less than five years older is not an important?).
- ***Question 12***: Practitioners at one service were opposed to the inclusion of the words anal/oral/vaginal, which were considered inappropriate and of providing no clinical value. The question does not ask which type of intercourse was experienced but uses the terms to clarify that all types are included in the term 'intercourse'. It was unclear whether perhaps practitioners felt that the inclusion of these terms would be misinterpreted by the client to mean they had to disclose which type occurred.

> *"…some of the wording is not very young person friendly on the questionnaire."*
> Pilot site lead

- ***Question 14:*** The use of the term 'forced' was highlighted by practitioners across two services as potentially problematic as young people may not associate this with the behaviour they are experiencing. Thus it was felt that while this question may be appropriate with an adult cohort who are asked to reflect on past experiences, children and adolescents who are currently experiencing such issues may not reflect this in their response, increasing the chances of false negatives. Practitioners at another service questioned whether such explicit questions should be asked to young people and noted that parents may query why those questions were necessary and the purpose they served.
- ***Response options:*** Across all services, there was strong opposition amongst practitioners to asking clients how often the childhood adversities had occurred (Questions 6-12, and 17). It was noted that asking the number of times which abuse occurred could have severe negative connotations for the client and be misinterpreted to downplay the severity and importance of experiencing abuse 'once or twice' compared to 'many times'. This was particularly pertinent around the sexual abuse questions. Again it was felt that the number of times abuse happened had no clinical value to addressing such abuse, and more pertinently the

> *"So it's the granularity that I don't' understand the need for… and I'm not sure you need to ask children those particular questions to be able to develop services that meet that need."*
> Pilot site lead

consequences potentially linked to such abuse, would not be different whether the client reported once, twice or several times.

- ***Additional CSAE questions:*** The REACh team perceived that simply asking the ACE questions can be helpful to clients. However, they were less sure about the additional CSAE questions. They felt that further work was needed to explore this, including exploration of the short and long-term impacts of asking the questions for clients (e.g. impact on health and wellbeing/engagement with services) and services (e.g. referral pathways).

> *"We know in our experience people feel relieved to have the ACE questions asked but we don't know what the addition of the CSA/CSE questions is."*
>
> REACh team member

- ***Additional ACEs:*** It was also suggested by some practitioners that some other childhood adversities should be included, including bereavement and perhaps that there should be some clarification around intoxication and issues of consent (relating to CSAE). Similar to the concern that young people may not recognise a behaviour as grooming, it was felt that false negatives could also occur in situations where sexual encounters took place (over the age of 16 years) where the young person could not consent due to intoxication, but does not recognise this behaviour as a form of abuse.
- ***Permissions:*** Practitioners at CAMHS did not agree that parental permission is not necessary for clients over the age of 14 years, and suggested that parents should be included in the process.

5. Views on implementing REACh

5.1 Pilot sites

Overall, all pilot sites reported being supportive of developing and implementing ACE-informed services. Where routine enquiry was implemented (15 clients across two services), it was generally viewed as acceptable to practitioners and clients (see Box 7 and 8). However, concerns were raised around the rationale and appropriateness of implementing routine enquiry using the ACE-CSE questionnaire within these types of services. Across all pilot sites, practitioners noted that routine enquiry should be of direct benefit to the client, minimising the risk of further harm (including through disclosing adversities) and where applicable promoting recovery and support processes. Practitioners within the clinical focus group held within CAMHS noted that routine enquiry about ACEs is based on two assumptions: 1) the ACEs are likely to have a major impact on a person's physical and/or mental health; 2) that individuals may not disclose without some form of enquiry/questioning taking place. They noted that this may imply that the person must have had good reasons for not disclosing before, for example because disclosure of ACEs is a difficult and even frightening prospect. The conclusion from this is that the very rationale supporting the development of routine enquiry also highlights that it is likely to be an extremely difficult process for that person to take part in, and would have the potential to create or increase risk, or even be harmful. The risk of routinely asking in the wrong way at the wrong time, could include losing the client from the service and denying them the therapeutic process for which they had initially presented for (within CAMHS). It was argued that therapy is already a very difficult process for clients to engage in and maintain.

> *"We noted that tackling the impact of ACEs is not the same as enquiring and it is important that these two issues are not conflated."*
>
> CAMHS clinical focus group

Similar concerns were noted within the sexual violence support service; although they do see adult survivors of historical abuse, this service predominately sees victims of recent abuse, with time limited support specifically focused around this. Thus, it was reported that it was not acceptable to implement REACh until client-practitioner rapport is developed and it is an appropriate time to explore adversities beyond sexual abuse with the client (i.e. they appear resilient enough to answer the questions and discuss any subsequent disclosures). Clients can access up to eight support sessions with the practitioner – it was reported that implementation of enquiry using the ACE-CSE questionnaire may not be appropriate until the client has attended a number of sessions, which may vary by client. Enquiry during the last few sessions, however, was seen as potentially unethical, as the practitioner may not have adequate

> *"…when a rapport has been built and we know that client's resilient, because we don't have a very robust onwards referral path either…we didn't want to do (routine enquiry during) the last session because we didn't want to leave somebody with a huge amount of, oh my god I've just realised how awful my childhood was and we're actually going 'Bye' it's not ethical."*
>
> Pilot site lead

time (beyond the time allocation to each client) to provide any additional support resulting from any subsequent disclosures. Following completion of the sessions, if the client requires further support they are referred to their GP. It was felt that routine enquiry would only be appropriate and sustainable if the service received additional funding to allow them to offer further therapy/support when disclosures are made. Within the drug and alcohol service, queries about the best time to implement routine enquiry were also raised, considering the need to balance developing client-practitioner rapport with obtaining adequate information to inform treatment plans.

Further, it was questioned as to how the information about adversities in childhood was linked to service delivery. For example, practitioners within CAMHS noted that such adversities (if historic) are risk factors for various mental and physical health problems, however, once these have occurred they are static and cannot be changed. A service such a CAMHS primarily deals with the impact of those risk factors, i.e. the presenting mental health problems. Thus exploration of how these mental health problems potentially originated (i.e. link with adversities) was noted as less helpful. It was reported that in clinicians' experience the majority of children and young people they see have such adversities by the time they access CAMHS. Thus, knowledge of this experience is not useful without knowing how to use it to support the client. Linked to this was the concern that using a structured questionnaire carries the risk of accepting the responses at full face value, and if the client reports no ACEs, being lulled into a false sense of security around that individual's past experiences. Critically, across all services, concerns were raised about the potential volume of disclosures, a consequential increase in referrals to other agencies, and a lack of availability of services for onward referral. While it was felt that knowledge of such support was satisfactory, concerns were raised over the case loads of such support services and the implications of placing clients in need of services on waiting lists after prompting the disclosure of such issues.

> *"We struggle to get mental health support at the best of times… I think what you need is the wraparound support if you're asking these questions, you need players in place to support identified needs."*
>
> Pilot site lead

A number of practitioners across pilot sites suggested that routinely enquiring with every client across various services did not appear to be supported by research evidence, and/or with some cohorts of clients, and in some service settings, there was even a risk it could be harmful. For example, within the sexual violence support service, due to legal concerns, during this pilot routine enquiry was not implemented with clients who were, or may be, going through criminal justice/legal proceedings. Some concerns were raised around implementing routine enquiry with young people. For example, it was noted that some of the wording of the questions is not always appropriate for a young person and may also be misinterpreted (see Section 4.3). Concerns were raised around young people potentially feeling uncomfortable answering the questions and finding the process difficult. Practitioners at one pilot site felt that previous evidence which seemed to support a view that the very of act of disclosure could provide relief and promote awareness of ACEs was of

more relevance to adults. For example, by parents becoming aware of their own ACEs, they have the opportunity to address potential ACEs in their own child's life and thus this awareness may bring about the relief felt following disclosure. However, this may not necessarily be the case for young people. While disclosures of ongoing abuse could lead to safeguarding procedures which address this, they felt that it was not clear how disclosures of historical abuse could positively impact outcomes. Further, practitioners within CAMHS raised concerns around implementing routine enquiry with someone who is presenting with serious mental health issues. The rationale was that routine enquiry is inextricably linked to a power dynamic that some groups may be more vulnerable to, notably children who are brought by parents to appointments, looked after children, inpatients, those detained under the mental health act, those with a diagnosis of psychosis, and those who have already been subject to ACEs. The risk for these cohorts of clients is of replication of an unhelpful power dynamic with clinical and engagement consequences. There was concern that routine enquiry, potentially done by an unskilled worker carries risk, and may facilitate such unhelpful power dynamics.

> *"The flip side of that is if you are working with adults who have children, maybe for them to look at themselves and their experiences and think do you know what, that's what's going on for my child, and never linked the two. Having those honest conversations and questions it's a starting point that wasn't there before."*
>
> Pilot site lead

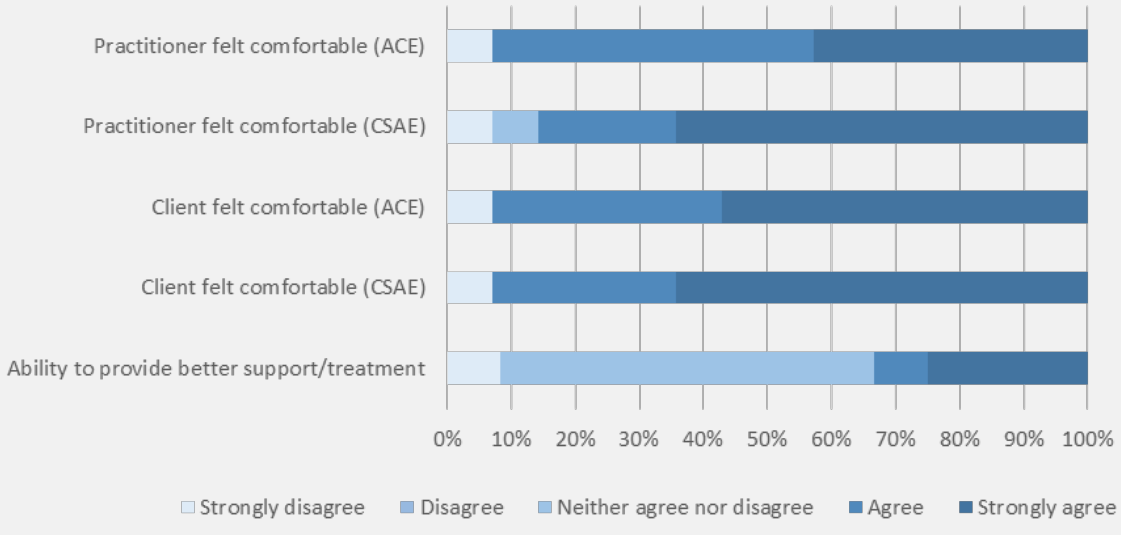
There was concern amongst some practitioners about the lack of evidence around the short and long-term impact of REACh. Further, practitioners within one service felt that a potentially unwarranted assumption was held which linked early enquiry during the assessment and support process to better outcomes. It was argued that evidence pointed to the nature of the therapeutic relationship and of trust being more important in promoting disclosures than timing or the use of a questionnaire. Within one pilot site, there were some concerns that implementing routine enquiry using the ACE-CSE questionnaire may have affected clients negatively. It was reported that practitioners felt that clients who had engaged in routine enquiry were not as positive at the end of their therapy, compared to those who hadn't, possibly due to the refocus on childhood issues rather than focusing on the primary issue they had contacted the service to resolve. However, this was not confirmed and clients had expressed that they had appreciated being asked.

> *"…each time the therapist has done it [ACE-CSE], is that it kind of brings the clients down, so they are feeling empowered and positive and coming to terms with their experience and then you ask them these questions…[they] are actually then taken away to a place where they don't feel as empowered because they are remembering other things. None of the clients have said that it's a problem but they have said how upsetting it is to think about."*
>
> Pilot site lead

Box 7: Practitioner feedback surveys on implementing routine enquiry (n=14)

- The majority of practitioners agreed (strongly agree/agree) that they had felt comfortable discussing ACEs (92.9%) and CSAE (85.7%) with clients; and that they believed that their client also felt comfortable discussing ACEs and CSAE with them (92.9%).
- Generally, practitioners noted (free text) that the client appeared comfortable throughout the enquiry, and reacted positively to the questions and any subsequent discussion. One practitioner did note that a client physically reacted (e.g. sweating hands and breathlessness), however they were able to engage in a positive discussion, which grounded and stabilised the client.
- Across a third (33.3%) of enquiries, practitioners agreed that they felt able to give better support or treatment to their client because they had a better understanding of their childhood experiences (Figure 3).
- In over half (58.3%) of enquiries practitioners felt that the inclusion of the ACE-CSE questionnaire in the assessment, and any subsequent related discussions, increased the assessment time (by an average of 14.3 minutes; range 5-20 minutes). Where there was further discussion, the discussions (as reported by the practitioners) focused on: clarifying the questions (n=1); exploring the history of abuse (n=3); and reflection around repeated abuse (identified through questions including a 'many times' answer; n=1).

Figure 3: Practitioner views of the use of the ACE-CSE tool with clients (n=14 enquiries)



Box 8: Client feedback surveys on the routine enquiry (n=15)

- Overall, the majority of clients agreed (strongly agree/agree) that: the questions were clear and they understood what was being asked (86.7%); they felt providing information to the practitioner about childhood experience was acceptable (100.0%); it is important that the practitioner understands what happened during their childhood (86.7%); the service is a suitable place to ask these questions (93.3%); and the appointment with the practitioner was improved because the practitioner understood their childhood better (86.7%). 66.7% agreed that they felt comfortable answering the questions (Figure 4).

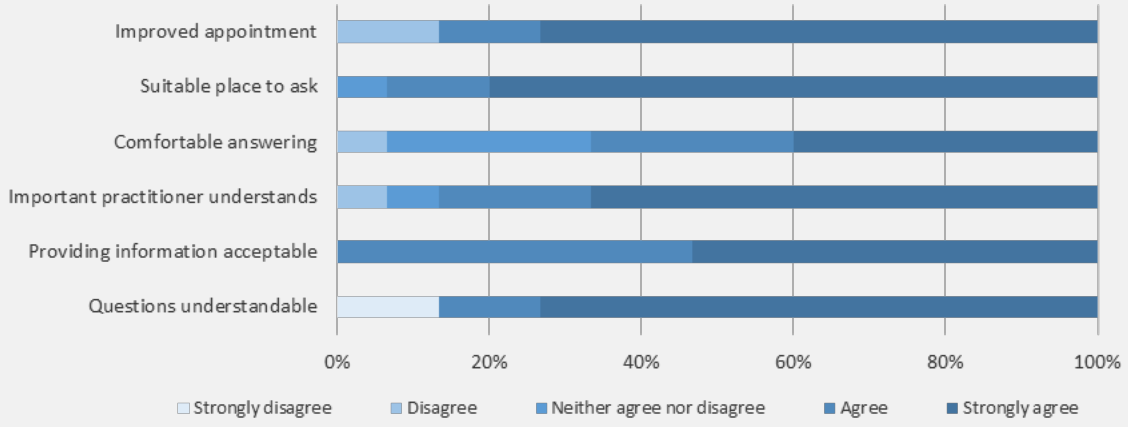
"Can give a better understanding of your struggles, especially if you are afraid of sharing your experiences with others."

"Sometimes it is really important for workers to know."

"Questions aren't worded right - before 18 or ever?"

"After each session I do feel quite upset having spoken about my experiences as a child, although it does help."

Figure 4: Client views of the use of the ACE-CSE tool (n=15)



5.2 Beyond pilot sites

Some challenges and concerns were noted by the REACh team regarding implementation of REACh using the Implementation Pack beyond the pilot sites, particularly in relation to ensuring that it is implemented in services that are ready and it is done safety.

- **Ensuring services are ready to enquire**: was highlighted as critical to the success of REACh to date. This has involved a REACh team member working with an organisation to assess their readiness and support them in completing any necessary changes, prior to training and/or implementation. Whilst learning from REACh was translated into the Implementation Pack, the nature of it means it excludes this focused one-to-one

practical support and/or assessment and monitoring. Without this, some REACh team members suggested that other processes would need to be put in place to ensure REACh is implemented appropriately. For example ensuring that the OR-CAP is adequately considered, completed, actioned upon and reviewed to ensure organisations are ready to enquire, before training and routine enquiries commence. This was noted as critical to ensuring that routine enquiry using the ACE-CSE questionnaire is implemented in services safely.

- **Routine enquiry with under 18s**: To date, the REACh programme has only been implemented with clients aged 18+ years. The team noted that there was little evidence of the reliability and acceptability of using the ACE-IQ with young people.
- **Safeguarding, disclosures and referrals:** Some concerns were raised regarding how different services across the country may interpret guidance around managing disclosures of historical abuse, including reporting requirements.
- **Engagement of key stakeholders:** It was felt that a range of partners and services still need to be aware of the impact of ACEs across the life course and the value of implementing REACh (using the standard ACE and ACE-CSE questionnaire), with any concerns or queries discussed and where applicable, addressed, before rolling out REACh to other services.

6. Summary and key considerations

To explore the development and implementation of routine enquiry about childhood adversity (REACh) across key services in England, a Department of Health pathfinder project was implemented. Led by Lancashire NHS Foundation Trust (LCFT), the pathfinder project aimed to develop and pilot an Implementation Pack, which aimed to enable services to implement routine enquiry using the ACE-CSE questionnaire (developed as part of the project) with clients (aged 14+ years) during routine assessments. The implementation of REACh was based on an underlying assumption that this would lead to more effective identification of clients who may have experienced, or are experiencing, childhood adversities, and where applicable subsequent provision of support (and relief) for clients. This study presents an evaluation of the use of the Implementation Pack in enabling three pilot site services to implement routine enquiry with their clients.

All three pilot sites completed the OR-CAP and implemented staff training, with two implementing routine enquiries with clients (total n=15). However, while early piloting of the Implementation Pack appeared to suggest that this approach to developing and implementing REACh (using the ACE-CSE questionnaire) could potentially be feasible (Quigg et al, 2017), concerns across all services ultimately led to the decision that it would not be implemented (CAMHS), be ceased (drug and alcohol service), would not continue post piloting (sexual violence support service), or would only be implemented with certain clients during the pilot. Reasons for this were multi-faceted, and appeared to centre around three intrinsically linked aspects:

1. The feasibility of implementing REACh (using the ACE-CSE questionnaire) through the use of the standalone Implementation Pack;
2. Staff uncertainties around the rationale, appropriateness and value of REACh (using the ACE-CSE questionnaire) across these types of services; and,
3. Implementation of the pilot within services that were going through an organisational restructure (resulting in a change in the pathfinder leadership team, and staff implementing the pilot within services).

These aspects are discussed in more detail below, with key considerations provided to inform future research, policy and practice.

All pilot sites recognised the need to develop ACE-informed services. However, it was noted that routine enquiry should only be implemented if it has direct benefit to the client, minimises risks of harm, and promotes recovery and support processes. Where routine enquiry was implemented, it was generally reported as acceptable to practitioners and clients. However, engagement in the pathfinder raised significant concerns across various practitioners around the rationale, appropriateness and value of implementing routine enquiry using the ACE-CSE questionnaire, within these types of services. Queries around rational focused on whether routine enquiry was being implemented to understand the

national prevalence of CSAE, and, or to support clients more effectively, through understanding their experience of childhood adversity and how it may be linked to current health problems. If to identify prevalence only, this approach was not deemed as appropriate. However, queries were also raised around how, and if, the information gathered from the ACE-CSE questionnaire could assist the practitioner/service in identifying the support needs of clients, and support them, or refer them onto other services, more effectively. Concerns were specifically raised about the appropriateness and value of the ACE-CSE questions relating to CSAE (questions 10-16; Appendix 5), and asking clients how often the childhood adversities had occurred. It was noted that the Implementation Pack, and potentially the academic literature, does not provide sufficient information on how to use the information gathered from routine enquiry on ACEs to inform service provision and the support offered to clients, particularly within the types of services included in the pathfinder project. Recent literature on screening for ACEs also raises similar concerns (Finkelhor, 2017).

One of the underlying assumptions of the development of REACh using an ACE (or equivalent) questionnaire is that the enquiry process itself may be therapeutic as it allows the client to discuss traumatic events and reflect on how these events may be linked to their current health issues (Felitti, 2010). However, some pilot site practitioners raised concerns that this may not be the case for all clients, and suggested that it will likely be related to a number of factors including client's resiliency, the rapport between the client and practitioner, how and when the questions are asked, and how practitioners respond (also noted by the REACh team). Suggestions were made around including additional guidance on how to respond appropriately to disclosures of ACEs. Ensuring professionals are aware of the power they hold in promoting disclosures of abuse, and subsequent access to support, and providing them with relevant skills, has been noted elsewhere (Dube, 2018; Public Health England, 2017). Further, guidance on responding to disclosures of domestic violence in sexual health settings (Pathak et al, 2017; Sacks et al, 2016) may provide a basis from which to further develop such guidance for REACh. However, it was also noted that there are fundamental differences between responding to disclosures of abuse by adults compared to children, and that this needed to be made clear, with appropriate guidance included for each cohort separately. For example, it was noted that children experiencing ongoing abuse or neglect require safeguarding procedures to be implemented, and these safeguarding responsibilities and actions should be clearer in the Implementation Pack. In addition, more clarity was needed on how to respond to disclosures of historic abuse by a minor. Recent guidance on CSE prevention and intervention provides core principles that all professionals working with children and young people should be supported to embed in their practice. Ensuring they respond appropriately to disclosures of abuse and understand their safeguarding responsibilities and local reporting routes, form two of these principles (Public Health England, 2017). Yet, throughout this pathfinder further concerns were also raised around the limited availability (both within and external to the pilot site services) of specialist support for clients who may require it (following a disclosure). Thus, similar to elsewhere, concerns were expressed around the ethics of identifying ACEs without the ability to offer appropriate support to those who may need it (Finkelhor, 2017).

Two of the pilot sites raised questions about the appropriateness and value of implementing routine enquiry with clients in their service. Within CAMHS concerns were raised around the clinical value of the questions in the ACE-CSE questionnaire, given that the provision of support (i.e. treatment) within this service focuses on the sequelae (i.e. mental health issues) rather than the adversity experienced. Similarly, treatment and support within the sexual violence support service is focused on the sexual violence experienced (the client's presenting issue). The value of identifying and discussing other childhood adversities was questioned and reported as potentially detrimental to the client's recovery process, particularly as they are likely to be at a crisis point within these services. Clients across the pilot sites are in contact with the services as they are suffering from trauma and/or are engaged in health harming behaviours (e.g. substance misuse). Practitioners highlighted that initial contact with clients across these types of services should focus on developing the client-practitioner relationship, as this is crucial to engaging clients in treatment and recovery processes. The inclusion of routine enquiry during initial (or early) client assessments was suggested as possibly detrimental to these processes, as clients may then be reluctant to engage with the service. Further, concerns were raised around possible harmful effects (e.g. further traumatisation) on the client if questions are asked at the wrong time, or in an inappropriate manner. Thus, within the sexual violence support service, routine enquiry was not implemented until the practitioner perceived the client to be resilient enough to complete the ACE-CSE questionnaire, and discuss the responses with the practitioner. However, it was noted that this would typically be near the end of a client's pathway within this service, and thus concerns were raised about the inability of the service to provide any additional support that may be required amongst those disclosing ACEs, beyond the set number of support sessions available to clients. The importance of considering a client's level of resiliency when enquiring about childhood adversity has also been raised elsewhere (Leitch, 2017). While findings from the small sample of clients engaged in routine enquiry in the current study, and studies with survivors of abuse from elsewhere (Nelson et al, 2008; Schachter et al, 2008) suggest that it is acceptable to clients to ask about adversity in childhood, similar to practitioner concerns in the current study, wider research and clinical guideline stress the importance of timing in eliciting such disclosures (ACSA, 2013). Not providing any further supportive action following disclosure is considered harmful, while conversely the transfer of care from one practitioner, where trust has to been established, to another to provide support, can evoke feelings of abandonment and erode trust (Sneddon et al, 2016).

Whilst studies suggest that developing trauma-informed services can be beneficial as it can increase client centred interactions and client satisfaction (Leitch, 2017), little evidence currently exists on the value of routine enquiry about childhood adversity, using the ACE (or equivalent) questionnaire, or the responses or interventions required for those reporting childhood adversities (Finkelhor, 2017; Leitch, 2017). Whilst work in the USA and UK is currently developing on this (Ford et al, 2017; Larkin et al, 2014; McGee et al, 2015) this lack of evidence was noted as a key concern across the pilot sites to justify implementing REACh. The need to develop a clear theoretical and, or evidenced based rational for routine screening for childhood adversities across services, including what exactly such programmes are

screening for and why, and what to do with the information gathered, has recently been highlighted in the academic literature (Finkelhor, 2017). While some researchers speculate that the screening process itself is therapeutic (Fellitti, 2010) allowing the client to reflect on the role of early adversity in current health problems, this is argued to be far from evidence-based and contrary to other behavioural health findings on the need for multiple sessions to treat trauma (Van Emmerik et al., 2002). Findings from this pathfinder suggest that such information is critical if REACh is to be considered acceptable and beneficial by practitioners and implemented across targeted services. Further, questions were raised around whether it was appropriate to use a questionnaire to implement REACh. Suggestions were made around gathering the information through other mediums, such as through a broader discussion with the client or through case reviews (where direct enquiry may not be appropriate and a case review is feasible). This was particularly pertinent regarding enquiries with children and young people. Recognising disclosures as a process rather than a discrete event, is noted in the recent guidance on CSE prevention and intervention (Public Health England, 2017).

Whilst findings suggest that more evidence is needed to inform the development, implementation and embedding of REACh, concerns were also raised around the ability of services to do this through the provision of a standalone Implementation Pack. Generally, it was felt that broader approaches were required to ensure services and practitioners are ACE-informed. Furthermore, to ensure that services are adequately prepared to implement routine enquiry, then trainers and implementers require additional support and guidance, such as, for example a train the trainer approach and a support hotline. A fundamental part of the REACh programme involves direct support from a REACh team member, prior to and following implementation of routine enquiry - one pilot site reported that without such support they did not feel that they could implement the REACh. Specific suggestions around developing the Implementation Pack were made also, and these along with other recommendations for developing the pack are summarised in Appendix 6.

Changes that occurred during the development of the pathfinder, particularly project leadership, and subsequent pressures to implement routine enquiry within short timeframes, appear to have been detrimental to the implementation of routine enquiry across the pilot sites, and may have led to additional queries and concerns. Crucially, one service was engaged in the piloting whilst going through an organisation restructure – a time when the REACh team reported that routine enquiry should not be implemented. Further, due to timeframes, it appears that the OR-CAP may not have been adequately completed, or the service prepared, prior to training being implemented. The pilot site leads/trainers within this service reported requiring more support to implement routine enquiry beyond the Implementation Pack (and despite other concerns raised around the rationale and value of routine enquiry). Whilst not ideal, this experience of aiming to implement routine enquiry within a short and somewhat pressurised time period, has eluded crucial learning for any further roll-out of REACh using the Implementation Pack. If routine enquiry is to be rolled out, services should be allowed adequate time to prepare their organisation and practitioners to implement routine enquiry safely. Learning from the REACh programme suggests that if an organisation and practitioners are not ready to

enquire, routine enquiry should not be implemented, and this is further supported by this pathfinder project. Thus, following through with the full REACh programme, particularly organisational readiness and training is vital before implementing REACh.

Conclusion

Following provision of the Implementation Pack, none of the pilot site services fully implemented REACh using the ACE-CSE questionnaire. A key reason for this was the need to demonstrate a clear theoretical and, or evidenced based rationale for REACh across the targeted services. Variations in piloting of the Implementation Pack, and thus fidelity to the original REACh model may have heightened practitioner concerns around implementation of REACh. Equally however, this pathfinder raises questions around the feasibility of implementing REACh across the target services through the provision and use of the piloted standalone Implementation Pack. A number of changes to the Implementation Pack were also identified (see Appendix 6). Further consideration needs to be given to the complexity of enquiry of this nature, and the support and training needs of both services and staff implementing enquiry. Ensuring a service is ready to implement REACh, prior to implementation of staff training and routine enquiry, is a core prerequisite of the REACh model. One pilot site was unable to prepare their service through provision of the Implementation Pack alone, whilst another appeared to have attempted to implement training within a service that was not fully prepared. Whilst further investigation is needed, this pathfinder suggests that, beyond revision of the Implementation Pack, some services may need additional support (e.g. from a professional with knowledge of REACh) to assess whether their service is ready to implement REACh, and if so, to do so effectively.

Key considerations for research, policy and practice

- Through both research and practice, further develop understanding of the rationale, process and impact of implementing REACh (using the ACE and ACE-CSE questionnaire) across the targeted services, including:
    - Demonstrating how information identified through REACh can support clients and develop service provision and support pathways.
    - Exploring if and how routine enquiry could be implemented effectively across services (considering whether this will vary by client and service type).

- Further consider the support and training needs of services (and their staff) in implementing REACh, and identify if revisions to the Implementation Pack (see Appendix 6) would allow services to successfully implement REACh, or if additional support would still be required.

- Ensure that any roll-out of the REACh model is documented, monitored and where possible evaluated, with particularly consideration given to the impact (positive and negative) of enquiry on clients (immediate and long-term) and services (including practitioners and service demand).

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8. Appendices

Appendix 1: Methods

Mixed methods were used to evaluate the piloting of the Implementation Pack. The methods used are summarised below.

REACh programme team interviews

Semi-structured interviews were conducted with key members of the REACh programme team (four LCFT staff) at two stages: pilot initiation (i.e. immediately following the provision of the first section of the Implementation Pack to the pilot sites) and two-three months after. The interviews were conducted either face-to face (pilot initiation) or via telephone (two-month stage) and explored:

- Project initiation:
    - Background to REACh;
    - The aim and objectives of the pathfinder project, what it entails and expected outcomes;
    - How they (and other partners) have developed the Implementation Pack, including how the ACE-IQ (WHO, 2017) was adapted to incorporate additional questions on CSAE (producing the ACE-CSE questionnaire);
    - Any challenges or barriers they came across through developing the Implementation Pack, and if and how they were addressed; and,
    - Any concerns they have about the development, implementation and embedding of routine enquiry using the Implementation Pack and ACE-CSE questionnaire across the three pilot sites.
- Two-three month stage:
    - Experiences of implementing the pathfinder project across the three pilot sites;
    - Views on the usability, comprehensiveness and effectiveness of the Implementation Pack; and,
    - Perceptions of a national roll-out of routine enquiry about adversity in childhood using the Implementation Pack and ACE-CSE questionnaire.

Pilot site project lead interviews (project monitoring diaries and other documentation)

Semi-structured telephone interviews were conducted with a pilot site lead at each service (n=3) around two-three months after they received the first section of the Implementation Pack (i.e. OR-CAP); and with the new pilot site leads at CAMHS and the drug and alcohol service in autumn 2017. Prior to the interviews taking place, interviewees were asked to review their project monitoring diaries, that they were asked to complete on a bi-weekly basis to document the development, implementation and embedding of routine enquiry within their service[11]. Interviews lasted around 45 minutes and explored (where applicable):

[11] Not achieved across all the services due to time constraints.

- Progress in developing, implementing and embedding routine enquiry: E.g., what their approach entails, fidelity, reach, knowledge and attitudes, uptake and acceptability (staff and clients);
- Barriers and enablers to developing, implementing and embedding routine enquiry: e.g. resources, structures, knowledge, attitudes;
- Areas of success and project development;
- The potential benefits and limitations of developing, implementing and embedding routine enquiry: e.g. to clients, practitioners and the service;
- The extent and nature of specialist care required by clients as a result of identifying adverse childhood experiences through routine enquiry;
- What is needed to develop, implement and embed routine enquiry successfully;
- Views on the usability and comprehensiveness of the Implementation Pack; and,
- The effectiveness of the Implementation Pack in supporting them/their service/front line practitioners in developing, implementing and embedding routine enquiry.

Pre and post training surveys

The pilot site leads at each of the three services were provided with research materials to allow them to implement a pre, post and follow up training assessment. This involved the pilot site leads recruiting trainees to the study through providing them with a participant information sheet and an opportunity to ask questions, obtaining consent, and then asking all consenting participants to complete a questionnaire prior to the start of the training, again immediately at the end, and then eight weeks post training. The questionnaire examined: attitudes to implementing routine enquiry; confidence in understanding what is meant by routine enquiry, ACEs and CSAE; how they believe routine enquiry will impact on their current practice and clients; and views regarding the training programme and recommendations for its improvement. Each self-complete questionnaire took around five to 10 minutes to fill in. Following completion, pilot sites leads collated all surveys and returned them to researchers directly (either in person or via a secure SharePoint). 35 complete pre and post training surveys were returned to the researchers.

Audit of routine enquiry data collection

Where routine enquiry has been implemented, anonymised data gathered through the ACE-CSE questionnaire was collected by services and shared anonymously with the research team via a secure SharePoint to provide an overview of the prevalence of ACEs, including CSAE, amongst participating clients (n=15).

Client feedback survey

Practitioners implementing routine enquiry were provided with research materials to allow them to implement a post-enquiry feedback survey with eligible clients[12]. This involved practitioners recruiting clients to the study through providing them with a participant information sheet and an opportunity to ask questions, obtaining consent, and then asking all

[12] Eligibility criteria: completed ACE-CSE tool; aged 14+ years; competent to provide informed consent; able to read/write in English.

consenting participants to complete a questionnaire at the end of their session, or at another appropriate time. The questionnaire examined whether the client: felt the questions posed were clear and understandable; felt comfortable answering the questions; felt the service was a suitable place to be asked the questions; and if they felt that their appointment was improved because the practitioner understood their childhood. Each self-complete questionnaire took around five minutes to complete. Following completion, project leads collated all surveys (n=15) and returned them to researchers directly (via a secure SharePoint).

Practitioner feedback surveys

Practitioners trained to implement routine enquiry were asked to complete a practitioner feedback survey for each enquiry they implemented using the ACE-CSE questionnaire. Following provision of a participant information sheet and opportunity to ask questions, all consenting practitioners were provided with copies of the survey for completion. The survey explored their own and their clients experience of routine enquiry, and whether they felt better able to support the client as a result of understanding their experience of childhood adversity. Each self-complete questionnaire took around five minutes to complete. Following completion, pilot site leads collated all surveys (n=14) and returned them to researchers directly (via a secure SharePoint).

Clinical research focus group

Within CAMHS, following the completion of the OR-CAP and the training of staff, trainee and senior management concerns were raised regarding the implementation of routine enquiry using the ACE-CSE questionnaire. LCFT held a clinical focus group with CAMHS practitioners, the pilot site project leads, senior management staff and a member of the REACh team. The aim of the focus group was to consider the issues which had arose and to make recommendations to the Department of Health about the future of the pilot project. The focus group was not conducted or attended by a member of the research team but the documented views and recommendations of the group (provided by LCFT to the research team) have been included and considered in the findings of this report.

Data analyses

All interviews were recorded and transcribed, with thematic analysis carried out on the interview transcripts to identify common themes throughout the data. Information from the interviews and that included in project documentation (e.g. OR-CAP), including completed project monitoring diaries, were reviewed and summarised to provide an overview of the piloting of the Implementation Pack. All information collected in research surveys or the ACE-CSE questionnaire was entered, cleaned and analysed in SPSS, with summary descriptive findings presented in this report.

Research approvals

Ethical approval for the research study was obtained from both the NHS Research Ethics Committee (16/NW/0759), and Liverpool John Moores Research Ethics Committee. Full study permissions have been provided by the Health Research Authority, LCFT and Change Grow Live. All researchers have full Disclosure and Barring Service checks.

Figure A1: The Department of Health pathfinder project: development of an implementation pack to support routine enquiry about adversity in childhood

	2015		2016			2017	2018
Pathfinder development	Government commitment to improve the quality of central Government data collection and reporting on child sexual abuse (HM Government, 2015)	LCFT approached to engage in pathfinder project	Pilot sites identified	Pathfinder requirements identified/ agreed	Implementation Pack drafted & reviewed	Implementation Pack piloted across 3 sites	
Research			Partner workshop to inform development of pathfinder & research	Study development & research approvals		Data collection & interim report	Final research report
Other	Engagement with other key partners (e.g. NHS England, Public Health England)						

LCFT: Lancashire Care NHS Foundation Trust.

Appendix 2: The REACh programme team

At the time of interviews (January-April 2017), the REACh team was made up of five LCFT staff members who had differing roles, responsibilities, experience and investment with the REACh programme. Two members (programme lead/Clinical Psychologist and programme development lead/trainer) had been involved in the REACh programme since its initiation[13], and had a key role in developing and implementing the programme across a number of services and refining the programme accordingly. Further, they had been active in promoting REACh across the UK, and supporting other areas seeking to implement similar work. Another team member (Clinical Psychologist) came on board during the previous two years and had supported both the continued development and implementation of REACh (particularly the development of the pathfinder project). In 2016, a project manager was employed to provide management support across all the programmes of work related to REACh within LCFT (including the pathfinder project). The final member of the team provided administrative support across all REACh projects. The REACh team were working on a number of projects beyond the pathfinder project, including work to implement REACh in a GP practice and developing an ACE-informed school. In March 2017 (during the pathfinder project), as a result of an organisational restructure the REACh programme lead ceased employment at LCFT. Subsequently, REACh, and the pathfinder project was led by another LCFT staff member (a Consultant Clinical Psychologist).

[13] I.e. over the past 3-4 years.

Appendix 3: Examples of OR-CAP sections

SECTION ONE - COMMITMENT - Why?

We know that implementing and embedding routine enquiry into an organisation will fail if there is not a high level of organisational commitment. Without this, often, staff attend training and within six months the number of enquiries reduces significantly or ceases altogether. Using existing systems and processes insofar as possible will ensure that the practice becomes embedded. This will also ensure that commitments in relation to data collection can be met.

1.1	**Management commitment**
	Evidence could include: ➢ Participation in the regular Department of Health Programme meetings ➢ Completion of the organisational readiness audit and associated action plans ➢ Regular meetings where the implementation progress is on the agenda
	Evidence:
	Any action required:

SECTION FOUR - TRAINING AND DEVELOPMENT – Why?

Whilst many professionals regularly ask sensitive questions we have found that enquiring directly about adversity and abuse can be challenging for them or they do not do it at all. Consistently we are told by practitioners that they are waiting for the 'right' time, worried that they will 'make things worse' or not know what to do if a disclosure is made. Developing their confidence and skills in enquiring and responding is essential. It also ensures that the client experience is positive and supportive.

4.1	**We have identified the person/people who will facilitate the routine enquiry learning sessions**
	Evidence could include: Requesting nominations, considering: ➢ Experience ➢ Availability ➢ Confidence with the subject area ➢ Being up to date with mandatory training e.g. safeguarding and information governance
	Evidence:
	Any action required:

Appendix 4: Summary of staff training package

The training pack provided in the Implementation Pack, aimed to provide essential support for services to train their staff in implementing routine enquiry using the ACE-CSE questionnaire. The pack includes two key components: a manual for the facilitator who is providing the training and power point training slides. It also provides links to external resources (e.g. pre-training learning modules) and to videos of role-play scenarios (e.g. routine enquiry with a young person). The training is designed to be delivered over one day. While it is recommended that the full training is delivered, it is also recognised that in some circumstances, organisations may feel that their teams have the necessary skills and/or experience in asking sensitive questions and responding to disclosures. In these circumstances, it may be appropriate for a shorter version of the training to be provided, however, it is recommended that the core components (detailed below) are still covered.

Pre-learning modules

Prior to participating in, or facilitating routine enquiry training, all staff implementing the ACE-CSE questionnaire are required to access and complete the pre-learning modules provided online by LCFT and the Children's Society. The Making Every Contact Count module developed by LCFT[14], provides a brief overview of what ACEs are, the prevalence rate of ACEs, the impact they may have on later health and wellbeing, how to be ACE-aware and how to prevent ACEs. The Seen and Heard[15] e-learning by the Children's Society was co-designed with the Department of Health to help healthcare professionals and partners protect, and identify, children and young people at risk of sexual abuse and exploitation, and help them to create an environment where young people are more likely to disclose. It uses a number of interactive modules, quizzes and videos of young people's views and experiences.

Training facilitator guidance manual

The facilitator guidance is intended to support professionals to deliver routine enquiry training to colleagues, to facilitate the practice change required in their organisation. Session facilitators are expected to have: relevant knowledge and experience; training delivery experience; and, specific knowledge about ACEs, sexual abuse or sexual exploitation. The facilitator guidance provides information on:

- Who should attend the training;
- Resources needed;
- Providing support for staff;
- Gathering local/organisation specific support for service-users;
- Considering the experience of the attendees;
- Information for attendees prior to the session;
- Pre-reading and/or pre-learning activities;

[14] http://www.walkgroveonline.com/MECC_Review/index.htm#~modal

[15] https://www.seenandheard.org.uk/

- Key messages of the training package;
- Comments from previous practitioners who engaged in ACE routine enquiry; and,
- Facilitator timings and notes for each training slide.

Training slides

The training slides have been developed to provide a generic, standardised training, which covers information necessary for routine enquiry across all services, and also with the scope for facilitators to add service specific information. The general topics covered are:

- Ambition of the Department of Health in rolling out routine enquiry about adversity in childhood;
- Information about child sexual abuse and ACEs;
- The necessity and benefits of enquiry;
- Previous practitioners' experiences implementing routine enquiry;
- Recommendations for sensitive and appropriate enquiry, including practice;
- How to enquire sensitively as part of everyday practice;
- How to respond appropriately;
- Awareness of assumptions and biases;
- Information about the ACE-CSE questionnaire;
- Data collection and recording procedures;
- Information about safeguarding responsibilities, information governance, confidentiality and gaining consent;
- Information about self-care and support for service users and practitioners; and,
- List of local support/further referral organisations and services.

The training also includes a number of activities intended to both provide information but also generate discussion on organisation specific practices, concerns and potential resolutions to such concerns:

- Group discussion on the facilitators and barriers to disclosure for adults/young people;
- Group discussion on the facilitators and barriers to enquiry for professionals;
- Group discussion on where in the service-user pathway the enquiry should take place;
- Practice exercise on enquiring and responding;
- Group discussion on responding to various scenarios, which might occur during enquiry and problem-solving using clinical skills and experience.

Following training all practitioners should be able to:

- Understand why routinely enquiring about trauma, abuse and adversity is important;
- Identify possible ACEs which may impact on later health and wellbeing;
- Understand the impacts of childhood adversity;
- Understand the essential good practice principles of routine enquiry;
- Understand how to ask and respond to disclosures appropriately;
- Assess someone's capacity to and consequently take consent; and,
- Understand responsibilities in terms of confidentiality and safeguarding.

Appendix 5: ACE-CSA questionnaire

ACE-CSA Questionnaire

FRONT PAGE FOR PROFESSIONAL USE ONLY
Please ensure all information is explained to the service user

- We now know that certain experiences during the first 18 years of life can have harmful effects on our health and wellbeing
- This information can help us to work together to find the right help and advice for you, if needed.
- If you agree, we would like you to answer some questions about these types of experiences
- You can fill out the questionnaire on your own or you can do it together with your worker
- You **do not** have to complete the questionnaire and you can stop at any time
- You **do not** have to answer every question
- If you want to, once you have finished this questionnaire, we can talk about your responses together and think about what this means for you.
- If you have trouble understanding any of the questions or would like to ask any questions of your own, please feel free to ask me at any point. You **do not** have to wait until the end.

CONFIDENTIALITY – WHAT DOES THIS MEAN?

- We understand that for you to feel comfortable talking about private information, it is important that you feel safe to talk about anything and feel confident that what we talk about stays between us.
- However, it is important that you understand that if you tell me anything that makes me think that you or anyone else may be at risk of harm, I may need to share that information.
- This is important to make sure we can help you and others to be safe.
- However, if I do need to share any information, I will, wherever possible, make sure that you are aware of what information will be shared and who it will be shared with.
- Information will be shared with NHS Digital to help the Department of Health to improve health services. However, this information will be stored securely and your name and any other identifiable information will be removed to protect your privacy.

Gillick competence / mental capacity	*Professional use only*

Can the service-user:

Understand why this questionnaire is being completed	☐
Understand what is involved in completing the questionnaire	☐
Understand what the information will be used for	☐
Remember and explain what you have discussed	☐
Use that information as part of the process of making the decision to take part	☐
Communicate that decision	☐

If all of the above are ticked, the service-user has capacity to consent

Date routine enquiry completed (DD/MM/YYYY): _____

Organisation where care was provided: _____ code: _____

Type of organisation where routine enquiry was conducted:

☐ GUM Clinic ☐ Sexual Health Clinic
☐ Adult Mental Health ☐ Children's Mental Health
☐ Sexual Assault Referral Centre ☐ Drug / Alcohol Substance Misuse ☐ Other

Please hand to the service user for completion

Consent Form

Consent	Please tick the box if you agree

I understand the reason for this health assessment ☐

I understand that information may be shared if there is a risk to myself or anyone else ☐

I understand that I do not have to answer any questions if I do not want to ☐

I have had chance to ask any questions ☐

I consent to completing the questionnaire ☐

I consent to share anonymised information with NHS digital ☐

NAME OF SERVICE-USER	
SIGNATURE	
DATE SIGNED	
SIGNATURE OF HEALTH PROFESSIONAL	
DATE SIGNED	

Demographics

Age now:

☐ Under 16 ☐ 16-17 ☐ 18-30 ☐ 31-40

☐ 41-50 ☐ 51-60 ☐ 61-80 ☐ 81-100

☐ Prefer not to say

Gender:

☐ Male ☐ Female

☐ Transgender ☐ Prefer not to say

Ethnicity:

☐ British ☐ Irish ☐ Any other White British

☐ White & Black Caribbean ☐ White & Black African ☐ White & Asian

☐ Any Other Mixed Background ☐ Indian ☐ Pakistani

☐ Bangladeshi ☐ Any Other Asian Background ☐ Caribbean

☐ African ☐ Any Other Black Background ☐ Chinese

Childhood experiences – About your life up to age 18 years

Before the age of 18 years (or up until now if you are currently under 18 years)...

1. Did you live with anyone who was **depressed, mentally ill** or **suicidal**?
   ☐ 1. Yes ☐ 2. No
2. Did you live with anyone who was a **problem drinker** or **alcoholic**?
   ☐ 1. Yes ☐ 2. No
3. Did you live with anyone who used **illegal street drugs** or who **abused prescription medications**?
   ☐ 1. Yes ☐ 2. No
4. Do you live with anyone who served time or was sentenced to serve time in a **prison** or **young offenders institution**?
   ☐ 1. Yes ☐ 2. No
5. Were your parents **separated** or **divorced**?
   ☐ 1. Yes ☐ 2. No
6. How often did your parents or adults in your home ever slap, hit, kick, punch or beat **each other** up?
   ☐ 1. Never ☐ 2. Once or twice ☐ 3. Many times
7. How often did a parent or any adult in the household ever **hit, beat, kick** or **physically hurt you** in any way?
   ☐ 1. Never ☐ 2. Once or twice ☐ 3. Many times
8. How often did a parent or adult in your home ever swear at you, insult you, or put **you down**?
   ☐ 1. Never ☐ 2. Once or twice ☐ 3. Many times
9. Did your parent(s) for long periods of time make you go without enough food or drink, clean clothes, or a clean and warm place to live?
   ☐ 1. Never ☐ 2. Once or twice ☐ 3. Many times

Section 2:

*We would now like to ask you to answer some more questions about other specific experiences **during the first 18 years of your life.** Again, you do not have to complete this section if you do not want to and you do not have to answer every question. If you would prefer not to complete section 2, please hand the questionnaire back to your worker.*

Before the age of 18 years (or up until now if you are currently under 18 years)

10. a) How often did anyone at least 5 years older than you (including adults) ever **touch you sexually**?
    ☐ 1. Never ☐ 2. Once or twice ☐ 3. Many times

    b) How often did anyone less than 5 years older, the same age or younger than you ever touch you sexually when you did not want to or felt unable to say no?
    ☐ 1. Never ☐ 2. Once or twice ☐ 3. Many times

11. a) How often did anyone at least 5 years older than you (including adults) **try to make you touch them sexually**?
    ☐ 1. Never ☐ 2. Once or twice ☐ 3. Many times

    b) How often did anyone less than 5 years older, the same age or younger than you ever try to make you touch them sexually when you did not want to or felt unable to say no?
    ☐ 1. Never ☐ 2. Once or twice ☐ 3. Many times

12. a) How often did anyone at least 5 years older than you (including adults) **force you** to have any type of **sex** (oral, anal or vaginal)?

☐ 1. Never ☐ 2. Once or twice ☐ 3. Many times

b) How often did anyone less than 5 years older, the same age or younger than you ever force you to have any type of sex (oral, anal or vaginal)?

☐ 1. Never ☐ 2. Once or twice ☐ 3. Many times

13. Have you ever been **asked to show** or **send images** of a **sexual nature**, OR been asked to **behave in a sexual way** in person or via social media *(i.e. Facebook, Twitter, Instagram/ Snapchat, other)*

☐ 1. Yes ☐ 2. No

14. Have you ever done or were you ever forced or asked to do **anything sexual** *(in person, online or via social media)* **in exchange for** money, drugs/alcohol, gifts, affection, protection/safety, accommodation, employment, status (popularity), or anything else OR because you felt threatened?

☐ 1. Yes ☐ 2. No

15. Is any of this sexual activity **still** happening?

☐ 1. Yes ☐ 2. No

If Yes, who has been involved in the sexual activity? (choose all that apply)

☐ 1.Family member ☐ 2. Non-Family member

16. Have you ever told anyone about **any** of this sexual activity?

☐ 1. Yes ☐ 2. No

If Yes, did you receive any support?

☐ 1. Yes ☐ 2. No

Resilience

17. While you were growing up, before the age of 18, was there an adult in your life who you could trust and talk to about any personal problems?

☐ 1. Never ☐ 2. Once or twice ☐ 3. Many times

Thank you for completing this health questionnaire. Please hand this form back to your worker.

If you would like to discuss anything on this form, please speak with your worker. Your worker will be able to talk with you about your responses on this form and discuss ways these experiences may have affected you. They can also discuss ways to support you, should you feel that you want any support.

Appendix 6: Key considerations for Implementation Pack development

Implementation Pack:

- Produce an overview document that accompanies all the Implementation Pack materials and describes what it is, including details of: its purpose; who should use it; how it should be used; who needs to be involved; what's required from the service; what the Implementation Pack includes; and other useful resources and contacts.
- Include details of when a service would be expected to be ready to commence enquiries (e.g. OR-CAP complete; staff trained); advise that prior to commencement checks are made to ensure the service and trained practitioners are ready to enquiry (mutually agreeing a start date).
- Highlight that the development, implementation and embedding of routine enquiry within the service should be continually reviewed.

OR-CAP:

- Review and revise the OR-CAP to ensure that the importance of completing each section is highlighted and organisations know how to be sure they have completed each section adequately. This could include producing an example of a completed OR-CAP, illustrating gaps, actions and development processes.
- Provide suggestions of who may need to be involved to adequately complete the OR-CAP.
- Note that sections within the OR-CAP may need to be revisited throughout the development and implementation of routine enquiry within the service (e.g. quality monitoring and review; staff training requirements).
- Add a section on embedding routine enquiry into the service (following implementation of enquiries, which may include monitoring of enquiries and additional staff training (e.g. new or other staff / refresher training).
- Where possible, provide web links to identified resources/references.
- Remove any unnecessary reference to the pilot project and research.
- Ensure all abbreviations are written in full somewhere in the document.

Facilitator pack

- If possible, identify and recommend an adequate amount of time that trainers will require to prepare themselves to deliver the training (suggest that the service allocates this time to the trainer).
- Highlight the importance of trainees completing pre-learning, particularly if the available training time is limited.
- Produce a pull-out summary guide for trainers which details key minimum learning outcomes of any level of training delivered, and elements/activities that are recommended to always be included (e.g. activities that promote awareness and familiarity with routine enquiry using the ACE-CSE questionnaire, and discussion on how to implement it within the service).

- Slide 32 facilitator notes: Include information on why asking the questions in the ACE-CSE questionnaire are useful to: the client; the service; and the development of local/national policy and practice (see below for corresponding slide amendments).
- Include details of how the pre-learning module 'Seen and Heard' can be accessed.

Training slides

- Consider if it would be more appropriate for trainers to learn about ACEs first, followed by more detail on CSAE specifically.
- Amend slide 18 so it aims to explore trainee understanding of ACEs (not re-cap as all trainees may not have completed pre-training). Move the 'Quick Re-Cap Exercise' to after slide 22 (i.e. after all trainees have learnt about ACEs).
- Slide 32: revise so it highlights the value of asking the questions in the ACE-CSE questionnaire for: the client; the service; and the development of local/national policy and practice (rather than a focus on data collection). Information should be based on clear theoretical assumptions and logic model, grounded were possible in research evidence.
- Provide further instruction and/or materials for a shorter training session (for trainees with adequate prior knowledge/experience) - e.g. suggest that all slides should be used, however trainers can reduce/vary detail and depth of discussions according to trainee requirements, OR produce a shorter (minimum) version of the training slides.
- Embed videos into the training slides.

ACE-CSE questionnaire

- Review the questionnaire and included questions, and produce an annex that provides:
  - A rationale for the structure of the questionnaire (e.g. ACE questions before CSAE questions);
  - A rationale for why it includes these specific childhood adversities and not others (e.g. bereavement); and,
  - An explanation of the purpose of each question, particularly the CSAE questions (focusing on the importance for clients and service provision, and as a latter point, monitoring), and why they are asked in this particular way.

Videos

- Consider sending the videos for external peer review (by relevant experts, practitioners and lay persons) to ensure they are suitable (particularly the scenarios, e.g. young person scenario); if required amend videos accordingly.
- Provide each video link with an appropriate descriptive title, so that trainers and trainees can easily identify which video they wish to view.

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