KING'S COLLEGE LONDON

PROMOTING RECOVERY IN MENTAL HEALTH: EVALUATION REPORT

Siân Oram
Lauren Capron
Kylee Trevillion

August 2016
Acknowledgements

We would like to express our thanks to the service users and staff at Camden and Islington NHS Foundation Trust and Sussex Partnership NHS Foundation Trust who participated in and supported this research. We also gratefully acknowledge support from the NIHR Clinical Research Network and assistance from Hugh Hathaway, Raquel Catalao, Nicole Cousins, and Stacey Hemmings.

This report has been independently produced and all views expressed in the report are those of the authors.
# Table of Contents

Table of Contents .................................................................................................................................................. 4
Abbreviations ......................................................................................................................................................... 6
Background ............................................................................................................................................................. 7
Promoting Recovery in Mental Health .................................................................................................................. 8
  Project background and objectives ....................................................................................................................... 8
  Project sites ........................................................................................................................................................... 8
  Project activities ................................................................................................................................................... 8
Evaluation Methods ............................................................................................................................................... 11
  Study 1: Document review.................................................................................................................................. 11
  Study 2: Qualitative research with key stakeholders and NHS professionals ......................................................... 11
  Study 3: Pre- and post-training surveys with NHS professionals ............................................................................. 12
  Study 4: Survey and qualitative research with service users who have experienced domestic or sexual violence ................................................................................................................................. 13
Ethics ..................................................................................................................................................................... 15
Findings ................................................................................................................................................................... 16
  1. Domestic and sexual violence policies .................................................................................................................. 16
     Core Principle 1: Evidence of an Understanding of Sexual Violence and its Impact ............................................ 16
     Core Principle 2: Evidence of strategies that promote the identification of domestic and sexual violence .................................................................................................................................................................. 17
     Core Principle 3: Evidence of strategies for risk assessment ..................................................................................... 18
     Core principle 4: Evidence of strategies for the provision of information to service users ........................................... 18
     Core principle 5: Evidence of strategies that promote the safety, security and dignity of service users ........................................................................................................................................................................... 19
     Core principle 6: Evidence of strategies to promote the care and referral of service users .............................................. 19
  2. Confidence and competence of staff to respond to domestic and sexual violence. ....................................... 21
     Study 1: Staff Survey .......................................................................................................................................... 21
     Sample .................................................................................................................................................................. 21
     Previous training .................................................................................................................................................. 21
     Knowledge of domestic and sexual violence protocols ............................................................................................. 21
     Domestic and sexual violence enquiry ..................................................................................................................... 22
     Identification of new cases ....................................................................................................................................... 23
     Knowledge about domestic and sexual violence ....................................................................................................... 23
     Knowledge about how to respond to domestic and sexual violence ............................................................................... 26
     Readiness to respond to domestic and sexual violence ............................................................................................. 24
Study 2: Qualitative research with frontline staff .........................................................26
Sample ..........................................................................................................................26
Role in responding to domestic and sexual violence ......................................................26
Identifying domestic and sexual violence: current practice ......................................27
Responding to domestic and sexual violence: current practice ...................................28
Identifying and responding to domestic and sexual violence: facilitators ..................29
Identifying and responding to domestic and sexual violence: barriers .......................30
Awareness and experience of the PRIMH intervention .............................................31
3. Satisfaction, health, and wellbeing of service users who have experienced domestic and sexual violence. .................................................................33
   Sample ......................................................................................................................33
Experiences of violence ..............................................................................................33
Satisfaction with services ............................................................................................36
Improvements in service responses ..........................................................................39
Quality of life ................................................................................................................42
Social inclusion ...........................................................................................................42
Unmet health and social care needs ............................................................................42
4. Key stakeholders’ experiences of the PRIMH project .............................................44
   Barriers and facilitators of project success ...............................................................45
Summary ......................................................................................................................49
   Key findings .............................................................................................................49
   Policy development .................................................................................................49
   Workforce development .........................................................................................49
   Service user and multi-agency involvement and outcomes ....................................51
Limitations ...................................................................................................................52
Recommendations .......................................................................................................54
References ....................................................................................................................55
Appendix 1 ....................................................................................................................56
Appendix 2: NHS Survey Questionnaire ....................................................................62
Appendix 3: Scales used during interviews with service users ..................................68
## Abbreviations

<table>
<thead>
<tr>
<th>Abbreviations</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>AR-DSA</td>
<td>Awareness and Response to Domestic and Sexual Abuse</td>
</tr>
<tr>
<td>AVA</td>
<td>Against Violence and Abuse</td>
</tr>
<tr>
<td>BARTA</td>
<td>Be Aware and Respond to Abuse</td>
</tr>
<tr>
<td>CQUIN</td>
<td>Commissioning for Quality and Innovation</td>
</tr>
<tr>
<td>DASAL</td>
<td>Domestic and Sexual Abuse Link Practitioner</td>
</tr>
<tr>
<td>IESD</td>
<td>Innovation, Excellence and Strategic Development Fund</td>
</tr>
<tr>
<td>MARAC</td>
<td>Multi Agency Risk Assessment Conference</td>
</tr>
<tr>
<td>NICE</td>
<td>National Institute for Health and Clinical Excellence</td>
</tr>
<tr>
<td>PRIMH</td>
<td>Promoting Recovery In Mental Health</td>
</tr>
<tr>
<td>PTSD</td>
<td>Post-Traumatic Stress Disorder</td>
</tr>
</tbody>
</table>
Mental health services have a key role in responding to domestic and sexual violence. Women and men with mental disorders – including depression, anxiety, post-traumatic stress disorder, eating disorder, and psychosis – are more likely to be victims of domestic and sexual violence than are people in the general population.¹ Recent research with mental health service users in London found that 70% of women and 50% of men had ever experienced domestic violence, while 27% of women and 10% of men had experienced domestic violence in the past year.² Sixty-one percent of women reported having experienced sexual violence during adulthood, and 10% reported having experienced sexual violence in the past year.³ Yet, domestic and sexual violence are under-detected by mental health services: it is estimated that just 10-30% of cases are identified.³⁻⁴ Levels of enquiry about domestic and sexual violence are low,⁵⁻⁷ and in the absence of direct enquiry many service users do not readily disclose their experiences of abuse.⁸ Mental health professionals’ responses to disclosures of abuse are often perceived as inadequate by service users, who describe a failure of some staff to acknowledge or validate their experiences of abuse and to promote their safety.⁸

Previous research has suggested that barriers to enquiry and effective responses to domestic and sexual violence include perceptions by staff that they lack the necessary expertise or time, have competing priorities, fear offending or re-traumatising service users, or are prevented from enquiring due to the presence of partners and family members during consultations.⁴⁻⁵⁻¹⁰

Limited research exists on how to improve responses to domestic and sexual violence in mental health or other health settings. Indeed, the 2014 National Institute for Health and Clinical Excellence (NICE) guidelines on responding to domestic violence highlighted the need for evidence in this area.¹¹

Reviews of interventions conducted in non-mental health and social care settings have found that although training interventions can be effective in improving health professionals’ knowledge about domestic violence, broader organisational support and systemic change is required to bring about sustainable improvements in professionals’ identification of and responses to domestic violence.¹²⁻¹³

Achieving consistent and sustainable improvements to domestic and sexual violence by mental health services is likely to require strategic-level intervention in order to generate managerial and corporate support, facilitate multi-agency working partnerships and establish clear care pathways of referral. However, responses to Freedom of Information requests submitted in 2011-12 to Mental Health Trusts in England found that only three of the 50 Trusts that responded had a domestic and sexual violence strategy and only three included basic information on asking about domestic and sexual violence in their core documents relating to this issue. Thirty-four Trusts reported that staff were required to learn about domestic and sexual violence; 30 of the 34 Trusts reported that staff training was through short sessions (ranging from 30 minutes to 2.5 hours) within mandatory safeguarding sessions. Four Trusts reported providing individual therapeutic support and two providing group therapy.
specifically to address domestic and sexual violence.\textsuperscript{14}

This report presents the findings of an evaluation of a strategic-level intervention – Promoting Recovery in Mental Health (PRIMH) - that aimed to improve the responses of Mental Health Trusts to domestic and sexual violence.

**Promoting Recovery in Mental Health**

**Project background and objectives**

In 2013, Against Violence and Abuse (AVA), a national second-tier charity, was awarded funding from the Department of Health Innovation, Excellence and Strategic Development (IESD) fund to develop and deliver an intervention to improve mental health service responses to domestic and sexual violence. King’s College London participated in the application to the IESD fund as the project evaluation partner.

The project aimed to work strategically with two Mental Health Trusts (healthcare organisations responsible for the provision of secondary mental health services) to improve organisational responses to domestic and sexual violence, including moving responses beyond the management of risk to a focus on recovery from abuse. The objectives of the project were to work with Trusts to achieve the following:

1. The implementation of holistic responses to domestic and sexual violence within Trust safeguarding, clinical and recovery frameworks;
2. The creation of a strategy to implement good practice;
3. The mentoring of senior staff to become domestic and sexual violence champions;
4. The delivery of “train the trainer” training and developing domestic and sexual violence competency frameworks to inform long-term workforce development;
5. The delivery of training to frontline services;
6. The strengthening of relationships with local domestic and sexual violence services; and
7. The involvement of service users in informing and influencing service delivery.

**Project sites**

Mental Health Trusts were invited by AVA to apply to participate in the intervention. Nine Trusts applied, from which Camden and Islington NHS Foundation Trust and Sussex Partnership NHS Foundation Trust were selected to participate.

Camden and Islington NHS Foundation Trust provides mental health services to residents of the London boroughs of Camden and Islington, plus substance misuse services in Westminster and a substance misuse and psychological therapies service to people living in Kingston. It operates over 20 sites and employs over 1,700 full time equivalent staff.

Sussex Partnership NHS Foundation Trust manages around 100 sites across the South East of England, including services in East Sussex; West Sussex; Brighton and Hove; London; Kent; Medway; and Hampshire. It employs over 5,000 staff (including 1,700 nurses, 300 doctors, and 1,500 other clinical and professional staff).

**Project activities**

Intervention activities began in Camden and Islington NHS Foundation Trust and Sussex Partnership NHS Foundation Trust in January 2014. In Camden and Islington NHS Foundation Trust the PRIMH intervention was known as AR-DSA.
(Awareness and Response to Domestic and Sexual Abuse) and in Sussex Partnership NHS Foundation Trust as BARTA (Be Aware and Respond To Abuse). For ease, we refer to the PRIMH project – rather than to AR-DSA and BARTA – throughout this report. Activities were coordinated by an AVA project worker with several years’ experience of working in frontline, policy, and strategic roles in the domestic violence sector. The project worker was available to each Trust for two days per week over the course of the project.

Steering groups were convened at each Trust to provide advice and support in implementing the project plans, which focused on achieving four key objectives in order to develop confidence and competence in responding to domestic and sexual violence. These were to:

(1) Develop clear policies around, and care pathways for service users and staff who disclose, experiencing or perpetrating domestic and/or sexual violence;
(2) Promote the message across the Trusts that domestic and sexual violence is ‘core business’;
(3) Create a workforce that is knowledgeable, skilled, and confident in enquiring about and responding to disclosures of domestic and sexual violence;
(4) Develop closer links with relevant local domestic and sexual violence multi-agency partnership structures and service providers.

At Camden and Islington NHS Foundation Trust the steering group was chaired initially by the Women’s Lead (who was also the project lead for the Trust), and from June 2014 by the Trust’s Chief Operating Officer. At Sussex Partnership NHS Foundation Trust the steering group was chaired by the Director of Social Care. There were changes in key personnel at both Trusts over the course of the project and a change in project worker from June 2015. At Camden and Islington NHS Foundation Trust there were a number of changes in safeguarding manager and a change in project lead in year two at Sussex Partnership NHS Foundation Trust.

Year one activities at Camden and Islington NHS Foundation Trust included: updating the domestic violence policy and expanding its scope to include sexual violence; inputting into the clinical risk policy to ensure domestic and sexual violence was addressed; introducing domestic and sexual violence into the safeguarding level two and three curricula; developing and delivering standalone domestic and sexual violence training sessions; preparing a five-session Recovery College course for service users on Recovery from Abuse; updating domestic and sexual violence resource lists for survivors of abuse; and organising a half-day conference on domestic and sexual violence for White Ribbon Day. Activities at Sussex Partnership NHS Foundation Trust in year one included drafting a domestic and sexual violence policy; developing and delivering standalone domestic and sexual violence training sessions; recruiting domestic and sexual abuse link (DASAL) practitioners and developing a DASAL training programme; and creating a project webpage.

1 DASAL practitioners are Trust employees who received enhanced training through the PRIMH intervention in order to (1) help team members enhance the care, treatment, and experience of service users with experiences of domestic and sexual violence; (2) act as a central source of information about domestic and sexual violence in their teams; (3) support their teams to engage with external domestic and sexual violence agencies and multi-agency forums; (4) promote the Trust-wide domestic and sexual violence training programmes, with the option to become domestic and sexual violence trainers. They are not expected to take on
In year two, activities at Camden and Islington NHS Foundation Trust included delivering domestic and sexual violence training through level two and three safeguarding training and standalone sessions; delivering Recovery College Recovery from Abuse courses, recruiting and training DASAL practitioners; organising a White Ribbon event and a female genital mutilation (FGM) seminar; and sustainability planning. During the same period at Sussex Partnership NHS Foundation Trust activities included the finalisation of the domestic and sexual violence policy; delivering standalone domestic and sexual violence training sessions; delivering Recovery College Recovery from Abuse courses; importing the AVA e-learning programme on domestic and sexual violence, substance use and mental health onto the Trust website; organising a White Ribbon event; and sustainability planning.

Training sessions were delivered at the two Trusts from November 2014 onwards. At Camden and Islington NHS Foundation Trust, 341 staff attended 31 standalone domestic and sexual violence training sessions and 412 attended trainings integrated into either level 2 or level 3 safeguarding training, delivered over 29 sessions. Training sessions conducted at Sussex Partnership NHS Foundation Trust were attended by 231 members of staff.

---

all referrals involving domestic and sexual violence, and do not replace the role of safeguarding leads.
Evaluation Methods

The independent evaluation of the PRIMH intervention, conducted by King’s College London, aimed to evaluate changes in strategic- and operational-level responses to domestic and sexual violence; changes in the confidence and competence of staff to respond to domestic and sexual violence; and changes the satisfaction, health, and wellbeing of service users who had experienced domestic or sexual violence.

The evaluation comprised four components: (1) Review of Trust policies, procedures, and resources about domestic and sexual violence; (2) Qualitative research with NHS professionals to explore their views and opinions about the Trusts’ roles in addressing domestic and sexual violence and their experiences and expectations of the PRIMH intervention; (3) Pre- and post-training surveys to assess staff knowledge, attitudes and behaviour in relation to domestic and sexual violence; (4) Survey and qualitative research with service users who have experienced domestic or sexual violence, explore their experiences of Trust responses to violence and abuse. Baseline research was conducted between June 2014 and December 2014; follow-up data were collected between August 2015 and February 2016.

Study 1: Document review

Study 1 aimed to critically examine policies, protocols, procedures, and resources relating to domestic and sexual violence prior to and after the implementation of the PRIMH intervention.

The study involved a review of policies, protocols and procedures that included guidelines, strategies and/or recommendations on the identification, referral and provision of care for people experiencing violence and abuse. Only current policies, protocols and procedures were examined; superseded documentation was excluded. NHS Trust policies, protocols and procedures that made reference to the subject of domestic and sexual violence but did not include strategies and/or recommendations on the identification, referral and provision of care for people experiencing violence and abuse were not reviewed.

Researchers were given access to the Trust Intranet webpages in order to identify and download eligible documents, and additional materials were provided by project leads at the two Trusts. Data from policies, protocols and procedures were extracted and reviewed against criteria based on national operating standards and NICE guidance on domestic and sexual violence (see Appendix).

Analysis of Trust documentation considered the information content of the policies only. Factors such as information organisation and layout and other aspects influencing reader comprehension and retention of information were not considered, although these areas might present future opportunities for improvement of policy implementation.

Study 2: Qualitative research with key stakeholders and NHS professionals

Study 2 aimed to evaluate key stakeholders’ views and opinions about the Trusts’ roles in addressing service users’ experiences of violence and abuse and their expectations and experiences of taking part in the PRIMH intervention. Data were collected prior to and after the
implementation of the PRIMH intervention.

Qualitative interviews were conducted with the project worker, Trust project leads, and with members of Trust staff who had adult or child safeguarding responsibilities. We aimed to conduct six pre-intervention and six post-intervention interviews. Interviews followed a topic guide and explored (1) experiences of identifying, referring and providing care for people who have been abused (Trust staff only); (2) views regarding Trust responses to domestic and sexual violence; (3) expectations and experiences of participating in the PRIMH intervention. The project worker also maintained reflective logs over the course of the project and shared these with the evaluation team.

Focus group interviews were also held to collect qualitative data from frontline NHS professionals at the two Trusts. Project leads and local Clinical Studies Officers were asked to advertise the focus groups; we aimed to recruit 20 professionals to the pre-intervention focus groups and 20 professionals to the post-intervention focus groups. Focus groups were facilitated by two members of the research team and followed a discussion guide. The guide focused on professionals’ views about the Trusts’ roles in identifying, referring and caring for service users who have experienced violence and abuse; the Trusts’ relationships and links with services that support people experiencing domestic and sexual violence; and experiences and expectations of the PRIMH intervention.

Interviews and focus groups were digitally recorded, transcribed verbatim and analysed using thematic analysis in NVIVO 10.

Study 3: Pre- and post-training surveys with NHS professionals

Study 3 aimed to evaluate changes in clinicians’ knowledge, confidence and competence to respond to service users’ experiences of violence and abuse before and after attending domestic and sexual violence training.

Data were collected from NHS professionals who attended face-to-face domestic and sexual violence training at the two Trusts. Professionals were asked by local Clinical Studies Officers (at Sussex Partnership NHS Foundation Trust) and by trainers (at Camden and Islington NHS Foundation Trust) to provide written informed consent and to complete self-administered questionnaires immediately before and after the training session. Participants were also contacted by email at three or more months post-training and asked to participate in a follow-up online survey. We estimated that 240 professionals would participate in the survey, based on 15 training sessions being offered at each Trust, with an average of 16 people attending each session.

The survey questionnaire (see Appendix) was adapted from instruments used in our previous research on trafficking and on domestic violence, and measured healthcare provider knowledge, confidence and competence to identify and respond to domestic and sexual violence. Piloting suggested the questionnaire would take approximately 10–15 minutes to complete.

Data were analysed in STATA 11. Comparisons between Trusts and time points were conducted using chi-square tests and one-sample mean-comparison tests.
Study 4: Survey and qualitative research with service users who have experienced domestic or sexual violence

Study 4 aimed to (1) measure service satisfaction, health and well-being among service users with experiences of domestic and sexual violence; (2) to explore service users’ experiences and opinions about clinicians’ responses to violence and abuse.

Survey and qualitative interviews were conducted with service users prior to and after the implementation of the PRIMH intervention. Service users were eligible to participate if they were aged 18 years and older and had experienced domestic or sexual violence. Individuals were not eligible to participate in the study if they were not currently receiving treatment or support from either Camden and Islington NHS Foundation Trust or Sussex Partnership NHS Foundation Trust, did not have a sufficient level of English to complete the study questionnaires, were considered by their care team or the research team to be too unwell or distressed to participate, or were unable to give informed consent to participate.

We aimed to conduct survey interviews with 50 service users prior to the intervention and 50 service users after the implementation of the intervention. We also aimed to conduct approximately 30 qualitative interviews with service users; 15 prior to the intervention and 15 post-intervention. Project leads and other NHS professionals in the two sites were asked to identify and seek participation from service users who may have been eligible to take part. Posters were also placed in Trust waiting areas and information about the study disseminated through service user research networks to enable service users to self-refer to the study. Pre-intervention participants were re-contacted during the post-intervention research to ask whether they would like to take part in a second interview.

During survey interviews, data were collected on socio-demographic and clinical characteristics; experiences of domestic and sexual violence, including when the violence occurred, the perpetrator(s) of domestic and sexual violence, and the impact of domestic and sexual violence on mental health and wellbeing; service satisfaction, mental wellbeing; personal recovery; quality of life; social inclusion; and unmet health and social care needs. Details of the instruments used are provided in the Appendix. With the exception of data on unmet health and social care needs, which were collected using a researcher-administered questionnaire, survey data were collected through self-administered questionnaire.

The survey interview was followed by a brief (15-30 minute) qualitative interview that, following a topic guide, explored service users’ experiences of and opinions about Trust responses to domestic and sexual violence. Qualitative interviews were digitally recorded with participants’ consent. Travel expenses were reimbursed and participants were given a £15 high street shopping voucher to thank them for their time.

Survey data were analysed using STATA 11. Audio files were transcribed verbatim and analysed using thematic analysis in NVIVO 10. Participants provided consent for the evaluation team to use quotations

---

2 The evaluation originally intended to include service users aged 16 years and above, to align with the current UK Home Office definition of domestic violence. This was amended to 18 years and above following at the request of the approving NHS research ethics committee.
from their interviews; quotations are accompanied by pseudonyms.
Ethics

Ethics approval was provided by the Harrow NHS Research Ethics Committee (reference 14/LO/0114). The Research and Development offices of the two participating Trusts also provided site specific study approvals. Informed consent was obtained from all participants prior to data collection. Staff and service users were informed that they did not have to answer any questions about which they felt uncomfortable. Consent was sought to audio-record responses to qualitative interviews. All interviews were conducted by trained female researchers, and standard operating procedures regarding the identification and management of distress were in place. A consultant psychiatrist was on call during service user interviews in case concerns arose about participant safety. All service user participants were given information about national support services and were asked at the end of their interview whether they would like to discuss the issues raised during the interview with their clinician.
1. **Domestic and sexual violence policies**

Domestic and sexual violence policies were reviewed for evidence of adherence to six core principles: (1) evidence of an understanding of domestic and sexual violence and its impact; (2) evidence of strategies to promote the identification of domestic and sexual violence; (3) evidence of strategies for risk assessment; (4) evidence of strategies for the provision of information to service users; (5) evidence of strategies that promote the safety, security, and dignity of service users; (6) evidence of strategies to promote the care and referral of service users.

Key indicators operationalised each of these six principles (see Appendix). As shown in Table 1, Camden and Islington NHS Foundation Trust’s pre- and post-intervention policies met 63% (48/76) and 71% (54/76) of criteria, respectively, and Sussex Partnership NHS Foundation Trust’s post-intervention policy met 72% (55/76) of criteria.

Work had begun on a draft domestic and sexual violence policy at Sussex Partnership NHS Foundation Trust prior to the implementation PRIMH project but, as the policy had not been ratified, it was not available for analysis. Findings for Sussex Partnership NHS Foundation Trust are therefore limited to analysis of the policy developed during the course of the PRIMH project. As reported in the interim evaluation report (which reported on findings at baseline), documentation provided by Sussex Partnership NHS Foundation Trust for the pre-intervention period included risk assessment and referral materials, such as the Trust’s Risk Screening Tool, the Domestic Abuse Stalking and Harassment Risk Identification Checklist, and a form for referring to Multi-Agency Risk Assessment Conferences (MARAC). However, guidance on the appropriate use of these resources was lacking.

**Core Principle 1: Evidence of an Understanding of Sexual Violence and its Impact**

Analysis of pre-intervention documents found that Camden and Islington NHS

<table>
<thead>
<tr>
<th>Core Principle</th>
<th>No. Indicators</th>
<th>No. indicators met</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Evidence of an understanding of domestic and sexual violence and its impact</td>
<td>12</td>
<td>9</td>
<td>10</td>
<td>n/a</td>
<td>8</td>
</tr>
<tr>
<td>(2) Evidence of strategies to promote the identification of domestic and sexual</td>
<td>10</td>
<td>8</td>
<td>7</td>
<td>n/a</td>
<td>8</td>
</tr>
<tr>
<td>violence</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(3) Evidence of strategies for risk assessment</td>
<td>11</td>
<td>4</td>
<td>5</td>
<td>n/a</td>
<td>7</td>
</tr>
<tr>
<td>(4) Evidence of strategies for the provision of information to service users</td>
<td>14</td>
<td>10</td>
<td>11</td>
<td>n/a</td>
<td>11</td>
</tr>
<tr>
<td>(5) Evidence of strategies that promote the safety, security, and dignity of</td>
<td>11</td>
<td>6</td>
<td>8</td>
<td>n/a</td>
<td>7</td>
</tr>
<tr>
<td>service users</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(6) Evidence of strategies to promote the care and referral of service users</td>
<td>18</td>
<td>11</td>
<td>13</td>
<td>n/a</td>
<td>14</td>
</tr>
<tr>
<td>Total</td>
<td>76</td>
<td>48</td>
<td>54</td>
<td>n/a</td>
<td>55</td>
</tr>
</tbody>
</table>

Table 1: Domestic and sexual violence policies: number of indicators met.
Foundation Trust’s Domestic Violence Safeguarding Policy demonstrated a good understanding of domestic violence and its impact, but provided limited guidance regarding sexual violence and had not been updated to reflect the Home Office’s inclusion of coercive control in the definition of domestic violence in 2014 or of 16-17 year olds as people who could be victims of domestic violence. Training materials - but not the policy - described the impact of domestic and sexual violence on physical and mental health.

Post-intervention analyses found that both the updated Camden and Islington NHS Foundation Trust policy and the new Sussex Partnership NHS Foundation Trust policy used the new UK Home Office definition of domestic violence and described how controlling and coercive behaviours were defined. Both described the mental and physical health impact of domestic and sexual violence. Post-intervention policies also recognised the link between domestic and sexual violence and the abuse/neglect of children, and provided brief information about the impact on children living in households where abuse occurs. However, although Camden and Islington NHS Foundation Trust’s pre-intervention policy acknowledged that children might be used by abusers as part of a pattern of control over their victims, this was not recognised in either post-intervention policy.

All three policies promoted the treatment of service users with dignity and respect, with acknowledgement of their rights to be fully involved in decision making around their care, but none dealt explicitly with potential barriers to disclosure. The policies stated that staff should never raise the subject of domestic abuse if anybody else (including family and friends) was present, with Sussex Partnership NHS Foundation Trust’s policy stating explicitly that this was because the friend or family member could be a perpetrator of abuse. Other potential barriers to disclosure, including those based around religious or cultural beliefs, were alluded to through quotes.

Core Principle 2: Evidence of strategies that promote the identification of domestic and sexual violence

Neither post-intervention policy included adequate evidence of strategies to promote public awareness of domestic and sexual violence. Both included recommendations from the 2014 NICE guidance on domestic violence, including that information should be displayed “in suitable places, making sure information is in a range of formats and locally used languages”. However, neither delegated the responsibility to disseminate such information in their respective ‘Duties’ sections.

There was, however, evidence in all three policies strategies to promote knowledge among staff of services, policies, and procedures on domestic and sexual violence. The policies included clear information regarding responsibility for the dissemination and implementation of the policies and training expectations, and statements that staff would be provided with supervision and support to identify and assess domestic and sexual violence.

The existence of information sharing protocols with key services, including the police, was highlighted in both the pre- and post-intervention policies authored by Camden and Islington NHS Foundation Trust. It was not clear whether similar procedures were in place at Sussex Partnership NHS Foundation Trust, although the policy did note that its scope extended to “supporting multi-agency responses to domestic and sexual abuse,”
including through the appropriate sharing of information”.

Core Principle 3: Evidence of strategies for risk assessment

Each of the three policies asserted that incorporating assessment for domestic and sexual abuse into the routine assessment of all service users, alongside the Trust risk assessment processes, was one of the specific objectives of the policies. Sussex Partnership NHS Foundation Trust’s policy additionally highlighted that routine enquiry is “required under the [Department of Health’s] Care Programme Approach guidance” and recommended by NICE. Regarding risk assessment, whereas Camden and Islington NHS Foundation Trust’s pre-intervention policy had made reference only to a generic safeguarding adults alerts form, both post-intervention policies made reference to the Domestic Abuse, Stalking and Harassment (DASH) risk identification checklist for determining risk to service users. Guidance on how to use this risk identification checklist was, however, lacking, as was information about safety planning.

None of the three policies made clear reference to the need for clinicians to explain their roles and responsibilities in relation to risk assessments, nor to the value of explaining the process and rationale of risk assessments to service users. Moreover none of the policies acknowledged the potential limits of risk assessment processes as dependent on the type and quality of information offered by service users.

Core principle 4: Evidence of strategies for the provision of information to service users

Both post-intervention policies highlighted that professionals should respond to disclosures of abuse sensitively and non-judgementally. Sussex Partnership NHS Foundation Trust’s policy included a list of questions that could be used to start conversations about domestic and sexual violence, while Camden and Islington NHS Foundation Trust’s post-intervention policy recommended asking service users about their preferences regarding the gender of their care professionals.

Policies also demonstrated good evidence of strategies for providing information about domestic and sexual violence to service users across the range of indicators considered. All three provided information about the Trust’s role in tackling domestic and sexual violence, with Camden and Islington NHS Foundation Trust’s post-intervention policy making specific reference to responsibilities under the Care Act 2014. Information was also provided regarding strategies to promote privacy and ensure confidentiality, how to document and report disclosures of violence and abuse, and key agencies that could be contacted for referral and further advice. All three acknowledged that service users had the right to make their own decisions, with Camden and Islington NHS Foundation Trust’s policy specifically highlighting that service users are likely to be reluctant to report their experiences to the police and Sussex Partnership NHS Foundation Trust highlighting that service users are unlikely to want to be referred to multiple services. Guidance on how to provide information and support in a manner that facilitates service user decision-making was lacking, however, as was guidance on cross-
cultural communication and recognition of the need to review information offered and options agreed over time.

**Core principle 5: Evidence of strategies that promote the safety, security and dignity of service users**

All three policies recognised the need to prioritise service user safety, security and dignity; to assess the safety and security of children and non-abusive family members; and to follow procedures to protect service users and others from further violence and abuse. Guidance on how to do this was included in the post-intervention policies, including guidance on risk assessment and referral procedures (see previous sections).

Strategies to promote recovery from violence and abuse at Sussex Partnership NHS Foundation Trust were focused on referral to appropriate external specialist support services and MARACs, although the policy noted that "staff should be mindful of where they are able to take action themselves, or in partnership with an external agency, rather than simply referring on". Camden and Islington NHS Foundation Trust’s post-intervention policy, however, explicitly stated that it is the "role of mental health staff to offer interventions that protect service users in the short term as well as providing long term services that psychological benefit, e.g. psycho-educational work, developing strategies for coping with responses to trauma and also addressing the trauma” and suggested professionals consider referrals to the Trust’s trauma services, substance misuse service, personality disorder service, and women's crisis house. None of the policies acknowledged the need for staff to identify barriers to service users' abilities to access services, however, and also did not include information about service user involvement in the development and delivery of relevant services or strategies to promote service users’ awareness of their rights and entitlements.

**Core principle 6: Evidence of strategies to promote the care and referral of service users**

All policies included guidance on how enquiry about and disclosures of domestic and sexual violence and actions taken should be recorded. No information was provided, however, regarding whether and how compliance with this guidance would be monitored.

The policies highlighted that service users with experiences of domestic and sexual violence may have a range of support needs, and that while some of these may be met by the Trust, others may require referral to external agencies. Sussex Partnership NHS Foundation Trust highlighted for example that support might include physical health checks, forensic examinations, safe accommodation, protection orders, emotional support, financial support, immigration advice, parenting support, and ongoing advocacy and support from specialist domestic violence agencies. Camden and Islington NHS Foundation Trust highlighted that in addition to mental health support needs, service users may have needs relating to housing and benefits, parenting, immigration, and support from specialist domestic and sexual violence agencies. Information and contact details for a range of support organisations was included in the post-intervention policies. The policies provided evidence of referral pathways to specialist services, for the provision of information to service users about these services, and for information sharing. Evidence for multi-agency coordination
included details of safeguarding and MARAC procedures.
2. Confidence and competence of staff to respond to domestic and sexual violence.

Study 1: Staff Survey

Attendance at the standalone training sessions was not mandatory and evaluation findings should be interpreted in the context of the sample being a self-selected group of NHS professionals likely to have had a particular interest in domestic and sexual violence.

Sample

A total of 158 participants who took part in the BARTA and AR-DSA training sessions completed evaluation questionnaires. Of these participants 56 were from Camden & Islington NHS Foundation Trust (35.4%) and 102 were from the Sussex Partnership NHS Foundation Trust (64.6%). From this sample 156 participants completed the pre-training questionnaire (98.7%), 151 participants completed the post-training questionnaires (95.6%) and 33 participants completed the follow-up questionnaire (20.9%). The sample included 17 male (10.9%) and 139 female (89.1%) NHS professionals; with a mean age of 39.2 (± 10.6) years.

Previous training

At baseline, two-fifths of participants (64/154; 41.6%) reported that they had previously received training on domestic and sexual violence within their NHS role. The proportion of participants reporting previous domestic and sexual violence training did not vary significantly between the two Trusts. However, the Trusts did differ significantly with regards to the recency of domestic and sexual violence training, with participants from Camden & Islington having more recent training (mean 1.7 years (±1.4)) than those from Sussex Partnership (mean 3.6 years (±3.2); p=.017).

Participants who had previously attended domestic and sexual violence training reported that it had covered types of domestic and sexual violence (84.4%), indicators of domestic and sexual violence (78.1%), general information (73.4%), and making referrals and giving information on national/local services (59.4%). Training was less frequently reported to have included information on the health problems associated with domestic and sexual violence (37.5%) and care approaches (29.7%).

Knowledge of domestic and sexual violence protocols

Prior to training, 78 participants (52.0%) reported that there was a protocol for responding to domestic and sexual violence at their Trust; 16.7% reported that it was widely used, 32.7% that it was used to some extent and 2.7% that there was a protocol but it was not used. 45.3% of respondents were unsure whether a protocol was in place while 2.7% reported that there was no protocol in place for dealing with domestic and sexual violence. No significant differences were found when examining the distribution of responses across the two Trusts. Participants who completed post-training questionnaires reported a significant increase in awareness of Trust protocols for responding to domestic and sexual violence (p<.001).

---

3 2 participants did not disclose their gender, 13 did not disclose their age.

4 8 participants did not respond to this question
Domestic and sexual violence enquiry

Participants were asked prior to training about their enquiry about domestic and sexual violence. Figure 1 presents the distribution of responses to the question “How often in the past 6 months have you asked about the possibility of domestic and sexual violence when seeing patients with the following presentations? Injuries, substance misuse, post-traumatic-stress disorder, headaches, depression/anxiety, eating disorders, and psychotic disorders”

Overall, there were no presentations for which more than half of respondents always or nearly always asked about domestic and sexual violence.

Participants at Camden and Islington NHS Foundation Trust were significantly more likely to report that they always or nearly always asked service users who presented with injuries about domestic and sexual violence than were participants at Sussex Partnership NHS Foundation Trust (52.1% vs. 34.5%, p=0.002). No other significant differences between the two NHS Trusts were identified.

More than a third of participants reported that they never or seldom asked patients with psychotic disorders, depression/anxiety, eating disorders, or substance misuse about domestic or sexual violence. Over 70% reported that they never or seldom asked about domestic or sexual violence when patients presented with headaches.

Figure 1: Domestic and Sexual Violence Enquiry
Identification of new cases

Prior to training, 42.1% of participants (64/152) reported that they had identified no new cases of domestic and sexual violence in the previous six months. 37.5% participants (57/152) reported that they had identified 1-5 new cases, 6.6% participants (10/152) reported that they had identified 6-10 new cases, 3.3% participants (5/152) reported that they had identified 11-20 new cases and 4.0% participants (6/152) had identified 21 or more new cases of domestic and sexual violence in the previous six months (Figure 2). Participants from Camden and Islington NHS Foundation Trust reported identifying significantly more new cases of domestic and sexual violence in the previous six months than did participants from Sussex Partnership NHS Foundation Trust (p=.022).

Figure 2: Case identification in previous six months

Of the 78 participants who reported having identified new cases of domestic and sexual violence in the previous six months, 62.8% (49/72) reported that they had provided information (e.g. phone numbers, pamphlets), 56.4% (44/72) documented a patient’s statement in the medical records, 52.6% (41/72) counselled a patient about their options, 51.3% (40/72) provided referral and/or resource information to the patient, 44.9% (35/72) offered validating/supportive statements, 42.3% (33/72) made a referral, 39.7% (31/72) helped a patient develop a personal safety plan, 39.7% (31/72) contacted a DSV service provider and 38.5% (30/72) conducted a safety assessment.

Knowledge about domestic and sexual violence

Responses to questions regarding domestic and sexual violence knowledge are summarised in Table 2. Prior to training, all participants correctly answered that they have a duty of care to consider an instance of a child witnessing domestic violence in terms of child protection, even if the child is not in immediate danger. More than two-thirds also answered correctly that supporting a patient’s decision to remain in an abusive relationship would not condone the abuse; that if they suspect a patient is experiencing violence but has not disclosed they should document their concerns in the patient’s medical records; and that allowing partners or friends to be present during the consultation of a patient who has experienced domestic and sexual violence does not ensure patients’ safety. However, prior to training fewer than two-thirds of participants correctly answered 5 6.6% participants (10/152) reported the question was not applicable as they were not in clinical practice.
that alcohol consumption is not the greatest predictor of domestic and sexual violence; that patients who have experienced domestic and sexual violence are at a greater risk of injury when they leave the relationship; and that patients who have experienced domestic and sexual violence were able to make appropriate choices about how to handle their situation.

Comparison of the pre- and post-training responses found a significant increase in the total number of questions answered correctly. At Camden & Islington NHS Foundation Trust scores rose from an average of 4.3/7 prior to training to an average of 5.2/7 post-training (p=.002). Similarly, scores at Sussex Partnership NHS Foundation Trust rose from an average of 4.5/7 prior to training to an average of 5.3/7 post-training (p<.001).

Analysis of responses to individual questions found an increase in the proportion of correct answers for all questions except one: a small decrease was observed in the number of participants correctly answering that that they have a duty of care to consider an instance of a child witnessing domestic violence in terms of child protection, even if the child is not in immediate danger.

However, despite the increase in correct responses following training, only 65.8% of participants completing the post-training questionnaires correctly answered that alcohol consumption was not the greatest single predictor of domestic or sexual violence, and 50.4% correctly reported that patients who have experienced domestic or sexual violence were able to make appropriate choices about how to handle their situation.

Limited conclusions can be drawn regarding knowledge retention due to low levels of participation in the follow-up survey. However, there was no significant difference between responders and non-responders to the follow-up in the total post-training score. Analysis found that for participants who took part in the follow-up survey, there was no significant reduction in knowledge score.
Table 2: Knowledge about DSV s both Camden & Islington NHS Foundation Trust and Sussex Partnership NHS Trust

<table>
<thead>
<tr>
<th>Total Sample</th>
<th>Camden &amp; Islington NHS Foundation Trust</th>
<th>Sussex Partnership NHS Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Correct answers pre-training</td>
<td>Correct answers post-training</td>
<td>Correct answers pre-training</td>
</tr>
<tr>
<td>Alcohol consumption is the greatest single predictor of domestic/sexual violence? (FALSE) (n (%))</td>
<td>64 (41.8)</td>
<td>98 (65.8)</td>
</tr>
<tr>
<td>If you suspect a patient is experiencing violence but they do not disclose it you should NOT document your concerns in their medical records (FALSE) (n (%))</td>
<td>121 (79.1)</td>
<td>126 (84.0)</td>
</tr>
<tr>
<td>Being supportive of a patient’s choice to remain in a domestically/sexually abusive relationship would condone the abuse (FALSE) (n (%))</td>
<td>113 (74.3)</td>
<td>117 (80.4)</td>
</tr>
<tr>
<td>Patients who have experienced domestic/sexual violence are able to make appropriate choices about how to handle their situation (TRUE) (n (%))</td>
<td>65 (43.6)</td>
<td>72 (50.4)</td>
</tr>
<tr>
<td>Patients who have experienced domestic/sexual violence are at a greater risk of injury when they leave the relationship (TRUE) (n (%))</td>
<td>87 (58.0)</td>
<td>132 (87.4)</td>
</tr>
<tr>
<td>Allowing partners or friends to be present during the consultation of a patient who has experiences domestic/sexual violence ensures their safety (FALSE) (n (%))</td>
<td>103 (69.1)</td>
<td>132 (88.0)</td>
</tr>
<tr>
<td>Clinicians have a duty of care to consider an instance of a child witnessing domestic violence in terms of child protection, even if the child is not in immediate danger (TRUE) (n (%))</td>
<td>154 (100)</td>
<td>135 (98.5)</td>
</tr>
<tr>
<td>Total number of correct answers (mean ±SD))</td>
<td>4.41 (1.57)</td>
<td>5.22 (1.60)</td>
</tr>
</tbody>
</table>
Knowledge about how to respond to domestic and sexual violence

Participants’ perceptions of their preparedness to respond to domestic and sexual violence are shown in Figure 3.

Prior to training, over half of the participants expressed "low" or "very low" levels of knowledge regarding responding to perpetrators of domestic and sexual violence (67.1%) and documenting domestic and sexual violence in a patient’s medical records (54.9%). Low levels of knowledge were also reported regarding local and national policies on reporting domestic and sexual violence (51.3%); creating a safety plan for a patient who has experienced domestic and sexual violence (50.3%); and how to help a patient who has experienced domestic and sexual violence to assess their risk of harm (50.0%). Just under half of the participants reported low levels of knowledge about the stages of change a patient may experience in understanding and changing their situation (44.1%), understanding of what to say or not to say to a patient who has experienced domestic and sexual violence (42.5%) and what to ask to identify potential cases of domestic and sexual violence (40.5%). Over a third of participants expressed low levels of knowledge regarding how to make appropriate referrals for patients who have experienced domestic and sexual violence (39.0%) and health problems commonly experienced by patients who have experienced domestic and sexual violence (38.7%).

Immediately following training, professionals reported an increase in their perceived knowledge of how to respond to domestic and sexual violence. Post-training, over three-quarters of participants reported having "quite a bit" or "a lot" of knowledge about why a patient might not disclose domestic and sexual violence (82.7%); what questions to ask to identify potential new cases of domestic and sexual violence (82.1%); their role in identifying and responding to domestic and sexual violence (80.0%); signs and symptoms associated with domestic and sexual violence (77.9%); and what to say/not to say to a patient experiencing domestic and sexual violence (76.1%). More than two-thirds reported "quite a bit" or "a lot" of knowledge about how to make appropriate referrals for patients who have experienced domestic and sexual violence (72.2%) and how to help a patient who has experienced domestic violence to assess their risk of harm (67.1%).

However, under two-thirds of participants reported knowing "quite a bit" or "a lot" about the common health problems experienced by people who experience domestic and sexual violence (62.8%); the local and national policies on reporting domestic and sexual violence (58.3%); the stages of change a patient experiences in understanding and changing their situation (56.3%); and how to document domestic and sexual violence in a medical record (52.3%).

When examining the pre- and post-training scores there was a significant increase in perceived knowledge levels for all questions (p < .001), with no difference in response between the two NHS Trusts.

Analysis of follow-up data suggested good overall retention of knowledge about how to respond to domestic and sexual violence, although the sample size is small. Some significant reductions in knowledge levels were, however, observed, included with regards to what questions to ask to identify potential cases of domestic and sexual violence (84.9% vs. 75.3% reporting knowing "a lot" or "quite a bit"; p = .017);
what to say and what not to say to a patient who has experienced domestic and sexual violence (84.9% vs. 54.8%; vs. p=.039); how to help a patient who has experienced domestic and sexual violence assess their risk of harm (82.3% vs. 46.9%; p=.007); and how to make appropriate referrals for patients who have experienced domestic and sexual violence (72.7% vs. 46.9%; p=.039).
Figure 3 – NHS professionals’ perceived knowledge of how to respond to domestic and sexual violence prior to and immediately after training.
Readiness to respond to domestic and sexual violence

Professionals’ perceptions of their readiness to respond to domestic and sexual violence prior to and immediately after training are shown in Figure 4. High levels of agreement were observed at baseline regarding healthcare professionals’ responsibility to respond to suspected cases of domestic and sexual violence (96.7%), as were high levels of disagreement that healthcare professionals’ could do little to help patients who did not acknowledge their experiences of abuse (73.3%).

Significant improvements were observed across several key indicators following training. In particular, the proportion of participants reporting that they had not had sufficient training to assist patients who had experienced domestic and sexual violence dropped from 44.7% to 22.5% (p<0.001); the proportion agreeing that they were comfortable discussing domestic and sexual violence with patients increased from 67% to 88.7% (p<0.001); and the proportion of participants agreeing they felt confident to accurately and confidently document domestic and sexual violence rose from 46.7% to 75.5% (p<.001). Prior to training, the proportion of participants reporting that they could match therapeutic interventions to the “Readiness To Change” of a patient who has experienced domestic violence was 34.3%. This increased significantly (p<0.001), but remained relatively low at 56.4%.

Improvements were also observed with regards to professionals’ confidence to make appropriate referrals. Significant improvements were seen in confidence to make referrals for women (56.2% vs. 88.9%, p<0.001) and children (50% vs. 82.8%, p<0.001) who had experienced domestic and sexual violence. Confidence to refer men who had experienced domestic and sexual violence also improved significantly (26% vs. 61.3%, p<0.001), although remained lower than for women and children. Post-training there was a small but significant decrease in the proportion of participants agreeing that the police should be called immediately if a person was suspected to have experienced domestic or sexual violence (13.7% versus 10.7%, p<0.001).

Although the proportion of participants reporting that their workplace encouraged them to address domestic and sexual violence increased significantly after training from 72.6% to 85.4% (p<.001), less change was observed with regards other workplace-related factors. This included the proportion agreeing that their workplace allowed them enough time to ask about domestic and sexual violence (71.2% vs. 73.6%) and that they had adequate time to respond to patients with experiences of domestic and sexual violence (58.3% vs. 59.5%).
Figure 4: Professionals' perceptions of readiness to respond to domestic and sexual violence

<table>
<thead>
<tr>
<th>Number</th>
<th>Statement</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Healthcare workers have a responsibility to respond to suspected cases of domestic/sexual violence</td>
<td>85%</td>
</tr>
<tr>
<td>2</td>
<td>My workplace encourages me to address issues of domestic/sexual violence</td>
<td>75%</td>
</tr>
<tr>
<td>3</td>
<td>My workplace allows me enough time to ask about domestic/sexual violence if I suspect a person might be being abused</td>
<td>65%</td>
</tr>
<tr>
<td>4</td>
<td>I feel comfortable discussing issues of domestic/sexual violence with patients</td>
<td>60%</td>
</tr>
<tr>
<td>5</td>
<td>I am able to gather the necessary information to identify domestic/sexual violence as the underlying cause of patient's illness (e.g., depression)</td>
<td>55%</td>
</tr>
<tr>
<td>6</td>
<td>If a patient who has experienced domestic/sexual violence does not acknowledge the abuse, there is very little that I can do to help</td>
<td>50%</td>
</tr>
<tr>
<td>7</td>
<td>My practice setting allows me adequate time to respond to patients who have experienced domestic/sexual violence</td>
<td>45%</td>
</tr>
<tr>
<td>8</td>
<td>There is adequate space for me to provide care for patients who have experienced domestic/sexual violence</td>
<td>40%</td>
</tr>
<tr>
<td>9</td>
<td>I do not have sufficient training to assist individuals in situations of domestic/sexual violence</td>
<td>35%</td>
</tr>
<tr>
<td>10</td>
<td>I am confident I can document domestic/sexual violence accurately and confidentially</td>
<td>30%</td>
</tr>
<tr>
<td>11</td>
<td>I should call the police immediately if I suspect that a person has been domestically/sexually abused</td>
<td>25%</td>
</tr>
<tr>
<td>12</td>
<td>I can match therapeutic interventions to the readiness to change of a patient who has experienced domestic violence</td>
<td>20%</td>
</tr>
<tr>
<td>13</td>
<td>I am confident I can make the appropriate referrals for women who have experienced domestic/sexual violence</td>
<td>15%</td>
</tr>
<tr>
<td>14</td>
<td>I am confident I can make the appropriate referrals for men who have experienced domestic/sexual violence</td>
<td>10%</td>
</tr>
<tr>
<td>15</td>
<td>I am confident I can make the appropriate referrals for children (under 18) who have experienced domestic/sexual violence</td>
<td>5%</td>
</tr>
</tbody>
</table>
Study 2: Qualitative research with frontline staff

Focus groups were held with frontline staff from the two Trusts to explore (1) experiences of identifying and responding to domestic and sexual violence, and (2) awareness of and participation in the PRIMH intervention. Focus group attendance was not mandatory and evaluation findings should be interpreted in the context of the sample being a self-selected group of NHS professionals likely to have had a particular interest in domestic and sexual violence.

Findings from baseline focus groups are reported in the interim project report. Baseline findings highlighted that prior to the PRIMH project many staff felt poorly equipped to enquire about and respond to domestic and sexual violence, and that enquiry about abuse was inconsistent across services. Participants reported a range of barriers to enquiry, including fear of re-traumatising service users, anxiety about not knowing what to do if abuse was disclosed, and discomfort due to personal experiences of abuse. Heavy workloads and competing priorities were also frequently cited as barriers to enquiry, with professionals reporting a lack of time firstly to build trusting relationships in which service users would feel comfortable to disclose experiences of abuse and secondly to be able to respond appropriately.

Sample

Four focus groups were conducted at baseline, attended by 21 members of staff (7 at Camden and Islington NHS Foundation Trust and 14 at Sussex Partnership NHS Foundation Trust). Six focus groups were conducted during the post-intervention phase, attended by 36 members of staff (21 at Camden and Islington NHS Foundation Trust and 15 at Sussex Partnership NHS Foundation Trust). Team-specific focus groups were held at Camden and Islington NHS Foundation Trust in the post-intervention phase due to difficulties recruiting participants to multi-team focus groups; three teams participated.

Role in responding to domestic and sexual violence

Professionals attending the post-intervention focus groups perceived three major roles for mental health professionals with regards to domestic and sexual violence.

Firstly, they reported that because domestic and sexual violence was a risk to the safety of their service users and impacted on service users' mental health, they had a duty understand, identify, and report it. Most professionals spoke about this duty in the context of working for a statutory service, although others also suggested that they had a moral responsibility to respond. Several highlighted that the development of Trust policies on domestic and sexual violence and the provision of basic information and training at staff inductions was important in not only informing staff about how to respond but also in setting an expectation that responding to domestic and sexual violence was everyone's business.

Secondly, they suggested that mental health professionals' role included educating service users about abuse. Several described how many service users did not recognise that they had been the victims - or perpetrators - of abuse, creating a barrier to disclosure and referral. In this context, professionals suggested that providing education and information to service users about abuse was a crucial component of how services
responded to domestic and sexual violence. Participants working in learning disability teams also highlighted a role for professionals in assessing service users’ understanding of relationships and abuse.

Finally, professionals described their role in terms of making referrals to safeguarding and to specialist domestic and sexual violence agencies external to the Trust. In relation to this point, several participants suggested that mental health services were limited in what direct support they could currently provide for people with experiences of domestic and sexual violence.

In order to fulfil these roles, professionals suggested it was important for mental health professionals to be aware of the prevalence, risk, and signs of domestic and sexual violence; to be aware of what procedures to follow if domestic and sexual violence was disclosed or suspected; to provide an opportunity for disclosure; and to provide information about available support.

Frontline professionals and managers attending focus groups made a number of recommendations for how Trusts could support them in fulfilling these responsibilities. At a basic level, professionals suggested that services should advertise to service users that they could speak in confidence to members of staff about their experiences of abuse. Safe implementation of this recommendation would require staff to be equipped to respond safely to disclosures of abuse. It should, however, be considered for services that have undertaken domestic and sexual violence training. Professionals also suggested that the Trusts should go further in providing services for victims and perpetrators of domestic and sexual violence, including through the appointment of a specialist domestic violence worker and the provision of specialist therapeutic and other support services.

Identifying domestic and sexual violence: current practice

Frontline professionals attending the post-intervention focus groups reported that current practice and confidence to enquire about domestic and sexual violence was variable across the Trusts.

Participants reported that many members of staff found it difficult to ask about domestic and sexual violence, describing it as a “sensitive” and “delicate” area. They suggested it was important that staff be trained in how to ask about domestic and sexual violence, and highlighted in particular the need for new members of staff to be supported to do so.

Although participants from a number of services reported that questions about experiences of abuse formed part of their standard assessment forms, other participants suggested that this was not uniformly the case. Professionals who asked about domestic and sexual violence as part of standard assessment processes also varied in the extent to which they were comfortable doing so. Some reported that asking the question of every service user made them comfortable over time and that domestic and sexual violence was just one of a number of difficult topics covered during assessments. Others explained that it was important not to make assumptions about to whom questions about domestic and sexual violence would be relevant, and that asking about abuse as part of standard practice avoided this.

Several professionals reported feeling less confident to ask about perpetration of domestic and sexual violence than they
were asking about domestic and sexual violence victimisation.

Ward staff were not represented in the focus groups, but a number of staff from other services expressed their opinions that responses to domestic and sexual violence were in particular need of improvement in ward settings. They suggested that awareness of domestic and sexual violence was lower on wards, where the focus was on diagnosis and symptom management, and that the environment of the ward was not conducive to disclosure (for example, due to a lack of privacy). Concerns were also expressed by one member of staff that disclosures of violence were sometimes dismissed and attributed to delusions.

**Responding to domestic and sexual violence: current practice**

Two forms of response to disclosures of domestic and sexual violence were described. Firstly, staff described alerting others to the potential risk of harm through speaking with their managers, initiating safeguarding procedures, and making referrals to children’s social services, or, less commonly, to multi-agency risk assessment conferences (MARAC). Although staff reported that MARACs were helpful for information sharing, they also expressed frustration at the lack of concrete actions that arose from the meetings. Secondly, staff described making referrals to external support agencies that had specialist knowledge about domestic and sexual violence. Staff described themselves as less confident about how to respond to perpetrators of domestic and sexual violence, and suggested there was a need for more guidance on this. In particular they expressed concerns about how to seek further information following a disclosure of violence perpetration, avoiding collusion, referral procedures, and appropriate options for intervention.

A further issue of concern for many members of staff, which was voiced across several focus groups, was what to do when patient did not want any action taken in response to a disclosure of domestic or sexual violence victimisation. Staff described feeling powerless and frustrated under these circumstances, and described service users’ decisions to return to their abusive partners as emotionally challenging.

Despite these feelings of frustration, staff recognised the importance of providing support to patients who remained in abusive relationships, describing how staff should not only work to assess patients’ safety but also to ensure they were treated with dignity and respect. Indeed, some staff suggested mental health services had a tendency to expect too much too quickly after a disclosure, and cautioned against assuming patients were willing and able to leave abusive relationships or to take up referrals to external support agencies.

However, many professionals also expressed dissatisfaction regarding what they could offer patients who did want support following a disclosure of domestic or sexual violence. This was in relation both to what could be offered within the Trust and to the availability of external support. Provision was felt to be particularly lacking for men, both for victims and perpetrators.

Most professionals attending the post-intervention focus groups were familiar with domestic violence agencies in their local area. Yet, several described instances of having made referrals that seemingly disappeared into the "ether" or the "abyss", and explained that they did not understand what happened to information
once a referral had been made. Others highlighted that they did not have enough time to support patients to engage with external agencies. The most frequently raised issue, however, was the availability of support from external domestic violence agencies. Participants described that cuts to local agencies had resulted in fewer services, longer waiting lists, and the loss of specialist posts. Waiting lists operated by services supporting women victims of domestic and sexual violence were reported to be as long as six months in some cases, and participants reported that some external agencies did not accept referrals for people with mental health or substance use problems. Situations in which patients were discharged from services - or from crisis care - before external support had been secured was a concern for a number of professionals, who felt it was "risky" for patients to begin to talk about their experiences without the security of ongoing support. Some professionals in these situations described having argued to keep patients on their caseload beyond the point they would have usually been discharged.

**Identifying and responding to domestic and sexual violence: facilitators**

The key facilitators to identifying and responding safely to domestic and sexual violence, as described by frontline professionals attending post-intervention focus group interviews were: (1) working within a supportive team environment; (2) having access to internal and external expertise; (3) domestic and sexual violence enquiry being part of normal practice; (4) having well-developed systems for information sharing; and (5) suitable referral options being available.

Several participants explained that identifying and responding to domestic and sexual violence could be complex and emotionally difficult. Participants described that working within a supportive team environment helped them to manage this. Supportive teams were described as providing staff with regular supervision, opportunities to discuss challenging cases at multi-disciplinary meetings and debriefings, and time to attend multi-agency information sharing meetings. Participants from these teams described there being an expectation that domestic and sexual violence would be enquired about as part of normal practice, and that new members of staff in particular were provided with support and advice about how to ask about domestic and sexual violence. Participants also described the importance of feeling part of a team, which they explained as having someone to talk to about concerns. Closely related to this was having access to advice on identifying and responding to domestic and sexual violence. Safeguarding leads were described as an important source of advice and information, and participants were supportive of plans to introduce domestic and sexual abuse "link practitioners" into the Trusts. However, participants also spoke about the expertise within their teams and described that being in close physical proximity to their colleagues helped them to draw on the resources and knowledge of their colleagues.

A number of participants also spoke positively about their relationships with external domestic and sexual violence agencies, and how drawing on the expertise of these agencies improved their response to service users who had experienced these forms of abuse.

Participants described that being in contact with colleagues and other agencies important not only for developing their own understanding of domestic and sexual
violence, but also sharing information about risks to service users and the actions that were being taken in response to these risks. Electronic care records facilitated information sharing within Trusts, and participants were generally satisfied with the information access that this provided them with. Electronic care records could also provide an opportunity to integrate questions about abuse into routine assessment forms, reinforcing the message that asking about domestic and sexual violence was part of normal practice.

Experiences of information sharing across agencies, however, were suggested to be more variable and, often, dependent on personal relationships with agency contacts.

Finally, participants spoke about the importance of having suitable referral options for service users who had experienced domestic and sexual violence. In particular, they highlighted the importance of having access to specialist domestic and sexual violence agencies that were able to work with service users over a sustained period of time, and which were aware of the needs of service users with mental health problems.

**Identifying and responding to domestic and sexual violence: barriers**

Participants described several barriers to identifying and responding safely and effectively to service users who had experienced domestic and sexual violence including (1) lack of time; (2) lack of knowledge and expertise; (3) lack of practical and emotional support; (4) reluctance of service users to disclose abuse or accept referrals; (5) lack of referral options. Similar barriers were described during pre-intervention focus groups.

Analysis suggested that some professionals viewed identifying and responding to domestic and sexual violence as additional rather than integral to their clinical and therapeutic duties. In the context of what staff described as competing institutional priorities and heavy workloads, the time needed to ask about and respond to domestic and sexual violence was suggested to pose a barrier to enquiry. In addition to talking about the need to take time to develop supportive and trusting relationships in which to discuss issues of abuse, staff also described how following-up disclosures of abuse with paperwork, referrals, and meetings was time-consuming. This was reported to be exacerbated by a lack of cover - which prevented attendance at meetings and at training sessions- and, for some staff, a lack of information sharing within and between services and a lack of easily accessible guidance on how to respond.

The need for clearer and more accessible guidance came up across several focus groups, suggesting that a lack of knowledge and expertise continued to be a barrier to enquiry about domestic and sexual violence for some professionals. Concerns focused more on how to respond to a disclosure of violence than on how to ask about violence, and staff highlighted in particular the need for more information on how to respond to perpetrators, how to escalate risk issues, and what to do if service users did not want onward referrals to specialist services. Some staff reported that this information was not readily accessible on Trust Intranets. Misconceptions about the types of behaviours that constituted domestic and sexual were also described as potentially hindering effective responses to these forms of abuse by other staff, as was personal discomfort in asking - and hearing - about abuse.
Indeed, many members of staff described experiencing feelings of frustration, powerlessness, and upset when working with service users who had experienced domestic and sexual violence, particularly when service users came to understand that they had been abused, returned to abusive relationships, turned down referrals for further support, or had to wait to access support following referral. Several participants perceived that the emotional and practical support they needed to cope with these feelings was lacking within Trusts, and described this as a barrier to identifying and responding effectively to domestic and sexual violence. Some participants attributed this to feeling disconnected from their team, describing that because of heavy workloads or extensive travel to and from appointments they spent little time with their colleagues. Others reported that the focus of supervision sessions had changed over time to be less supportive.

Participants also spoke about the reluctance of service users to disclose experiences of violence. Suggested reasons for this reluctance included a lack of awareness that what they had experienced constituted abuse; fears of not being believed, of being judged, and of the involvement of social services; and, in cases where both partners were in contact with services, concerns about the potential impact of a disclosure of violence on their partners’ access to care. Staff explained that they could do little to help service users who had or were currently experiencing abuse if no disclosure was made, even if they had a sense that something was “not right”. This contrasted with findings of the staff survey, in which a high proportion of staff both prior to and after training disagreed that there was little they could do to help patients who did not acknowledge their experiences of abuse. Several participants also reported that many service users who disclosed abuse did not want to be referred for further support, or that they disengaged from external agencies having been referred. Staff again reported that in this context they felt there was little they could do to support service users.

Although the majority of participants were aware of domestic and sexual violence agencies in their local area, several participants perceived that suitable referral options were lacking. This was particularly acute for perpetrators and for male victims but, as described above, was also a problem in relation to services for female victims of violence. A number of participants also highlighted the lack of referral options within Trusts, highlighting in particular the lack of psychology provision for service users with experiences of domestic and sexual violence.

**Awareness and experience of the PRIMH intervention**

The majority of professionals attending the post-intervention focus group interviews reported that their knowledge of and engagement with PRIMH was limited to having attended the domestic and sexual violence training developed and delivered through the project. Awareness of the broader PRIMH project was limited even among those who attended the training, with the majority reporting little or no awareness of the training having been part of a broader initiative or of the name of those initiatives. Focus group moderators therefore provided participants with information about other aspects of the project and solicited their views.

Participants were generally enthusiastic about the development of a domestic and sexual violence policy. Although some
participants suggested it was more important to have access to people who could provide advice than to a policy document, many argued that having a specific policy on domestic and sexual violence sent out a clear message that the issue was being taken seriously by the Trusts. One participant also stated that having a specific policy was important because domestic and sexual violence should not be subsumed within safeguarding, although there were important links between the two.

The majority of professionals attending focus groups also supported the creation of the network of domestic and sexual abuse link practitioners, with some asking for information about how they could be involved in this initiative. Others were critical, however, of the expectation that staff would take on link practitioner roles in addition to their existing responsibilities.

Feedback regarding the quality of training was positive. Through the PRIMH project, brief information about domestic and sexual violence was integrated into safeguarding training and more detailed information provided in three hour standalone training sessions. A number of participants reported that the PRIMH trainings were the first domestic and sexual violence trainings they had accessed and that the provision of training signalled the importance of the issue to the Trusts. The integrated training was described as having been useful in providing a basic introduction to the issue and highlighting what services were available locally, but as insufficient to equip staff to respond to domestic and sexual violence. In particular, staff highlighted that more information was needed about what to do when domestic and sexual violence was identified. Focus group participants who had attended the standalone training sessions described them as accessible, clear, and practical. Praise was also given for the style of delivery, particularly the use of open discussion, and the provision of information about referral pathways.

However, even participants attending these extended training sessions reported that they were too brief to fully meet their needs. Participants also suggested that training could be developed further to provide tailored advice to specific service areas such as substance misuse, older adults, and learning disability.

Several participants expressed the view that training on domestic and sexual violence should be made mandatory; this finding should be interpreted within the context of the sample being likely to have a higher than average interest in domestic and sexual violence. Participants explained that training that was not mandatory competed for time with training that was, and attendance depended on being able to make a case to managers about its importance. Others suggested that training should not be provided on a one-off basis, and recommended "booster sessions" be provided to refresh skills.

A number of staff, however, reported that they had not been aware that training had been taking place. They explained that because they received so many emails, information communicated only in this way was likely to be overlooked. Others reported that they had known about the training but had not been able to attend as soon as they would have liked because the timing or location of the training session was inconvenient.
3. Satisfaction, health, and wellbeing of service users who have experienced domestic and sexual violence.

Sample

Interviews were conducted with 37 service users; 20 from Camden and Islington NHS Foundation Trust (54.0%) and 17 from Sussex Partnership NHS Foundation Trust (46.0%). Twenty interviews were conducted prior to the implementation of the PRIMH intervention, and 17 post-intervention.  

As shown in Table 3, the majority of participants were female (34/37; 91.9%), with a mean age of 41.9 (±10.4) years. Most participants were single, separated, divorced, or widowed, although just under a quarter reported being currently married or cohabiting with a partner. Participants had been in contact with mental health services for a mean of 12.5 years (±9.4); diagnoses included depressive disorders (n=21), anxiety disorders (n=18), PTSD (n=17), substance abuse disorders (n=6), schizophrenia and related disorders (n=5), personality disorders (n=6), eating disorders (n=4), and bipolar disorder (n=2). Ten participants reported that they had been admitted as psychiatric inpatients in the year prior to interview.

Experiences of violence

Thirty-four participants (94.4%) reported having ever been hit, kicked, bitten, pushed, or hurt by a partner or a family member. Twenty-nine participants had experienced this form of physical violence from a current or former partner, 21 from a parent or step-parent and 16 from another family member. Ten had experienced this form of physical violence in the year prior to interview.

Four-fifths of participants reporting this form of abuse reported having been physically injured the last time this happened to them (27/34; 79.4%). Participants also reported experiencing fear (n=30), vulnerability (n=28), difficulty sleeping (n=25), depression (n=24), and helplessness (n=24).

| Table 3 - Sample characteristics (n=37) |
|---------------------------------------|------------------|
|                                       | N=37 (%)         |
| Gender                                |                  |
| Male                                  | 3 (8.1)          |
| Female                                | 34 (91.9)        |
| Marital status                        |                  |
| Single                                | 21 (56.8)        |
| Married/Cohabiting                    | 9 (24.3)         |
| Separated/Divorced/Widowed            | 7 (18.9)         |
| Clinical diagnosis*                   |                  |
| Anxiety disorder                      | 18 (48.7)        |
| Bipolar Disorder                      | 2 (5.4)          |
| Depressive disorder                   | 21 (56.8)        |
| Eating disorder                       | 4 (10.8)         |
| Personality disorder                  | 6 (16.2)         |
| Post-traumatic stress disorder        | 17 (46.0)        |
| Schizophrenia and related disorders   | 5 (3.5)          |
| Substance abuse disorder              | 6 (16.2)         |
| Admitted as an inpatient in the past year | 10 (27.0)     |
| Mean duration of mental health service contact (SD) (years) | 12.5 (9.4) |

* Column total >37, as 23 participants had more than one clinical diagnosis
Twenty-three participants (65.7%) reported having been attacked with a weapon: 17 by a current or former partner, eight by a parent or step-parent, and six by another family member. Eight participants had been attacked in this way in year prior to interview. Four-fifths of participants reporting this form of abuse reported having been physically injured the last time this had happened to them (19/23; 82.6%). Participants also reported difficulty sleeping (n=20), fear (n=19), feeling vulnerable (n=19), crying (n=18) and depression (n=15).

Participants also reported financial abuse and coercive control. Twenty-two participants (22/35; 64.7%) reported having ever been prevented from having a fair share of the household money, most commonly by a current or former partner (n=21) but also by parents and step-parents (n=5) and other family members (n=2). Twenty-two participants (22/34; 62.9%) reported that they had ever been prevented from seeing friends or relatives by a current or former partner.

Sexual violence was reported by 86% (32/37) of participants. None reported having experienced this form of violence in the year prior to interview, although six reported having experienced this form of violence in the two years prior to interview. Participants reported that the perpetrators of sexual violence had been current or former partners (n=18), acquaintances (n=14), family members (n=7) and strangers (n=7). Participants consequently reported a loss of confidence, feeling vulnerable, (n=23), fear (n=21), difficulty sleeping (n=21), feeling helpless (n=20) and guilt (n=19).

Most women who took part in the post-intervention interviews reported that mental health professionals had previously asked them about their experiences of physical violence. Although some women reported feeling shame when asked about their experiences of domestic violence, most highlighted the importance of professionals enquiring directly about abuse:

“[When I was asked about domestic violence], oh it was vile, absolutely vile. Just talking about it... I mean, it used to make me... It used to make me feel so ashamed.”

(Rachel, experienced physical and sexual violence)

“I think if it had been kind of delicately, or sensitively enough, asked, with that conversation initiated, I think I probably would have disclosed it. I think it’s important for staff to, you know, initiate that conversation.”

(Olivia, experienced physical and sexual violence)

Indeed, service users commented that although they had seen posters and leaflets about domestic and sexual violence in clinic waiting areas, this was not enough to encourage them to disclose about their experiences in the absence of direct enquiry:

“I’m not sure if I would’ve spoken up about it if I’d just seen a leaflet, [it would] have not been enough for me to go someone and be like, “I’ve seen this leaflet, I want to talk to these people”. So I’m glad that [the service] suggested it.”

All names presented in this section are pseudonyms.
Although the majority of participants reported having been asked about physical violence, several women reported that enquiry about sexual violence had been more limited:

“They didn’t ask me about what had gone on; [my practitioner had] no clue. I mean, there was, you know, sexual coercion went on in that last relationship, she never asked me.”

Although participants emphasised the importance of professionals asking about domestic and sexual violence, they also highlighted a range of barriers to disclosure. Barriers reported by service users who took part in pre-intervention interviews were described in our baseline report, and included not recognising behaviours as abusive, feelings of guilt and shame, fear of not being believed, and the presence of abusive partners or family members during appointments. Similar barriers were described by the women who took part in post-intervention interviews.

During post-intervention interviews, several service users reported that they had not wanted to disclose their experiences of domestic and sexual violence due to feelings of shame and guilt, fear that speaking about their experiences of abuse would be re-traumatising, and fear of not being believed:

“It does trigger a lot of...In your head.”

“[Sexual violence] wasn’t really touched upon that much, to be honest...It would be difficult to talk about, but I think it’s obviously very relevant”

Participants also spoke about feelings of embarrassment being a barrier to disclosing sexual violence:

“I hate it when somebody asks me about [sexual violence]...I just want to shut the person out. I feel embarrassed to explain it. But it’s sometimes good to explain it, to explore it.”

Fear of not being believed was particularly acute for women who perceived that they were not stereotypical victims of domestic and sexual violence. Others reflected that they had not recognised what they had been experiencing within relationships as abuse, or that they had blamed themselves for their experiences.

Yet others reported having had limited opportunity to discuss their experiences of abuse, including because their treatment focused on their diagnosis and symptoms rather than on factors such as domestic and sexual violence, which they perceived as key to understanding their needs:
“It was more for my anxiety and depression rather than the kind of root cause of it which I feel is the thing that I really need to sort of talk about and sort out really.”

(Grace, experienced physical and sexual violence)

“The outcome is that I’ve had from my care what I could have had even if I’d never experienced abuse, because they focused on the Asperger’s. Yes, they’re very reluctant to put the sort of PTSD label on it”

(Anna, experienced physical and sexual violence)

Satisfaction with services

Service users were asked to rate their satisfaction with Trust responses to their experiences of domestic and sexual violence using the Client Reported Outcomes questionnaire. No significant differences in satisfaction were detected when comparing responses prior to and after the implementation of PRIMH. Similarly, scores on the Client Satisfaction Questionnaire indicated no significant change in levels of satisfaction over time (p=0.955) and no significant difference in levels of satisfaction between sites (0.483).

Table 4 shows participants’ satisfaction with Trust responses to their experiences of domestic and sexual violence. Overall, half of the participants agreed or strongly agreed that staff at their service were well-informed about violence and abuse, with less than 15% of participants disagreeing with this statement. Similarly, more than half of participants agreed or strongly agreed that they could recognise abusive behaviour (27/36); that they felt comfortable talking about their experiences of violence and abuse with staff at their service (23/36); and that their experiences of violence and abuse were taken seriously (19/35). However, only 58.3% (21/36) of participants reported that they would recommend their current service to someone who had experienced violence.
Table 4: Service user satisfaction with Trust responses to domestic and sexual violence

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree/Disagree</th>
<th>Not Sure</th>
<th>Strongly Agree/Agree</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>I think that staff at this service are well-informed about violence and abuse (n=36)</td>
<td>5 (13.9)</td>
<td>9 (25.0)</td>
<td>20 (55.6)</td>
<td>2 (5.6)</td>
</tr>
<tr>
<td>I feel comfortable talking about my experience of violence and abuse with staff at this service (n=36)</td>
<td>9 (25.0)</td>
<td>3 (8.3)</td>
<td>23 (63.9)</td>
<td>1 (2.8)</td>
</tr>
<tr>
<td>I think that my experience of violence and abuse are taken seriously by agencies and professionals (n=35)</td>
<td>6 (17.1)</td>
<td>6 (17.1)</td>
<td>19 (54.3)</td>
<td>4 (11.4)</td>
</tr>
<tr>
<td>I feel safe at home (n=36)</td>
<td>7 (19.4)</td>
<td>9 (25.0)</td>
<td>20 (55.6)</td>
<td>-</td>
</tr>
<tr>
<td>I recognise abusive behaviour from others (e.g. violence and control) (n=36)</td>
<td>3 (8.3)</td>
<td>6 (16.7)</td>
<td>27 (75.0)</td>
<td>-</td>
</tr>
<tr>
<td>I am free of abuse/violence but may need support now and then (n=36)</td>
<td>6 (16.7)</td>
<td>5 (13.9)</td>
<td>25 (69.4)</td>
<td>-</td>
</tr>
<tr>
<td>I am confident dealing with authorities, such as housing, benefit departments</td>
<td>20 (55.6)</td>
<td>5 (13.9)</td>
<td>10 (27.8)</td>
<td>1 (2.80)</td>
</tr>
<tr>
<td>I feel informed in my contact with the police (n=33)</td>
<td>13 (39.4)</td>
<td>4 (12.1)</td>
<td>7 (21.2)</td>
<td>9 (27.3)</td>
</tr>
<tr>
<td>I feel supported in my contact with the police (n=33)</td>
<td>13 (39.4)</td>
<td>2 (6.1)</td>
<td>8 (24.2)</td>
<td>10 (30.3)</td>
</tr>
<tr>
<td>I feel supported in the contact I have with criminal/civil and/or family courts (n=35)</td>
<td>11 (31.4)</td>
<td>5 (14.3)</td>
<td>4 (11.4)</td>
<td>15 (42.9)</td>
</tr>
<tr>
<td>I have enough information about the criminal justice system (n=35)</td>
<td>19 (54.3)</td>
<td>5 (14.3)</td>
<td>5 (14.3)</td>
<td>6 (17.1)</td>
</tr>
<tr>
<td>I have enough information about civil and family proceedings (n=34)</td>
<td>14 (40.0)</td>
<td>4 (11.8)</td>
<td>6 (17.7)</td>
<td>10 (29.4)</td>
</tr>
<tr>
<td>It is important to me that the service provides ‘women only’ spaces (n=36)</td>
<td>3 (8.3)</td>
<td>6 (16.7)</td>
<td>23 (63.9)</td>
<td>4 (11.1)</td>
</tr>
<tr>
<td>I have been given information about support services for people who experience violence (n=36)</td>
<td>12 (33.3)</td>
<td>3 (8.3)</td>
<td>19 (52.8)</td>
<td>2 (5.6)</td>
</tr>
<tr>
<td>The service respected my confidentiality (n=36)</td>
<td>3 (8.3)</td>
<td>3 (8.3)</td>
<td>26 (72.2)</td>
<td>4 (11.1)</td>
</tr>
<tr>
<td>I would recommend the service to someone who has experienced violence (n=36)</td>
<td>4 (11.1)</td>
<td>8 (22.2)</td>
<td>21 (58.3)</td>
<td>3 (8.3)</td>
</tr>
</tbody>
</table>
Analysis of interviews conducted prior to the implementation of PRIMH found that service users described professionals' responses to disclosures of domestic and sexual violence as inconsistent both within and between services. While some participants highlighted examples of professionals creating a comfortable and safe environment in which to discuss their experiences of abuse, believing their disclosures, and understanding the seriousness of the violence they were suffering, others reported negative experiences. These included perceptions that an emphasis on clinical diagnosis and medication had overshadowed discussions of their experiences of abuse and its impact on their lives, and reports that responses had been unsupportive, patronizing or blaming.

Some service users described positive encounters in which healthcare professionals had acknowledged the impact of what had happened and reacted swiftly to risk, responses which they perceived as respectful and validating:

“I never felt any... Like I was being judged... You know, or that I should feel silly or anything like that. Just, yes, completely comfortable in that they were there to support me, you know? And completely understood and accepted that the things that I'd experienced were actually really horrible.”

(Elizabeth, experienced physical and sexual violence)

“They treated me very respectfully, because of the urgency with which they dealt with that. It was... Yes, they dealt with it so quickly and so thoroughly. It really did... It actually made me feel very valued and very validated.”

(Olivia, experienced physical and sexual violence)

Analysis of post-intervention interviews similarly found that service users’ experiences of mental health service responses to disclosures of abuse were inconsistent. This was also found during focused analyses of the accounts of the four women - Rachel, Olivia, Donna and Suzanne - who had experienced physical domestic violence in the year prior to interview:

“One service didn’t offer much help at all, and another service was really helpful... [I was] very dissatisfied with one... The other service did a whole safeguarding form, put me in touch with other agencies... They were really thorough. And really, really informative. So it’s very mixed.”

(Olivia, experienced physical and sexual violence)

Although some service users appreciated a rapid response to their disclosures of abuse, others emphasised the importance of being supported to proceed more slowly:

“It was gently, and I think a lot of people have to be a bit more sensitive around you. You can’t have someone that’s just going to go in there and get them to... You feel like you’re going to get interrogated or name and shame the person or, you know, go into great detail”
Related to this, service users described how it could be difficult to understand and act on the information that was given to them in response to a disclosure of domestic and sexual violence, and that it was important to provide support to enable informed decision-making:

“I just think they don’t get how perhaps confused you are, and even women who look really quite capable, perhaps in those situations, and the sort of affect it has on your thinking when you’ve been in that situation for so long, and how that can make it really difficult to make an informed decision, even though you look like someone who’s capable of making an informed decision.”

(Anna, experienced physical and sexual violence)

However, service users also discussed having experienced negative responses from healthcare professionals to whom they disclosed domestic and sexual violence. Several, including service users with past year experiences of abuse, perceived that that staff had been uncomfortable receiving a disclosure of abuse and had not known how to respond:

“I could also kind of tell that they seemed a bit out of their comfort zone, or their depth of dealing with someone who’d just come to them with this”

(Suzanne, experienced physical and sexual violence)

Some service users also described encounters in which they perceived that staff were not listening to – or were being dismissive of – what they were sharing:

“Nobody has asked what took place or how I feel towards what happened. Or whether I would like to speak to somebody. It’s just under the carpet, I guess.”

(Charlotte, experienced physical violence)

Other service users described responses that they perceived as blaming and accusatory or that mirrored the dynamics of their abusive relationships.

Improvements in service responses

Two out of the four post-intervention respondents who had disclosed exposure to domestic and sexual violence in the twelve months prior to interview commented that they had noticed an improvement in service responses to domestic and sexual violence over time, especially with regards to professionals’ awareness of and attitudes to domestic and sexual violence:

“They didn’t used to be [aware], but they are now... Yes, I just think in the last sort of two or three years... Previously it was very much left to me to well, if you’re in a violent relationship you should leave him. That changed quite dramatically about two or three years ago, and they were going, you’re in a violent relationship, we’ve got to help you leave him... ”

(Rachel, experienced physical and sexual violence)
Analysis of all post-intervention interviews (including interviews with women who had not experienced violence in the past year) similarly found that a number of women reported improvements in service responses to domestic and sexual violence over time. However, the timeframe over which women were reporting improvements was not always clear.

**Experiences of accessing Trust therapeutic and support services**

Service users were asked about their access to and perceptions of the usefulness of therapies and other services they had received at the Trusts in relation to their experiences of domestic and sexual violence. Service users had been offered a range of support and therapeutic services, delivered in group and individual settings. Whereas some service users reported that they had benefited from attending support groups, others found talking about their experiences of domestic and sexual violence in a group setting distressing:

“**There are group things and stuff like that...I did try a couple and I was just so anxious at actually being with a group of people, even though it was something, oh this is going to be really helpful, just being with a group of people for me was just such a stressful situation... So it’s like it would almost be like going backwards.**”

*(Elizabeth, experienced physical and sexual violence)*

Another service user highlighted her concerns about the degree to which information shared within a group setting would remain confidential:

“**You could say, oh it’s confidential until you’re blue in face, but... until you know people. I attend a woman’s group here once a week but there are things that I wouldn’t bring up in that group that I would talk about individually with my care co-ordinator.**”

*(Yazmin, experienced physical and sexual violence)*

Particularly mixed experiences were reported in relation to support groups led or facilitated by service users:

“I enrolled in a course at the Recovery College ...I wasn’t very happy with that, I only attended once. There were quite a lot of things that weren’t very appropriate from the course facilitators. It’s a real shame actually because I do think service user led things can be really helpful and empowering”

*(Olivia, experienced physical and sexual violence)*

“They do a peer support group every week which you can just drop into which is good. And they do quite a lot of different courses, depending on whether you’re sort of still in that relationship or like doing recovery stuff.”

*(Sophie, experienced sexual violence)*

More consistency was found in relation to service users’ preferences for having a female therapist and receiving support in women-only spaces:
“[My therapist] knows what it’s like to be a woman in this world... I guess different people work for different people but from my experience, the way that I’ve been treated by often middle-class, sort of slightly old men especially when talking about my experiences which have predominantly been abuse from older men... I just shut down and don’t say anything at all.”

(Tracey, experienced physical and sexual violence)

“I mean for me, I know one of the groups, it was mostly women, but there were a couple of men there, and for me that was... I felt uncomfortable”

(Elizabeth, experienced physical and sexual violence)

However, several service users also spoke about the lack of therapeutic provision through the Trusts, often due to long waiting times but also due to restrictions on the length of time a service user can access a particular therapy:

“I did have some counselling a long time ago, and both times I’ve had sort of... I’ve waited about a year and then chased it up, you know?”

(Grace, experienced physical and sexual violence)

“You can only have 20 weeks and we have to stop now whether you’re okay or not... On the one hand I do appreciate it, and on the other hand it’s a bit like, if somebody had a physical illness and you got halfway through treating them, you wouldn’t say, oh, we’re not allowed to do any more for six months.”

(Elizabeth, experienced physical and sexual violence)

Two participants reported that they had accessed therapies through private providers due to the lack of availability and choice offered to them through their mental health Trusts.

Experiences of accessing external support services

As shown in Table 4, responses to survey interviews conducted after the implementation of PRIMH suggested that many women did not feel informed or supported in their contact with a number of key external agencies: 55.6% (n=20) disagreed or strongly disagreed that they were confident in dealing with housing and benefit departments; 54.3% (n=19) that they had enough information about the criminal justice system; 40% (n=14) that they had enough information about civil and family proceedings; and 39.4% (n=13) that they were informed and support in their contact with the police. However, more than half of women participating in post-intervention interviews reported having been given information about support services for people who had experienced domestic or sexual violence (n=19, 52.8%).

During qualitative interviews, a number of service users reported that they had been referred by mental health professionals to external support services, most often domestic violence agencies. Service users who had been able to access support from domestic violence agencies were generally satisfied with the support that they received from them. However, some
service users reported having experienced long waiting times to access external support services, and also that poor communication – sometimes on the part of the Trust and sometimes on the part of external agencies – had prevented or delayed their access to services:

“I was told that there was a three month waiting list, which was a bit upsetting at the time. But the person told me that they would email me some stuff, which I never received. So, yes, that was kind of the end of that.”

(Suzanne, experienced physical and sexual violence)

This service user, continued on to explain that it was important to have access to other forms of support while waiting to be accepted for external agency support:

“Maybe if there was something in place to support people while they’re on a waiting list, just so that they know that they’re still being helped. There’s still someone they can talk to. They’re still being supported while they wait for whatever service it is they are waiting to access.”

(Suzanne, experienced physical and sexual violence)

Some service users also reported that support groups that they had attended – and found useful – had recently closed:

“They’ve stopped the group now, which is such a shame. It’s been running for about 15 years apparently, and that was the last group. But it was amazing.”

(Charlotte, experienced physical violence)

Quality of life

Quality of life was assessed using the MANSA questionnaire. The questionnaire is scored out of 84, with higher scores indicating higher self-reported quality of life. No significant differences were found when comparing responses prior to and following the implementation of PRIMH (pre= 47.3/84; post= 41.5/84; p=0.117), or when comparing responses between the two Trusts (Camden and Islington NHS Foundation Trust= 45.2/84; Sussex Partnership NHS Foundation Trust= 43.6/84; p=0.666).

Social inclusion

Three aspects of social inclusion were measured: social isolation, social relations, and social acceptance. Questions are self-rated on a Likert scale of 1-4, with higher scores indicating higher perceived social inclusion. No significant differences were found when comparing responses prior to and following the implementation of PRIMH (pre= 2.5/4; post =2.3/4; p=0.388) or when comparing responses between the two Trusts (Camden and Islington NHS Foundation Trust= 2.5; Sussex Partnership NHS Foundation Trust= 2.2; p=0.173). Overall, the mean social inclusion score was 2.38 (±.6)/4, with individual subscales scored as follows: social isolation 2.6/4 (±.7), social relations 2.2/4 (±.7), and social acceptance 2.6/4 (±.7).

Unmet health and social care needs

Unmet health and social care needs were rated by the research team using the Camberwell Assessment of Need for Mothers (Short Version). Among pre-intervention interviewees the mean
The mean number of unmet needs was 6.0 (SD 4.2). Among post-intervention interviewees the mean number of unmet needs was 5.8 (SD 4.3).

Significant differences were identified when comparing unmet health and social care needs prior to and after the implementation of PRIMH. In the post-intervention period, fewer participants were rated as having unmet needs relating to general physical illness, disability or medication side-effects (31.6% vs. 5.9%; $p=0.044$), and help with benefits (35.3% vs. 17.7%; $p=0.018$). However, more post-intervention participants were rated as having unmet needs relating to sleep problems (26.3% vs. 70.6%; $p=0.036$). No differences were found when comparing ratings for the two Trusts.

Overall, the highest levels of unmet needs related to difficulties forming or maintaining close/intimate relationships (54.3%; 19/35), experiencing or continuing to be affected by violence and abuse (47.1%; 16/34), and problems with sleep (47.2%; 17/36). High levels of unmet need were also identified with regards to suffering from psychological distress, anxiety, or depression (41.7%; 15/36), having appropriate accommodation (38.9%; 14/36) and budgeting money (41.2%; 14/34).
4. Key stakeholders’ experiences of the PRIMH project.

Interviews with the project leads, project worker, and safeguarding leads at the two Trusts explored experiences of participating in PRIMH and perceptions of factors that had supported - or challenged - the success of the project. These data were supplemented by the project workers’ reflective logs and minutes from the meetings of the project steering groups at the two Trusts.

Stakeholders’ views

Stakeholders at both Trusts spoke extremely positively about their experiences of participating in PRIMH and the dedicated access to domestic and sexual violence expertise that the project had provided. Interviewees reported that the basic structure of the PRIMH project had worked well and that it was important to be realistic about the extent of organisational change that could be achieved by a project of limited size and duration.

Stakeholders perceived that the project had contributed to increased awareness of domestic and sexual violence among frontline staff and to increased rates of identification. The project and safeguarding leads at Camden and Islington NHS Foundation Trust, for example, estimated a 50% increase in calls from frontline staff in relation to domestic and sexual violence issues. It has not been possible to independently assess this due to limitations in the Trust’s systems for collecting and monitoring domestic and sexual violence data. At both Trusts, safeguarding leads reported that the key concerns for the frontline staff who contacted them were whether to intervene when domestic and sexual violence was identified, and whether to break patient confidentiality in relation to a suspicion or disclosure of domestic or sexual violence.

Stakeholders at both Trusts suggested that further work was needed beyond the end of the PRIMH project to embed domestic and sexual violence into the “core business” of their organisations. Analysis of meeting minutes and other project documentation similarly suggests that for much of the project, Trusts’ ownership of the project was lacking and responsibility for the majority of project actions was held by the project worker and project leads. Some interviewees continued to voice concerns at the end of the evaluation period that responsibility for the project was held by a small number of key individuals, the loss of whom could jeopardise its sustainability. There were also concerns that although high quality training had been developed and delivered through the PRIMH project, attendance at training was not mandatory, and that there had been no improvement in data capture relating to domestic and sexual violence enquiry and response.

However, interviewees also described steps that the Trusts had taken to embed and sustain some of the gains made during the project. At Camden and Islington NHS Foundation Trust, for example, the expectation that the role of Women’s Lead would include responsibilities in relation to domestic and sexual violence became more formalised over the course of the PRIMH project. Such an approach could be usefully taken in relation to other roles in the future (e.g. safeguarding leads and managers). The decision to integrate domestic and sexual violence training into level two and three safeguarding training should ensure that basic information and guidance provision continues at Camden and Islington NHS Foundation Trust beyond the end of the project. “Train the trainer” training has also been provided to
Domestic and Sexual Abuse Link (DASAL) practitioners at the two Trusts to enable the continued provision of standalone domestic and sexual violence training. Both Trusts have agreed to fund AVA to provide ongoing domestic and sexual violence consultancy beyond the end of the PRIMH project, including training and support to the DASAL network.

Interviewees and project documentation also highlighted the difficulties that had been experienced at both Trusts with regards to involving service users in the development and delivery of PRIMH activities. Both project steering groups included a service user representative, whose involvement was described as being very valuable. At Camden and Islington NHS Foundation Trust, the existence of a Women’s Strategy Group meant that a decision was taken not to form a separate survivor reference group to the PRIMH project. Project documentation suggests, however, that the group did not provide regular consistent input into the steering group across the duration of the project, and that there was reluctance to engage current service users in the project due to ongoing and urgent support needs. At Sussex Partnership NHS Foundation Trust no such group existed, and for much of the project the project worker found it difficult to find opportunities to engage with service users about the project due to staff concerns that doing so would be too distressing for service users.

Barriers and facilitators of project success

Perceived risks to project success included a lack of organisational support, resource (both internal and external), and data monitoring capacity; project visibility; and organisational size. Conversely, the availability of dedicated resources and strong organisational support were perceived to increase the likelihood of project success. During post-intervention interviews, external, rather than internal, factors were described as having been influential in raising the priority of domestic and sexual violence within organisations, despite evidence of the prevalence of domestic and sexual violence among service users being perceived as a powerful message within trainings. The characteristics of key project individuals were also described as being important to the success of the project, as was the quality of the training offer.

Organisational support

Interviewees highlighted a number of ways in which organisational support influenced project success, and linked the extent of organisational support for and prioritisation of the project to the resources that were made available to it. The importance of having demonstrable executive level support, for example having a member of the board chair project steering group meetings (as at Sussex Partnership NHS Foundation Trust) or participating in high profile events (as at Camden and Islington NHS Foundation Trust), was highlighted in particular. Interviewees suggested that executive presence had demonstrated to staff that domestic and sexual violence

---

7 The two Trusts have taken different approaches to recruiting DASAL practitioners. At Camden and Islington NHS Foundation Trust staff interested in becoming DASAL practitioners have been asked to put themselves forwards, while at Sussex Partnership NHS Foundation Trust each care group has been asked to nominate a member of staff in order to ensure an even distribution of DASAL practitioners across the Trust. This evaluation does not include analysis of the optimal strategy for ongoing training, which may depend on a variety of factors including the internal structure and geographical spread of the Trusts.
was an important issue for the Trust and helped secure support for the project from service managers across the Trust. Stakeholders at the two Trusts also highlighted the role of external drivers in increasing the priority afforded to domestic and sexual violence by their organisations, thereby increasing support for the project. In particular they highlighted the Care Act 2014 - which added domestic violence to an existing list of categories of abuse from which adults should be protected - as having been important in making domestic violence a greater priority within adult safeguarding. At Camden and Islington NHS Foundation Trust stakeholders also highlighted the importance of a 2014/15 Commissioning for Quality and Innovation (CQUIN) target to ensure that 20% of 1,726 frontline staff were trained to recognise the indicators of domestic violence and abuse and to ask relevant questions to help people disclose their past or current experiences of such violence or abuse, in line with NICE Guidance. Delivery of domestic and sexual violence training through a number of training programmes meant that by the end of the reporting period, this target had been met. Camden and Islington NHS Foundation Trust had also been involved in two domestic homicide reviews (local multi-agency reviews convened after a domestic homicide with the purpose of improving future responses); analyses suggested that this had also been important in increasing the profile and priority of domestic violence within the Trust and in securing senior involvement in the project.

In contrast, interviewees highlighted that insufficient support and representation from across the range of Trust divisions and services had been a risk to project success. Lack of representation reduced the pool of knowledge and expertise available to the project and risked the

particular experiences and needs of certain groups (e.g. older adults, learning disabilities) being overlooked. Furthermore, stakeholders suggested that lack of representation of divisions such as human relations, audit, IT, and communications had reduced project efficiency and impacted on the extent to which responding to domestic and sexual violence could be integrated into organisational business.

Finally, the project coordinators and project worker suggested that a lack of broader support and commitment to the project had meant that responsibility for the majority of project actions fell to them or to a small number of individuals, reducing the rate at which progress could be made and, again, impacting on the extent to which domestic and sexual violence was integrated into organisational business. The availability and willingness of staff to attend steering group meetings and take on project action was suggested to have been negatively influenced by competing priorities within the Trusts.

Organisational size

Participants from both organisations spoke about the difficulty of transforming practice and embedding change in large, complex organisations, particularly in the context of limited resources. The workforces of the Trusts were large and, in the case of Sussex Partnership NHS Foundation Trust, spread over several counties. This posed challenges in terms of the numbers of staff to be trained to identify and respond to domestic and sexual violence and in the distribution and coverage of DASAL practitioners.
Resources

The availability of project resources was also described by stakeholders as key to understanding the extent and rate at which the project could deliver improvements to the two Trusts.

Foremost among these resources was the project worker, who had dedicated time to work on the project and provided access to expertise and knowledge that was not available within the Trusts. The project worker time was provided to each Trust at two days per week: this was described by both organisations as a limiting factor to the extent and speed of progress that was possible within the time frame of the project. Project leads also reported that participating in the project also took up a significant proportion of their time, and suggested that it was important to include this role within their job description and expectations.

Stakeholders also spoke about other resources that they perceived to be important to the success of the project, and reported that their availability varied. Administrative resource and support (e.g. in scheduling, advertising, and managing training, and in advertising the project), for example, was important in ensuring the project worker's time was used to greatest effect. Funding was also needed to run and publicise events.

More broadly, stakeholders highlighted that the success of the project had also depended on frontline staff being released to attend training and being supported (and having capacity) to participate in train-the-trainer sessions and take on link practitioner roles. This - and other resource issues - was suggested to be closely linked to the extent to which the two organisations supported the project and prioritised domestic and sexual violence in relation to other issues. PRIMH was perceived by stakeholders at both Trusts to have received fewer resources (for example in terms of time, funding, and support to ensure staff attended training sessions) than had previous projects such as physical health and smoking cessation.

Staff availability to attend PRIMH domestic and sexual violence training may have also been affected by requirements that all staff attended IT training after both Trusts changed IT systems over the course of the project. Changes in IT systems may have also led to changes in the recording of domestic and sexual violence enquiries and disclosures.

Project visibility

Participants suggested that strong branding and project visibility would be important to project success, for example by demonstrating to staff that the Trusts saw domestic and sexual violence as an important issue and by increasing staff awareness of the problem and of the resources available to them. During post-intervention interviews participants had mixed views on the extent to which the project had achieved high levels of visibility. Most suggested, however, that this aspect of the project could have been stronger, including through greater resourcing and administrative and communications support.

Characteristics of key individuals

Stakeholders from both Trusts spoke highly of the project worker and project leads, and perceived that the success of the project was highly dependent on these individuals' skills and characteristics and on the quality of their working relationships. Interviewees also highlighted the importance of having
interest and commitment from Trust executives and safeguarding managers.

It is difficult to quantify the impact of the change in project worker at the end of year one. However, analysis suggested that both project workers enjoyed good working relationships with the project leads at the two Trusts, with the project benefiting from the synergy between project leads' knowledge about the structure and function of mental health services and the project workers' knowledge about domestic and sexual violence.

At both Trusts enthusiasm for the project was initially high, but the project steering groups' attendance at meetings and participation in project activities reduced over time. In this context, the commitment, resilience, and motivation of both the project worker and the project leads were vital to the progress of the project. Stakeholders also highlighted that the project worker needed to be - and had been - able to provide challenge to existing ways of responding to domestic and sexual violence and to encourage project steering group members to take ownership of the project.

Training strategy

The development and delivery of domestic and sexual violence training was a key component of the intervention at the two Trusts. In addition to providing a three hour standalone training course, the Trusts also integrated information about domestic and sexual violence into induction and safeguarding training.

Senior stakeholders from both Trusts spoke about the high quality of the standalone training sessions and felt this provision was a key strength of the project, with knowledgeable trainers and scenario-based learning. Domestic and sexual violence training was not made mandatory at either Trust, which, in the context of limited time being available to release staff, was perceived as having limited the reach of the training. However, participants also described that as a result of the project, information about domestic and sexual violence had been integrated into induction training. This was suggested to be important in ensuring staff understood that responding to domestic and sexual violence was part of their role at the Trust.

Data collection and monitoring capacity

Participants at both Trusts expressed disappointment with systems for monitoring and reporting data on domestic and sexual violence. They suggested that monitoring rates of enquiry about abuse, the number of safeguarding alerts made in relation to domestic and sexual violence issues, and the number of MARAC referrals made would have not only helped to track the impact of the PRIMH intervention over time, but could have also contributed to the success of the project by increasing accountability and improving the targeting of project actions.

---

8 One participant highlighted that data on MARAC referrals would be difficult to interpret, because some service users may be referred to MARAC by an external agency following contact between the Trust and that agency about the risk to the service user.
Summary

Key findings
Findings from research conducted at baseline suggested that prior to the implementation of PRIMH, responses to domestic and sexual violence at the two participating trusts were inconsistent. Staff reported a lack of preparedness to identify and respond to cases of abuse, and service users reported both positive and negative experiences in relation to enquiry about and responses to domestic and sexual violence. No domestic or sexual violence policy was in place at Sussex Partnership NHS Foundation Trust, and Camden and Islington NHS Foundation Trust’s domestic violence policy had not been updated to include changes to the UK definition of domestic violence and included limited information and guidance about sexual violence. The interim report concluded that there was a clear need to strengthen strategic and operational frameworks for responding to domestic and sexual violence at the two participating mental health trusts.

The PRIMH intervention aimed to improve mental health service responses to domestic and sexual violence, including by developing clear policies and care pathways for service users and staff who disclose experiencing or perpetrating domestic and/or sexual violence; promoting the message that domestic and sexual violence is ‘core business’ for Trusts; creating a workforce that is knowledgeable, skilled and confident in enquiring about and responding to disclosures of domestic and sexual violence; and developing closer links with relevant local domestic and sexual violence multi-agency partnership structures and service providers.

Participants involved in the PRIMH intervention at a strategic level were positive about the project and its potential to achieve change. This evaluation suggests that the PRIMH intervention had important successes despite being modestly resourced (each Trust received only two days per week of project worker time) and running for a period of just 2.5 years.

Policy development
Through the project, Trusts were supported to develop robust policies and procedures for identifying and responding to domestic and sexual violence: Camden and Islington NHS Foundation Trust updated and developed their existing policy and a policy was created at Sussex Partnership NHS Foundation Trust where one had previously not been in place. Policies regarding staff with historical or current experiences of domestic and sexual violence have not yet been developed. Interviews with project stakeholders and frontline staff highlighted, however, that a proportion of Trust staff have experienced abuse.

Workforce development
Domestic and sexual abuse link practitioner (DASAL) networks were created at both Trusts and link practitioners provided with train-the-trainer training in order to support the sustainability of training beyond the life of the project. Training was also provided to 870 members of staff; more than 40% of the Camden and Islington NHS Foundation Trust workforce and 5% of the larger Sussex Partnership NHS Foundation Trust workforce. Data from qualitative studies and pre- and post-training surveys point to the high quality of the PRIMH training.
Integrating domestic and sexual violence training into mandatory level two and three safeguarding training enabled Camden and Islington NHS Foundation Trust to substantially increase training coverage. It is important to note, however, that although the integrated training was well-regarded by staff, it was perceived by safeguarding leads and frontline staff alike as providing only an introduction to the issues of domestic and sexual violence. Longer sessions – as provided by the standalone trainings – were required in order to provide the detailed information and guidance needed to equip staff to identify and respond appropriately. These sessions were very well-received by staff, who described them as high quality, informative, and practical. Staff suggested that refresher or “booster” sessions should be provided in the future to maintain awareness and skills, and recommended tailoring training to service areas, including substance misuse, older adults, and learning disability.

Comparison of pre- and post-training survey data suggests that training was particularly effective in improving staff knowledge of why service users might not disclose experiences of abuse, what questions to ask to identify violence and what to say in response, and how to make appropriate referrals. This is important in the context of the low levels of abuse enquiry and case identification reported by staff immediately prior to training, and service users’ reports that they would be unlikely to disclose experiences of abuse if not directly asked. Less than half of staff reported always or nearly always enquiring about abuse, including with service users presenting with psychosis, depression, anxiety, eating disorders and injuries, and 42% reported having identified no new cases of domestic and sexual violence in the past six months.

Pre-training survey data also suggested inadequate responses to disclosures of domestic and sexual violence: among staff who reported having identified a new case of domestic or sexual violence in the six months prior to training, only 56% had documented it in patients’ records, 51% had provided referral and resource information, and 39% had conducted a safety assessment. Although staff reported improved confidence to respond to disclosures following attendance at PRIMH training, the extent to which behaviour change was achieved and knowledge was retained in the medium to long term is uncertain (see Limitations).

Although a high proportion of staff disagreed both in pre-training and post-training surveys that there was little they could do for service users who did not disclose their experiences of abuse, this was not reflected in focus group discussions. Several focus group participants similarly suggested that there was little they could do for service users who did not want to be referred for external agency support after disclosing domestic or sexual violence. These findings underline the value of reviewing what services are available within Trusts for service users with experiences of abuse, and including information within policy documents, training materials, and safeguarding advice.

Findings also highlighted that staff lacked knowledge and confidence to respond to domestic and sexual violence perpetration. PRIMH was primarily focused on improving mental health service responses to victims of domestic and sexual violence, and this is reflected in the content of policies and training materials developed and delivered during PRIMH. Future work at Camden and Islington NHS Foundation Trust, Sussex Partnership NHS Foundation Trust, and other Trusts...
considering adopting the PRIMH model should take account the need to support staff to address both domestic and sexual violence victimisation and perpetration. Staff highlighted a number of cases in which both the victims and perpetrators were mental health service users; improving responses to domestic and sexual violence perpetration is likely to benefit current and potential victims within mental health services and beyond.

Qualitative research with staff highlighted the importance of not only providing staff with training about how they should identify and respond to domestic and sexual violence, but also of creating a working environment in which they are supported to put their skills into practice. Key points raised by frontline staff included having enough time to ask about and respond to domestic and sexual violence (including time to attend multi-agency safeguarding and risk assessment meetings), and being supported by colleagues to ask about abuse and to cope with the emotional impact of working with abuse. Arrangements for support should be considered particularly carefully for new members of staff and for staff who may have limited face-to-face contact with their team, for example because they are community based or travel between sites.

**Service user and multi-agency involvement and outcomes**

The evaluation found limited evidence of strengthened relationships with local domestic and sexual violence services and of the involvement of service users in informing and influencing service delivery. Stakeholder interviews at both Trusts highlighted that although project steering groups had benefited from each having a service user representative, achieving broader service user engagement with the project had been challenging.

Evaluation findings suggest that Trusts should continue to seek to include service users in the development and delivery of future work to improve responses to domestic and sexual violence. In both pre- and post-training surveys, a high proportion of staff disagreed that service users who had experienced domestic and sexual violence were able to make appropriate choices about how to handle their situation. Service users reported that it could be difficult to understand and act upon information provided by mental health professionals in response to disclosures of domestic or sexual violence, and highlighted the importance of being supported to make informed decisions about referral and support options. Our review of domestic and sexual violence policies found that they did not provide guidance on how to give information and support in a manner that facilitates service user decision-making or make clear reference to the need for staff to explain to service users their roles and responsibilities in relation to domestic and sexual violence. Service user input would be valuable in addressing these points.

Based on qualitative and survey data, it seems unlikely that the project was able to improve service user experience and outcomes over the short project delivery and evaluation time. The implementation of improved policies and procedures for identifying and responding to domestic and sexual violence and rolling out of staff training and support may, however, translate into improved service user outcomes in the future. Although only 27% of service users interviewed had experienced violence in the year prior to interview, 54% reported difficulties forming or maintaining close or intimate relationships and 47% were experiencing or continuing to be affected by abuse. Difficulties with sleeping, anxiety and depression were common, as were
difficulties with housing and budgeting, and more than half lacked confidence dealing with housing and benefits authorities. Housing and financial difficulties are likely to be acute for service users who have left abusive relationships and may contribute to service users’ decisions to remain in, or return to, abusive relationships.

Qualitative data suggested that awareness and visibility of the project among staff was poor, even among staff who had attended domestic and sexual violence training sessions delivered through the PRIMH project. Several post-intervention focus group participants who had not attended training sessions reported that they were not aware that domestic and sexual violence training was available, and a small number reported that they were aware of training but had not been able to attend.

However, the decision of both Trusts to commit resources to maintaining a relationship with AVA beyond the project end date is an extremely positive development, and demonstrates the esteem with which the project has been held and the ‘Trusts’ willingness to recognise domestic and sexual violence as an important issue for their organisations.

Limitations

The evaluation experienced a number of challenges, including a lack of audit capacity to extract information on enquiry and response to domestic and sexual violence, poor response rates to the post-training follow-up survey, and difficulties recruiting service users to survey interviews.

Evaluation protocols had proposed analysing routinely collected data (e.g. information on number of admissions, health of the nation outcome scale [HONOS] scores) and the numbers of MARAC referrals for service users with experiences of domestic and sexual violence pre-and post-intervention if such data could be provided by audit teams. These data would have supported the evaluation of the project’s impact on service user outcomes. Also proposed was analysis of data on rates of routine enquiry, in order to support evaluation of the project's impact on staff behaviour. Trusts were unable to support these requests, including due to a lack of capacity within audit teams.

The conclusions that can be drawn regarding staff behaviour change (i.e. frequency of enquiry about domestic and sexual violence, rates of identification, and actions taken in response to disclosure of violence) during the course of the project are also limited by the low response rate to the post-training follow-up questionnaires. The 158 staff who participated in the pre- and immediate post-training surveys gave consent to be contacted by email to take part in a follow-up survey: responses were received from just 33 (21.2%) of participants, despite several reminder emails and a £250 prize draw incentive. The low response rate also meant that it was not possible to assess whether the gains in knowledge and confidence in identifying and responding to domestic and sexual violence seen in the immediate post-training period were maintained at follow-up.

Finally, recruitment of service users was challenging during both the pre-intervention and post-intervention phases of the evaluation. In order to recruit participants to the service user interviews, mental health professionals across the two participating trusts were asked to identify patients who had experienced domestic or sexual violence and to provide them with
basic information about the study. In the experience of the evaluation team, self-referrals of mental health service users to domestic and sexual violence research are generally low. However, because the identification of domestic and sexual violence by mental health services has also been found to be low, we included self-referral as a supplementary recruitment strategy and advertised the study in Trust waiting areas and through service user networks.

The previous experience of the evaluation team is that mental health service users value the opportunity to talk about their experiences and that participating in research interviews conducted by trained interviewers does not lead to undue distress. However, during the pre-intervention research, mental health professionals raised a number of queries and concerns about referring their service users during presentations by the evaluation team and local clinical studies officers. Concerns included that they did not have the appropriate expertise to sensitively approach their service users about the research, the potential for distress among participants and how this would be managed, what questions service users would be asked during the interviews, and whether new information disclosed by the service user during interview would be communicated to clinical teams. As described in the previous section, similar concerns about service user distress were raised in relation to the project worker speaking with service users in order to engage them in the development and delivery of the PRIMH project. Although we were able to exceed recruitment targets in respect of qualitative interviews, pre-intervention recruitment fell short of target for survey interviews.

During the post-intervention phase of the research, a number of strategies were implemented in an attempt to improve recruitment. These included increasing the number of visits to clinical teams to present baseline findings and answer questions about the research and emails to service managers and frontline staff from senior trust staff to encourage referrals. Recruitment difficulties nonetheless persisted throughout the post-intervention phase of the evaluation, with teams continuing to raise concerns about the sensitivity of the research and, in particular, that they would have to provide additional support to service users who experienced distress as a result of participating in the interviews.

Recruitment in the post-intervention phase therefore continued to be largely dependent on service users self-referring to the research. Although we have been able to collect rich qualitative data on mental health service users' experiences of service responses to domestic and sexual violence, only limited analysis of changes in quantitative measures of wellbeing and service satisfaction has been possible.

We recommend the continued monitoring of the PRIMH project if it is rolled out, and would encourage Trusts to give careful consideration during the planning stages to internal mechanisms for data collection and monitoring.


**Recommendations**

If PRIMH is rolled out more widely, lessons learned from this evaluation could contribute to its future success:

1. Project steering groups should include membership of the executive board and representation from a range of divisions (e.g. nursing, safeguarding, human relations, communications, information technology, and audit) and staff roles (e.g. psychiatry, psychology, and nursing);

2. Trusts should provide internal resources to support the project, including with respect to staff time for project leadership and administration, and funding for communications and events;

3. Project resources should also allow for the creation and maintenance of a strong project brand and visibility;

4. Consideration should be given at an early stage to internal mechanisms for data collection and monitoring;

5. Improving the identification and response to domestic and sexual violence perpetration should be included within the scope of the project;

6. Training should be embedded into long term training provision and structures, and integrated into related training including safeguarding and risk assessment;

7. Link practitioners and train-the-trainers should be selected to ensure service coverage, and the avoidance of over-dependence on Trust lead and project worker;

9. Sustainability planning is needed from the beginning of the project, and may include planning for the provision of specialist services for people who have experienced domestic and sexual violence;

10. Policies and training materials should include information about what staff can do to help service users who do not disclose experiences of abuse; who do not want to be referred to domestic and sexual violence agencies after disclosure; or are on waiting lists for domestic and sexual violence agency support.
References

## Core Principle One: Evidence of an understanding of domestic and sexual violence and its impact

<table>
<thead>
<tr>
<th>Document Type</th>
<th>Number of Key Indicators Present (underline)</th>
<th>Details of Indicators (add phrasing from documentation)</th>
<th>Level of Evidence (# indicators present)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1. Definition of domestic and sexual violence</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Details on the prevalence of domestic and sexual violence and its impact on victims and their families</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Acknowledgement that domestic and sexual violence is unacceptable and a violation of human rights</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>4. Recognition that domestic and sexual violence takes place in a range of contexts</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>5. Recognition that domestic and sexual violence is characterised by power and control</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>6. Recognition of the link between domestic and sexual violence and the abuse/neglect of children</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>7. Recognition that children may be used by abusers as part of a pattern of control over their victim</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>8. Acknowledgement of implications of domestic and sexual violence for help-seeking and service provision</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>9. Acknowledgement of the physical health impacts of domestic and sexual violence</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>10. Acknowledgement of the mental health impacts of domestic and sexual violence</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>11. Acknowledgement of barriers to disclosure and promotion of treating service users with respect and dignity</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>12. Awareness of social/cultural identities, needs, experiences and circumstances and how these impact on experiences of violence/abuse</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Core Principle Two: Evidence of strategies that promote the identification of domestic and sexual violence

<table>
<thead>
<tr>
<th>Document Type</th>
<th>Number of Key Indicators Present (underline)</th>
<th>Details of Indicators (add phrasing from documentation)</th>
<th>Level of Evidence (# indicators present)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1. Promotion of public awareness of domestic and sexual violence and its impact on health</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Promotion of information on violence and abuse across the Trust (in a range of formats and locally used languages)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Promotion of staff knowledge of services, policies and procedures on domestic and sexual violence</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>4. Provision of training for staff in relation to indicators of domestic and sexual violence and how to enquire about abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>5. Provision of training for staff in relation to responding to different social/cultural identities and circumstances</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>6. Establishment of routine enquiry about domestic and sexual violence</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>7. Evidence of the adoption of appropriate assessment instruments to assess relevant factors (e.g. living arrangements, family and personal situation, mental health status)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>8. Provision of supervision to support staff in identifying abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>9. Establishment of local partnerships to raise awareness and support the prevention of domestic and sexual violence</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>10. Provision of clear information-sharing protocols</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Core Principle Three: Evidence of strategies for risk assessment

<table>
<thead>
<tr>
<th>Document Type</th>
<th>Number of Key Indicators Present (underline)</th>
<th>Details of Indicators (add phrasing from documentation)</th>
<th>Level of Evidence (# indicators present)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1. Guidance on how to determine factors that contribute to service users risk of victimisation</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Guidance on how to determine factors that contribute to service users risk of perpetration of abuse</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
3. Acknowledgement of the potential limits of risk assessment processes (e.g. how they are dependent on what is disclosed/what information is collected)
4. Guidance on the importance of making sure that service users understand clinicians roles and responsibilities in relation to risk assessments, their reasons for collecting information and whom their information will be shared with
5. Evidence of formalised approach to risk, including evidence of documentation on safety planning
6. Guidance on conducting risk assessments/safety plans
7. Guidance on the information required to make an assessment of perpetration of abuse (including risk of re-offending) and whether there are factors contributing to the abusive behaviour which can be addressed
8. Guidance on explaining the process and rationale of risk assessments to service users (including the resultant outcome (e.g. referral to MARAC)) and protective actions that can be implemented
9. Evidence of procedures to review and monitor level of risk to/from service users (including risk for children)
10. Guidance on circumstances warranting additional assessments
11. Details of any legal/organisational requirements regarding the documentation of risk assessments (e.g. data protection/confidentiality) and any referral processes

| Core Principle Four: Evidence of strategies for the provision of information for service users |
|---|---|---|
| **Document Type** | **Number of Key Indicators Present (underline)** | **Details of Indicators (add phrasing from documentation)** |
| | | **Level of Evidence (≠ indicators present)** |
| 1. | Details of the Trust’s role in tackling domestic and sexual violence (including provision of information and support) | |
| 2. | Identification of potential barriers to disclosure of abuse by service users (including communication barriers) | |
3. Guidance on how to identify appropriate and relevant sources of information for abused service users (including details of key agencies/organisations that can be contacted for advice)
4. Details of any legal/organisational requirements regarding documentation (e.g. data protection) and reporting of disclosures of violence and abuse (including limits of confidentiality)
5. Evidence of strategies to promote privacy and ensure confidentiality regarding discussions of abuse and disclosure
6. Guidance on sensitive, non-discriminatory and empathic communication with abused service users
7. Good practice guidance on cross-cultural communication (including non-verbal communication) with abused service users
8. Details of strategies for the safe discussion of sources of support and options with abused service users
9. Guidance on how to provide support and information in a manner that facilitates effective decision-making and action by service users
10. Acknowledgement of the right of service users to make their own decisions
11. Details of any legal/organisational requirements regarding referrals (including referrals to child and adult protection)
12. Strategies for the preparation and agreement of plans for service users’ access to support services
13. Details on how to maintain accurate and complete records regarding experiences of abuse, information offered, options discussed and actions taken
14. Recognition of the need to review information offered and options agreed over time

| Core Principle Five: Evidence of strategies that promote the safety, security and dignity of service users |
|---|---|---|
| Document Type | Number of Key Indicators Present (underline) | Details of Indicators (add phrasing from documentation) | Level of Evidence (# indicators) |
12. Recognition of need to prioritise service users’ safety, security and dignity
13. Recognition of need to assess safety/security of children and non-abusive family members
14. Guidance on what information to gather and assess in order to identify associated risks to service users’ safety and health and well-being
15. Acknowledgement of the need to identify any barriers that may exist in relation to service users ability to access services
16. Evidence of actions or procedures to protect people and significant others from further violence and abuse
17. Evidence of strategies to ensure confidentiality and protect against breaches of security
18. Evidence of strategies/actions to promote recovery
19. Promotion of service users’ self-help behaviours, autonomy and independence
20. Promotion of service users involvement in the development and delivery of relevant service provisions
21. Presence of strategies to promote service users’ awareness of their rights and entitlements
22. Evidence of strategies to support service users with co-morbid substance misuse problems

**Core Principle Six: Evidence of strategies to promote the care and referral of service users**

<table>
<thead>
<tr>
<th>Document Type</th>
<th>Key Indicators Present (underline)</th>
<th>Details of Indicators (add phrasing from documentation)</th>
<th>Level of Evidence (# indicators present)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1. Awareness of relevant legislation/statutory guidelines to enable service users to access their rights and entitlements</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Establishment of provision/assistance for service users with specific needs (e.g. disabilities, insecure immigration status)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Evidence of formalised approach to appropriate care and service provision for service users</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Implementation of clear referral pathways to local services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Acknowledgement of the need for clinicians to outline their roles and responsibility in supporting abused service users</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Details on the roles and responsibilities of local authorities in supporting abused service users</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>Information on benefits available to certain individuals in relation to experiences of violence and abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>Presence of procedures for sharing information safely with other agencies (e.g. information sharing protocols) including data protection and confidentiality guidance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>Evidence of establishment of multi-agency networks to promote access to services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>Evidence of referral pathways to specialist services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td>Evidence of co-ordinated responses to domestic and sexual violence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td>Presence of strategies for local partnerships to prevent violence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13.</td>
<td>Promotion of information about the range of service provision for service users</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14.</td>
<td>Presence of commissioning strategies for domestic and sexual violence, with input from support services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.</td>
<td>Evidence of an integrated care pathway for identifying, referring and supporting service users experiencing violence and abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16.</td>
<td>Evidence of promotion of key information to enable service users to have autonomy over decisions and to make informed decisions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17.</td>
<td>Evidence of strategies for effective recording, monitoring and data collection of evidence, needs and outcomes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18.</td>
<td>Evidence of working with other agencies to provide support and promote safety of service users (e.g. MARACs)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 2: NHS Survey Questionnaire

PRE-TRAINING SURVEY

Please answer the following questions, which will help us to understand NHS training needs. The survey is voluntary and should take approximately 15 minutes. This is not an exam; please record your first, instinctive answer. All information will be collected anonymously and used exclusively for research purposes.

<table>
<thead>
<tr>
<th>Background Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1</strong> Gender: Female ☐ Male ☐ Age (years): ________________ Ethnicity: __________________________</td>
</tr>
<tr>
<td><strong>2</strong> Current NHS role (e.g. clinical psychologist/receptionist): ______________ Year of qualification (if applicable): __________</td>
</tr>
<tr>
<td>Clinical setting/speciality (e.g. community mental health team, inpatient unit): __________________________</td>
</tr>
<tr>
<td>Average caseload: Not seeing patients ☐ less than 20 ☐ 20-39 ☐ 40-59 ☐ 60-79 ☐ 80-99 ☐ 100 or more ☐</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Training</th>
</tr>
</thead>
</table>
| **3a** Have you ever received training on domestic and/or sexual violence within your NHS role?  
Yes ☐ (please answer below) No ☐ (please go to Q4)  
Approximately how much training have you received? __________(hours) or __________(days)_________  
How long ago did you last receive this training (years)? __________________________ |
| What type of training was it?  
Watched a video ☐ Completed web-based programme ☐ Attended skills-based training/workshop ☐  
Medical/nursing/other school-clinical setting ☐ Attended lecture or talk ☐ Other in depth training (more than four hours) ☐  
Other ☐ specify:____________________ - ____________________________________ |
| **3b** Which of the following areas were covered during the training? (Mark as many as apply)  
General information: definitions and case studies ☐ Health problems associated with domestic/sexual violence ☐  
Types of domestic/sexual violence ☐ Making referrals, giving information on national/local services ☐  
Indicators of domestic/sexual violence ☐ Care approaches ☐  
Other ☐ (please specify): __________ - ____________________________________ |

| **4a** Is there a protocol for dealing with domestic/sexual violence at your Trust?  
Yes, and widely used ☐ Yes, and used to some extent ☐ Yes, but not used ☐ No ☐ Unsure ☐ |

| **4b** Are domestic/sexual violence patient education or resource materials (posters, brochures, etc.) available at your Trust?  
Yes ☐ No ☐ |

| **5** How often in the past 6 months have you asked about the possibility of domestic/sexual violence when seeing patients with the following (please tick the box that follows the presentation):  
____ |
<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Seldom</th>
<th>Sometimes</th>
<th>Nearly Always</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>Injuries</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substance misuse</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PTSD</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Headaches</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression/anxiety</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eating disorder</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychotic disorder</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please indicate how much you feel you know about the following:

<table>
<thead>
<tr>
<th></th>
<th>Very Little</th>
<th>A Little</th>
<th>Some</th>
<th>Quite a bit</th>
<th>A Lot</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 Local and/or national policies on reporting domestic/sexual violence</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 Your role in identifying and responding to domestic/sexual violence</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 Signs and symptoms associated with domestic/sexual violence</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9 Health problems commonly experienced by people who experience domestic/sexual violence</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 What questions to ask to identify potential cases of domestic/sexual violence</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11 What to say/not say to a patient who has experienced domestic/sexual violence</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12 Why a patient might not disclose domestic/sexual violence</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13 The stages a patient experiences in understanding and changing his/her situation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14 How to document domestic/sexual violence in a medical record</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15 How to help a patient who has experienced domestic/sexual violence assess their risk of harm</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16 How to help a patient who has experienced domestic violence to create a safety plan</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17 How to make appropriate referrals for patients who have experienced domestic and sexual violence</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18 How to respond to perpetrators of domestic/sexual violence</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please answer True or False to the following questions:

<table>
<thead>
<tr>
<th></th>
<th>True</th>
<th>False</th>
<th>Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>19 Alcohol consumption is the greatest single predictor of domestic/sexual violence</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
If you suspect a patient is experiencing violence but they do not disclose it you should NOT document your concerns in their medical record

Being supportive of a patient’s choice to remain in a domestically/sexually abusive relationship would condone the abuse

Patients who have experienced domestic/sexual violence are able to make appropriate choices about how to handle their situation

Patients who have experienced domestic violence are at a greater risk of injury when they leave the relationship

Allowing partners or friends to be present during the consultation of a patient who has experienced domestic/sexual violence ensures their safety

Clinicians have a duty of care to consider an instance of a child witnessing domestic violence in terms of child protection, even if the child is not in immediate danger

Please tick the box that indicates how many new cases of domestic/sexual violence you estimate you have identified in the last 6 months?

<table>
<thead>
<tr>
<th>None</th>
<th>&gt;</th>
<th>1-5</th>
<th>6-10</th>
<th>11-20</th>
<th>21 or more</th>
<th>N/A – not in clinical practice</th>
</tr>
</thead>
</table>

In the past 6 months, which of the following actions have you taken when you identified domestic/sexual violence? (Tick all that apply)

- Have not identified domestic violence
- Conducted a safety assessment
- Offered validating/supportive statements
- Helped a patient develop a personal safety plan
- Provided information (e.g. phone numbers, pamphlets)
- Contacted a domestic/sexual violence service provider
- Documented a patient’s statements in the medical records
- Provided referral and/or resource information to the patient
- Counselling a patient about their options
- Made a referral

Do you feel you have adequate knowledge of referral resources in the community (including shelters or support groups) for patients who have experienced domestic/sexual violence? Yes ☐ No ☐ Unsure ☐

Do you provide education or resource materials for patients who have experienced abuse? (Tick one)

- Yes, almost always ☐
- No, due to inadequate referral resources in the community ☐
- Yes, when it is safe for the patient ☐
- No, because I do not feel these materials are useful in general ☐
- Yes, but only on the patient’s request ☐
- No, other reason ☐

Please indicate how much you agree with the following

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 Healthcare workers have a responsibility to respond to suspected cases of domestic/sexual violence</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>31 My workplace encourages me to address issues of domestic/sexual violence</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>Description</td>
<td>Options</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>-----------------------------------------------------------------------------</td>
<td>---------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>32</td>
<td>My workplace allows me enough time to ask about domestic/sexual violence if I suspect a person might be being abused</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>33</td>
<td>I feel comfortable discussing issues of domestic/sexual violence with patients</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>34</td>
<td>I am able to gather the necessary information to identify domestic/sexual violence as the underlying cause of patient's illnesses (e.g. depression)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>35</td>
<td>If a patient who has experienced domestic/sexual violence does not acknowledge the abuse, there is very little that I can do to help</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>36</td>
<td>My practice setting allows me adequate time to respond to patients who have experienced domestic/sexual violence</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>37</td>
<td>There is adequate private space for me to provide care for patients who have experienced domestic/sexual violence</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>38</td>
<td>I do not have sufficient training to assist individuals in situations of domestic/sexual abuse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>39</td>
<td>I am confident I can document domestic/sexual violence accurately and confidentially</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>40</td>
<td>I should call the police immediately if I suspect that a person has been domestically/sexually abused.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>41</td>
<td>I can match therapeutic interventions to the readiness to change of a patient who has experienced domestic violence</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>42</td>
<td>I am confident I can make the appropriate referrals for women who have experienced domestic/sexual violence</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>43</td>
<td>I am confident I can make the appropriate referrals for men who have experienced domestic/sexual violence</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>44</td>
<td>I am confident I can make the appropriate referrals for children (under 18) who have experienced domestic/sexual violence</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Thank you very much for your time.

At the end of the training please go to the next page and complete the Post-Training Survey.
Please answer the following questions, which will help us to understand NHS training needs. The survey is voluntary and should take approximately 15 minutes. This is not an exam; please record your first, instinctive answer. All information will be collected anonymously and used exclusively for research purposes.

<table>
<thead>
<tr>
<th>Please indicate how much you feel you know about the following</th>
<th>Very Little</th>
<th>A Little</th>
<th>Some</th>
<th>Quite a bit</th>
<th>A Lot</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Local and/or national policies on reporting domestic/sexual violence</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>2 Your role in identifying and responding to domestic/sexual violence</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>3 Signs and symptoms associated with domestic/sexual violence</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>4 Health problems commonly experienced by people who experience domestic/sexual violence</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>5 What questions to ask to identify potential cases of domestic/sexual violence</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>6 What to say/not say to a patient who has experienced domestic/sexual violence</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>7 Why a patient might not disclose domestic/sexual violence</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>8 The stages a patient experiences in understanding and changing his/her situation</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>9 How to document domestic/sexual violence in a medical record</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>10 How to help a patient who has experienced domestic/sexual violence assess their risk of harm</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>11 How to help a patient who has experienced domestic violence to create a safety plan</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>12 How to make appropriate referrals for patients who have experienced domestic and sexual violence</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>13 How to respond to perpetrators of domestic/sexual violence</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

Please answer True or False to the following questions

<table>
<thead>
<tr>
<th>Please answer True or False to the following questions</th>
<th>True</th>
<th>False</th>
<th>Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>14 Alcohol consumption is the greatest single predictor of domestic/sexual violence</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>15 If you suspect a patient is experiencing violence but they do not disclose it you should NOT document your concerns in their medical record</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>16 Being supportive of a patient’s choice to remain in a domestically/sexually abusive relationship would condone the abuse</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>17 Patients who have experienced domestic/sexual violence are able to make appropriate choices about how to handle their situation</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
Patients who have experienced domestic violence are at a greater risk of injury when they leave the relationship  

Allowing partners or friends to be present during the consultation of a patient who has experienced domestic/sexual violence ensures their safety  

Clinicians have a duty of care to consider an instance of a child witnessing domestic violence in terms of child protection, even if the child is not in immediate danger  

<table>
<thead>
<tr>
<th>Please indicate how much you agree with the following</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>21 Healthcare workers have a responsibility to respond to suspected cases of domestic/sexual violence</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>22 My workplace encourages me to address issues of domestic/sexual violence</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>23 My workplace allows me enough time to ask about domestic/sexual violence if I suspect a person might be being abused</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>24 I feel comfortable discussing issues of domestic/sexual violence with patients</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>25 I am able to gather the necessary information to identify domestic/sexual violence as the underlying cause of patient’s illnesses (e.g. depression)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>26 If a patient who has experienced domestic/sexual violence does not acknowledge the abuse, there is very little that I can do to help</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>27 My practice setting allows me adequate time to respond to patients who have experienced domestic/sexual violence</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>28 There is adequate private space for me to provide care for patients who have experienced domestic/sexual violence</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>29 I do not have sufficient training to assist individuals in situations of domestic/sexual abuse</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>30 I am confident I can document domestic/sexual violence accurately and confidentially</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>31 I should call the police immediately if I suspect that a person has been domestically/sexually abused.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>32 I can match therapeutic interventions to the readiness to change of a patient who has experienced domestic violence</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>33 I am confident I can make the appropriate referrals for women who have experienced domestic/sexual violence</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>34 I am confident I can make the appropriate referrals for men who have experienced domestic/sexual violence</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>35 I am confident I can make the appropriate referrals for children (under 18) who have experienced domestic/sexual violence</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
Appendix 3: Scales used during interviews with service users.

1. Composite Abuse Scale (CAS) – assessed domestic and sexual violence. The CAS is a 30-item questionnaire assessing the frequency/severity of abuse and harassment in the previous year. Items are rated from 1='Never' to 5='Daily', with total scores ranging from 0-150. The CAS has previously been used in research with victims of domestic and sexual violence who are in contact with mental health services;

2. Modified version of the Client Satisfaction Questionnaire (CSQ) - assessed general service satisfaction. The CSQ is an eight-item questionnaire with items rated on a four-point scale, with total scores ranging from 8-32;

3. Warwick-Edinburgh Mental Well-being Scale (WEMWBS) – assessed mental wellbeing. The WEMWBS is a 14-item questionnaire covering positive affect (e.g. feelings of optimism, cheerfulness), satisfying interpersonal personal relationships, and positive functioning (e.g. energy, self-acceptance, personal development, competence and autonomy). Items are rated on a five-point scale, with total scores ranging from 14-70. The scale has previously been used in research with mental health service users.

4. Process of Recovery Questionnaire (QPR) – assessed personal recovery. The PRQ is a 22-item questionnaire measuring anguish, connection to others, confidence and purpose, others’ care or help, living situation, and hopes or cares for self. Items are rated on a five-point scale and are scored by summing the two sub-scales, ‘intrapersonal’ (17 items) and ‘interpersonal’ (five items).

5. Manchester Short Assessment of Quality of Life (MANSA) – assessed quality of life. The MANSA is a 25-item questionnaire measuring quality of life among people experiencing mental illness. The questionnaire contains items including details of housing/employment status, satisfaction with quality of life and physical/mental health status, rated on a scale between 1 = ‘Couldn’t be worse’ and 7 = ‘Could’ve be better’. The MANSA has previously been used in research with victims of domestic and sexual violence who are in contact with mental health services;

6. Anglia Ruskin and UCLan Social Inclusion Scale (SIS) – assessed social inclusion. The SIS is a 16-item questionnaire measuring social isolation (four items), social relations (nine items) and social acceptance (five items). Each item is rated from 1 = ‘Not at all’ to 4 = ‘Yes definitely’, with total scores ranging from 16 to 64. The Social Inclusion Scale has been used in research with victims of domestic and sexual violence who are in contact with mental health services.

7. Camberwell Assessment of Need for Mothers (short version) (CAN-M(S)) – assessed unmet needs. The CAN-M(S) is a researcher-administered questionnaire that incorporates the full 22-items of the original CAN measure, plus four additional items measuring the needs of pregnant women and mothers experiencing mental illness (i.e., pregnancy care, practical/emotional demands of childcare). The 22 generic domain items are applicable to men. Scores of either 1 = ‘Met need’, 2='Unmet need’ or 0 = ‘No problem’ are assigned per item; The CAN-M(S) has been used in previous
research with victims of domestic and sexual violence who are in contact with mental health services;