What happened to you? The Care Programme Approach and Routine Enquiry revisited

Professor Charlie Brooker, Royal Holloway, University of London

Professor John Read, University of East London

Dr Warren Larkin, Visiting Professor, University of Sunderland

Angela Kennedy, Trauma Informed Care Lead, Tyne, Esk and Wear Mental Health Trust

Professor Karen Tocque, University of Chester

What happened to you? The Care Programme Approach and Routine Enquiry revisited

Background

Violence and abuse play a causal role in many mental health problems. Knowing whether users of mental health services were abused or neglected as children could be considered essential for developing comprehensive formulations and effective treatment plans. Routine Enquiry about abuse involves asking direct questions in relation to abuse/sexual violence of a specified population group when they present to a service. In 2008, it became national Department of Health policy, that, once trained, all mental health staff conducted Routine Enquiry (RE) with all those people subject to the Care Programme Approach (CPA) being seen in Mental Health Services (1).

In 2015 all Mental Health Trusts were asked questions about clinical practice in relation to RE in a national survey and the majority responded (79%). All responding Trusts stated that they recorded whether RE took place but only five audited the activity using case records.

On average just 66% of staff had been trained to undertake RE (2,3). This study also elicited, through the Health and Social Care Information Centre (HSCIC), that of the 335,727 people on the CPA in England in 2014-15, RE was recorded for 17% of these service users. Over half of the provider Trusts (57%) did not submit any information to the HSCIC about the proportion of those subject to the CPA where RE was recorded. The findings from this study strongly align

with those of a recent systematic review which aimed to determine how often mental health staff find out whether their clients' were abused or neglected as children (4). Twenty one relevant studies were identified. The majority of people who use mental health services are never asked about child abuse or neglect. The majority of cases of child abuse or neglect are not identified by mental health services. Of abuse or neglect cases identified by researchers, only 28% is found in the clients' files; with the following specific percentages: emotional abuse - 44%, physical abuse - 33%, sexual abuse - 30%, emotional neglect - 17%, and physical neglect - 10%. Between 0% and 22% of mental health service users report being asked about child abuse. Men, and people diagnosed with psychotic disorders, are asked less than other people. In keeping with many other previous researchers the authors conclude that policies compelling routine enquiry, training and trauma-informed services are required.

We know that abuse, trauma and other adverse experiences have been found to co-occur. For instance, if a person experiences one type of abuse or adversity, they are 87% more likely to experience other types of abuse and adversity; the more types of abuse and adversity a person experiences, the higher the risk of harmful health and social outcomes later in life (5).

These findings indicate a public health imperative to prevent, where possible and to respond more appropriately to people's experiences of adversity in our society. Health and social care services have an opportunity at the point of initial contact or during routine assessment, to routinely ask service users about childhood adversity including abuse and subsequent adult trauma. The Future in Mind report (2015) acknowledged the impact of experiencing or witnessing adversity and trauma by stating, 'Experiencing or witnessing

violence and abuse or severe neglect has a major impact on the growing child and on long term chronic problems into adulthood' (6). The report also made a commitment to, 'Ensuring assessments carried out in specialist services include sensitive enquiry about neglect, violence and physical, sexual or emotional abuse.'

Furthermore, the 'Tackling Child Sexual Exploitation' report, (2015), which set out how the government intended to deal with child sexual exploitation in the UK, signalled a commitment from government to introduce routine enquiry (7). The report stated a clear intention to, 'Expand routine enquiry from 2015-2016 made by professionals in targeted services such as mental health, sexual health and substance misuse services.' It went on to say, 'Professionals should include questions about child abuse, to help ensure early intervention, protect those at risk and to ensure victims receive the care they need.'

Therefore, the current study aimed to revisit the arrangements made by NHS Mental Health Trusts to ensure that RE took place for service users on the CPA and across all other types of service provision.

Method

Freedom of Information (FOI) requests were sent to all Mental Health Trusts (n=58) in July 2017. The FOI asked questions that concerned: RE strategy; accountability, training, the use of trauma screening measures, pathways and audit (the questions are given in full in Appendix A).

Results

Response: The response rate obtained after several reminders was 86% (n=50/58). Two Trusts stated that they did not hold the data requested and were omitted, leaving 48 responses (83%) for analysis.

Responses to FOI Questions (see Appendix A): Approximately one-third of the 48 responding trusts (n=17, 36%) stated that they had a strategy for RE, often as part of larger strategies concerning the CPA or Safeguarding. Around two-thirds stated that there was an accountable officer at Trust Board Level for RE (n=31, 65%). Most often this was the Director of Nursing.

27% (n=13) of Trusts had a training target for staff in RE but 77% could not say what progress had been achieved in meeting this target. Just over one-third of Trusts (n=17, 35%) used a structured assessment tool to assess trauma severity. This was most often the case for psychologists working in specialist services such as Children and Adolescent Mental Health Services. A variety of assessments were used such as the Impact of Events scale, the Trauma Screening Questionnaire or the PCL-5.

The return of data to NHS Digital, under the CPA data collection arrangements, on the proportion of service users receiving RE is voluntary. Only five Trusts (11%) stated that they returned data, and one Trust stated that it intended to submit returns next year. Six trusts provided the current proportion of eligible service users where RE took place: 95%; 85%; 23%; 14%; 9% and 3%. This constitutes an overall average of 38%.

Trusts were asked if the use of RE extended beyond service users on the CPA. Just over half of Trusts stated that RE extended beyond those on the CPA (n=25, 54%). The examples given by Trusts included: all service users (n=14); all

service users apart from children [n=1]; IAPT [n=2]; and Trauma Services [n=2]. Trusts were further asked, if trauma was identified, were there pathways in place to ensure the service user received expert care and treatment if necessary. Nearly half of Trusts (n = 22, 46%), stated that such pathways were in place. Three Trusts reported that they would use pathways developed by the Sexual Assault Referral Centre (SARC) for counselling.

Trusts were asked if they audited the use or RE and only five Trusts reported that they did (10%). One Trust reported an Audit (and sent the report) but this was only for an audit of RE about Domestic Abuse. The other four Trusts did not submit the audit reports that were requested. Thus none of the 48 Trusts included a full audit report in their response to the FOI request.

The data for all responses to the FOIs is given in Figure 1.

Figure 1 here

Finally a score was constructed for each Trust by awarding one point for a positive response to each of the seven answers listed [b] to [h] at Appendix A. Trusts were categorised according to whether they had a strategy for RE or not and a mean score was calculated for each category: did have a strategy; did not have a strategy (but assessed RE); did not have a strategy (Figure 2).

Figure 2 here

First, the group of trusts that had a strategy for RE had an overall average score of 3.2, (n=17 Trusts). The possible range of scores is 0-7 so on average the best Trusts less than half of the total possible. This masks individual Trust variation with the highest scoring Trusts only managed 5/6 (n=3 Trusts). However, 15 Trusts scored 0 or 1. In general, having a strategy doubles a Trust's overall score from 1.6 to 3.2 (two-sided t-test, t= 4.082, p<0.001).

Discussion

In 2016 we reported a survey of Mental Health Trusts and their approach to RE in clinical practice. The results were disappointing. Although all Trusts reported that RE took place very few of them (n=5) audited the practice; only two-thirds of staff had been trained to deliver RE and just 43% of Trusts chose to submit data on RE, under the CPA reporting requirements, to Health and Social Care Information Centre (now NHS Digital). Since that report Read and his colleagues have published a systematic review on RE which concludes that although there have been improvements in the last 30 years 'mental health services are still missing half of the cases identified by researchers'. This updated survey confirms this conclusion by Read and his colleagues. In 2017, only about a third of Trusts reported a strategy for RE. Furthermore, staff training is crucial to deliver RE. The original policy statement from the Department of Health in 2008 (1) stated that:

'Questions should be asked by suitably trained staff at assessment about the experience of physical, sexual or emotional abuse at any time in the service user's life. The response, with brief details, should be recorded in case records/care plans. If the specific question is not asked, the reason(s) for not doing so should be recorded.'

The survey reported here has established that whilst ten mental health services reported that 90-100% of staff are 'suitably trained' the majority of Trusts do not hold these data. In the recent systematic review by Read et al (4) research into RE training is explored in some detail. The authors conclude that 'previous training is a predictor of self-reported probability of abuse enquiry'. The Royal College of Psychiatrists has published the rationale for, and description of, a one day training package on how to ask about, and respond disclosures of, sexual and physical abuse [8]. In this context it is concerning that so few Trusts know the proportion of their workforce that has received RE training.

If RE is a national policy requirement the view that RE data submitted to NHS Digital is voluntary seems inconsistent. In our previous report of the use of RE in Mental Health Trusts we established from the HSCIC that only 17% of CPA service users had data returned on whether or not they were offered RE. In 2015, 43% of Trusts were returning data on RE centrally however many of the returns were incomplete. In 2017, in this latest survey, the figure had reduced from 43% of Trusts just two years earlier to 11%. It is therefore hard to say anything confidently about the population on the CPA who are offered RE by Mental Health Trusts, other than that there is extreme inconsistency. Our data suggest that the average lies somewhere between 3%-95% but is much more likely to be at the lower end of the range as so few Trusts provided these data.

The 2017 survey also reported on pathways and audit. One odd finding was that whilst nearly half of the Trusts reported that pathways existed for those with Trauma three Trusts stated that these would be to a Sexual Assault Referral Centre (SARC). This is surprising and disappointing given that NHS

England has laid out the pathways for those mental health problems seen in a SARC as follows (9):

'There are also health interdependencies with mental health services and it is essential that service users have a choice of care provision in on-going support and counselling. When service users' mental health needs exceed the remit of SARC provision i.e. needs are greater than Improving Access to Psychological Therapies (IAPT) level 3 support, the SARC will need to refer the individual to local community mental health services or acute services. Referrals should be with consent or, in the case of adults without capacity, in their best interests'.

Clearly SARCs should be referring to Mental Health Services, especially as recent research has shown that 19% of SARCs attendees have been admitted as in-patient psychiatric in-patient units on average on three different occasions (10). Their admission rate is 90 times higher than for the general population. The audit of RE in Mental Health Trusts has not changed very much over the past two years. In 2015 14% of Trusts audited and in 2017 this had reduced to 10%. It is particularly concerning that only one of 53 Trusts supplied an audit report when asked, and that one was limited to Domestic Violence.

In summary it would seem that RE is not a topic that is enthusiastically embraced by Mental Health Trusts in England. Perhaps this should be no surprise. Data on RE requests is not regarded by NHS Digital to be mandatory. The CQC inspects in relation to four main key areas of enquiry: safety, effectiveness, caring and well-led. Under 'safety', the following indicator is outlined: are there reliable systems in place to keep people safe and

safeguarded from abuse? However, no CQC inspection report comments on the adequacy of RE, nor is it investigated. Finally since the introduction of RE into the CPA as a requirement in 2008 there has been no national policy initiative that has addressed either the topic of RE or the development of Trauma Services. See the National Audit Office for a review of recent policy that confirms this statement (11).

The lack of policy has not prevented the development of trauma informed approaches to mental healthcare by a few Mental Health Trusts.

The Routine Enquiry about Adversity in Childhood (REACh) approach was developed in Lancashire and designed to raise awareness amongst professionals and the public about the often long term negative impact of childhood adversity and trauma. This programme evaluates and supports trauma-informed organisational practice and culture change by embedding RE about adverse childhood experiences (ACEs) within every appropriate assessment.

After auditing and supporting organisational readiness, REACh involves a one-day training session for staff on why, when and how to enquire safely and sensitively, alongside ongoing organisational support, helping teams to navigate potential risks and challenges and to ensure appropriate staff support is in place.

This approach to promoting practice change in NHS and partner organisations has been shown to be feasible and acceptable to both staff and service users, with clear benefits to all stakeholders.

In 2015, an independent evaluation of the REACh programme (12) found that Reach training equips practitioners with the knowledge and tools to conduct

routine enquiry effectively with the people they support. All practitioners who attended the training reported that it was useful, enjoyable and increased their knowledge and awareness of childhood adversity and trauma, including its widespread impacts. REACh was found to initiate earlier intervention, as a result of speedier disclosures**.** Importantly, practitioners reported no issues with implementing REACh in their practice and reported no increase in service need following the enquiries made. Participants and managers felt that they were able to create with the individual a more appropriate intervention plan if they have enquired about previous experiences, dealing with the root cause of presenting issues rather than the 'symptom'.

In the North-East. Tees, Esk and Wear Valleys (TEWV) NHS Foundation Trust have had a trauma pathway in adult acute/community mental health teams for some time. In line with good practice (13) trauma approaches are now being disseminated to other services within the Trust such as those for offenders, child and adolescent mental health services (CAMHs) and tertiary psychosis services. Routine Enquiry is at the forefront of core team training but staff are encouraged to have meaningful and contextualised conversations about trauma rather than ask a simple question. Video resources have been made to support this RE training. The video emphasises the critical role of validating and compassionate relationships in facilitating disclosures over time. Because it is natural to hide things we feel ashamed or distressed about, it is not expected that people coming for help will always disclose at an early point in their care but this conversation gives the message that we are open to taking these issues into account. The training also emphasises that it can be re-traumatising for some people to talk about their trauma, especially when they

repeatedly tell their story but nothing changes in the way they are understood or in the care that they are offered (14). The core training also gives staff some basic strategies for managing distress or dissociation around disclosure, e.g., grounding skills and breathwork. Guidelines for navigating complex legal and ethical issues around disclosures are in development. RE conversations are becoming integrated into assessment processes and form part of the standard tasks of teams by the programs integration with Quality Improvement Systems. The electronic care record was amended so that there is specific section for trauma narratives and trauma related triggers pull through directly into the risk assessment log. All service users have a formulation based on the information from RE, which then informs the care plan and all services have access to some trauma specific psychological therapy. There is an online recovery college with the first basic psycho-education and self-management course for trauma already launched and others in the pipeline. This can be accessed by anyone living or working within Trust borders, after disclosure. However it is also going to be used as a tool for staff's CPD. The benefit of having the same program for both is that staff with their own trauma issues can access it without exposure and as trauma impacts on all our lives at times to various degrees, it breaks down a 'them and us' attitude to mental health. Finally, TEWV are making all of their new peer support 'trauma informed', so there is integration of trauma informed approaches into their Recovery Programme. All of the TIC products and artefacts are co-produced with people with lived experience of trauma. All of these products and processes contribute to an incremental culture change. Staff attitudes, understanding, skills and behaviours evolve over time. Good practice in RE is not a simple task and requires systemic change (13).

Limitations

The advantages of using FOIs in order to facilitate research have been well described (15) and include access to standardised data from multiple organisational sources; a time-limited response period; and the low-cost nature of the exercise to the researcher. Hence the good response rate we obtained for this survey. However, one of the major difficulties, however well-crafted the FOI might be, is variability in the target responder's interpretation of the question. In a number of instances a response to our FOIs was either ignored altogether or could not be validated. For example, five Trusts stated that they audited RE but only one of these responders could send such a report. The same was true was for the question on staff training completion. Nonetheless although questions could be legitimately raised about the validity of our data, any response from organisations, especially those with a vested interest in the results, will always flag this concern.

Conclusion

It seems self-evident that knowing about important adverse and traumatic events is essential if mental health services are to develop meaningful formulations and effective treatment plans. It is unacceptable, in 2020, that the extent to which service users are being asked about abuse and violence remains something of a mystery at both local and national levels. The limited amount of information that is being gathered suggests that staff training continues to be lacking and that the majority of service users are still not being asked and are therefore not being offered appropriate support and treatment.

At a time when many of our large institutions have been exposed as having tolerated sexual abuse for decades it is, perhaps, equally collusive that the institutions charged with supporting us when we are extremely distressed by adverse life events fail to provide the necessary help, or to even bother to find out what has happened in our lives.

References

1. Department of Health. (2008). *Re-focussing the Care Programme Approach: Policy and positive practice guidance.* London: Department of Health

2. Brooker, C., Tocque, K., Brown, M., & Kennedy, A. (2016a). Sexual violence and the Care Programme Approach. *British Journal of Psychiatry, 209,* 359-360.

3. Brooker, C., Tocque, K., Kennedy, A., & Brown, M. (2016b). The Care Programme Approach: Sexual violence and clinical practice in mental health. *Journal of Forensic and Legal Medicine,* 43, 97-101.

4. Read,J., Harper, D., Tucker, l and Kennedy, A (2017) Do adult mental health services identify child abuse and neglect? A systematic review *International Journal of Mental Health Nursing*, 2017 Aug 17. doi: 10.1111/inm.12369.

5. Allen, J.G. and Fonagy, P. eds. (2006). The handbook of mentalization-based treatment. John Wiley & Sons

6. Department of Health. (2015) *The Future in Mind.* Department of Health

7. Department of Health. (2015) *Tackling Child Sexual Exploitation.* Department of Health.

8. Read J, Hammersley P, Rudegeair T. (2001). Why, when and how to ask about abuse. *Advances in Psychiatric Treatment* **13**: 101-110.

9. NHS England (2016) Service specification No. 30 Sexual Assault Referral Centres https://www.england.nhs.uk/wp-content/uploads/2017/04/service-spec-30.pdf

10. Brooker,C., Tocque,K., and Paul,S (2017) Assessment of the mental health status of a one year cohort attending a two Sexual Assault Referral Centres in England *submitted for publication Journal of Forensic and Legal Medicine*

11. National Audit Office (2016) Mental health services: preparations for improving access HC 492 Session 2015-16 21 April 2016

12. Real Life Research (2015). An Evaluation of REACh: Routine enquiry into adversity in childhood. *Independent evaluation of work commissioned by Blackburn local authority public health team.*

13.Sweeney,A., Clement,S., Filson,B and Kennedy,A (2016) "Trauma-informed mental healthcare in the UK: what is it and how can we further its development?", *Mental Health Review Journal*, Vol. 21 Issue: 3, pp.174-192, https://doi.org/10.1108/MHRJ-01-2015-0006

14. FIlson, B. (2011), "Is anyone really listening?", National Council Magazine. Special Issue: Breaking the Silence
Trauma-informed Behavioral Healthcare, Nos 2/15, p. 15

15. Savage,A and Hyde,R (2014) Using Freedom of Information requests to facilitate research *International Journal of Research Methodology,* Vol. 17, No. 3, 303–317, http://dx.doi.org/10.1080/13645579.2012.742280

Appendix A The Questions posed about Routine Enquiry in the Freedom of Information Requests.

a) Does your Trust have a strategy for the implementation of routine enquiry (RE) ? Yes/No
If so, please attach a copy of the strategy in your reply.

b) Is there an accountable officer at Trust Board level responsible for the implementation of RE.? Yes/No
If so, what is the name and title of this individual?

c) Does you Trust have a training target for the implementation of RE? What proportion of mental health staff have been trained in RE?

d) Does your Trust train staff in the use of an assessment tool that elicits the severity of the trauma a service user might have been experienced? e.g. The Trauma Screening Questionnaire? Yes/No
If so, what tool does your Trust use?

e) . Does your Trust provide information to NHS Digital, under the CPA data collection arrangements, on the number of service users who have been subject to RE, Yes/No

If so, in the last NHS financial year, what proportion of your service users received RE as part of their assessment?

f) DH Policy at present only insists on RE being used with service users on the CPA, does your Trust ask for RE to take place with other groups of service users? Yes /No

If so, which groups?

g) If through the process of RE taking place, a service user is found to have a history of sexual abuse/violence, is there a pathway in place to ensure that the service users receives expert care/treatment? Yes/No
If so, please attach a copy

h) Does your Trust audit the implementation of RE in clinical settings? Yes/No
If, yes, can you attach a copy of your latest audit report

List of Figures

Figure 1 Proportion of Trusts Responding Positively to the Freedom of Information Request

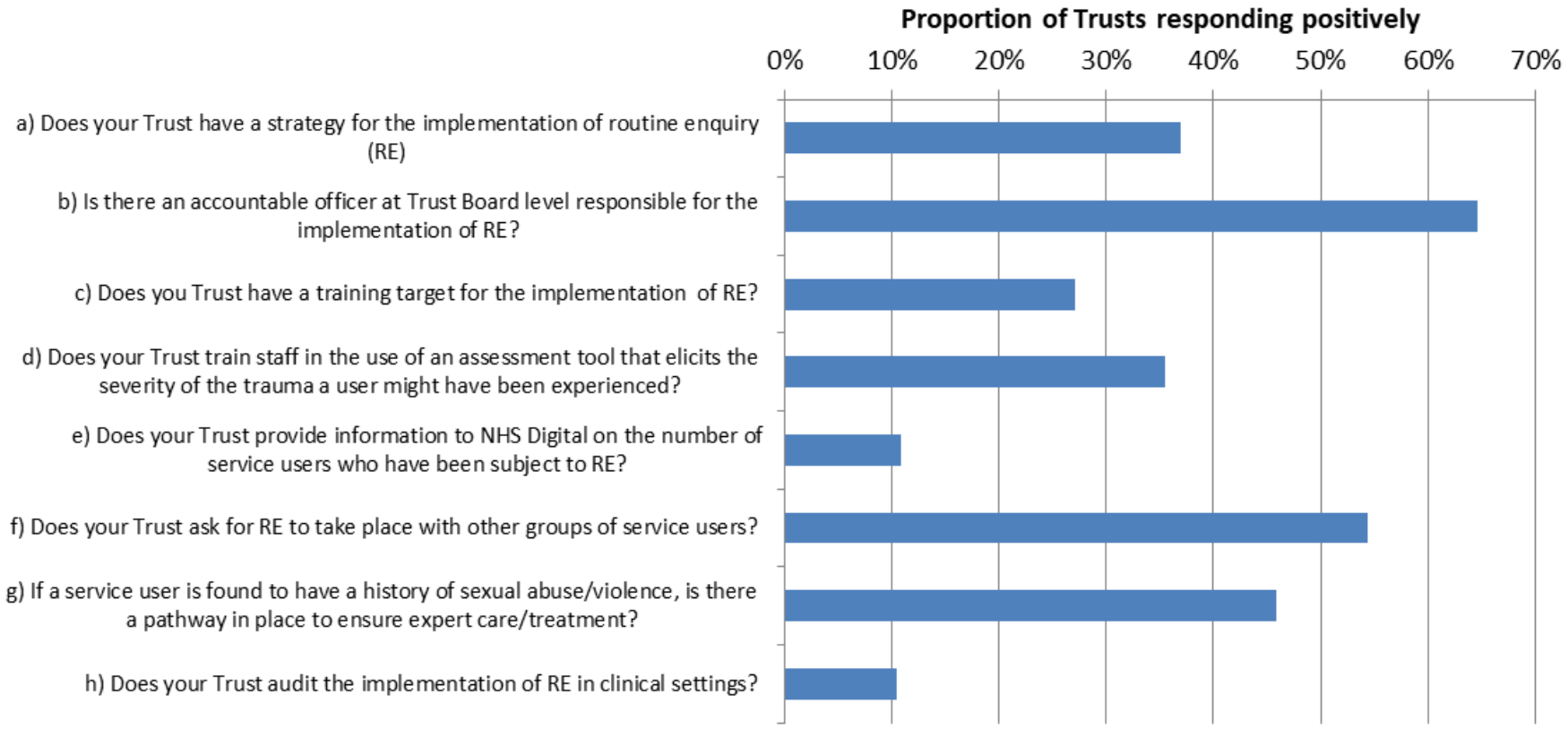

Figure 2 Trusts scores by existence of an RE Strategy, showing the mean and 95% confidence interval of the total score.