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Evaluation of a system wide approach to implementing routine enquiry about adversity in childhood (REACh) across Nottinghamshire (Interim report)

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About this report

In 2019, the Public Health Institute, Liverpool John Moores University was commissioned to carry out a two-year evaluation of a system wide approach to implementing Routine Enquiry about Adversity in Childhood (REACh™) across Nottinghamshire. This report provides interim findings from the evaluation, covering April 2019 to February 2020[1].

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- The evaluation funders Nottinghamshire County Council.
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- All participants who took part in the surveys and interviews.

[1] As a result of COVID-19 and in line with UK Government guidance around social distancing, in March 2020 elements of the programme were cancelled and in April full programme implementation was paused.

SUMMARY OF INTERIM FINDINGS

Evaluation of a system wide approach to implementing Routine Enquiry about Adversity in Childhood (REACh™) across Nottinghamshire

PREVENTING AND RESPONDING TO ADVERSE CHILDHOOD EXPERIENCES IN NOTTINGHAMSHIRE

Adverse childhood experiences (ACEs) include a range of stressful and potentially traumatic experiences that children can be exposed to. These can include experience of child maltreatment, or living in a dysfunctional household and/or community. Research consistently shows that ACEs are associated with increased risk of poor health and well-being across the lifecourse. In recent years, Nottinghamshire County Council and partners have increased efforts to prevent and respond to the impacts of ACEs, and in 2019 commenced a **test and learn project to develop and implement the Routine Enquiry about Adversity in Childhood (REACh™) programme across services in the county**.

THE REACh™ PROGRAMME

The programme aims to enable services and practitioners to implement ACE enquiry as part of routine assessment processes, with all or selected service users. **ACE enquiry involves the use of an ACE questionnaire to facilitate service users' disclosure of ACEs in the context of a person-centred conversation**. The REACh™ model includes **five key stages to ensure services are organisationally ready to implement ACE enquiry**, to train and support practitioners prior to and during implementation, to embed practice change and to evaluate outcomes.

DEVELOPMENT AND IMPLEMENTATION OF THE WHOLE SYSTEM APPROARCH TO REACh™

Nottinghamshire REACh™ programme strategy group

REACh™ programme team and project manager
County/service level engagement and support; whole system project management

Nottinghamshire REACh™ programme implementation group
Community of practice; support; information sharing

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PARTICIPATING SERVICES ACROSS NOTTINGHAMSHIRE

Nine out of 13 services who explored their participation in the REACh™ programme agreed to participate in the test and learn project. Additional partners are considering their participation.

HEALTHCARE SERVICES
Health visitors, GP social prescribing team

SUPPORT SERVICES
Substance use, intimate partner violence, children's centres, family services

CRIMINAL JUSTICE SERVICES
Police, community rehabilitation service, youth justice

Regional engagement and strategic support
Director of Public Health annual reports (2017; 2018); Public Health Nottinghamshire Substance Misuse Framework (2017/22); Nottinghamshire Violence Reduction Unit (2019/20)

DEVELOPMENT AND IMPLEMENTATION OF THE REACh™ PROGRAMME MODEL

READINESS, TRAINING AND SUPPORT

- A considered approach to programme implementation, including pre-implementation workshops, completion of readiness audits by participating services, and staff training and follow-up support was viewed highly in terms of supporting services to fully consider if and how REACh™ may be implemented in their service.

Over 500 practitioners have participated in the Nottinghamshire REACh™ training programme. Training is associated with significant increases in trainees':

Knowledge on ACEs and ACE enquiry

Confidence to ask service user's about ACEs

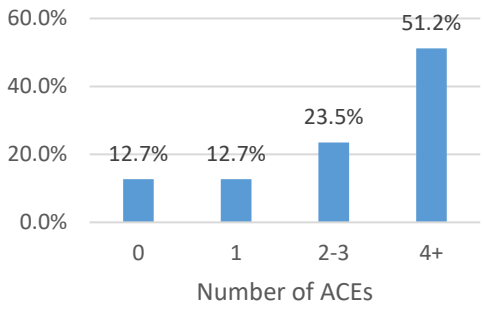
Confidence to respond to disclosures and refer for support

- For various reasons, services are at different stages of programme development and implementation, and require differing levels of support. Some organisations will take longer to implement and embed the programme than others.
- Some services need additional time to consider and plan programme implementation, even after completion of the readiness audit and staff training.
- The varying and continuing training needs of current and future practitioners engaged directly or indirectly in the programme was highlighted as a key consideration for programme implementation and sustainability.
- The strategic and implementation groups have been important in the development and implementation of the programme across and within services.

IMPLEMENTATION OF TARGETED AND ROUTINE ACE ENQUIRY

- All services have established plans to implement ACE enquiry following a person-centred approach.
- ACE enquiry has commenced in five services (with over 200 service users), with all other services due to commence in 2020.
- Data from a sample of services users suggest much higher levels of ACEs amongst clients in one service, compared to the English population survey data (4+ ACEs; 51% vs 10% respectively).
- To date, findings suggests that ACE enquiry is acceptable to practitioners and service users, who have engaged with it so far, and a number of positive outcomes for service users are starting to emerge. (Several case studies are presented in the full report).

Prevalence of 10 ACEs* – substance use support service users (n=173)



"…as well as being a burden off my shoulders that I've carried around for all these years…opened up a doorway that I've been looking for a long, long time…why couldn't anyone have told me about this (ACE enquiry) before" (Service user)

SUMMARY AND CONCLUSION

- The interim findings suggest that it is feasible and acceptable to implement the REACh™ programme across a range of service types. The whole system approach, including the readiness, training and support processes of the Nottinghamshire REACh™ model have proven key in supporting programme implementation.
- Over 500 practitioners have been trained, with significant increases in their knowledge about ACEs and ACE enquiry, and confidence to discuss adversities with clients and support them appropriately.
- All services implementing (or planning to implement) ACE enquiry are following a person-centred approach. A number of services have reported positive outcomes for clients. No negative outcomes have been reported.
- Data from a sample of services users suggest much higher levels of ACEs amongst clients in one service, compared to the English population survey data.
- The whole system approach to implementing the Nottinghamshire REACh™ programme test and learn project should continue into year two, accompanied by programme implementation support, monitoring and evaluation.

* Based on the 10 ACEs included in the English population ACE survey. The ACE tool used in the REACh™ programme includes 14 questions exploring 10 or more ACEs.

Contents

1. Introduction

A growing body of global research has identified the heavy burden that adverse childhood experiences (ACEs) place on individuals' health and social prospects across the lifecourse. ACEs include all forms of child maltreatment, as well as other factors that affect the environment in which a child grows up that increase children's exposure to trauma, including living with a household member who misuses substances, has a mental health problem or has been incarcerated. Critically, experience of ACEs has been associated with greater risk of a range of health harming behaviours, chronic disease and ultimately early death. For example, studies consistently link ACEs to smoking, alcohol and drug use, risky sexual activity and violence *(1,2)*, and to conditions such as mental illness, sexually transmitted infections, obesity, heart disease, and cancers *(3–5)*. Importantly, the more ACEs children suffer, the greater their risk of poor outcomes in later life *(2,6,7)*. These relationships also mean that individuals that have suffered ACEs can be vulnerable to exposing their own children to ACEs, leading to cycles of adversity, social disadvantage and poor health that may affect families across generations *(8–10)*.

As understanding and awareness of the influence of childhood adversity throughout the lifecourse has grown, policy makers and practitioners have increased their focus on preventing and responding to ACEs *(11–13)*. Across many areas in the United Kingdom (UK), various stakeholders have, and continue to explore if and how existing community systems and/or prevention approaches may be enhanced to prevent or mitigate the impacts of ACEs *(11)*. Enquiring about ACEs with adults is one such approach that has been piloted in recent years across a number of UK settings *(14–18)*. ACE enquiry aims to move professionals away from responding to ad hoc disclosures of childhood adversity, to sensitively and routinely enquiring about ACEs with, in the most part adult clients. As part of a countywide approach to preventing and responding to ACEs, in 2019 Nottinghamshire County Council embarked on a test and learn project, to implement a whole system approach to routine ACE enquiry across the county, commissioning Warren Larkin Associates Ltd to implement the Routine Enquiry about Adversity in Childhood (REACh™) programme. The REACh™ programme includes:

- Supporting services to develop processes for implementing REACh™ within their service, ensuring that they are organisationally ready to implement ACE enquiry prior to implementation;
- Training practitioners within the service to increase knowledge and awareness of ACEs and associated impacts, and develop practitioner skills and confidence to implement ACE enquiry sensitively with clients; and,
- Supporting services to embed practice change and ACE enquiry into assessment and support procedures, promoting ACE awareness in individual practitioners and across services, and to monitor and evaluate outcomes.

In 2019/2020, the REACh™ programme team (i.e. Warren Larkin Associates Ltd) and Nottinghamshire County Council worked with a range of universal and targeted services across the county to support and enable them to implement REACh™. This report provides interim findings from an evaluation of the development, implementation and impacts of REACh™ across services in Nottinghamshire (see Appendix 7.1 for details of the full evaluation).

2. Literature review

2.1 Adverse childhood experiences (ACEs)

Adverse childhood experiences (ACEs) incorporate a range of stressful and potentially traumatic experiences that children can be exposed to whilst growing up *(3)*. ACEs include all forms of child maltreatment, as well as other factors that affect the environment in which a child grows up, including living in a dysfunctional household and/or community where there is poverty or violence (experiences that may indicate a lack of safety or nurturing, essential factors for healthy child development) *(2,19)*. Whilst there is no universal definition of what ACEs incorporate, following the first ACE study in the USA (Box 1) a range of ACE studies have been conducted across countries that focus on 10 types of childhood trauma *(2,3,20)*. The ten common ACEs explored in research include being a victim of abuse (physical, sexual or psychological abuse, or emotional neglect); witnessing domestic violence; parental separation; and having a member of the household who has been in prison, misuses drugs or alcohol, or has a mental health problem.

In 2013, a nationally representative household survey across England estimated that 48% of adults (aged 18-69 years) had experienced at least one ACE and 9% four or more *(3)* (Table 1). Comparable levels of ACEs across adult populations have been identified in recent studies conducted at regional (e.g. Luton, Hertfordshire and Bedfordshire; *(20)*) and national (e.g. Wales; *(21)*) levels across the UK. Further, data from the Crime Survey for England and Wales estimates that one fifth of adults (an estimated 8.5 million people, aged 18-74 years) experienced at least one form of child abuse (i.e. emotional, physical or sexual abuse, or witnessing domestic violence or abuse), before the age of 16 years *(22)*. ACEs are often hidden and thus it is difficult to accurately estimate the current prevalence of ACEs amongst children *(23)*, however sources of administrative data can illustrate the breadth and potential extent of some types of adversity children are currently experiencing in the UK. For example:

- In 2019 the Children's Commissioner estimated that across England *(24)*:
  - 2.3 million children were living with risk because of a vulnerable family background.
  - 723,000 children were receiving statutory support or intervention.
- Information from the Office of National Statistics shows that, at the end of 2019 *(23,25,26)*:

Box 1: The original ACE study, USA

The original ACE study was conducted between 1995-97 by Dr Felitti from Kaiser Permanente in the USA *(2)*. Dr Felitti ran a successful obesity clinic, with most patients losing weight. However, a high number of patients were also dropping out of the programme prematurely, particularly patients that had successfully lost weight. Upon investigation, Felitti identified that many patients were suffering from unresolved childhood trauma, and that to them their eating behaviours were a solution, helping them to cope with their distress. Subsequently, Dr Felitti and colleagues from the US Centers for Disease Control and Prevention (CDC) developed and implemented the Adverse Childhood Experiences (ACE) study, asking over 17,000 Kaiser Permanente adult patients about their experience of ACEs, and exploring the relationship with their health and wellbeing. The study identified a high level of ACEs amongst the study sample, and critically a dose-response relationship between ACEs and current health and wellbeing.

- 2,230 children in England were the subject of a child protection plan.
- 49,570 children in England were looked after by their local authority because of experience or risk of abuse or neglect.

Crucially, ACEs typically occur in clusters with children who experience one ACE at increased risk of experiencing other ACEs. Findings from a recent study which combined data from 10 European studies (including over 1.5 million adults from 12 countries) suggest that 19% had experienced more than one ACE. Estimates from a recent meta-analysis suggest that potentially 142 million individuals in Europe have experienced multiple ACEs *(27)*. The clustering of ACEs has important implications for prevention and support, particularly given the dose-response relationship between increased numbers of ACEs and greater risk of experiencing poor health and social outcomes.

Table 1: Prevalence of adverse childhood experiences (ACEs) amongst adults in England (2013) *(3)*

	Adverse childhood experience	Prevalence
Child maltreatment	Verbal abuse	17.3%
	Physical abuse	14.3%
	Sexual abuse	6.2%
Childhood / childhood household included	Parental separation	22.6%
	Alcohol use	9.1%
	Domestic violence	12.1%
	Mental illness	12.1%
	Drug use	3.9%
	Incarceration	4.1%
For every 100 adults in England, 48 suffered at least one ACE, 9 suffered four or more		

2.2 ACEs and impacts across the lifecourse

A growing body of global research has identified the heavy burden that ACEs may place on individuals' health and social prospects across the lifecourse. ACEs can have immediate consequences for a child's health through physical and mental injury, and in severe cases can result in death *(28)*. Beyond the direct immediate impact of abuse and adversity, ACEs increase risk of adopting health-harming behaviours and studies consistently link ACEs to smoking, harmful alcohol consumption, drug use, risky sexual activity and violence across the lifecourse *(1,3,29,30)*. Importantly, the more ACEs children suffer the greater their risk of poor outcomes in later life (see Box 2).

The adoption of health-harming behaviours is one mechanism through which later life chronic ill health is linked to ACEs. However, biomedical studies suggest that toxic stress and trauma can also directly affect the development of children's nervous, endocrine, and immune systems *(31–33)*. Such disrupted development leads to increased allostatic load (physiological damage), impaired cognitive, behavioural and emotional functioning in both the short and long-term, and is a precursor to chronic,

stress-related physical and mental illness later in life *(31–33)*. Impaired cognitive and behavioural functioning can impact on children's opportunities and abilities to access and engage with education, and this can have consequences for long-term socioeconomic outcomes. Studies suggest experiencing ACEs is associated with poor education attainment, and school absence and dropout *(34–37)*. Findings from a US study show that adults with three or more ACEs were one and a half times more likely not to graduate from high school and two and a half times more likely to be unemployed *(37)*. Findings from a UK study demonstrate similar results; compared to adults with no ACEs, those with four or more were over one and a half times more likely to have no qualifications, and almost three times more likely to be currently unemployed *(38)*. ACEs are also strongly related to mental and physical health, chronic disease and early mortality. Results from the World Health Organization (WHO) mental health surveys suggest that 30% of adult mental illness across 21 countries is attributable to ACEs *(39)*. Studies from the US and the UK demonstrate a graded relationship between the number of ACEs experienced and the presence of adult diseases including ischemic heart disease, cancer, chronic lung disease, skeletal fractures and liver disease *(2,40)*. The substantial increased health risks associated with experiencing ACEs have implications for health service provision, and across England and Wales studies suggest that health service use is indeed higher amongst adults who have experienced ACEs *(7,38)*. These findings suggest preventing and addressing early childhood adversity could potentially reduce demand on strained health care and other social services.

The strong graded relationships between ACEs and health outcomes, health-harming behaviours and socioeconomic outcomes also have implications for the intergenerational transmission of ACEs. Many of the outcomes associated with ACEs, for example poor mental health, substance use and experiencing violence, represent adversities for the next generation. The disrupted allostasis, neural functioning and increased inflammation in parents with exposure to ACEs may in turn also affect their children through physiologic or epigenetic pathways *(41)*. Further, ACEs are linked to dysfunctional parent-child interactions and with parenting attitudes and behaviours *(42,43)*. Research on the prevalence and mechanisms of intergenerational transmission of ACEs is limited *(44,45)*, however some research has found that higher number of parental ACEs are associated with increased risk of poor child health outcomes *(46)*. Thus individuals that have suffered ACEs can be vulnerable to exposing their own children to ACEs and associated poor outcomes, leading to cycles of adversity, social disadvantage and poor health that affect families across generations.

Box 2: ACEs and associated harms in adulthood in England (2013) *(3)*

In a nationally representative household study of ACEs across England, compared to adults with no ACEs, adults with four or more ACEs were:

- 2 times more likely to a current binge drinker, or have a poor diet
- 3 times more likely to be a current tobacco smoker
- 5 times more likely to have engaged in sex before the age of 16 years
- 6 times more likely to have ever used cannabis or had an unplanned teenage pregnancy
- 7 times more likely to have been a victim or perpetrator of violence in the past year
- 11 times more likely to have ever used crack cocaine or heroin, or to have been incarcerated

2.3 Preventing and responding to ACEs

In the original ACE study, the authors concluded that primary, secondary and tertiary prevention is necessary to prevent ACEs and mitigate their negative impacts on health and wellbeing *(2)*. At community and individual levels there is a range of evidence-based interventions shown to prevent ACEs such as child maltreatment (e.g. home visitation) *(47,48)*. While the eradication of child abuse

and other types of adversity remains the primary aspiration, developing children's resilience to cope with adversity can mitigate the impact of ACEs and prevent the associated harmful effects *(1)*. A range of factors can impart resilience, including individual traits such as self-regulation and executive function, access to trusted adult support, and community and system level factors, including supportive infrastructure, community values, supportive social networks and connections and availability of resources *(48–50)*. Those who have experienced ACEs but have access to early life support and resilience building assets have been shown to be less likely to experience long-term consequences, compared to individuals who experience ACEs but who have no such support or resilience *(51–53)*.

The clustering of ACEs and their association with a broad range of outcomes, mean multidisciplinary prevention is necessary across different sectors including health, social, criminal justice and educational services. Evidence suggests that different sectors can play a key role in preventing ACEs and reducing their associated effects *(54,55)*. For example, in health sectors, targeted interventions for families such as home visitation, have demonstrated some effectiveness in reducing child abuse, domestic violence, and maternal depression, and improving parent-child interaction and child outcomes *(56–59)*. In the educational sector, school-based interventions aimed at supporting children's social and emotional development and preventing health-harming behaviours, can mitigate the impacts of adversity which children experience at home and prevent further incidents of victimisation (e.g. bullying) *(60)*. Multi-sector efforts are increasingly underway to develop trauma-informed services, which recognise the relationship between current health and social problems and previous experience of trauma *(61,62)*. The underlying principle is that health, social, criminal justice and educational services which are trauma-informed, are likely to provide better outcomes for those presenting with chronic adversity in their childhood histories *(63–65)*. Further, a system-wide trauma-informed approach provides a common language and understanding about trauma-informed practice across different sectors and has the potential to improve joined up working. Consequently, much can be done to both prevent ACEs and reduce their consequent harms at individual, community and societal levels. However, the hidden nature of ACEs can prevent children and adults from accessing and receiving support and prevent service providers from identifying those who would benefit from such support.

2.4 Routine or targeted ACE enquiry

An emerging strategy for responding to ACEs is routine or targeted enquiry about ACEs, predominately with adults in health and other settings *(66,67)*. It is typically completed using items from the 'ACE questionnaire' to ask service users about their history of ACEs. Models of ACE enquiry aim to train practitioners to proactively and sensitively ask clients about their history of ACEs. This is based on the premise that disclosures about ACEs are rarely made spontaneously by clients and even in cases of spontaneous disclosure responses by professionals are typically ad hoc. One study of psychiatric patients found that 82% disclosed trauma when they were asked, compared to just 8% who spontaneously disclosed *(68)*. Crucially, awareness of ACEs and their impact is not sufficient for practitioners to routinely enquire about ACEs, with one study of doctors in the US finding that, despite 80% agreeing they had a responsibility to ask about ACEs, only half felt confident to do so and the majority reported that they did not regularly enquire with their patients *(69)*.

It has been argued that awareness of ACEs through routine or targeted enquiry offers the opportunity to identify individuals at high risk of poor health, wellbeing and behavioural outcomes and tailor support and treatment options accordingly *(70–72)*. It has also been suggested that the enquiry process itself may be therapeutic for adult clients because it allows the client to disclose their experiences, reflect on the role of these experiences in current health and behavioural problems, and

elicit sympathetic acknowledgement and understanding of these experiences from their practitioner *(66,73)*. Routine enquiry about ACEs with adults was first implemented by the author of the original ACE study (Felitti), who reported a 35% reduction in GP attendance and 11% reduction in Emergency Department attendance for individuals who had engaged in routine enquiry *(72)*. Since then, emerging evidence from studies of routine enquiry implementation suggest that, in general, service users find enquiry about ACEs to be acceptable, important and that their experience of service support was improved as a result of their practitioner knowing about their childhood *(15,75–78)*.

Further research is however needed around the process of implementing routine or targeted ACE enquiry, and implications for services, including the ease of embedding enquiry into standard practice *(79)*. To date routine enquiry has generally been implemented and evaluated in health settings, thus the expansion of such enquiry to other settings necessitates further research and evaluation *(79)*. Crucially, evidence on outcomes for service users' health, wellbeing, or service use as a result of enquiry is scarce. A recent scoping review of the evidence base for routine enquiry into childhood adversity found no published research which supported the reports from Felitti and other colleagues that routine enquiry about ACEs provides positive therapeutic benefits *(79)*. Findings from a recent qualitative study of practitioners trained to routinely enquire about ACEs indicate that practitioners perceive routine enquiry to have a positive impact on their clinical practice through an increase in therapeutic conversations, collaborative working and more empathic ACE-informed understanding of their client difficulties, which in turn is perceived as facilitating more lasting change for clients. However, further research on how practitioners respond to disclosure of ACEs and implications for treatment and referrals for further support is needed to support these findings *(79)*. The lack of an existing evidence base on outcomes of enquiry has fuelled concern about the widespread implementation of routine enquiry without further research. Recent debates and concerns about routine enquiry *(19,81–86)* have focused on the:

- Types of adversities enquired about (i.e. beyond the 10 commonly explored ACEs);
- Validity of the ACE tool as a screening measure (i.e. accuracy and diagnostic sensitivity), and conversely if it should be viewed as a screening tool or rather a tool to facilitate service users' disclosure of ACEs in the context of a person centred conversation;
- The use of the ACE tool to 'score' a person's ACEs;
- The use of the ACE tool within a strengths based approach (considering protective factors);
- Availability and accessibility of evidenced based treatments for those identified with ACEs; and,
- Potential for negative effects of routine enquiry (e.g. retraumatisation) and overtreatment.

Whilst valid concerns, the current lack of evidence around routine enquiry about ACEs means its appropriateness and effectiveness in supporting people who have experienced ACEs is still relatively unknown *(84)*. In recent years however, a number of pilot projects have been implemented and evaluated across the UK *(15–17)*. Findings from these evaluations suggest that routine ACE enquiry can be implemented across different settings, is acceptable to practitioners and clients, and has potential benefits, including developing the client-practitioner relationship. Studies also suggest that many service users had not previously disclosed their ACEs to another practitioner. The implementation of ACE enquiry is currently being piloted and/or implemented across a number of UK areas (e.g. Wales, Scotland, and Lancashire) and other countries (e.g. USA and Macedonia), and many settings are monitoring and evaluating implementation and impacts.

3. Evaluation aim, objectives and methods

The aim of the study is to evaluate the feasibility, acceptability and impact of the implementation of the REACh™ programme across services in Nottinghamshire County Council. The evaluation has five core objectives:

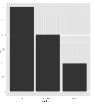
1. To understand and document the development, implementation and embedding of the REACh™ programme across and within services in Nottinghamshire, including facilitating and mediating factors.
2. To explore practitioners' views on the programme, and perceived impacts on service delivery and client-practitioner relationships.
3. To identify client and practitioner acceptability of the programme.
4. To consider the impact of the programme on clients, practitioners, services and partner agencies including, service demand, client engagement within services, and health, social and other outcomes.
5. To identify the prevalence of ACEs amongst clients attending services, and associations with socio-demographic and lifestyle factors, and service utilisation.

The evaluation is being implemented across 2019/20 and 2020/21. This report provides interim findings based on the development and implementation of the programme in 2019/20. A mixed-methods approach is being used to gather evidence to address the evaluation objectives (see 7.2 for full details). To date, a range of qualitative and quantitative methods have been implemented including:

Interviews (n=14) with programme commissioners (n=2) and the REACh™ programme team (n=3), and service level implementers (n=7) from four of nine participating services.

Pre (n=398) and post (n=436) training surveys assessing practitioner knowledge on ACEs, and confidence to discuss ACEs with clients (and respond); and monitoring of training implementation.

Review of programme documentation (e.g. strategy group minutes; REACh™ programme documentation / materials) and observations of programme implementation (e.g. strategy group; training sessions).



Collation of available secondary data collected by two of the five services implementing routine ACE enquiry.

Review of service user feedback case studies prepared by practitioners, and testimonials.

4. Interim research findings

4.1 Nottinghamshire REACh™ programme model

The REACh™ programme model has five core stages: organisational readiness, planning and implementation, staff training, and, follow-up support. A final stage involves evaluation and research to encourage services to monitor and assess implementation (and subsequently build the evidence base of routine or targeted ACE enquiry). In Nottinghamshire, implementation of the REACh™ programme is embedded into a whole system place based approach to preventing and responding to ACEs.

4.1.1 REACh™ readiness audit

Figure 1: The REACh™ programme model

The first stage of the model looks at the readiness of services and organisational teams to undertake REACh™. In Nottinghamshire, to support the whole system approach to implementation, and based on REACh™ programme team experiences of implementation elsewhere, a pre-readiness process workshop for service leaders was introduced (that had not been used before). The workshop provided services interested in the programme with an overview of the Nottinghamshire test and learn project, the REACh™ model (with a particularly focus on readiness and practice change management), and the programme evaluation. It aimed to allow services an opportunity to meet the REACh™ programme team and project manager (council employee appointed to the project throughout 2019/20 to support with countywide implementation), and explore and consider if the programme was appropriate for their service, and if they could engage with the test and learn project. Subsequently, services leads who felt they could explore their participation further were invited to work through a readiness audit to assess the suitability and potential implementation of REACh™ within their service, with their staff and clients.

"I guess where there isn't organisation buy-in there will be problems…I often find some of the smaller organisations if they don't have the resource to ensure that supervision is regular and consistent, then you might not embed it as well." (REACh™ programme team [RPT])

"What we could do better at is that staff and teams are ready and are really thinking about how they can put it in place, so that staff aren't just being trained, because people get it, it can be about winning hearts over and they get it. It's about making sure that the system is ready to enable people (staff) to store it [information], record it safely, and have the right dialogue with service users/patients/clients, so that they feel like the information they are sharing is being managed sensitively, safely, keeping them safe." (RPT)

In previous implementations of REACh™, the readiness audit was completed at organisational level, but for Nottinghamshire it was completed at the 'anticipated' lead implementation team level. This change was implemented as the REACh™ programme team felt that differences in perspectives between frontline staff and the service managers and organisational leaders (in large organisations) may not be adequately accounted for if the readiness exercise happened at organisational level.

> *"...there's more often than not a difference of perspective between the frontline staff, the team leader and the service manager and then the organisational leaders….So we've made sure that we ask the team leaders to talk to their teams and complete it." (RPT)*

In addition, support for consideration and completion of the readiness checklist was provided as required by the REACh™ programme team and project manager. The readiness checklist looks at a number of key elements that have been identified by the REACh™ programme team (through experience of previous implementation) as vital for the REACh™ model to be used successfully and sustainably. These include looking at:

- Whether there is organisational commitment to implement REACh™, and the service and staff are ready and willing to do so;
- Where routine or targeted ACE enquiry may naturally sit (that makes sense) within the service and client care pathway, including identifying which staff need to receive training, and the level of training (e.g. ACE aware or full REACh™ training);
- Safeguarding arrangements for clients and onward referral for specialist care;
- Staff supervision and self-care, and support for staff who are affected by ACEs; and,
- Programme monitoring and evaluation.

4.1.2 Planning and implementation (practice change management)

The readiness audit aims to enable practitioners to assess if their service is an appropriate setting to implement routine ACE enquiry, and if so explore whether they have the systems and processes in place to ensure effective delivery. It may be that these elements are already 'adequately' established or that activity may be needed to put them in place. Services work to ensure the key success factors (listed above) for REACh™ implementation are in place, before implementing the next phases of the model. When the key readiness factors are in place or 'significantly in process' then the model moves onto the staff training phase. It is anticipated that services will review organisational readiness and practice change management repeatedly throughout the duration of implementation.

4.1.3 Staff training

Prior to identified staff receiving full REACh™ training (see Box 3), materials are sent out to trainees approximately two weeks before the training takes place. These materials include: information about REACh™; the Seen and Heard Children's Society materials (individuals are asked to watch the Tyler video *(85)*); and, a chapter from the Young Minds book addressing adversity *(86)*. Pre-learning was identified as a mechanism through which individuals within the teams / organisation could gain a better understanding of what it is they are going to be looking at. Importantly it also enabled them to *"…understand what their personal reactions are to it in terms of whether it touches on something that's personally difficult or something that they haven't dealt with" (RPT)*. It is hoped that where any issues are identified, individuals then have time to seek support where required from their manager / supervisor before attending the training. The full REACh™ training takes place over a full day and covers:

- **The underpinning research** - the evidence around ACEs and the science of childhood trauma, the case for change, and evidence on routine / targeted ACE enquiry.
- **The practice of enquiry -** this includes discussion about where enquiry fits best for a team or service care pathway, role play practice, going through the routine enquiry ACE questionnaire and how this might be embedded in practice, and watching some routine enquiry specific training videos.

The REACh™ programme team describe routine ACE enquiry as the use of an ACE questionnaire to facilitate service users' disclosure of ACEs in the context of a person-centred conversation. Interviewees highlighted a number of benefits of routine enquiry including that:

- It equips professionals with a structured way of asking questions: *"questions that actually we all think as professionals we'd be fine asking but often some of those questions we're not fine asking and it helps to have a methodology behind how we ask" (RPT).*
- It helps professionals to identify early childhood traumas in the people they work with.
- Teams/professionals are able to allocate resource more effectively and sooner because the right questions have been asked: *"…we would have got there in the end, but it would have took six, nine months of intervention with a family before they tell you that kind of thing" (RPT).*

The ACE tool used in the REACh™ programme is a 14 item questionnaire (Table 2; Appendix 7.3), covering child maltreatment and household experiences, an opportunity to raise any other childhood adversities/traumas, and a final question asking about the presence of a trusted adult during their childhood (a factor associated with building resiliency and mitigating the impacts of ACEs *(49)*).

Table 2: Questions from the Nottinghamshire REACh™ ACE tool

While you were growing up, during your first 18 years	
1	Did you live with a parent or other adult in the household who was depressed, mentally ill or suicidal?
2	Did you live with a parent or other adult in the household who was a problem drinker or alcoholic?
3	Did you live with a parent or other adult in the household who used illegal drugs or who misused prescription medications?
4	Did you live with a parent or other adult in the household who served time in a prison or young offenders' institution?
5	Were your parents ever separated or divorced?
6	Did your parents or other adult in your home ever slap, hit, kick, punch or beat each other?
7	Did a parent or other adult in the household swear at you, insult you, put you down, or humiliate you or act in a way that made you feel worthless or scared?
8	Did a parent or other adult in the household push, grab, slap, or throw something at you or ever hit you so hard that you had marks or were injured?
9	Did you go without enough food or drink, clean clothes, or a clean and warm place to live for long periods of time?
10	Did an adult or other person touch you or make you touch their body in a sexual way or attempt or actually have oral, anal, or vaginal intercourse with you?
11	Have you been asked to show or send images of a sexual nature, or been asked to behave in a sexual way in person or via social media (i.e. Facebook, Twitter, Instagram, Snapchat or other)?
12	Have you ever done or were you ever forced, threatened or asked to do anything sexual (in person, online or via social media) in exchange for money, drugs , alcohol, gifts, affection, protection/safety, accommodation, employment, status (popularity), or anything else?
13	Are there any other experiences from your life that you feel we should know about?
14	While you were growing up, before the age of 18, was there an adult in your life who you could trust and talk to about any personal problems?

Box 3: The REACh™ one day training programme

Objectives

- Increase practitioners' knowledge about the impact of childhood adversity on adult health and social outcomes.
- Increase practitioners' knowledge, confidence and skills in routinely asking and responding to disclosures of childhood adversity.
- Develop understanding about what is required in a service context to embed routine or targeted enquiry about adversity in childhood.

Delivery

- Pre-learning materials accessed two weeks prior to training:
  - Young Minds Addressing Adversity report;
  - Children's Society Seen and Heard materials (Tyler video); and,
  - Information on evaluations of routine ACE enquiry.
- One full day training delivered by staff from the REACh™ programme team:
  - Mixed methods used in delivery including PowerPoint presentation, videos, role-play and group work / discussions.

Content

- The evidence base underpinning the REACh™ model:
  - Evidence around ACEs, including prevalence and impacts;
  - Concept of resilience and its mitigating impact on ACEs;
  - Current policy context;
  - The case for change (why things need to be done differently at system and societal level); and,
  - Evidence from previous evaluations of routine ACE enquiry.
- The REACh™ ACE tool:
  - Reflection on the items included, and principles of confidentiality.
- The practice of routine enquiry:
  - Why, when and how to enquire safely and sensitively;
  - Consideration of whether routine enquiry will be routine (considered for all service users) or targeted (implemented with specific service users);
  - Responding to disclosures and safeguarding; and,
  - Navigating potential risks and challenges.

4.1.4 Follow-up support

Follow-up support is provided by the REACh™ programme team in the form of phone or Skype calls with team leaders and supervisors for six months after implementation has commences. The follow-up support aims to provide advice and support for staff, and ensure sustained practice change, as described by one programme team member:

"So if you get people some great resources and tell them to get on with it, it tends not to happen. If you train people really well but then don't support them with supervision or ask them how it's going or give them the opportunity for peer support, again then you know it will probably just dwindle off it won't maintain itself. So the process is a mix of….experience and lessons learned out in the field and secondly looking at implementation science and in my leadership work looking at what make programmes successful." (RPT)

4.1.5 Implementing a whole system countywide approach to preventing ACEs

In 2017, the Nottinghamshire Director of Public Health's annual report dedicated a section to investing in future generations and ensuring a healthy start for all *(12)*. The report highlighted ACEs and their role in overall health within the wider population, and raised the prevention of ACEs as a key priority for Nottinghamshire, setting a number of recommendations and actions (Box 4). This report provided Nottinghamshire County Council with a strategic whole system approach to identifying and addressing ACEs in its population. Throughout 2017/18, local partners explored approaches to preventing and responding to ACEs, and in 2018 requested a presentation from Warren Larkin Associates Ltd to understand the REACh™ programme. The Director of Public Health's 2018 annual report had a specific focus on developing a public health approach to violence prevention. Again, it raised ACEs as a key public health issue and a recommendation for the County Council Public Health team to *"pilot work to empower service users to exercise increased control by equipping frontline staff to* enquire about experience of childhood adversity" *(87)*. Subsequently, the Adult Social Care and Public Health Committee approved funding for the development and implementation of ACE enquiry across services in Nottinghamshire, and in 2019 Warren Larkin Associates Ltd were procured by Nottinghamshire County Council to commence implementation of the REACh™ programme in 2019. Preventing and responding to ACEs has been included in a number of local strategies and work programmes, such as the Nottinghamshire Substance Misuse Framework (2017-22). The implementation of REACh™ (the focus of this evaluation), is set within the context of this broader countywide whole system approach to preventing and responding to ACEs.

In March 2019, a pre-implementation launch event was held to introduce countywide stakeholders to the concept of REACh™, the rationale and anticipated approach to implementation across Nottinghamshire (including that it is a test and learn project with accompanying evaluation), and evidence of routine ACE enquiry from academic literature. The event was attended by around 100 local policy makers, leaders and practitioners from a range of services (e.g. local authority, health, specialist support services, criminal justice) and gave partners an opportunity to reflect on the countywide plans and if and how their organisation could participate. The identification of services to take part in the REACh™ programme, and who were invited to attend the event, was decided collaboratively between the programme commissioners and the REACh™ programme team: *"…to determine which services should be trained…we've looked at where the ACEs science is and what it leads to and then looked at those services that actually support those health harming behaviours almost and pick those services" (Commissioner)*. Relevant services were invited by the council to engage with the REACh™ programme (free of charge to the service), and in 2019/20, services volunteering to participate went on to explore their engagement more formally with the REACh™ programme team and programme commissioners. The REACh™ programme has previously been implemented in other UK areas in individual services including specialist support services (e.g. substance use) and health (e.g. health visiting, GP practices) *(14,16,17)*. The overarching difference for REACh™ Nottinghamshire (compared to other areas where it has been / is being implemented) is that routine / targeted enquiry aims to be delivered across a number of different services / organisations, rather than in one service / organisation in one area.

Box 4: Nottinghamshire Director of Public Health 2017 report: Investing in the future: making a healthy start - ACE recommendations and actions *(12)*

- All healthcare, education and policing staff in Nottinghamshire should receive regular training in how to recognise and appropriately respond to signs of abuse and other types of trauma in children and young people. The ACE model should be used as a way of thinking about the impact of childhood trauma on psychological, physical and social health for both professional and public audiences.
- All agencies should work together to prevent ACEs in order to reduce health and social inequalities, and to address the root causes of a significant proportion of police call-outs, A&E attendances and benefits dependence in Nottinghamshire.
- Develop trauma-informed professional practice in schools, policing and healthcare in Nottinghamshire, in order to begin to break the ACE cycle for affected children.
- Continue to invest in programmes that a) support at-risk parents and families to reduce the likelihood of ACEs, and b) provide positive mentorship and resilience building for young people in order to mitigate the effects of ACEs that they may have suffered.

4.2 Nottinghamshire REACh™ programme: year one processes

4.2.1 Implementation

This section provides an overview of how the REACh™ programme was implemented across Nottinghamshire from April 2019 to February 2020 (referred to as 2019/20 hereafter). A summary of programme implementation is provided in Figure 2 and Table 3.

County level implementation: During 2019/20, a number of core activities have been implemented to facilitate a whole system approach to programme implementation, including strategy and implementation group meetings, process workshops and memorandum of understanding.

- ***Strategy group meetings*** aim to support countywide implementation and provide strategic support to participating services. Agenda items include: commissioning, quality assurance, governance and reporting, activity reporting and risk register, organisational readiness and training, implementation group update, and evaluation update. Five 2-hour meetings have been held from May 2019 to February 2020, including representatives from programme commissioners (chair), providers (Warren Larkin Associates Ltd - programme delivery; LJMU - evaluation) and participating services (joining as they commence the project).

- ***Implementation group meetings*** aim to support service level implementation. Agenda items include: progress and good practice; challenges and solutions; issues to escalate to managers and/or the strategic group; participation in the evaluation; and development of a community of practice. Five 2-hour meetings have been held from October 2019 to February 2020, including the project manager (chair), a member of the REACh™ programme team, and representatives from each participating service (joining as they commence the project) (e.g. team leaders/supervisors or a nominated REACh™ champion).

- ***Process workshops*** aimed to support team leaders / members in developing their understanding of the Nottinghamshire REACh™ programme, and if and how it may fit into their service, and address any initial queries or concerns service staff may have. Two 3-hour workshops were held in April 2019, including representatives across services, and led by the REACh™ programme team and project manager.

- ***A memorandum of understanding*** has been developed between Nottinghamshire County Council, the REACh™ programme team, and the implementing services. This ensures services are committed to the REACh™ programme model and includes an intellectual property agreement to ensure the teams know how the materials they are given may be used.

Service level implementation: During 2019/20, Warren Larkin Associates Ltd were commissioned to develop the REACh™ programme across a range of services (identified in collaboration with the commissioning team) in Nottinghamshire, deliver training to 900 practitioners, and provide services with follow-up support for six months post-training. For services, the programme was provided freely, and services volunteered to participate in the test and learn project. During 2019/20, 13 services from across Nottinghamshire explored (or are exploring) their potential engagement in the REACh™ programme, and nine have fully committed to their participation including:

1. Change Grow Live: specialist drug and alcohol support service.
2. Nottinghamshire Women's Aid Ltd (NWA): specialist domestic abuse support service.

3. Nottinghamshire Community Rehabilitation Company (CRC): probation service.
4. Nottinghamshire Healthcare Trust: children's centres (NHCTCC).
5. Nottinghamshire Healthcare Trust: Healthy Child Programme (0-19 years) (NHCTHCP).
6. Nottinghamshire County Council: youth justice service (NCCYJS).
7. Nottinghamshire County Council: family service (early help).
8. Nottinghamshire Police: school early intervention officers (SEIOs).
9. Primary Integrated Community Service: GP social prescribing team.

Table 3 provides a summary of implementation across the nine services. A further two services have recently explored their potential participation, and are now working toward establishing their engagement with the programme – a sexual violence support service and youth service.

- **Readiness audit, planning implementation:** All services have completed a readiness audit and assessed themselves as an appropriate setting to implement REACh™, following completion of actions identified in the audit (and queries raised following staff training). Five services were implementing ACE enquiry, two were starting imminently, and one had recently completed their readiness audit and was moving on to the change management and staff training stages.

- **Staff training:** 27 REACh™ training sessions were implemented from May 2019 to February 2020[2], with an average of 19 trainees per session (see Appendix 7.4). Five training sessions included staff from across two or three services, with all other sessions including one service. In total, 725 training spaces were offered to services, 552 delegates signed up to the training and 511 attended the training (thus 77% of training spaces available were filled). Most services had completed their training of staff, with few staff not available for previous training sessions (e.g. due to sickness / leave) due to attend in March/April[3]. Some training sessions included observers - stakeholders from services / evaluation team who were interested to learn more about the REACh™ programme. All training attendees received pre-training learning. Four further training sessions were scheduled for March and April 2020, and training places were being offered to new services who were currently exploring their potential participation in the programme, and any remaining practitioners who require training from participating services. In addition, some services have received refresher training (2-3 hours) from the REACh™ programme team, to develop their confidence and skills.

- **ACE enquiry:** In 2019/20, five services commenced the implementation of ACE enquiry with clients, following a person-centred approach. Thus, the ACE tool is being used with service users at an appropriate point in their pathway, when the practitioner deems that it is appropriate for the service user (e.g. not in crisis; there is a good relationship between the service user and practitioner). The remaining services plan to commence enquiry in 2020.

- **Follow-up support:** Most (7/9) services were receiving follow-up (post-training) support (via the REACh™, programme team and the implementation group) to develop processes to implement and/or embed routine ACE enquiry.

[2] Two training sessions were cancelled in February 2020.
[3] Cancelled due to UK social distancing measures implemented due to COVID-19.

Figure 2: Nottinghamshire REACh™ programme implementation, 2019/20

Nottinghamshire REACh™ programme strategy group

REACh™ programme team^* / project manager^
County / service level engagement and support; whole system project management

Nottinghamshire REACh™ programme implementation group
Community of practice; support; information sharing

Healthcare services

Universal child services: healthy child programme (0-19) (Health visitors), Integrated community care (GP social prescribing team)

Whole system approach**

Family support services

Children's centres, early help and family services

Criminal justice

Police (school early intervention officers), Community Rehabilitation Company, youth justice service

Specialist support services

Substance use, domestic violence

Regional strategic support

Director of Public Health annual reports (2017; 2018); Public Health Nottinghamshire Substance Misuse Framework (2017/22); Nottinghamshire Violence Reduction Unit

^ Support available during year 1, and *for 6 months post-training. ** Additional services are exploring their participation.

Table 3: Details of implementation of the REACh™ programme across Nottinghamshire (2019/20)[4]

Service	Readiness		Training	Routine enquiry implementation		
	Strategic lead	Readiness audit	Stage and n trained	Lead identified	ACE enquiry	Target group and enquiry point
Substance use support	✓	✓	Training complete ~80 staff trained	✓	✓ (n>150) Commenced Q3 19/20	Whole service, new clients age 18+, voluntary, during single/multi-agency/group sessions as appropriate (determined by practitioner [DbP])
Community rehabilitation service	✓	✓	Training complete ~70 staff trained	✓	Commencing 2020	Whole service (county only), new service users age 18+, voluntary, during session as appropriate (DbP) (with case manager only)
Police	✓	✓	Training near complete 19 staff trained	✓	Commencing 2020	School early intervention officers only, young people (YP) aged 14+, voluntary, during support session with YP as appropriate (DbP)
Children's centres	✓	✓	Training complete ~130 staff trained	✓	✓(n<20) Commenced Q3 19/20	Whole service, parents age 14+, voluntary, during session as appropriate (DbP)
Healthy Families Team (0-19 service)	✓	✓	Training near complete ~120 staff trained	✓	To commence 2020/21	Health visitors only, mothers aged 18+, voluntary, at antenatal, 6-8 week visit or 'listening visits', during session as appropriate (DbP)
Domestic abuse support	✓	✓	Training complete >50 staff trained	✓	✓ (n<20) Commenced Q3 19/20	Refuge only, women age 18+ in refuge and out of crisis, voluntary, during session as appropriate (DbP)
Youth justice service	✓	✓	Training complete ~45 staff trained	✓	✓ Commenced Q4 19/20	Whole service, YP age 14+ years, voluntary, during session as appropriate (DbP)
Early help and family services	✓	✓	Training ongoing ~50 staff trained	✓	✓ To commence 2020/21	Whole service, clients age 18+, voluntary, during session as appropriate (DbP)
GP social prescribing team	✓	✓	8 staff to be trained	✓	To commence 2020/21	Whole service, new clients age 18+, during person centred assessment (with wider tool kit), voluntary, during session as appropriate (DbP)

[4] April 2019 to February 2020.

4.2.2 Fidelity and adaptations

A core aim of the Nottinghamshire REACh™ programme is to implement a whole system, place based approach to routine ACE enquiry across Nottinghamshire. It was hoped that the test and learn pilot would explore the acceptability of routine or targeted enquiry within services, whether service users are accepting of the questions they are being asked, whether they see a benefit, and how this might impact upon their outcomes. From the outset, it was acknowledged that delivery may look 'slightly different' because teams have different service models and service user needs, along with differing service outputs and outcomes, although it was anticipated that the five stages of the model would be followed.

> *"…we want to test out whether these services are the right services for routine enquiry to be implemented. In terms of acceptability of asking those questions to service users within those specific services….so it's about acceptability within those services, whether service users accept the questions, whether they see a benefit from those questions being asked within those particular services and therefore whether they then get the right help, if required, to move forward with their lives."(Commissioner)*

Few deviations from the core principals of the REACh™ model were noted. For some initial training sessions, some trainees did not receive the pre-learning materials prior to training attendance, or knew little about the training or how and why it was being implemented in their service. Trainers noted that the training was being delivered in the same way across sessions, keeping the fidelity, but it was highlighted how some of the training was contextualised for the services being trained and/or adapted during the session to focus on questions or concerns raised by trainees. For example, training with youth offending and police services had an increased focus on the criminal justice system, and the use of the ACE tool with young people. Training with health visitors also highlighted potential limitations around implementing routine enquiry and supporting mothers over the three visits that were available through their universal offer. Through the training, discussions were facilitated to explore how this could be implemented, and how health visitors could ensure mothers had the support they may require.

> *"..there's some contextualised stuff in there, so for the youth offending team, for example, we really focused on how that questionnaires used with younger people, younger adults and people transitioning into adulthood…because you contextualise that questionnaire with that young person. You may take a bit more time explaining what sexual abuse maybe is or explaining what living with a mental illness is." (RPT)*
>
> *"I think we've been doing a lot of learning in Nottingham[shire] after each training session, for me, because delivering to a family support team is totally different than delivery to a group of probation officers and so you have to sometimes tweak a bit of the content or the messaging to make it contextualised for them." (RPT)*

4.2.3 Facilitating factors

The process workshops implemented at the start of the project, were considered critical to ensuring that services could identify the value of programme implementation. This pre-work was thought to encourage 'buy in' and support and was seen to work towards 'future proofing' REACh™ *"…from experience where there's a will and a buy in it's possible and it's successful" (RPT)*. Some services subsequently explored implementation in comparable services to further understand what

implementation may look like in their service and whether it is appropriate for their service / clients, and to learn from other implementation areas. Engagement with services implementing REACh™ in others areas was viewed as useful in helping some services decide upon their engagement with the programme, dispelling practitioner concerns, and helping inform implementation.

The readiness audit was perceived as hugely beneficial in assessing whether the service was ready to implement the programme. It was felt that consideration of not just whether a service wants to buy into a programme but also whether they were able to buy in was rarely considered by pilot projects and this was an important positive of the REACh™ programme. The services were able to use the readiness checklist to demonstrate what they were doing to get ready. Having a clear sense from the beginning of what they were doing and why, and how they were going to implement it, helped to gain buy in to the programme at a strategic / managerial level and from practitioners.

> *"In all honesty it's one of the only times we've actually been asked as a partner to show what we are doing to get ready….so that was really helpful for us because sometimes when we are asked to buy in we are not asked about how we are doing that so it was really good to be able to present this is what* we are doing to get a buy in." *(Practitioner, Service 3)*

Staff training was seen as an opportunity to start conversations with practitioners where the training information posed potential questions, and also to identify potential barriers to implementation early and put mechanisms in place to help. For example, where professionals did not think it was their place to carry out ACE enquiry; and where individuals attending the training may not be in a position to deliver ACE enquiry, but they have gained knowledge and expertise in the area and can help to identify where routine enquiry may sit within their service / organisation.

Figure 3: Example of trainee's pictorial brainstorm of ACEs

> *"It gives people options and the opportunity to challenge and say 'it doesn't sit comfortably with me, I don't think I should be asking these questions' or 'actually we might not be able to manage demand'." (RPT)*
>
> *"..we do have those conversations about well you've still gained the knowledge, you've still gained the expertise around what's going on and you understand what's going on around your service, but this might not sit with you. And so a lot of the work is then around where does it then sit in the service." (RPT)*
>
> *"There was a fantastic guy there, a probation officer, who said that said he can see this is really fundamental to everything they are doing and he sees it every day, but I don't know if I am in the right position to ask because I don't see them much, and I don't see them for very long. But there are people in the probation service that could." (RPT)*

In the post-training survey, trainees were asked their opinion on what they felt the best aspects of the training were. Some common responses included that the training was informative, provided positive discussions, demonstrated impactful use of routine enquiry (via video's) and that the trainers where both professional and knowledgeable.

> *"The course overall was excellent, the video of different potential outcomes was informative" (Trainee)*
>
> *"Delivery was clear and trainers knowledgeable and enthusiastic about the topic" (Trainee)*

A considered approach to programme implementation was identified as important, including the readiness audit, staff training and additionally a period of preparation and consideration between training and implementation of routine enquiry. This was so that teams could take away the learning after the training, return to their service, and ensure that everything is in place before routine enquiry begins. This approach was felt to be more beneficial than leaving the training and trying to 'run' with routine enquiry straight away. Some services sent a small group of staff and/or managers to early training sessions, to allow them to learn more about the programme and what the training entailed, prior to finalising their approach to implementation, and sending further staff on the training. One of the training facilitators spoke about their own experience of being involved in the implementation of REACh™ as part of a team using routine enquiry in a pilot that took place in Lancashire. Some of the learnings from this pilot focussed upon readiness to implement REACh™ and the wider system-change model and support processes that needed to be in place. It was felt that these learnings had been built into the Nottinghamshire REACh™ programme. The considered approach to implementation was welcomed across services.

> *"So the staff are trained, but now it's about when do they implement this…..I've been working with a drug and alcohol team and it's looking imminently that they're going to start rolling that out. They've just been identifying who with. Where could they start that process? What support do we have….?" (RPT)*
>
> *"Me and my team went to start using routine enquiry, when actually the model, the wider system change model wasn't in place. The preparation hadn't been done. The management and supervision structures hadn't been considered. And so it was a leap into the unknown where when you look at now in Nottinghamshire how the feasibility's been looked at. People have really considered where they sit. Do they have the structures in place. It just makes it easier for practitioners or professionals to pick this up and once they're ready to go with it…." (RPT)*
>
> *"The process was very much a see how this can be absorbed into your practice and understand where it fits. I think that's really considerate and that's the way we think anyway but it is really positive for us that's being delivered to other organisations that might not have the ability to work like us… because we have relatively small numbers compared to larger state agencies. It was good to hear that that pace and rhythm was rolled out to everybody." (Practitioner, Service 3)*

The ACE tool was viewed by some services as key to ensuring consistency in routine / targeted enquiry, and promoting acceptability amongst practitioners and service users. This related to the perception that service users would feel less singled out as it is something being asked to all clients, and staff would feel more at ease in enquiring about ACEs as the conversation would be more structured.

"Survivors do feel more comfortable with a list of questions because it looks formal, we are not just asking for the sake of it… it also makes people feel less alone because if it was just them there wouldn't be a standardised checklist."(Practitioner)

4.2.4 Anticipated and actual barriers

The scale of implementing a whole system approach was identified early on as a potential challenge, especially due to the differing commissioning specifications of the organisations being worked with. *"Ultimately [we're] dealing with a lot of organisations, ultimately some of them are commissioned by the council so they've got a little bit of influence, but many of them are not commissioned by the council and we're relying on good will essentially" (RPT)*. It was acknowledged that even with the processes put in place to deliver routine enquiry on this large scale, organisations may still not be in a position to implement the programme. Organisational changes with services going through tender exercises / procurement processes and being subject to service level inspections were all seen to create a challenging backdrop to the implementation of any practice change initiative such as REACh™ – *"we know from the past that when all that stuff's going on they go into survival mode and new things are probably not what they need" (RPT).*

"…some of the teams are not going to be in a position for timing reasons, for organisational reasons, for personal reasons, whatever, that it probably won't be something they can prioritise even if they want to, but I'm thinking, I'm hoping that'll be the minority rather than the majority." (RPT)

"Time constraints in our role and a lack of resources to refer to." (Trainee)

Issues with implementation were experienced in a few organisations and included lack of resource and competing or over-riding priorities. During 2019/20, a number of services experienced some delays in implementation of the REACh™ programme, including engagement in the training and/or implementation of routine enquiry, due to service level inspections and/or competing service level demands placing pressures on their resources. One health service reported having to withdraw their interest due to national developments in care provision, resulting in them having no capacity to engage in the REACh™ programme, despite a willingness to do so. Whilst this meant that patients at this health service would not be exposed to routine enquiry in this setting, it was reported that pathways from the service to another "REACh™" service had been strengthened, meaning that patients who are referred for support will be offered routine ACE enquiry. In addition, tender exercises / procurement processes were raised as key risks for two organisations participating in the programme. Both services were tendering for the renewal of their service during 2019/20 - both were successful and thus were able to continue their engagement in the programme. One service reported the complexity of engaging staff within the programme, who were not under their direct management responsibility. However, it was also acknowledged that embedding system wide change could be challenging and that it was ok for services to be in different places: *"we're not all at that place at the moment, but we will all get to that place at some point" (Practitioner).*

"We have had a couple of organisations where things have not gone smoothly. They felt they were either unable to carry it out, or they were keen but were not able to do the back-office / management of it…Also, a small team but in a larger organisation were deeply disappointed that they couldn't do it because as we're moving from readiness to training the national directive has escalated and they can't do both. It's very frustrating." (Commissioner)

The ***cultural landscape*** of some organisations was seen as a potential barrier to implementation - *"culture eats strategy for breakfast" (Commissioner).* Asking frontline staff to do something that is essentially quite different to what they are doing already was seen to have the potential to cause varying levels of anxiety. One example was given of an organisation where it was felt that work was needed in the team *"to orientate themselves to this being a targeted and relationship building activity and a therapeutic activity rather than a crime busting activity" (RPT)*.

> *"…the senior person who was there chipped in and said 'no the first thing you're doing is building a relationship. The second thing is that's a step forward for that young person. Then you've got an opportunity to safeguard them that you didn't have before. And then the third thing is if there is an opportunity or a requirement to pursue a crime or an offender then we will do, but it's in that order, because otherwise we're missing the point.'" (RPT)*
>
> *"Resistance from professionals to change their practice, set in their ways." (Trainee)*

Another example was also given of a training session where it was difficult to engage with some of the attendees. There were many potential reasons provided for this, such as organisational, structural and cultural issues, however, it was highlighted that it is sometimes difficult to get to the crux of the reason for this. Where issues like this are present it was considered difficult to see the hoped-for change in engagement because *"there's stuff going on behind the scenes that's bigger than this" (RPT).*

Within this, the notion of accountability versus reducing dependency was discussed. This focussed upon the importance of professionals moving away from the 'doing' on behalf of clients to 'allowing people to do for themselves', supporting clients to commence a personal journey of recovery that may focus on making sense of their experiences. It was felt that practitioners / professionals may be used to being very active on their client's behalf (e.g. providing interventions / referral to services) and ensuring that there is an audit trail of this activity, rather than providing clients with information and then allowing them 'do' for themselves.

> *"…these practitioners in these services are all about 'we'll assess this and then what can we do, what can we advise, what can we give, what can we organise'... They're busy doers and some of this is about standing back and allowing people to do for themselves and that's significant". (Commissioner)*
>
> *" …there's this whole thing about risk and they're thinking because I'm not doing anything am I putting myself at risk in case anything happens with this service user and that's a massive cultural shift". (Commissioner)*
>
> *"…the other thing is that sense of well have we got a leaflet, I want to be able to write down somewhere that I've done something, that I've not abandoned this person, that it doesn't look like nothing is happening and I think that's quite a challenge for people's mind-set and quite a worry because are they going to get blamed if something goes wrong. Have they got an audit trail that would support the fact that they've done their job well as best as they can." (Commissioner)*

It was acknowledged that for some teams this will be an enhancement to what they are already doing and it would 'fit really well', but for others it will be a 'massive culture shock' where a cultural shift in practice was required: *"It's more of a cultural shift. The idea that they can have a therapeutic relationship with somebody. Ultimately, they're trying to help… people steer the right path and recover*

from situations that might have been bringing them into conflict with the judicial system. While they're willing and very open, culturally it's just a very different thing you're asking them to do" (RPT). The process to date was seen to have been a 'learning curve' that had enabled partners to look at how services engage. In terms of system readiness, the emphasis was still placed upon the importance of organisations being in a position to practically implement REACh™.

Practice change management was noted as key to programme implementation. In order for professionals to use ACE enquiry following training, it was considered essential for a wider system change model to have been considered and be in place. Change management was seen as crucial, from not only a professional and organisational point of view, but also ensuring that this change is appropriately managed at the client level. Within this is discussion around distributed leadership and the emphasis upon the role of therapeutic relationships between professionals and clients.

> *"…what underpins it around change management from system change, organisations, straight down through teams, individuals and also then that experience of change management is also then mirrored with the clients as they're working with the clients to help them change."(Commissioner)*
>
> *"The primary aim is that despite any transactional activity that any partners wish to do, the core is around therapeutic relationships, building relationships and authenticity really with clients so it's quite a shift change from how things have been done in the past." (Commissioner)*

Time between staff training and implementation: For some services, there was a gap between staff training and implementation of routine enquiry, and this was a concern for services and the REACh™ programme team. Thus, some services requested follow-up training sessions, and/or implemented internal training sessions for staff.

> *"…what I worry about is them leaving it too long to implement because you actually need to get on and do it afterwards because then all the myths about it become bigger, they are not practicing it." (RPT)*

4.2.5 Future considerations

Whole system approach: The progress made during the test and learn project to date was commended across all partners, with one partner reporting it as *"fabulous"* and that there is a *"genuine interest in and commitment" (Commissioner).* To continue to be successful and sustainable, various partners noted that routine enquiry needs to be led, supported and advocated for at a strategic, managerial and practitioner level. It was felt that to truly embed REACh™ across a whole system it needed to be built into commissioning and measured as an outcome. It was felt that those things that are 'measured, monitored and scrutinised' externally are prioritised.

> *"Unless it becomes legislation or policy and there's some sort of incentive for organisations either because they're scrutinised externally or they have to report data to public or government agencies or they get some kind of financial incentive or penalties as a result of it, then it's always going to be a matter of competing with the amount of resource they've got." (RPT)*

"If we're going for a system-wide change then it needs to be built into other organisations contracts and specs and those conversations need to continue. Our commissioners have been really great at having that conversation with us and I'm just wondering if that's happening with other commissioners. Are they fully on board, are they having those conversations with their providers. I think that's how we'll really embed a culture across the system talking about trauma informed practice." (Practitioner, Service 1)

The strategic and implementation groups were seen to be a good platform to share resources, information and experiences. One service noted how beneficial and encouraging it was to see everyone so invested in REACh^{TM} via these meetings. It was felt that disseminating information in a transparent way was important for everyone, so they were aware of what is going on where. It was also suggested that there could be practitioner champion meetings to inform delivery and provide a truly bottom-up approach.

"…there is something really beneficial about coming together and saying it is still high on our agenda, it is still what we're doing...as manager there's only so much change you can make, and the best change and the most impactful change comes from the people, from the practitioners, and is there something around having a system-wide champions meeting. Those that attend are practitioners and not managers, so having that bottom-up and not top-down approach because at the minute, you go to strategic and operational meetings and they are the managers. Actually what we really need to influence is our practitioners and get them involved in this movement."(Practitioner, Service 1)

"I think it's important that all the different strands of what's happening within the programme needs to be discussed at that strategic meeting so that at least all the stakeholders are aware of what's happening, at least in their own organisations. Because, there's a natural assumption that we all talk to each other within an organisation and sometimes we do and sometimes we're not particularly that good at it. So we need to get better at it but I think it would be a lot easier if we could cover all those bits and bobs at this strategic meeting. (Practitioner, Service 2)

Implementation support: It was felt that there are huge levels of communications and administration required to support programme delivery across the whole system. For example, the administration required to support the delivery of the training across multiple services, including scheduling and logistics, was noted as much greater than expected. Training sessions were organised by the project manager and delivered across a range of localities in Nottinghamshire. The implementation group was noted as particularly important in developing, embedding and sustaining the programme across services. It is anticipated that the group would evolve into a community of practice for support and sustainability after the

"…the sustainability question is an interesting one…I think there's some predictable ones in there around one, new starters, two, what happens if a service is recommissioned by a competitor, most staff will transfer, but the organisation coming in hasn't bought in so what do we do with that. I guess if you were going to do it long term, you would have to look at some kind of annual update, refresher, where it almost doesn't matter who does it, but there is that opportunity as part of the core and that would keep it alive, would keep it healthy." (RPT)

REACh™ programme team contact has concluded. It was noted however that the group might benefit from more support in the coming year to enable the development of a sustained community of practice. Further, it was suggested that to support readiness and programme implementation, it may be useful to start the 'follow-up' support process prior to training taking place (for new services).

***Staff training**:* Staffing was raised as a future consideration, specifically relating to organisations that may have a high turnover of staff, organisations that have undergone tender processes / have had an increase in funding, thus resulting in new starters / organisations becoming involved. In these instances it was questioned whether there would be, for example, 'mop' up training sessions or annual refresher courses (including the latest information on the topic). The use of organisational champions who have already undertaken the training and delivered ACE enquiry was also suggested. A train the trainer model was seen as a potential way of ensuring that new staff are trained: *"train the trainer is good and we've got quite a lot of people wanting to do that because they can see the benefit of it" (practitioner).* Discussion also focussed around the potential for the provision of digital resources for training and information provision.

> *"The one thing I always think of is around new starters. So this is great for everyone who's working now, but as staff turnover happens, how do we ensure people are then trained and is there a mechanism to make sure people can access the training in the future, because if you have a team of four and two of them leave, and then you only have half your team doing it, it won't have the same impact or it won't mean as much to the service."* (*RPT)*
>
> *"So if those people are already trained, where do they go to, how do they access the latest information that's going to keep them at the top of their game when they do routine enquiries in the future." (Practitioner, Service 2)*
>
> *"We're hoping we get a few more regular training dates because there's always new staff coming in, new partners coming in and it's really important that everyone's on board." (Practitioner, Service 1)*

As an add-on to the current training, a trainer felt that there may be the option for a second day of training on therapeutic skills for non-therapists and resilience building activities. It was also suggested that adversity awareness training for all workforces could be achieved through short ACE awareness and trauma-informed practice sessions.

> *"You assume this is just an adjunct to what people are already doing, but when you get into the conversations you realise that resources vary hugely across teams and across localities so if we were able to spend a bit more time helping teams to build up that therapeutic range of options I think that would be quite a nice thing to do." (RPT)*

Amongst trainees completing the post-training survey, recommendations for developing the training content and delivery varied. Some common themes related to how the training could be tailored to their specific organisational structure; ideas as to how to ask the questions in different ways (e.g. picture cards); the length of training being shortened or split into two sessions; and, introducing case studies specific to the service being trained to help relatability.

"Give options of different ways to ask the questions for different age groups e.g. cards, pictures on a questionnaire." (Trainee)

"Perhaps deliver case studies appropriate to the different services attending. It was beneficial hearing from people in different roles but specific case studies would have helped me understand more where it would be in my role." (Trainee)

***Supervision for staff**:* Supervision opportunities were seen to be very helpful and supportive and had been identified as a 'crucial success factor' that was identified in the readiness exercise. It was deemed the responsibility of the individual organisations to ensure that there is provision of support for their staff who are implementing REACh™. For example, staff may be living with ACEs and are 'fine', but then something might trigger when supporting a service user. Some organisations were seen to be using existing opportunities such as team meetings and staff development sessions. One trainee noted a concern however stating that *"my manager isn't completing the training therefore how can she support me and my team?" (Trainee).*

"I predict that the teams that do have that opportunity will embed practice and it'll last. The teams that don't have that opportunity might not be as successful." (RPT)

Reflective practice was identified by the REACh™ programme team as a key success factor in implementing routine / targeted ACE enquiry. As part of the Nottinghamshire REACh™ programme, the REACh™ team have advised services to implement regular group sessions to provide front line staff an opportunity to discuss their experiences, concerns, anxieties and successes as a team. Key suggested features of these meetings include:

"…look after yourself, take care, speak to someone before you start routine enquiry, make sure there's something in place to come and talk." (RPT)

- They focus on ACE enquiry and trauma related practice;
- They are regular meetings (4-6 weeks), facilitated by a trusted and credible professional;
- The group sets the meeting ground rules and processes are agreed at the start;
- They provide a safe supportive space to discuss any aspect of the work; and,
- They allow staff to share good practice points and lessons learned.

Services have been asked to consider how they can implement reflective practice into their service (and across services) especially during the first 6-12 months following the REACh™ training, and if they require additional support from the REACh™ programme team or project manager.

Raising awareness of the programme: There was discussion around using posters that staff developed during their training as a way of promoting routine enquiry within services and more widely as a public health campaign *"generated by the people that support the people" (RPT).* A short film was being made with one of the organisations to capture the views of their service users around routine / targeted ACE enquiry. In addition to this services highlighted the potential for a public health awareness raising campaign (e.g. using posters in public places) to run alongside the delivery of the programme.

Enhancing the whole system approach and reducing duplication: It was stated that to have a truly whole system approach to routine / targeted enquiry, there are gaps in the workforce that would need to be trained such as primary care, GPs, midwifery services and schools. Further considerations were needed for organisations that delivered services across the county (where the programme is being implemented) and city (outside the programme implementation area). Some stakeholders noted that it was important when bridging gaps between organisations that work needs to be done around duplication so that services communicate with each other where routine enquiry has already taken place.

> *"...it would be nice to stop that duplication if there was some ways of Nottinghamshire teams knowing which teams are asking, which are ACE aware. Can they have conversations with other professionals about adversity". (RPT)*

Routine enquiry with young people: Queries have been raised by some services about the use of the ACE tool with young people, and discussions explored Gillick competency, safeguarding, parental engagement and the wording of the ACE questions. Two services engaged in the programme are implementing routine enquiry with young people (age 14+) and have developed detailed protocols and guidance for staff (developed in collaboration with service staff and the REACh™ programme team) to support and monitor implementation with young people. For example, one service has produced guidance on:

- How to introduce the questionnaire;
- Stopping mid-questionnaire;
- Rating the young person's mood;
- Things to remember (e.g. asking the questions does not change what they have experienced or how it impacts upon them, but it may change the conversations that we have);
- Ideas for conversations as you complete the questionnaire;
- Making links for the young person; and,
- Confidentiality.

As with all participating services, these services are monitoring implementation and ensuring they engage with practitioners and service users to understand and review programme implementation in real time. In another service, one adult service user was reported (by a practitioner) as stating *"I would of really of benefitted from being asked these [ACE questions] when I was younger, at secondary school-around 13/14 years old. If I'd of had this opportunity things might of been very different for me".*

Flexible approach to implementation: Feedback that service leads received from practitioners and service users suggested that implementation of routine enquiry should take a flexible approach considering the needs of the client and the practitioner, and the support systems available for service users. For example, through allowing trained practitioners to commence their implementation of routine enquiry only when they felt comfortable doing so; and enabling them to use their professional judgement to decide when it is an appropriate time to implement routine enquiry with a service user (e.g. they have a good rapport with the service user; the service user is out of crisis; there is adequate support available should the person need support). Ensuring service users have a choice to take part or not, and if they choose not to, that they have an opportunity to revisit it later, was also noted as important.

"If you asked these questions right at the beginning you would not get a true reflection…this should be person centred and should be asked when you are at the point of trust with your [support worker]. I think at least three sessions should have taken place before you even think of approaching this"

"A good time to ask these questions would be when…you are at your most vulnerable during your work with the [support worker]…I think it would then start to make sense, link to your original problems / the referral and gives you the reasons the way you may behave the way you do"

"I think it is far better for the [support worker] to read out the questions out loud to you as this is more impactful and may get better results"

(Practitioner report of service user feedback)

ACE tool: One service who explored client views on routine enquiry and the ACE tool highlighted some concerns that were raised by clients, particularly in relation to the sensitivity of some of the ACE questions (e.g. sexual abuse), and where and when the ACE tool will be implemented, and how confidential the setting may or may not be (e.g. if attending services with others, such as children). Further, service users highlighted the importance of exploring (through conversation and the tool) if clients feel they need support and if there are other aspects in their childhood, which may have affected them (e.g. lack of parental love and affection).

"These yes / no boxes are quite rigid. I think you need to stop after each question is asked as I needed to quantify my reasons. You could do with another column with yes / no, in answer to 'Do you require further support in this area either by your [support worker] or to be signposted on to other services?"

"After being read the guidelines and confidentiality statement (on the back) I was left wondering-What is it for?? How will it be used?? It would be helpful if you read out a paragraph with the answer to this".

""I feel there is one question missed on the questionnaire. I was exposed to D/V [domestic violence]. This was physically myself or watching my parent's abusive relationship. My Dad drank and both parents had mental health issues when I was growing up. Out of all of these, the thing that had the most massive effect on me was not being loved by my Mum, having no emotional attachment or emotional warmth from my Mother. This has affected my whole life, my confidence, my relationships, my friendships and my own parenting. Where is your question about this, which I think is massive?"

"What are your safeguards in terms of, this may be the first time someone has been asked these questions, they are vulnerable and ready to tell someone (making reference to Q10 'Did an adult or other person, touch you or make you touch their body in a sexual way or attempt, or actually have oral, anal or vaginal intercourse with you)."

"These are intrusive question but I was expecting them"

(Practitioner report of service user feedback)

4.3 Nottinghamshire REACh™ programme: year one outcomes and impacts

4.3.1 Anticipated outcomes and impacts

Commissioners and the REACh™ programme team identified a number of anticipated and hoped-for future outcomes for the programme:

- The commissioners considered REACh™ to follow an asset-based approach that would **support** and **encourage Nottinghamshire residents to take control of their situations**. It was felt that this in turn would have a **positive impact upon communities,** as they will feel happier and more supported and able to **look after their own children better**.

"….this really is a shift from experiencing adversity and feeling like that they can't really change anything and feeling quite disempowered because of things that have happened to them, to that sort of self-awareness through all the different self-esteem, self-confidence to self-efficacy, making changes. So it's a start. It's a good starting point." (Commissioner)

"Ultimately we know that there's no more resources in the system so it's about evaluating, if doing something different produces results which support residents of Notts to make better, to make choices around their outcomes so that they're not bouncing around the system." (Commissioner)

"For me I want to be able to see that communities and individuals, the emotional cost to them struggling with this burden has been relieved, so it's a financial cost, the emotional cost that communities will be happier and more supported and be able to manage their own children better, understand why they feel the way they feel, why we present to services for care and also an improvement in outcomes, it will be difficult to measure but lovely to see." (RPT)

- **Developing stronger relationships** with clients, by developing trust earlier, which leads to more honest and open conversations. This in turn will then help professionals to **identify issues more quickly** than they might have done had they not have used routine / targeted enquiry and allow for **more effective allocation of resources.**
- **Increase in safeguarding referrals due to an increased ability to safeguard individuals (improving safety)** – this could be seen as both a negative outcome, as more resource is required, at least initially, but also as a positive outcome as individuals are being safeguarded, when they might not previously have been.

"I think for what is a genuine increase for some people is around safeguarding referrals. Certainly within Children's Centres…or where they're working in young people's services perhaps where they're encountering maybe 16-18 year olds are disclosing abuse and then there may be obviously situations where you're working with parents and they disclose abuse or criminality or criminal exploitation, something like that that then needs referring on. So there is on occasion a slight increase in safeguarding referrals or safeguarding processes within an organisation, but for me I always think that's a good thing if I'm honest..." (RPT)

"Lots of safeguarding, what I'd really love to show, because practitioners are having an issue about if we speak to people there going to disclose and it's at least safeguard it, all throughout training I say that's really good because if we didn't ask people they would be going home still at risk. So, I would love this to show that we have at least increased our ability to safeguard people because we routinely ask what's going on with them and they wouldn't usually have told us, so we can actually put a system in place to keep them safe. If we could show that we had kept more people safe by routinely asking that would be brilliant." (RPT)

- **Reducing the demand** upon services (and cost savings) through improved support and changing the way that individuals use / access services.

> *"…the first is saving around services, which is crude, but around the need for services, people might not have got the right support, might not have the time, might not be using services in the same way. And lots of evaluations show that people don't seem to use the services as much after it has been disclosed, if they've got the right support and the disclosure has been handled really well and the got some follow up." (RPT)*
>
> *"A lot of that will be from practitioners like family support services, around some families that keep coming back into the system, the strategies are not giving them the solutions that they need, so if they think we can start asking them about what's going on for them individually, that might start unblocking and joining the dots about what they've experienced and why they are needing support. This might give them the solution they need themselves with support to manage in a different way." (RPT)*

- **Changing attitudes and creating a shift in culture** through awareness raising, building knowledge and providing professionals with the tools / skills and confidence to implement routine enquiry. It was felt that this was important at every level to ensure that all staff (e.g. frontline and office staff, managers etc.) experience this culture shift: *"..some of it is around individual confidence to get going with it. So even though there might be a strategic push to get it going there are still some pockets that we need to work with. So there's understanding there's a reluctance at the moment….It's like anything. The more you practice the better you get at it" (Commissioner).*

> *"...to help professionals to feel confident and skilled and knowledgeable about adversity and its impact and to understand what their role is, what trauma informed practice is and how routine enquiry can fit into that and why there are potential reasons for asking people, help them understand the research. Help them understand the views and attitudes of people that have talked to us about the enquiry process and hopefully give them some skill and confidence in implementing that in their work place." (RPT)*
>
> *"…I'm hoping that it shifts the culture in some services, that it creates a level of interest, conversation, attitude change, people have an opinion of a subject that perhaps they didn't have an opinion of before, they didn't' know anything about. I hope we've shifted some beliefs about this whole thing and that people see it as necessary and vital, not just the enquiry part, but the wider knowledge and understanding." (RPT)*
>
> *"The whole model is set up to enable practitioners to be confident to ask and to be able to manage disclosure and to manage the worries around asking questions that they don't think they should be asking because they 'don't have training as therapists' and 'don't think they should be asking someone to tell me something that they might be upset about, I'm not a therapist..." (RPT)*

- **Improved working / communication between services** through the presence of strategy and implementation groups and **developing communities of practice**, with services / organisations 'thinking about how they work in the system' - *"We're trying to get people together who are moving in the same direction and want to learn from each other" (RPT).*

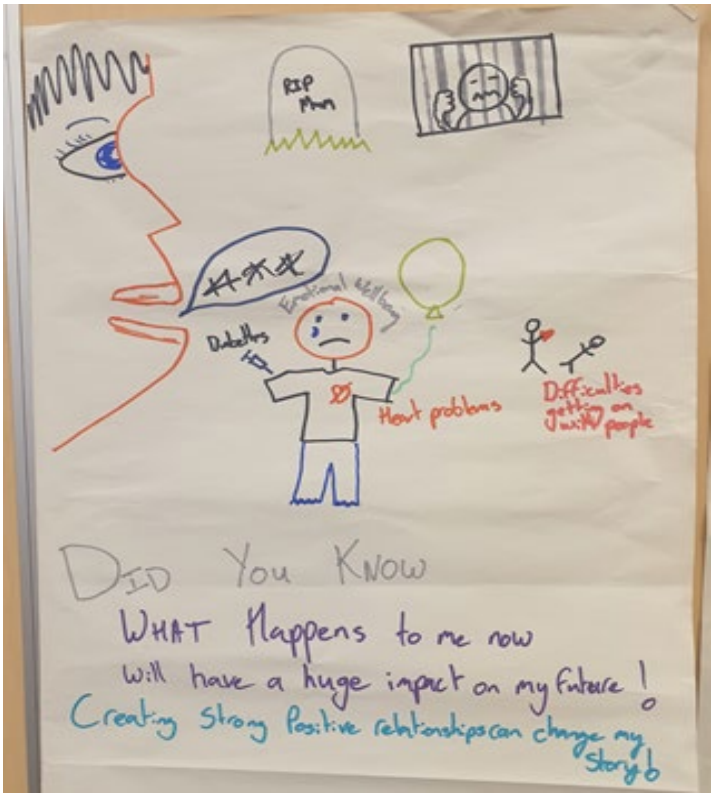
4.3.2 Outcome: developing trauma and ACE informed services and practitioners

During May 2019 to February 2020, over 500 practitioners from across Nottinghamshire received the REACh™ programme training, including access to pre-training materials (also available online for all

trainees post-training) and attendance at a one-day training session. As part of the training, evaluation surveys were implemented pre and post-training, to measure changes in attendees' knowledge and confidence, and post-training their views on the training. For initial training sessions, the Warren Larkin Associates (WLA) training surveys were implemented, and following ethical approval LJMU training surveys were implemented, collecting similar information but tailored to meet the long-term needs of the evaluation (see Appendix 7.2). Key findings are summarised below.

Impacts on knowledge: Participants were asked pre and post-training, to rate their knowledge (very good to very poor) for a number of statements (see Figure 5). Compared to pre-training, post-training participants were significantly ($p<0.001$) more likely to report having very good / good knowledge about: what is meant by ACEs and what the associated risks are; the importance of routine enquiry, and what is needed to support good practice and embed enquiry; and, actions to take when identifying ACEs, and the support needs of clients following disclosure.

Figure 4: Example of trainee's pictorial brainstorm of ACEs



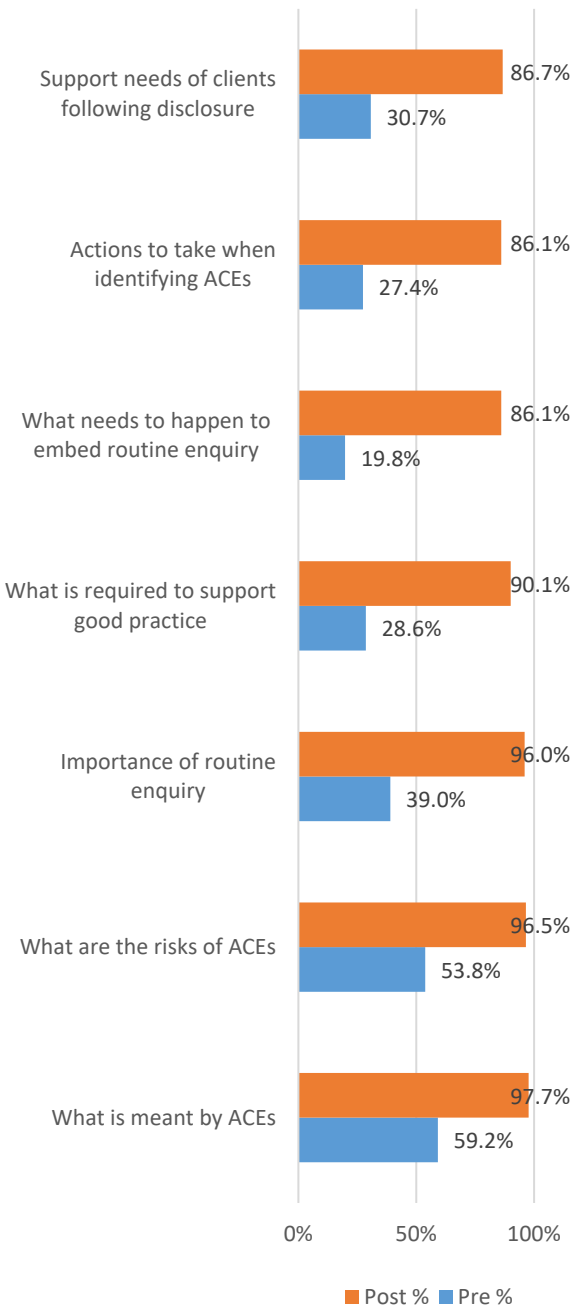
Impacts on confidence: Participants were asked pre and post-training, to rate their confidence (very to not at all) for a number of statements about implementing routine enquiry (see Figure 6). Compared to pre-training, post-training participants were significantly ($p<0.001$) more likely to report having confidence to: ask clients about ACEs, respond appropriately, and refer clients for support where needed. Post-training, trainees were asked what changes, if any, they would make to their practice as a result of attending the training. Responses included disseminating the information learnt about ACEs to colleagues; being more confident to ask questions; and, consistently undertaking in routine enquiry.

"I will be more confident is raising discussions about young people past experience." (Trainee)

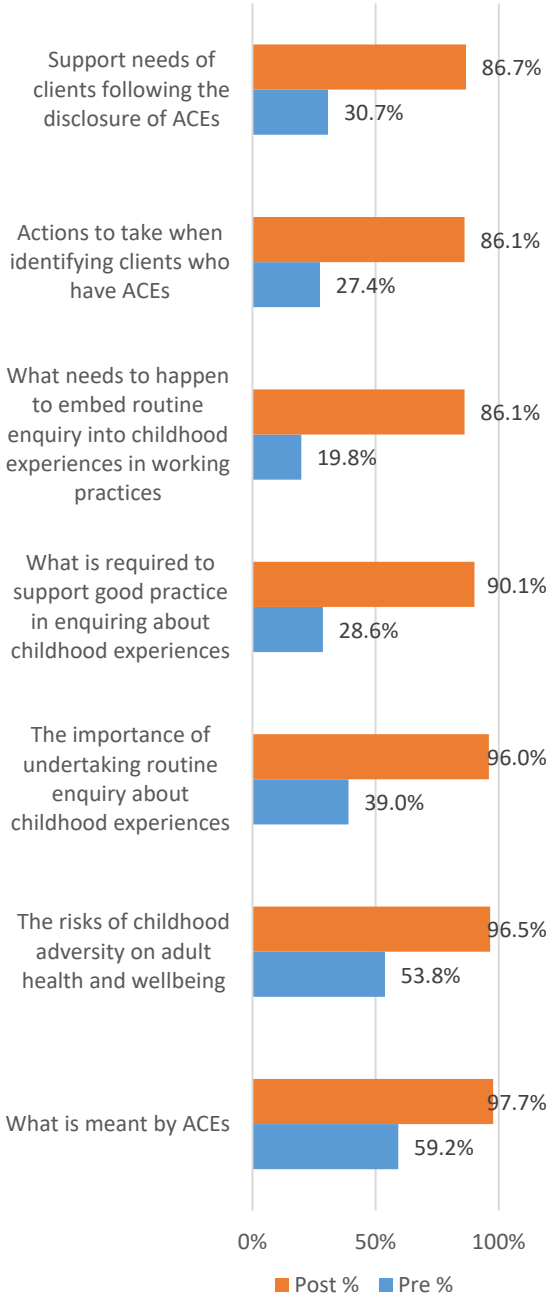
"Talk to my team about ACEs and whether they are able to implement what they learnt in practice." (Trainee)

Views on training: The majority of participants agreed (strongly agreed / agreed) that the training was easy to understand, the trainers were knowledgeable and interacted well with them, and that they would recommend the training to others (Figure 7).

Figure 5: Percentage of training participants who rated their knowledge as good / very good for selected statement on ACEs and routine enquiry; WLA surveys and LJMU surveys



WLA surveys



LJMU surveys

Figure 6: Percentage of training participants who expressed confidence for selected statements on implementing ACE enquiry

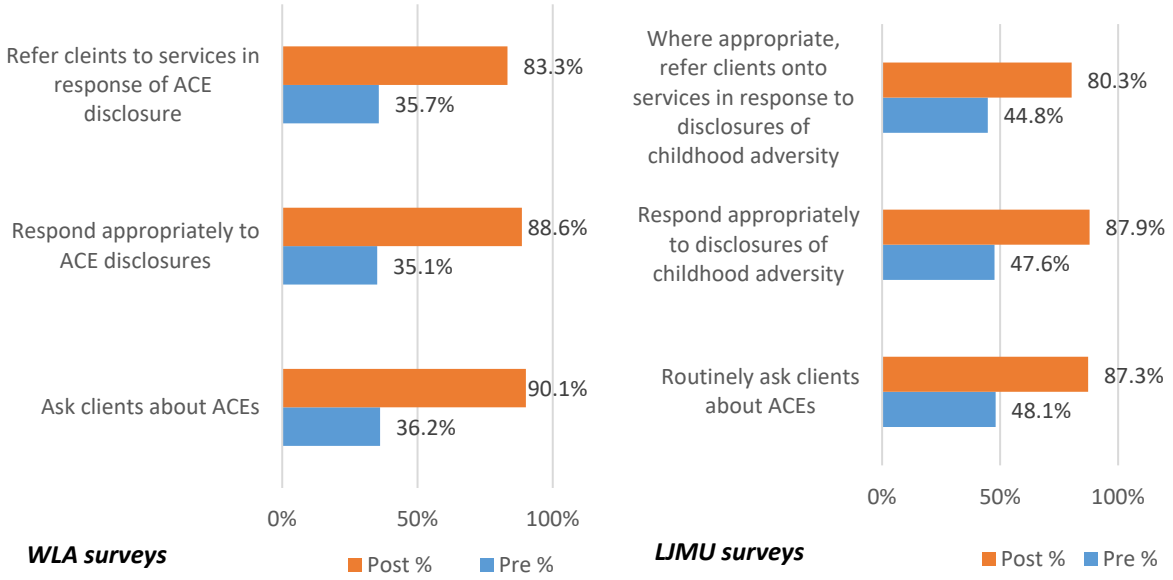
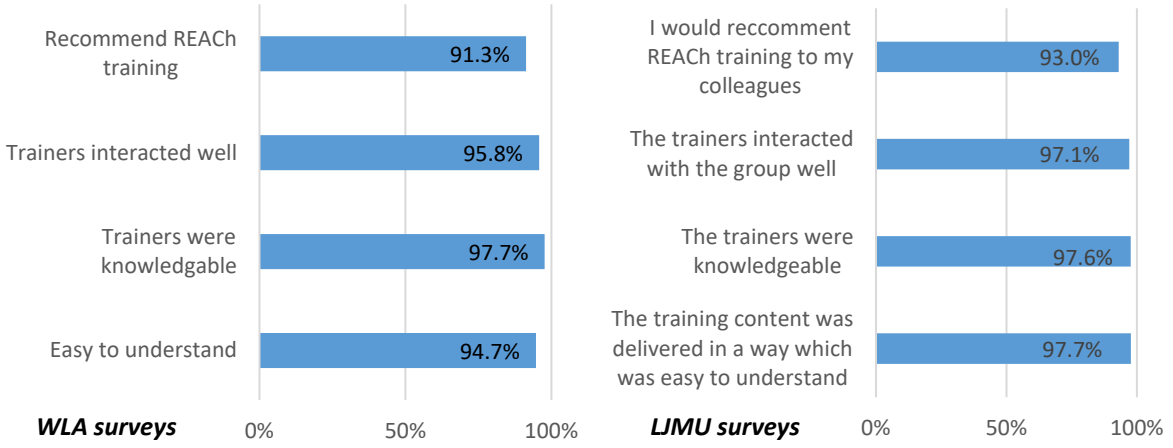


Figure 7: Percentage of training participants who agreed with selected statements on the training



4.3.3 Outcome: emerging impacts for service users, services and the whole system

Five out of nine services had commenced ACE enquiry with some service users, and partners highlighted that some organisations were beginning to show 'wonderful narratives' around the 'impactful experiences' they were having with their clients. Examples of impacts included:

> *"A couple of the teams are really seeing transformational results in people. We've had some really positive case studies shared with us. Even if we only make a difference to a handful of people then I think that's something worth celebrating." (RPT)*

- Parents reflecting on their childhood experiences and how this may relate to their own behaviour, and wanting to make changes to their behaviour to protect their children.
- Routine enquiry helping service users to recover.
- Service users providing practitioners with their views on ACE enquiry, and the ACE tool to inform and/or support future implementation. For example, in one service, clients who had engaged in ACE enquiry attended staff training sessions, to dispel staff concerns around how they thought clients may view ACE enquiry, and/or react following routine enquiry.

> *"Asking these questions could change the course of your future. It makes you relate to your current situation and more open to make changes for the sake of your own children"*
>
> *(Practitioner report of service user feedback)*

- Service users coproducing programme materials (e.g. video of their views on ACE enquiry to inform and support implementation).

It was stated that through the sharing of service level experience and service user feedback, and professionals talking to each other at the implementation group, ACE enquiry would become more embedded. It was acknowledged that it was still 'early days' and this would grow as organisations had been offering routine enquiry for longer. The implementation and steering groups were seen as a great platform to share ideas and resources across organisations, thus supporting / strengthening the whole system approach. It was highlighted that conversations were already beginning in Nottinghamshire, particularly where services had clients in common, and this was seen as a positive development - *"Some of them are talking about getting themselves together outside of our sessions [i.e. implementation group] to look at how they work and interact and become more integrated" (RPT).*

One of the participants felt that this multi-disciplinary approach strengthened the messages going out to communities about services / organisations valuing how individuals may be affected by things that have happened in their childhood.

> *"What's wonderful about Nottingham is that you have this kind of range of services. What I think that is going to communicate to those service users, is that we value what's happened in their childhood…I think if there is a range of services then there is going to be a stronger message going out to communities. In Nottingham[shire], I think that some clients will hear the message a few times and I think that that would be really good. And services and families will be touching on substance abuse issues, family support, prison, all of those things and I think that that is amazing and I think there are more services that can be included." (RPT)*
>
> *"There are more than just these [the organisations / services included in the current pilot], but this is amazing as a starting block…to have a whole community approach you need to think about all the services that families, young people and vulnerable adults come into contact with and make them all ACE aware and trauma informed." (RPT)*

The next phase of the evaluation will explore and evidence outcomes from the implementation of the Nottinghamshire REACh™ programme in more detail.

4.4 Case study 1 - Change Grow Live Nottinghamshire Substance Misuse Treatment and Recovery Service

4.4.1 Overview of service and clientele

This service is commissioned by Nottinghamshire County Council and provides adult (age 18+) drug and alcohol recovery services across the county in a range of community settings. Individuals can self-refer into the service, or be referred by an external partner (e.g. GPs, other treatment providers, housing providers, probation staff). The service has three hubs across the area of Nottinghamshire that are based in Hucknall, Mansfield and Worksop.

4.4.2 Process of REACh™ implementation

> *"People were concerned about how service users might react around asking them about these adversities." (Practitioner)*

Following completion of the readiness audit, staff members were invited to attend training. The majority of staff (around 80 out of around 100) have been on the training across eight sessions implemented from May to September 2019 (including four single and four multiagency sessions), with one final cohort due to attend training in 2020.

Some initial anxiety amongst staff was noted, specifically around asking the ACE questions as they were seen to be very clinical, as well as the support that would be available to both service users and staff in the case of a disclosure. The way in which this was addressed within the organisation was through a number of internal implementation training sessions. At these sessions, a REACh™ training video was played for staff, who were then asked to discuss in groups an individual task: 1) what they felt would happen if they offered routine ACE enquiry; 2) what support do staff need; 3) think of a time when they had made a disclosure and what was a helpful response; 4) think about a time when they had made a disclosure and what would have been an unhelpful response. This process was led by the Implementation Lead (IL) for REACH™, a post that was seen to be very beneficial because it was dedicated to the implementation of REACH™ across the three organisational hubs. The sessions were seen to be very useful in helping staff members to address their concerns, and provide them with answers around how should they 'do' ACE enquiry (for example, where are service users referred onto if they need further help and what happens in a session if someone becomes heightened or is triggered [staff and service users]). Also to enable them to look at what getting it 'right' or 'wrong' might look like. It was felt amongst staff that the qualities of compassion, warmth, being non-judgmental and having healthy relationships were all important when using ACE enquiry. The organisational safeguarding lead was part of the process to look at what actions, in relation to supporting staff, needed to be taken away from these meetings.

> *"What [they've] been able to do is go to each team meeting in each locality and provide insight, guidance, training and work with practitioners on a 1-2-1 basis as well." (Practitioner)*

The IL invited three service users to the implementation training meetings. They came from a group that the organisation ran, and where ACE enquiry had been introduced already. The IL, who facilitated the group, had been able to introduce REACh™ after someone had made a disclosure and it was felt that the service users were very happy to support the work that was being done. Service users attending the implementation session with staff was seen to be incredibly beneficial as it was a safe space that enabled service users and professionals to have conversations around perceptions and assumptions around ACE enquiry and it was seen to break down potential barriers. This was seen to

be a good example of collaboration and co-production and it was hoped that engaging with service users, stakeholders, families and other people would help to shape the service further.

> *"...they [the staff] could actually ask service users directly themselves. So it put a lot of myths to bed because the service users were saying they were absolutely fine…I've been carrying this for a long time and it's reinforced what you've already identified...they were glad that they could share this secret and they were able to be heard." (Practitioner)*
>
> *"I'd say it was the most powerful part of those implementation meetings because what happened was, the service user was also able to ask staff questions and saying to them what do you mean by that. They were able to get some clarity…by the end, staff and service users all then became one. It just worked so well." (Practitioner)*

4.4.3 Actual implementation / acceptability of REACh™

The majority of staff within the service have completed the training, and two hubs had commenced ACE enquiry with over 150 service users (Box 5), who were reported as being *"grateful of the conversation".* ACE enquiry was viewed as an opportunity to explore service user's experiences of ACEs, not simply by completing the ACE tool, but by using the tool to support a conversation, and critically to get to *"know the whole person rather than parts"*. An interviewee spoke specifically about a group that they facilitated. It had nine individuals, and following a disclosure by one group member, the group were invited to participate in ACE enquiry and all agreed to take part. The lead spoke about their initial anxiety about implementing REACh™, but that this may have been influenced by others' perceptions. They acknowledged, however, that they did not let this put them off because they *"knew it was the right thing to do"* and that as part of their job they were comfortable having conversations around ACEs with service users. It was considered important to ensure that service users were given the choice to take part in ACE enquiry and that they felt comfortable to answer the questions. Where a service user declined, that was seen to be fine, as they were still being given the freedom to come back and talk about it and ask questions about what it is.

> *"They [the service users] were absolutely so pleased that we're now starting to enquire about adversities." (Practitioner)*

The use of ACE enquiry within the group setting was highlighted as welcomed by service users, with group members described as *"relieved that we (the service) are finally acknowledging their ACEs".* Three service users went on to support the implementation of REACh™ across the service, by sharing their views on ACE enquiry and their acceptability of it, the impacts of ACEs during their life, and examples of (negative) experiences of disclosing ACEs in the past. Service users attended the implementation training meetings and two services users shared their experiences and views in a video, (developed for use in supporting implementation across the service and beyond). Here, service users highlighted their acceptability of ACE enquiry, and why they believe it is important for practitioners to ask the ACE questions, and critically the need for practitioners to take the time to listen. Ensuring that the practitioner acknowledged that the service user trusted them enough to share the information with them and that they allowed them the time to talk and reflect (rather than an immediate referral to another practitioner/service) was identified as invaluable

> *"…as well as being a burden of my shoulders that I've carried around for all these years, when (facilitator) briefly told me about this REACh project, it sort of opened up a doorway that I've been looking for a long-long time, and I thought you know what, why can't anyone have told me about this before" (Service user)*

in allowing the service user to open up and access the support they may need. One service user highlighted that practitioners should not be discouraged from implementing ACE enquiry if service users become upset.

> *"If someone's disclosing, hold them in that moment, keep them there, just listen and show interest, and don't try and [demonstrate you] haven't really got time to deal with this, you got to deal with it then, you've got to make time for that person" (Service user)*
>
> *"I wanted her to hear what I say saying, not in a professional term, but in a personal term, because I felt it the right time to tell this personal that was sat in that room with me" (Service user)*
>
> *"If we become upset angry about what's happened to us, and how it's affecting us, then that's fine, from our point of view we're saying that we really trust you if we're opening up in that way to you, so please do ask the questions and listen, and if someone has spoken to you about those things, we don't want to be told there's another service that can deal better with that as were opening up to you and feel comfortable with you, so please just be with us in that moment, just listen" (Service user)*

The importance of providing supervision for staff was raised. Group supervision was seen to be a forum where staff could come and discuss their cases, but it was highlighted that those that had been held thus far had not had very good attendance because of the high caseloads of staff. It was stated, however, that there would be an expectation for staff to attend the next one and that this would be supported at service manager / team leader level. Supervision conversations were also carried out by phone: *"staff can ring at any point…not one person has rung at any point and said this hasn't gone well, not one person."*

> *"There's only so much I can do, I'm not a team leader, so I do need the support of the team leaders." (Practitioner)*

With a large number of service users in the organisation it was felt that REACh™ should be available to all and that it would *"...hopefully naturally enhance the relationships between the service users and staff."* It was also viewed that all staff should use it and not just those who are *"willing to"*. When looking at possible areas of best practice, one of the hubs, where the greatest number of ACE enquiries had been completed, was highlighted. Here REACh™ is an agenda item during regular daily meetings, and if an enquiry is completed, the relevant staff member is praised and lessons are shared. They also have a REACh™ champion here and it was hoped that this would be rolled out to the other two areas. It was felt that these champions could become 'influencers' to encourage those staff members not currently engaging with REACh™.

> *"What we still find and this is the stage that we're at, is that some staff are absolutely running with it…and those conversations have taken place, but there are some staff that aren't featuring on that list of completing those." (Practitioner)*
>
> *"It was very organic and happened quite naturally." (Practitioner)*

Whilst one of the hubs has not commenced ACE enquiry due to external factors, it was hoped that they would be able to get them *"back on board"*. It was acknowledged that having a stable team was important and that where there may be potential issues such as funding cuts, the frontline team feeling overwhelmed or other changes, it was ok to say that REACh™ would not be the key focus during such times.

4.4.4 Facilitators and barriers to implementation

Building up a 'therapeutic alliance' with service users before engaging in ACE enquiry was noted as important, however it was also acknowledged that this may depend on the individual and the situation. For example, the assessment team at the organisation are the first people that the service user will see on engaging and may not therefore be identified as the best team to carry out the questions. It was, however, acknowledged that there will be people that come into the organisation for the first time and they will want to talk about their adversities immediately. An example of a detox group (two people) where the session focussed upon childhood adversity was provided. Through watching the ACEs video, one of the clients who had felt at the beginning of the session that they had not experienced any adversities, actually went on to identify a number of ACES - *"you could see this light bulb go on".* It was felt that this illustrated the importance of awareness raising amongst service users who may not realise that their experiences could have impacted upon them. An additional example focussed around using the ACE enquiry questionnaire in a clinic review setting with a doctor present. It was felt that in this setting, doctors have already begun to open up discussions with service

Box 5: Change, Grow, Live - ACE enquiry data

Up to 16th March, CGL had completed ACE enquiry with 173 (65.3% male) service users aged 18-74 years (64.2% aged 35-54 years). The majority (86.1%) were white British and 37.0% were from West Nottinghamshire, 24.3% North Nottinghamshire, 21.4% South and 17.3% East and Central. The majority (90.2%) of service users were in structured treatment (with others having had brief assessment). Over half (53.6%) of service users were currently / previously using opiates, whilst 27.2% were currently / previously consuming alcohol. The prevalence of each ACE and ACE count amongst service users is shown below:

Individual ACEs	**%**
Verbal abuse	55.8
Physical abuse	51.7
Sexual abuse	26.5
Neglect	14.6
Incarceration	22.2
Parental separation	53.5
Alcohol use	46.5
Domestic violence	52.4
Mental illness	46.8
Drug use	18.7
*Sexual exploitation	14.1
*Online sexual exploitation	9.9

ACE counts (12 item survey tool)	**%**
0 ACEs	12.7
1 ACE	12.7
2-3 ACEs	23.5
4 or more ACEs	51.2

ACE counts (*14 item REACh™ tool)	
0 ACEs	12.0
1 ACE	13.3
2-3 ACEs	22.3
4 or more ACEs	52.4

Almost one quarter (24.9%) of service users spoke about other experiences in their childhood / teens which they felt the practitioner should know about, which were not included in the set questions. 49.1% of service users reported having an adult they could trust and speak to about personal problems while growing up.

users and that it therefore provides an *"ideal opportunity to tag that [conversation around ACEs] onto the conversation"*. At one of the reviews the IL had attended, the service user had not identified themselves as having any adversities, but had ticked four on the questionnaire. As with the previous example, it was felt to have raised awareness and the service user was seen to begin to question whether these adversities may have caused their problems with substance use - *"I could literally see the thoughts that were going through his head"*. It was felt that this provided some evidence *"dispelling the getting to know people over 6-8 sessions"* belief before implementing routine enquiry.

> *"We need to be careful not to molly-coddle the situation too much because that then reinforces that there needs to be fear there." (Practitioner)*

Fear was seen to be a *"stifling factor"* in the implementation of REACh™ (i.e. staff fears of opening conversations). It was also highlighted that whilst service users were happy to take part in ACE enquiry, it was not necessarily as well received with all staff due to issues around resource and time. It was also commented that there may be barriers to implementation with staff who did not feel it was their job: *"whilst I don't know of anyone, it's there, they have that attitude of 'that's not my job I'm not a counsellor'."*

The gap between staff receiving the training and implementation was perceived to have potentially hindered the development of ACE enquiry within the organisation and posed the question whether staff may need to undertake the training again / have a refresher. A suggestion was made that training dates could be more regular, especially to accommodate for new staff and partners coming into the organisation – this was considered to be applicable to the whole system approach. Staff assumptions based upon personal experience rather than the evidence was also seen as a potential challenge.

4.4.5 Impact of engagement in REACh™

> *"I didn't imagine for a moment that it [ACE enquiry] would become a vital part of people's recovery. I would have done in terms of them [service users] not being able to hold the secret, that would be quite cathartic in itself, but the fact that people can then go on to do good things, I'm going to be a big advocate for that." (Practitioner)*

ACE enquiry was seen to have the potential to enable service users to take a step towards their recovery more quickly and that this was not an outcome that had been expected, for example, with one service user going on to undertake detox. An interviewee spoke about two of the people from the group that they facilitated going on to take part in the development of an ACE enquiry awareness raising video. This piece of work was seen to be an important part of their recovery by both the IL and service users, with the service users stepping out of their comfort and doing things that they would not usually do. The IL spoke of one of the service users saying that they would never have sat in front of a group of people talking about their experiences and being asked questions and asking questions themselves – they were seen to be identifying and realising this skill, changing their mind-set about their capabilities and the way they think about things. They also spoke about the second service user wanting to share their disclosure before taking part in the video. It was felt that this process provided service users with more control and choice in their recovery and that service users were the best advocates or champions *"to encourage others to have conversations around this [ACEs]."* Whilst these positive impacts were highlighted, and service users themselves highlighted the positive impacts for them following ACE enquiry, it was noted by the IL however, that it was too early to be able to begin to start making assumptions around impacts, gaps and strengths. This was because there had not 'been enough conversations' with service users.

"It's crazy isn't it, just opening up just someone like that, someone massive, and then something good can come to it" (Service user)

"Accepting what's happened to me as a child that that has affected me as an adult, and I always thought that I was over it but all I'd done was bury it really, so moving forward I can see myself working through that can coming out the other side with not needing to drink to push all those feeling down" (Service user)

"Opened up another door way, I wouldn't say it's put closure on my experience, bad experience, it partial closure but it's also helped me now to open up another door way, and to move on and deal with it in a positive way, whereas its always been something that I've been embarrassed about, and felt that I was guilty to a point, but over the years I have learnt that I wasn't guilty, I was the innocent party, I was abused" (Service user)

4.4.6 Next steps for REACH™ implementation

REACh™ was considered by this organisation to be more than just training and using a tool. It was seen as a long-term change in culture and mind-sets that was supported by a strong evidence base and that needed to be *"part and parcel"* of what the service does. Developments to the organisational contract[5], would be key to breaking this down and emphasised the long-term investment that the organisation is making into the development of trauma-informed practices and ACE enquiry. Interviewees felt that their energy, enthusiasm and belief in REACH™ would help to drive the programme forward and encourage others to *"believe that it's ok to ask these questions"*. They felt that offering ACE enquiry needs to become standard practice, almost mandatory to enquire about these adversities and the impact they have upon mental and physical health.

"I never thought it would ever have happened in my working career and it's long needed….so naturally I'm going to jump on board with that because it's something I feel very strongly about it and having worked with many people who've been sexually abused , neglected, physically abused, all of it, there's just not enough out there and having worked in criminal justice which is where all my experience has come from is that these people are labelled and yet we actually don't really know what's happened to them and when you find out then it makes sense." (Practitioner 1)

In terms of developing practice, the ILs are going to attend managers meetings at each of the three service localities to see what support they need and it was also suggested that routine ACE enquiry be put as an agenda item on supervision plans. The service is exploring if and how their young people's service can support the programme. To develop REACh™ in the clinical setting, the ILs spoke about wanting to attend clinical meetings with the doctors to put REACh™ on to the agenda.

"It's a massive opportunity to rescue someone from the past, and even from the present of what they're going through, up here (head/brain), the damage that's in there, feel it as an opportunity, you're saving that persons live really (Service user)

[5] Developments will begin in April 2020 and include a focus upon family, trauma informed practice and inter-generational substance misuse as well as a number of new key roles (consultant psychologist and assistant psychologist).

4.5 Case study 2 - Community Rehabilitation Company

4.5.1 Overview of service and clientele

The Community Rehabilitation Company (CRC) aims to "reduce reoffending and protect the public". They work "with people to assess their needs, manage risk and drive behaviour change; creating powerful rehabilitation journeys that reduce crime and help people to transform their lives" *(88)*. Their vision "is a safer society where people who have committed crimes are empowered to change, rebuild their lives and thrive" *(88)*. The CRC is one of 21 areas nationally and covers the areas of Derbyshire, Nottinghamshire, Leicestershire and Rutland. In Nottinghamshire, the CRC have offices in Worksop and Mansfield[6].

4.5.2 Process of REACh™ implementation

Following completion of the readiness audit, staff members were invited to attend training. To date, around 70 members of staff have been on the REACh™ training, across five sessions implemented from August to December 2019 (including two single and three multiagency sessions).

When looking at how REACh™ has been developed across the service and how it has been implemented across the different elements, it was felt that the service had *"been on a bit of a journey"*. It was explained how the service had become involved in the REACH™ programme after initially looking to independently implement REACh™ (they had been unable to do this due to changing contracts) as they wished to follow a more trauma-informed approach.

> *"Some while ago as an organisation, we committed to moving towards a more trauma-informed approach to our practice and all of our staff members had an awareness raising day to that effect with someone called [name] who is an expert in the field. I think we then…we had the intention of commissioning [name of organisation] independently to bring in the REACh approach across the whole of the organisation. What happened was, our contracts had been curtailed and the new contracts won't give us the opportunity to bid for contracts because we're going back into the public domain and therefore they're not willing to invest in the kind of commission of [name of organisation] to do that. And then around that time I became aware of the opportunity to get involved through the County Council public health initiative."*

The CRC has an internal REACh™ implementation group, including managers and a trauma specialist probation officer who attends the implementation group. There is also a lead individual (Operational Lead for Case Management) from the organisation who attends the overall REACh™ project steering group. The information from these groups is then brought back to the CRC with discussions developing about how REACh™ may then be implemented within the service. The readiness processes for the REACh™ programme had enabled them to review their current service, what is on offer and how this is implemented. Clinical supervision options for staff had recently been 'kick started' so that they have one-to-one supervision with their line manager every 6-8 weeks and then there is also the option for clinical supervision from an independent provider that the organisation commission. One-to-one supervision was something that was already carried out at the CRC, however, the clinical supervision

[6] The CRC have a significant presence in Mansfield of approximately 16 officers and it is from there that they also deliver their accredited programmes for 'unpaid work' (community service / community pay back) with approximately 800-900 clients/service users that they see from that office.

had recently been re-implemented – it was seen to be something that staff should have access to regardless of REACh™, but that it was the discussions around REACh™ that brought it to their attention.

> *"That's a bit of an odd one, because we do offer it, we offer it in Leicestershire and Derbyshire but we weren't offering it in Notts and no one really seemed to know why…So I think as we've started talking about REACh we've realised we've asked the questions why we're not doing it in Notts and no one really seems to know the answer. A lot of us weren't in our current posts when that situation developed. We've just brought that back on line."*

The service has booked in three dates in February where the implementation lead (IL) and their colleague (the trauma specialist probation officer) would be carrying out staff briefings - the purpose of which was to recap over the information that was delivered at the training, and look at how REACh™ may then be implemented as part of their probation practices. The IL emphasised the importance of looking at how REACh ™ fits into the case managers'[7] work and exploring their expectations around the programme in terms of delivery (i.e., localising it to their practice and seeing where it fits in), rather than just expecting them to do the training and commence enquiry. It was hoped that from mid-February service users would be *"openly exposed to routine enquiry"* and that all the necessary processes and support would be in place. It was anticipated that meetings with practitioners would provide *"a better idea of who's gonna run with it, who's not and what the kind of...where the resistance is and why".*

4.5.3 Actual implementation / acceptability of REACh™

The IL felt that everyone who had attended the training session, where they had been present, appeared positive towards REACh™. They spoke, however, of receiving feedback from practitioners who had attended the other sessions *"who were a bit less positive about it".* It was felt, however, that some of the practitioners may have been in more peripheral, rather than case manager roles, where rather than being asked to undertake ACE enquiry, they would be expected/asked *"…to be mindful of the fact that it's part of the practice that other people might be doing".*

> *"The noises from the training have been pretty good. Certainly a few people are really quite excited about it, but for some people they don't seem to fancy it… so we'll see how that goes!"*

Learning processes were also highlighted, which focussed around not necessarily realising or envisaging what the training would look like in advance; and that it has not been possible to brief staff in advance. This meant that a large number of practitioners were put forward for the training, but would not necessarily be conducting ACE enquiry. It was felt, organisationally, however, that it was important for all staff to have awareness and understanding of REACh™ and that the training enabled them (the IL) to understand if and how REACh™ could be implemented within their service.

[7] Each service user has a responsible case manager that is the owner of their case. They may have other workers who may deliver an intervention or supervise them on community service/unpaid work/community pay back or they may deliver an accredited programme to the service users. It is only the case manager who will be involved in delivering/implementing ACE enquiry as they have the primary relationship and responsibility for case management. Case managers would also identify where there is need for additional signposting or referral to other services.

"I think what I wasn't necessarily able to do, was go out and about and talk to all the staff about 'this is why we're doing this training', just because of restrictions around my own capacity and also, not really knowing until I'd done the training and we'd talked about it with the internal group as to how we were actually going to ask people to implement it…..[the training] was there and it was ready for us to go, but we had to get people on the training whilst we were thinking about implementation… almost like concurrent to the training process was the thinking process because it was presented to us by public health rather than something we'd planned ourselves."

ACE enquiry was seen to provide a more structured way for practitioners to speak to service users about the things they (the IL) would expect them to be speaking about anyway. The participant hoped that the practitioners would take the ACE enquiry questionnaire and *"make it part of standard probation practice".* The CRC was viewed as an appropriate setting for REACh™. It was also highlighted that some practitioners have more of a therapeutic approach and are having these types of conversations without being as structured or as comprehensive. For example via life maps in assessment that require practitioners to explore what has happened to people in the past - *"It's just bringing everyone into line with what I feel they should be doing anyway".* There was an acceptability of the ACE enquiry questions: *"They are what they are aren't they. You're asking people about specific things that have happened to them".*

"I would expect staff to be working with people and whatever their needs are , whether you need to reduce the risk of them committing further offences and clearly what we know is exploring these areas is gonna have a positive impact on that."

When looking at how the REACh ™ programme would be implemented and if it had been tailored to meet the needs of their service and clients, the service had developed a key principles document. This document detailed the key elements of ACE enquiry with clients, the timing of which would be determined on a case-by-case basis by the service user's case manager. Depending on the case, it was suggested that ACE enquiry interviews may vary in length, but that it is important that time is given to conducting the review and that it is done in a private space. Whilst it included the ACE tool, some of the text around confidentiality had been removed as this was already covered in the organisations own induction process. It was expected that new cases would undergo routine enquiry, but this would not necessary extend back to existing cases due to timing and appropriateness etc. It was discussed that it would be interesting to see whether in a year's time this has been the case and what has worked best for the service and their practitioners and clients.

"..we've developed a key principles document, which basically says we want you to complete routine enquiry with all of your service users, we're not going to tell you when because we want you to decide when that happens based on your relationship with the service user, but when you do it, this is what we want you to think about."

"I think we would be expecting people, certainly to begin with all new cases, but I think not with all cases because they [the case managers] might hold a caseload of sixty to seventy service users. So I'd say with new ones that come in, but I wouldn't say ruling out existing service users but equally not probably expecting everyone to do it to every single person on the caseload. Some people might be due to finish in a month and it might just not be the right thing to do for some service users, but I think in time what we're saying is the expectation is that you ask those questions to all your service users."

4.5.4 Facilitators and barriers to implementation

Key factors supporting the development and implementation of REACh ™ in the service were identified as the training, which was seen to be *"really good"*, and the engaging facilitators. The service had also been able to dedicate some of the time (two days a week) of the forensic probation officer to the project – this was seen to be helpful as it developed the knowledge of the practitioners, and provided the project/service with additional capacity (during a period of reduced capacity). Administration practicalities were raised as a small barrier to implementation. This specifically related to the time spent collating all the relevant information and coordinating staff across four or five different sites and disseminating relevant pre-training information and questionnaires etc. and the difficulty of reinforcing the importance of doing this against the backdrop of competing priorities.

> *"..it sometimes feels like we're limping along to the end of our contract. We're not filling vacancies. We've not really got a lot of slack anywhere. We've not got much in the way of support services. So we don't lack a will, but sometimes we lack a way because everyone's got stuff that they've got to do. But having [name] with a bit of capacity to do some of the leg work certainly has helped."*

4.5.5 Impact and next steps for REACH™ implementation

The participant spoke about having set up a way of recording the completion of ACE enquiry on their service system so that they can report against it. It was envisaged that each time a service user engages with the service, a specific code would be set up for ACE enquiry so it would be possible to see how many have done it and also look at what happened to them later in their journey. It was, however, acknowledged that this would be reliant on people recording it and highlighted that issues are present within the service around people recording things correctly.

4.6 Case study 3 - Police (school early intervention officers)

4.6.1 Overview of the service and clientele

Nottinghamshire Police Force is divided into city and county areas and the current REACh™ programme focuses upon the county area. The REACh™ programme is being implemented by school early intervention officers and the aim is to implement ACE enquiry with young people (aged 14+) who are supported by these staff members.

4.6.2 Process of REACh™ implementation

Following completion of the readiness audit, staff members were invited to attend training. Nineteen members of staff have initially been trained across the organisation (during one single service session). The REACh™ programme training was noted as providing valuable insight and awareness for some staff who were unaware of the impact that adversities can have. It was hoped that this would provide staff with a different perspective, *"a new thought process"*, one that was not automatically punitive. Enforcement was seen to be a small part of the staffs' role, with the focus being upon identifying and advocating for vulnerable young people.

> *"I know they have the pre-reading and everything but I do think they thought I can see that, they all got a cathartic memory where they thought 'oh, that child I had, I wonder what they'd had before'." (Practitioner 2)*
>
> *"The enforcement stuff is such a small part of their role. Their role is to be advocates for young people and to identify those key vulnerable people and work with them to prevent them from being victims of crime or to prevent them from going into that spiral of criminality and stuff like that so I think these officers in particular have got a different mind-set and that's probably why the majority of those guys have thought actually I get this, I see this is going to be of benefit. (Practitioner 1)*

> *"In essence they've got two months to set the groundwork, identify the young person, brief who they need to, set the scene and do the routine enquiry and then we'll come back in March and have a proper debrief and a bit of a reflective practice in terms of what went well, what didn't to take it through to the next phase." (Practitioner 1)*

At the beginning of 2020 an internal implementation meeting was held, where those who had been trained came together for a refresher around the training, discussions around any issues they felt would impact upon implementation, and the processes being followed by Nottinghamshire Police. It was felt that the potential for the programme to work could be seen, but that there was some contextualisation needed. This has involved looking at what support is available in the areas where the trained staff are working so that they are able to signpost if necessary. It was highlighted that they were *"making progress in terms of putting the foundations in terms of identifying who the groups are"*.

4.6.3 Actual implementation / acceptability of REACh™

All of those who were trained had until March 2020 to begin implementation. There are a number of processes that it has been recommended staff follow:

1. Find out what local services to signpost to (both internally and externally) so that a directory of services can be developed that the team can access and is to hand so that they can provide this to the young person there and then so they don't have to wait.
2. Identify who each staff member will work with; who is their young person (criteria – less complex cases, minimum age 14).
3. Sit down with each designated safeguarding lead (i.e. within school) and get them on board.
4. Start a formal problem-solving plan for supporting the young person.
5. Set up a meeting with the designated safeguarding lead and the young person and conduct routine enquiry.
6. Post-meeting, meet the designated safeguarding lead and discuss what has happened.
7. Complete the problem solving plan and respond appropriate, considering what will be done next to support that individual, including signposting and welfare support, and the time required to support the young person.
8. Meet the young person to brief them on what has formally been agreed. Keep them updated.
9. Problem solving plan to be followed as agreed with the young person - initially reviewed after three months followed by subsequent longer term reviews as required.

> *"I don't think there's been any feedback around the questions that they've said 'I'm not asking that'. That's all be accepted in terms of the structure." (Practitioner 1)*

It was highlighted that staff initially may have felt "*quite uncomfortable"* using the routine enquiry questions and felt that it may open up additional work, but that *"once we got past that…they were quite keen to be fair."* It was felt that as Police, they are used to asking difficult questions. Staff were pleased that they had taken part in the training and that it is important for them to know that they are not alone in carrying out ACE enquiry, that there is a *"network they can tap into"*. ACE enquiry was viewed as an extra tool in their toolbox to deal with complex young people and that in turn this will make a difference to the lives of young people.

4.6.4 Facilitators and barriers to implementation

It was identified that a potential barrier to engaging with young people was that historically, the Police are seen as authority figures and can be seen as intimidating. Feeling like they are being listened to was seen as an important factor in engaging young people, along with working with the schools to identify who might be most in need of help. Putting the Police into schools was seen as a way of breaking down these barriers, and it was felt that the locality of the school and the schools themselves may impact upon the success of ACE enquiry and how it is received.

> *"..this young person obviously trusts this police officer implicitly because she's agreed to do it. But the parents are involved in that one, so they've actually asked the parents if it's ok. Because the parents were worried, why's this child acting out or whatever they're doing. So that's one thing that we are doing." (Practitioner 2)*

It was discussed that one of the school's officers had already identified one person and had a pre- meeting to speak to the young person telling them what they're going to do, what sort of questions they will ask. This officer was said to have a *"really good relationship"* with the young person and their school; they have also engaged with the child's parents.

When looking at potential barriers to REACh™ it was acknowledged that initially there was the reaction from staff of *"this is going to involve a load more work for me"*. It was hoped, however, that with increasing awareness of REACh™ and sitting down with staff to talk about it, they would understand the *"wider significance"* of what they were being asked to do and that it was actually part of their job. Reflective practice was seen to be a good way of identifying potential challenges/barriers to implementation as well as successes. Engaging staff who were not directly line managed by implementation leads was identified as a potential barrier, due to difficulties in maintaining contact with these officers and engaging them in meetings. This again focussed around the importance of changing mind-sets and culture and ensuring those staff realise that *"it wasn't just a day's training, they've actually got to do something"*. Discussion also arose around the importance of everyone being on the same page, for example, when a disclosure is made that is a crime.

> *"It's dead easy for us with the seven or eight schools officers that we've got trained because we have direct line management over them and sometimes that kind of structure goes a long way to getting things done really. But there's another nine or ten people throughout the organisation who we don't line manage. So I guarantee there'll be issues with them actually delivering because we don't have much sway over them. So we'll have to negotiate with their supervisors to get them on board and to keep them on track for doing stuff." (Practitioner 1)*

4.6.5 Impact and next steps for REACH™ implementation

When looking at how engagement with REACh™ will be recorded and the outputs of this, discussion focussed around the development of the problem solving plan and the analysis stage of the problem solving plan. The young people would also be benchmarked against the systems that the Police have access to (i.e., their intelligence, and command and control systems), to see whether any engagement (prior to routine enquiry) with the young person has been 'good' or 'bad'. Where possible, data from schools would also be accessed to look at behaviour, attendance etc. This data would then be reviewed once interventions (in line with the problem-solving plan) had been implemented. It was acknowledged that some of the data may be more anecdotal, qualitative in the sense of getting feedback around changes in how the young person is feeling. It was highlighted that it may be a potential issue to access pupil information (e.g., details of behaviour, attendance) from schools, however this would be explored once routine enquiry had commenced.

The team were holding a meeting in March to review and assess implementation. It was felt that the sustainability of REACh™ could be achieved as long as the staff are using it and the organisation sees the benefits. It was commented that the publication of the evaluation ar0ound REACh™ would also play an important role in this.

> *"..we're hoping impact for the young person, seeing a change in their potential behaviour, either inside or outside of school, to make sure that they don't get put into the criminal justice system and to make them better people as they grow up. Because that's part of the schools officer's role isn't it to work with young people but to make them become better citizens in the future." (Practitioner 1)*

4.7 Case study 4 – Nottinghamshire Women's Aid

4.7.1 Overview of service and clientele

Nottinghamshire Women's Aid (NWA), commissioned by the council, is a specialist domestic abuse support provider in North Nottinghamshire, covering Mansfield, Bassetlaw, Newton, and Sherwood. The organisation serves a large geographical area as well as diverse communities within that area. The service offers free support to children, adolescents and adult women who are or who have been experiencing domestic abuse.

NWA offers several different types of services including: accommodation services; co-location services in police and court settings; independent domestic violence advocates (IDVAs); maternity IDVAs; and, community support.

4.7.2 Process of REACh™ implementation

Prior to NWA signing up to implement REACh™, representatives from the organisation attended a briefing on the programme in order to better understand its premise and aims (i.e. process workshop). This helped to inform whether REACh™ was suitable for the service. NWA was already an ACE aware organisation and it was considered important to see whether the terminology and thinking of the REACh™ approach fit within the service's practice and ethos. Particularly important to the service was understanding the intention of the programme and how it could benefit their survivors.

The readiness checklist was perceived as hugely beneficial in assessing whether the service was ready to implement REACh™. It was felt that consideration of not just whether a service wants to buy into a programme but also whether they were able to buy in was rarely considered by pilot projects and this was an important positive of the REACh™ programme. The service were able to use the readiness checklist to demonstrate what they were doing to get ready. Having a clear sense from the beginning of what they were doing and why helped to gain buy in to the programme amongst service trustees and practitioners. This has been facilitated by the business development co-ordinator sitting on the strategy group, and a practitioner on the implementation group.

> *"In all honesty it's one of the only times we've actually been asked as a partner to show what we are doing to get ready...so that was really helpful for us because sometimes when we are asked to buy in we are not asked about how we are doing that so it was really good to be able to present this is what we are doing to get a buy in."*

> *"The process was very much a see how this can be absorbed into your practice and understand where it fits. I think that's really considerate and that's the way we think anyway but it is really positive for us that's being delivered to other organisations that might not have the ability to work like us… because we have relatively small numbers compared to larger state agencies. It was good to hear that that pace and rhythm was rolled out to everybody."*

When the decision was made that NWA would take part in the REACh™ programme, the business development co-ordinator reviewed the organisation's different services and considered where best REACh™ would fit. Assessing where routine enquiry best sits in each individual organisation is part of the REACh™ model and this consideration was felt to be a strength of the programme.

For some services offered by the organisation a programme such as REACh™ was not considered appropriate, particularly in the initial phases of implementation when the organisation and staff were less familiar with the programme. For example, the family court service wasn't considered an appropriate service to pilot REACh™ because of some of the possible legal implications of disclosure. Whilst some services offered by NWA were considered potentially appropriate for piloting REACh™, careful consideration was still given to whether it could be implemented universally with all clients accessing the service, or whether a targeted approach was more appropriate. For example, routine enquiry was considered appropriate to implement within the NWA refuge service however it was not implemented universally and was not used with women in crisis.

> *"What we don't want to do is for them to think they are only getting into refuge because of the number of marks on the ACE questionnaire."*

4.7.3 Actual implementation / acceptability of REACh™

In the early phases of implementation ACE enquiry was conducted with a small select cohort of service users who practitioners identified as already having established relationships with. A further consideration was where in the support pathway ACE enquiry should be conducted. It was not considered appropriate to implement at point of referral. Further, in some services, such as refuge accommodation, survivors may perceive the questionnaire as a pathway into refuge and feel pressured to complete it. Thus, the ACE questionnaire is used within the refuge service but not until after the woman has entered the refuge, they have decided they are staying and they are no longer at a point of crisis (see Box 7 for an example of implementation). In general, support workers gauge when is the right session to introduce the questionnaire and it's done as part of routine emotional support sessions. As long as it was appropriate, practitioners typically aimed to conduct ACE enquiry near the beginning of support to allow ongoing support to be tailored based on what is disclosed or discussed. Furthermore, it was considered inappropriate to conduct ACE enquiry near the end of a period of support as this limits the time to continue discussions or address issues which might arise as a result of completing the questionnaire. In the initial phases of implementation, practitioners asked the questions and completed the questionnaire, however some survivors showed a preference for completing the ACE questionnaire

Box 6: NWA ACE enquiry data

Up to 25th February, NWA had completed ACE enquiry with 16 female service users aged 18-45 years. None of the women had ever completed an ACE questionnaire before. The prevalence of each ACE amongst the women is shown below:

Individual ACEs	%
Verbal abuse	50.0%
Physical abuse	50.0%
Sexual abuse	6.3%
Neglect	37.5%
Parental separation	56.3%
Alcohol use	37.5%
Domestic violence	43.8%
Mental illness	50.0%
Drug use	50.0%
Incarceration	12.5%

Seven (44%) women spoke about other experiences in their childhood/teens, which they felt the practitioner should know about, which were not included in the set questions. These experiences included being a young carer, experiencing domestic violence, child sexual exploitation, peer death, teenage pregnancy and miscarriage, family gambling, foster care, and parental suicide. 68.8% women reported having an adult they could trust and speak to about personal problems while growing up.

themselves. Thus, the method and timing of implementing ACE enquiry is quite flexible at NWA and takes a person-centred approach.

> *"Survivors do feel more comfortable with a list of questions because it looks formal, we are not just asking for the sake of it… it also makes people feel less alone because if it was just them there wouldn't be a standardised checklist."*

The ACE questionnaire was perceived by practitioners as being really positive for NWA clients. It was felt that routine enquiry helped women make connections between events in their childhood and current feelings and contexts, particularly for women who had children (e.g. Box 7). The ACE questionnaire was also implemented with expectant mothers and found to be acceptable to clients, with no negative responses or outcomes identified. One of the factors which was considered to contribute to the acceptability of routine enquiry by service users was the structured questionnaire format. It was felt that this was more familiar and acceptable than a general unstructured conversation about childhood adversities. The perception was that as questionnaires are commonly used now in lots of different services for different measures and outcomes people are accepting of their use to inform their care and support. This was also something mirrored by practitioners who were perceived as finding a structured questionnaire easier to implement than a more general conversation about ACEs with the client.

In general, most practitioners at NWA were reported to find the REACh™ programme acceptable and support its implementation. The nature of domestic abuse support work, which often deals with emotional conversations, was considered a facilitating factor in practitioners' acceptability of the programme. Furthermore, the ethos of the organisation is based on the premise that human experience is varied and their job is to understand survivors' experiences as completely as possible in order to best support the client. The REACh™ programme wasn't currently considered acceptable for use with NWA's teenage client group. There were concerns around childhood events being much more recent for teenagers compared to adults. In particular that adolescents may still be living with their parents and they are being asked questions about their parents and household.

> *"For me, our job is to understand a survivor's experience and to be able to deliver and practice in a way that's most beneficial. It comes along the same line as asking about domestic abuse and if I ask someone if their partner is physically abusive is that not offensive and they'll tell me where to go. I do think that although I appreciate that fear it's about providing that opportunity for discussion. It doesn't mean that person has to spill their deepest darkest secrets. But I think we come from a place where human experience is varied and the more we can support and understand the better for everybody. That's where we come from but it's easy for me to say because we are a specialist domestic abuse support service, we are very used to emotional conversations. I think people have the right to have that conversation."*

4.7.4 Facilitators and barriers to REACH™ implementation

The REACh™ programme and the ACE questionnaire built on this pre-existing knowledge and awareness of ACEs and provided practitioners and the service with a structured standard way of incorporating enquiring about ACEs into their standard practice. Gathering testimonies from key individuals who were regularly implementing routine enquiry was also identified as a facilitating factor in gaining support from other practitioners who were less confident.

One of the potential barriers to implementation was that staff, particularly those who have experienced ACEs, may feel uncomfortable conducting ACE enquiry. A procedure was put in place to address potential issues arising from staff disclosure of personal ACEs and/or for those who did not wish to implement enquiry. Firstly, the training was not compulsory. Over 50 staff were trained but some staff declined the training. Staff who did not feel comfortable attending the training were informed they still could do so in the future if they wished. The organisation operated an open and transparent policy around the implementation of the REACh™ programme and that it would be part of service delivery going forward. If staff had any concerns, they were asked to let their senior manager know. Supervision was provided and staff were made aware of the external support, in the form of free counselling available to them. For situations where a staff member did not want to implement ACE enquiry another staff member would do the ACE questionnaire with their clients instead.

"It really helped that ACEs is something that we talk about and are aware of any way as an organisation but I think what the ACE questionnaire allowed us to do is to focus in on that with a structure, which professionals really like… it was more an extension of the topic rather than it coming from completely out of their remit."

"We let everyone know, again if you didn't want to book on you just let the senior manager know. When they would flag it we had supervision with them and provided support around that like external support… said to them, as I said about transparency even though we understand where they are coming from absolutely, we can't say that they will never hear about the REACh™ programme and ACEs again because it's a programme that's part of our organisation now so it's about mutual responsibility so for example when it comes up in project meetings they need to think about how close they are to that and we are honest with saying how close do you feel comfortable. Is it that you don't want to ask the ACE questionnaire, or talk about what ACEs is."

A potential issue and implication of multiple agencies implementing REACh™ was the consequences it may have for cross-agency working. For example, where a survivor may complete the ACE questionnaire at NWA and their partner completes it within the probation service, the consequences of this for the survivor, the perpetrator and their relationship are currently unknown. From previous experience of cross-agency working, it was felt that perpetrators may use the ACE questionnaire as a justification for their behaviour and survivors who would have also had discussions around implications of ACEs on behaviours may apply the same principle to the perpetrator's behaviour.

4.7.5 Impact of engagement in REACH™

The REACh™ programme was perceived as allowing time for survivors to reflect and understand their experience (e.g. Box 7). Discussion of ACEs was felt to support survivors to have an understanding of how their current beliefs, perspectives and behaviours could be shaped from events in their childhood. Whilst some survivors did feel upset discussing their ACEs, in general the perception was that the insight survivors gained was valuable, with many saying *"I haven't thought about it like that"*. Making sense of childhood experiences and doing this in a supportive environment was believed to reduce feelings of shame and responsibility for what had happened and enable survivors to gain insight into their self-perception and self-talk. It was also felt that it was beneficial to practitioners to understand the client's history and this was not something that would have necessarily come to light at such an early point in the support pathway without routine enquiry.

4.7.6 Next steps for REACH™ implementation

> *"We are still working with that – we don't do anything we are not comfortable with because if we are not comfortable with it we can't ask survivors to be comfortable with it. What can we do to make us feel more comfortable and until that point we won't be asking the questionnaire to young people."*

The REACh™ programme is considered sustainable at NWA. There is organisational level buy in to the programme and it has been easily amalgamated into standard practice, and will be continued to be implemented, at the very least in the areas where it has been piloted so far. Having multiple external agencies involved in implementing REACh™ was also viewed as promoting sustainability. For example, the specialist maternity IDVAs work closely with the Nurse Family Partnership whose staff have also been trained which creates mutual understanding and terminology. It is less clear how the REACh™ programme can now be incorporated in some of the more specialist services, for example in court contexts or with adolescents.

Box 7: Example of implementation of ACE enquiry with a client – a practitioner's report

Before attending the refuge, the client lived (on the street) with an abusive partner, and had experienced physical abuse from a family member (whom they had sought refuge with). They came in to refuge frightened and presented with multiple support needs.

During the client's engagement with the service, and at an appropriate time, the routine enquiry process was explained to the client, and the client was happy to take part, acknowledging that it felt like a good idea and that their childhood events may have had an impact on them. The client also stated that they hoped that evaluation of the programme would inform future practice and lead to more joined up working between agencies (something they felt lacking through their own experiences of support agencies).The ACE questionnaire was completed, and multiple ACEs were identified and discussed during the session. The discussion covered ACEs and other childhood and adulthood experiences and trauma, associated behaviours (e.g. use of substances as a coping mechanism) and reflection on life experiences.

Throughout the session the client was supported emotionally, and was offered opportunities to pause and debrief on several occasions; the client wished to continue the discussion stating that she had not had the opportunity to talk about these things before and wanted to "get it all out". The client recognised that during her life, she had not had an adult she could trust or rely on to talk about the topics raised by the ACE tool and expressed a sense of relief at being able to share her experiences stating that she felt validated. The client also welcomed the opportunity to talk about other traumatic experiences occurring throughout their life (e.g. bereavement). The client reported that they were aware that they had experienced trauma in their life, and by being given the opportunity to discuss this in a single session, it compounded just how much they had been through. This appeared to be a moment of realisation for the client, who reported that they had struggled with their mental health and thought that this was something they could not improve. However, they now felt that engagement with counselling or mental health services would be very much beneficial to them. The client commented that by simple talking through the experiences they now felt lighter. This realisation also gave the practitioner an opportunity to acknowledge and praise the client for their strength of character and resilience and that they were here, making positive choices despite all that they had been through. The client remarked positively on being given the opportunity to discuss their experiences and to be listened to, despite being difficult topics. The client recognised the impact of their experiences but also that they happened to them not because of them and that they did not chose them. Following the session, the client made the decision to engage in other support services such as substance use and mental health; services they had previously been reluctant to engage with.

5. Key considerations and recommendations

Nine services across Nottinghamshire have committed to implementing ACE enquiry.

During 2019/20, 13 services from across Nottinghamshire were invited to voluntarily explore their engagement in the REACh™ programme, and nine services have fully committed. Participating services cover: healthcare; criminal justice; and, specialist support and family services. All services have identified strategic and implementation leads, completed a readiness audit, and most services have completed (or are due to complete) training. Each service is at a different stage of implementation, with five of the nine services having commenced ACE enquiry with service users, and others due to start imminently. To date, evaluation has identified a number of key factors that have facilitated or impeded the implementation of the programme, provided some early insight into service and practitioner acceptability, and has started to evidence potential outcomes for practitioners, clients and the whole system. Key considerations and recommendations for future programme development, implementation and evaluation across Nottinghamshire are detailed below.

Whole system approach

Countywide and service level strategies and activities have supported programme implementation.

Whole system implementation of the Nottinghamshire REACh™ programme has been supported by countywide and service level strategies and/or stakeholder engagement activities to raise awareness and support for the programme, promote culture and practice change, and support programme development, implementation and embedding. Such processes have been highlighted as vital to supporting programme implementation thus far. There is clear commitment and passion from services to engage with the test and learn project and continue to work towards implementing and embedding the programme within their respective services, and across the county. Maintaining, and potentially enhancing system wide support for implementation has been raised as a key factor to ensuring successful implementation and embedding of the programme in the future.

- The development, implementation, testing and learning from the programme should continue into year two. Governance and operational structures that monitor and support implementation, including the strategy and implementation groups, and service-level implementation groups should continue, to ensure safe and effective implementation, and monitoring of risks and harms.

Using tools and materials produced by services and sharing practitioner and service user perspectives of the programme has raised awareness of the programme and supported implementation across a number of participating services. Ensuring organisations beyond those currently involved in the test and learn project are aware of the programme and its key messages (e.g. partners are ACE/trauma informed) and can support the programme and engage with it as relevant is an important consideration. This can ensure all services are working from a comparable trauma-informed perspective and can facilitate implementation of ACE enquiry within their settings (e.g. police delivering ACE enquiry with young people in schools).

- Commissioners and implementing services should continue to highlight REACh™ and trauma-informed approaches across the county.
- Evidence captured from practitioners and service users on their views on the programme could be shared in different media formats to raise awareness of the programme and practitioner/client perspectives, within and across services in the county. The development of a video with service

users (and practitioners), capturing their views on the programme, and its use in shaping the programme across the county should continue to be explored.

From the outset, it was acknowledged that delivery may look different across services because they have different service models, outputs and outcomes, although it was anticipated that the five stages of the REACh™ model would be followed. Few deviations from the core principals of the REACh™ model were noted, supporting the notion that the programme can be implemented across different services *(14,15,17)*. Further, the test and learn project includes service types that are new to the piloting/implementation of ACE enquiry in the UK, such as probation and police. A number of additional service types were identified that could facilitate a whole system approach.

- Following further evaluation, and funding dependent, commissioners may wish to explore the potential of engaging additional services in the programme, or ways in which other services may complement the whole system approach to preventing and responding to ACEs.

Readiness, training and support

Readiness, training and support processes have been hugely beneficial to programme development across the county and within services.

REACh™ programme training has significantly increased knowledge on ACEs and routine enquiry, and confidence to ask service users about ACEs, and to respond appropriately.

The process workshop, readiness audit, staff training, and follow-up support were all rated highly in terms of supporting services to fully consider if and how REACh™ may be implemented in their service. To date, over 500 practitioners have participated in the REACh™ programme, accessing pre-learning materials and attending a one-day training session. Analyses of pre and post-training surveys suggests that the training is associated with significant increases in practitioners' understanding of ACEs and routine enquiry, and their confidence to ask service users about ACEs, respond appropriately and refer for additional support where needed. Attendees viewed the training extremely positively, although some areas for development and considerations for future implementation were noted.

- Where feasible, future delivery of the REACh™ programme training could be tailored towards the service(s) participating in the training, considering their planned implementation and potential challenges. The readiness document could be used to guide the tailoring of training sessions, prior to training implementation.

A number of services have implemented refresher training sessions prior to, and during implementation, to support and embed the programme. For some services, the gap between REACh™ training and implementation of ACE enquiry was noted as contributing to a need for additional staff training and/or support. The varying and continuing training needs of current and future practitioners engaged directly or indirectly in the programme was highlighted as a key consideration for programme implementation and sustainability.

- Services should consider if practitioners require additional training (e.g. resiliency building and therapeutic skills), beyond REACh™ training, to help them support service users effectively.
- Warren Larkin Associates should consider if and how they may support the future development and sustainability of the Nottinghamshire REACh™ programme. This may include development of a train-the-trainer REACh™ programme to enable local service implementation leads to deliver training for new staff / services and/or refresher training, and on-line training materials and/or development of additional resources additional resources (e.g. videos; online materials).

Some practitioners attending the training were not expected to implement ACE enquiry within their service. However, it was noted that raising awareness of ACEs and trauma-informed practices, and the REACh™ programme, could be advantageous to the system wide implementation of REACh™ within services and across the county.

- Wider services outside of the current REACh™ services should consider implementing training for practitioners across the county to develop awareness and understanding around ACEs and trauma-informed practices, and countywide prevention and respond approaches, services and/or interventions. Training could be embedding into existing training provision (e.g. safeguarding training) or through bespoke training packages.

Strategic and implementation groups support the development and implementation of the programme across and within services.

The strategic and implementation groups have been noted as particularly beneficial in supporting the development and implementation of the programme across and within services. The implementation group for instance has provided services an opportunity to share learning, concerns and to reflect on their practice. Reflective practice is promoted by the REACh™ programme team, and guidance has been provided on key principals to support reflective practice at a service level.

- The strategy and implementation group should be maintained to oversee and support programme development, implementation and embedding. Whilst the implementation group has only been in place for a few months, it has the potential to develop into a community of practice, and participants should consider how they can continue this approach beyond REACh™ programme and project manager engagement. The project manager and REACh™ programme team member should continue to support these meetings until sustainable processes for continued implementation are established.
- All services should ensure they implement and embed opportunities for reflective practice and staff supervision within their service, throughout the duration of the programme, ensuring that processes are monitored and concerns addressed when and where feasible.
- Consideration could be given to the development of REACh™ champions across services, who could further support programme development and reflective practices within and across services. This may require additional training for champions to support them in this role.

Change management

For valid reasons, services may be at different stages of implementation, and require differing levels of support.

Those services who provide, often long-term support to vulnerable people appear to be less likely to experience challenges relating to programme implementation. From a systems (and evaluation perspective), some organisations may take longer to embed and maintain the programme than others, who will adapt to this quickly. Critically, the interim findings suggest that services may need addition time to consider and plan programme implementation, even after completion of the readiness audit and staff training.

- During the test and learn project, participating services have had the autonomy to develop, implement and embed the programme, at a pace appropriate to the service, practitioners and service users. Implementation approaches have considered the key elements identified as critical to safe and sustained implementation, highlighted by the REACh™ programme team (detailed in the readiness audit), and by implementation leads (identified through completion of the audit, and engagement with practitioners and service users). Participating services should continue to

promote this considered approach, to ensure that change management is effectively and safely implemented across the services, enhancing the prospect of programme sustainability.

- The planning and change management elements of the programme should be considered as components that run continually throughout programme development, implementation and embedding. Implementing services should ensure they have adequate processes in place to review programme implementation, particularly once support from the REACh™ team has ceased. The readiness audit could be used to continually monitor programme implementation.

Implementation of ACE enquiry

All services are implementing ACE enquiry following a person-centred approach.

All services have developed plans for the implementation of ACE enquiry, considering which service users it may be appropriate for, and when it could be implemented in their care and support pathway. Whilst practitioners have been provided with implementation plans and guidance, critically across all services they are encouraged to use their professional judgement to determine if and when ACE enquiry should be implemented with a client. Thus, ACE enquiry is not 'routine' per se, but rather is being embedded in care pathways as appropriate to the client/service. This was seen as important to ensuring that the ACE tool and subsequent discussions are only implemented when it is appropriate for the service user (e.g. they are out of crisis; have a good rapport with the practitioner), and it is an appropriate point in the case pathway when they can still receive adequate support should they need it. Ensuring support is available for clients if they need it has been identified elsewhere as a key consideration as to whether ACE enquiry is implemented *(84)*. Further, services have allowed staff to consider if they want to implement ACE enquiry, and to do so only if they feel comfortable (considering the safeguarding and support needs of practitioners and clients). Equally, ensuring service users have a choice to participate (promoted in the REACh™ model), and if they choose not to, that they have an opportunity to revisit it later, was raised as important (including by one service user).

- This flexible and considered approach to implementation of ACE enquiry with service users should be viewed as a positive approach to ensuring safe, sustained and effectively implementation, and be supported throughout the duration of the test and learn project.
- Services should consider implementing procedures that enable service users to revisit ACE enquiry at a later point, if they do not wish to participate when first approached.

Some concerns have been raised around the availability and awareness of support services for clients who may require support following ACE enquiry. Whilst it is too early to identify if implementation of ACE enquiry results in increased demands for services or support provision, a suggestion from one service is that rather than it leading to increasing demands for support provision, it is allowing clients to accept support that is already available to them.

- Participating services should collaborate to develop a resource that demonstrates the different options available within and across services to support service users (and staff) who may be affected by trauma and adversities, and who are seeking support. This process could also form part of the readiness audit for future services implementing the REACh™ programme.

Whilst routine ACE enquiry is being implemented with children in the USA, little is known about the extent that the most vulnerable children find ACE screening to be acceptable, or the impacts it may have on them *(84)*. The REACh™ approach is being offered to young people aged 14+ across two Nottinghamshire services (police and youth offending) and both services have implemented a range of steps to carefully consider, support and monitor implementation. For example, both services have

processes in place to regularly receive feedback from practitioners, and one service is developing a directory of support services to ensure staff are aware of local support options for young people.

- Programme commissioners and participating services should continue to carefully monitor implementation, ensuring any risks or negative impacts are raised immediately, and lessons learnt, and positive outcomes are shared across partners. Consideration should be given to implementation with young people. The steering and implementation group meetings currently support such monitoring, and this role should continue into year 2.

Commissioners of the REACh™ programme note that a key aim of implementing the programme is to empower service users to recover from trauma and childhood adversity. The ACE tool asks a question about the presence of a trusted adult during childhood – a factor associated with mitigating the impacts of ACE across the lifecourse *(49)*. Together, this suggests that a core concept of the REACh™ programme model is strengths based; something not often considered in other ACE enquiry programmes *(84)*. At this stage of the evaluation, little is known about if and how a strengths-based approach is being implemented at a service or client level, although examples of ACE enquiry helping to support service users in their recovery for example have been noted.

- Participating services should consider if and how the Nottinghamshire REACh™ programme is taking a strengths-based approach and share learning of approaches across services.
- A wider outcome of the programme has been the engagement of service users in informing the delivery and/or supporting implementation across some services. Partners should further explore if and how service users may contribute to the development and/or implementation of the programme at a countywide and service level, including with young people.

The ACE tool

As services are in the early stages of implementation, little data is currently available to explore the nature and extent of ACEs reported by service users. Data from samples of service users from a domestic violence and substance use support service however shows much higher levels of ACEs reported compared to the England adult population *(3)*. This would suggest that these services, at least, are settings for REACh™ implementation.

Data from a small sample of services users suggest much higher levels of ACEs amongst clients in one service, compared to the England population.

It is important that ACE prevention efforts consider the role of other childhood exposures (e.g. poverty, bullying), and the complex nature of experiencing multiple, repeated or long-term exposure to trauma, and how this may relate to harms in the short and long-term *(84)*. The REACh™ ACE tool aims to provide service users with an opportunity to discuss and reflect on childhood experiences beyond the 10 commonly explored ACEs. Indeed, within the domestic violence support service, data shows a number of service users disclosed other adversities. An example of the use of the ACE tool, and subsequent discussions, facilitating a service user to reflect on their ACEs, subsequent health harming behaviours, and other traumas experienced throughout the lifecourse has been highlighted.

- The REACh™ programme does not promote an ACE scoring approach, but rather that the ACE tool and enquiry process is used as a mechanism to facilitate discussions around trauma and childhood adversity (including and beyond the '10 ACEs'), and to support clients as and where appropriate. This 'person-centred therapeutic conversation' approach should continue to be promoted.

It is important to acknowledge that ACEs are not deterministic. Whilst ACE studies show strong graded relationships between ACEs and health and social outcomes across the lifecourse, they also show that not everyone who experiences ACEs go on to experience harms, and a broad range of factors may protect people from exposure to future harm *(84)*. This was acknowledged by one service user, who suggested that the tool should include a separate question to identify if the client believes they may need support to help them recover from exposure to ACEs. Equally, however, the focus of the REACh™ model is to use the ACE tool to open up a conversation with clients, to explore their experiences and if they require support. For services that may have reduced capacity for detailed therapeutic conversations with clients, an additional question on support needs may be advantageous for clients.

- The test and learn project should explore if the processes of ACE enquiry implementation allow services users and practitioners adequate time to discuss ACEs and potential support needs, or if additional mechanisms need to be put in place to enable support needs to be identified within the available time period.

An evidence-based approach, monitoring and evaluation

The REACh™ model is underpinned by trauma informed practice, evidence suggesting that clients are more likely to disclose if asked, and evidence around the therapeutic benefits of disclosure, and harmful effects of emotional repression, and a number of theoretical assumptions (see logic model). Routine or targeted ACE enquiry however remains a relatively new approach, and whilst evaluation of pilot studies suggest positive indications around practitioner and service user acceptability *(14,15)*, more needs to be known *(79,84)*. Research on system wide multi-agency implementation of ACE enquiry has the potential to examine some of the current gaps in evidence including implementation in different settings (e.g. criminal justice), and impact on multi-agency working and system wide practices and cultures. In addition, it will expand the existing evidence base on the process of routine or targeted enquiry, including its feasibility, implications for service delivery, acceptability to clients and practitioners, and ultimately its impact on outcomes for service user health, wellbeing and health service utilisation.

Some consistent themes are emerging from the peer reviewed and grey literature around acceptability to staff and service users and feasibility in everyday service settings across multiple agencies. However, longer-term monitoring and evaluation is required to develop the evidence around routine or targeted ACE enquiry, including processes, outcomes and impacts.

The evaluation to date suggests that ACE enquiry is acceptable to those practitioners and clients who have engaged with it so far, and a number of positive outcomes for service users are starting to emerge, including some unexpected (e.g. clients co-producing programme materials and guiding programme implementation). Thorough evaluation of programme acceptability and outcomes is needed however, and this requires support from implementing services to help build the evidence base. As part of the test and learn project, all participating services have agreed (formally or in principal) to engage in the evaluation, and systems and processes have been, or are being implemented to enable further learning to be captured. This includes continuing to monitor and understand development and implementation processes. Critically, it also includes capturing perspectives from a wider group of implementing (and non-implementing) practitioners, and service users via interviews and surveys, and exploring programme outcomes.

- To ensure outcomes can be measured in year 2, the evaluation team and service implementation leads need to ensure systems and processes are set up and embedded to allow a broader range of

practitioners and service users to share their perspectives on the programme, and outcomes can be captured both qualitatively and quantitatively.

Year two of the evaluation will have an increased focus on outcomes for services, practitioners and clients, and the whole system. Evidence from outcomes associated with REACh™ can be mapped across the whole system. This will highlight key partners who may benefit from REACh but may not necessarily be funding the programme, and will have important implications for programme sustainability. It will also add to the emerging, but currently limited evidence base on routine/ targeted ACE enquiry *(79,84)*.

Conclusion

The whole system approach to implementing the Nottinghamshire REACh™ programme should continue into year two. Findings from this interim evaluation suggest that it is feasible to implement the programme across a range of service types, and across a whole county. Participating services are all self-selecting and participating because they have chosen to adopt the practice of routine or targeted ACE enquiry as part of a commitment to become more trauma-informed. Like pilot studies implemented elsewhere, whilst some services or practitioners may have had initial reservations about ACE enquiry, upon further exploration and engagement these concerns appear to have been allayed. A number of positive outcomes are evident from the programme at this stage. Over 500 practitioners have been trained, with significant increases in their knowledge about ACEs and routine or targeted enquiry, and confidence to discuss adversities with clients and support them appropriately. Five services have commenced ACE enquiry following a person-centred approach, and services are reporting positive outcomes for some of their clients. No negative outcomes or adverse reactions from service users have been reported to date. However, programme processes and outcomes should be continually monitored via the strategy and implementation groups, and evaluation processes. Whilst there is a real need for further study of routine and targeted enquiry and the longer-term impacts of this approach, emerging evidence of the REACh™ model suggests that when implemented following careful planning by trained and supported staff, ACE enquiry appears to be acceptable, feasible and can contribute to individual service users' recovery journeys.

Nottinghamshire REACh™ programme logic model (Interim evaluation phase, February 2020)

Assumptions

SERVICE USERS

- High ACEs prevalence across England; prevalence higher amongst clients in specialist support services
- ACEs associated with health harming behaviours, poor health and well-being, chronic disease and premature mortality; and increased health service utilisation
- Unmet need arising from exposure to ACEs
- Service users do not routinely disclose ACEs

STAFF: Staff may have difficulty recognising and supporting service users with harmful consequences of ACEs

SERVICES: Whole service-system approaches are more effective than those aimed at individuals / increase impact of individual interventions

Inputs

Organisational readiness: Service receives support to ensure it is ready to implement ACE enquiry prior to implementation, considering factors that lead to sustained practice change (e.g. service commitment; staff training and supervision; safeguarding; external support and referral pathways).

Pre-learning: staff who will be attending the training receive a number of learning aids to review before the training commences

Staff training: Staff receive training on ACEs, ACE enquiry and therapeutic response

Planning and implementation: Procedures and processes implemented to enable safe and effective ACE enquiry and therapeutic response. Routine ACE enquiry implemented.

Follow-up support: Service/staff receive on-going professional supervision and support

Outputs

Number of staff trained in ACEs, ACE enquiry and therapeutic response

Number of staff implementing ACE enquiry

Number of service users engaged in ACE enquiry, including:

- % completing ACE tool
- % requesting/accepting follow-up support

Service user views on ACE enquiry including acceptability and impact

Level of service utilisation and performance

Short-term outcomes

STAFF

- Increased knowledge and confidence in undertaking ACE enquiry & therapeutic response
- Increased ability to recognise consequences of experiencing ACEs and support clients
- Better therapeutic alliance with service user

SERVICE USERS

- Increased knowledge of how ACEs relate to current circumstances
- Experiences validated
- Freed from the psychological burden of concealment
- Move from thinking 'what is wrong with me' to 'what has happened to me'
- Increased trust and therapeutic alliance with staff
- Better understanding of what can help to improve their health and well-being, and where and how to access support
- Enhanced sense of control over their lives
- Better able to identify past and ongoing adversity in themselves and others' lives

SERVICE

- Increase in appointment time, support provision, and referrals to external support providers in the short-term (expected to decrease in the longer term)
- Services are better able to recognise and respond to patients/clients experiencing or at risk of harm; interventions delivered are more timely/appropriate/resilience building
- Improved working/communication between services

Longer-term outcomes

SERVICE USERS

- Better able to engage with services and to make use of treatment and advice
- Engage in healthier behaviours/ less health harming behaviours
- Can identify and are better able to undertake resilience-building activities
- Improvement in health, well-being, and quality of life
- Self-esteem and self-confidence improved
- Able to recognise and modify their own ACE-generating behaviour
- Improved self-reported recovery
- Increased self-care

STAFF

- Increased self-efficacy in practice and job

Impacts

Service users receive relevant support sooner

Care/support is person-centred, taking a life course approach

Service user's care experience is improved

Less demand for health and support services – cost savings to services

Services contribute better to improving population health and addressing health inequalities

Reduced ACEs in future generations

Service user's health and well-being and intermediate outcomes (e.g. resilience) improved

System-wide changes: shifting culture and working practices

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7. Appendices

7.1 The intervention area: Nottinghamshire

Nottinghamshire is a county in the East midlands region of England comprising of seven districts (Figure A1).

Figure A1: Regional map of Nottinghamshire, showing the seven districts and notable towns or cities *(92)*

* The population of Nottinghamshire is approximately 823,100 (2018 mid-year estimates); around 656,600 are aged 18+ and 166,500 aged 0-1 *(89)*.
* 16% of people live in the 20% most deprived areas in England *(89,90)* and 14% of the population live in social housing *(90)*.
* The healthy life expectancy for females is 62 and males 61 years (slightly lower than the national averages of 64 and 63) *(89)*.
* 74.7% of people in the county are employed *(89)*. For those aged 18-24 years, unemployment rates have been higher than national levels for eight of the past nine years and were 1.3% in May 2018, compared with 1.0% nationally *(91)*.

Local data can provide an indication of levels of health harming behaviours or poor health outcomes amongst the population. For instance:

* Compared to national statistics, successful completion of drug treatment is less (33.9% vs 36.9%) *(89)*. Additionally, only 22.8% of adults with substance misuse engage successfully with treatment following release from prison (compared to 34.2% nationally) *(89)*.
* Successful completion of alcohol treatment for 2017 was lower than national statistic at 33.8 (England- 38.9) *(89)*.
* 29.9% of offenders reoffend *(93).*
* The number of adults in contact with secondary mental health services who live in stable and appropriate accommodation is 42%, compared to 57% across England *(89)*.
* Emergency hospital admissions for intentional self-harm for 2017/18 were higher than the national average (197.7 vs 185.5) *(89)*.

7.2 Core evaluation methods

Stakeholder interviews: Semi-structured interviews will be conducted with key members of the REACh™ programme team, programme commissioners, and service level project leads at various time points throughout year one and two of the test and learn project. Interviews will explore: background to the test and learn project; REACh™ programme theory; experiences of, and progress in implementing REACh™ across the county/services, including supporting and mediating factors; the acceptability, uptake and impact of REACh™ amongst and on, service users, practitioners and services; areas for development; and, intervention sustainability across services/the county.

For the interim report, 14 interviews have been conducted with programme commissioners (n=2) and the REACh™ programme team (n=3), and service level implementers (n=7) from four of nine participating services.

Practitioner surveys and interviews

A series of surveys will be administered to the practitioners who participate in the REACh™ training sessions, and are thus anticipated to implement ACE enquiry.

Pre and post-training surveys: A pre-training questionnaire will provide a baseline assessment of trainees knowledge on ACEs, and confidence to discuss ACEs with clients (and respond); and how trauma-informed trainees are (using the validated 35-item Attitudes Related to Trauma-Informed Care [ARTIC] Scale). Pre-training survey questions around knowledge and confidence will be repeated in a post-training survey to assess the impact of the training, with additional questions exploring trainee views of the training session. For initial training sessions, the Warren Larkin Associates (WLA) training surveys were implemented[8], and following ethical approval LJMU training surveys were implemented[9], collecting similar information but tailored to meet the long-term needs of the evaluation (i.e. including the ARTIC scale).

To date, 398 pre and 436 post-training surveys have been completed and included in analyses presented in the interim report.

In year two, all practitioners from services who have commenced ACE enquiry will be invited to take part in a REACh™ implementation survey. The questionnaire will identify practitioner views of the implementation of REACh™ within their service including the acceptability and impact amongst and on, clients, practitioners and the service. It will also include the validated 45-item ARTIC, providing a measure of how trauma-informed practitioners, and the service are. Interviews will also be conducted with a sample of practitioners to further explore: experiences of, and progress in implementing REACh™ across the service, including supporting and mediating factors; the acceptability, uptake and impact of REACh™ amongst and on, service users, practitioners and the service; areas for development; and intervention sustainability across services/the county.

Client survey and interviews

In year two, the evaluation team will establish processes with participating services to implement a short feedback survey with service users who complete ACE enquiry. The questionnaire will identify

[8] WLA: Pre, n=185; post, n=263.
[9] LJMU: Pre, n=213; post, n=173.

whether the service user felt: the questions posed were clear and understandable; comfortable answering the questions; the service was a suitable place to be asked the questions; and their appointment was improved because the practitioner understood their childhood experiences. Interviews will also be conducted with a sample of servicer users to explore their experience and views on ACE enquiry in further detail, and short and long-term impacts.

Monitoring of programme development, implementation and outcomes

To add context to the evaluation, programme documentation or other information produced by the REACh™ programme team, commissioners or services that relates to programme development, implementation and embedding across the services/county will be collated and reviewed, and where relevant incorporated into evaluation outputs. In addition, evaluation team members will overtly observe programme events, such as training sessions across different service types, where the content and delivery of the training will be documented.

Review of programme documentation (e.g. strategy group minutes; REACh™ programme documentation/materials) and observations of programme implementation (e.g. strategy group meetings; pre-implementation meetings; training sessions).

Review of service user feedback case studies prepared by practitioners, and testimonials.

Audit of REACh™ and service level data: In year one and two, the evaluation team will work with the project leads within services to set up systems (using existing and/or new routine data collection methods) to collect information on the implementation and outcomes of REACh™. Where possible, ACE enquiry data will be linked to existing client data. This will allow an understanding of levels of implementation of ACE enquiry, and the profile of participating clients including demographics (e.g. age group, gender and ethnicity). We will work with services to identify current data collection measures that could be used to measure outcomes, and seek their approval to develop routine data collection systems to capture pertinent outcome measures that can be assessed at different time periods (and link these to ACE enquiry data). If possible, data will also be collected for clients not engaged in REACh™, who will act as a comparison group. We will seek to collect depersonalised individual level data in the first instance, otherwise summarised data.

The interim report includes secondary data collected by two of the five services implementing ACE enquiry, to provide an indication of ACEs identified amongst participating service users and their demographic profile

7.3 REACh™ ACE tool

Please read the following information. If you wish, you can ask a member of staff to help you.

- We know that certain experiences during the first 18 years of life can have harmful effects on our health and wellbeing as adults.
- This information can help us to work together to find the right help and advice for you.
- If you agree, we would like you to answer some questions about these types of experiences.
- You can fill out the questionnaire on your own or you can do it together with the person you are seeing today.
- You do not have to complete the questionnaire and you can stop at any time.
- You do not have to answer every question.
- If you want to, once you have finished this questionnaire, you can talk about your experiences with the person you are seeing and think about what these experiences mean for you.
- If you have trouble understanding any of the questions or would like to ask anything, please speak to the person you are seeing today.

Confidentiality – What Does This Mean?

- We want you to feel comfortable talking about private information, and to feel safe and confident that what we talk about stays between us.
- Your answers to these questions will remain part of your private care record and will not be shared with anyone without your permission.
- However, during your appointment, if you tell us anything that makes us think that you or anyone else may be at risk of serious harm, we may need to share that information.
- If your worker does need to share any information, they will try to make sure that you are aware of what information will be shared, and who it will be shared with.
- This helps you and others to be safe.

Adverse Childhood Experiences (ACE) Questionnaire

If you never experienced the things listed below, answer 'no'. If you experienced them once or twice or more frequently, please answer 'yes'.

While you were growing up, during your first 18 years		**Yes**	**No**
1	Did you live with a parent or other adult in the household who was depressed, mentally ill or suicidal?		
2	Did you live with a parent or other adult in the household who was a problem drinker or alcoholic?		
3	Did you live with a parent or other adult in the household who used illegal drugs or who misused prescription medications?		
4	Did you live with a parent or other adult in the household who served time in a prison or young offenders' institution?		
5	Were your parents ever separated or divorced?		
6	Did your parents or other adult in your home ever slap, hit, kick, punch or beat each other?		
7	Did a parent or other adult in the household swear at you, insult you, put you down, or humiliate you or act in a way that made you feel worthless or scared?		
8	Did a parent or other adult in the household push, grab, slap, or throw something at you or ever hit you so hard that you had marks or were injured?		
9	Did you go without enough food or drink, clean clothes, or a clean and warm place to live for long periods of time?		
10	Did an adult or other person touch you or make you touch their body in a sexual way or attempt or actually have oral, anal, or vaginal intercourse with you?		
11	Have you been asked to show or send images of a sexual nature, or been asked to behave in a sexual way in person or via social media (i.e. Facebook, Twitter, Instagram, Snapchat or other)?		
12	Have you ever done or were you ever forced, threatened or asked to do anything sexual (in person, online or via social media) in exchange for money, drugs , alcohol, gifts, affection, protection/safety, accommodation, employment, status (popularity), or anything else?		
13	Are there any other experiences from your life that you feel we should know about?		
14	While you were growing up, before the age of 18, was there an adult in your life who you could trust and talk to about any personal problems?		

7.4 Additional tables

Table A1: Training implementation

Session	Month	Number of delegates registered	Number of delegates attending	Services represented
Session 1	May	12	12	Drug and alcohol support service
Session 2	May	22	22	Drug and alcohol support service
Session 3	June	13	12	Drug and alcohol support service
Session 4	June	19	15	Drug and alcohol support service
Session 5	August	26	24	Domestic violence support service; probation
Session 6	August	28	24	Domestic violence and drug and alcohol support services; probation
Session 7	September	25	15	Domestic violence and drug and alcohol support services
Session 8	September	23	17	Domestic violence and drug and alcohol support services; probation
Session 9	September	24	22	Domestic violence and drug and alcohol support services
Session 10	September	29	22	Children's centres
Session 11	September	21	19	Children's centres
Session 12	September	23	22	Children's centres
Session 13	September	24	24	Children's centres
Session 14	October	15	15	Children's centres
Session 15	October	19	19	Nottinghamshire Police
Session 16	October	10	10	Domestic violence support service
Session 17	October	12	12	Domestic violence support service
Session 18	November	27	25	Children's centres
Session 19	November	24	23	Nottinghamshire County Council Youth Offending Team
Session 20	December	17	15	Probation
Session 21	December	16	12	Probation
Session 22	January	15	10	NHCTHCP
Session 23	January	15	13	NHCTHCP
Session 24	January	36	32	NHCTHCP
Session 25	January	26	28	NHCTHCP
Session 26	February*	13	20	NHCTHCP
Session 27	February	18	27	NHCTHCP
Total		552	511	

* Two sessions cancelled, covering 50 places. NHCTHCP (Nottinghamshire Healthcare Trust Healthy Child Programme [0-19years]).

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